DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

September 25, 2026

Trinity Wilson
Medicaid and CHIP Director
Washington State Health Care Authority
626 8th Avenue SE, P.O. Box 45502
Olympia, WA 98504

Dear Director Wilson:

The Centers for Medicare & Medicaid Services (CMS) is making a conforming change to Washington's "Medicaid Transformation Project 2.0" demonstration (Project Numbers 11-W-00304/0 and 21-W-00071/0) to align with recent changes to Medicaid and the Children's Health Insurance Program (CHIP) statutes, regulation, and policy. In this letter, CMS is also clarifying the applicability of these recent changes and related regulation and policy to the Medicaid Transformation Project 2.0 demonstration.

Public Law 119-21, which CMS refers to as the Working Families Tax Cut (WFTC) legislation, made changes to the Medicaid and CHIP provisions of the Social Security Act (the Act), including eligibility and financing changes. CMS has issued regulations and guidance implementing and interpreting many of the Medicaid and CHIP provisions of the WFTC legislation. Some of these statutory and related changes will affect this demonstration. Therefore, in this action, CMS is making a conforming change and clarifying the applicability of certain of these new requirements to the Medicaid Transformation Project 2.0 section 1115 demonstration during this demonstration period.

Specifically, in this action:

- We are changing the demonstration special terms and conditions (STCs) to conform with and clarify the applicability of sections 1903(v)(5) and 2107(e)(1)(R) of the Act (added and amended, respectively, by section 71109 of the WFTC legislation) and guidance related to those sections of the Act; these changes are effective October 1, 2026, through June 30, 2028.

Unless renewed or amended, all authorities granted to operate this demonstration will expire on June 30, 2028.

The conforming change to the STCs are authorized under STC 3.3, titled "Changes in Medicaid and CHIP Law, Regulation, and Policy," which provides that the state must, within the timeframes specified in federal law, regulation, or policy statement, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during the demonstration approval period. Under STC 3.3, CMS may amend the STCs to reflect such changes without requiring the state to submit an amendment. The clarifications are authorized

under STC 3.2, which specifies that all requirements of the Medicaid and CHIP programs, expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents, apply to the demonstration.

CMS has determined that this action for the Medicaid Transformation Project 2.0 demonstration is likely to assist in promoting the objectives of the Medicaid and CHIP statutes by aligning this section 1115 demonstration with new statutory requirements applicable to the Medicaid and CHIP programs and with how CMS has interpreted and implemented those requirements in regulations and guidance. The effective date of these actions is intended to align with the implementation timelines of this new statutory requirement.

This section 1115(a) demonstration action is subject to the limitations specified in Attachment Z below, which is appended to the demonstration's STCs, as changed and restated in our approval on June 18, 2025. Attachment Z makes a conforming change to the demonstration's STCs as further specified therein, and governs any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The changes in Attachment Z of this letter should be considered as part of the broader set of STCs that were approved on June 18, 2025, for the Medicaid Transformation Project 2.0 demonstration and will be incorporated into the full STCs at any future approval action for this demonstration.

Program Integrity

As part of this action, CMS would like to remind the state about program integrity obligations. States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid funds and must fully comply with all applicable Medicaid and CHIP laws and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in Title XIX and Title XXI of the Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity, including processes to identify, investigate, and refer suspected fraud and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid and CHIP services, including referrals to law enforcement, when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

Extent and Scope of Changes

Section 71109 – Alien Medicaid eligibility

Beginning October 1, 2026, sections 1903(v)(5) and 2107(e)(1)(R) of the Act, as added and amended, respectively, by section 71109 of the WFTC legislation, generally limit federal financial participation (FFP) for medical assistance (Medicaid) and child or pregnancy-related health assistance (CHIP), with limited exceptions, to U.S. citizens and U.S. nationals, lawful permanent residents (LPRs), Cuban/Haitian entrants, and Compact of Free Association (COFA) migrants.

Section 1903(v)(5) of the Act describes three exceptions to these FFP limitations: (1) care and services necessary for the treatment of an emergency medical condition as described in section 1903(v)(3) of the Act, (often referred to as "emergency Medicaid"), per section 1903(v)(2) of the Act; (2) full Medicaid and CHIP coverage provided to lawfully residing children and pregnant women under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) 214 option, per section 1903(v)(4) of the Act, applicable to CHIP through a cross reference at section 2107(e)(1)(Q) of the Act; and (3) Health Services Initiatives (HSIs), which are programs that are designed to improve the health of low-income children, authorized under section 2105(a)(1)(D)(ii) of the Act. Washington elected the CHIPRA 214 option for Medicaid coverage of lawfully residing children and pregnant women and CHIP coverage of lawfully residing children.

On April 8, 2026, CMS issued State Health Official (SHO) letter #26-001, which provides policy and operational guidance to states related to implementation of the changes made by section 71109 of the WFTC legislation.[1] On August 17, 2026, CMS issued a letter to Washington describing CMS's determination that continuing previously approved policies in section 1115 demonstrations that authorize federal matching funds for expenditures for services furnished to individuals who will be subject to the FFP limitations in sections 1903(v)(5) and 2107(e)(1)(R) of the Act would not be likely to promote the objectives of the Medicaid or CHIP statutes, as applicable and as modified by the WFTC legislation.[2] In this action, CMS is making a conforming change to align with and clarifying the applicability of sections 1903(v)(5) and 2107(e)(1)(R) of the Act to the STCs of the demonstration. This change and clarification, which are further described below, are expected to protect program integrity, ensure accurate eligibility determinations, and ensure proper claiming of FFP.

Aligning Designated State Health Programs authority with section 71109 changes

CMS has approved several demonstrations under the authority of section 1115(a) of the Act that provide federal matching funds for state expenditures for Designated State Health Programs (DSHP). On April 10, 2025, CMS sent a letter to states explaining that CMS does not anticipate approving new state proposals or renewing existing expenditure authority for section 1115

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/sho26001.pdf
[2] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/Washington_71109_Letter_08.17.26.pdf

demonstration expenditure authority for DSHP.[3] In this letter, CMS is clarifying that the time-limited authority in the Medicaid Transformation Project 2.0 demonstration for DSHP must align with new statutory limitations for FFP in section 1903(v)(5) of the Act that apply beginning October 1, 2026. This includes ensuring that DSHP expenditures are restricted to expenditures for individuals who are U.S. citizens and U.S. nationals, LPRs, Cuban/Haitian entrants, and COFA migrants, unless a limited exception applies, such as expenditures for lawfully residing children and pregnant women in accordance with the state's election of the CHIPRA 214 option as described in the state plan.

This letter is clarifying required compliance with the WFTC legislation and does not change current CMS guidance that section 1115 demonstration expenditure authority for DSHP in the Medicaid Transformation Project 2.0 demonstration is not expected to be extended beyond the currently approved demonstration period.

Aligning section 1115 expanded continuous eligibility authorities with section 71109 changes

CMS has approved several demonstrations under the authority of section 1115(a) of the Act that provide expenditure authority for expanded continuous eligibility. On July 17, 2025, CMS issued a Dear Colleague letter indicating that CMS does not anticipate approving new requests for expanded continuous eligibility or renewing existing section 1115 demonstration authority for expanded continuous eligibility, beyond what is required or available under the Medicaid and CHIP statutes, as applicable.[4] CMS has provided technical assistance to assist states as they begin upgrading eligibility systems, notifying beneficiaries, and conducting an orderly phase out of expanded continuous eligibility where it has been approved under section 1115 demonstration authority.

CMS clarified in SHO Letter #26-001 that states must apply the FFP limitations under section 1903(v)(5) of the Act for the following: 1) children in a continuous eligibility period under the state plan or section 1115 demonstrations under section 1902(e)(12) of the Act; 2) individuals covered during a period of continuous postpartum coverage under the state plan or section 1115 demonstrations under section 1902(e)(16) of the Act; and 3) individuals receiving authority for an expanded continuous eligibility period under the terms of a section 1115 demonstration. For Medicaid applicants and current Medicaid beneficiaries who are not U.S. citizens or U.S. nationals, LPRs, Cuban/Haitian entrants, or COFA migrants, and are not lawfully residing children or pregnant women eligible under the state's election of the CHIPRA 214 option, FFP remains available for emergency Medicaid coverage for such individuals in accordance with section 1903(v)(5) of the Act beginning October 1, 2026, and for the remainder of the expanded continuous eligibility period.

In this action, consistent with its August 17, 2026, letter to Washington, CMS is making a conforming change to reflect that populations receiving expanded continuous eligibility under section 1115(a)(2) expenditure authority in Washington's Medicaid Transformation Project 2.0 demonstration are subject to these new requirements beginning October 1, 2026. Specifically, CMS is adding subsection (a) to STC 5.1 and subsection (a) to STC 6.1 to affirm that the FFP

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[3] https://www.medicaid.gov/resources-for-states/downloads/dshp-dsip.pdf
[4] https://www.medicaid.gov/resources-for-states/downloads/contin-elig-ltr-to-states.pdf

limitations under sections 1903(v)(5) and 2107(e)(1)(R) of the Act are applicable to Washington's expanded continuous eligibility authorities in the Medicaid Transformation Project 2.0 demonstration.

Budget Neutrality

There are no changes to budget neutrality or allotment neutrality for this action.

Monitoring and Evaluation

The state is required to conduct systematic monitoring and evaluation in accordance with the demonstration STCs and to incorporate, as appropriate, the conforming change and clarification specified in this letter and attachment into these activities. Monitoring and evaluation should identify and describe any observed changes in metrics or outcome measures, including relevant context, as well as associated operational updates. In addition to other required content, these activities—including required deliverables and monitoring calls—should address any anticipated or actual challenges, risks, and program integrity considerations related to clarification of the applicability of the WFTC legislation and implementation of the conforming change and clarification in this letter and attachment.

Other Information

This action for the demonstration project is conditioned upon compliance with the previously approved waivers, expenditure authorities and STCs (as modified as stated in this letter) which set forth in detail the nature, character and extent of anticipated federal involvement in the project. In addition, this action is subject to CMS receiving written acceptance within 30 days of the date of this letter. Your project officer is Diona Kristian, who is available to answer any questions concerning your section 1115 demonstration. Ms. Kristian's contact information is as follows:

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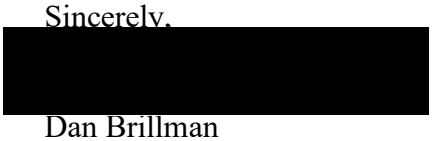
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Diona.Kristian@cms.hhs.gov

If you have questions regarding this action, please contact Sarah Aker, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at Sarah.Aker@cms.hhs.gov.

Sincerely,



Dan Brillman
Deputy Administrator, CMS
Director, Center for Medicaid and CHIP Services

Enclosure

cc: Edwin Walaszek, State Lead, Medicaid and CHIP Operations Group

Attachment Z
CONFORMING CHANGES TO SPECIAL TERMS AND CONDITIONS

This Attachment Z makes a conforming change to the STCs that were approved on June 30, 2023, and amended and restated on June 18, 2025, as follows. Language CMS is newly adding is in red text.

Edits to STC 5.1 (Children) and STC 6.1 (Postpartum Individuals): Aligning section 1115 expanded continuous eligibility authorities with section 71109 changes

STC 5.1(a): Expanded Continuous Eligibility for Noncitizens Ineligible for FFP. For current Medicaid beneficiaries in an expanded continuous eligibility period, beginning October 1, 2026, the state must apply the FFP limitations under section 1903(v)(5) of the Act. FFP is limited to payment for emergency Medicaid coverage during the remainder of the expanded continuous eligibility period for such Medicaid beneficiaries who are not U.S. citizens or nationals, Lawful Permanent Residents (LPRs), Cuban/Haitian entrants, or Compact of Free Association (COFA) migrants and are not eligible as a child or pregnant woman who is lawfully residing in the U.S. under the state's election of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) 214 option in accordance with section 1903(v)(4) of the Act.

STC 6.1(a): Expanded Continuous Eligibility for Noncitizens Ineligible for FFP. For current Medicaid beneficiaries in an expanded continuous eligibility period, beginning October 1, 2026, the state must apply the FFP limitations under section 1903(v)(5) of the Act. FFP is limited to payment for emergency Medicaid coverage during the remainder of the expanded continuous eligibility period for such Medicaid beneficiaries who are not U.S. citizens or nationals, Lawful Permanent Residents (LPRs), Cuban/Haitian entrants, or Compact of Free Association (COFA) migrants and are not eligible as a child or pregnant woman who is lawfully residing in the U.S. under the state's election of the CHIPRA 214 option in accordance with section 1903(v)(4) of the Act.

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

NUMBER: 11-W-00304/0 and 21-W-00071/0

TITLE: Washington State Medicaid Transformation Project 2.0

AWARDEE: Washington State Health Care Authority

Under the authority in Section 1115(a)(1) of the Social Security Act ("the Act"), the following waivers are granted to enable the State of Washington (referred to herein as the state or the State) to operate the Washington State Medicaid Transformation Project 2.0 Section 1115(a) Demonstration. These waivers are effective beginning July 1, 2023 and are limited to the extent necessary to achieve the objectives below. These waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in the accompanying document.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the Secretary of Health and Human Services has determined that the Washington State Medicaid Transformation Project Section 1115(a) Demonstration, including the granting of the waivers described below, is likely to assist in promoting the objectives of title XIX of the Act.

Except as provided below with respect to expenditure authority, all requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project for the period beginning July 1, 2023 through June 30, 2028.

None of these waivers apply to the Substance Use Disorder, Serious Mental Illness component of this demonstration (see Expenditure Authorities #9 and #10).

1. **Statewideness/Uniformity** **Section 1902(a)(1)**
42 CFR §431.50

To the extent necessary to enable the state to make delivery system reform incentive payments—based on a regional needs assessment–that vary regionally in amount and purpose.

2. **Reasonable promptness** **Section 1902(a)(8)**

To enable the state to limit the number of individuals receiving benefits through the Medicaid Alternative Care (MAC) or Tailored Support for Older Adults (TSOA) program.

To enable the state to limit the number of individuals who receive foundational community supports benefits under the demonstration.

3. **Freedom of Choice** **Section 1902(a)(23)(A)**

To the extent necessary to enable the state to restrict freedom of choice of provider for individuals receiving benefits through the Medicaid Alternative Care (MAC) or Tailored Support for Older Adults (TSOA) program.

To the extent necessary to enable the state to restrict freedom of choice of provider for individuals receiving foundational community supports benefits under the demonstration.

4. **Amount, Duration, Scope and Service** **Section 1902(a)(10)(B)**

To permit the state to provide benefits for the Tailored Supports for Older Adults (TSOA) expansion population that are not available in the standard Medicaid benefit package.

To permit the state to provide benefits not available in the standard Medicaid benefit package to individuals who have elected and enrolled to receive Medicaid Alternative Care (MAC) benefits.

To permit the state to provide benefits not available in the standard Medicaid benefit package to populations specified by Accountable Communities of Health (ACH).

To permit the state to offer a varying set of benefits to beneficiaries eligible for the Foundational Community Support program.

5. **Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release** **Section 1902(a)(84)(D)**

To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

Title XXI Waiver Authority

Coverage of Certain Screening, Diagnostic, Referral, and Case Management Services for Targeted Low-Income Children in the 30 Days Prior to Release **Section 2102(d)(2)**

To enable the state not to provide coverage of the screening, diagnostic, referral, and case management services identified in section 2102(d)(2) of the Act for a targeted low-income child as a state plan benefit in the 30 days prior to the release of such targeted low-income child from a public institution, to the extent and for the period that the state instead provides such coverage to such targeted low-income children under the approved expenditure authorities under this demonstration. The state will provide coverage to targeted low-income children in alignment

with section 2102(d)(2) of the Act at a level equal to or greater than would be required under the state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11-W-00304/0 and 21-W-00071/0

TITLE: Washington State Medicaid Transformation Project 2.0

AWARDEE: Washington State Health Care Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Washington State (referred to herein as the state) for the items identified below, which would not otherwise be included as expenditures under section 1903 and 2107(e)(2)(A) of the Act shall, for the period from July 1, 2023 through June 30, 2028, unless otherwise specified, be regarded as expenditures under the state's title XIX and title XXI plan.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the Secretary of Health and Human Services has determined that the Washington State Medicaid Transformation Project 2.0 Section 1115(a) Demonstration, including the granting of the expenditure authorities described below, is likely to assist in promoting the objectives of title XIX and title XXI of the Act.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable the state to operate the above-identified section 1115(a) demonstration.

1. **Delivery System Reform Incentive Payments to Accountable Communities of Health and Partnering Providers.** Expenditures for performance-based incentive payments to regionally based Accountable Communities of Health (ACH) and their partnering providers to address health systems and community capacity; financial sustainability through participation in value-based payment; Bi-directional integration of physical and behavioral health; community-based whole person care; improve health equity and reduce health disparities. The only expenditures permitted are incentive payments for prior periods of performance and administrative activities to close out the DSRIP program. This authority expires on June 30, 2024.

2. **Delivery System Reform Incentive Payments to Managed Care Organizations.** Expenditures for DSRIP payments to managed care organizations. The only expenditures permitted are incentive payments for prior periods of performance and administrative activities to close out the DSRIP program. This authority expires on June 30, 2024.

3. **Medicaid Alternative Care Unpaid Caregiver Supports.** Expenditures for costs to support unpaid caregivers serving individuals who are receiving MAC benefits.

4. **Medicaid Alternative Care Services for Eligible Individuals.** Expenditures for individuals aged 55 and older who are eligible for the standard Medicaid benefit package, meet the

functional eligibility criteria for HCBS under the state plan, but elect, instead, to receive MAC services specified in Section 8.

5. **Tailored Support for Older Adults Unpaid Caregiver Supports.** Expenditures for costs to support unpaid caregivers serving individuals who are receiving TSOA benefits.

6. **Tailored Support for Older Adults for Eligible Individuals.** Expenditures for services that are an alternative to long-term care services and supports for individuals aged 55 or older who are not otherwise eligible for CN or ABP Medicaid, meet functional eligibility criteria for HCBS under the state plan, and have income up to 400 percent of the supplemental security benefit rate established by section 1611(b)(1) of the Act.

7. **Presumptive eligibility for MAC and TSOA.** Expenditures for each individual presumptively determined to be eligible for MAC or TSOA services, during the presumptive eligibility period described in STC 8.11. In the event the state implements a waitlist, the authority for presumptive eligibility terminates.

8. **Foundational Community Supports.** Expenditures for home and community-based services (HCBS) and related services as described in Section 10.

9. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder.** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

10. **Residential and Inpatient Treatment for Individuals with Serious Mental Illness.** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment for a serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD).

11. **Continuous Eligibility for Children.** Expenditures for continued state plan benefits for individuals who have been determined eligible as specified in STC 5.2,who are not otherwise excluded under STC 5.4 for the applicable continuous eligibility period, and who would otherwise lose coverage during an eligibility redetermination, except as noted in STC 5.3.

12. **Continuous Eligibility for Postpartum Individuals.** Expenditures for full Medicaid state plan benefits for individuals with income up to 193 percent of the federal poverty level and meet all other Medicaid eligibility criteria who are determined eligible within the 12-month post-partum period who were not previously enrolled in Medicaid or CHIP during their pregnancy. The eligibility will continue from the end of the pregnancy through the 12th month of post-partum without regard to change in circumstance.

13. **Presumptive Eligibility for Home and Community-Based Supports.** Expenditures for each individual presumptively determined to be eligible for section 1915(c) COPES, section 1915(k) Community First Choice, or Medicaid Personal Care, during the presumptive eligibility period described in Section 9 of the STCs . Individuals found eligible for presumptive eligibility and

who receive services during the presumptive eligibility period will only be allowed one presumptive eligibility period in a 24-month period.

14. **Expenditures Related to Contingency Management.** Expenditures for Contingency Management services provided to qualifying beneficiaries in eligible provider settings that elect and are approved by Washington Health Care Authority (HCA) to pilot the Contingency Management benefit.

15. **Expenditures Related to Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid beneficiaries for up to 90 days immediately prior to the expected date of release from a participating state prison, county or city jail, youth correctional facility, or tribal jail.

16. **Expenditures for Pre-Release Administrative Costs**. Capped expenditures for payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure and interventions, which may not be recognized as medical assistance under Section 1905(a) or may not otherwise be reimbursable under Section 1903, to the extent such activities are authorized as part of the Pre-Release initiative.

17. **Health-Related Social Needs (HRSN) Services.** Expenditures for health-related social needs services not otherwise covered that are furnished to individuals who meet the qualifying criteria as described in Section 15 of the STCs. This expenditure authority is contingent upon adherence to the requirements within Section 16 of these STCs, as well as all other applicable STCs.

18. **Health-Related Social Needs Infrastructure**. Expenditures for payments for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payment, to the extent such activities are authorized under Section 15 of the STCs. This expenditure authority is contingent upon adherence to the requirements within Section 16 of the STCs, as well as all other applicable STCs.

19. **Former Foster Care Youth (FFCY) from another State.** Expenditures to extend eligibility for full Medicaid State Plan benefits to former foster care youth who are under age 26, who turned 18 on or before December 31, 2022, who were in foster care under the responsibility of another state or tribe upon attaining age 18 (or such higher age as the state has elected for termination of Federal foster care assistance under title IV-E of the Act), were enrolled in Medicaid on the date of aging out of foster care, and are now applying for Medicaid in Washington.

20. **Designated State Health Programs (DSHP).** Expenditures for designated programs, described in these STCs (Section 23), which are otherwise state-funded, and not otherwise eligible for Medicaid payment. These expenditures are subject to the terms and limitations and not to exceed specified amounts as set forth in these STCs. These expenditures are specifically contingent on compliance with STC 16, Provider Payment Rate Increase Requirement, as well as all other applicable STCs.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release Services:

21. **Statewideness** **Section 1902(a)(1)**

To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying beneficiaries on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

22. **Amount, Duration, and Scope of Services and Comparability** **Section 1902(a)(10)(B)**

To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying beneficiaries that is different than the services available to all other beneficiaries outside of carceral settings in the same eligibility groups authorized under the state plan or the demonstration.

23. **Freedom of Choice** **Section 1902(a)(23)(A)**

To enable the state to require qualifying beneficiaries to receive pre-release services, as authorized under this demonstration, through only certain providers.

Medicaid Requirements Not Applicable to the HRSN Medicaid Expenditure Authority:

24. **Statewideness** **Section 1902(a)(1)**

To the extent necessary to enable Washington to provide HRSN services or certain types of HRSN services, only in certain geographical areas of the state.

25. **Comparability: Amount, Duration, and Scope** **Section 1902(a)(10)(B), 1902(a)(17), 1902(a)(8)**

To the extent necessary to allow the state to offer HRSN services only to an individual who meets the qualifying criteria for HRSN services, including delivery system enrollment, as described in Section 15 of the STCs.

To the extent necessary to allow the state to delay the application review process for HRSN services in the even the state does not have sufficient funding to support providing these services to eligible beneficiaries.

Title XXI Expenditure Authority:

26. **Expenditures Related to Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying demonstration beneficiaries who would be eligible for the CHIP if not for their incarceration status, for up to 90 days immediately prior to the expected dated of release from a participating state prison, county or city jail, youth correctional facility, or tribal jail.

27. **Continuous Eligibility.** Expenditures for continued state plan benefits for individuals who have been determined eligible under groups specified in STC 5.2, who are not otherwise excluded under STC 5.4 for the applicable continuous eligibility period who would otherwise lose coverage during an eligibility redetermination, except as noted in STC 5.3.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00304/0 and 21-W-00071/0**

TITLE: **Washington State Medicaid Transformation Project 2.0 Section 1115(a) Demonstration**

AWARDEE: **Washington State Health Care Authority**

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the Washington State Medicaid Transformation Project (MTP) 2.0 section 1115(a) Medicaid and Children's Health Insurance Program (CHIP) demonstration (hereafter "MTP 2.0" or "demonstration") to enable Washington State (hereafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration, the state's obligations to CMS related to the demonstration. The STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs are effective as of July 1, 2023 through June 30, 2028, unless otherwise specified. All previously approved STCs are superseded by the STCs set forth below for the state's expenditures relating to dates of service during this demonstration extension, unless otherwise specified.

The STCs have been arranged into the following subject areas:

1	Preface
2	Program Description and Objectives
3	General Program Requirements
4	Populations Affected by the Demonstration
5	Continuous Eligibility for Children
6	Continuous Eligibility for Postpartum Individuals
7	Delivery System Reform Incentive Payment Program
8	Long Term Services and Supports
9	Presumptive Eligibility for Home and Community-Based Services
10	Foundational Community Supports
11	Substance Use Disorder Program and Benefits
12	Serious Mental Illness (SMI) Program and Benefits
13	Contingency Management
14	Reentry Demonstration Initiative

15	Health-Related Social Needs
16	Provider Payment Rate Increase Requirement
17	State Oversight of Medical Loss Ratios
18	General Financial Requirements
19	Monitoring Budget Neutrality
20	Monitoring and Reporting Requirements
21	Evaluation of the Demonstration
22	Schedule of State Deliverables for the Demonstration Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A	Developing the Evaluation Design
Attachment B	Preparing the Interim and Summative Evaluation Reports
Attachment C	DSRIP Planning Protocol
Attachment D	DSRIP Program Funding & Mechanics Protocol
Attachment E	Value-Based Roadmap
Attachment F	Financial Executor Role
Attachment G	Reserved
Attachment H	Tribal Engagement and Collaboration Protocol
Attachment I	Foundational Community Supports Protocol
Attachment J	Evaluation Design (Reserved)
Attachment K	SUD Implementation Plan
Attachment L	SUD Monitoring Protocol
Attachment M	Health IT Plan
Attachment N	SMI Implementation Plan
Attachment O	SMI Monitoring Protocol
Attachment P	Presumptive Eligibility for Home and Community Based-Services Definitions
Attachment Q	Contingency Management Protocol
Attachment R	Reentry Services Attachment
Attachment S	Reentry Demonstration Initiative Implementation Plan
Attachment T	Reentry Demonstration Initiative Reinvestment Plan
Attachment U	Protocol for HRSN Infrastructure and HRSN Services
Attachment V	Provider Rate Attestation Table
Attachment W	Monitoring Protocol
Attachment X	HRSN Implementation Plan
Attachment Y	Approved DSHP List

2. PROGRAM DESCRIPTION AND OBJECTIVES

In January 2017, the Federal government approved Washington's five-year MTP section 1115 demonstration. This demonstration enabled communities to improve the health system at the local level, including an emphasis on integrating physical and behavioral health services and value-based payment, through the Delivery System Reform Incentive Payment program. The demonstration offered new benefit packages to support individuals needing long-term services and supports and their caregivers. To address health-related social needs, the state offered supportive housing and supported employment to qualifying individuals. In addition, during this demonstration period the state implemented new initiatives to provide substance use disorder services and treatment for serious mental illness. The MTP demonstration was extended for one additional year in December 2021 and received an additional six-month temporary extension through June 30, 2023. In April 2023, the demonstration was amended to add continuous eligibility for children ages 0 through five.

Demonstration Objectives

In this demonstration extension approved for demonstration years 8 through 12, entitled "Medicaid Transformation Project 2.0," the state seeks to achieve the following objectives:

- **Expand coverage and access to care, ensuring that people can get the care they need.** Washington will expand coverage and access by implementing continuous coverage for children and postpartum individuals; providing a new set of services to incarcerated individuals to support successful reentry into their communities; and providing services for Medicaid enrollees receiving substance use disorder and mental health treatment services in institutions for mental disease (IMDs).

- **Advance whole-person primary, preventive, and home and community-based care.** Washington will support physical and behavioral health providers and expand crucial services beyond the clinical setting into communities by continuing to offer the Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA), which together provide enhanced benefits to individuals eligible for Medicaid but not currently receiving Medicaid-funded long-term services and supports (LTSS) and individuals "at risk" of future Medicaid LTSS use and who do not currently meet Medicaid financial eligibility criteria. Washington will also engage in new LTSS program innovations by extending presumptive eligibility to individuals applying for LTSS services.

- **Accelerate care delivery and payment innovation, focused on health-related social needs.** Washington will advance programs and policies that identify and address Apple Health enrollees' health-related social needs (HRSN). Through continuing Foundational Community Supports and implementing coverage of targeted HRSN services, Washington will support a suite of HRSN services and build essential capacity for community-based care coordination, service delivery, and payment.

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Patient Protection and Affordable Care Act.

3.2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is

required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

3.7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS in writing for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a complete amendment request as described in this STCs, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. **Extension of the Demonstration.** States that intend to request an extension must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 CFR 431.412(c) States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit phase-out plan consistent with the requirements of STC 3.9.

3.9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration, in whole or in part, consistent with the following requirements:

a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. **Transition and Phase-Out Plan Requirements.** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries , as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. **Transition and Phase-Out Plan Approval.** The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. **Transition and Phase-Out Procedures.** The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 35.916(f)(1). For individuals determined ineligible for Medicaid or CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214. In addition, the state must assure all

applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230.

e. **Exemption from Public Notice Procedures 42 CFR §431.416(g).** CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR §431.416(g).

f. **Enrollment Limitation during Demonstration Phase-Out.** If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. **CMS Right to Amend, Suspend, or Terminate.** CMS may amend, suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the amendment, suspension or termination, together with the effective date.

3.11. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

3.12. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.13. **Public Notice, Tribal Consultation and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR §431.408 prior to submitting an application to extend the demonstration. For applications to amend the

demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the SMDL #01-024, dated July 17, 2001, or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on demonstrations in accordance with 42 CFR §431.408(b)(2).

3.14. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.15. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.16. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(b)(5).

4. POPULATIONS AFFECTED BY THE DEMONSTRATION

4.1. **Eligibility Groups Affected by the Demonstration.** All individuals eligible under the Medicaid State Plan and certain individuals eligible under the CHIP State Plan are affected by the demonstration. Such individuals derive their eligibility through the Medicaid State Plan or CHIP State Plan and are subject to all applicable Medicaid or CHIP laws and regulations in accordance with the Medicaid State Plan or CHIP State Plan, except as expressly waived in this demonstration and described in these STCs. In addition, this demonstration extends eligibility to demonstration expansion populations. Specifically, this demonstration affects:

a. All individuals who are currently eligible under the state's Medicaid State Plan and certain individuals eligible under the CHIP State Plan as part of the reentry initiative;

b. Individuals eligible for Tailored Supports for Older Adults (TSOA) who are not otherwise eligible for CN or 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 400% of the supplemental security benefit rate established by section 1611(b)(1) of the Act;

c. Children aged 0 up to age 6 who would otherwise lose Medicaid or separate CHIP (S-CHIP) coverage during an eligibility determination but are still within the continuous eligibility period;

d. Individuals who are in the 12-month postpartum period, have income up to and including 193 percent of the FPL and meet all other Medicaid eligibility criteria, were not previously enrolled in Medicaid or CHIP during their pregnancy, who would otherwise lose coverage during an eligibility determination but are still within the continuous eligibility period; and

e. Individuals who would be eligible for CHIP if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a participating state prison, county or city jail, youth correctional facility, or tribal jail.

f. Out-of-state former foster care youth, who are defined as individuals under age 26 that meet the following criteria:

   i. were in foster care under the responsibility of a state other than Washington or a tribe in such other state when they turned age 18 (or such higher age as the state has elected for termination of Federal foster care assistance under title IV-E of the Act);

   ii. were enrolled in Medicaid at the time of aging out of foster care;

   iii. turned 18 on or before December 31, 2022;

   iv. are now applying for Medicaid in Washington; and

v. are not otherwise eligible for Medicaid.

Out-of-state former foster care youth will receive the same Medicaid State Plan benefits and be subject to the same cost-sharing requirements effectuated by the state for the mandatory Title IV-E foster care youth eligibility category enacted by the Adoption Assistance and Child Welfare Act of 1980 (Pub. L. 96-272).

5. CONTINUOUS ELIGIBILITY FOR CHILDREN

5.1. **Affected Individuals.** Except as provided in STC 5.3, individuals ages zero through the end of the month of their sixth birthday, who enroll in Medicaid or S-CHIP shall qualify for continuous eligibility until the end of the month in which their sixth birthday falls.

5.2. **Continuous Eligibility Period.** The state is authorized to provide continuous eligibility for children ages zero until the end of the month in which their sixth birthday falls, regardless of the delivery system through which these populations receive Medicaid or S-CHIP benefits.

a. This provision shall be effective beginning with Medicaid enrollments and renewals that are undertaken on or after the date when the continuous coverage requirement authorized by the Families First Coronavirus Response Act (FFCRA) ends. For CHIP, this provision is effective as of January 08, 2025.

b. Subject to the effective date, once effective, coverage shall be continuous for children ages 0 through 5 who qualify for continuous eligibility until the end of the month in which their 6th birthday falls. The child's continuous eligibility period begins on the effective date of the child's eligibility under 42 CFR 435.915 or 457.340(g), or the effective date of the most recent determination.

c. Because individuals are continuously eligible regardless of changes in circumstances, the state does not need to conduct renewals or redeterminations of eligibility consistent with 42 CFR 435.916 and 435.919 or 457.343 and 457.344 for individuals who qualify for continuous eligibility until the end of the individual's continuous eligibility period, except in the limited circumstances of a beneficiary meeting one of the exceptions outlined in STC 5.3.

d. At the end of the continuous eligibility period, Washington must conduct a renewal of Medicaid or S-CHIP eligibility and consider eligibility on all bases consistent with 42 CFR 435.916(d)(1) or 42 CFR 457.343 prior to terminating coverage. Individuals determined eligible on another basis at the end of the continuous eligibility period will be moved to the appropriate group at that time. Individuals determined eligible on another basis resulting in a reduction of Medicaid eligibility or services or increase in cost sharing or premiums will be provided advance notice of termination in accordance with 42 CR 435.917 and 42 CFR 431, Subpart E. Individuals determined ineligible for Medicaid or S-CHIP on all bases will be provided advance notice of termination in accordance with 42 CR 435.917 and 42 CFR 431, Subpart E and 42 CFR 457.110 and

457.340 and assessed for potential eligibility for other insurance affordability programs in accordance with 42 CFR 435.916(d)(2).

5.3. **Exceptions.** Notwithstanding STC 5.2, if any of the following circumstances occur during an individual's designated continuous eligibility period, the individual's Medicaid or S-CHIP eligibility shall be redetermined or terminated:

a. The beneficiary attains the age limit of the continuous eligibility period or eligibility group (if applicable);

b. The beneficiary is no longer a Washington resident;

c. The beneficiary or their representative requests termination of eligibility;

d. The beneficiary dies;

e. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual; or

f. For S-CHIP, the child becomes eligible for Medicaid.

5.4. **Eligibility Exclusions.** The following children are excluded from receiving continuous eligibility:

a. Have only established Medicaid eligibility as medically needy (as set forth in section 1902(a)(10)(C) of the Act),

b. Have been determined presumptively eligible for Medicaid or separate CHIP but have not yet received an eligibility determination based on a regular application, or

c. Upon the adult and child's renewal are determined to only be eligible for Medicaid based on transitional medical assistance (as set forth in section 1925 of the Act)

5.5. **Beneficiary-Reported Information and Periodic Data Checks.**

a. The state must have procedures designed to ensure that beneficiaries can make timely and accurate reports of any change in circumstances that may affect their eligibility as outlined in STC 5.3 (such as a change in state residency) and are able to report other information relevant to the state's implementation or monitoring and evaluation of this demonstration, such as changes in income. The beneficiary must be able to report this information through any of the modes of submission available at application (online, in person, by telephone, or by mail).

b. For individuals who qualify for a continuous eligibility period that exceeds 12 months, the state must continue to attempt to verify residency at least once every 12 months. The state should follow its typical processes that it would otherwise use to verify continued residency at renewal if continuous eligibility was not available for these individuals.

c. Additionally, at least once every 12 months, the state must follow its typical processes to attempt to confirm the individual is not deceased, consistent with the data sources outlined in the state's verification plan(s) and/or confirmed by the household per 42 CFR 435.952(d) or 457.380. The state must redetermine eligibility if the state receives information that indicates a change in state residency or that the individual is deceased, verifying the change consistent with 42 CFR 435.919 or 457.344 and in accordance with 42 CFR 435.940 through 435.960 and the state's verification plan developed under 42 CFR 435.945(j) or 457.380.

d. Because individuals are receiving continuous eligibility beyond their eligibility period, the state does not need to complete the individual's annual renewal or act on changes in circumstances that would otherwise affect eligibility, except as detailed in STC 5.3, until the end of the individual's continuous eligibility period. Additionally, if the state obtains information about changes that may affect eligibility (e.g., change in income), they are not permitted to use the information related to the change to end the continuous eligibility period early and terminate coverage, unless the change relates to one or more of the exceptions detailed in STC 5.3.

e. The state is required to provide CMS a narrative update annually on the processes it conducted and a summary of its findings regarding the successes and challenges in conducting such verifications. This information shall be provided in the demonstration's Annual Monitoring Reports (see STC 20.8).

5.6. **Annual Updates to Beneficiary Information.** For all continuous eligibility periods longer than 12 months, the state must have procedures and processes in place to accept and update beneficiary contact information and must attempt to update beneficiary contact information on an annual basis, which may include examining data sources annually and partnering with coordinated care organizations to encourage beneficiaries to update their contact information. The state is reminded that updated contact information obtained from third-party sources with an in-state address is not an indication of a change affecting continuous eligibility. Contact information with an out-of-state or no forwarding address indicates a potential change in circumstance with respect to state residency, but without additional follow up by the state per 42 CFR 435.952(d) or 457.380(f), the receipt of this third-party data is not sufficient to make a definitive determination that beneficiaries no longer meet state residency requirements.

Each demonstration year, through the Annual Monitoring Reports (see STC 20.8), the state must submit to CMS a summary of activities and outcomes from these efforts to update beneficiary contact information on an annual basis.

5.7. **Annual Reminders of Continued Eligibility.** The state must have procedures and processes in place to provide individuals who qualify for a continuous eligibility period that exceeds 12 months an annual reminder of continued eligibility. The annual reminder of continued eligibility must:

a. Be written in plain language;

b. Be accessible to persons who are limited English proficient and individuals with disabilities, consistent with 42 CFR 435.905(b); and

c. If provided in electronic format, comply with requirements for electronic notices in 42 CFR 435.918.

The annual reminder of continued eligibility must, at a minimum, include:

a. An explanation of the individual's continuous eligibility, including the end date of the continuous eligibility period;

b. The circumstances under which the individual must report, and procedures for reporting, any changes that may affect the individual's eligibility;

c. Basic information on the level of benefits and services available as described at 42 CFR 435.917(b)(1)(iv); and

d. If the beneficiary's eligibility is based on having household income at or below the applicable MAGI standard, the content regarding non-MAGI eligibility described at 42 CFR 435.917(c).

5.8. **Cost Sharing within Continuous Eligibility.** Individuals receiving continuous eligibility enrolled in this demonstration may be subject to cost sharing responsibilities, such as monthly premiums and co-payments, to the extent allowable under title XIX and XXI requirements or as approved under current section 1115 demonstration authority. However, beneficiaries may not be disenrolled from this demonstration for failure to pay a premium during the individual's continuous eligibility period approved in the demonstration.

6. CONTINUOUS ELIGIBILITY FOR POSTPARTUM INDIVIDUALS

6.1. **Affected Individuals.** Except as provided in STC 6.3, individuals who are in the 12- month postpartum period, have income up to and including 193 percent of the FPL and meet all other Medicaid eligibility criteria, were not previously enrolled in Medicaid or CHIP during their pregnancy, and who enroll in Medicaid shall qualify for continuous eligibility until the end of the 12th month following the end of the pregnancy.

6.2. **Continuous Eligibility Period.** The state is authorized to provide continuous eligibility for postpartum individuals described in STC 6.1, regardless of the delivery system through which these populations receive Medicaid benefits.

a. Subject to the effective date, once effective, coverage shall be continuous for postpartum individuals described in STC 6.1 who qualify for continuous eligibility until the end of the 12th month following the end of the pregnancy. The individual's continuous eligibility period begins on the effective date of the individual's eligibility under Expenditure Authority 12. The state will redetermine eligibility consistent with 42 CFR 435.916(f)(1) at the end of the continuous eligibility period. The state will continue to redetermine eligibility during a period of continuous eligibility in limited circumstances, if appropriate, as described in STC 6.3.

6.3. **Exceptions.** Notwithstanding STC 6.2, if any of the following circumstances occur during an individual's designated continuous eligibility period, the individual's Medicaid eligibility shall be redetermined or terminated:

a. The individual is no longer a Washington resident;

b. The individual requests termination of eligibility;

c. The individual dies; or

d. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual.

6.4. **Redetermination of Eligibility After the Postpartum Continuous Eligibility Period.** At the end of the postpartum continuous eligibility period, Washington will redetermine Medicaid eligibility on all bases consistent with 42 CFR 435.916(f)(1) prior to terminating coverage. Individuals determined eligible on another basis at the end of the postpartum period will be moved to the appropriate group at that time. Individuals determined ineligible for Medicaid on all bases will be provided advance notice of termination in accordance with 42 CFR 435.917 and 42 CFR 431, Subpart E and assess for potential eligibility for other insurance affordability in accordance with 42 CFR 435.916(f)(2).

6.5. **Benefits.** Individuals who are eligible for the 12-month continuous postpartum coverage described in STC 6.1 receive full state plan benefits during the continuous coverage period.

6.6. **Beneficiary-Reported Information and Periodic Data Checks.** The state must have procedures designed to ensure that beneficiaries can make timely and accurate reports of any change in circumstances that may affect their eligibility as outlined in this demonstration, such as a change in state residency, and are able to report other information relevant to the state's implementation or monitoring and evaluation of this demonstration, such as changes in income. The beneficiary must be able to report this information through any of the modes of submission available at application (online, in person, by telephone, or by mail).

7. DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM

The only expenditures permitted for DSRIP are incentive payments for prior periods of performance and administrative activities to close out the DSRIP program. Section 7 of these STCs is included only for the purpose of determining remaining payments to conclude the DSRIP program. DSRIP authority expires on June 30, 2024.

This demonstration authorizes Accountable Communities of Health (ACHs) to coordinate and oversee regional projects aimed at improving care for Medicaid beneficiaries with a focus on building health systems capacity, care delivery redesign, prevention, and health promotion, and preparing for value-based payments.

ACHs are self-governing organizations with multiple community representatives defined in STC 7.3, that address care in regions with non-overlapping boundaries that also align with Washington's regional service areas for Medicaid purchasing. They are focused on improving health and transforming care delivery for the populations that live within the region. ACHs are not new service delivery organizations, do not provide direct services, nor are they a replacement of managed care. ACHs must be headquartered in the region they serve and include in their governing bodies representatives of managed care organizations, health care providers, and other relevant organizations within the region (see STC 7.3). Managed care organizations (MCOs) will continue in their current roles, serving the majority of Medicaid enrollees in the provision and coordination of State Plan services and will be incentivized to implement value-based payment strategies.

ACHs, through their governing bodies, are responsible for managing and coordinating the partnering providers. The ACHs must meet the qualifications set forth in STCs 7.2-7.3 and must meet certain targets to earn incentive payments. In addition, they will certify whether or not the partnering providers have met the milestones as required for earning incentive payments within their region. The ACH will certify to the independent assessor (see STC 7.1) whether or not partnering providers have achieved the milestones. The independent assessor will review the ACH's certification and make recommendations to the state related to distribution of payment. Once the state affirms the recommendations from the independent assessor, the state will send them to the financial executor to distribute incentive payments to the partnering ACH providers.

Incentive payments for partnering providers and the ACHs will transition from pay-for-reporting to outcome-based over the course of the demonstration. The performance of this initiative will be measured at the statewide and regional ACH level, and incentive payments will be paid out accordingly. The maximum allowable expenditures available for total ACH incentive payments are enumerated in STC 7.25 below (see

Table 2). The state will allocate total funds across the ACHs based on a CMS-approved methodology to be submitted in the DSRIP Program Funding and Mechanics Protocol (Attachment D). Each regional ACH includes a coalition of partnering providers, and the ACH primary decision-making body will apply on behalf of partnering providers for such incentive payments as a single ACH.

7.1. **Role of Independent Assessor.** The state will contract with an independent assessor to review ACH project proposals using the state's review tool and consider anticipated project performance. The independent assessor has no affiliation with the ACHs or their partnering providers. The independent assessor shall make recommendations to the state regarding approvals, denials or recommended changes to project plans to make them approvable. This entity (or another entity identified by the state) will also assist with the mid-point assessment and any other ongoing reviews of ACH Project Plan.

a. **Review tool**. The state will develop a standardized review tool that the independent assessor will use to review ACH Project Plans and ensure compliance with these STCs and associated protocols. The review tool will be available for public comment according to the timeframe specified in the Program Funding and Mechanics Protocol (Attachment D). The review tool will define the relevant factors, assign weights to each factor, and include a scoring for each factor.

b. **Mid-point assessment.** During DY 3, the state's independent assessor shall assess project performance to determine whether ACH Project Plans merit continued funding and provide recommendations to the state. If the state decides to discontinue specific projects, the project funds may be made available for expanding successful project plans in DY 4 and DY 5, as described in the Program Funding and Mechanics Protocol (Attachment D).

7.2. **ACH Management.** Each ACH must identify a primary decision-making process, a process for conflict resolution and structure (e.g., a Board or Steering Committee) that is subject to the outlined composition and participation guidelines. The primary decision-making body will be the final decision-maker for the ACH regarding the selection of projects and participants based on the regional needs assessment. Each ACH and the state will collaborate and agree on each ACH's approach to its decision-making structure for purposes of this demonstration. The overall organizational structure established by the ACH must reflect capability to make decisions and be accountable for the following five domains, at a minimum. The ACH must demonstrate compliance with this STC in the ACH Project Plan.

a. *Financial*, including decisions about the allocation methodology, the roles and responsibilities of each partner organization, and budget development.

b. *Clinical*, including appropriate expertise and strategies for monitoring clinical outcomes. The ACH will be responsible for monitoring activities of providers participating in care delivery redesign projects and should incorporate clinical leadership, which reflects both large and small providers and urban and rural providers.

c. *Community*, including an emphasis on health equity and a process to engage the community and consumers.

d. *Data*, including the processes and resources to support data-driven decision making and formative evaluation.

e. *Program management and strategy development.* The ACH must have organizational capacity and administrative support for regional coordination and communication on behalf of the ACH.

7.3. **ACH Composition and Participation.** At a minimum, each ACH decision-making body must include voting partners from the following categories:

a. One or more primary care providers, including practices and facilities serving Medicaid beneficiaries;

b. One or more behavioral health providers, including practices and facilities serving Medicaid beneficiaries;

c. One or more health plans, including but not limited to Medicaid Managed Care Organizations; if only one opening is available for a health plan, it must be filled by a Medicaid Managed Care Organization;

d. One or more hospitals or health systems;

e. One or more local public health jurisdiction;

f. One or more representatives from the tribes, IHS facilities, and UIHPs in the region, as further specified in STC 7.6;

g. Multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in the region. This includes, but is not limited to, transportation, housing, employment services, education, criminal justice, financial assistance, consumers, consumer advocacy organizations, childcare, veteran services, community supports, legal assistance, etc.

The ACHs must create and execute a consumer engagement plan as part of the ACH Project Plan. The consumer engagement plan will detail the multiple levels of the decision-making process to ensure ACHs are accurately assessing local health needs, priorities and inequities. As part of the ACH Project Plan ACHs must provide documentation of at least two public meetings held for purposes of gathering public comment and must also provide details for how their submitted project plan incorporates feedback from the public comment process.

To ensure broad participation in the ACH and prevent one group of ACH partners from dominating decision-making, at least 50 percent of the primary decision-making body must be non-clinic, non-payer participants. In addition to balanced sectoral representation, where multiple counties exist within an ACH, a concerted effort to include a person from each county on the primary decision-making body must be demonstrated.

7.4. **American Indians/Alaska Natives (AI/AN) Managed Care Protections.** This section 1115 demonstration will not alter the statutory exemption of AI/ANs from requirements to enroll in managed care or alter the requirements for the state and managed care entities to come into

compliance with the Medicaid Managed Care Regulations published April 26, 2016, including the Indian-specific provisions at 42 CFR §438.14.

7.5. **Indian Health Care Providers.**

a. The state will assure compliance by the state itself and by any managed care or ACH contractor with the requirements of section 1911 of the Social Security Act and 25 U.S.C. § 1647a(a)(1), to accept an entity that is operated by IHS, an Indian tribe, tribal organization, or urban Indian health program as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program, if the entity attests that it meets generally applicable State or other requirements for participation as a provider of health care services under the program.

b. The state will assure compliance by the state itself and by any managed care or ACH contractor with the requirements of 25 U.S.C. § 1621t, to licensed health professionals employed by the IHCP shall be exempt from the Washington State licensure requirements if the professionals are licensed in another state and are performing the services described in the contract or compact of the Indian health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

7.6. **Tribal Engagement and Collaboration Protocol.** The state, with tribes, IHS facilities, and urban Indian Health Programs, must develop and submit to CMS for approval a Tribal Engagement and Collaboration Protocol (Attachment H) no later than 60 calendar days after demonstration approval date. Once approved by CMS, this document will be incorporated as Attachment H of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved expenditure and waiver authorities and STCs.

ACHs will be required to adopt either the State's Model ACH Tribal Collaboration or Communication Policy or a policy agreed upon in writing by the ACH and every tribe and Indian Health Care Provider (IHCP) in the ACH's region. The model policy establishes minimum requirements and protocols for the ACH to collaborate and communicate in a timely and equitable manner with tribes and Indian healthcare providers.

In addition to adopting the Model ACH Tribal Collaboration and Communication Policy, ACH governing boards must make reasonable efforts to receive ongoing training on the Indian health care delivery system with a focus on their local tribes and IHCPs and on the needs of both tribal and urban Indian populations.

Further specifications for engagement and collaboration in Medicaid transformation between (a) tribes, IHS facilities, and urban Indian health programs and (b) ACHs and the state, will be described by the Tribal Engagement and Collaboration Protocol (Attachment H). At a minimum, the Tribal Engagement and Collaboration Protocol must include the elements listed below:

a. Outline the objectives that the state and tribes seek to achieve tribal-specific interests in Medicaid transformation; and

b. Specify the process, timeline and funding mechanics for any tribal-specific activities that will be included as part of this demonstration, including the potential for financing the tribal-specific activities through alternative sources of non-federal share.

7.7. **Tribal-Specific Projects.** Consistent with the government-to-government relationship between the tribes and the State, tribes, IHCPs, or consortia of tribes and IHCPs can apply directly through the State to receive funding for eligible tribal-specific projects. Tribes and IHCPs will not be required to apply for tribal-specific projects through ACHs or the TCE, and the TCE and ACHs will not participate in the approval process for tribal-specific projects.

a. Indian Health Care Provider Health Information Technology Infrastructure. The state will work with the tribes and IHCPs to develop a tribal-specific project, subject to CMS approval, that will enhance capacity to: (i) effectively coordinate care between IHCPs and non-IHCPs, (ii) support interoperability with relevant State data systems, and (iii) support tribal patient-centered medical home models (e.g., IHS IPC, NCQA PCMH, etc.).

b. Other Tribal-Specific Projects. The state will work with tribes on tribal-specific projects, subject to CMS approval, that align with the objectives of this demonstration, including requirements that projects reflect a priority for financial sustainability beyond the demonstration period.

c. The Tribal Engagement and Collaboration Protocol (Attachment H) will provide further specifications for process, timeline and funding mechanics for any tribal-specific projects that will be included as part of this demonstration. To the extent applicable, the Tribal Engagement and Collaboration Protocol must align with project requirements set forth in these STCs.

7.8. **Financial Executor.** In order to assure consistent management of and accounting for the distribution of DSRIP funds across ACHs, the state shall select through a procurement process a single Financial Executor. The Financial Executor will be responsible for administering the funding distribution plan for the DSRIP that specifies in advance the methodology for distributing funding to providers partnering with the ACHs. The funding methodology will be described in the DSRIP Program Funding and Mechanics Protocol (Attachment D) and submitted to CMS for approval.

a. The Financial Executor will perform the following responsibilities: (a) provide accounting and banking management support for DSRIP incentive dollars; (b) distribute earned funds in a timely manner to participating providers in accordance with the state approved funding distribution plans; (c) submit scheduled reports to the state on the actual distribution of transformation project payments, fund balances and reconciliations; and (d) develop and distribute budget forms to participating providers for receipt of incentive funds (see

Attachment G).[1] Financial Executor performance will be subject to audit by the state.

b. The distribution of funds must comply with all applicable laws and regulations, including, but not limited to, the following federal fraud and abuse authorities: the anti-kickback statute (sections 1128B(b)(1) and (2) of the Act); the physician self-referral prohibition (section 1903(s) of the Act); the gainsharing civil monetary penalty (CMP) provisions (sections 1128A(b)(1) and (2) of the Act); and the beneficiary inducement CMP (section 1128A(a)(5) of the Act). State approval of an ACH funding distribution plan does not alter the responsibility of ACHs to comply with all federal fraud and abuse requirements of the Medicaid program.

7.9. **Attribution Based on Residence.** The state will use defined regional service areas, which do not have overlapping boundaries, to determine populations for each ACH. Determination will be made based on beneficiary residence. There is only one ACH per regional service area, as described in the DSRIP Program Funding and Mechanics Protocol (Attachment D).

7.10. **ACH Provider Agreements Under DSRIP.** In addition to the requirements specified in the DSRIP Program Funding and Mechanics Protocol (Attachment D), ACHs must establish a partnership agreement between the providers participating in projects.

7.11. **Project Objectives.** ACHs will design and implement projects that further the objectives, which are elaborated further in the DSRIP Planning Protocol (Attachment C).

a. *Health Systems and Community Capacity.* Creating appropriate health systems capacity in order to expand effective community-based treatment models; reduce unnecessary use of intensive services and settings without impairing health outcomes; and support prevention through screening, early intervention, and population health management initiatives.

b. *Financial Sustainability Through Participation in Value-based Payment.* Medicaid transformation efforts must contribute meaningfully to moving the state forward on value-based payment (VBP). Paying for value across the continuum of Medicaid services is necessary to assure the sustainability of the transformation projects undertaken through the Medicaid Transformation Demonstration. For this reason, ACHs will be required to design project plan activities that enable the success of Alternative Payment Models required by the state for Medicaid managed care plans (see Table 1 under STC 7.22 for the APM goals per DY).

c. *Bi-directional Integration of Physical and Behavioral Health.* Requiring comprehensive integration of physical and behavioral health services through new care models, consistent with the state's path to fully integrated managed care by January 2020. Projects may include: co-location of providers; adoption

[1] For a comprehensive description of the Financial Executor role, see Attachment G.

of evidence-based standards of integrated care; and use of team-based approaches to care delivery that address physical, behavioral and social barriers to improved outcomes for all populations with behavioral health needs. Along with directly promoting integration of care, the projects will promote infrastructure changes by supporting the IT capacity and protocols needed for integration of care, offering training to providers on how to adopt the required changes; and creating integrated care delivery protocols and models. The state will provide increased incentives for regions that commit to and implement fully integrated managed care prior to January 2020.

d. *Community-Based Whole-Person Care.* Use or enhance existing services in the community to promote care coordination across the continuum of health for beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health. In addition, develop linkages between providers of care coordination by utilizing a common platform that improves communication, standardizes use of evidence-based care coordination protocols across providers, and to promote accountable tracking of those beneficiaries being served. Projects will be designed and implemented to promote evidence-based practices that meet the needs of a region's identified high-risk, high-needs target populations.

e. *Improve Health Equity and Reduce Health Disparities.* Implement prevention and health promotion strategies for targeted populations to address health disparities and achieve health equity. Projects will require the full engagement of traditional and non-traditional providers, and project areas may include: chronic disease prevention, maternal and child health, and access to oral health services, and the promotion of strategies to address the opioid epidemic.

7.12. **Project Milestones.** Progress towards achieving the goals specified above will be assessed based on achievement of specific milestones and measured by specific metrics that are further defined in the DSRIP Planning Protocol (Attachment C). These milestones are to be developed by the state in consultation with stakeholders and members of the public and approved by CMS. Generally, progress milestones will be organized into the following categories:

a. *Project planning progress milestones.* This includes plans for investments in technology, tools, stakeholder engagement, and human resources that will allow ACHs to build capacity to serve target populations and pursue ACH project goals in accordance with community-based priorities. Performance will be measured by a common set of process milestones that include project development plans, consistency with statewide goals and metrics, and demonstrated engagement from relevant providers who commit to participate in project plan activities.

b. *Project implementation progress milestones.* This includes milestones that demonstrate progress towards process-based improvements, as established by the state, in the implementation of projects consistent with the demonstration's objectives of building health and community systems capacity; promoting care delivery redesign through bi-directional integration of care and care

coordination; and fostering health equity through prevention and health promotion. Examples of progress milestones include: identify number of providers and practices implementing evidence-based and promising practices for integration; complete a plan for regional implementation of fully integrated managed care. In addition, performance will be monitored by project-level and system-wide outcome measures consistent with the objectives of the demonstration outlined in STC 7.11 and specific project area.

c. *Scale and sustain progress milestones*. This includes milestones that demonstrate project implementation progress, as established by the state, related to efforts to scale and sustain project activities in pursuit of the demonstration objectives. Performance will be monitored by project-level and system-wide outcome measures consistent with the objectives of the demonstration outlined in STC 7.11 and specific project areas. The state will identify a sub-set of project-level and system-wide measures that will transition to pay for performance. The identification of measures that transition and the timing of transition to pay for performance will be outlined in the DSRIP Planning Protocol (Attachment C).

7.13. **ACH Performance Indicators and Outcome Measures.** The state will choose performance indicators and outcome measures that are connected to the achievement of the goals identified in STC 7.11 and in the DSRIP Planning Protocol (Attachment C). The DSRIP performance indicators and outcome measures will comprise the list of reporting measures that the state will be required to report under each of the DSRIP projects.

a. The state and CMS will accept GPRA measures in lieu of comparable statewide common performance measures when such substitution will reduce duplicative reporting and avoid excessive administrative burdens on tribes and IHCPs.

7.14. **MCO Role in DSRIP.** Managed care organizations are expected to serve in leadership or supportive capacity in every ACH. This ensures that delivery system reform efforts funded under this demonstration are coordinated from the beginning across all necessary sectors – those providing payment, those delivering services and those providing critical, community-based supports. Managed care organizations have the following roles and responsibilities under this demonstration:

a. Continue to meet all contractual requirements for the provision and coordination of Medicaid state plan services, including utilization management, care coordination and any new requirements consistent with the Medicaid transformation demonstration.

b. Participate in the design and implementation of delivery system reform projects.

c. Actively provide leadership in every Accountable Community of Health where a MCO is providing services, whether through participation in governance or other supportive capacity.

d. Collaborate with provider networks to implement value-based payment models, aligned to the HCP-LAN framework and report on the status of those arrangements to the state when requested.

e. Ensure business approaches evolve to sustain new models of care delivery and population health management, during and beyond the six-year demonstration.

MCOs are expected to participate in delivery system reform efforts as a matter of business interest and contractual obligation to the state, and for this reason, do not receive incentive payments for participation in ACH-led transformation projects, with one exception. A portion of delivery system reform incentives is uniquely set aside to reward managed care plan attainment of value-based payment models, consistent with STC 7.23a. The incentive amounts are further defined in the DSRIP Planning Protocol (Attachment C), the DSRIP Program Funding and Mechanics Protocol (Attachment D) and the Roadmap (Attachment E).

7.15. **DSRIP Planning Protocol.** The state must develop and submit to CMS for approval a DSRIP Planning Protocol no later than 60 calendar days after the demonstration approval date. CMS has 60 calendar days to review and approve the protocol. Once approved by CMS, this document will be incorporated as Attachment C of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved expenditure authorities and STCs. Changes to the protocol will apply prospectively unless otherwise indicated in the protocols. The DSRIP Planning Protocol must:

a. Outline the global context, goals and outcomes that the state seeks to achieve through the combined implementation of individual projects by ACHs;

b. Detail the requirements of the ACH Project Plans, consistent with STC 7.17, which must include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance;

c. Specify a set of outcome measures that must be reported at the ACH level, regardless of the specific projects that they choose to undertake;

d. Include required baseline and ongoing data reporting, assessment protocols, and monitoring/evaluation criteria aligned with the evaluation design and the monitoring requirements in section 20 and 21 of the STCs.

e. Include a process that allows for potential ACH Project Plan modification (including possible reclamation, or redistribution, pending state and CMS approval) and an identification of circumstances under which a plan modification may be considered, which shall stipulate that the state or CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved.

f. When developing the DSRIP Planning Protocol, the state should consider ways to structure the different projects and demonstrate that it will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section 21 of the STCs. Participating ACHs

will use the same metrics for similar projects to enhance evaluation and learning experience between ACHs.

7.16. **DSRIP Program Funding and Mechanics Protocol.** The state must develop a DSRIP Program Funding and Mechanics Protocol to be submitted to CMS for approval no later than 60 days after the demonstration approval date. CMS has 60 days to review and approve the protocol. Once approved by CMS, this document will be incorporated as Attachment D of these STCs and, once incorporated, may be altered only with CMS approval, and only to the extent consistent with the approved expenditure authorities and STCs. Changes to the protocol will apply prospectively, unless otherwise indicated in the protocols. DSRIP payments for each ACH partnering provider are contingent on the partnering providers fully meeting project metrics defined in the approved ACH Project Plan. In order for providers to receive incentive funding relating to any metric, the ACH must submit all required reporting, as outlined in the DSRIP Program Funding and Mechanics Protocol (Attachment D). In addition, the DSRIP Program Funding and Mechanics Protocol must:

a. Describe and specify the role and function of a standardized ACH report to be submitted to the state on a quarterly basis that outlines a status update on the ACH Project Plan, as well as any data or reports that ACHs may be required to submit baseline information and substantiate progress. The state must develop a standardized reporting form for the ACHs to document their progress.

b. Specify an allocation formula across ACHs based on covered Medicaid lives per ACH, scale of project, type of project, level of impact on beneficiaries, number of providers, and other factors;

c. Specify parameters for an incentive payment formula to determine DSRIP incentive payments commensurate with the value, impact, and level of effort required, to be included in the ACH budget plan.

d. Specify that an ACH failure to fully meet a performance metric or non-compliance under its ACH Project Plan within the time frame specified will result in a forfeiture of the associated incentive payment.

e. Include a description of the state's process to develop an evaluation plan for DSRIP as a component of the draft evaluation design as required by STC 21.3.

f. Ensure that payment of funds allocated in an ACH Project Plan to outcome measures will be contingent on the ACH certifying and reporting DSRIP performance indicators to the state via the independent assessor and on the ACH meeting a target level of improvement in the DSRIP performance indicator relative to baseline. A portion of the funds allocated in DSRIP Year 3 and DSRIP Year 4, and a majority of funds allocated in DSRIP Year 5, must be contingent on meeting a target level of improvement. ACH partnering providers may not receive credit for metrics achieved prior to approval of their ACH Project Plans.

g. Require that, for DSRIP years 4 and 5, all incentive dollars are contingent upon the state achieving fully integrated managed care by January 2020 for physical and behavioral health services. The state will report on progress toward this outcome on its annual report.

h. Include criteria and methodology for project valuation, including a range of available incentive funding per project.

i. Include pre-project plan milestones for capacity-building incentive payments.

7.17. **ACH Project Plans.** ACHs must develop a Project Plan that is consistent with the transformation objectives of this demonstration and describes the steps the ACH will take to achieve those objectives. The plan must be based on the DSRIP Planning Protocol (Attachment C), and further developed by the ACH to be directly responsive to the needs and characteristics of the communities that it serves. In developing its ACH Project Plan, an ACH must solicit and incorporate community and consumer input to ensure it reflects the specific needs of its region. ACH Project Plans must be approved by the state and may be subject to additional review by CMS. In accordance with the schedule outlined in these STCs and the process described further in the DSRIP Program Funding and Mechanics Protocol (Attachment D), the state and the assigned independent assessor must review and approve ACH Project Plans in order to authorize DSRIP funding for DY 1 and DY 2 and must conduct ongoing reviews of ACH Project Plans as part of a mid-point assessment in order to authorize DSRIP funding for DY 3 – 5. The state is responsible for conducting these reviews for compliance with approved protocols. The independent assessor recommendations should be considered final and not subject to CMS review. The DSRIP Planning Protocol (Attachment C) will provide a structured format for ACHs to use in developing their ACH Project Plan submission for approval. At a minimum, it will include the elements listed below.

a. Each ACH Project Plan must identify the target populations, projects, and specific milestones for the proposed project, which must be chosen from the options described in the approved DSRIP Planning Protocol (Attachment C).

b. Goals of the ACH Project Plan should be aligned with each of the objectives as described in STC 7.11 of this section.

c. Milestones should be organized as described above in STCs 7.12-7.13 of this section reflecting the overall goals of the demonstration and subparts for each goal as necessary.

d. The ACH Project Plan must describe the needs being addressed and the proposed period of performance, beginning after January 9, 2017.

e. Based on the proposed period of performance, the ACH must describe its expected outcome for each of the projects chosen. ACHs must also describe why the ACH selected the project drawing on evidence for the potential for the interventions to achieve these changes.

f. The ACH Project Plan must include a description of the processes used by the ACH to engage and reach out to stakeholders including a plan for ongoing engagement with the public, based on the process described in the DSRIP Planning Protocol (Attachment C).

g. ACHs must demonstrate how the projects support sustainable delivery system transformation for the target populations. The projects must implement new, or significantly enhance existing, health care initiatives.

h. For each stated goal or objective of a project, there must be an associated outcome metric that must be reported in all years. The initial ACH Project Plan must include baseline data on all applicable quality improvement and outcome measures.

i. ACH Project Plans must include an ACH Budget Plan, which specifies the allocation of funding proposed for each metric and milestone. ACHs may not receive credit for metrics achieved prior to approval of their ACH Project Plans.

7.18. **Monitoring.** The independent assessor and the state will be actively involved in ongoing monitoring of ACH projects, including but not limited to the following activities.

a. **Review of milestone achievement.** At least two times per year, ACHs seeking payment for providers under the DSRIP program shall submit reports to the state demonstrating progress on each of their projects as measured by project-specific milestones and metrics achieved during the reporting period. The reports shall be submitted using the standardized reporting form approved by the state. Based on the reports, the Independent Assessor will calculate the incentive payments for the progress achieved according to the approved ACH Project Plan. The Independent Assessor's determination shall be considered final. The ACH shall have available for review by the state, upon request, all supporting data and back-up documentation. These reports will serve as the basis for authorizing incentive payments to providers for achievement of DSRIP milestones.

b. **Quarterly DSRIP Operational Protocol Report.** The state shall provide quarterly updates to CMS and the public on the operation of the DSRIP program. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration and whether there has been progress toward the goals of the demonstration. The reports will document key operational and other challenges, to what they attribute the challenges and how the challenges are being addressed, as well as key achievements and to what conditions and efforts they attribute the successes.

c. **Learning collaboratives.** With funding available through this demonstration, the state will support regular learning collaboratives, which will be a required activity for all ACHs.

d. **Additional progress milestones for at risk projects.** Based on the information contained in the ACH semi-annual report or other monitoring and evaluation

information collected, the state may identify particular projects as being "at risk" of not successfully completing its ACH project in a manner that will result in meaningful delivery system transformation. Projects that remain "at risk" are likely to be discontinued at the midpoint assessment.

e. **Annual discussion.** In addition to regular monitoring calls, the State shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned.

7.19. **Data.** The state shall make the necessary arrangements to assure that the data required from the ACHs and from other sources, are available as required by the CMS approved DSRIP Planning Protocol (Attachment C).

7.20. **Health IT.** The state will use Health Information Technology ("Health IT") to link services and core providers across the continuum of care to the greatest extent possible. The state is expected to achieve minimum standards in foundational areas of Health IT and to develop its own goals for the transformational areas of Health IT use. The state will discuss how it plans to meet the Health IT goals/milestones outlined below in the DSRIP Planning Protocol (see STC 7.15 and Attachment C). Through quarterly reporting, the state will further enumerate how it has, or intends to, meet the stated goals.

a. The state must have plans with achievable milestones for Health IT adoption or health information exchange for providers both eligible and ineligible for the Medicaid Electronic Health Records (EHR) Incentive Programs and execute upon that plan.

b. The state shall create a pathway, or a plan, for the exchange of clinical health information for Medicaid consumers statewide to support the demonstration's program objectives.

c. The state shall advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing state policies—and in all applicable state procurements (e.g. including managed care contracts).

i. Where there are opportunities at the state and provider level to leverage federal Medicaid funds that could use a standard referenced in 45 CFR §170, the state must adopt it.

ii. Where there are opportunities at the state and provider level to leverage federal Medicaid funds that could use a standard not already referenced in 45 CFR §170 but are included in the ISA, the state should attempt to use the federally-recognized ISA standards barring no other compelling state interest.

d. The state shall require the electronic exchange of clinical health information, utilizing the Consolidated Clinical Document Architecture (C-CDA), with all

members of the interdisciplinary care. The state will provide a Health IT strategy by April 1, 2017 that details existing HIT capabilities that support this goal, and develop a mutually-agreed upon timeframe between CMS and the state for any identified enhancements.

e. The state shall ensure a comprehensive Medicaid enterprise master patient index that supports the programmatic objectives of the demonstration. The state will provide a Health IT strategy by April 1, 2017 that details existing HIT capabilities that support this goal, and develop a mutually-agreed upon timeframe between CMS and the state for any identified enhancements.

f. The state shall ensure a comprehensive provider directory strategy that supports the programmatic objectives of the demonstration. The state will provide a Health IT strategy by April 1, 2017 that details existing HIT capabilities that support this goal, and develop a mutually-agreed upon timeframe between CMS and the state for any identified enhancements.

g. The state will pursue improved coordination and improved integration between Behavioral Health, Physical Health, Home and Community-Based Providers and community-level collaborators for Improved Care Coordination (as applicable) through the adoption of provider-level Health IT infrastructure and software—to facilitate and improve integration and coordination to support the programmatic objectives of the demonstration. The state will provide a Health IT strategy by April 1, 2017 that details existing HIT capabilities which support this goal, and develop a mutually-agreed upon timeframe between CMS and the state for any identified enhancements.

h. The State shall ensure a comprehensive Health IT-enabled quality measurement strategy that support the programmatic objectives of the demonstration. The state will provide a Health IT strategy by April 1, 2017 that details existing HIT capabilities which support this goal, and develop a mutually-agreed upon timeframe between CMS and the state for any identified enhancements.

7.21. **Value-Based Roadmap.** Recognizing that the DSRIP investments must be sustained through new payment methods, and that managed care plans will play a critical role in the long-term sustainability of this effort, the state must take steps to plan for and reflect the impact of DSRIP in managed care business approaches.

Within 60 days of STC approval, and subsequently, by October 1st of each demonstration year, the state must submit an updated Value-based Roadmap ("Roadmap") which establishes targets for VBP attainment, related incentives under DSRIP for MCOs and ACHs, a description of how managed care is transforming to support new models of care, and Medicaid MCO contract changes being made to align with the Medicaid Transformation Demonstration project. The state will also address the payment mechanism, including an implementation plan detailing when the state will submit any required documentation in order to meet payment timelines.

The Roadmap will be updated annually to ensure that best practices and lessons learned can be incorporated into the state's overall vision of delivery system reform. This Roadmap will describe what the state and its stakeholders consider the payment reforms required for a high quality and a financially sustainable Medicaid delivery system.

Recognizing the need to formulate this plan to align with the stages of DSRIP, this will be a multi-year plan. It will necessarily be flexible to properly reflect future DSRIP progress and accomplishments. Progress on the Roadmap will also be included in the quarterly DSRIP report.

The Roadmap shall address the following:

a. Targets for regional ACH and statewide MCO attainment of VBP Goals, per STC 7.22.

b. Approaches that MCOs and the state will use with providers to encourage practices consistent with DSRIP objectives and metrics and the VBP targets.

c. Use of DSRIP measures and objectives by the state in their contracting strategy approach for managed care plans.

d. MCO contract amendments to include any necessary reporting of DSRIP objectives and measures.

e. Alternative payment models deployed between MCOs and providers to reward performance consistent with DSRIP objectives and measures.

f. Measurement of MCOs based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans.

g. Evolution toward further alignment with MACRA and other advanced APMs.

7.22. **Models of Value-Based Payment.** The state has established VBP goals consistent with the HCP-LAN *Alternative Payment Models* (APM) Framework[2] and the Quality Payment Program (QPP) under MACRA, further defined in Table 1. The goals are in alignment with broader U.S. Department of Health and Human Services' (HHS) delivery system reform goals.

Under DSRIP, regional and managed care plan-level incentives will be established. Specifically, the state agrees to VBP target thresholds at or above which incentive payments can be earned by partnering ACH providers and MCOs. See Table 1. The state will ensure both improvement from baseline and attainment are taken into consideration in the development of the VBP incentive program. The thresholds will be further defined in the DSRIP planning protocol (Attachment C) and Roadmap (Attachment E).

[2] Available at https://hcp-lan.org/groups/apm-fpt/apm-framework/

Table 1. Percentage of Provider Payments in HCP-LAN APM Categories at or above which Incentives Are Provided to Providers and MCOs under DSRIP

VBP Goals (consistent with HCP-LAN Framework)*						
	DY1	**DY2**	**DY3**	**DY4**	**DY5**	**DY6**
HCP LAN Category 2C – 4B	30%	50%	75%	85%	85%	85%
Subset of goal above: HCP LAN Category 3A – 4B	-	10%	20%	30%	50%	50%
Payments in Advanced APMs			Yes/No	Yes/No	Yes/No	Yes/No

a. Starting in DY 1, VBP incentives will be based on the percentage of provider payments in categories 2C – 4B of the HCP-LAN Framework, with progressive targets throughout the demonstration.

b. By DY 2, the state will implement in its Roadmap (Attachment E) additional criteria that incentivizes ACH and MCO attainment of upside/downside provider risk arrangements (HCP-LAN categories 3A-4B). The incentive structure will be further defined in the DSRIP Planning Protocol (Attachment C) and Roadmap (Attachment E).

c. By DY 3, the additional targets (*) outlined in Table 1 above to be defined in the Roadmap, will incentivize implementation of MACRA Advanced APMs in provider contracts.

d. Beginning in DY 4, to be eligible for any region or plan-level incentives under the Roadmap, at least 30 percent of all provider payments must meet or exceed category 3A of the HCP-LAN framework with additional incentives provided for meeting categories 3B through 4B with the following elements:

   i. Shared upside and downside risk (where entities will be required to bear more than a nominal risk for monetary losses).

   ii. Payment tied to provider improvement and attainment of quality performance metrics from the Washington Statewide Common Measure set, using HCA Quality Improvement Model or similar tool.

   iii. Care transformation requirements consistent with ACH-led DSRIP activities, including appropriate recognition of state level best practice recommendations, such as the Bree Collaborative.[3]

[3] Bree Collaborative is a public-private consortium established in 2011 by the Washington State Legislature "to provide a mechanism through which public and private health care stakeholders can work together to improve

iv. Use of certified EHR technology and health information exchange services in support of VBP methods.

e. The state will submit annually, by no later than October 1 of each demonstration year, an updated Roadmap (Attachment E) to meet the specifications of this section and to ensure the roadmap aligns with evolving MACRA and other state-based payment models. All thresholds for VBP incentive payments exclude payments for services provided by or through Indian health care providers.

f. The Roadmap will describe how the state will validate and categorize value-based arrangements using a third-party validator.

g. Contractual obligations for MCOs are integral to this demonstration, including requirements that MCOs attain defined levels of value-based payment with their provider networks while achieving quality improvement across a core set of quality metrics to be included in the managed care contracts. A premium withhold has been established to incentivize improved quality performance, and that withhold will increase over the first five years of the demonstration. The withhold for DY 6 will be at or above the DY 5 level. These value-based purchasing targets and quality measures align to the DSRIP program structure and will change to adapt to future requirements and protocols developed throughout this demonstration.

7.23. **Challenge and Reinvestment Pools.** Under DSRIP, the state will set aside no more than 15 percent of annually available DSRIP funds to reward MCO and ACH partnering providers for provider-level attainment of VBP targets stipulated in STC 7.22. Two pools are created to facilitate incentive payments:

a. *Challenge Pool.* An annual budget, not to exceed 5 percent of total available DSRIP funding, is established as incentive payments for MCO attainment and progression toward VBP targets. In addition, if unearned incentives from the MCO premium withholds and DSRIP funding for MCO VBP attainment (see STC 7.23(g)) remain after the annual performance period, any remaining funds will be used for incentive payments for MCOs meeting exceptional standards of quality and patient experience, based on a subset of measures to be defined in the DSRIP planning protocol (Attachment C) and Roadmap (Attachment E).

b. *Reinvestment Pool*. An annual budget, not to exceed 10 percent of total available DSRIP funding, is established to reward ACH partnering providers (regional) attainment and progression toward VBP targets. To the extent unearned incentives remain after the annual performance period from ACH Projects or VBP unearned incentives, any remaining funds will be used for incentive

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quality, health outcomes, and cost effectiveness of care in Washington State." Annually, the Bree identifies up to three areas where there is substantial variation in practice patterns and/or high utilization trends that do not produce better care outcomes. Recommendations from the Bree are sent to the Health Care Authority to guide state purchasing for programs such as Medicaid and Public Employees Benefits Board (PEBB).

payments to the ACH for performance against a core subset of measures to be defined the DSRIP planning protocol (Attachment C) and Roadmap (Attachment E). These funds must be spent on demonstration objectives.

7.24. **Federal Financial Participation (FFP) for DSRIP.** The state may claim, as authorized expenditures under the demonstration, up to $994 million total computable for six years, performance-based incentive payments to ACH partnering providers or MCOs that support change in how care is provided to Medicaid beneficiaries through payment and delivery system reforms. DSRIP payments are an incentive for successfully meeting associated metrics and outcomes rather than payment of claims for the provision of medical care. For this reason, DSRIP payments shall not be considered patient care revenue for purposes of offsetting allowable uncompensated care costs under the DSRIP Funding and Mechanics Protocol under demonstration authority.

a. DSRIP payments are not direct reimbursement for expenditures or payments for services. DSRIP payments are intended to support and reward ACHs and their partnering providers for delivery system transformation efforts and are eligible for federal matching at the administrative rate and not as medical assistance. DSRIP payments are not considered patient care revenue, and shall not be offset against disproportionate share, MCO expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) or other allowable administrative expenses.

b. The state may not claim FFP for DSRIP until after CMS has approved the DSRIP Planning Protocol (Attachment C) and DSRIP Funding and Mechanics Protocol (Attachment D). Once approved, the state may receive FFP for expenditures beginning January 1, 2017.

c. The state may not claim FFP for DSRIP payments in each year for DSRIP Year 1 through DSRIP Year 6 until the state has concluded whether or not the ACHs, MCOs, and partnering providers have met the performance indicated for each payment. The state must inform CMS of the funding of all DSRIP payments through a quarterly payment report to be submitted to CMS within 60 days after the end of each quarter. ACH and MCO reports must contain sufficient data and documentation to allow the state and CMS to determine if the ACH, MCO, and partnering providers have fully met the specified metric or VBP goal, and ACHs and MCOs must have available for review by the state or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to approved DSRIP activities.

d. The non-federal share of payments to ACHs, MCOs, and partnering providers may be funded by state general revenue funds, intergovernmental transfers, designated state health programs, or any other allowable source of non-federal share consistent with federal law. The funding will flow to the participating providers according to the methodology specified in the DSRIP Funding and Mechanics Protocol.

e. The state must inform CMS of the funding of all DSRIP payments to providers through quarterly reports submitted to CMS within 60 calendar days after the end of each quarter, as required in STC 20.8. This report must identify the funding sources associated with each type of payment received by each provider.

DSRIP Funding. The amount of demonstration funds available for the DSRIP Program is shown in

7.25. **Table 2** below.

Table 2. DSRIP Funding and At-Risk Percentages

	DY1	DY2	DY3	DY4	DY5	DY6
	01/01/17 – 12/31/17	**01/01/18 – 12/31/18**	**01/01/19 – 12/31/19**	**01/01/20 – 12/31/20**	**01/01/21 – 12/31/21**	**01/01/22 – 12/31/22**
Maximum Allowable Funds*	$242,100,000	$240,600,000	$187,180,434	$151,510,022	$71,250,000	$101,679,588
Percent at Risk for Performance	0%	0%	5%	20%	20%	20%
Dollar Amount at Risk for Performance	N/A	N/A	$9,359,022	$0	$14,250,000	$20,335,918

**These amounts reflect actual spending in DY1 – DY5.*

Funding at Risk for VBP and Quality Improvement Goals under DSRIP. A share of total DSRIP funding will be at risk if the state fails to demonstrate progress toward meeting the demonstration's VBP goals as outlined in STC 7.22, Table 1 and quality measures to be defined in the DSRIP Planning Protocol (Attachment C). The percentage at risk will gradually increase from 0 percent in DY 1-2 to 5 percent in DY 3 and 20 percent in DY 5 and DY 6. The at risk for DY 4 is waived due to COVID-19 performance implications. The at-risk outcome measures will be developed by the state and included in the DSRIP Planning Protocol for approval by CMS. They must be statewide and measure progress toward the state's Medicaid transformation goals.

7.26. **Life Cycle of the Six-Year DSRIP Program.** Synopsis of anticipated activities planned for this demonstration and the corresponding flow of funds.

a. Demonstration Year 1- Planning and Design: In the first year of the demonstration, the state will undertake implementation activities, including the following:

i. *Submit the DSRIP Planning Protocol (Attachment C) and* DSRIP *Program Funding and Mechanics Protocol (Attachment D)*. Working closely with

stakeholders and CMS, the state will submit the two required protocols in accordance with STCs 7.15 and 7.16 by March 9, 2017.

ii. *Develop and oversee certification process for ACHs*. The state will develop a process for ACHs to be certified to lead Medicaid transformation projects. Certification will require, among other things, that the ACHs: (1) describe their governance plan and process to ensure compliance with principles outlined in the STCs; and (2) describe the stakeholder, tribal engagement, and public processes that will be used to solicit community input.

iii. *Develop and oversee project plan application process for ACHs*. The state will develop a project plan application in accordance with the approved DSRIP Planning Protocol (Attachment C) and the DSRIP Program Funding and Mechanics Protocol (Attachment D). The ACHs must complete the project plan applications within the timeframe determined by the state.

iv. *Review and approve project plans submitted by ACHs*. Once the ACHs submit project plans and they are reviewed by the independent assessor, the state will approve applications in accordance with the DSRIP Funding and Mechanics Protocol (Attachment D).

v. *Establish Statewide Resources to Support ACHs*. The demonstration will also support ACHs with statewide resources. Specifically, ACHs will be provided with technical assistance and the opportunity to participate in learning collaboratives that facilitate the sharing of best practices and lessons learned across ACHs. The statewide resources will be developed to coordinate with other ongoing and emerging delivery system reform efforts in the state.

b. Demonstration Years 2-4: Implementation, Performance Measurement and Outcomes:

i. In these years, the state will move the distribution of DSRIP payments to more outcome-based measures, making them available over time only to those ACH partnering providers that meet performance metrics.

c. Demonstration Years 5 and 6: Performance Measurement and Sustainability:

i. DSRIP investments that meet the demonstrations objectives will continue through value-based payment objectives, led by MCOs and supported by ACHs and the provider community.

8. LONG TERM SERVICES AND SUPPORTS

8.1. **Medicaid Alternative Care (MAC).** Currently eligible Medicaid beneficiaries who are eligible for, but have chosen not to receive, Medicaid-funded LTSS will be eligible for a new Medicaid Alternative Care (MAC) benefit package. These individuals *do not* constitute a new MEG. The demonstration allows them a benefits choice that will enable them to remain in their homes for a longer period. Eligibility criteria include:

a. Age 55 or older;

b. Eligible for Categorically Needy (CN) or Alternative Benefit Plan (ABP) services; and

c. Eligible to receive the LTSS Medicaid benefit currently available under optional State Plan 1915(k) or HCBS authorities—but have chosen to receive services under MAC instead.

The state will not apply post-eligibility treatment of income to the MAC population because they will not be receiving LTSS.

8.2. **MAC Benefits Package.** Administered by the state, or its delegate, the MAC benefit package will be offered through a person-centered planning process where services from one or more of the service categories in STC 8.2(a) through (d) are identified in a plan of care—up to a specified limit as defined in state rule—to individuals who are age 55 or older and eligible for CN or ABP coverage—and not currently receiving Medicaid-funded LTSS. Beneficiaries receiving MAC would also be eligible for Medicaid medical services but would not be eligible for other Medicaid optional state plan or 1915(c) LTSS benefits at the same time. MAC is an alternate benefit package that individuals may choose so they can remain in their home with care provided through their unpaid family caregiver. If an eligible individual chooses to access state plan or 1915(c) LTSS benefits, they would no longer be eligible to receive MAC services. With the exception of services authorized under presumptive eligibility, services offered under this benefit will not duplicate services covered under the state plan, Medicare or private insurance, or through other federal or state programs. The following are the MAC benefits with corresponding descriptions:

a. Caregiver Assistance Services. Services that take the place of those typically performed by the unpaid caregiver in support of unmet needs the care receiver has for assistance with activities of daily living (ADL) and instrumental ADL. Services include:

i. Housework/errands/yardwork,

ii. Transportation (in accordance with the participant's service plan),

iii. Respite (in home and out of home),

iv. Home delivered meals,

v. Home safety evaluation,

vi. Minor home modifications and repairs required to maintain a safe environment,

vii. Nurse delegation (in conjunction with in-home respite care, as needed),

viii. Pest Eradication,

ix. Specialized Deep Cleaning, and

x. Community Choice Guide services.

b. Training and Education. Services and supports to assist caregivers with gaining skills and knowledge to implement services and supports needed by the care receiver to remain at home or skills needed by the caregiver to remain in their role. Services include:

i. Support groups,

ii. Group training,

iii. Caregiver coping/skill building training,

iv. Consultation on supported decision making,

v. Caregiver training to meet the needs of the care receiver,

vi. Financial or legal consultation, and

vii. Health and wellness consultation.

c. Specialized Medical Equipment & Supplies. Goods and supplies needed by the care receiver. Goods and supplies include:

i. Supplies,

ii. Specialized Medical Equipment (includes durable medical equipment and adaptive equipment),

iii. Personal emergency response system, and

iv. Assistive Technology.

d. Health Maintenance & Therapy Supports. Clinical or therapeutic services that assist the care receiver to remain in their home or the caregiver to remain in their caregiving role and provide high quality care. Services are provided for the purpose of preventing further deterioration, improving or maintaining current level of functioning. Supports and services categorized here include those typically performed or provided by people with specialized skill, certification or licenses. Services include:

i. Adult day health,

ii. RDAD and EB exercise programs,

iii. Health Promotion and Wellness Services, and

iv. Counseling.

8.3. **Tailored Supports for Older Adults.** The demonstration also establishes a new eligibility expansion category for individuals who are "at risk" of becoming eligible for Medicaid in order to access LTSS. This "At Risk" or "Tailored Supports for Older Adults" (TSOA) eligibility group is comprised of individuals that could receive Medicaid State Plan benefits under 42 CFR §435.236 and §435.217. Under the Demonstration, these individuals may access a new LTSS benefit package that will preserve their quality of life while delaying their need (and the financial impoverishment) for full Medicaid benefits. The individuals must:

a. Be age 55 or older;

b. Be a U.S. citizen or in eligible immigration status;

c. Not be currently eligible for CN or ABP Medicaid;

d. Meet functional eligibility criteria for NFLOC as determined through an eligibility assessment; and

e. Have income up to 400% of the SSI Federal Benefit Rate.

i. To determine eligibility for TSOA services, the state will consider the income of the applicant, not their spouse/dependents, when determining if gross income is at or below the 400% SSI Federal Benefit Rate limit; and

ii. To determine income, Washington will use the Social Security Income (SSI)-related income methodologies currently in use for determining eligibility for Medicaid LTSS. No post-eligibility treatment of income will apply and eligibility will be determined using only the applicant's income.

iii. The individual's separate non-excluded resources are at or below the current monthly private nursing facility rate multiplied by six months or, for a married couple, that non-excluded resources (calculated as of the first point at which the individual is deemed to have the status of an "institutionalized spouse") are at or below a combination of the current monthly private nursing facility rate multiplied by six months plus the current state Community Spouse Resource Allowance, based on the individual's verified household resources.

1. To determine resources, the State will use the Social Security Income (SSI)-related resource rules currently in use for determining eligibility for Medicaid LTSS with the following exceptions:

2. Transfer of asset penalties do not apply.

3. Excess home equity provisions do not apply.

8.4. **TSOA Benefits Package.** Administered by the state or its delegate, the TSOA benefit package will be offered to individuals determined to be "at risk" for Medicaid (as described in the previous section) will be offered through a person-centered planning process where services from one or more of the service categories are identified in a plan of care up to a specified limit as defined in state rule. Individuals receiving TSOA services will not be eligible for CN or ABP Medicaid-funded medical services or other Medicaid-funded optional State Plan or 1915(c) LTSS benefits. Individuals who later become CN or ABP Medicaid-eligible will no longer be eligible for TSOA services. Individuals receiving MN Medicaid-funded medical services or are eligible for a Medicare Savings Program (MSP) are eligible for TSOA services. With the exception of services authorized under presumptive eligibility, services offered under this benefit will not duplicate services covered under the state plan, Medicare or private insurance, or through other federal or state programs. The following are the TSOA benefits with corresponding descriptions:

a. TSOA Benefits. The TSOA benefits include all the same benefits outlined in STC 8.2 (a)(i), (a)(viii), (a)(ix), (a)(x) and (b) through (d).

b. Personal Assistance Services. Supports involving the labor of another person to help demonstration participants carry out everyday activities they are unable to perform independently. Services may be provided in the person's home or to access community resources. Services include but are not limited to:

i. Personal Care,

ii. Nursing delegation,

iii. Adult day care,

iv. Transportation (in accordance with the participant's service plan),

v. Home delivered meals,

vi. Home safety evaluation, and

vii. Home modifications and repairs (associated with the home modifications) required to maintain a safe environment.

8.5. **Person Centered Planning.** The state agrees to use person-centered planning processes to identify participants', applicants' and unpaid caregivers' LTSS needs, the resources available to meet those needs, and to provide access to additional service and support options as needed. The state assures that it will use person centered planning tools that will be in compliance with the characteristics set forth in 42 CFR 441.301(c)(1)-(3).

8.6. **Self-Directed Supports.** The state agrees to provide resources to support participants or their proxies (e.g., a surrogate, parent or legal guardian/representative) in directing their own care when that care is provided by an individual provider. This support assures, but is not limited to, participants' compliance with laws pertaining to employer responsibilities and provision for back-up attendants as needs arise. The state agrees to assure that background checks on employees and their results are available to participants. State policies and guidelines will include, but not be limited to: criteria for who is eligible to self-direct, a fiscal

agent/intermediary, and training materials to assist participants with learning their roles and responsibilities as an 'employer' and to ensure that services are consistent with care plan needs and allocations.

a. Program enrollees will have full informed choice on the requirements and options to: self-direct services; have a qualified designated representative direct services on their behalf, or select traditional agency-based service delivery. State and provider staff will receive training on these options.

8.7. **Conflict of Interest.** The state agrees that the entity responsible for assisting the individual with development of the person-centered service plan may not be an LTSS service provider, unless that service planning entity is the only qualified and willing entity available to conduct the service. If a service planning entity is the only willing and qualified entity to conduct the service, the state must establish firewalls between the service provision and planning functions to ensure conflict of interest protections. The state assures that conflict of interest protections will be in compliance with the characteristics set forth in 42 CFR 441.301(c)(1)(v)(vi). The state also assures that the independent evaluation and determination of eligibility for LTSS is performed by an agent that is independent and qualified as defined in 42 CFR 441.730.

8.8. **Home and Community-Based Setting Requirements.** The state will assure compliance with the characteristics of home and community-based settings in accordance with 42 CFR 441.301(c)(4), for those services that could be authorized under sections 1915(c) and 1915(i).

8.9. **Quality Measures.** The state will develop a Quality Improvement System (QIS) that includes:

a. Performance measurement and reporting in accordance with the quality reporting and review standards outlined in *Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers* guidance issued March 12, 2014, and reporting timelines outlined in *Revised Interim Procedural Guidance* issued February 6, 2007.

Performance measures should address the following areas:

i. Identification of needs and goals, and access to services (Level of Care/Functional assessment and Person-Centered Plan of Care at least annually);

ii. Services are delivered in accordance with the Person-Centered Plan of Care

iii. Providers meet required qualifications;

iv. Settings meet the home and community-based setting requirements for those services that could be authorized under 1915(c) and 1915(i);

v. Number of substantiated incidents of neglect, exploitation or abuse and average time to resolution;

vi. The State Medicaid Agency (SMA) retains authority and responsibility for program operations and oversight; and

vii. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1115 participants by qualified providers.

b. Ongoing quarterly/annual reporting that includes:

i. Number of LTSS beneficiaries broken out by program (MAC and TSOA);

ii. Number of new MAC and TSOA person-centered service plans;

iii. Percent of MAC and TSOA level of care re-assessments annually; and

iv. Number of people self-directing services under employer authority.

8.10. **Critical Incident Reporting.** The state has a system as well as policies and procedures in place through which providers must identify, report and investigate critical incidents that occur within the delivery of MAC and TSOA. Provider contracts reflect the requirements of this system. The state also has a system as well as policies and procedures in place through which to detect, report, investigate, and remediate abuse, neglect, and exploitation. Providers and participants are educated about this system. Provider obligations include specific action steps that providers must take in the event of known or suspected abuse, neglect or exploitation.

8.11. **Presumptive Eligibility.** The state will provide the MAC and TSOA services outlined in STCs 8.2 and 8.4 to individuals during a presumptive eligibility (PE) period following a determination by the state or a qualified entity—on the basis of preliminary information—that the individual appears to meet functional and financial eligibility requirements, using simplified methodology prescribed by the state and approved by CMS. In the event the state implements a waitlist, the authority for presumptive eligibility terminates.

a. *Qualified entity* – Presumptive eligibility will be determined by both the state and state designated qualified entities. A qualified entity is an entity that:

i. Participates with the Department of Social and Health Services (DSHS) as an Area Agency on Aging (AAA), subcontractor of an AAA or as a state designated tribal entity to provide limited eligibility functions and other administrative functions as delegated in contract;

ii. Notifies the DSHS of its election to make presumptive eligibility determinations under this section, and agrees to make presumptive eligibility determinations consistent with State policies and procedures; and

iii. The state will include language specific to presumptive eligibility requirements to its existing contracts with qualified entities who shall conduct presumptive eligibility determinations.

b. *Qualified staff* – Presumptive eligibility shall be determined by staff of qualified entities who have met at least the following qualifications imposed by the state.

i. A College degree and at least two years of social service experience or an equivalent level of education plus relevant experience;

ii. Complete PE training prior to determining PE; and

iii. The state will provide CMS the initial training curriculum and PE determination form for review and approval prior to program implementation. Subsequent content changes will be submitted to CMS for review at the time the change is made.

c. *Quality Assurance and Monitoring* – The state will monitor both state staff and qualified entities for adherence to policies applicable to presumptive eligibility determinations through contract monitoring and quality assurance reviews.

i. Post implementation the state will conduct a targeted review of implementation to validate PE determinations are being made in accordance with established criteria; and

ii. As part of the state's Quality Improvement Strategy, a sample of PE determinations will be reviewed yearly to determine that PE was established appropriately.

d. *Presumptive Functional Eligibility* – The following information will be collected as part of the presumptive functional eligibility assessment to determine if the individual appears to meet nursing facility level of care as defined in state rule. Indicators include:

i. Does the individual need daily care provided or supervised by a registered nurse (RN) or licensed practical nurse (LPN); or

ii. Does the individual have an unmet or partially met for assistance with 3 or more qualifying ADLs; or

iii. Does the individual have a cognitive impairment and require supervision due to one or more of the following: Disorientation, memory impairment, impaired decision making, or wandering and a need for assistance with 1 or more qualifying ADLs; or

iv. Does the individual have an unmet or partially met need for assistance with 2 or more qualifying ADLs; and

v. Functional eligibility shall be confirmed by the State for ongoing program eligibility.

e. *Presumptive Financial Eligibility* – Presumptive financial eligibility will be determined by a financial screen, based on application attestation, to determine if the applicant meets the following requirements:

i. For TSOA:

1. State resident;

2. Social Security Number (SSN);[4]
3. The individual's separate non-excluded income is equal to or less than 400% of the SSI Federal Benefit Rate.
4. The individual's separate non-excluded resources are at or below the current monthly private nursing facility rate multiplied by six months or, for a married couple, that non-excluded resources (calculated as of the first point at which the individual is deemed to have the status of an "institutionalized spouse") are at or below a combination of the current monthly private nursing facility rate multiplied by six months plus the current state Community Spouse Resource Allowance, based on the individual's self-attested statement of their household resources.

ii. For MAC:

1. The state or qualified entity will confirm the individual is presumptively eligible in a categorically needy or alternative benefit plan program that offers healthcare coverage to the target population using the state's eligibility and enrollment data system.

f. *Period of Presumptive Eligibility* – Period of presumptive eligibility means a period that begins on the date on which a qualified entity determines that an applicant is presumptively eligible[5] and ends with the earlier of:

i. In the case of an individual on whose behalf a Medicaid or TSOA application has been filed, the day on which a decision is made on that application; or

ii. In the case of an individual on whose behalf a Medicaid or TSOA application has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made.

g. *Presumptive Eligibility Service Level* – As part of the presumptive eligibility determination the state shall assess the individual for both functional eligibility (NFLOC) and financial eligibility concurrently.

8.12. **Estate Recovery.** Participants in MAC and TSOA are exempted from Medicaid estate recovery requirements due to:

a. Scope of Medicaid estate recovery;

b. Limitation on access to Medicaid-funded state plan or demonstration HCBS for MAC participants;

[4] If an applicant does not have a SSN established it will not preclude the applicant from applying for TSOA or MAC, the state shall provide the individual with assistance applying for an SSN or getting the person's SSN.

[5] To receive services past the PE period, the state must have completed a full financial eligibility determination and/or a NFLOC assessment.

c. Services available to MAC participants are outside the scope of services generally defined by CMS as HCBS; and

d. TSOA is a non-Medicaid population.

8.13. **Wait List.** The state may institute a waitlist for those who are eligible for MAC or TSOA services but are unable to access the services because funding for services under the demonstration is not available. If the state determines expenditures for this program will exceed the expenditure authority within a given demonstration year, the state may impose a wait list. The state will implement the waitlist and ensure that no existing beneficiaries lose services as a result of the waitlist. In the event the state implements a waitlist, the authority for presumptive eligibility terminates.

9. PRESUMPTIVE ELIGIBILITY FOR HOME AND COMMUNITY-BASED SERVICES

9.1. **Presumptive Eligibility (PE) for Home and Community-Based Services (HCBS).** The demonstration also establishes PE for individuals in need of expedited access to HCBS under Medicaid state plan and 1915(c) waiver authorities and Medicaid medical coverage regardless of how individuals enter the LTSS system. The demonstration allows individuals to access specific benefits quickly, in the most appropriate and least restrictive setting, while full functional and/or financial eligibility are determined.

9.2. **Eligibility and Phase In.** Individuals who plan to enroll in Community First Choice, COPES and Medicaid Personal Care (MPC) who self-attest to meet functional and financial requirements will be deemed presumptive eligible until such time the PE period ends as defined in STC 9.6 below. The state will phase in presumptive eligibility in two stages and anticipates that each phase will be operationalized for several months before implementing the next phase. Progress on implementation of Phase 1 and 2 shall be included in quarterly monitoring reports described in STC 20.8. The state will phase in presumptive eligibility as follows:

a. Phase 1. The initial phase will include individuals discharging home from an acute care or community psychiatric hospital setting or diversion from these facilities who plan to enroll in Community First Choice, COPES, or MPC. In the initial phase, the state will provide the limited benefit package outlined in STC 9.8 during the PE period to these individuals.

b. Phase 2. The second phase will expand to include all individuals seeking HCBS services in their own home. The second phase will provide the limited benefit package outlined in STC 9.8 to any individual determined to meet HCBS PE eligibility criteria and wishing to receive state plan or 1915(c) waiver HCBS services in their own home.

9.3. **Qualified Entity.** Presumptive eligibility will be determined by both the state and state designated qualified entities. The state or qualified entity, on the basis of preliminary information and using a simplified methodology described in STC 9.4, STC 9.5 and Attachment P, will make a determination that the individual appears to meet functional and financial eligibility requirements. A qualified entity is an entity that Participates with the Department of Social and Health Services (DSHS) as an Area Agency on Aging (AAA), subcontractor of an AAA or as a state designated tribal entity to provide limited eligibility functions and other administrative functions as delegated in contract.

9.4. **Presumptive Functional Eligibility**. Individuals will self-attest to meeting functional eligibility to determine if the individual appears to meet nursing facility level of care (NFLOC) or MPC level of care as defined in state rule.

9.5. **Presumptive Financial Eligibility**. Individuals will self-attest to meeting financial eligibility requirements to determine if the applicant meets the eligibility requirements.

9.6. **Period of Presumptive Eligibility.** Period of presumptive eligibility means a period that begins on the date on which a qualified entity determines that an applicant is presumptively eligible[6] and ends:

a. In the case of an individual on whose behalf a Medicaid application has been filed, the day on which a decision is made on that application; or

b. In the case of an individual on whose behalf a Medicaid application has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made.

9.7. **Presumptive Eligibility Limits**. Applicants who are approved for presumptive eligibility and receive services during the PE period will only be allowed one PE period every twenty-four months.

9.8. **Benefits.** The following benefits will be provided to PE eligible individuals. PE eligible individuals will receive HCBS PE benefits through a person-centered planning process. Individuals cannot receive HCBS PE benefits while also receiving services under a 1915(c) or 1915(k) program. PE services are not duplicative of services covered under private insurance, Medicare, state plan Medicaid, or through other federal or state programs.

a. The following are the HCBS NFLOC PE benefits which include a subset of services available under the 1915(c) COPES waiver and the 1915(k) Community First Choice state plan option:

i. Personal care services, up to 103 hours per month, which are included in the Electronic Visit Verification (EVV) system implementation;

ii. Nurse delegation;

iii. Personal Emergency Response System (PERS);

iv. Home delivered meals, up to two meals per day;

v. Specialized medical equipment and supplies;

vi. Assistive/Adaptive technology and equipment;

vii. Community transition or sustainability services: goods and services which are nonrecurring set-up items and services to assist with expenses to move from an acute care hospital or diversion from a community psychiatric hospital stay to an in-home setting where the individual is directly responsible for his or her own living expenses and may include at least one of the following:

1. Security deposits that are required to lease an apartment or home;

[6] The state must have completed a full financial and functional eligibility determination for the individual to receive HCBS services in the state's Medicaid state plan and 1915(c) waiver programs after the end of the PE period.

2. Activities to assess need, arrange for, and obtain needed resources, including essential household furnishings;
3. Set-up fees or deposits for utility or services access, including telephone, electricity, heating, water, and garbage;
4. Services necessary for health and safety such as pest eradication, and one-time cleaning prior to occupancy; and
5. Moving expenses.

viii. Minor home accessibility modifications necessary for hospital discharge. Home accessibility modifications are limited to those adaptations or improvements to the home that are of direct medical or remedial benefit to the participant and are not of general utility. Adaptations that add to the total square footage of the home are also excluded from this benefit except when necessary to complete an adaptation;

ix. Community choice guide: Specialty services which provide assistance and support to ensure an individual's successful transition to the community and/or maintenance of independent living; and

x. Supportive Housing services, defined in WAC 182-559-150, means active search and promotion of access to, and choice of, safe and affordable housing that is appropriate to the client's age, culture, and needs. Housing must meet the home and community-based settings requirements.

b. The HCBS MPC PE benefits include personal care services up to 34 hours per month, which are included in the Electronic Visit Verification (EVV) system implementation.

9.9. **Post-eligibility Treatment of Income**. Participants in 1915(c) HCBS PE are subject to post-eligibility treatment of income (PETI) based on self-attested available income and allowable deductions, including a personal needs allowance (PNA) during the PE period. The cost of care applied during the PE period will not be retroactively adjusted when full eligibility is determined. An individual financially eligible for a CN or ABP program does not pay toward the cost of care in home. Once full functional and financial eligibility determinations are complete, an updated PETI will be applied the first of the month following that determination, if appropriate based on client's final eligibility determination.

9.10. **Estate Recovery**. Participants in HCBS PE are subject to Medicaid estate recovery requirements.

10. FOUNDATIONAL COMMUNITY SUPPORTS

10.1. **Foundational Community Supports Program.** Under this program, the state will provide a set of HCBS for eligible individuals.

10.2. **Foundational Community Supports Services 1.** One-time community transition services to individuals moving from institutional to community settings and those at imminent risk of institutional placement.

10.3. **Foundational Community Supports Eligibility 1.** Eligible individuals include those who would be eligible under a section 1915(c) waiver program who, but for the Foundational Community Supports Program, would be in an institutional placement. (For example, those at imminent risk of institutionalization include those individuals with a disabling condition who meet an institutional level of care.)

10.4. **Post Approval Protocol 1.** The post-approval protocol (Attachment I), which will be subject to CMS approval, will include the service definitions for the one-time transition services and payment methodologies.

10.5. **Foundational Community Supports Services 2.** HCBS that could be provided to the individual under a 1915(c) waiver or 1915(i) SPA.

10.6. **Foundational Community Supports Eligibility 2.** Eligibility for these services include individuals who could be eligible under a section 1915(c) waiver or 1915(i) SPA program.

10.7. **Post Approval Protocol 2.** The post-approval protocol (Attachment I), which will be subject to CMS approval, will include the content that would otherwise be documented in a 1915(c) waiver and/or 1915(i) SPA, and will include service definitions, payment methodologies, and the administrative approach.

10.8. **Submission of Post Approval Protocol.** The state will submit the protocol for services identified in STC 10.4 and STC 10.7 above to CMS for review within 60 days following demonstration approval, and will not provide services under the program until receiving CMS approval.

10.9. **Wait List.** The state may institute a waitlist for those who are eligible for the Foundational Community Supports Program but are unable to access the services because funding for services under the demonstration is not available. If the state determines expenditures for this program will exceed the expenditure authority within a given demonstration year, the state may impose a wait list. The state will implement the waitlist and ensure that no existing beneficiaries lose services as a result of the waitlist.

11. SUBSTANCE USE DISORDER PROGRAM AND BENEFITS

11.1. **Substance Use Disorder (SUD) Program Benefits.** Effective upon CMS's approval of the SUD Implementation Plan, the demonstration benefit package for Washington Medicaid beneficiaries will include SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD), which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Medicaid beneficiaries who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD services, that would otherwise be matchable if the beneficiary were not residing in an IMD once CMS approved the state's Implementation Plan. Washington will aim for a statewide average length of stay of 30 days or less in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in Section 20.6, to ensure short-term residential treatment stays.

Under this demonstration beneficiaries will have access to high quality, evidence-based OUD/SUD treatment services across a comprehensive continuum of care, ranging from residential and inpatient treatment to on-going chronic care for these conditions in cost-effective community-based settings.

11.2. **SUD Implementation Plan and Health IT Plan.**

a. The state must submit SUD Implementation Plan within ninety (90) calendar days after approval of the SUD program under this demonstration. The state may not claim FFP for services provided in IMDs to beneficiaries who are primarily receiving SUD treatment and withdrawal management services until CMS has approved the Implementation Plan. Once approved, the SUD Implementation Plan will be incorporated into the STCs, as Attachment K, and once incorporated, may be altered only with CMS approval. After approval of the Implementation Plan, FFP will be available prospectively, not retrospectively.

b. Failure to submit a SUD Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 20.2.

c. At a minimum, the SUD Implementation Plan must describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of the SUD component of this demonstration program:

i. *Access to Critical Levels of Care for OUD and other SUDs*: Coverage of OUD/SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; medication assisted treatment (medication as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state); intensive levels of care in residential and inpatient settings; and medically supervised withdrawal management, within 12-24 months of demonstration approval;

ii. *Use of Evidence-based SUD-specific Patient Placement Criteria*: Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other comparable assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of SUD program demonstration approval;

iii. *Patient Placement*: Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of SUD program demonstration approval;

iv. Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities: Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in Washington Administrative Code regulations: WAC 246-341.[7] The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of OUD/SUD program demonstration approval;

v. *Standards of Care:* Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval;

[7] http://apps.leg.wa.gov/wac/default.aspx?cite=388-877

vi. *Standards of Care*: Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval;

vii. *Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OUD*: An assessment of the availability of providers in the critical levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval;

viii. *Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD:* Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

ix. *Improved Care Coordination and Transitions between Levels of Care:* Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports, following stays in these facilities within 24 months of SUD program demonstration approval.

x. *SUD Health IT Plan:* Implementation of a Substance Use Disorder Health Information Technology Plan which describes technology that will support the aims of the demonstration. Further information which describes milestones and metrics are detailed in STC 11.2(d) and Attachment M.

d. **SUD Health Information Technology Plan ("Health IT Plan").** The SUD Health IT plan applies to all states where the Health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #17-003, states must submit to CMS the applicable Health IT Plan(s), to be included as a section(s) of the associated Implementation Plan(s) (see STC 11.2[a] and 11.2[c]), to develop infrastructure and capabilities consistent with the requirements outlined in each demonstration-type.

The Health IT Plan should describe how technology can support outcomes through care coordination; linkages to public health and prescription drug monitoring programs; establish data and reporting structure to monitor outcomes and support data driven interventions. Such technology should, per 42 CFR § 433.112(b), use open interfaces and exposed application programming interfaces and ensure alignment with, and incorporation of, industry standards adopted by the Office of the National Coordinator for Health IT in accordance with 42 CFR part 170, subpart B.

i. The state must include in its Monitoring Protocol (see STC 20.6) an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.

ii. The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Report (see STC 20.8).

iii. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

iv. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally recognized standards.

v. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally recognized ISA standards.

vi. Components of the Health IT Plan include:

1. The Health IT Plan must describe the state's alignment with Section 5042 of the SUPPORT Act requiring Medicaid providers to query a Qualified Prescription Drug Monitoring Program (PDMP).
2. The Health IT Plan must address how the state's Qualified PDMP will enhance ease of use for prescribers and other state and federal stakeholders. States should favor procurement strategies that incorporate qualified PDMP data into electronic health records as discrete data without added interface costs to Medicaid providers, leveraging existing federal investments in RX Check for Interstate data sharing.
3. The Health IT Plan will describe how technology will support substance use disorder prevention and treatment outcomes described by the demonstration.
4. In developing the Health IT Plan, states should use the following resources:

- States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).

- States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

- States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

- States should review the Office of the National Coordinator's Interoperability Standards Advisory (https://www.healthit.giv/isa/) for information on appropriate standards which may not be required per 45 CFR part 170, subpart B for enhanced funding, but still should be considered industry standards per 42 CFR §433.112(b)(12).

11.3. **SUD Evaluation.** The SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as described in Sections 20 (Monitoring and Reporting Requirements) and 21 (Evaluation of the Demonstration) of these STCs.

11.4. **Unallowable Expenditures Under the SUD Expenditure Authority**. In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

12. SERIOUS MENTAL ILLNESS (SMI) PROGRAM AND BENEFITS

12.1. **SMI Program Benefits.** Under this demonstration, beneficiaries will have access to the full range of otherwise covered Medicaid services, including SMI treatment services. These SMI services will range in intensity from short-term acute care in inpatient settings for SMI, to ongoing chronic care for such conditions in cost-effective community-based settings. The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve a statewide average length of stay of no more than 30 days for beneficiaries receiving treatment in an IMD treatment setting through this demonstration's SMI Program, to be monitored pursuant to the SMI Monitoring Plan as outlined in STCs 12.2 – 12.6 below.

12.2. **SMI Implementation Plan.**

a. The state must submit the SMI Implementation Plan within 90 calendar days after approval of the November 6, 2020, demonstration amendment for CMS review and comment. If applicable, the state must submit a revised SMI Implementation Plan within sixty (60) calendar days after receipt of CMS's comments. The state may not claim FFP for services provided to beneficiaries residing in IMDs primarily to receive treatment for SMI under expenditure authority #11 until CMS has approved the SMI implementation plan and the SMI financing plan described in STC 12.2(e). After approval of the required implementation plan and financing plan, FFP will be available prospectively, but not retrospectively.

b. Once approved, the SMI Implementation Plan will be incorporated into the STCs as Attachment N, and once incorporated, may be altered only with CMS approval. Failure to submit an SMI Implementation Plan, within 90 calendar days after approval of the demonstration, will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 20.2.

c. At a minimum, the SMI Implementation Plan must describe the strategic approach, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

i. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.

1. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition

of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.

2. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.
3. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating hospitals and residential treatment settings in which beneficiaries receiving coverage pursuant to the demonstration are residing meet applicable state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;
4. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;
5. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);
6. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-

site staff, telemedicine, and/or partnerships with local physical health providers).

ii. *Improving Care Coordination and Transitions to Community-Based Care.*

1. Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment);
2. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who have been experiencing or are likely to experience homelessness or who would be returning to unsuitable or unstable housing with community providers that coordinate housing services, where available;
3. Implementation of a requirement that psychiatric hospitals and residential treatment settings that are discharging beneficiaries who have received coverage pursuant to this demonstration have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary and the community-based provider to which the beneficiary was referred within 72 hours of discharge and to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider they were referred to;
4. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers); and
5. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

iii. *Increasing Access to Continuum of Care Including Crisis Stabilization Services.*

1. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability (the state must provide updates on how it has increased the availability of mental health services in every Annual Monitoring Report);
2. Commitment to implementation of the SMI/SED financing plan described in STC 12.2(e). The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI/SED program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 20.8;
3. Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible; and
4. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay.

iv. Earlier Identification and Engagement in Treatment and Increased Integration.

1. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment sooner, including through supported employment and supported education programs;
2. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers; and
3. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

d. **SMI/SED Health Information Technology (Health IT) Plan.** The Health IT plan is intended to apply only to those State Health IT functionalities impacting beneficiaries within this demonstration and providers directly funded by this demonstration. The state will provide CMS with an assurance that it has a 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. If the state is unable to provide such an assurance, it will submit to CMS a Health IT Plan, to be included as a section of the

applicable Implementation Plan (see STC 12.2[c]), to develop the infrastructure/capabilities of the state's health IT infrastructure.

i. The Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI/SED goals of the demonstration. The plan(s) will also be used to identify areas of health IT ecosystem improvement. The Plan must include implementation milestones and projected dates for achieving them (see Attachment N) and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.

ii. The state will include in its Monitoring Plans (see STC 20.6) an approach to monitoring its SMI/SED Health IT Plan which will include performance metrics to be approved in advance by CMS.

iii. The state will monitor progress, each DY, on the implementation of its SMI/SED Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Report (see STC 20.8).

iv. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SMI Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

v. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B "Standards and Implementation Specifications for HIT". If there is no relevant standard in 45 CFR 170 Subpart B, the state should review the Office of the National Coordinator for Health Information Technology's Interoperability Standards Advisory (https://www.healthit.gov/isa/) to locate other industry standards in the interest of efficient implementation of the state plan.

vi. Components of the Health IT Plan include:

    1. The Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of *SED/SMI* care delivery. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

    2. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals, 2) Electronic care

plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.

3. In developing the Health IT Plan, states should use the following resources:

   - States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" *(https://www.healthit.gov/playbook/health-information-exchange/)*.

   - States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

   - States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

e. **SMI Financing Plan.** As part of the SMI implementation plan referred to in STC 12.2(d), the state must submit, within 90 calendar days after approval of the demonstration, a financing plan for approval by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the implementation plan in Attachment N and once incorporated, may only be altered with CMS approval. Failure to submit an SMI Financing Plan within 90 days of approval of the demonstration will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI program under this demonstration. Components of the financing plan must include:

   i. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and

f. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings.

12.3. **Monitoring, Reporting, and Evaluation.** The SMI Evaluation will be subject to the same requirements as the overall demonstration evaluation, as described in Sections 20 (Monitoring

and Reporting Requirements) and 21 (Evaluation of the Demonstration) of these STCs. The state will follow CMS guidelines to ensure the evaluation design is amended to provide a rigorous evaluation of the SMI component of the demonstration.

12.4. **Maintenance of Effort (MOE).** The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI/SED program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 20.8.

12.5. **Availability of FFP for the SMI Services Under Expenditure Authority #10**. Federal Financial Participation is only available for services provided to beneficiaries who are residing in an IMD when the beneficiary is a short-term resident in the IMD primarily to receive treatment for mental illness. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the state shows at its Mid-Point Assessment that it is meeting the requirement of a 30-day average length of stay (ALOS) for beneficiaries residing in an IMD who are receiving covered services under the demonstration. Demonstration services furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the Mid-Point Assessment, the state may only claim FFP services furnished to beneficiaries during IMD for stays of up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days or 45 days, as relevant.

12.6. **Unallowable Expenditures Under the SMI IMD Expenditure Authority.** In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

b. Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.

c. Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

13. CONTINGENCY MANAGEMENT

13.1. Contingency Management Overview

a. Beginning no earlier than July 1, 2023, HCA will implement a new contingency management benefit for eligible Apple Health beneficiaries with a substance use disorder in eligible provider settings that elect and are approved by HCA to pilot the benefit. The pilots will allow Washington to evaluate and assess the effectiveness of a contingency management benefit before determining whether it should be available statewide.

b. Under the pilot, the contingency management benefit will be available in participating providers, that opt and are approved by HCA to provide this benefit, to qualified beneficiaries who meet the eligibility requirements described below.

13.2. **Eligibility**. To qualify for the contingency management benefit, an Apple Health beneficiary (not including TSOA) must meet the following conditions:

a. Be assessed and determined to have a substance use disorder for which the contingency management benefit is medically necessary and appropriate based on the fidelity of treatment to the evidence-based intervention. The presence of additional substance use disorders and/or diagnoses does not disqualify an individual from receiving the contingency management benefit;

b. Not be enrolled in another contingency management program for substance use disorder;

c. Receive services from an eligible provider that offers the contingency management benefit in accordance with HCA policies and procedures; and

d. Contingency management should not be used instead of medication for the treatment of opioid use disorder, but can be used in combination with medication. For substance use disorders with FDA-approved medication treatments, medication should always be an option along with contingency management, and these approaches may be used together. Medication treatment should be prioritized for OUD and AUD.

13.3. **Service Description**.

a. The contingency management benefit consists of a series of motivational incentives for meeting treatment goals. The motivational incentives may consist of cash equivalents, e.g., gift cards of low retail value, with restrictions placed on the incentives so they are not used to purchase weapons, cannabis, tobacco, alcohol, over-the-counter preparations containing possible intoxicants such as dextromethorphan, or pornographic material, or to participate in gambling (e.g., through the purchase of lottery tickets). The motivational incentives are consistent with evidence-based clinical research for treating a substance use

disorder and as described below. These motivational incentives are central to contingency management, based on the best available scientific evidence for treating a substance use disorder and not as an inducement to use other medical services.

b. The contingency management benefit utilizes an evidence-based approach that recognizes and reinforces individual positive behavior change consistent with substance non-use or treatment/medication adherence. The contingency management benefit provides motivational incentives for treatment/medication adherence or non-use of substances as evidenced by, for example, negative point of care drug tests.

c. Contingency management is offered along with other therapeutic interventions, as appropriate, such as cognitive behavioral therapy, that meet the definition of rehabilitative services as defined by 1905(a) of the Social Security Act and 42 CFR 440.130(d). The provision of the contingency management benefit is not conditioned on a beneficiary's engagement in other psychosocial services.

d. For purposes of this demonstration, these motivational incentives are considered a Medicaid-covered item or service and are used to reinforce objectively verified, recovery behaviors using a clinically appropriate contingency management protocol consistent with evidence-based research. Consequently, neither the Federal anti- kickback statute (42 U.S.C. § 1320a-7b(b), "AKS") nor the civil monetary penalty provision prohibiting inducements to beneficiaries (42 U.S.C. 1320a-7a(a)(5), "Beneficiary Inducements CMP") would be implicated.

e. The contingency management benefit consists of a set of modest motivational incentives available for beneficiaries that meet treatment goals. Under the benefit, a beneficiary will be limited in motivational incentives during the course of a contingency management treatment episode as detailed in in the Contingency Management Protocol in Attachment Q, which will be submitted to CMS for review and approval before the program can be implemented.

    i. To qualify for a contingency management motivational incentive, a beneficiary must demonstrate treatment/medication adherence or non-use of substances.

    ii. The size, nature and distribution of all contingency management motivational incentives shall be determined in strict accordance with HCA procedures and protocols, listed in Attachment Q. These procedures and protocols will be based on established clinical research for contingency management. The following guardrails shall ensure the integrity of the contingency management benefit and mitigate the risk of fraud, waste or abuse associated with the motivational incentive:

        1. Providers have no discretion to determine the size or distribution of motivational incentives which will be determined by HCA.

2. Motivational incentives will be managed through a software program that includes safeguards against fraud and abuse. These safeguards will be detailed in HCA guidance and listed in the Contingency Management Protocol Attachment Q.
3. To calculate and generate the motivational incentives in accordance with the schedule in Attachment Q, providers shall enter the evidence of the Apple Health beneficiary receiving the contingency management benefit into a software program.

13.4. **Eligible Contingency Management Providers**.

a. The contingency management benefit will be delivered by eligible providers that meet specified programmatic standards and agree to deliver the contingency management benefit in strict accordance with standardized procedures and protocols that will be detailed in HCA guidance and listed in the Contingency Management Protocol Attachment Q.

b. To be eligible to offer the contingency management benefit, a provider shall offer the benefit in strict accordance with HCA standards that will be outlined in HCA guidance included in Attachment Q and shall meet the following requirements:

   i. Must be enrolled in Apple Health, and certified to provide Apple Health services including without limitation primary care, behavioral health and substance use service providers;

   ii. Require the staff providing or overseeing the contingency management benefit to participate in contingency management-specific training developed and offered by HCA's designated contractor;

   iii. Undergo a readiness review by HCA and HCA's designated contractor to ensure that they are capable to offer the contingency management benefit in accordance with HCA standards that will be detailed in HCA guidance; and

   iv. Participate in ongoing training and technical assistance as requested or identified by HCA's designated contractor or HCA through ongoing monitoring to meet HCA standards.

   v. Shall comply with any billing and data reporting requirements established by HCA to support research, evaluation, and performance monitoring efforts, including but not limited to satisfactory claims submission, data and quality reporting, and survey participation.

c. The following practitioners delivering care at eligible providers can deliver the contingency management benefit through activities, such as administering point-of-care drug tests, informing beneficiaries of the results of the evidence/point of care drug test, entering the results into a software program, providing educational information, and distributing motivational incentives, as part of the contingency management benefit:

i. Licensed Practitioner of the Healing Arts (LPHAs);

ii. SUD counselors that are either certified or registered by an organization that is recognized by HCA and accredited with the National Commission for Certifying Agencies;

iii. Certified peer support specialists; and

iv. Other trained staff under supervision of an LPHA.

13.5. **Program Oversight.**

a. HCA shall monitor the ongoing performance, including fidelity of treatment to the evidence-based practice, of contingency management providers and identify and support providers requiring further training or technical assistance in accordance with HCA set standards, to be outlined in HCA guidance.

b. HCA will provide training, technical assistance and monitoring to providers throughout the implementation process. The training and technical assistance will be provided through a qualified contractor designated by HCA, and will include staff training, provider readiness reviews, and ongoing technical assistance during the first phase of the pilot.

13.6. **Pilot Evaluation.** In alignment with the MTP 2.0 demonstration evaluation requirements outlined in Section 21 of these STCs, HCA will conduct an evaluation of the effectiveness of the Contingency Management program to assess its overall effectiveness, including cost-effectiveness of these services, and its effects on beneficiary health and recovery outcomes. To the extent feasible, the state will conduct the evaluation to support assessment stratified by stimulant use disorder and other types of SUD.

13.7. **Changes in Medicaid Policy on Contingency Management.** In accordance with STC 3.3, nothing in this demonstration absolves Washington from being subject to future guidance on contingency management and the state would otherwise need to come into compliance with such guidance.

14. REENTRY DEMONSTRATION INITIATIVE

14.1. **Overview of Pre-Release Services and Program Objectives.** This component of the demonstration will provide for pre-release services up to 90 days immediately prior to the expected date of release to qualifying Medicaid and CHIP beneficiaries and demonstration beneficiaries who would be eligible for CHIP except for their incarceration status, who are residing in state prisons, county and city jails, youth correctional facilities, or tribal jails, as specified by the implementation timeline in STC 14.8 and the implementation plan in STC 14.9. The objective of this component of the demonstration is to facilitate beneficiaries' access to certain healthcare services and case management, provided by Medicaid participating providers or CHIP participating providers, while beneficiaries are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to communities. This bridge to coverage begins prior to release and is expected to promote continuity of care and improve health outcomes for justice-involved individuals. Further, coverage beyond 30 days (for up to 90 days immediately before the expected date of release) is expected to provide a longer runway for enrollees to identify and begin to receive needed services, contribute to a reduction in post-release acute care utilization, and lead to a reduction in health crises, overdoses, and overdose-related deaths. The purpose of this reentry demonstration initiative is to provide short-term Medicaid and CHIP enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other SUD and behavioral health treatment, as appropriate for the individual, to reduce decompensation, suicide-related death, overdose, overdose-related death, and all-cause death in the near-term post-release.

During the demonstration, the state seeks to achieve the following goals:

a. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings prior to release;

b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release;

c. Improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers;

d. Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings, and in the community to maximize successful reentry post-release;

e. Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs;

f. Provide intervention for certain behavioral health conditions and use stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs, with the goal of reducing decompensation, suicide-related death, overdose, and overdose-related death in the near-term post-release; and

g. Reduce post-release acute care utilization such as emergency department visits, inpatient hospitalizations, and all-cause deaths among recently incarcerated Medicaid beneficiaries and individuals otherwise eligible for CHIP if not for their incarceration status through robust pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) as well as increased receipt of preventive and routine physical and behavioral health care.

14.2. **Qualifying Criteria for Pre-Release Services.** In order to qualify to receive services under this component of the demonstration, a beneficiary must meet the following qualifying criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a state prison, county or city jail, youth correctional facility, or tribal jail as defined in STC 14.4; and

b. Have been determined eligible for Medicaid or CHIP, or otherwise eligible for CHIP if not for their incarceration status.

c. Have an expected release date within 90 days.

14.3. **Scope of Pre-Release Services.** The pre-release services authorized under the reentry demonstration initiative include the following services, which are further described in Attachment R.

a. The pre-release services are:

i. Case management to assess and address physical and behavioral health needs, and HRSN;

ii. MAT for all types of SUD as clinically appropriate, with accompanying counseling;

iii. Physical and behavioral health clinical consultation services provided through telehealth or in-person, as needed, to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning;

iv. Medications and medication administration;

v. Services provided by community health workers with lived experience;

vi. Laboratory and radiology services; and

vii. A 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate) and durable medical equipment and supplies, provided to the beneficiary immediately upon release from the correctional facility, consistent with approved Medicaid or CHIP state plan coverage authority and policy.

b. The expenditure authority for pre-release services through this initiative comprises a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the reentry demonstration initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule, remain subject to the inmate exclusion rule. Accordingly, other benefits and services covered under the Washington Medicaid or CHIP State Plans, as relevant, that are not included in the above-described pre-release services (e.g., EPSDT treatment services) are not available to qualifying beneficiaries through the reentry demonstration initiative.

14.4. **Participating Facilities.** The pre-release services will be provided at state prisons, county or city jails, youth correctional facilities, and tribal jails, or outside of the correctional facility with appropriate transportation and security oversight provided by the carceral facility, subject to HCA approval of a facility's readiness, according to the schedule described in STC 14.8. States must be mindful of and ensure the policies, procedures, and processes developed to support implementation of these provisions do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems. Correctional facilities that are also institutions for mental diseases (IMDs) are not allowed to participate in the reentry demonstration initiative.

14.5. **Participating Providers.**

a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under Washington state scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws.

b. Participating providers eligible to deliver services under the reentry demonstration initiative may be either community-based or correctional-facility based providers.

c. All participating providers and provider staff, including carceral providers, shall have necessary experience and receive appropriate training, as applicable to a given carceral facility, prior to furnishing demonstration-covered pre-release services under the reentry demonstration initiative.

d. Participating providers of reentry case management services may be community-based or carceral providers who have expertise working with justice-involved individuals.

14.6. **Suspension of Coverage.** Upon entry of a Medicaid or CHIP enrolled beneficiary into a participating correctional facility, HCA must not terminate and generally shall suspend their Medicaid or CHIP coverage, as described in the Reentry Demonstration Initiative Implementation Plan.

a. If an individual is not enrolled in Medicaid or CHIP when entering a correctional facility, the state must ensure that such an individual receives assistance with completing an application for Medicaid and with submitting an application to the county departments of social services, unless the individual declines such assistance or wants to decline enrollment.

14.7. **Coverage of Individuals Otherwise Eligible for CHIP During Incarceration.** If an individual who is incarcerated would be eligible for CHIP if not for their incarceration status, and they qualify to receive pre-release services per STC 14.2, pre-release services will be covered under this demonstration's expenditure authority.

14.8. **Reentry Demonstration Initiative Implementation Timeline**. Delivery of pre-release services under this demonstration will be implemented as described below. All participating state prisons, county and city jails, youth correctional facilities, and tribal jails must demonstrate readiness, as specified below, prior to participating in this initiative (FFP will not be available in expenditures for services furnished to qualifying beneficiaries who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). The Health Care Authority will determine that each applicable facility is ready to participate in the reentry demonstration initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

a. Pre-release Medicaid and CHIP application and enrollment processes for individuals who are not enrolled in Medicaid or CHIP prior to incarceration and who do not otherwise become enrolled during incarceration;

b. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth. Washington will require participating facilities to select a Services Level for implementation. Service Level One is structured as the minimum benefit package for pre-release coverage: case management services to assess and address physical and behavioral health needs and HRSN; MAT services for all types of SUD as clinically appropriate, with accompanying counseling; and a 30-day supply of all prescription medications provided to the beneficiary immediately upon release from the correctional facility. The state may define additional Service Level categories in its Implementation Plan. A facility must implement all the services within its chosen Service Level. As applicable, additional service levels may be phased-in by facilities in any order, e.g., Service Level Two would not be a prerequisite for phasing-in Service Level Three;

c. A participating facility may move between Service Levels as it is able to stand-up additional benefits. Participating facilities plans for Service Level selection and movement should be captured in the state's implementation plan, including with a timeline for initial implementation and any shifting between Service Levels;

d. Coordination amongst partners with a role in furnishing health care and HRSN services to beneficiaries, including, but not limited to, social service departments, Accountable Communities of Health, managed care plans, county behavioral health agencies, county departments of health, and community-based providers;

e. Appropriate reentry planning, pre-release care management, and assistance with care transitions to the community, including connecting beneficiaries to physical and behavioral health providers and their managed care plan, and making referrals to care management and community supports providers that take place throughout the 90-day pre-release period, and providing beneficiaries with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate), consistent with approved Medicaid and CHIP state plan coverage authority and policy;

f. Operational approaches related to implementing certain Medicaid and CHIP requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the reentry demonstration initiative;

g. A data exchange process to support the care coordination and transition activities described in (d) and (e) of this subsection;

h. Reporting of requested data from HCA to support program monitoring, evaluation, and oversight; and

i. A staffing and project management approach for supporting all aspects of the facility's participation in the reentry demonstration initiative, including information on qualifications of the providers that the correctional facilities will partner with for the provision of pre-release services.

14.9. **Reentry Demonstration Initiative Implementation Plan.** The state is required to submit a Reentry Demonstration Initiative Implementation Plan to describe, at a minimum, the state's approach to implementing the reentry demonstration initiative, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The state must submit the draft Implementation Plan to CMS no later than 9 months after approval of the reentry demonstration initiative. The state must submit any required clarifications or revisions to their draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. The finalized Implementation Plan will be incorporated into the STCs as Attachment S.

In the Implementation Plan, the state is expected only to provide additional details regarding the implementation of the reentry demonstration initiative that are not already captured in the STCs (including any other attachments). CMS will provide the state with a template to support developing the Implementation Plan.

The Reentry Demonstration Initiative Implementation Plan must describe the implementation settings, the time period that pre-release services are available, and the state's Service Level approach to implementation, including facilities opting into each and identification of each. The Implementation Plan should further describe the state's approach for handling facilities who opt into a Service Level after the initial implementation of the demonstration has begun. Other than providing such contextual information, the core requirement of the Implementation Plan is for the state to describe the specific processes, including timelines and programmatic content where applicable, for meeting the below milestones, such as to remain on track to achieve the key goals and objectives of the program. For each milestone—and specifically for any associated actions that are integral aspects for attaining the milestone—the Implementation Plan must document the current state of affairs, the intended end state to meet the milestone, the date by which the milestone is expected to be achieved, and the activities that must be executed by that date for the milestone to be achieved. Furthermore, for each milestone, the Implementation Plan must identify the main anticipated implementation challenges and the state's specific plans to address these challenges. The Implementation Plan is also required to document the state's strategies to drive positive changes in health care quality for all beneficiaries, thereby reducing disparities and improving health equity. The state will be required to provide the following information related to, but not limited to, the following milestones and actions.

a. **Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated.** The state must describe its plans to fully effectuate, no later than two years from approval of the expenditure authority, a state policy to identify Medicaid and CHIP eligible individuals or individuals who would be eligible for CHIP, except for their incarceration status, and suspend a beneficiary's eligibility or benefits during incarceration. It must describe its processes to undertake robust outreach to ensure beneficiary and applicant awareness of the policy and assist individuals with Medicaid and CHIP application, enrollment, and renewal processes. Additionally, the state must describe how it will notify individuals of any Medicaid and CHIP eligibility determinations or actions. Other aspects to be included in the Implementation Plan related to this milestone include the state's plan to make available a Medicaid/CHIP and/or managed care plan identification number or card to an individual, as applicable, upon release; and establish processes to allow and assist all individuals who are incarcerated at a participating facility to access and complete a Medicaid/CHIP application, including providing information about where to complete the Medicaid/CHIP application for another state (e.g., relevant state Medicaid agency website) if the individual will be moving to a different state upon release.

b. **Milestone 2: Covering and ensuring access to the expected minimum set of pre-release services for individuals who are incarcerated, to improve care**

transitions upon return to the community. The state must describe its plan to implement a screening process to identify individuals who qualify for pre-release services, consistent with the qualifying criteria outlined in these STCs. The state must detail how the Medicaid agency and the carceral facilities will ensure that beneficiaries can access the pre-release benefit package, as clinically appropriate. The state must describe its approach and plans for implementing processes to assure that all pre-release service providers, as appropriate for the provider type, have the necessary experience and training, and case managers have knowledge of (or means to obtain information about) community-based providers in the communities where individuals will be returning upon release.

c. **Milestone 3: Promoting continuity of care**. The state must describe its process to ensure that beneficiaries receive a person-centered plan for coordination post-release to address health needs, including HRSN and LTSS, as applicable. The state must detail its plans and timeline for implementing state policies to provide or facilitate timely access to post-release medical supplies, equipment, medication, additional exams, or other post-release services to address the physical and behavioral health care needs identified during the case management assessment and the development of the person-centered care plan. The state must describe its processes for promoting and ensuring collaboration between case managers, providers of pre-release services, and providers of post-release services, to ensure that appropriate care coordination is taking place. As applicable, the state must also describe the planning or projected activities to ensure that Medicaid/CHIP managed care plan contracts include requirements and processes for transfer of relevant health information from the carceral facility, community-based providers, and/or state Medicaid agency to the managed care plan to support continuity and coordination of care post-release.

d. **Milestone 4: Connecting to services available post-release to meet the needs of the reentering population**. The state must describe how it will develop and implement a system to monitor the delivery of post-release services and ensure that such services are delivered within the appropriate timeframe. The Implementation Plan must also capture how the state will monitor and adjust, as needed, ongoing post-release case management and describe its process to help ensure the scheduling and receipt of needed services. The state must describe how it will connect demonstration beneficiaries to other services needed to address HRSN, LTSS and other social supports as identified in the development of the person-centered care plan. Additionally, the state must describe how it will ensure that case managers are able to effectively serve demonstration beneficiaries transitioning into the community and recently released beneficiaries who are no longer demonstration beneficiaries.

e. **Milestone 5: Ensuring cross-system collaboration**. The state must provide an assessment that outlines how the Medicaid agency and participating correctional systems will confirm they are ready to ensure the provision of pre-release services to eligible beneficiaries, including but not limited to how correctional facilities will facilitate access to incarcerated beneficiaries for community health

care providers, including case managers, either in person or via telehealth. The state must also document its plans for establishing communication, coordination, and engagement between corrections systems, community supervision entities, health care provider and provider organizations, the state Medicaid agency, and supported employment and supported housing organizations. The state must also develop a system (for example, a data exchange, with requisite data-sharing agreements) and establish processes to monitor individuals' health care needs, HRSN, and their access to and receipt of health care services pre- and post-release, and identify anticipated challenges and potential solutions. Further, the state must develop and share its strategies to improve awareness and education about Medicaid/CHIP coverage and health care access among stakeholders, including those who are incarcerated, community supervision agencies, corrections institutions, health care providers, and relevant community organizations (including community organizations serving the reentering population).

14.10. **Reentry Initiative Reinvestment Plan.** To the extent that the reentry demonstration initiative covers services that are the responsibility of and were previously provided or paid by the carceral facility or carceral authority with custody of qualifying beneficiaries, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services, as further defined in the Reentry Demonstration Initiative Reinvestment Plan. The Reinvestment Plan will define the amount of reinvestment required over the term of the demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required pursuant to this STC. FFP projected to be expended for new services covered under the reentry demonstration initiative, defined as services not previously provided or paid by the carceral facility or carceral authority with custody of qualifying beneficiaries prior to the individual facility's implementation of the reentry demonstration initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the reentry demonstration initiative, with respect to the relevant increase in expenditures, as described in the Reentry Demonstration Initiative Reinvestment Plan), is not required to be reinvested pursuant to this STC.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments include, but are not limited to:

i. The state share of funding associated with new services covered under the reentry demonstration initiative, as specified in this STC;

ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the HRSN of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

iii. Improved access to and/or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the reentry demonstration initiative opportunity;

iv. Improved health information technology and data sharing;

v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

vi. Expanded or enhanced community-based services and supports, including services and supports to meet the HRSN of the justice-involved population; and,

vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b. Within 9 months of approval, the state will submit a Reentry Demonstration Initiative Reinvestment Plan as part of the implementation plan referred to in STC 14.9 for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the demonstration period. Actual reinvestments will be reported to CMS in Attachment T.

14.11. **Reentry Demonstration Initiative Planning and Implementation.**

a. The Reentry Demonstration Initiative Planning and Implementation Program will provide expenditure authority to fund supports needed for Medicaid/CHIP pre-release application and suspension/unsuspension planning and purchase of certified electronic health record technology to support Medicaid/CHIP pre-release applications. Reentry demonstration initiative planning and implementation funds will provide funding over the course of the MTP 2.0 demonstration to support planning and IT investments that will enable implementation of the reentry demonstration initiative services covered in a period for up to 90 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning among HCA, carceral facilities participating in the reentry demonstration initiative (e.g., state prisons, county and city jails, youth correctional facilities, tribal jails), community-based providers, probation offices, community health workers, managed care plans, sheriff's offices, local county social services departments, and others. The specific use of this funding will be proposed by the Qualified Applicant submitting the application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the carceral facility) and must be properly cost-allocated to Medicaid

or CHIP, as necessary, and once finalized will be included in the Reentry Demonstration Initiative Implementation Plan at Attachment S within the STCs. These allowable expenditures may include the following:

i. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants which are to be used for assisting the reentry demonstration initiative population with Medicaid and CHIP application and enrollment for demonstration coverage (e.g., for inmates who would be eligible for CHIP but for their incarceration status) and coordinating pre-release and post-release services for enrollees. This includes the development of electronic interfaces for prisons, jails, youth correctional facilities, and tribal jails to communicate with Medicaid/CHIP IT systems to support Medicaid/CHIP enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with correctional facilities, local county social services departments, county behavioral health agencies, and others, such as managed care plans and community-based providers, in order to support the provision of pre-release services delivered in the period up to 90 days immediately prior to the expected date of release and reentry planning.

ii. **Hiring of Staff and Training.** Expenditures for Qualified Applicants to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination of Medicaid/CHIP enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 90 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

iii. **Adoption of Certified Electronic Health Record Technology**. Expenditures for providers' purchase or necessary upgrades of certified electronic health record (EHR) technology and training for the staff that will use the EHR.

iv. **Purchase of Billing Systems**. Expenditures for the purchase of billing systems for Qualified Applicants.

v. **Development of Protocols and Procedures**. Expenditures to support the specification of steps to be taken in preparation for and execution of the Medicaid/CHIP enrollment process and suspension/unsuspension process for eligible individuals and coordination of a period for up to 90 days immediately prior to the expected date of release and reentry planning services for individuals qualifying for reentry demonstration initiative services.

vi. **Additional Activities to Promote Collaboration.** Expenditures for additional activities that will advance collaboration among Washington's correctional institutions (county jails, youth correctional facilities, state

prisons, and tribal jails), correctional agencies (e.g., Washington Department of Corrections, Sheriff's Offices, Probation Offices, etc.), local county social services departments, county behavioral health agencies, managed care plans, community-based providers and others involved in supporting and planning for the reentry demonstration initiative. This may include conferences and meetings convened with the agencies, organizations, and stakeholders involved in the initiative.

vii. **Planning.** Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identifying uninsured who are potentially eligible for Medicaid/CHIP; (2) assisting with the completion of an application; (3) submitting an application to the county social services department or coordinating suspension/unsuspension; (4) screening for eligibility for pre-release services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering necessary services to eligible individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing on-going oversight and monitoring process upon implementation.

viii. **Other activities to support a milieu appropriate for provision of pre-release services.** Expenditures to provide a milieu appropriate for pre-release services in a period for up to 90 days immediately prior to the expected date of release, including accommodations for private space such as movable screen walls, desks, and chairs, to conduct assessments and interviews within correctional institutions, and support for installation of audio-visual equipment or other technology to support provision of pre-release services delivered via telehealth in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry. Expenditures may not include building, construction or refurbishment of correctional facilities.

b. The state may claim FFP in Reentry Demonstration Initiative Planning and Implementation Program expenditures for no more than the annual amounts outlined in Table 3. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 3. Annual Limits of Total Computable Expenditures for Reentry Demonstration Initiative Planning and Implementation Program

	DY8	DY9	DY10	DY11	DY12

Total Computable Expenditures	$0	$121,570,000	$106,373,750	$75,981,250	$0

c. Reentry Demonstration Initiative Planning and Implementation funding will receive the applicable administrative match for the expenditure.

14.12. **Qualified Applicants**. Qualified Applicants for the Reentry Demonstration Initiative Planning and Implementation Program will include correctional institutions (county or city jails, youth correctional facilities, tribal jails, and state prisons), the Washington Department of Corrections, other state agencies supporting carceral health, Probation Offices, Sheriff's Offices, county behavioral health agencies, county departments of social services, county departments of public health, community-based organizations, Accountable Communities of Health, managed care plans, and other entities as relevant to the needs of justice-involved individuals as approved by HCA.

15. HEALTH-RELATED SOCIAL NEEDS

Over the life of the Medicaid Transformation Project demonstration, Washington has taken steps to offer programs and services (e.g., Foundational Community Supports) that address health-related social needs (HRSN) for individuals meeting certain clinical and risk-based needs criteria. This section of the STCs establishes a framework for new HRSN services expenditure authority. Washington is authorized to use expenditure authority to provide the set of HRSN services listed in STC 15.2, subject to the restrictions described below and in Section 16.

This demonstration also authorizes Accountable Communities of Health (ACHs), as Community Hubs, to provide services described in STC 15.2(c) to eligible Apple Health enrollees; provide vital HRSN service administration support to the HRSN fee-for-service program; and build HRSN service capacity across the state (see STC 15.4).

ACHs are self-governing organizations that address care in regions with non-overlapping boundaries that also align with Washington's regional service areas for Medicaid purchasing. They are focused on improving health and transforming care delivery for the populations that live within the region. ACHs must be headquartered in the region they serve and include in their governing bodies representatives of managed care plans, health care providers, and other relevant organizations within the region.

Washington will couple this section 1115 demonstration authorization with a set of services offered via in lieu of services and settings (ILOSs) authority pursuant to 42 CFR 438.3(e)(2), which will be the primary authority for HRSN services offered through Washington's managed care plans. HRSN services authorized under the section 1115 demonstration will be provided through a combination of Apple Health's fee-for-service system and managed care system, with some services administered through community-based organizations, Foundational Community Supports and Community Hubs and the Native Hub.

15.1. **Health-Related Social Needs (HRSN) Services.** The state may claim FFP for expenditures for certain qualifying HRSN services identified in Attachment U and this STC, subject to the restrictions described below, including Section 16. Expenditures are limited to expenditures for items and services not otherwise covered under Title XIX, but consistent with Medicaid demonstration objectives that enable the state to continue to increase the efficiency and quality of care. HRSN services must be clinically appropriate for the beneficiary and based on medical appropriateness using clinical and other health related-social needs criteria. The state is required to align clinical and health-related social criteria across services and with other non-Medicaid social support agencies, to the extent possible. The HRSN services may not supplant any other available funding sources such as housing or nutrition supports available to the beneficiary through local, state, or federal programs. The HRSN services will be the choice of the beneficiary; a beneficiary can opt out of HRSN services anytime; and the HRSN services do not absolve the state or its managed care plans of their responsibilities to provide required coverage for other medically necessary services. Under no circumstances will the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on receipt of

HRSN services. The state must submit additional details on covered services as outlined in STC 15.7 (Service Delivery) and Attachment U.

15.2. **Allowable HRSN services**. The state may cover the following HRSN services:

a. Nutrition Supports:

i. Nutrition counseling and education, including healthy meal preparation;

ii. Medically tailored meals, up to 3 meals a day delivered in the home or private residence, for up to 6 months;

iii. Meals or pantry stocking for children under 21 and pregnant individuals, up to 3 meals a day delivered in the home or private residence, for up to 6 months;

iv. Fruit and vegetable prescriptions, for up to 6 months;

v. Short-term (no more than 30 days) grocery provision, for an LTSS eligible beneficiary experiencing a significant disruption in the ability to obtain an adequate level of nutrition that would avoid an unnecessary emergency department visit, hospital admission, or institutional placement;

1. Eligibility. The LTSS beneficiary eligible for this benefit has been identified by the state as being at-risk due to an acute behavioral or physical health episode or due to clinical factors is unable to procure groceries on an emergency basis.

2. Benefit Guidelines.

a. The grocery benefit may only be used on purchases consistent with Supplemental Nutrition Assistance Program (SNAP) guidelines;

b. The grocery benefit will be capped at 200% of the Maximum Monthly U.S. Department of Agriculture (USDA) SNAP Allowance; and

c. The benefit can be utilized no more than once per calendar year.

3. Transition. The state agrees it will work with the state SNAP agency and others to provide assistance to beneficiaries in enrolling with SNAP during the benefit period, where appropriate, and work with the beneficiary where appropriate to address lasting health or physical needs that lead to the disruption in nutrition.

b. Housing Supports, including:

i. Recuperative care and short-term post-hospitalization housing, as described in STC 15.3;

ii. Housing transition navigation services, including:

1. Housing transition navigation to assist enrollees with obtaining housing, such as tenant screening and assessment;

2. Housing tenancy and sustaining services to help enrollees maintain safe and stable tenancy once housing is secured, such as early mitigation to avoid risk of eviction or lease violations, education regarding lease agreement and responsibilities; and

3. Transition costs/housing deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to help a person establish a basic household (i.e., security deposit, first-month's rent, utilities activation fees, movers, relocation expenses, pest eradication, pantry stocking, and the purchase of household goods and furniture).

iii. Rent/temporary housing for up to 6 months, specifically for individuals transitioning out of institutional care or congregate settings such as nursing facilities, large group homes, congregate residential settings, Institutions for Mental Diseases (IMDs), correctional facilities, and acute care hospitals; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5; and youth transitioning out of the child welfare system including foster care;

1. Utility costs including activation expenses and back payments to secure utilities, limited to individuals receiving rent/temporary housing as described above.

iv. Community transition services to help individuals to live in the community and avoid further institutionalization:

1. Non-emergency, non-medical transportation; and

2. Personal care and homemaker services.

v. Stabilization centers, which are alternative destinations for individuals who are found to be publicly intoxicated and would otherwise be transported to the emergency department or jail. Stabilization centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober. Stays are limited to less than 24 hours. Service does not include room and board;

vi. Day habilitation programs to help an enrollee acquire, retain, and improve self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. Stays are limited to less than 24 hours. Service does not include room and board;

vii. Caregiver respite services: Intermittent temporary supervision provided on a short-term basis in the enrollee's home, a health care facility or an adult day center. Services provided to the enrollee are primarily non-medical and may include attending to the enrollee's basic self-help needs and other activities of daily living (ADL), including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by a caregiver; and

viii. Medically necessary environmental accessibility and remediation adaptations: Physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual or enable the individual to function with greater independence in the home, such as:

1. Asthma remediation; and
2. Accessibility and safety adaptations.

c. Case management, outreach, and education including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees. This includes HRSN service coordination and referral activities to be completed by Community Hubs and the Native Hub as described in Attachment U.

15.3. **Recuperative Care and Short-Term Post-Hospitalization Housing.**

a. Recuperative care and short-term post hospitalization housing settings provide a safe and stable place for eligible individuals transitioning out of institutions, and who are at risk of incurring other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits (as determined by a provider at the plan or network level), to receive treatment on a short-term basis. Eligible settings for recuperative care and short-term post hospitalization housing must have clinicians who can provide appropriate medical and/or behavioral health care. Short-term post hospitalization housing settings must also offer transitional supports to help enrollees secure stable housing and avoid future readmissions. Recuperative care may be offered for up to ninety (90) days in duration, and short-term post-hospitalization housing may be offered once during the demonstration period for no more than six (6) months in duration. Electing organizations will implement recuperative care and short-term post-hospitalization housing in accordance with the detailed service definitions, standards and requirements in Attachment U.

b. The HRSN Services Protocol, described in STC 15.7, must include a description of the state's documented process to authorize Recuperative Care and Short-Term Post Hospitalization Housing Service for beneficiaries for whom there is

an assessed risk of a need for other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits. This process must document that a provider using their professional judgement has determined it to be medically appropriate for the specific beneficiary as provision of the Recuperative Care and Short-Term Post Hospitalization Housing Service is likely to reduce or prevent the need for acute care or other Medicaid services. This documentation could be included in a care plan developed for the beneficiary. In addition to this clinical documentation requirement, states may also impose additional provider qualifications or other limitations and protocols and these must be documented within the managed care plan contracts, HRSN Services Protocol, and state guidance.

c. Eligible settings for recuperative care and short-term post-hospitalization housing must have appropriate clinicians who can provide medical and/or behavioral health care. The facility cannot be primarily used for room and board without the necessary additional recuperative support services. For example, a hotel room in a commercial hotel, where there are no medical or behavioral health supports provided onsite appropriate to the level of need, would not be considered an appropriate setting, but if a hotel had been converted to a recuperative care facility with appropriate clinical supports, then it would be an eligible setting.

15.4. **HRSN Infrastructure**.

a. The state may claim FFP in infrastructure investments in order to support the development and implementation of HRSN services, subject to STC 15.5. This FFP will be available for the following activities:

   i. Technology – e.g., electronic closed-loop referral systems, shared data platforms, EHR modifications, integrations, adaptations or data bridges, screening tool and/or case management systems, databases/data warehouses, data analytics and reporting, data protections and privacy, accounting and billing systems.

   ii. Development of business or operational practices – e.g., procurement and planning, developing policies and workflows for referral management, privacy, quality improvement, trauma-informed practices, evaluation, member navigation.

   iii. Workforce development – e.g., cultural competency training, trauma-informed training, Community Health Worker certification, training staff on new policies and procedures.

   iv. Outreach, education, and stakeholder convening – e.g., design and production of outreach and education materials, translation, obtaining community input, investments in stakeholder convening.

b. The state may claim FFP in HRSN infrastructure expenditures for no more than the annual amounts outlined in Table 4.

i. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration approval period and the state may claim the remaining amount in a subsequent demonstration years.

Table 4. Annual Limits of Total Computable Expenditures for HRSN Infrastructure

	DY8	DY9	DY10	DY11	DY12
Total Computable Expenditures	$35,000,000	$75,000,000	$75,000,000	$65,000,000	$20,000,000

c. Infrastructure investments will receive the applicable administrative match for the expenditure.

d. This infrastructure funding is separate and distinct from the payment to the applicable managed care plans for delivery of HRSN services. The state must ensure that HRSN infrastructure expenditures described in STC 15.4(a) are not factored into managed care capitation payments, and that there is no duplication of funds.

e. The state may not claim any FFP in HRSN infrastructure expenditures until the Protocol for HRSN Infrastructure is approved, as described in STC 15.7. Once approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the beginning of the demonstration approval date.

f. To the extent the state requests any additional infrastructure funding, or changes to its scope as described within this STC, the state must submit an amendment to the demonstration for CMS's consideration.

15.5. **Excluded HRSN**. Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:

a. Construction costs (bricks and mortar) except as needed for approved medically necessary home modifications as described in STC 15.2(b)(viii);

b. Capital investments;

c. Room and board outside of specifically enumerated care or housing transitions or beyond 6 months;

d. Research grants and expenditures not related to monitoring and evaluation;

e. Costs for services in prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting;

f. Services provided to individuals who are not lawfully present in the United States or are undocumented;

g. Expenditures that supplant services and activities funded by other state and federal governmental entities;

h. School based programs for children that supplant Medicaid state plan programs, or that are funded under the Department of Education or state, and the local education agency;

i. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and

j. Any other projects or activities not specifically approved by CMS as qualifying for demonstration coverage as a HRSN item or service under this demonstration.

15.6. **Covered Populations.** Expenditures for HRSN services may be made for the targeted populations specified in Attachment U, consistent with this STC. Individuals eligible to receive HRSN services are Medicaid eligible and have a documented medical need for the services and the services must be determined medically appropriate, as described in the HRSN Services Section in STC 15.2, for the documented need. Medical appropriateness must be based on clinical and health-related social risk factors. This determination must be documented in the beneficiary's care plan or medical record. Additional detail on targeted populations, including the clinical and other health related-social needs criteria, is outlined in Attachment U. Targeted populations may include consistent with Attachment U, the following. The state may add populations through the operational protocol subject to CMS review and approval.

a. **Nutrition Supports.** Individuals with chronic conditions (e.g., diabetes, cardiovascular disorders, human immunodeficiency virus (HIV), cancer) or post-discharge (e.g., post-discharge following stabilization for an eating disorder), who screen positive for food, housing, or financial insecurity, or report being unable to meet or maintain medically-recommended nutrition goals without assistance.

b. **Housing Supports (recuperative care and short-term post-hospitalization housing, housing transition navigation services, day habilitation services, and rent/temporary housing for up to six months).**

i. Individuals transitioning out of institutional care or congregate settings.

ii. Individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5.

iii. Youth transitioning out of the child welfare system.

c. **Community Transition Services (non-emergency, non-medical transportation and personal care and homemaker services).** Individuals with functional impairments as defined for HCBS or medical necessity and no other adequate support system, as well as individuals at risk for hospitalization or institutionalization.

d. **Stabilization Centers.** Adults who are intoxicated but conscious, cooperative, able to walk, nonviolent, and free from immediate medical distress, who would otherwise be transported to the emergency department or jail; or have presented at the ED and can safely be diverted to a stabilization center.

e. **Caregiver Respite Services.** Individuals who live in the community and are compromised in their activities of daily living and/or have been assessed to have a behavioral health need (e.g., a child with a serious emotional disturbance (SED)) and whose unpaid caregivers require relief to avoid the enrollee being placed in an institution.

f. **Medically Necessary Home/Environmental Accessibility and Remediation Adaptations.** Individuals at risk for institutionalization due to inaccessible living environments and individuals with poorly controlled asthma, or other medical condition(s) exacerbated by in-home environmental factors.

g. **Case Management, Outreach, and Education.** Individuals who screen positive for food, housing, financial insecurity, or other health-related social needs, and/or individuals who need navigation assistance (e.g., benefit application, referral to programs).

15.7. **Protocols for HRSN Infrastructure and HRSN Services.** The state must submit, for CMS approval, the Protocol for HRSN Infrastructure and the Protocol for HRSN Services no later than 180 days after approval of these authorities. The protocol(s) must include, as appropriate, a list of the HRSN services and service descriptions, the criteria for defining a medically appropriate population for each service, the process by which that criteria will be applied including care plan requirements or other documented processes, proposed uses of HRSN infrastructure funds, and provider qualification criteria for each service. Each protocol may be submitted and approved separately. The state must resubmit an updated protocol, as required by CMS feedback on the initial submission. The protocol may be updated as details are changed or added. The state may not claim FFP in HRSN services or HRSN infrastructure expenditures until CMS approves the associated protocol. Once the associated protocol is approved, the state can claim FFP in HRSN services and HRSN infrastructure expenditures retrospectively to the beginning of the demonstration approval date. The approved protocols will be appended to the STCs as Attachment U.

Specifically, the protocols must include the following information:

a. Proposed uses of HRSN infrastructure expenditures, including the type of entities to receive funding, the intended purpose of the funding, the projected expenditure amounts, and an implementation timeline.

b. A list of the covered HRSN services (not to exceed those allowed under STC 15.2), with associated service descriptions and service-specific provider qualification requirements.

c. A description of the process for identifying beneficiaries with health-related social needs, including outlining beneficiary eligibility, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.

d. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may deem the service to be medically appropriate.

   i. Plan to identify medical appropriateness based on clinical and social risk factors.

   ii. Plan to publicly maintain these clinical/social risk criteria to ensure transparency for beneficiaries and stakeholders.

e. A description of the process for developing care plans based on assessment of need.

   i. Plan to initiate care plans and closed-loop referrals to social services and community providers based on the outcomes of screening.

   ii. Description of how the state will ensure that HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma-informed.

15.8. **Service Delivery**:

a. Terms applicable to all HRSN Services.

   i. Any applicable HRSN 1115 services that are delivered by managed care plans must be included in the managed care contract submitted to CMS for review and approval in accordance with 42 CFR 438.39(a).

   ii. HRSN 1115 services may be paid on a FFS basis when provided by the state. HRSN 1115 services, when provided by a managed plan, must be paid as outlined below. The state must also comply with Section 15 for all HRSN services.

b. In accordance with STC 15.14, CMS expects the state to have appropriate encounter data associated with each HRSN service. This is necessary to ensure appropriate fiscal oversight for HRSN services as well as monitoring and evaluation. This is also critical to ensure appropriate base data for Medicaid managed care rate development purposes as well as appropriate documentation for claims payment in both managed care and FFS. Therefore, CMS requires that for HRSN services provided in a managed care delivery system, the state must include the name and definition of each HRSN service as well as the coding

to be used on claims and encounter data in the managed care plan contracts. For example, the state must note specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) costs that identify each HRSN service. Additionally, for HRSN services provided in an FFS delivery system, this information must be clearly documented for FFS providers. CMS will also consider this documentation necessary for approval of any rate methodologies per STC 15.15.

15.9. **Contracted Providers**. The following requirements must be consistent with managed care plan and/or any other applicable contracts (such as Community Hubs and the Native Hub) and are applicable to all HRSN services that are authorized through the demonstration. They are not applicable to services offered under ILOS authority pursuant to 42 CFR 438.3(e)(2).

a. The state must require managed care plans, Community Hubs, the Native Hub and/or other applicable entities to contract with HRSN service providers ("Contracted Providers") to deliver HRSN services authorized under the demonstration, as applicable, except for case management services under STC 15.2(c).

b. The state will contract directly with Community Hubs and the Native Hub to provide case management services under STC 15.2(c). Community Hubs and the Native Hub will be the sole Contracting Providers for case management services under this demonstration.

   i. Nine Community Hubs, each operated by a regional ACH, will provide case management services to Apple Health managed care and fee-for-service enrollees in their associated region.

   ii. The Native Hub, operated by an entity selected by the state, will provide case management services to Apple Health enrollees statewide, with close coordination and engagement with Washington Tribes.

c. The state must require managed care plans, Community Hubs and the Native Hub to establish a network of providers and ensure the Contracted Providers have sufficient experience and training in the provision of their applicable HRSN services. Contracted Providers do not need to be licensed unless otherwise required by the state; however, staff offering services through Contracted Providers must be licensed when appropriate and applicable.

d. The managed care plan, Community Hub and Native Hub, as applicable, and contracted provider must agree to a rate set by the state for the provision of applicable HRSN services, consistent with state guidance for these services, and in compliance with all related federal requirements.

i. Any state direction on payment arrangements for HRSN services that constitutes a state directed payment for a risk-based managed care plan must satisfy the requirements in 42 CFR 438.6(c).

e. Community Hubs and the Native Hub will provide HRSN services under STC 15.2 to otherwise eligible Medicaid beneficiaries under STC 15.6, regardless of tribal membership, race, or national/ethnic origin. The Native Hub will provide such services statewide and the Community Hubs may limit services to their associated regions.

15.10. **Provider Network Capacity.** The state must require managed care plans, Community Hubs, Native Hubs, or other implementing entities to ensure the HRSN services authorized under the demonstration are provided to eligible beneficiaries in a timely manner and shall develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision of the HRSN services, in accordance with the managed care plan contracts and other state Medicaid agency guidance.

15.11. **Compliance with Federal Requirements**. The state shall ensure HRSN services are delivered in accordance with all applicable federal statute, regulation or guidance.

15.12. **Person Centered Plan.** The state shall ensure there is a person-centered service plan for each individual receiving HRSN services. The person-centered service plan must be person-centered, identify the individual's needs and individualized strategies and interventions for meeting those needs, and be developed in consultation with the individual and the individual's chosen support network as appropriate. The person-centered service plan is reviewed and revised at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

15.13. **Conflict of Interest**. The state shall ensure appropriate protections against conflicts of interest in the service planning and delivery of HRSN services. The state agrees that appropriate separation of assessment, service planning and service provision functions are incorporated into the state conflict of interest policies.

15.14. **CMS Approval of Managed Care Contracts.** As part of the state's submission of associated Medicaid managed care plan contracts to implement HRSN services through managed care, the state must provide documentation including, but not limited to:

a. Beneficiary and plan protections, including but not limited to:

i. HRSN services must not be used to reduce, discourage, or jeopardize Medicaid beneficiaries' access to Medicaid covered services;

ii. Medicaid beneficiaries always retain their right to receive the Medicaid covered service on the same terms as would apply if HRSN services were not an option;

iii. Medicaid beneficiaries who are offered or utilize an HRSN retain all right and protections afforded under 42 CFR 438;

iv. Managed care plans are not permitted to deny a beneficiary a medically appropriate Medicaid covered service on the basis that they are currently receiving HRSN services, have requested these services, or have previously received these services; and

v. Managed care plans are prohibited from requiring a beneficiary to utilize HRSN services.

b. Managed care plans must timely submit data requested by the state or CMS, including, but not limited to:

i. Data to evaluate the utilization and effectiveness of the HRSN services;

ii. Any data necessary to monitor health outcomes and quality of care metrics at the individual and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identify), race, ethnicity, disability status and preferred language to inform health quality improvement efforts, which may thereby mitigate health disparities;

iii. Any data necessary to monitor appeals and grievances for beneficiaries;

iv. Documentation to ensure appropriate clinical support for the medical appropriateness of HRSN services, including documentation for recuperative care and short-term post hospitalization housing described in STC 15.3; and

v. Any data determined necessary by the state or CMS to monitor and oversee the HRSN initiatives.

c. All data and related documentation necessary to monitor and evaluate the HRSN services initiatives, including cost assessment, to include but not limited to:

i. The managed care plans must submit timely and accurate encounter data to the state for beneficiaries eligible for HRSN services. When possible, this encounter data must include data necessary for the state to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts and subsequent efforts to mitigate health disparities undertaken by the state;

ii. Any additional information requested by CMS, the state or legally authorized oversight body to aid in on-going evaluation of the HRSN services or any independent assessment or analysis conducted by the state, CMS, or a legally authorized independent entity;

iii. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports its progress in building and sustaining its partnership with existing housing agencies and nutrition agencies to utilize

their expertise and existing housing resources and avoid duplication of efforts; and

iv. Any additional information determined reasonable, appropriate and necessary by CMS.

15.15. **Rate Methodologies**. All rate and/or payment methodologies for authorized HRSN services outlined in these STCs must be submitted to CMS for review and approval prior to implementation, including but not limited to FFS payment as well as non-risk payments and capitation rates in managed care delivery systems, as part of the HRSN Implementation Plan (see STC 15.19) at least 60 days prior to implementation. States must submit all documentation requested by CMS, including but not limited to the payment rate methodology as well as other documentation and supporting information (e.g., state responses to Medicaid non-federal share financing questions). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting FFS payment rates.

15.16. **Maintenance of Effort (MOE).** The state must maintain a baseline level of state funding for ongoing social services related to housing transition supports and nutrition supports for the duration of the demonstration, not including one time or non-recurring funding. Within 180 days of demonstration approval, the state will submit a plan to CMS that specifies how the state will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 20.8, with any justifications, including declines in available state resources, necessary to describe the findings, if the level of state funding is less than the comparable amount of the pre-determined baseline.

15.17. **Partnerships with State and Local Entities**. The state must have in place partnerships with other state and local entities (e.g., U.S. Department of Housing and Urban Development (HUD) Continuum of Care Program, local housing authority, SNAP state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and nutrition supports, if available, upon the conclusion of temporary Medicaid payment for such supports, in alignment with beneficiary needs identified in the care plans as appropriate. The state will submit a plan to CMS as part of the HRSN Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing and nutrition supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Monitoring Reports described in STC 20.8, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Monitoring Reports.

15.18. **Provider Payment Rate Increase.** As a condition of the HRSN services and infrastructure expenditure authorities, Washington must comply with the provider rate increase requirements in Section 16 of the STCs.

15.19. HRSN Implementation Plan

a. The state is required to submit a HRSN Implementation Plan that will elaborate upon and further specify requirements for the provision of HRSN services and will be expected to provide additional details not captured in the STCs regarding implementation of demonstration policies that are outlined in the STCs. The state must submit the MOE information required by STC 15.16 for CMS approval no later than 180 calendar days after approval of this demonstration. All other Implementation Plan requirements outlined in this STC must be submitted no later than 9 months after the approval of this demonstration. The Implementation Plan shall be submitted to CMS but does not require CMS approval. CMS will ensure it is complete and contains sufficient detail for purposes of on-going monitoring. The state may update the implementation plan as initiatives are changed or added, with notification to CMS. The Implementation Plan will be appended as Attachment X.

b. At a minimum, the Implementation Plan must provide a description of the state's strategic approach to implementing the policy, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The Implementation Plan does not need to repeat any information submitted to CMS under the Protocols for HRSN Infrastructure and Services; however, as applicable, the information provided in the deliverables must be aligned and consistent with one another.

c. The Implementation Plan must include information on, but not limited to, the following:

   i. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services stakeholders to the extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation;

   ii. Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries);

   iii. Plans for changes to IT infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, eligibility and consent, screening, referrals, and service provision;

   iv. A plan for tracking and improving the share of Medicaid beneficiaries in the state who are eligible and enrolled in the Supplemental Nutrition Assistance

Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Temporary Assistance for Needy Families (TANF), and federal and state housing assistance programs, relative to the number of total eligible beneficiaries in the state;

v. An implementation timeline and evaluation considerations impacted by the timeline, such as staged rollout, that can facilitate robust evaluation designs;

vi. Information as required per STC 15.15 (HRSN Rate Methodologies);

vii. Information as required per STC 15.16 (MOE); and

viii. Information as required per STC 15.17 (Partnerships with State and Local Entities).

d. Failure to submit the Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of authority for HRSN Infrastructure and HRSN Services under this demonstration.

16. PROVIDER PAYMENT RATE INCREASE REQUIREMENT

16.1. The provider payment rate increase requirements described hereafter is a condition for HRSN and DSHP expenditure authorities, as referenced in Expenditure Authorities 17, 18, and 20.

16.2. As a condition of approval and ongoing provision of FFP in HRSN and DSHP expenditures over this demonstration period of performance, DY 8 through DY 12, the state will in accordance with these STCs increase and (at least) subsequently sustain Medicaid FFS provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates, by at least two percentage points in the ratio of Medicaid to Medicare provider rates for each of the service categories that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent. If the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for only the state's Medicaid fee-for-service program or only Medicaid managed care, the state shall only be required to increase provider payments for the delivery system for which the ratio is below 80 percent. If the state's average Medicaid rates already equal or exceed 80 percent of Medicare in any of these three categories for either FFS or managed care, then the state is not subject to a provider rate increase requirement in that service category and delivery system, but the state must at least sustain rates for such categories at existing levels for the remainder of the demonstration period.

16.3. The state may not decrease provider payment rates for other Medicaid or demonstration-covered services for the purpose of making state funds available to finance provider rate increases required under this STC (i.e., cost-shifting).

16.4. The state will, for the purposes of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increase as may be required under this section, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health care services.

16.5. No later than 90 days after of the demonstration effective date, and if the state makes FFS payments, the state must establish and report to CMS the state's average Medicaid to Medicare FFS provider rate ratio for each of the three service categories – primary care, behavioral health, and obstetric care, using either of the methodologies below:

a. Provide to CMS the average Medicaid to Medicare provider rate ratios for each of the three categories of services as these ratios are calculated for the state and the service category as noted in the following sources:

i. For primary care and obstetric care services, in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3); AND

ii. For behavioral health services, the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." Substance Abuse Treatment, Prevention, and Policy (2022) 17:49 (Table 3); OR

b. Provide to CMS for approval for any of the three service categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:

i. Service codes must be representative of each service category as defined in STC 16.4;

ii. Medicaid and Medicare data must be from the same year and not older than 2019; and

iii. The state's methodology for selecting the year of data, determining Medicaid code-level utilization, the service codes within the category, the geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

16.6. To establish the state's ratio for each service category identified in STC 16.4 as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:

a. The average FFS ratio as provided in STC 16.5(a), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the state pay providers based on state plan FFS payment rate schedules); or

b. The data and methodology for any or all of the service categories as provided in STC 16.5(b) using Medicaid managed care provider payment rate and utilization data.

16.7. In determining the ratios required under STC 16.5 and 16.6, the state may not incorporate FFS supplemental payments that the state made or plans through December 31, 2029, to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR 438.6(a) and 438.6(d).

16.8. If the state is required to increase provider payment rates for managed care plans per STC 16.2 and 16.6, the state must:

a. Comply with the requirements for state-directed payments in accordance with 42 CFR 438.6(c), as applicable; and

b. Ensure that the entirety of a two-percentage point increase applied to the provider payment rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.

16.9. For the entirety of DY10 through DY12, the provider payment rate increase for each service in a service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate in DY 8 and such rate will be in effect on the first day of DY10. A required payment rate increase shall apply to all services in the service category as defined under STC 16.4.

16.10. If the state uses a managed care delivery system for any of the service categories defined in STC 16.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY 10 through DY 12, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate in DY 8 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment rate increase shall apply to all services in a service category as defined under STC 16.4.

16.11. If the state has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing a required payment rate increase by the first day of DY 10 (or, as applicable, the first day of the first rating period that starts in DY 10), the state will provide an alternative effective date and rationale for CMS review and approval.

16.12. The state will provide the information to document the payment rate ratio required under STC 16.5 and 16.6, via submission to the Performance Metrics Database and Analytics (PMDA) portal for CMS review and approval.

16.13. For demonstration years following the first year of provider payment rate increases, the state will provide an annual attestation within the state's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, the previous year.

16.14. No later than 90 days following the demonstration effective date, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 16.5 and 16.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment V:

Table 5: Provider Rate Increase Attestation Table Template

Washington DSHP and HRSN Related Provider Payment Rate Increase Assessment – Attestation Table		
The reported data and attestations pertain to DSHP and HRSN related provider payment increase requirements for the demonstration period of performance DY 8 through DY 12.		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-Service Ratio**	**Medicaid Managed Care to Medicare Fee-for-Service Ratio**
Primary Care Services	[*insert percent, or N/A if state does not make Medicaid fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories*]
	[*insert approach, either ratio derived under STC 16.5(a) or STC 16.5(b)*]	[*insert approach, either ratio derived under STC 16.6(a) or STC 16.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio*]
Obstetric Care Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for providers for covered service categories*]
	[*insert approach, either ratio derived under STC 16.5(a) or STC 61.5(b)*]	[*insert approach, either ratio derived under STC 16.6(a) or STC 61.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio*]
Behavioral Health Care Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]*
	[*insert approach, either ratio derived under STC 16.5(a) or STC 16.5(b)*]	[*insert approach, either ratio derived under STC 16.6(a) or STC 16.6(b)*]; insert data source and time period (e.g., applicable 12-month rating

		period) for each of Medicaid and Medicare to derive the ratio]

In accordance with STCs 16.1 through 16.14, including that the Medicaid provider payment rates used to establish the ratios do not reflect FFS supplemental payments or Medicaid managed care pass-through payments under 42 CFR § 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in each of the three service categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the state's Medicaid or demonstration service delivery model.. Such provider payment increases for each service will be effective beginning on [*insert date*] and will not be lower than the highest rate for that service code in DY 8 plus a two percentage point increase relative to the rate for the same or similar Medicare billing code through at least [*insert date*].

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a FFS delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health care, and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise any service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 16.6(b) will be based on Medicaid managed care provider payment rate and utilization data.

[*Select the applicable effective date, must check either a. or b. below*]

☐a. The effective date of the rate increases is the first day of DY 10 and will be at least sustained, if not higher, through DY 12.

☐b. Washington has a biennial legislative session that requires provider payment approval and the timing of that session precludes the state from implementing the payment increase on the first day of DY 10. Washington will effectuate the rate increases no later than the CMS approved date of [*insert date*], and will sustain these rates, if not made higher, through DY 12.

Washington [*insert does or does not*] make Medicaid state plan FFS payments for the following categories of service for at least some populations: primary care, behavioral health care, and/or obstetric care.

For any such payments, as necessary to comply with the DSHP and Health-Related Social Need STCs, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan FFS payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to

calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new SPA, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*]
Washington [*insert does or does not*] include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care. For any such payments, as necessary to comply with the DSHP and Health-Related Social Need STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 16.7 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than *[insert date*]
If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 16.8, I attest that necessary arrangements will be made to assure that 100 percent of the two percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.
Washington further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 16.
I, *[insert name of SMD or CFO (or equivalent position*] [*insert title*], attest that the above information is complete and accurate. [*Provide signature*_____] [*Provide printed name of signatory*] [*Provide date*_____]

17. STATE OVERSIGHT OF MEDICAL LOSS RATIOS

17.1. For risk-based plans, the state must submit the plan-generated reports detailed in 42 CFR 438.8(k) as well as any other documentation used to determine compliance with 42 CFR. 438.8(k) to CMS at DMCPMLR@cms.hhs.gov.

a. For managed care plans that delegate risk to subcontractors, the state's review of compliance with 42 CFR 438.8(k) must consider MLR requirements related to such subcontractors; see https://www.medicaid.gov/federal-policy-guidance/downloads/cib051919.pdf. The state must submit its plan to operationalize STC 17.1 through 17.4 to CMS for review and approval at DMCPMLR@cms.hhs.gov no later than six months after the demonstration approval. The plan must outline key deliverables and timelines to meet the requirements of STC 17.1 through 17.4.

17.2. Effective January 1, 2025, the state must require risk-based plans contracted with the state to impose reporting requirements equivalent to the information required in 42 CFR 438.8(k) on their subcontractor plans or entities.

17.3. No later than July 1, 2026, the state must require risk-based plans contracted with the state to impose remittance requirements equivalent to 42 CFR 438.8(j) on their subcontractor plans or entities.

17.4. STC 17.1, 17.2 and 17.3 must apply for all of the following entities:

a. Risk-based plans for which the state receives federal financial participation for associated expenditures;

b. Full and partially delegated plans;

c. Other subcontractors, as applicable, that assume delegated risk from either the primary managed care plan contracted with the state, or plans referenced in STC 17.4(b); and

d. Other subcontractors, as applicable, that assume delegated risk from entities referenced in STC 17.4(c).

17.5. The state must work with CMS to effectuate an audit of the MLR data for all complete rating periods (i.e., MLR reporting periods) in this 1115 demonstration package. Final audit results and reporting must be provided to CMS no later than two years after the expiration of the current demonstration period.

17.6. The state will update the contract language to require managed care plans to provide HRSN services as described in STC 15.2, as applicable. When HRSN services are included in risk-based capitation rates, expenditures for HRSN services should be reported in the MLR reporting as incurred claims. Managed care plans should not report expenditures for HRSN services in the MLR until after the transition to include HRSN services in risk-based capitation rates.

17.7. The state must develop an MLR monitoring and oversight process specific to HRSN services. If the HRSN services are incorporated in the capitation rates using a phased approach, the process must explain the approach. This process must be submitted to CMS, for review and approval, no later than 60 days prior to the incorporation of HRSN services in risk-based capitation rates. The state may submit this process to CMS at DMCPMLR@cms.hhs.gov. This process must specify how HRSN services will be identified for inclusion in capitation rate setting and in the MLR numerator. The state's plan must indicate how expenditures for HRSN administrative costs and infrastructure will be identified and reported in the MLR as non-claims costs.

18. GENERAL FINANCIAL REQUIREMENTS

18.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

18.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

18.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

18.4. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

18.5. **Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

18.6. **Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

18.7. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 20.2. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

18.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in Section 19:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

18.9. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

18.10. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 3. Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Non-Expansion Adults	Main	X		X	Expenditures authorized under the demonstration for Medicaid beneficiaries specified in STC 16 (excluding SUD and SMI IMD expenditures).
DSRIP	Main			X	Expenditures authorized under the demonstration for delivery system transformation.
MAC and TSOA Not Eligible	Main			X	Expenditures authorized under the demonstration for beneficiaries receiving presumptive eligibility for TSOA and MAC services and determined ineligible.
MAC and TSOA	Hypo 1		X	X	Expenditures authorized under the demonstration for beneficiaries receiving MAC and TSOA services. Excludes expenditures for individuals who received MAC and TSOA services during the presumptive eligibility period and determined ineligible.
HepC Rx	Hypo 2		X	X	Expenditures for prescription drugs ("HepC Rx") related to a diagnosis of Hepatitis C for individuals affected by or eligible under the demonstration.
Foundational Community Supports 1 & 2	Hypo 3		X	X	One-time community transition services to individuals moving from institutional to community settings and those at imminent risk of institutional placement, and HCBS that could be provided to the individual under a 1915(c) waiver or 1915(i) SPA.
SUD IMD: Medicaid Disabled	Hypo 4	X		X	Expenditures for costs of SUD-related medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD, for Medicaid disabled individuals.
SUD IMD: Medicaid Non-Disabled	Hypo 4	X		X	Expenditures for costs of SUD-related medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD, for Medicaid non-disabled individuals.
SUD IMD: Newly Eligible	Hypo 4	X		X	Expenditures for costs of SUD-related medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD, for newly eligible individuals.
SUD IMD: American Indian/Alaskan Native	Hypo 4	X		X	Expenditures for costs of SUD-related medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD, for American Indian/Alaskan Native individuals.

SMI IMD: Medicaid Disabled	Hypo 5	X		X	Expenditures for costs of SMI-related medical assistance that could be covered, were it not for the statutory IMD payment exclusion, provided to otherwise eligible individuals during a month in an IMD pursuant to the SMI Program under this demonstration, for Medicaid disabled individuals.
SMI IMD: Medicaid Non-Disabled	Hypo 5	X		X	Expenditures for costs of SMI-related medical assistance that could be covered, were it not for the statutory IMD payment exclusion, provided to otherwise eligible individuals during a month in an IMD pursuant to the SMI Program under this demonstration, for Medicaid non-disabled individuals.
SMI IMD: Newly Eligible	Hypo 5	X		X	Expenditures for costs of SMI-related medical assistance that could be covered, were it not for the statutory IMD payment exclusion, provided to otherwise eligible individuals during a month in an IMD pursuant to the SMI Program under this demonstration, for newly eligible individuals.
SMI IMD: American Indian/Alaskan Native	Hypo 5	X		X	Expenditures for costs of SMI-related medical assistance that could be covered, were it not for the statutory IMD payment exclusion, provided to otherwise eligible individuals during a month in an IMD pursuant to the SMI Program under this demonstration, for American Indian/Alaskan Native individuals.
CE Children Non-Disabled	Hypo 6	X		X	Expenditures for continued benefits for non-disabled children who have been determined eligible for the continuous eligibility period who would otherwise lose coverage during an eligibility determination
CE Children Disabled	Hypo 6	X		X	Expenditures for continued benefits for disabled children who have been determined eligible for the continuous eligibility period who would otherwise lose coverage during an eligibility determination
CE Postpartum Individuals	Hypo 7	X		X	Expenditures for continued benefits for postpartum individuals who have been determined eligible for the continuous eligibility period.
PE for HCBS	Hypo 8	X		X	Expenditures for individuals presumptively determined to be eligible for section 1915(c) COPES, section 1915(k) Community First Choice, or Medicaid Personal Care.
Reentry Services	Hypo 9	X		X	Expenditures for targeted services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to the expected date of release from participating state prisons, county jails, youth correctional facilities, or tribal jails.
Reentry Non-Services	Hypo 9		X	X	Expenditures for planning and supporting the reentry demonstration initiative.
HRSN Services	Capped Hypo		X	X	Expenditures for approved HRSN initiatives.

HRSN Infrastructure	Capped Hypo		X	X	Infrastructure expenditures for approved HRSN initiatives.
HRSN Community Transition Services	Main			X	Expenditures for the transportation, personal care and homemaker services under the approved HRSN initiative.
Contingency Management	Main			X	Expenditures for evidence-based motivational incentives for meeting treatment goals.
DSHP	Main			X	All expenditures for DSHP as described in Section 23.
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.

BN: budget neutrality; MEG: Medicaid expenditure group; WOW: without waiver; WW: with waiver

18.11. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00304/0). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in Section 19, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in Section 20, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 4. MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
Non-Expansion Adults	Report all medical assistance expenditures authorized under the demonstration for Medicaid beneficiaries specified in STC 16 (excluding SUD and SMI IMD expenditures).		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/09/17	6/30/28
DSRIP	Report all expenditures authorized under the demonstration for delivery system transformation.		Follow standard CMS 64.10 Category of Service Definitions	Date of service/Date of payment	ADM	N	1/09/17	6/30/24
MAC and TSOA Not Eligible	Report all expenditures authorized under the demonstration for beneficiaries receiving presumptive eligibility for TSOA and MAC services and determined ineligible.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	1/09/17	6/30/28
MAC and TSOA	Expenditures authorized under the demonstration for beneficiaries receiving MAC and TSOA services.	Excludes expenditures for individuals who received MAC and TSOA services during the presumptive eligibility period and determined ineligible.	Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	1/09/17	6/30/28
HepC Rx	Report all expenditures for prescription drugs ("HepC Rx") related to a diagnosis of Hepatitis C for individuals affected by or eligible under the demonstration.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	1/09/17	6/30/28
Foundational Community Supports 1 & 2	Report all expenditures for one-time community transition services to individuals moving from institutional to community settings and those at imminent risk of institutional placement		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	1/09/17	6/30/28

	and expenditures for HCBS that could be provided to the individual under a 1915(c) waiver or 1915(i) SPA.							
SUD IMD: Medicaid Disabled	Report all expenditures for costs of SUD-related medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD, for Medicaid disabled individuals.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	07/01/18	6/30/28
SUD IMD: Medicaid Non-Disabled	Report all expenditures for costs of SUD-related medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD, for Medicaid non-disabled individuals.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	07/01/18	6/30/28
SUD IMD: Newly Eligible	Report all expenditures for costs of SUD-related medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD, for newly eligible individuals.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	07/01/18	6/30/28
SUD IMD: American Indian/Alaskan Native	Report all expenditures for costs of SUD-related medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD, for American Indian/Alaskan Native individuals.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	07/01/18	6/30/28
SMI IMD: Medicaid Disabled	Report all expenditures for costs of SMI-related medical assistance that could be covered, were it not for the statutory IMD payment exclusion, provided to otherwise eligible individuals during a month in an IMD pursuant to the SMI Program under this demonstration, for Medicaid disabled individuals.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	11/06/20	6/30/28

SMI IMD: Medicaid Non-Disabled	Report all expenditures for costs of SMI-related medical assistance that could be covered, were it not for the statutory IMD payment exclusion, provided to otherwise eligible individuals during a month in an IMD pursuant to the SMI Program under this demonstration, for Medicaid non-disabled individuals.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	11/06/20	6/30/28
SMI IMD: Newly Eligible	Report all expenditures for costs of SMI-related medical assistance that could be covered, were it not for the statutory IMD payment exclusion, provided to otherwise eligible individuals during a month in an IMD pursuant to the SMI Program under this demonstration, for newly eligible individuals.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	11/06/20	6/30/28
SMI IMD: American Indian/Alaskan Native	Report all expenditures for costs of SMI-related medical assistance that could be covered, were it not for the statutory IMD payment exclusion, provided to otherwise eligible individuals during a month in an IMD pursuant to the SMI Program under this demonstration, for American Indian/Alaskan Native individuals.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	11/06/20	6/30/28
CE Children Non-Disabled	Expenditures for continued benefits for non-disabled children who have been determined eligible for the continuous eligibility period who would otherwise lose coverage during an eligibility determination.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	4/14/2023	6/30/28
CE Children Disabled	Expenditures for continued benefits for disabled children who have been determined eligible for the continuous eligibility period who would otherwise lose coverage during an eligibility determination.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	4/14/2023	6/30/28
CE Postpartum Individuals	Expenditures for continued benefits for postpartum individuals who have		Follow standard CMS 64.9 Category of	Date of service	MAP	Y	7/1/23	6/30/28

	been determined eligible for the continuous eligibility period.		Service Definitions					
PE for HCBS	Expenditures for individuals presumptively determined to be eligible for section 1915(c) COPES, section 1915(k) Community First Choice, or Medicaid Personal Care.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/23	6/30/28
Reentry Initiative Services	Expenditures for targeted services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to the expected date of release from participating state prisons, county jails, youth correctional facilities, or tribal jails.		` Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	7/1/23	6/30/28
Reentry Initiative Non-services	Expenditures for planning and supporting the reentry demonstration initiative.		Follow standard CMS 64.10 Category of Service Definitions	Date of service	ADM	N	7/1/23	6/30/28
HRSN Services	Expenditures for approved HRSN initiatives.		Follow standard CMS 64.9 or 64.10 Category of Service Definitions	Date of service	MAP/ADM	N	7/1/23	6/30/28
HRSN Infrastructure	Infrastructure expenditures for approved HRSN initiatives.		Follow standard CMS 64.10 Category of Service Definitions	Date of service	ADM	N	7/1/23	6/30/28
HRSN Community Transition Services	Expenditures for the transportation, personal care and homemaker services under the approved HRSN initiative.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	7/1/23	6/30/28
Contingency Management	Expenditures for evidence-based motivational incentives for meeting treatment goals.		Follow standard CMS 64.9 Category of	Date of service	MAP	N	7/1/23	6/30/28

			Service Definitions					
DSHP	Report all DSHP expenditures.		Follow standard CMS 64.10 Category of Service Definitions.	Date of Payment	ADM	N	01/08/25	6/30/28
ADM	Report all additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	01/09/17	6/30/28

ADM: administration; DY: demonstration year; MAP: medical assistance payments; MEG: Medicaid expenditure group

18.12. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the table below.

Table 5. Demonstration Years

Demonstration Year (DY)	Dates	Duration
DY 8	July 1, 2023 to June 30, 2024	12 months
DY 9	July 1, 2024 to June 30, 2025	12 months
DY 10	July 1, 2025 to June 30, 2026	12 months
DY 11	July 1, 2026 to June 30, 2027	12 months
DY 12	July 1, 2027 to June 30, 2028	12 months

18.13. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in Section 19. CMS will provide technical assistance, upon request.[8]

18.14. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

18.15. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make

[8] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

18.16. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 18.16.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from

a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

   i. Provider rate increases that are anticipated to further strengthen access to care;

   ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

   iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

   iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

   v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

   vi. High cost innovative medical treatments that states are required to cover; or,

   vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

   i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and

   ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

19. MONITORING BUDGET NEUTRALITY

19.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test, Hypothetical Budget Neutrality Tests, and a Capped Hypothetical Budget Neutrality Test, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

19.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 3, Master MEG Chart and

19.3. Table 4, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

19.4. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

19.5. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the Capped Hypothetical Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the capped hypothetical amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table 6. Main Budget Neutrality Test

MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Trend Rate	DY 8	DY 9	DY 10	DY 11	DY 12
Non-Expansion Adults Only	PC	Both	5.3%	$650.35	$684.82	$721.12	$759.34	$799.59
Contingency Management	Agg	WW Only	N/A	$178,750	$370,625	$670,000	$812,500	$925,000
HRSN Community Transition Services	Agg	WW Only	N/A	The state must have savings to offset these expenditures.				
DSRIP	Agg	WW Only	N/A	$0^	N/A	N/A	N/A	N/A
MAC and TSOA Not Eligible	Agg	WW Only	N/A	The state must have savings to offset these expenditures.				
DSHP	Agg	WW Only	N/A	N/A	The state must have savings to offset these expenditures.			

**PC: Per Capita; Agg = Aggregate*

^Incentive payments may be made in DY 8 for prior periods of performance and administrative activities to close out the DSRIP program. Total DSRIP payments for the section 1115 demonstration may not exceed total authorized limits.

19.6. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget

Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

19.7. **Hypothetical Budget Neutrality Test 1: MAC and TSOA.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 7. Hypothetical Budget Neutrality Test 1

MEG	PC or Agg	WOW Only, WW Only, or BOTH	Trend Rate	DY 8	DY 9	DY 10	DY 11	DY 12
MAC and TSOA	Agg	Both	N/A	$24,434,211	$25,796,815	$27,378,892	$29,057,998	$30,840,081

19.8. **Hypothetical Budget Neutrality Test 2: HepC Rx.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 8. Hypothetical Budget Neutrality Test 2

MEG	PC or Agg	WOW Only, WW Only, or BOTH	Trend Rate	DY 8	DY 9	DY 10	DY 11	DY 12
HepC Rx	Agg	Both	N/A	$13,882,016	$14,481,719	$15,107,330	$15,759,966	$16,440,797

19.9. **Hypothetical Budget Neutrality Test 3: Foundational Community Supports 1 & 2.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 9. Hypothetical Budget Neutrality Test 3

MEG	PC or Agg	WOW Only, WW Only, or BOTH	Trend Rate	DY 8	DY 9	DY 10	DY 11	DY 12
Foundational Community Supports 1 & 2	Agg	Both	N/A	$43,925,338	$45,033,762	$46,170,179	$47,335,297	$48,529,839

19.10. **Hypothetical Budget Neutrality Test 4: SUD Expenditures.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 4 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 10. Hypothetical Budget Neutrality Test 4

MEG	PC or Agg	WOW Only, WW Only, or BOTH	Trend Rate	DY 8	DY 9	DY 10	DY 11	DY 12
SUD Medicaid Disabled	PC	Both	4.9%	$1,413.87	$1,483.15	$1,555.82	$1,632.06	$1,712.03
SUD Medicaid Non-Disabled	PC	Both	5.1%	$563.89	$592.65	$622.88	$654.65	$688.04
SUD Newly Eligible	PC	Both	5.5%	$636.91	$671.94	$708.90	$747.89	$789.02
SUD American Indian/ Alaskan Native	PC	Both	5.1%	$2,799.15	$2,941.91	$3,091.95	$3,249.64	$3,415.37

19.11. **Hypothetical Budget Neutrality Test 5: SMI Expenditures.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 5. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 5 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 11. Hypothetical Budget Neutrality Test 5

MEG	PC or Agg	WOW Only, WW Only, or BOTH	Trend Rate	DY 8	DY 9	DY 10	DY 11	DY 12
SMI Medicaid Disabled	PC	Both	4.9%	$1,991.27	$2,088.84	$2,191.19	$2,298.56	$2,411.19
SMI Medicaid Non-Disabled	PC	Both	5.1%	$458.86	$482.26	$506.86	$532.71	$559.88
SMI Newly Eligible	PC	Both	5.5%	$803.05	$847.22	$893.82	$942.98	$994.84
SMI American Indian/ Alaskan Native FFS	PC	Both	5.1%	$5,574.50	$5,858.80	$6,157.60	$6,471.64	$6,801.69

19.12. **Hypothetical Budget Neutrality Test 6: Continuous Eligibility for Children Expenditures.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 6. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 6 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 12. Hypothetical Budget Neutrality Test 6

MEG	PC or Agg	WOW Only, WW Only, or BOTH	Trend Rate	DY 8	DY 9	DY 10	DY 11	DY 12
CE Children Non-Disabled	PC	Both	4.9%	$329.45	$345.59	$362.52	$380.28	$398.91
CE Children Disabled	PC	Both	4.9%	$2,776.64	$2,912.70	$3,055.42	$3,205.14	$3,362.19

19.13. **Hypothetical Budget Neutrality Test 7: Continuous Eligibility for Postpartum Individuals Expenditures.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 7. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 7 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 16. Hypothetical Budget Neutrality Test 7

MEG	PC or Agg	WOW Only, WW Only, or BOTH	Trend Rate	DY 8	DY 9	DY 10	DY 11	DY 12
CE Postpartum Individuals	PC	Both	5.1%	$245.83	$258.37	$271.55	$285.40	$299.96

19.14. **Hypothetical Budget Neutrality Test 8: PE for HCBS.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 8. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 8 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 17. Hypothetical Budget Neutrality Test 8

MEG	PC or Agg	WOW Only, WW Only, or BOTH	Trend Rate	DY 8	DY 9	DY 10	DY 11	DY 12
PE for HCBS	PC	Both	5.1%	$3,827.00	$4,022.18	$4,227.31	$4,442.90	$4,669.49

19.15. **Hypothetical Budget Neutrality Test 9: Reentry Demonstration Initiative Expenditures**. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 9. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 9 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 18. Hypothetical Budget Neutrality Test 9

MEG	PC or Agg	WOW Only, WW Only, or BOTH	Trend Rate	DY 8	DY 9	DY 10	DY 11	DY 12
Reentry Services	PC	Both	5.0%	$0	$865.62	$908.90	$954.35	$1,002.07
Reentry Non-Services	Agg	Both	N/A	$0	$121,570,000	$106,373,750	$75,981,250	$0

19.16. **Capped Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives**. When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in section 15), CMS considers these expenditures to be "capped hypothetical" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, capped hypothetical expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped hypothetical expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent Capped Hypothetical Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the Capped Hypothetical Budget Neutrality Test's expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state's capped hypothetical spending exceeds the Capped Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped hypothetical.

19.17. **Capped Hypothetical Budget Neutrality Test: HRSN.** The table below identifies the MEGs that are used for the Capped Hypothetical Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Capped Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the Capped Hypothetical Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 19: Capped Hypothetical Budget Neutrality Test							
MEG	**Agg**	**WOW Only, WW Only, or Both**	**DY 8**	**DY 9**	**DY 10**	**DY 11**	**DY 12**
HRSN Services	Agg	Both	$163,494,276	$342,101,215	$342,101,215	$342,101,215	$342,101,215
HRSN Infrastructure	Agg	Both	$35,000,000	$75,000,000	$75,000,000	$65,000,000	$20,000,000

19.18. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

19.19. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the demonstration period, which extends from 07/01/2023 to 6/30/2028. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward savings, that is, net savings from up to 10 years of the immediately prior demonstration approval period(s), excluding DY 6 and DY 7, (01/09/2017 to 12/31/2021). If at the end of the demonstration approval period the Main Budget Neutrality Test or Capped Hypothetical Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

19.20. **Budget Neutrality Savings Cap**. The amount of savings available for use by the state during this demonstration period will be limited to the lower of these two amounts: 1) the savings amount the state has available in the current demonstration period, including carry-forward savings as described in STC 19.18, or 2) 15 percent of the state's projected total Medicaid expenditures in aggregate for this demonstration period. This projection will be determined by taking the state's total Medicaid spending amount in its most recent year with completed data and trending it forward by the President's Budget trend rate for this demonstration period. Fifteen percent of the state's total projected Medicaid expenditures for this demonstration period is $15,096,611,484.

19.21. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 20. Budget Neutrality Test Corrective Action Plan Calculation

Demonstration Year	Cumulative Target Definition	Percentage
DY 8	Cumulative budget neutrality limit plus	2.0 percent
DY 8 through 9	Cumulative budget neutrality limit plus:	1.5 percent
DY 8 through DY 10	Cumulative budget neutrality limit plus:	1.0 percent
DY 8 through DY 11	Cumulative budget neutrality limit plus:	0.5 percent
DY 8 through DY 12	Cumulative budget neutrality limit plus:	0.0 percent

19.22. **Monitoring Budget Neutrality for FFCY.** CMS has determined that FFCY demonstration coverage is budget neutral based on CMS's assessment that the expenditure authority granted for the demonstration has minimal federal Medicaid expenditures and these populations could have been covered through waiver only authority. The state will not be allowed to obtain budget neutrality "savings" from FFCY demonstration coverage. The demonstration will not include a budget neutrality expenditure limit for FFCY; however, the state is required to report total expenditures and member months in their demonstration monitoring reports, per STC 20.8. The state must still report quarterly claims and report expenditures on the CMS 64.9 WAIVER form. Failure to report FFCY expenditures and member months will result in reinstatement of the budget neutrality requirement. CMS reserves the right to request budget neutrality worksheets, requirements, limits, and analyses from the state at any time, or whenever the state seeks a change to the demonstration, per STC 3.7.

20. MONITORING AND REPORTING REQUIREMENTS

20.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

a. The following process will be used: 1) 30 calendar days after the deliverable(s) were due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (c) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable(s) were not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable(s) into alignment with CMS requirements:

b. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

c. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay, the steps the state has taken to address such issue(s), and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

d. If CMS agrees to an interim corrective process in accordance with subsection (c) above, and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meet the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

e. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

20.2. **Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones.** Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Protocol and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

20.3. **Submission of Post-Approval Deliverables.** The state must submit deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

20.4. **Electronic Submission of Reports.** The state must submit all monitoring and evaluation report deliverables required in these STCs (e.g., quarterly reports, annual reports, evaluation reports) electronically, through CMS' designated electronic system.

20.5. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all section 1115 demonstration, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

20.6. **SUD and SMI/SED Monitoring Protocols.** The state must submit to CMS a Monitoring Protocol(s) for each of the SUD and SMI/SED programs authorized by this demonstration within 150 calendar days after approval of this demonstration extension. The SUD and SMI/SED Monitoring Protocol(s) must be developed in cooperation with CMS and are subject to CMS approval. The state must submit revised Monitoring Protocol(s) within 60 calendar days after receipt of CMS's comments, if any. Once approved, the SUD and SMI/SED Monitoring Protocol(s) will be incorporated into the STCs, as Attachment(s) L and O. Progress on the performance measures identified in the SUD and SMI/SED Monitoring Protocols must be reported via the Quarterly and Annual Monitoring Reports. Components of the SUD and SMI/SED Monitoring Protocols include:

a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in Attachments K and N, and reporting information relevant to the state's SMI/SED Financing Plan

described in Attachment N, and information relevant to the state's Health IT Plan(s) described in STCs 11.2(d) and 12.2(d);

b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general monitoring and reporting requirements described in Section 20 of the demonstration; and

c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

20.7. **Monitoring Protocol(s).** The state must submit to CMS a Monitoring Protocol(s) addressing components of the demonstration not covered by the SUD and SMI/SED Monitoring Protocols no later than 150 calendar days after the approval of the demonstration (to include but may not be limited to: HRSN, Re-entry, Presumptive Eligibility for HCBS). The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs as Attachment W. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to the same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, if applicable and relevant for different policies. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as for specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., the performance metrics described in STC 20.8(b), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, sexual orientation and gender identity, and geography) and demonstration component.

The Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Health Equity Measure Slate, and outlining the corresponding data sources and reporting timelines, as applicable to the demonstration initiatives and populations. If needed, the state may submit an amendment to the Monitoring Protocol within 150 days after the receipt of the final Health Equity Measure Slate from CMS. This slate of measures represents a critical set of equity-focused metrics known to be important for

closing key equity gaps in Medicaid/CHIP (e.g., the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e., social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track implementation progress and performance relative to the goals and milestones, as provided in the Implementation Plan.

The state will also be expected to set up its HRSN service delivery system to allow screening of beneficiaries for identified needs, develop appropriate closed-loop referral system or other feedback loop to ensure beneficiaries receive service referrals and provisions, and provide any applicable update on this process via the Monitoring Reports, in alignment with information provided in the Monitoring Protocol.

In addition, the state must describe in the Monitoring Protocol methods and timeline to collect and analyze non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include, but are not limited to: 1) community resource referral platforms, 2) records of social services receipt from other agencies (such as SNAP or TANF benefits, or housing assistance), 3) other data from social services organizations linked to beneficiaries (e.g., services rendered, resolution of identified need, as applicable), and 4) social needs screening results from electronic health records, health plans, or other partner agencies, and 5) data related to carceral status Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community, as applicable. Across data sources, the state must make efforts and consult with relevant non-Medicaid social service agencies to collect data in ways that support analyses of data on beneficiary subgroups.

For the qualitative elements (e.g., operational updates as described in STC 20.8(a), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

20.8. **Monitoring Reports.** The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each demonstration year (DY). The fourth-quarter information that would ordinarily be provided in a separate Quarterly Monitoring Report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than 90 calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework to be provided by CMS, which is subject to change as monitoring systems are developed/evolve and be provided in a structured manner that supports federal tracking and analysis.

a. **Operational Updates.** Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; updates on the state's financing plan and maintenance of effort described in STC 15.16; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. **Performance Metrics.** The performance metrics will provide data to demonstrate how the state is progressing toward meeting the goals and milestones – including relative to their projected timelines – of the demonstration's program and policy implementation and infrastructure investments, and transitional non-service expenditures, as applicable and must cover all key policies under this demonstration. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as on beneficiaries' outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals.

   The demonstration's metrics reporting must cover categories including, but not limited to: enrollment and renewal, including access to providers, utilization of services, and quality of care and health outcomes. The state must undertake robust reporting of quality of care and health outcomes metrics aligned with the demonstration's policies and objectives to be reported for all demonstration populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, and geography) and by demonstration component, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities. To that end, CMS underscores the importance of the state's reporting of quality of care and health outcomes metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g., NQF "disparities-sensitive" measures) and prioritizing key outcome measures and their clinical and non-clinical (i.e., social) drivers of health. In coordination with CMS, the state is expected to select such measures for reporting in alignment with a critical set of equity-focused measures CMS is finalizing as part of its upcoming guidance on the Health Equity Measure Slate, as applicable to the demonstration initiatives and populations. If needed, the state may submit an amendment to its monitoring

plan no more than 150 days after receiving the final Health Equity Measure Slate from CMS to incorporate these measures.

i. For HRSN components, in addition to reporting on the metrics described above, the state must track beneficiary participation, screening, receipt of referrals and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations, and the contracted providers of applicable services (e.g., managed care plans and their contracted HRSN providers. In alignment with STC 15.17, the state must additionally monitor and provide narrative updates on its progress in building and sustaining its partnership with existing housing and/or nutrition agencies to leverage their expertise and existing housing and/or nutrition resources instead of duplicating services. Furthermore, the state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as SNAP and WIC) for which they are eligible. The Monitoring Reports must also provide status updates in accordance with the Monitoring Protocol on the implementation of infrastructure investments tied to the HRSN initiatives.

ii. The state's selection and reporting of quality of care and health outcome metrics outlined above must also accommodate the newly approved reentry demonstration initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones and goals of the reentry demonstration initiative. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services (e.g., case management, medication-assisted data [MAT], clinical/behavioral health assessment pre-release and primary and behavioral health services post-release), provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating carceral settings. In addition, the state is expected to monitor the number of beneficiaries served and types of services rendered under the demonstration Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in its Monitoring Reports narrative details outlining its progress with implementing the initiative, including any challenges encountered and plans for addressing them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

In addition to tracking enrollment and renewal metrics, systematic monitoring of the continuous eligibility policies must support—at a minimum—understanding the trends in preventive care services, including vaccination among populations of focus, and utilization of costlier and potentially avoidable services, such as inpatient hospitalizations and non-emergent use of emergency departments.

iii. For the postpartum care component, the state's reporting must cover metrics for domains including but not limited to: enrollment, primary and preventative care, maternal health, infant health, and if applicable, behavioral health.

iv. For the SUD component, the state's monitoring must align with the CMS-approved SUD Monitoring Protocol (see STC 20.6),), and will cover metrics in alignment with assessment of need and qualification for SUD treatment services and the demonstration's six milestones as outlined in the State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMDL #17-003).[9]

v. For the Contingency Management program, the state's reporting must cover metrics for domains including but not limited to enrollment, overall incentives provided, and average incentives provided per beneficiary during the treatment phase as well as types and counts of aftercare and treatment services rendered during the aftercare phase.

vi. For the SMI component, the state's monitoring must align with the CMS-approved SMI Monitoring Protocol (see STC 20.6),), and will cover metrics in alignment with assessment of need and qualification for SMI treatment services and the demonstration's four milestones as outlined in the State Medicaid Director Letter (SMDL) dated November 13, 2018 (SMDL #18-011).[10]

vii. The state must also establish monitoring metrics to help track operational progress of the MAC and TSOA programs. At a minimum, the metrics must capture the number of individuals found eligible and ineligible for these programs, the number and composition of service utilization, and any corresponding health outcomes, as applicable.

viii. For the presumed eligibility policies, the state must, at a minimum, collect performance metrics that establish the rates of presumed eligible beneficiaries eventually found to be eligible and ineligible and the types and counts of services rendered to beneficiaries during the presumed eligibility period.

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[9] SMDL #17-003, Strategies to Address the Opioid Epidemic. Available at: https://www medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

[10] SMDL #17-003, Strategies to Address the Opioid Epidemic. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

ix. For the continuous eligibility policy, monitoring metrics must support tracking enrollment and ex parte renewals. The state must describe successes and challenges related to annual attempts to update beneficiary contact information, provide beneficiaries reminders of continued eligibility, verify beneficiary residency, and confirm that the beneficiary is not deceased, for all beneficiaries who qualify for a continuous eligibility period that exceeds 12 months.

In addition, if the state, health plans, or health care providers will contract or partner with organizations to implement the demonstration, the state must use monitoring metrics that track the number and characteristics of contracted or participating organizations and corresponding payment-related metrics; these metrics are specifically relevant for the state's HRSN initiatives and the DSHP-funded initiatives.

The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. **Budget Neutrality and Financial Reporting Requirements.** Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the Form CMS-64.

d. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

e. **SUD Health IT and/or SMI/SED Health IT.** The state will include a summary of progress made in regards to SUD and SMI/SED Health IT requirements outlined in STCs 11.2(d) and 12.2(d).).

20.9. **SUD Mid-Point Assessment.** The state must contract with an independent entity to conduct an independent Mid-Point Assessment by June 30, 2026. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period experiences as context, and conduct

the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning and conduct of the Mid- Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCOs, health care providers (including SMI/SED and/or SUD treatment providers), beneficiaries, community groups, and other key partners.

a. The state must require that the assessor provide a Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than 60 calendar days after June 30, 2026. If requested, the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.

b. For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the SUD Implementation Plan and SUD Monitoring Protocol for ameliorating these risks. Modifications to the Implementation, Financing Plan, and Monitoring Protocol are subject to CMS approval.

c. Elements of the Mid-Point Assessment must include:

   i. An examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Plans and toward meeting the targets for performance measures as approved in the SUD Monitoring Protocol;

   ii. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

   iii. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

   iv. For milestones or targets identified by the independent assessor as at medium to high risk of not being met, recommendations for adjustments in the state's SUD Implementation Plan, or to pertinent factors that the State can influence that will support improvement, and

   v. An assessment of whether the state is on track to meet the SUD budget neutrality requirements in these STCs.

20.10. **SMI/SED Mid-Point Assessment.** The state must contract with an independent entity to conduct an independent Mid-Point Assessment by June 30, 2026. If the demonstration is not extended or is extended for a term that ends on or before this date, then this Mid-Point Assessment must address the entire term for which the SMI/SED Program under this demonstration was authorized as is possible given the necessary time for metrics calculation. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period

experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning and conduct of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of managed care organizations (MCOs), health care providers (including SMI/SED treatment providers), and beneficiaries, community groups, and other key partners.

a. The state must require that the assessor provide a Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than 60 calendar days after June 30, 2026. If requested, the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.

b. For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS proposed modifications to the SMI/SED Implementation Plan, the SMI/SED Financing Plan, and the SMI/SED Monitoring Protocol, for ameliorating these risks. Modifications to the applicable Implementation Plan, Financing Plan, and/or Monitoring Protocol are subject to CMS approval.

c. Elements of the Mid-Point Assessment must include:

   i. An examination of progress toward meeting each milestone and timeframe approved in the SMI/SED Implementation Plan, the SMI/SED Financing Plan, if applicable, and toward meeting the targets for performance measures as approved in the SMI/SED Monitoring Protocol;

   ii. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

   iii. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

   iv. For milestones or targets identified by the independent assessor as at medium to high risk of not being met, recommendations for adjustments in the state's SMI/SED Implementation Plans and/or SMI/SED Financing Plan or to other pertinent factors that the state can influence that will support improvement; and

   v. An assessment of whether the state is on track to meet the SMI/SED budget neutrality requirements in these STCs.

20.11. **Reentry Demonstration Initiative Mid-Point Assessment.** The state must contract with an independent entity to conduct a mid-point assessment of the reentry demonstration initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment Report.

The Mid-Point Assessment Report must integrate all applicable implementation and performance data from the first 2.5 years of implementation of the reentry demonstration initiative. The report must be completed by the end of the third year of demonstration implementation. In the event that the reentry demonstration initiative is implemented at a timeline within the demonstration approval period, such as not to provide adequate implementation period to contribute toward a meaningful mid-point assessment, the report may be completed during a future extension of the demonstration, assuming it would also extend the authority for the reentry demonstration initiative. In the event that CMS and the state do not extend the reentry demonstration initiative beyond the demonstration's approval period ending on June 30, 2028, the mid-point assessment must be completed and the report submitted to CMS no later than when the demonstration's Summative Evaluation Report is due to CMS, which is 18 months after the end of the demonstration approval period (STC 21.8). If requested, the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.

The state must require the independent assessor to provide a draft of the Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies used, the findings on demonstration progress and performance, including identifying any risks of not meeting milestones and other operational vulnerabilities, and recommendations for overcoming those challenges and vulnerabilities. In the design, planning, and execution of the mid-point assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: pre- and post- release providers participating in the state's reentry demonstration initiative, eligible and participating beneficiaries, and other key partners in carceral and community settings.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the Reentry Demonstration Initiative Implementation Plan and the Monitoring Protocol for ameliorating these risks subject to CMS approval.

Elements of the Mid-Point Assessment Report must include, but not be limited to:

a. An examination of progress toward meeting each milestone and timeframe approved in the Reentry Demonstration Initiative Implementation Plan and toward meeting the targets for performance metrics as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and progress toward performance metrics targets to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Reentry Demonstration Initiative Implementation Plan or to pertinent factors that the state can influence that will support improvement.

CMS will provide additional guidance for developing the state's Reentry Initiative Mid-Point Assessment Report.

20.12. **Compliance with Managed Care, Network Adequacy, Quality Strategy and EQR Reporting Requirements**. The state must comply with all managed care reporting regulations at 42 CFR Part 438 except as expressly identified as not applicable in the expenditure authorities incorporated into these STCs.

20.13. **State Data Collection.** The state must collect data and information necessary to oversee service utilization and rate setting by provider/plan, comply with the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP, obtain NCQA and other accreditations that the state may seek, and comply with other existing federal measure sets.

a. The state will use this information in ongoing monitoring of individual well-being, provider/plan performance, and continuous quality improvement efforts, in addition to complying with CMS reporting requirements.

b. The state must maintain data dictionary and file layouts of the data collected.

c. The raw and edited data will be made available to CMS within 30 days of a written request.

20.14. **Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS will withdraw an authority, as described in STC3.11, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

20.15. **Close-Out Report.** Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 21.7 and 21.8, respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out report.

d. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

e. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 20.1.

20.16. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operations, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, enrollment and access and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

20.17. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time, and location of the forum in a prominent location on its Medicaid website. The state must also post the most recent Annual Monitoring Report on its Medicaid website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

21. EVALUATION OF THE DEMONSTRATION

21.1. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable – in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 20.1.

21.2. **Independent Evaluator.** The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

21.3. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with:

a. Attachment A (Developing the Evaluation Design) of these STCs,

b. CMS's evaluation design guidance for SUD and SMI/SED, including guidance about substance use disorder, serious mental illness, and overall demonstration sustainability, and

c. Any applicable CMS evaluation guidance and technical assistance for the demonstration's other policy components.

The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined culturally appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation

approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic) – as these implementation strategies help create strong comparison groups and facilitate robust evaluation. The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STC 20.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design or submit a new Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

21.4. **Evaluation Budget.** A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

21.5. **Evaluation Design Approval and Updates.** The state must submit to CMS a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's Medicaid website within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Quarterly and Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.

21.6. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals. For example, hypotheses for the SUD component of the demonstration must support an assessment of the demonstration's success in achieving the core goals of the program through addressing, among other outcomes, initiation and compliance with treatment, utilization of health services in appropriate care settings, and reductions in key outcomes such as deaths due to overdose.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP; Consumer Assessment of Health Care Providers and Systems (CAHPS); the Behavioral Risk Factor Surveillance System (BRFSS) survey; and/or measures endorsed by National Quality Forum (NQF).

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policy components, including but not limited to the HRSN demonstration components, continuous eligibility, housing related support services, and the reentry demonstration initiative, and beneficiary experiences with access to and quality of care as well as changes in incidence of beneficiary medical debt. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration components in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

a. Specifically, evaluation hypotheses for the HRSN-relevant initiatives must focus on areas such as assessing the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on the prevalence and severity of beneficiaries' HRSNs and the provision of and beneficiary utilization of HRSN services. Furthermore, the HRSN evaluation must include analysis of how the initiatives affect utilization of preventive and routine care and beneficiary physical and mental health outcomes.

   In addition, the state must coordinate with its managed care plans to secure necessary data—for a representative beneficiary population eligible for the HRSN services—to conduct a robust evaluation of the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such an assessment will require setting up a data infrastructure and/or data sharing arrangement to collect data on beneficiary screening and rescreening and prevalence and severity of beneficiaries' HRSNs, among others. If the data system is not operational to capture necessary data for a quantitative evaluation by the time the state's evaluation activities must be conducted, the state must

provide applicable qualitative assessment to this effect leveraging suitable primary data collections efforts (e.g., beneficiary surveys).

Hypotheses must be designed to help understand, in particular, the impacts of HRSN-relevant initiatives on beneficiary health outcomes and experience. In alignment with the demonstration's objectives to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population, and/or community level.

The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing supports, nutrition services, medical respite, and community-based resources change over time in concert with new Medicaid funding toward those services. In addition, in light of how demonstration HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. Evaluation of the HRSN initiative is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

b. Evaluation of the reentry demonstration initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the reentry demonstration initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross- system communication and coordination; connections between carceral and community services; access to and quality of care in carceral and community settings; preventive and routine physical and behavioral health care utilization; non-emergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

   The state must also provide a comprehensive analysis of services rendered by type of service over the duration of the 90-day coverage period immediately prior to the expected date of release—to the extent feasible, and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this

coverage timeline facilitated providing more coordinated, efficient and effective reentry planning, enabled pre-release management and stabilization of physical and behavioral health conditions, and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage or pre-release services.

The demonstration's evaluation efforts will be expected to include an examination of carceral provider qualifications and standards, as well as the experiences of carceral and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, similar to the state's HRSN initiative, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the reentry demonstration initiative, including covering associated services.

c. Hypotheses for the SUD program must include an assessment of the objectives of the SUD component of this section 1115 demonstration. Examples include (but are not limited to): initiation and engagement with treatment, utilization of health services (emergency department and inpatient hospital settings), and a reduction in key outcomes, such as deaths due to overdose.

d. Hypotheses for the contingency management program must align with the goals of the SUD program. They should aim to increase rates of identification, initiation, and engagement in treatment; increase adherence to and retention in treatment; reduce overdose deaths; reduce utilization of emergency departments and inpatient hospital settings for treatment where preventable or medically inappropriate; reduce readmissions where preventable or medically inappropriate; and improve access to care for physical health outcomes among beneficiaries.

e. Hypotheses for the SMI/SED program must include an assessment of the objectives of the SMI/SED component of this 1115 demonstration. Examples include (but are not limited to): utilization and length of stay in emergency departments, reductions in preventable readmissions to acute care hospitals and residential settings, availability of crisis stabilization services, and care coordination.

f. For the continuous eligibility policy, the state must evaluate the impact of the policy on all relevant populations, appropriately tailored for the specific time span of eligibility. Evaluation hypotheses must focus on, but may not be limited to, enrollment continuity, utilization of age-appropriate preventive care, inpatient admissions and avoidable emergency care, and health disparities.

g. Hypotheses for the postpartum care initiative must cover outcomes related to primary and preventative care utilization, maternal and infant health, and if applicable, treatment for behavioral health, with a focus on addressing any demographic disparities.

h. Hypotheses for the MAC and TSOA initiatives must focus on areas such as assessing the impacts and effectiveness of the MAC and TSOA services in mitigating identified needs of beneficiaries.

i. For the presumptive eligibility policies for HCBS, the state must investigate the extent to which beneficiaries access to care changes, including but not limited to changes in time to first appointments. Also, the state should leverage monitoring data to evaluate whether the processes for presuming eligibility are accurate and reliable (i.e., the vast majority of presumed-eligible beneficiaries are eventually found to be eligible).

j. The state's evaluation efforts must develop robust hypotheses and research questions to assess the effectiveness of the state's DSHP-funded initiatives in meeting the desired goals of such programs in advancing and complementing its broader HRSN and other applicable initiatives for its Medicaid beneficiaries and other low-income populations. The analysis must be designed to help demonstrate how these programs support, for example, expanding coverage, improving access, reducing health disparities, and/or enhancing certain home- and community-based services or services to address HRSN or behavioral health.

As part of its evaluation efforts, the state must also conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. As noted above, the state must analyze the cost and cost effectiveness of the HRSN services and budgetary effects of the HRSN services; the overall medical assistance service expenditures; uncompensated care and associated costs for populations eligible for continuous eligibility, including in comparison to populations not eligible for such policies; and the reentry demonstration initiative. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

Finally, the state must accommodate data collection and analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities.

21.7. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension of the demonstration, the Interim Evaluation Report should be posted to the state's Medicaid website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration / phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for the extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses and a description of how the design was adapted should be included. If the state is not requesting an extension for a demonstration, an Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

f. The Interim Evaluation Report must comply with Attachment B (Preparing the Evaluation Report) of these STCs.

21.8. **Summative Evaluation Report.** The state must submit to CMS a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs, and in alignment with the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.

b. Once approved by CMS, the state must post the final Summative Report to the state's Medicaid website within 30 calendar days.

21.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan

may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

21.10. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

21.11. **Public Access.** The state shall post the final documents (e.g., Implementation Plan, Monitoring Protocol, Monitoring Reports, Mid-Point Assessment, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

21.12. **Additional Publications and Presentations.** For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration, over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

22. MONITORING ALLOTMENT NEUTRALITY

22.1. **Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement.** The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:

a. Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid Manual.

b. Use of Waiver Forms. Title XXI demonstration expenditures will be reported on the following separate forms designated for CHIP (i.e., Forms CMS-21 Waiver and/or CMS-21P Waiver), identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The state must submit separate CMS-21 waiver forms for each title XXI demonstration population.

c. Premiums. Any premium contributions collected under the demonstration shall be reported to CMS on the CMS-21 Waiver form (specifically lines 1A through 1D as applicable) for each title XXI demonstration population that is subject to

premiums, in order to assure that the demonstration is properly credited with the premium collections.

d. Claiming Period. All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the Form CMS-21 Waiver, net expenditures related to dates of service during the operation of the demonstration.

22.2. **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the demonstration. The state will continue to estimate matchable CHIP expenditures on the quarterly Forms CMS-21B for CHIP. On these forms estimating expenditures for the title XXI funded demonstration populations, the state shall separately identify estimates of expenditures for each applicable title XXI demonstration population.

a. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must report demonstration expenditures through Form CMS-21W and/or CMS-21P Waiver for the CHIP population. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver form with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

22.3. **Title XXI Administrative Costs.** All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.

22.4. **Limit on Title XXI Funding.** The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration populations described in STC 16 during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and the demonstration populations identified in these STCs) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

22.5. **Exhaustion of Title XXI Funds for CHIP Population.** If the state exhausts the available title XXI federal funds in a federal fiscal year during the period of the demonstration, the state must continue to provide coverage to the approved title XXI separate state plan population.

23. DESIGNATED STATE HEALTH PROGRAMS

23.1. **Designated State Health Programs (DSHP).** The state may claim FFP for designated state health programs subject to the limits described in this Section 23. DSHP are specific state programs that: (1) are population- or public health-focused; (2) aligned with the objectives of the Medicaid program with no likelihood that the DSHP will impede the primary objective of Medicaid, which is to provide coverage of services for low-income and vulnerable populations; and (3) serve a community largely made up of low-income individuals. This DSHP authority will enable the state to use state dollars that it otherwise would have spent on the DSHP specified in the Approved DHSP List (Attachment Y), for which it may claim and use FFP as specified on demonstration expenditures to support DSHP-funded initiatives, as described in STC 23.3(c). This DSHP authority will be available from DY9 – DY12.

a. The DSHP will have an established limit in the amount of $592,000,000 total computable expenditures, in aggregate, for DY9 – DY12.

b. The state may claim FFP for up to the annual amounts outlined in Table 21, plus any unspent amounts from prior years. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed the total for this demonstration period. The total amount of DSHP FFP that the state may claim in DY 9 through 12 combined may not exceed the non-federal share of amounts actually expended by the state for the DSHP- funded initiatives.

Table 21. Annual Limits in Total Computable Expenditures for DSHP.

	DY9	DY10	DY11	DY12
Total Computable Expenditures	**$113,249,020**	**$159,583,660**	**$159,583,660**	**$159,583,660**

c. The state must contribute $52,235,294 in original, non-freed up DSHP funds, for the remaining demonstration period towards its initiatives described in STC 23.3. These funds may only derive from other allowable sources of non-federal share and must otherwise meet all applicable requirements of these STCs and the Medicaid statute and regulations.

d. The state attests, as a condition of receipt of FFP under the DSHP expenditure authority, that all non-federal share for the DSHP is allowable under all applicable statutory and regulatory requirements, including section 1903(w) of the Act and its implementing regulations. The state acknowledges that approval of the DSHP expenditure authority does not constitute approval of the underlying sources of non- federal share, which may be subject to CMS financial review.

e. The Approved DSHP List is limited to programs that are: (1) population- or public heath- focused; (2) aligned with the objectives of the Medicaid program with no likelihood that the program will impede the primary objective of Medicaid to provide coverage for services for low-income and vulnerable populations; and (3) serve a community largely made up of low-income individuals. The state may only claim FFP for DSHP effective January 08, 2025. The Approved DSHP List is Attachment Y. Any changes the state wants to make to its DSHP program will require an amendment as specified in STC 3.7.

23.2. **Prohibited DSHP Expenditures.**

a. Allowable DSHP expenditures do not include any expenditures that are funded by federal grants or other federal sources (for example, American Rescue Plan Act funding, grants from the Health Resources and Services Administration, the Centers for Disease Control and Prevention) or that are included as part of any maintenance of effort or non-federal share expenditure requirements of any federal grant.

b. Additionally, allowable DSHP expenditures do not include expenditures associated with the provision of non-emergency care to individuals who do not meet citizenship or immigration status requirements to be eligible for Medicaid. To implement this limitation, 3.9 percent of total provider expenditures or claims through DSHP identified as described in STC 23.1 will be treated as expended for non-emergency care to individuals who do not meet citizenship or immigration status requirements, and thus not matchable. This adjustment is reflected in the Approved DSHP List (Attachment Y). Therefore, the state can claim up to the program limits in the Approved DSHP List.

c. In addition to 23.2.(a), the following types of expenditures are not permissible DSHP expenditures: expenditures that are already eligible for federal Medicaid matching funds, that are not likely to promote the objectives of Medicaid, or are otherwise prohibited by federal law. Exclusions that have historically fallen into these categories include, but are not limited to:

i. Bricks and mortar;

ii. Shelters, vaccines, and medications for animals;

iii. Coverage/services specifically for individuals who are not lawfully present or are undocumented;

iv. Revolving capital funds; and

v. Non-specific projects for which CMS lacks sufficient information to ascertain the nature and character of the project and whether it is consistent with these STCs.

23.3. **DSHP-Funded Initiatives.**

a. **Definition.** DSHP-funded initiatives are Medicaid or CHIP section 1115 demonstration activities supported by DSHPs, for which the state may claim FFP in accordance with STC 23.1 and 23.2 to fund the DSHP-funded initiatives as specified in STC 23.3(c).

b. **Requirements.** CMS will only approve those DSHP-funded initiatives that it determines to be consistent with the objectives of the Medicaid statute; specifically, to expand coverage (e.g., new eligibility groups or benefits), improve access to covered services including home- and community-based services and behavioral health services, improve quality by reducing health disparities, or increase the efficiency and quality of care.

c. **Approved DSHP-Funded Initiatives.** The initiatives listed below are approved DSHP-funded initiatives for this demonstration. Any new DSHP-funded initiative requires approval from CMS via an amendment to the demonstration that meets the applicable transparency requirements.

   i. HRSN services; and

   ii. HRSN infrastructure.

23.4. **DSHP Claiming Protocol.** The state will develop a DSHP Claiming Protocol, which the state will make available to CMS upon request. State expenditures for the DSHP must be documented in accordance with the protocol. The state may only claim FFP for DSHP effective January 08, 2025.

a. For all eligible DSHP expenditures, the state will maintain and make available to CMS upon request:

   i. Certification or attestation of expenditures.

   ii. Actual expenditure data from state financial information system or state client sub-system. The Claiming Protocol will describe the procedures used that ensure that FFP is not claimed for the non-permissible expenditures listed in STC 23.2.

b. The state will claim FFP for DSHP quarterly based on actual expenditures.

23.5. **DSHP Claiming Process.** Documentation of all DSHP expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs.

a. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. To the extent that DSHPs receive federal funds from any other federal programs, such funds shall not be used as a source of non- federal share to support expenditures for DSHPs or DSHP-funded initiatives under this demonstration.

b. The administrative costs associated with DSHPs (that are not generally part of normal operating costs for service delivery) shall not be included in any way as demonstration and/or other Medicaid expenditures.

c. DSHP will be claimed at the administrative matching rate of 50 percent.

d. Expenditures will be claimed in accordance with the CMS-approved DSHP Claiming Protocol.

e. DSHP program expenditures are eligible for federal match, for dates of payment made on or after the approval date of the DSHP expenditure authority within an amendment, extension, or new demonstration, as long as the services or costs were incurred in the State Fiscal Year (SFY) that corresponds to the date of the DSHP expenditure authority.

23.6. **Sustainability Plan.** The DSHP Sustainability Plan will describe the scope of DSHP-funded initiatives the state wants to maintain and the strategy to secure resources to maintain these initiatives beyond the current approval period. As part of the monitoring reports the state shall submit the DSHP Sustainability Report section in its annual report.

24. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION PERIOD

Due	Deliverable	STC
Administrative		
30 calendar days after demonstration approval	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
Post Approval Protocols		
60 calendar days after approval date (completed)	Submit Draft DSRIP Planning Protocol (Attachment C) and DSRIP Program Funding & Mechanics Protocol (Attachment D)	STCs 7.15, 7.16
90 calendar days after approval date (completed)	Submit Tribal Engagement and Collaboration Protocol (Attachment H)	STC 7.6
October 1, 2017 (completed)	Submit Value-Based Roadmap (Attachment E)	STC 7.21
60 calendar days after approval date (completed)	Submit Financial Executor Role (Attachment F)	STC 7.8
60 calendar days after approval date (completed)	Submit Foundational Community Supports Protocol (Attachment I)	STC 10.8
90 days after SUD program approval date (completed)	SUD Implementation Plan	STC 11.2
90 days after SMI program approval date (completed)	SMI Implementation Plan	STC 12.2
150 days after SUD program approval date	SUD and SMI/SED Monitoring Protocol	STC 20.6
150 days after approval date	Monitoring Protocol(s)	STC 20.7
9 months after approval date	Reentry Demonstration Initiative Implementation Plan	STC 14.9
9 months after approval date	Reentry Demonstration Initiative Reinvestment Plan	STC 14.10
180 days after approval date	Protocols for HRSN Infrastructure and HRSN Services	STC 15.7
60 days prior to implementation of HRSN	HRSN Rate Methodology	STC 15.15
180 days after approval date	HRSN MOE	STC 15.16
9 months after approval date	HRSN Implementation Plan	STC 15.19
90 days after approval date	Provider Rate Attestation Table	STC 16.14

Evaluations		
180 calendar days after approval date	Submit Draft Evaluation Design	STC 21.3
One year prior to the expiration of the demonstration	Submit Draft Interim Evaluation Report	STC 21.7
60 calendar days after receipt of CMS comments	Submit Revised Interim Evaluation Report	STC 21.7
Within 18 months after approval period ends	Submit Draft Summative Evaluation Report	STC 21.8
60 calendar days after receipt of CMS comments	Submit Revised Summative Evaluation Report	STC 21.8
No later than 60 calendar days after June 30, 2026	Submit SUD Mid-point Assessment	STC 20.10
No later than 60 calendar days after June 30, 2026	Submit SMI/SED Mid-point Assessment	STC 20.11
No later than 60 days after the third year of demonstration implementation	Submit Reentry Demonstration Initiative Mid-Point Assessment	STC 20.12
Quarterly/Annual/Final Reports		
Quarterly Deliverables, except 4th quarter: Due 60 days after end of each quarter	Quarterly Monitoring Reports	STC 20.8
90 days after end of demonstration year	Annual Monitoring Reports	STC 20.8
60 calendar days after the end of each quarter.	Quarterly Expenditure Reports (CMS 64)	STC 20.8
90 days after end of each demonstration year	Annual Budget Neutrality Reports	STC 20.8
Close-out Report due 120 days after the end of the demonstration	Close-out Report	STC 20.15

ATTACHMENT A
Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

The evaluation design is the state's plan for how it will accomplish the evaluation. In most cases, states must arrange with an independent evaluator to conduct the evaluation. The state, per the Special Terms and Conditions (STC), is required to submit an evaluation design to CMS for CMS approval after the demonstration is approved. The evaluation design needs to specify the state's hypotheses, evaluation questions, associated measures and analytic methods. To support the development of the evaluation design in accordance with CMS priorities and expectations, CMS is providing the following outline for the evaluation design. It is recommended that states and independent evaluators use this outline to develop the evaluation design for submission to CMS.

The sections in this outline include background, evaluation questions and hypotheses, methodology, methodological limitations, and attachments. It is important to include as much detail as possible when completing this outline, to provide CMS with the best information with which to review the evaluation design.

CMS expects evaluation designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. If the state needs technical assistance using this outline or developing the evaluation design, the state should contact its project officer.

Developing the Evaluation Design
Recommended Outline

Expectations for Evaluation Designs

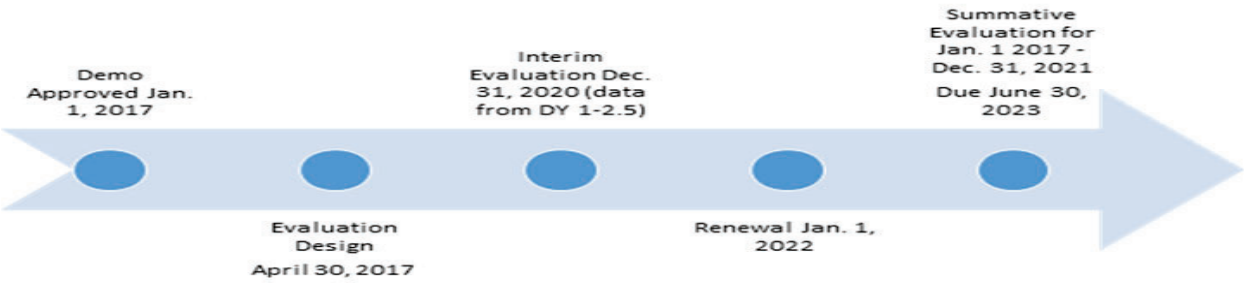
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- **A.** General Background Information;
- **B.** Evaluation Questions and Hypotheses;
- **C.** Methodology;
- **D.** Methodological Limitations;
- **E.** Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3) Identify the state's hypotheses about the outcomes of the demonstration:
   a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
   b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) Evaluation *Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
    a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
    b. Qualitative analysis methods may be used, and must be described in detail.
    c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
    d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
    e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
    f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

   If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
   a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
   b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
   c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
   d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

E. Special Methodological Considerations- CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include:

1) When the state demonstration is:
   a. Long-standing, non-complex, unchanged, or
   b. Has previously been rigorously evaluated and found to be successful, or
   c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes; and
    b. No or minimal appeals and grievances; and
    c. No state issues with CMS 64 reporting or budget neutrality; and
    d. No Corrective Action Plans (CAP) for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

F. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be

required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT B
Preparing the Evaluation Report

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

The evaluation report provides the analysis and summary of the hypotheses tested in the evaluation. The hypotheses, evaluation questions, and measures should align with those identified in the CMS approved evaluation design. The state, per the Special Terms and Conditions (STC), is required to submit to CMS an interim evaluation report and a summative evaluation report. To support the development of the interim and summative evaluation reports, CMS is providing the following outline for the evaluation reports. It is recommended that states and independent evaluators use this outline to develop the evaluation reports for submission to CMS.

The sections in this outline include an executive summary, background information, evaluation questions and hypotheses, methodology, methodological limitations, results, conclusions, interpretations, lessons learned and recommendations, and attachments. It is important to provide as much detail as possible when completing this outline, to provide CMS with the best information with which to review the evaluation reports.

If the state needs technical assistance using this outline or preparing the evaluation reports, the state should contact its project officer.

Preparing the Evaluation Report
Recommended Outline

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

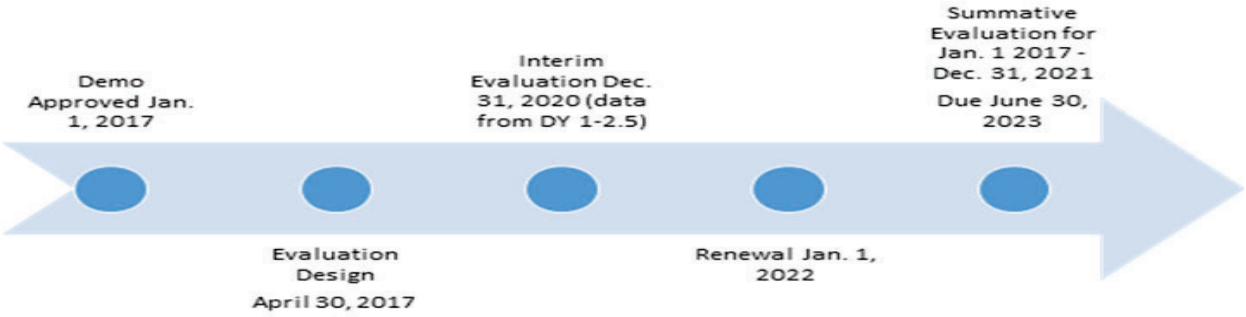
The format for the Interim and Summative Evaluation reports are as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination

of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. **Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. **General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
   1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
   2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
   3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
   4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal

level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2) Identify the state's hypotheses about the outcomes of the demonstration;
   a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
   b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
   c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Evaluation Design*—Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc?
2) *Target and Comparison Populations*—Describe the target and comparison populations; include inclusion and exclusion criteria.
3) *Evaluation Period*—Describe the time periods for which data will be collected
4) *Evaluation Measures*—What measures are used to evaluate the demonstration, and who are the measure stewards?

5) *Data Sources*—Explain where the data will be obtained, and efforts to validate and clean the data.
6) *Analytic methods*—Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations
This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results.
1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
   a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:
1) What lessons were learned as a result of the demonstration?
2) What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

1) Evaluation Design: Provide the CMS-approved Evaluation Design

ATTACHMENT C
DSRIP Planning Protocol

I. Preface

On January 9, 2017, the Centers for Medicare & Medicaid Services (CMS) approved Washington State's request for a section 1115(a) Medicaid demonstration entitled *Medicaid Transformation Project* demonstration (hereinafter MTP or "demonstration"). Part of this demonstration is a Delivery System Reform Incentive Payment (DSRIP) program, through which the state will make performance-based funding available to regionally-based Accountable Communities of Health (ACH) and their partnering providers. The demonstration is currently approved through December 31, 2021.

The Special Terms and Conditions (STC) of the demonstration set forth in detail the nature, character, and extent of federal involvement in the demonstration, the state's implementation of the expenditure authorities, and the state's obligations to CMS during the demonstration period. The DSRIP requirements specified in the STCs are supplemented by two attachments to the STCs. The DSRIP Planning Protocol (this document, Attachment C) describes the ACH Project Plans, the set of outcome measures that must be reported, transformation projects eligible for DSRIP funds, and timelines for meeting associated metrics.

This protocol is supplemented by a Project Toolkit and Project Measure and Performance Table. The toolkit provides additional details and requirements related to the ACH projects and will assist ACHs in developing their Project Plans.

In accordance with STC 34, the state may submit modifications to this protocol for CMS review and approval. Any changes approved by CMS will apply prospectively unless otherwise specified by CMS.

II. ACH Project Plan Requirements

a. Introduction

ACH Project Plans will provide an outline of the work that an ACH, through its partnering providers, will undertake. The plans must be developed in collaboration with community stakeholders and be responsive to community needs. The plans will provide details on how the selected projects respond to community-specific needs and further the objectives of the demonstration. The

plans also will describe the ACH's capacities, composition and governance structure. In order to be eligible to receive DSRIP incentive payments, an ACH must have an approved Project Plan.

There are three steps for ACH Project Plan approval:

1. ACHs must satisfy a two-phase certification process that will confirm the ACHs are prepared to submit Project Plan applications. Completion of each phase will qualify the ACHs for Project Design funding. Certification criteria will be set forth by the state, and ACHs will submit both phases of certification information to the state within the required time frames. The state will review and approve each certification phase prior to distribution of Project Design funds for that phase.

    a. Phase 1 certification requirements must be submitted to the state by May 15, 2017.
    b. Phase 2 certification requirements must be submitted to the state by August 14, 2017.

    Certification criteria are described further below.
2. ACHs must develop and submit a Project Plan application for approval. The components of the Project Plan are described in STC 36 and further detailed in this protocol. Completed Project Plan applications are due to the state by November 16, 2017.
3. The state and its contracted Independent Assessor will evaluate and (if appropriate) approve ACH Project Plans. ACHs with approved Project Plans are eligible to receive performance-based incentive payments. The state and the Independent Assessor will approve Project Plans as early as November 20, 2017, and no later than December 22, 2017.

The state will develop and post a draft Project Plan Template for public feedback prior to releasing a final version. Design funds attached to each certification phase will support ACHs as they address specific requirements and submit their Project Plans. As ACHs develop Project Plans, they must solicit and incorporate community and consumer input to ensure that Project Plans reflect the specific needs of the region. After the Project Plans are submitted to the state, they will be reviewed by an Independent Assessor contracted by the state. The Independent Assessor will review and make recommendations to the state for approval of Project Plans. The state must approve of Project Plans in order to authorize DSRIP incentive funding. Project Plans may be subject to additional review by CMS.

b. ACH Certification Criteria

The certification process is intended to ensure that each ACH is prepared to serve as the lead entity and single point of accountability to the state for the transformation projects in its region. The certification application solicits information to ensure that: (a) the ACH is qualified to fulfill the role of overseeing and coordinating regional transformation activities; (b) the ACH meets the composition standards outlined in STC 23; and (c) the ACH is eligible to receive project design funds. There are two phases to the certification process. According to a timeline developed by the state, each ACH must complete both phases and receive approval from the state before submitting a Project Plan application.

Phase 1 Certification: Each ACH must demonstrate compliance and/or document how it will comply with state expectations in the following areas, at a minimum:

1. Governance and Organizational Structure, including compliance with principles outlined in STC 22 and decision-making expectations outlined by the state.
2. Initiation or continuation of work with regional Tribes, including adoption of the Tribal Engagement and Collaboration Policy or alternate policy as required by STC 24.
3. Community and Stakeholder Engagement to demonstrate how the ACH is accountable and responsive to the community.
4. Budget and funds flow, including how design funds will support project plan development.
5. Clinical capacity and engagement to demonstrate engagement and input from clinical providers.
6. Other requirements as the state may establish.

Phase 2 Certification: Each ACH must demonstrate that it is in compliance with state expectations in the following areas, at a minimum:

1. Governance and Organizational Structure, including compliance with principles outlined in STC 22 and decision-making expectations outlined by the state. ACHs will describe whether any developments or adjustments have occurred since Phase 1 Certification.
2. Tribal Engagement and Collaboration describing specific activities and events that further the relationship between the ACH and Tribes.
3. Community and Stakeholder Engagement to describe concrete actions that have occurred since Phase 1 Certification. Provide details for how

the ACH will satisfy public engagement requirements for Project Plan development outlined in STC 23.

4. Budget and funds flow to summarize strategic use of funding and decision making processes regarding incentive funding distribution.
5. Data-informed decision making strategies, including processes for applying available data to project selection and implementation planning.
6. Transformation project planning to describe progress on project selection processes.
7. Other requirements as the state may establish.

c. *ACH Project Plan Requirements*

As part of this demonstration, each ACH and its regional participating providers will be responsible for implementing a set of projects selected from the Project Toolkit. The Project Plan:

- Provides a blueprint of the work that each region, coordinated by the ACH, will undertake through the implementation of these projects.
- Explains how the regional work responds to community-specific needs, relates to the mission of the ACH, and furthers the objectives of the demonstration.
- Provides details on the ACH's composition and governance structure, specifically any adjustments to refine the model based on initial lessons learned.
- Demonstrates ACH compliance with the terms and conditions of participation in the demonstration.
- Incorporates the voice and perspective of the community and consumers through outreach and engagement.

Each ACH will submit a Project Plan to the state for review. The Project Plans will be used by the state to assess ACH preparedness in planning and implementing its local demonstration program and the regional alignment with the demonstration's overall objectives and requirements. The state's contracted Independent Assessor will review and evaluate Project Plans and make recommendations to the state for approval/remediation of each Plan. In addition, commitments made by an ACH in its Project Plan must be consistent with the terms of a contract between the state and the ACH, outlining the requirements and obligations of the ACH as the lead and other partnering providers in the ACH in order to be eligible to receive DSRIP incentive funding.

The Project Plan Template will provide a structured format and outline the information required to be submitted by each ACH as part of its Project Plan. The template will be divided into two main sections and will include scoring criteria. Section I will focus on how the ACH, through its partnering providers, is being directly responsive to the needs and characteristics of the community it serves. It will include details regarding the ACH's overall programmatic vision, composition, and decision-making processes. Section II will ask ACHs to provide detailed project-specific plans. The state may add additional requirements to the Project Plan application in addition to what is outlined below.

The categories for Section I of the Project Plan template will include:

1. *ACH Theory of Action and Alignment Strategy*: Rationale explaining how the ACH plans to improve the quality, efficiency, and effectiveness of care processes in its community.

2. *Governance*: Description of how the ACH complies with the state's governance and decision-making expectations.

3. *Regional Health Needs Inventory:* Description of how the ACH used available data to identify target populations and ensure that project selection responds to community-specific needs, aims to reduce health disparities, and furthers the objectives of the demonstration.

4. *Community and Consumer Engagement and Input*: Evidence of public input into the project plans, including consumer engagement. ACHs must demonstrate that they solicited and incorporated input from community members and consumers. The plan must also describe the processes the ACHs will follow to engage the public and how such engagement will continue throughout the demonstration period.

5. *Tribal Engagement and Collaboration*: Demonstration that the ACH has complied with the Tribal Engagement and Collaboration requirements.

6. *Budget and Funds Allocation*: Description of how decisions about the distribution of funds will be made, the roles and responsibilities of each partner in funds distribution and a detailed budget for the remaining years of the demonstration.

7. *Value-based Payment Strategies:* Description of the regional strategies to support attainment and readiness of statewide VBP targets.

For each selected project, Section II requires, that ACHs provide details regarding:

1. *Partnering Organizations*: Description of the partnering providers, both traditional and non-traditional, that have committed to participate in projects. Partnering providers must serve and commit to continuing to serve the Medicaid population. ACHs must ensure that together, these partnering providers serve a significant portion of Medicaid covered lives in the region and represent a broad spectrum of care and related social services that are critical to improving how care is delivered and paid for. Additional details on recommended implementation partners will be provided in Project Toolkit guidance documents.

2. *Relationships with Other Initiatives:* The ACH will attest to securing descriptions of any initiatives that its partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place and ensuring these projects are not duplicative of DSRIP projects. In DY 2, partnering providers will be required to provide descriptions and attest that DSRIP projects are not duplicative of other funded projects and do not duplicate the deliverables required by the former project(s). If projects are built on one of these other projects, or represent an enhancement of such a project, that may be permissible but the ACH will be required to explain how the DSRIP project is not duplicative of activities already supported with other federal funds.

3. *Monitoring and Continuous Improvement*: Description of the ACH's plan for monitoring project implementation progress and continuous improvement or adjustments in alignment with Section V (Process for ACH Project Plan Modification).

4. *Expected Outcomes*: Description of the outcomes the ACH expects to achieve in each of the project stages, in alignment with the metrics and parameters provided by the state.

5. *Sustainability:* Description of how the projects support sustainable delivery system transformation for the target population.

6. *Regional Assets, Anticipated Challenges and Proposed Solutions*: Description of the assets that the ACH and partnering providers bring to the delivery system transformation efforts, and the challenges or barriers they expect to confront in improving outcomes and lowering costs for the target populations. For identified challenges, the ACH must describe how

it expects to mitigate the impact of these challenges and what new capabilities will be required to be successful.

7. *Implementation Approach and Timing*: Explanation of the planned approach to accomplishing each set of required project milestones for each of the selected projects.

III. Project Toolkit

a. *Overview of Project Categories*

Each ACH, through its partnering providers, is required to implement at least four transformation projects and participate in statewide capacity building efforts to address the needs of Medicaid beneficiaries. These projects will be spread across the following three domains:

1. Health Systems and Community Capacity Building
2. Care Delivery Redesign (at least two projects)
3. Prevention and Health Promotion (at least two projects)

The Domains, and the strategies defined within each Domain, are interdependent. Domain 1 is focused on systemwide planning and capacity-building to reinforce transformation projects. Domain 1 strategies are to be tailored to support efforts in Domain 2 and Domain 3; projects in Domain 2 and Domain 3 integrate and apply Domain 1 strategies to the specified topics and approaches.

ACHs will develop detailed implementation plans. As described in Section IV, project progress will be measured based on state-defined milestones and metrics that track project planning, implementation, and sustainability.

b. *Description of project domains*

i. Health Systems and Community Capacity Building

This domain addresses the core health system capacities to be developed or enhanced to transition the delivery system according to Washington's Medicaid Transformation demonstration. Domain 1 does not outline individual projects, but rather three required focus areas to be implemented and expanded across the delivery system, inclusive of all provider types, to benefit the entire Medicaid population. The three areas of focus are: financial sustainability through value-based payment, workforce, and systems for population health management. Each of these areas will need to be addressed progressively throughout the five-year

timeline to directly support Domain 2 and Domain 3 transformation project success.

ii. **Care Delivery Redesign**
Transformation projects within this domain focus on innovative models of care that will improve the quality, efficiency, and effectiveness of care processes. Person-centered approaches and integrated models are emphasized. Domain 2 includes one required project and three optional projects. ACHs will be required to select at least one of the optional projects for a minimum of two Domain 2 projects in total.

iii. **Prevention and Health Promotion**
Transformation projects within this domain focus on prevention and health promotion to eliminate disparities and achieve health equity across regions and populations. Domain 3 includes one required project and three optional projects. ACHs will be required to select at least one of the optional projects for a minimum of two Domain 3 projects in total.

Table 1. Menu of Transformation Projects

#	Project	Description
	Health Systems and Community Capacity Building	Foundational activities that address the core health system capacities to be developed or enhanced to transition the delivery system in accordance with the demonstration's goals and transformation objectives.
	Financial sustainability through value-based payment	Paying for value across the continuum of care is necessary to ensure thesustainability of the transformation projects undertaken through this demonstration. A transition away from paying for volume may be challenging to some providers, both financially and administratively. Asnot all provider organizations are equipped at present to successfully operate in these payment models, providers may need assistance to develop additional capabilities and infrastructure.
	Workforce	The health services workforce will need to evolve to meet the demands ofthe redesigned system of care. Workforce transformation will be supported through the provision of training and education services, hiringand deployment processes, and integration of new positions and titles to support transition to team-based, patient-centered care and ensure the equity of care delivery across populations.

Systems for population healthmanagement		The expansion, evolution, and integration of health information systemsand technology will need to be supported to improve the speed, quality, safety, and cost of care. This includes linkages to community-based care models. Health data and analytics capacity will need to be improved to
		support system transformation efforts, including combining clinical and claims data to advance VBP models and to achieve the triple aim.
Care Delivery Redesign		Strategies that focus on innovative models of care to improve the quality, efficiency, and effectiveness of care processes. Person-centeredapproaches and integrated models are emphasized.
2A	**Bi-directional integration of physicaland behavioral health through care transformation**	The Medicaid system aims to support person-centered care that delivers the right services in the right place at the right time. Primary care servicesare a key gateway to the behavioral health system, and primary care providers need additional support and resources to screen and treat individuals for behavioral health care needs, provide or link with appropriate services, and manage care. Similarly, for persons not engagedin primary care services, behavioral health settings can be equipped to provide essential primary care services. Integrating mental health, substance use disorder, and primary care services has been demonstrated to deliver positive outcomes and is an effective approach to caring for people with multiple health care needs. Through a whole-person approachto care, physical and behavioral health needs will be addressed in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through managed care organizations, for people enrolled in Medicaid.

2B	**Care coordination**	Care coordination is essential for ensuring that children and adults withcomplex health service needs are connected to the evidence-based interventions and services that will improve their outcomes. Appropriately coordinated care is especially important for high-risk populations, such as those living with chronic conditions, those impacted by the social determinants of health such as unstable housing and/or food insecurity, the aging community, and those dependent on institutionalizedsettings. Communities are challenged to leverage and coordinate existing services, as well as establish new services to fill gaps. Without a centralized approach to "coordinating the coordinators," a single person might be assigned multiple care coordinators who are unaware of one another, potentially provide redundant services, and risk creating confusion for the individual.
2C	**Transitional care**	Points of transition out of intensive services/settings, such as individualsdischarged from acute care, inpatient care or from jail or prison into the community are critical intervention points in the care continuum. Transitional care services provide opportunities to reduce or eliminate avoidable admissions, readmissions and jail use. Individuals discharged from intensive settings may not have a stable environment to return to or may lack access to reliable care. Transitions can be especially difficult on beneficiaries and caregivers when there are substantial changes in medications or routines or an increase in care tasks. This project includes multiple care management and transitional care approaches.
2D	**Diversion interventions**	Diversion strategies provide opportunities to re-direct individuals away from high-cost medical and legal avenues and into community-based health care and social services that can offer comprehensive assessment,care/case planning and management to lead to more positive outcomes. This strategy promotes more appropriate use of emergency care servicesand also supports person-centered care through increased access to primary care and social services, especially for medically underserved populations.
Prevention and Health Promotion		Projects focus on prevention and health promotion to eliminate disparities and achieve health equity across regions and populations.

3A	**Addressing opioid usepublic health crisis**	The opioid epidemic affects communities, families, and overwhelms law enforcement, health care and social service providers. Opioid use disorderis a devastating and life-threatening chronic medical condition and accessto treatments that support recovery and access to lifesaving medications to reverse overdose needs to be improved. This project will support strategies focused on addressing prevention, treatment, overdose prevention and recovery supports aimed at supporting whole-person health
3B	**Reproductive and maternal/child health**	Focusing on the health of women and children is a primary focus for theMedicaid program as Medicaid funds more than half of the births in the state and provides coverage to more than half of Washington's children.This project focuses on ensuring access to ongoing women's health careto improve utilization of effective family planning strategies. It further focuses on providing mothers and their children with home visits that have been demonstrated to improve maternal and child health. Home visitors work with the expectant or new mother in supporting a healthy pregnancy, by recognizing and reducing risk factors, promoting prenatalhealth care through healthy diet, exercise, stress management, ongoing well-woman care, and by supporting positive parenting practices that facilitate the infant and young child's safe and healthy development. Child health promotion is a state priority to keep children as healthy andsafe as possible, which includes parents accessing timely and routine preventative care for children, especially well-child screenings and assessments.
3C	**Access to oral healthservices**	Oral health impacts overall health and quality life, and most oral disease is preventable. Oral disease has been associated with increased risk for serious adverse health outcomes. Increasing access to oral health servicesfor adults provides an opportunity to prevent or control the progression oforal disease, and to reduce reliance on emergency departments for oral pain and related conditions. This project focuses on providing oral health screening and assessment, intervention, and referral in the primary care setting, or through the deployment of mobile clinics and/or portable

		equipment. The project seeks to leverage the primary care workforce, andto strengthen relationships between primary care and dental providers, through stronger referral networks, improved communications, and shared incentives.
3D	**Chronic disease prevention and control**	Chronic health conditions are prevalent among Washington's Medicaid beneficiaries, and the number of individuals with or at risk for chronic disease is increasing. Disease prevention and effective management is critical to quality of life and longevity. Many individuals face cultural, linguistic and structural barriers to accessing quality care, navigating the health care system, and understanding how to take steps to improve their health. Improving health care services and health behaviors is only part ofthe solution. Washington State recognizes the impact that factors outside the health care system have on health and is committed to a "health in all policies" approach to effective health promotion and improved treatment of disease. The Chronic Disease Prevention and Control Project focuses on integrating health system and community approaches to improve chronic disease management and control.

IV. Project Stages, Milestones, and Metrics

a. Overview

In accordance with STC 35, over the duration of the demonstration, the state will shift accountability from a focus on rewarding achievement of progress milestones in the early years of the demonstration to rewarding improvement on performance metrics in the later years of the demonstration. During Years 2, 3 and 4, ACHs will be required to report against several progress milestones for each project, as described further below and as detailed in the Project and Metrics Specification guide. These progress milestones are, by definition, 'pay-for-reporting' or 'P4R,' since ACHs will be rewarded based on reported progress. Project progress milestones are defined in the Project Toolkit, specific to each project focus, and organized into three core categories: project planning milestones, project implementation progress milestones, and scale and sustain milestones.

To monitor performance, ACHs will be accountable for achieving targeted levels of improvement for project-specific outcome measures. These measures are primarily "pay-for-performance," or "P4P," since ACHs are only rewarded if

defined outcome metric targets are achieved. However, a subset of these measures will be rewarded on a P4R basis for reasons that include: to allow ACHs time for project implementation activities; to allow time to establish necessary reporting infrastructure; and to allow for the testing of new, innovative outcome measures

for project areas where there is a lack of nationally-vetted, widely used outcomemeasures. Performance metrics are consistent with the objectives of the demonstration as outlined in STC 30.

Table 2 below summarizes the different categories of measures. Each category isdescribed in further detail below.

Table 2. Demonstration Milestone/Metric Categories

Milestone/Metric Type	DY1 (2017)	DY2 (2018)	DY3 (2019)	DY4 (2020)	DY5 (2021)	DY6 (2022)
Project Progress Milestones	NA	P4R	P4R	P4R	NA	NA
Performance Metrics	NA	NA	P4R/P4P	P4R/P4P	P4R/P4P	P4R/P4P
Value-based Payment Metrics	P4R/P4P	P4R/P4P	P4R/P4P	P4R/P4P	P4P	N/A[1]

b. *Progress Milestones (Capacity Building Elements, Progress/Planning Milestones,and Metrics)*

During demonstration Year 1, each ACH will be responsible for the development,submission and approval of a Project Plan application. As part of the Project Planapplication, the ACH will provide a timeline for implementation and completion of each project, in alignment with progress milestones specified in the Project Toolkit and accompanying documents. General categories of progress milestones required to be completed for each project include:

- Identify target population and assess partnering providers' capacity tofulfill project requirements. Collectively, partnering providers should serve a significant portion of

[1]As described in the DSRIP Funding and Mechanics Protocol, it is important to note that this change only relates to MCO and ACH VBP incentives under DSRIP P4R and P4P. The VBP adoption targets remain for statewide accountability and are reinforced through the Apple Health Appendix and the state's managed care withhold program.

Medicaid covered lives in the region andrepresent a broad spectrum of care and related social services that are critical to improving how care is delivered and paid for.

- Engage and obtain formal commitment from partnering providersresponsible for carrying out project activities.
- Develop a detailed implementation plan, including timing of activities,financial sustainability, workforce strategies, and population health management.
- Ongoing reporting of standardized process measures, including number ofindividuals served, number of staff recruited and trained, and impact measures as defined in the evaluation plan.

c. *Performance Metrics* (Statewide and Project-level Outcome Metrics)

See Appendix II for the project metrics that will be used to measure progress against meeting project goals and targeted levels of improvement against outcome-based performance indicators. Section III of the Funding and MechanicsProtocol provides further detail on how identified measures will be used to evaluate ACH performance.

d. Value-based Payment Milestones

Pursuant to STC 40, the state will update its Value-based Roadmap annually, which will address how the state will achieve its goal of converting 90 percent ofMedicaid provider payments to reward outcomes by 2022. This Roadmap is a document that describes the payment reforms required for a high-quality and financially sustainable Medicaid delivery system and establishes VBP targets and incentives for the Managed Care Organizations (MCOs) and ACHs. This document also serves to revise and clarify the details surrounding Washington State's VBP incentives and framework.

Achievement of VBP targets will be assessed at both a regional and MCO- specific level. As indicated in Table 3, ACHs and MCOs will be rewarded basedon reported progress in the early years of the demonstration. This will shift to rewarding for performance on the VBP targets.

Table 3. Value-based Payment Milestone Categories

Through this demonstration, the DSRIP program and initiatives such as

the HealthCare Payment Learning Action Network will yield new best practices. Therefore,this Roadmap will be updated annually throughout the demonstration to ensure long-term sustainability of the improvements made possible by the DSRIP investment and that best practices and lessons learned can be incorporated into thestate's overall vision of delivery system reform.

Washington will submit quarterly progress updates to CMS, which will includethe progress made both in terms of total dollars included in VBP arrangements and quantitative and qualitative lessons learned.

V. Process for Project Plan Modification

No more than twice a year, ACHs may submit proposed modifications to an approvedProject Plan for state review and approval/denial. In certain limited cases it may become evident that the methodology used to identify a performance goal and/or improvement target is no longer appropriate, or that unique circumstances/developments outside of an ACH's control require the ACH to modifyits original plan. Examples of these circumstances could include a significant regulatory change that requires an ACH to cease a planned project intervention or initiate substantial changes to the way a standard performance metric is measured, requiring an ACH to modify its planned approach.

In order to request a Project Plan modification, an ACH must submit a formal request,with supporting documentation, for review by the state. The state will have 60 calendar days to review and respond to the request. Allowable Project Plan modifications are not anticipated to change the overall ACH project incentive valuation. However, modifications to decrease scope of a project may result in a decrease in the valuation of potential earnable funds. Unearned funds as a result of a decrease in the scope of a project will be directed to the Reinvestment pool and earned in accordance with the DSRIP Funding and Mechanics Protocol (Attachment D). The state will not permit modifications that lower expectations for performance because of greater than expected difficulty in meeting a milestone. Removal of a planned project intervention may result in a forfeiture of funding for that project as determined by the state,

VI. Health Information Technology. (The state will discuss how it plans to meet the Health IT goals/milestones outlined in the STCs.)

In accordance with STC 39, the state will use Health Information Technology ("Health IT") and Health information exchange services to link core providers acrossthe continuum of care to the greatest extent possible. To detail how the state will achieve its stated Health IT goals, the state will provide a Health IT strategy by April1, 2017. That document provides detailed tactics and initiatives, technical gaps addressed, critical actions, policy levers and key metrics in place or planned for the following key business processes:

1. Addressing data needs and gaps
2. Acquiring Clinical Data
3. Leveraging Data Resources
4. Supporting clinical decisions with integrated patient information
5. Ensuring data integrity
6. Making large sets of clinical data available for program and business decisions

Washington State Health Care Authority

Medicaid Transformation Project (MTP) Toolkit

May 2022

Centers for Medicare and Medicaid Services (CMS) approved Washington's MTP Toolkit in June 2017 as part of the Delivery System Incentive Payment (DSRIP) planning protocol. The CMS-approved Project Toolkit contains the final projects, evidence-based approaches/strategies, and metrics for the Medicaid Transformation Project. (MTP) A timeline and summary of modifications made to this document (since CMS approval) are below.

- June 2017: approved by CMS as part of the DSRIP planning protocol.
- October 2017: revised to reflect the removal of five project pay-for-performance (P4P) metrics. The list of metrics and associated rationale and other resources are available on the MTP metrics page.
- July 2018: revised to streamline and clarify reporting requirements associated with achievement values (AVs), updated to reflect change in pay-for-reporting (P4R) metrics, minor change to one P4P metric (inpatient hospital utilization replaced by acute hospital utilization, per Healthcare Effectiveness Data and Information Set (HEDIS) 2018 recommendation).
- August 2019: the state adopted adjustments to the set of DSRIP accountability metrics associated with the Project Toolkit. More information is available on the MTP metrics page. The following P4P metric updates were incorporated into the Project Toolkit:
    - Metric: dental sealants for children at elevated risk: deactivate for ACH P4P accountability for demonstration year (DY)4. Assess activation for DY5 when revised specifications available. Applies to Project 3C.
    - Metric: medication management for people with asthma (National Quality Forum (NQF) 1799)): No change to DY3. In DY4, remove medication management for people with asthma and replace with asthma medication ratio (NQF 1800). Applies to Project 2A and 3D.
- September 2019: typos corrected in Appendix A: P4R and P4P AV association.
- June 2021: updated P4P metrics consisting with HEDIS changes for DY4 and DY5. The following measures were updated based on the changes:
    - Metric: Children's and Adolescent's Access to Primary Care Practitioners (CAP) was retired.
    - Metric: Child and Adolescent Well-Care Visits 3-21 Years of Age replaces CAP.
    - Metric: Well-Child Visits in the 3-6 Years of Age was retired.
    - Metric: Child and Adolescent Well-Care Visits 3-11 Years of Age replaces Well-Child Visits 3-6 Years of Age.
    - Metric: Well-Child Visits in the First 15 Months of Life was retired.
    - Metric: Well-Child Visits in the First 30 Months of life replaces Well-Child Visits in the First 15 Months of Life.
    - Metric: Comprehensive Diabetes Care: Medical Attention for Nephropathy retired.
    - Metric: Kidney Health Evaluation with Patients with Diabetes replaces CDC: Nephropathy.
- May 2022: DY6 adjustments, including project achievement values added to each project section for P4R and P4P.

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Using the Project Toolkit: definitions

Project objective: aim the project is intended to achieve.

Target population: population the project is intended to address. For each project selected, the Accountable Community of Health (ACH) must define the target population, informed by regional needs, and based on the target population defined in the toolkit. ACHs may choose one or more target populations.

Evidence-based approach: menu of interventions available for the project. One or more evidence-based approaches are identified to serve as a menu of interventions for each project. ACHs may pursue one of the following approaches:

- Selecting one evidence-based approach for the entire project.
- Combining evidence-based approaches for the entire project.
- Applying different evidence-based approaches for different target populations/geographies for the project.

ACHs are required to implement one of the evidence-based approaches identified under the selected project or identify another, similar evidence-based approach. If selecting an alternative evidence-based approach, the ACH must demonstrate convincingly its equivalency to those in the toolkit, including the ability to achieve required project metrics.

Project stages and milestones: each project progresses from project planning, implementation, and sustainability. Each project is divided into three stages, which has defined milestones. ACHs must provide proof of completion of each milestone within a specified timeline to earn receive full project incentive funds from DY2 to DY4. To the extent possible, milestones, timeline, and proof of completion are standardized across projects. ACHs are awarded AVs for successful completion of project milestones according to the toolkit timeline.

P4R recurrent deliverables and P4P project metrics: in addition to milestones listed in the project stage, each ACH will be responsible for additional, recurrent P4R deliverables from DY2 to DY6. Each ACH will be held accountable and awarded incentive funds based on a P4P basis from DY3 through DY6 for the metrics listed in the toolkit. All P4P measurement and calculations will be produced by the state on an annual basis. Specifics on project performance measurement are further detailed in the DSRIP Measurement Guide.

Project incentive funds are earned on AVs for each specified item in the toolkit (project milestones, recurrent P4R deliverables, P4R metrics, and P4P metrics). See Appendix A: AV snapshot by project for a full schedule of AVs.

Project implementation guidelines: additional details on the project's core components, including health systems and community capacity building strategies and evidence-based approaches that are intended to guide ACHs' development of project implementation plans and quality improvement plans (QIPs).

Appendix A: P4R and P4P AV association: tables provide a quick reference for AVs for P4R and P4P funds by project by year.

Appendix B: Project Toolkit P4P metrics: ACHs are accountable for achieving targeted levels of improvement for project-specific outcome metrics. The tables provide a quick reference of the final project performance metrics used to measure ACH progress toward meeting project goals and targeted levels of improvement against outcome-based performance indicators.

Domain 1: health systems and community capacity building

This domain addresses the core health system capacities to be developed or enhanced to transition the delivery system under MTP. Domain 1 outlines three required focus areas: financial sustainability through value-based payment, workforce, and systems for population health management. Each of these areas will need to be addressed progressively throughout the five-year timeline to directly support Domain 2 and Domain 3 transformation project success.

Financial sustainability through value-based purchasing (VBP)

Overarching goal

Achieve the target of driving 90 percent of state-financed health care to value-based payment by the end of 2021.

The success and sustainability of the state's DSRIP program is largely dependent on moving along the value-based payment continuum as a state and at the regional level. ACHs may earn VBP incentives by reporting progress on VBP milestones (P4R), and improvement and attainment of VBP targets (P4P) in their region. ACHs will be primarily rewarded on progress in the early years, shifting to performance in later years.

VBP categories as defined by the Health Care Payment Learning Action Network (HCP-LAN) Framework will be used for calculating the annual targets below. Targets will be calculated by dividing the total Medicaid dollars spent in HCP-LAN categories 2C and higher by total Medicaid managed care organization (MCO) payments to providers.

Annual targets

Percentage of provider payments in HCP-LAN categories 2C or above required to earn VBP incentives.

Table 1: VBP targets

	DY1	DY2	DY3	DY4	DY5	DY6
HCP-LAN category 2C-4B	30%	50%	75%	85%	90%	90%[1]
Subset of goal above: HCP-LAN category 3A-4B	-	10%	20%	30%	50%	N/A
Payment in Advanced alternative payment methods (APMs)	-	-	TBD	TBD	TBD	N/A

Further information on regional, MCO, and statewide VBP targets, and how incentives are earned are available in the Apple Health Appendix and the DSRIP Measurement Guide.

Governance

HCA will create and facilitate a statewide Medicaid Value-based Payment (MVP) Action Team. The MVP Action Team will serve as a learning collaborative to support ACHs and MCOs in attainment of Medicaid VBP targets. It will serve as a forum to help prepare providers for value-based contract arrangements and to provide guidance on HCA's VBP definition (based on the HCP-LAN Framework). Representatives may include state, regional and local leaders, and stakeholders.

[1] As described in the Funding and Mechanics Protocol, statewide accountability for VBP remains in DY6 but state will no longer provide regional ACH incentives and statewide MCO incentives. This change was made due to the limited total funding available in DY6 and the significant VBP advancement DY1-DY5. As such, the subset goal and APM requirement are not applicable to DY6.

Project stages

Table 2: stage 1 – financial sustainability through VBP planning

Responsibility (regional/ statewide)	Activity	Timeline (complete no later than)
Statewide	The MVP Action Team will assist HCA in performing an assessment to capture or validate a baseline of the current VBP levels. To the extent assessments have already been conducted, the MVP Action Team will build from those assessments. Building from existing work when applicable, the MVP Action Team will: • Assist HCA in deploying survey/attestation assessments to facilitate the reporting of VBP levels to understand the current types of VBP arrangements across the provider spectrum. • Perform and/or review assessments of VBP readiness across regional provider systems. • Develop recommendations to improve VBP readiness across regional provider systems.	DY2, Q4

Regional	To support regional attainment of VBP targets, ACHs will achieve the following milestones:
	• Inform providers of VBP readiness tools to assist their move toward value-based care. Some viable tools may include:
	  ○ NACHC Payment Reform Readiness Toolkit
	  ○ AMA Steps Forward – preparing your practice for value-based care
	  ○ Rural Health Value Team's comprehensive Value-Based Care Strategic Planning Tool
	  ○ Assessments deployed by the Healthier Washington Collaboration Portal (WA Portal), formerly known as the Practice Transformation Support Hub, and the Transforming Clinical Practice Initiative (TCPI).
	  ○ Adoption of diagnostic coding in dental for bi-directional medical/dental data sharing and population health.
	• Connect providers to training and/or technical assistance offered through HCA, WA Portal, MCOs, and/or the ACH.
	• Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the annual Paying for Value provider survey.
	• Support providers in developing strategies to move toward value-based care.
		DY2, Q4

Table 3: stage 2 – financial sustainability through VBP implementation

Responsibility (regional/ statewide)		Timeline (complete no later than)
Statewide	Perform ongoing monitoring of regional, MCO, and statewide VBP attainment as described in the Apple Health Appendix.	DY5, Q4
Regional	To support regional attainment of VBP targets, ACHs will achieve the following milestones: • Identify providers who are struggling to implement practice transformation and move toward value-based care.	DY3, Q4

	• Support providers to implement strategies to move toward value-based care. • Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of the annual Paying for Value provider survey.	
	To support regional attainment of VBP targets, ACHs will achieve the following milestones: • Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of the annual Paying for Value provider survey. • Continued identification and support of providers struggling to implement practice transformation and move toward value-based care.	DY4, Q4

Table 4: stage 2.1 – Continued sustainability through VBP implementation

Responsibility (regional/ statewide)		Timeline (complete no later than)
Statewide	Perform ongoing monitoring of regional, MCO, and statewide VBP attainment as described in the Apple Health Appendix. MCO VBP incentives will be phased out in DY6 due to the limited total funding available in DY6 and the significant VBP advancement DY1-DY5.	DY6, Q4
Regional	VBP achievement values will be phased out in DY6 due to the limited total funding available in DY6 and the significant VBP advancement DY1-DY5.	DY6, Q4

Workforce

Overarching goal

Promote a health workforce that supports comprehensive, coordinated, and timely access to care.

Governance

Throughout the design and implementation of transformation efforts, ACHs and partnering providers must consider workforce needs pertaining to selected projects and the broader objectives of MTP. There are several statewide taskforces and groups with expertise in identifying emerging health workforce needs and providing actionable information to inform the evolving workforce demands of a redesigned system of care. ACHs should leverage existing resources available to inform workforce strategies for the projects their region is implementing.

Project stages

Table 4: stage 1 – workforce planning

Responsibility (regional/ statewide)	Activity	Timeline (to complete no later than)
Statewide	• Based on identified regional workforce gaps and needs, provide recommendations and guidance to support and evolve the health care workforce consistent with MTP goals and objectives.	DY2, Q4

	• Identify existing educational and other resources available to educate, train, and re-train individuals to promote a workforce that supports and promotes evolving care models.	

Regional	• Consider workforce implications as part of project implementation plans and identify strategies to prepare and support the state's health workforce for emerging models of care under MTP.
	• Develop workforce strategies to address gaps and training needs, and to make overall progress toward the future state of MTP:
	  ○ Identify regulatory barriers to effective team-based care and practice transformation.
	  ○ Incorporate strategies and approaches to cultural competency and health literacy trainings.
	  ○ Incorporate strategies to mitigate impact of health care redesign on workforce delivering services for which there is a decrease in demand.
		DY2, Q4

Table 5: stage 2 – workforce implementation

Responsibility (regional/statewide)		Timeline (complete no later than)
Statewide and regional	• Implement practice transformation and workforce strategies. • Administer necessary resources to support all efforts.	DY4, Q4

Systems for population health management

Overarching goal

Leverage and expand health information technology (HIT) and health information exchange (HIE) infrastructure and tools to capture, analyze, and share relevant data.

For the purposes of MTP, population health management is defined as:

- Data aggregation
- Data analysis
- Data-informed care delivery
- Data-enabled financial models

Governance

Governance is envisioned as a multi-tiered approach. Data and measurement activity in service of MTP will be facilitated by the Washington State Health Care Authority (HCA), in coordination with departments of Social and Health Services (DSHS) and Health (DOH).

- The Office of the National Coordinator develops policy and system standards for interoperability, which govern Certified Electronic Health Record Technology (CEHRT) and sets the national standards for how health information systems can collect, share, and use information. The use of interoperable HIT and HIE is expected to support care coordination and integration, quality improvement, and value-based payment.

- HCA will coordinate efforts among multiple state government agencies to link Medicaid claims, social services data, population health information, and social determinants of health data, as well as direct efforts to increase accessibility of data in line with current legislation.
- HCA will work with ACHs to ensure that:
    - Data products are developed that meet ACH project need.
    - Data are combined in ways that meet local needs.
    - Access to data accommodates different levels of IT sophistication, local use, and support improved care.

Project stages

Table 6: stage 1 – systems for population health management planning and implementation

Responsibility (regional/ statewide)	Activity	Timeline (complete no later than)

Statewide	• HCA will provide guidance to ACHs in assessing current population health management capacity in service of Domain 2 and Domain 3 projects.
	• HCA will Identify tools available for population health management, which may include:
	  ○ Agency for Healthcare Research and Quality's (AHRQ) Practice-Based Population Health.
	  ○ Office of the National Coordinator for Health IT's 2016 Interoperability Standards Advisory.
	  ○ SAMHSA-HRSA's Center for Integrated Health Solutions Population Health Management webinars.
	• The HCA will promote on-demand access to standard care summaries and medical records within the Clinical Data Repository (CDR) through the HIE and claims through the development of an integrated health information system.
	• To support the work, HCA will coordinate with the state-designated entity for HIE, OneHealthPort, which is responsible for building and implementing the infrastructure used for HIE and developing tools and services that support broader access and utilization of both HIE and clinical data. In addition, OneHealthPort works for and with the provider community to help develop community best practices for data exchange and use.
		DY4 Q2

Regional	To support transformation projects, ACHs will convene key providers and health system alliances to share information with the state on: • Provider needs to effectively access and use population health data. • Local health system stakeholder needs for population health, social service, and social determinants of health data. ACHs must address systems for population health management within their project implementation plans. This must include: • Identified work steps and deliverables to implement information exchange for community-based, integrated care. Implementation plans should be tailored based on regional providers' current state of readiness and the implementation strategies selected within Domains 2 and 3.	DY4 Q2

	• Actionable steps taken to develop or enhance information exchange between providers at points of care, which will allow for the ability to track and follow up on patients with target conditions. • Identified opportunities to leverage transformation incentives, resources, and activities to respond to needs and gaps identified in the current infrastructure and support statewide information exchange systems.	

Domain 2: care delivery redesign

Transformation projects within this domain focus on innovative models of care that will improve the quality, efficiency, and effectiveness of care processes.

Project 2A: bi-directional integration of physical and behavioral health through care transformation

Project objective

This project uses a whole-person approach to care by addressing physical and behavioral health needs in one system through an integrated network of providers. This approach offers better coordinated care for patients and more seamless access to the services they need. This project will support and advance MTP and bring together the financing and delivery of physical and behavioral health services through MCOs for people enrolled in Medicaid.

Target population

All Medicaid beneficiaries (children and adults), particularly those with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD).

Guidelines

ACHs must implement a project that includes at least one approach from integrating:

- Behavioral health into primary care settings.
- Primary care into the behavioral health setting.

Evidence-based approaches for integrating behavioral health into a primary care setting:

- Bree Collaborative's Behavioral Health Integration Report and Recommendations
- Collaborative Care Model
    - The Collaborative Care Model is a team-based model that adds a behavioral health care manager and a psychiatric consultant to support the primary care provider's management of individual patients' behavioral health needs.
    - The model can be either practice-based or telehealth-based, so it can be used in both rural and urban areas.
    - The model can be used to treat a wide range of behavioral health conditions, including depression, SUD, bipolar disorder, post-traumatic stress disorder (PTSD), and other conditions.

Approaches based on emerging evidence for integrating primary care into behavioral health settings:

These approaches are described in the report "Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness."

For any approach, apply core principles of the Collaborative Care Model (see above) to integration into the behavioral health setting.

- Off-site, enhanced collaboration
- Co-located, enhanced collaboration
- Co-located, integrated

Project stages

Table 7: stage 1 – bi-directional integration planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity of integrated care model adoption: describe the level of integrated care model adoption among the target providers/organizations serving Medicaid beneficiaries. Explain which integrated models or practices are currently in place and describe where each target provider/organization currently falls in the levels of collaboration as outlined in the Standard Framework for Integrated Care.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity building • **Identify how strategies for health systems/community capacity building focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Define target population(s) and evidence-based approach(es)/promising practices informed by regional health needs.**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify and engage initial partnering providers, including behavioral and physical health providers, organizations, and relevant committees or councils.** • **Execute Master Services Agreement for partnering providers receiving funds through the FE portal.**	Report milestone completion in semi-annual report	DY2, Q2
Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.** • **For 2020 adopters of integrated managed care: ensure planning reflects timeline and process to transition to integration of physical and behavioral health, including engaging and convening county commissioners, Tribal Governments, MCOs, behavioral health and primary care providers, and other critical partners.**	Timely submission of implementation plan	DY2, Q3

Support regional transition to integrated managed care (2020 regions only) • **Note: This milestone only applies to those ACH regions that were not early or mid-adopters for integrated managed care.** • **Engage and convene county commissioners, Tribal Governments, MCOs, behavioral health and primary care providers, and other critical partners to develop a plan and description of a process to transition to integrated managed care.**	Report milestone completion in semi-annual report	DY2, Q4

Table 8: stage 2 – bi-directional integration implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures, and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches.**	Timely submission of QIP	DY3, Q2
Description of training and implementation activities • **Ensure each partnering provider and/or organization is provided with, or has secured, the training and technical assistance resources and HIT/HIE tools necessary to perform their role in the integrated care activities.** • **Obtain technology tools needed to create, transmit, and download shared care plans and other HIE technology tools to support integrated care activities.** • **Provide participating providers and organizations with financial resources to offset the costs of infrastructure necessary to support integrated care activities.**	Demonstrate progress in semi-annual report	DY3, Q4
Attestation of successfully integrating managed care • **Implementation of integrated managed care (applicable to mid-adopter regions).**	Report milestone completion in semi-annual report	

Table 9: stage 3 – bi-directional integration scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase use of technology tools to support integrated care activities by additional providers/organizations.** • **Identify new, additional target providers/organizations.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model and adopting guidelines, policies, and procedures as required.**		

Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.** • **Leverage regional champions and implement a train-the-trainer approach to support the spread of best practices.**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 10: stage 3.1 – bi-directional integration continued sustainability and transitioning

Project milestone	Proof of completion required	Due
Completion of all P4R reporting • **Completion of required P4R metrics. This includes any MeHAF and WA-ICA transition[2] support to advance bidirectional clinical integration.** • **Support providers through coaching, training, technical assistance, learning cohorts.** • **Provider engagement and continuation along the integration care continuum.**	Demonstrate progress in DY6 P4R report	DY6, Q4

Table 11: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 (2018)	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of independent external evaluator (IEE) activities	DY2, Q4
DY3 (2019)	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Maine Health Access Foundation (MeHAF) Site Self-Assessment Survey))	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (MeHAF Site Self-Assessment Survey)	DY3, Q4

[2] The WA-ICA is a new integration assessment tool that will replace the MeHAF beginning in DY6. This is a direct replacement for the existing P4R requirements. This tool was selected based on provider feedback and significant collaboration among ACHs, MCOs and HCA.

	P4P: state-produced	• All-Cause Emergency Department (ED) Visits per 1000 Member Months • Antidepressant Medication Management • Children's and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Medication Management for People with Asthma (5 – 64 Years) • Mental Health Treatment Penetration (Broad Version) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual
DY4 (2020)	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (MeHAF Site Self-Assessment Survey)	DY4, Q2
		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (MeHAF Site Self-Assessment Survey)	DY4, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Antidepressant Medication Management • Asthma Medication Ratio • Child and Adolescent Well-Care Visits (3-21 Years of Age) • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Kidney Health Evaluation with Patients with Diabetes • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual
DY5 (2021)	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (MeHAF Site Self-Assessment Survey)	DY5, Q2
		• Completion of semi-annual report (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (MeHAF Site Self-Assessment Survey)	DY5, Q4

	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Antidepressant Medication Management • Asthma Medication Ratio • Child and Adolescent Well-Care Visits (3-21 Years of Age) • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Kidney Health Evaluation with Patients with Diabetes • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual
DY6 (2022)	P4R: ACH-reported	• Completion of DY6 P4R report 1 (template available January 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Completion of required P4R metrics.	DY6, Q1
		• Completion of P4R report 2 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Completion of required P4R metrics.	DY6, Q3
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Antidepressant Medication Management • Asthma Medication Ratio • Child and Adolescent Well-Care Visits (3-21 Years of Age) • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Kidney Health Evaluation with Patients with Diabetes • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual

Project implementation guidelines

This section provides additional details on the project's core components and should guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems community and capacity building strategies

- **Population health management/HIT:** current level of adoption of electronic health records (EHRs) and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes,

information to enable population health management and quality improvement processes, and provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.

- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Shortage of mental health providers, SUD providers, social workers, nurse practitioners, primary care providers, care coordinators and care managers.
    - Opportunities for use of telehealth and integration into work streams.
    - Workflow changes to support integration of new screening and care processes, care integration, and communication.
    - Cultural and linguistic competency and health literacy deficiencies.
- **Financial sustainability:** alignment between current payment structures and guidelines for physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Guidance for evidence-based approaches

Integrating behavioral health into primary care setting

Standards adopted by the Bree Collaborative in the Behavioral Health Integration Report and Recommendations (As part of this option, regions will implement the core components that are consistent with the standards adopted by the Bree Collaborative).

Summary of core elements and minimum standards for integrated care element specifications under consideration by the Bree Collaborative:

- Integrated Care Team: each member of the integrated care team has clearly defined roles for both physical and behavioral health services. Team members, including clinicians and non-licensed staff, may participate in team activities, either in person or virtually.
- Routine access to integrated services: access to behavioral health and primary care services are available routinely as part of the care team's daily workflow and on the same day as patient needs are identified, as feasible. Patients can be engaged and receive treatment in person or by phone or videoconferencing, as convenient for the patient.
- Accessibility and sharing of patient information: the integrated care team has access to actionable medical and behavioral health information via a shared care plan at the point of care. All clinicians work together to jointly support their roles in the patient's shared care plan.
- Access to psychiatry services: access to psychiatry consultation services is available in a systematic manner to assist the care team in developing a treatment plan and to advise the team on adjusting treatments for patients who are not improving as expected.
- Operational systems and workflows support population-based care: a structured method is in place for proactive identification and stratification of patients for behavioral health conditions. The care team

tracks patients to make sure each patient is engaged and treated-to-target (i.e., to remission or other appropriate individual improvement goals).

- Evidence-based treatments: age-appropriate, measurement-based interventions for physical and behavioral health interventions are adapted to the specific needs of the practice setting. Integrated practice teams use behavioral health symptom rating scales in a systematic and quantifiable way to determine whether their patients are improving.
- Patient involvement in care: the patient's goals are incorporated into the care plan. The team communicates effectively with the patient about their treatment options and asks for patient input and feedback into care planning.

Collaborative Care Model

As part of this option, regions can choose to focus initially on depression screening and treatment program (such as tested in the IMPACT model). Many successful Collaborative Care pilot programs begin with an initial focus on depression and later expand to treat other behavioral health conditions, including SUD.

Implement the core components and tasks for effective integrated behavioral health care, as defined by the Advancing Integrated Mental Health Solutions (AIMS) Center of the University of Washington and shown here:

- Patient identification and diagnosis:
    - Screen for behavioral health problems using valid instruments.
    - Diagnose behavioral health problems and related conditions.
    - Use valid measurement tools to assess and document baseline symptom severity.
- Engagement in integrated care program:
    - Introduce collaborative care team and engage patient in integrated care program.
    - Initiate patient tracking in population-based registry.
- Evidence-based treatment:
    - Develop and regularly update a biopsychosocial treatment plan.
    - Provide patient and family education about symptoms, treatments, and self-management skills.
    - Provide evidence-based counseling (e.g., motivational interviewing, behavioral activation).
    - Provide evidence-based psychotherapy (e.g., problem-solving treatment, cognitive behavioral therapy, interpersonal therapy).
    - Prescribe and manage psychotropic medications as clinically indicated.
    - Change or adjust treatments if patients do not meet treatment targets.
- Systematic follow-up, treatment adjustment, and relapse prevention:
    - Use population-based registry to systematically follow all patients.
    - Proactively reach out to patients who do not follow-up.
    - Monitor treatment response at each contact with valid outcome metrics.
    - Monitor treatment side effects and complications.
    - Identify patients who are not improving to target them for psychiatric consultation and treatment adjustment.
    - Create and support relapse prevention plan when patients are substantially improved.

- Communication and care coordination:
    - Coordinate and facilitate effective communication among all providers on the treatment team, regardless of clinic affiliation or location.
    - Engage and support family and significant others as clinically appropriate.
    - Facilitate and track referrals to specialty care, social services, and community-based resources.
- Systematic psychiatric case review and consultation (in-person or via telemedicine):
    - Conduct regular (e.g., weekly) psychiatric caseload review on patients who are not improving.
    - Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals.
    - Provide psychiatric assessments for challenging patients, either in-person or via telemedicine.
- Program oversight and quality improvement:
    - Provide administrative support and supervision for program.
    - Provide clinical support and supervision for program.
    - Routinely examine provider- and program-level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) and use this information for quality improvement.

Integrating primary care into behavioral health setting

Offsite enhanced collaboration

Primary care and behavioral health providers located at a distance from one another will move beyond basic collaboration (in which providers make referrals, do not share any communication systems, but may or may not have periodic non-face-to-face communication, including sending reports), to enhanced collaboration that includes tracking physical health outcomes, with the following core components:

- Providers have regular contact and view each other as an interdisciplinary team, working together in a client-centered model of care.
- A process for bi-directional information sharing, including shared treatment planning, is in place and is used consistently.
- Providers may maintain separate care plans and information systems, but regular communication and systematic information sharing results in alignment of treatment plans, and effective medication adjustments and reconciliation to effectively treat beneficiaries to achieve improved outcomes.
- Care managers and/or coordinators are in place to facilitate effective and efficient collaboration across settings ensuring that beneficiaries do not experience poorly coordinated services or fall through the cracks between providers.
- Care managers and/or coordinators track and monitor physical health outcomes over time using registry tools, facilitate communication across settings, and follow up with patients and care team members across sites.

Co-located, enhanced collaboration or co-located, integrated

Apply and implement the core principles of the Collaborative Care Model to the integration of primary care; implement the core components and tasks for effective integration of physical health care into the behavioral health setting.

- Patient identification and diagnosis:
    - Screen for and document chronic diseases and conditions, such as obesity, diabetes, heart disease and others.
    - Diagnose chronic diseases and conditions.
    - Assess chronic disease management practices and control status.
- Engagement in integrated care program:
    - Introduce collaborative care team and engage patient in integrated care program.
    - Initiate patient tracking in population-based registry.
- Evidence-based treatment:
    - Develop and regularly update a biopsychosocial treatment plan.
    - Provide patient and family education about symptoms, treatments, and self-management skills.
    - Provide evidence-based self-management education.
    - Provide routine immunizations according to Advisory Committee on Immunization Practices (ACIP) recommendations as needed.
    - Provide the U.S. Preventive Services Task Force screenings graded A and B as needed.
    - Prescribe and manage medications as clinically indicated.
    - Change or adjust treatments if patients do not meet treatment targets, refer to specialists as needed.
- Systematic follow-up, treatment adjustment:
    - Use population-based registry to systematically follow identified patients.
    - Proactively reach out to patients who have difficulty following up.
    - Monitor treatment response at each contact with valid outcome metrics.
    - Monitor treatment side effects and complications.
    - Identify patients who are not improving and identify them for specialist evaluation or connection to increased primary care access/utilization.
- Communication and care coordination:
    - Coordinate and facilitate effective communication among all providers on the treatment team, regardless of clinic affiliation or location.
    - Engage and support family and significant others as clinically appropriate.
    - Facilitate and track referrals to specialty care, social services, and community-based resources.
- Systematic case review and consultation (in person or via telemedicine):
    - Conduct regular (e.g., weekly) chronic disease and condition caseload review on patients who are not improving.
    - Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals.
- Program oversight and quality improvement:

- Provide administrative support and supervision to support an integrated team.
- Provide clinical support and supervision for care team members who are co-located.
- Routinely examine provider-level and program-level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) and use to inform quality improvement processes and activities.

Project 2B: community-based care coordination

Project objective

Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.

Target population

Medicaid beneficiaries (adults and children) with one or more chronic disease or condition (such as arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity, and stroke), or mental illness/depressive disorders, or moderate to severe SUD and at least one risk factor (e.g., unstable housing, food insecurity, high emergency management services (EMS) utilization).

Evidence-based approach

Pathways Community HUB

Project stages

Table 12: stage 1 – community-based care coordination planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively focus on the need for regional community-based care coordination.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for health systems community and capacity building focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Define target population(s) and evidence-based approach(es)/promising practices informed by regional health needs.**	Report milestone completion in semi-annual report	DY2, Q2

Completion of initial partnering provider list
• **Identify and engage project implementation partnering provider organizations, including:**
  ○ **Review national HUB standards and provide training on the HUB model to stakeholders.**
  ○ **Identify, recruit, and secure formal commitments for participation from all implementation partners, including patient-centered medical homes, health homes, care coordination service providers, and other community-based service organizations, with a written agreement specific to the role each will perform in the HUB.**
  ○ **Determine how to fill gaps in resources, including augmenting resources within existing organizations and/or hiring at the HUB lead entity.**
  ○ **Execute Master Services Agreement for partnering providers receiving funds through the financial executor (FE) portal.**
	Report milestone completion in semi-annual report	DY2, Q2

Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.**	Timely submission of implementation plan	DY2, Q3
Identified HUB lead entity and description of qualifications • **Identify project lead entity, including:** ○ **Establishing HUB planning group, including payers.**	Report milestone completion in semi-annual report	DY2, Q4

Table 13: stage 2 – community-based care coordination implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways.**	Timely submission of QIP	DY3, Q2
Description of training and implementation activities **Implement project, which includes the Phase 2 (creating tools and resources) and 3 (launching the HUB) elements specified by AHRQ:** • **Create and implement checklists and related documents for care coordinators.** • **Implement selected pathways from the Pathways Community HUB Certification Program or implement care coordination evidence-based protocols adopted as standard under a similar approach.** • **Develop systems to track and evaluate performance.** • **Hire and train staff.** • **Implement technology-enabled care coordination tools and enable the appropriate integration of information captured by care coordinators with clinical information captured through statewide HIE.**	Demonstrate progress in semi-annual report	DY3, Q4
Description of each pathway scheduled for initial implementation and expansion/partnering provider roles and responsibilities to support Pathways implementation.	Demonstrate progress in semi-annual report	DY3, Q4

Table 14: stage 3 – community-based care coordination scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Expand the use of care coordination technology tools to additional providers and/or patient populations.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model, and adopting guidelines, policies, and procedures as required.**		
Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 15: community-based care coordination P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Mental Health Treatment Penetration (Broad Version) • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q2

		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual
DY6 – 2022	P4R: ACH-reported	• Completion of DY6 P4R report 1 (template available January 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q1
		• Completion of P4R report 2 (template available July 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q3
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual

Project implementation guidelines

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of electronic health records (EHRs) and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, information to enable population health management and quality improvement processes, and provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Shortage of mental health providers, SUD providers, social workers, nurse practitioners, primary care providers, care coordinators and care managers.
    - Opportunities for use of telehealth and integration into work streams.
    - Workflow changes to support integration of new screening and care processes, care integration, and communication.
    - Cultural and linguistic competency and health literacy deficiencies.
- **Financial sustainability:** alignment between current payment structures and guidelines for physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Project 2C: transitional care

Project objective

Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.

Target population

Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care to home or to supportive housing, and beneficiaries with serious mental illness (SMI) discharged from inpatient care, or client returning to the community from prison or jail.

Evidence-based approaches for care management and transitional care:

1) Interventions to Reduce Acute Care Transfers, INTERACT™4.0: a quality improvement program that focuses on the management of acute change in resident condition.

2) Transitional Care Model: a nurse-led model of transitional care for high-risk older adults that provides comprehensive in-hospital planning and home follow-up.

3) The Care Transitions Intervention® (CTI): a multi-disciplinary approach toward system redesign incorporating physical, behavioral, and social health needs and perspectives. Note: the CTI is also known as the Skill Transfer Model™, the Coleman Transitions Intervention Model®, and the Coleman Model®.

4) Care Transitions Interventions in Mental Health provides a set of components of effective transitional care that can be adapted for managing transitions among persons with SMI.

Evidence-informed approaches to transitional care for people with health and behavioral health needs leaving incarceration

Despite the relative dearth of specific, outcomes-focused research on effective integrated health and behavioral health programs for people leaving incarceration, considerable evidence on effective integrated care models, prison/jail reentry, and transitional programming has paved the way for increased understanding of critical components of an integrated transitional care approach. See the following:

- American Association of Community Psychiatrists' Principles for Managing Transitions in Behavioral Health Services

Project stages

Table 16: transitional care planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively deliver care transition services.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for Health systems/community capacity • **Identify how strategies for health systems community and capacity building focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Define target population(s) and evidence-based approach(es)/promising practices informed by regional health needs.**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify, recruit, and secure formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach.** • **For projects targeting people transitioning from incarceration: identify and secure formal partnerships with relevant criminal justice agencies (including but not limited to correctional health, local releasing, and community supervision authorities), health care and behavioral health care service providers, and reentry-involved community-based organizations, including state and local reentry councils.** • **Execute Master Services Agreement for partnering providers receiving funds through the FE portal.**	Report milestone completion in semi-annual report	DY2, Q2

Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.**	Timely submission of implementation plan	DY2, Q3

Table 17: transitional care implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways.**	Timely submission of QIP	DY3, Q2
Description of training and implementation activities • **Implement project, including the following core components across each approach selected:** • **Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.** • **Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure care team members, including client and family/caregivers, have access to the electronic shared care plan).** • **Establish mechanisms for coordinating care management and transitional care plans with related community-based services and supports, such as those provided through supported housing programs.** • **Incorporate activities that increase the availability of POLST forms across communities/agencies, where appropriate.** • **Develop systems to monitor and track performance.**	Demonstrate progress in semi-annual report	DY3, Q4

Table 18: transitional care scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model, and adopting guidelines, policies, and procedures as required.**		

Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 19: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days)	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Submission of QIP • Metric reporting	DY4, Q2
		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Percent Homeless (Narrow Definition) • Plan All-Cause Readmission Rate (30 Days)	Annual

DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Percent Homeless (Narrow Definition) • Plan All-Cause Readmission Rate (30 Days)	Annual
DY6 – 2022	P4R: ACH-reported	• Completion of DY6 P4R report 1 (template available January 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q1
		• Completion of P4R report 2 (template available July 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q3
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Percent Homeless (Narrow Definition) • Plan All-Cause Readmission Rate (30 Days)	Annual

Project implementation guidelines

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of electronic health records (EHRs) and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, information to enable population health management and quality improvement processes, and provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:

- Shortage of mental health providers, SUD providers, social workers, nurse practitioners, primary care providers, care coordinators and care managers.
- Opportunities for use of telehealth and integration into work streams.
- Workflow changes to support integration of new screening and care processes, care integration, and communication.
- Cultural and linguistic competency and health literacy deficiencies.

- **Financial sustainability:** alignment between current payment structures and guidelines for physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Guidance for evidence-based approaches

Evidence-based approaches for care management and transitional care

INTERACT™4.0

The skilled nursing facility (SNF) and the project implementation team will utilize INTERACT™4.0 toolkit and resources and implement the following core components:

- Educate leadership in the INTERACT™ principles.
- Identify a facility champion who can engage other staff and serve as a coach.
- Develop care pathways and other clinical tools for monitoring patients that lead to early identification of potential instability and allow intervention to avoid hospital transfer.
- Provide all staff with education and training to fill their role in the INTERACT™ model.
- Educate patients and families and provide support that facilitates their active participation in care planning.
- Establish enhanced communication with acute care hospitals, relying on technology where appropriate.
- Establish quality improvement process, including root cause analysis of transfers and identification and testing of interventions.
- Demonstrate cultural competence and client engagement in the design and implementation of the project.

Transitional Care Model

Implement the essential elements of this model:

- Use of advanced knowledge and skills by a transitional care nurse (TCN) to deliver and coordinate care of high-risk older adults within and across all health care settings. The TCN is primary coordinator of care throughout potential or actual episodes of acute illness.
- Comprehensive, holistic assessment of each older adult's priority needs, goals, and preferences.
- Collaboration with older adults, family caregivers, and team members in implementation of a streamlined, evidenced-based plan of care designed to promote positive health and cost outcomes.
- Regular home visits by the TCN with available, ongoing telephone support (seven days per week) through an average of two months.

- Continuity of health care between hospital, post-acute, and primary care clinicians facilitated by the TCN by accompanying patients to visits to prevent or follow-up on an acute illness care management.
- Active engagement of patients and family caregivers with a focus on meeting their goals.
- Emphasis on patients' early identification and response to health care risks and symptoms to achieve longer-term positive outcomes and avoid adverse and untoward events that lead to acute care service use (e.g., ED visits, re-hospitalizations).
- Multidisciplinary approach that includes the patient, family caregivers, and health care providers as members of a team.
- Strong collaboration and communication between older adults, family caregivers, and health care team members across episodes of acute care and in planning for future transitions (e.g., palliative care).
- Ongoing investment in optimizing transitional care via performance monitoring and improvement.

Care Transitions Intervention®

Implementation guidance:

- A meeting with a Transitions coach in the hospital (where possible, as this is desirable but not essential) to discuss concerns and to engage patients and their family caregivers.
- Set up the Transitions coach in home follow-up visit and accompanying phone calls designed to increase self-management skills, personal goal attainment, and provide continuity across the transition.

Care transitions interventions in mental health

Set of components of effective transitional care that can be adapted for managing transitions among persons with serious mental illness:

- Adapt components of care transitions interventions to focus on points of transition for the SMI population, including discharge from intensive behavioral health care, and discharge from emergency room (ER) for mental health, alcohol, or other drug dependence.
- Prospective modeling: employ prospective modeling to identify who is at greatest risk. Consider different patterns of morbid conditions within and among mental illnesses, SUDs, and general medical/surgical conditions that might require modifications.
- Patient and family engagement: create culturally competent engagement strategies to drive authentic inclusion of patient and/or family in treatment/transitional care plan. Adapt engagement strategies for individuals with SMI.
- Transition planning: establish an appropriate client-specific plan for transition to the next point of care. Consider how to utilize step-down mental health services, such as day treatment and intensive outpatient care. Consider trade-offs between length of stay for stabilization and risk of rehospitalization. Include assessment of need of primary care planning as well as substance abuse and dual disorders. An assessment and specific plan for housing and other social services should be included.
- Information transfer/personal health record: ensure all information is communicated, understood, and managed, and links patients, caregivers, and providers. Establish protocols to ensure privacy and other regulations are followed. Establish pathways for information flow among providers and clinics.

- Transition coaches/agents: define transition coach role, tasks, competencies, training, and supervision requirements. Consider the need for mental health providers, such as social workers, to serve as transition agents or to train other personnel in mental health tools and techniques. Consider use of health information technology to augment/assist coaches.
- Provider engagement: providers at each level of care should have clear responsibility and plan for implementing all transition procedures/interventions. Communication and hand-off arrangements should be pre-specified in a formal way.
- Quality metrics and feedback: gather metrics on follow-up post-hospitalization, rehospitalization and other feedback on process and outcomes and consumer/family perspective. Utilize metrics in quality improvement and accountability.
- Shared accountability: all providers share in expectations for quality as well as rewards/penalties. Accountability mechanisms may include financial mechanisms and public reporting about quality and value. Consumers/families share in accountability as well.

Evidence-informed approaches to transitional care for people with health and behavioral health needs leaving incarceration

For projects targeting people transitioning from incarceration, include in the implementation plan at a minimum:

- Strategy to increase Medicaid enrollment, including:
    - Process for identifying (1) individuals who are covered under Medicaid and whose benefits will not be terminated because of incarceration, (2) individuals whose Medicaid eligibility will terminate because of incarceration, and (3) individuals who will likely be Medicaid-eligible at release, regardless of current or prior beneficiary status.
    - Process for completing and submitting Medicaid applications for individuals (2) and (3) above, timed appropriately such that their status moves from suspended to active at release.
    - Agreements in place with relevant criminal justice agencies to ensure individuals (1) above receive community-based, Medicaid-reimbursable care in a timely matter when clinically appropriate (with a focus on populations "at risk," such as the elderly, LGBTQ, chronically ill, those with serious mental illness and/or SUD, and more).
- Strategy for beginning care planning and transition planning prior to release, including:
    - A process for conducting in-reach to prison/jails and correctional facilities, which leverages and contemplates resources, strengths, and relationships of all partners.
    - A strategy for engaging individuals in transitional care planning as a one component to a larger reentry transition plan.
    - A strategy for ensuring care planning is conducted in a culturally competent manner and contemplates social determinants of health, barriers to accessing services or staying healthy, as well as barriers to meeting conditions of release or staying crime-free.

Project 2D: diversion interventions

Project objective

Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations.

Target population

Medicaid beneficiaries presenting at the ED for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergent condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.

Evidence-supported diversion strategies

- ED diversion: a systematic approach to re-directing and managing persons who present at the ED for non-emergency conditions, which may be oral health, general physical health, and/or behavioral health conditions.
    - ER is for emergencies
    - Non–ED Interventions to Reduce ED Utilization: A Systematic Review
- Community Paramedicine Model: an evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations. Additional resources include:
    - communityparamedic.org
    - Community paramedicine evaluation tool
    - RHI Hub
- Law Enforcement Assisted Diversion (LEAD®): a community-based diversion approach with the goals of improving public safety and public order and reducing the criminal behavior of people who participate in the program.

Project stages

Table 20: stage 1 – diversion interventions planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively deliver diversion services.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for Domain I focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2

Definition of evidence-based approaches or promising practices and target populations • **Select target population and evidence-supported approach informed by regional health needs.** • **If applicable: determine which non-emergent condition(s) should be the focus of ED diversion and/or community paramedicine (oral health, general physical health, and/or behavioral health conditions).**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify, recruit, and secure formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach.** • **For lead: establish a community advisory group that includes representation from community members, health care and social services, law enforcement and community public safety leaders.** • **Execute Master Services Agreement for partnering providers receiving funds through the FE portal.**	Report milestone completion in semi-annual report	DY2, Q2
Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.**	Timely submission of implementation plan	DY2, Q3

Table 21: stage 2 – diversion interventions implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures, and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways.**	Timely submission of QIP	DY3, Q2

Description of training and implementation activities
• **Implement project, including the following core components across each approach selected:**
  ○ **Ensure participating partners are provided with, or have access to, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.**
  ○ **Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure team members, including client, have access to the information appropriate to their role in the team).**
  ○ **Establish mechanisms for coordinating care management plans with related community-based services and supports, such as those provided through supported housing programs.**
	Demonstrate progress in semi-annual report	DY3, Q4

Table 22: stage 3 – diversion interventions scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Expand the model to additional communities and/or partner organizations.**	Demonstrate progress in semi-annual report.	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model, and adopting guidelines, policies, and procedures as required.**		
Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 23: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Percent Homeless (Narrow Definition)	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q2
		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4

	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Percent Arrested • Percent Homeless (Narrow Definition)	Annual
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Percent Arrested • Percent Homeless (Narrow Definition)	Annual
DY6 – 2022	P4R: ACH-reported	• Completion of DY6 P4R report 1 (template available January 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q1
		• Completion of P4R report 2 (template available July 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q3
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Percent Arrested • Percent Homeless (Narrow Definition)	Annual

Project implementation guidance

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of electronic health records (EHRs) and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, information to enable population health management and quality improvement processes, and provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Shortage of mental health providers, SUD providers, social workers, nurse practitioners, primary care providers, care coordinators and care managers.
    - Opportunities for use of telehealth and integration into work streams.
    - Workflow changes to support integration of new screening and care processes, care integration, and communication.
    - Cultural and linguistic competency and health literacy deficiencies.

- **Financial sustainability:** alignment between current payment structures and guidelines for physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Guidance for evidence-based approaches

ED diversion

While there is no single model for effective ED diversion, a variety of examples can be found that share common elements. The following elements must be reflected in the implementation, unless noted otherwise:

- ED will establish linkages to community primary care provider(s) to connect beneficiaries without a primary care provider to one, or for the purpose of notifying the current primary care provider of the ED presentation and coordinating a care plan. Where available, care coordinators can facilitate this process.
- ED will establish policies and procedures for identifying beneficiaries with minor illnesses who do not have a primary care provider. After completing appropriate screenings validating a non-emergency need, will assist the patient in receiving a timely appointment with a primary care provider.

Community Paramedicine Model

This is an evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations

Approved medical program directors (MPDs), working with first responders, ED practitioners, and primary care providers to develop protocols, which may include transporting beneficiaries with non-emergency needs to alternate (non-ED) care sites, such as urgent care centers and/or patient-centered medical homes. Providers may collaborate to develop community paramedicine programs. Core issues to be addressed in the design of a community paramedicine program should include:

- A detailed explanation about how the community paramedics would be trained and would maintain their skills.
- A description of how appropriate medical supervision would be ensured.
- A description of how data to evaluate quality assurance and quality improvement activities would be obtained and monitored.
- An evaluation plan for assessing the impacts on quality and cost of care, and how the local EMS agency will ensure that all patients are treated equally regardless of insurance status and health condition, among other factors.
- A plan for integrating the community paramedicine program with other community-based health care and social service programs and for analyzing the potential impacts of the community paramedicine program on these providers, including safety-net providers.
- How to leverage the potential of EHRs and HIE to facilitate communication between community paramedics and other health care providers.

Law Enforcement Assisted Diversion, LEAD®

LEAD is a community-based diversion approach with the goals of improving public safety and public order and reducing the criminal behavior of people who participate in the program.

Review resources and assistance available from the LEAD® National Support Bureau. Many components of LEAD® can be adapted to fit local needs and circumstances, however, the following core principles must be built into the implementation:

- Establish the LEAD® program as a voluntary agreement among independent decision-makers.
- Engage law enforcement and generate buy-in, including obtaining commander-level support.
- Identify a dedicated project manager.
- Tailor the LEAD® intervention to the community.
- Provide intensive case management – to link diverted individuals to housing, vocational and educational opportunities, treatment, and community services. Participants may need access to medication-assisted therapy and other drug treatment options; they may also need access to food, housing, legal advocacy, job training, and other services.
    - Apply a harm reduction/housing first approach – develop individual plans that address the problematic behavior as well as the factors driving that behavior.
    - Consider the use of peer supports.
- Provide training in the areas of trauma-informed care and cultural competencies.
- Prepare an evaluation plan.

Domain 3: prevention and health promotion

Transformation projects within this domain focus on prevention and health promotion to eliminate disparities and achieve health equity across regions and populations. Domain 3 includes one required project and three optional projects.

Project 3A: addressing the opioid use public health crisis (required)

Project objective

Support the achievement of the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.

Target population

Medicaid beneficiaries, including youth, who use, misuse, or abuse prescription opioids and/or heroin.

Recommended resources for identifying promising practices/evidence-supported strategies

Clinical guidelines

- AMDG's Interagency Guideline on Prescribing Opioids for Pain
- CDC Guideline for Prescribing Opioids for Chronic Pain (United States, 2016)
- Substance Use during Pregnancy: Guidelines for Screening and Management

Statewide plans

- 2016 Washington State Interagency Opioid Working Plan
- Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan

Implementation plans must demonstrate a multi-pronged approach that includes strategies targeting the following essential components:

- Prevention: prevent opioid use and misuse
- Treatment: link individuals with OUD with treatment services
- Overdose prevention: intervene in opioid overdoses to prevent death
- Recovery: promote long-term stabilization and whole-person care

Project stages

Table 24: stage 1 – prevention and health promotion planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess the current regional capacity to effectively impact the opioid crisis and include strategies to leverage current capacity and address identified gaps.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for health systems/community capacity focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Select target population and evidence-based approach informed by regional health needs. (Consider areas with limited access to treatment for opioid disorder, and rates of opioid use, misuse, and abuse.)**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify and engage project implementation partnering provider organizations.** • **Identify established local partnerships that are addressing the opioid crisis in their communities and establish new partnerships where none exist.** • **Identify, recruit, and secure formal commitments for participation in project implementation including professional associations, physical, mental health and SUD providers and teaching institutions.** • **Execute Master Services Agreement for partnering providers receiving funds through the FE portal.**	Report milestone completion in semi-annual report	DY2, Q2
Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.**	Timely submission of implementation plan	DY2, Q3

Table 25: stage 2 – prevention and health promotion implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches.**	Timely submission of QIP	DY3, Q2

Description of training and implementation activities
• **Implement selected strategies/approaches across the core components:**
  ○ **Prevention**
  ○ **Treatment**
  ○ **Overdose prevention**
  ○ **Recovery supports**
• **Monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical guidelines and incorporate any changes into project implementation plan.**
• **Convene or leverage existing local partnerships to implement project; one or more such partnerships may be convened:**
  ○ **Each partnership should include health care services, including mental health and SUD providers, community-based service providers, executive and clinical leadership, consumer representatives, law enforcement, criminal justice, emergency medical services, and elected officials; identify partnership leaders and champions. Consider identifying a clinical champion and one or more community champions.**
  ○ **Establish a structure that allows for efficient implementation of the project and provides mechanisms for any workgroups or subgroups to share across teams, including implementation successes, challenges, and overall progress.**
  ○ **Continue to convene the partnership(s) and any necessary workgroups on a regular basis throughout implementation phase.**
	Demonstrate progress in semi-annual report	DY3, Q2

Address gaps in access and availability of providers offering recovery support services • **Develop a plan to address gaps in the number or locations of providers offering recovery support services, (this may include the use of peer support workers).**	Demonstrate progress in semi-annual report	DY3, Q4

Table 26: stage 3 - prevention and health promotion scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase scale of activities by adding partners and/or reaching new communities under the current initiative (e.g., to cover additional high-needs geographic areas), as well as defining a path forward to deploy the partnership's expertise, structures, and capabilities to address other yet-to-emerge public health challenges.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Review and apply data to inform decisions regarding specific strategies and action to be spread to additional settings or geographical areas.**		

Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide or support ongoing training, technical assistance, and community partnerships to support spread and continuation of the selected strategies/approaches.** • **Convene and support platforms to facilitate shared learning and exchange of best practices and results to date (e.g., the use of interoperable HIE by additional providers providing treatment of persons with OUD).**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 27: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • P4R metrics (Project 3A P4R metrics)	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Project 3A P4R metrics)	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Patients prescribed chronic concurrent opioids and sedatives prescriptions • Patients prescribed high-dose chronic opioid therapy	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Project 3A P4R metrics)	DY4, Q2
		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Project 3A P4R metrics)	DY4, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months	Annual

		• Patients prescribed chronic concurrent opioids and sedatives prescriptions • Patients prescribed high-dose chronic opioid therapy • SUD Treatment Penetration (Opioid)	
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Project 3A P4R metrics)	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Project 3A P4R metrics)	DY5, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Patients prescribed chronic concurrent opioids and sedatives prescriptions • Patients prescribed high-dose chronic opioid therapy • SUD Treatment Penetration (Opioid)	Annual
DY6 – 2022	P4R: ACH-reported	• Completion of DY6 P4R report 1 (template available January 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Completion of required P4R metrics	DY6, Q1
		• Completion of P4R report 2 (template available July 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q3
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Patients prescribed chronic concurrent opioids and sedatives prescriptions • Patients prescribed high-dose chronic opioid therapy • SUD Treatment Penetration (Opioid)	Annual

Project implementation guidance

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management systems/HIT:** adoption of technology with the capability to support identification of persons at high-risk for opioid overdose, notifications to health care providers of opioid overdose events, monitoring of prescribing practices, and implementation of quality improvement processes; a plan to build enhancements in EHRs and other systems to support clinical decisions in accordance with guidelines; an assessment of the current level of use of the PDMP and ED Information Exchange; and strategies to increase use of PDMP and interoperability with EHRs. Overall, in line with Goal 4 of the State Interagency Opioid Working Plan; develop a plan to use data and information to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.

- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Efforts to enhance medical, nursing, and physician assistant school curricula on pain management, the PDMP, and recognition and treatment of opioid use disorder (OUD).
    - Partnering with professional associations and teaching institutions to educate dentists, osteopaths, nurses, and podiatrists on current opioid prescribing guidelines.
    - Encouraging licensing boards of authorized prescribers to mandate continuing education credits (CEUs) on opiate prescribing and pain management guidelines.
    - Encouraging family medicine, internal medicine, obstetrics/gynecology (OB/GYN) residency programs to train residents on care standards/medications for OUD.
    - Identifying critical workforce gaps in the substance use treatment system and develop initiatives to attract and retain skilled professionals in the field.
- **Financial sustainability:** alignment between current payment structures and guidelines for care about opioid prescribing; and evidence-supported treatments and recovery supports for OUDs that incorporate current state and anticipated future state of VBP arrangements to support opioid abuse prevention and control efforts into the regional VBP transition plan.

Guidance for evidence-based approaches

Implementation plan

Each region will develop a plan that provides a detailed description of how the ACH will implement selected strategies and activities that together create a comprehensive strategy addressing prevention, treatment, overdose prevention, and recovery supports aimed at supporting whole-person health.

Prevention: prevent opioid misuse and abuse

- Promote use of best practices among health care providers for prescribing opioids for acute and chronic pain:
    - Promote the use of the prescription drug monitoring plan (PDMP) and its linkage into EHR systems to increase the number of providers regularly using the PDMP and the timely input of prescription medication data into the PDMP.
    - Train, coach, and offer consultation with providers on opioid prescribing and pain management.
    - Promote the integration of telehealth and telephonic approaches.
    - Support innovative telehealth in rural and underserved areas to increase capacity of communities to support OUD prevention and treatment.
- Together, with the Center for Opioid Safety Education and other partners like statewide associations, raise awareness and knowledge of the possible adverse effects of opioid use, including overdose, among opioid users:
    - Promote accurate and consistent messaging about opioid safety and to address the stigma of addiction by public health, health care providers, law enforcement, community coalitions, and others specific to the region and local communities.
- Prevent opioid initiation and misuse in communities, particularly among youth:

    - Build awareness and identify gaps as they relate to ongoing prevention efforts (e.g., school-based programs); connect with local health jurisdictions and DOH and HCA's Department of Behavioral Health and Recovery (DBHR) to understand the efforts currently underway in the region.
- Promote safe home storage and appropriate disposal of prescription pain medication to prevent misuse:
    - Identify and map drug take back programs to highlight where additional programs could be implemented or expanded to meet community need.
    - Promote the use of home lock boxes to prevent unintended access to medication.

Treatment: link individuals with OUD to treatment services

- Build capacity of health care providers to recognize signs of possible opioid misuse, effectively identify OUD, and link patients to appropriate treatment resources:
    - Effective treatment of OUD includes medication and psychosocial supports. Conduct inventory of existing treatment resources in the community (e.g., formal treatment programs and practices/providers providing medications for opioid use disorder (MOUD)(methadone, buprenorphine, naltrexone)).
    - Educate providers across all health professions on how to recognize signs of opioid misuse and OUD among patients and how to use appropriate tools to identify OUD.
    - Offer patients brief interventions and referrals to MOUD and psychosocial support services, if needed.
    - Build skills of health care providers to have supportive patient conversations about problematic opioid use and treatment options.
    - Give pharmacists tools on where to refer patients who may be misusing prescription pain medication.
- Expand access to, and utilization of, clinically appropriate evidence-based practices for OUD treatment in communities, particularly MOUD:
    - Increase the number of providers certified to prescribe OUD medications in the region; promote the application and receipt of physician, Advanced Registered Nurse Practitioner (ARNP), and physician assistant waivers for providers in a variety of settings, such as hospitals, primary care clinics, correctional facilities, mental health and SUD treatment agencies, methadone clinics, and other community-based sites.
    - Together with HCA identify policy gaps and barriers that limit availability and utilization of buprenorphine, methadone, and naltrexone and contribute to the development of policy solutions to expand capacity.
    - Build structural supports (e.g., case management capacity, nurse care managers, integration with SUD providers) to support medical providers and staff to implement and sustain MOUD, such as methadone and buprenorphine. Examples of evidence-based models include the hub and spoke and nurse care manager models.

    - Promote and support pilot projects that offer low barrier access to buprenorphine in efforts to reach persons at high risk of overdose. For example, in EDs, correctional facilities, syringe exchange programs, and SUD and mental health programs.
    - Build linkages/communication pathways between those providers providing medication and those providing psychosocial therapies.
- Expand access to and utilization of OUD medications in the criminal justice system:
    - Train and provide technical assistance to criminal justice professionals to endorse and promote agonist therapies for people under criminal sanctions.
    - Optimize access to chemical dependency treatment services for offenders who have been released from correctional facilities into the community and for offenders living in the community under correctional supervision, through effective care coordination and engagement in transitional services.
    - Ensure continuity of treatment for persons with an identified OUD need upon exiting correctional facilities by providing direct linkage to community providers for ongoing care.
- Increase capacity of syringe exchange programs to effectively provide overdose prevention and engage beneficiaries in support services, including housing.
    - Provide technical assistance to local health jurisdictions and community-based service organizations to organize or expand syringe exchange and drug user health services.
    - Develop/support linkages between syringe exchange programs and physical health providers to treat any medical needs that require referral.
- Identify and treat OUD among pregnant and parenting women (PPW) and Neonatal Abstinence Syndrome (NAS) among newborns:
    - Disseminate the guideline Substance Abuse during Pregnancy: Guidelines for Screening and Management.
    - Disseminate the Washington State Hospital Association Safe Deliveries Roadmap standards to health care providers.
    - Educate pediatric and family medicine providers to recognize and appropriately manage newborns with NAS.
    - Increase the number of obstetric and maternal health care providers permitted to dispense and prescribe MOUD through the application and receipt of Drug Enforcement Administration (DEA)-approved waivers.
    - Establish or enhance community pathways to support PPW with connecting to care services that address whole-person health, including physical, mental, and SUD treatment needs during, through and after pregnancy.

Overdose prevention: intervene in opioid overdoses to prevent death

- Educate individuals who use heroin and/or prescription opioids, and those who may witness an overdose, on how to recognize and appropriately respond to an overdose.
    - Provide technical assistance to first responders, chemical dependency counselors, and law enforcement on opioid overdose response training and naloxone programs.

    - Assist EDs to develop and implement protocols on providing overdose education and take-home naloxone to individuals seen for opioid overdose.
- Make system-level improvements to increase availability and use of naloxone.
    - Establish standing orders in all counties and all opioid treatment programs to authorize community-based naloxone distribution and lay administration.
    - Promote co-prescribing of naloxone for pain patients as best practice, per Agency Medical Director's Group (AMDG) guidelines.
- Together with the Center for Opioid Safety Education, promote awareness and understanding of Washington State's Good Samaritan Law.
    - Educate law enforcement, prosecutors, and the public about the Good Samaritan Response Law.

Recovery: promote long-term stabilization and whole-person care

- Enhance/develop or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery.
- Establish or enhance community-based recovery support systems, networks, and organizations to develop capacity at the local level to design and implement peer and other recovery support services as vital components of recovery-oriented continuum of care.
- Support whole person health in recovery:

Connect SUD providers with primary care, behavioral health, social service, and peer recovery support providers to address access, referral, and follow up for services.

Project 3B: reproductive and maternal/child health

Project objective

Ensure that people have access to high-quality reproductive health care throughout their lives and promote the health safety of Washington's children.

Target population

Medicaid beneficiaries who are people of reproductive age, pregnant persons, parents of children ages 0-3, and children ages 0-17.

Evidence-based approach

- Strategies to improve adult health to ensure families have intended and healthy pregnancies that lead to healthy children. The Centers for Disease Control and Prevention (CDC) has provided 10 recommendations that aim to improve a person's health before conception, whether before a first or a subsequent pregnancy.
- Evidence-based home visiting model for pregnant high-risk persons, including high-risk, first-time parents. Potential approaches can include Nurse Family Partnership (NFP) or other federally recognized evidence-based home visiting model currently operating in Washington State.

Evidence-based model or promising practice to improve regional well-child visit rates and childhood immunization rates. Project stages

Table 28: stage 1 – reproductive and maternal/child health planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively focus on the need for high-quality reproductive and maternal and child health care.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for Domain I focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Select evidence-based approach(es) and specific target population(s) informed by regional health needs.**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify, recruit, and secure formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach.** • **Execute Master Services Agreement for partnering providers receiving funds through the FE portal.**	Report milestone completion in semi-annual report	DY2, Q2

Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.**	Timely submission of implementation plan	DY2, Q3

Table 29: stage 2 – reproductive and maternal/child health implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures, and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches.**	Timely submission of QIP	DY3, Q2
Description of training and implementation activities • **Implement project, including the following core components across each approach selected:** ○ **Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.** ○ **Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure care team members, including client and family/caregivers, have access to the care plan).** ○ **Establish mechanisms, including technology enabled, interoperable care coordination tools, for coordinating care management and transitional care plans with related community-based services and supports, such as those provided through supported housing programs.** ○ **Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes, and tracking outcomes.**	Demonstrate progress in semi-annual report	DY3, Q4

Table 30: stage 3 – reproductive and maternal/child health scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model and adopting guidelines, policies, and procedures as required.**		

Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of transformation activities post-DSRIP.**		

Table 31: project metrics and recurrent deliverables associated with AVs

Year	Type	Metric/deliverable	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Chlamydia Screening in Women • Mental Health Treatment Penetration (Broad Version) • SUD Treatment Penetration • Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Age	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q2
		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Childhood Immunization Status (Combo 10) • Chlamydia Screening in Women • Contraceptive Care – Access Measures (NQF# 2903, 2902) • Performance assessed by annual improvement on at least one of the Contraceptive Care Access measures. • Mental Health Treatment Penetration (Broad Version) • Timeliness of Prenatal Care • SUD Treatment Penetration	Annual

		• Well-Care Visits (3-11 Years of Age) • Well-Child Visits in the First 30 Months of Life	
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Childhood Immunization Status (Combo 10) • Chlamydia Screening in Women • Contraceptive Care – Access Measures (NQF# 2903, 2902) • Performance assessed by annual improvement on at least one of the Contraceptive Care Access measures. • Mental Health Treatment Penetration (Broad Version) • Timeliness of Prenatal Care • SUD Treatment Penetration • Well-Care Visits (3-11 Years of Age) • Well-Child Visits in the First 30 Months of Life	Annual
DY6 – 2022	P4R: ACH-reported	• Completion of DY6 P4R report 1 (template available January 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q1
		• Completion of P4R report 2 (template available July 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q3
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Childhood Immunization Status (Combo 10) • Chlamydia Screening in Women • Contraceptive Care – Access Measures (NQF# 2903, 2902) • Performance assessed by annual improvement on at least one of the Contraceptive Care Access measures. • Mental Health Treatment Penetration (Broad Version) • Timeliness of Prenatal Care • SUD Treatment Penetration • Well-Care Visits (3-11 Years of Age) • Well-Child Visits in the First 30 Months of Life	Annual

Project implementation guidelines

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Shortage of mental health providers, SUD providers, social workers, nurse practitioners, primary care providers, care coordinators and care managers.
    - Opportunities for use of telehealth and integration into work streams.
    - Workflow changes to support integration of new screening and care processes, care integration, communication.
    - Cultural and linguistic competency, health literacy deficiencies.
- **Financial sustainability:** alignment between current payment structures and guidelines for reproductive, maternal and child health care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support improvement of reproductive, maternal and child health efforts into the regional VBP transition plan. Development of model benefit(s) to cover reproductive, maternal and child health services.

Guidance for evidence-based approaches

Approaches to improve reproductive, maternal, and children's health

Implementation of evidence-based and emerging strategies to improve reproductive health

The CDC provided 10 recommendations that aim to improve a person's health before conception, whether before a first or a subsequent pregnancy. The recommendations fall into 10 areas: 1) individual responsibility across the lifespan, 2) consumer awareness, 3) preventive visits, 4) interventions for identified risks, 5) interconception care, 6) pre-pregnancy checkup, 7) health insurance coverage for people with low incomes, 8) public health programs and strategies, 9) research, and 10) monitoring improvements.

Strategies to improve adult health to ensure families have intended and healthy pregnancies that lead to healthy children. Specifically, ACHs should consider evidence-based models to improve utilization of effective reproductive health strategies, including pregnancy intention counseling, healthy behaviors and risk reduction, effective contraceptive use, safe and quality perinatal care, interconception care, and general preventive care.

- Washington State acted on these recommendations by providing a program for uninsured people to obtain basic family planning services (Take Charge and working with providers to improve obstetric outcomes) and grants (Personal Responsibility and Education Plan), and through other actions.

- This project builds on current efforts and provides a mechanism for communities to further the implementation of the recommendations.

Implementation for a home-visiting model should follow evidence-based practice standards.

- Evidence-based home visiting model for pregnant, high-risk people, including high-risk, first-time people. Potential approaches can include NFP or other federally recognized evidence-based home visiting model currently operating in Washington State. If chosen, implementing agencies must meet all fidelity, essential requirements, and/or program standard requirements as defined by the model developer. The project must demonstrate a valid need for home-visiting service expansion and that services will be coordinated. The following models are currently operating in Washington State:
    - NFP provides first-time, low-income persons and their children with nurse-led, home-based support and care.
    - Early Head Start Home-Based Model (EHS) works with parents to improve child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness.
    - Parents as Teachers (PAT) promotes optimal early development, learning and health of children by supporting and engaging their parents and caregivers.
    - Family Spirit offers culturally tailored home-visiting to promote the optimal health and wellbeing of American Indian parents and their children.

Implementation of an evidence-based model or promising practice to improve regional well-child visit rates (for ages 3-6) and childhood immunization rates.

If chosen, implementing agencies must meet all fidelity, essential requirements and/or program standard requirements as defined by the model developer. Possible approaches include:

- Bright Futures
- Stony Brook Children's Hospital Enriched Medical Home Intervention (EMHI)

Project 3C: access to oral health services

Project objective

Increase access oral health services to prevent or control the progression of oral disease and ensure that oral health is recognized as a fundamental component of whole-person care.

Target population

All Medicaid beneficiaries, especially adults.

Evidence-based approach

- Oral Health in Primary Care: integrating oral health screening, assessment, intervention, and referral into the primary care setting.
- Mobile/Portable Dental Care: national maternal and child health resource center providers a manual to guide planning and implementation of mobile dental units and portable dental care equipment for school-age children, which could be adapted for adults.

Project stages

Table 32: stage 1- access to oral health services planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively impact access to oral health services**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for health systems/community capacity focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Select target population and evidence-based approach informed by regional health needs.** ○ **Identify communities or sub-regions with demonstrated shortages of dental providers or otherwise limited access to oral health services.**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify, recruit, and secure formal commitments for participation from implementation partners, to include, at minimum, primary care providers and dentists, via a written agreement.** ○ **Must demonstrate sufficient initial engagement to implement the approach in a timely manner. (Include dentists/dental practices and periodontists who will serve as referral sources.)**	Report milestone completion in semi-annual report	DY2, Q2
Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building**	Timely submission of implementation plan	DY2, Q3

(HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.		

Table 33: stage 2- access to oral health services implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches.**	Timely submission of QIP	DY3, Q2
Description of training and implementation activities • **Implement project, including the following core components across each approach selected:** ○ **Implement bi-directional communications strategies/interoperable HIE tools to support the care model.** ○ **Establish mechanisms for coordinating care with related community-based services and supports.** ○ **Develop workflows to operationalize the protocol, specifying which member of the care performs each function, inclusive of when referral to dentist or periodontist is needed.** ○ **Establish referral relationships with dentists and other specialists, such as ear, nose, and throat specialists (ENTs) and periodontists.** ○ **Ensure each member of the care team receives the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.** ○ **Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes.** ○ **Engage with payers in discussion of payment approaches to support access to oral health services.**	Demonstrate progress in semi-annual report	DY3, Q4

Table 34: stage 3- access to oral health services scale and sustain

Project Milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase scope and scale, expand to serve additional high-risk populations, and add partners or service sites to spread approach to additional communities.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model, and adopting guidelines, policies, and procedures as required.**		
Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 35: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Application Delivered by Non-Dental Health Professional • Utilization of Dental Services	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q2

		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Periodontal Evaluation in Adults with Chronic Periodontitis • Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Application Delivered by Non-Dental Health Professional • Utilization of Dental Services	Annual
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Dental Sealants for Children at Elevated Caries Risk • Periodontal Evaluation in Adults with Chronic Periodontitis • Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Applications Delivered by Non-Dental Health Professional • Utilization of Dental Services	Annual
DY6 – 2022	P4R: ACH-reported	• Completion of DY6 P4R report 1 (template available January 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q1
		• Completion of P4R report 2 (template available July 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q3
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Dental Sealants for Children at Elevated Caries Risk • Periodontal Evaluation in Adults with Chronic Periodontitis • Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Applications Delivered by Non-Dental Health Professional • Utilization of Dental Services	Annual

Project implementation guidelines

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable

population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.

- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Shortage of dentist, hygienist, and other dental care providers, and primary care providers.
    - Access to periodontal services.
    - Training and technical assistance to ensure cultural and linguistic competency, health literacy needs.
- **Financial sustainability:** alignment between current payment structures and integration of oral health services; incorporate current state and anticipated future state of value-based payment arrangements to support access to oral health efforts into the regional VBP transition plan; promote VBP readiness tools and resources, such as the adoption of diagnostic coding in dental for bi-directional medical/dental data sharing and population health.

Guidance for evidence-based approaches

Oral health in primary care

Planning:

For oral health in primary care, consider a phased approach to implementation, such as:

- Begin with screening patients for signs and symptoms of early disease and develop a structured referral process for dentistry.
- Offer fluoride varnish for pediatric patients per the USPSTF61 and AAP guidelines; consider indications for fluoride varnish for high-risk adults.
- Focus on patient/caregiver risk assessment and risk reduction through patient education, dietary counseling, and oral hygiene training.
- Identify a particular high-risk patient population (e.g., adult patients with diabetes, pregnant persons) and begin with a pilot before expanding population/practice wide.
- Articulate the activities in each phase, and the associated timeline.

Implementation:

- Establish and implement clinical guideline or protocol that incorporates the following five elements of the Oral Health Delivery Framework:
    - Ask about symptoms that suggest oral disease and factors that place patients at increased risk for oral disease. Two or three simple questions can be asked to elicit symptoms of oral dryness, pain or bleeding in the mouth, oral hygiene and dietary habits, and length of time since the patient last saw a dentist. These questions can be asked verbally or included in a written health risk assessment.
    - Look for signs that indicate oral health risk or active oral disease. Assess the adequacy of salivary flow; look for signs of poor oral hygiene, white spots or cavities, gum recession, or periodontal inflammation; and conduct examination for signs of disease. During a well-visit

or complete physical exam, this activity could be included as a component of the standard Head, Ears, Eyes, Neck, and Throat Exam (HEENT exam) resulting in a comprehensive assessment that includes the oral cavity—a "HEENOT" exam.
    - Decide on the most appropriate response. Review information gathered and share results with patients and families. Determine a course of action using standardized criteria based on the answers to the screening and risk assessment questions; findings of the oral exam; and the values, preferences, and goals of the patient and family.
    - Act by delivering preventive interventions and/or placing an order for a referral to a dentist or medical specialist. Preventive interventions delivered in the primary care setting may include: 1) changes in the medication list to protect the saliva, teeth, and gums, 2) fluoride therapy, 3) dietary counseling to protect the teeth and gums, and to promote glycemic control for patients with diabetes, 4) oral hygiene training 5) therapy for tobacco, alcohol, or SUD and 6) referrals to dental.
    - Document the findings as structured data to organize information for decision support, measure care processes, and monitor clinical outcomes so that quality of care can be managed.
- Establish and implement workflows to operationalize the protocol, specifying which member of the care performs each function, inclusive of when referral to dentist or periodontist is needed.
- Ensure each member of the care team receives the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.
- Establish referral relationships with dentists and other specialists, such as ENTs and periodontists.
- Engage with payers in discussion of payment approaches to support the model.

Mobile/portable dental care:

The national maternal and child health resource center provides a manual to guide planning and implementation of mobile dental units and portable dental care equipment for school-age children, which could be adapted for adults.

Planning:

- Specify where the mobile units and/or portable equipment will be deployed. Consider locations where Medicaid beneficiaries access housing, transportation, or other community-based supports, as well as rural communities, migrant worker locations, and American Indian reservations.
- Secure commitments from potential sites and develop a list of potential future sites.
- Specify the scope of services to be provided, hours of operation, and staffing plan.
- Include steps to show how ACH will research, and comply with, laws, regulations, and codes that may impact the design or implementation of the mobile unit and/or portable equipment.
- Include the timeline for educating providers, beneficiaries, and communities about the new service.

Implementation will include the following core components:

- Establish guidelines, policies, protocols, and/or procedures as necessary to support the full scope of services being provided.
- Secure necessary permits and licenses required by the state or locality.
- Establish referral relationships with primary care providers, dental providers, and other specialists, e.g., ENTs and periodontists, as needed.
- Acquire mobile unit and/or portable equipment and other supplies.
- Recruit, hire, and train staff.
- Implement the provider, client, and community education campaign to raise awareness of the new service.

Project 3D: chronic disease prevention and control

Project objective

Integrate health system and community approaches to improve chronic disease management and control.

Target population

Medicaid beneficiaries (adults and children) with or at risk for arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity, and stroke, with a focus on those populations experiencing the greatest burden of chronic disease(s) in the region.

Evidence-based approach:

Chronic Care Model

Project stages

Table 36: stage 1 – chronic disease prevention and control planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively impact chronic disease.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for health systems/community capacity focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Select specific target population(s), guided by disease burden and overall community needs, ACHs will identify the population demographic and disease area(s) of focus, ensuring focus on population(s) experiencing the highest level of disease burden.** • **Select evidence-based guidelines and best practices for chronic disease care and management using the Chronic Care Model approach to improve asthma, diabetes, and/or heart disease control, and address obesity in their region.**	Report milestone completion in semi-annual report	DY2, Q2

• **Region may pursue multiple target chronic conditions and/or population-specific strategies in their overall approach.**		
Completion of initial partnering provider list • **Identify, recruit, and secure formal commitments for participation from all implementation partners, including health care providers (must include primary care providers) and relevant community-based service organizations.** • **Form partnerships with community organizations to support and develop interventions that fill gaps in needed services.** • **Execute Master Services Agreement for partnering providers receiving funds through the FE portal.**	Report milestone completion in semi-annual report	DY2, Q2
Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.**	Timely submission of implementation plan	DY2, Q3

Table 37: stage 2 – chronic disease prevention and control implementation

Project milestone	Proof of completion	Due
Description of partnering provider progress in adoption of policies, procedures, and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches.**	Timely submission of QIP	DY3, Q2

Description of training and implementation activities
• **Implement disease/population-specific Chronic Care Implementation Plan for identified populations within identified geographic areas, inclusive of identified change strategies to develop and/or improve:**
  ○ **Self-management support**
  ○ **Delivery system design**
  ○ **Decision support**
  ○ **Clinical information systems (including interoperable systems)**
  ○ **Community-based resources and policy**
  ○ **Health care organization**
• **Implementation should ensure integration of clinical and community-based strategies through communication, referral, and data-sharing strategies.**
	Demonstrate progress in semi-annual report	DY3, Q4

Table 38: stage 3 – chronic disease prevention and control scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase scale of approach, expand to serve additional high-risk populations, include additional providers and/or cover additional high-needs geographic areas, to disseminate and increase adoption of change strategies that result in improved care processes and health outcomes.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model, and adopting guidelines, policies, and procedures as required.**		
Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide or support ongoing training, technical assistance, learning collaborative platforms, to support shared learning, spread and continuation, and expansion of successful change strategies (e.g., the use of interoperable clinical information systems by additional providers, additional populations, or types of information exchanged).**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 39: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Children's and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Medication Management for People with Asthma (5 – 64 Years)	Annual

DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q2
		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Asthma Medication Ratio • Child and Adolescent Well-Care Visits (3-21 Years of Age) • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Kidney Health Evaluation with Patients with Diabetes • Statin Therapy for Patients with Cardiovascular Disease (Prescribed) • Well Child Visit in the first 30 months of Life	Annual
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Asthma Medication Ratio • Child and Adolescent Well-Care Visits (3-21 Years of Age) • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Kidney Health Evaluation with Patients with Diabetes • Statin Therapy for Patients with Cardiovascular Disease (Prescribed) • Well Child Visits in the first 30 months of Life	Annual
DY6 – 2022	P4R: ACH-reported	• Completion of DY6 P4R report 1 (template available January 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q1
		• Completion of P4R report 2 (template available July 2022) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY6, Q3
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Asthma Medication Ratio • Child and Adolescent Well-Care Visits (3-21 Years of Age) • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Kidney Health Evaluation with Patients with Diabetes	Annual

		• Statin Therapy for Patients with Cardiovascular Disease (Prescribed) • Well Child Visits in the first 30 months of Life	

Project implementation guidelines

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable chronic disease population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Shortage of community health workers, certified asthma educators, certified diabetes educators, home health care providers.
    - Access to specialty care, opportunities for telehealth integration.
    - Workflow changes to support registered nurses and other clinical staff to be working to the top of professional licensure. Training and technical assistance to ensure a prepared, proactive practice team and prepared, proactive community partners.
    - Cultural and linguistic competency, health literacy needs.
- **Financial sustainability:** alignment between current payment structures and guidelines are, inclusive of community-based services (such as home-based asthma visits, diabetes self-management education, and home-based blood pressure monitoring); incorporate current state and anticipated future state of VBP arrangements to support chronic disease control efforts into the regional VBP transition plan. Consider inclusion of the following within reimbursement models: bundled services, group visits, once-daily medication regimens, community-based self-management support services.

Guidance for evidence-based approaches

Chronic Care Model

Regions are encouraged to focus on more than one chronic condition under the Chronic Care Model approach.

Examples of specific strategies to consider within Chronic Care Model approach:

- The Community Guide
- Million Hearts Campaign
- CDC-recognized National Diabetes Prevention Programs (NDPP)
- Community Paramedicine model: locally designed, community-based, collaborative model of care that leverages the skills of paramedics and EMS systems to address care gaps identified through a community specific health care needs assessment.

Specific change strategies to be implemented across elements of the Chronic Care Model: self-management support, delivery system design, decision support, clinical information systems, community-based resources and policy, and health care organization.

- **Self-management support strategies and resources** to empower and prepare patients to manage their health and health care, such as: incorporate the 5As (assess, advise, agree, assist, arrange) into regular care, such as:
    - Completing and update asthma action plans
    - Providing access to asthma self-management education, diabetes self-management education, and Stanford Chronic Disease Management Program
    - Supporting home-based blood pressure monitoring
    - Providing motivational interviewing
    - Ensuring cultural and linguistic appropriateness
- **Delivery system design strategies** to support effective, efficient care, such as implementing and supporting team-based care strategies; increasing the presence and clinical role of non-physician members of the care team; increasing frequency and improving processes of planned care visits and follow-up; referral processes to care management and specialty care.
- **Decision support strategies** to support clinical care that is consistent with scientific evidence and patient preference, such as development and/or provision of decision support tools (guideline summaries, flow sheets, etc.); embed evidence-based guidelines and prompts into EHRs; provide education as needed on evidence-based guidelines via case-based learning, academic detailing, or modeling by expert providers; establish collaborative management practices and communication with specialty providers; incorporate patient education and engagement strategies.
- **Clinical information systems strategies** to organize patient and population data to facilitate efficient and effective care, such as utilization of patient registries; automated appointment reminder systems; bi-directional data sharing and encounter alert systems; provider performance reporting.
- **Community-based resources and policy strategies** to activate the community, increase community-based supports for disease management and prevention, and development of local collaborations to address structural barriers to care such as community paramedicine; tobacco-free policy expansion; tobacco cessation assistance; nutritional food access policies; National Diabetes Prevention Program; home-based and school-based asthma services; worksite nutritional and physical activity programs; and behavioral screen time interventions.
- **Health care organization strategies** that ensure high-quality care, such as engagement of executive and clinical leadership; support for quality improvement processes; shared learning structures; intersection with care coordination efforts; and financial strategies to align payment with performance.

Appendix A: P4R and P4P AV association

By project and reporting period

AV snapshot: Project 2A - bi-directional integration of physical and behavioral health through care transformation

Table 39: P4R AV earning potential (Project 2A)

P4R milestones and recurrent deliverables	Schedule of AVs									
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)		DY6 (2022)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0									
Completed strategy development for Domain I (health and community systems capacity building)	1.0									
Definition of evidence-based approaches or promising practices and target populations	1.0									
Completion of initial partnering provider list	1.0									
Completed implementation plan		1.0								
Support regional transition to integrated managed care (2020 regions only)		1.0								
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0							
Completion and approval of QIP			1.0							
Description of training and implementation activities				1.0						
Attestation of successfully integrating managed care			1.0		1.0					
Description of scale and sustain transformation activities						1.0				
Description of continuous quality improvement methods to refine/revise transformation activities						1.0				
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0				
Demonstrate sustainability of transformation activities						1.0				
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0		
Collection and reporting of provider-level P4R metrics			1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Total earnable P4R AVs per reporting period	5.0	5.0	8.0	6.0	6.0	9.0	5.0	5.0	4.0	4.0

Table 40: P4P AV earning potential (Project 2A)

P4P project metric	Schedule of AVs			
	DY3 (2019) Q1-Q4	DY4 (2020) Q1-Q4	DY5 (2021) Q1-Q4	DY6 (2022) Q1-Q4
Acute Hospital Utilization	Inactive	1.0	1.0	1.0
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0	1.0
Antidepressant Medication Management	1.0	1.0	1.0	1.0
Asthma Medication Ratio	Inactive	1.0	1.0	1.0
Children's and Adolescents' Access to Primary Care Practitioners	1.0	Inactive	Inactive	Inactive
Child and Adolescent Well-Care Visits (3-21 Years of Age)	Inactive	1.0	1.0	1.0
Comprehensive Diabetes Care: Eye Exam (retinal) performed	Inactive	1.0	1.0	1.0
Comprehensive Diabetes Care: Hemoglobin A1c Testing	1.0	1.0	1.0	1.0
Comprehensive Diabetes Care: Medical Attention for Nephropathy	1.0	Inactive	Inactive	Inactive
Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence	Inactive	1.0	1.0	1.0
Follow-up After ED Visit for Mental Illness	Inactive	1.0	1.0	1.0
Follow-up After Hospitalization for Mental Illness	Inactive	1.0	1.0	1.0
Kidney health Evaluation for Patients with Diabetes	Inactive	1.0	1.0	1.0
Medication Management for People with Asthma: Medication Compliance 75%	1.0	Inactive	Inactive	Inactive
Mental Health Treatment Penetration (Broad Version)	1.0	1.0	1.0	1.0
Plan All-Cause Readmission Rate (30 Days)	1.0	1.0	1.0	1.0
SUD Treatment Penetration	1.0	1.0	1.0	1.0
Total earnable P4P AV per performance period	9.0	14.0	14.0	14.0

AV snapshot: Project 2B - community-based care coordination

Table 41: P4R AV earning potential (Project 2B)

P4R milestones and recurrent deliverables	Schedule of AVs									
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)		DY6 (2022)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0									
Completed strategy development for Domain I (health and community systems capacity building)	1.0									
Definition of evidence-based approaches or promising practices and target populations	1.0									
Completion of initial partnering provider list	1.0									
Completed implementation plan		1.0								
Project 2B: Identified HUB lead entity and description of qualifications		1.0								
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0							
Completion and approval of QIP			1.0							
Description of training and implementation activities				1.0						
Project 2B: Description of each pathway scheduled for initial implementation and expansion / partnering provider role & responsibilities to support Pathways implementation				1.0						
Description of scale and sustain transformation activities						1.0				
Description of continuous quality improvement methods to refine/revise transformation activities						1.0				
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0				
Demonstrate sustainability of transformation activities						1.0				
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0		
Total earnable P4R AVs per reporting period	5.0	5.0	6.0	6.0	4.0	8.0	4.0	4.0	3.0	3.0

Table 42: P4P AV earning potential (Project 2B)

P4P project metric	Schedule of AVs			
	DY3 (2019) Q1-Q4	DY4 (2020) Q1-Q4	DY5 (2021) Q1-Q4	DY6 (2022) Q1-Q4
Acute Hospital Utilization	Inactive	1.0	1.0	1.0
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0	1.0
Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence	Inactive	1.0	1.0	1.0
Follow-up After ED Visit for Mental Illness	Inactive	1.0	1.0	1.0
Follow-up After Hospitalization for Mental Illness	Inactive	1.0	1.0	1.0
Mental Health Treatment Penetration (Broad Version)	1.0	1.0	1.0	1.0
Percent Homeless (Narrow Definition)	1.0	1.0	1.0	1.0
Plan All-Cause Readmission Rate (30 Days)	1.0	1.0	1.0	1.0
SUD Treatment Penetration	1.0	1.0	1.0	1.0
Total earnable P4P AV per performance period	5.0	9.0	9.0	9.0

AV snapshot: Project 2C -transitional care

Table 43: P4R AV earning potential (Project 2C)

P4R milestones and recurrent deliverables	Schedule of AVs									
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)		DY6 (2022)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0									
Completed strategy development for Domain I (health and community systems capacity building)	1.0									
Definition of evidence-based approaches or promising practices and target populations	1.0									
Completion of initial partnering provider list	1.0									
Completed implementation plan		1.0								
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0							
Completion and approval of QIP			1.0							
Description of training and implementation activities				1.0						
Description of scale and sustain transformation activities						1.0				
Description of continuous quality improvement methods to refine/revise transformation activities						1.0				
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0				
Demonstrate sustainability of transformation activities						1.0				
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0		
Total earnable P4R AVs per reporting period	5.0	4.0	6.0	5.0	4.0	8.0	4.0	4.0	3.0	3.0

Table 44: P4P AV earning potential (Project 2C)

P4P project metric	Schedule of AVs, by year			
	DY3 (2019) Q1- Q4	DY4 (2020) Q1- Q4	DY5 (2021) Q1-Q4	DY6 (2022) Q1-Q4
Acute Hospital Utilization	Inactive	1.0	1.0	1.0
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0	1.0
Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence	Inactive	1.0	1.0	1.0
Follow-up After ED Visit for Mental Illness	Inactive	1.0	1.0	1.0
Follow-up After Hospitalization for Mental Illness	Inactive	1.0	1.0	1.0
Percent Homeless (Narrow Definition)	1.0	1.0	1.0	1.0
Plan All-Cause Readmission Rate (30 Days)	1.0	1.0	1.0	1.0
Total earnable P4P AV per performance period	3.0	7.0	7.0	7.0

AV snapshot: Project 2D - diversion interventions

Table 45: P4R AV earning potential (Project 2D)

P4R milestones and recurrent deliverables	Schedule of AVs									
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)		DY6 (2022)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0									
Completed strategy development for Domain I (health and community systems capacity building)	1.0									
Definition of evidence-based approaches or promising practices and target populations	1.0									
Completion of initial partnering provider list	1.0									
Completed implementation plan		1.0								
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0							
Completion and approval of QIP			1.0							
Description of training and implementation activities				1.0						
Description of scale and sustain transformation activities						1.0				
Description of continuous quality improvement methods to refine/revise transformation activities						1.0				
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0				
Demonstrate sustainability of transformation activities						1.0				
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0		
Total earnable P4R AVs per reporting period	5.0	4.0	6.0	5.0	4.0	8.0	4.0	4.0	3.0	3.0

Table 46: P4P AV earning potential (Project 2D)

P4P project metric	Schedule of AVs, by year			
	DY3 (2019) Q1- Q4	DY4 (2020) Q1- Q4	DY5 (2021) Q1-Q4	DY6 (2022) Q1-Q4
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0	1.0
Percent Arrested	Inactive	1.0	1.0	1.0
Percent Homeless (Narrow Definition)	1.0	1.0	1.0	1.0
Total earnable P4P AV per performance period	2.0	3.0	3.0	3.0

AV snapshot: Project 3A - addressing the opioid use public health crisis

Table 47: P4R AV earning potential (Project 3A)

P4R milestones and recurrent deliverables	Schedule of AVs									
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)		DY6 (2022)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0									
Completed strategy development for Domain I (health and community systems capacity building)	1.0									
Definition of evidence-based approaches or promising practices and target populations	1.0									
Completion of initial partnering provider list	1.0									
Completed implementation plan		1.0								
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0							
Completion and approval of QIP			1.0							
Description of training and implementation activities				1.0						
Address gaps in access & availability of providers offering recovery support services				1.0						
Description of scale and sustain transformation activities						1.0				
Description of continuous quality improvement methods to refine/revise transformation activities						1.0				
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0				
Demonstrate sustainability of transformation activities						1.0				
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0		
Collection and reporting of provider-level P4R metrics			1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Total earnable P4R AVs per reporting period	5.0	4.0	7.0	7.0	5.0	9.0	5.0	5.0	4.0	4.0

Table 48: P4P AV earning potential (Project 3A)

P4P project metric	Schedule of AVs, by year			
	DY3 (2019) Q1- Q4	DY4 (2020) Q1- Q4	DY5 (2021) Q1-Q4	DY6 (2022) Q1-Q4
Acute Hospital Utilization	Inactive	1.0	1.0	1.0
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0	1.0
Patients prescribed chronic concurrent opioids and sedatives prescriptions	1.0	1.0	1.0	1.0
Patients prescribed high-dose chronic opioid therapy	1.0	1.0	1.0	1.0
SUD Treatment Penetration (Opioid)	Inactive	1.0	1.0	1.0
Total earnable P4P AV per performance period	3.0	5.0	5.0	5.0

AV snapshot: Project 3B - reproductive and maternal/child health

Table 49: P4R AV earning potential (Project 3B)

P4R milestones and recurrent deliverables	Schedule of AVs									
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)		DY6 (2022)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0									
Completed strategy development for Domain I (health and community systems capacity building)	1.0									
Definition of evidence-based approaches or promising practices and target populations	1.0									
Completion of initial partnering provider list	1.0									
Completed implementation plan		1.0								
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0							
Completion and approval of QIP			1.0							
Description of training and implementation activities				1.0						
Description of scale and sustain transformation activities						1.0				
Description of continuous quality improvement methods to refine/revise transformation activities						1.0				
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0				
Demonstrate sustainability of transformation activities						1.0				
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0		
Total earnable P4R AVs per reporting period	5.0	4.0	6.0	5.0	4.0	8.0	4.0	4.0	3.0	3.0

Table 50: P4P AV earning potential (Project 3B)

P4P project metric	Schedule of AVs, by year			
	DY3 (2019) Q1- Q4	DY4 (2020) Q1- Q4	DY5 (2021) Q1-Q4	DY6 (2022) Q1-Q4
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0	1.0
Childhood Immunization Status (Combo 10)	Inactive	1.0	1.0	1.0
Chlamydia Screening in Women	1.0	1.0	1.0	1.0
Child and Adolescents Well-Child Visits (3-11 Years of Age)	Inactive	1.0	1.0	1.0
Contraceptive Care – Most & Moderately Effective Methods	Inactive	1.0	1.0	1.0
Contraceptive Care – Postpartum	Inactive	1.0	1.0	1.0
Mental Health Treatment Penetration (Broad Version)	1.0	1.0	1.0	1.0
SUD Treatment Penetration	1.0	1.0	1.0	1.0
Timeliness of Prenatal Care	Inactive	1.0	1.0	1.0
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Age	1.0	Inactive	Inactive	Inactive
Well-Child Visits in the First 15 Months of Life	Inactive	Inactive	Inactive	Inactive
Well-Child Visits in the First 30 Months of Life	Inactive	1.0	1.0	1.0
Total earnable P4P AV per performance period	5.0	10.0	10.0	10.0

AV snapshot: Project 3C - access to oral health services

Table 51: P4R AV earning potential (Project 3C)

P4R milestones and recurrent deliverables	Schedule of AVs									
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)		DY6 (2022)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0									
Completed strategy development for Domain I (health and community systems capacity building)	1.0									
Definition of evidence-based approaches or promising practices and target populations	1.0									
Completion of initial partnering provider list	1.0									
Completed implementation plan		1.0								
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0							
Completion and approval of QIP			1.0							
Description of training and implementation activities				1.0						
Description of scale and sustain transformation activities						1.0				
Description of continuous quality improvement methods to refine/revise transformation activities						1.0				
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0				
Demonstrate sustainability of transformation activities						1.0				
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0		
Total earnable P4R AVs per reporting period	5.0	4.0	6.0	5.0	4.0	8.0	4.0	4.0	3.0	3.0

Table 52: P4P AV earning potential (Project 3C)

P4P project metric	Schedule of AVs, by year			
	DY3 (2019) Q1- Q4	DY4 (2020) Q1- Q4	DY5 (2021) Q1-Q4	DY6 (2022) Q1-Q4
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0	1.0
Dental Sealants for Children at Elevated Caries Risk	Inactive	Inactive	1.0	1.0
Periodontal Evaluation in Adults with Chronic Periodontitis	Inactive	1.0	1.0	1.0
Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Application Delivered by Non-Dental Health Professional	1.0	1.0	1.0	1.0
Utilization of Dental Services	1.0	1.0	1.0	1.0
Total earnable P4P AV per performance period	3.0	4.0	5.0	5.0

AV snapshot: Project 3D - chronic disease prevention and control

Table 53: P4R AV earning potential (Project 3D)

P4R milestones and recurrent deliverables	Schedule of AVs									
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)		DY6 (2022)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0									
Completed strategy development for Domain I (health and community systems capacity building)	1.0									
Definition of evidence-based approaches or promising practices and target populations	1.0									
Completion of initial partnering provider list	1.0									
Completed implementation plan		1.0								
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0							
Completion and approval of QIP			1.0							
Description of training and implementation activities				1.0						
Description of scale and sustain transformation activities						1.0				
Description of continuous quality improvement methods to refine/revise transformation activities						1.0				
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0				
Demonstrate sustainability of transformation activities						1.0				
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0		
Total earnable P4R AVs per reporting period	5.0	4.0	6.0	5.0	4.0	8.0	4.0	4.0	3.0	3.0

Table 54: P4P AV earning potential (Project 3D)

P4P project metric	Schedule of AVs, by year			
	DY3 (2019) Q1- Q4	DY4 (2020) Q1- Q4	DY5 (2021) Q1-Q4	DY6 (2022) Q1-Q4
Acute Hospital Utilization	Inactive	1.0	1.0	1.0
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0	1.0
Asthma Medication Ratio	Inactive	1.0	1.0	1.0
Children's and Adolescents' Access to Primary Care Practitioners	1.0	Inactive	Inactive	Inactive
Child and Adolescent Well-Care Visits (3-21 Years of Age)	Inactive	1.0	1.0	1.0
Comprehensive Diabetes Care: Eye Exam (retinal) performed	Inactive	1.0	1.0	1.0
Comprehensive Diabetes Care: Hemoglobin A1c Testing	1.0	1.0	1.0	1.0
Comprehensive Diabetes Care: Medical Attention for Nephropathy	1.0	Inactive	Inactive	Inactive
Kidney Health Evaluation for Patients with Diabetes	Inactive	1.0	1.0	1.0
Medication Management for People with Asthma: Medication Compliance 75%	1.0	Inactive	Inactive	Inactive
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	Inactive	1.0	1.0	1.0
Total earnable P4P AV per performance period	5.0	8.0	8.0	8.0

Appendix B: Project Toolkit for P4P metrics

The following table provides a high-level description for the Project Toolkit P4P metrics. Full measure specifications and measure production information can be referenced in the DSRIP Measurement Guide.

Table 55: Project Toolkit P4P metrics

Name of measure	Term used to reference the measure
National Quality Forum (NQF)#	Measures endorsed by NQF will have an identification number. A full list of NQF-endorsed measures are available through the Quality Positioning System (QPS).
Measure steward	An individual or organization that owns a measure is responsible for maintaining the measure. Measure stewards are often the same as measure developers, but not always. Measure stewards are also an ongoing point of contact for people interested in a measure.
Measure description	Summary information to provide high-level understanding of measure intent.
ACH P4P metrics for project incentives, by year	Outlines the DYs when the measure is "activated" or associated with project P4P incentives. P4P begins DY3; however, not all measures are "activated" at the same time.
Associated toolkit projects	Indicates the projects for which the metric is associated with project P4P incentives.
ACH high-performance metric	Indicates whether the metric is associated with earning incentives from the ACH high-performance pool.

Table 56: ACH project P4P metrics

Name of metric	NQF#	Measure steward	Measure description	ACH P4P metrics for project incentives, by year				Associated toolkit projects	ACH high-performance metric
				DY3 (2019)	DY4 (2020)	DY5 (2021)	DY6 (2022)		
Acute Hospital Utilization	N/A	NCQA (HEDIS)	The rate of acute inpatient discharges among Medicaid beneficiaries, 18 years of age and older, during the measurement year. Measure is expressed as a rate per 1,000 denominator member months.	Inactive	P4P	P4P	P4P	2A, 2B, 2C, 3A, 3D	N
All-Cause ED Visits per 1000 Member Months	N/A	DSHS (Research and Data Analysis (RDA) Division)	The rate of Medicaid beneficiary visits to an ED during the measurement year, including visits related to mental health and SUD. Measure is expressed as a rate per 1,000 denominator member months.	P4P	P4P	P4P	P4P	2A, 2B, 2C, 2D, 3A, 3B 3C, 3D	Y
Antidepressant Medication Management	0105	NCQA (HEDIS)	The percentage of Medicaid beneficiaries, 18 years of age and older, who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment	P4P	P4P	P4P	P4P	2A	Y

			during the measurement year.						
Asthma Medication Ratio	1800	NCQA (HEDIS)	The percentage of Medicaid beneficiaries, 5-64 years of age, who were identified as having persistent asthma and had a ratio of controller medication to total asthma medications of 0.50 or greater during the measurement year.	Inactive	P4P	P4P	P4P	2A, 3D	Y (DY4, DY5)
Children's and Adolescents' Access to Primary Care Practitioners	N/A	NCQA (HEDIS - modified)	The percentage of Medicaid beneficiaries, 12 months-19 years of age, who had an ambulatory or preventive care visit during the measurement year.	P4P	Inactive	Inactive	Inactive	2A, 3D	N
Child and Adolescent Well-Care Visits	N/A	NCQA (HEDIS - modified)	The percentage of Medicaid beneficiaries, 3-21 years of age, who had at least one comprehensive well-care visit during the measurement year.	N/A	P4P	P4P	P4P	2A, 3D	N
Child and Adolescent Well-Care Visits	N/A	NCQA (HEDIS - Modified)	The percentage of Medicaid beneficiaries, 3-11 years of age, who had at least one comprehensive well-care visit during the measurement year.	N/A	P4P	P4P	P4P	3B	Y

Childhood Immunization Status (Combo 10)	0038	NCQA (HEDIS)	The percentage of Medicaid beneficiaries who turned 2 years of age during the measurement year who, by their second birthday, received all vaccinations in the Combo 10 vaccination set.	Inactive	P4P	P4P	P4P	3B	N
Chlamydia Screening in Women	0033	NCQA (HEDIS)	The percentage of female Medicaid beneficiaries, 16-24 years of age, identified as sexually active and who had at least one test for chlamydia during the measurement year.	P4P	P4P	P4P	P4P	3B	N
Comprehensive Diabetes Care: Eye Exam (retinal) Performed	0055	NCQA (HEDIS)	The percent of Medicaid beneficiaries, 18-75 years of age, with diabetes (type 1 and type 2) who had a retinal or dilated eye exam by an eye care professional during the measurement year, or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement year.	Inactive	P4P	P4P	P4P	2A, 3D	N
Comprehensive Diabetes Care: Hemoglobin A1c Testing	0057	NCQA (HEDIS)	The percent of Medicaid beneficiaries, 18-75 years of age, with diabetes (type 1 and type 2) who received a Hemoglobin A1c (HbA1c) test during the measurement year.	P4P	P4P	P4P	P4P	2A, 3D	N
Comprehensive Diabetes Care: Medical	0062	NCQA (HEDIS)	The percent of Medicaid beneficiaries, 18-75 years of age, with diabetes (type 1 and type 2) who	P4P	Inactive	Inactive	Inactive	2A, 3D	N

Attention for Nephropathy			had a nephropathy screening test or evidence of nephropathy during the measurement year.						
Contraceptive Care – Most and Moderately Effective Methods	2903	US Office of Population Affairs	The percent of female Medicaid beneficiaries, 15-44 years of age, at risk of unintended pregnancy that are provided a most effective (i.e., sterilization, implants, intrauterine devices, or systems (IntraUterine Device (IUD) or IntraUterine System (IUS) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved method of contraception during the measurement year.	Inactive	P4P	P4P	P4P	3B	N
Contraceptive Care – Postpartum	2902	U.S. Office of Population Affairs	The percent of female Medicaid beneficiaries, 15-44 years of age, who had a live birth that are provided a most effective (i.e., sterilization, implants, intrauterine devices, or systems [IUD/IUS]) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved method of contraception within 3 and 60 days of delivery during the measurement year.	Inactive	P4P	P4P	P4P	3B	N

Dental Sealants for Children at Elevated Caries Risk	2508, 2509	Dental Quality Alliance (DQA)	The percent of Medicaid beneficiaries, 6-14 years of age, at elevated risk of dental caries who received a sealant on a permanent first molar tooth (age 6-9 years) or a sealant on a permanent second molar tooth (age 10-14 years) during the measurement year.	Inactive	Inactive	P4P	P4P	3C	N
Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence	2605	NCQA (HEDIS)	The percent of ED visits for Medicaid beneficiaries, 13 years of age and older, with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit. 2. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. ED visit and follow-up must occur during the measurement year.	Inactive	P4P	P4P	P4P	2A, 2B, 2C	N

Follow-up After ED Visit for Mental Illness	2605	NCQA (HEDIS)	The percent of ED visits for Medicaid beneficiaries, 6 years of age and older, with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit. 2. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. ED visit and follow-up must occur during the measurement year.	Inactive	P4P	P4P	P4P	2A, 2B, 2C	N
Follow-up After Hospitalization for Mental Illness	0576	NCQA (HEDIS)	The percent of discharges for Medicaid beneficiaries, 6 years of age and older, who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: 1. The percentage of discharges for which the member received follow-up within 7 days after discharge. 2. The percentage of	Inactive	P4P	P4P	P4P	2A, 2B, 2C	N

			discharges for which the member received follow-up within 30 days after discharge. Hospitalization discharge and follow-up must occur during the measurement year.						
Kidney Health Evaluation for Patients with Diabetes		NCQA (HEDIS)		Inactive	P4P	P4P	P4P	2A, 3D	N
Medication Management for People with Asthma: Medication Compliance 75%	1799	NCQA (HEDIS)	The percent of Medicaid beneficiaries, 5-64 years of age, who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for the treatment period during the measurement year. Rate are reported for the percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.	P4P	Inactive	Inactive	Inactive	2A, 3D	Y (DY3 only)
Mental Health Treatment Penetration (Broad Version)	N/A	WA DSHS (RDA)	The percent of Medicaid beneficiaries, 6 years of age and older, with a mental health service need identified within the past two years, who received at least one	P4P	P4P	P4P	P4P	2A, 2B, 3B	Y

			qualifying service during the measurement year.						
Patients Prescribed Chronic Concurrent Opioids and Sedatives Prescriptions	N/A	Bree Collaborative	The percent of Medicaid beneficiaries prescribed opioids and a concurrent sedative prescription, among beneficiaries prescribed chronic opioids.	P4P	P4P	P4P	P4P	3A	N
Patients Prescribed High-dose Chronic Opioid Therapy	N/A	Bree Collaborative	The percent of Medicaid beneficiaries prescribed chronic opioid therapy. Two rates reported according to dosage threshold: 1. Greater than or equal to 50mg morphine equivalent dosage in a quarter. 2. Greater than or equal to 90mg morphine equivalent dosage in a quarter.	P4P	P4P	P4P	P4P	3A	N
Percent Arrested	N/A	WA DSHS (RDA)	The percent of Medicaid beneficiaries, aged 18 and older, who were arrested at least once during the measurement year.	Inactive	P4P	P4P	P4P	2D	Y
Percent Homeless (Narrow Definition)	N/A	WA DSHS (RDA)	The percent of Medicaid beneficiaries who were homeless in at least one month during the measurement year. Narrow definition excludes “homeless with housing” living arrangement code from	P4P	P4P	P4P	P4P	2B, 2C, 2D	Y

			the Automated Client Eligibility System (ACES).						
Periodontal Evaluation in Adults with Chronic Periodontitis	N/A	Dental Quality Alliance (DQA)	The percent of Medicaid beneficiaries, ages 30 years and older, with history of periodontitis who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the measurement year.	Inactive	P4P	P4P	P4P	3C	N
Plan All-Cause Readmission Rate (30 Days)	1768	NCQA (HEDIS)	The percent of acute inpatient stays among Medicaid beneficiaries, 18 years of age and older, during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	P4P	P4P	P4P	P4P	2A, 2B, 2C	Y
Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Application Delivered by Non-Dental Health Professional	N/A	HCA	The percent of Medicaid beneficiaries, 0-5 years of age, who received a topical fluoride application from a professional provider (non-dental medical provider) during any medical visit during the measurement year.	P4P	P4P	P4P	P4P	3C	N

Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	N/A	NCQA (HEDIS)	The percent of Medicaid beneficiaries, male 21-75 years of age and females 40-75 years of age, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) who were dispensed at least one high- or moderate-intensity statin medication during the measurement year.	Inactive	P4P	P4P	P4P	3D	N
SUD Treatment Penetration	N/A	DSHS (RDA)	The percent of Medicaid beneficiaries 12 years of age and older with an SUD treatment need identified within the past two years, and who received at least one qualifying SUD treatment during the measurement year.	P4P	P4P	P4P	P4P	2A, 2B, 3B	Y
SUD Treatment Penetration (Opioid)	N/A	DSHS (RDA)	The percent of Medicaid beneficiaries, 18 years of age and older, with an opioid used disorder treatment need identified within the past two years, who received medication assisted treatment (MAT) or medication-only treatment for OUD during the measurement year.	Inactive	P4P	P4P	P4P	3A	N
Timeliness of Prenatal Care	N/A	NCQA (HEDIS)	The percent of live birth deliveries that received a prenatal care visit in the first trimester, on the enrollment start date or within 42 days of	Inactive	P4P	P4P	P4P	3B	N

			enrollment during the measurement year.						
Utilization of Dental Services	N/A	DQA	The percent of Medicaid beneficiaries who received preventative or restorative dental services in the measurement year.	P4P	P4P	P4P	P4P	3C	N
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Age	1516	NCQA (HEDIS - modified)	The percent of Medicaid beneficiaries 3–6 years of age who had one or more well-child visits during the measurement year.	P4P	Inactive	Inactive	Inactive	3B	Y
Well-Child Visits in the First 30 Months of Life		NCQA (HEDIS - modified)	The percent of Medicaid beneficiaries who turned 30 months old during the measurement year and who had six or more well-child visits during their first 15 months of life and two or more visits between 15 to 30 months.	Inactive	P4P	P4P	P4P	3B	N

ATTACHMENT D: DSRIP FUNDING AND MECHANICS PROTOCOL

I. Accountable Communities of Health

a. Introduction

This demonstration aims to transform the health care delivery system through regional, collaborative efforts led by ACHs. ACHs are self-governing organizations with multiple community representatives that are focused on improving health and transforming care delivery for the populations that live within the region. Providers within ACH regions will partner to implement evidence-based programs and emerging innovations, as defined in the DSRIP Planning Protocol (Attachment C), that address the needs of Medicaid beneficiaries. ACHs, through their governing bodies, are responsible for managing and coordinating the projects undertaken with partnering providers as well as state reporting.

This protocol provides detail and criteria that ACHs and their partnering providers must meet in order to receive DSRIP funding and the process that the state will follow to ensure that ACHs will meet these standards.

b. ACH Service Regions

There are nine ACHs that cover the entire state, with the boundaries of each aligned with the state's Medicaid Regional Service Areas (RSA). The RSAs were designated in 2014 through legislation that required the state to continue regionalizing its Medicaid purchasing approach. The RSA geographic boundaries were designated by assessing the degree to which they:

- Support naturally occurring health care delivery system and community service referral patterns across contiguous counties;
- Reflect active collaboration with community planning that prioritizes the health and well-being of residents;
- Include a minimum number of beneficiaries (at least 60,000 covered Medicaid lives) to ensure active and sustainable participation by health insurance companies that serve whole region; and
- Ensure access to adequate provider networks, consider typical utilization and travel patterns, and consider the availability of specialty services and the continuity of care.

ACH Name	Counties in RSA
Better Health Together	Adams, Ferry, Lincoln, Pend Oreille, Spokane Stevens
Greater Columbia ACH	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, Yakima
SWACH	Clark, Klickitat, Skamania
Cascade Pacific Action Alliance	Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, Wahkiakum
Olympic Community of Health	Clallam, Kitsap, Jefferson
Healthier Here	King

Elevate Health	Pierce
North Sound ACH	Island, San Juan, Skagit, Snohomish Whatcom
North Central ACH	Chelan, Douglas, Grant, Okanogan

c. ACH Composition and Partnering Provider Guidelines

Each ACH consists of partnering providers. The commitment to serving Medicaid beneficiaries, as well as the diversity and expertise of those providers and social service organizations, is important in evaluating Project Plan applications.

d. The ACH serves as the lead for the projects with partnering providers that are participating in Medicaid transformation projects. The ACH must submit a single Project Plan application on behalf of the partnering providers, and serve as the single point of performance accountability in the Independent Assessor's evaluation of projects and metrics. *ACH Governance and Management*

Each ACH must describe its primary decision-making process, process for conflict resolution, and its structure (e.g., a Board or Steering Committee) that is subject to composition and participation guidelines as outlined in STC 23. Each ACH's primary decision-making body will be responsible for approving the selection of transformation projects. Each ACH will comply with STCs 22 and 23 in its decision-making structure, which compliance the state will review and approve as part of ACH certification.

The overall organizational structure of the ACH must reflect the capability to make decisions and oversee regional efforts in alignment with the following five domains, at a minimum:

- Financial
- Clinical
- Community
- Data and Performance Monitoring
- Program management and strategy development

The ACH's responsibilities include engaging stakeholders region-wide; supporting partnering providers in planning and implementing projects in accordance with requirements of the demonstration; developing budget plans for the distribution of DSRIP funds to partnering providers in accordance with the funding methodology provided in this protocol; collaborating with partnering providers in ACH leadership and oversight; and leading and complying with all state and CMS reporting requirements.

II. Projects, Metrics and Metric Targets

a. Overview of Projects

ACHs must select and implement at least four Transformation projects from the Project Toolkit (described in the DSRIP Planning Protocol [Attachment C]). ACHs must provide project details in the Project Plan application and describe how selected projects are directly responsive to the needs and characteristics of the Medicaid populations served in the region.

Projects described in the DSRIP Planning Protocol (Attachment C) are grouped into three domains: Health Systems and Community Capacity, Care Delivery Redesign, and Prevention and Health Promotion. The ACHs are responsible for demonstrating progress in relation to progress milestones and outcome metrics for each project.

b. Project Metrics

As part of their Project Plans, ACHs must develop timelines for implementation of projects, in alignment with state-specified process milestones included in Attachment C. Metrics that track progress in project planning, implementation, and efforts to scale and sustain project activities will be used to evaluate ACH milestone achievement.

ACHs must report on these metrics in their semi-annual reports (described in Section V). For each reporting period, ACHs are eligible to receive incentive payments for progress milestones and improvement toward performance metric targets. For designated performance metrics, ACHs will be awarded Achievement Values (AV), based on the mechanism described in Section IV of this protocol.

c. Outcome Metric Goals and Improvement Target

ACHs will have a performance goal for each outcome metric. On an annual basis, the state will measure ACH improvement from a baseline toward this goal to evaluate whether or not the ACH has achieved the metric improvement target. Each ACH will have its own baseline starting point. Both existing and new measures' baselines will be set based on performance during Demonstration Year (DY) 1.

Annual improvement targets for ACH outcome metrics will be established using one of two methodologies:

(1) Gap to Goal Closure: This methodology will be used for metrics that have available state or national Medicaid, or other comparable populations, 90th percentile benchmarks. Outcome targets will be based on these state or national performance benchmarks, whenever available, but adjustments may be made to reflect the socioeconomic and demographic characteristics of the populations serviced by ACHs, where possible.

The "gap" in this methodology is defined as the difference between the baseline (or end of prior DY) performance and the 90th percentile benchmark. Annual improvement targets will be an up to 10 percent closure of the gap year over year.

An example to illustrate the gap to goal methodology: If the baseline data for a measure is 52 percent and the goal is 90 percent, the gap to the goal is 38. The target for the project's first year of performance would be 38 times 10 percent, equaling a 3.8 percent increase in the result (target 55.8%). Each subsequent year would continue to be set with a target using the most recent year's data. For example, should an ACH meet or exceed the first year's target of 55.8 percent, the next annual target would be up to 10 percent of the new gap to the goal. This will account for smaller gains in subsequent years as performance improves toward the goal or measurement ceiling.

In cases where ACH performance meets or exceeds the performance goal (i.e., the 90 percent performance in the example above), incentives are earned based on continued

performance above the goal. If an ACH has already surpassed the goal in the baseline year, the measure will be dropped and value of the remaining measures rebased.

(2) Improvement-Over-Self: For those metrics without a state or national Medicaid benchmark available, including innovative metrics, the state will set a standard percent improvement relative to each ACH's previous DY performance. This percent improvement target will be determined on a metric-by-metric basis based on available evidence of a reasonable expectation for magnitude of change. Improvement targets for these metrics will be set to be consistent with the magnitude of change required to meet targets in the gap-to-goal methodology measures. The improvement-over-self-target for each metric will be consistent across each ACH.[1]

If an ACH baseline rate for an IOS metric reflects the maximum possible rate (100% or 0% depending on whether higher or lower rates indicate better outcomes) and thus an improvement target cannot be calculated, the measure will be dropped and the value of the remaining measures rebased.

III. Incentive Funding Formula and Project Design Funds

a. Demonstration Year 1 (DY1)

i. Project Design Funds

In accordance with STCs 35(i) and 45, during DY1, the state will provide project design funds to ACHs for completing the designated certification process. The design funds are a fixed component distributed equally across ACHs for completing the certification process described in Attachment C and can be used to develop specific and comprehensive Project Plans. This funding allows ACHs to begin to develop the technology, tools, and human resources to support the necessary capacity ACHs need to pursue demonstration goals in accordance with community-based priorities.

Design funds payments will total up to 25 percent of allowable expenditures in DY1 with payments distributed in two phases between June and September 2017. As described in the DSRIP Planning Protocol (Attachment C), ACHs are required to complete the two-phase certification process for receipt of design funds. In order to be eligible for incentive payments, beyond design funds, an ACH must submit and receive state approval of a Project Plan.

ii. Project Funding

[1] CMS approved 5.16.22, for DY5 and DY6 annual improvement targets for ACH outcome metrics will be established using the IOS methodology for all metrics given the differential disruption to the health care system across the nation and the associated impact to national data collection. Due to these factors, using a gap-to-goal method to set improvement targets would be problematic.

The state will distribute the remaining DY1 DSRIP funding (excluding state administrative expenses) to certified ACHs upon approval of the Project Plan application. The amount of DSRIP funding available for each ACH will be scaled based on application scoring by the Independent Assessor as outlined in STC 36.

b. Demonstration Years 2 through 6 Funding and Project Valuation

In accordance with STC 35(h), the state has developed criteria and methodology for project valuation by which ACHs will continue to earn incentive payments in DY 2 through 6 by reporting on and achieving progress measures and performance-based outcome metrics. Project valuation is calculated during DY1 once each certified ACH submits a Project Plan application detailing project selection and implementation strategies. Based on this content, the state determines maximum incentive payments allotted to each ACH, by project, which will be available for distribution to partnering providers. As described in STC 35, the annual maximum project valuation is determined based on the attributed number of Medicaid beneficiaries residing in the ACH RSA(s) and on the Project Plan application scores.

The maximum amount of ACH incentive funding is determined according to the methodology described in (c) below. Once each project is assigned a maximum valuation, the project's corresponding, individual progress measures and outcome metrics are valued according to the methodology described in (d) below.

Maximum ACH and project valuations are subject to monitoring by the state and CMS. In the event that an ACH does not meet the expected targets for each project's reporting-based progress measures and performance-based outcome metrics, the ACH's project valuation may be commensurately reduced from the maximum available project valuation. In addition, ACHs may receive less than their maximum available project valuation if DSRIP funding is reduced based on performance of the statewide measure bundle described in Section VII.

c. Calculating Maximum ACH Project Valuation

Each DY, a maximum statewide amount of DSRIP project funding will be identified. For approved tribal specific projects, a percentage of annual DSRIP funding will be allocated to tribal-specific projects in a manner consistent with this Protocol and the Tribal Protocol, which describes tribal projects and funds flow. Remaining project funds will be available to ACHs based on the methodology outlined below.

<u>Step 1: Assigning Project Weighting</u>

The state has weighed the projects in the Transformation Project Toolkit (Attachment C) relative to one another as a percentage of the total annual DSRIP project funding available, known as the project weight. ACHs must select at least four projects, including Project 2A (Bi-Directional Integration of Physical and Behavioral Health through Care Transformation), Project 3A (Addressing the Opioid Use Public Health Crisis) and least two additional projects, one from Domain 2 and one from Domain 3.

Each project has associated metrics that ACHs must achieve to earn funding tied to the project. An ACH's payment for project implementation is based on pay-for-reporting (P4R) in DY1 and DY2 and based on both P4R and pay-for-performance (P4P) in DY3, DY4[2], DY5, and DY6. The maximum amount of incentive funding that an ACH can earn is determined based on the ACH's project selection[3], the value of the projects selected, the quality and score of Project Plan applications, and the number of Medicaid beneficiaries[4] attributed to the ACH. Project weights outlined in Table 1 were assigned with consideration of the following factors:

- Alignment with statewide measures to better incentivize the achievement of statewide objectives.
- Number of Medicaid beneficiaries within scope and capacity of projects to address population need and improve population health.
- Potential cost-savings to ensure that the state's Medicaid per-capita cost is below national trends.
- Existence of evidence-based strategies to ensure a reduction in avoidable use of intensive services.
- Focus on quality of services, rather than quantity, to accelerate transition to value-based payment.

Table 1. Transformation Project Weighting

Project Weighting	
Project	Weight
2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation	32%
2B: Community-Based Care Coordination	22%
2C: Transitional Care	13%
2D: Diversions Interventions	13%
3A: Addressing the Opioid Use Public Health Crisis	4%
3B: Reproductive and Maternal and Child Health	5%
3C: Access to Oral Health Services	3%
3D: Chronic Disease Prevention and Control	8%

Projects listed in order of Project Weighting

Project 2A (Bi-Directional Integration of Care and Primary Care Transformation) represents the state's primary objective under Initiative 1 of the demonstration. Project 2A requires the highest level of integration of all other projects and, therefore, houses the largest corresponding set of P4P metrics. Furthermore, Project 2A has the potential to yield the

[2] Due to COVID-19 and related performance impacts in CY 2020, CMS approved flexibility for 2020 P4P achievement value calculations. The flexibility allows the state to compare results by metric (2019 regional results, 2019 statewide average, or the 2020 regional results). The Independent Assessor will apply whichever result provides the greatest AV calculation.

[4] For DY6, CMS approved a minimum regional threshold for project incentives. The minimum threshold is set at $5 million and the state will consider both the minimum threshold and the regional beneficiary calculation, applying the greater of the two.

greatest achievement of value for Medicaid members through an evidence-based approach—and is likely to result in significant cost-savings for both the state and federal government. Regions that have implemented fully integrated managed care are be better positioned to scale project 2A and are eligible for an enhanced DY1 valuation based on project plan scoring methodology.

Project 2B (Community-Based Care Coordination) has the potential to realize significant healthcare spending reductions while providing local services to many of the state's most vulnerable Medicaid beneficiaries. To earn payments for this project, an ACH must transition early in the demonstration to P4P.

The project weights of Project 2C (Transitional Care) and Project 2D (Diversion Interventions) are each 13 percent. Both projects allow ACHs to select one or more evidence-based approaches to result in cost-savings for a smaller population of Medicaid beneficiaries compared to Projects 2A and 2B. In addition, these two projects have a smaller number of measures moving to P4P throughout the demonstration period compared to other Domain 2 projects.

Project 3D (Chronic Disease Prevention and Control) has the greatest project weighting in Domain 3s, at 8 percent. Project 3D has the potential to yield significant results for a large population of Medicaid beneficiaries by including multiple chronic diseases within the project. By affecting a large population through an evidence-based model, Project 3D has the potential to result in significant cost savings.

Project 3B (Reproductive and Maternal and Child Health) impacts a large subpopulation of Medicaid beneficiaries. This project offers several optional evidence-based approaches to drive success and a suitable number of metrics to measure performance.

Project 3A (Addressing the Opioid Use Public Health Crisis) will affect a subset of the state's substance use disorder (SUD) population of Medicaid beneficiaries, anticipated to be proportionally smaller than most other Domain 3 projects, by aligning with Governor Inslee's Executive Order 16-09.[1] Based on public comments and feedback to the Project Toolkit (Attachment C), Project 3A has now been escalated as a required project for all ACHs.

Project 3C (Access to Oral Health Services) is primarily targeted at the adult population, who will benefit from the evidence-based approach selected by the ACH, and there is a defined number of P4R metrics that will be used to measure an ACH's performance.

Step 2: Calculating Maximum ACH Project Funding

In accordance with STC 28 and STC 35(b), the state developed an allocation methodology for maximum ACH project funding based on project selection, transformation impact of projects, and attribution based on residence. The state will use the defined RSA boundaries to determine beneficiary attribution for the funding methodology using the November 2017 client-by-month file. The relative level of Medicaid attribution determined at that time will determine maximum DSRIP funds per ACH throughout the demonstration, as outlined below. Maximum funding by project is calculated by multiplying the total state ACH project funds available by the respective project weight (see Table 1 for project weighting). A minimum threshold for calculating maximum regional ACH project and IHCP funding will

be set at $5 million per region for DY6. The state will consider both the minimum threshold and the regional beneficiary calculation, applying the greater of the two. Based on this change, the minimum threshold will apply to two of the nine ACHs and IHCP funding, resulting in a weighted decrease to the other ACHs.[5]

Maximum Statewide Funding by Project = [Total Annual Statewide ACH Project Funds Available by DY] x [Project Weight]

In order to determine the maximum annual ACH funding by project, the maximum annual statewide funding by project is multiplied by total Medicaid beneficiaries residing in the ACH RSA.

Maximum ACH Funding by Project = [Maximum Annual Statewide Funding by Project] x [Percent of Total Attributed Medicaid Beneficiaries]

This formula will be repeated for all selected projects, and the sum of selected project valuations equals the maximum amount of financial incentive payments each ACH can earn for successful project implementation over the course of the demonstration. Each ACH is required to select at least four projects, including Project 2A and Project 3A. If ACHs choose fewer than the total eight projects, project weights will be rebased proportionately for DY2 through DY6. This maximum ACH valuation will be earned upon achieving defined reporting-based progress measures and performance-based outcome metrics and may be reduced based on application of the statewide penalty described in Section VII.

For DY1, the maximum ACH Funding by Project will be adjusted based on Project Plan scores. Each ACH Project Plan will be scored by the Independent Assessor. The scoring criteria will be developed in conjunction with the Project Plan template (see DSRIP Planning Protocol).

d. Earning Incentive Payments

In DY2 through DY6, ACHs earn incentive payments for successful implementation and reporting of selected projects. Successful implementation is defined for each project as meeting the associated reporting-based progress measures and performance-based outcome metrics.

Within each payment period, ACHs are evaluated against these designated metrics and awarded Achievement Values (AV), which are point values assigned to each metric that is payment-driving. The maximum value of an AV is one (1) in the instance in which an ACH meets the designated metric.

The amount of incentive funding paid to an ACH will be based on the amount of progress made toward achieving its improvement target on each outcome metric. An ACH may achieve an AV based on meeting a minimum threshold of 25% of its gap-to-goal target in the year. If this performance threshold is not achieved, and ACH would forfeit the project incentive payment associated with that metric.

Enhanced AV valuation can be achieved if the ACH realizes a higher percentage of the gap-to-goal performance target, beyond the 25% threshold:

[5] This change was made in collaboration with the regional ACHs and partners. The impacts of the change are understood, and partners agree this will result in a more equitable incentive distribution in DY6.

- 100 percent achievement of performance goal (achievement value = 1)
- Less than 100 percent achievement of performance goal and at least 75 percent achievement of performance goal (achievement value = .75)
- Less than 75 percent achievement of performance goal and at least 50 percent achievement of performance goal (achievement value = .50)
- Less than 50 percent achievement of performance goal and at least 25 percent achievement of performance goal (achievement value = .25)
- Less than 25 percent threshold achievement (achievement value = 0)

To determine Total Achievement Value (TAV) for each project in a given payment period, the AVs earned within the project are summed according to their relative weighting as illustrated in Table 2. From there, the Percentage Achievement Value (PAV) is calculated by dividing the TAV by the weighted total of possible AVs for the project in that payment period. The purpose of the PAV is to represent the proportion of metrics an ACH has achieved for each project in each payment period and will be used to determine the distribution of dollars earned out of the maximum annual ACH project funding as follows:

Table 2. Example Calculation of Achievement Values

Measure/Metric	Achievement Value
Outcome Metric 1	0
Outcome Metric 2	1
Outcome Metric 3	0.5
TAV	**1.5**
PAV	**50.0%**

To support the expected outcomes from successful project implementation, ACHs are solely responsible for P4R progress measures in DY1 and DY2. The state will transition a robust set of outcome metrics to be P4P, meaning a portion of project funds are dependent on ACH demonstrating improvement toward performance targets in the out years. Table 3 illustrates the timing and distribution of transition to P4P:

Table 3. Transition to Pay-for-Performance, Percentage of Annual DSRIP Incentive Payment Allocation

Metric Type	DY1	DY2	DY3	DY4	DY5	DY6
P4R	100%	100%	75%	50%	25%	25%
P4P	0%	0%	25%	50%	75%	75%

e. Managed Care Integration

A primary goal of the demonstration is to support implementation of a fully integrated physical health and behavioral health managed care system. Although there are RSAs that have made progress toward integration, a majority of the state requires significant investments to achieve statewide integration of physical and behavioral health services by January 2020.

Regions that implement fully integrated managed care prior to 2020 are eligible to earn incentive payments above the maximum valuation for project 2A. To earn incentives above the maximum valuation for project 2A, regions must submit binding letters of intent to implement full integration. This will be reported in Project Plan submissions. The incentive payment is calculated using a base rate of up to $2 million and a per member rate based on total attributed Medicaid beneficiaries, with payments distributed to the ACH in the calendar year of completion.

Integration Incentive = [Base Rate] + [Member Adjustment x Total Attributed Medicaid Beneficiaries] x [Phase Weight]

The incentives for fully integrated managed care will be distributed in two phases associated with reporting on progress measures: binding letter(s) of intent, and implementation. These phases represent two key activities towards integration. ACHs and partnering providers are eligible for an incentive payment for reporting on the completion of each phase.

Table 4. Weighting of Integration Progress Measures by Phase

Phase Weights	
Phase 1: Binding Letter(s) of Intent	40%
Phase 2: Implementation	60%

f. Value-based Payment Incentives

In accordance with STCs 41 and 42 and the state's Value-based Roadmap (Attachment F), the state will set aside no more than 15 percent of annually available DSRIP funds to reward MCO and ACH partnering providers for provider-level attainment of VBP targets as well as progression from baseline as described in STCs 41 and 42. VBP targets reflect goal levels of adoption of Alternative Payment Models (APM) and Advanced APMs in managed care contracting.

In DY6 the state will no longer provide regional ACH incentives and statewide MCO incentives. This change was made due to the limited total funding available in DY6 and the significant advancement made DY1-DY5 surrounding VBP. The STCs state that no more than 15 percent of annually available DSRIP funds can be set aside to reward VBP progress, and the state is choosing not to use that flexibility in DY6. This change was discussed extensively with MCOs and ACHs.[6] There is a shared understanding that the change will ensure DSRIP funding is maximized in DY6 for provider incentives and sustainability efforts. In addition, the state believes there are adequate accountabilities and incentives in place to support continued VBP progress as outlined in the Apple Health Appendix, including the managed care withhold. It is important to note that this change only relates to MCO and ACH VBP incentives under DSRIP. The VBP adoption targets remain for statewide accountability and are reinforced through the Apple Health Appendix and the state's managed care withhold program.

IV. ACH Reporting Requirements

[6] MCOs and ACHs will be officially notified of this DY6 change once approved.

These activities are detailed below.

a. Pay for Reporting for ACH Project Achievement

Two times per year, ACHs seeking payment under the demonstration shall submit reports that include the information and data necessary to evaluate ACH projects using a standardized reporting form developed by the state. ACHs must use the document to report on their progress against the milestones and metrics described in their approved Project Plans. Based on these reports, as well as data generated by the state on performance metrics, the state will calculate aggregate incentive payments in accordance with this protocol. The ACH reports will be reviewed by state and the Independent Assessor. Upon request, ACHs will provide back-up documentation in support of their progress.

These reports will be due as indicated below after the end of each reporting period:

- DY1-DY5: For the reporting period encompassing January 1 through June 30 of each year; the semi-annual report and the corresponding request for payment must be submitted by the ACH to the state before July 31.
- DY1-DY5: For the reporting period encompassing July 1 through December 31 of each year; the semi-annual report and the corresponding request for payment must be submitted by the ACH to the state before January 31.
- DY6: The first P4R report and corresponding request for payment must be submitted by the ACH to the state before April 8.
- DY6: The second P4R report and corresponding request for payment must be submitted by the ACH to the state before October 7.

The state shall have 30 calendar days after these reporting deadlines to review and approve or request additional information regarding the data reported for each milestones/metric and measure. If additional information is requested, the ACH shall respond to the request within 15 calendar days and the state shall have an additional 15 calendar days to review, approve, or deny the request for payment, based on the additional information provided. The state shall schedule the payment transaction for each ACH within 30 calendar days following state approval of the semi-annual report. Approved payments will be transferred to the Financial Executor until the ACH provides direction for payment distribution to partnering providers.

The state must use this documentation in support of claims made on the MBES/CBES 64.9 Waiver form, and this documentation must be made available to CMS upon request.

V. State Oversight Activities

The state will provide oversight to ensure accountability for the demonstration funds being invested in Washington State, as well as to promote learning with the state and across the country from the work being done under the MTP demonstration. Throughout the demonstration, the state and/or its designee will oversee the activities of ACHs and submit regular reports to CMS pursuant to STC 37.

Each ACH must enter into a contract with the Washington State Health Care Authority

(HCA) to be eligible to receive project design funds, as well as other incentive funding under the demonstration. This contract sets forth the requirements and obligations of the ACHs as the leads for DSRIP and other partnering providers. The contract addresses reporting requirements, data sharing agreements, performance standards, compliance with the STCs of the demonstration, and the ACH's agreement to participate in state oversight and audit activity to ensure program integrity of the demonstration. In the contract, HCA requires ACHs to participate in semi-annual reporting outlined in this protocol as a condition for qualifying for demonstration funds.

The state will support ACHs by providing guidance and support on the state's expectations and requirements. Additionally, state activities designed to ensure program integrity are detailed below:

a. *Quarterly Operational Reports*

The state will submit progress reports on a quarterly basis to CMS. The reports will present the state's analysis of the status of implementation; identify challenges and effective strategies for overcoming them; review any available data on progress toward meeting metrics; describe upcoming activities; and include a payment summary by ACH as available. The reports will provide sufficient information for CMS to maintain awareness regarding progress of the demonstration.

b. *Learning Collaboratives*

Annual learning collaboratives will be sponsored by the state to support an environment of learning and sharing among ACHs. Specifically, the collaboratives will promote the exchange of strategies for effectively implementing projects and addressing operational and administrative challenges. ACHs will be required to participate and contribute to learning collaboratives as specified in STCs 37(c) and 45(a)(v).

c. *Program Evaluation*

In accordance with STCs 35 and 107, the state will develop an evaluation plan for the DSRIP component of the draft evaluation design. The state will contract with an independent evaluator to evaluate the demonstration. The evaluator will be selected after a formal bidding process that will include consideration of the applicant's qualifications, experience, neutrality, and proposed budget. Evaluation drafts and reports will be submitted in accordance with deadlines in section 7 of the STCs.

VI. Statewide Performance and Unearned DSRIP Funding

a. *Accountability for State Performance*

The state is accountable for demonstrating progress toward meeting the demonstration's objectives. Funding for ACHs and partnering providers may be reduced in DY3, DY4[7], DY5 and DY6 if the state fails to demonstrate quality and improvement on the

[7] Due to COVID-19 impacts, Statewide accountability has been waived for DY 4. At-risk funding is therefore reduced from 10% to 0% for DY4.

statewide measures listed below. STC 44 specifies the amount of annual DSRIP funding at risk based on statewide performance on these measures. The funding reductions will be applied proportionally to all ACHs based on their maximum Project Funding amount.

A statewide performance goal will be established for the statewide metrics. The state will be accountable for achieving these goals by the end of the demonstration period. During DY3 and DY4[7], annual assessment of quality and improvement from a defined baseline toward these goals will be used to measure and evaluate whether or not the statewide metric improvement target has been achieved.

Statewide Accountability Metrics

1. Mental Health Treatment Penetration
2. Substance Use Disorder Treatment Penetration
3. Outpatient Emergency Department Visits per 1000 Member Months
4. Plan All-Cause Readmission Rate (30 days)
5. ~~Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life~~[8]
5. Child and Adolescents Well-Care Visits 3-11 Years of Age
6. Antidepressant Medication Management
7. Medication Management for People with Asthma (5 – 64 Years)
8. Controlling High Blood Pressure[9]
9. ~~Comprehensive Diabetes Care - Blood Pressure Control~~[10]
10. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control

The state will establish a baseline performance for each measure. The state will adapt the Quality Improvement Score (QIS) methodology, originally developed by HCA for measuring MCO performance, to determine statewide performance across the statewide accountability measures for the demonstration. Each measure is assessed for both achievement of quality and improvement on an annual basis beginning DY3. The weighted sum of all the individual measure quality improvement scores will yield the overall QIS.

The overall QIS is then used to indicate whether a reduction of funding is warranted, and to calculate the percentage of funding at risk that should be reduced for that demonstration year. Annual improvement will reflect closing of the relative gap between prior performance year and the goal by up to 10 percent each year, as described in Attachment C, Section III(c). Quality will be assessed based on existing national benchmark standards where possible. For newer, innovative measures that do not have established national estimates, quality will be determined based on available evidence of reasonable expectation for magnitude of change.

[8] In 2021, NCQA Hedis® retired Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life. This measure was replaced with Child and Adolescents Well-Care visits 3 – 11 Years of Age. This change will apply to DY 4 and DY 5 results.
[9] Controlling high blood pressure has been removed from Statewide accountability QIS counts. The measure is inactive for DY3-DY5.
[10] Comprehensive Diabetes Care: Blood Pressure Control is retired by NCQA® starting 2022 performance period. HCA is still determining an adequate replacement and will provide an update when approved.

If the state fails to achieve its annual quality improvement score on a given statewide accountability metric, funding will be reduced by the amount tied to the QIS.

The draw of the FFP match for all at-risk funds under statewide accountability metrics, or reporting of payments on the CMS-64 form, will not occur until the QIS have been approved by the state and CMS. The state will submit the QIS and supporting documentation to CMS for review and approval. CMS will have 90 calendar days to review and approve the QIS. Once the at-risk payments are approved, the state will disburse the portion of the withheld at-risk funds that were earned, and the state will report such expenditures on the CMS 64 form and draw down FFP accordingly. The state may not claim FFP for any at-risk expenditures until CMS has issued formal approval.

b. Reinvestment of Unearned DSRIP Funding

DSRIP funding that is unearned because the ACH failed to achieve certain performance metrics for a given reporting period may be directed toward DSRIP High Performance incentives. Unearned project funds directed to high performers will be used to support the scope of the statewide DSRIP program or to reward ACHs whose performance substantively and consistently exceeds their targets as measured according to a modified version of the QIS described above. The state does not plan to withhold any amounts to subsidize this reinvestment pool.

VII. Demonstration Mid-point Assessment

In accordance with STC 21, a mid-point assessment will be conducted by the Independent Assessor in DY3. Based on qualitative and quantitative information, and stakeholder and community input, the mid-point assessment will be used to systematically identify recommendations for improving individual ACHs and implementation of their Project Plans. If the state decides to discontinue specific projects that do not merit continued funding, the project funds may be made available for expanding successful project plans in DY 4 through DY 6.

ACHs will be required to participate in the mid-point assessment and adopt recommendations that emerge from the review. The state may withhold a percentage or all future DSRIP incentive funds if the ACH fails to adopt recommended changes, even if all other requirements for DSRIP payment are met.

Attachment E
Value-Based Roadmap

Washington State Health Care Authority

Value-based Purchasing (VBP) Roadmap Apple Health Appendix

2021 update

February 2022

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Purpose

The Apple Health Appendix reflects specific initiatives and changes pertaining to the Medicaid (Apple Health) program, in alignment with the Health Care Authority's (HCA's) VBP Roadmap.[1] In Washington State, Apple Health is the name for Medicaid. When referencing Washington's Medicaid program in this document, it will be referred to as Apple Health.

This document describes how Apple Health is changing, with the support of the Medicaid Transformation Project (MTP), the targets for VBP attainment, and the related incentives under the Delivery System Reform Incentive Payment (DSRIP) program. (The DSRIP program is for managed care organizations (MCOs) and Accountable Communities of Health (ACHs).)

This document addresses the following topics:

- Identified VBP targets and approach for measuring, categorizing, and validating progress toward regional ACH and statewide MCO attainment of VBP goals.
- Alternative payment models (APMs) deployed between MCOs and health care providers to reward performance consistent with DSRIP objectives and measures.
- Use of DSRIP measures and objectives by HCA in its contracting strategy approach for managed care plans.
- Measurement of MCOs based on utilization and quality that is consistent with DSRIP objectives and measures.
- Inclusion of DSRIP objectives and measures reporting in MCO contract amendments.
- Evolution toward further alignment with the Medicare and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) and other advanced APMs.
- Approaches that MCOs and HCA will use with providers to encourage practices consistent with DSRIP objectives, measures, and VBP targets.

In accordance with the special terms and conditions (STCs) of Washington's Section 1115 Medicaid demonstration waiver (called MTP), HCA will update the Apple Health Appendix annually to capture best practices and incorporate lessons learned into HCA's overall vision for delivery system reform. The appendix is a living document throughout the duration of MTP. It is subject to change and adjustment to ensure that Washington State can achieve its VBP goals.

Introduction

Apple Health and VBP reform

To reach the goals defined in the VBP Roadmap (different than the Apple Health Appendix), Apple Health must play a leading role. One main goal for HCA is to drive and sustain delivery system transformation by shifting 90 percent of state-financed health care into value-based arrangements by the end of 2021.

On January 9, 2017, Washington State and the Centers for Medicare & Medicaid Services (CMS) reached agreement on a groundbreaking, five-year project that allows the state to invest in comprehensive Medicaid delivery and payment reform efforts through DSRIP.

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[1] Learn more about HCA's roadmap activities and paying for health and value strategy on the HCA website. If you would like a copy of the first edition of HCA's VBP Roadmap, please contact J.D. Fischer.

VBP strategies are foundational to MTP and serve as a vehicle for delivery system reform activities. HCA's commitment to advancing VBP strategies extends beyond MTP. This document covers efforts to increase adoption of VBP models statewide, along with those required under MTP's STCs.

As Washington continues to transition the health care purchasing strategy for Apple Health, HCA recognizes that a comprehensive and successful transformation requires a multi-layered approach that addresses the needs of MCOs, individual providers, and Medicaid beneficiaries. Initiatives under MTP, including community led delivery system reform strategies, play a crucial role in promoting overall system transformation.

Alignment and Health Care Payment (HCP) & Learning Action Network (LAN)

HCA strives to align its efforts with the perspectives of MCOs and providers. These partners are integral to implementing new purchasing methodologies. As HCA implements VBP strategies, Medicare is making significant strides in implementing similar VBP reforms. Likewise, HCA—through the Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) programs and multiple commercial payers in the state—are building VBP into their contracting strategies.

Providers must frequently navigate all these systems, which presents significant opportunities to align VBP methodologies across payer markets. This requires that HCA leverage purchasing power through Apple Health, PEBB, and SEBB to ensure that system reforms support and reinforce each other without leading to unnecessary burden for providers. Aligning the transition to VBP with other payers, where feasible, simplifies implementation for providers and allows them to achieve the greatest impact for their clinicians and patients.

The primary tool for multi-payer alignment is the use of the Refreshed HCP-LAN APM Framework[2] across all of HCA's books of businesses. These categories form the framework for the implementation of VBP in Washington by defining payment models subject to incentives and penalties, aligned with HCA's delivery system transformation goals. This framework recognizes a variety of approaches that can advance value-based care and provide flexibility to providers to participate in value-based payment models. The framework also addresses the circumstances of the services providers give and the communities they serve.

By adopting a national framework, Washington ensures that providers do not face conflicting guidance on how to classify payment models. This uniformity with national standards will enhance provider engagement and reduce administrative burden for providers learning to operate under VBP methodologies.

Advancing Washington State's Apple Health VBP goals

Key levers and strategies that drive and support VBP adoption among Apple Health providers include:

- Apple Health MCO contract requirements
- MTP and the DSRIP program
- The state's role as a convener
- VBP strategies for rural communities

A central component of implementing VBP is incentivizing MCOs to adopt VBP with network providers through their contract with HCA. One way to do this is an MCO withhold, where HCA withholds a portion of

[2] Learn more about the HCP-LAN APM Framework refresh.

the MCO's monthly premium. MCOs may earn the withheld funds by achieving defined targets for quality, VBP adoption, and provider incentive payments.

The shift from fee-for service (FFS) to VBP also requires delivery system changes. Time-limited DSRIP funds available through MTP allow providers to make these changes through investment in the delivery system transformation process and build provider capacity and infrastructure to succeed in VBP arrangements.

In turn, VBP adoption can reinforce and sustain DSRIP-funded delivery system transformation investments. This occurs through longer-term payer, provider, member, and community partnerships, as well as investments in population health management capabilities. The goal is a transformed system that improves the health and well-being of Washington communities.

HCA is also pursuing targeted strategies for specific provider entities and settings. For example, on July 1, 2017, HCA converted 16 federally qualified health centers (FQHCs) to a value-based payment methodology. Under this payment methodology, FQHCs are incentivized to manage the health of their population according to select quality metrics and are held accountable for performance on these measures.

Rural transformation efforts

On September 10, 2021, CMS announced that Washington State was one of four state awardees for the Community Health Access and Rural Transformation (CHART) Model grant.[3] HCA is the lead agency for the CHART Model, which will test whether an aligned all-payer capitated APM and a community care redesign plan designed by the community will improve access to whole-person care, decrease population health disparities, and reduce costs. HCA will test this model in the North Central region of Washington State, which includes Chelan, Douglas, Grant, and Okanogan counties.

Under the CHART Model, HCA will partner with Participant Hospitals (PHs), North Central community and Tribal leaders, and payers on the CHART Advisory Council to build a Community Transformation Plan (CTP) that meets North Central community's needs. The CTP will feature evidence-informed innovative care delivery models and strategies to improve access to care, quality of care, and health outcomes for all North Central residents.

The COVID-19 pandemic further underscores the need for more predictably financing of services that prioritize value and population health. This model will advance appropriate care, meet community needs, and support rural providers though the health system transformation process. Focus areas include:

- Redesigning rural health system financing
- Enhancing population health management
- Addressing the rural health care workforce
- Leveraging digital health, telehealth, and secure information exchange

By changing the way providers are paid and aligning with incentives to transform the delivery system, Washington will build sustainable solutions for payers and providers that increase health access across rural communities. Through these strategies, MCOs and providers are supported and rewarded for advancing VBP during MTP and beyond.

MTP - statewide accountability

The STCs outlines the requirements for Washington State pertaining to VBP withhold amounts based on statewide advancement of VBP adoption and quality metric goals.

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[3] Learn more about the CHART Model on the CMS website.

- **What this means:** if Washington State does not achieve the targets within the statewide accountability framework, the maximum available DSRIP funds will not be earned. The amount at risk is five percent in demonstration year (DY)3, ten percent for DY4, and increases to 20 percent in DY5.
    - Statewide performance across the 10 quality measures determines 80 percent of the funding "at risk."
    - Attainment of statewide VBP targets determines 20 percent of the funding "at risk."

MCO contract requirements: VBP withhold

A primary way to advance state VBP goals is through Apple Health MCO contract requirements. HCA currently contracts with five MCOs, paying them a per-member per-month (PMPM) premium to deliver Medicaid services to many of the state's Medicaid beneficiaries. According to HCA's contractual arrangement, each MCO must negotiate VBP arrangements with network providers. To ensure accountability, HCA withholds a percentage of each MCO's PMPM premium. MCOs may earn back the withheld funds by demonstrating quality improvement and implementing VBP arrangements with providers.

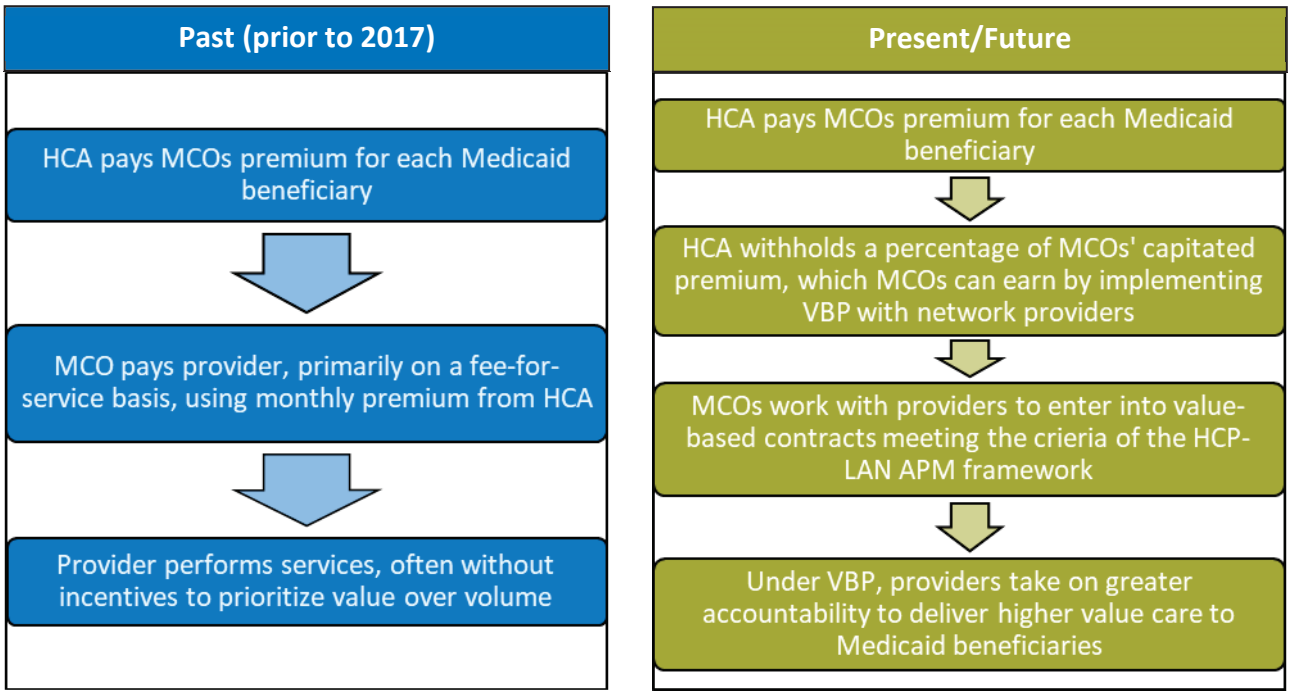
The structure of the MCO withhold reinforces the quality emphasized by CMS and MTP. It incentivizes the adoption of VBP methodologies between the MCOs and providers, with a focus on regional VBP adoption and provider accountability, and an additional emphasis on quality improvement. By incentivizing VBP in the MCO contracts through the withhold program, along with the other efforts described in this document, HCA expects VBP adoption to expand and continue well beyond MTP.

Consistent with federal requirements defined under 42 CFR 438.6(b), HCA ensures that through the VBP withhold, MCO performance is reasonably achievable. This results in actuarially sound MCO rates so that rates appropriately cover all reasonable and expected costs for each MCO. HCA's contracted actuaries include confirmation of the soundness of the rates in the rate certification provided to CMS.

MCO contract withhold framework

Under the withhold, a percentage of each MCOs' monthly PMPM premium is withheld, pending achievement of certain targets.

Figure 1: HCA and MCO contracts: past, present, future



The total percentage withhold is established each year (table below). The amount withheld may be earned back in three ways, each of which seeks to advance VBP:

- **VBP adoption (12.5 percent):** the VBP portion of the withhold focuses on the percent of an MCO's total payments to providers within a recognized VBP arrangement. The original target for this element aimed to increase the percent of VBP arrangements from 30 to 90 percent by 2021. Because of the COVID-19 pandemic, HCA decreased the 2021 MCO VBP adoption target to 85 percent to provide flexibility to MCOs and providers to focus on maintaining access. Qualifying VBP arrangements must meet the definition of Category 2C or higher within the HCP-LAN categorization.
- **Provider incentives (12.5 percent):** the provider incentives portion of the withhold focuses on the percent of funding, within recognized VBP arrangements, that is directly conditioned on meeting quality and financial metrics. Up to 12.5 percent of the provider incentives portion of the withhold may be earned back by linking qualifying provider incentive payments to quality and financial attainment or losses. The target was set at 0.75 percent of assessed payments in 2017 and increased to 1.25 percent for 2020 and 2021. See table 1 for more details.
- **Quality improvement (75 percent):** House Bill 1109 (2019) required changes to the quality improvement portion of the withhold. Beginning in 2020, the quality improvement portion of the withhold may be earned back by achieving top national Medicaid quartile scores or demonstrating statistically significant improvement, as determined by an external quality review organization.

Following receipt of quality performance metric results, on or before July 1 after the performance year, HCA will determine the percentage of the withhold earned back by the MCO, based on the MCO's achieving quality improvement targets. Up to 75 percent of the withhold may be earned by achieving quality improvement targets. The amount of the withhold earned back is based on the proportion of measures for which the MCO achieved either top national Medicaid quartile or statistically significant improvement.[4]

These three components of HCA's withhold program, as well as the annual target percentages that must be met for MCOs to receive the full withhold amount are outlined in the table below and described in detail in MCO contracts.

Table 1: MCO contract withhold targets: VBP adoption, provider incentives, and quality improvement

VBP adoption	
Year	**Target**
2017	30%
2018	50%
2019	75%
2020	85%
2021	85%
2022	90%

Provider incentives	
Year	**Target**
2017	.75%
2018	1%
2019	1%
2020	1.25%
2021	1.25%
2022	1.25%

Quality improvement	
Year	**Target**
2017	0.2
2018	0.2
2019	0.2
2020	100%
2021	100%
2022	100%

Note: because of COVID-19, the percentage of total VBP adoption target in DY5 is downgraded from 90 percent to 85 percent as of August 14, 2020. This means the target will not change from 2020 to 2021.

[4] The measures are under review for contract year 2021. They were not available at the time of this update (October 1).

MCO VBP data submission requirements

To assess MCO performance against the MCO contract withhold components, MCOs are required to provide VBP performance data as outlined in Exhibit D: VBP of the MCO contracts. The reporting covers data pertaining to the adoption and intensity of value-based payment methodologies by the MCO. They submit data to an external third-party independent assessor (IA) to validate performance under the VBP exhibit. The data for each component of the withhold is as follows:

- **VBP adoption:** MCOs report the dollar amounts of regional and statewide payments to providers under value-based arrangements in each category of APMs as defined under the HCP-LAN Framework.
- **Provider incentives:** MCOs report on the extent of regional and statewide payment incentives and payment disincentives represented in their VBP contracts with providers, as a share of total provider payments.
- **Quality improvement:** the quality improvement portion of the withhold relies on provisions in the MCO contracts, related to the submission of clinical quality data.

Medicaid VBP adoption is calculated based on the share of MCO payments to providers that are made through VBP arrangements in HCP-LAN Category 2C or higher, for the purposes of:

- The state's MCO withhold program
- MCO DSRIP VBP incentives
- ACH DSRIP VBP incentives
- State accountability for DSRIP VBP targets

Validation of MCO VBP data

This IA is responsible for validating data submitted by the MCOs for the VBP adoption and provider incentives portions of the withhold. For 2021, measuring calendar 2020 VBP adoption, MCOs were required to submit to the IA:

- **VBP performance data:** MCOs complete a template provided by HCA with VBP performance data relating to the VBP adoption and provider incentives.
- **Supplemental packet:** MCOs provide documentary support for a sample of 45 providers identified by the IA. The MCO identifies the categorization of each provider contract according to the HCP-LAN Framework, with supporting documentation from the provider contract to illustrate the categorization and qualifying incentives.

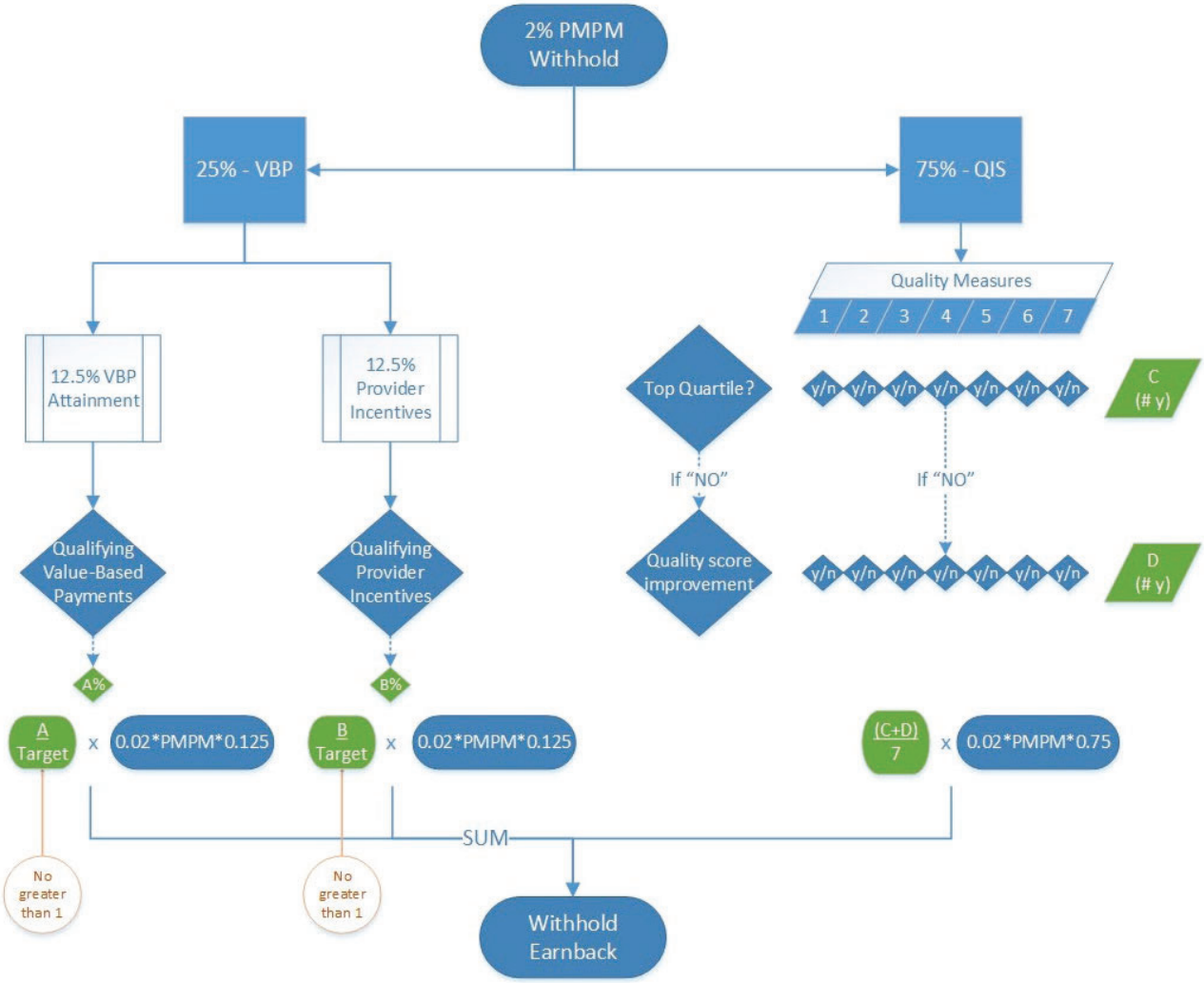
The table on the next page is an example of how MCOs report their payments to providers by ACH region and APM category.

Table 2: MCO VBP performance data template

Medicaid total assessed payments by APM category													
Category			Region: Accountable Communities of Health										
APM category	APM Sub-category	Strategy	Better Health Together	Cascade	Greater Columbia	HealthierHere	North Central	North Sound	Olympic	Elevate Health	SWACH	Out-of-State	All
1 FFS - no link to quality	1	Fee-for-service											
2 FFS - link to quality	2A	Foundational payments for infrastructure & operations											
	2B	Pay-for-reporting											
	2C	Rewards for performance											
3 APMs built on FFS architecture	3A	APMs with upside gainsharing											
	3B	APMs with upside gainsharing and downside risk											
	3N	Risk-based payments - no link to quality											
4 Population-based payment	4A	Condition-specific, population-based payment											
	4B	Comprehensive population-based payment											
	4C	Integrated finance & delivery systems											
	4N	Capitated payments - no link to quality											
Total annual payments													

The figure below illustrates the methodology by which HCA assesses MCO withhold performance.

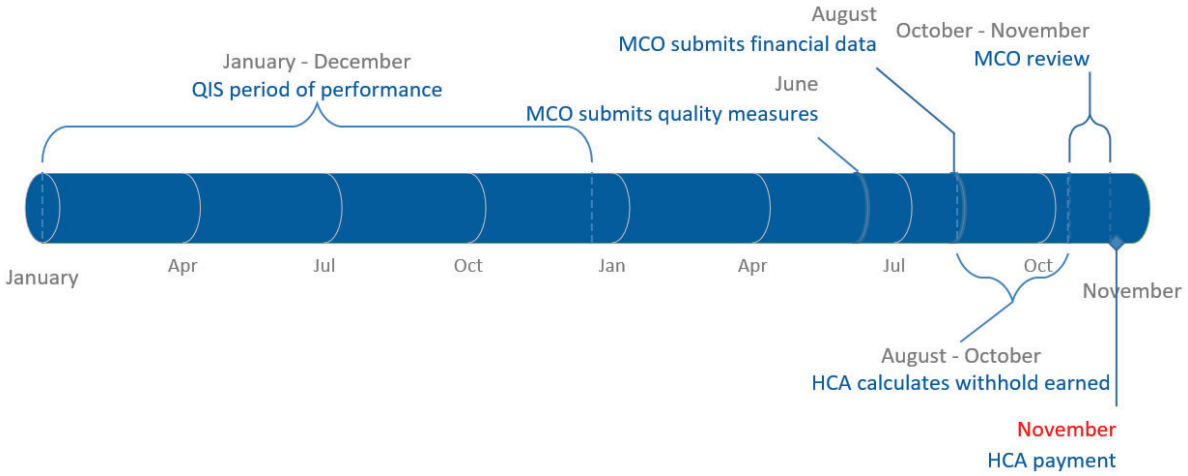
Figure 2: methodology for determining the amount of the withhold earned



Timeline

To allow time for MCOs to gather and report the required data, the assessment of performance occurs from August through November of the year after performance year. The two-year performance and review period continues on a rolling basis as shown, so the following performance year begins while HCA reviews the data for the prior performance year.

Figure 3: timeline for MCO VBP data submission, validation, and payment



For example, MCOs will report on 2021 data in August 2022. The validation process is conducted, with the process completed and payment of the percentage of the withhold earned to be scheduled within HCA's payment systems by November 30, 2022.

Supporting VBP advancement through MTP

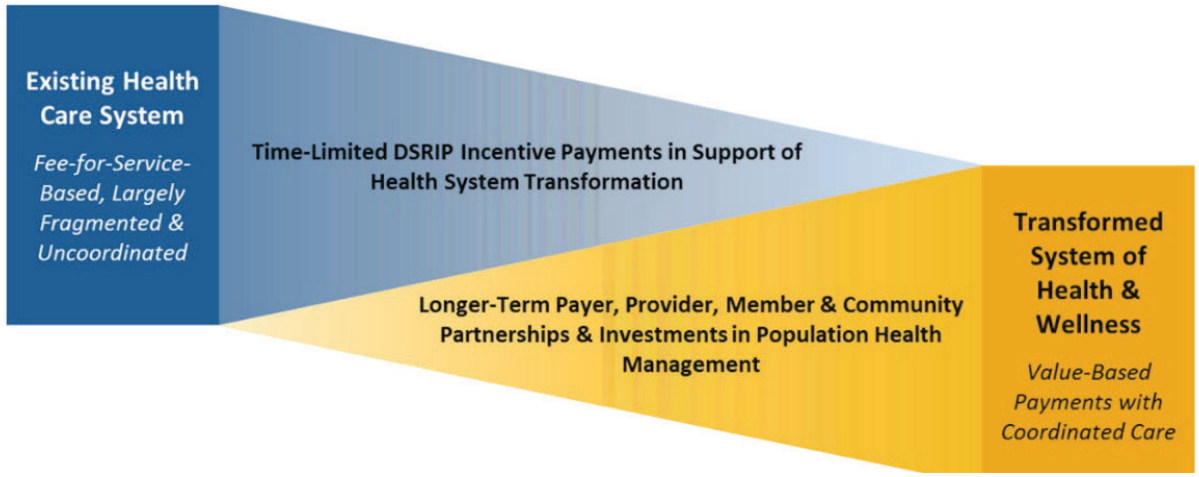
VBP advancement overview

Under MTP, the DSRIP program provides resources to providers to move along the VBP continuum. Investment in foundational strategies that promote provider readiness for VBP is necessary to ensure the sustainability of MTP.

To encourage MCOs and providers to pursue VBP arrangements, DSRIP incentives are available for MCO and ACH achievement of VBP adoption targets as defined in the STCs. VBP adoption targets under MTP are based on the percentage of payments to providers that fall into Categories 2C of the HCP-LAN Framework, starting in DY1, with progressive targets through DY5.

Ultimately, DSRIP funds allow providers to make delivery system changes required for the implementation of VBP strategies, while VBP contracts can help sustain these changes by financially rewarding their outcomes.

Figure 4: DSRIP program and VBP



Advancing the shift toward VBP arrangements in place of traditional FFS models is a primary component of DSRIP accountability during MTP. This is highlighted below for the following entities:

- Washington is accountable for advancing quality outcomes and VBP adoption goals. In DY3-5, a portion of DSRIP incentives are at risk, depending on statewide performance in the following:
    - Demonstration of physical and behavioral health integration in managed care.
    - Improvement and attainment of quality targets across a set of quality metrics.
    - Improvement and attainment of defined statewide VBP targets.
- MCOs are eligible to earn DSRIP VBP incentives for reporting data required to assess MCO and ACH VBP adoption levels (per MCO contract requirements) and achievement and improvement toward annual VBP adoption targets.
    - MCOs can earn incentives for VBP adoption through DSRIP, like their contractual expectations.
- ACHs can also earn DSRIP VBP incentives through reporting of regional efforts to advance VBP, as well as achievement and improvement toward annual VBP adoption targets.

For more details about the DSRIP accountability framework, see the DSRIP Measurement Guide.

Statewide accountability for VBP advancement

Beginning in 2019 (DY3), a portion of statewide DSRIP funding is at risk,[5] depending on the state's advancement of VBP adoption and performance on a set of quality metrics. If the state does not achieve its targets, available DSRIP funding will be reduced in accordance with the STCs.

By the end of 2021 (DY5), 90 percent[6] of total Medicaid MCO payments to providers must be made through designated VBP arrangements for the state to secure maximum available DSRIP incentives.

Definition of achievement: statewide VBP adoption targets are consistent with HCP-LAN Category 2C or higher VBP arrangements. VBP adoption is measured by two factors: improvement toward and achievement of the annual target. If the VBP adoption target is achieved, then the full VBP portion of the statewide accountability withhold is earned. If the target is not achieved, a portion of the withhold can still be earned based on the state's improvement in VBP adoption from the prior year using the improvement scoring methodology as presented in equation 2.

The remainder of this section describes how a portion of the withhold is earned and calculated when the VBP adoption target is not met.

Table 3: annual statewide VBP adoption target and scoring weights

	VBP adoption target (HCP-LAN 2C or higher)	Scoring weights	
		Improvement	Achievement
DY3	75%	50%	50%
DY4[7]	85%	75%	25%
DY5	90%	75%	25%

[5] Because of COVID 19, statewide accountability for DY4 has been waived. This eliminated at-risk loss of dollars from 10 percent to zero (0), effective June 8, 2020.
[6] HCA is pursuing an amendment to downgrade statewide VBP target to 85 percent, consistent with MCO contract changes for 2021.
[7] February 24, 2022, CMS approved a scoring weight adjustment for DY4, DY5 and DY 6.

Note: because of COVID-19, HCA is asking CMS to downgrade the DY5 target for total VBP adoption from 90 percent to 85 percent. This would mean the target would not change from 2020 to 2021.

Table 4: statewide accountability VBP adoption - measurement years

DY	Performance year	Baseline year
3	2019	2018
4	Waived	Waived
5	2021	2020

Data source: according to their contract requirements with HCA, MCOs must attest to their VBP adoption levels annually by reporting total payments in each HCP-LAN category. The IA will calculate and validate statewide performance according to this annual data source. The statewide accountability VBP baseline year is the year prior to the performance year. This timeline aligns with MCO VBP adoption assessment according to the contractual agreement with HCA.

Payments to providers are defined as total Medicaid payments to providers (in dollars) for services, including inpatient, outpatient, physician/professional, and other health services, excluding any pass-through payments or other services carved out from MCO contracts. This amount excludes payments related to case payments, administrative dollars, Washington State Health Insurance Pool, premium tax, Safety Net Assessment Fund, provider access payment, or trauma funding.[8]

Calculating the level of VBP adoption: VBP adoption is calculated based on the share of MCO payments to providers made through VBP arrangements in HCP-LAN Category 2C or higher.[9]

Equation 1: level of VBP adoption (%)

$$\text{Level of VBP adoption (\%)} = \frac{\text{MCO payments to providers (in \$) made through VBP arrangements at or above category 2C}}{\text{Total MCO payments to providers (in \$)}}$$

The state is measured on achievement of VBP adoption targets, as well as improvement over the state's prior year VBP adoption level. If the state meets the VBP adoption target for the performance year, then the improvement score is 100 percent. If the state does not meet the VBP adoption target for the performance year, then the improvement score is calculated as the percent change from the baseline year to the performance year (equation 2). The weighted improvement score is measured by rewarding improvement over the baseline up to 100 percent of the improvement weight, which for DY4 would equal a maximum of 75 percent of the at-risk dollars as presented in Table 3.

Equation 2: VBP improvement score

$$\text{Improvement Score} = \frac{\text{PY VBP adoption actual} - \text{Baseline}}{\text{PY VBP adoption target} - \text{Baseline}}$$

[8] For calendar year (CY) 2017, HCA included payments for pharmacy service in the numerator and denominator when calculating the level of VBP adoption. In 2018, pharmacy was removed from the MCO PMPM, so as of 2018, all such payments are excluded when calculating the level of VBP adoption.

[9] Payments for behavioral health services are included when paid by an MCO, including integrated MCOs. Payments for behavioral health services paid by behavioral health organizations prior to integration are not included.

Where the calculation of the **improvement score** produces a negative percentage, the improvement score is zero (0) percent. The improvement score is capped at 100 percent. However, if achievement is not met, then improvement score is capped at 75 percent.

The overall VBP performance score is calculated by first finding the VBP adoption target score and the VBP adoption actual score for the performance period, and then multiplying each score by the relevant scoring weights defined in Table 3.

The example below illustrates the portion of funds associated with VBP adoption earned by the state with an overall performance score of 82 percent. This performance would earn the state 46 percent of the 20 percent of overall dollars at-risk for statewide performance.

Table 5: example calculation of statewide accountability VBP adoption

DY4 VBP adoption assessment (DY4 VBP target = 85%)	Value/score	Calculation
DY4 performance	82%	
DY3 (baseline)	77%	
Adoption target	85%	
Improvement score	61%	Based on "equation 2" graphic above (0.82 – 0.77) / (0.85 - 0.77)
Overall VBP score	46%	(Achievement Score * Weight) + (Improvement Score * Weight) = (0 * 25%) + (61% * 75%) or equivalent to 0% + 46%

For more information about the overall statewide accountability approach and components, see the DSRIP Measurement Guide.

DSRIP incentives for MCO VBP achievement

Washington's MCOs are critical partners in delivery system reform efforts, particularly to ensure the state's success in meeting its VBP goals. As stated in the STCs, MCOs are expected to serve in a leadership or supportive capacity in every ACH. This ensures delivery system reform efforts are coordinated across all necessary sectors—those providing payment, delivering services, and providing critical, community-based supports.

In support of MTP, MCOs will demonstrate improvement toward and achievement of the state's VBP targets and will play a critical role in the success and sustainability of Washington's DSRIP program.

Available incentives

MCOs are expected to participate in delivery system reform efforts as a matter of business interest and contractual obligation to the state. For this reason, they do not receive incentive payments for participation in ACH-led transformation projects. However, MCOs are eligible to earn MCO VBP incentives (through the challenge pool) for achieving annual MCO VBP targets. The amount of incentives available to an individual MCO is determined by the attributed statewide managed care member months under signed Apple Health contracts for the performance year.[10]

Table 6: annual DSRIP funding available for MCO DSRIP VBP incentives

DY1	DY2	DY3	DY4	DY5

[10] Annual DSRIP incentives are based on best available information and subject to change. In MCO contracts, these incentives are referred to as base earnable funds.

N/A	$8,000,000	$8,000,000	$8,000,000	$8,000,000

MCO VBP incentives are earned according to pay-for-reporting (P4R) and pay-for-performance (P4P) expectations. Each year, MCOs have a defined portion of incentives available for achieving P4R criteria and P4P targets. The percent of available incentives split between P4R and P4P is defined by the STCs.

Table 7: annual percent of potential earnable MCO DSRIP VBP incentives, by P4R and P4P

MCO DSRIP VBP incentives	DY2	DY3	DY4	DY5
P4R	50%	25%	0%	0%
P4P	50%	75%	100%	100%

The managed care contracts, including HCA's Apple Health Managed Care, Apple Health Integrated Managed Care, and Apple Health Foster Care, further specify how the incentives are distributed. If more than one of these contracts is effective between HCA and the MCO, the incentives earned will not be calculated separately for each contract. Instead, the incentives are calculated as a single payment, based on data aggregated from each of MCO's applicable Apple Health contract(s).

Assessment of progress and performance

The performance year for determining whether MCOs completed milestones in support of advancing VBP and achieved VBP targets is aligned with a given DY. The assessment period will occur during fall (October–December), following the performance year.

P4R

MCOs are eligible to earn MCO VBP incentives for P4R in DY2 and DY3 only (no VBP incentives were available in DY1). These incentives are available to the MCOs for the complete and timely reporting of data required to assess the MCO progress toward meeting VBP adoption targets. The required data is specified in contract between HCA and the MCO.

P4P

For DY2-5, the P4P portion of MCO VBP incentives are available for successful achievement of and improvement toward specified VBP adoption targets. Each MCO is measured based on MCO-provided data (validated by the IA) and must meet performance expectations for the given year.

Performance targets, as well as improvement and achievement weighting for MCO VCP score determination, are outlined below.

Table 8: MCO VBP adoption targets

Year	Performance targets	
	HCP-LAN 2C or higher performance target	HCP-LAN 3A-4B performance subtarget
DY1	30%	N/A
DY2	50%	10%
DY3	75%	20%
DY4	85%	30%

DY5	90%[11]	50%

MCO improvement and achievement are weighted differently throughout MTP. MCO improvement toward VBP adoption targets is more heavily weighted in the early years, while credit for full achievement of those targets is increasingly weighted in the later years.

Table 9: MCO VBP P4P score weights

Year	Calculation weight		
	Achievement score	Achievement subset score	Improvement score
DY1	40%	0%	60%
DY2	35%	5%	60%
DY3	45%	5%	50%
DY4[12]	20%	5%	75%
DY5	20%	5%	75%

Based on its performance, the MCO is eligible to earn all or part of the available MCO VBP incentives. HCA and the IA will use data, which the MCOs are contractually required to submit, to identify the following:

- **Achievement score:** an achievement score for each MCO is calculated annually. If the MCO has reached or exceeded the HCP-LAN 2C or higher performance target for the performance year, then the achievement score will be 100 percent. If not, the achievement score is zero (0) percent.
- **Achievement subset score:** in DY2-5, HCA will assess whether the MCO has met the annual achievement subset criteria. In DY3, the achievement subset criteria requires that the MCOs have at least one VBP contract as a MACRA APM. In DY4 and 5, the achievement subset criteria requires that the MCOs have at least one VBP contract in Category 3B or above and including at least one of the following features:
    - More than nominal risk for shared losses
    - Payments tied to provider improvement or attainment on metrics from the Washington Statewide Common Measure Set using HCA quality improvement model or similar tool
    - Care transformation requirements, including state-level best practices
    - Use of certified electronic health record (EHR) technology in support of VBP methods
- **Improvement score:** an improvement score for each MCO is calculated annually. If the MCO has met the performance target for the DY, the improvement score is 100 percent. If the MCO has not met the performance target for the performance year, the improvement score is calculated as the percent change from the baseline year to the performance year towards the change in performance target. See Table 5 for more information.
  The improvement score is capped at 100 percent. Where the prior calculation produces a negative percentage, the improvement score is zero (0) percent. However, if achievement is not met, then improvement score is capped at 75 percent.

[11] HCA submitted a revision to CMS to maintain the target score of 85 percent from DY4-5. This is pending approval.
[12] February 24, 2022, CMS approved a scoring weight adjustment DY4, DY5 and DY6.

- **Eligibility for MCO VBP incentives (performance subtarget):** MCOs must also meet a minimum threshold of VBP adoption in Category 3A and above (performance subtarget) to earn any MCO VBP incentives in DY4 and 5. The performance subtarget is also applied as a threshold for distribution of remaining funds only in DY2 and 3. This is described in the secondary process below.

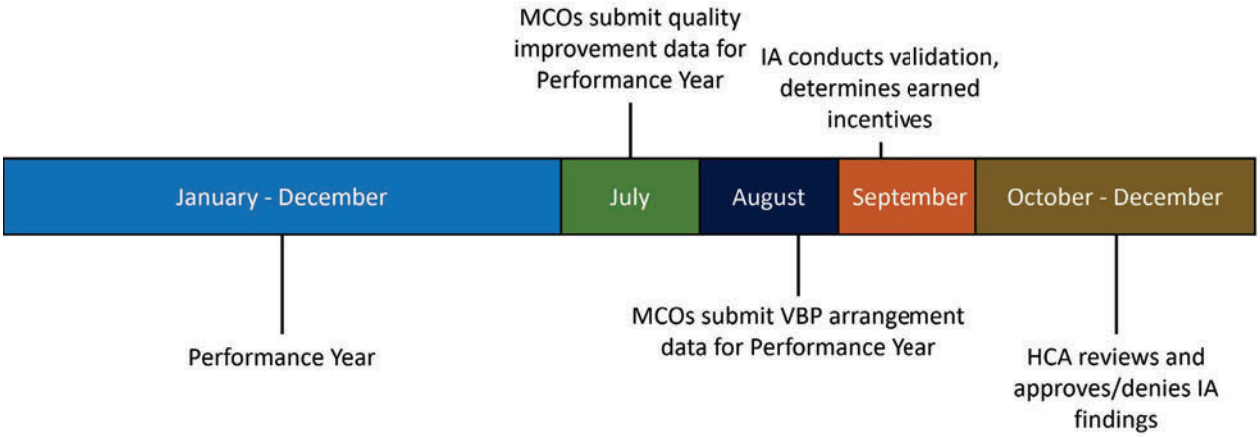
Table 10: annual HCP-LAN 3A-4B subtarget threshold for MCO DSRIP VBP incentives

	DY1	DY2	DY3	DY4	DY5
HCP-LAN 3A–4B performance subtarget	N/A	Eligibility: remaining funds Target= 10%	Eligibility: remaining funds Target= 20%	Eligibility: all funds Target= 30%	Eligibility: all funds Target= 50%

Incentive payment determination

The IA is responsible for determining whether reporting and performance expectations have been met.

Figure 5: assessment timeline for MCO VBP incentives



Distribution of remaining incentives

If there are any remaining MCO VBP incentives for a given performance year after initial allocation, a secondary process is initiated to allocate the unearned incentives. Each MCO is eligible to earn a share of any remaining incentives, based on achievement of the factors defined below.

Table 11: MCO eligibility to earn remaining MCO DSRIP VBP incentives

HCP-LAN 3A-4B performance subtarget	Relative quality improvement performance
The MCO must meet the HCP-LAN 3A-4C performance subtarget for the performance year. • If the MCO has not met the annual performance subtarget, they will not be eligible for any of the remaining incentives. • If the MCO has met the annual performance subtarget, they are eligible for a percentage of remaining incentives.	If the MCO meets the HCP-LAN 3A-4C **performance subtarget**, the MCO will receive a percentage of remaining MCO VBP incentives. This percentage is determined by the MCO's relative performance on the set of quality measures, as defined in MCO contracts with HCA. The state and IA will use the quality metric results to determine the amount of remaining incentives earned for eligible MCOs.

Important: MCOs must meet the HCP-LAN 3A-4C **performance subtarget** during DY4 and 5 to be eligible for any MCO VBP incentives, as part of the primary VBP adoption assessment. This is in addition to any remaining incentives, as part of the secondary process.

DSRIP incentives for ACH VBP achievement

Provider readiness for VBP models and contracts are critical to meet statewide and regional VBP targets, as well as other state VBP goals. ACHs serve in a supportive role to help assess and support provider VBP readiness and practice transformation, and to connect providers to relevant training and resources. ACHs are awarded incentives for demonstrated improvement and achievement of VBP adoption targets in the ACH region. During DSRIP, ACHs are accountable for investing resources to support partnering providers. For example, ACHs should be distributing earned incentives to support their partnering provider needs in moving along the VBP continuum.

Under DSRIP, transformation efforts are driven by ACHs and coalitions of partnering providers as they select and implement a set of strategies from the MTP Project Toolkit to address regional health needs. To be successful, ACHs must integrate foundational cross-cutting health system and community capacity building elements that address workforce, systems for population health management, and financial sustainability through VBP.

Across the project stages, providers partnering with their ACH are eligible to receive incentive payments by contributing to the completion of project milestones and regional improvement on quality and outcome measures. The incentives earned by providers allow them to make the investments necessary to be successful in the project, as well as promote efforts to scale and sustain strategies that prove to improve whole-person health of their communities. To be financially sustainable, however, other sources of funding must be identified to sustain these strategies, which could come through success in VBP contracts.

While VBP arrangements vary in complexity and provider risk, all require that providers can effectively measure and influence the quality and cost of care provided. The presence and maturity of many underlying capabilities influence whether providers succeed under their VBP arrangements. ACHs have made efforts to understand the current state of VBP capabilities among their provider partners, and how ACHs can leverage DSRIP funds to support development of capabilities moving forward. ACHs determine the allocation methodology for earned VBP incentive DSRIP funds among partnering providers in their region.

Available incentives

ACH can earn VBP incentives for P4R and P4P. ACH VBP incentives are funded through the reinvestment pool. Potential earnable ACH VBP incentives are distributed evenly across all nine ACHs. However, ACHs will earn incentives based on VBP performance outcomes. All unearned incentives will be redirected to the high-performance pool. Annual DSRIP incentives are based on best available information, and subject to change.

Table 12: annual DSRIP funding available for ACH VBP incentives

DY1	DY2	DY3	DY4	DY5
N/A	$3,600,000	$4,500,000	$5,400,000	$6,300,000

Note: both ACH VBP and integration incentives are funded through the reinvestment pool. Earned incentives for ACHs that achieve key integration milestones may affect the amount of ACH VBP incentives available for a given year.

ACHs are eligible to earn VBP incentives through reported progress on VBP milestones (P4R), and improvement toward and achievement of VBP adoption targets (P4P) in their regions. With VBP adoption, ACHs are rewarded on reported progress in the early years and rewarded more on full attainment of targets in later years. The table below indicates the percent of VBP incentives available to ACHs for P4R and P4P throughout the transformation.

Table 13: annual percent of potential earnable ACH VBP incentives, by P4R and P4P

ACH VBP incentives	DY1	DY2	DY3	DY4	DY5
Pay-for-reporting (P4R)	100%	75%	50%	25%	0%
Pay-for-performance (P4P)	0%	25%	50%	75%	100%

Assessment of progress and performance

P4R

ACHs report on VBP P4R milestones as part of their semi-annual reports. ACH VBP incentives for P4R are earned by providing complete and timely evidence of milestone completion for the annual reporting period. ACH VBP P4R milestones evolve as the transformation progresses. Note that P4R milestones phase out as accountability transitions to demonstrating performance against VBP targets in the later years.

Table 14: ACH VBP P4R milestones

Milestone	Reflective of activities that occurred during:
• N/A (none; no DSRIP funding allocated to VBP incentives for DY1).	DY1 (2017)
• Inform providers of VBP readiness tools to assist their move toward value-based care. • Connect providers to training and/or technical assistance (TA) offered through HCA, the Healthier Washington Collaboration Portal, MCOs, and/or the ACH. • Support assessments of regional VBP attainment by encouraging/incentivizing completion of the state provider survey. • Support providers to develop strategies to move toward value-based care.	DY2 (2018)
• Identification and support of providers struggling to implement practice transformation and move toward value-based care. • Support providers to implement strategies to move toward value-based care. • Continued support of regional VBP attainment assessments by encouraging/incentivizing completion of the state provider survey.	DY3 (2019)
• Continued support of regional VBP attainment assessments by encouraging/incentivizing completion of the state provider survey. • Continued identification and support of providers struggling to implement practice transformation and move toward value-based care.	DY4 (2020)
• N/A (all incentives reward performance; no incentives for reporting)	DY5 (2021)

P4P

The IA calculates VBP adoption by ACH region each year for the prior measurement year. The calculation is based on data provided by MCOs. HCA and IA obtain the data used to calculate regional ACH VBP achievement from annual MCO reporting on VBP adoption, both by region and by HCP-LAN category.

The resulting data is validated by the IA and aggregated across all MCOs by region and HCP-LAN category. ACH achievement of regional VBP adoption targets is contingent on MCO VBP adoption performance. ACHs are expected to engage with MCOs and providers in their region to encourage VBP adoption but are not expected to be directly involved in VBP contracts themselves.

ACH VBP P4P incentives are associated with VBP adoption targets, as required by the STCs. Regional VBP adoption is calculated based on the share of MCO payments to providers that are made through VBP arrangements in the HCP-LAN Category 2C or higher.

Table 15: ACH VBP adoption targets

Year	Performance targets	
	HCP-LAN 2C or higher adoption target	HCP-LAN 3A-4B adoption subtarget
DY1	30%	N/A
DY2	50%	10%
DY3	75%	20%
DY4	85%	30%
DY5	90%	50%

Achievement of annual ACH VBP P4P outcomes will consider full achievement of VBP adoption targets and improvement from prior year performance toward VBP adoption targets.

Table 16: ACH VBP P4P score weights

Year	Calculation weight		
	Achievement score	Achievement subset score	Improvement score
DY1	N/A	N/A	N/A
DY2	35%	5%	60%
DY3	45%	5%	50%
DY4[13]	20%	5%	75%
DY5	20%	5%	75%

The amount of ACH VBP P4P incentives earned by the ACH based on performance will reflect the following components:

- Achievement of ACH VBP adoption target (HCP-LAN 2C or higher performance target)
- Achievement of defined subset criteria
- Improvement from prior year VBP adoption
- Minimum threshold for ACH VBP incentives (HCP-LAN 3A-4C performance subtarget)

Based on its performance, an ACH is eligible to earn all or part of the available incentives for ACH VBP P4P. HCA and IA will use data the MCOs are contractually required to identify the following:

- **Achievement score:** an achievement score for each ACH region is calculated annually. If the ACH region has reached or exceeded the HCP-LAN 2C-4C performance target for the performance year, the achievement score will be 100 percent. If not, the achievement score is zero (0) percent.
    - **Achievement subset score:** in DY2-5, HCA will assess whether the ACH region has met the annual achievement subset criteria. If the achievement subset criteria have been met, the achievement subset score will be 100 percent. If the achievement subset criteria have not been met, the achievement subset score will be zero (0) percent.

[13] February 24, 2022, CMS approved a scoring weight adjustment DY4, DY5 and DY6.

- **Improvement score:** an improvement score for each ACH region is calculated annually. If the ACH region has met the performance target for the DY, then the improvement score is 100 percent. If the ACH region has not met the performance target for the performance year, then the improvement score is calculated as the percent change from baseline year to the performance year towards the change in performance target.

  The improvement score is capped at 100 percent. Where the prior calculation produces a negative percentage, the improvement score is zero (0) percent. See Figure 5 for more information. However, if achievement is not met, then improvement score is capped at 75 percent. ACHs must also meet a minimum threshold of VBP adoption in Category 3A and above (performance subtarget) to earn any ACH VBP incentives in DY4 and 5.

Table 17: annual HCP-LAN 3A-4B subtarget threshold for ACH VBP incentives

	DY1	DY2	DY3	DY4	DY5
HCP-LAN 3A – 4B Subtarget	N/A	None	None	30%	50%

Incentive payment determination

P4R

The achievement of ACH VBP P4R milestones is assessed by the IA. Each VBP P4R milestone is associated with one (1.0) achievement value (AV). The percentage of VBP P4R funds earned for the year is equal to the percent of VBP P4R AVs earned out of the total possible number of AVs.

ACHs attest to milestones and provide evidence of completion (e.g., narrative responses, lists of activities), which are assessed on a binary (complete/incomplete) scale. The period for achieving P4R milestones is during the same DY.

Table 1: schedule of ACH VBP P4R milestone AVs

ACH VBP P4R milestones	DY2 Quarter (Q)1-Q4	DY3 Q1-Q4	DY4 Q1-Q4
Inform providers of VBP readiness tools to assist their move toward value-based care.	1.0	-	-
Connect providers to training and/or TA offered through HCA, the Healthier Washington Collaboration Portal, MCOs, and/or the ACH.	1.0	-	-
Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey.	1.0	1.0	1.0
Support providers to develop strategies to move toward value-based care.	1.0	-	-
Identification and support of providers struggling to implement practice transformation and move toward value-based care.	-	1.0	-
Support providers to implement strategies to move toward value-based care.	-	1.0	-
Continued identification and support of providers struggling to implement practice transformation and move toward value-based care.	-	-	1.0
	4.0	**3.0**	**2.0**

To identify the earned VBP P4R incentives for each ACH, the average AV for all P4R milestones that apply in the year (the percent AV completion) is multiplied by the ACH VBP incentives associated with P4R in the measurement year. In the example below, an ACH that earns three out of four possible AVs for the reporting period would earn 75 percent of available ACH VBP incentives associated with P4R. Refer to the DSRIP Measurement Guide for details.

Table 19: example ACH VBP P4R AV calculation (for reporting period DY2)

ACH VBP P4R milestones for reporting period DY2 Q1-Q4	Earned AV	Possible AV
Inform providers of VBP readiness tools to assist their move toward value-based care.	0.0	1.00
Connect providers to training and/or TA offered through HCA, the Healthier Washington Collaboration Portal, MCOs, and/or the ACH.	1.0	1.00
Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey.	1.0	1.00
Support providers to develop strategies to move toward value-based care.	1.0	1.00
Total achievement value (TAV)	**3.0**	4.0
Percentage achievement value (PAV)	(3.0 / 4.0) = 75%	100%

Earned incentives are distributed annually to ACHs, aligned with the timing of payment cycles for ACH project incentive payments.

P4P

The IA calculates the final ACH VBP P4P score by adding the weighted scores for improvement, performance target, and performance subset target achievement. The final score for all components will determine the proportion of potential ACH VBP P4P incentives earned by an ACH for a given performance year. Full credit is earned by meeting or exceeding the defined target for the associated year. ACHs do not earn additional incentives for exceeding improvement or performance expectations. Examples of ACH VBP incentive calculations are available in the DSRIP Measurement Guide.

ACHs earn VBP P4P incentives on an annual basis. Earned incentives are distributed in alignment with earned project P4P and VBP P4R incentive payments. Because of the data compilation and validation process, there is an approximate 18-month lag between the end of the performance year and when ACH VBP P4P incentives are paid.

Distribution of remaining incentives

If a region does not meet progress (P4R) or performance (P4P) expectations, the ACH's unearned VBP incentives will be used to fund ACH high-performance incentives.

State role as connector

Recognizing the importance of alignment between VBP strategies and delivery system reform efforts, HCA continues to play a connector role between ACHs and MCOs. Priorities include preparing partners for VBP readiness and ensuring delivery system reform investments and efforts align with and advance contractual and payment strategies. HCA facilitates monthly sessions with MCOs and launched a work group that includes MCOs and ACHs. HCA's goal with this work group is to help promote information sharing and alignment surrounding contractual expectations, payment, and support being offered to partners.

ACH/HCA Learning Symposium

As part of the STCs, ACHs and HCA will host an annual Learning Symposium, which encourages cross-collaboration and information sharing between HCA, ACHs, partners, and others. Like last year, ACHs are playing a larger role in developing and putting on the event. The event will take place virtually on November 2-4, 2021, with sessions focused on:

- Social determinants of health
- COVID-19 impacts
- Tribal partnerships

- Youth-focused initiatives
- The future of ACHs
- Washington's MTP waiver renewal

The Learning Symposium supports advancement of MTP objectives with a focus on statewide collaboration.

Understanding the payer and provider experience

Understanding the payer and provider experience with VBP is crucial to monitor progress along the VBP continuum. Every year, HCA issues Paying for Value surveys to Washington State plans/payers and providers. Core objectives of the surveys are to:

- Track both health plan and provider experience in moving toward the state's goal of paying for health and value.
- Identify explanatory factors, such as enablers and barriers, which may promote or block desired progress.

HCA is responsible for performing analysis of data collected from provider survey respondents. Individual organization responses are not shared publicly. HCA summarizes a few key findings from the Paying for Value surveys in the VBP Roadmap. The surveys are available on HCA's Tracking success page. Results from the 2021 Paying for Value surveys will be available in the fall of 2021.

For MTP to be successful, an in-depth understanding of the provider perspective is necessary. Provider feedback informs transformation project plan design in the planning stage and can inform transformation activities throughout the implementation and scale/sustain stages.

In their role as convener, ACHs are positioned to support statewide assessment of provider experience in moving to VBP arrangements by encouraging and incentivizing completion of the provider survey among their partnering providers.

Annual update

HCA updates this document on an annual basis. Upcoming editions will include more information on progress made toward achieving state and MTP VBP adoption targets, as well as the state's role in assuring alignment with MACRA and other advanced APM updates.

Resources

- Learn more about VBP, roadmap activities, and HCA's paying for health and value strategy on the HCA website.
- Learn more about Washington's MTP.
- Sign up to receive announcements about VBP or MTP.

Attachments

The next page shows Attachment A: the HCP-LAN APM Framework and HCA's VBP standard.

Attachment A: HCP-LAN APM Framework and HCA's VBP standard

Figure 6: refreshed HCP-LAN APM Framework for VBP or APMs

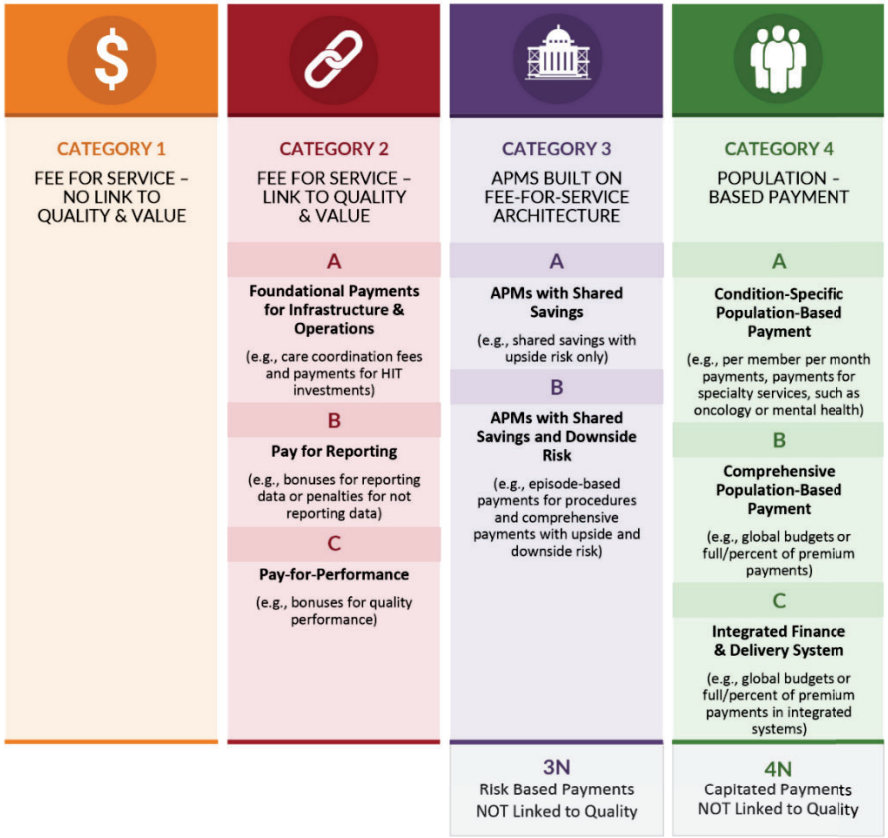
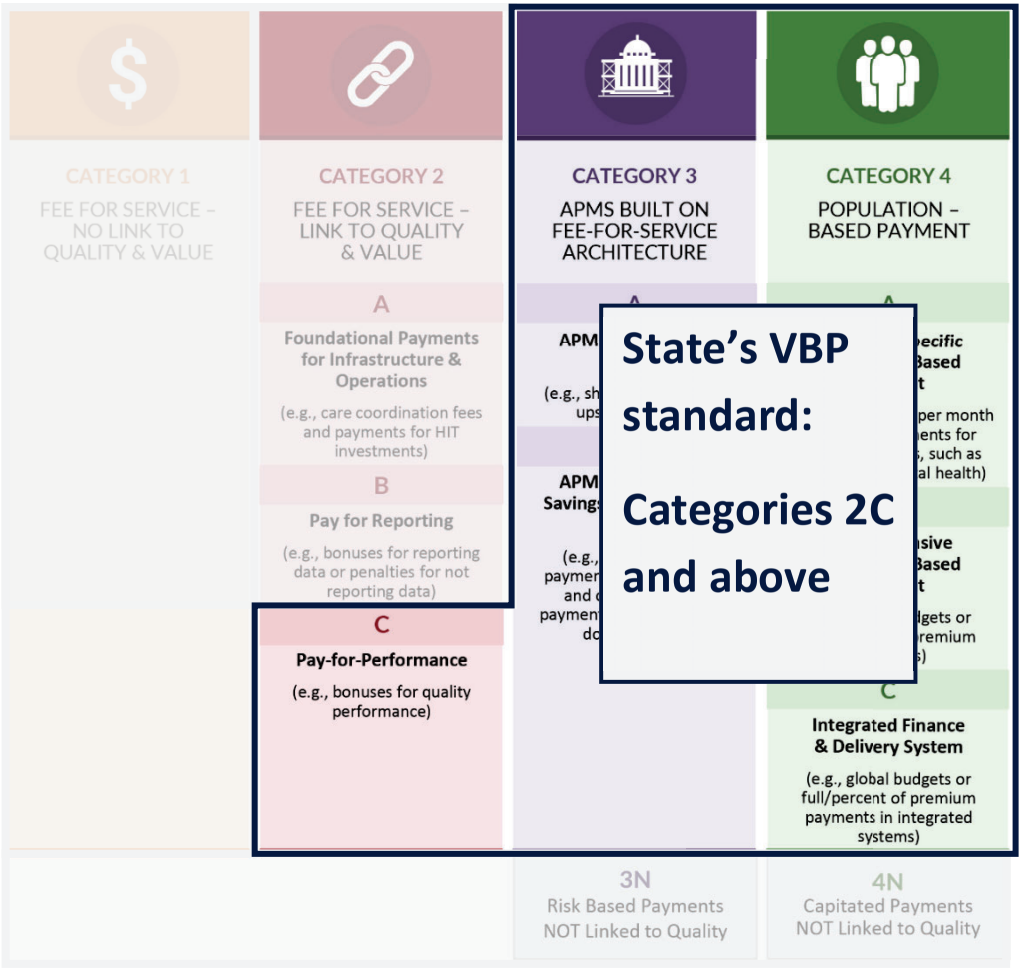


Figure 7: Washington State's VBP standard



ATTACHMENT F

Financial Executor Role

In coordination with HCA and representatives of the state's nine ACHs, the contracted financial executor (FE) shall be responsible for administering a funding distribution plan as described in Attachment D.

ACHs, through their governing bodies, are responsible for managing and coordinating with partnering providers. The ACHs must meet the qualifications set forth in STCs 21 - 23 and must meet the targets enumerated in Attachment C in order to earn incentive payments. In addition, ACHs will certify as to whether or not the partnering providers have met the milestones required for earning incentive payments within their region. The ACH will also certify to the independent assessor whether or not partnering providers have achieved the milestones (see STC 21). The independent assessor (IA) will review the ACH's certification and make recommendations to the state related to distribution of payment. Once the state affirms the recommendations from the IA, it will send the incentive payments to the FE for distribution to the partnering providers.

The contracted FE will perform the work and complete the deliverables outlined below.

1. Establish a system for recording, processing, distributing and reporting on the payment of incentive funds and other financial transactions between HCA, ACHs and partnering providers in accordance with Attachment D.
    - 1.1. Establish a standardized process and forms to track payments to partnering providers and instruct partnering providers and ACHs in their use.
    - 1.2. The distribution of funds must comply with all applicable laws and regulations, including, but not limited to, the following federal fraud and abuse authorities: the anti-kickback statute (sections 1128B(b)(1) and (2) of the Social Security Act (the "Act")); the physician self-referral prohibition (section 1903(s) of the Act); the gainsharing civil monetary penalty (CMP) provisions (sections 1128A(b)(1) and (2) of the Act); and the beneficiary inducement CMP (section 1128A(a)(5) of the Act); as well as with HCA and Washington state rules and generally accepted accounting principles.
2. Provide financial accounting and banking management support for all incentive payments.
    - 2.1. Establish and maintain appropriate accounts as directed by HCA for the tracking of incentive payment receipts and holding of funds and issuance of payments.
    - 2.2. Regularly track and report on all transactions from such accounts, including but not limited to payments, receipts, refunds and reconciliations.
3. Distribute earned funds in a timely manner to partnering providers in accordance with HCA-approved funding distribution plans.
    - 3.1. Upon instruction and approval from the ACH, issue payments to partnering providers within 14 business days.

3.2. Respond to inquiries from ACHs and partnering providers regarding payments made or owed amounts, within 5 business days.

3.3. Identify, record, resolve and report on any under- or over-payments, including issuing requests for refunds if necessary.

3.4. Record and regularly report to ACHs on funds processed and payments made.

4. Submit scheduled reports to HCA and ACHs on the distribution of transformation project payments, fund balances and reconciliations–in accordance with relevant state and federal rules.

5. Develop and distribute budget forms to partnering providers for receipt of incentive funds.

6. As requested, assist HCA in responding to inquiries from CMS regarding financial transactions and any audits that may be required.

Attachment G
Reserved

Attachment H
Indian Health Care Provider (IHCP) Protocol
(Formerly known as the "Tribal Engagement and Collaboration Protocol")

I. RESTATEMENT OF NATIONAL POLICY

In Section 3 of the Indian Health Care Improvement Act (codified at 25 U.S. Code § 1602), Congress declared that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to American Indians:

1. To ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;
2. To raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;
3. To ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;
4. To increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;
5. To require that all actions under this chapter shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this chapter and the national policy of Indian self-determination;
6. To ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and
7. To provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service."

II. DEFINED TERMS

1. **Accountable Community of Health** or **ACH** has the meaning set forth in the Special Terms and Conditions for the Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration.

2. **American Indian/Alaska Native** or **AI/AN** means "Indian" as defined in 25 U.S. Code § 1603(13).

3. **Community Health Aide Program** or **CHAP** refers to that program authorized under 25 U.S. Code § 1616*ℓ*.

4. **Indian Health Care Provider** or **IHCP** has the meaning set forth in 42 C.F.R. § 438.14(a).

5. **Indian Health Service or IHS** means the agency within the U.S. Department of Health and Human Services responsible for providing federal health services to AI/ANs.

6. **Tribe** means "Indian tribe" as defined in 25 U.S. Code § 1603(14).

7. **Urban Indian Health Program** or **UIHP** means an Urban Indian Organization as defined in 25 U.S. Code § 1603(29) that receives IHS funding to provide health care services to AI/ANs.

III. DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM

1. **Objectives.** With the IHCP specific projects, the state and the tribes and UIHPs seek to achieve the following interests in Medicaid transformation.

   a. ***Collaborative Medicaid Transformation***. Due to treaty obligations and the special trust responsibility, tribes have government-to-government relations with both federal and state governments and IHS facilities and UIHPs have the right to be solicited for advice on Medicaid matters that affect them or their AI/AN patients. In addition, under chapter 43.376 of the Revised Code of Washington, state agencies are required to make reasonable efforts to collaborate with Indian tribes in the development of policies, agreements, and program implementation that directly affect tribes. In recognition of these relationships and requirements, the Medicaid Transformation Demonstration will support the tribes', IHS facilities', and UIHPs' planning efforts by allocating a total of $5,400,000 of Demonstration Year 1 (DY1) incentive payment funds to support the planning and various infrastructure investments related to IHCP-specific projects.

   b. ***IHCP Health Systems and Capacity.*** In recognition of the complexity of IHCP health systems due to the legacy of the IHS Resource and Patient Management System (RPMS) and federal reporting requirements under the Government Performance and Results Act of 1993, the Medicaid Transformation Demonstration will provide incentive payments for achieving milestones that reflect the development of more effective health systems and greater capacity within IHCPs to support and expand the coordination of physical and behavioral health care and social services for Medicid clients and to enable IHCPs to help reduce unnecessary use of intensive services and settings by Medicaid clients without impairing health outcomes. To support financial sustainability, investments in IHCP health systems and capacity will be made in ways that maximize their access and availability to as many tribes, IHS facilities, and UIHPs as possible using information technology protocols and platforms in common use with the state Medicaid program and providers, while respecting individual tribal government needs. Potential investments areas include:

      i. <u>Workforce Capacity and Innovation</u>

         A. *CHAP Board*. Support for the creation of a certification board, similar to the Community Health Aide Certification Board (as defined in 25 U.S. Code § 1616ℓ) in Alaska, to oversee the training and continuing education for Dental Health Aide Therapists, Behavioral Health Aides, Community Health Aides, and other mid-level providers.

         B. *CHAP Education*. Support for the creation of an education program, housed within an established institution of higher education, for various community health aides, including behavioral health aides.

C. *CHAP Provider Implementation*. Support for incorporating new CHAP Board-certified providers into tribal health programs.

ii. Health Systems

A. *Electronic Behavioral Health Records*. Support for the installation of electronic behavioral health records that interface with electronic health records.

B. *Clinical Data Repository*. Support for the creation of the system interfaces for tribal health programs, IHS facilities, and UIHPs to export and import client clinical data into one or more clinical data repositories including state-contracted data repositories (such as Link4Health operated by OneHealthPort and the Emergency Department Information Exchange (EDIE) operated by CollectiveMedical Technologies, Inc.).

C. *Population Health Management*. Support for the creation of a population health management tool for tribal health programs, IHS facilities, and UIHPs to use, drawing data from clinical data repositories and other state-contracted data repositories (such as Link4Health operated by OneHealthPort and the Emergency Department Information Exchange (EDIE) operated by CollectiveMedical Technologies, Inc.).

c. ***Financial Sustainability***. The tribes, IHS facilities, and UIHPs will be given greater flexibility in how they assure the sustainability of the transformation projects undertaken through the Medicaid Transformation Project demonstration in recognition of the special trust responsibility and the following recent CMS guidance, which the state is in the process of implementing:

i. CMS State Health Official Letter #16-002, dated February 26, 2016; and

ii. CMS Frequently Asked Questions (FAQs): Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives (SHO #16-002), dated January 18, 2017.

d. ***Statewide Improvement of Behavioral Health for AI/AN Medicaid Clients***. In recognition of the significant health disparities in AI/AN mental health and substance use disorder and intergenerational trauma (collectively, behavioral health), the special trust responsibility, and the significant investments tribes and UIHPs have made in integrating physical and behavioral health despite enduring decades of severe underfunding, the Medicaid Transformation Project demonstration will offer flexibility outside of the approved DSRIP Planning Protocol to support culturally relevant IHCP-specific innovations that seek to improve the behavioral health of Medicaid-enrolled AI/ANs statewide by providing directed support for each IHCP to implement IHCP-specific physical and behavioral health and social service innovations identified in the following resources:

i. The National Tribal Behavioral Health Agenda (https://www.nihb.org/behavioral_health/behavioral_health_agenda.php);

ii. The Urban Indian Health Institute (UIHI) Report: "Supporting Sobriety Among American Indians and Alaska Natives: A Literature Review – February 2014" (http://www.uihi.org/download/supporting-sobriety-among-american-indians-alaska-natives-literature-review-february-2014/?wpdmdl=11604); and

iii. The UIHI Report: "Addressing Depression Among American Indians and Alaska Natives: A Literature Review – August 2012" (http://www.uihi.org/download/addressing-depression-among-american-indians-alaska-natives-literature-review/?wpdmdl=11408).

e. ***Other Tribal- or IHCP-Specific Objectives*** as may be agreed upon by the Centers for Medicare and Medicaid Services, the state, and the proposing tribes and/or IHCPs.

2. **Timeline.**

a. ***IHCP Planning Funds Plan***. No later than December 31, 2017, the tribes and IHCPs will submit to the state a consolidated IHCP Planning Funds Plan. Upon review and acceptance of the IHCP Planning Funds Plan, the state will issue $5,400,000 out of Demonstration Year 1 incentive payment funds in accordance with the instructions received from the tribes and IHCPs. To be accepted by the state, the IHCP Planning Funds Plan must include:

i. Statewide Inventory of Indian Health and Indian Health Care, which includes:

A. An inventory of the health needs, including the behavioral health needs, of the different AI/AN communities in Washington State, both tribal and non-tribal (such as urban), with a particular focus on the barriers to care for Medicaid-covered AI/ANs;

B. An inventory of the physical health care, behavioral health care, dental care, and social service resources available at tribes, IHS facilities, and UIHPs in Washington State;

C. An inventory of the data, health information technology, and population health management systems at tribes, IHS facilities, and UIHPs in Washington State and analogous social service/case management data and information systems at tribes in Washington State;

D. An inventory of the evidence-based and promising practices, including behavioral health-related practices, that have been used by tribes, IHS facilities, and UIHPs to improve health care and health outcomes for their clients; and

E. An inventory of the barriers (federal and state laws and regulations, practical impacts of Medicaid and Medicare programs, etc.) to

implementing these evidence-based and promising practices, including behavioral health-related practices.

ii. Plan for Statewide Improvement of AI/AN Behavioral Health, which includes:

A. A framework based on the National Tribal Behavioral Health Agenda;

B. Strategies within the framework that build on the services available at tribes, IHS facilities, and UIHPs, and on the evidence-based and promising practices that have been used by tribes, IHS facilities, and UIHPs to improve AI/AN behavioral health and behavioral health care;

C. Anticipated investments in data, health information technology, and population health management systems at tribes, IHS facilities, and UIHPs and analogous social service/case management data and information systems at tribes to enable tribes, IHS facilities, and UIHPs to implement the strategies and evidence-based and promising practices; and

D. Explanations of how these strategies and investments will achieve the objectives of the Medicaid Transformation Demonstration.

iii. Instructions for Payment of Earned IHCP Planning Funds, including:

A. *Decision Making*. The tribes and UIHPs have agreed that decisions regarding payment of earned IHCP Planning Funds will be made by majority vote of tribes and UIHPs, with each having one vote to be held by the AIHC delegate from the tribe or UIHP unless the tribe or UIHP directs that vote to be held by someone else. If the IHCP Planning Funds are earned before the tribes and UIHPs agree on how to allocate the funds, the state will not allocate the earned funds until the tribes and UIHPs instruct the state on whom will receive the funds and in what amounts.

B. *Funding Priorities*. The tribes and UIHPs have agreed that the IHCP Planning Funds will be allocated to support the following:

- Work that was done to earn the IHCP Planning Funds, including completion of the Tribal Protocol;

- Work that needs to be done to complete the IHCP Projects Plan, with one portion allocated equally to every tribe and UIHP in the state and the remaining portion allocated based on percentage of a total, such AI/AN Medicaid clients or IHS User Population; and

- Infrastructure investments to increase the ability of all tribes and UIHPs to attain the milestones in the IHCP Projects Plan, such as

the CHAP Board and the clinical data repository/population health management.

b. ***IHCP Projects Plan***. No later than October 1, 2018, the tribes and IHCPs will submit to the state a consolidated IHCP Projects Plan, which will include both a statewide default project focused on statewide improvement of behavioral health for AI/AN and any additional projects that the tribes and IHCPs agree upon. Upon acceptance of the IHCP Projects Plan, the state will issue incentive payments upon achievement of the milestones in the IHCP Projects Plan in accordance with the instructions received from the tribes and IHCPs.

3. **Process.** The following provisions supercede the various protocols related to the DSRIP program:

a. ***ACH Certification - Tribal Requirement***. The State will require every ACH to adopt and demonstrate compliance with the Model ACH Tribal Collaboration and Communication Policy, attached hereto as Exhibit A, or a policy agreed upon in writing by the ACH and every IHCP in the ACH region, as part of the ACH certification process.

b. ***Application to IHCPs***. The term "ACH" in the DSRIP Planning Protocol will be interpreted to include IHCPs where appropriate to enable IHCPs to participate in the DSRIP Program in accordance with the terms of this Tribal Protocol.

c. ***No Requirement for Tribal Certification***. The State will not require any IHCP to undergo the ACH certification process in order to participate in the DSRIP Program. HCA will work with IHCPs to maintain compliance with federal requirements applicable to IHCPs participating in the DSRIP Program.

d. ***DSRIP Program Models***. For IHCPs participating in the DSRIP Program, the State will accept evidence-based or promising care models developed for, or tailored to, AI/AN clients that otherwise meet the requirements of the Transformation Project Toolkit (Attachment C to the Special Terms and Conditions for the Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration).

e. ***DSRIP Program Guidance and Technical Assistance for IHCPs***. The State will work with the Tribal Coordinating Entity to provide targeted guidance and technical assistance to help IHCPs implement one or more projects in the IHCP's regional ACH Project Plan or the IHCP Projects Plan or both, including appropriate milestones and outcome measurement goals that qualify for incentive payments.

f. ***Regional Health Needs Inventories (RHNIs) and Regional Health Improvement Plans (RHIPs)***. In respect for the sovereignty and representative governmental processes of tribes and their knowledge of their citizens and their systems, the State will accept tribe-developed alternatives to formal RHNIs or RHIPs as a demonstration of population health needs for participation in the DSRIP Program. In respect for the complex systems of IHCPs and their unique role in helping the U.S. Department of Health and Human Services meet its federal trust responsibility to AI/ANs (including urban Indians and AI/ANs not living near their Indian reservations or villages), the State will accept IHCP-

developed alternatives to formal RHNIs or RHIPs as a demonstration of population health needs for participation in the DSRIP Program.

g. ***No Required Projects for IHCPs***. The State will support tribes and IHCPs in their choices of DSRIP Program projects. IHCPs will not be required to implement either of the required projects listed in the Transformation Project Toolkit, nor will they be required to implement a minimum number of projects as provided for in the Transformation Project Toolkit.

h. ***Statewide Tribal-IHCP Projects***. The State encourages and will support IHCPs in a statewide IHCP effort to implement one or more projects in the IHCP Projects Plan, with incentive payments for collaborative sharing of expertise and individual IHCP efforts.

i. ***Financial Sustainability***. In respect for the sovereignty of Tribes and their responsibility in meeting the health needs of their clients, the State will not require IHCPs to adopt value-based payment methodologies, nor will the State be required to include IHCPs in value-based payment incentive programs, in meeting the financial sustainability requirements of the demonstration. In respect for the complex systems of IHCPs and their unique role in helping the U.S. Department of Health and Human Services meet its federal trust responsibility to AI/ANs (including urban Indians and AI/ANs not living near their Indian reservations or villages), the State will not require IHCPs to adopt value-based payment methodologies in meeting the financial sustainability requirements of the demonstration. For IHCPs, the State will accept alternative financial sustainability models.

j. ***Performance Measurement***. The State will accept Government Performance and Results Act (GPRA), and/or Universal Data System (UDS) measures in lieu of comparable statewide common performance measures when such substitution will reduce duplicative reporting and avoid excessive administrative burden on IHCPs.

4. **Funding and Mechanics.** The following provisions supercede the various protocols related to the DSRIP program:

   a. ***Application to IHCPs***. The term "ACH" in the DSRIP Program Funding and Mechanics Protocol will be interpreted to include IHCPs where appropriate to enable IHCPs to participate in the DSRIP Program in accordance with the terms of this Tribal Protocol.

   b. ***IHCP Incentive Funds***. Notwithstanding STC 28 and STC 35(b) and in accordance with DSRIP Funding and Mechanics Protocol III(c), the state will use the ratio of AI/AN Medicaid enrollees to total Medicaid enrollees to determine the percentage of the maximum statewide amount of DSRIP project funding to allocate to IHCP-specific projects (also referred to in the DSRIP Funding and Mechanics Protocol as tribal-specific projects).

IV. MEDICAID ALTERNATIVE CARE AND TAILORED SUPPORTS FOR OLDER ADULTS

1. **Eligibility to Provide Health Care Services and Acceptance of Tribal Attestation.** To the extent that services provided under the Medicaid Alternative Care (MAC) and Tailored Supports

for Older Adults (TSOA) programs are health care services, the state will accept any IHCP as a provider eligible to receive payment under the MAC and TSOA programs for health care services furnished to an AI/AN on the same basis as any other provider qualified to participate as a provider of health care services under the MAC and TSOA programs in accordance with 25 U.S.C. § 1647a(a)(1). To the extent permitted by federal and state law, the state will accept tribal attestation of compliance with state provider requirements for health care services if a tribe establishes provider entity standards with comparable client protections.

2. **Exemption from Washington State Licensure.** To the extent that services provided under the MAC and TSOA programs are provided by licensed health professionals, the state will accept health professionals employed by the tribe who are licensed in another state and are performing services described in the contract or compact of the Indian health program under Indian Self-Determination and Education Assistance Act in accordance with 25 U.S.C. § 1621t.

3. **Client Presumptive Eligibility Assessments.** To the extent that any IHCP has the capacity and desire to perform presumptive eligibility assessments under the MAC and TSOA programs in accordance with federal and state requirements, the state will pay the standard case management rate for such activity.

4. **Client Services.** To the extent that any IHCP has the capacity and desire to provide client services under the MAC and TSOA programs in accordance with federal and state requirements (including federal conflict of interest rules), the state will pay the Medicaid contracted provider rate for each service.

5. **Coordination with IHCPs.** The state will make available to IHCPs training dates, information, and curriculum pertaining to the MAC and TSOA programs.

V. FOUNDATIONAL COMMUNITY SUPPORTS

1. **Eligibility to Provide Health Care Services and Acceptance of Tribal Attestation.** To the extent that services provided under the Foundational Community Supports program are health care services, the state and its administrative entity will accept any IHCP as a provider eligible to receive payment under the Foundational Community Supports program for health care services furnished to an AI/AN on the same basis as any other provider qualified to participate as a provider of health care services under the Foundational Community Supports program in accordance with 25 U.S.C. § 1647a(a)(1). To the extent permitted by federal and state law, the state will accept tribal attestation of compliance with state provider requirements for health care services if a tribe establishes provider entity standards with comparable client protections.

2. **Exemption from Washington State Licensure.** To the extent that services provided under the Foundational Community Supports program are provided by licensed health professionals, the state will accept health professionals employed by the tribe who are licensed in another state and are performing services described in the contract or compact of the Indian health program under Indian Self-Determination and Education Assistance Act in accordance with 25 U.S.C. § 1621t.

3. **Client Services.** To the extent that any IHCP has the capacity and desire to provide client services under the Foundational Community Supports program in accordance with federal and

state requirements, the state will pay the Medicaid contracted provider rate for each service through the administrative entity.

4. **Coordination with IHCPs.** The state will make available to IHCPs training dates, information, and curriculum pertaining to the Foundational Community Supports program. The state will facilitate one or more meetings between IHCPs and the Foundational Community Supports program administrative entity and providers to increase mutual understanding of capacity and systems related to the Foundational Community Supports program.

ATTACHMENT I
Foundational Community Supports Program

Per STC Section 10, the following protocol outlines the services and payment methodologies for the Foundational Community Supports (FCS) Program. Under this program, the state will provide a set of Home and Community Based Services (HCBS), including Community Support Services (CSS), and Supported Employment-Individual Placement and Support (IPS), to populations that meet the needs-based criteria specified below. These services include HCBS that could be provided to the individual under a 1915(i) state plan amendment (SPA).

Community Support Services (CSS)

Target Criteria

CSS eligibility is available to Medicaid clients age 16 or older who meet the following needs-based criteria that would otherwise be allowable under a 1915(i) SPA:

Needs-Based Criteria

Individual meets at least one of the following health needs-based criteria and is expected to benefit from CSS:

1) Individual assessed to have a behavioral health need, which is defined as one or both of the following criteria:
   a) Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or

b) Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment. The ASAM is a multi-dimensional assessment approach for determining an individual's need for SUD treatment.

2) Individual assessed to have a need for assistance, demonstrated by the need for:
   a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388-106-0010, one of which may be body care, and/or
   b) Hands-on assistance with one or more ADLs, one of which may be body care.
3) Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support).

AND

Individual has at least one of the following risk factors:

1) Homelessness, defined as living in a place not meant for human habitation, a safe haven, or an emergency shelter, as these terms are understood or defined in 24 CFR 578.3:
   a) For at least 12 months, or
   b) On at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months.

2) History of frequent and/or lengthy stays in the settings defined in 24 CFR 578.3, or from, a skilled nursing facility as defined in WAC 388-97-0001.
   a) Frequent is defined as more than one contact in the past 12 months.
   b) Lengthy is defined as 90 or more consecutive days within an institutional care facility.
3) History of frequent adult residential care stays, where
   a) Frequent is defined as more than one contact in the past 12 months.
   b) Adult residential care includes
      i) Residential treatment facilities defined in WAC 246-337-005,
      ii) Adult residential care, enhanced adult residential care, or assisted living facilities defined in WAC 388-110-020, and
      iii) Adult family homes defined in WAC 388-76-10000.
4) History of frequent turnover of in-home caregivers, where within the last 12 months the individual utilized 3 or more different in-home caregiver provider agencies and the current placement is not appropriate for the individual.
5) A Predictive Risk Intelligence System (PRISM) Score of 1.5 or above
   a) The PRISM Risk Score uses diagnosis, prescription, age, and gender information from claims and encounter data to create an index of a client's expected future medical expenditures relative to the expected future medical expenditures of a comparison group (disabled Medicaid adults). The algorithm uses risk factor categories developed at University of California, San Diego known as the Chronic Illness and Disability Payment System (CDPS) and MedicaidRx, which were deemed by the Society of Actuaries to be effective methods of risk adjustment. The PRISM risk score is updated on a monthly basis by the Washington State Department of Social and Health Services' Research and Data Analysis division using the past fifteen months of claims, encounter, and demographic data. A risk score of 1.5 means that an individual's expected future medical expenditures will be 50 percent greater than that of the average Medicaid disabled client. The PRISM risk score was approved by CMS for targeting clients for the Health Home Program and Financial Alignment Dual Demonstration.

Service Definitions for HCBS That Could Be Provided under a 1915(i) SPA

Community Support Services (CSS) benefits package. CSS includes services that would otherwise be allowable under a Section 1915(i) authority, are determined to be necessary for an individual to obtain and reside in an independent community setting, and are tailored to the end goal of maintaining individual recipients' personal health and welfare in a home and community-based setting. CSS may include one or more of the following components:

Pre-tenancy supports:

a. Conducting a functional needs assessment identifying the participant's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual), assistance in budgeting for housing/living expenses, assistance in connecting the individual with social services to assist with filling out applications and submitting appropriate documentation in order to obtain sources of

income necessary for community living and establishing credit, and in understanding and meeting obligations of tenancy.

b. Assisting individuals to connect with social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs.
c. Developing an individualized community integration plan based upon the functional needs assessment as part of the overall person-centered plan. Identifying and establishing short and long-term measurable goal(s), and establishing how goals will be achieved and how concerns will be addressed.
d. Participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
e. Providing supports and interventions per the person-centered plan:
    - Including the purchase of pay-as-you-go cell phone devices as a means to access telehealth services for pre-tenancy supports.

Tenancy sustaining services:

a. Service planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
b. Coordinating and linking the recipient to services including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports.
    - Including the purchase of pay-as-you-go cell phone devices as a means to access telehealth services for pre-tenancy supports.
c. Entitlement assistance including assisting individuals in obtaining documentation, navigating and monitoring application process, and coordinating with the entitlement agency.
d. Assistance in accessing supports to preserve the most independent living such as individual and family counseling, support groups, and natural supports.
e. Providing supports to assist the individual in the development of independent living skills, such as skills coaching, financial counseling, and anger management.
f. Providing supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
g. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
h. Connecting the individual to training and resources that will assist the individual in being a good tenant and lease compliance, including ongoing support with activities related to household management.

The CSS benefit does not include:

a. Payment of rent or other room and board costs;
b. Ongoing minutes or data plans for cell phone devices;
c. Capital costs related to the development or modification of housing;
d. Expenses for utilities or other regular occurring bills;

e. Goods or services intended for leisure or recreation;
f. Duplicative services from other state or federal programs
g. Services to individuals in a correctional institution.

Supported Employment – Individual Placement and Support

Target Criteria

IPS eligibility include Medicaid clients age 16 or older who meet the following criteria that would otherwise be allowable under a 1915(i) SPA:

Needs-based criteria

Individual meets at least one of the following health needs-based criteria and is expected to benefit from IPS:

1) Individual assessed to have a behavioral health need, which is defined as one or both of the following:
   a) Mental health needs, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support), resulting from the presence of a mental illness.
   b) Substance use needs, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment. The ASAM is a multi-dimensional assessment approach for determining an individual's need for SUD treatment.
2) Individual assessed to have a need for assistance demonstrated by the need for:
   a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388-106-0010, one of which may be body care, and/or
   b) Hands-on assistance with one or more ADLs, one of which may be body care.
3) There is objective evidence of physical impairments because of which the individual needs assistance with basic work-related activities, including one or more of the following: Sitting, standing, walking, lifting, carrying, handling, manipulative or postural functions (pushing, pulling, reaching handling, stooping or crouching), seeing, hearing, communicating, remembering, understanding and following instructions, responding appropriately to supervisors and co-workers, tolerating the pressures of a work setting, maintaining appropriate behavior, using judgment, and adapting to changes in a routine work setting.

AND

Individual has at least one of the following Risk Factors:

1) Unable to be gainfully employed for at least 90 consecutive days due to a mental or physical impairment.
2) An inability to obtain or maintain employment resulting from age, physical disability, or traumatic brain injury.
3) More than one instance of inpatient substance use treatment in the past two years.
4) At risk of deterioration of mental illness and/or substance use disorder, including one or more of the following:
   a) Persistent or chronic risk factors such as social isolation due to a lack of family or social supports, poverty, criminal justice involvement, or homelessness.

b) Care for mental illness and/or substance use disorder requires multiple provider types, including behavioral health, primary care, long-term services and supports, and/or other supportive services.
c) Past psychiatric history, with no significant functional improvement that can be maintained without treatment and/or supports.

5) Dysfunction in role performance, including one or more of the following:
   i) Behaviors that disrupt employment or schooling, or put employment at risk of termination or schooling suspension.
   ii) A history of multiple terminations from work or suspensions/expulsions from school.
   iii) Cannot succeed in a structured work or school setting without additional support or accommodations.
   iv) Performance significantly below expectation for cognitive/developmental level.

Service Definitions for HCBS That Could Be Provided under a 1915(i) SPA

Supported Employment – Individual Placements and Support (IPS) benefit package: The IPS benefit package will be offered to eligible clients through a person-centered planning process where eligible services are identified in the plan of care. IPS includes services that would otherwise be allowable under a Section 1915(i) authority, and are determined to be necessary for an individual to obtain and maintain employment in the community. IPS services are individualized and may include any combination of the following services:

Pre-employment services

a. Pre-vocational/job-related discovery or assessment
b. Person-centered employment planning
   - Including the purchase of pay-as-you-go cell phone devices as a means to access telehealth services for pre-employment services.
c. Individualized job development and placement
d. Job carving
   - Job carving is defined as working with client and employer to modify an existing job description— containing one or more, but not all, of the tasks from the original job description when a potential applicant for a job is unable to perform all of the duties identified in the job description.
e. Benefits education and planning
   - Benefits education and planning is defined as counseling to assist the client in fully understanding the range of state and federal benefits they might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the client's options for returning to work.
f. Transportation (only in conjunction with the delivery of an authorized service)

Employment sustaining services

a. Career advancement services
   - Career advancement services are defined as services that expand opportunities for professional growth, assist with enrollment in higher education or credentialing and certificate programs to expand job skills or enhance career development, and assist the individual in monitoring his/her satisfaction with employment, and determining level of interest and opportunities for advancement with current

employer, and/or changing employers for career advancement.

b. Negotiation with employers
    - Negotiation with employers is defined as services where a provider identifies and addresses job accommodations or assistive technology needs with the employer on behalf of the individual. Job accommodations can include the following: adjusting work schedule to reduce exposure to triggering events (i.e., heavy traffic triggering symptoms of agoraphobia); providing a private area for individuals to take breaks if they experience an increase in symptoms; access to telephone to contact support person if needed while at work; adjusting job schedule to accommodate scheduled appointments; and small, frequent breaks as opposed to one long one. Assistive Technology can include the following: bedside alarms, electronic medication reminders while at work or at home, and use of headset/iPod to block out internal or external distractions.
c. Job analysis
    - Job analysis is defined as the gathering, evaluating, and recording of accurate, objective data about the characteristics of a particular job to ensure the specific matching of skills and amelioration of maladaptive behaviors.
d. Job coaching
e. Benefits education and planning
    - Benefits education and planning is defined as counseling to assist the client in fully understanding the range of state and federal benefits they might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the clients' options for returning to work.
f. Transportation (only in conjunction with the delivery of an authorized service)
g. Asset development
    - Asset development is defined as services supporting the client's accrual of assets that have the potential to help clients improve their economic status, expand opportunities for community participation, and positively impact their quality of life experience. Assets as defined as something with value that is owned by an individual, such as money in the bank, property, and retirement accounts.
h. Follow-along supports
    - Follow-along supports are defined as on-going supports necessary to assist an eligible client to sustain competitive work in an integrated setting of their choice. This service is provided for, or on behalf of, a client, and can include communicating with the client's supervisor or manager, whether in the presence of the client or not (if authorized and appropriate). There is regular contact and follow-up with the client and employer to reinforce and stabilize job placement. Follow along support and/or accommodations are negotiated with an employer prior to client starting work or as circumstances arise.
        - Including the purchase of pay-as-you-go cell phone devices as a means to access telehealth services for follow-along supports.

The IPS benefit does not include:

a. Generalized employer contacts that are not connected to a specific enrolled individual or an authorized service
b. Employment support for individuals in sub-minimum wage, or sheltered workshop settings
c. Facility-based habilitation or personal care services

d. Wage or wage enhancements for individuals
e. Duplicative services from other state or federal programs
f. Ongoing minutes or data plan for cell phone devices

HCBS Supported Employment

IPS services defined in this protocol shall adhere to 42 CFR 440.180(c)(2)(iii), 441.302(i) and 441.303(h).and shall not include habilitation services such as facility-based day habilitation or personal care. Furthermore, services are to be provided in conjunction with a client's existing services and supports, and are therefore separate from special education or related services defined under sections 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16 and 17)) or as services under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. section 730).

HCBS requirements

a. **Person-Centered Planning.** The state agrees to use person-centered planning processes to identify eligible clients' Foundational Community Supports needs and the resources available to meet those needs, and to identify clients' additional service and support needs.
b. **Conflict of Interest.** The state agrees that the entity that authorizes the services is external to the agency or agencies that provide FCS services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.
c. **Home and Community-Based Setting Requirements.** The state will assure compliance with the home and community-based settings requirements for those services that could be authorized under section 1915(i).

Provider Qualifications
Contracted providers must ensure staff providing FCS services maintain appropriate qualifications in order to effectively serve FCS enrollees. Below are typical provider qualifications, however they may be substituted with appropriate combination of education, experience and skills, as determined by the provider contract.

Provider	Education (typical)	Experience (typical)	Skills (preferred)	Services
Community Support Services Providers	Bachelor's degree in a human/social services field; may also be an Associate's degree in a relevant field, with field experience.	1-year case management experience, or Bachelor's degree in a related field and field experience.	Knowledge of principles, methods, and procedures of services included under community support services (as outlined above), or comparable services meant to support client ability obtain and maintain residence in independent community settings.	Pre-tenancy supports; tenancy sustaining services (as outlined above).
Supported Employment – IPS Providers	Bachelor's degree in a human/social services field; may also be an Associate's degree in a relevant field, with field experience.	1-year case management experience, or Bachelor's degree in a related field and field experience.	Knowledge of principles, methods and procedures of services included under supported employment – individual placement and support (as outlined above), or comparable services that support client ability to obtain and maintain employment.	Pre-employment services; employment sustaining services (as outlined above).

Payment Methodologies

HCA will reimburse a Third-Party Administrator (TPA) for the CSS and IPS services provided at the CSS and IPS rates. The rates shall not exceed the amount expended by the TPA for the direct service costs incurred by the provider. Rates may vary by region and may be developed based on a target cost per CSS and IPS service, along with variables such as geographic location, FCS-related travel costs, intensity of services, and duration of services or contracted provider per unit costs.

The TPA is required to submit quarterly reports and an annual report to HCA. Ongoing quarterly/annual reporting will include, at a minimum: (i) Number of FCS beneficiaries broken out by program (CSS and IPS supported employment); (ii) Number of new CSS and IPS supported employment person-centered service plans; (iii) Percent of clients receiving CSS and/or IPS supported employment services whose needs are re-assessed annually; and (iv) Amount of funds spent on CSS and IPS supported employment services. The purpose of the reports is to demonstrate that the program is conducted in compliance with the requirements set forth in the STCs and post-approval protocols, attachments, any agreement between HCA and the TPA, and policy letters and/or guidance from HCA.

The TPA will invoice HCA for FCS services provided to a specific Medicaid beneficiary. As part of this invoicing process, the TPA must submit documentation to HCA of the Medicaid

beneficiary's eligibility status, the dates of service, and the types of service that were provided.

The TPA is required to ensure FCS providers meet minimum documentation standards and cooperate in any evaluation activities by HCA, CMS, or their contractors. The state assures that there is no duplication of federal funding and the state has processes in place to ensure there is no duplication of federal funding.

Attachment J
Evaluation Design

Independent Evaluation Design Document
Washington State Medicaid Transformation Project
Section 1115(a) Medicaid Demonstration Extension:

Medicaid Transformation Project 2.0 Demonstration Evaluation Design

Prepared by
Oregon Health & Science University
Center for Health Systems Effectiveness (CHSE)

Prepared for
Washington State Health Care Authority

Submitted to The Centers for Medicare and Medicaid Services
February 28, 2025

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Section 1: Overview of the Medicaid Transformation 2.0 Project Demonstration

On June 30, 2023, the Centers for Medicare and Medicaid Services (CMS) approved Washington State's request for a Section 1115 Medicaid demonstration entitled Medicaid Transformation Project 2.0" (MTP 2.0) (Project Number: 11-W-00304/0 and 21-W-00071/0). The MTP 2.0 demonstration builds on the state's five-year Medicaid Transformation Project (MTP 1.0), which was initiated in January 2017. MTP 1.0 empowered local communities to enhance their healthcare systems, integrating physical and behavioral health services and implementing value-based payments. The MTP 1.0 demonstration introduced new benefit packages to aid individuals who require long-term services and supports (LTSS) and their caregivers. It also addressed health-related social needs (HRSN) by providing eligible individuals with supportive housing and employment services. Additionally, the program incorporated initiatives for substance use disorder (SUD) treatments and services for serious mental illness (SMI). The MTP demonstration received a one-year extension in December 2021 and an additional six-month extension until June 30, 2023. In April 2023, the demonstration was revised to include continuous eligibility for children from birth through the age of 6.

MTP 2.0 builds upon the foundations laid by MTP 1.0, extending its scope and introducing new initiatives to further improve Medicaid and CHIP beneficiaries' health outcomes in Washington. It retains a strong focus on integrating care, addresses social determinants of health, and innovates within the Medicaid program, similar to MTP 1.0. MTP 2.0 also introduces several new initiatives, described below. It places a stronger emphasis on addressing HRSN, includes novel approaches to maintaining coverage for children and postpartum individuals, and increases the likelihood of coverage for incarcerated individuals prior to release. The approval is effective July 1, 2023, through June 30, 2028.

Over the next five years, Washington will:

- **Expand Coverage and Access to Care**: Washington aims to broaden healthcare access and coverage. This includes implementing continuous coverage for children and postpartum individuals, offering services to support incarcerated individuals' reintegration into society, and providing services for Medicaid enrollees receiving treatment for substance use disorders and mental health issues in Institutions for Mental Disease (IMDs).

- **Advance Whole-Person Care**: The state will continue the Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) programs, which offer enhanced benefits to eligible individuals not currently receiving Medicaid-funded LTSS and those at risk of needing LTSS in the future. The initiative also includes innovative LTSS programs like extending presumptive eligibility to those applying for LTSS services.

- **Accelerate Innovation in Care Delivery and Payment**: The project is committed to promoting programs and policies that address the HRSN of Apple Health enrollees. By continuing the Foundational Community Supports (FCS) and introducing targeted HRSN services, Washington aims to develop a comprehensive suite of HRSN services. This approach enhances community-based care coordination, service delivery, and payment models.

Over the next five years, Washington will extend existing programs:

- Medicaid Alternative Care (MAC) & Tailored Supports for Older Adults (TSOA)
- Foundational Community Supports (FCS)
- Services for enrollees with SUD, including those who are short-term residents in residential and inpatient treatment facilities that meet the definition of an IMD
- Services for enrollees with Serious Mental Illness (SMI) and children and adolescents with serious emotional disturbances (SED), including those who are who are short-term residents in IMDs
- Accountable Communities of Health (ACHs) and Indian Health Care Providers (ICHPs) transition to hub service

Washington will also introduce several new initiatives:

- Continuous Medicaid and S-CHIP enrollment for children ages 0-5
- Continuous eligibility up to 12 months after pregnancy to postpartum individuals who were not enrolled in Medicaid or the Children's Health Insurance Program (CHIP) while pregnant (previously state-funded since June 2022)
- Re-entry coverage for individuals leaving a prison, jail, or youth correctional facility
- Long-term Supports and Services Presumptive eligibility (LTSS PE) to support timely access to in-home and community-based long-term services and supports
- Contingency management (CM) for SUD treatment
- HRSN services to address unmet social needs, like housing and nutrition, to improve health outcomes and reduce health disparities
- Community Hubs to provide community-based care coordination, including screening patients, determining patient needs, and connecting patients to community organizations that can provide services to meet HRSN
- A statewide Native Hub of Indian health care providers, tribal social service divisions, and Native-led, Native-serving organizations focused on whole-person care coordination, including services to meet HRSN

MTP 2.0 represents a comprehensive effort to enhance Medicaid services in Washington, building on the achievements of MTP 1.0 and introducing new initiatives to address emerging needs and challenges. It aims to promote better health outcomes, particularly for vulnerable populations, by integrating medical and social services, thereby advancing the overall goals of the Medicaid program.

Section 2: Evaluation Goals and Objectives

Evaluation activities will be led by an independent external evaluator (IEE) and supported by state agency teams with complementary data management and analytic subject matter expertise. The evaluation will encompass both an assessment of the impact of the Demonstration on the entire delivery system and an evaluation of specific initiatives. Evaluation goals will include:

Assessment of overall Medicaid system performance under the Demonstration. This assessment will be based on longitudinal changes in statewide performance levels from January 1, 2017, through June 30, 2028, spanning MTP 1.0 and MTP 2.0. The evaluation will assess changes in MTP 2.0 relative to an MTP 1.0 baseline. The assessment will include the following measurement domains:

- Access to primary care, behavioral health care, and other preventive health care services
- Quality of care
- Reduction in use of costly emergency department (ED), inpatient, or institutional care
- Social outcomes, including housing stability and employment, were measured using beneficiary-level administrative data drawn from Washington's rich integrated data environment (described further below)
- Overall Medicaid expenditures on a per beneficiary per month basis

Measurement of program-level impacts. MTP 2.0 includes twelve programs (four program extensions and eight new initiatives). Outcomes will be assessed for each program. Evaluations will leverage Washington's nation-leading integrated data environment to provide a rich set of outcomes, national Medicaid claims data, and qualitative data and analysis. The sections below provide general background information for each program, evaluation questions and hypotheses, methodology, and considerations of limitations and alternative approaches.

Quarterly briefings, project implementation support (formative evaluation). The IEE will provide quarterly presentations to facilitate discussion with Washington Health Care Authority (HCA) staff and other agencies involved in implementing the Demonstration. These presentations will facilitate an exchange of ideas, progress, and opportunities for productive change. This information will be instrumental in the early phases of project implementation, helping identify and address risks or opportunities to enhance project execution. Later briefings will contribute to a more comprehensive analysis of project impacts and outcomes. These exchanges will serve as a formative evaluation of the establishment and initial stages of Demonstration-funded programs.

The statewide assessment. Statewide assessment of overall Medicaid system performance will focus on determining the impact of MTP 2.0 on the trends observed before its initiation in several key areas: access to care, care quality, health and social outcomes, and Medicaid cost metrics. The assessment will compare changes during MTP 2.0 performance metrics at the state level against MTP 1.0 benchmarks across various measurement areas outlined earlier. Because the COVID-19 Public Health Emergency (PHE) occurred during MTP 1.0, the evaluation will consider multiple benchmarks when assessing MTP 2.0, including 2017-2019 (pre-PHE), 2020-2022 (PHE), and 2023, a year in the most acute effects of the pandemic had subsided, and many of the MTP 2.0 initiatives had not yet been implemented.

While individual program evaluations target specific populations, the statewide analysis will encompass a wider Medicaid population, capturing the collective effect of all MTP 2.0-related activities. The statewide impact assessment will also concentrate on higher-risk groups anticipated to benefit

substantially from the demonstration. These populations include, but are not limited to, individuals with SMI or concurrent disorders, those with multiple chronic conditions, those requiring LTSS, residents of underserved regions, and enrollees from BIPOC (Black, Indigenous, People of Color) groups.

Section 3. Overview of Major Evaluation Components and Activities

A mixed methods approach combines the strengths of both qualitative and quantitative research, providing a comprehensive analysis framework. Quantitative research offers statistical rigor and generalizability, allowing for the measurement of trends and patterns across large populations; in contrast, qualitative research provides depth and context, uncovering the underlying reasons, opinions, and motivations behind those trends. By integrating these methods, a mixed methods approach ensures a more holistic understanding of complex issues, capturing the measurable outcomes and the nuanced human experiences and perceptions that drive them.

Qualitative analysis. Evaluation activities will include qualitative analysis of program implementation and operations to support both formative evaluation deliverables and quantitative analysis of program impacts. Qualitative analysis will address program implementation questions such as how programs are designed, what components facilitate success and what barriers impede progress, how state agencies can better support providers and organizations to improve care for the Medicaid population, and what types of regulations, policies, or programmatic changes should be prioritized to achieve the goals of MTP 2.0.

The design and execution of qualitative methods supporting the evaluation will be the lead responsibility of the IEE. Their duties will encompass establishing the number of qualitative interviews, selecting appropriate populations or sample frames for participant recruitment, scheduling the timing of focus groups, interviews, and surveys, tailoring data collection tools to align with specific research questions and hypotheses, and crafting these data collection tools. The qualitative analysis will likely involve participants such as beneficiaries, providers, managed care organization (MCO) staff, and state agency employees. Individual Accountable Communities of Health (ACH) projects are anticipated to categorize different groups for qualitative analysis sampling, aiming for inclusive representation from both the targeted beneficiaries and providers.

Quantitative analyses leveraging integrated administrative data.

The evaluation will leverage the integrated administrative data maintained in the Department of Social and Health Services Integrated Client Databases (ICDB) to support quantitative evaluation activities. For more information on the ICDB, see https://www.dshs.wa.gov/ffa/rda/research-reports/dshs-integrated-client-databases).

The ICDB was explicitly designed to support the evaluation of health and social service interventions in Washington State, and has been widely used in evaluation studies published in peer-reviewed journals.[1]

The ICDB contains more than 20 years of individual-level, massively dimensional data for nearly 6 million persons residing in Washington State over that time span. It contains data from approximately 20 administrative data systems, including the State's ProviderOne Medicaid Management Information System (MMIS data system and all other data sources necessary to implement the quantitative evaluation design described in this document, except in a few areas discussed below where new data collection may be required.

More specifically, the ICDB contains:

- Service event level utilization data across all Medicaid funded delivery systems (physical, mental health, substance use disorder, long-term services and support, and developmental disability services);

- Expenditure data at the service event and per-member per-month level of aggregation by major service modality, for all Medicaid beneficiaries over the time period relevant to this evaluation (with a few caveats related to issues like the methods for applying pharmacy rebates);
- Risk factors associated with chronic and acute disease conditions, including mental illness and substance use disorders, derived from the CDPS and Medicaid-Rx risk models and related tools; (For more information about the CDPS and Medicaid-Rx, visit http://cdps.ucsd.edu/).
- Assessment data on functional support needs, cognitive impairment, and behavioral challenges for persons receiving LTSS services;
- Data on "social outcomes" including arrests, employment and earnings, and homelessness and housing stability;
- Client demographics (age, gender, race/ethnicity);
- Medicaid enrollment by detailed coverage category;
- MCO enrollment or fee-for-service Medicaid coverage status;
- Medicare Parts A, B, and D integration for persons dually enrolled in Medicaid and Medicare; and
- Geographic residential location spans which are critical to regional attribution models.

The ICDB is updated on a quarterly basis. The ICDB analytical data infrastructure is complemented by a suite of Healthcare Effectiveness Data and Information Set (HEDIS) and related metric measurement algorithms that currently regularly produce a suite of health care and social service-related metrics on at least a semi-annual basis for all Medicaid beneficiaries in Washington State meeting measure specification requirements. Furthermore, the state agency teams maintaining the ICDB have deep expertise in identity management processes that may be necessary to link new ad hoc data sources if required.

Among the advantages to leveraging the State's nation-leading integrated analytical data environment is the elimination of dependencies on external entities for data collection and measurement, which otherwise would likely result in variation across projects in data integrity and measurement quality. We also note that the State's analytical environment can readily absorb new and changing measurement concepts, and apply those concepts retroactively for all relevant history to maintain consistent time series for analysis. As programs continue to be developed and implemented, we will determine what metrics will be most appropriate to evaluate the different components of MTP 2.0. In general, evaluation metrics will be selected based on a combination of factors including:

- Availability of stewarded metric specifications (preference will be given to HEDIS stewarded metrics and metrics in the Washington State Common Measure Set);
- Feasibility of implementation of metric specifics in the State's analytical data environment;
- Program and policy staff recommendations around key program outcomes; and
- CMS requirements for evaluation metrics.

We anticipate primarily using HEDIS stewarded metrics and supplementing with CMS stewarded metrics, such as those in program monitoring protocols, and State stewarded metrics. (For more information about state-stewarded metrics, please see the Cross-System Outcomes Measures for Adults Enrolled in Medicaid at https://www.dshs.wa.gov/ffa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid).

Quantitative analyses leveraging national Medicaid claims data. For selected programs, the evaluation will use the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) dataset for 2016-2026. TAF is a successor to the Medicaid Analytic eXtract (MAX) files. The TAF data are more

comprehensive than MAX in population (e.g., including all managed care enrollees) and content (detailed enrollee and program enrollment information). The TAF data include demographics and eligibility information, inpatient claims, pharmacy claims, and other claims (e.g., primary care physician, laboratory services). The independent external evaluator currently has TAF files from 2017-2020 in-house; data from 2026 are anticipated to be available in November 2028, allowing for analyses through the first 3.5 years of the demonstration. As feasible, we plan to include TAF analysis for a subset of outcome metrics in the summative report.

Evaluation Deliverables.
The evaluation of the Demonstration will meet the following timeframes and deliverables.

Table 3.1. Evaluation Timeline and Milestones

Deliverable	Responsible Party	Date
Draft Evaluation Design	State	January 26, 2024
- Comments from CMS	CMS	60 days from receipt
- Final evaluation design	State	60 days from receipt
Institutional Review Board updates obtained	State	Q2 2025- Q4 2025
Quarterly briefings from the independent external evaluator to highlight key findings from quarterly activities, data analysis, reflections and insight on the implementation of projects drawing on key informant interviews, document review, meetings attended, and activity review**.**	IEE	Beginning March 2025
Specification for data required from state including a timeline, data gap analysis, and plan to address data gaps	IEE	As applicable, starting Q2 2025
Production and validation of baseline measures (statewide and by specific populations as delineated in the project plan)	IEE	Q2 2025– Q2 2028
Quarterly, semi-annual, and annual metric updates (depending on metric frequency)	State	As applicable starting Q2 2025
State progress reports will include information on submittals from IE and progress of evaluation.	State	Include in Quarterly and Annual reports
Conduct and Analyze Qualitative Interviews (key informant interviews for 11 MTP 2.0 projects; additional beneficiary interviews for 5 MTP 2.0 projects)		Q2 2025 – Q3 2028
Draft Serious Mental Illness and Substance Use Disorder Midpoint Assessment (SUD and SMI MPA)	State	August 28, 2026
- CMS comments	CMS	60 days from receipt
- Final SMI MPA	State	60 days from receipt of CMS comments

(continued)**Table 3.1. Evaluation Timeline and Deliverables (continued)**

Draft Interim Evaluation Report	State	June 30, 2027
- CMS comments	CMS	60 days from receipt

- Final Interim Evaluation Report	State	60 days from receipt of CMS comments
Draft Reentry Midpoint Assessment	State	July 31, 2028
- CMS comments	CMS	60 days from receipt
- Final Interim Evaluation Report	State	60 days from receipt of CMS comments
Draft Summative Evaluation Report	State	December 30, 2029
- CMS comments	CMS	60 days from receipt
- Final Summative Evaluation Report	State	60 days from receipt of CMS comments

Section 4: Statewide Assessment

General Background Information

In addition to assessments of individual waiver demonstration initiatives described in other sections of this proposal, the evaluation will assess the performance of Washington State's Medicaid system during MTP 2.0. Following the approach used in the evaluation of MTP 1.0, we will measure performance with metrics categorized across 11 domains. Our evaluation of MTP 1.0 included data from 2017; we will measure outcomes through 2028 in the proposed evaluation.

This long time series allows the advantage of a rich longitudinal assessment of changes across a variety of populations and measures. They will also allow for the assessment across different transition periods, including observations prior to the COVID-19 PHE (2017-2019), COVID-19 PHE period (2020-2022), the transition into MTP 2.0 (July 2023), and the initiation of various components of MTP 2.0, with some components introduced in a staggered fashion in 2023 and beyond.

In addition to this long time series, we will supplement these data by comparing changes in Washington to similar measures nationally or among a select cohort (e.g., states drawn from the West Coast), leveraging the national TAF data. The comparison of Washington to national averages or a selected cohort of states will provide novel information to Washington's Medicaid administrators. This information could include a greater understanding of where Washington stands relative to the national average at a given point in time or whether changes (improvements or reductions in quality; narrowing or widening of disparities) observed in Washington are unique to the state or also observed in peer states.

The statewide assessment is not predicated on any specific hypotheses or research questions. Instead, it is an opportunity for the evaluator to provide feedback to the state on the overall trajectory of its Medicaid program.

Methodology

Evaluation Design. This quantitative analysis will assess statewide changes between 2017 and 2028, using a combination of visual trends, analyses by subgroups, and comparisons of changes occurring throughout MTP 2.0 to a 2023 baseline year.

Medicaid population and subgroups. We will assess changes across the following subgroups.

Table 4.1. Subgroups

Health condition	Chronic condition	People diagnosed with at least one chronic physical health condition, such as asthma or diabetes, from a list of chronic conditions
	Serious mental illness (SMI)	People diagnosed with at least one mental health condition, such as schizophrenia or bipolar disorder, from a list of chronic conditions
Geography of residence	Rural	People who resided in zip codes with a population center of less than 49,000
	High poverty	People who resided in zip codes where the median income was in the bottom fifth of Washington state's income distribution
Race and ethnicity[1]	American Indian/Alaska Native[2] Asian Black Hawaiian or pacific islander Hispanic White	Race and ethnicity groups from Medicaid enrollment records

Evaluation Period. We propose to analyze data for July 1, 2017, through June 30, 2028, assuming that claims data for FY 2028 are available on January 1, 2029.

Evaluation Measures. We propose to use the following list of outcome measures, noting that the list below is tentative pending additional information about program implementation, parameters and availability of additional measures.

[1] The statewide assessment will provide additional consideration and information to contextualize the evaluation findings to reflect the impact that institutional racism had and continues to have on health outcomes.

[2] We acknowledge that there is an inherently political aspect to identification as American Indian/Alaska Native. Institutional and historical disparities and the lack of knowledge of the sovereign immunity of Tribal Nations in Washington create additional complexities in access to care and health care outcomes for those living in Indian Country.

Table 4.2. Evaluation Measures

Domain	Measure name	HEDIS Measure Identifier
Social determinants of health	Homelessness	
	Employment	
	Criminal Justice Involvement	
Prevention and Screening	Childhood Immunization Status	CIS
	Immunizations for Adolescents	IMA
	Lead Screening in Children	LSC
	Cervical Cancer Screening	CCS
	Chlamydia Screening in Women	CHL
	Care for Older Adults	COA
	Oral Evaluation, Dental Services	OED
	Topical Fluoride for Children	TFC
Respiratory Conditions	Appropriate Testing for Pharyngitis	CWP
	Pharmacotherapy Management of COPD Exacerbation	PCE
	Asthma Medication Ratio	AMR
Cardiovascular Conditions	Controlling High Blood Pressure	CBP
	Persistence of Beta-Blocker Treatment After a Heart Attack	PBH
	Statin Therapy for Patients With Cardiovascular Disease	SPC
	Cardiac Rehabilitation	CRE
Diabetes	Glycemic Status Assessment for Patients With Diabetes	GSD
	Blood Pressure Control for Patients With Diabetes	BPD
	Eye Exam for Patients With Diabetes	EED
	Kidney Health Evaluation for Patients With Diabetes	KED
	Statin Therapy for Patients With Diabetes	SPD

(continued)

Table 4.2. Evaluation Measures (continued)

Domain	Measure name	Measure Identifier
Behavioral Health	Diagnosed Mental Health Disorders	DMH
	Follow-Up After Hospitalization for Mental Illness	FUH
	Follow-Up After Emergency Department Visit for Mental Illness	FUM
	Diagnosed Substance Use Disorders	DSU
	Follow-Up After High-Intensity Care for Substance Use Disorder	FUI
	Follow-Up After Emergency Department Visit for Substance Use	FUA
	Pharmacotherapy for Opioid Use Disorder	POD
	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD
	Diabetes Monitoring for People With Diabetes and Schizophrenia	SMD
	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	SMC
	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	SAA
Care Coordination	Advance Care Planning	ACP
	Transitions of Care	TRC
	Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions	FMC
Overuse/Appropriateness	Non-Recommended PSA-Based Screening in Older Men	PSA
	Appropriate Treatment for Upper Respiratory Infection	URI
	Use of Imaging Studies for Low Back Pain	LBP
	Potentially Harmful Drug-Disease Interactions in Older Adults	DDE
	Use of High-Risk Medications in Older Adults	DAE
	Deprescribing of Benzodiazepines in Older Adults	DBO
	Use of Opioids at High Dosage	HDO
	Use of Opioids From Multiple Providers	UOP
	Risk of Continued Opioid Use	COU

(continued)

Table 4.2. Evaluation Measures (continued)

Domain	Measure name	Measure Identifier
Access/Availability of Care	Adults Access to Preventive/Ambulatory Health Services	AAP
	Initiation and Engagement of Substance Use Disorder Treatment	IET
	Prenatal and Postpartum Care	PPC
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	APP
Utilization and Risk Adjusted Utilization	Well-Child Visits in the First 30 Months of Life	W30
	Child and Adolescent Well-Care Visits	WCV
	Antibiotic Utilization for Respiratory Conditions	AXR
	Plan All-Cause Readmissions	PCR
	Hospitalization Following Discharge From a Skilled Nursing Facility	HFS
	Acute Hospital Utilization	AHU
	Emergency Department Utilization	EDU
	Hospitalization for Potentially Preventable Complications	HPC
Cost	Total healthcare expenditures	

Data Sources. We will use the ICDB, supplemented by TAF data as feasible.

Analytic Methods.
We will display these changes visually and provide quantitative measures for changes between a baseline year, which we designate as 2023, and the evaluation year. For the interim report (due June 2027), we will assess changes through June 2026. For the summative report, we will assess changes through December 2028. In addition to these longitudinal changes, we will also provide a comparison to national trends for selected outcomes using TAF data, recognizing that these data may have a lag that is one to three years behind the Medicaid data provided directly by Washington. The goal of these analyses would be to allow for a comparison of Washington's performance – using TAF data – to selected states, over a shorter time period. These TAF analyses would be complementary to analyses of ICDB data, which allow for a longer time period covering more recent years.

Quarterly Briefings

The IEE will conduct quarterly briefings with staff from HCA and DSHS, providing a valuable platform to present and discuss key findings derived from the quarterly evaluation activities. These briefings will help provide transparency and accountability and offer insights into the progress and challenges of implementing various projects. By drawing on diverse sources such as key informant interviews, comprehensive document reviews, and ongoing quantitative analyses, these briefings will ensure a holistic understanding of the ongoing work. The real-time exchange of information during these sessions will foster a collaborative environment and enable immediate feedback and constructive dialogue. This approach will facilitate informed decision-making and strategic planning, enhancing the effectiveness of

the waiver demonstration. Furthermore, these briefings will contribute significantly to the continuous improvement of practices and policies, ultimately benefiting the state of Washington through informed and responsive governance. We anticipate that the format of these briefings, which emphasizes interaction and live exchange, will allow for the immediate clarification of queries, the sharing of novel findings or concerning data anomalies, and the opportunity to align evaluation efforts with the state's evolving needs and priorities.

Section 5: Foundational and Community Supports

General Background Information

This initiative continues and expands the foundational community supports (FCS) program. The FCS program provides supportive housing and employment services to Medicaid recipients with complex healthcare needs. It includes Community Support Services (CSS, also referred to as supportive housing) and Individual Placement and Support (IPS, also called supported employment). CSS includes the following services: housing assessment and planning, outreach to and relationship management with landlords, assisting with housing applications, and education training and coaching for securing housing. CSS does not provide ongoing rental support. IPS includes the following services: employment assessment and planning, outreach to employers, assisting with job applications, education, training, and coaching for securing employment. At the end of 2021, the FCS program had just over 10,000 monthly enrollments in CSS and IPS services. Both programs focus on care coordination and linking enrollees to mental health and substance use treatment.

The waiver renewal includes the following changes to the FCS program:

1. Expand CSS eligibility criteria: lower minimum age from 18 to 16 years. Washington estimates that this change will lead to only a minor expansion of the eligible population by approximately one percentage point; however, it will align the eligibility criteria with other systems of care for adolescents and young adults ages 16-25.
2. Expand IPS eligibility criteria: include additional justice-involved risk factors. IPS eligibility is expanded to individuals exiting jail or prison or those on parole. Previously, these individuals were often not considered for FCS because eligibility is based on Medicaid records, and incarcerated individuals are currently not enrolled in Medicaid. The population affected by this change is large enough (about 7,700 individuals) to increase FCS enrollment moderately.
3. Provide one-time transition support to enrollees exiting behavioral health inpatient treatment facilities who were homeless the month before their admission. Support services include security deposits, first and last month's rent, and basic home goods. HCA estimates that approximately 2,700 individuals will be affected by this change. This expansion of benefits may reduce inpatient length of stay because discharge from behavioral health inpatient treatment facilities often requires proof of some residency.
4. Extend the eligibility of CSS service authorization from 6 to 12 months. This change aligns CSS services with a new law (the Apple Health and Homes Act, ESHB 1866), passed in 2022, that established a housing benefit, renewable in 12-month increments, for permanent housing units for CSS recipients.

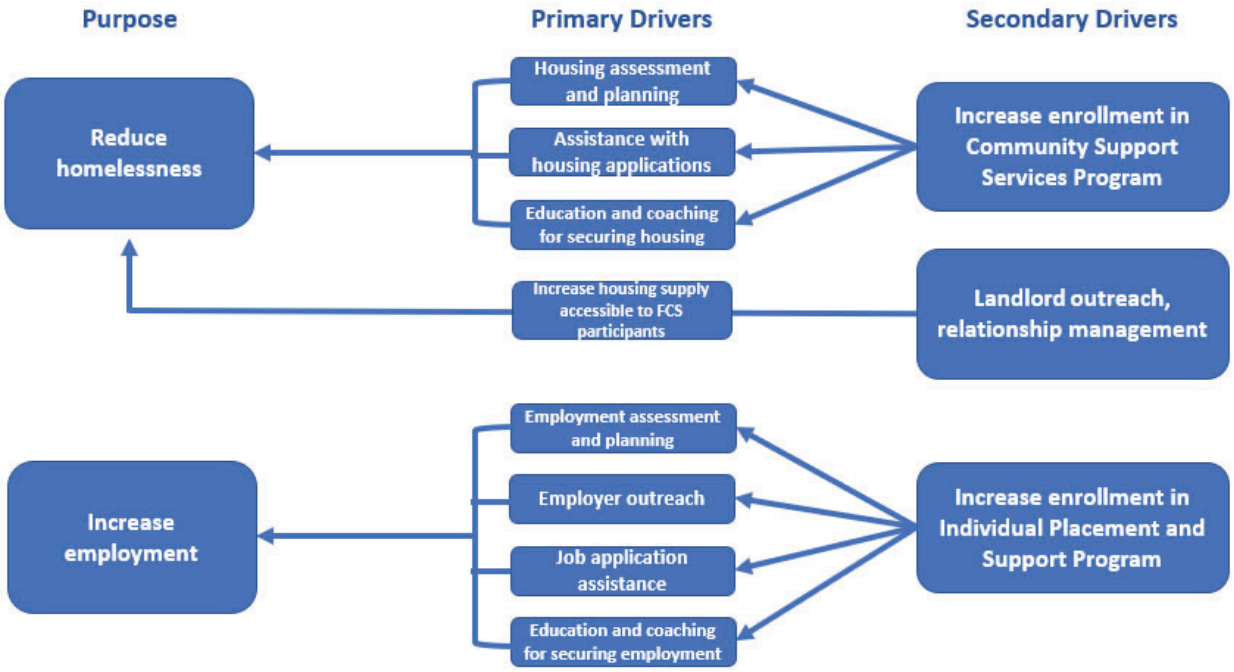
The FCS program will also coordinate a portion of the HRSN housing navigation services. Since May 2022, the state has supported a short-term rental subsidy that included first and last month's rent, with plans to include these services as part of the demonstration in mid-2024.

Evaluation Questions and Hypotheses

Driver Diagram. Exhibit 5.1 below depicts the relationship between the initiative's purpose to reduce homelessness and increase employment and the primary and secondary drivers that are necessary to achieve

this overall goal. Eight primary drivers contribute directly towards achieving the initiative's purpose, with three secondary drivers that are necessary to support the primary drivers.

Exhibit 5.1. Driver Diagram



Demonstration hypotheses associated with this initiative pertain to understanding whether the provision of FCS—supportive housing and supported employment—will improve health outcomes and reduce costs for a targeted subset of the Medicaid population. We consider the following questions and hypotheses.

H1. Participation in FCS is associated with improved social outcome metrics (reduced homelessness, increased employment, reduced risk of criminal justice involvement).
H2. Participation in FCS is associated with increased access to and engagement in treatment for mental illness and substance use disorders.
H3. Participation in FCS is associated with improvements in the quality of care for behavioral and physical health conditions.
H4. Participation in FCS is associated with reduced emergency department utilization and avoidable utilization of inpatient hospital services related to physical or behavioral health conditions.
H5. Participation in FCS is associated with reduced per-member per-month health care expenditures.

The Foundational Community Supports Program will be supported with the use of electronic health information exchange (e.g., providers' use [creation and transmission] of employment and housing assessment templates, and registration and use of the Clinical Data Repository [CDR]).

Qualitative data collection and analysis will answer the following evaluation questions:

I1. What was the experience of those providing FCS with the program?
I2. What was the experience of providing the new housing subsidy benefit?

I3. How has the service authorization extension (from six to 12 months) impacted the Foundational Community Supports (FCS) program?
I4. How do the components of the FCS program align with (or vary from) adopted evidence-based models of care (fidelity), and why? What role do the fidelity reviews, which occurred in MTP 1.0, play in learning and sharing best practices? How have these reviews changed, if they have?
I5. How does the FCS Program use HIT to support eligibility determinations and service delivery, and what factors emerged as barriers and facilitators to HIT use? How were challenges addressed?
I6. How is the FCS Program impacted by local investments in housing supports?

Methodology

Evaluation Design. We will use a mixed methods design in which quantitative analyses of claims data are informed and explained by qualitative interviews. The quantitative analyses will use a difference-in-differences approach, comparing outcomes for Medicaid beneficiaries receiving FCS to a propensity score-matched group of beneficiaries who do not receive FCS. Qualitative data will include collecting and analyzing any relevant revised or new program documents and conducting and analyzing semi-structured interviews with key program leaders and personnel implementing these programs.

Target and Comparison Populations. The target population of this component is Medicaid beneficiaries who receive FCS services. The comparison group will be derived by propensity score matching individuals who did not receive FCS services to the treatment population using the time before FCS enrollment. The matching approach aligns the timing of FCS enrollment across individuals. Our approach will follow the approach developed by the state of Washington as closely as possible, recognizing that we may not have the same information available to the state. As a sensitivity analysis, we will not use pre-intervention outcome measures in the matching algorithm due to regression to the mean concerns.

We will also consider the following stratifications:

- Stratification by program participation:
  - Those receiving CSS.
  - Those receiving IPS.
  - Those receiving both CSS and IPS.
- Stratification by the type of provider through which FCS was accessed:
  - Aging and Long-Term Support Administration (ALTSA)
  - HCA
- Subgroups. To the extent possible, we will consider conducting analyses for the following subgroups:
  - Geography of residence: Rural vs. Non-rural, with rural defined as residence in zip codes with a population center of less than 49,000
  - Race and ethnicity
  - Gender
  - Age

Evaluation Period. We propose to analyze data for July 1, 2023, through June 30, 2028, assuming that claims data for CY 2028 are available on January 1, 2029.

Evaluation Measures. We propose using the following evaluation measures.

Table 5.1. Evaluation Measures

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Goal: Link enrollees with housing and employment supports **FCS Hypothesis 1: Participation in FCS is associated with improved social outcome metrics (reduced homelessness, increased employment, reduced risk of criminal justice involvement).**				
FCS Research Question 1.1: How is participation in the FCS Program associated with social outcome metrics?	• Homelessness • Transition out of homelessness • Transition into homelessness • Employment • Criminal Justice Involvement	Eligible Medicaid enrollees	ICDB	Difference-in-Differences
Goal: Link enrollees with behavioral health services **FCS Hypothesis 2: Participation in FCS is associated with increased access to and engagement in treatment for mental illness and substance use disorders.**				
FCS Research Question 2.1: How is participation in the FCS Program associated with increased access to and engagement in treatment for mental illness and substance use disorders and improvements in the quality of care for behavioral and physical health conditions.	• Diagnosed Mental Health Disorders • Antidepressant Medication Management • Follow-Up After Hospitalization for Mental Illness • Follow-Up After Emergency Department Visit for Mental Illness • Diagnosed Substance Use Disorders • Follow-Up After High-Intensity Care for Substance Use Disorder • Follow-Up After Emergency Department Visit for Substance Use	Eligible Medicaid enrollees	ICDB	Difference-in-Differences

(continued)

Table 5.1. Evaluation Measures (continued)

Goal: Link enrollees with behavioral health services **FCS Hypothesis 3: Participation in FCS is associated with improvements in the quality of care for behavioral and physical health conditions.**				
FCS Research Question 3.1: How is participation in the FCS Program associated with improvements in care for people with chronic conditions?	• Controlling High Blood Pressure • Persistence of Beta-Blocker Treatment After a Heart Attack	Eligible Medicaid enrollees	ICDB	Difference-in-Differences

	• Statin Therapy for Patients With Cardiovascular Disease • Cardiac Rehabilitation • Glycemic Status Assessment for Patients With Diabetes • Blood Pressure Control for Patients With Diabetes • Eye Exam for Patients With Diabetes • Kidney Health Evaluation for Patients With Diabetes • Statin Therapy for Patients With Diabetes			
Goal: Encourage appropriate and efficient use of health services **FCS Hypothesis 4: Participation in FCS is associated with reduced emergency department utilization and avoidable utilization of inpatient hospital services related to physical or behavioral health conditions.**				
FCS Research Question 4.1: How is participation in the FCS Program associated with acute care measures of hospital and emergency department use?	• Plan All-Cause Readmissions • Hospitalization Following Discharge From a Skilled Nursing Facility • Acute Hospital Utilization • Hospitalization for Potentially Preventable Complications	Eligible Medicaid enrollees	ICDB	Difference-in-Differences
FCS Research Question 4.2: How is participation in the FCS Program associated with emergency department utilization?	• Emergency Department Utilization	Eligible Medicaid enrollees	ICDB	Difference-in-Differences

(continued)

Table 5.1. Evaluation Measures (continued)

Goal: Encourage appropriate and efficient use of health services **FCS Hypothesis 5: Participation in FCS is associated with reduced per-member per-month health care expenditures.**				
FCS Research Question 5.1: How is participation in the Foundational Community Supports Program associated with reduced per-member per-month health care expenditures?	• Total healthcare expenditures	Eligible Medicaid enrollees	ICDB	Difference-in-Differences

Table 5.2. Implementation Questions

Implementation questions assessed via qualitative analyses				
FCS Implementation Question 1: What was the experience of those providing FCS with the program?	- Identification of barriers and facilitators in FCS success - Description of how challenges were addressed	Service providers from Aging and Long-Term Support Administration, Health Care Authority, and Amerigroup	Key informants	Document review Qualitative analysis
FCS Implementation Question 2: What was the experience of those providing the new FCS housing benefit?	- Identification of barriers and facilitators to new FCS housing subsidy benefit - Description of how challenges were addressed - Description of how new benefit addressed challenges that emerged in MTP 1.0	Service providers from Aging and Long-Term Support Administration, Health Care Authority, and Amerigroup	Key informants	Document review Qualitative analysis
FCS Implementation Question 3: How has the service authorization extension (from six to 12 months) impacted the FCS program?	- Description of impact of new housing subsidy benefit on FCS program	Service providers from Aging and Long-Term Support Administration, Health Care Authority, and Amerigroup	Key informants	Document review Qualitative analysis
FCS Implementation Question 4: How do the components of the FCS program align with (or vary from) adopted evidence-based models of care (fidelity) and why?	- Role of fidelity reviews and other components of FCS	Service providers from Aging and Long-Term Support Administration, Health Care Authority, and Amerigroup	Key informants	Document review Qualitative analysis

(continued)

Table 5.2. Implementation Questions (continued)

FCS Implementation 5: How does the FCS Program use HIT to support eligibility determinations and service delivery?	- Identification of barriers and facilitators that apply to HIT	Service providers from Aging and Long-Term Support Administration, Health Care Authority, and Amerigroup	Key informants	Document review Qualitative analysis
FCS Implementation Question 6: How is the FCS Program impacted by local investments in housing supports?	- Identification of local investments in housing supports. - Description of impact on FCS program, including impact of change over time with greater Medicaid funding for housing supports	Service providers from Aging and Long-Term Support Administration, Health Care Authority, and Amerigroup	Key informants	Document review Qualitative analysis

We will also consider alternative homelessness measures:

- Transition into homelessness.
  - Definition: Percent of individuals who were with housing in the previous calendar quarter but without housing in the current quarter
- Transition out of homelessness.
  - Definition: Percent of individuals without housing in the previous calendar quarter but with housing in the current quarter.
  - Denominator: Individuals without housing in the previous calendar quarter
  - Numerator: Individuals without housing in the previous calendar quarter and with housing in the current calendar quarter

Note: we define these measures using the previous quarter for the denominator so that the last pre-enrollment quarter does not include changes due to FCS enrollment.

Data Sources. We will use the ICDB for these analyses. We will also coordinate with HCA to identify key informants for qualitative data collection.

Analytic Methods.

Quantitative approach

The unit of analysis is at the individual-quarter level. We use a difference-in-differences approach and define the pre-intervention period as the last two quarters before first FCS enrollment (also called the index quarter) and the post-intervention period as the third and fourth quarter following the index quarter. We will consider alternative specifications of the pre-intervention and post-intervention periods for our analysis to address outcome changes around FCS enrollment that might affect difference-in-differences estimates. The regression equation may be written as follows:

$$Y_{it} = \alpha Treat_i + \beta Post_t + \delta(Treat_i x Post_t) + \lambda X_{it} + \epsilon_{it},$$

Where Y_{it} is the outcome of interest, $Treat_i$ is an indicator equal to one if individual i is in the treatment group, $Post_t$ is an indicator equal to one for the post-intervention period, X_{it} are demographic characteristics, ϵ_{it} is the error term, and the parameter of interest is δ.

Special considerations

- We will monitor changes in enrollment that might be related to program changes (lower minimum age; inclusion of justice-involved risk factors; extended eligibility of CSS service authorization from 6 to 12 months).
- We will assess through interviews whether the Apple Health and Homes Act (ESHB 1866) makes obtaining housing easier for FCS beneficiaries. If possible, we will quantitatively assess the effects of this law as well (e.g., by stratifying before and after its implementation in 2022).
- We will continue to assess the effects of the COVID-19 PHE and the end of PHE, for instance, by stratifying our analysis by calendar year.
- When defining pre- and post-intervention periods for the matched control group, we will use the following process. For each FCS enrollee, we will identify comparison individuals by matching according to FCS participant characteristics at their time of enrollment. We will then assign the actual enrollment date of the matched FCS enrollee to their comparison individual, using that as a synthetic FCS enrollment date. The "pre-intervention period" will be defined as pre-enrollment date (actual for the treated group and synthetic for the comparison group), and the "post-intervention period" will be defined as observations after that enrollment date.

Additional design considerations

Some of the analyses identified above require examining a subset or stratification of the target population. When listing outcome variables, for concision, we have typically listed the target population as "eligible Medicaid beneficiaries," noting that in some cases, the eligible populations will change. For example, an outcome variable like "blood pressure control among patients with diabetes" is only relevant for patients with diabetes; statin therapy for patients with cardiovascular disease is only relevant for patients with cardiovascular disease. We will define these outcomes and subpopulations accordingly.

We also note that analyses of these subpopulations require assumptions that are similar to those of the larger subpopulations. For example, analyses that use the difference-in-differences approach rest on the assumption of parallel trends, and these assumptions extend to any analyses that focus on subsets or stratification.

The evaluation team has extensive experience in working with difference-in-difference models, including theoretical and empirical articles using difference-in-differences,[2–4,4–10] with several incorporating the most recent advances in sensitivity analyses and robustness checks.[2,4,11,12] For each analysis, we will assess the quality of the comparison group or the robustness of the assumptions. We note that, from a practical point of view, there are tradeoffs between (a) the number of outcomes that can be analyzed and (b) the extent to which the parallel trends assessment can be rigorously assessed and accounted for. Our evaluation will seek a balance in providing rigorous analyses and transparency in our assumptions in a manner commensurate with the number of outcomes and analyses conducted.

Where possible, we will implement sub-setting or stratification characteristics based on pre-intervention data. This will involve identifying relevant characteristics and ensuring they are measured prior to the implementation of the reform. By doing so, we aim to mitigate endogeneity concerns and enhance the validity of our analysis. In scenarios where defining sub-setting characteristics prior to the demonstration start is infeasible, we will explore the use of separate modeling approaches.

While we are committed to incorporating these methodologies, it is essential to retain some flexibility in our approach. The dynamic nature of Medicaid reforms and the variability in data availability

necessitates an adaptable research design. We will continuously assess the feasibility and appropriateness of these methods throughout the evaluation process. We will regularly review the implementation of these strategies and make adjustments as necessary. This iterative process will help ensure that our evaluation remains methodologically sound and aligned with the objectives of the reform.

Qualitative approach

A multi-disciplinary team with expertise in qualitative methods, primary care, practice improvement, and public health will conduct semi-structured interviews with program administrators or individuals with experience delivering technical assistance to service providers from ALTSA, HCA, and Amerigroup. Participants will be asked about their experiences providing technical assistance, the provider organizations they worked with, key program elements and changes, how these elements align with evidence, and their implementation successes and challenges. We will also conduct interviews with individuals from organizations that delivered FCS to learn about the clients they serve, their experiences with billing and providing supportive housing and employment, including the new housing subsidy benefit and extended service authorization period, fidelity across implementation organizations, and how they assessed the FCS program success. These organizations and the professionals we interview will be purposefully selected to maximize variation on characteristics such as type of support delivered, organization type, size, and location.

From our prior work on MTP 1.0, we already have a strong understanding of the specific individuals, departments, and organizations that were involved in FCS. We also learned that provider organizations' experiences varied by geography, size, provider type, and population served (e.g., medical organizations' experiences differed from community social service organizations), and we will sample based on those attributes. We anticipate interviewing approximately 3-5 state program administrators and representatives from Amerigroup and 20-25 individuals with experience delivering FCS. Sampling, data collection, and analysis will proceed iteratively; we will conduct a small number of interviews, analyze these data in a preliminary manner, and use the emerging findings to refine our interview guides and guide our sampling strategies to maximize learning. Our evaluation team will collaborate with HCA to identify contact information and a list of potential interviewees from HCA, ALTSA, and Amerigroup. We will work together to determine the best methods for identifying and recruiting organizations providing FCS.

Interviews will be conducted virtually using a video-conference format, preferably, and phone, if needed. Interviews will be audio-recorded with participant permission and generally last 45-60 minutes. Interviews will be professionally transcribed and reviewed for accuracy. All qualitative interviews will be de-identified and organized into Atlas.ti (Version 9, Atlas.ti Scientific Software Development GmbH, Berlin, Germany) for management and analysis. We will bring our knowledge from previous document reviews of FCS to this work. We will review any updated or new materials if available.

Data analysis will follow the five-step process outlined by Miller and Crabtree[13] in Table 5.3. We will analyze data in real-time so that emerging insights can inform subsequent data collection, as needed, and we can monitor when saturation is reached. Our team will listen to interviews and tag text in the transcript to code emerging themes. We will continue to analyze data in a group until we have developed a code book (list of codes with clear definitions) and there is consistency in how the team understands and applies these codes to the data. At this point, we will divide the remaining data, which will be analyzed independently and reviewed by a second analyst. We will continue to meet to discuss emerging findings, analytical questions, and coding differences.[13–15]

Table 5.3. Five-Phase Data Analysis Process

1. Describing: Listen to and analyze (immersion) each interview to identify overarching patterns and preliminary findings (crystallization). Integrate with findings from other data sources as relevant.
2. Organizing: Create a preliminary summary of results describing experiences, context, and factors that affect implementation (barriers and facilitators) as relevant. Conduct deeper, comparative analyses across the sample.
3. Connecting: Summarize and integrate findings with quantitative data; Create matrices (c.f., Miles and Huberman) to make comparisons and identify cross-cutting findings.
4. Corroborating/legitimating: We will seek additional data to confirm/disconfirm findings. Additional data/clarification will be sought from participants and others as needed.
5. Representing the account: We identify ways of sharing findings that are meaningful for target audiences.

Mixed methods analysis

The process described above will result in rich interpretive summaries and matrices that can be mixed with quantitative data. Quantitative data will identify the outcomes of the FCS program, and qualitative data will help inform that work and explain how the FCS program changed social outcome metrics (reduce houselessness, increase employment, reduce risk of criminal justice involvement) and why or why not, including the barriers and facilitators of implementing the program. Interviews will also focus on an assessment of the impacts of local investments in housing supports and the ways those may change with greater Medicaid funding for those services.

We will create a summary of qualitative and quantitative findings, and we will blend these in mixed methods summaries to identify how qualitative data explain the patterns emerging from the quantitative analyses. We will also develop these findings into a series of joint displays that we will use to refine and communicate these mixed methods findings. Mixed methods analyses will proceed in a series of meetings by the qualitative and quantitative teams. During meetings, we will review qualitative and quantitative findings, discuss possible emerging themes, and identify concordance or discordance of quantitative and qualitative findings. We will conduct additional follow-up analysis of non-concordant findings, if necessary.

Methodological Limitations.

The primary limitation of this approach is the extent to which selection into FCS is based on variables that are observable and incorporated into the propensity score match. Propensity score analysis, while useful, has notable limitations, primarily stemming from its reliance on the assumption that group differences are attributable to observable characteristics. This method presumes that all relevant variables influencing group assignment are measured and included, which may not always be true. Consequently, unobserved confounders - variables that affect treatment assignment and outcomes but are not included in the analysis - can lead to biased results. This limitation highlights the potential risk of drawing inaccurate conclusions, as the propensity score model might not fully account for all the factors driving the observed outcomes.

Section 6: Medicaid Alternative Care (MAC) & Tailored Supports for Older Adults (TSOA)

General Background Information

As population aging increases the need for long-term services and supports (LTSS), states are increasingly seeking strategies to meet the demand for Medicaid LTSS (e.g., in-home, assisted living facility, and nursing facility services) at manageable costs. Washington State implemented the Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) programs in September 2017 as part of MTP 1.0.

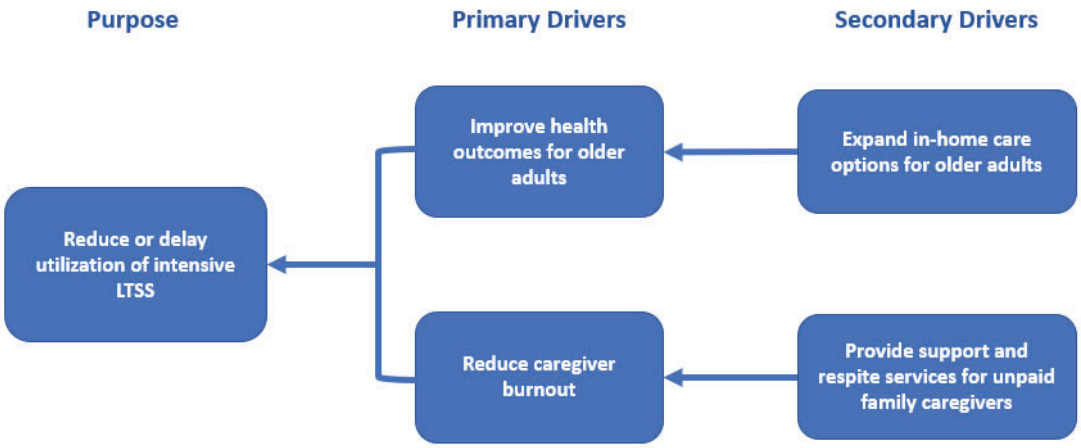
TSOA targets low-income older adults who are not yet enrolled in Medicaid, need help with activities of daily living, and are at risk of depleting financial assets to the point that they would become eligible for Medicaid. MAC also targets the same population but those who are enrolled in Medicaid. MAC and TSOA services are free and include limited hours of supportive care (e.g., personal care, home modification, meal delivery services, and household chores) for its participants and (where applicable) respite services for their informal caregivers. The goals of MAC and TSOA programs are decreasing caregiver distress and offering additional service options to delay or avoid the use of more intensive and costly Medicaid-paid LTSS.

Under MTP 2.0, Washington State will continue to offer both MAC and TSOA, with some minor changes to the eligibility criteria for these programs. These include an increase in income and resource limits for TSOA eligibility and four new services added to the MAC and TSOA benefits package: nurse delegation, pest eradication, specialized deep cleaning, and the community choice guide.

Evaluation Questions and Hypotheses

Driver Diagram. Exhibit 6.1 below depicts the relationship between the initiative's purpose to reduce or delay the utilization of intensive LTSS and the primary and secondary drivers that are necessary to achieve this overall goal. Two primary drivers contribute directly towards achieving the initiative's purpose, with two secondary drivers necessary to support the primary drivers.

Exhibit 6.1. Driver Diagram



Demonstration hypotheses associated with this initiative pertain to understanding whether the MAC and TSOA programs will improve health outcomes and reduce costs for a targeted subset of the Medicaid population. We hypothesize that participation in the MAC and TSOA programs will lead to:

- **H1.** Participation in the MAC and TSOA programs will be associated with decreases in hospitalizations, ED visits, and 30-day readmission rates.
- **H2.** Participation in the MAC and TSOA programs will be associated with reductions in mortality rates.
- **H3.** Participation in the MAC and TSOA programs will be associated with reductions in total healthcare expenditures.
- **H4.** Participation in the TSOA program will decrease the need for Medicaid enrollment.
- **H5.** Participation in the MAC and TSOA programs will be associated with decreases in the use of traditional LTSS, including home-based, community-based, and nursing-facility services.

Qualitative data collection and analysis will answer the following evaluation questions:

- **I1.** What are the factors that explain the effectiveness of the MAC and TSOA programs?
- **I2.** What are beneficiaries' experiences with MAC and TSOA benefits?

Contingent on funding, we will also conduct a beneficiary survey will be to describe the experiences, outcomes, and conditions/circumstances of caregivers and care receivers participating in the programs.

Methodology

Evaluation Design. We will use a mixed method design where quantitative analyses of claims data are informed and explained by qualitative interviews.

Target and Comparison Populations. In our analyses of MAC, the target populations include individuals who participated in MAC, and the comparison group includes a matched group of individuals at least 55 years old and enrolled in Medicaid who did not participate in MAC. In our analyses of TSOA, the target populations include individuals who participated in TSOA, and the comparison group includes a matched group of individuals at least 55 years old and enrolled in Medicare only (no Medicaid enrollment) who did not enroll in TSOA.

Evaluation Period. We propose to analyze data from July 1, 2023-June 30, 2028, assuming that claims data for CY 2028 will be available on January 1, 2029.

Evaluation Measures. We propose using the following evaluation measures.

Table 6.1. Evaluation Measures

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Goal: Reduce acute care use by providing additional service options at an earlier point for enrollees **MAC/TSOA Hypothesis 1: Participation in the MAC and TSOA programs will be associated with decreases in hospitalizations, ED visits, and 30-day readmission rates.**				
MAC/TSOA Research Question 1.1: How is participation in the MAC and TSOA programs associated with decreases in hospitalizations, emergency department (ED) visits, and 30-day readmission rates?	• Acute Hospital Use among Adults • Emergency (ED) Department Visit Rate • Plan All-Cause Readmissions	Eligible Medicaid enrollees	ICDB	Difference-in-Differences
Goal: Reduce mortality by providing additional service options at an earlier point for enrollees **MAC/TSOA Hypothesis 2: Participation in the MAC and TSOA programs will be associated with reductions in mortality rates.**				
MAC/TSOA Research Question 2.1: Is participation in the MAC and TSOA programs associated with reductions in mortality rates?	• Mortality rate	Eligible Medicaid enrollees	ICDB	Difference-in-Differences
Goal: Reduce health care expenditures by providing additional service options at an earlier point for enrollees **MAC/TSOA Hypothesis 3: Participation in the MAC and TSOA programs will be associated with reductions in total healthcare expenditures.**				
MAC/TSOA Research Question 3.1: How is participation in the MAC and TSOA programs will be associated with reductions in total healthcare expenditures?	• Total healthcare expenditures (both Medicaid and Medicare expenditures) • Total Medicaid expenditures • Total Medicare expenditures	Eligible Medicaid enrollees	ICDB	Difference-in-Differences
Goal: Reduce Medicaid enrollment by providing additional service options at an earlier point for enrollees **MAC/TSOA Hypothesis 4: Participation in the TSOA program will decrease the need for Medicaid enrollment.**				
MAC/TSOA Research Question 4.1: Is participation in the TSOA program associated with decreases in Medicaid enrollment?	• Enrollment in Medicaid	Eligible Medicaid enrollees	ICDB	Difference-in-Differences

Goal: Reduce the use of LTSS by providing additional service options at an earlier point for enrollees **MAC/TSOA Hypothesis 5: Participation in the MAC and TSOA programs will be associated with decreases in the use of traditional LTSS, including home-based, community-based, and nursing-facility services.**				
MAC/TSOA Research Question 5.1: How is participation in the MAC and TSOA programs associated with decreases in the use of traditional LTSS, including home-based, community-based, and nursing-facility services	• Use of Medicaid home-based services • Use of Medicaid community-based services • Use of Medicaid nursing facility services	Eligible Medicaid enrollees	ICDB	Difference-in-Differences

Table 6.2. Implementation Questions

Implementation questions assessed via qualitative analyses				
MAC/TSOA Implementation Question 1: What are the factors that explain the effectiveness of the MAC and TSOA programs?	- Identification of barriers and facilitators to implementing MAC and TSOA - Identification of factors that contribute to MAC and TSOA program success	Program administrators from the ALTSA, HCA and AAAs	Key informants	Document review Qualitative analysis
MAC/TSOA Implementation Question 2: What are beneficiaries' experiences with the MAC and TSOA programs?	- Understanding of MAC and TSOA process, challenges, and benefits for enrollees	Eligible MAC and TSOA enrollees	Interviews with enrollees	Qualitative analysis

Data Sources. We will use the ICDB for these analyses. We will also coordinate with HCA to identify key informants for qualitative data collection.

Analytic Methods.

Quantitative approach

We use the same analytic methods to evaluate MAC and TSOA.

We will create cohorts of treatment and comparison populations. The treatment group will consist of MAC or TSOA participants. We will use a matching method to identify a "comparison" group that looks similar to the target group in their demographics and other characteristics. More specifically, our matching will be:

- 1:5 matching without replacement
- Based on year, quarter, sex, state, county of residence, history of any mental health condition, history of any substance use condition, balance on the means of age and CDPS risk scores, functional and cognitive impairments, and other additional factors suggested by Washington State.

- Conducted using the R package `rsmatch` to implement risk-set matching, which is designed for time-varying observational studies.

Once we have produced matched samples, we will conduct our regression analysis. Our unit of observation will be person-quarter. We will conduct an event study design (i.e., a difference-in-differences approach used when the treatment occurs over time) to understand the association of MAC (or TSOA) participation with the aforementioned outcomes. We will compare outcomes for MAC (or TSOA) participants before and after their enrollment in MAC (or TSOA) to outcomes of a comparison group that did not enroll in MAC (or TSOA) during the same period. The pre-treatment period will be the last two quarters before MAC (or TSOA) enrollment (index quarter), and the post-treatment period will be the third and fourth quarters following the index quarter. The regression equation is written as follows:

$$Y_{it} = \alpha Treat_i + \beta Post_t + \delta(Treat_i \times Post_t) + \lambda X_{it} + \epsilon_{it},$$

where Y_{it} is the outcome of interest for individual *i* during quarter t, $Treat_i$ is an indicator equal to one if individual i is in the target (vs comparison) group, $Post_t$ is an indicator equal to one for the post-intervention period, X_{it} are demographic and other characteristics, ϵ_{it} is the error term, and the parameter of interest is δ.

<u>Special considerations</u>

- We will consider alternative specifications of the pre-intervention and post-intervention period to address outcome changes around MAC (TSOA) participation.
- We will monitor changes in MAC (or TSOA) participation that might be related to program changes, including changes in the amount of personal needs allowance for traditional LTSS users.
- The final evaluation will also account for the "WA Cares Fund" benefit. This benefit is scheduled to be implemented in July 2026 and will allow eligible individuals to access long-term care services and supports costing up to $36,500 (adjusted annually up to inflation) – covering services such as enabling family members to become paid caregivers, making homes accessible to stay independent longer, or getting temporary support and services after an accident.
- When defining pre- and post-intervention periods for the matched control group, we will use the following process. For each MAC or TSOA enrollee, we will identify comparison individuals by matching according to MAC or TSOA participant characteristics at their time of enrollment. We will then assign the actual enrollment date of the matched MAC or TSOA enrollee to their comparison individual, using that as a synthetic MAC or TSOA enrollment date. The "pre-intervention period" will be defined as pre-enrollment date (actual for the treated group and synthetic for the comparison group), and the "post-intervention period" will be defined as observations after that enrollment date.

<u>Additional design considerations</u>

Some of the analyses identified above require examining a subset or stratification of the target population. When listing outcome variables, for concision, we have typically listed the target population as "eligible Medicaid beneficiaries," noting that in some cases, the eligible populations will change. For example, an outcome variable like "blood pressure control among patients with diabetes" is only relevant for patients with diabetes; statin therapy for patients with cardiovascular disease is only relevant for patients with cardiovascular disease. We will define these outcomes and subpopulations accordingly.

We also note that analyses of these subpopulations require assumptions similar to those of the larger subpopulations. For example, analyses that use the difference-in-differences approach rest on the assumption of parallel trends, and these assumptions extend to any analyses that focus on subsets or stratification.

The evaluation team has extensive experience in working with difference-in-difference models, including theoretical and empirical articles using difference-in-differences,[2–4,4–10] with several incorporating the most recent advances in sensitivity analyses and robustness checks.[2,4,11,12] For each analysis, we will assess the quality of the comparison group or the robustness of the assumptions. We note that, from a practical point of view, there are tradeoffs between (a) the number of outcomes that can be analyzed and (b) the extent to which the parallel trends assessment can be rigorously assessed and accounted for. Our evaluation will seek a balance in providing rigorous analyses and transparency in our assumptions in a manner commensurate with the number of outcomes and analyses conducted.

Where possible, we will implement sub-setting or stratification characteristics based on pre-intervention data. This will involve identifying relevant characteristics and ensuring they are measured prior to the implementation of the reform. By doing so, we aim to mitigate endogeneity concerns and enhance the validity of our analysis. In scenarios where defining sub-setting characteristics prior to the demonstration start is infeasible, we will explore the use of separate modeling approaches.

While we are committed to incorporating these methodologies, it is essential to retain some flexibility in our approach. The dynamic nature of Medicaid reforms and the variability in data availability necessitates an adaptable research design. We will continuously assess the feasibility and appropriateness of these methods throughout the evaluation process. We will regularly review the implementation of these strategies and make adjustments as necessary. This iterative process will help ensure that our evaluation remains methodologically sound and aligned with the objectives of the reform.

Qualitative approach

To understand MAC and TSOA, we will collect relevant program documents and conduct interviews with the individuals who lead and administer these benefits, such as program administrators from ALTSA and HCA, as well as the Area Agencies on Aging (AAA) who coordinate and manage services for beneficiaries and their caregivers after the state determines eligibility. We will collect relevant documents about these programs and conduct 20-25 interviews with program leaders. These interviews will include questions about state and program leader experiences implementing these programs and assisting organizations in managing the services. Interviews will also seek to understand participants' experiences assisting beneficiaries and caregivers, working with partner organizations, the successes and challenges they encountered implementing the MAC and TSOA programs, and how they have addressed these challenges, if they have.

In addition, we will interview MAC and TSOA beneficiaries. TSOA and MAC provide free services to unpaid caregivers caring for family members. TSOA also supports individuals who do not have an unpaid caregiver. Preliminary findings from MTP 1.0 suggest that TSOA is used by more beneficiaries than the MAC program. For these reasons, we will recruit and conduct interviews with 10-15 TSOA beneficiaries, with variation on participation type (individuals with and without a caregiver), as well as region, with representation from across the thirteen AAAs in the State of Washington. For the MAC program, we will interview 8-10 beneficiaries, who also vary by AAA region.

When appropriate and possible, interviews will be conducted with the caregiver and the patient. Interviews will examine beneficiaries' experiences applying for and maintaining benefits, their experiences working with ALTSA, their local AAA, and their experiences receiving services (e.g., support groups and counseling, respite and personal care, medical equipment and supplies). Interviews will be 30 minutes in length. Patients (TSOA) or caregiver-patient dyads (MAC and TSOA) who participate in an interview will receive a $30 gift card as a "thank you." Our evaluation team will collaborate with HCA to identify contact information and a list of potential interviewees from ALTSA and the AAAs. We will work together to determine the best methods for identifying and recruiting beneficiaries and their caregivers.

Data collection and mixed methods analysis will be conducted using the same process described in Section 5.

MAC/TSOA Beneficiary Survey

Pending funding availability and contracting, survey data are expected to be collected by the survey unit of the DSHS Research and Data Analysis Division (RDA), with the independent external evaluator having primary responsibility for analyzing the collected data. DSHS-RDA will collaborate with the independent external evaluator and other program partners (such as DSHS-ALTSA who administers the programs) to design the surveys.

The primary purpose of the MAC/TSOA beneficiary survey will be to describe the experiences, outcomes, and conditions/circumstances of caregivers and care receivers participating in the programs. Survey instruments will be designed to complement the information available in administrative data, and collect additional key data and more in-depth information. Surveys can address questions beyond those involved in screening, establishing eligibility, and assessment.

Data to be collected with these surveys are expected to include:

- Opportunities and challenges encountered in program operations;
- Satisfaction with program participation;
- Care receiver quality of life;
- Values/preferences related to decision-making around these programs;
- Qualitative descriptions of caregiver and care receiver experiences, in their own words; and
- In-depth data regarding issues addressed in self-report data from assessments and related data (e.g., caregiver quality of life and LTSS placement intentions).

The study population for the surveys will be caregiver/care receiver dyads enrolled in MAC and TSOA, or TSOA individuals who have a completed care plan to receive first-time stage 3 services. All survey samples will be stratified by program.

Methodological Limitations

Our main data source – claims – lacks information about key quality domains, including measures of care satisfaction, care experience, and caregivers' experience. In addition, we will use a matching method to identify a "comparison" group that looks similar to the target group in their demographics and other characteristics. However, the identified comparison group may still differ in unobservable characteristics, particularly those that are correlated with MAC or TSOA program participation and dependent variables. If this were the case, our results would be biased. Further, we will estimate the effects of MAC and TSOA participation during the third and fourth post-enrollment quarters. Therefore,

we would not be able to observe the longer-term effects of MAC and TSOA participation. We will consider addressing this limitation by examining changes for a longer post-enrollment period, but such analysis would imply lower power due to a smaller sample size. Finally, we do not have access to administrative records of services delivered to people enrolled in MAC and TSOA programs, limiting our ability to assess services received and how they relate to outcome changes.

Section 7: SUD Assessment

General Background Information

This initiative continues the SUD waiver, which became effective on July 17, 2018. The SUD waiver was an amendment to the Section 1115 MTP waiver. It authorized Washington to receive federal financial participation (FFP) for the provision of all Medicaid state plan services, including SUD treatment services provided in residential and inpatient treatment facilities that meet the definition of an IMD for an average of 30 days.

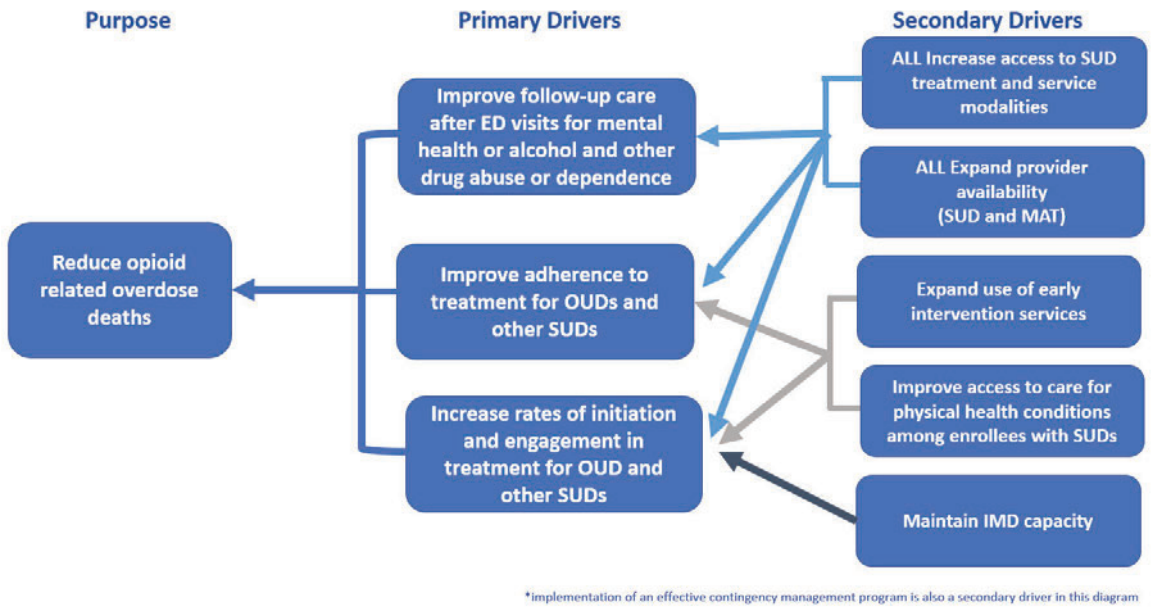
Beyond removing the IMD exclusion, the SUD waiver includes other provisions to improve care, including the following milestones:

1. Access to critical levels of care for Opioid Use Disorder (OUD) and other SUDs: coverage of OUD / SUD treatment services across a comprehensive continuum of care.
2. Use of evidence-based SUD-specific patient placement criteria: establishment of a requirement that providers assess treatment needs based on SUD-specific assessment tools (e.g., American Society of Addiction Medicine criteria or other comparable assessment and placement tools).
3. Patient placement: establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that interventions are appropriate for the diagnosis and level of care.
4. Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities.
5. Standards of care: establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards.
6. Standards of care: establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.
7. Sufficient provider capacity at each level of care, including medication-assisted treatment for SUD / OUD.
8. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and SUD / OUD.
9. Improved care coordination and transitions between levels of care.
10. SUD health information technology plan: implementation of a substance use disorder health information technology plan that describes the technology to support the aims of the demonstration.

Evaluation Questions and Hypotheses

Driver Diagram. Exhibit 7.1 below depicts the relationship between the initiative's purpose to reduce opioid-related overdoses and the primary and secondary drivers that are necessary to achieve this overall goal. Three primary drivers contribute directly towards achieving the initiative's purpose, with five secondary drivers that are necessary to support the primary drivers.

Exhibit 7.1. Driver Diagram



Demonstration hypotheses associated with this initiative pertain to understanding whether the SUD waiver will improve health outcomes and reduce costs for a targeted subset of the Medicaid population. We consider the following questions and hypotheses.

This evaluation tests the hypothesis specified in Special Terms and Conditions (STC) 111. Broadly, we will test whether the SUD waiver will increase Medicaid beneficiary access to inpatient and residential SUD treatment services as part of an effort to provide the full continuum of treatment services and increase the likelihood that Medicaid beneficiaries receive SUD treatment in the setting most appropriate for their needs.

We will use administrative data to answer questions about the effect of expanded FFP for IMD services on measures of access, quality, health outcomes, and expenditures. We will focus on these key questions:

(1) Does the demonstration increase access to and utilization of SUD treatment services?
(2) Does the receipt of SUD services improve appropriate physical health care use?
(3) Are rates of opioid-related overdose deaths impacted by the demonstration?
(4) What was the impact on total expenditures and expenditures for SUD-related services?

We consider the following hypotheses:

H1. The SUD waiver will increase the number of providers of substance use treatment.
H2. The SUD waiver will increase the percentage of beneficiaries who adhere to treatment.
H3. The SUD waiver will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.
H4. The SUD waiver will increase the quality of care for people with SUD.
H5. The SUD waiver will reduce overdose deaths, particularly those due to opioid overdoses.
H6. The SUD waiver will be associated with changes in expenditures for services.

Qualitative data collection and analysis will answer the following evaluation questions:

I1. What was the experience of implementing the SUD waiver?
I2. What are the factors that explain the effectiveness of the SUD waiver?

From work on MTP 1.0, we know the establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site was a substantial change. Therefore, we will also interview SUD treatment providers, specifically residential treatment providers, about their experiences implementing the MOUD requirement.

Methodology

Evaluation Design.
We will use a mixed methods design where quantitative analyses of claims data are informed and explained by qualitative data (document review of waiver application, interviews). The quantitative analyses will use a difference-in-differences approach, using national Medicaid claims data to compare outcomes for enrollees in states that have not implemented an SUD waiver. These data will be supplemented with data from the state of Washington to track specific outcomes, including deaths and deaths attributable to opioid overdoses. Qualitative analysis will use an inductive approach.

Target and Comparison Populations. The target population includes Washington's Medicaid beneficiaries or measure-specific subpopulations and SUD providers. The comparison population includes Medicaid beneficiaries from states that have not yet implemented a SUD IMD waiver by the end of the evaluation period for outcomes that can be constructed using the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF).

Evaluation Period. We propose to analyze TAF data from January 1, 2016, through December 31, 2026, assuming that TAF claims data for CY 2026 are available in November 2028. This approach would allow for analyses of 4.5 years of data before the initiation of Washington's waiver (January 2016 through June 2020), 4 years of data of the SUD waiver that includes MTP 1.0 and the COVID-19 PHE (July 2020 through June 2023), and 3.5 years of data from the MTP 2.0 waiver (July 2023 through December 2026), creating a long time-series of data that includes outcomes from enrollees in Washington and enrollees from comparison states that do not enact SUD waivers.

Evaluation Measures.
We propose using the following evaluation measures. The following table shows proposed measures, metric type, reporting frequency, and whether they can be constructed in TAF data.

Table 7.1. Evaluation Measures

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Goal: Increase the number of providers offering substance use treatment **SUD Hypothesis 1: The SUD waiver will increase the number of providers of substance use treatment.**				
SUD Research Question 1.1: Is the SUD waiver associated with an increase in the number of providers of substance use treatment?	• The number of providers who billed Medicaid for a SUD service • The number of providers who billed Medicaid for MAT	Medicaid providers	ICDB or National Medicaid TAF data	Difference-in-Differences

(continued)

Table 7.1. Evaluation Measures (continued)

Goal: Increase adherence to SUD treatment **SUD Hypothesis 2: The SUD waiver will increase the percentage of beneficiaries who adhere to treatment of OUD and SUDs.**				
SUD Research Question 2.1: How is the SUD waiver associated with the percentage of beneficiaries who adhere to treatment of OUD and SUDs?	• 180 days of continuous pharmacotherapy treatment for OUD • SUD Treatment Rate • Number of Medicaid beneficiaries who used outpatient services for SUD • Number of Medicaid beneficiaries who used residential and/or inpatient services for SUD • Number of Medicaid beneficiaries who used withdrawal management services • Number of Medicaid beneficiaries who have a claim for medications for opioid use disorders	Eligible Medicaid enrollees	ICDB or National Medicaid TAF data	Difference-in-Differences
Goal: Reduce the use of acute services by providing better access to SUD treatment services **SUD Hypothesis 3: The SUD waiver will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.**				
SUD Research Question 3.1: How is the SUD waiver associated with changes in the rate of emergency department and inpatient visits within the beneficiary population for SUD?	• Emergency department visits for SUD • 30-day and 7-day follow-up for ED visits for mental health conditions • Follow-Up After Emergency Department Visit for Substance Use	Eligible Medicaid enrollees	ICDB or National Medicaid TAF data	Difference-in-Differences
Goal: Improve the quality of SUD services **SUD Hypothesis 4: The SUD waiver will increase the quality of care for SUD.**				
SUD Research Question 4.1: How is the SUD waiver associated with changes in the quality of care?	• Access to preventive/ambulatory health services for adult Medicaid beneficiaries with SUD • Continuity of Pharmacotherapy for Opioid Use Disorder • People with an Opioid Prescription at or above 50mg MED	Eligible Medicaid enrollees	ICDB or National Medicaid TAF data	Difference-in-Differences

(continued)

Table 7.1. Evaluation Measures (continued)

Goal: Reduce overdose deaths **SUD Hypothesis 5: The SUD waiver will reduce overdose deaths.**				
SUD Research Question 5.1: How is the SUD waiver associated with changes in overdose deaths, particularly those due to opioid overdoses?	• Overdose death rates	Eligible Medicaid enrollees	National Medicaid TAF data, supplemented with CDC WONDER data	Difference-in-Differences
Goal: Reduce expenditures by providing access to SUD treatment services **SUD Hypothesis 6: The SUD waiver will be associated with changes in expenditures for services**				
SUD Research Question 6.1: How is the SUD waiver associated with changes in expenditures for services?	• Expenditures for SUD services • Total healthcare expenditures	Eligible Medicaid enrollees	ICDB or National Medicaid TAF data	Difference-in-Differences

Table 7.2. Implementation Questions

Implementation questions assessed via qualitative analyses				
SUD Implementation Question 1: What was the experience of implementing the SUD waiver?	- Identification of barriers and facilitators to implementing SUD waiver - Description of how key challenges in IMC implementation were managed.	Providers; administrators at HCA and RDA; managers at managed care organizations	Key informants	Document review Qualitative analysis
SUD Implementation Question 2: What are the factors that explain the effectiveness of the SUD waiver?	- Description of how the SUD waiver impacts access to IMDs and access to and utilization of SUD treatment services, as well as coordination with outpatient services - Description of SUD treatment providers experience implementing the MOUD requirement	Providers; administrators at HCA and RDA; managers at managed care organizations	Key informants	Document review Qualitative analysis

Data Sources. The evaluation will use the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) dataset for 2016-2026. The independent external evaluator currently has TAF files from 2017-2020 in house and data from 2026 are anticipated to be available in November 2028. We plan to include TAF analysis for a subset of outcome metrics in the summative report. Data Sources. We will also coordinate with HCA to identify key informants for qualitative data collection.

Analytic Methods.

Quantitative approach

The primary analysis will use a difference-in-differences design (measures that allow the construction of a comparison group from other states).

The general regression approach will use the following specification:

$$y_{it} = \lambda WA_i + \beta_1 DMTP20_23 + \beta_2 DY8_t + \beta_3 DY9_t + \beta_4 DY10_t + \beta_5 DY11_t + \theta_1 MTP1_t \cdot WA_i + \theta_2 DY8_t \cdot WA_i + \theta_3 DY9 \cdot WA_i + \theta_4 DY10_t \cdot WA_i + \theta_5 DY11_t \cdot WA_i + \gamma X_{it} + \varepsilon_{it}$$

where y_{it} is the outcome measure, WA_i is an indicator variable for an individual residing in the state of Washington $MTP20_23_t$ is a binary variable equal to one that captures the SUD demonstration under MTP 1.0 (July 2020 through June 2023), DY8-10 are dummy variables representing the Demonstration Years 8, 9, and 10 (the first, second, and third years of the MTP 2.0 demonstration), DY11 captures the last six months of the Demonstration Year 11., X_{it} are covariates and ε_{it} is the error term. In this case, the period from January 2016 through June 2020 is the reference period, capturing activity before the SUD waiver was implemented. The coefficients of interest are $\theta_1$through θ_5, capturing the aggregated changes occurring during MTP 1.0 (which includes the COVID-19 PHE), and then year-specific changes occurring in the first 3.5 years of MTP 2.0, with the interaction terms (e.g., $DY8_t \cdot WA_i$) reflecting the difference-in-differences, netting out the secular changes occurring in non-waiver states.

Considerations for these regressions include:

- Functional form. The equation shows a linear regression specification. We will generally use this specification because of computational efficiency but will consider non-linear specifications (e.g., logistic regressions) in some instances (e.g., binary outcomes with low prevalence, such as the overdose death rate) and, in this case, translate coefficients into average marginal effects.
- Reporting of waiver effects. The above equation includes one estimate for each demonstration year. We will consider averaging some of these coefficients (e.g., the last two demonstration years) to simplify the presentation of the results. We will report the baseline prior to waiver implementation, levels during the (suitably chosen) post-intervention period, and the pre-post estimate.
- Death data are included in the TAF data, but their completion rates and accuracy are uncertain. If for example, a beneficiary disenrolled from Medicaid on May 31 and died of an overdose two days later, that death would not be captured. We will supplement our data with information from the Centers for Disease Control and Prevention (CDC) Wide-ranging Online Data for Epidemiologic Research (WONDER) database.

Differences-in-differences models require parallel trends, i.e., hypothetical changes in outcomes of individuals in Washington should be identical to changes in outcomes of individuals in comparison states if Washington had not implemented the waiver. While this assumption cannot be directly tested, we can assess whether there are parallel trends for the baseline period. We will consider trend adjustment if there is evidence of non-parallel trends. The independent external evaluator has extensive experience in working with difference-in-differences models and making adjustments when pre-policy trends are not parallel.[2,2–4]

<u>Additional design considerations</u>

Some of the analyses identified above require examining a subset or stratification of the target population. When listing outcome variables, for concision, we have typically listed the target population as “eligible Medicaid beneficiaries,” noting that in some cases, the eligible populations will change. For example, an outcome variable like “blood pressure control among patients with diabetes” is only relevant for patients with diabetes; statin therapy for patients with cardiovascular disease is only relevant for patients with cardiovascular disease. We will define these outcomes and subpopulations accordingly.

We also note that analyses of these subpopulations require assumptions that are similar to those of the larger subpopulations. For example, analyses that use the difference-in-differences approach rest on the assumption of parallel trends, and these assumptions extend to any analyses that focus on subsets or stratification.

The evaluation team has extensive experience in working with difference-in-difference models, including theoretical and empirical articles using difference-in-differences,[2–4,4–10] with several incorporating the most recent advances in sensitivity analyses and robustness checks.[2,4,11,12] For each analysis, we will assess the quality of the comparison group or the robustness of the assumptions. We note that, from a practical point of view, there are tradeoffs between (a) the number of outcomes that can be analyzed and (b) the extent to which the parallel trends assessment can be rigorously assessed and accounted for. Our evaluation will seek a balance in providing rigorous analyses and transparency in our assumptions in a manner commensurate with the number of outcomes and analyses conducted.

Where possible, we will implement sub-setting or stratification characteristics based on pre-intervention data. This will involve identifying relevant characteristics and ensuring they are measured prior to the implementation of the reform. By doing so, we aim to mitigate endogeneity concerns and enhance the validity of our analysis. In scenarios where defining sub-setting characteristics prior to the demonstration start is infeasible, we will explore the use of separate modeling approaches.

While we are committed to incorporating these methodologies, it is essential to retain some flexibility in our approach. The dynamic nature of Medicaid reforms and the variability in data availability necessitates an adaptable research design. We will continuously assess the feasibility and appropriateness of these methods throughout the evaluation process. We will regularly review the implementation of these strategies and make adjustments as necessary. This iterative process will help ensure that our evaluation remains methodologically sound and aligned with the objectives of the reform.

Qualitative approach

We will use the approach described in Section 5 to collect and analyze qualitative data. To understand the IMD waiver, we will review the waiver application and conduct semi-structured interviews with informants with experience-based knowledge of SUD treatment systems affected by the waiver. These informants will be selected to represent multiple sectors within the treatment delivery system, including provider organizations (emphasizing residential treatment), MCOs, and representatives from the HCA. Among provider organizations, the team will aim to maximize variation in geographic regions, provider size, and payer mix (predominantly Medicaid versus broad payer mix). We anticipate conducting approximately 15 interviews and will continue the process of iterative sampling, data collection, and analysis until saturation is reached.

Methodological Limitations.

One consideration is the data quality of TAF data**.** Data quality issues can negatively affect our analysis by introducing attenuation bias, affecting changes over time, or restricting our sample for the mixed methods analysis. We seek to address these concerns in our research design by focusing on outcome measures for which quality is likely high. We have also examined TAF data quality using a newly available data quality assessment. Still, we understand that data quality issues will be an important part of our analytic work. After obtaining TAF data, our team will examine potential data quality challenges in

a number of ways. First, we will draw from our experience working with Medicaid claims data to perform routine quality checks for all variables used in our analysis (e.g., outliers, missing or implausible values, drastic changes over time). Based on these quality checks, we will refine our exclusion criteria and develop sensitivity checks. Second, we will perform several regression checks. These might include using alternative functional forms, excluding potentially problematic covariates, or repeating regressions with subpopulations. Third, we will monitor TAF data quality briefs published regularly by CMS and TAF quality assessment. Our team has strong expertise in combining and harmonizing Medicaid claims from multiple states.

Section 8: SMI Assessment

General Background Information

This initiative continues and expands the Serious Mental Illness (SMI) waiver, which became effective on December 23, 2020. The waiver permits the allocation of federal matching funds to support short-term residential treatment services at an IMS for specific groups, with a maximum duration of 60 days and an average length of stay not exceeding 30 days. The waiver is applicable to two groups: (a) individuals who are currently covered under the state's Medicaid State Plan and (b) individuals qualified for TSOA. To be eligible for the latter, individuals must be 55 years or older, not already eligible for Categorically Needy or Alternative Benefit Plan Medicaid, meet the functional eligibility requirements for Home and Community-Based Services (HCBS) as outlined in the state plan or under section 1915(c), and have an income that does not exceed 300% of the supplemental security income rate as specified by section 1611(b)(1) of the Social Security Act.

Individuals facing a psychiatric crisis may require treatment in residential or inpatient settings. These environments provide crucial benefits such as ensuring safety, facilitating stabilization, and offering the chance to initiate or modify medication regimes. They also support the integration of multidisciplinary clinical teams and informal support networks. A nationwide issue, the scarcity of inpatient beds has resulted in an increase in ED visits for mental health issues. Often, patients with acute psychiatric conditions are held, or "boarded," in the ED, sometimes for periods ranging from 3 to 5 days, or in some cases, even longer. This boarding practice has led to significant operational challenges for hospitals and raised serious concerns about the safety and well-being of patients, along with the potential for adverse outcomes.

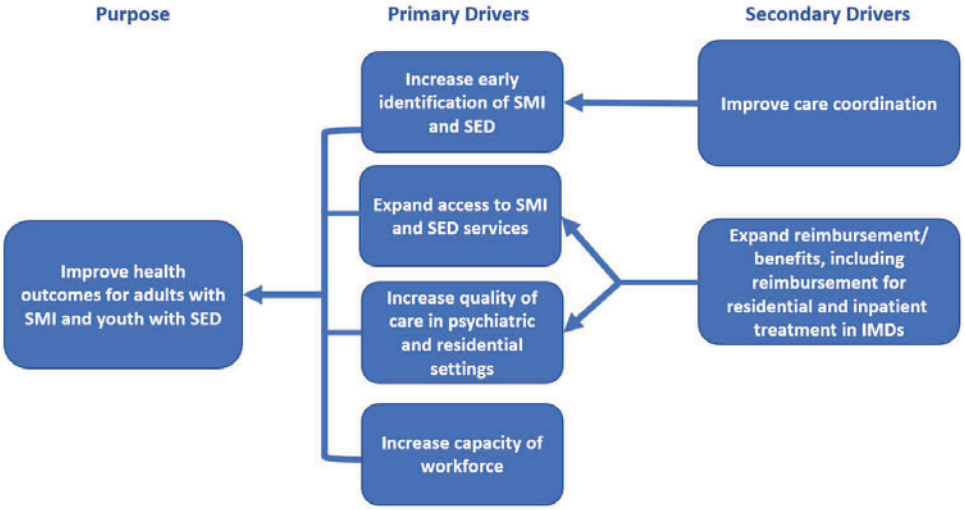
Beyond removing the IMD exclusion, the SMI waiver includes other provisions to improve care. For example, the SMI waiver included four milestones:

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

Evaluation Questions and Hypotheses

Driver Diagram. Exhibit 8.1 below depicts the relationship between the initiative's purpose to improve mental health outcomes and overall health for adults with SMI and youth with SED and the primary and secondary drivers necessary to achieve this overall goal. Three primary drivers contribute directly towards achieving the initiative's purpose, with three secondary drivers necessary to support the primary drivers.

Exhibit 8.1. Driver Diagram



Demonstration hypotheses associated with this initiative pertain to understanding whether the SMI waiver will improve health outcomes and reduce costs for adults with SMI and youth with SED. We consider the following questions and hypotheses.

We will test whether the SMI waiver will increase Medicaid beneficiaries' access to the full continuum of treatment services and increase the likelihood that Medicaid beneficiaries receive SMI treatment in the setting most appropriate for their needs. Specific hypotheses include the following:

- **H1.** The SMI/SED demonstrations will reduce utilization and length of stay in EDs among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment.
- **H2.** The SMI/SED demonstration will reduce preventable readmissions to acute care hospitals and residential settings following psychiatric hospitalization
- **H3.** The SMI/SED demonstration will improve the availability of crisis stabilization services
- **H4.** Access of beneficiaries with SMI/SED to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care, as measured through the increases in:
    - Primary care visits
    - Outpatient specialty mental health visits
- **H5.** The SMI/SED demonstration will impact health care spending.

Qualitative data collection and analysis will answer the following evaluation questions:

- **I1.** What are SMI/SED program leaders and administrators, as well as psychiatric hospital, residential, and crisis stabilization program leaders' and administrators' experiences with the SMI/SED waiver implementation, including barriers and facilitators to implementation?
- **I2.** What factors explain why the SMI/SED waiver does (or does not) improve access to and quality of care?

Methodology

Evaluation Design. We will use a mixed methods design where quantitative analyses of claims data are informed and explained by qualitative interviews. The quantitative analyses will use a difference-in-differences approach, using national Medicaid claims data to compare outcomes for enrollees in states that have not implemented an SMI waiver.

Target and Comparison Populations. The target population includes Washington's Medicaid beneficiaries with SMI or SED. The comparison population includes Medicaid beneficiaries from states that have not yet implemented an SMI IMD waiver by the end of the evaluation period.

Evaluation Period. We propose to analyze TAF data from January 1, 2016 through December 31, 2026. This approach would allow for analyses of 4 years of data before the initiation of Washington's SMI waiver and before the beginning of the COVID-19 PHE (January 2016 through December 2019), 1 year of data that included the COVID-19 PHE but preceded the SMI waiver (2020), 2.5 years of data of the SMI waiver that includes COVID-19 PHE (January 2021 through June 2023), and 3.5 years of data from the MTP 2.0 waiver (July 2023 through December 2026), creating a long time-series of data that includes outcomes from enrollees in Washington and enrollees from comparison states that do not enact SMI waivers.

Evaluation Measures. We propose using the following evaluation measures.

Table 8.1. Evaluation Measures

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Goal: Reduce the use of acute services by providing better access to mental health treatment services **SMI/SED Hypothesis 1: The SMI/SED demonstrations will reduce utilization and length of stay in EDs among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment.**				
SMI/SED Research Question 1.1: How is the SMI/SED demonstrations associated with changes in utilization and length of stay in EDs among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment?	• ED Visits for mental health conditions • ED Visits among beneficiaries with SMI/ED • Hospital Admissions for mental health conditions • 30-day and 7-day follow-up for ED visits for mental health conditions • ED visits with length of stay > 2 days	Eligible Medicaid enrollees	ICDB or National Medicaid TAF data	Difference-in-Differences

(continued)

Table 8.1. Evaluation Measures (continued)

Goal: Reduce the use of preventable readmissions by providing better access to mental health treatment services **SMI/SED Hypothesis 2: The SMI/SED demonstration will reduce preventable readmissions to acute care hospitals and residential settings following psychiatric hospitalization.**				
SMI/SED Research Question 2.1: How is the SMI/SED demonstrations associated with changes in preventable readmissions to acute care hospitals and residential settings following psychiatric hospitalization?	• 30-day readmission rates after psychiatric hospitalization	Eligible Medicaid enrollees	ICDB or National Medicaid TAF data	Difference-in-Differences
Goal: Improve the availability of crisis stabilization services **SMI/SED Hypothesis 3: The SMI/SED demonstration will improve the availability of crisis stabilization services.**				
SMI/SED Research Question 3.1: How is the SMI/SED demonstrations associated with changes in the availability of crisis stabilization services?	• Use of crisis services, defined as crisis line service, mobile crisis services, hourly or per diem crisis services, residential crisis services, or crisis respite services.	Eligible Medicaid enrollees	ICDB or National Medicaid TAF data	Difference-in-Differences
Goal: Improve access to community-based services **SMI/SED Hypothesis 4: Access of beneficiaries with SMI/SED to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care.**				
SMI/SED Research Question 4.1: How is the SMI/SED demonstration associated with changes in access of beneficiaries with SMI/SED to community-based services to address their chronic mental health care needs under the demonstration, including through increased integration of primary and behavioral health care?	• Primary care visits • Outpatient specialty mental health visits	Eligible Medicaid enrollees	ICDB or National Medicaid TAF data	Difference-in-Differences

(continued)

Table 8.1. Evaluation Measures (continued)

Goal: Reduce health care expenditures by improving access to mental health services **SMI/SED Hypothesis 5: The SMI/SED demonstration will impact health care spending.**				
SMI/SED Research Question 5.1: How is the SMI/SED demonstrations associated with changes in health care spending?	• Expenditures for mental health services • Total healthcare expenditures	Eligible Medicaid enrollees	ICDB or National Medicaid TAF data	Difference-in-Differences

Table 8.2. Implementation Questions

Implementation questions assessed via qualitative analyses				
SMI/SED Implementation Question 1: What are SMI/SED program leaders and administrators, as well as psychiatric hospital, residential, and crisis stabilization program leaders' and administrators' experiences with the SMI/SED waiver implementation, including barriers and facilitators to implementation?	- Identification of barriers and facilitators to implementing SUD waiver, including access to IMDs and coordinating with outpatient services	Informants selected to represent multiple sectors within the treatment delivery system, with an emphasis on the residential treatment system and crisis stabilization services	Key informants	Qualitative analysis
SMI/SED Implementation Question 2: What factors explain why the SMI/SED waiver does (or does not) improve access to and quality of care (e.g., reduction of ED visits, unnecessary readmission)?	- Description of factors that contribute to that explain impact of SMI/SED waiver on access to and quality of care - Identification of how and why access and quality of care varies, for example, by geography, with attention to implications for health equity	Informants selected to represent multiple sectors within the treatment delivery system, with an emphasis on the residential treatment system and crisis stabilization services	Key informants	Qualitative analysis

Data Sources. The evaluation will use the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) dataset for 2016-2026. The independent external evaluator currently has TAF files from 2017-2020 in house and data from 2026 are anticipated to be available in November 2028. We plan to include TAF analysis for a subset of outcome metrics in the summative report. We will also coordinate with HCA to identify key informants for qualitative data collection.

Analytic Methods.

Quantitative approach

The primary analysis will use a difference-in-differences design (measures that allow the construction of a comparison group from other states).

The general regression approach will use the following specification:

$$y_{it} = \lambda WA_i + \beta_1 D_2020_t + \beta_1 D_2021_23_t + \beta_3 DY8_t + \beta_4 DY9_t + \beta_5 DY10_t + \beta_6 DY11_t + \theta_1 D_2020_t \cdot WA_i + \theta_2 D_2021_23_t \cdot WA_i + \theta_3 DY8_t \cdot WA_i + \theta_4 DY9 \cdot WA_i + \theta_5 DY10_t \cdot WA_i + \theta_6 DY11_t \cdot WA_i + \gamma X_{it} + \varepsilon_{it}$$

where y_{it} is the outcome measure, WA_i is an indicator variable for an individual residing in the state of Washington, D_2020_t is a binary variable equal to one that captures calendar year 2020 (the first year of the PHE, and the year prior to the SMI waiver initiation), $D_2021_23_t$ captures the period January 2021 through June 2023, representing the first 30 months of the SMI waiver occurring during MTP 1.0, and including portions of the COVID-19 PHE, DY8-10 are dummy variables representing the Demonstration Years 8, 9, and 10 (the first, second, and third years of the MTP 2.0 demonstration), DY11 captures the last six months of the Demonstration Year 11., X_{it} are covariates and ε_{it} is the error term. In this case, the period from January 2016 through December 2019 is the reference period, capturing activity before the SUD waiver was implemented. The coefficients of interest are θ_1 through θ_6, capturing the aggregated changes occurring with the onset of the PHE, during MTP 1.0 (which includes the COVID-19 PHE), and then year-specific changes occurring in the first 3.5 years of MTP 2.0, with the interaction terms (e.g., $DY8_t \cdot WA_i$) reflecting the difference-in-differences, netting out the secular changes occurring in non-waiver states.

Considerations for these regressions include:

- Functional form. The equation shows a linear regression specification. We will generally use this specification because of computational efficiency. However, we will consider non-linear specifications (e.g., logistic regressions) in some instances (e.g., binary outcomes with low prevalence, such as the overdose death rate) and, in this case, translate coefficients into average marginal effects.
- Reporting of waiver effects. The above equation includes one estimate for each demonstration year. We will consider averaging some of these coefficients (e.g., the last two demonstration years) to simplify the presentation of the results. We will report baseline levels prior to waiver implementation, levels during the (suitably chosen) post-intervention period, and the pre-post estimate.

Differences-in-differences models are based on the assumption of parallel trends, meaning that, hypothetically, the changes in outcomes for individuals in Washington should mirror those in comparison states if Washington had not enacted the waiver. Although we cannot directly test this assumption, it is possible to examine the existence of parallel trends during the baseline period. If we find indications of diverging trends, we may need to adjust for these discrepancies. The independent external evaluator, who is highly experienced in employing differences-in-differences models, is equipped to make necessary adjustments in cases where pre-policy trends do not align.[2,2–4]

<u>Additional design considerations</u>

Some of the analyses identified above require examining a subset or stratification of the target population. When listing outcome variables, for concision, we have typically listed the target population as “eligible Medicaid beneficiaries,” noting that in some cases, the eligible populations will change. For example, an outcome variable like “blood pressure control among patients with diabetes” is only relevant for patients with diabetes; statin therapy for patients with cardiovascular disease is only relevant for patients with cardiovascular disease. We will define these outcomes and subpopulations accordingly.

We also note that analyses of these subpopulations require assumptions that are similar to those of the larger subpopulations. For example, analyses that use the difference-in-differences approach rest on the assumption of parallel trends, and these assumptions extend to any analyses that focus on subsets or stratification.

The evaluation team has extensive experience in working with difference-in-difference models, including theoretical and empirical articles using difference-in-differences,[2–4,4–10] with several incorporating the most recent advances in sensitivity analyses and robustness checks.[2,4,11,12] For each analysis, we will assess the quality of the comparison group or the robustness of the assumptions. We note that, from a practical point of view, there are tradeoffs between (a) the number of outcomes that can be analyzed and (b) the extent to which the parallel trends assessment can be rigorously assessed and accounted for. Our evaluation will seek a balance in providing rigorous analyses and transparency in our assumptions commensurate with the number of outcomes and analyses conducted.

Where possible, we will implement sub-setting or stratification characteristics based on pre-intervention data. This will involve identifying relevant characteristics and ensuring they are measured prior to the implementation of the reform. By doing so, we aim to mitigate endogeneity concerns and enhance the validity of our analysis. In scenarios where defining sub-setting characteristics prior to the demonstration start is infeasible, we will explore the use of separate modeling approaches.

While we are committed to incorporating these methodologies, it is essential to retain some flexibility in our approach. The dynamic nature of Medicaid reforms and the variability in data availability necessitates an adaptable research design. We will continuously assess the feasibility and appropriateness of these methods throughout the evaluation process. We will regularly review the implementation of these strategies and make adjustments as necessary. This iterative process will help ensure that our evaluation remains methodologically sound and aligned with the objectives of the reform.

Qualitative approach

Data collection and mixed methods analysis will be conducted using the same process described in Section 5. To understand the SMI/SED waiver, we will review the waiver application and conduct semi-structured interviews with informants with experience-based knowledge of SMI treatment systems affected by the waiver. These informants will be selected to represent multiple sectors within the treatment delivery system, with an emphasis on the residential treatment system and crisis stabilization services. The team will aim to maximize variation in geographic regions, provider organization (to vary on number of beds), and payer mix (predominantly Medicaid versus broad payer mix). We anticipate conducting approximately 15 interviews (2-3 with state leaders, five interviews with MCOs, and 6-8 with provider organization leaders). However, we will continue the iterative sampling and data collection process until saturation is reached. Our evaluation team will collaborate with HCA to identify contact information and a list of potential interviewees. We will work together to determine the best methods for identifying and recruiting organizations impacted by the SMI/SED waiver.

Methodological Limitations. The TAF data are relatively new, and we acknowledge the need to assess data quality. Our approach includes leveraging our experience with Medicaid claims data to conduct routine quality checks (e.g., identifying outliers, missing values, or significant temporal variations). These checks will inform our criteria for data exclusion and the establishment of various sensitivity tests. Additionally, we will undertake multiple regression analyses, employing alternative methodologies, omitting questionable covariates, and focusing on specific subpopulations. Furthermore, we will

consistently review TAF data quality reports published by CMS and their quality assessments. Our expertise in merging Medicaid claims data from different states further strengthens our analytical capabilities.

We also note that the SMI waiver occurs during a period of significant changes in the health care system, including the introduction of the 9-8-8 hotline, disruptions from the COVID-19 PHE, and the expansion of the Certified Community Behavioral Health Clinics (CCBHC) model. There may also be a shift of long-term care center admissions to community settings that could create an upward bias in the measure of hospital admissions for mental health conditions. We recognize that all of these changes present potential confounders. However, the difference-in-differences approach is designed to net out these types of secular changes unrelated to the SMI policy. To ensure that our study detects effects attributable to the waivers, we will use visual and statistical assessments of our data to understand national and regional trends (e.g., occurring with the PHE or the 9-8-8 implementation) and use qualitative interviews to assess how states are using their Medicaid programs to respond to ongoing changes.

Section 9: Continuous eligibility for children ages 0-5

General Background Information

Since January 2020, Washington has offered continuous coverage to children 0-5 enrolled in Medicaid through two policy mechanisms. First, through the continuous coverage requirement authorized by the Families First Coronavirus Response Act (FFCRA), the state maintained Medicaid coverage for its full Medicaid and CHIP population—including those under the age of 6—throughout the COVID-19 public health emergency (PHE) from January 2020 until the April 2023 initiation of the state's Medicaid unwinding process. Subsequently, in April 2023, CMS approved the MTP 2.0 demonstration, which included a Medicaid continuous eligibility (CE) provision for children 0-5. Notably, the original MTP 2.0 demonstration did not include CE for children 0-5 enrolled in CHIP; however, the CHIP population was added via a demonstration amendment approved by CMS and implemented by HCA in January 2025. As a result, children 0-5 who enrolled in CHIP prior to the unwinding process (April 2023 through May 2024) either temporarily returned to 12-month periods of eligibility or were disenrolled.

Through the MTP 2.0 demonstration, since April 2023 for the Medicaid CE population and since January 2025 for the CHIP CE population, Washington will provide children eligible for Medicaid or separate CHIP (S-CHIP) coverage (family incomes up to 317% FPL) at the time of application with continuous eligibility from birth until the end of the month when their sixth birthday falls. Aside from instances when a child dies or is no longer a resident of the state of Washington, this enrollment will be continuous regardless of changes in circumstances that would otherwise cause a loss of eligibility, such as fluctuations in income.

Families with children living in low-income households face economic uncertainty, grappling with frequent variations in their income and expenses. These fluctuations often result in children being disenrolled, only to re-enroll within a short period of time, a phenomenon referred to as "churn." As an illustration, in 2017, the cumulative disenrollment rate over 12 months was 9.9% in states with 12-month continuous eligibility compared to 14.0% in states without the policy.[16] Further, Washington state data indicate that children of color disproportionately experience gaps in coverage. Children who experience churn are more likely to delay care, receive less preventive care, have unmet medical needs, and utilize the emergency room more frequently.[17,18] Furthermore, when children have stable coverage and continuous access to care, they are more likely to receive support services for health needs that, if unaddressed, can limit school readiness. Such health needs include developmental delays, mental health needs, asthma, vision impairment, and hearing impairment. HCA estimates that an average of 24,862 young children 0-5 enrolled in Medicaid and 16,707 children 0-5 enrolled in CHIP will be continuously enrolled through MTP 2.0 demonstration authority.

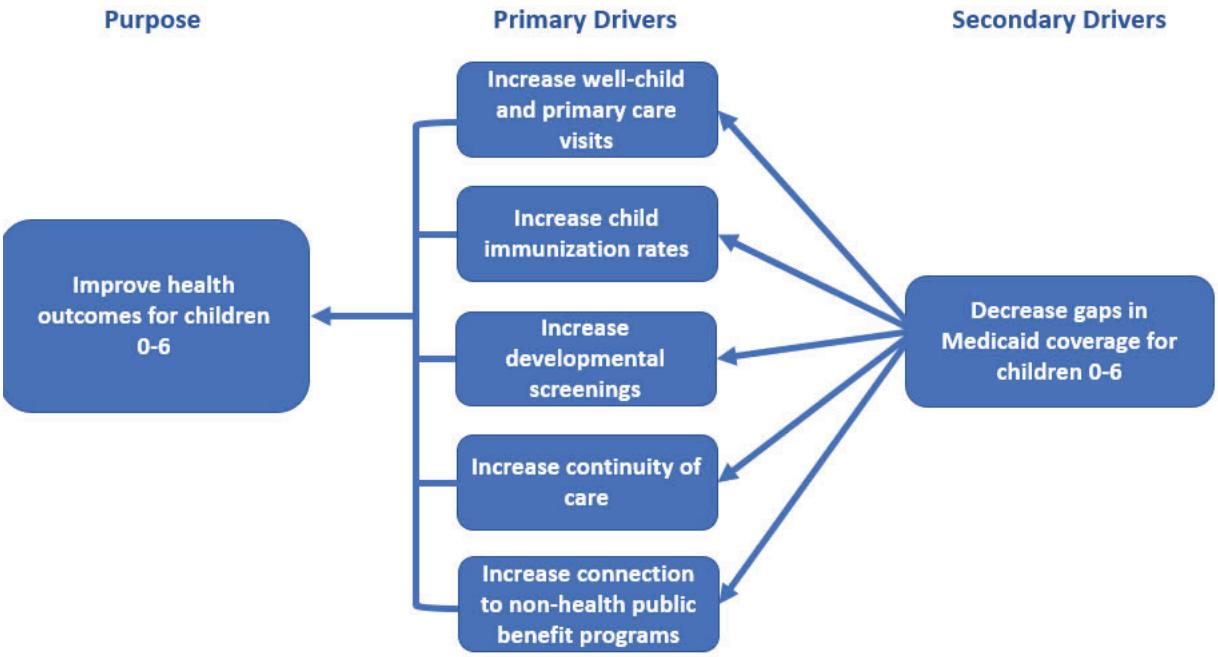
Continuous eligibility is a valuable tool to support young children's access to critical developmental screenings, vaccinations, and other preventive services in the early, formative years of life. For example, the American Academy of Pediatrics recommends 16 check-ups for children in their first six years of life, with more frequent visits in the initial months and years following birth. Continuous coverage can ensure children maintain access to preventive services to support their healthy development.

Evaluation Questions and Hypotheses

Driver Diagram. Exhibit 9.1 below depicts the relationship between the initiative's purpose to reduce opioid-health for children 0-5 and the primary and secondary drivers that are necessary to achieve this overall goal.

Five primary drivers contribute directly towards achieving the initiative's purpose, with one secondary driver supporting the primary drivers.

Exhibit 9.1. Driver Diagram



Demonstration hypotheses associated with this initiative pertain to questions of coverage and the implications of increased coverage for children. We consider the following questions and hypotheses.

- **H1.** The continuous eligibility for children policy will be associated with increased enrollment and reduced churn for children 0-5.
- **H2.** The continuous eligibility for children policy will be associated with increases in in the measures of healthcare access and service utilization children 0-5.
- **H3.** The continuous eligibility for children policy will be associated with decreased emergency department visits and hospitalizations children 0-5.
- **H4.** The continuous eligibility for children policy will be associated with increased enrollment in non-health benefits programs for children 0-5.
- **H5.** The Continuous Medicaid eligibility for children eligibility policy will be associated with decreased children in poverty.

Qualitative data collection and analysis will answer the following evaluation questions:

- **I1.** What factors facilitated or impeded the implementation of the continuous eligibility for children policy?
- **I2.** What factors facilitated or impeded the policy from achieving maximum impacts on service use and health?
- **I3.** What communication efforts and messaging facilitate or impede knowledge of the continuous eligibility for children program among beneficiaries and key entities?
- **I4.** What is the experience of the continuous eligibility policy for Apple Health members and their caregivers?

Methodology

Evaluation Design. We will combine qualitative interviews to assess implementation efforts, national survey data from the American Community Survey (ACS), and analyses of the ICDB administrative data. The qualitative interviews will focus on implementation of the provision, experience of the provision by beneficiary caregivers, and experience and perceived impact of the provision by healthcare providers and community-based organizations that serve young children and their families. For the ACS-based outcomes, we will conduct a difference-in-differences analysis comparing outcomes in Washington with outcomes in other states (states in consideration include Idaho, Nevada, and Utah).

For claims-based (ICDB) outcomes, we will conduct a pre-post analysis that compares outcomes for members in the post-intervention period with outcomes in the pre-intervention period. We will also include data from the COVID-19 Public Health Emergency (PHE) (2020-2022). Analyses of the ICDB will focus on claims-based outcomes, comparing trends across several different regimes of enrollment. We will include several different types of claims-based outcomes in our analysis:

- Outcome metrics related to insurance coverage
- Quality metrics, reported as % of qualifying members who meet metrics specific criteria
- Utilization metrics, reported PMPM

We note that we cannot measure outcomes for children who lose Medicaid coverage. Instead, we will compare utilization metrics (which are reported PMPM) for children enrolled in the 0-5 CE period and compare those to the COVID-19 PHE period with 2017-2019 as reference years. Among Medicaid-enrolled children, we expect that children with continuous coverage will have higher rates of screening and well-child visits than during those in the 2017-2019 years.

We will also assess two alternatives for reported utilization metrics. As an alternative to PMPM rates, we will measure rates for “any enrolled Medicaid child.” This measurement approach may reduce some bias in generating a PMPM measure, where, e.g., a child who received a well-child visit but was only enrolled 6 months would have a higher PMPM rate than a child who received a well-child visit and was enrolled 12 months, even though the health outcomes would be the same.

As a second alternative, we will create measures of total utilization (e.g., total well-child visits paid for by Medicaid). This measure does not roll up to an enrollee-level measure. However, it provides insight into whether the continuous eligibility provision was associated with more preventive and screening measures delivered through Medicaid.

Target and Comparison Populations. The target population of this component is Medicaid and CHIP enrollees ages 0-5 who are included in the continuous eligibility provision. Comparison populations differ according to outcomes and analyses and may include Medicaid enrollees of the same age in different states and Medicaid enrollees of the same age at different periods in Washington.

Evaluation Period.
Since this policy intervention was implemented at different times for the Medicaid and CHIP groups respectively, we will define the periods for these populations separately. For claims-based (ICDB) outcomes, we will examine the periods for these populations as follows:

- Medicaid enrollees ages 0-5 (through the end of month of their sixth birthday)
    - Pre-Period: 2017-2019
    - PHE: 2020-2022
    - Post-Period: 2023-2027*
- CHIP enrollees ages 0-5 (through the end of the month of their sixth birthday)
    - Pre-Period: 2017-2019
    - PHE: 2020-2022
    - Transition Period: 2023-2024
    - Post-period: 2025-2027

Though the MTP 2.0 continuous eligibility provision was not in effect until April 2023, children 0-5 enrolled in Medicaid experienced continuous eligibility since 2020. Given the impact of the PHE across 2020-2022, we define 2023 as the start of the post-intervention period.

For ACS measures, we will examine the following periods for these populations as follows:

- Pre-Period: 2017-2019
- PHE: 2020-2022
- Transition Period**: 2023-2024
- Post-Period: 2025-2027

Some ACS outcomes (such as uninsurance rates for children) are defined more broadly and will be reported statewide. During the "transition period," children enrolled in Medicaid were subject to multi-year continuous coverage; however, children enrolled in CHIP were subject to 12-month periods of continuous coverage.

Evaluation Measures. We propose using the following evaluation measures.

Table 9.1. Evaluation Measures

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Goal: Reduce churn and increase the number of children enrolled in Medicaid and CHIP **CE Hypothesis 1: The continuous eligibility for children policy will be associated with increased enrollment and reduced churn for children 0-5.**				
CE Research Question 1.1: How is the Continuous eligibility for children policy associated with coverage gains?	• Uninsured rates for children	Children 0-5	ACS	Difference-in-Differences
CE Research Question 1.2: How does the continuous eligibility policy for children impact rates of churn?	• Total enrollment • Monthly disenrollment rates • Rates of gaps in Medicaid coverage • Lengths of gaps in Medicaid coverage	Children 0-5 subject to the CE policy	Medicaid enrollment data and ICDB	Descriptive analysis Pre-post with controls

(continued)

Table 9.1. Evaluation Measures (continued)

Goal: Improve preventive services among children **CE Hypothesis 2: The continuous eligibility for children policy will be associated with increases in measures of healthcare access and service utilization for children 0-5.**				
CE Research Question 2.1: Is the Continuous **eligibility for children** provision associated with increases in measures of service utilization?	• Childhood immunization status • Child and Adolescent Well-Care Visits • Continuity of care • Primary care visits • Visits with a non-primary care specialist physician • Developmental Screening in the First Three Years of Life • Utilization: Well-Child Visits	Children 0-5 subject to the CE policy	ICDB	Pre-post with controls
Goal: Decrease the use of acute services **CE Hypothesis 3: The continuous eligibility for children policy will be associated with decreased emergency department visits and hospitalizations for children 0-5.**				
CE Research Question 3.1: Is the Continuous **eligibility for children** provision associated with decreases in emergency department visits and hospitalizations?	• Emergency Department Visits • Acute Hospital Utilization	Children 0-5 subject to the CE policy	ICDB	Pre-post with controls
Goal: Increase connection to non-health care public benefit programs **CE Hypothesis 4: The continuous eligibility for children policy will be associated with increased enrollment in public benefits programs for children 0-5.**				
CE Research Question 4.1: Is the Continuous eligibility for children provision associated with increased enrollment to non-health care public benefit programs?	• Enrollment in SNAP • Enrollment in WIC • Enrollment in TANF	Children 0-5 subject to the CE policy who are also eligible for specified public benefits programs	Medicaid enrollment data and ICDB	Pre-post with controls
Goal: Reduce the number of children in poverty **CE Hypothesis 5: The Continuous eligibility for children policy will be associated with a decrease in the number of children in poverty.**				
CE Research Question 5.1: Is the Continuous Medicaid enrollment provision associated with decreased children in poverty?	• Poverty status	Children 0-3	ACS	Difference-in-Differences

Table 9.2. Implementation Questions

Implementation questions assessed via qualitative analyses				
CE Implementation Question 1: What factors facilitated or impeded the implementation of the continuous eligibility for children policy?	- Description of implementation of continuous eligibility for children policy, including deviations for implementation plan - Identification of barriers and facilitators to implementing the continuous eligibility provision - Description of outreach and communication efforts - Description of impacts to administrative burden related to redetermination for HCA and MCO staff	State administrators; informants from Medicaid managed care organizations; community partners; pediatricians	Key informants	Qualitative analysis
CE Implementation Question 2: What factors facilitated or impeded the policy from achieving maximum impacts on service use and health?	- Description of factors that facilitated or impeded maximum impact of the policy on service use, and ultimately health?	State administrators; informants from Medicaid managed care organizations; community partners; Caregivers of Medicaid enrollees subject to CE policy	Key informants	Qualitative analysis
CE Implementation Question 3: What communication efforts and messaging facilitate or impede knowledge of the continuous eligibility for children program among beneficiaries and key entities?	- Description of communications and outreach efforts initiated by state administrators, managed care organizations, community partners, and pediatricians - Description of messaging and talking points and their clarity and effectiveness to recipients of those messages (i.e. eligible children and their caregivers, pediatricians) - Description of caregiver of eligible child understanding continuous eligibility policy eligibility criteria, benefits, and timelines	State administrators; informants from Medicaid managed care organizations; community partners; pediatricians	Key informants	Qualitative analysis

(continued)

Table 9.2. Implementation Questions (continued)

CE Implementation Question 4: What is the experience of the CE policy for Apple Health members and their caregivers?	- Description of beneficiary/caregiver's experience of continuous eligibility policy, including barriers and facilitators to enrollment - Description of impact of continuous eligibility policy on eligible children's access to and receipt of care - Description of impact of continuous eligibility on beneficiary/caregiver burden, including time to maintain enrollment and stress - Description of beneficiary/caregiver satisfaction with continuous eligibility benefits	Caregivers of Medicaid enrollees subject to CE policy ; community partners; pediatricians	Key informants	Qualitative analysis

Data Sources. We will use the ICDB, Medicaid and other public benefits enrollment data, and ACS for these analyses. We will also coordinate with HCA to identify key informants for qualitative data collection, including a representative beneficiary population.

Analytic Methods.

<u>Quantitative approach – ACS data</u>

We will use a modified difference-in-differences approach, comparing changes in Washington to changes in other states. We modify our approach because of enrollment changes occurring during the COVID-19 PHE, when disenrollments were halted. We will analyze data from 2017 through 2027.We will estimate the following regression:

$$y_{it} = \lambda WA_i + \beta_1 D_2020_22_t + \beta_2 D_2023_24_t + \beta_3 2025_27_t + \theta D_2020_22_t * WA_i + \theta D_2023_24_t * WA_i + \theta D_2025_27_t * WA_i + \gamma X_{it} + \varepsilon_{it}$$

where y_{it} is the outcome measure, WA_i is an indicator variable for an individual residing in the state of Washington. The variable $D_2020_22_t$ captures calendar years 2020 through 2022, capturing the most significant period of the COVID-19 PHE. The variable D_2023_24 captures the transition period when children insured through Medicaid had continuous coverage, but those insured through CHIP did not. The variable D_2025_25 represents the post-period, after full state-wide implementation of children insured through Medicaid or CHIP. Coefficients of interest for the tables bellow are those that correspond with the relevant interaction terms.

<u>Quantitative approach – Claims (ICDB) data</u>

For outcomes based on claims data, we will conduct a pre/post analysis for two separate groups, with time periods defined differently based on the implementation of the intervention for each group:

1. For children with coverage through Medicaid, we will estimate the following regressions:

   $y_{it} = \beta_1 D_2020_22_t + \beta_2 D_2023_27_t + \gamma X_{it} + \varepsilon_{it}$ [Full sample 2017-2027] (1)

   $y_{it} = \beta_1 D_2023_27_t + \gamma X_{it} + \varepsilon_{it}$ [Restricted sample 2020-2027] (2)

2. For children with coverage through CHIP, we will estimate the following regression:

$$y_{it} = \beta_1 D_2020_22_t + \beta_2 D2023_24_t + \beta_3 D2025_27_t + \gamma X_{it} + \varepsilon_{it} \quad (3)$$

The reference for models (1) and (3) is 2017-2019, while the reference for model (2) 2020-2022 (PHE period). These flexible models will allow for comparisons of the continuous eligibility provision to the pre-pandemic period (2017-2019) and comparisons to the outcomes that occurred during the PHE when enrollment should have been consistent, but utilization trends may have differed. For children with coverage through CHIP, we will also define a post-PHE pre-intervention period when some disenrollment occurred. The coefficients of interest from the equations above are as follows:

- Equation 1: β_1 (ΔBL to PHE) and β_2 (ΔBL to Post-Period); Medicaid enrollees
- Equation 2: β_1 (ΔPHE to Post-Period); Medicaid enrollees
- Equation 3: β_1 (ΔBL to PHE) and β_3 (ΔBL to Post-Period); CHIP enrollees

Additional design considerations

Where possible, we will implement sub-setting or stratification characteristics based on pre-intervention data. This will involve identifying relevant characteristics and ensuring they are measured prior to the implementation of the reform. By doing so, we aim to mitigate endogeneity concerns and enhance the validity of our analysis. In scenarios where defining sub-setting characteristics prior to the demonstration start is infeasible, we will explore the use of separate modeling approaches.

While we are committed to incorporating these methodologies, it is essential to retain some flexibility in our approach. The dynamic nature of Medicaid reforms and the variability in data availability necessitates an adaptable research design. We will continuously assess the feasibility and appropriateness of these methods throughout the evaluation process. We will regularly review the implementation of these strategies and make adjustments as necessary. This iterative process will help ensure that our evaluation remains methodologically sound and aligned with the objectives of the reform.

Qualitative approach

We will conduct semi-structured interviews with Medicaid administrators and representatives from Managed Care Organizations (MCOs) to gather insights into their adaptive strategies in planning and care coordination in response to the continuous coverage provision. To assess the effectiveness of state communications regarding continuous coverage for children, the team will analyze state-issued materials and conduct structured interviews with parents. This dual approach will help evaluate the clarity and reach of these communications and their influence on parent awareness and utilization of coverage. We will also conduct in-depth interviews with pediatricians to understand how their practices are affected, including financial aspects, patient relationships, and the dynamics of trust and collaboration. We will complete interviews with a range of stakeholders, including agency leaders, MCOs, healthcare providers, community-based organizations, and primary caregivers of beneficiaries. We plan to conduct approximately 40 interviews until saturation is achieved. These interviews will include approximately 25 interviews with primary caregivers, who will receive a $30 gift card as a “thank you” for their participation.

Mixed methods analysis

The mixed methods analysis will be conducted through collaborative sessions that combine the qualitative and quantitative research teams. During these meetings, both teams will jointly review and contrast the outcomes from their respective research approaches. The primary objective will be to identify emerging themes and to explore areas of concordance or discordance between the qualitative and quantitative data. Each session will conclude with a collective decision on whether to delve deeper into discrepancies or unexpected findings based on their relevance and significance to the research objectives.

Methodological Limitations. There are a variety of limitations to consider in the current approach. There may be changes in Washington unrelated to the policy (such as economic fluctuations, healthcare trends, or other policy changes) that could affect outcomes and be difficult to disentangle in our current approach. There may also be variations in how the policy is implemented across different regions within the state, leading to heterogeneous effects not captured by a standard difference-in-differences approach.

In addition, the continuous eligibility provision might lead to estimates that suggest that visit and screening rates will be lower after the policy is implemented. This could occur if more healthy children are enrolled, and they are less likely to need health care (including preventive care). However, we have proposed several alternative measures (including counts of total visits) that should allow us to assess the extent to which these phenomena occur.

Section 10: Continuous eligibility for postpartum individuals

General Background Information

Since June 2022, Washington has offered continuous postpartum Medicaid coverage to postpartum people up to 12 months after the end of the pregnancy, regardless of changes in the postpartum person's income or whether they were enrolled in Medicaid/CHIP during pregnancy. This expansion continuous postpartum eligibility—referred to in Washington as After Pregnancy Coverage (APC)—is achieved through a combination of two policy mechanisms, both of which went into effect June 2022: Washington's State Plan Amendment (SPA) and substitute Senate Bill 5068. Implemented in June 2023, MTP 2.0's postpartum coverage initiative authorizes Washington to receive the federal match for providing this continuous postpartum Medicaid eligibility.

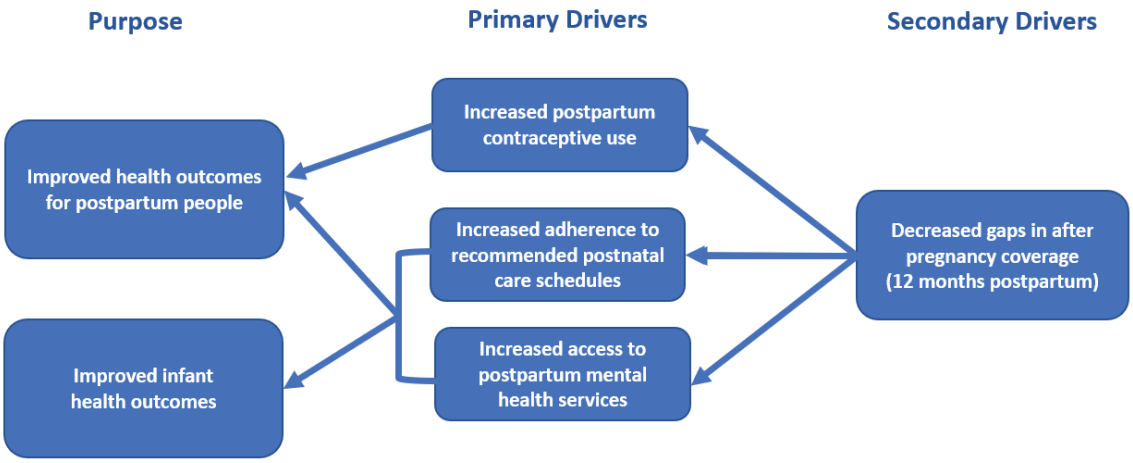
Continuous postpartum eligibility represents a shift from traditional Medicaid policies that often terminate or significantly alter coverage shortly after childbirth, leaving many new parents without essential healthcare services during a vulnerable time. In recent years, there has been a growing recognition of the critical importance of postpartum care in ensuring the health and well-being of new parents and their infants. Often referred to as the "fourth trimester," the postpartum period is a time of significant physical and emotional change; as such, access to comprehensive health services is vital. However, for many, the postpartum period is marked by a lack of continuous healthcare coverage, leading to gaps in care that can have serious consequences for the postpartum person and their infant.

Overall, the continuous eligibility for postpartum individuals policy in Washington State is anticipated to yield several significant benefits. Primarily, it ensures uninterrupted access to healthcare for postpartum people during the entire first year while they transition from pregnancy to full recovery, a period when many experience unmet health needs. Nearly 70% of postpartum people describe at least one physical problem in the first year of the postpartum period. Continuous postpartum coverage may improve health outcomes by facilitating ongoing postnatal care, including physical examinations, mental health services, and services supporting breastfeeding and infant care. Additionally, by maintaining coverage irrespective of income changes, this policy offers coverage stability that is especially important for populations at higher risk of postpartum complications, including people with low incomes and people of color. Furthermore, the policy may have broader socioeconomic benefits, including reducing healthcare costs associated with emergency care and fostering a healthier, more productive workforce by ensuring new parents are physically and mentally well-supported during this transformative phase of life.

Evaluation Questions and Hypotheses

Driver Diagram. Exhibit 10.1 below depicts the relationship between the initiative's purpose to improve health for postpartum people and their infants and the primary and secondary drivers necessary to achieve this overall goal. Three primary drivers contribute directly towards achieving the initiative's purpose, with one secondary driver supporting the primary drivers.

Exhibit 10.1. Driver Diagram



We consider the following questions and hypotheses.

- **H1.** Continuous eligibility for postpartum individuals will increase the months of continuous coverage in the postpartum period.
- **H2.** Continuous eligibility for postpartum individuals will result in increased adherence to recommended postnatal care schedules, including regular check-ups and screenings for postpartum individuals.
- **H3.** Continuous eligibility for postpartum individuals will increase the likelihood of receiving mental health treatment among individuals diagnosed with postpartum depression and anxiety.
- **H4.** Continuous eligibility for postpartum individuals will be associated with improvements in infant health outcomes, such as reduced rates of emergency department visits and hospital readmissions.

Qualitative data collection and analysis will answer the following implementation questions:

- **I1.** What barriers and facilitators did program leaders face in implementing the policy?
- **I2.** What communication efforts and messaging facilitate or impede knowledge of the continuous postpartum eligibility among beneficiaries and key entities?
- **I3.** What factors explain why the postpartum coverage policy did (or does not) improve access to and quality of care?

Methodology

Evaluation Design. Though the 12-months of continuous postpartum eligibility policy is funded through a blend of state and federal dollars—and was not authorized to receive the federal match until the June 2023 approval of the MTP 2.0 demonstration, Washington state has offered up to 12 months of continuous eligibility to postpartum people eligible for Medicaid/CHIP since June 2022. We propose analyzing the overall policy intervention, independent of specific authority or funding source that allowed for the policy's implementation. We will supplement these analyses with qualitative interviews.

Target and Comparison Populations. The target population is members (ages 12-54) who qualified for up to 12 months of postpartum after pregnancy coverage (APC) and their infants, with enrollments occurring between July 2022 and June 2027. The comparison population will be a similar group of enrollees with a pregnancy ending between January 2017 and December 2019 and infants enrolled in Medicaid or CHIP with births occurring between those dates. Note that length of observation period may vary for members of this group, but they should have coverage and be observable through the 2nd month following the end of pregnancy under former eligibility criteria. Members who remained enrolled after that two-month period will be observed for 12 months following the end of pregnancy, or until loss of coverage. Observation periods for infant's outcomes vary by metric.

Evaluation Period. We propose to analyze data from June 2022 through June 2027 and use a comparison cohort observed from January 2017 through December 2019 (three years of pre-PHE and pre-policy data).

Evaluation Measures. We propose to use the following list of evaluation measures.

Table 10.1. Evaluation Measures

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Goal: Increase continuous coverage and continuity of care for postpartum people **CE Postpartum Hypothesis 1: Continuous eligibility for postpartum individuals will increase the months of continuous coverage in the postpartum period.**				
CE Postpartum Research Question 1.1: How is continuous postpartum coverage associated with changes in months of coverage in the postpartum period?	• Length of Postpartum Insurance Coverage • Percent of individuals continuously enrolled for 12 months postpartum	Eligible Medicaid enrollees	ICDB	
Goal: Increase access to preventive care in the postnatal period **CE Postpartum Hypothesis 2: Continuous eligibility for postpartum individuals will result in increased adherence to recommended postnatal care schedules, including regular check-ups and screenings for postpartum individuals.**				
CE Postpartum Research Question 2.1: How is continuous postpartum coverage associated with changes in adherence to recommended postnatal care schedules, including regular check-ups and screenings for postpartum individuals?	• Postpartum Care (PPC) • Chlamydia Screening for Women (CHL) • Continuity of Pharmacotherapy for Opioid Use Disorder; limited to postpartum people with OUD (CONT-PHARM-OUD) • Long-Acting Reversible Contraceptives within 90 Days of Delivery (CCP_90DAY_LARC) • Effective Contraception within 90 Days of Delivery (CCP_90DAY_TOTAL)	Eligible Medicaid enrollees	ICDB	Modified pre-post analysis.

(continued)

Table 10.1. Evaluation Measures (continued)

Goal: Increase access to mental health services in the postnatal period **CE Postpartum Hypothesis 3: Continuous eligibility for postpartum individuals will increase the likelihood of receiving mental health treatment among individuals diagnosed with postpartum depression and anxiety.**				
CE Postpartum Research Question 3.1: How is continuous postpartum coverage associated with changes in the likelihood of receiving mental health treatment among individuals diagnosed with postpartum depression and anxiety?	• Mental Health Treatment Penetration – Broad Version (SUPPL-MH-B) • Antidepressant Medication for Adults - 12 Weeks and 6 Months (HEDIS-AMM-84D & HEDIS-AMM-180D)	Eligible Medicaid enrollees	ICDB	Modified pre-post analysis
Goal: Improve infant health **CE Postpartum Hypothesis 4: Continuous postpartum coverage will be associated with improvements in infant health outcomes, such as reduced rates of emergency department visits and hospital readmissions.**				
CE Postpartum Research Question 4.1: How is continuous postpartum coverage associated with changes in infant health outcomes, such as reduced rates of emergency department visits and hospital readmissions?	• Emergency Department Visits among newborns • Hospitalizations among Newborns • Well child visits within first 30 months of life (W30_15mo) • Immunization for Children (CIS_COMB10)	Newborns enrolled in Medicaid	ICDB	Modified pre-post analysis

Table 10.2. Implementation Questions

Implementation questions assessed via qualitative analyses				
CE Postpartum Implementation Question 1: What barriers and facilitators did program leaders face in implementing the policy?	- Identification of barriers and facilitators to implementing the continuous eligibility provision - Description of deviations from implementation plan - Description of how implementations challenges were addressed, or why they were not addressed	State administrators, informants from Medicaid managed care organizations	Key informants	Qualitative analysis

(continued)

Table 10.2. Implementation Questions (continued)

CE Postpartum Implementation Question 2: What communication efforts and messaging facilitate or impede knowledge of the continuous postpartum eligibility among beneficiaries and key entities?	- Description of communications and outreach efforts initiated by state administrators, managed care organizations, community partners, and healthcare providers - Description of messaging and talking points and their clarity and effectiveness to recipients of those messages (i.e. eligible postpartum individuals; healthcare providers) - Description eligible postpartum individuals understanding continuous postpartum eligibility policy eligibility criteria, benefits, duration period, and options for coverage upon termination of postpartum eligibility extension - Description of how program communication differed, if it did, for individuals who were covered during pregnancy and those who received Medicaid/CHIP coverage in the postpartum period	State administrators; informants from Medicaid managed care organizations; healthcare providers (including obstetricians, gynecologists, primary care providers); beneficiaries currently or formerly eligible for continuous postpartum eligibility	Key informants	Qualitative analysis
CE Postpartum Implementation Question 3: What factors explain why the postpartum coverage policy did (or does not) improve access to and quality of care for postpartum individuals and their infants?	- Identification of links between coverage and access to care - Description of how and why policy impact on access to and quality of vary , for example, by race and ethnicity or geography, with attention to implications for health equity?	State administrators; informants from Medicaid managed care organizations; healthcare providers (including obstetricians, gynecologists, primary care providers); beneficiaries currently or formerly eligible for continuous postpartum eligibility	Key informants	Qualitative analysis

Data Sources. We will use the ICDB for these analyses. We will also coordinate with HCA to identify key informants for qualitative data collection, including a representative beneficiary population.

Analytic Methods.
We will compare outcomes for individuals covered by this policy to individuals who were similar but enrolled in a period that preceded the PHE and the expanded coverage policy. We will estimate a regression of the following form:

$$Y_{it} = \beta Post_SPA_policy_t + \lambda X_{it} + \epsilon_{it},$$

Where Y_{it} is the outcome of interest, $Post_SPA_policy_t$ is an indicator equal to one for postpartum individuals with births occurring in the post intervention period, X_{it} are demographic characteristics, ϵ_{it} is the error term, and the parameter of interest is β. We will cluster the error term at the primary care service area (PCSA) level. This approach allows for the control of various confounding variables, such as age and pre-existing health conditions, aiding in isolating the policy's effects. Additionally, comparing to a cohort that predates both the policy and the PHE helps separate the effects of the policy from the unique healthcare challenges posed by the pandemic.

Covariates to include in regression analysis:

- CDPS indicators: cancer, cardiovascular, CNS, diabetes, eye, gastro, genital, hematological, infectious, metabolic, pulmonary, renal, skeletal, skin
- Age group: <18, 18 to 24, 25 to 34, 35 to 44, 45 to 54
- Rural: rural, urban

Additional design considerations
Some of the analyses identified above require examining a subset or stratification of the target population. When listing outcome variables, for concision, we have typically listed the target population as “eligible Medicaid beneficiaries”, noting that in some cases the eligible populations will change. For example, an outcome variable like “blood pressure control among patients with diabetes” is only relevant for patients with diabetes; statin therapy for patients with cardiovascular disease is only relevant for patients with cardiovascular disease. We will define these outcomes and subpopulations accordingly.

Where possible, we will implement sub-setting or stratification characteristics based on pre-intervention data. This will involve identifying relevant characteristics and ensuring they are measured prior to the implementation of the reform. By doing so, we aim to mitigate endogeneity concerns and enhance the validity of our analysis. In scenarios where defining sub-setting characteristics prior to the demonstration start is infeasible, we will explore the use of separate modeling approaches.

While we are committed to incorporating these methodologies, it is essential to retain some flexibility in our approach. The dynamic nature of Medicaid reforms and the variability in data availability necessitates an adaptable research design. We will continuously assess the feasibility and appropriateness of these methods throughout the evaluation process. We will regularly review the implementation of these strategies and make adjustments as necessary. This iterative process will help ensure that our evaluation remains methodologically sound and aligned with the objectives of the reform.

Qualitative approach
To inform and contextualize quantitative data, we will conduct a qualitative study involving Medicaid administrators, Managed Care Organization (MCO) administrators, and healthcare providers to gain a deeper understanding of the impacts of Washington State's 12-month continuous postpartum eligibility

policy. This qualitative approach will conduct semi-structured interviews with key stakeholders. Informants will be selected to reflect a wide range of stakeholders impacted by the postpartum coverage policies, including providers, tribal providers, MCOs, and representatives from HCA. Through these interviews, we will explore their perspectives on the policy's implementation, challenges, and successes. The goal is to gain insights into the administrative and operational aspects of the policy, such as changes in enrollment processes, healthcare delivery adaptations, and any barriers encountered in policy execution. Providers' perspectives will be particularly valuable in understanding how the policy has affected clinical practices, patient engagement, and care outcomes. This qualitative approach will also identify unanticipated positive and negative consequences and provide context to the quantitative data, thereby offering a comprehensive understanding of the policy's overall impact. By synthesizing the experiences and viewpoints of these stakeholders, we will provide nuanced recommendations for policy refinement and implementation strategies, contributing to the broader knowledge base of effective healthcare policy administration. We anticipate conducting approximately 20 interviews across both deliverables; however, we will continue the process of iterative sampling until saturation is reached.

Methodological Limitations. One limitation of this approach is that the comparison group for the analysis is selected from the period preceding the policy change and COVID-19 PHE. Changes in healthcare practices, technology, and societal factors over time could also influence the observed differences between the cohorts, not just the policy implementation. The lingering effects of the COVID-19 pandemic on the healthcare system and patient behavior might still influence post-policy outcomes, complicating the analysis. Finally, the awareness of the policy among individuals and any resulting changes in healthcare service utilization post-policy implementation need to be carefully considered, as they could significantly impact the study's findings.

Section 11: Reentry from a carceral setting

General Background Information

This program is a new component of Washington's waiver. Washington will provide limited coverage for certain pre-release services for up to 90 days immediately prior to the expected release date to qualifying Medicaid and CHIP enrollees and demonstration enrollees who are residing in state prisons, county and city jails, youth correctional facilities, or tribal jails.

Under the Medicaid Inmate Exclusion Policy (MIEP), states have been prohibited from using Medicaid dollars to provide health care services to incarcerated individuals who would otherwise be eligible for coverage. Under MTP 2.0, Washington will also alter its strategy for individuals in carceral settings to reduce barriers to accessing Medicaid/CHIP post-release.

The program includes three mandatory pre-release services and four optional pre-release service:

1. **Reentry targeted case management** to address physical and behavioral health needs
2. **Medication for alcohol and opioid use disorder** when clinically appropriate
3. **30-day supply of medications and medical supplies at release**
4. Medications during the pre-release period
5. Lab and radiology
6. Services provided by community-health workers with lived experience
7. Physical and behavioral clinical consultation

Given the importance of addressing the multifaceted needs of carceral and re-entry populations, the initiative aims to provide incarcerated individuals pre-release healthcare services and case management so that they can establish relationships with community-based providers that facilitate successful care transitions. This bridge in Medicaid/CHIP coverage aims to promote continuity of care and improve health outcomes for justice-involved individuals.

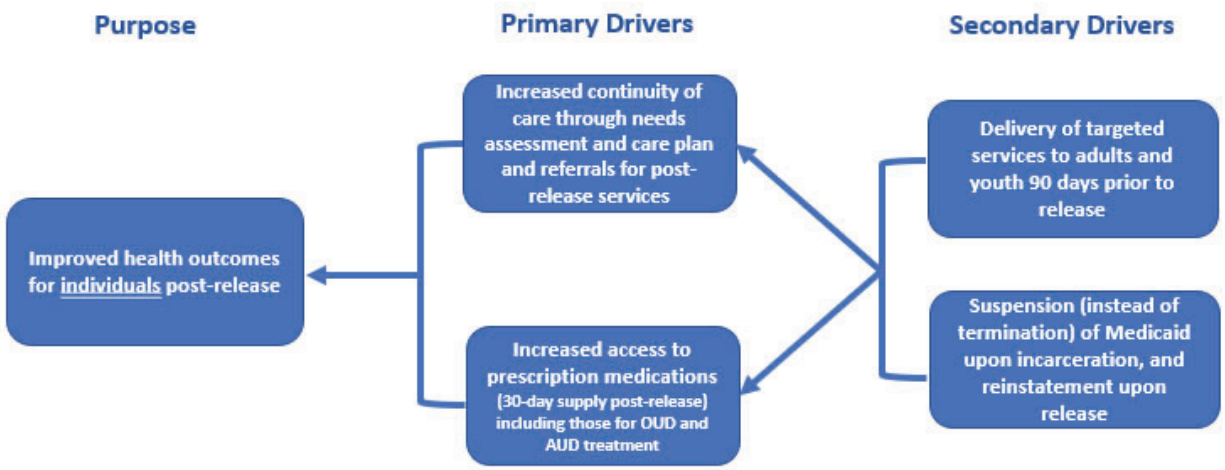
Through House Bill 1348 (2021-2022 biennium) and Senate Bill 5304 (2023-2024 biennium), the Washington State Legislature directed HCA to provide specific benefits for incarcerated individuals during the 30 days prior to release. The waiver authority authorizes pre-release services for a longer pre-release period—up to 90 days—for adults and youth incarcerated in state prisons, county or city jails, youth correctional facilities, or tribal jails. Minimum benefits include case management to address physical and behavioral health needs, medications for SUD, and a 30-day supply of all prescription medications prescribed for the beneficiary at the time of release. HCA estimates a population of around 4000.

Washington plans to roll out the reentry program in a phased manner, with one cohort beginning July 1, 2025, one beginning January 1, 2026, and one beginning July 1, 2026. The state is requiring participating facilities to offer the three mandatory pre-release services (Reentry Targeted Case Management, medications for opioid use disorder (MOUD) and medications for alcohol use disorder (MAUD), and 30-day supply of medications and medical supplies at release) and have the option to also offer 4 additional services (medications during the prerelease period, lab and radiology, services by community health workers with lived experience, and physical and behavioral clinical consultations).

Evaluation Questions and Hypotheses

Driver Diagram. Exhibit 11.1 below depicts the relationship between the initiative's purpose to improve health outcomes for individuals post-release and reduce recidivism and the primary and secondary drivers necessary to achieve this overall goal. Two primary drivers contribute directly towards achieving the initiative's purpose, with two secondary drivers necessary to support the primary drivers.

Exhibit 11.1. Driver Diagram



As specified in CMS guidance, we will investigate the following hypotheses:

- **H1.** The reentry demonstration will increase Medicaid coverage and the continuity of Medicaid coverage for individuals in carceral settings just prior to release.
- **H2.** The reentry demonstration will improve access to services and service uptake in carceral settings and after release.
- **H3.** The reentry demonstration will increase investments in health care and related services to improve the quality of care and maximize successful reentry for soon-to-be released individuals and those transitioning into Medicaid upon release.
- **H4.** The demonstration will reduce all-cause deaths in the near-term post-release.
- **H5.** The demonstration will reduce emergency department (ED) visits and inpatient hospitalizations among recently released Medicaid beneficiaries.

Qualitative data collection and analysis will answer the following implementation questions, as outlined by CMS specifications:

- **I1.** Which key entities are collaborating to implement and operationalize the demonstration, and what are their main roles?
- **I2.** What challenges or barriers have key entities experienced while implementing the demonstration, and what strategies did they use to overcome them?
- **I3.** How have key entities participating in the demonstration contributed to the coordination of care for beneficiaries?
- **I4.** What strategies has the state used to increase coverage among Medicaid-eligible individuals and sustain coverage for individuals enrolled in Medicaid prior to incarceration?
- **I5.** What strategies has the state used to provide benefits to individuals before release?

- **I6.** What strategies did the state use to promote continuity of care, and connect individuals to health and HRSN services after release?
- **I7.** How do pre-release health providers, case managers, and community-based providers describe their experience with the demonstration?
- **I8.** How did the state involve individuals with lived experience in the design and implementation of the demonstration?
- **I9.** What is the experience of receiving reentry services in a carceral setting?

Methodology

Evaluation Design. We will use a mixed methods design, conducting qualitative interviews that focus on the implementation of the program. Pending post-release beneficiary recruitment feasibility, we will also conduct a set of post-release interviews with people who previously received reentry services while incarcerated for inclusion in the Summative Evaluation Report. The quantitative analyses compare outcomes for Medicaid enrollees released from state custody and receiving reentry services to a propensity-score weighted group of enrollees released from state custody who do not receive reentry services. This analysis is predicated on the assumption that some individuals released from state custody during MTP 2.0 will be eligible for Medicaid but will not receive reentry services. If reentry services are comprehensive, we will use an alternative approach (described below).

Target and Comparison Populations. The target population of this component is Medicaid beneficiaries who receive reentry services. The comparison group will be derived by propensity score weighted individuals who did not receive reentry services.

Evaluation Period. We propose to analyze data for July 1, 2025, through June 30, 2028, assuming that claims data for CY 2028 are available on January 1, 2029, and that the reentry program is implemented on July 1, 2025.

Evaluation Measures. We propose using the following evaluation measures.

Table 11.1. Evaluation Measures

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Goal: Increase Medicaid/CHIP coverage **Reentry Hypothesis 1: Reentry services will lead to increases in Medicaid/CHIP coverage and continuity of Medicaid coverage for individuals in carceral settings just prior to release.**				
Reentry Research Question 1.1: How did the implementation of the demonstration impact Medicaid enrollment for participants?	• Number of incarcerated individuals newly enrolled in Medicaid out of all individuals incarcerated in the facility • Number of incarcerated beneficiaries whose Medicaid benefits were maintained or suspended rather than terminated out of all individuals incarcerated in the facility	Incarcerated individuals released from comparable facilities that are not, or not yet participating in the in the reentry demonstration	ProviderOne enrollment data, data from the Jail Booking and Reporting System (JBRS), Department of Corrections (DOC). Available in the ICDB.	Descriptive analysis of quarterly trends
Reentry Research Question 1.2: How did Medicaid enrollment differ by beneficiary characteristics and facility type?	Same as above	Same as above, subgroup analysis by beneficiary characteristics (sex, race, age) and facility type (jails vs. prison)	ICDB	Descriptive analysis of trends
Goal: Increase access to services in carceral settings and after release **Reentry Hypothesis 2: The reentry demonstration will improve access to services and service uptake in carceral settings and after release.**				
Reentry Research Question 2.1: How has the availability of pre-release services changed with the implementation of the demonstration?	• Ratio of individual providers that provide service to incarcerated Medicaid beneficiaries to incarcerated Medicaid beneficiaries • Ratio of facilities that provide services to incarcerated Medicaid beneficiaries	N/A	ProviderOne data, data from JBRS in ProviderOne	Descriptive analysis of annual provider-to-enrollee ratios (e.g., describing trends over time.)

(continued)

Table 11.1. Evaluation Measures (continued)

Reentry Research Question 2.2: How has the demonstration affected individuals' access to and uptake of pre-release and post-release services, including services that address HRSNs?	• Likelihood of receiving case management before release • Likelihood of receiving MAT services before release • Likelihood of receiving 30-day supply of prescription upon release • Number of social service referrals for HRSN pre-release • Likelihood of receiving preventative care and office visits within 6 months of release • Likelihood of receiving behavioral health care within 6 months of release • Likelihood of having a claim for MAT within 6 months of release • Receipt of social services for HRSN post-release	Incarcerated individuals released from comparable facilities that are not, or not yet participating in the in the reentry demonstration	Variables will be constructed through a combination of case management and care coordination data; ProviderOne data, JBRS data, and Medicaid claims, included in ICDB (HRSN-related measures may require data from HUBs). Services that are not billed to Medicaid may be inaccessible or difficult to track.	Pre-release measures will be assessed by over time at a statewide and per-beneficiary level. Post-release measures will be assessed through difference-in-differences
Reentry Research Question 2.3: How do these measures differ by beneficiary characteristics and facility type?	Same as above	Same as above, subgroup analysis by beneficiary characteristics (sex, race, age) and facility type (jails vs. prison)	ICDB	Same as above

(continued)

Table 11.1. Evaluation Measures (continued)

Goal: Increase investment in health care and related services and improve quality of care **Reentry Hypothesis 3: The reentry demonstration will increase investments in health care and related services to improve the quality of care and maximize successful reentry for soon-to-be-released individuals and those transitioning into Medicaid upon release.**				
Reentry Research Question 3.1: How have investments aimed to improve the delivery of pre-release and post-release health care and related services impacted the quality of care for individuals soon-to-be-released or recently released?	• Asthma in Younger Adults Admission Rate (HEDIS Measure PQI15) • Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (HEDIS Measure PQI05-AD) • Heart Failure Admission Rate (HEDIS Measure PQI08-AD) • Diabetes Short-Term Complications Admission Rate (HEDIS Measure PQ101-AD) • HIV Viral Load Suppression (HVL-AD) • Initiation and Engagement of Substance Use Disorder Treatment (HEDIS Measure IET-AD) • Use of Pharmacotherapy for Opioid Use Disorder (HEDIS Measure OUD-AD) • Access to Primary Care for Adults with SMI • Access to Primary Care for Adults with SUD • Mental Health Services Utilization – Inpatient • Residential and Inpatient SUD Services (per 1,000 Member Months)	Incarcerated individuals released from comparable facilities that are not, or not yet participating in the in the reentry demonstration		Difference-in-differences

(continued)

Table 11.1. Evaluation Measures (continued)

Reentry Research Question 3.2: How did beneficiaries' experiences of the quality of care pre- and post-release differ by beneficiary characteristics and facility type?	Same as above	Same as above, subgroup analysis by beneficiary characteristics (sex, race, age) and facility type (jails vs. prison)	ICDB	Differences-in-differences
Goal: Reduce all-cause deaths **Hypothesis 4: The demonstration will reduce all-cause deaths in the near-term post-release.**				
Reentry Research Question 4.1: How did all-cause deaths in the near-term post-release change during the demonstration?	• All-cause mortality rate within 30 days post-release • All-cause mortality rate within 6 months post-release • All-cause mortality rate within 12 months post-release	Incarcerated individuals released from comparable facilities that are not, or not yet participating in the in the demonstration	ProviderOne data, data from JBRS in ProviderOne, Vital Statistics. Available in the ICDB.	Differences-in-differences
Reentry Research Question 4.2: How did all-cause deaths near-term differ by beneficiary characteristics?	Same as above	Same as above, subgroup analysis by beneficiary characteristics (sex, race, age) and facility type (jails vs. prison)	ICDB	Differences-in-differences
Goal: Reduce ED visits and inpatient hospitalizations **Reentry Hypothesis 5: The demonstration will reduce emergency department (ED) visits and inpatient hospitalizations among recently release Medicaid beneficiaries.**				
Reentry Research Question 5.1: How did the use of ED visits among recently released Medicaid beneficiaries change during the demonstration?	• Number of ED visits within 30 days post-release • Number of ED visits within 6 months post-release • Number of ED visits within 12 months post-release • Emergency Department Visits for SUD (30 days, 6 months, and 12 months post-release) • Mental Health Services Utilization-Emergency Department (30 days, 6 months, and 12 months post-release)	Incarcerated individuals released from comparable facilities that are not, or not yet participating in the in the reentry demonstration	ProviderOne data, data from JBRS in ProviderOne. Available in the ICDB.	Differences-in-differences

(continued)

Table 11.1. Evaluation Measures (continued)

Reentry Research Question 5.2: How did the use of inpatient care among recently released Medicaid beneficiaries change during the demonstration?	• Number of Inpatient visits within 30 days post-release • Number of Inpatient visits within 6 months post-release • Number of Inpatient visits within 12 months post-release • Residential and Inpatient SUD Services (30 days, 6 months, and 12 months post-release) • Mental Health Services Utilization-Inpatient (30 days, 6 months, and 12 months post-release)	Incarcerated individuals released from comparable facilities that are not, or not yet participating in the in the reentry demonstration	ProviderOne data, data from JBRS in ProviderOne. Available in the ICDB.	Differences-in-differences
Reentry Research Question 5.3: How did the use of ED and inpatient visits differ by beneficiary characteristics?	Same as above	Same as above, subgroup analysis by beneficiary characteristics (sex, race, age) and facility type (jails vs. prison)	ICDB	Differences-in-differences

Table 11.2 Implementation Questions

Implementation questions assessed via qualitative analyses				
Reentry Implementation Question 1: Which key entities are collaborating to implement and operationalize the demonstration, and what are their main roles?	- Identification of barriers and facilitators to implementing the reentry program - Description of how and why the roles or participation of those key entities changed during the demonstration - Description of how key entities describe their overall experience with implementing the demonstration	State Medicaid administrators; MCOs; administrators in prison/jail system; pre-release health providers; pre- and post-release case managers; community-based providers	Key informants	Qualitative analysis

(continued)

Table 11.2 Implementation Questions (continued)

Reentry Implementation Question 2: What challenges or barriers have key entities experienced while implementing the demonstration, and what strategies did they use to overcome them?	- Description of program barriers to implementation	State Medicaid administrators; MCOs; administrators in prison/jail system; pre-release health providers; pre- and post-release case managers; community-based providers	Key informants	Qualitative analysis
Reentry Implementation Question 3: How have key entities participating in the demonstration contributed to the coordination of care for beneficiaries?	- Identification of how key entities understand their role in contributing to coordination of care for beneficiaries - Description of how key entities understand their challenges and successes towards successful coordination for beneficiaries	Pre-release health providers; pre- and post-release case managers; community-based providers	Key informants	Qualitative analysis
Reentry Implementation Question 4: What strategies has the state used to increase coverage among Medicaid-eligible individuals and sustain coverage for individuals enrolled in Medicaid prior to incarceration?	- Identification of strategies used by state to increase coverage	State Medicaid administrators; MCOs; administrators in prison/jail system	Key informants	Qualitative analysis
Reentry Implementation Question 5: What strategies has the state used to provide benefits to individuals before release?	- Identification of strategies used by state to provide pre-release benefits (including providing case management, person-centered care plans, medication-assisted treatment, and a 30-day supply of medication upon release, as clinically appropriate), such as fostering strategic partnerships, improving cross-system collaboration, and implementing changes to data collection or data sharing practices - Description of how strategies varied by facility type or beneficiary characteristics	State Medicaid administrators; MCOs; administrators in prison/jail system	Key Informants	Qualitative analysis

(continued)

Table 11.2 Implementation Questions (continued)

Reentry Implementation Question 6: What strategies did the state use to promote continuity of care, and connect individuals to health and HRSN services after release?	- Description of strategies used by state, such as strategic partnerships, fostering cross-system collaboration, and implementing changes to data collection or data sharing practices	State Medicaid administrators; MCOs; administrators in prison/jail system; pre-release health providers; pre- and post-release case managers; community-based providers	Key informants	Qualitative analysis
Reentry Implementation Question 7 How do pre-release health providers, case managers, and community-based providers describe their experience with the demonstration?	- Description of provider experience with the demonstration - Identification of barriers and challenges - Description of suggestions for improving the demonstration	Pre-release health providers; pre- and post-release case managers; community-based providers	Key informants	Qualitative Analysis
Reentry Implementation Question 8: How did the state involve individuals with lived experience in the design and implementation of the demonstration?	- Description of state efforts to involve individuals with lived experience - Description of how the state modified implementation based on input from demonstration participants, individuals with lived experience, health care providers, or corrections staff	State Medicaid administrators; MCOs; administrators in prison/jail system; pre-release health providers; pre- and post-release case managers; community-based providers	Key informants	Qualitative analysis
Reentry Implementation Question 9: What is the experience of receiving reentry services in a carceral setting?	- Description of formerly incarcerated person's experience receiving reentry services - Description of formerly incarcerated person's satisfaction with reentry services and benefits - Description of impact of receiving reentry services on access to and receipt of health care services - Description of impact of receiving reentry services on reintegration into the community	Formerly incarcerated people (post-release) who received reentry services while incarcerated* * pending recruitment feasibility	Key informants	Qualitative analysis

Data Sources. We will use the ICDB for the majority of the quantitative analyses outlined above, as Washington's Jail Booking and Reporting System (JBRS) is integrated in HCA's ProviderOne data system and is accessible via ICDB. We will also coordinate with HCA to identify key informants.

Analytic Methods.

Quantitative approach

Quantitative analyses will be used to address Hypotheses 1-5. We provide detailed analytic plans for each hypothesis and research question below.

For these analyses, we will conduct a retrospective cohort study linking Washington Medicaid and state corrections release data. We will include individuals ages 19 to 64 years who were released from state custody and enrolled in Medicaid within 180 days of release.

Reentry Hypothesis 1: Reentry services will lead to increases in Medicaid/CHIP coverage and continuity of Medicaid coverage for individuals in carceral settings just prior to release.

Reentry Research Question 1.1: How did the implementation of the demonstration impact Medicaid enrollment for participants?

> RQ 1.1 focuses on the enrollment of individuals leaving carceral settings. Because this is a new policy and because it focuses only on enrollment – which applies only to those who fall under the policy – there is no natural "pre-policy period" or comparison group. We will address these questions with descriptive analyses showing the trends in enrollment, focusing on (1) the number of incarcerated individuals newly enrolled in Medicaid out of all individuals incarcerated in the facility and (2) the number of incarcerated beneficiaries whose Medicaid benefits were maintained or suspended rather than terminated out of all individuals incarcerated in the facility. We will calculate these as quarterly rates and display changes over time.

Reentry Research Question 1.2: How did Medicaid enrollment differ by beneficiary characteristics and facility type?

> For RQ 1.2, we will provide sub-analyses stratified by beneficiary characteristics (sex, race and ethnicity, and age categories [18-34, 35-49, 49-64) and facility type (jails vs. prison).

Reentry Hypothesis 2: The reentry demonstration will improve access to services and service uptake in carceral settings and after release.

Reentry Research Question 2.1: How has the availability of pre-release services changed with the implementation of the demonstration?

> RQ 2.1 focuses on providers and facilities that are providing services to individuals leaving carceral services. As with RQ 1.1., there is no natural pre-period or comparison group. Thus, we will calculate these ratios and display changes over time.

Reentry Research Question 2.2: How has the demonstration affected individuals' access to and uptake of pre-release and post-release services, including services that address HRSNs?

> R2.2. focuses on several outcomes, some of which occur during or pre-release, and some of which occur post-release. Analyses for these will differ according to the timing of the measure.
>
> Pre-release measures include the likelihood of receiving case management before release, likelihood of receiving MAT services before release, likelihood of receiving 30-day supply of

prescription upon release, number of social service referrals for HRSN pre-release. For these measures, there is no natural comparison group (since services are not available to those not in the re-entry program) and no natural pre-period. Thus, we will display the provision of these services over time, at a statewide level (to test for an overall increase in these services) and on a per-beneficiary level, focusing on those in the re-entry program (to assess how the amount of services to discharged beneficiaries changes over time).

Post-release measures include the likelihood of receiving preventative care and office visits within 6 months of release, likelihood of receiving behavioral health care within 6 months of release, likelihood of having a claim for MAT within 6 months of release, and receipt of social services for HRSN post-release. These measures are theoretically available to anyone leaving a carceral setting.

To assess these changes, we will rely on the anticipated roll-out of these services in Washington. The planned implementation will be done in phases, and it is anticipated that not all facilities will be included. As noted above, the roll-out will occur in three waves: July 1, 2025, January 1, 2026, and July 1, 2026.

We propose to estimate a dynamic difference-in-differences model for staggered implementation, using data from January 1, 2023 (when most COVID-19 disruptions had dissipated) through December 31, 2028. The dynamic difference-in-differences approach is preferred over the traditional "two-way fixed effects (TWFE)" model, which can produce biased results in the presence of treatment effect heterogeneity. As with other difference-in-differences approaches, this specification compares pre- and post-implementation period changes in enrollees that exit facilities with reentry programs to pre- and post- implementation period changes in comparison facilities. To account for staggered waiver implementation, the model defines implementation dynamically as follows:

$$Y_{ist} = \gamma_s + \lambda_t + \left(\sum_{l=-L^{pre}}^{L^{post}} \theta_l \, D_{st}^{l}\right) + \beta X_{ist} + \varepsilon_{ist}, \qquad (1)$$

where Y_{ist} is the outcome of interest for individual i exiting facility s at time t; γ_s are facility fixed effects; λ_t are time fixed effects of each study quarter, with one quarter omitted as a reference period; l is a counter for time since the program initiation, where negative numbers indicate pre-waiver initiation periods, zero indicates the first quarter of program implementation, and positive numbers subsequent program implementation periods; L^{pre} and L^{post} are maximum pre- and post-waiver initiation quarters; $\mathrm{D}_{\mathrm{st}}^{\mathrm{l}}$ are program implementation indicators; $\mathrm{X}_{\mathrm{ist}}$ is a vector of covariates and $\varepsilon_{\mathrm{ist}}$ are other unobserved factors.

The coefficients θ_{l} represent the common "event study" parameters, capturing changes leading up to and following treatment. The program implementation indicators, $\mathrm{D}_{\mathrm{st}}^{\mathrm{l}}$, take a value of one if an program (i) will be implemented l periods from now in facility s at time t (for $\mathrm{l} < 0$), representing outcomes in quarters leading up to the implementation; (ii) is initiated in facility s at time t (if $\mathrm{l} = 0$); and (iii) was initiated l periods ago (if $\mathrm{l} > 0$), representing outcomes in quarters following the intervention. The model described in equation (1) thus estimates changes in outcomes relative to the last pre-treatment periods in facilities implementing the reentry program relative to changes in outcomes that occurred in comparison facilities over time.

There have been a variety of recent advances in the difference-in-differences and event study literature. The evaluation team is well-versed in these and has developed models that accommodate the variation in treatment timing approaches, including work by Sun and Abraham and Callaway (2021) and Sant'Anna (2020).

The regression above is written as a linear regression. Given the nested nature of the data (beneficiaries within institutions), we will also explore an alternative approach, using a multilevel regression, nesting individuals within the institutions from which they are discharged. Theoretically, this would account for more variance in the model and increase statistical power. We note that there may be some obstacles and tradeoffs with this approach. There may be data constraints that allow us to link enrollees to specific institutional locations from which they were discharged. In addition, multilevel models often introduce new assumptions (i.e., random effects at each level of the model must be assumed to be normally distributed and uncorrelated with the outcome variable, which may not hold in the case of reentry services), which, if not met, can introduce bias. These models can also be computationally intensive, making analyses of large numbers of enrollees across multiple outcomes challenging.

We also note that the approach described above relies on the ability to link JBRS data with Medicaid beneficiaries in the period before reentry (e.g., going back through January 2023). In the event that the pre-policy linkages present data quality issues, we will adjust our approach to analyze data that focus on periods when data linkages are valid. In this case, our "treated" group will consist of enrollees who discharged from jails or prisons that are part of the reentry program, and the "untreated" group will consist of enrollees discharged from institutions not participating in the reentry program. We will use propensity scores to weight the untreated group. Propensity scores will be estimated using logistic regression, considering demographic factors such as age, gender, region of residence, race and ethnicity, as well as health risk markers derived from claims data.

The untreated group (those who did not receive reentry services) will be weighted to match the treated group (those who received reentry coverage) on these propensity scores, thereby creating a balanced comparison that minimizes confounding variables. The weighting process will use the inverse probability of treatment weighting (IPTW) approach to achieve this balance. Once we have derived these weights, we will incorporate them into a regression specification as follows:

$$Y_{it} = \beta Treat_i + \lambda X_{it} + \epsilon_{it},$$

Where Y_{it} is the outcome of interest, $Treat_i$ is an indicator equal to one for individuals receiving reentry services, X_{it} are demographic characteristics, ϵ_{it} is the error term, and the parameter of interest is β. We will conduct a weighted regression, where the untreated group receives weights based on the propensity score model. This "doubly robust" regression allows for the control of various confounding variables, such as age and pre-existing health conditions.

<u>Reentry Research Question 2.3: How do these measures differ by beneficiary characteristics and facility type?</u>

For RQ 2.3, we will provide sub-analyses stratified by beneficiary characteristics (sex, race and ethnicity, and age categories [18-34, 35-49, 49-64) and facility type (jails vs. prison).

Reentry Hypothesis 3: The reentry demonstration will increase investments in health care and related services to improve the quality of care and maximize successful reentry for soon-to-be-released individuals and those transitioning into Medicaid upon release.

Reentry Research Question 3.1: How have investments aimed to improve the delivery of pre-release and post-release health care and related services impacted the quality of care for individuals soon-to-be-released or recently released?

RQ 3.1 focuses on a variety of HEDIS measures (e.g., Asthma in Younger Adults Admission Rate; Diabetes Short-Term Complications Admission Rate; Use of Pharmacotherapy for Opioid Use Disorder). We will follow the same analytic approach as described in the post-release measures for RQ 2.1.

Reentry Research Question 3.2: How did beneficiaries' experiences of the quality of care pre- and post-release differ by beneficiary characteristics and facility type?

For RQ 3.2, we will provide sub-analyses stratified by beneficiary characteristics (sex, race and ethnicity, and age categories [18-34, 35-49, 49-64) and facility type (jails vs. prison).

Reentry Hypothesis 4: The demonstration will reduce all-cause deaths in the near-term post-release

Reentry Research Question 4.1: How did all-cause deaths in the near-term post-release change during the demonstration?

RQ 4.1 focuses on all-cause mortality rate (within 30 days post-release, 6 months, and 12 months post-release). We will follow the same analytic approach as described in the post-release measures for RQ 2.1.

Reentry Research Question 4.2: How did all-cause deaths near-term differ by beneficiary characteristics?

For RQ 4.2, we will provide sub-analyses stratified by beneficiary characteristics (sex, race and ethnicity, and age categories [18-34, 35-49, 49-64) and facility type (jails vs. prison).

Reentry Hypothesis 5: The demonstration will reduce emergency department (ED) visits and inpatient hospitalizations among recently released Medicaid beneficiaries.

Reentry Research Question 5.1: How did the use of ED visits among recently released Medicaid beneficiaries change during the demonstration? Reentry Research Question 5.2: How did the use of inpatient care among recently released Medicaid beneficiaries change during the demonstration?

RQs 5.1 and 5.2 focus on utilization measures that apply to all individuals released from jails or prisons. We will follow the same analytic approach as described in the post-release measures for RQ 2.1.

Reentry Research Question 5.3: How did the use of ED and inpatient visits differ by beneficiary characteristics?

For RQ 5.3, we will provide sub-analyses stratified by beneficiary characteristics (sex, race and ethnicity, and age categories [18-34, 35-49, 49-64) and facility type (jails vs. prison).

Additional Details that apply to generally to the Quantitative Approach – testing hypotheses for 30 days vs. 90 days of reentry services

In addition to the general tests above, contingent on CMS approval for Washington and the availability of data to categorize enrollees and the length of which pre-release services are provided, we will conduct additional analyses that are intended to test for differences in outcomes for individuals who receive 30 days of coverage or less, compared individuals who receive coverage for a period over 30 days and up to 90 days immediately prior to a beneficiary's expected release date. We will follow a design similar to that described above, redefining the treatment group as individuals with 60 to 90 days of coverage and the comparison group as individuals with less than 30 days of coverage.

Additional design considerations

Some of the analyses identified above require examining a subset or stratification of the target population. When listing outcome variables, for concision, we have typically listed the target population as "eligible Medicaid beneficiaries," noting that in some cases, the eligible populations will change. For example, an outcome variable like "Asthma in Younger Adults Admission Rate (HEDIS Measure PQI15)" is only relevant for a specified population. We will define these outcomes and subpopulations accordingly.

We also note that analyses of these subpopulations require assumptions similar to those of the larger subpopulations. For example, analyses that use the difference-in-differences approach rest on the assumption of parallel trends, and these assumptions extend to any analyses that focus on subsets or stratification.

While we are committed to incorporating these methodologies, it is essential to retain some flexibility in our approach. The dynamic nature of Medicaid reforms and the variability in data availability necessitates an adaptable research design. We will continuously assess the feasibility and appropriateness of these methods throughout the evaluation process. We will regularly review the implementation of these strategies and make adjustments as necessary. This iterative process will help ensure that our evaluation remains methodologically sound and aligned with the objectives of the reform.

Qualitative approach

Our qualitative analysis will include interviews with Medicaid officials, correctional facility administrators and providers, and community providers who coordinate services with carceral settings. We will use semi-structured interviews, along with a review of documents collected from publicly available and from the participants we interview. These conversations will be designed to identify the barriers and facilitators impacting the policy's implementation. We aim to provide context about the policy's practical dimensions, such as modifications in enrollment procedures, adjustments in healthcare provision, and any obstacles faced in the policy's implementation. We will engage carceral and community service providers to understand their experiences both providing services in carceral settings and developing relationships to facilitate the transition of individuals into the community post-release. Across our analyses, we will observe cross-system communication and coordination between carceral and community settings. This qualitative component of the evaluation will further help uncover unintended effects, both beneficial and detrimental, providing additional context to our quantitative findings. We anticipate conducting approximately 30 interviews across a range of key informants, including state leaders responsible for program implementation, carceral facility leaders, and

participating providers delivering re-entry services (both in-reach providers and carceral providers). Pending post-release beneficiary recruitment feasibility, we will also conduct up to 10 interviews of post-release interviews with people who previously received reentry services while incarcerated. Formerly incarcerated participants will receive a $30 gift card as a “thank you” for participating. Our evaluation team will collaborate with HCA to develop the best methods for identifying and recruiting beneficiaries who received reentry services while incarcerated. All data collection, analysis, and mixed methods analysis will be conducted using the same process as described in Section 5.

Methodological Limitations. Our analysis relies on a cohort study design where the comparison cohort is weighted to the treatment group using a propensity score model. While propensity score weighting is useful for addressing observable confounders, it cannot account for unmeasured variables that may influence outcomes. In the context of using claims data, this means that critical aspects of general health or well-being, which are not typically captured in such datasets, remain unaddressed. Consequently, this could lead to residual confounding, affecting the validity of our findings. Additionally, the quality of the propensity score model is contingent on the comprehensiveness and accuracy of the variables included; any omission of key predictors could bias the results. Our approach also assumes that the treatment effect is uniform across all individuals, which may not be true in practice, potentially leading to oversimplified conclusions about the intervention's impact.

Section 12: Long-Term Services and Supports Presumptive Eligibility

General Background Information

Long-Term Services and Supports Presumptive Eligibility (LTSS PE) is a new benefits package under MTP 2.0 that allows the state to waive certain Medicaid requirements while individuals are applying for in-home and community-based LTSS. LTSS PE gives applicants presumed eligible immediate access to a limited set of in-home and community-based LTSS prior to a final financial eligibility determination and full functional eligibility assessment. While presumptive eligibility has been used for MAC and TSOA users, this initiative expands its application.

LTSS PE seeks to eliminate the institutional bias in Medicaid that can inadvertently funnel older adults and people with disabilities into institutional care. In doing so, LTSS PE aims to expedite the delivery of benefits in the most appropriate and least restrictive setting, averting unnecessary or premature nursing facility care. Prior to LTSS PE, individuals with pending community or in-home LTSS services applications were met with a crossroads: wait two to three months to establish full functional and financial eligibility, relying on family support or private pay before urgently needed services would begin or enter a skilled nursing facility that can bear the cost of providing services immediately until they are retroactively paid upon full eligibility determination. LTSS PE creates a new path for individuals seeking community or in-home LTSS services by creating a mechanism for home and community-based service providers to provide services and be paid without delay.

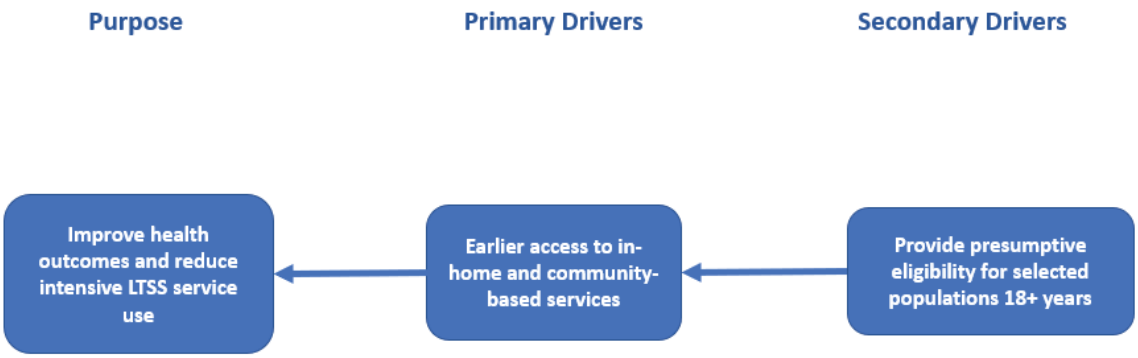
Individuals 18 years and older may qualify for LTSS PE if they live in their own home, have been discharged from an acute care hospital or community psychiatric hospital within the last 30 days (during phase one), can attest that their income is below the monthly limit, and are not receiving any other Medicaid-funded LTSS. The LTSS PE program can cover personal care services for clients with a Medicaid Personal Care (MPC) level of care or personal care services for clients with a Nursing Facility Level of Care (NFLOC), as well as a variety of other services, including home delivered meals, and community transitions or sustainability services.

LTSS PE will be implemented in three phases. The first phase will open LTSS PE to people discharged from an acute care or psychiatric hospital. The second phase removes the requirement of recent discharge and expands LTSS PE to individuals seeking services in their own homes. The third and final phase will expand LTSS PE to people seeking community-based LTSS in a residential licensed facility. HCA anticipates that the program will apply to a small number of individuals in the first few months but will grow to apply to approximately 20 individuals per month.

Evaluation Questions and Hypotheses

Driver Diagram. Exhibit 12.1 below depicts the relationship between the initiative's purpose to improve health outcomes and reduce intensive LTSS service use and the primary and secondary drivers necessary to achieve this overall goal. Within this initiative, one primary driver contributes directly towards achieving the initiative's purpose, with one secondary driver necessary to support the primary drivers.

Exhibit 12.1. Driver Diagram



Our evaluation questions address the following hypotheses:

H1. The LTSS PE program will reduce the waiting time to receive home and community-based services.

H2. The LTSS PE program will accurately identify individuals who could benefit from MAC & TSOA.

H3. The LTSS PE program will reduce skilled nursing facility (SNF) use.

Methodology

Evaluation Design. The LTSS PE analysis will be primarily descriptive.

Target and Comparison Populations. The target population will be those enrolled in LTSS PE.

Evaluation Period. We propose to analyze data for July 1, 2023, through June 30, 2028, assuming that claims data for CY 2028 are available on January 1, 2029.

Evaluation Measures. We propose using the following evaluation measures.

Table 12.1. Evaluation Measures

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Goal: Improve access to in-home or community-based services provided through MAC & TSOA **LTSS PE Hypothesis 1: The LTSS PE program will reduce the waiting time to receive home and community-based services.**				
LTSS PE Research Question 1.1: How does access to care change?	• Number of days to from application to the MAC or TSOA program to their first utilization of services • Number and percentage of people using LTSS PE	Eligible Medicaid enrollees	ICDB, supplemented with application data	Descriptive analysis

(continued)

Table 12.1. Evaluation Measures (continued)

Goal: Identify enrollees who could benefit from MAC & TSOA services **LTSS PE Hypothesis 2: The LTSS PE program will accurately identify individuals who could benefit from MAC & TSOA.**				
LTSS PE Research Question 2.1: How does the accuracy rate in LTSS PE determinations after full financial and functional eligibility determinations change over time?	• Assessments of screening tool and subsequent eligibility determinations	Eligible Medicaid enrollees	ICDB, supplemented with application data	Descriptive analysis
Goal: Reduce SNF use **LTSS PE Hypothesis 3: The LTSS PE program will reduce skilled nursing facility (SNF) use.**				
LTSS PE Research Question 3.1: How do the number and percentage of people admitted to a skilled nursing facility change after implementing LTSS PE?	• Skilled nursing facility use	Eligible Medicaid enrollees	ICDB, supplemented with application data	Descriptive analysis
LTSS PE Research Question 3.2: What are the characteristics of people who use LTSS PE compared to those who do not?	• Demographic data	Eligible Medicaid enrollees	ICDB, supplemented with application data	Descriptive analysis
LTSS PE Research Question 3.3: How does HCBS service use differ among enrollees who use LTSS PE compared to those who do not use LTSS PE?	• HCBS services.	Eligible Medicaid enrollees	ICDB, supplemented with application data	Descriptive analysis/ Regression of LTSS PE users vs. non-users

Data Sources. We will use the ICDB for these analyses.

Analytic Methods.

Quantitative approach

We will describe the first two outcome measures each month throughout the evaluation period. We will also stratify our data by multiple factors, as applicable:

- County of residence (for the first three outcomes)
- Urban vs rural area (for the first three outcomes)
- MSA-level number of personal care workers per 1,000 residents (for the first outcome)
- County-level SNF beds per 1,000 residents (for the third outcome)

We will also describe the key demographic and health characteristics (age, sex, race/ethnicity, chronic conditions, functional and cognitive impairments, urban/rural area, Medicare eligibility) and the type of HCBS received between people who started in presumptive status and the rest.

Contingent on feasibility, we will also collect pre-demonstration data for the PE assessment and use these data to assess wait times between application and provision of services before, during, and after the program's implementation to characterize changes in access to care. We will use these data to describe how wait times between eligibility application, eligibility confirmation, and first receipt of in-home services change with the PE program.

To mitigate any small sample issues associated with an anticipated low volume of participants (approximately 20 individuals per month), we will limit the extent to which we stratify any outcomes and, alternatively, aggregate data over extended periods, producing quarterly, semi-annual, or annual summaries to ensure robust and privacy-compliant reporting of program outcomes.

Qualitative approach

We do not plan to conduct a qualitative study to understand the effect of LTSS PE.

Methodological Limitations. An important limitation of this study is the lack of a control group or comparison data. We do not have data on the experience of individuals who might need HCBS but do not enroll under LTSS PE. We cannot identify the counterfactual scenario without data on individuals not enrolled in the LTSS PE program. This limitation restricts our ability to draw definitive conclusions about the program's impact and effectiveness. Additionally, without a comparison group, the analysis is constrained in its capacity to isolate the program’s effects from other external factors that may influence the observed outcomes.

Section 13: Contingency Management

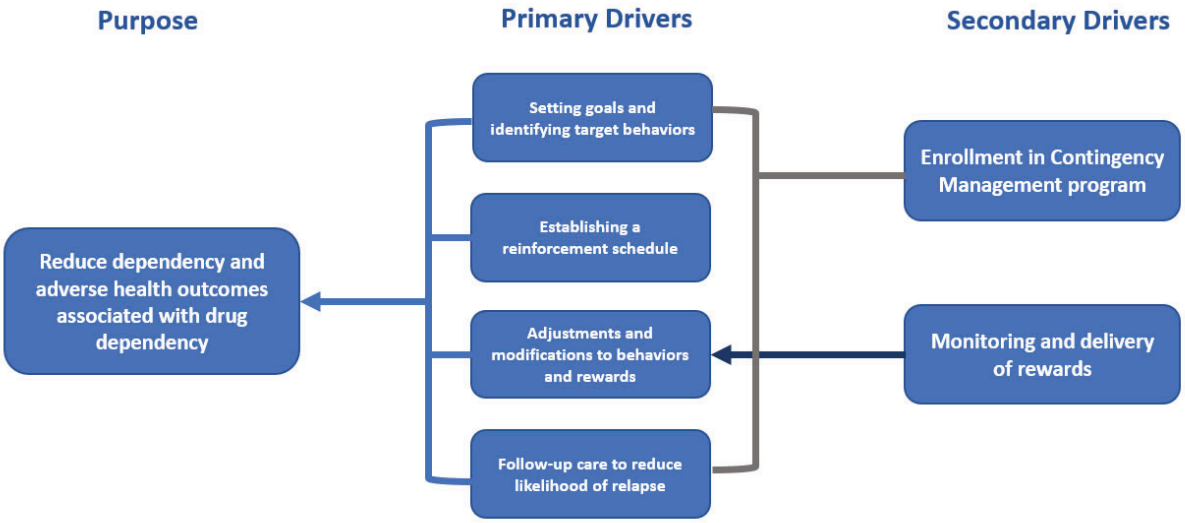
General Background Information

Contingency management (CM) is a new component of MTP 2.0. CM is an evidence-based approach in the treatment of substance use disorders that utilizes behavioral principles to reinforce abstinence and positive behavior changes that apply to drug-using behaviors. This approach is grounded in the theory of operant conditioning, where desirable behaviors are rewarded, thus increasing the likelihood of their recurrence. In the context of substance use treatment, CM typically involves providing patients with tangible incentives or rewards for evidence of abstinence (e.g., negative point-of-care drug tests) or engagement in treatment-related activities. CM is considered among the most effective interventions for stimulant use disorders (methamphetamines). Within Washington's demonstration, under CM, participants with qualifying stimulant use disorders may receive small gift cards for goods and services, with a maximum amount of $599 per 12-month period. Washington will provide training and implementation assistance to participating treatment sites to ensure they are prepared to administer CM.

Evaluation Questions and Hypotheses

Driver Diagram. Exhibit 13.1 below depicts the relationship between the initiative's purpose to reduce drug dependency and adverse health outcomes and the primary and secondary drivers necessary to achieve this overall goal. Five primary drivers contribute directly towards achieving the initiative's purpose, with one secondary driver necessary to support the primary drivers.

Exhibit 13.1. Driver Diagram



Hypotheses associated with this initiative pertain to its effectiveness in improving outcomes for Medicaid enrollees with substance use disorders. We hypothesize that CM will:

H1. CM will increase rates of initiation and engagement in substance use disorder treatment.
H2. CM will reduce overdose deaths.
H3. CM will reduce utilization of emergency departments, inpatient admissions, and hospital readmissions.
H4. CM will improve access to primary care.
H5. CM will improve social outcome metrics.

Qualitative data collection and analysis will answer the following evaluation questions:

I1. What are program leader and administrator experiences with CM implementation? What were barriers and facilitators to implementing this program?
I2. What were they key elements of CM, and how do those align with fidelity?
I3. What were participants experiences in the CM program?
I4. How did the CM program affect access to primary care and social outcomes?

General Background Information

Authority to use waiver funds to address health-related social needs (HRSN) is a new component of MTP 2.0. In recent years, states aiming to enhance Medicaid outcomes and reduce costs have focused on addressing HRSN. These factors focus on addressing individual-level outcomes resulting from barriers to accessing healthy food, safe and stable housing, healthcare and transportation. . Neglecting these needs often leads to poorer health results and increased healthcare expenses. Tackling these health-related social needs can enhance health outcomes and lower Medicaid costs. Washington's latest waiver, approved by CMS, allows for the inclusion or expanded coverage of specific HRSN services. The HRSN services include nutrition education; medically tailored food assistance; short-term grocery resources; recuperative care and short-term posthospitalization housing; short-term post-transition housing for up to six months; housing supports; and medically necessary home modifications and remediations to address high-risk clinical conditions. Additional support includes case management, outreach, education, and infrastructure investments to bolster these services. Expanding Medicaid's reach by covering specific HRSN services and supports is anticipated to further Medicaid's goals. This approach is designed to help beneficiaries maintain their coverage continuity and gain access to necessary healthcare services. HRSN services will be delivered through both fee-for-service and managed care systems, with some services offered via nine regional Community Hubs and one statewide Native Hub.

The waiver approvals also clarify that these services apply only to specific populations. Targeted populations may include: individuals post-discharge or those with chronic conditions, who screen positive for food, housing, or financial insecurity, individuals transitioning out of institutional care or congregate settings; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter; youth transitioning out of the child welfare system; enrollees who live in the community and are compromised in their activities of daily living and/or have been assessed to have a behavioral health need, and whose unpaid caregivers require relief to avoid the enrollee being placed in an institution; adults who are intoxicated but conscious, cooperative, able to walk, nonviolent, and free from immediate medical distress, who would otherwise be transported to the emergency department or

jail; or have presented at the emergency department and can safely be diverted to a stabilization center; individuals at risk for institutionalization due to inaccessible living environments; individuals with poorly controlled asthma, or other medical condition(s) exacerbated by in-home environmental factors; and individuals with functional impairments and no other adequate support system.

Methodology

Evaluation Design. We will use a mixed methods design where qualitative interviews inform and explain quantitative analyses of claims data. The quantitative analyses will use a difference-in-differences approach, comparing outcomes for Medicaid beneficiaries receiving CM to a propensity-score matched group of beneficiaries who do not receive CM. Qualitative analysis will be inductive, focusing on operant condition, the theory that informs this program.

Treatment and Comparison Populations. The treatment population of this study is CM participants. The comparison population will be a group of matched non-participants who qualify for the program but are not selected.

Evaluation Period. We propose to analyze data for July 1, 2023, through June 30, 2028, assuming that the CM initiative begins July 1, 2024 (allowing us 12 months of observation prior to the entry into CM) and further assumes that claims data for CY 2028 are available on January 1, 2029.

Evaluation Measures. We propose using the following evaluation measures.

Table 13.1. Evaluation Measures

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Goal: Increase engagement with treatment **CM Hypothesis 1: CM will increase rates of initiation and engagement in substance use disorder treatment.**				
CM Research Question 1.1: How is CM associated with changes in the rates of initiation and engagement in substance use disorder treatment?	• Substance Use Disorder (SUD) Treatment Rate • Initiation and Engagement of Substance Use Disorder Treatment	Eligible Medicaid enrollees	ICDB	Difference-in-Differences
Goal: Reduce overdose deaths by increasing engagement with treatment **CM Hypothesis 2: CM will reduce overdose deaths.**				
CM Research Question 2.1: How is CM associated with changes in overdose deaths?	• Overdose deaths	Eligible Medicaid enrollees	ICDB	Difference-in-Differences

(continued)

Table 13.1. Evaluation Measures (continued)

Goal: Reduce the use of acute services by increasing engagement with treatment **CM Hypothesis 3: CM will reduce utilization of emergency departments, inpatient admissions, and hospital readmissions.**				
CM Research Question 3.1: How is CM associated with changes in the utilization of emergency departments, inpatient admissions, and hospital readmissions?	• Emergency (ED) Department Visit Rate • Acute Hospital Use among Adults • Hospital Readmission within 30 Days	Eligible Medicaid enrollees	ICDB	Difference-in-Differences
Goal: Increase access to primary care **CM Hypothesis 4: CM will improve access to primary care.**				
CM Research Question 4.1: How is CM associated with changes in access to primary care?	• Primary care visits	Eligible Medicaid enrollees	ICDB	Difference-in-Differences
Goal: Reduce homelessness and contacts with the justice system **CM Hypothesis 5: CM will improve social outcome metrics.**				
CM Research Question 5.1: How is CM associated with changes in the social outcome metrics?	• Homelessness • Transition out of homelessness (defined below) • Transition into homelessness (defined below) • Employment • Criminal Justice Involvement	Eligible Medicaid enrollees	ICDB	Difference-in-Differences

Table 13.2 Implementation Questions

Implementation questions assessed via qualitative analyses				
CM Implementation Question 1: What are program leader and administrator experiences with CM implementation? What were barriers and facilitators to implementing this program?	- Identification of barriers and facilitators to implementing the reentry program	State Medicaid administrators; administrators in prison/jail system; behavioral health providers	Key informants	Qualitative analysis
CM Implementation Question 2: What were they key elements of CM, and how do those align with fidelity?	- Identification of key elements of CM, and alignment with fidelity	State Medicaid administrators; administrators in prison/jail system; behavioral health providers	Key informants	Qualitative analysis

(continued)

Table 13.2 Implementation Questions (continued)

CM Implementation Question 3: What were participants experiences in the CM program?	- Description of CM program participants experiences - What did beneficiaries find helpful about the program - Where do participants see opportunities to strengthen the program and its impact	Participants in CM	Key informants	Qualitative analysis
CM Implementation Question 4: How did the CM program affect access to primary care and social outcomes?	- Understanding of CM experience among participants	Participants in CM	Key informants	Qualitative analysis

Data Sources. We will use the ICDB for these analyses. We will also coordinate with HCA to identify key informants for qualitative data collection.

Analytic Methods.

Quantitative approach

The unit of analysis is at the individual-quarter level. We use a difference-in-differences approach, which requires defining a pre- and post-intervention period relative to the first CM enrollment (also called the index quarter). Several considerations influence the selection of appropriate pre- and post-intervention periods. First, the post-intervention period should be sufficiently long to capture the full effects of the policy. Second, a longer post-intervention period implies a smaller sample size due to right-censoring. Third, the pre-and post-intervention period should not include temporary outcome changes around the time of enrollment that do not reflect the effects of the policy. To balance these considerations, we propose excluding the last two quarters before the index quarter as the pre-intervention period and the first two quarters following the index quarter as the post-intervention period. Following a preliminary review of outcome trends of CM participants relative to their enrollment, we will consider alternative pre- or post-intervention period definitions (e.g., the first full year following enrollment) to ensure that our design captures the effects of the policy. Propensity scores will be estimated using logistic regression, considering demographic factors such as age, region of residence, race and ethnicity, and gender. We will match exactly on the primary drug or drug dependencies (e.g., methamphetamines, alcohol, opioids, or marijuana.).

The regression equation may be written as follows:

$$Y_{it} = \alpha Treat_i + \beta Post_t + \delta(Treat_i x Post_t) + \lambda X_{it} + \epsilon_{it},$$

Where Y_{it} is the outcome of interest, $Treat_i$ is an indicator equal to one if individual i is in the treatment group, $Post_t$ is an indicator equal to one for the post-intervention period X_{it} are demographic characteristics, ϵ_{it} is the error term, and the parameter of interest is δ.

Special considerations:

- We will assess whether outcomes move in parallel for the treatment and comparison group prior to CM enrollment. Parallel trends before enrollment suggest that subsequent changes can be

attributed to the effects of CM; we will discuss implications for interpreting results in cases where trends are not parallel.

- One option to address non-parallel trends is to include pre-enrollment outcomes in the propensity score matching step. However, matching on pre-intervention outcome trends may introduce regression to the mean bias. Alternatively, we may select appropriate pre- and post-intervention periods to minimize the influence of temporary outcome changes around the time of enrollment.
- The regression approach estimates the average effects of CM enrollment for the full post-enrollment period. Alternatively, we can specify multiple post-intervention periods to capture short-term and longer-term effects of the program.
- Pending a sufficient sample size, we will also consider stratification by demographic groups (e.g., gender, age, race and ethnicity) or geography (rural versus urban).

Additional design considerations

Some of the analyses identified above require examining a subset or stratification of the target population. When listing outcome variables, for concision, we have typically listed the target population as "eligible Medicaid beneficiaries," noting that in some cases, the eligible populations will change. For example, an outcome variable like "blood pressure control among patients with diabetes" is only relevant for patients with diabetes; statin therapy for patients with cardiovascular disease is only relevant for patients with cardiovascular disease. We will define these outcomes and subpopulations accordingly.

We also note that analyses of these subpopulations require assumptions similar to those of the larger subpopulations. For example, analyses that use the difference-in-differences approach rest on the assumption of parallel trends, and these assumptions extend to any analyses that focus on subsets or stratification.

The evaluation team has extensive experience in working with difference-in-difference models, including theoretical and empirical articles using difference-in-differences,[2–4,4–10] with several incorporating the most recent advances in sensitivity analyses and robustness checks.[2,4,11,12] For each analysis, we will assess the quality of the comparison group or the robustness of the assumptions. We note that, from a practical point of view, there are tradeoffs between (a) the number of outcomes that can be analyzed and (b) the extent to which the parallel trends assessment can be rigorously assessed and accounted for. Our evaluation will seek a balance in providing rigorous analyses and transparency in our assumptions in a manner that is commensurate with the number of outcomes and analyses conducted.

Where possible, we will implement sub-setting or stratification characteristics based on pre-intervention data. This will involve identifying relevant characteristics and ensuring they are measured prior to the implementation of the reform. By doing so, we aim to mitigate endogeneity concerns and enhance the validity of our analysis. In scenarios where defining sub-setting characteristics prior to the demonstration start is infeasible, we will explore the use of separate modeling approaches.

While we are committed to incorporating these methodologies, it is essential to retain some flexibility in our approach. The dynamic nature of Medicaid reforms and the variability in data availability necessitates an adaptable research design. We will continuously assess the feasibility and appropriateness of these methods throughout the evaluation process. We will regularly review the implementation of these strategies and make adjustments as necessary. This iterative process will help ensure that our evaluation remains methodologically sound and aligned with the objectives of the reform.

Qualitative approach

We will use the same approach described in Section 5 above to collect and analyze qualitative data. To understand CM, we will collect relevant program documents and conduct semi-structured interviews with informants, including HCA administrators who are implementing and/or knowledgeable about CM, individuals at Washington State University leading the training efforts and managing the fidelity reviews, and leaders at participating sites. For the participating sites, we will aim to conduct interviews with state leaders of CM (N=3), WSU trainers (N=7), and one representative from the majority of pilot sites (N=20). We anticipate conducting approximately 30 interviews, but we will continue the process of iterative sampling and data collection until saturation is reached.

To answer the last research question, we will conduct approximately 15 interviews (30 minutes) with beneficiaries who participated in the CM pilot. The interviews will focus on learning about their experiences with this type of treatment incentive. We will aim to sample participants who received care from a range of the participating sites. Interview participants will receive a $30 gift card as a "thank you." Our evaluation team will collaborate with HCA to develop the best methods for identifying and recruiting beneficiaries who participated in the CM pilot.

Methodological Limitations. One of the primary limitations of this evaluation design is the extent to which we can accurately identify participants in the CM program. Ideally, the CM program will include a patient registry that can be linked to claims data for evaluation purposes. A second concern is uncertainty around the total number of CM participants. For the evaluation to be statistically powerful and reliable, a sufficient number of participants is crucial. Third, the analysis is limited to administrative records and thus does not include information regarding the use of gift cards. Fourth, people are not randomly assigned to the CM program, and their outcomes might, therefore, systematically differ from those of the comparison group in ways that could affect the validity of the difference-in-differences design.

Section 14: Health-Related Social Needs

Implementing the HRSN Initiative

Washington State's HRSN protocol establishes a detailed and innovative framework for addressing adverse social determinants of health among Medicaid beneficiaries. The HRSN initiative enables Medicaid enrollees to access evidence-based, non-medical services tailored to address unmet social needs that contribute to poor health outcomes. The protocol defines a comprehensive set of services, including nutrition supports (e.g., medically tailored meals, grocery provisions, and fruit and vegetable prescriptions), housing-related services (e.g., short-term post-hospitalization housing, rent assistance, and environmental modifications), and other supports like case management and caregiver respite. These interventions are guided by eligibility criteria that include a combination of clinical and social risk factors. Eligibility is determined through evidence-based screening tools that assess needs such as food insecurity, housing instability, financial challenges, and interpersonal safety.

Central to the protocol's implementation is the integration of Washington's nine Accountable Communities of Health (ACHs) and one statewide Native Hub, which serve as regional anchors for service delivery. ACHs, as independent nonprofit organizations, align with the state's Medicaid purchasing regions to ensure localized, community-driven services. Community Hubs and the Native Hub established under this framework will provide care coordination, outreach, and education, acting as connectors between individuals and the services they require. This approach allows for tailored service delivery while ensuring that all eligible beneficiaries across the state have access to support.

The protocol emphasizes the importance of medical appropriateness and individual choice in the provision of services. Beneficiaries may opt out of services at any time, and participation does not preclude access to other medically necessary care. To facilitate continuity of care, the state is developing shared care plans that can be accessed by providers, managed care organizations (MCOs), and community-based organizations. These plans ensure that services are coordinated effectively and that referrals are tracked to completion using a closed-loop system.

To receive funding, Hubs must establish advisory bodies, demonstrate contract and risk management capabilities, and submit detailed policies for care management, data collection, and privacy. They must implement a HRSN screening process aligned with other Hubs and submit plans for outreach, closed-loop referrals, and community-driven responsive service delivery. Each Hub must develop person-centered care plans, updated annually, and expand its network to include community partners for referrals. The model is intended to improve access to community-based services that are not integrated into Washington's Medicaid systems.

Washington has proposed a per-member-per-month (PMPM) payment rate of $2.68 to ensure financial stability for hubs, recognizing their limited reserves and community-focused missions. Payments will be conditioned on quarterly data reporting, with end-of-year reconciliations to validate service performance and cost alignment.

Implementation of the HRSN program has a phased launch.

Phase 1a launched January 1, 2025, directing uses nine Community Hubs and the statewide Native Hub to focus on "social care supports":

- Case management
- Outreach
- Education

Phase 1b will launch Spring and Summer 2025 and will include:

- Housing transition navigation services
- Rent/temporary housing
- Medical respite (e.g., recuperative care and short-term post-hospitalization housing. Launch date: July 2025)

Later phases will include:

- Nutrition supports
- Home accessibility, remediation, and adaptation services (medically necessary environmental accessibility and remediation adaptation)
- Caregiver respite services
- Community transition services (including transportation for non-emergency, non-medical needs and personal care and homemaker services)Stabilization centers *
- Day habilitation*

* pending future rate methodology approvals of the services

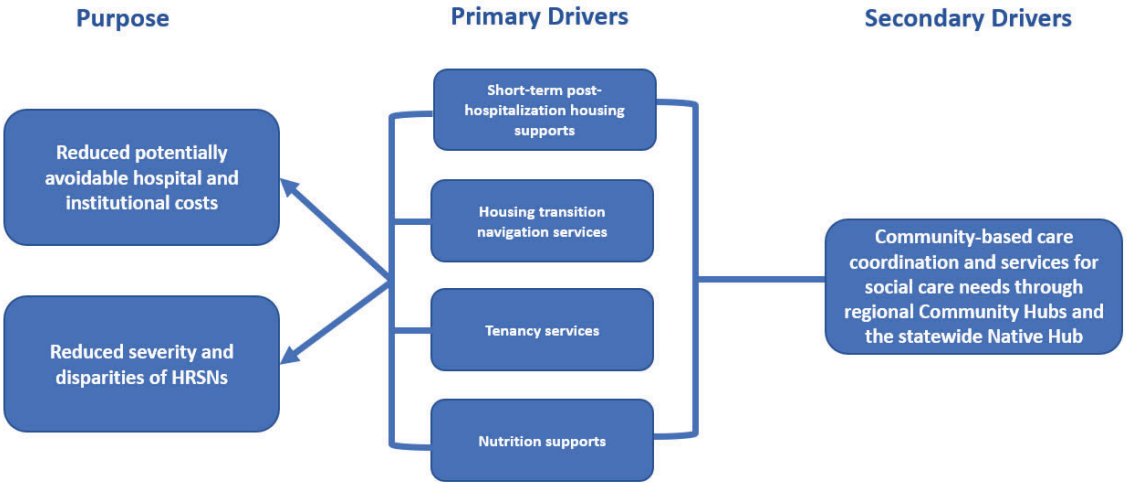
The state is pursuing dual funding mechanisms, utilizing both fee-for-service and managed care models. For managed care enrollees, selected HRSN services may be provided under in-lieu-of-services (ILOS) authority, further expanding access.

The HRSN protocol also incorporates robust public communication strategies, ensuring transparency and stakeholder engagement. It allows for flexibility in adapting services based on evolving needs, including updating eligibility criteria and expanding service offerings.

Evaluation Questions and Hypotheses

Driver Diagram. Exhibit 14.1 below depicts the relationship between the initiative's purpose to improve health outcomes and reduce unnecessary medical service use and the primary and secondary drivers that are necessary to achieve this overall goal. In this example, four primary drivers contribute directly towards achieving the initiative's purpose, with one secondary driver necessary to support the primary drivers.

Exhibit 14.1. Driver Diagram



We will address the following hypotheses:

- **H1.** The demonstration will meet or reduce the severity of HRSN for beneficiaries overall and among subpopulations who experience inequities in HRSN.
- **H2.** By meeting or reducing the severity of HRSN, the demonstration will increase beneficiaries' use of preventive and routine care and reduce their use of potentially avoidable hospital and institutional care (ED visits, inpatient care, and nursing facilities).
- **H3.** By meeting or reducing HRSN, the demonstration will improve physical and mental health outcomes among beneficiaries overall and among subpopulations who experience disparities in physical and mental health outcomes.

Evaluation Measures. Following CMS guidance, we consider the following hypotheses, research questions, and implementation questions.

Table 14.1. Evaluation Measures

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Goal: Meet or reduce severity of HRSN **HRSN Hypothesis 1. The demonstration will meet or reduce the severity of HRSN for beneficiaries overall and among subpopulations who experience inequities in HRSN.**				
HRSN Research Question 1.1: How does the HRSN demonstration impact the use of HRSN services?	• Number of people receiving HRSN services • Types of HRSN services received, including **Phase 1a Services** • HRSN referrals • Outreach • Education **Phase 1b Services** • Housing transition • Navigation services • Rent/temporary housing • Medical respite (e.g., recuperative care and short-term post-hospitalization housing. Launch date: July 2025) **Later Phase Services** • Nutrition supports • Stabilization centers * • Day habilitation* ○ Caregiver respite Home accessibility, remediation, and adaptation services Community transition services • Percent of people who received more than 1 HRSN service *pending future rate methodology approvals of the services	Likely to be an indicator file from Hubs that will flag HUB enrollment for individuals; Additional work needed to identify what data may be available as appropriate; ProviderOne	Inclusion of this variable is tentative. If the service is billed to Medicaid (as a claim or encounter) then this will be feasible. If not, additional data will be required from facilities and/or HUBs.	Descriptive analysis of quarterly trends

(continued)

Table 14.1. Evaluation Measures (continued)

HRSN Research Question 1.2: How does the HRSN demonstration impact rates of HRSN and their severities?	• Receipt of Substance Use Disorder Treatment for Medicaid Beneficiaries Following Release from a Correctional Facility • Receipt of Outpatient Mental Health Treatment for Medicaid Beneficiaries Following Release from a Correctional Facility. • Employment (Percentage of enrollees ages 18 to 64 with any earnings in the year, as reported by the Washington State Employment Security Department • Arrest Rate (Percentage of enrollees ages 18 to 64 years of age who were arrested at least once in the year, as reported by the Washington State Patrol.) • The percentage of Medicaid enrollees who were homeless in at least one month in the measurement year (referred to as HOME-N) • The percentage of Medicaid enrollees who were homeless or unstably housed in at least one month in the measurement year (HOME-B)	Eligible Medicaid enrollees, including HRSN beneficiaries	ICDB supple-mented with JBRS and HRSN data	Generalized Random Forest
HRSN Research Question 1.3: How does the HRSN demonstration impact disparities in HRSN?	Same as 1.2	Same as 1.2, disaggregated as feasible	Same as 1.2	Same as 1.2
HRSN Research Question 1.4: How do beneficiaries understand the HRSN demonstration?	Description of beneficiary understanding of HRSN demonstration	Beneficiaries receiving HRSN services	Key informants	Qualitative analysis
HRSN Research Question 1.5: How does the HRSN demonstration impact beneficiary use of HRSN services?	Description of impact of HRSN demonstration services on beneficiaries	Beneficiaries receiving HRSN services	Key informants	Qualitative analysis

(continued)

Table 14.1. Evaluation Measures (continued)

Goal: Increase beneficiaries' use of preventive and routine care and reduce potentially avoidable hospital and institutional care. **HRSN Hypothesis 2: By meeting or reducing the severity of HRSN, the demonstration will increase beneficiaries' use of preventive and routine care and reduce avoidable hospital and institutional care utilization (ED visits, inpatient care, and nursing facilities).**				
HRSN Research Question 2.1: How does the HRSN demonstration impact beneficiaries' use of preventive and routine care?	• Adults Access to Preventive/Ambulatory Health Services (AAP) • Child and Adolescent Well-Care Visits (WCV) • Immunizations for Adolescents (IMA) • Cervical Cancer Screening (CCS) • Chlamydia Screening in Women (CHL)	Eligible Medicaid enrollees, including HRSN beneficiaries	Pre-post analysis	Generalized Random Forest
HRSN Research Question 2.2: How does the HRSN demonstration impact the use of hospital and institutional care?	• Plan All-Cause Readmissions (PCR) • Acute Hospital Utilization (AHU) • Emergency Department Utilization (EDU)	Eligible Medicaid enrollees Eligible Medicaid enrollees, including HRSN beneficiaries	ICDB supple-mented with HRSN data	Generalized Random Forest
HRSN Research Question 2.3: How does the HRSN demonstration impact disparities in the use of hospital and institutional care?	Same as 2.2	Same as 2.2, disaggregated as feasible	Same as 2.2	Same as 2.2
HRSN Research Question 2.4: How does the HRSN demonstration affect health care expenditures?	• Total health care expenditures	Eligible Medicaid enrollees	ICDB supple-mented with HRSN data	Pre-post analysis
Goal: Improve physical and mental health outcomes **HRSN Hypothesis 3: By meeting or reducing HRSN, the demonstration will improve physical and mental health outcomes among beneficiaries overall and among subpopulations who experience disparities in physical and mental health outcomes.**				
HRSN Research Question 3.1: How does the HRSN demonstration impact beneficiaries' physical and mental health outcomes?	Description of HRSN demonstration impact on beneficiary physical and mental health outcomes	Beneficiaries receiving HRSN services; HCA, MCOs, HRSN Connectors and Service Providers	Key informants	Qualitative analysis
HRSN Research Question 3.2: How does the HRSN demonstration impact disparities in health outcomes?	- Description of HRSN demonstration impact on disparities in health outcomes	Beneficiaries receiving HRSN services; HCA, MCOs, HRSN Connectors and Service Providers	Key informants	Qualitative analysis

Table 14.2. Implementation Questions

Implementation questions assessed via qualitative analyses				
HRSN Implementation Question 1: Which key entities are collaborating to implement and operationalize the demonstration, and what are their main roles? How and why have the roles or participation of those key entities changed during the demonstration?	- Identification of key entities - Description of key roles and changes in those roles	HCA, MCOs, HRSN Connectors and Service Providers	Key informants	Document review Qualitative Analysis
HRSN Implementation Question 2: What are barriers and facilitators for key entities implementing the demonstration, and what strategies have key entities used to overcome barriers?	- Identification of implementation barriers and facilitators - Identification of key strategies to overcome barriers - Description of suggestions to improve implementation	HCAHCA, MCOs, HRSN Connectors and Service Providers	Key informants	Document review Qualitative Analysis
HRSN Implementation Question 3: What facilitators and barriers to participation do beneficiaries experience, and what does this information suggest about the need for refinements to beneficiary and provider outreach as well as demonstration implementation or design more broadly?	- Description of barriers and facilitators to implementation - Description of suggestions to improve implementation	Beneficiaries receiving HRSN services	Key informants	Document review Qualitative Analysis
HRSN Implementation Question 4: What strategies and tools do key entities use to identify beneficiaries with social risk factors and facilitate beneficiary participation in the demonstration?	- Identification of strategies and tools used to identify members with HRSNs and facilitate member participation - Identification of adaptations	HCA, MCOs, HRSN Connectors and Service Providers	Key informants	Document review Qualitative Analysis
HRSN Implementation Question 5: How are key entities implementing HRSN case management and providing HRSN services through the demonstration?	- Description of HRSN case management and service delivery strategies	HCA, MCOs, HRSN Connectors and Service Providers	Key informants	Document review Qualitative Analysis

(continued)

Table 14.2. Implementation Questions (continued)

HRSN Implementation Question 6: What infrastructure are key entities developing or acquiring using demonstration funds? What did the state learn about promising practices to build infrastructure to support HRSN screening, case management, and service delivery?	- Description of infrastructure developed or acquired through demonstration funds - Lessons learned about infrastructure development practices to support HRSN screening, case management, and service delivery	HCA, MCOs, HRSN Connectors and Service Providers	Key informants	Document review Qualitative Analysis
HRSN Implementation Question 7: How does the local availability of and investment in social services outside of the demonstration change during the demonstration?	- Description of local availability and investment in social services outsides those in the demonstration	HCA , MCOs, HRSN Connectors and Service Providers	Key informants	Document review Qualitative Analysis

Data Sources. We will use a variety of data sources, including the ICDB (which includes data on social outcomes, including homelessness, criminal justice involvement, and employment) and coordination with managed care organizations, Native and Community Hubs, and HCA, to identify registries of patients receiving HRSN services. We will also coordinate with HCA and managed care plans to identify a representative beneficiary population eligible for qualitative interviews.

Methodology

Evaluation Design. To evaluate the implementation questions (IQ 1-7), we will collect relevant documents related to the HRSN program and conduct semi-structured interviews with Medicaid administrators, MCOs, Accountable Communities of Health (ACHs), and community-based organizations. To test hypotheses 1-3, we will conduct quantitative analyses of claims-based outcomes. To answer the research questions 1.1 to 3.2, we will conduct semi-structured interviews with Medicaid beneficiaries that receive HRSN benefits to understand their experiences with the benefit, as well as how receiving the benefit impacts their access to and quality of care.

Target and Comparison Populations. The target population consists of Washington Medicaid enrollees receiving HRSN services. Our primary analyses will not include a comparison population.

Evaluation Period. We propose to analyze data for January 1, 2023, through June 30, 2028, assuming that the initial phase of HRSN services begins July 1, 2024 (allowing us 18 months of observation prior to the provision of HRSN) and further assumes that claims data for CY 2028 are available on January 1, 2029.

Analytic Methods.

Quantitative approach

Descriptive analyses will include measures of HRSN use (e.g., percentage of members who received HRSN, per capita spending associated with HRSN use, types of HSRN services, and regional and demographic characteristics associated with HRSN use.)

To analyze social outcomes (homelessness, criminal justice involvement, employment) and utilization, we will use Generalized Random Forests (GRF) to evaluate the effects of the HRSN program. We will analyze outcomes for enrollees receiving any HRSN service.[19] We will conduct a separate analysis for enrollees receiving the Housing Transition Services (HTS) component.

We choose GRF rather than a difference-in-differences approach because the program will be rolled out across the state at the same time and there is not a clear comparison group, other than the eligible enrollees who do not use HRSN services. GRF is a powerful, data-driven approach that extends traditional regression models by flexibly capturing nonlinear relationships and interactions between individual characteristics and policy effects. Unlike standard regression methods, which assume a fixed functional form, GRF learns the structure of the data adaptively, identifying how the policy's impact varies across different subgroups of Medicaid enrollees. This allows us to uncover whether certain individuals benefit more or less from receiving HRSN or HTS services, providing nuanced insights that would be missed in simpler models. The evaluation team has experience in working with GRF estimation.[20,21]

To account for the phased rollout of the policy, we will apply GRF separately to each implementation phase—Phase 1a (January 2025), Phase 1b (March 2025), and Phase 1c (September 2025). This phase-specific analysis enables us to compare enrollees who received HRSN services broadly versus those who received HTS specifically, while adjusting for differences in observed characteristics. By doing so, we can assess whether the expansion of services over time leads to different patterns in emergency department utilization, while ensuring that comparisons are made within a consistent policy environment at each stage.

For each phase of the HRSN rollout, we will estimate the following function:

$$Y_i = \alpha + \tau_i(HRSN_i) + \lambda X_i + \epsilon_i,$$

Where Y_i is the outcome of interest, $HRSN_i$ takes a value of 1 if the individual received HRSN services, and X_i represents enrollee characteristics. The symbol τ_i represents the heterogeneous treatment effect function that it estimated nonparametrically through GRF.

A key advantage of GRF in this analysis is that, despite its flexibility in modeling complex interactions, the estimated treatment effects remain easily interpretable for lay audiences, much like traditional linear regression results. The output provides clear, localized average treatment effects for different subgroups, making it straightforward to communicate how receiving HRSN or HTS services influences utilization. This balance of interpretability and analytical rigor ensures that our findings are both robust for policymakers and accessible to non-technical stakeholders interested in understanding the real-world impact of these Medicaid policy changes.

One consideration of the GRF is that it is more computationally intensive than a traditional regression approach. We believe that we will be able to automate these estimation procedures across a range of outcomes and populations. In the event that this is not feasible, we will assess other approaches, including a pre-post analysis that would focus on changes in outcomes among people who receive HRSN.

As details of the HRSN benefit are clarified, we will assess other modeling approaches, including interrupted time series and difference-in-differences. We note that the CMS Evaluation Design Technical Assistance Guide for Section 1115 Demonstrations: Health-Related Social Needs recommends that evaluators consider a difference-in-differences regression model if data from other states are available. Theoretically, we could use TAF data to create a cohort of data from other states and then use the implementation dates of HRSN implementation dates to serve as a "post" period. Alternatively, if different regions roll out their HRSN implementations in a staggered fashion, this may create opportunities for a difference-in-difference approach using data within Washington.

For each quantitative analysis, we will also conduct analyses for race and ethnicity subgroups, rural vs. urban populations, and gender.

Additional design considerations

Where possible, we will implement sub-setting or stratification characteristics based on pre-intervention data. This will involve identifying relevant characteristics and ensuring they are measured prior to the implementation of the reform. By doing so, we aim to mitigate endogeneity concerns and enhance the validity of our analysis. In scenarios where defining sub-setting characteristics prior to the demonstration start is infeasible, we will explore the use of separate modeling approaches.

While we are committed to incorporating these methodologies, it is essential to retain some flexibility in our approach. The dynamic nature of Medicaid reforms and the variability in data availability necessitates an adaptable research design. We will continuously assess the feasibility and appropriateness of these methods throughout the evaluation process. We will regularly review the implementation of these strategies and make adjustments as necessary. This iterative process will help ensure that our evaluation remains methodologically sound and aligned with the objectives of the reform.

Qualitative approach

Our qualitative work will include two components. The first component will focus on questions of implementation. We will examine how HRSN implementation happened and if it happened as envisioned, identify the factors that functioned as facilitators or barriers to implementation, and determine the strategies and tools used to identify beneficiaries with social risk factors and facilitate beneficiary participation. We will also query about the types of services being deployed across different regions, assessing, for example, the extent to which housing capacity may inhibit opportunities to expand housing supports or how the availability of social services and participating community organizations may change over time.

To assess these questions, we will purposively select approximately 20-25 key informants working to implement and operationalize the HRSN demonstration. We anticipate this will include state, MCO, ACH administrators, and Community Hub care coordinators managers. We will also interview approximately 12-15 representatives from community-based organizations across the state that deliver HRSN services. We will select these informants to maximize variation in organization type, geographic region, service provided, and role.

To answer IQ7 ("How does the local availability of and investment in social services outside of the demonstration (such as housing supports) change during the demonstration?"), we plan to conduct follow-up interviews with a selected group of key informants approximately one year after the first interview is conducted. The first interviews will be 45-60 minutes in length; follow-up interviews will be shorter (approximately 30 minutes long) and focus on IQ7. Once the state submits the Protocol for HRSN Infrastructure and the Protocol for HRSN Services, we will include those documents in our analysis and revise the data collection plan accordingly.

The second component of our qualitative work will focus on appreciating beneficiaries' understanding of the HRSN benefit and their experience with it, including the role HRSN services have in mitigating beneficiary needs and how these services affect preventive and routine care utilization and physical and mental health outcomes. The evaluator will work with HCA and Washington's MCOs to secure data for a representative beneficiary population eligible for the HRSN services.

HRSN beneficiaries will be purposively selected to maximize variation on key subpopulations of interest, which we will modify with input from the state. We will exclude American Indians and Alaska Natives (AI/AN) from this sample as they will be the focus of data collection and analysis in Section 15 (Native Hub). We will plan to oversample for underrepresented groups as needed to ensure that saturation is reached. For child beneficiaries who are children (newborns to 18), we will interview a primary caregiver.

To accomplish this, we will work with and leverage state infrastructure. Interviews will be conducted by video or telephone as needed. Interviews will be approximately 30 minutes in length and audio-recorded with permission. Participants will receive a $30 gift card as a "thank you."

Interview data will be collected and analyzed in the same manner described in Section 5, with the exception of follow-up interviews, which will be shorter.

Methodological Limitations. The primary limitation of this approach is the uncertainty around HRSN, how it will be implemented, and whether we will be able to consistently identify enrollees who receive HRSN and link those connections to claims data. An additional limitation is the extent to which new data structures can be created to capture HRSN services accurately since these will look different than traditional medical claims data.

Section 15: Native Hub

General Background Information

The Native Hub is a new component of MTP 2.0. In a government-to-government relationship, the state will work with Tribes to create a single statewide Native Hub to provide navigation services and support similar to the nine community hubs. The Native Hub is a network of Tribes, Indian Health Care Providers (IHCPs), Tribal social service divisions, and Native-led, Native-serving organizations providing HRSN services for targeted populations, focusing on American Indian and Alaska Native beneficiaries. Washington's Medicaid beneficiaries who identify as American Indian and Alaska Native are predominantly covered by Washington's fee-for-service program (i.e., not enrolled in a managed care plan).

The Native Hub is designed to support whole-person care coordination, including assessments of what types of care individuals receive, whether they have an established care coordinator, and connecting with others, providing HRSN services across the state as a source of information and best practices. The Native Hub is also charged with providing closed-loop referrals to other organizations based on a collective database populated by others serving Native people.

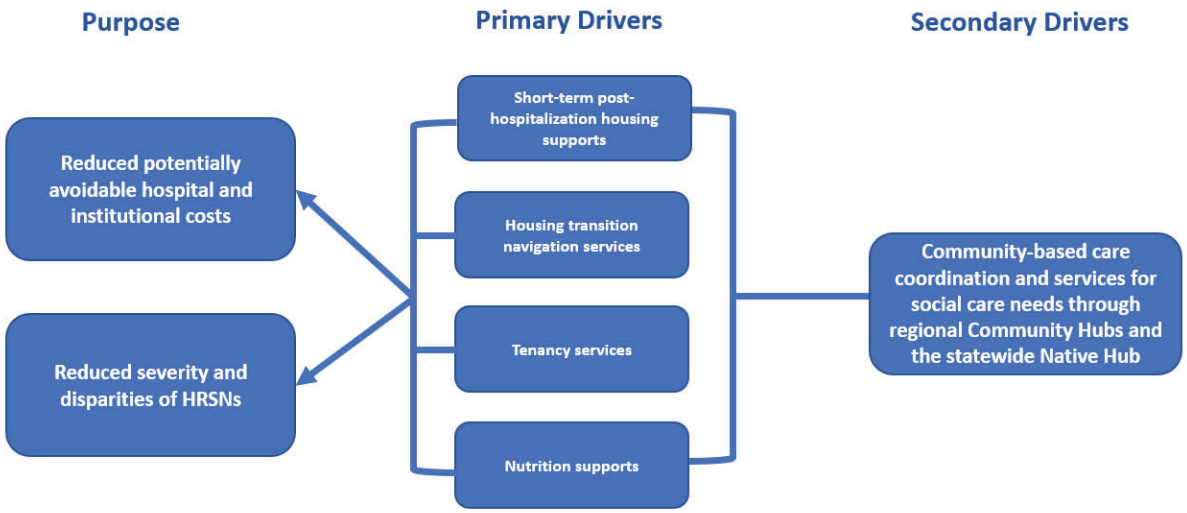
Additionally, the Native Hub seeks to raise awareness among managed care organizations, large medical systems, and state agencies of the role Tribes and IHCPs play in caring for Native individuals. Due to the complexities of American Indians and Alaska Natives as a political status, which allows for certain unique rules in health care purchasing and policy, it is not uncommon for the relationship between an individual and the IHCP as the primary medical home to be broken.

The unique rules and challenges that exist for Indian health care purchasing and policy are the context within which an evaluation must occur. Experts exist who understand the cultural and political realities that Tribes, IHCPs, and Native individuals are faced with when navigating the health care system. It will be imperative to this evaluation to connect with some of those experts in order to properly evaluate if the Native Hub is successful.

Evaluation Questions and Hypotheses

Driver Diagram. Exhibit 15.1 below depicts the relationship between the initiative's purpose to improve health outcomes and reduce unnecessary medical service use and the primary and secondary drivers that are necessary to achieve this overall goal. Four primary drivers contribute directly towards achieving the initiative's purpose, with one secondary driver necessary to support the primary drivers.

Exhibit 15.1. Driver Diagram



Our evaluation questions parallel those described in our overall HRSN services evaluation. In addition, we will examine the ability of the Native Hub to create capacity in Indian Country and the development of cross-system connections and awareness. We will assess implementation questions and research questions that assess the effectiveness of the Native Hub.

Within the context of the Native Hub and Indian Country, we will address the following hypotheses.

- **H1.** The Native Hub will meet or reduce the severity of HRSN for American Indian and Alaska Native beneficiaries.
- **H2.** By meeting or reducing the severity of HRSN, the Native Hub will increase American Indian and Alaska Native beneficiaries' use of preventive and routine care and reduce their use of potentially avoidable hospital and institutional care (ED visits, inpatient care, and nursing facilities).
- **H3.** By meeting or reducing HRSN, the Native Hub will improve physical and mental health outcomes among beneficiaries overall and among American Indian and Alaska Native beneficiaries.

Methodology

Evaluation Design. Our research questions will focus on quantitative analyses of claims-based outcomes led by the IEE team and qualitative interviews with American Indian and Alaska Native enrollees led by an Indigenous subcontractor to assess their experiences with access to and quality of care. Qualitative data will inform and explain quantitative findings.

Target and Comparison Populations. The target population consists of Washington American Indian and Alaska Native Medicaid enrollees receiving HRSN services. Our primary analyses will not include a comparison population.

Evaluation Period. We propose to analyze data for January 1, 2023, through June 30, 2028, assuming that the Native Hub will be providing HRSN services beginning on July 1, 2024 (allowing us 12 months of

observation prior to the provision of HRSN services) and further assumes that claims data for CY 2028 are available on January 1, 2029.

Evaluation Measures. We propose using the following evaluation measures.

Table 15.1. Evaluation Measures

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Goal: Reduce HRSN **Native Hub Hypothesis 1: The Native Hub will meet or reduce the severity of HRSN for American Indian and Alaska Native beneficiaries.**				
Native Hub Research Question 1.1: How does the HRSN demonstration impact the use of HRSN services for American Indian and Alaska Native beneficiaries?	• Number of American Indian and Alaska Native beneficiaries receiving HRSN services • Types of HRSN services received (including Phase 1a, Phase 1b, and later Phase services, described above in Section 14. • Percent of American Indian and Alaska Native beneficiaries who received more than 1 HRSN service	American Indian and Alaska Native Medicaid enrollees	ICDB supple-mented with HRSN data. Additional work needed to identify what data may be available as appropriate; ProviderOne	Descriptive analysis of quarterly trends

(continued)

Table 15.1. Evaluation Measures (continued)

Native Hub Research Question 1.2: Among American Indian and Alaska Native beneficiaries, how does the HRSN demonstration impact rates of HRSN and their severities?	• Receipt of Substance Use Disorder Treatment for Medicaid Beneficiaries Following Release from a Correctional Facility • Receipt of Outpatient Mental Health Treatment for Medicaid Beneficiaries Following Release from a Correctional Facility. • Employment (Percentage of enrollees ages 18 to 64 with any earnings in the year, as reported by the Washington State Employment Security Department) • Arrest Rate (Percentage of enrollees ages 18 to 64 years of age who were arrested at least once in the year, as reported by the Washington State Patrol.) • The percentage of Medicaid enrollees who were homeless in at least one month in the measurement year (referred to as HOME-N) • The percentage of Medicaid enrollees who were homeless or unstably housed in at least one month in the measurement year (HOME-B)	American Indian and Alaska Native Medicaid enrollees	ICDB supple-mented with HRSN data. Additional work needed to identify what data may be available as appropriate; ProviderOne	Generalized Random Forest
Goal: Improve the use of preventive care **Native Hub Hypothesis 2: By meeting or reducing the severity of HRSN, the Native Hub will increase American Indian and Alaska Native beneficiaries' use of preventive and routine care and reduce their use of potentially avoidable hospital and institutional care (ED visits, inpatient care, and nursing facilities).**				
Native Hub Research Question 2.1: How does the Native Hub impact beneficiaries' use of preventive and routine care?	• Primary Care Visits • Childhood Immunization Status • Immunizations for Adolescents • Lead Screening in Children • Cervical Cancer Screening • Chlamydia Screening in Women	American Indian and Alaska Native Medicaid enrollees	ICDB supple-mented with HRSN data. Additional work needed to identify what data may be available as appropriate; ProviderOne	Pre-post analysis

(continued)

Table 15.1. Evaluation Measures (continued)

Native Hub Research Question 2.2: How does the HRSN demonstration impact beneficiaries' use of hospital and institutional care?	• Plan All-Cause Readmissions • Acute Hospital Utilization • Emergency Department Utilization	American Indian and Alaska Native Medicaid enrollees	ICDB supple-mented with HRSN data. Additional work needed to identify what data may be available as appropriate; ProviderOne	Pre-post analysis

Data Sources. We will use a variety of data sources, including the ICDB (which includes data on social outcomes, including homelessness, criminal justice involvement, and employment) and coordination with managed care organizations and HCA, to identify registries of patients receiving HRSN services. We will consult with HCA's Office of Tribal Affairs on issues pertaining to data sovereignty. The Indigenous subcontractor will also coordinate with HCA and managed care plans to identify a representative beneficiary population eligible for qualitative interviews.

Analytic Methods.

Quantitative approach

Our study will encompass both descriptive and comparative analyses. The descriptive component will focus on quantifying the utilization of HRSN services among enrollees, including the variety of services used. We will also assess demographic and regional trends in HRSN usage and the frequency with which American Indian and Alaska Native enrollees access HRSN services through the Native Hub.

Analyses of social outcomes (homelessness, criminal justice involvement, employment) and utilization (e.g., outcomes listed in RQ 1.2, RQ 2.1, and RQ 2.2) will follow the approach described in Section 15, using a Generalized Random Forest to flexibly estimate the impact of HRSN services in each phase.

Methodological Limitations. The primary limitation of this approach is the uncertainty around HRSN and the Native Hub, including the extent to which we can reliably identify enrollees who receive HRSN through the Native Hub and link those services to claims data. An additional limitation is the extent to which new data structures can be created to capture HRSN services accurately since these will look different than traditional medical claims data.

Section 16: Community Hubs

General Background Information

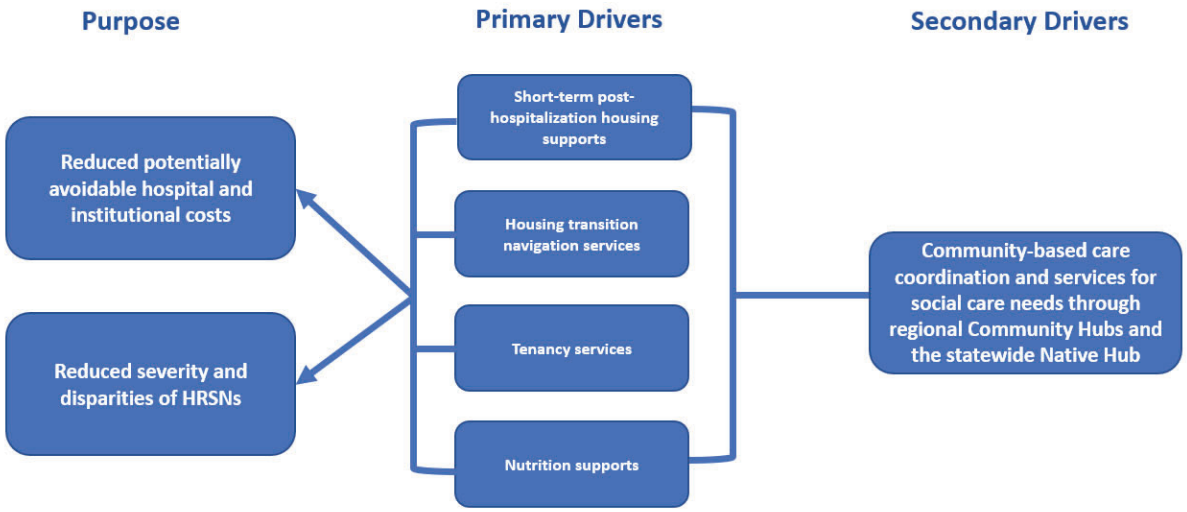
The Community Hub (referred to by the State as Community Care Hub) is a new component of MTP 2.0. Nine Community Hubs will be developed to provide case management, outreach, and education services to eligible individuals and support HRSN administration, in addition to one statewide Native Hub. The Community Hubs will be run by Washington's Accountable Communities of Health (ACHs)—independent entities that have closely partnered with the state and communities to advance Medicaid transformation priorities, including through the original Medicaid Transformation Project demonstration.

Through Community Hubs, eligible individuals will benefit from enhanced community-based care coordination and connection to appropriate community resources and organizations. Community Hubs are intended to play a critical role in pinpointing both community-wide and individual unmet HRSNs, connecting a network of community organizations to guarantee that individuals are linked to essential community services and support systems.

Evaluation Questions and Hypotheses

Driver Diagram. Exhibit 16.1 below depicts the relationship between the initiative's purpose to improve health outcomes and reduce unnecessary medical service use and the primary and secondary drivers that are necessary to achieve this overall goal. In this example, we focus on housing supports. As HRSN services are more clearly defined, we will extend these drivers to focus on other core services. In this example, four primary drivers contribute directly towards achieving the initiative's purpose, with one secondary driver necessary to support the primary drivers.

Exhibit 16.1. Driver Diagram



Our evaluation of Community Hubs will be conducted in parallel with our overall HRSN services evaluation, with a focus on differences within the nine individual Community Hubs.
We will assess the following evaluation and implementation questions:

H1. In each of the nine Community Hubs, the demonstration will effectively meet or reduce the severity of HRSN for individuals.
H2. Community Hubs will improve the connection to community-based, non-clinical care.
H3. Community Hubs will reduce the use of acute care and reduce reliance on potentially avoidable hospital and institutional care (such as ED visits, inpatient care, and nursing facilities).

I1. How does heterogeneity across ACHs influence the design and operationalization of Community Hubs?
I2. How do local factors serve as barriers or facilitators in standing up Community Hubs?
I3. How do Community Hubs differ in the types of HRSN services they plan to emphasize? What explains those differences?
I4. What infrastructure do Community Hubs develop or acquire?
I5. How does the local availability of and investment in social services influence the work of Community Hubs?

Inclusion of Native Hub as part of Community Hub interviews. Implementation questions IQ1-IQ5 focus on Community Hubs. However, we will include interviews of stakeholders and administrators involved in the Native Hub for questions IQ2-IQ5 in order to provide additional information that compares how these work is structured and operationalized. The manner in which this inclusion takes shape will depend in part on the planning and design of the Native Hub.

Methodology

Evaluation Design. To evaluate the implementation questions (IQ 1-5), we will collect relevant documents related to the Community Hub demonstration and conduct semi-structured interviews with Community Hubs, Health Department and Care Connect administrators across the nine regions across the state. Evaluation of hypotheses and research questions will focus on quantitative analyses of claims-based outcomes. Qualitative data will inform and explain quantitative analyses.

Target and Comparison Populations. The target population consists of Medicaid enrollees receiving HRSN services. Our primary analyses will not include a comparison population.

Evaluation Period. We propose to analyze data for January 1, 2023, through June 30, 2028, assuming that the Community Hubs will be providing HRSN services beginning on July 1, 2024 (allowing us 12 months of observation prior to the provision of HRSN services) and further assumes that claims data for CY 2028 are available on January 1, 2029.

Evaluation Measures. We propose using the following evaluation measures.

Table 16.1. Evaluation Measures

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Goal: Deploy and provide HRSN services to reduce severity of HRSN. **HRSN Infrastructure Hypothesis 1: In each of the nine Community Hubs, the demonstration will effectively meet or reduce the severity of HRSN for individuals.**				

HRSN Infrastructure Research Question 1.1: What are the variations in the rates of HRSN service use across different Community Hubs?	• Number of people receiving HRSN services
	• Types of HRSN services received, including
	
	Phase 1a Services
	• Case management \
	• Outreach
	• Education
	
	Phase 1b Services
	• Housing transition
	• Navigation services
	• Rent/temporary housing
	• Medical respite (e.g., recuperative care and short-term post-hospitalization housing. Launch date: July 2025)
	
	Later Phase Services
	• Nutrition supports
	• Stabilization centers*
	• Day habilitation*
	• Caregiver respite
	  • Home accessibility, remediation, and adaptation services
	  • Community transition services
	
	• Percent of people who received more than 1 HRSN service
	*pending future rate methodology approvals of the services
		Likely to be an enrollment file from Hubs that will flag HUB enrollment for individuals; Additional work needed to identify what data may be available as appropriate; ProviderOne	Inclusion of this variable is tentative. If the service is billed to Medicaid (as a claim or encounter) then this will be feasible. If not, additional data will be required from facilities and/or HUBs.	Descriptive analysis of differences across hubs

(continued)

Table 16.1. Evaluation Measures (continued)

HRSN Infrastructure 1.2: How does the HRSN demonstration impact outcomes related to social determinants of health across different Community Hubs?	• Receipt of Substance Use Disorder Treatment for Medicaid Beneficiaries Following Release from a Correctional Facility • Receipt of Outpatient Mental Health Treatment for Medicaid Beneficiaries Following Release from a Correctional Facility. • Employment (Percentage of enrollees ages 18 to 64 with any earnings in the year, as reported by the Washington State Employment Security Department) • Arrest Rate (Percentage of enrollees ages 18 to 64 years of age who were arrested at least once in the year, as reported by the Washington State Patrol.) • The percentage of Medicaid enrollees who were homeless in at least one month in the measurement year (referred to as HOME-N) • The percentage of Medicaid enrollees who were homeless or unstably housed in at least one month in the measurement year (HOME-B) •	Eligible Medicaid enrollees, including HRSN beneficiaries	ICDB supple-mented with JBRS and HRSN data	Generalized Random Forest for each hub
Goal: Improve the use of preventive care **HRSN Infrastructure Hypothesis 2: Community Hubs will improve the connection to community-based, non-clinical care.**				
HRSN Infrastructure Research Question 2.1: How does the HRSN demonstration impact beneficiaries' use of preventive and routine care across different Community Hubs?	• Primary Care Visits • Childhood Immunization Status • Immunizations for Adolescents • Lead Screening in Children • Cervical Cancer Screening • Chlamydia Screening in Women	Eligible Medicaid enrollees, including HRSN beneficiaries	ICDB supple-mented HRSN data	Generalized Random Forest for each hub

(continued)

Table 16.1. Evaluation Measures (continued)

Goal: Reduce the use of acute care and institutional care **HRSN Infrastructure Hypothesis 3: Community Hubs will reduce the use of acute care and reduce reliance on potentially avoidable hospital and institutional care (such as ED visits, inpatient care, and nursing facilities).**				
HRSN Infrastructure Research Question 3.1: How does the HRSN demonstration impact the use of hospital and institutional care across different Community Hubs?	• Plan All-Cause Readmissions • Acute Hospital Utilization • Emergency Department Utilization	Eligible Medicaid enrollees	ICDB supple-mented HRSN data	Generalized Random Forest for each hub

Table 16.2. Implementation Questions

Implementation questions assessed via qualitative analyses				
HRSN Infrastructure Implementation Question 1: How does heterogeneity across ACHs influence the design and operationalization of Community Hubs?	- Understanding of differences in the development of Community Hubs	State Medicaid administrators; representatives from ACHs; MCO representatives	Key informants	Qualitative analysis Document review
HRSN Infrastructure Implementation Question 2: How do local factors serve as barriers or facilitators in standing up Community Hubs?	- Identification of barriers and facilitators to implementing HRSN	State Medicaid administrators; representatives from ACHs; MCO representatives	Key informants	Qualitative analysis Document review
HRSN Infrastructure Implementation Question 3: How do Community Hubs differ in the types of HRSN services they plan to emphasize?	- Identification of differences among types of HRSN services emphasized by specific community Hubs	State Medicaid administrators; representatives from ACHs; MCO representatives	Key informants	Qualitative analysis Document review
HRSN Infrastructure Implementation Question 4: What infrastructure do Community Hubs develop or acquire?	- Identification of Community Hub infrastructure development	State Medicaid administrators; representatives from ACHs; MCO representatives	Key informants	Qualitative analysis Document review
HRSN Infrastructure Implementation Question 5: How is the local availability of and investment in social services influence the work of Community Hubs?	- Identification of variation in local availability and investment in social services across specific Community Hub service areas	State Medicaid administrators; representatives from ACHs; MCO representatives	Key informants	Qualitative analysis Document review

Data Sources. We will use a variety of data sources, including the ICDB (which includes data on social outcomes, including homelessness, criminal justice involvement, and employment), and coordination with managed care organizations and HCA to identify registries of patients receiving HRSN services. We will also coordinate with HCA and managed care plans to identify key informants, including a representative beneficiary population eligible for qualitative interviews.

Analytic Methods.

Quantitative approach

Our study will encompass both descriptive and comparative analyses. The descriptive component will focus on quantifying the utilization of HRSN services among enrollees and assessing differences across Community Hubs.

Analyses of social outcomes (homelessness, criminal justice involvement, employment) and utilization (e.g., outcomes listed in RQ 1.2, RQ 2.1, and RQ 3.1) will follow the approach described in Section 15, using a Generalized Random Forest to flexibly estimate the impact of HRSN services in each phase. We will conduct separate outcomes for each HUB.

Qualitative approach

Our qualitative work will examine how Community Hub implementation happened and if it happened as envisioned, identifying how certain factors functioned as facilitators or barriers to implementation and how this varied based on local conditions and ACH attributes. We will also identify the strategies and tools key entities use to address challenges.

To assess these questions, we will purposively select approximately 15-20 key informants working to implement and operationalize Community Hubs. Participants will include representatives from Community Hubs, HCA, and Care Connect administrators working to implement and operationalize the Community Hubs across the 9 ACHs. We will select informants to maximize variation in organization type, geographic region, and role.

Methodological Limitations. The primary limitation of this approach is the uncertainty around HRSN and the Community Hubs, including the extent to which we can reliably identify individuals who receive HRSN through the Community Hubs and link those services to claims data. An additional limitation is the extent to which new data structures can be created to capture HRSN services accurately since these will look different than traditional medical claims data.

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ATTACHMENTS

Attachment 1: Independent External Evaluator

For the broader 1115 Waiver evaluation, Washington selected an independent external evaluator (IEE) 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 Sciences 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 External Evaluator for the SMI/SED amendment evaluation.

The IEE certifies that, to the best of its knowledge, there exists no actual or potential conflict between the business or economic interests of Evaluator, its employees, or its agents, on the one hand, and the business or economic interests of the State, on the other hand, arising out of, or relating in any way to, the subject matter of the proposed evaluation plan. If any changes occur with respect to the IEE's status regarding conflict of interest, the IEE shall promptly notify the State in writing. The IEE will conduct evaluation activities in an independent manner in accordance with the CMS-approved draft evaluation design.

Attachment 2: Evaluation Budget

The budget for the full evaluation contract totals $13,344,075 over five and a half years (Q3 2024 – Q4 2029). This anticipated full Independent Evaluator budget is inclusive of all staff, administrative, and other costs, with two exceptions: the proposed budget includes Native Hubs quantitative (claims-based) evaluation. Washington's Health Care Authority (HCA) will explore with the Office of Tribal Affairs any additional evaluation needs and data questions that are Tribal specific. This will be addressed in a different workstream and not part of the OHSU evaluation. Second, HCA will explore the option of a beneficiary survey for the MAC/TSOA program; its implementation will be performed as funding resources allow.

Table A – MTP 2.0 Evaluation 5-Quarter Proposed Budget

#	Deliverable	Due	Deliverables Total
1. Ongoing communications with HCA on waiver and evaluation progress			
1.1.1-1.1.3	Detailed Project Analytic Plans (1.1.1 includes analytic plans for 9 projects, 1.1.2 includes analytic plans for 4 projects, both for interim report; 1.1.3 includes updates to 13 analytic plans for summative report)	Q4 2024; Q3 2025 Q1 2028	293,904
1.2.1 - 1.2.13	Institutional Review Board Approvals for 13 projects	Q3 2024 - Q3 2025	256,210
1.3.1 - 1.3.16	Progress presentations (quarterly, 16 total)	Q4 2024 - Q2 2029	886,000
		subtotal	**$1,436,114**
2. Collect and Analyze Qualitative Data			
2.1.1-2.1.2	Foundational Community Supports Interviews	Q4 2024; Q3 2025	193,836
2.2.1-2.2.2	MAC and TSOA Interviews	Q4 2024; Q3 2025	302,026
2.3.1-2.3.2	SUD Waiver Interviews	Q3 2026; Q2 2027	168,275
2.4.1-2.4.2	SMI/SED IMD Waiver Interviews	Q3 2027; Q2 2028	168,275
2.5.1-2.5.2	Continuous Eligibility Children 0-5 Interviews	Q2 2025; Q2 2027	290,135
2.6.1 - 2.6.2	Continuous eligibility for postpartum individuals Interviews	Q3 2025; Q2 2027	204,425
2.7.1 - 2.7.2	Reentry Interviews	Q4 2026; Q2 2028	293,650
2.8.1 - 2.8.2	Contingency Management Interviews	Q4 2025; Q3 2027	223,242
2.9.1 - 2.9.2	HRSN Benefit Interviews	Q4 2026; Q3 2028	594,267
2.10.1, 2.10.2	Community Hubs Interviews	Q4 2026; Q3 2028	259,200
		subtotal	**$2,697,331**
3. Analyze Quantitative Data			
3.1.1-3.1.5	Production and validation of baseline measures (statewide and by specific populations as delineated in the project plan)	Q2 2026 - Q2 2028	$1,854,080
3.2.1-3.2.16	Quarterly updates to performance measures and models, starting Q3 2024 (these inform quarterly progress updates, tasks 1.3.1 - 1.3.16)	Q3 2024- Q2 2028	858,675
		subtotal	**$2,712,755**

Table A, continued

4. Reports			
4.1	Draft Interim Evaluation Report (estimated deadline 4/30/27)	Q2 2027	1,716,475
4.2	Final Interim Report (estimated deadline 6/30/27)	Q2 2027	672,475
4.3	Draft SUD Midpoint Assessment (estimated deadline 6/26/26)	Q2 2026	248,525
4.4	Final SUD Midpoint Assessment (estimated deadline 8/28/26)	Q3 2026	182,625
4.5	Draft SMI IMD Midpoint Assessment Report (estimated deadline 6/26/26)	Q2 2026	251,175
4.6	Final SMI Midpoint Assessment Report (estimated deadline 8/28/26)	Q3 2026	168,225
4.7	Draft Reentry Midpoint Assessment Report (due 5/26/28)	Q2 2028	251,175
4.8	Final Reentry Midpoint Assessment Report (estimated deadline 7/31/28)	Q3 2028	168,225
4.9	Draft Summative Evaluation Report (estimated deadline 9/30/29)	Q3 2029	1,937,775
4.10	Final Summative Evaluation Report (estimated deadline 12/30/29)	Q4 2029	901,200
		subtotal	**$6,497,875**
MTP 2.0 Evaluation full-waiver (5.5 years) budget proposal total		**$13,344,075**	

Attachment 3: Evaluation Timeline and Milestones

Deliverable	Responsible Party	Date
Draft Evaluation Design	State	January 26, 2024
- Comments from CMS	CMS	60 days from receipt
- Final evaluation design	State	60 days from receipt
Institutional Review Board updates obtained	State	Q1 2052- Q4 2025
Quarterly briefings from independent external evaluator to highlight key findings from quarterly activities, data analysis, reflections and insight on the implementation of projects drawing on key informant interviews, document review, meetings attended, and activity review**.**	Independent External Evaluator (IEE)	Beginning February 2025
Specification for data required from state including a timeline, data gap analysis, and plan to address data gaps	IEE	As applicable, starting Q1 2025
Production and validation of baseline measures (statewide and by specific populations as delineated in project plan)	IEE	Q2 2024 – Q2 2028
Quarterly, semi-annual, and annual metric updates (depending on metric frequency)	State	As applicable starting Q2 2025
State progress reports will include information on submittals from IE and progress of evaluation.	State	Include in Quarterly and Annual reports
Conduct and Analyze Qualitative Interviews (key informant interviews for 11 MTP 2.0 projects; additional beneficiary interviews for 5 MTP 2.0 projects)		Q4 2024 – Q2 2029
Draft Serious Mental Illness Midpoint Assessment (SMI MPA)	State	August 28, 2026
- CMS comments	CMS	60 days from receipt
- Final SMI MPA	State	60 days from receipt of CMS comments
Draft Substance Use Disorder Midpoint Assessment (SUD MPA)	State	August 28, 2026
- CMS comments	CMS	60 days from receipt
- Final SUD MPA	State	60 days from receipt of CMS comments
Draft Interim Evaluation Report	State	June 30, 2027
- CMS comments	CMS	60 days from receipt
- Final Interim Evaluation Report	State	60 days from receipt of CMS comments
Draft Reentry Midpoint Assessment	State	July 31, 2028
- CMS comments	CMS	60 days from receipt
- Final Interim Evaluation Report	State	60 days from receipt of CMS comments
Draft Summative Evaluation Report	State	December 30, 2029
- CMS comments	CMS	60 days from receipt
- Final Summative Evaluation Report	State	60 days from receipt of CMS comments

Attachment 4: Acronyms List

MTP Medicaid Transformation Project

LTSS Long-term Services and Supports

HRSN Health-Related Social Needs

SUD Substance Use Disorder

SMI Serious Mental Illness

SED Serious Emotional Disturbances

IMD Institutions for Mental Disease

MAC Medicaid Alternative Care

TSOA Tailored Supports for Older Adults

FCS Foundational Community Supports

CHIP The Children's Health Insurance Program

LTSS PE Long-term Services and Supports Presumptive Eligibility

CM Contingency management

IEE Independent External Evaluator

ED Emergency Department

HCA Health Care Authority (Washington)

DSHS Washington State Department of Social and Health Services

PHE Public Health Emergency

BIPOC Black, Indigenous, People of Color

MCO Managed Care Organization

ACH Accountable Communities of Health

ICDB Integrated Client Databases

CDPS Chronic Illness and Disability Payment System

HEDIS Healthcare Effectiveness Data and Information Set

T-MSIS Transformed Medicaid Statistical Information System

TAF T-MSIS Analytic File

MAX Medicaid Analytic eXtract (files)

CSS Community Support Services

IPS Individual Placement and Support

ALTSA Aging and Long-Term Support Administration

AAA Area Agencies on Aging

FFP Federal Financial Participation

IMD Institutions for Mental Disease

OUD Opioid Use Disorder

MAT Medication Assisted Treatment

STC Special Terms and Conditions

HCBS Home and Community-Based Services

ACS American Community Survey

ATTACHMENT K
SUD Implementation Plan Protocol

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Introduction

Opioid misuse and addiction is a public health crisis in Washington State and across the country. In communities across the state, this epidemic is devastating families and overwhelming law enforcement and social services. In 2016, there were 694 opioid related deaths in Washington State. Of these deaths, 382 individuals died from a prescription opioid overdose, 278 died from a heroin overdose, and 90 died from a fentanyl overdose. This high mortality is due to the increase in heroin overdose deaths even though prescription opioid overdose deaths have decreased.

The state is committed to providing appropriate care for individuals with substance use disorder (SUD). In October 2016, Governor Jay Inslee issued Executive Order 16-09, marshalling the state's resources to combat this crisis, including preventing opioid use disorder (OUD) as well as treating it. In addition, Washington will respond to the opioid use public health crisis by utilizing its Section 1115 demonstration waiver to pursue the following goals, aligned with the Centers for Medicare and Medicaid Services (CMS):

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increased adherence to and retention in treatment for OUD and other SUDs;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUD; and
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

The following implementation plan outlines Washington's path to provide a full continuum of care for all Medicaid beneficiaries with OUD and other SUDs, and expanding access and improving outcomes in the most cost-effective manner possible. The plan is organized by six key milestones identified by CMS:

1. Access to critical levels of care for OUD and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including Medication Assisted Treatment (MAT);
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

Washington has already made great progress on many of these milestones, and believes it can accomplish all six goals of the SUD waiver by focusing on a cohesive review processes for SUD

residential admission assessments, ensuring sufficient provider capacity and expansion of access to MAT, as well as enhancing care coordination.

Milestone 1: Access to critical levels of care for OUD and other SUDs

Washington State's Medicaid funded programs provide access to all critical levels of care for OUD and other SUD. Prepaid Inpatient Health Plan (PIHP) contracts with the state's Behavioral Health Organizations (BHOs) require BHOs to provide access to the American Society of Addition Medicine (ASAM) levels described below. As regions around the state move toward the Integrated Managed Care (IMC) model, contracts with Managed Care Organizations (MCOs) will retain these requirements.

The outpatient benefits described below are delivered pursuant to the "Chemical dependency treatment" service requirements located at (13)(d)(2)(c) on Page 40 of Attachment 3.1-A of the State Plan, while the "detox" and inpatient services are provided pursuant to the service requirements located at (13)(d)(2)(b) on Page 38 of Attachment 3.1-A of the State Plan.

Inpatient and detoxification (withdrawal management) services must be provided in state certified facilities. SUD counseling in the categories described below must be provided by a state licensed Chemical Dependency Professional (CDP) or trainee (CDP-T).

The Washington Administrative Code (WAC) outlines treatment requirements for the following service categories:

WAC Requirements by Service Category[33]	
Service Category	**WAC**
Outpatient SUD	WAC 388-877-0738 to 0753
Residential SUD	WAC 388-877-1108 to 1116
General Residential Requirements	WAC 388-877-1108
ASAM 3.5 Intensive Inpatient SUD	WAC 388-877-1110
ASAM 3.1 Recovery House	WAC 388-877-1112
ASAM 3.1 Long-Term SUD Residential SUD	WAC 388-877-1114
Specific Rules for Youth Residential SUD	WAC 388-877-1116
Withdrawal Management	WAC 388-877-1100 to 1106
Opioid Treatment Programs	WAC 388-877-1000 to 1025

[33] http://apps.leg.wa.gov/wac/default.aspx?cite=388-877

ASAM Level 1 Outpatient Services
Current State:

Currently, outpatient services consist of less than nine hours of service per week provided in both individual and group treatment services of varying duration and intensity according to a prescribed plan which is developed before treatment begins. Providers document an individual service plan review for each individual once a month for the first three months and quarterly thereafter or sooner if required by other laws.

State Plan Page Number/Section:

- (13)(d)(2)(c) on Page 40.

Future State:

- No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None.

ASAM Level 2.1 Intensive Outpatient Services
Current State:

Intensive outpatient services include a minimum of 72 hours of treatment for a maximum of 12 weeks. The treatment includes the following: at least three sessions are required each week during the first four weeks of treatment, with each session occurring on separate days of the week, and group sessions of at least one hour and attending self-help groups in addition to the 72 hours of treatment services.

State Plan Page Number/Section:

- (13)(d)(2)(c) on Page 40.
-

Future State:

- No changes are expected at this ASAM level of care.
-

Summary of Actions Needed:

- None.

ASAM Level 3 Residential Services
Current State:

Residential services are dependent upon initial and ongoing ASAM assessments. Treatment consists of individual and group counseling, education, and activities for clients who have completed withdrawal management services (formerly referred to as detox). This level of SUD treatment provides services in accordance with ASAM level 3.1 and 3.5. Note: ASAM level 3.7 is included in the withdrawal management section below. Length of stay is not fixed, although some treatment programs are oriented to offer 30 to 60 day programs. Actual length of stay is dependent on progress towards treatment goals and reassessment.

State Plan Page Number/Section:

- (13)(d)(2)(b) on Page 38.

Future State:

- No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None.

Medication Assisted Treatment
Current State:

Washington has two Medication Assisted Treatment (MAT) options: Opiate Treatment Programs (OTP) and Office Based Opiate Treatment Programs (OBOT). Traditionally OTP programs have provided methadone, but some providers are also providing Buprenorphine MAT services. The Department of Social and Health Services' Division of Behavioral Health and Recovery (DBHR) has certified 25 OTP programs in addition to four Veterans Administration OTP programs.

State Plan Page Number/Section:

- (13)(d)(2)(c) on Page 40
-

Future State:

- No changes are expected at this ASAM level of care.
-

Summary of Actions Needed:

- None.

Withdrawal Management
Current State:

Withdrawal management services are provided to assist in safe withdrawal from the physical effects of psychoactive substances. The need for withdrawal management (WM) services is determined by patient assessment using the ASAM guidelines.

There are three levels of detox facilities recognized in Washington. Assessment of severity, medical complications, and specific drug or alcohol withdrawal risk determine placement within each level of service. All programs are licensed under the single ASAM Withdrawal Management requirements.

Sub-acute Detox (ASAM 3.2-WM): Clinically Managed Residential Facilities are considered sub-acute detox. They have limited medical coverage by staff and counselors who monitor patients and generally, any treatment medications are self-administered. These facilities are regulated by the Department of Health (DOH) and are DBHR-certified.

Acute Detox (ASAM 3.7-WM): Medically Monitored Inpatient Programs are considered acute detox. They have medical coverage by nurses with physicians on-call at all times for consultation. They have "standing orders" and available medications to help with withdrawal symptoms. Facilities for these programs are not hospitals, but do have referral relationships. These facilities are regulated by DOH and are DBHR-certified.

Acute Hospital Detox ASAM 4.0-WM): Medically Managed Intensive Inpatient Programs are considered acute hospital detox. The programs have medical coverage by RN and nurses with doctors available 24/7. There is full access to medical acute care including ICU if needed. Doctors, nurses, and counselors work as a part of an interdisciplinary team who medically manage the care of the patient. These facilities are regulated by DOH and hospital licensed, but are not DBHR-certified. This level of care is considered hospital care and not part of the behavioral health benefits provided through BHOs/MCOs.

State Plan Page Number/Section:

- (13)(d)(2)(b) on Page 38.

Future State:

- No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None.

Milestone 2: Widespread use of evidence-based, SUD-specific patient placement criteria

Current State:

The state requires all SUD providers to assess and provide treatment services using the ASAM criteria. The DBHR currently requires SUD assessments as defined in the WAC. The ASAM Patient Placement Criteria (PPC) are used to guide admission, continued service, and discharge planning.

The BHO/MCO authorization process is an independent review of residential authorization treatment. The residential agency providing the services must obtain independent approval from the BHO or MCO. This review process varies by managed care organization but in all cases is required to be based upon medical necessity and ASAM placement criteria.

In the Fee-for-Service (FFS) system there are no managed care or administrative services organizations providing review of admissions to residential SUD facilities. In most cases, an individual in the FFS system is assessed by a licensed outpatient provider not associated with the residential facility. This independent provider determines whether the individual meets the ASAM residential level of care and when appropriate makes a referral to a residential facility.

Current Monitoring Activities

Current state rules (WACs) require providers to use ASAM criteria for admission, continued services, and discharge planning and decisions.

WAC Requirements by Service Category[34]	
Service Category	**WAC**
Outpatient SUD	WAC 388-877-0738 to 0753
Residential SUD	WAC 388-877-1108 to 1116

All agencies providing these services are monitored by the state licensing and certification team. This team provides on-site visits that include a clinical review of charts at least once every three years for outpatient and annually for residential facilities. This review includes monitoring of ASAM treatment standards for types of services, hours of clinical care and staff credentials. These audits include a review of the appropriateness of placement and length of stay.

In addition to the licensing activities, BHOs and MCOs are required to monitor providers for appropriateness of clinical decision making, including the use of ASAM for admission, continued services, and discharge planning.

Evidence Based Admission Criteria

The state believes the current WAC rules requiring providers to use ASAM for admission, continued services, and discharge planning and decisions meets the requirement for evidenced-based SUD placement criteria.

[34] http://apps.leg.wa.gov/wac/default.aspx?cite=388-877

Future State:

Independent Review Process

To avoid barriers and delays for access to care, the state's approach to independent review for the FFS system is to have initial assessments performed independently from the treating facility. Given that most of the individuals affected by this FFS requirement are AI/AN, this approach offers more flexibility and is preferred over requiring that assessments be performed by an entirely different organization. Because of the limited number of Tribal providers, requiring an entirely separate organization would force AI/AN individuals to seek assessments from non-Tribal providers.

Summary of Actions Needed:

Within 12 months, FFS staff within the Federal Programs team at DBHR/HCA will update the SUD FFS Billing Guide to include a requirement that any FFS SUD residential stays must include an assessment for residential ASAM level of care prior to admit to the residential facility, and that the assessment must be completed independently of the SUD residential facility.

Implementation Timeline, Milestone 2	
Date	**Action**
July 1, 2018	Effective date of 1115 SUD/IMD Waiver Amendment.
September 2018	Convene workgroup that includes subject matter experts and staff responsible for the FFS Billing Guide. Include data management staff.
November 2018	• Finalize data reporting content and format. • Assess needs for changes to the data reporting system.
January 2019	Complete billing guide changes. Distribute to providers.
February 2019	Complete any changes to the data reporting system.

Milestone 3: Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities

Provider Qualification and Treatment Standards
Current State:

WAC rules require programs to meet ASAM Criteria and to adhere to ASAM treatment standards for types of services, hours of clinical care and staff credentials. These standards are found in the following WAC sections:

WAC Requirements by Service Category[35]	
Service Category	**WAC**

[35] http://apps.leg.wa.gov/wac/default.aspx?cite=388-877

General Residential Requirements	WAC 388-877-1108
ASAM 3.5 Intensive Inpatient SUD	WAC 388-877-1110
ASAM 3.1 Recovery House	WAC 388-877-1112
ASAM 3.1 Long-Term Residential SUD	WAC 388-877-1114
Specific Rules for Youth Residential SUD	WAC 388-877-1116

In addition to meeting the WAC administrative and personnel requirements, an agency providing substance use disorder residential treatment services must ensure all SUD assessment and counseling services are provided by a CDP or a CDPT under the supervision of an approved supervisor.

All of the Medicaid-covered service components described in the sections below are rehabilitative services of diagnostic evaluation and face-to-face individual or group counseling, pursuant to the state plan.

Intensive inpatient services (ASAM 3.5 Intensive Inpatient SUD WAC 388-877-1110) are SUD residential treatment services that provide a minimum of 20 hours of treatment services, including a program of individual and group counseling, education, and activities. An agency providing intensive inpatient services must:

- Complete the individual service plan within five days of admission.
- Conduct and document at least weekly, one face-to-face individual substance use disorder counseling session with the individual.
- Document progress notes, referrals and discharge summaries within required timeframes.

Recovery house services (ASAM 3.1 Recovery House WAC 388-877-1112) are SUD residential treatment services that provide social, vocational, and recreational activities to assist individuals adjust to abstinence, and to assist aid in job training, employment, or participating in other types of community services. Recovery house services require program-specific certification by the department's division of behavioral health and recovery.

Youth residential services (WAC 388-877-1116) are substance use disorder residential treatment services provided to an individual 17 years of age or younger. The agency is required to ensure at least one adult staff member of each gender is present or on call at all times if co-educational treatment services are provided. All staff members are trained in safe and therapeutic techniques for dealing with a youth's behavior and emotional crisis, including:

- Verbal de-escalation.
- Crisis intervention.
- Anger management.
- Suicide assessment and intervention.
- Conflict management and problem solving skills.

- Group meetings to promote personal growth, leisure, and other therapy or related activities.

These programs must provide seven or more hours of supervised, structured recreation each week. Provide and document each youth one or more hours per day, five days each week, of supervised academic tutoring or instruction by a certified teacher when the youth is unable to attend school for an estimated period of four weeks or more.

Requirements for providers to use evidence based practices (e.g. motivational interview, cognitive-behavioral therapy).

Providers are not required to utilize any specific evidence-based practices. However, WAC 388-877-0410 (3)(c)(ii), does require agencies to develop and maintain a written internal quality management plan and process that continuously improves the quality of care through use of evidence-based and promising practices.

Requirements for availability of a physical exam or consultation with a physician/ARNP.

Residential SUD facilities are required to complete a health assessment or physical exam. The level of detail and type of exam depends on how the facility is licensed with the DOH. To qualify as a residential SUD facility, the facility must be licensed by DOH in one of the following categories:

- Hospital (chapter 246-320 WAC);
- Private psychiatric or alcoholism hospital (chapter 246-322 WAC);
- Private alcohol and substance use disorder hospital (chapter 246-324 WAC); or
- Residential treatment facility (chapter 246-337 WAC).

The physical exam requirements can be found in the WACs listed above under the "patient care services" section of each rule.

Future State:

No changes.

Summary of Actions Needed:

None.

Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards

Current State:

DBHR licenses and certifies treatment programs and regulates treatment agencies providing services for SUD, community mental health (voluntary and involuntary commitment services),

and problem and pathological gambling. The DBHR Certification, Licensing, and Customer Relations Section supports our state's goal to improve services to vulnerable adults.

There are approximately 584 licensed and certified SUD treatment agencies, 202 community mental health agencies offering treatment services at 553 sites, and 21 problem and pathological gambling treatment agencies. Certification and licensing activities reduce health risks for patients and family members by ensuring that treatment agencies are:

- Surveyed within 12 months of initial approval and every three years; and
- In compliance with regulations; and
- Evaluated rapidly when complaints are received.[36]

Current licensing and certification standards are driven by the Revised Code of Washington (RCW), Code of Federal Regulations, and federal block grants. These standards were established to ensure:

- Quality health care services of equal intensity, duration, and scope.
- Quality management.
- Consistent application of clinical standards and practices.
- Consistent implementation of patient health and safety standards.
- Certified and licensed chemical dependency and mental health professionals are operating within the scope of their practice.
- Consistent risk management monitoring of substance use disorder treatment programs and community mental health agencies.
- Rapid response to complaints regarding substance use disorder treatment programs, community mental health agencies, and providers to ensure patient health and safety.

Opioid Treatment Programs

The DBHR licenses and certifies opioid treatment programs (OTPs) in Washington State. DBHR helps ensure that programs comply with federal and state laws and regulations through regular on-site surveys.

DBHR is a federally recognized OTP Accreditation Body by the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. Each OTP must be accredited and can choose DBHR or another approved accreditation body.

DBHR, through its licensing and regulatory program, supports compliance with nationally recognized standards for agencies that provide SUD treatment services. DBHR integrated requirements and standards of the ASAM criteria in 1998. Washington administrative rules require licensed agencies to use the ASAM criteria for making admission, continued services,

[36] https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/licensing-and-certification-behavioral-health-agencies

and discharge decisions. Agencies must use the ASAM criteria while conducting and developing SUD assessments, individual service plans, treatment plan reviews transitioning to levels of care, and coordinating discharge planning.

Current Monitoring Activities

All state agencies providing these services are monitored by the state licensing and certification team. This team provides on-site visits that include a clinical review of charts at least once every three years for outpatient providers and annually for residential facilities. This review includes monitoring of ASAM treatment standards for types of services, hours of clinical care and staff credentials. These audits include a review of the appropriateness of placement and length of stay.

In addition to the licensing activities, BHOs and MCOs are required to monitor providers for appropriateness of clinical decision making, including the level and types of services provided in agreement with ASAM levels of care.

Future State:

No changes. The state believes the current WAC rules requiring providers to use ASAM for admission, continued services, and discharge planning and decisions meets this requirement.

Summary of Actions Needed:

None.

Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off site

Current State:

The state does not require residential treatment facilities to offer MAT on-site. However, the state has promoted the use of MAT in these settings through provider training. Through these trainings, the state has encouraged providers to focus on patient choice when making decisions around the use of MAT. In addition, the state has utilized the Substance Abuse and Mental Health Services Administration's (SAMHSA) Prescription Drug and Opioid Addition (PDOA) and State Targeted Response (STR) grants to develop greater acceptance and availability of MAT.

Tribal and Urban Indian representatives in Washington have expressed objections to the requirement to offer or facilitate access to MAT for AI/AN clients. It is the state's understanding that CMS cannot offer an exemption for Tribal or Urban Indian residential treatment facilities at this time.

Tribal providers that do not provide of facilitate access to MAT as a treatment choice will not be included in the demonstration.

Future State:

The state will implement a requirement that residential treatment facilities offer MAT on-site or facilitate access off-site.

Summary of Actions Needed:

The HCA will work with the DOH to make these WAC changes. As of July 1, 2017 the policy and federal programs functions within DBHR will integrate into HCA. At the same time the DBHR licensing and certification team will become part of the DOH. These requirements will be implemented in two stages:

1. Within 12 months: The state will add to PIHP and MCO contracts a requirement that they require residential treatment providers to offer MAT on-site or facilitate access off-site.
2. Within 24 months: The state will update the WAC to include a requirement that residential treatment providers offer MAT on-site or facilitate access off-site.

Implementation Timeline, Milestone 3	
Contract Changes	
Date	**Action**
July 1, 2018	Effective date of 1115 SUD/IMD Waiver Amendment.
September 2018	• Begin developing new contract language that meets the requirements described above. • Convene group of subject matter experts to advise on development of requirements.
November 2018	Finalize new contract language.
January-March 2019 (or sooner)	Begin contract negotiations with MCOs/BHOs regarding new language.
April-June 2019 (or sooner)	Update MCO and BHO contracts to include the new requirements.
WAC Changes	
Date	**Action**
January 2019	Convene group that includes SUD subject matter experts and DOH/HCA staff responsible for updating WACs.
April 2019	Finalize draft WAC language.

May 2019	Begin public notice and rules hearing process.
September 2019	Finalize rules changes.
January 2020	Effective date of WAC changes.

Milestone 4: Sufficient provider capacity at critical levels of care including for Medication Assisted Treatment

Current State:

The state expects to develop the assessment described in this milestone within 12 months of demonstration approval. An initial assessment of providers enrolled in Medicaid and accepting new patients is described below.

Residential SUD Treatment

- 84 Providers – total licensed residential treatment agencies (includes withdrawal management). It is unknown at this time how many of these residential providers offer MAT services.
- 32 of these residential providers offer withdrawal management services.

Outpatient SUD Treatment

- There are 500 SUD outpatient providers, and 24 of these offer MAT services. The 24 agencies are licensed Opiate Treatment Programs (OTPs). Four new OTPs are planned for early 2018. Other licensed outpatient SUD agencies contract with waivered clinicians to provide MAT services.

Future State:

The state will complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state including those that offer MAT:

- Outpatient services.
- Intensive outpatient services.
- MAT (medications as well as counseling and other services).
- Intensive care in residential and inpatient settings.
- Medically supervised withdrawal management.

The assessment will help the state determine whether it has sufficient provider capacity in the areas listed above. If any area is determined to be below capacity, the report will include the state's plans to increase availability of this service.

Summary of Actions Needed:

This activity will be completed within 12 months. The HCA will work with the state's data analytics team to complete this task.

Implementation Timeline, Milestone 4	
Date	**Action**
July 1, 2018	Effective date of 1115 SUD/IMD Waiver Amendment.
September 2018	• Convene workgroup that includes the state's data analytics team. • Outline the parameters of the data requirements.
November 2018	Finalize data reporting content and format.
January 2019	Complete data analysis.
February 2019	If any area is below capacity, determine next steps to increase availability of this service.
April 2019	Finalize the report and send to CMS.

Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD

Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse

Current State:

The Washington Agency Medical Directors' Group (AMDG) develops guidelines for medical providers caring for patients of state agency programs in Washington State. The AMDG 2015 Interagency Guideline on Prescribing Opioids for Pain recommends best practices for opioid-based and non-opioid pain management to improve care of patients with chronic pain and to reduce their risk of addiction and overdose.[37] These guidelines are published as an educational tool for medical providers caring for patients of state agency programs, and state agencies use the guidelines to evaluate health technologies, including devices, durable medical equipment, procedures, diagnostics, and off-label drug use.

[37] http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

Along with the AMDG Guideline, five prescribing profession boards and commissions have adopted rules on the management of chronic, non-cancer pain:

- Medical Quality Assurance Commission
- Board of Osteopathic Medicine and Surgery
- Nursing Care Quality Assurance Commission
- Dental Quality Assurance Commission
- Podiatric Medical Board

While still in draft form and being reviewed by the respective commissions and boards, each medical specialty will require at least one hour of continuing education for practitioners licensed to prescribe opioids. Prescribers will attest to having met this requirement.

The relevant WACs for each profession can be found in DOH's Pain Management Adopted Rules.[38]

For Washington's Apple Health (Medicaid) program, the Washington State Health Care Authority implemented clinical policies pertaining to opioid prescriptions on November 1, 2017. This policy is intended to be a prevention and patient safety tool and limits the quantity of opioids that can be prescribed to opiate naïve patients for non-cancer pain.[39] This policy takes effect through both managed care organizations and fee-for-service.

Programs administered by the Health Care Authority are also required to implement the recommendations put forth by the Dr. Robert Bree Collaborative. In 2017 the Bree Collaborative issued recommendations for Opioid Prescribing Metrics.[40] The HCA Medicaid program has adopted three of these measures used in annual reports to providers who are the highest prescribers in the areas of: numbers of patients on high dose opioids, number of patients receiving high MEDs of opioids and those receiving opioids concurrently with other sedative hypnotics. These reports are informational and meant for quality improvement.

Additionally, the following pain management resources are available to providers:

- The University of Washington Department of Anesthesiology and Pain Medicine's Pain Medicine Provider Toolkit has a comprehensive list of clinical tools and patient education materials.
- The University of Washington School of Medicine COPE program offers a suite of free CME courses for primary care doctors, nurses, physician assistants, and other health care specialists who treat patients with chronic pain and want to learn how to safely address opioid prescribing.

[38] https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/OpioidPrescribing/AdoptedRules
[39] https://www.hca.wa.gov/assets/billers-and-providers/opioid-policy.pdf
[40] http://www.breecollaborative.org/wp-content/uploads/Bree-Opioid-Prescribing-Metrics-Final-2017.pdf

- The WA State Department of Health Pain Management Resources website includes pain rules, dosage calculator, clinical tools, and CME training opportunities.
- The American Medical Association also offers CME courses and webinars on safe opioid prescribing.

Future State:

- No changes. Continue current activities.

Summary of Actions Needed:

- None.

Expanded coverage of, and access to, naloxone for overdose reversal

Current State:

DBHR has worked to increase Naloxone since 2015. Using Substance Abuse Block Grant (SABG) funding and working with the University of Washington Alcohol and Drug Abuse Institute (ADAI), DBHR has created a comprehensive website to provide education, locations for purchasing, and information on the distribution network. The collaboration between DBHR and ADAI has influenced changes to state laws including Washington State law RCW 69.50.315, which allows anyone "at risk for having or witnessing a drug overdose" to obtain naloxone and administer it in an overdose. This includes people who use opioids, family members, friends and professionals.

Washington State's 2015 "Naloxone law" RCW 69.41.095 also permits naloxone to be prescribed directly to an "entity" such as a police department, homeless shelter or social service agency for staff to administer if they witness an overdose when performing their professional duties. Additionally, RCW 69.41.095 also permits non-medical persons to distribute naloxone under a prescriber's standing order.

Immunity from liability. Several laws in Washington (commonly called "Good Samaritan" laws) give certain protections to laypersons trying to assist in a medical emergency. RCW 4.24.300 provides immunity from civil liabilities when responding in a medical emergency. RCW 69.50.315 further protects both the overdose victim and the person assisting in an overdose from prosecution for drug possession.

The Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO)[41] is a collaborative five-year grant project between the DBHR and the ADAI with the purpose of preventing opioid overdose and deaths from opioid overdose, and building local infrastructure to

[41] The DBHR currently directs the grant to Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO) (FOA) No. SP-16-005: Catalogue of Federal Domestic Assistance (CFDA) NO.: 93.243.

plan, implement, evaluate and fund overdose prevention efforts in the long-term. WA-PDO will develop a statewide network of opioid overdose experts and interventions, leveraging ADAI's Center for Opioid Safety Education program (COSE) as the central hub and four regional nodes coordinating WA-PDO overdose prevention activities; this will efficiently extend core overdose prevention expertise and centralized resources at COSE to four diverse, high-need areas (HNA) across the state.

WA-PDO will reach adults who use prescription opioids/heroin and professionals and community members who may be first responders at an overdose. Core interventions include stakeholder engagement, overdose prevention/response training, and naloxone distribution. Over the five-year project our activities will reach 2,400 police, fire, and emergency medical services personnel responders; 13,200 lay responders, 1,400 health care providers; 120 pharmacies; and 160 community organizations across four priority regions.

The Washington State Targeted Response (WA-STR) Naloxone project will provide medication to vulnerable and underserved populations in partnership with ADAI. Despite the resources provided by the 2016 Preventing Death from Opioids (PDO) grant, there remains a substantial gap between need and availability of take-home-naloxone provided to those at highest risk for witnessing an overdose. This program will help meet this need by providing additional naloxone to places at both high relative risk (in terms of the local opioid overdose mortality rate) and high absolute risk (in terms of the total number of fatal opioid overdoses and estimated heroin using population).

Currently all Syringe Exchange programs in Washington are distributing Naloxone as a component of the work provided by ADAI utilizing funding provided through DBHR SABG, PDO and WA-STR funding. The website stopoverdose.org continues to be a major source of education and training. ADAI continues to provide outreach and training for professional first-responders requesting training and naloxone.

Future State:

- No changes. Continue current activities.

Summary of Actions Needed:

- None.

Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs

Current State:

The Washington State Department of Health Prescription Monitoring Program (sometimes referred to as Prescription Review) is a centralized online database that holds controlled

substance prescription information for all patients across the state. Prescribers are able to review their patients' prescription history information before they prescribe or dispense drugs. This allows them to look for duplicate prescribing, possible misuse, drug interactions and other potential concerns. More information and factsheets on program rules, registration, use, and reports are available on the Prescription Monitoring Program website.[42]

The HCA sends opioid prescribing reports to physicians as part of the Centers for Disease Control's (CDC) Prescription Drug Overdose grant. These reports are intended to inform providers of their prescribing practices to support quality improvement efforts. The metrics used in this report mirror the Dr. Robert Bree Collaborative Opioid Prescribing Metrics[43] and are tailored to HCA's Medicaid population where applicable. The best practices recommendations reflect the CDC's guidelines for prescribing opioids.[44]

Future State:

- No changes. Continue current activities.

Summary of Actions Needed:

- None.

Milestone 6: Improved care coordination and transitions between levels of care

Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities

Current state:

While the state understands the value of coordination between levels of care and expects providers to provide warm hand-offs during the transition between residential and outpatient treatment, there are not any rules or policies in place requiring this for SUD services. The concept of coordination between the outpatient and inpatient settings has long been a part of the mental health system through discharge planning requirements and dedicated "hospital liaison" positions. However, the state recognizes that the SUD residential and outpatient systems may not yet coordinate to this level.

Additional policies to ensure coordination of care for co-occurring physical and mental health conditions

Washington State is moving toward an integrated managed care system. In this system, each Medicaid individual's behavioral health and physical health care is coordinated by a single entity (an MCO). There is an expectation that having both behavioral health and physical health services managed by one organization will improve coordination among those systems.

[42] http://www.wapmp.org/
[43] http://www.breecollaborative.org/wp-content/uploads/Opioid-Prescribing-Metrics-Specifications-Draft-2017.pdf
[44] https://www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-a.pdf

In addition to these system-wide changes, the state has current contract language requiring coordination with primary care providers (PCP) or, if the client does not have a PCP, that the behavioral health provider refer the individual to a PCP.

Future State:

The state will implement a requirement that MCOs, residential treatment providers, and outpatient providers work to develop policies and practices that enhance care coordination, including transitions between levels of care following residential treatment stays.

Summary of Actions Needed:

HCA will work with the DOH to make these WAC changes. As of July 1, 2017 the policy and federal programs functions within DBHR will integrate into HCA. At the same time the DBHR licensing and certification team will become part of the DOH.

1. Within 12 months: The state will add these requirements to PIHP and MCO contracts.
2. Within 24 months: The state will update the WAC to include these requirements

Implementation Timeline, Milestone 6	
Contract Changes	
Date	**Action**
July 1, 2018	Effective date of 1115 SUD/IMD Waiver Amendment
September 2018	• Begin developing new contract language that meets the requirements described above. • Convene group of subject matter experts to advise on development of requirements.
November 2018	Finalize new contract language.
January-March 2019 (or sooner)	Begin contract negotiations with MCOs/BHOs regarding new language.
April-June 2019 (or sooner)	Update MCO and BHO contracts to include the new requirements.
WAC Changes	
Date	**Action**
January 2019	Convene group that includes SUD subject matter experts and DOH/HCA staff responsible for updating WACs.
April 2019	Finalize draft WAC language.
May 2019	Begin public notice and rules hearing process.
September 2019	Finalize rules changes.
January 2020	Effective date of WAC changes.

Attachment A: SUD Health Information Technology (IT) Plan

The table below identifies Washington's SUD Health Information Technology (IT) Plan, including current and planned future state, and specific actions and timeline, to address needed enhancements over the course of the demonstration.

Section I. State Health IT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
5. Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and OUD, that is: *--Enhance the state's health IT functionality to support its PDMP; and* *--Enhance and/or support clinicians in their usage of the state's PDMP.*	*Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP, and supports to enhance clinicians' use of the state's health IT functionality to achieve the goals of the PDMP.*	*Provide an overview of plans for enhancing the state's PDMP, related enhancements to its health IT functionalities, and related enhancements to support clinicians' use of the health IT functionality to achieve the goals of the PDMP.*	*Specify a list of action items needed to be completed to meet the HIT/PDMP milestones identified in the first column. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item*
Prescription Drug Monitoring Program (PDMP) Functionalities			
Identify funding sources to enhance the functionality of the PDMP and support its use by clinicians			Funding is needed to support the design, development, operation, and/or maintenance of each of the tasks described below in the SUD HIT Plan. Contingent on the availability of funds, the Health Care Authority (HCA), in collaboration with the

			Department of Health (DOH), will: • Explore options for funding (i) PDMP enhancements (as described in the activities below) and (ii) the use of the PDMP by clinicians on behalf of Medicaid and non-Medicaid patients; and • Develop a financial mapping tool that identifies sources of funds (e.g., HITECH, MMIS, grants, private sector funds) that will be used to execute the activities in this SUD HIT Plan on behalf of Medicaid and non-Medicaid patients and their treating providers. For example, the ability to accurately match patient who are prescribed opioids with patients in the PDMP, and match patients in the PDMP with other data sources is

			critically important for most tasks in the SUD HIT Plan. Activities F and I below describe the need to explore options to enable patient matching. The financial mapping tool will identify funding sources that will be used to implement these activities. Timeline: 3 – 6 months
Enhanced interstate data sharing in order to better track patient specific prescription data	The Washington Prescription Monitoring Program[45] (PMP) is intended to improve patient care and stop prescription drug misuse by collecting dispensing records for Schedule II, III, IV and V drugs, and making the information available to medical providers and pharmacists as a tool in patient care. Washington State allows healthcare professionals licensed in and by	The state will continue current enhancement activities, and identify the most appropriate solution for additional state-to-state data sharing. Per the 2016 Washington State Interagency Opioid Working Plan,[46] the state is working to reduce current policy and technical barriers to enable	Contingent on the availability of funds, the Health Care Authority (HCA) and the Department of Health (DOH) will identify facilitators and barriers, as well as options to enhance interstate data sharing to better track of patient specific prescription data. Considerations will include identifying the costs of, and funding mechanisms for,

[45] https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PrescriptionMonitoringProgramPMP
[46] http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

	other states to register for and access the Washington PMP. Washington provides links to three regional PDMP websites (AK, OR, and ID) and a link to the national PDMP training and TA center. Washington also has agreements with Oregon and Idaho allowing PDMP data exchange in emergency departments via the Emergency Department Information Exchange (EDIE).	sharing of PMP data with border states (Goal 4, Strategy 1). Currently under review are PMP InterConnect (per National Association of Boards of Pharmacy) and Rx Check (per Bureau of Justice Assistance). Solution must meet State of Washington data security standards and be HIPPA compliant.	supporting the collaboration and identification of options. HCA and DOH will develop and implement a strategy to identify the costs of and secure funding needed to support additional state-to-state data sharing. Timeline: 12-24 months.
Enhanced "ease of use" for prescribers and other state and federal stakeholders	DOH has offered education and training regarding the PMP, and provided guidance to providers regarding access to PMP and resources. Washington State rules support and require the use of the PMP for the following: (1) Opioid prescribing rules suggest that providers should include review of any available PMP data when evaluating patients for chronic non-cancer pain; (2) The workers' compensation	The state must develop solutions that effectively balance the need for security with ease of use to support provider use of the PMP. A workgroup of subject matter and technical experts from DOH, Washington Technology Solutions (WaTech) and the Office of Cyber Security are gathering feedback and evaluating options in collaboration with providers and professional associations that	Contingent on the availability of funds, HCA and DOH will identify and implement feasible PMP Portal enhancements per workgroup recommendations. Some enhancements may be contingent on availability of funds. If implementation of identified enhancements rely on acquiring funding, the state will work to identify potential funding sources to support the

	program requires prescribers to use the PMP.	meet the state's shared goals of security and patient safety.[47]	implementation of PMP Portal enhancements. HCA in collaboration with DOH will develop and implement a strategy to identify the costs of and secure funding needed to identify and implement PDMP enhancements to facilitate "ease of use" for prescribers and other stakeholders. Timeline: 12-24 months
Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange	The PMP's connection to HIE has been in place since late 2013. EDIE was the first to take advantage of that connection. EDIE is in use across all acute care hospitals in Washington State. PMP data went live on the EDIE system in November 2014. Through 2015 more than 2.2 million PMP queries were completed by EDIE, about 120% more than the number of queries made by all other health	Per the 2016 Washington State Interagency Opioid Working Plan,[49] the state is exploring options to require health care systems to connect to the PMP through the statewide electronic health information exchange (Goal 4, Strategy 1). DOH is also exploring alternative connectivity options	DOH will work to reintroduce legislation (ESHB 2489) during the 2019 legislative session. DOH will then work with partner agencies to prioritize and support adoption of bill. Implementation of enhanced PDMP connections to the statewide HIE is contingent on acquiring funding, including

[47] https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PrescriptionMonitoringProgramPMP/EaseofUseProject
[49] http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

	care providers (HCPs) in all other health care settings over the PMP web portal for the year. The connection between the DOH PMP system vendor, OneHealthPort HIE and Epic EHR system were successfully piloted in the summer of 2015. EPIC developed and released a module to its Washington clients in December of 2015. This new module allows Epic users to transact and transmit PMP data directly to the patient record in the native EMR. At present providers can access the PMP by building a connection to the OneHealthPort HIE and integrating the PMP transaction into their EHR (rather than separately logging into the PMP Portal).	through the use of third party vendors. These vendors would provide application programming interface (API) options for medical entities whose vendor will not create the HIE connection, or for entities without the means to acquire the HIE connection. The state will pursue PDMP database vendor enhancements, use of state developed database architecture, or possible utilization of database architecture developed by another state.	funding for the following activities: • The state will identify additional third party vendors to develop API for HIE connections, and determine costs of per instance use, or single payment and "open source" distribution of state purchased API. • DOH and HCA will work to upgrade the PMP API interface to adopt standards identified by CMS. Per CMS rule-1694-p, the PMP API interface will need to be updated in response to the IPPS requirement to adopt NCPDP 2017071 by 2019 for e-prescribing. The interface currently uses an older widely adopted standard NCPDP 10.6. The state will require technical

	DOH has worked to support legislation (ESHB 2489[48]) that would mandate federally certified electronic health record systems to be utilized in the State of Washington to ensure the system can integrate with the state PMP via the HIE. However, legislation has not passed.		assistance and funding for needed upgrades to the PDMP system, any vendor fees, and additional staff to work on this Design, Development, and Implementation (DDI) work. The state will identify sources of additional funding for a state operated database, and pursue a public RFP per state contracting best practices for non-government entity. HCA and DOH will develop and implement a strategy to identify the costs of and secure funding as needed to upgrade the PDMP and enhance connectivity to the statewide health information exchange, including:

[48] http://apps2.leg.wa.gov/billsummary?BillNumber=2489&Year=2017&BillNumber=2489&Year=2017

			• upgrades to the new NCPDP standard (required by CMS), • any vendor fees, additional staff to work on this DDI work; and • changes to the health information exchange service provided by OneHealthPort, the statewide health information exchange organization, to support these PDMP enhancements. Timeline: 24+ months.
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns[50] (see also "Use of PDMP" #2 below)	The primary goal for using the PMP is patient safety, with additional goals of providing the highest quality of care and reducing harm. The PMP informs the HCP of a patient's controlled substance prescription history. That helps prevent drug-drug interactions that may lead to an adverse outcome, and therapeutic duplication. It alerts the HCP to length of time a patient	The state will explore further enhancements to the PMP functionality, including additional tools or alerts for HCPs.	Contingent on the availability of funds, HCA and DOH, in collaboration with Health Care Providers (HCPs and Managed Care Organizations (MCOs) will (1) identify clinical decision support (CDS) tools or alerts that could be usefully integrated into the PMP; and (2) integrate

[50] Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr mm6610a1.

	has taken prescription opioids, and understanding of undertreated pain. PMP data can alert the HCP of (1) patients receiving opioids, benzodiazepines, and other drugs that can create an adverse outcome at the same time, (2) patients receiving high morphine equivalent dose (MED) opioids, and (3) people who have potential abuse patterns, such as having seen five or more opioid prescribers and dispensers. The PMP also allows prescribers and dispensers to check for possible prescription misuse, multiple prescribers, adverse drug interactions, and undertreated pain.		these CDS into the PMP API. To the extent practical and appropriate, the CDS tools/alerts identified in this activity will support the use cases developed in Activities below. HCA and DOH will develop and implement a strategy to identify the costs of and secure funding as needed to identify and integrate CDS tools/alerts into the PMP API. Timeline: 12-24 months.
Current and Future PDMP Query Capabilities			
Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query)	The PMP database via the OneHealthPort HIE requires a match of the requested patient record. The query via the HIE is a one-to-one return based on provider search criteria (ie. "John Smith" returns only "John Smith").	Per the 2016 Washington State Interagency Opioid Working Plan[51] the state will work to: (1) link PMP data to overdose death and hospitalization data to determine relationships between prescribing, patient risk behavior, and overdoses, and	Contingent on the availability of funds, HCA in collaboration with DOH will: 1. Consider the accuracy of patient matching for patients with data in the PDMP with other data

[51] http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

	The MTP HIT Strategic Roadmap and HIT Operational Plan identify a need for improved patient entity matching, including a focus on and task to identify various Master Person Identifiers (MPIs) used across programs and discuss options and considerations of multiple vs. single MPI.	disseminate results to individual counties, (2) develop and disseminate population-level PMP reports on buprenorphine prescribing practices, (3) develop measures using PMP data to monitor prescribing trends and assess impact of interventions on prescribing practices, and (4) explore options to aggregate and analyze PMP data by health plan/payer. As part of future PDMP database development, RFP/architecture design will require improved clustering and aggregation of patient identifiers.	sources (e.g., data on hospitalizations, overdose deaths) 2. If the accuracy of patient matching needs improvement, then HCA, in collaboration with DOH will: (1) identify facilitators and barriers, and (2) explore options to link Patient Identifiers and Provider Identifiers across different systems to improve the accuracy of matching patients with data in the PDMP with other data sources; and 3. Develop and implement a strategy to improve the accuracy of patient matching with regard to the PDMP. HCA and DOH will develop and implement a strategy to identify consider the actions will include identifying the need for and if needed costs of and funding mechanisms needed to implement the strategy to improve the accuracy of for

			linking Patient Identifiers and Provider matching Identifiers across different systems Timeline: 12-24 months.
Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow	As mentioned above, integration of the PMP, OneHealthPort HIE and Epic has occurred. The Epic EHR has the biggest footprint among Washington State health care providers (compared to other EHR vendors). The PMP has assisted eight medical entities move to data exchange production or testing across the state. This includes EHR systems utilizing Epic, Cerner, AllScripts and NextGen. Once medical entities move into production with a given EHR, PMP staff attempt to identify other healthcare providers/entities utilizing that EHR in order to	Per the 2016 Washington State Interagency Opioid Working Plan[52] the state will work to: (1) Promote the use of the PMP, including use of delegate accounts, among health care providers to help identify opioid use patterns, sedative co-prescribing, and indicators of poorly coordinated care/access. (2) Link PMP data to overdose death and hospitalization data to determine relationships between prescribing, patient risk behavior, and overdoses, and disseminate results to individual counties. (3) Develop and disseminate population-level PMP reports on buprenorphine	Contingent on the availability of funds, HCA in collaboration with DOH will sponsor work to: • identify for 3-5 use cases the clinical workflows/business processes for accessing the PDMP prior to prescribing an opioid or other controlled substance; and • develop change management guidance for implementing the identified clinical workflows/business processes

[52] http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

	possibly connect those medical providers/entities to the HIE via the API already developed. The state is supportive of clinicians accessing the PDMP prior to prescribing an opioid and have developed this interface in conjunction with ONC and the vendor community.	prescribing practices. (4) Enhance medical, nursing, and physician assistant school curricula on pain management, PMP, and treatment of opioid use disorder. (5) Educate law enforcement on the PMP and how it works" (6) Increase PMP reporting frequency from weekly to daily. (7) Provide easy access to the PMP data for providers through electronic medical record systems. (8) Provide MED calculations within the PMP for chronic opioid patients with automated program alerts for providers. (9) Evaluate policy interventions for effectiveness and impact (e.g., pain management rules, mandatory PMP registration). Additionally, regional work is being completed by Accountable Communities of Health (ACH) to support and reinforce the 2016 Washington	HCA and DOH will develop and implement a strategy to identify the costs of and secure funding for the identification of the use cases and associated clinical work flows/business processes, and change management guidance Timeline: 24+ months.

		State Interagency Opioid Working Plan.	
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription	As mentioned above, integration of the PMP, OneHealthPort HIE and Epic has occurred. The Epic EHR has the biggest footprint among Washington State health care providers (compared to other EHR vendors). The state is supportive of clinicians accessing the PDMP prior to prescribing an opioid and have developed this interface in conjunction with ONC and the vendor community.	As described above, the 2016 Washington State Interagency Opioid Working Plan[53] goals and strategies, as well as supportive regional work completed by ACHs, are intended to increase the use of the PMP prior to the issuance of an opioid prescription.	Contingent on the availability of funds: • In addition to pursuing the strategies described in the 2016 Washington State Interagency Opioid Working Plan, HCA and DOH will collaborate to identify facilitators and barriers to develop enhanced supports for clinician review of the PMP. • HCA in collaboration with DOH will develop and implement a strategy to identify the costs of and secure funding for any additional/enhanced

[53] http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

			clinician supports to use the PDMP. Timeline: 24+ months.
Master Patient Index / Identity Management			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	The master patient index, or Master Data Management (MDM), is a component of the Enterprise Architecture. The foundation was created with the Medicaid Eligibility and Enrollment modernization MMIS purchase of the IBM Truven software. The state recognizes limitations in currently supported patient matching in the PDMP, and intends to find ways to link this issue to improve data linkage and identity mapping.	DOH and HCA will explore feasibility and options of developing a shared Master Patient Index and Master Provider Index.	As described above and contingent on the availability of funds: HCA and DOH will explore the need to and options for enhancing patient matching (such as developing a shared Master Patient Index and Master Provider Index; or creating a the ability to crosswalk of patient/provider identifiers between the PDMP and other data sources); and implement a strategy to improve the accuracy of patient matching with regard to the PDMP. HCA, in collaboration with and DOH, will develop and implement a strategy to identify the costs of and secure funding to enhance the patient matching between the PDMP and other

			data sources. Timeline: 12-24 months.

Attestation Requirements

Statement 1*: Indicate whether the state has 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.*

Washington State has Health IT infrastructure in place to support the goals of the SUD demonstration. This SUD HIT plan lists infrastructure enhancements, contingent on securing necessary funding, which support expanding effective and reusable health information technology and exchange capabilities statewide. The state agencies, HCA and DOH, will collaborate over the next 12-24 months to identify and pursue funding opportunities that will support improvements to the state health IT infrastructure.

HCA will lead the development of the financial mapping tool. HCA and DOH will collaborate in the development and implementation of the:

- SUD Monitoring Protocol that will provide the strategies to increase utilization and improve functionality of prescription drug monitoring programs as described above in the SUD Health Information Technology (IT) Plan; and
- Strategy to identify the costs of and secure funding needed for each of the activities identified about in the SUD Health IT Plan.

Statement 2*: Indicate whether the state's SUD Health IT Plan is "aligned with the state's broader State Health IT Plan (SMHP) and if applicable, the state's Behavioral Health (BH) Health IT Plan."*

Washington State's SUD Health IT plan is aligned with the broader State Medicaid Health IT Roadmap and Operational Plan approved by CMS under the Medicaid Transformation Project. Upon approval of the IMD Waiver, the state will review the Health IT Operational Plan and incorporate any additional tasks needed to align with approved SUD HIT Plan. Washington State is updating its State Medicaid Health IT Plan and commits to aligning the SMHP with the approved SUD HIT Plan.

Statement 3: *Indicate that the state will include appropriate standards referenced in the ONC Interoperability Standards Advisory (ISA) https://www.healthit.gov/isa/ and 45 CFR 170 Subpart B in subsequent MCO contract amendments or Medicaid funded MCO/ Health Care Plan re-procurements.*

The Washington State Health Care Authority includes appropriate standards referenced in the ONC Interoperability Standards Advisory (ISA) in its Managed Care contracts.

Section II. Implementation Administration
The state's point of contact for the SUD Health IT Plan is listed below.

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Attachment L: Monitoring Metric Supplemental Information

Medicaid Section 1115 SUD Demonstration Monitoring Protocol – Additional Information to Support Monitoring Metric Specifications

Revised and Resubmitted January 24, 2020

Background and Introduction

The State will leverage three different analytic teams to produce the required metric reporting. These analytic teams include the Department of Social and Health Services Research and Data Analysis Division, the Health Care Authority's Analytics, Research, and Measurement team, and the Health Care Authority's Division of Behavioral Health and Rehabilitation. Between the three analytic teams, the State has an extensive existing data infrastructure that the State intends to leverage for the CMS reporting requirements. This existing infrastructure currently completes reporting for various entities, including the Adult and Child Common Measure Set and substance use disorder related Substance Abuse Mental Health Services Administration (SAMHSA) reporting. This analytic infrastructure also supports a number of ongoing activities in the realm of health care transformation. These include, but are not limited to, Washington's movement towards the integration of behavioral and physical health care and all three initiatives of the initial Medicaid Transformation Project (Transformation through Accountable Communities of Health, Long-Term Services and Supports of the Aging Population, and Foundational Community Support Services).

The State analytic teams have reviewed the CMS provided specifications and reporting procedures. Per the instructions in the Monitoring Protocol, the State will explain any deviations from the CMS-provided specifications that are needed to match the health care context and data infrastructure within Washington State. The State created this attachment to minimize duplication of explanation of requested modifications which apply to multiple metrics, and to provide details on state-specified metrics that would not fit within the given metric workbook template.

The State thanks CMS for the opportunity to align the specifications with the State's health care context, data infrastructure, and existing 1115(a) demonstration. We welcome any questions or concerns from CMS regarding these requests.

Overview of 1115 SUD Demonstration Monitoring Metrics

This section describes the data sources the State will be drawing on, how the State will align the Substance Use Disorder (SUD) measurement periods with the State's broader 1115(a) demonstration reporting cycle, and will note the reporting level for all metrics.

Description of Data Sources

Integrated Client Databases. SUD demonstration monitoring metric production will use the integrated administrative data maintained in the Department of Social and Health Services Integrated Client Databases (ICDB). The ICDB was explicitly designed to support quasi-experimental evaluation of health and social service interventions in Washington State, and has been widely used in evaluation studies published in peer-reviewed journals[1] and for the production of performance and monitoring measures.

[1] For a recent example, see Jingping Xing, Candace Goehring and David Mancuso. Care Coordination Program For Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs Care Coordination Program For Washington State. Health Affairs, 34, no.4 (2015):653-661.

The underlying reporting arrays are regularly updated to align with State requirements. The State has analyzed completion factors based on the historical encounter data submitted to the State's MMIS by contracted MCOs responsible for SUD services. This completion factor analysis indicates that fewer than 90% of ultimately accepted encounters are uploaded and successfully accepted into the MMIS by five months from the month the service was provided to the client. Reporting with a 90-day lag would result in an even greater systematic undercount of services provided in the most recent reporting period. The State believes that reporting information that is known to be undercounted will negatively impact the IMD waiver program. The State requests a 6-month reporting lag to allow for reporting of information that is more complete. Even with the proposed 6-month reporting lag, we recommend provisions for updating information previously reported with more complete data when it becomes available.

The State also requests the ability to calculate the monthly metrics once per quarter. Per CMS' technical assistance document Reporting 1115 SUD Demonstration Monitoring Metrics "…if a state submits data on a quarterly basis, the submission should contain three monthly values for each monthly metric, each produced at the same time relative to their measurement periods." However, the underlying production schedule for the State's analytic environment is quarterly. The State is unable to change the global production cycle and fundamental infrastructure to accommodate this monitoring expectation. In addition, some of the data necessary for the monthly metrics is updated quarterly and would not be up to date for two months of each quarter. For example, information needed for the criminal justice involvement submetrics is received on a quarterly basis from the Washington State Identification System arrest database maintained by the Washington State Patrol. The State understands that part of CMS' reasoning for producing the monthly metrics at the same time relative to their measurement periods is due to the dynamic nature of Medicaid data. Observing a 6-month reporting lag mitigates this impact.

Death Certificate Data. The Washington State Department of Health maintains the death certificate data received from the Center for Health Statistics. The Health Care Authority's Analytics, Research, and Measurement team will work with the death certificate data for the two fatal overdose metrics. However, death certificate data is not finalized until Q4 in the year following the measurement year. For example, death certificate data for 2017 was not finalized until October 2018. This will result in additional lag time in reporting for the two fatal overdose metrics that require this data.

Measurement Period

Per CMS's instructions and in alignment with the Special Terms and Conditions (STCs) 72, 74, and the Schedule of State Deliverables for the Demonstration Period (XIII), Washington will align the reporting cycles for the SUD Demonstration Amendment with the broader section 1115(a) demonstration quarterly and annual reporting cycles. Table 1 shows the current reporting cycle to the broader section 1115(a) demonstration.

Aligning to this reporting cycle will require a small modification to the measurement periods in the technical specification document. The effective date of the Washington SUD demonstration is July 17, 2018. However, to align with this reporting structure, we will use July 1, 2018 as the start date for the measurement periods. This does not change the effective date of the demonstration. Washington is in favor of this modification, as it closely aligns with our current data infrastructure and reporting processes. For example, Medicaid enrollment is verified monthly in Washington, and thus all eligibility requirements will need to be based around calendar months.

TABLE 1.

Washington's 1115(a) Waiver Quarterly and Annual Reporting Cycle

Quarter/Annual Report Cycle	MTP Reporting Period	Report Due Date
DY2 Q4 (Annual Report DY2)	Jan 2018 – Dec 2018	03/01/2019
DY3 Q1	Jan 2019 – March 2019	06/03/2019
DY3 Q2	April 2019 – June 2019	09/03/2019
DY3 Q3	July 2019 – Sept 2019	12/02/2019
DY3 Q4 (Annual Report DY3)	Jan 2019 – Dec 2019	03/02/2020
DY4 Q1	Jan 2020 – March 2020	06/01/2020
DY4 Q2	April 2020 – June 2020	09/01/2020
DY4 Q3	July 2020 – Sept 2020	12/01/2020
DY4 Q4 (Annual Report DY4)	Jan 2020 – Dec 2020	03/01/2021
DY5 Q1	Jan 2021 – March 2021	06/01/2021
DY5 Q2	April 2021 – June 2021	09/01/2021
DY5 Q3	July 2021 – Sept 2021	12/01/2021
Final Report	Jan 2021 – Dec 2021	06/30/2022

In addition, this also aligns with reporting cycles for other related SUD projects and the Washington State fiscal year. The modified measurement periods for the monthly, quarterly, and annual metrics are described next and in the table below.

- For metrics with a monthly measurement period, the first monthly measurement period is the month the SUD demonstration began – July 1, 2018 to July 31, 2018. The second month is August 1, 2018 to August 31, 2018, and so forth.
- For metrics with a quarterly measurement period, the first quarter of the demonstration is the first three months of the demonstration – July 1, 2018 to September 30, 2018.
- For the CMS-constructed metrics with an annual measurement period, the first annual measurement period is the first twelve months of the demonstration – July 1, 2018 to June 30, 2019.
- For the established quality measures, the first annual measurement period is the calendar year in which the demonstration began – January 1, 2018 to December 31, 2018.

As previously discussed with CMS, the State believes setting the baseline to the year prior to the change in authorizing expenditure authority is needed to appropriately set demonstration targets, annual goals, and to ultimately respond to the demonstration hypothesis specific to the SUD amendment (STC 111e). Thus, the State requests to define the baseline year as July 1, 2017 – June 30, 2018 for the CMS-constructed metrics and January 1, 2017 – December 31, 2017 for the established quality measures.

The State will begin reporting after a monitoring protocol has been agreed upon by the State and CMS, and sufficient time is provided to implement the metric specifications as stated in the agreed upon monitoring protocol. The requested reporting schedule in Table 2 below may change depending on when the monitoring protocol is approved. The reporting schedule also specifies a baseline reporting period of July 1, 2017 – June 30, 2018 for CMS constructed metrics and January 1 – December 31, 2017 for established quality measures. In addition, Table 2 employs the 6-month reporting lag that is necessary for the State to submit data that does not substantially undercount the number of services provided.

TABLE 2.

Proposed Reporting Schedule for Washington Metrics for SUD Demonstration

Dates of reporting quarter	WA's SUD DY: Jul 1 – Jun 30	WA's broader 1115 DY: Jan 1 – Dec 31 (type of report)	Report due (per STCs schedule)	SUD metrics included in report	Reporting period(s) for SUD metrics in a given report†
Jul – Sept 2018	DY1 Q1	DY2 Q3 (quarterly)	12/1/2018	No SUD metrics reported. Monitoring protocol under development.	N/A
Oct – Dec 2018	DY1 Q2	DY2 Q4 (annual)	3/1/2019	No SUD metrics reported. Monitoring protocol under development.	N/A
Jan – Mar 2019	DY1 Q3	DY3 Q1 (quarterly)	6/1/2019	No SUD metrics reported. Monitoring protocol under development.	N/A
Apr – Jun 2019	DY1 Q4	DY3 Q2 (quarterly)	9/1/2019	No SUD metrics reported. Metric specifications being implemented by State.	N/A
Jul – Sept 2019	DY2 Q1	DY3 Q3 (quarterly)	12/1/2019	(1) Monthly metrics (2) CMS defined metrics* (3) Established quality metrics	(1) July 2017 – March 2019 (2) July 2017 – June 2018 (3) January – December 2017 January – December 2018
Oct – Dec 2019	DY2 Q2	DY3 Q4 (annual)	3/1/2020	(1) Monthly metrics (2) CMS defined metrics	(1) April – June 2019 (2) July 2018 – June 2019
Jan – Mar 2020	DY2 Q3	DY4 Q1 (quarterly)	6/1/2020	(1) Monthly metrics	(1) July – September 2019
Apr – Jun 2020	DY2 Q4	DY4 Q2 (quarterly)	9/1/2020	(1) Monthly metrics (2) Established quality metrics	(1) October – December 2019 (2) January – December 2019
Jul – Sept 2020	DY3 Q1	DY4 Q3 (quarterly)	12/1/2020	(1) Monthly metrics	(1) January – March 2020
Oct – Dec 2020	DY3 Q2	DY4 Q4 (annual)	3/1/2021	(1) Monthly metrics (2) CMS defined metrics	(1) April – June 2020 (2) July 2019 – June 2020
Jan – Mar 2021	DY3 Q3	DY5 Q1 (quarterly)	6/2/2021	(1) Monthly metrics	(1) July – September 2020
Apr – Jun 2021	DY3 Q4	DY5 Q2 (quarterly)	9/1/2021	(1) Monthly metrics (2) Established quality metrics	(1) October – December 2020 (2) January – December 2020
Jul – Sept 2021	DY4 Q1	DY3 Q3 (quarterly)	12/1/2021	(1) Monthly metrics	(1) January – March 2021
Oct – Dec 2021**	DY4 Q2	DY5 Q4 (annual)	3/1/2022	(1) Monthly metrics (2) CMS defined metrics	(1) April – June 2021 (2) July 2020 – June 2021

**Given the additional delay in complete death certificate data, reporting on Metric #26 and Metric #27 (overdose death count and rate) will be delayed by one year. Baseline information will be available for the Annual Report DY3, Year 1 information will be available for Annual Report DY4, etc. Additional information about this delay is describes in the next section.*

***SUD Demonstration ends on December 31, 2021. Data from July 1, 2021 to December 31, 2021 will not be available before the final annual report is due to CMS.*

†For reporting periods with multiple types of SUD metrics, the list number corresponds with the SUD metric list number in the prior column. For example, in DY2 Q1, the monthly metrics will be reported for the July 2017 through March 2019 time period. The CMS defined metrics will be reported for the July 2017 to June 2018 time period, and so forth.

Reporting Level

For each metric, the demonstration population is defined as the whole state. In addition, the State's SUD amendment is not focused on a particular geographic area or a specific subpopulation of Medicaid beneficiaries. Thus, per previous conversations with CMS, the State will not be reporting a separate model population.

Reporting 1115 SUD Demonstration Monitoring Metrics Defined by CMS

This section defines the subpopulations for metric reporting and provides additional information about the State's approach to metric calculation and reporting.

Subpopulation Definitions

- Age (children <18, adults 18-64, and older adults 65+): Age will be determined as of the first day of the measurement period. This is consistent with CMS provided instructions.
- Dual-eligible status (Medicaid only or Medicare-Medicaid eligible): Dual eligibility will be determined as of the first day of the measurement period. This is consistent with CMS provided instructions.
- Pregnancy status (yes, no): Pregnancy will be determined as of the first day of the measurement period. This is consistent with CMS provided instructions.
- Criminal Justice Status: The State will use data in the ICDB from the Washington State Identification System arrest database maintained by the Washington State Patrol. An individual will be counted as "criminally involved" during the measurement period if they were arrested in the reference month or within the prior 6 months. An individual will be counted as "not criminally involved" during the measurement period if they were not arrested in the reference month or within the prior 6 months.
- OUD Diagnosis: The State will use an existing definition of OUD diagnosis which closely aligns with the HEDIS 2018 Opioid Abuse and Dependence value set. The OUD_Narrow_Flag in the ICDB incorporates the same codes as HEDIS 2018 Opioid Abuse and Dependence value set and one additional code, F1121 Opioid dependence, in remission. The OUD_Narrow_Flag has been used in a variety of research studies and reporting contexts and more appropriately reflects Washington State's approach to identifying those who may need or benefit from treatment for opioid use disorder under this SUD amendment and other opioid related initiatives within the state. In addition, the number of unique individuals who are captured in the ICDB OUD_Narrow_Flag and not the HEDIS 2018 Opioid Abuse and Dependence Value Set is minimal. Table 4 below shows the number of unduplicated persons in each time frame who would be included in the HEDIS 2018 value set versus the ICDB OUD_narrow_flag in three time periods.

Table 4.
Unique Persons Counted in HEDIS vs. ICDB OUD Value Set Over Time.

Unique Persons Counted In:	Jan 2016	Jan 2017	Jan 2018
HEDIS 2018 Opioid Abuse and Dependence Value Set	16,151	20,290	22,202
ICDB OUD_Narrow_Flag	16,495	20,715	22,917
Difference	344	425	715

Metric Calculation and Reporting

As CMS noted, Medicaid data is dynamic prior to reaching a data maturity threshold. For Washington State, that threshold is six-months. Observing a six-month data lag allows the State to represent the most complete data set for the measurement period. Any data lag less than six-months will result in potentially incomplete data and misrepresentative metric results. In addition, the six-month data lag allows for the inclusion of up to date information from data sources that are updated on a quarterly

cadence, such as the Washington State Identification System arrest database, which the State will be using to define the "criminally involved" subpopulation as noted above.

Using a six-month data lag also allows the State to leverage the existing quarterly performance measurement processes to calculate the required metrics. Thus, required monthly reporting will be calculated at the same time once per quarter. All the data will be, at a minimum, matured to six-months thus minimizing the likelihood of any variability due to data completeness.

Metric Specifications

This section provides additional detail on a subset of metric specifications. Other metric specification modifications are noted in the Monitoring Protocol 1115 SUD Metrics Workbook.

Metric #9: Intensive Outpatient and Partial Hospitalization Services

The State recommends dropping this metric as a required reporting metric. At this time, intensive outpatient services are not reported as a distinct type of service in the State's administrative data system. Thus, services that other states may identify as intensive outpatient services appear as outpatient services in Washington's data infrastructure. In addition, Washington does not provide partial hospitalization services and the provision of this service is not included in the STCs. The current Service Encounter Reporting Instructions (SERI v2019-1 effective July 1, 2019) does not contain codes for intensive outpatient services and/or partial hospitalizations for substance use disorder and no data is available to report on this metric.

The State updated the monitoring protocol to indicate a deviation from the technical specifications for Metric #8 (Outpatient Services).

Metric #18 and #21: PQA Metric Alignment with Medicaid Transformation Project 3A Performance Metrics

The State recommends using the Bree Collaborative metrics that are currently being used in the CMS approved project toolkit as pay-for-performance metrics[2] and in the Washington Statewide Common Measure Set[3] in lieu of the PQA stewarded metrics #18 and #21. Specifically, the Bree Collaborative metrics "Patients Prescribed High-Dose Chronic Opioid Therapy" and "Patients Prescribed Concurrent Opioids and Sedatives" are pay-for-performance metrics for Project, 3A: Addressing the Opioid Use Public Health Crisis, which is a required project for all Accountable Communities of Health (ACH). These two metrics are similar, but not identical, to Metric #18 (Use of Opioids at High Dosage in Persons Without Cancer) and Metric #21 (Concurrent Use of Opioids and Benzodiazepines).

The Dr. Robert Bree Collaborative (Bree Collaborative) was established by the Washington State Legislature in 2011 to identify ways to improve health care in Washington State. A diverse group of stakeholders are appointed by the Governor that represent all aspects of the Washington health care system[4]. Each year, the Bree Collaborative forms expert workgroups on health care service areas in need of improvement. In July of 2017, the Bree Collaborative put forth a set of opioid prescribing guidelines[5]

[2] CMS approved Medicaid Transformation Project Toolkit is available at https://www.hca.wa.gov/assets/program/project-toolkit-approved.pdf

[3] For more information about the Statewide Common Measure Set, see https://www.hca.wa.gov/about-hca/healthier-washington/performance-measures

[4] For more information about the Bree Collaborative, see http://www.breecollaborative.org/about/.

[5] The full set of opioid prescribing guidelines from the Bree Collaborative is available at http://www.breecollaborative.org/wp-content/uploads/Bree-Opioid-Prescribing-Metrics-Final-2017.pdf

to assist providers in understanding prescribing practices and the impact of the opioid epidemic across the state. Drawing on the extensive subject matter expert review the Bree Collaborative incorporated into their development of these metrics, two of these metrics are included in Initiative 1 of the Medicaid Transformation Project (Transformation through Accountable Communities of Health).

In addition, Washington is one of a few states that have developed a Statewide Common Measure Set as a foundation for health care accountability and performance measurement. Bree opioid prescribing metrics have been added to the Common Measure Set to improve measurement of progress toward healthier outcomes. As such, stakeholders across the state are already familiar with the Bree Collaborative metrics.

The proposed measures thus represent a carefully developed and reviewed set of metrics that provide essential information about opioid use in the State in the context of larger efforts to address substance use disorder and improve health among State residents. The use of Bree metrics in this context would help the State to further align opioid-related projects within the state.

There are differences between the details of the PQA measures and the measures the State proposes to use. The State feels these differences potentially make the State's measures more informative and applicable to the Washington health care context:

- The State's measures include prescribing to children.
  - Most opioid prescriptions are not for children but they are at particularly high risk for dependence and other complications when they are prescribed.
- PQA's measure for concurrent use of opioids and other drugs includes only benzodiazepines as additional drugs. The State's measure includes other sedatives such as barbiturates and muscle relaxants (carisoprodol [Soma]), and commonly prescribed sleep aids such as eszopiclone (Lunesta), suvorexant (Belsomra), zaleplon (Sonata), and zolpidem (Ambien).
  - These drugs were included in the State's proposed measure after extensive clinical consideration of which drugs presented heightened risks when used with opioids.
- The State's measures will capture some problematic opioid usage that could be missed in the PQA approach.
  - The PQA measure may omit prescriptions that fit the measure definitions but bridge the end and beginning of two measurement years.
- The State's measures include a two-year lookback window (measurement year and the year prior to the measurement year) rather than a one-year lookback for cancer diagnoses.
  - The longer lookback allows for more complete information about cancer status
- While the State's recommended high dosage measure can be used to report usage at the 120 MED level, the State recommends adopting the 90 MED threshold recommended by CDC and in accordance with the 2019 PQA specification update.

Overall, use of the Bree specified measures in lieu of the PQA metrics will allow the State to provide enhanced information that will coordinate well with the State's other efforts to address substance use disorder and improve population health. Detailed specifications of the two Bree measures are below.

Patients Prescribed Chronic Concurrent Opioids and Sedatives

Metric Description: Percent of Medicaid beneficiaries prescribed chronic opioids and a concurrent chronic sedative prescription, among beneficiaries prescribed chronic opioids. The Bree Collaborative

recommends quarterly reporting. All qualifying observations for a given quarter count towards the overall, annual estimate for the measurement year. This means that an individual who meets the eligibility criteria and has at least 60 days supply of opioids and has a concurrent sedative prescription in two calendar quarters in the measurement year will contribute 2 qualifying observations to each metric threshold calculation.

Definition of terms used in this metric:

- *Days Supply in Quarter:* The number of days each prescription should last (days supply) is generally provided for each prescription. Days supply is calculated at the pharmacy by dividing the number of units (e.g., tablets, capsules, patches) dispensed by the maximum number of units to be used in one day. The total days supply is the sum of the days supply from all opioid prescriptions prescribed during the calendar quarter, including overlapping prescriptions (and includes days that may extend into the next calendar quarter).
- *Chronic Opioid Prescription:* ≥60 days supply of opioids prescribed in the calendar quarter.
- *Chronic Concurrent Opioid and Sedative Prescription:* ≥60 days supply of opioids prescribed and ≥60 days supply of sedatives prescribed in the same calendar quarter.

Data Source: Medicaid claims/encounter and enrollment data.

Identification Window: Four quarters that comprise the measurement year.

Eligible Population	
Age	All ages.
Gender	N/A
Minimum Medicaid enrollment	3 out of 3 months for each qualifying quarter.
Allowable gap in Medicaid enrollment	None within each qualifying quarter.
Medicaid enrollment anchor date	N/A
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid and beneficiaries with primary insurance other than Medicaid.

Denominator: Medicaid beneficiaries who meet the above eligibility criteria, with a ≥60 days supply of opioids in the calendar quarter.

Required exclusions for denominator.

- Eligible population exclusions are listed in the eligible population table above.
- Metric specific exclusions:
    - Beneficiaries in hospice care.
    - Beneficiaries with a cancer diagnosis.
    - All prescriptions for buprenorphine are excluded.

Numerator: Beneficiaries must qualify for inclusion in the denominator to be eligible for inclusion in the numerator. Medicaid beneficiaries who meet the above eligibility criteria and prescribed ≥60 days

supply of opioids and prescribed ≥60 days supply of sedative hypnotics, benzodiazepines, carisoprodol, and/or barbiturates in the same calendar quarter (note: these sedative classes are updated frequently).

Sedative Classes	Generic Names
Benzodiazepines	- Alprazolam - Chlordiazepoxide - Clonazepam - Clorazepate - Diazepam - Estazolam - Flurazepam - Lorazepam - Midazolam - Oxazepam - Quazepam - Temazepam - Triazolam
Barbiturates	- Butabarbital - Butalbital - Mephobarbital - Phenobarbital - Secobarbital
Skeletal muscle relaxants	- Carisoprodol
Non-benzodiazepine hypnotic	- Chloral hydrate - Eszopiclone - Meprobamate - Suvorexant - Zalelon - Zolpidem

Required exclusions for numerator.

- All prescriptions for buprenorphine are excluded.

Patients Prescribed High-Dose Chronic Opioid Therapy

Metric Description: Percent of Medicaid beneficiaries prescribed chronic opioid therapy hreater than or equal to 90mg morphine equivalent dosage in a quarter. The Bree Collaborative metric is based on quarterly reporting. All qualifying observations for a given quarter count towards the overall, annual estimate for the measurement year. This means that an individual who meets the eligibility criteria and has at least 60 days supply of opioids in three calendar quarters in the measurement year will contribute 3 qualifying observations to each metric threshold calculation.

Definition of terms used in this metric:

- *Days Supply in Quarter:* The number of days each prescription should last (days supply) is generally provided for each prescription. Days supply is calculated at the pharmacy by dividing the number of units (e.g., tablets, capsules, patches) dispensed by the maximum number of units to be used in one day. The total days supply is the sum of the days supply from all opioid

prescriptions prescribed during the calendar quarter, including overlapping prescriptions (and includes days that may extend into the next calendar quarter).

- *Chronic Opioid Prescription:* ≥60 days supply of opioids prescribed in the calendar quarter.
- *Average Morphine Equivalent Dose (MED) per day, inclusive of overlapping opioid prescriptions:* The MED for each prescription is calculated by multiplying the number of units prescribed by the strength per unit and then multiplying by the conversion factor (see list of conversion factors). The total MED is the sum of the MED from all opioid prescriptions prescribed during the calendar quarter, including overlapping prescriptions (and includes MED that may extend into the next calendar quarter). The total MED of all opioids is divided by 90 days to produce the average MED per day value.

Data Source: Medicaid claim/encounter and enrollment data.

Identification Window: Four quarters that comprise the measurement year.

Eligible Population	
Age	All ages.
Gender	N/A
Minimum Medicaid enrollment	3 out of 3 months for each qualifying quarter.
Allowable gap in Medicaid enrollment	None within each qualifying quarter.
Medicaid enrollment anchor date	N/A
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid and beneficiaries with primary insurance other than Medicaid.

Denominator: Medicaid beneficiaries who meet the above eligibility criteria, with a ≥60 days supply of opioids in the calendar quarter.

Required exclusions for denominator.

- Eligible population exclusions are listed in the eligible population table above.
- Metric specific exclusions:
    - Beneficiaries in hospice care.
    - Beneficiaries with a cancer diagnosis.
    - All prescriptions for buprenorphine are excluded.

Numerator: Beneficiaries must qualify for inclusion in the denominator to be eligible for inclusion in the numerator and greater than or equal to 90mg morphine equivalent dosage in a quarter.

Morphine Equivalent Dosage Conversion Factors: The MED for each prescription is calculated by multiplying the number of units prescribed by the strength per unit and then multiplying by the conversion factor. The total MED is the sum of the MED from all opioid prescriptions prescribed during the calendar quarter, including overlapping prescriptions (and includes MED that may extend into the next calendar quarter). The total MED of all opioids is divided by 90 days. Conversion factors are updated by the Washington State Agency Medical Directors' Group.

Opioid Prescriptions	Conversion Factor
Belladonna alkaloids/opium alkaloids	1
Butorphanol tartrate	7
Codeine	0.15
Dihydrocodeine	0.25
Fentanyl buccal, sublingual or lozenge	0.13
Fentanyl film or oral spray	0.18
Fentanyl nasal spray	0.16
Hydrocodone	1
Hydromorphone	4
Levomethadyl acetate hydrochloride	8
Levorphanol tartrate	11
Meperidine hydrochloride	0.1
Methadone, 1 – 20 mg/day	4
Methadone, 21 – 40 mg/day	8
Methadone, 41 – 60 mg/day	10
Methadone ≥61 – 80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3
Pentazocine	0.37
Propoxyphene	0.23
Tapentadol	0.4
Tramadol	0.1

Required exclusions for numerator.

- All prescriptions for buprenorphine are excluded.

Metric #22: Continuity of Pharmacotherapy for Opioid Use Disorder

The State would like to modify the specifications provided for this measure to ensure internal measure consistency and broader consistency with the other measures reported in this monitoring protocol and the Washington health care context.

- Use the OUD_Narrow_Flag (as described in the subpopulation definition section above) to identify opioid use disorder.
- Limit the continuation of pharmacotherapy metric to users of Buprenorphine and Buprenorphine-Naloxone combination therapy for opioid use disorder. This will exclude users of other therapy, such as Naltrexone and Methadone. The State's billing data does not account for all of the services delivered that are necessary to compute this measure. Pharmacy claims are more comprehensive and reflect more accurate service delivery in Washington State.
- The State is able to identify those who receive Methadone. However, the billing practices do not allow for the calculation of days covered by Methadone administration (unlike Buprenorphine and Buprenorphine combination medications). This is a requirement for the calculation of this metric. Based on the State's proposal of including only those who are prescribed Buprenorphine and Buprenorphine combination medications as pharmacotherapy for an opiate use disorder, approximately 60% of those receiving treatment will be captured. The State does not expect that the excluded services would be substantially affected by the demonstration.
- Restrict the measurement year to a 12 month period (rather than two years), but allow for identification of opioid use disorder with a two year look back window (measurement year and year prior to measurement year). This will facilitate the identification of a more stable population and decrease the likelihood of missing qualifying instances of treatment due to attrition of Medicaid enrollees.

The State also notes inconsistencies in how the measure is calculated based on the CMS supplied description of the numerator/denominator (percent of adults with pharmacotherapy for opioid use disorder who have at least 180 days of continuous treatment) and the final metric calculation directions (dividing the numerator by the denominator for *each unit of measurement*). The final metric calculation instructions appears to result in a proportion of days covered metric (similar to the HEDIS Anti-depression Medication Management metric). The State will use the initial description and calculate the percentage of adults with pharmacotherapy for opioid use disorder who have at least 180 days of continuous treatment.

HIT Metric Specifications

During the initial review of the monitoring protocol by CMS, some concerns were noted about the selected HIT metrics. Per the conversation the State had with ONC and CMS staff on May 1, 2019 from 1-2pm PST, the State has not made any modifications to the HIT metrics as submitted with the initial Monitoring Protocol.

Q1: Statewide Fatal Drug Overdose. The State considered the sample metrics provided by CMS, including sample metrics related to use of the Prescription Drug Monitoring Program (PDMP) and selected the metric on statewide fatal drug overdoses (including submetrics all opioids, heroin, prescription opioids, and synthetic opioids). This metric (and submetrics) will be reported to CMS and displayed using the public-facing, technology-enabled PDMP dashboard. The CMS report and PDMP dashboard will be used to monitor whether fatal drug overdoses (including by type of drug) are slowing.

Metric Description: Number of fatal drug overdoses in the state of Washington, not restricted to Medicaid beneficiaries. Submetrics are reported for the following types of drugs: all opioids, heroin, prescription opioids (excluding synthetic opioids), and synthetic opioids (not methadone).

Data Source: Department of Health death certificate data.

Identification Window: Measurement year (July 1 – June 30 of relevant year)

Eligible Population	
Age	All Ages
Gender	N/A
Minimum Medicaid enrollment	N/A – measure is not restricted to Medicaid beneficiaries
Allowable gap in Medicaid enrollment	N/A – measure is not restricted to Medicaid beneficiaries
Medicaid enrollment anchor date	N/A – measure is not restricted to Medicaid beneficiaries
Medicaid benefit and eligibility	N/A – measure is not restricted to Medicaid beneficiaries

Statewide Fatal Drug Overdoses: Information on the underlying cause of death is extracted from death certificates for deaths that occurred in the relevant measurement period.

All drugs is defined by the following ICD-10 codes as underlying cause of death:

- X40-X44: Accidental poisonings by drugs.
- X60-X64: Intentional self-poisoning by drugs.
- X85: Assault by drug poisoning.
- Y10-Y14: Drug poisoning of undetermined intent.

Statewide Fatal Drug Overdoses – All Opioids: Information on the underlying cause of death is extracted from death certificates for deaths that occurred in the relevant measurement period.

All opioids is defined by the following ICD-10 codes in the multiple causes of death field:

- T40.0 (Opium)
- T40.1 (Heroin)
- T40.2 (Natural and Semi-synthetic opioids)
- T40.3 (Methadone)
- T40.4 (Synthetic opioids, other than methadone)
- T40.6 (Other and Unspecified narcotics)

Statewide Fatal Drug Overdoses – Heroin: Information on the underlying cause of death is extracted from death certificates for deaths that occurred in the relevant measurement period.

Heroin is defined by the following ICD-10 codes in the multiple causes of death field:

- T 40.1 (Heroin)

Statewide Fatal Drug Overdoses – Prescription Opioids (excluding synthetic opioids): Information on the underlying cause of death is extracted from death certificates for deaths that occurred in the relevant measurement period.

Prescription opioids is defined by the following ICD-10 codes in the multiple causes of death field:

- T40.2 (Natural and Semi-synthetic opioids)
- T40.3 (Methadone)

Statewide Fatal Drug Overdoses – Synthetic Opioids (Not Methadone): Information on the underlying cause of death is extracted from death certificates for deaths that occurred in the relevant measurement period.

Synthetic opioids (not methadone) is defined by the following ICD-10 codes in the multiple causes of death field:

- T40.4 (Synthetic opioids, other than methadone)

***Q2: Substance Use Disorder Treatment Penetration Rate*.** After reviewing the list of sample metrics provided by CMS, the State was concerned about the limitations and uncertainties in technology adoption by providers treating individuals with SUD (e.g., limited use of close loop referral services, lack of an electronic consent management system, limitations and variations in provider/resource directories). Thus, the State is proposing a metric that relies on the use of electronic claims/encounter data to identify individuals with a SUD treatment need who received a qualifying SUD service.

Metric Description: Percent of Medicaid beneficiaries aged 12 and older with a substance use disorder treatment need identified within the past two years, who received at least one qualifying substance use disorder treatment during the measurement year.

Data Source: Administrative data.

Identification Window: Measurement year and the year prior to the measurement year.

Eligible Population	
Age	Age 12 and older. Age is as of the last day of the measurement year.
Gender	N/A
Minimum Medicaid enrollment	Measurement year. Enrollment must be continuous.
Allowable gap in Medicaid enrollment	One gap of one month during the measurement year.
Medicaid enrollment anchor date	Last day of measurement year.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid and beneficiaries with primary insurance other than Medicaid.

Denominator: Medicaid beneficiaries, aged 12 and older on the last day of the measurement year, with a substance use disorder treatment need identified in either the measurement year or the year prior to the measurement year.

Substance use disorder treatment need is identified by the occurrence of any of the following in the identification window:

1. Diagnosis of a drug or alcohol use disorder in any health service event (SUD-Tx-Pen-Value-Set-1)
2. Receipt of brief intervention (SBIRT) services (SUD-Tx-Pen-Value-Set-4)
3. Receipt of medically managed detox services (SUD-Tx-Pen-Value-Set-5)
4. Receipt of a substance use disorder treatment service meeting numerator criteria:
    a. Procedure and DRG codes indicating receipt of inpatient/residential, outpatient, or methadone OST: SUD-Tx-Pen-Value-Set-2

b. NDC codes indicating receipt of other forms of medication assisted treatment for SUD: SUD-Tx-Pen-Value-Set-3
c. Outpatient encounters meeting procedure code and primary diagnosis criteria: SUD-Tx-Pen-Value-Set-6.xls: procedure code in SUD-Tx-Pen-Value-Set-6 AND primary diagnosis code in SUD-Tx-Pen-Value-Set-1
d. Outpatient encounters meeting taxonomy and primary diagnosis criteria: billing or servicing provider taxonomy code in SUD-Tx-Pen-Value-Set-7 AND primary diagnosis code in SUD-Tx-Pen-Value-Set-1

Value sets required for the denominator.

Name	Value Set
SUD-Tx-Pen- Value-Set-1	All value sets are available upon request.
SUD-Tx-Pen-Value-Set-2	
SUD-Tx-Pen-Value-Set-3	
SUD-Tx-Pen-Value-Set-4	
SUD-Tx-Pen-Value-Set-5	
SUD-Tx-Pen-Value-Set-6	
SUD-Tx-Pen-Value-Set-7	

Numerator: Include in the numerator all individuals receiving at least one substance use disorder treatment service meeting at least one of the following criteria in the 12-month measurement year:

1. Procedure and DRG codes indicating receipt of inpatient/residential, outpatient, or methadone OST: SUD-Tx-Pen-Value-Set-2
2. NDC codes indicating receipt of other forms of medication assisted treatment for SUD: SUD-Tx-Pen-Value-Set-3
3. Outpatient encounters meeting procedure code and primary diagnosis criteria:
    a. Procedure code in SUD-Tx-Pen-Value-Set-6 AND
    b. Primary diagnosis code in SUD-Tx-Pen-Value-Set-1
4. Outpatient encounters meeting taxonomy and primary diagnosis criteria:
    a. Billing or servicing provider taxonomy code in SUD-Tx-Pen-Value-Set-7 AND
    b. Primary diagnosis code in SUD-Tx-Pen-Value-Set-1

Value sets required for the numerator.

Name	Value Set
SUD-Tx-Pen- Value-Set-1	All value sets are available upon request.
SUD-Tx-Pen-Value-Set-2	
SUD-Tx-Pen-Value-Set-3	
SUD-Tx-Pen-Value-Set-6	
SUD-Tx-Pen-Value-Set-7	

Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential Substance Use Disorder Service. After reviewing the list of sample metrics provided by CMS, as with metric Q2, the State was concerned about the limitations and uncertainties in technology adoption by providers treating individuals with SUD (e.g., lack of use of shared care plans, lack of connectivity between correctional health systems and community-based providers, limitations and variations in

provider/resource directories). Thus, the State focused on developing a metric that links delivery of recovery supports provided through the Foundational Community Supports (FCS) program (implemented as part of the Medicaid Transformation Program) to persons who had received SUD services in an inpatient or residential treatment facility. The metric relies on the use of electronic eligibility and claims/encounter data.

Metric Description: Percent of Foundational Community Supports (FCS) eligible Medicaid beneficiaries, age 18 and older, with a substance use disorder related inpatient or residential treatment stay within the past two years, who enrolled in at least one FCS service during the measurement year.

Data Source: Administrative data.

Identification Window: Measurement year and the year prior to the measurement year.

Eligible Population	
Age	Age 18 and older. Age is as of the last day of the measurement year.
Gender	N/A
Minimum Medicaid enrollment	Measurement year. Enrollment must be continuous.
Allowable gap in Medicaid enrollment	One gap of one month during the measurement year.
Medicaid enrollment anchor date	Last day of measurement year.
Medicaid benefit and eligibility	Beneficiaries who qualify for Medicaid in any of the following categories: Categorically Needy Blind/Disabled, Categorically Needy Aged, Categorically Needy Apple Health for Workers with Disabilities (HWD), Categorically Needy Pregnant Women, Affordable Care Act Expansion Adults, Categorically Needy Family Medical, Categorically Needy Children, Children's Health Insurance Program (CHIP), Categorically Needy Children- Foster Care between 18 to 26 Years of Age

Denominator: Medicaid beneficiaries, who meet the eligibility requirements as stated above, with a substance use disorder related inpatient or residential treatment stay within the measurement year or the year prior to the measurement year.

Numerator: Beneficiaries must qualify for inclusion in the denominator to be eligible for inclusion in the numerator. Include in the numerator all individuals who ever enrolled in at least one FCS service during the measurement year.

September 2019 Release of Updated Medicaid Section 1115 Substance Use Disorder (SUD) Demonstration Monitoring Tools: Monitoring Protocol Alignment Form

The Centers for Medicare & Medicaid Services (CMS) September 2019 release of the section 1115 substance use disorder (SUD) demonstration monitoring protocol tools incorporates updated guidance on reporting metrics and narrative information, and other clarifications reflecting the valuable feedback shared by states during review and use of the earlier release of these tools.

States with a monitoring protocol submitted to or approved by CMS as of October 2019 are not required to resubmit the protocol using the updated monitoring protocol tools. Instead, CMS developed this form to support states in providing the key information included in the updated protocol tools, or propose an alternative plan. States should review the monitoring protocol updates detailed in the sections below and select the appropriate checkboxes to complete the Section 1115 SUD Demonstration Monitoring Protocol Alignment Form. States should submit the completed form to the Performance Management Database and Analytics (PMDA) system under the deliverable designated as "SUD Monitoring Protocol," and upload this with the set of documents that represent the state's completed monitoring protocol. After reviewing the form, CMS will reach out to the state if there are any additional information needed, and will inform the state when the form is deemed complete and final. If the state has any questions while completing this form, please email the 1115 monitoring and evaluation TA mailbox (1115MonitoringAndEvaluation@cms.hhs.gov) and copy the demonstration's CMS project officer on the message.

1. Updates to Section 1115 SUD Demonstration Technical Specifications for Monitoring Metrics (Version 2.0)

In the monitoring workbook of the state's protocol (Part A), CMS asked the state to review the technical specification for each metric and either attest to reporting the metric according to the specification, or propose deviations from the specification for CMS approval. CMS recently released an updated version of the section 1115 SUD demonstration technical specifications manual (Version 2.0, dated August 23, 2019). Relative to the Version 1.0 manual released in October 2018, the Version 2.0 manual contains critical revisions to specifications for the following CMS-constructed metrics:

- Metric #5: Medicaid Beneficiaries Treated in an Institution for Mental Disease (IMD) for SUD
- Metric #6: Any SUD Treatment
- Metric #10: Residential and Inpatient Services
- Metric #25: Readmissions for SUD

- Metric #29: SUD Spending Within IMDs
- Metric #31: Per Capita SUD Spending within IMDs
- Metric #36: Average Length of Stay in IMDs

These changes reflect the valuable feedback shared by states during review and use of the first version of the technical specifications manual, and are critical for ensuring the metrics are calculated consistently across states.

To promote consistent reporting across states and within a state over time, CMS requests that the state review updates to each of these metrics described in the accompanying Summary of Updates to the Section 1115 SUD Demonstrations Technical Specifications for Monitoring Metrics (Version 2.0), and respond below to confirm whether it will require deviations from the specifications (other than those already described in the state's submitted or approved protocol).

☒ The state reviewed the Summary of Updates to the Section 1115 SUD Demonstration Technical Specifications for Monitoring Metrics (Version 2.0) and attests it does not require any deviations from the specifications (other than those already described in the state's submitted or approved protocol).

☐ The state has reviewed the Summary of Updates to the Section 1115 SUD Demonstration Technical Specifications for Monitoring Metrics (Version 2.0) and proposes the following deviations: *Insert narrative description of proposed deviations from the revised specification, indicating to which metric(s) the proposed deviation applies. State should provide justification for any proposed deviation.*

2. Clarifications to baseline reporting periods

Recent updates to the section 1115 SUD metric technical specifications manual and monitoring tools have implications for the baseline reporting periods for certain metrics. The updated technical specifications manual (Version 2.0) and monitoring tools released in September 2019 include updated guidance related to baseline reporting periods for the following metrics:

- **Metric #22 (Continuity of Pharmacotherapy for Opioid Use Disorder)** is an established quality measure that is calculated over a 2-year period. The baseline reporting period for this metric should be the calendar year in which the state's demonstration began, and the year prior. The updated manual contains additional guidance clarifying the baseline reporting period for measures calculated over a 2-year period.

- **Metric #25 (Readmissions among Beneficiaries with SUD)** is now considered to be a CMS-constructed metric. The baseline reporting period for this metric should be aligned with the baseline reporting period for other CMS-constructed metrics.

- **Metric #32 (Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD)** is now clearly categorized in the monitoring workbook as an established quality measure. The baseline reporting period for this metric should be aligned with the baseline reporting period for other established quality measures.

CMS requests the state review the baseline reporting period guidance for these metrics and respond below to confirm it will align reporting with the provided guidance, or propose deviations.

☐ The state reviewed the baseline reporting period guidance for Metrics #22, #25, and #32 and will align its baseline reporting with the updated guidance for each metric.

☒ The state has reviewed the baseline reporting period guidance for Metrics #22, #25, and #32 and proposes the following deviations: *The state requests to maintain the agreed upon deviation for Metric #22 (See Attachment A).*

ATTACHMENT M
Health IT Protocol

Introduction

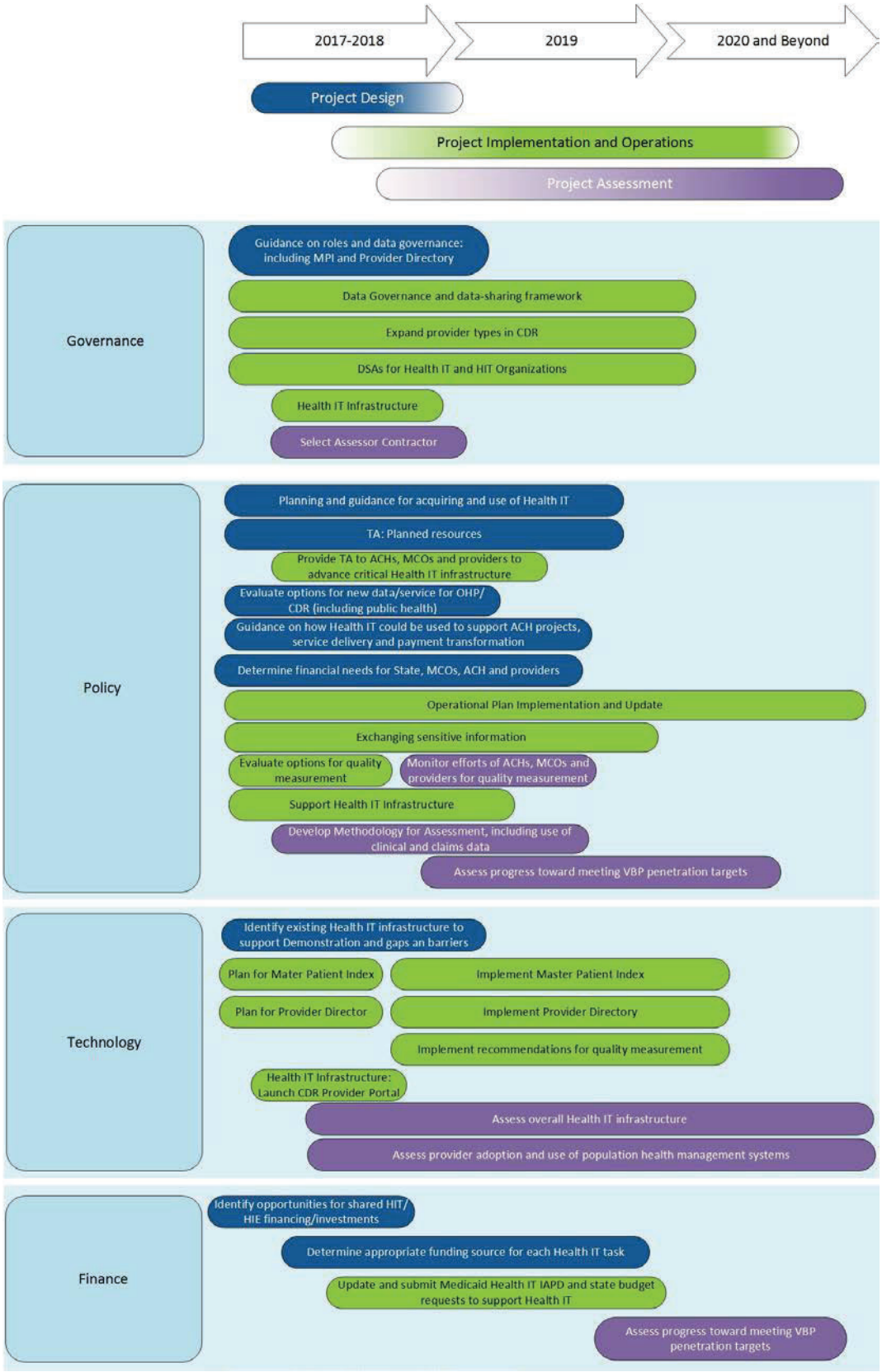
The Washington State Medicaid Transformation Demonstration is a five-year agreement between the state and the federal government that provides up to $1.1 billion in federal investment for regional and statewide health system transformation projects that benefit Apple Health (Medicaid) Clients. Achieving health system transformation for Washington State will require the use of interoperable health information technology (Health IT) and health information exchange (HIE). Interoperable Health IT[54] and HIE[55] have the potential to improve the quality, continuity, coordination, and safety of patient care, while at the same time reducing unnecessary and costly services. Furthermore, the use of these technologies will help facilitate the State's broader goals of moving toward value-based purchasing.

This Health IT Strategic Roadmap identifies activities necessary to advance the use of interoperable Health IT and HIE across the care continuum in support of the programmatic objectives of the Demonstration. The Roadmap divides efforts into the three phases of the Demonstration: Project Design, Project Implementation and Operations, and Project Assessment, and articulates the role the State, Medicaid Managed Care Organizations, providers and Accountable Communities of Health (ACH) have in advancing Health IT and HIE. In addition to this Roadmap, the State has created an Operational Plan that details the first 16 months (remainder of 2017 and 2018) of activities that provide actionable steps to advance Health IT and HIE in support of the Demonstration. The Operational Plan is appended to this document and will be revised quarterly to reflect progress and document next steps. The Operational Plan will be updated in 2018 to provide the details for 2019 and annually mid-year for the details of the following year. The following diagram highlights the key elements of the strategic roadmap and operational plan:

[54] Health Information Technology is the range of technologies to store, share, and analyze health information, including clinical and claims related data

[55] Health information exchange is the electronic exchange of health information to facilitate delivery system and payment transformation, care coordination and improved health outcomes

Washington Health IT/HIE Roadmap



Background
Washington State understands the role of and need for interoperable Health IT and HIE to enable the efficient exchange and use of health information, a foundational requirement to achieving the triple aim. In 2009, the Washington State Legislature passed Substitute Senate Bill 5501 to accelerate the secure electronic exchange of high-value health information within the state. This legislation resulted in the designation of OneHealthPort as the lead HIE organization. Subsequently, a clinical data repository (CDR) was created to address some of the challenges with interoperability.

Purpose and Goals
Washington State is undertaking an innovative and ambitious agenda through the Demonstration to advance coordination of care and improve patient outcomes that will be supported, in part, through its use of the CDR and additional activities identified in this Roadmap. The purpose of the Roadmap is to identify the broad goals of how Health IT and HIE will support the Demonstration, recognizing that the more detailed tasks are identified, expanded upon, and tracked in the accompanying operational plan. The Roadmap is built on the following goals:

- Develop policies and procedures to advance the widespread use of interoperable Health IT and HIE across the care continuum;
-
- Coordinate at the regional and statewide level to ensure that interoperable Health IT and HIE efforts are shared and identified best practices are shared throughout the state;
- Improve coordination and integration among behavioral health, physical health, and Home and Community Based Services (HCBS) providers, as well as community-level collaborators;
- Support the acquisition and implementation of interoperable Health IT particularly for providers who are ineligible for the Electronic Health Record (EHR) incentive program;
- Encourage use of clinical and claims data by the State, ACHs, payers, and others to support a variety of health improvement activities as represented by ACH project plans;
- Develop or expand the critical infrastructure needed to facilitate population health management, including prescription drug monitoring, disease registries and electronic lab reporting;
- Support the electronic exchange of interoperable clinical health information, using standards identified in Interoperability Standards Advisory (ISA);
- Support the development and use of a Medicaid enterprise master patient index and comprehensive provider directory strategy to facilitate more efficient information exchange;

- Align with the Washington State Health IT & HIE Strategy; and
- Ensure the roadmap provides guidance & alignment throughout the duration of the Demonstration, as well as beyond the Demonstration's end date.

Demonstration Health IT Framework

The work of the Health IT Strategic Roadmap is intended to align with the Demonstration's three phases of work: design, implementation and operations, and assessment. These phases are cyclical, with project assessment feeding into future project design. Activities described in this document require work by the State and the ACHs to assemble the infrastructure, develop policies and procedures, and implement incentives to advance the use of Health IT and HIE in support of broader Demonstration activities. As described in this document, these phases support, and are consistent with, the three project stages (design, implementation and operations, and assessment) in the State's approved DSRIP Planning Protocol. This framework recognizes the varying levels of interoperability that exist among regions and providers in the state, allowing regional efforts to advance Health IT and HIE in coordination with the broader statewide approach.

Project Design

Initial phase August to December 2017

During the project design phase, the State will engage and collaborate with ACHs, providers, payers, OneHealthPort, and other stakeholders to develop and disseminate the tasks and deliverables (which will inform the Operational Plan) to advance the use of Health IT for population health management.

This phase will identify the gaps and opportunities to advance in the Health IT and HIE infrastructure, policies and procedures, and incentives necessary to facilitate population health management. ACHs will be expected to identify payers (including Medicaid MCO payers) and providers (e.g., physical health, behavioral health, long-term services and supports, and other community-based services/providers) to collaborate with the State and other stakeholders to assist in and inform the development of the Operational Plan.

The State will provide guidance to the ACHs on how Health IT and HIE elements will be required for incorporation in the ACH project plans and what resources will be made available to support project implementation. ACHs will incorporate this guidance into their project plans to be submitted in November.

Task	Additional Description	Proposed Due Date
The State will engage and collaborate with ACHs, providers, payers (including Medicaid MCOs), OneHealthPort, and other stakeholders to develop and disseminate an Operational Plan	The Operational Plan will address the following topics: <u>Governance:</u> • Roles of stakeholders • Data governance • Health IT governance <u>Policy:</u> • Shared policies and technical standards for secure Health IT and HIE systems • Performance measures related to the adoption and use of Health IT and HIE <u>Technology:</u> • Types of and how population health management systems that could be used to support: ACH projects, service delivery and payment transformation, and quality and performance management • Gaps and barriers <u>Finance</u> • Determine financial needs for State, MCOs, ACHs and providers • Determine appropriate funding source, including role of Medicaid Financing (IAPDU-SPA-Waiver)	2017

The State will develop and disseminate guidance for planning, acquisition and use of Health IT and HIE	Policy: • This guidance will include interoperable HIT and HIE to support ACH activities Finance: • Opportunities for shared HIT/HIE financing/investments	2017 -2018

The State will identify technical assistance needs to assist in the acquisition, adoption, implementation, and use of Health IT and HIE. The State will notify ACHs of these planned resources.	Policy:
	
	• State will develop and make available to ACHs TA resources for HIT/HIE activities in support of Demonstration activities. TA resources may include assistance related to:
	  o Billing IT and HIT applications;
	  o Vendor evaluation and selection criteria;
	  o Workflow considerations; and
	  o Use of the CDR
		2017 – 2018 (initially and ongoing through 2020)

The State will determine the need, and if so how and when, to integrate key Medical, clinical, and public health data with the Clinical Data Repository	Policy:
	
	This data will potentially include:
	
	• Assessment and care plan data; and
	• Public Health data such as:
	  o Immunizations
	  o Prescription drug monitoring
		2017-2018

Project Implementation and Operations

Initial phase January 2018-

The project implementation phase will consist of implementing the Operational Plan, collaboratively addressing the Health IT and HIE gaps, aligning statewide initiatives, and positioning the ACHs and state for success in their programmatic objectives.

The Operational Plan will seek to identify and address gaps in Health IT and HIE, prioritizing the most important elements to support Health IT and HIE and ACH-proposed projects. The State will focus on several elements, including data governance and data sharing frameworks, facilitating HIE across multiple provider types, and developing a master patient index and statewide provider directory.

The State is also committed to ongoing alignment among all Health IT- and HIE-related activities within the state, including State Innovation Model efforts, Medicaid Health IT Plan, and Health IT Implementation Advanced Planning Document (IAPD).

During the project implementation phase, ACHs will assist the State in identifying critical gaps and will collaborate with providers, payers, and other stakeholders to develop and support the use of best practices in leveraging Health IT and HIE to support their transformation efforts.

Task	Additional Description	Proposed Due Date
The State will implement, review, update, and disseminate the Operational Plan	Policy: The State, in collaboration with stakeholders, will: • Annually update the Operational Plan and implement Accordingly • Identify and share emerging best practices • Identify and assist in resolving emerging issues; and • Provide quarterly updates on progress on implementing the Operational Plan to CMS/ONC	2017, 2018, 2019, 2020
State will support and advance critical HIT/HIE infrastructure	The State will support several activities needed to advance the HIT/HIE infrastructure, including: Governance: • The State will develop and disseminate guidance to the ACHs, payers and providers related to exchange of information, including data governance and data sharing framework • The State will develop and disseminate guidance to the ACHs, payers and providers related to onboarding and registration of additional provider types, including expanding the provider types sending and receiving content from the CDR	2018

Task	Additional Description	Proposed Due Date
	• The State will develop and disseminate guidance to the ACHs, payers and providers related to establishing electronic health information sharing agreements with HIT/HIE organizations Policy: This includes developing and disseminating guidance and providing TA to the ACHs, payers, providers, and other stakeholders on the activities, including the following: • Supporting the onboarding of additional providers to the CDR • Use of Consolidated Clinical Document Architecture (C-CDA) in electronic health information exchange activities • The State will develop and disseminate guidance to the ACHs, payers, providers, and other stakeholders related to exchanging sensitive information (e.g. SUD data) Technology: • Launching of the CDR provider portal • Develop and/or purchase other technology as identified and needed	
The State will disseminate information on efforts to streamline Behavioral Health reporting	Policy: State will seek to align reporting requirements to support and align with HIE/HIT standards and support data use	2018

Task	Additional Description	Proposed Due Date
	State will disseminate information on the results of the alignment effort, including requirements	
The State will determine and implement the most appropriate method for the creation and management of the Master Patient Index	Policy: • Document gaps and barriers in existing State infrastructure • Identify work plan for developing a Master Patient Index for use across information systems (e.g. MMIS, OHP) Technology: • Acquire /implement technology solution based on work plan	2018-2019
The State will determine and implement the most appropriate method for the creation and management of the Provider Directory	Policy: • Document gaps and barriers in existing State infrastructure • Identify work plan for developing a Provider Directory for use across information systems (e.g. MMIS, OHP) Technology: • Acquire/implement technology solution based on work plan	2018-2019
The State will evaluate options and draft recommendations for leveraging clinical and claims data to support needed quality measurement/analytic activities of the state,	Policy: • The state with stakeholder input will evaluate options for leveraging clinical and claims data to support needed quality measurement/analytic activities of the state, MCOs, ACHs, providers and payers.	2018

Task	Additional Description	Proposed Due Date
MCOs, ACHs, providers and payers.	• Based on the evaluation of options, the state will draft recommendations for leveraging clinical and claims data to support needed quality measurement/analytic activities of the state, MCOs, ACHs, providers and payers.	
State will implement approved recommendations for leveraging clinical and claims data to support quality measurement/analytic activities of the state and will oversee the efforts of the Medicaid MCOs, ACHs and providers	Technology: • The State will implement approved recommendations for leveraging clinical and claims data to support quality measurement/analytic activities of the state	

The State will use the HIT/HIE Strategic Roadmap and Operational Plan to update and align key documents and activities	Policy:
	
	• Based on the completion of the OP for 2017-2018, the state will update as needed
	  • SIM HIT documents;
	  • State Medicaid HIT plan;
	  • Health IT IAPD; and
	  • Medicaid EHR Incentive Program
	  State initiated MACRA Advanced Alternative Payment models.
	
	• Based on the updated OP for 2019, the state will update as needed the same documents.
		2017 for 2017 and 2018

Task	Additional Description	Proposed Due Date
	• Based on the updated OP for 2020, the state will update as needed the same documents.	2018 for 2019 2019 for 2020
The state will update and submit Medicaid Health IT IAPD and state budget requests to support implementation of Health IT, including interoperable HIE and services	Finance: • Prepare Implementation Advance Planning Document Update • Prepare state budget requests	As required

Project Assessment

Initial phase beginning January 2019

The project assessment phase will focus on assessing the direction of the Health IT and HIE in ACH projects and their utility in achieving the goals of the Demonstration. The assessment for each project will be tailored to the specifics of the project and will be conducted by an independent, external evaluator. Assessments will include a mix of qualitative and quantitative analysis, using a variety of data types including clinical, administration, and survey data.

Information obtained through these assessments will be made available to future project planning efforts to ensure any identified shortcomings are not repeated.

Task	Additional Description	Proposed Due Date
The State will contract with and support an independent external evaluator	This evaluator will perform the following: • Develop a methodology to qualitatively and quantitatively assess the impact of the	2019

	Demonstration on delivery systems, clinical care, health outcomes, and costs; • Assess overall Medicaid system performance under the DSRIP program; • Assess overall Health IT infrastructure; • Assess progress toward meeting VBP penetration targets; • The State will oversee the efforts of the Medicaid MCOs, ACHs and providers; • Assess progress toward meeting VBP penetration targets; and • Assess impact of the Demonstration on provider adoption and use of population health management systems, including the use of interoperable HIT and HIE. • •	

It is understood that the Health IT and HIE needs of the State and the ACHs are evolving, which will require both the Roadmap and the Operational Plan to be updated regularly. HCA will provide annual updates to the Health IT Roadmap to document changes in priorities and highlight progress made during the duration of the Demonstration. HCA will also provide reports and updated Operational Plan quarterly to document the progress towards completing activities identified in the Health IT Strategic Roadmap.

Attachment N
SMI Implementation Plan

Section 1115 SMI/SED Demonstration Implementation Plan
July 23, 2019

Overview: The implementation plan documents the state's approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

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

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on "Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]" over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

This template is being finalized for review and approval by OMB through the Paperwork Reduction Act (PRA). Until such time, its use is optional, although it conveys the nature and extent of implementation information that CMS is seeking on SMI/SED demonstrations. When this template is OMB approved, then the state will be required to use it.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

Memorandum of Understanding: The state Medicaid agency should enter into a Memorandum of Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

State Point of Contact: Please provide the contact information for the state's point of contact for the implementation plan.

Name and Title: Chase Napier, Medicaid Transformation Manager
Telephone Number: (360) 725-0868
Cell Number: (360) 581-3515
Email Address: chase.napier@hca.wa.gov

This template is being finalized for review and approval by OMB through the Paperwork Reduction Act (PRA). Until such time, its use is optional, although it conveys the nature and extent of implementation information that CMS is seeking on SMI/SED demonstrations. When this template is OMB approved, then the state will be required to use it.

1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

State	*Washington State.*
Demonstration name	*Washington State Medicaid Transformation Project No. 11-W-00304/0*
Approval date	*January 9, 2017*
Approval period	*January 9, 2017-December 31, 2021*
Implementation date	*01/01/2021*

This template is being finalized for review and approval by OMB through the Paperwork Reduction Act (PRA). Until such time, its use is optional, although it conveys the nature and extent of implementation information that CMS is seeking on SMI/SED demonstrations. When this template is OMB approved, then the state will be required to use it.

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt does not pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions. Answers should be concise, but provide enough information to fully answer the question.

This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a 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	*Current Status:* At present Washington State currently has 11 mental health Institution for Mental Diseases facilities providing acute inpatient care. All residential facilities are currently licensed by the state to primarily provide treatment for mental illnesses and are Joint Commission accredited. All hospitals are Medicare participating facilities in compliance with Medicare CoPs licensed by the Washington State Department of Health.

accreditation entity prior to participating in Medicaid	*Future Status:* The state will only use federal financial participation for facilities that are licensed by the state to provide short term acute residential treatment and accredited by the Joint Commission or other federally recognized accreditation body.
	Summary of Actions Needed: Revise MCO contracts and FFS payment systems to only allow payments involving Medicaid FFP for exclusion age IMD when services are provided in appropriately licensed and nationally accredited IMD facilities with ALOS of 30 days or less and no individual stay of more than sixty days.
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	*Current Status:* The inpatient mental health facilities contracted by MCOs in accordance with the provisions of 42 CFR 438.6(e) that meet the institution for mental diseases designation in Washington are Joint Commission accredited and subject to Joint Commission auditing and certification processes. In addition, all psychiatric hospitals and free standing evaluation and treatment facilities are licensed by the Washington State Department of Health. The Department of Health provides annual and unannounced site visits to both facility types. Regulations for evaluation and treatment services can be found in WAC 246-341-1134 Such facilities must meet the agency licensure, certification, administrative, personnel, and clinical requirements in WAC 246-341-0100 through 246-341-0650 and the applicable inpatient services requirements in WAC 246-341-1118 through 246-341-1132. Additionally, the Washington State Legislature recently passed Substitute House Bill 2426 in March of 2020 which became effective on of the date of the Governor's signature. This legislation: • Establishes penalties for psychiatric hospitals and RTFs that fail or refuse to comply with state licensing standards, including civil fines and stop placements. • Requires psychiatric hospitals and RTFs to report patient elopements and specified types of deaths that occur on their grounds.

	• Requires the Department of Health to post health care facility inspection related information on its website.
	Future Status: The state believes it meets the requirements of this milestone.
	Summary of Actions Needed: N/A
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	*Current Status:* **Managed Care:** Approximately 85% of Washington State Medicaid recipients are enrolled in managed care entities which are at risk for their inpatient psychiatric services at participating facilities not owned by or directly contracted with the state. Authorization and payment of services follow CMS approved language which follows the requirements of 42 CFR 438.206 with patient protections for access to emergency services as required by 42 CFR 438.114. Staff making authorization decisions must be credentialed in mental health (MCO IMC contract term 11.1.4). Managed care entities must publish their criteria used for utilization management decision making. Managed care entities must report on utilization management authorization turnaround time compliance (MCO IMC contract term 11.1.6.5). The state requires Managed Care Organization utilization management decision making to take into account the greater and particular needs of diverse populations, as reflected in health disparities, risk factors (such as Adverse Childhood Experiences for enrollees of any age), historical trauma, and the need for culturally appropriate care. **Fee-for-Service:**

	An expedited prior authorization (EPA) process is utilized for FFS services billed directly to the health care authority (HCA) Authorization criteria for inpatient psychiatric services is published in HCA's provider guide for mental health services and hospitals. The billing provider must document how EPA criteria were met in the client's file and make this information available to HCA upon request. When the patient's situation does not meet published criteria for EPA, formal written PA is required. All services are subject to retrospective review
	Future Status: **Managed Care:** The state believes it meets the requirements of this milestone for this population. **Fee-for-Service:** The state believes it meets the requirements of this milestone for this population.
	Summary of Actions Needed: N/A
1.d Compliance with program integrity requirements and state compliance assurance process	*Current Status:* All facilities participating in the state's Medicaid program must be enrolled with the HCA. HCA has a process for conducting risk-based screening of all newly enrolling providers and revalidating existing providers pursuant to 42 CFR Part 455 Subparts B and E. HCA requires providers enter into Medicaid provider agreements pursuant to 42 CFR 431.107.
	Future Status: The state believes it meets the requirements of this milestone.

	Summary of Actions Needed: N/A
1.e 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	*Current Status:* Washington State's Medicaid inpatient psychiatric care network includes two distinct levels of care: 1. Psychiatric hospitals 2. Residential treatment facilities licensed as evaluation and treatment centers At this time, all of the state's inpatient psychiatric Institution for Mental Diseases facilities are Medicare participating, nationally accredited, state licensed hospitals. Under Washington State Law, RCW 71.24.510, an integrated comprehensive screening and assessment process for substance use and mental disorders is required for any provider offering treatment under the community behavioral health services act which would include all psychiatric hospitals and residential settings. WAC 246-341-0610 also requires facilities to provide a clinical assessment (including an assessment for suicide ideation and SUD). WAC 246-341-0610 also includes the requirement to refer for provision of emergency/crisis services. State rules and managed care contracts require assessment of co-occurring substance use disorder and physical health issues. When comorbid conditions arise, facilities must treat the condition on site or refer the individual to treatment. **Relevant Washington Administrative Code provider rules applicable to FFS and MCO services:** 1. (E&T) WAC 246-337-080 residential treatment facilities must provide or accept a current health screening upon admission of all residents including a tuberculosis and symptom screen. They are required to assist residents with all health care needs and refer to the appropriate level of care when needed. Residential treatment facilities must have policies and procedures in place to address how they will deal with medical emergency situations and that outline the referral process.

	2. (E&T) WAC 246-341-0610 All behavioral health agencies, including residential treatment facilities and crisis stabilization units, must provide a thorough assessment of the client upon admit. This assessment includes a medical history and information about the individual's primary care physician. 3. (Hospitals) WAC 246-341-1126 and (Psychiatric Hospitals) WAC 246-322-170 Facilities must provide a health assessment within 24 hours of admission. The assessment is completed by a nurse practitioner, physician, or physician's assistant and must determine whether the individual needs to be transferred to another level of care due to medical concerns. In addition, facilities must have access to a medical provider for consultation 24 hours a day, 7 days a week. 4. (E&T) WAC 246-341-0610 Each agency licensed by the department of health to provide any behavioral health service must conduct an assessment of any risk of harm to self and others, including suicide, homicide, and a history of self-harm. In addition, all clinical staff in Washington State must attend a training on suicide assessment. **Relevant Managed Care Contract Requirements:** HCA contracts with five Managed Care Organizations to cover inpatient mental health services. HCA contracts require Managed Care Organizations to manage co-occurring disorders at all levels of care: 1. All individuals must be screened using the GAIN-SS SUD and mental health co-occurring disorder tool. 2. Managed Care Organizations must ensure network providers are trained on co-occurring disorders. (IMC 9.11.2.4) 3. Utilization management staff must have an understanding of co-occurring assessment and treatment. (IMC 11.1.4; 11.1.18) **Relevant Fee-for-Service Program Requirement:** Psychiatric hospitals and residential treatment facilities contracted with the state to provide services are required to follow appropriate Washington Administrative Codes related to this topic.

	Future Status: The state believes that the Washington Administrative Code requirements for health and co-morbid screening and treatment within inpatient facilities meets the requirements of this milestone.
	Summary of Actions Needed: N/A
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	*Current Status:* Per WAC 246-341-0320: Agency licensure and certification—on-site reviews and plans of correction. To obtain and maintain a department-issued license and to continue to provide department-certified behavioral health services, each agency is subject to an on-site review to determine if the agency is in compliance with the minimum licensure and certification standards. (1) A department review team representative(s) conducts an entrance conference with the agency and an on-site review that may include: (a) A review of: (i) Agency policies and procedures; (ii) Personnel records; (iii) Clinical records; (iv) Facility accessibility; (v) The agency's internal quality management plan, process, or both, that demonstrates how the agency evaluates program effectiveness and individual participant satisfaction; and (vi) Any other information, including the criteria in WAC 246-341-0335 (1)(b), that the department determines to be necessary to confirm compliance with the minimum standards of this chapter; and

	(b) Interviews with: (i) Individuals served by the agency; and (ii) Agency staff members. (2) The department review team representative(s) concludes an on-site review with an exit conference that includes a discussion of findings. (3) The department will send the agency a statement of deficiencies report that will include instructions and time frames for submission of a plan of correction. (4) The department requires the agency to correct the deficiencies listed on the plan of correction: *(a)* By the negotiated time frame agreed upon by the agency and the department review team representative; or immediately if the department determines health and safety concerns require immediate corrective action.
	Future Status: The state believes that the Washington Administrative Code requirements for agency licensure and certification meet the requirements for this milestone.
	Summary of Actions Needed: N/A

Prompts	Summary
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.	*Current Status:* Washington State's behavioral health delivery system strives for a culture of effective care coordination among all provider types and between all levels of care. The HCA's move to integrate management of physical and behavioral health and the state's efforts through the other four 1115 demonstration waiver initiatives are evidence of this commitment. While many coordination of care requirements have been in place in the mental health system for decades, the state continues to improve the overall behavioral and physical health link. The state Medicaid director's letter (SMD # 18–0011) announcing the 1115 Mental Health Institution for Mental Diseases waiver opportunity states that nationwide only 38% of adult beneficiaries had a follow-up within 7 days of discharge from a psychiatric admission. 60% had a follow-up visit within 30 days of discharge. Washington State's most recent numbers are significantly higher than the national average. In 2018, 64% had a follow-up within 7 days, and 81% within 30 days. **Relevant Washington Administrative Code Rules:** The state's inpatient and residential treatment facilities licensing rules require consideration of discharge planning early in the individual's stay. Inpatient facilities must coordinate care with the individual's current or future outpatient provider. Discharge plans are documented. 1. (Hospital) WAC 246-320-226 The initial assessment must include a consideration of discharge planning and estimated timeframe. Discharge planning must be coordinated with the outpatient agency and family or caregivers. 2. (Psychiatric Hospital) WAC 246-322-170 Hospitals must provide discharge planning and documentation including

	a review of the patient's hospitalization, condition upon discharge, and recommendations for follow-up and continuing care. Discharge planning must be coordinated with outpatient providers. 3. (E&T) WAC 246-337-095 Evaluation and Treatment Centers must document a discharge summary including recommendations for follow up care. 4. (Inpatient MH) WAC 246-341-1126(d) The initial treatment plan must include a plan for discharge and follow up care. 5. (Crisis Stabilization and Crisis Triage) WAC 246-341-1150 and WAC 246-341-1142 Crisis stabilization and crisis triage units must coordinate with outpatient providers and develop a discharge plan with dates, times, and addresses of follow up care appointments. (All BHA) WAC 246-341-0640 Related to documentation of discharge, including requirements around coordination and information sharing with community based providers. This provision applies to all Behavioral Health Administrations. **Relevant Managed Care Contract Requirements:** As mentioned under Milestone II.E, the state requires Managed Care Organizations to ensure individuals are screened for comorbid conditions. Coordination with physical health and substance use disorder providers is part of the screening and referral process. Managed Care organizations are also required to ensure coordination occurs between inpatient and outpatient levels of care. Contract requirements include: 1. Managed Care Organizations are required to be actively involved in discharge planning. (16.4.6) 2. Managed Care Organizations must develop a plan with inpatient facilities regarding discharge planning responsibilities. This includes a follow-up call within two to three business days of discharge. (14.17) 3. Individuals have a follow up outpatient appointment within seven calendar days of discharge from an inpatient facility. (6.10.1) 4. To monitor proper post-discharge care, the state mandates a 30-day readmission performance measure. (7.3.7)

	Relevant Fee-for-Service Programs: The following programs available to beneficiaries covered by the Medicaid fee-for-service program support pre-discharge planning and care transitions: Health Home program – This program provides care management and coordination, transition planning, support for the individual and family, referrals to support services in the hopes of promoting better health. Services are provided by a care coordinator who works with the patient and family to develop a health action plan, assist in transitions between types of care and work with providers. Beneficiaries with a chronic condition, including SMI, and at risk for a second condition are eligible. 1. Primary Care Case Management (PCCM) program – This program provides primary care case management through enrolled Indian health service, Tribal, and Urban Indian Health program providers, including support for pre-discharge planning and care transitions. 2. Medicaid Administrative Claiming programs – these programs partially reimburse governmental entities, including the Indian Health Service and Tribes, for time staff spent helping individuals apply for, understand, and access Medicaid services. **Current Statewide Strategies:** The state has invested in several strategies to improve coordination of care and post discharge treatment for individuals leaving inpatient care. Some of these efforts are described below. 1. The Peer Bridgers program delivers services to individuals in state and community hospitals prior to discharge and after their return to their communities. The Peer Bridger develops a relationship of trust with the participant. In developing this trust, the Peer Bridger may function as a role model, peer support, a mentor, a teacher, an advocate, and an ally as they communicate hope and encouragement. 2. State Plan Services: Washington's Medicaid State Plan includes a rehabilitation case management service allowing liaisons from the community to actively participate in discharge planning for individuals receiving psychiatric inpatient care. Currently, when these services occur in an IMD, state-only funds are used for ineligible services.

	3. Step Down Facilities: The Legislature appropriated funding for a new community facility type to address the need for additional discharge placements for individuals leaving the state psychiatric hospitals. Intensive behavioral health treatment facilities serve individuals who possess higher levels of behavioral challenges that existing alternative behavioral health facilities cannot accommodate. 4. Program for Assertive Community Treatment (PACT) teams provide wrap around services for individuals in outpatient treatment. When the individual is in an inpatient facility, the PACT team coordinates care with the inpatient unit and work to ensure stable housing and follow-up care. Currently there are 14 PACT teams across the state. In May 2019 the Legislature provided funding for eight additional PACT teams statewide 5. Washington State's Department of Commerce announced $7.1 million in grants to six health care providers across Washington, adding 71 additional beds to facilities that help people with a wide variety of behavioral health issues. Twenty-eight of the 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 systems by shifting out of large institutions to smaller, community-based facilities. 6. State-tribal collaboration to improve access to behavioral health care for American Indians and Alaska Natives. The state is currently in collaboration with a newly formed Tribal Centric Behavioral Health Advisory Board to develop a comprehensive plan to increase access to crisis services and culturally appropriate behavioral health care services for American Indians and Alaska Natives in Washington State. This plan includes a Tribal Crisis Coordination Hub to support tribes, Indian health care providers, and non-tribal providers with inpatient placement, transition planning, and care coordination across the continuum of treatment for American Indians and Alaska Natives beneficiaries.
	Future Status: HCA will amend contract and WAC language to ensure that psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community based providers in care transitions.
	Summary of Actions Needed: AHCA will amend its MCO contracts to require pre-discharge planning and participation of community providers no later than January 2022.

	HCA will amend WAC no later than July 1, 2022 in order to assure that FFS clients will receive pre-discharge planning and include the participation
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	*Current Status:* HCA understands that housing is an integral part of stability for the individuals we serve. Safe and stable housing increases the chances that individuals remain stable in the community and reduces the likelihood of unnecessary inpatient stays. The state has requirements in place requiring providers and managed care entities to address housing issues. In addition, there are several statewide initiatives addressing this issue. **Relevant Washington Administrative Code Rules:** In addition to screenings and assessments for comorbid disorders described in other sections, state rules require facilities to assess for housing and employment needs. 1. (E&T) WAC 246-341-0610 All behavioral health agencies, including residential treatment facilities and crisis stabilization units, must provide a thorough assessment of the client upon admit. This assessment includes a medical history and information about the individual's primary care physician. The assessment must also include an employment and housing assessment. **Relevant Managed Care Contract Requirements:** The state's requirements that Managed Care Organizations participate in discharge planning and coordinate care include a focus on determining and addressing an individual's housing needs. 1. Managed Care Organizations must establish protocols for discharge planning that include community supports necessary for recovery, including housing, transportation, employment and educational concerns, and social supports. (11.1.29.3) 2. Within 60 days of enrollment, Managed Care Organizations must conduct initial health screening assessments, to include a housing and housing instability assessment. (14.3.4).

	3. Managed Care Organizations must demonstrate ongoing coordination with housing agencies (14.1.9.1/14.10.1.17). **Relevant Fee-for-Service Programs:** 1. Health Homes and Medicaid Administrative Claiming programs provide support for coordination with housing service providers, including tribal housing support programs for American Indians and Alaska Natives beneficiaries covered by the Medicaid fee-for-service program. **Current Statewide Strategies:** 1. Washington State has several coordinated entry programs that assist homeless or at-risk individuals in obtaining housing. These programs are available in each region of the state. 2. The state has developed an institutional discharge planning toolkit that involves guidance and a housing assessment tool for individuals discharging from institutions. 3. Initiative 3 of the state's 1115 demonstration waiver focuses on supportive housing and employment services. As of March 2019, 1,991 beneficiaries were enrolled in supportive housing. Non-traditional providers and behavioral health providers, including Indian health care providers, are able to participate in this program. 4. The Legislature appropriated funding for a new community facility type to address the need for additional discharge placements for individuals leaving the state psychiatric hospitals. Intensive behavioral health treatment facilities serve individuals who possess higher levels of behavioral challenges that existing alternative behavioral health facilities cannot accommodate. Intensive behavioral health treatment facilities are intended to serve as a bridge for high needs individuals who stay between12 to 18 months before transitioning to more independent living in supported housing projects. 5. The Housing and Recovery through Peer Services (HARPS) program builds on the successes of the Permanent Options for Recovery-Centered Housing (PORCH) project. PORCH provided consumers with meaningful choice and control of housing and support services, using peer housing specialists. The HARPS project reduces homelessness and supports the recovery and resiliency of individuals with serious mental illness. Each team consists of three full-time employees (a mental health professional and two certified peer counselors). One of the priority target populations for the HARPS program is individuals discharging from inpatient psychiatric care. The state Legislature recently funded four additional HARPS teams with a focus on individuals discharging from

	forensic facilities. Program for Assertive Community Treatment (PACT) teams provide wrap around services for individuals in outpatient treatment. When the individual is in an inpatient facility, the PACT team coordinates care with the inpatient unit and work to ensure stable housing and follow-up care. Currently there are 14 PACT teams across the state. In May 2019 the Legislature provided funding for eight additional PACT teams statewide.
	Future Status: The state believes that the Washington Administrative Code requirements and statewide strategies meet the requirements of this milestone.
	Summary of Actions Needed: N/A
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	*Current Status:* **Current Status:** The state understands the importance of immediate follow-up care upon discharge from an inpatient or residential facility. The rules and initiatives in place demonstrate the state's commitment to ensuring clients receive adequate and immediate care when discharging from a psychiatric facility. **Relevant Washington Administrative Code Rules:** While there are no specific statewide rules regarding follow-up within 72 hours of discharge, see Milestones II.A and II.B for a full discussion of Washington Administrative Code requirements around discharge planning and coordination of care reviews. **Relevant Managed Care Contract Requirements:** As described under Milestone II.A, Managed Care Organizations must develop a plan with inpatient facilities regarding discharge planning responsibilities. This includes a follow-up call within two to three business days of discharge. (14.17) See section II.A and II.B for a full discussion of contract requirements related to discharge planning and coordination of care with outpatient providers.

	Relevant Fee-for-Service Programs: Health Homes and Medicaid Administrative Claiming programs provide support for coordination with housing service providers, including tribal care coordination and tribal governmental social service programs for American Indians and Alaska Natives beneficiaries covered by the Medicaid fee-for-service program. **Current Statewide Strategies:** See Milestones II.A and II.B for a full discussion of the state's efforts around discharge planning and coordination of care. HCA's Medicaid Program Operations and Integrity reviews data in partnership with state's division of Research and Data Analysis (RDA) and contracted MCOs to monitor follow up after ED and Inpatient readmission rates to monitor trends and institute corrective actions as needed.
	Future Status: Residential treatment facilities and psychiatric hospitals will contact beneficiaries and community based providers through the most effective means possible within 72 hours post discharge.
	Summary of Actions Needed: HCA will amend its MCO contracts to shorten the contact period to 72 hours. Timeline: no later than January 2022. HCA will amend the administrative code it is responsible for to add the 72 hour follow-up requirement to provider WAC in order to assure FFS clients will receive these services. Timeline: no later than July 1, 2022.
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	*Current Status:* **Current Status:** Washington State demonstrates its commitment to reducing the length of stay in emergency departments through a number of efforts focused on clinical interventions and coordination of care. **Relevant Washington State Law:** Washington law require designated crisis responders to respond to emergency department requests within specified time frames. When an individual self-presents in an emergency department, the hospital may only hold the person for up to six

	hours before the designated crisis responder must make their determination (RCW 71.05.050). If a peace officer delivers the individual to the emergency department, the individual must be examined by a mental health professional within three hours. The designated crisis responder must determine if the individual meets involuntary treatment criteria within 12 hours of patient arrival. If the individual does not meet criteria, the DCR formulates a plan for less restrictive treatment to facilitate discharge from the emergency department. **Relevant Managed Care Contract Requirements:** Reducing unnecessary emergency department visits is a focus of the managed care system in Washington State. Contract requirements include efforts around coordination of care and sharing of information. Examples include: 1. Managed Care Organizations must have a process for communicating with primary care providers around overuse of the ED. (14.5.7.3.3) 2. Unnecessary emergency department visits is a required measure Managed Care Organizations must include in their quality plans. (7.1.1.2.16) 3. Managed Care Organizations utilize the Emergency Department Information Exchange (EDIE) to track and intervene with emergency department high utilizers. **Relevant Fee-for-Service Programs:** The Health Home program helps to prevent or decrease lengths of stay in emergency departments among beneficiaries with SMI or SED prior to admission through intensive case management and care coordination services for eligible beneficiaries (individuals with one or more chronic conditions, a predictive risk scores of 1.5 or greater per WAC 182-557-0200, and covered by the Medicaid fee-for-service program). **Current Statewide Strategies:** The state has implemented a number of programs directed at reducing unnecessary emergency department visits and reducing the overall length of stay in emergency departments for individuals presenting with a behavioral health issue. 1. The Peer Bridgers program delivers services to individuals in state and community hospitals prior to discharge and after their return to their communities. The Peer Bridger develops a relationship of trust with the participant. In developing this trust, the Peer Bridger may function as a role model, peer support, a mentor, a teacher, an

	advocate, and an ally as they communicate hope and encouragement. 2. Crisis Triage and Stabilization Investments: Between 2017-18, the state funded several new triage and crisis stabilization facilities across the state. Three facilities are open and four expected to open in the coming year, for a total of 102 crisis stabilization and triage beds across six regions of the state. The 2019 state Legislature funded even more 16-bed triage and stabilization facilities. The Legislature also funded Mobile Outreach Crisis Teams. 3. The Legislature recently funded five mental health peer respite centers to divert individuals from crisis services as well as a pilot program to provide mental health drop-in center services. 4. The Housing and Recovery through Peer Services (HARPS) program builds on the successes of the Permanent Options for Recovery-Centered Housing (PORCH) project. PORCH provided consumers with meaningful choice and control of housing and support services, using peer housing specialists. The HARPS project reduces homelessness and supports the recovery and resiliency of individuals with serious mental illness. Each team consists of three full-time employees (a mental health professional and two certified peer counselors). One of the priority target populations for the HARPS program is individuals discharging from inpatient psychiatric care. The state Legislature recently funded four additional HARPS teams with a focus on individuals discharging from forensic facilities. 5. Program for Assertive Community Treatment (PACT) teams provide wrap around services for individuals in outpatient treatment. When the individual is in an inpatient facility, the PACT team coordinates care with the inpatient unit and works to ensure stable housing and follow-up care. Currently there are 14 PACT teams across the state. In May 2019 the Legislature provided funding for eight additional PACT teams statewide. 6. Washington State's Department of Commerce announced $7.1 million in grants to six health care providers across Washington, adding 71 additional beds to facilities that help people with a wide variety of behavioral health issues. Twenty-eight of the 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 systems by shifting out of large institutions to smaller, community-based facilities. 7. Co-Responders with Law Enforcement: The state continues to expand programs that fund mental health

	professionals who ride along with law enforcement as they respond to calls where mental health conditions may be involved. 8. Emergency Department is for Emergencies: This legislative initiative prompted by House Bill 2127 in 2012 promotes the implementation of emergency room best practices and requires Washington hospitals to implement seven best practices: 1) tracking ED visits to avoid ED shopping, 2) patient education, 3) institute an extensive case management program, 4) reduction of inappropriate ED visits by collaborative use of prompt visits to primary care, 5) narcotic guidelines to discourage narcotic seeking behavior, 6) data tracking for patients prescribed controlled substances, 7) outcome measurement and reporting. 9. Development of Behavioral Health Aides: The state is collaborating with tribes to support behavioral health aides, who can provide early identification and treatment support for beneficiaries with SED or SMI, to prevent emergency department admission.
	Future Status: The state believes that the Washington Administrative Code requirements and statewide investments and strategies meet the requirements of this milestone.
	Summary of Actions Needed: N/A
2.e Other State requirements/policies to improve care coordination and connections to community-based care	*Current Status:* See sections above.
	Future Status: N/A

	Summary of Actions Needed: N/A

Prompts	Summary
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a 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.	***Current State:*** The state has conducted the initial SMI service availability assessment through compilation of RDA, Washington Medical Commission, DOH, HCA, MCO, and BH-ASO data.
	Future Status

	HCA's DBHR will work with its partners to conduct and report the required SMI assessments on an annual basis.
	Summary of Actions Needed: • MD and PA demographics related to specialization and board certification will be obtained from the Washington Medical Commission. • Non-prescribing MH professional and facilities information will be provided by DOH and HCA annually. • Network adequacy reports of Medicaid contracted MCOs shall also be used to supplement information drawn from the state MMIS system. • The Research Data Analysis division of our Department of Social and Health Services will provide enrollee data. • The state will convene workgroups on data reporting on a bi-monthly basis to assure that data is collected and collated in a timely manner. • The state will report metrics required by this demonstration in annual monitoring reports.
3.b Financing plan	*Current Status:* Financing Plan is included in separate section see below.
	Future Status: See Below.
	Summary of Actions Needed: See Below.

3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	*Current Status:* Washington state is actively planning on building a statewide bed registry to track inpatient and crisis bed availability. Development of a bed tracking system is essential to support our evidence based system of care aim of delivering timely and appropriate interventions and treatment support to those impacted by SMI and/or SED WATrac is a Washington Department of Health sponsored web-based system that facilitates emergency response. King County, the county with the largest population, is currently using WATrac's bed tracking features too coordinate placements.
	Future Status: The state will have a statewide bed tracking registry with the capacity to include all psychiatric treatment beds and secure withdrawal management beds intended to support the stability and treatment of the Serious Mental Ill (SMI) and the Serious Emotional Disturbance (SED) populations. To this end the state has applied for grants and is seeking funding from the legislature.
	Summary of Actions Needed: • Convening a stakeholder advisory group consisting of representatives from the Behavioral Health Advisory Committee (BHAC), which provides leadership in implementation of Washington's Mental and Substance Use Block Grants and includes members with lived experience, state agencies, community treatment organizations, the state hospital association, and advocacy groups will be assembled to assist in guiding the decisions on the bed registry project. This will include development of system business requirements and use requirements. • Development and activation of an advisory workgroup comprised of key stakeholders • Development of bed registry system functionality and business case requirements • Selection of a bed registry tracking system for statewide use • Procurement or enhancement of a bed registry system if possible within grant funding, and/or an agency budget request package to cover the funding gap • A rapid user acceptance pilot of a small number of facilities • Development of training curriculum and a training plan for statewide implementation

	• Amending administrative rules and/or MCO contracts to require use of the registry • The state intends to have a tailored bed registry in place no later than January of 2022.
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	*Current Status:* **Relevant Washington Administrative Code (WAC) Rules:** (E&T) WAC 246-341-0610 Related to assessments for all Behavioral Health Administration Facilities must provide an age-appropriate, strengths-based psychosocial assessment that considers current needs and the patient's relevant history according to best practices. Such information may include, if applicable: (a) Identifying information; (b) Presenting issues; (c) Medical provider's name or medical providers' names; (d) Medical concerns; (e) Medications currently taken; (f) Mental health history; (g) Substance use history, including tobacco; (h) Problem and pathological gambling history; (i) An assessment of any risk of harm to self and others, including suicide, homicide, and a history of self-harm; (j) A referral for provision of emergency/crisis services must be made if indicated in the risk assessment; (k) Legal history, including information that a person is or is not court-ordered to treatment or under the supervision of the department of corrections; (l) Employment and housing status; (m) Treatment recommendations or recommendations for additional program-specific assessment; and (n) A diagnostic assessment statement, including enough data to determine a diagnosis supported by the current and applicable Diagnostic and Statistical Manual of Mental Disorders (DSM-5). **Relevant Managed Care Contract Requirements:** Managed Care Organization contracts include several requirements around utilization management and authorization of inpatient care: • 1.35 Care management must include evidence-based approach for screening and intervention;

	• 9.11.2.2.1 Must train behavioral health providers on evidence-based practices; • 14.3.2.1 Use of evidence-based screening tools; • 11.1.4 Requirements of utilization management staff; • 11.1.15-18; • 11.1.11 Inter rater reliability; • 11.1.9 Utilization management policy requirements; • 11.1.29 LOC guidelines. FFS follows the same WAC listed above in this section. For Mental Health Rehabilitation services the FFS program follows 13.d of the state plan. The intake assessment used is determined by the licensed mental health professional, and should be culturally and age relevant prior to the provision of any other mental health services (pg. 77(9) of 13.d state plan). The appropriate assessment will determine medical necessity, and length of stay based on the individual's needs (pg. 69(4) of 13.d state plan https://www.hca.wa.gov/assets/program/SP-Att-3-Services-General-Provisions.pdf
	Future Status: We believe this requirement is met
	Summary of Actions Needed: N/A
3.e Other state requirements/policies to improve access to a full continuum of care including	*Current Status:* The state described its requirements around access to a full continuum of care in the sections above.

crisis stabilization	*Future Status:* N/A
	Summary of Actions Needed: N/A

Prompts	Summary
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a 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	*Current Status:* **Current Statewide Strategies:** 1. Trauma Informed approach a. HCA awarded nearly 1.4 million dollars in grants to organizations across the state to build on the trauma-informed work already happening across the state, and to support interest that has been unfunded to date. b. HCA offered free trainings throughout Washington State on trauma informed approach for state employees, direct care staff, supervisors, leaders, and community members, including train the trainer sessions. Online versions of the training will be available soon. c. HCA, in collaboration with other state agencies and people throughout the state, is creating a toolkit of trauma informed resources. d. Federal block grant funds, awarded through the Substance Abuse and Mental Health Service Administration, are allocated for HCA's trauma-informed work. 2. Initiative 3, Supported Employment, includes services that identify and assist individuals in obtaining employment based on their preferences, and support to maintain employment to reduce higher cost services and incarceration. In March 2019, 2,562 clients were enrolled in Supported Employment. 3. The Becoming Employed Starts Today (BEST) project is designed to promote sustainable access to evidence-based supported employment. Becoming Employed Starts Today provides consumers with meaningful choice and control of employment, provides support services, uses peer counselors, reduces unemployment, and supports the recovery and resiliency of individuals with serious mental illness, including co-occurring disorders. The project will provide services to 450 people over five years.

	4. In May 2019 the state Legislature eliminated the income and age limits from the Healthcare for Workers with Disabilities program. Funding was provided for additional clients expected to enroll in this program as a resultof these eligibility changes.
	Future Status: The state believes the efforts described above meet the requirements of this milestone.
	Summary of Actions Needed: N/A
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	*Current Status:* As of January 2020, every region in the state is participating in Integrated Managed Care which is a significant advancement in the trajectory toward behavioral health integration and whole-person care. Beginning July 2020, the state began requiring Managed Care Organization utilization management decision making to take into account the greater and particular needs of diverse populations, as reflected in health disparities, risk factors (such as adverse childhood experiences for enrollees of any age), historical trauma, and the need for culturally appropriate care. **Current Statewide Strategies:** 1. WISe Services – Wraparound intensive services for youth in need of intensive services. 2. Jail services Targeted at linking individuals with outpatient care upon release. 3. Juvenile justice programs – healing courts 4. Telehealth 5. School settings School-Based Health Care Services (SBHS) services for children with a disability aged 0-20 who

	receive Medicaid via a categorically needy program or medically needy program when included in their IEP or IFSP. 6. Primary care PHQ-9 screening tool promotion. 7. The state recently increased funding to develop a statewide plan to implement evidence-based specialty care programs that provide early identification and intervention for individuals experiencing psychosis. This includes funding to increase the number of teams providing these services from five to ten. 8. The Legislature recently funded five mental health peer respite centers to divert individuals from crisis services as well as a pilot program to provide mental health drop-in center services. 9. The state obtained funding to create and operate a tele-behavioral health video call center staffed by the University of Washington's Department of Psychiatry and Behavioral Sciences to serve emergency department providers, primary care providers, and county and municipal correctional facility providers with on demand tele-psychiatry and substance use disorder consultation. 10. Other Consultation a. The Partnership Access Line (PAL), operated by Seattle Children's Hospital through funding from HCA, connects pediatric and adolescent primary care providers to child and adolescent psychiatrists for consultations on mental health care, including diagnostic clarification, medication adjustment or treatment planning. In partnership with the University of Washington, PAL for Schools connects school staff and students to psychologists and psychiatrists at Seattle Children's and the University of Washington. b. PAL also partners with Washington's Mental Health Referral Service for Children and Teens which connects patients and families with evidence-supported outpatient mental health services in their community.

	Future Status: Community Health Aide program (CHAP) – Behavioral Health Aides. The state is collaborating with tribes to support behavioral health aides, who can expand capacity for tribal behavioral health services and enable more integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment. The state and local partners are in the process of identifying a common integration assessment tool to be administered across behavioral and physical health providers in the state. This effort will be informed by ACHs and MCOs based on integration advancement in recent years, including the use of various integration assessment approaches. The workgroup has met over the course of the past six months and is currently reviewing preliminary data and lessons learned related to integration assessment conducted by ACHs under the Medicaid Transformation Project.
	Summary of Actions Needed: The state will continue to evaluate the effectiveness of CHAP in addressing behavioral health, including the effective use of culturally appropriate providers), which includes providers such as Community Health Aides (CHAs), Behavioral Health Aides (BHAs), and Dental Health Aide Therapists (DHATs). The state and tribes will consider additional expansion through MTP funding to tribes and IHCPs. In early 2021, the state and partners will decide on the common integration assessment tool. This will also require the identification of specific expectations regarding the administration of the tool and evaluation of results. The state will continue engagement with ACHs, MCOs and providers to ensure the tool is implemented and data utilized to measure the advancement of behavioral health integration in non-specialty settings. This is a significant milestone and will reinforce the partnership between ACHs and MCOs to expand behavioral health integration as Integrated Managed Care ramps up.

4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	*Current Status:* Current Statewide Strategies: 1. Wraparound intensive services (WISe). Washington State's Wraparound with Intensive Services (WISe) provides comprehensive behavioral health services and supports to Medicaid eligible youth, up to 21 years of age, with complex behavioral health needs. WISe is designed to provide individualized, culturally competent services that strive to keep youth with intense mental health needs safe in their own homes and communities, while reducing unnecessary hospitalizations. . To assist in achieving this goal, WISe also offers 24/7 crisis stabilization services. WISe offers a higher level of care through these core components: Time and location of services: WISe is community- based. Services are provided in locations and at times that work best for the youth and family, such as in the family home and on evenings and weekends. Team-based approach: Using a Wraparound approach, WISe relies on the strengths of an entire team to meet the youth and family's needs. Intensive care coordination between all partners and team members is essential in achieving positive outcomes. Each team is individualized and includes the youth, family members, natural supports, a therapist, a youth partner and/or family partner, and members from other child-serving systems when they are involved in a youth's life. Other team members could include family friends, school personnel, a probation officer, a religious leader, a substance use disorder treatment provider, or a coach/teacher. The team creates ONE Cross- System Care Plan that identifies strategies and supports, using the youth and family's voice and choice to drive their plan. 2. The Peer Bridgers program delivers services individuals in state and community hospitals prior to discharge and after their return to their communities. The Peer Bridger develops a relationship of trust with the participant. In developing this trust, the Peer Bridger may function as a role model, peer support, a mentor, a teacher, an advocate, and an ally as they communicate hope and encouragement. 3. State Plan Services: Washington's Medicaid State Plan includes a rehabilitation case management service

	allowing liaisons from the community to actively participate in discharge planning for individuals receiving psychiatric inpatient care. This is currently a state funded service for individuals in institute of mental disease facilities. 4. Crisis Triage and Stabilization Investments: Between 2017-18, the state funded several new triage and crisis stabilization facilities across the state. Three facilities are open and four expected to open in the coming year, for a total of 102 crisis stabilization and triage beds across six regions of the state. The 2019 state Legislature funded even more 16-bed triage and stabilization facilities. The Legislature also funded Mobile Outreach Crisis Teams. 5. The Legislature recently funded five mental health peer respite centers to divert individuals from crisis services as well as a pilot program to provide mental health drop-in center services. 6. Step Down Facilities: The Legislature appropriated funding for a new community facility type to address the need for additional discharge placements for individuals leaving the state psychiatric hospitals. Intensive behavioral health treatment facilities serve individuals who possess higher levels of behavioral challenges that existing alternative behavioral health facilities cannot accommodate. 7. The Housing and Recovery through Peer Services (HARPS) program builds on the successes of the Permanent Options for Recovery-Centered Housing (PORCH) project. PORCH provided consumers with meaningful choice and control of housing and support services, using peer housing specialists. The HARPS project reduces homelessness and supports the recovery and resiliency of individuals with serious mental illness. Each team consists of three full-time employees (a mental health professional and two certified peer counselors). One of the priority target populations for the HARPS program is individuals discharging from inpatient psychiatric care. The state Legislature recently funded four additional HARPS teams with a focus on individuals discharging from forensic facilities. 8. Program for Assertive Community Treatment (PACT) teams provide wrap around services for individuals in outpatient treatment. When the individual is in an inpatient facility, the PACT team coordinates care with the inpatient unit and works to ensure stable housing and follow-up care. Currently there are 14 PACT teams across

	the state. In May 2019 the Legislature provided funding for eight additional PACT teams statewide. 9. Washington State's Department of Commerce announced $7.1 million in grants to six health care providers across Washington, adding 71 additional beds to facilities that help people with a wide variety of behavioral health issues. Twenty-eight of the 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 systems by shifting out of large institutions to smaller, community-based facilities. 10. In addition, the state requires Managed Care Organization utilization management decision making to take into account the greater and particular needs of diverse populations, as reflected in health disparities, risk factors (such as adverse childhood experiences for enrollees of any age), historical trauma, and the need for culturally appropriate care.
	Future Status: The state believes the efforts described above meet the requirements of this milestone. The state has been collaborating with tribes and Indian health care providers to develop a WISe provider curriculum that is culturally appropriate to serving American Indians and Alaska Native individuals and families. The state has also established a wraparound intensive services case rate for tribes and Indian health care providers.
	Summary of Actions Needed: N/A

4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	*Current Status:* New Journeys is a collaborative effort of HCA (The State Medicaid Agency and Mental Health Authority), the University of Washington, and Washington State University. New Journeys is a growing program focusing on first episode psychosis.
	Future Status: Expand program as legislative funding allows.
	Summary of Actions Needed: Monitor outcomes of New Journeys.

Prompts	Summary
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
F.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	*Current Status* Crisis Triage and Stabilization services: the state has funded several new triage and crisis stabilization facilities across the state. Current capacity is a total of 105 crisis stabilization and triage beds in eight facilities across six regions of the state. The 2019 state Legislature funded additional 16-bed triage and stabilization facilities. The Legislature also enhanced funding for Mobile Crisis Outreach. . Step Down Facilities: the Legislature appropriated funding for a new community facility type to address the need for additional discharge placements for individuals leaving the state psychiatric hospitals. Intensive behavioral health treatment facilities serve individuals who possess higher levels of behavioral challenges that existing alternative behavioral health facilities cannot accommodate. Peer Respite Centers: the Legislature recently funded five mental health peer respite centers to divert individuals from crisis services as well as a pilot program to provide mental health drop-in center services. Washington State's Department of Commerce announced $7.1 million in grants to six health care providers across Washington, adding 71 additional beds to facilities that help people with a wide variety of behavioral health issues. Twenty-eight of the 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 systems by shifting out of large institutions to smaller, community-based facilities. Co-Responders with Law Enforcement: The state continues to expand programs that fund mental health professionals who ride along with law enforcement as they respond to calls where mental health conditions may be involved.

	Future Status • To better serve the needs of the individual and in an effort to prevent needless hospitalization or unwarranted incarceration, the state is implementing programs designed to intervene at the point of contact with law enforcement. By broadening the options available through WAC the state provides law enforcement discretion in determining the level of care needed to better address the needs of the individual. The state is establishing broader guidelines for utilizing community based interventions as primary options. By working with licensed mental health professionals, mobile crisis response services and community crisis stabilization or crisis triage facilities, law enforcement officers are able to safely release individuals to settings which can address stabilization concerns and better determine level of acuity, housing needs, behavioral health needs, rather than placing them in the judicial systems where individuals may decompensate without treatment. • Enhancement of Mobile Crisis Response Teams (eMCR): currently the enhancement was only in three of the states ten regions. The state anticipates continuing to develop enhanced capacity in the remaining seven regions in stages. This enhanced MCR services are designed to work in a coordinated effort with Co-responders services to provide pre-arrest diversions by reducing its response time in an effort to free law enforcement from addressing behavioral health by handing off these services to programs designed to better meet their needs. The MCR model integrates a multidisciplinary approach to improve behavioral health outcomes. The MCR services includes teams of licensed clinicians, community behavioral health specialists, and individuals with lived experience and, is designed to operate 24-hours, seven days a week. • Development of six additional enhanced Crisis Stabilization and Crisis Triage facilities equipped to accept police drop-offs or mental health holds for evaluations by a mental health professional. These enhanced facilities are a place for individuals recovering from a behavioral health crisis to receive stabilization support from a multi-disciplinary treatment team. While designed to reduce the impact of individuals that are unduly incarcerated due to a lack of pre-arrest options for officers, as mentioned above, the state has taken wide steps to address this through WAC. These enhanced facilities will be operated 24-hours, seven days a weeks by a multidisciplinary team of clinicians, Certified Peers with lived experience, prescribers and behavioral health specialist. 171 crisis triage beds will be added. • Development of short-term emergency hotel and motel vouchers for individuals that are homeless or unsafely sheltered in facilities that further contribute to exposure to environments that lead to interaction with problematic elements. Working in unison with the Housing and Recovery through Peer Services (HARPS), a program which is designed to serves and support individuals that experience behavioral health disorders (either

	a mental health disorder, substance use disorder or both) and who demonstrate a medical necessity for housing supports. HARPS provides oversight for individuals utilizing vouchers to ensure that continued housing needs will be met to include more permanent housing supports. Tribes in the 3 regions are also provided to address housing needs for their community members. • Tribal Crisis Coordination Hub: The state is collaborating with tribes to develop a tribal crisis coordination hub, to help Indian Health Care Providers more efficiently place patients in inpatient treatment and with care coordination and transition planning.
	Summary of Actions Needed • Open six additional crisis stabilization centers across the state beginning in January of 2021. HCA will use currently allocated braided funding utilizing over 15 million dollars of Washington Department of Commerce grants. (Timeline: 1-14 months.) • As part of the Governor's budget request, additional funding will be devoted to enhanced mobile crisis response teams and other programs such as vouchers. (Timeline: 12 months.) • HCA will move money into contracts upon approval through appropriate regional rate increases and general fund state dollar allocations to BH-ASOs for non-Medicaid individuals. (Timeline: 6-12 months following budget approval.) • Contracts will be amended to reflect changes in funding. (Timeline: 6-12 months following budget approval.) • HCA will coordinate with the American Indian Health Commission to contract for the implementation of the tribal crisis coordination hub. (Timeline: completion of project imminent.) • The legislatively mandated Children and Youth Behavioral Health Work Group is expected to be making recommendations for youth mobile crisis models during the upcoming 2021 legislative session.
F.b Increase availability of on-going community-based services, e.g., outpatient, community	*Current Status* Program for Assertive Community Treatment (PACT) teams provide wrap around services for individuals in outpatient treatment. When the individual is in an inpatient facility, the PACT team coordinates care with the inpatient unit and

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.	works to ensure stable housing and follow-up care. Currently there are 14 PACT teams across the state. In May 2019 the Legislature provided funding for eight additional PACT teams statewide. Intensive Residential Teams: This is a team based approach to serving individuals with significant behavioral health disorders who reside in assisted living facilities and group homes. Services are geared towards individuals who are recently discharged from long term involuntary treatment or who are at risk of losing their placement due to increased symptoms of their mental illness The teams will provide medication management, medication monitoring, clinical mental health interventions, group treatment services, therapeutic psychoeducation and peer services. Treatment will focus on the reinforcement of safety, the promotion of stability and independence of the individual in their structured settings, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and without this level of intervention would be at risk for more restrictive levels of care such as psychiatric inpatient hospitalization or are at risk for involuntary treatment. Services are team-based and will be provided within adult family homes and assisted living centers. Within Initiative 3 of the current Medicaid Transformation Waiver, Foundational Community Supports (FCS) provides supportive housing and supported employment services for high-risk Medicaid who have behavioral health needs or other risk factors including chronic homelessness, substance use disorder, or qualifying long-term care or physical disability care need. The primary goal of these services is to promote self-sufficiency, promote integration into the community, and reduce potentially avoidable use of more intensive services, by helping individuals with significant support needs obtain and maintain stable housing or competitive employment. FCS has created a strong connection between entry points such as hospital discharge planners, coordinated entry sites, community services offices and the third party administrator who manages the FCS provider network. These targeted Medicaid benefits follow two evidence-based practices: Individual Placement and Support for the supported employment services, and SAMHSA's Permanent Supportive Housing for the supportive housing services. Accountable Communities of Health also provide incentives to Community Behavioral Health providers and Community Social Service providers to increase support for persons transitioning from behavioral health treatment to community, and to promote prevention.
	Future Status As Washington seeks to support Initiative 1 of the Medicaid Transformation Waiver: Accountable Communities of Health. Initiative 1 provides incentives for providers who are committed to changing how we deliver care. Each region,

	through its Accountable Community of Health (ACH), pursues projects aimed at transforming the Medicaid delivery system to serve the whole person and use resources more wisely., the Accountable Communities of Health are working to determine how they can continue support of regional community based services.
	Summary of Actions Needed HCA will move money into MCO contracts upon approval through appropriate regional rate increases and general fund state dollar allocations to BH-ASOs for non-Medicaid individuals. (Timeline 6 -12 months following budget approval.) Contracts will be amended to reflect changes in funding. (Timeline 6 -12 months following budget approval.) The Medicaid Transformation Project evaluation will inform overall delivery system performance, including community supports to address behavioral health and stabilization needs, integration of behavioral and physical care, and community-based care coordination to address social needs in the community setting. The draft interim evaluation will be available in December 2020. Subsequent evaluation reports and mid-point assessments will be made available over the course of 2021-2023. These evaluation efforts, among other monitoring activities, will inform additional service and funding needs including sustainability of stabilization and intervention supports being provided through the Medicaid Transformation Project.

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[1] The HIT Plan should also describe, among other items, the: • *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* • *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	

Statement 1: Please provide an assurance that the state has a 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. If this is not yet the case, please describe how this will be achieved and over what time period	**Behavioral Health Provider Survey:**
	From January 9 through April 12 2019, HCA fielded the Behavioral Health Provider Survey (BHPS), a web-based survey of publicly funded behavioral health agencies that provided mental health and/or substance use disorder services. Out of the 611 behavioral health agencies eligible to participate, 316 completed and another 30 partially completed the survey, for a 56.6 percent response rate. The 2019 survey included questions regarding the providers' adoption and use of electronic health records, including certified electronic health records. Findings from the 2019 survey included:
	• Regardless of type and size, 85% of behavioral health agencies overall reported using an electronic health record or a certified electronic health record.
	  ○ 15% of behavioral health agencies use a paper record system.
	  ○ More substance use disorder agencies (29.8%) use a paper record system than mental health (18.3%) and mental health substance use disorder agencies (7.2%)
	• 93% of mental health substance use disorder agencies reported using an electronic health records or certified electronic health records system compared to 82% of mental health only and 70% of substance use disorder only agencies.
	• 91% of large agencies use an electronic health records or certified electronic health records system compared to 87% of medium and 84% of small agencies.

	• Regardless of type and size, over 90% of agencies using a paper record system plan or are thinking of transitioning to electronic health records. HCA recognizes that the 2019 survey responses by behavioral health agencies regarding their use of electronic health records or certified electronic health records exceed or is nearly the same as rates of electronic health records and certified electronic health records use reported by physicians eligible for the HITECH Electronic Health Records incentive programs. The Office of the National Coordinator for Health IT reports that in 2017 almost 86% of physicians reported using any electronic health records and nearly 80% reported using a certified electronic health records (https://dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php). Given that behavioral health agencies were not eligible for incentives or technical assistance available to physicians via the HITECH electronic health records Incentive Programs, the 2019 survey findings raise questions not only about the relative extent of electronic health records or certified electronic health records adoption among behavioral health agencies but also about its use and functions in behavioral health agencies' clinical operations and wider role in a healthcare ecosystem. Following consultation with the Office of the National Coordinator for Health IT, HCA modified the electronic health records questions in our Behavioral Health Provider survey to reflect the electronic health records questions that are expected to be included in a future Substance Abuse and Mental Health Services Administration survey on Health IT. HCA supplemented these questions by including additional functionality required in the Mental Health Institute of Mental Disease Waiver. As a result, the 2020 HCA Behavioral Health Provider survey will attempt to drill down on specific uses of the electronic health records by the behavioral health (including mental health) providers. The 2020 Behavioral Health Provider survey questions will gather information about specific functionality, use and exchange, including: • Use of electronic health records to create and use electronic care plans; • Use of electronic health records to record referrals, including closed loop referrals; and • Use of electronic health records to support interoperable screenings, intake, and assessments tools. Responses to these questions will help us: • Target needed enhancements to electronic health record functionality required by the Mental Health Institute of Mental Disease Waiver; and Identify and make available supports for the use this functionality by behavioral health agencies that provide

	mental health services. The 2020 Behavioral Health Provider survey is currently being programmed into a web survey. Beta-testing of the web survey will immediately follow. We plan to launch the survey by March 23, 2020 and the survey will remain open until we have obtained a robust response rate. The 2020 Behavioral Health Provider survey will target Washington state-certified, community-based behavioral health agencies that offer publicly funded mental health and/or substance use disorder treatment services. Correctional and hospital-based treatment programs are not included. The draft survey questionnaire is attached. See Q17k, pages 9-10, of the attached draft questionnaire for questions related to electronic health records/certified electronic health records adoption and use. **Accountable Communities of Health:** In Washington State, Medicaid Transformation is being supported by nine regional Accountable Communities of Health. Accountable Communities of Health support a variety of projects and engage in a variety of activities. These projects include support for the integration of physical health and behavioral health services, use of electronic care plans, and closed-loop referrals. Washington State's health IT infrastructure continues to evolve at every level (i.e., state, delivery system, health plan/Managed Care Organization and individual provider) to achieve the goals of the demonstration. **2020 Health IT Operational Plan:** Critical activities/tasks needed to advance the Health IT infrastructure/ecosystem in Washington State are specified in our annual, calendar year Health IT Operational Plan. The 2020 Health IT Operational Plan can be found on HCA's website at: https://www.hca.wa.gov/about-hca/health-information-technology/washington-state-medicaid-hit-plan. Click on the 2020 Operational Plan. A key strategic initiative underway within the HCA and included in our 2020 Health IT Operational Plan are initial steps to explore: (i) how best to promote the adoption of certified electronic health record technology for providers that do not use certified electronic health record solutions or do not have needed functionality to support caregiving. This initiative includes a particular focus on behavioral health, rural, and/or tribal providers; and Department of Corrections/jails providers.

	This work involves the identification of potential funding sources and pursuit of viable option(s). This effort may lead to the development of request for information or potentially a request for proposals to connect these technology solutions with providers needing them. In addition, the 2020 Health IT Operational Plan identifies several key activities that will be undertaken during the calendar year that will support the goals of this demonstration, including work to advance: • Electronic care planning; • Electronic closed loop referrals; • Exchange of summary of care documents at transitions in care; • Electronic consent management; • Use of provider directories; • Work to support the use of a master patient index. In addition, as reflected in our 2020 Health IT Operational Plan, HCA is supporting other work to strengthen and enhance the state's health IT infrastructure. **Managed Care Organizations:** As the State Medicaid Agency in Washington State, the HCA recognizes the important role that Medicaid Managed Care Organizations play in supporting Medicaid service providers. As reflected in our State Health IT Operational Plan and this application, HCA has and will continue to incorporate requirements for Managed Care Organizations to support their network providers in their use of interoperable Health IT. For example, our January 1, 2020 Managed Care Organizations contract includes requirements that Managed Care Organizations promote bi-directional behavioral and physical health integration through education, training, financial, and nonfinancial incentives to promote integrated care including the use of electronic health records, clinical data repository, decision support tools, client registries, data sharing, and other similar program innovations.

[1] See SMDL #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Statement 2: Please confirm that your state's SUD 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. If this is not yet the case, please describe how this will be achieved and over what time period.	Washington State's substance use disorder and mental health, Health IT Plans are aligned with and integrated into our State's Medicaid Health IT Plan.
	
	HCA's annual, calendar year 2020 Health IT plan can be found on HCA's website at: https://www.hca.wa.gov/about-hca/health-information-technology/washington-state-medicaid-hit-plan. Click on the 2020 Operational Plan.
	
	• Tasks for the Health IT Plan for mental health Institute of Mental Disease Waiver are in rows 6-20.
	  ○ Implementation of these tasks is contingent on funding.
	  ○ HCA's 2020 Health IT Operational Plan adds in the following financial mapping task:
	  ▪ HCA (DBHR and Health Information Technology) will develop a financial map that identifies sources of funds (e.g., decision package, MMIS, CMS grants, Substance Abuse and Mental Health Service Administration Grants) to execute the health information technology/health information exchange activities required in the mental health information technology plan in the Mental Health Institute of Mental Disease Waiver.
	  ▪ Know: HCA anticipates financial mapping will be an ongoing activity.
	• Tasks for the Health IT Plan for the substance use disorder institute of mental disease Waiver are in rows 21-30.
	
	The Health IT Operational Plan is updated at the end of each calendar year to identify additional tasks that will be implemented in the next calendar year.

Statement 3: Please confirm that the state 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. The ISA outlines relevant standards including but	The state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory and 45 CFR 170 Subpart B and, based on that assessment, intends to include these standards as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts and in the design, development, and implementation of health IT tools. The state anticipates that (i) the assessment of the applicability of Interoperability Standards Advisory standards will be ongoing as these standards evolve and (ii) standards will be included in the state's Medicaid Managed Care contracts and in the design, development, and implementation of health IT tools as standards emerge and as gaps in our infrastructure are identified and can be addressed. For example, in our January 2020 Medicaid Managed Care Organization contract requirements: • Managed Care Organization contractors are required to (i) support provider use of health information

not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	technology/health information exchange tools and services including certified electronic health record Technology and (ii) develop policies and procedures for care coordination and care management services that encourage and support the use of health information technology and health information exchange technologies (e.g., certified electronic health records, existing statewide health information exchange and health information technology, and other technology solutions) to coordinate care across the care continuum including with entities that provide mental health, substance use disorder services, and oral health services. Managed Care Organization contractors are required to participate in a workgroup with HCA to explore the extent to which the health information technology infrastructure can be developed to support care coordination and continuity of care requirements. • As part of our 2020 Health IT Operational Plan we have included a task requiring: HCA and Managed Care Organization staff participate in a workgroup to identify, prioritize, and explore methods to address gaps in an interoperable health information technology infrastructure to support these services, including electronic care plans and closed loop referrals. We anticipate that this workgroup will include consideration of standards available via the Interoperability Standards Advisory. We anticipate that future Managed Care Organizations contract requirements will require the use ISA standards related to care plans and closed loop referral (as these standards emerge). • Managed Care Organization contractors are required to develop data exchange protocols (in accordance with applicable privacy laws, including HIPAA and 42 C.F.R. Part 2) including consent to release before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health coordination (including sharing of claims and pharmacy data, treatment plans or care plans, crisis plans) to coordinate service delivery, and care management for each enrollee. As reflected in our 2020 Health IT Operational Plan, HCA is supporting work as part of its Substance Use Disorder Institute of Mental Disease Waiver (leveraging funds available via the Partnership/SUPPORT Act) to specify requirements to enable the electronic exchange of information subject to 42 CFR Part 2 and will use available Health IT interoperability standards. Once these requirements are final and ready for widespread use, we anticipate that future Managed Care Organization contract language will incorporate the use of these

	requirements. • Managed Care Organization contractors are required to submit to HCA their "Population Health Management" Plans. Population Health Management Systems are defined in our Managed Care Organizations contract language as "health information technology and health information exchange technologies that are used at the point-of-care, and to support service delivery. Examples of health information technology tools include, but are not limited to, electronic health records, OneHealthPort clinical data repository, registries, analytics, decision support and reporting tools that support clinical decision-making and care management. The overarching goal of Population Health Management Systems is to expand interoperable health information technology and health information exchange infrastructure and tools so that relevant data (including clinical and claims data) can be captured, analyzed, and shared to support value-based purchasing models and care delivery redesign. We anticipate that future Managed Care Organization contract requirements related to Population Health Management activities will require the use of specific Interoperability Standards Advisory standards.

[2] Available at https://www.healthit.gov/isa/.

Prompts	Summary
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [3] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."*[4]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider	*Current State:* *1) # and/or % of Behavioral Health Providers who have adopted "Certified" EHRs (CEHRT-Certified EHR Technologies) and utilize it for e-referrals and or closed loop referrals.* *2) # and/or % of Behavioral Health Providers who utilize "Direct" secure messaging for e-referrals and or closed loop referrals* *3) # and/or % of Primary Care Providers who have adopted "Certified" EHRs (CEHRT-Certified EHR Technologies) that are utilizing it for e-referrals and or closed loop referrals with mental health providers* *4) # or % of Primary Care Providers who utilize "Direct" secure messaging for e-referrals and or closed loop referrals with Mental Health Providers* **Behavioral Health Provider Survey:** As described in Assurance Statement #1 above, responses by behavioral health agencies (including those providing mental health services) to the 2019 Behavioral Health Provider survey raise questions about the relative extent of electronic health records/certified electronic health records adoption among these agencies and their use of electronic health records/certified electronic health records to support the behavioral health agencies' clinical operations and wider role in a health care ecosystem. As a result, the 2020 HCA Behavioral Health Provider survey will drill down on specific uses of the electronic health records by the behavioral health (including mental health) providers and gather information about specific functionality, use and exchange, including the use of electronic health records to record referrals, including closed loop referrals.

	Responses to these questions will help us: • Target needed enhancements to electronic health record functionality required by the Mental Health Institute of Mental Disease Waiver; and • Identify and make available supports for the use this functionality by behavioral health agencies that provide mental health services. **The HCA 2020 Health IT Operational Plan includes the following requirements (contingent on the availability of funds):** Task 8-01: HCA staff will, based on a review of ACH submitted documents, consult with A Accountable Communities of Health to better understand some of the shared needs identified across several Accountable Communities of Health (e.g., shared care plans, population health management, closed loop referral); and identify activities and funding sources that could be leveraged to support sustainable shared health information technology/health information exchange needs and technical support for providers across Accountable Communities of Health. Task 8-02: Q1- Q4: HCA staff, in consultation with representatives from Accountable Communities of Health and their partnering providers (e.g., acute care, primary care, behavioral health, Federally Qualified Health Centers, jails) and other stakeholders will produce written descriptions of: • Emerging / best practices across communities to provide health information technology-enabled integrated person-level care, and • Opportunities for shared /sustaining investments. The paper will include descriptions of practices and opportunities to provide health information technology-enabled integrated person-level care including the use of e-consults and close-loop referral processes, shared care plans, and population health. Task 8-04: Q1-Q2: HCA health information technology section staff, in collaboration with Policy and DBHR staff, will engage Managed Care Organizations in a workgroup to: Identify how plans define: service coordination, care coordination services, care management, and complex care management services; and

	• Identify, prioritize, and methods to address gaps in an interoperable health information technology infrastructure to support these services, including electronic care plans and closed loop referrals. HCA staff will summarize for the Medicaid Transformation Priorities Steering Committee gaps identified by the workgroup and suggested methods for addressing these gaps. Task 2-05: HCA staff will engage and collaborate with Accountable Communities of Health and Managed Care Organization representatives to identify: • Mechanisms that are being/could be used to support close loop referrals (e.g., digital health commons) and e-referrals (e.g., use of collective medical tools, including mental health providers' use of these tools and considerations that are needed to advance the use of these tools (including aligning with health IT standards to support interoperable exchange and standard implementation across the state).
	Future State: Contingent on the availability of funds, mental health providers in Washington State will pilot the use Health IT functionalities to support referrals in care, including closed loop referrals.

	Summary of Actions Needed:
	
	• HCA will conduct a survey in 2020 of behavioral health providers' adoption and use of certified electronic health records technologies including the use of this technology to support electronic referrals to and from physicians and mental health providers.
	  o The HCA/DBHR is leading the survey of behavioral health providers.
	  o Preliminary survey results will be published by July 2020.
	
	• Contingent on the availability of funds, HCA will engage a contractor to support Tasks 8-01 and 8-02; and integrate information that emerges from Tasks 8-04 and 2-05 into written documents describing:
	  o Current practices and opportunities to support and advance the use of health information technology-enabled integrated person-level care including the use of e-consults and close-loop referral processes, interoperable care plans, and population health.
	  o The availability of standards in the Interoperability Standards Advisory to support interoperable exchange of this content.

	○ Opportunities for shared/sustaining investments. • The HCA health information technology section will: ○ Lead this work in collaboration with other HCA components, Managed Care Organizations, Accountable Communities of Health, technology vendors, and behavioral health and physical health providers; and ○ Present the scope of work, progress reports, and recommendations to the (i) HCA Medicaid Steering Committee and (ii) Mental Health Institute of Mental Disease Waiver Workgroup. • Contingent on the availability of funds, a contract for this scope of work will be awarded in July and work will be completed in December 2020. • Contingent on the availability of funds, HCA will engage a contractor to specify requirements and design an open source FHIR-Based APIs for ○ E-consults; ○ Close-loop referral processes; and ○ Interoperable care plans, including the identification of care team members (including mental health providers). • Contingent on the availability of funds, a contract for this scope of work will be awarded in January 2021 and work will be completed in June 2021. • Contingent on the availability of funds, HCA will support pilots (including physicians and mental health providers) using the FHIR-Based APIs for: ○ E-consults; and ○ Close-loop referral processes: The pilot will include use of a FHIR-Based API to support electronic and closed loop referrals: ▪ Between physicians/mental health providers. ▪ From institution/hospital/clinic to physician/mental health provider. ▪ From physician/mental health provider to community-based supports. ○ Care plans • Contingent on the availability of funds, a contract for this scope of work will be awarded in March 2021 and work will be complete in December 2021.

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[3] See SMDL #16-003, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf.

[4] Guidance for Administrative Claiming through the "No Wrong Door System" is available at https://www.medicaid.gov/medicaid/finance/admin-claiming/no- wrong-door/index.html.

1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	*Current State:* See Section 1.1.
	Future State: See Section 1.1.
	Summary of Actions Needed: See Section 1.1.
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports	*Current State:* See Section 1.1.
	Future State: See Section 1.1.

	Summary of Actions Needed: See Section 1.1.
Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	Current State: **Behavioral Health Provider Survey:** As described in Assurance Statement #1 above, responses by behavioral health agencies (including those providing mental health services) to the 2019 Behavioral Health Provider survey raise questions about the relative extent of electronic health records/certified electronic health records adoption among these agencies and their use of electronic health records/certified electronic health records to support the behavioral health agencies' clinical operations and wider role in a healthcare ecosystem. As a result, the 2020 HCA Behavioral Health Provider survey will drill down on specific uses of the electronic health records by the behavioral health (including mental health) providers and gather information about specific functionality, use and exchange, including the use of electronic health records to create and use electronic interoperable care plans accessible by all relevant members of the care team, including mental health providers. Responses to these questions will help us: • Target needed enhancements to electronic health records functionality required by the Mental Health Institute of Mental Disease Waiver; and • Identify and make available supports for the use this functionality by behavioral health agencies that provide mental health services. **The HCA 2020 Health IT Operational Plan includes the following requirements (contingent on the availability of funds):** Task 2-06: Requires that the HCA health information technology section, in collaboration with other HCA staff, will gather information on use of electronic/interoperable care plans by behavioral health (including mental health), providers; collaborate and coordinate with Managed Care Organizations via a workgroup to develop a shared care plan template; and coordinate with Department of Corrections and jails to consider the need for and use of care plans between health care providers in jails/prisons and community-based health providers.

	Task 2-07: HCA/DBHR staff, in collaboration with other HCA staff, will:
	
	• Identify best practice standards for transition planning from inpatient and residential care prior to discharge.
	• Consider strategies to incentivize discharge outcomes that ensure housing stability.
	• Advance recommendations to implement best practices for successful discharge planning.
	
	HCA Policy staff will explore opportunities to support information exchange on behalf of incarcerated persons 30 days prior to release.
	
	Health information technology section staff, in coordination with HCA Policy, DBHR, and data governance staff, will explore opportunities and approaches to support creation, exchange, and access of CCDs/other health records including:
	• From youth-oriented systems of care to and from adult systems of care; and
	• On behalf of incarcerated persons, including:
	  ○ Providing technical assistance to these providers regarding:
	  ▪ The creation, exchange and access to CCDs via clinical data repository.
	  ▪ View/download of the Problems, Medication, and Interventions (PAMI) report from the clinical data repository.
	  ○ Access to clinical data repository/ Problems, Medication, and Interventions by health providers upon incarceration.
	
	HCA/DBHR staff, in coordination with other HCA staff, will work to align the requirements in Task 2-07 in the Health IT Operational Plan with Managed Care Organization requirements, including in Sec. 14 of the Managed Care Organization Integrated Managed Care contract.
	
	Managed Care Organization Requirements:
	Task 2-07 in the Health IT Operational Plan cross references several requirements in Sec. 14 of the Managed Care Organization Integrated Managed Care contract, including requirements that the MCO:
	
	• Develop in collaboration agencies and systems transition plans to that identify enrollees' goals, objectives, and strategies to achieve goals as these individuals transition between systems of care;

	• Complete the Uniform Discharge Tool reporting template for every individual discharging from a mental health inpatient setting hospital stay. • Coordinate with the behavioral health treatment agencies to ensure there is adequate coordination for enrollees transitioning between various levels of treatment services to ensure continuity of care (i.e., an enrollee receives timely and applicable follow-up services from ancillary referral agencies). This includes ensuring that discharge plans and facilitation to post-discharge services are documented in the enrollee's electronic health record. Task 2-09: Requires the HCA health information technology section to: • Contract to gather information on additional data sources including use/barriers/options to encourage use of electronic/interoperable care plans and electronic assessment/screening/ intake tools (among other requirements). • Coordinate with Office of the National Coordinator for Health IT and CMS and other states to standardize selected intake assessment and screening tools. • Link standardized care plans and electronic assessment/screening/intake tools with health information technology standards. • Create FHIR enabled interoperable tools for the exchange of care plans and electronic assessment/screening/intake tools. • Pilot use of the FHIR-enabled interoperable care plans and electronic assessment/screening/intake tools. Task 8-01: HCA staff will, based on a review of Accountable Communities of Health submitted documents, consult with Accountable Communities of Health to better understand some of the shared needs identified across several Accountable Communities of Health (e.g., shared care plans, population health management, closed loop referral); and identify activities and funding sources that could be leveraged to support sustainable shared health information technology/health information exchange needs and technical support for providers across Accountable Communities of Health. Task 8-02: Q1- Q4: HCA staff, in consultation with representatives from Accountable Communities of Health and their partnering providers (e.g., acute care, primary care, behavioral health, federal qualified health centers, jails) and other stakeholders will produce written descriptions of: • Best practices across communities to provide health information technology-enabled integrated person-level

	care; and • Opportunities for shared/sustaining investments. The paper will include descriptions of practices and opportunities to provide health information technology-enabled integrated person-level care including the use of e-consults and close-loop referral processes, shared care plans, and population health. Task 8-04: Q1-Q2: HCA health information technology section staff, in collaboration with Policy and DBHR staff, will engage Managed Care Organizations in a workgroup to: • Identify how plans define: service coordination, care coordination services, care management, and complex care management services; and • Identify, prioritize, and methods to address gaps in an interoperable health information technology infrastructure to support these services, including electronic care plans and closed loop referrals. HCA staff will summarize for the Medicaid Transformation Priorities Steering Committee gaps identified by the Workgroup and suggested methods for addressing these gaps. Task 8-05: references Medicaid managed care management and care coordination services. This section of the Health IT Operational Plan references the: **MCO Requirements:** Managed Care Organizations contract requirements that became effective 1/1/2020 require that Managed Care Organizations: • Support, to the maximum extent possible, the development and implementation of, and updates to interoperable electronic care plans; • Ensure that such care plans are transmitted to the clinical data repository when developed and updated; and • Participate in a workgroup with HCA to assess the utilization of interoperable care plans and barriers to using electronic care plans.

	Task 12-07: Requires that HCA, in collaboration with Accountable Communities of Health and providers, identify existing health information technology standards and interoperable care management tools that could be deployed in conjunction with the health information exchange and clinical data repository (e.g., consider: shared care planning, post-discharge care management for patients recently discharged from inpatient mental health facilities). Task 12-08: Requires HCA to develop a Discharge Summary API (for use by providers with limited technology adoption) and guidance that conforms to the Discharge Summary C-CDA specifications adopted for the 2015 version of certified electronic health records.
	Future State: Contingent on the availability of funds, mental health providers in Washington State will pilot use Health IT functionalities to support the: • Creation and use of electronic interoperable care plan accessible by all relevant members of the care team, including mental health providers including via the clinical data repository; • Creation, exchange, and access of clinical data repository's/other health records via the clinical data repository. • Creation and exchange interoperable discharge tools

	Summary of Actions Needed:
	
	HCA will conduct a survey in 2020 of behavioral health providers' adoption and use of certified electronic health records technologies including the use of this technology to support electronic referrals to and from physicians and mental health providers.
	• The HCA/DBHR is leading the survey of behavioral health providers.
	• Preliminary survey results will be published by July 2020.
	• Contingent on the availability of funds, using the contractor to be identified for work referenced in Sec. 1 (Closed Loop Referrals and e-Referrals), HCA will engage this contractor to support Tasks 2-06 (in addition to Tasks 8-01 and 8-02; and Tasks 8-04) to incorporate into written document a description of:
	
	  ○ Current practices and opportunities to support and advance the use of health information technology-enabled integrated person-level care including the use of e-consults and close-loop referral processes, interoperable care plans, and population health.
	  ▪ The description will include information on the opportunities and barriers to exchange

	interoperable care plans and other documents on behalf of incarcerated persons and persons being released from incarceration, including the exchange of information 30 days prior to release from incarceration. o The availability of standards in the Interoperability Standards Advisory to support interoperable exchange of this content. o Opportunities for shared/sustaining investment. Per Section 1 (Closed Loop Referrals and e-Referrals), and contingent on the availability of funds, the contract for this scope of work will be awarded in July and work will be complete in December 2020. • Contingent on the availability of funds, HCA will engage a contractor to map the work flow of mental health providers related to: o Completion of intake, screening, and assessment tools; o Development of care plans; o Referrals for ancillary services; and o Discharge/transition planning. • The workflow will highlight opportunities and barriers to the use of health IT to support interoperable exchange and re-use of this information within and across care providers. • The HCA health information technology section, Policy, and DBHR staff will co-lead this work: o In collaboration with other HCA components, Managed Care Organization, Accountable Communities of Health, technology vendors, and behavioral health and physical health providers; and o Present the scope of work, progress reports, and recommendations to the (i) HCA Medicaid Steering Committee and (ii) Mental Health Institute of Mental Disease Waiver Workgroup. • Contingent on the availability of funds, a contract for this scope of work will be awarded in July and work will be complete in December 2020. • Contingent on the availability of funds and the ability to leverage the expertise of Oregon Health Sciences University and activities underway via the Sec. 1003 Roadmap to Recovery grant, HCA will:

	○ Engage the Oregon Health Sciences University to identify best/promising practices to support transition planning prior to discharge on behalf of individuals transitioning from inpatient and residential care; ○ Identify and advance recommendations to implement best practices for successful discharge planning as part of the Roadmap to Recovery produced under the Sec. 1003 grant. HCA, Clinical Quality and Care Transformation, in collaboration with DBHR staff, will lead this work. If needed, a contract for this scope of work will be awarded no later than September 2020 and will be complete by March 2021. • Contingent on the availability of funds, HCA will engage a contractor to specify requirements for and design open source FHIR-based APIs that could be piloted using certified electronic health records for the exchange: ○ Interoperable care plans, including the identification of care team members (including mental health providers); and ○ Interoperable discharge summaries. Requirements will include the transmission and receipt of care plans and discharge summary documents to the clinical data repository, between providers using certified electronic health records (including members of the care team), and by providers to Managed Care Organizations. The health information technology section will lead this work. Contingent on the availability of funds a contract for this scope of work will be awarded in January 2021 and work will be complete in December 2021. • Contingent on the availability of funds, HCA will support pilots using the FHIR-Based APIs to support the creation and electronic exchange of: ○ Care plans ○ Discharge summaries • The pilot will include mental health providers:

	○ Sending electronic interoperable care plans and discharge summaries to other providers, the clinical data repository, and Managed Care Organizations. ○ Receiving interoperable care plans and discharge summaries from other providers. ○ Sending interoperable care plans and discharge summaries to the clinical data repository. ○ Viewing interoperable care plans and discharge summaries created by other providers in the clinical data repository. The health information technology section will lead this work. • Contingent on the availability of funds a contract for this scope of work will be awarded in January 2021 and work will be complete in December 2021.
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	*Current State:* See description above in Sec. 2.1.
	Future State: See description above in Sec. 2.1.
	Summary of Actions Needed: See description above in Sec. 2.1.
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic	*Current State:* See description above in Sec. 2.1.

communications	*Future State:* See description above in Sec. 2.1.
	Summary of Actions Needed: See description above in Sec. 2.1.
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* See description above in Sec. 2.1.
	Future State: See description above in Sec. 2.1.
	Summary of Actions Needed: See description above in Sec. 2.1.
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	*Current State:* See description above in Sec. 2.1.
	Future State: See description above in Sec. 2.1.

	Summary of Actions Needed: See description above in Sec. 2.1.
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	*Current State:* Beginning in 2018: • HCA sponsored an environmental scan to identify states and communities that had deployed electronic consent management solutions intended to support the exchange of information subject to 42 CFR Part 2; and • Whether these solutions incorporated the use of health IT standards to support the exchange of this sensitive information. • HCA led a public-private substance use disorder workgroup that assisted in the development and publication of "Sharing Substance Use Disorder Information: A Guide for Washington State". The guide helps clarify the applicable federal regulations and law (e.g., HIPAA and 42 CFR Part 2) and includes additional provider and patient resources, such as a sample paper consent form. • In addition, HCA started work to specify the requirements that an electronic consent management solution would need to support to comply with 42 CFR Part 2 requirements. **The HCA 2020 Health IT Operational Plan includes the following requirements:** Task 2.08: HCA health information technology section is required to: • Enter into contracts to support: o Development of technical assistance materials for substance use disorder and mental health providers re: privacy requirements (related to 42 CFR Part 2).

	○ Substance use disorder provider workflow related to consent. ○ Vendor procurement and system development for consent management solution. ○ Pilot an electronic consent management solution. ○ Seek continued funding to expand consent management past pilot. Task 3-09: Beginning in Q3 - Q4, the HCA health information technology section is required to: develop and pilot an electronic consent management solution that can be used to support the exchange of information subject to 42 CFR Part 2 and allow for the appropriate re-disclosure of this information. Task 14-01: Requires that HCA continue conversations with Tribal partners and the American Indian Health Commission on the value of health information exchange including how the technical solution to be deployed for consent management could be extended to protect tribal member's health information in the clinical data repository. In 2020, leveraging federal funds available through the Partnership/SUPPORT Act, HCA contracted for work that includes: • Development and implementation of technical assistance materials for providers regarding requirements related to the consent and sharing of information subject to 42 CFR Part 2: • Completion of the requirement specifications for an electronic consent management solution that supports information exchange in compliance with 42 CFR Part 2; and Solicitation of a request for proposal for an electronic consent management solution.
	Future State: Contingent on the availability of funds, mental health providers in Washington State who treat individuals with substance use disorders and are subject to the requirements of 42 CFR Part2 will pilot the: • Exchange protected information in compliance with 42 CFR Part 2; and • Use an electronic consent management tool that supports the exchange protected information in compliance with 42 CFR Part 2.

	Summary of Actions Needed: Contingent on the availability of funds, HCA will: • Develop/acquire an electronic consent management solution that support the exchange of protected information in compliance with 42 CFR Part 2; and • Pilot the use of an electronic consent management solution, including by mental health providers who treat persons with substance use disorders and are subject to 42 CFR Part 2 requirements.
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	*Current State:* **Behavioral Health Provider Survey:** As described in Assurance Statement #1 above, responses by behavioral health agencies (including those providing mental health services) to the 2019 Behavioral Health Provider survey raise questions about the relative extent of electronic health records/certified electronic health records adoption among these agencies and their use of electronic health records/certified electronic health records to support the behavioral health agencies' clinical operations and wider role in a healthcare ecosystem. As a result, the 2020 HCA Behavioral Health Provider survey will drill down on specific uses of the electronic health records by the behavioral health (including mental health) providers and gather information about specific functionality, use and exchange, including the use of electronic health records to record intake, assessment, and screening information including whether that information is interoperable with other health information technology systems. Responses to these questions will help us: • Target needed enhancements to electronic health records functionality required by the Mental Health Institute of Mental Disease Waiver; and • Identify and make available supports for the use this functionality by behavioral health agencies that provide mental health services. **The HCA 2020 Health IT Operational Plan includes the following requirements (contingent on the availability of funds):**

	Task 2-09: Requires the HIT Section: • Contract to gather information on additional data sources including use/barriers/options to encourage use of electronic/interoperable care plans and electronic assessment/screening/intake tools (among other requirements). • Coordinate with Office of the National Coordinator for Health IT, CMS and other states to standardize selected intake, assessment and screening tools. • Link standardized care plans and electronic assessment/screening/intake tools with health information technology standards. • Create FHIR enabled interoperable tools for the exchange of care plans and electronic assessment/screening/intake tools. • Pilot use of the FHIR-enabled interoperable care plans and electronic assessment/screening/intake tools. Task 12-05: Requires the HCA health information technology section to design and develop four use cases for providers/entities with limited health information technology/electronic health records technology to • Create and; • Transmit and/or; • Download information to/from the clinical data repository. Initial use case may focus on health action plans. If additional funds become available, use cases could focus on discharge plans/assessment, screening and intake tools. **Managed Care Organization Requirements:** The January 2020 Managed Care Organization requirements include several requirements related intake, screening, and assessment applicable to behavioral health providers including (but not limited to) the following sections of the Integrated Managed Care Plan: • Sec. 9.5 Health Care Provider Subcontracts; • Sec. 9.7 Administrative Functions with Subcontractors and Subsidiaries (changed in Sec. 9.8 effective July 1, 2020); • Sec. 9.11 Provider Education (changed in Sec. 9.12 effective July 1, 2020); • Sec. 9.16 Behavioral Health Administrative Service Organization (BH-ASO) (changed to 917 effective July 1,

	2020); • Sec. 14.3 Population Health Management: Identification and Triage; • Sec. 14.5 Bi-Directional Behavioral and Physical Health Integration; • Sec. 14.6 Care Coordination Services (CCS); • Sec. 14.13 Children's Long-Term Care Inpatient Program; • Sec. 17.1 Contract Services.
	Future State: Contingent on the availability of funds, mental health providers in Washington State will pilot use of health IT functionalities to record interoperable intake, assessment, and screening information.

	Summary of Actions Needed:
	
	• HCA will conduct a survey in 2020 of behavioral health providers' adoption and use of c certified electronic health records technologies including the use of this technology to support electronic and interoperable intake, assessment and screening tools.
	
	• HCA/DBHR is leading the survey of behavioral health providers.
	
	• Preliminary survey results will be published by July 2020.
	
	• Contingent on the availability of funds, HCA will engage a contractor to support work required in the Health IT Operational Plan Tasks 2-06 and 12.05. Specifically, this contractor will:
	
	  o Gather information (from mental health providers, Managed Care Organizations, and technology vendors) and produce a written description of:
	
	  ▪ Assessment, screening, and intake tools that are commonly used by mental health providers and/or required (e.g., by Managed Care Organizations) in Washington State; and
	  ▪ Whether any of these tools are electronic, included in electronic health records, and

interoperable with other Health IT systems (i.e., incorporate standards from the Interoperability Standards Advisory).

- If needed, and in consultation with HCA, create a framework for prioritizing which intake, assessment and screening tools should be made electronic and linked with health IT standards (including FHIR). For example, the framework would take into account intake, assessment and screening tools:
  - Used for different populations and conditions (including for patients experiencing their first episode of psychosis);
  - That are required to be used in Washington State;
  - That are freely available for use (e.g., open source);
  - That are electronic;
  - That have been (at least partially) linked to health IT standards;
  - That other states that have received a Mental Health Institute of Mental Disease Waiver are seeking to advance.

The HCA health information technology and DBHR sections will co-lead this work and present the scope of work, progress reports, and recommendations to the (i) HCA Medicaid Steering Committee and (ii) Mental Health Institute of Mental Disease Waiver workgroup.

- Contingent on the availability of funds, a contract for this scope of work will be awarded in July and work will be complete in December 2020.
- Contingent on the availability of funds, by February 2021, the Steering Committee and the Mental Health Institute of Mental Disease Waiver workgroup will collectively determine which intake, screening, and assessment tools will be linked with health IT standards to support interoperable exchange and re-use.
- Based on decisions made by the Medicaid Steering Committee and Mental Health Institute of Mental Disease Waiver workgroup and contingent on the availability of funds, HCA will engage a contractor to:
  - Specify requirements and design open source FHIR-Based APIs that could be implemented using certified electronic health records for the exchange intake, screening, and assessment tools; and

	○ Support pilots that include mental health providers using the FHIR-Based APIs to support the creation and exchange of intake, screening, and assessment tools. The HCA health information technology section will lead this work. • Contingent on the availability of funds, a contract for this scope of work will be awarded in March 2021 and work will be complete in December 2021. • The HCA health information technology section will present the scope of work, progress reports, and recommendations to the HCA Medicaid Steering Committee and the Mental Health Institute of Mental Disease Waiver workgroup.
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	*Current State:* The 2020 Health IT Operational Plan includes the following task: Task 2.10: The State will complete the following: • HCA, Policy and the health information technology section will explore: ○ Medicaid Managed Care coverage and payment policies regarding telehealth. ○ Activities being undertaken by the University of Washington related to telehealth to identify whether there are gaps that need to be filled and options for addressing these gaps. HCA Clinical Quality and Care Transformation Clinical Policy staff will leverage and analyze information emerging via the following workgroups to help inform telehealth coverage policies to support access to high quality services: • National Academy for State Health Policy (NASHP) convened a Telehealth Affinity Group of policymakers and stakeholders to learn about the Patient Centered Outcomes Research Institute (PCORI)'s emerging telehealth research and explore associated policy challenges and solutions. • MED Telehealth workgroup (a forum for state agencies) to discuss telehealth issues facing Medicaid programs including coverage policies, utilization, expenditures, patient privacy and security, and patient outcomes. The workgroup also explores best practices and evidence related to telehealth and monitors emerging telehealth

	advancements that may be relevant to Medicaid agencies. • Identify, disseminate, and promote information on telehealth, including grant opportunities HCA Clinical Quality and Care Transformation is recruiting a Behavioral Health Telehealth Program Manager who will be responsible for: • Drafting policy guidance about the telehealth technology landscape with a focus on the needs of the behavioral healthcare system. • Reviewing best practice models of telehealth services related to behavioral health care within and outside of Washington State to evaluate effective methods of telehealth clinical consultation and evaluation. • Consulting with representatives from state agencies, payers, provider and other service organizations to identify opportunities and barriers to use, coverage, and payment of telehealth services on behalf of children and adults with behavioral health needs. • Exploring Medicaid managed care coverage and payment policies regarding telehealth. • Participating in the National Academy of State Health Policy and other similar telehealth workgroups. • Identifying, defining, and developing possible funding sources to support existing and planned telehealth initiatives. • Providing a road map for future planning for telehealth implementation within substance use disorder treatment and behavioral healthcare settings.
	Future State: By July 2021, HCA will: • Provide policy guidance about the use tele-behavioral health technology in Washington State. • Include in Managed Care Organization contract language examples of when tele-behavioral technologies could be used to support the integration of physical and mental health services.

	Summary of Actions Needed: Beginning in April 2020, the HCA Clinical Quality and Care Transformation Behavioral Health Telehealth Program Manager will lead, in collaboration with other HCA Sections (e.g., health information technology, Medicaid Program Operations and Integrity), the development of a tele-behavioral health landscape assessment. By December 2020, the HCA Clinical Quality and Care Transformation will draft policy guidance about the tele-behavioral health technology in Washington State. By April 2021, HCA will publicly disseminate policy guidance about the tele-behavioral health technology in Washington State. By January 2021, the HCA Clinical Quality and Care Transformation will submit draft Managed Care Organization contract language that includes examples of when tele-behavioral technologies could be used to support the integration of physical and mental health services. This language will be integrated into Managed Care Organization contract requirements effective July 1, 2021.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[5])	*Current State:* **Managed Care Organization Contract Provisions:** Include the several requirements related to supporting the continuity of care including as individuals transition between care settings, ensuring the delivery of needed services and referrals, addressing the needs for persons at risk of re-hospitalization, and provider responsibilities if the individual discontinues treatment. Some of these requirements are listed below: 14 Care Coordination 14.1 Continuity of Care The Contractor shall ensure Continuity of Care for Enrollees in an active course of treatment for a chronic or acute physical or behavioral health condition… The Contractor shall ensure medically necessary care for Enrollees is not interrupted and transitions from one setting or level of care to another are supported with a continuity of care period that is no less than ninety (90) days for all new Enrollees. 14.1.8 The Contractor shall provide for the smooth transition of care for Enrollees who lose Medicaid eligibility while hospitalized in behavioral health inpatient or residential treatment facilities or while incarcerated or in

	homeless shelters. The Contractor shall include protocols for coordination with the BH-ASO to facilitate referral for state funded or federal block grant services, when such funds are available, in order to maintain Continuity of Care. 14.6 Care Coordination Services (including): 14.6.6 The Care Coordinator is responsible for: 14.6.6.1 Conducting IHS [Initial Health Screen] or collecting IHS data from providers, to assess Enrollees for unmet health care or social service needs; 14.6.6.2 Communicating utilization patterns to providers and ensuring action by the provider on under or over-utilization patterns requiring action; 14.6.6.3 Ensuring clinical and social service referrals are made to meet identified Enrollee health and community service needs; 14.6.6.4 Ensuring referrals are made and services are delivered, including any follow-up action; 14.6.6.6 Ensuring collaboration with the regional Behavioral Health Administrative Services Organization (BH-ASO), including developing processes to ensure an Enrollee is followed up with within seven (7) calendar days of when the Enrollee has received crisis services. Section. 14.17:Transitional Services 14.17.1 The Contractor shall ensure transitional services described in this Section are provided to all Enrollees who are transferring from one care setting to another or one level of care to another. 14.17.3.1 Development of an individual Enrollee plan to mitigate the risk for re-institutionalization, re-hospitalization or treatment recidivism to include: 14.17.3.1.1 Information that supports discharge care needs, Medication Management, interventions to ensure follow-up appointments are attended, and follow-up for self-management of the Enrollee's chronic or acute conditions, including information on when to seek medical care and emergency care. Formal or informal caregivers shall be included in this process when requested by the Enrollee; 14.17.3.1.2 A written discharge plan, including scheduled follow-up appointments, provided to the Enrollee and all treating providers; 14.17.3.1.3 Systematic follow-up protocol to ensure timely access to follow-up care post discharge and to identify and re-engage Enrollees who do not receive post discharge care; 14.17.3.1.4 Organized post-discharge services, such as home care services, after-treatment services, and occupational and physical therapy services; 14.17.3.1.5 Telephonic reinforcement of the discharge plan and problem-solving two (2) to three (3) business days following Enrollee discharge; 14.17.3.1.6 Information on what to do if a problem arises following discharge;

	14.17.3.1.7 For Enrollees at high risk of re-hospitalization, a visit by the PCP or Care Coordinator at the Facility before discharge to coordinate transition; 14.17.3.1.9 For Enrollees at high risk of re-hospitalization, the Contractor shall ensure the Enrollee has an in- person assessment by the Enrollee's PCP or Care Coordinator for post-discharge support within seven (7) calendar days of hospital discharge. The assessment must include follow-up of: discharge instructions, assessment of environmental safety issues, medication reconciliation, an assessment of support network adequacy and services, and linkage of the Enrollee to appropriate referrals; 14.17.3.1.10 Scheduled outpatient Behavioral Health and/or primary care visits within seven (7) calendar days of discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of discharge; 14.17.3.1.11 Follow-up to ensure the Enrollee saw his/her provider; and 14.17.3.1.12 Planning that actively includes the patient and family caregivers and support network in assessing needs. 14.17.5.3 If the Enrollee discontinues services, the Subcontractor will document as such and attempt to facilitate transition back into the community. 14.17.5.4 If a behavioral health treatment agency discontinues treatment of an Enrollee, the agency must meet all discharge requirements noted in subsections 14.17.5.2 and 14.17.5 above. In addition, MCO contract provisions include the several requirements related to the development and use of Population Health Management Plans and Interventions. 14.2 Population Health Management: Plan The Contractor shall develop a plan to address Enrollee needs across the continuum of care, and ensure services are coordinated for all Enrollees. The plan shall be reviewed by HCA during the annual monitoring review. The Population Health Management plan shall include at a minimum the following focus areas: 14.2.1 Keeping Enrollees healthy; 14.2.2 Managing Enrollees with emerging risk; 14.2.3 Enrollee safety and outcomes across settings; 14.2.4 Managing multiple chronic conditions; and 14.2.5 Managing individuals with multiple service providers (e.g., physical health and behavioral health). The Contractor's Population Health Management plan shall establish methods to identify targeted populations for each focus area and include interventions that meet the requirements of NCQA and the subsections below. The Contractor's Population Health Management plan shall take into account available and needed: (i) data and

	analytic infrastructure, (ii) HIT and HIE infrastructure and tool, and (iii) other resources needed to support population health management activities. 14.3 Population Health Management: Identification and Triage 14.3.6 The Contractor will risk stratify the population to determine the level of intervention enrollees require. 14.4 Population Health Management: Interventions 14.4.1 The Contractor shall work with providers to achieve population health management goals, and shall provide PCPs with clinical information about their patients to improve their care. 14.4.1.1 The Contractor shall make clinical decision support tools available to providers for use at the point of care that follow evidence-based guidelines for: 14.4.1.1.1 Behavioral health conditions. 14.4.1.1.2 Chronic medical conditions. 14.4.1.1.3 Acute conditions. 14.4.1.1.4 Unhealthy behaviors. 14.4.1.1.5 Wellness. 14.4.1.1.6 Overuse/appropriateness issues.
	Future State: MCO contract language will be refined to enhance the identification of and interventions for persons at risk of discontinuing treatment. Contingent on the availability of funds, a closed loop referral tool will be available for piloting by mental health providers. (See Section #1.)

	Summary of Actions Needed: HCA/DBHR staff will lead a workgroup to identify methods to reduce the risk of patients discontinuing/stopping treatment. The workgroup will include HCA staff (i.e., staff from HCA Clinical Quality and Care Transformation (including clinical; analytics research and measurement; and health information technology, and Medicaid Program Operations and Integrity staff). The workgroup will: • Take into account the written documents and closed loop referral tool developed under Section 1 (Closed Loop Referrals and e-Referrals). • Consider whether and if so, how Managed Care Organization Population Health Management Plans, identification, and interventions could be enhanced to identify and intervene on behalf of individuals at risk discontinuing/stopping treatment. Consider other needed enhancements to Managed Care Organization contract language to better identify patients at risk for discontinuing or stopping treatment, and intervene on behalf of these individuals (including notifying their care teams to ensure continuation or resumption of treatment). The workgroup will convene beginning in September 2020, develop a charter describing the scope and focus of its activities, and develop recommendations to enhance the identification of and interventions for persons at risk of discontinuing treatment. The workgroup will present its charter, progress reports, and recommendations to the: • HCA/DBHR leadership; • HCA Medicaid Steering Committee; and; • Mental Health Institute of Mental Disease Waiver Workgroup. • Enhancements to Managed Care Organizations contract language will be advanced in January and September 2021.

[5] Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	*Current State:* **Evidence-based Specialty Care Programs: Early Identification and Intervention for Individuals Experiencing Psychosis:** The state recently increased funding to develop a statewide plan to implement evidence-based specialty care programs that provide early identification and intervention for individuals experiencing psychosis. This includes funding to increase the number of teams providing these services from five to ten by October 1, 2020. **New Journeys:** New Journeys is a collaborative effort of HCA (The State Medicaid Agency and Mental Health Authority), the University of Washington, and Washington State University. New Journeys is a program focusing on first episode psychosis. **The 2020 Health IT Operational Plan requires that the State complete the following:** • The health information technology section, Policy, and Medicaid Program Operations and Integrity will collaborate to identify health IT/health information exchange tools that could support care coordination workflow of HCA, payers, and providers and options for developing needed tools; and • The health information technology section and DBHR will identify the providers involved in caring for persons experiencing their first episode of psychosis, the workflow involved, and the technical tools needed to support care coordination on behalf of these individuals.
	Future State: Contingent on the availability of funds, mental health providers providing services to persons experiencing their first episode of psychosis will pilot health IT tools that support: • Interoperable intake, screenings, and assessments; • Electronic and interoperable care plans; and • E-closed loop referrals. See Sections 1, 2, and 4 above.

	Summary of Actions Needed: *See Sections 1, 2, and 4 above.* HCA staff (DBHR, health information technology section, Policy, and Medicaid Program Operations and Integrity) and staff from the University of Washington and Washington State University will collaborate to identify any additional health IT/health information exchange tools that could support caring for and care coordination on behalf of persons experiencing their first episode of psychosis. DBHR staff will take the lead in initiating these conversations, no later than September 2020. If additional health IT tools are identified as needed, in January 2021, HCA/DBHR will present recommendations to: • DBHR leadership; • HCA Medicaid Steering Committee; and • Mental Health Institute of Mental Disease Waiver Workgroup.
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	*Current State:* Currently, the state is in the planning phase to create a multi-agency master person index that will facilitate identity management across multiple agencies and programs. The state's health and human service agencies (Department of Health, Department of Social and Health Services, Health Care Authority, Department of Children, Youth and Families and the Health Benefit Exchange) are partnering to pursue this effort. We are currently in the planning phase and are working to develop a proof of concept and a roadmap for implementation

	Future State: Contingent on funding, technical solutions to match a child's electronic medical records to a parent's electronic medical records, the use of an agency master person index, and implementation of needed data governance policies; the state envisions a future where a child's and parent's electronic medical records could be linked to provide safe and efficient care.
	Summary of Actions Needed: The following high-level deliverables will be needed to achieve the stated goal of tag or linking a child's medical records with their respective parent/caretaker's medical record: • Issue a request for proposal for master person index expert consultants to develop a roadmap. • Develop implementation roadmap. • Identify funding sources for implementation. • Establish system and data governance processes. • If necessary, procure tools to implement the identified solution. • Implement the identified solution per the guidance of the master person index roadmap. • Connect electronic health record or other health information technology to the master person index via FHIR transactions.
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	*Current State:* The state continues to support and expand the use of and content in the statewide clinical data repository. The state is exploring the feasibility of a statewide electronic health record/rural HER particularly for providers that do not have/use certified electronic health records (e.g., behavioral health providers). As described above, contingent on funding, the state is supporting enhancements to its Health IT information infrastructure that will support the capture of additional clinical information and work to develop and use a master person index.

	Future State: Contingent on funding, the state envisions a future where information across all episodes of care is linked to the correct patient and available when and where needed to support and improve service delivery at the point of care.
	Summary of Actions Needed: See actions needed described above.

Section 3: Relevant documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.

HCA 2020 Health IT Operational Plan: https://www.hca.wa.gov/about-hca/health-information-technology/washington-state-medicaid-hit-plan (Click on the 2020 Operational Plan.)

Draft 2020 Behavioral Health Provider Survey (BHPS) questionnaire
"Sharing Substance Use Disorder Information: A Guide for Washington State"
https://www.hca.wa.gov/assets/billers-and-providers/60-0015-sharing-substance-use-disorder-information-guide.pdf

Attachment O: SMI Monitoring Protocol

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - Planned metrics (Version 2.0)
State: Washington
Demonstration Name: Washington State Medicaid Transformation Project (MTP) Demonstration

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Planned Metrics

Standard information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Milestone or reporting metric	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority by State	State will report (Y/N)	Baseline Reporting Period (MM/DD/YYYY – MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data source, definition, codes, target population, etc.)	State plans to phase in reporting (Y/N)	Reporting which metric will be phased in (Format SMI/SED DYQ, Eg. DY1Q1)	Explanation of any plans to phase in reporting over time
1	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings (SUB-2)	Two rates will be reported for this measure: 1. SUB-2: Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. 2. SUB-2a: Patients who received the brief intervention during the hospital stay.	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Medical record review or claims	Year	Annually	Recommended	N								
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
3	All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20)	Number of all-cause ED visits per 1,000 beneficiary months among adult Medicaid beneficiaries age 18 and older who meet the eligibility criteria of beneficiaries with SMI.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Decrease	Decrease	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (PPT)	The rate of unplanned, 30-day, readmission for demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The measurement period used to identify cases in the measure population is 12 months from January 1 through December 31.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Decrease	Decrease	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
5	Medication Reconciliation Upon Admission	Percentage of patients for whom a designated prior to admission (PTA) medication list was generated by referencing one or more external sources of PTA medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Electronic/paper medical records	Year	Annually	Recommended	N								
6	Medication Continuation Following Inpatient Psychiatric Discharge	This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2019 - 12/31/2020	Increase	Increase	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
7	Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)	Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: •Percentage of discharges for which the child received follow-up within 30 days after discharge •Percentage of discharges for which the child received follow-up within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
8	Follow-up After Hospitalization for Mental Illness: Age 18 and older (FUH-AD)	Percentage of discharges for beneficiaries age 18 years and older who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm and who had a follow-up visit with a mental health practitioner. Two rates are reported: •Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge •Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of alcohol or other drug (AOD) abuse dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: •Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit •Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
10	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: •Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
11	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (count)	Number of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health.	Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended	N								
12	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (rate)	Rate of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health.	Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended	N								
13	Mental Health Services Utilization – Inpatient	Number of beneficiaries in the demonstration population who use inpatient services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Consistent	Consistent	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
14	Mental Health Services Utilization – Intensive Outpatient and Partial Hospitalization	Number of beneficiaries in the demonstration population who used intensive outpatient and/or partial hospitalization services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
15	Mental Health Services Utilization – Outpatient	Number of beneficiaries in the demonstration population who used outpatient services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
16	Mental Health Services Utilization – ED	Number of beneficiaries in the demonstration population who use emergency department services for mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Decrease	Decrease	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
17	Mental Health Services Utilization – Telehealth	Number of beneficiaries in the demonstration population who used telehealth services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
18	Mental Health Services Utilization – Any Services	Number of beneficiaries in the demonstration population who used any services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
19a	Average Length of Stay in IMDs	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD. Three rates are reported: •ALOS for all IMDs and populations •ALOS among short-term stays (less than or equal to 60 days) •ALOS among long-term stays (greater than 60 days)	Milestone 3	CMS-constructed	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Stabilize at no more than	Stabilize at no more than	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
19b	Average Length of Stay in IMDs (IMDs receiving FFP only)	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD receiving federal financial participation (FFP). Three rates are reported: •ALOS for all IMDs and populations •ALOS among short-term stays (less than or equal to 60 days) •ALOS among long-term stays (greater than 60 days)	Milestone 3	CMS-constructed	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Stabilize at no more than	Stabilize at no more than	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
20	Beneficiaries With SMI/SED Treated in an IMD for Mental Health	Number of beneficiaries in the demonstration population who have a claim for inpatient or residential treatment for mental health in an IMD during the reporting year.	Milestone 3	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Consistent	Consistent	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
21	Count of Beneficiaries With SMI/SED (monthly)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 11 months before the measurement period.	Milestone 4	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
22	Count of Beneficiaries With SMI/SED (annually)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 12 months before the measurement period.	Milestone 4	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
23	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9%) (HPC-M-AD)	Percentage of beneficiaries age 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) whose most recent Hemoglobin A1c (HbA1c) level during the measurement year is >9.0%.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Decrease	Decrease	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
24	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, AND if positive, a follow-up plan is documented on the date of the positive screen.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Recommended	N								
25	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)	Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, AND if positive, a follow-up plan is documented on the date of the positive screen.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Electronic medical records	Year	Annually	Recommended	N								
26	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	The percentage of Medicaid beneficiaries age 18 years or older with SMI who had an ambulatory or preventive care visit during the measurement period.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
27	Tobacco Use Screening and Follow-up for People with SMI or Alcohol or Other Drug Dependence	The percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Two rates are reported: •Percentage of adults with SMI who received a screening for tobacco use and follow-up for those identified as a current tobacco user •Percentage of adults with AOD who received a screening for tobacco use and follow-up for those identified as a current tobacco user	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Recommended	N								
28	Alcohol Screening and Follow-up for People with SMI	The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Recommended	N								
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics	The percentage of children and adolescents ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: •Percentage of children and adolescents on antipsychotics who received blood glucose testing •Percentage of children and adolescents on antipsychotics who received cholesterol testing •Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Percentage of Medicaid beneficiaries age 18 years and older with new antipsychotic prescriptions who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
32	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	The sum of all Medicaid spending for mental health services not in inpatient or residential settings during the measurement period.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Consistent	Consistent	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
33	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	The sum of all Medicaid costs for mental health services in inpatient or residential settings during the measurement period.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Consistent	Consistent	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
34	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	Per capita costs for non-inpatient, non-residential services for mental health, among beneficiaries in the demonstration population during the measurement period.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Consistent	Consistent	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
35	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	Per capita costs for inpatient or residential services for mental health among beneficiaries in the demonstration population during the measurement period.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Consistent	Consistent	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Milestone or reporting basic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline Reporting Period (MM/DD/YYYY--MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data source, definition, codes, target association, etc.)	State plans to phase in reporting (Y/N)	Report in which metric will be phased in (Format SMI/SED DY0; Ex. DY1Q1)	Explanation of any plans to phase in reporting over time
36	Grievances Related to Services for SMI/SED	Number of grievances filed during the measurement period that are related to services for SMI/SED.	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Consistent	Consistent	N	See Attachment A for requested deviations.	Y	DY1 Q3	See Attachment A for requested reporting schedule.
37	Appeals Related to Services for SMI/SED	Number of appeals filed during the measurement period that are related to services for SMI/SED.	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Consistent	Consistent	N	See Attachment A for requested deviations.	Y	DY1 Q3	See Attachment A for requested reporting schedule.
38	Critical Incidents Related to Services for SMI/SED	Number of critical incidents filed during the measurement period that are related to services for SMI/SED.	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	01/01/2020 - 12/31/2020	Consistent	Consistent	N	See Attachment A for requested deviations.	Y	DY1 Q3	See Attachment A for requested reporting schedule.
39	Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Total Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Consistent	Consistent	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
40	Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Per capita Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Consistent	Consistent	Y		Y	DY1 Q3	See Attachment A for requested reporting schedule.
Q1	*Community Base d Psychiatric Hospitals Using HIT for Discharge Summaries*	The percentage of community-based psychiatric hospitals that use Collective Medical (CM)	Health IT	State-specific	*Other annual metrics*	Survey	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase			Y	DY1 Q3	See Attachment A for requested reporting schedule.
Q2	*Mental Health Treatment Penetration Rate*	The percentage of Medicaid beneficiaries, 6 years of age and older, with a mental health se	Health IT	State-specific	*Other annual metrics*	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase			Y	DY1 Q3	See Attachment A for requested reporting schedule.
Q3	*Foundational Community Supports for Beneficiaries with Inpatient or Residential Mental Health Services*	Percent of Foundational Community Supports (FCS) eligible Medicaid beneficiaries, age 18	Health IT	State-specific	*Other annual metrics*	Claims	Year	Annually	Required	Y	01/01/2020 - 12/31/2020	Increase	Increase			Y	DY1 Q3	See Attachment A for requested reporting schedule.
State-specific metrics																		
Add rows for any additional state-specific metrics																		

State	*Washington*
Demonstration Name	*Washington State Medicaid Transformation Project (MTP) Demonstration*

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Definitions

Narrative description of the SMI/SED demonstration population

See Attachment A

	Serious Mental Illness (SMI)	Serious Emotional Disturbance (SED)
Narrative description of how the state defines the population for purposes of monitoring (including age range, diagnosis groups, and associated service use requirements)	*See Attachment A*	*See Attachment A*
Codes used to identify population[b] *States may use ICD-10 diagnosis codes or state-specific treatment, diagnosis, or other types of codes to identify the population. When applicable, states should supplement ICD-10 codes with state-specific codes.*	*See Attachment A*	*See Attachment A*
Procedure (e.g., CPT, HCPCS) or revenue codes used to identify/define service requirements[b] *If the state is not using procedure or revenue codes, the state should include the data source(s) (e.g., state-specific codes) used to identify/define service requirements.*	*Per agreement with CMS, state definition of SMI/SED is still under development.*	*Per agreement with CMS, state definition of SMI/SED is still under development.*

[a]The examples are based on a definition of SMI from the National Committee for Quality Assurance (NCQA). The examples provided are intended to be illustrative only. The example codes provided are not comprehensive.
[b]States may choose to include codes as separate tabs in this workbook.

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - Planned subpopulations (Version 2.0)
State *Washington*
Demonstration Name *Washington State Medicaid Transformation Project (MTP) Demonstration*

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Planned Subpopulations

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	If the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format: comma separated)	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format: metric number, comma separated)
EXAMPLE: *Age group* *(Do not delete or edit this row)*	*EXAMPLE:* *Children (Age<16), Transition-age youth (Age 16-24), Adults (Age 25–64), Older adults (Age 65+)*	*EXAMPLE:* *Required*	*EXAMPLE:* *Metrics #1 1, 1 2, #13, 14, 15, 16, 17, 18, 21, 22*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *N*	*EXAMPLE:* *Children/Young adults (ages 12-21), Adults (ages 21-65)*	*EXAMPLE:* *Y*	*EXAMPLE:*
Standardized definition of SMI	Individuals who meet the standardized definition of SMI	Required	Metrics #1 3, 1 4, 15, 16, 17, 18, 21, 22	CMS-provided	Y			Y	
State-specific definition of SMI	Individuals who meet the state-specific definition of SMI	Required	Metrics #1 3, 1 4, 15, 16, 17, 18, 21, 22	State-specific	Y			Y	
Age group	Children (Age<16), Transition-age youth (Age 16-24), Adults (Age 25–64), Older adults (Age 65+)	Required	Metrics #1 1, 1 2, 13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y		Y	
Dual–eligible status	Dual-eligible (Medicare-Medicaid eligible), Medicaid only	Required	Metrics #1 3, 1 4, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y		Y	
Disability	Eligible for Medicaid on the basis of disability, Not eligible for Medicaid on the basis of disability	Recommended	Metrics #1 3, 1 4, 15, 16, 17, 18, 21, 22	CMS-provided	N				
Criminal justice status	Criminally involved, Not criminally involved	Recommended	Metrics #1 3, 1 4, 15, 16, 17, 18, 21, 22	CMS-provided	N				
Co-occurring SUD	Individuals with co-occurring SUD	Recommended	Metrics #1 3, 1 4, 15, 16, 17, 18, 21, 22	CMS-provided	N				
Co-occurring physical health conditions	Individuals with co-occurring physical health conditions	Recommended	Metrics #1 3, 1 4, 15, 16, 17, 18, 21, 22	CMS-provided	N				
(Insert row(s) for any state-specific subpopulation(s))									

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Reporting Schedule

Instructions:

(1) In the reporting periods input table (Table 1), use the prompt in column A to enter the requested information in the corresponding row of column B. All report
(2) Review the state's reporting schedule in the SMI/SED demonstration reporting schedule table (Table 2). For each of the reporting categories listed in column E,

Table 1. Reporting Periods Input Table

	Demonstration reporting periods/dates
Dates of first SMI/SED reporting quarter:	
(Format SMI/SED DYQ; Ex. DY1Q1)	DY1Q1
Start date (MM/DD/YYYY)[a]	01/01/2021
End date (MM/DD/YYYY)	03/01/2021
Broader section 1115 demonstration reporting period corresponding with the first SMI/SED reporting quarter, if applicable. If there is no broader demonstration, fill in the first SMI/SED reporting period. (Format DYQ; Ex. DY3Q1)	DY5Q1
First SMI/SED report due date (per STCs) (MM/DD/YYYY)	06/02/2021
First SMI/SED report in which the state plans to report annual metrics that are established quality measures (EQMs):	
Baseline period for EQMs (Format CY; Ex. CY2019)	CY2020
associated with report (Format SMI/SED DYQ; Ex. DY1Q1)	DY2Q2
Start date (MM/DD/YYYY)	04/01/2022
End date (MM/DD/YYYY)	06/30/2022
Dates of last SMI/SED reporting quarter:	
Start date (MM/DD/YYYY)	10/01/2022
End date (MM/DD/YYYY)	12/31/2022

Table 2. SMI/SED Demonstration Reporting Schedule

Dates of SMI/SED reporting quarter (MM/DD/YYYY - MM/DD/YYYY) Start date	End date	Report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DYQ; Ex. DY1Q3)[b] SMI/SED	Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column G="Y")	Proposed deviations from standard reporting schedule (Format DYQ; Ex. DY1Q3)
01/01/2021	03/01/2021	06/02/2021	DY5Q1	Narrative information	DY1Q1	N		
				Grievances and appeals	DY1Q1	Y	See Attachment A	None
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
04/01/2021	06/30/2021	08/29/2021	DY5Q2	Narrative information	DY1Q2	N		
				Grievances and appeals	DY1Q2	Y	See Attachment A	None
				Other monthly and quarterly metrics	DY1Q1	Y	See Attachment A	None
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
07/01/2021	09/30/2021	11/29/2021	DY5Q3	Narrative information	DY1Q3	N		
				Grievances and appeals	DY1Q3	Y	See Attachment A Will report from January 2020 - March 2021	DY1Q1
				Other monthly and quarterly metrics	DY1Q2	Y	See Attachment A Will report from January 2020 - March 2021	DY1Q1
				Annual availability assessment				
				Annual metrics that are established quality measures		Y	Will report baseline annual metrics (January - December 2020) with this report)	CY2020
				Other annual metrics		Y	Will report baseline annual metrics (January - December 2020) with this report)	
10/01/2021	12/31/2021	03/01/2022	DY5Q4	Narrative information	DY1Q4	N		
				Grievances and appeals	DY1Q4	Y	See Attachment A	DY1Q2
				Other monthly and quarterly metrics	DY1Q3	Y	See Attachment A	DY1Q2
				Annual availability assessment	AA1			
				Annual metrics that are established quality measures				
				Other annual metrics				
01/01/2022	03/31/2022	06/29/2022	DY6Q1	Narrative information	DY2Q1	N		
				Grievances and appeals	DY2Q1	Y	See Attachment A	DY1Q3
				Other monthly and quarterly metrics	DY1Q4	Y	See Attachment A	DY1Q3
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics	DY1	Y	State proposed reporting other annual metrics for the measurement period of Oct 2020 – Sept 2021	
04/01/2022	06/30/2022	08/29/2022	DY6Q2	Narrative information	DY2Q2	N		
				Grievances and appeals	DY2Q2	Y	See Attachment A	DY1Q4
				Other monthly and quarterly metrics	DY2Q1	Y	See Attachment A	DY1Q4
				Annual availability assessment				
				Annual metrics that are established quality measures	CY2021	N		
				Other annual metrics				
07/01/2022	09/30/2022	11/29/2022	DY6Q3	Narrative information	DY2Q3	N		
				Grievances and appeals	DY2Q3	Y	See Attachment A	DY2Q1
				Other monthly and quarterly metrics	DY2Q2	Y	See Attachment A	DY2Q1
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
10/01/2022	12/31/2022	03/01/2023	DY6Q4	Narrative information	DY2Q4	N		
				Grievances and appeals	DY2Q4	Y	See Attachment A	DY2Q2
				Other monthly and quarterly metrics	DY2Q3	Y	See Attachment A	DY2Q2
				Annual availability assessment	AA2			
				Annual metrics that are established quality measures				
				Other annual metrics				
				Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				

01/01/2023	03/31/2023	06/29/2023	DY7Q1	Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
04/01/2023	06/30/2023	08/29/2023	DY7Q2	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
07/01/2023	09/30/2023	11/29/2023	DY7Q3	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
10/01/2023	12/31/2023	02/29/2024	DY7Q4	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
01/01/2024	03/31/2024	06/29/2024	DY8Q1	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
04/01/2024	06/30/2024	08/29/2024	DY8Q2	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
07/01/2024	09/30/2024	11/29/2024	DY8Q3	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
10/01/2024	12/31/2024	03/01/2025	DY8Q4	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
01/01/2025	03/31/2025	06/29/2025	DY9Q1	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
04/01/2025	06/30/2025	08/29/2025	DY9Q2	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
07/01/2025	09/30/2025	11/29/2025	DY9Q3	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				
10/01/2025	12/31/2025	03/01/2026	DY9Q4	Narrative information				
				Grievances and appeals				
				Other monthly and quarterly metrics				
				Annual availability assessment				
				Annual metrics that are established quality measures				
				Other annual metrics				

Add rows for all additional demonstration reporting quarters

Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations
Monitoring Protocol Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's serious mental illness and serious emotional disturbance (SMI/SED) demonstration or the SMI/SED component of the broader demonstration

The state should complete this title page as part of its SMI/SED monitoring protocol. This form should be submitted as the title page for all monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are below the table.

State	*Washington State.*
Demonstration name	*Washington State Medicaid Transformation Project No. 11-W-00304/0*
Approval period for section 1115 demonstration	*January 9, 2017-December 31, 2021).*
SMI/SED demonstration start date[a]	*Enter the start date for the section 1115 SMI/SED demonstration or SMI/SED component if part of a broader demonstration (11/06/2020).*
Implementation date of SMI/SED demonstration, if different from SMI/SED demonstration start date[b]	*01/01/2021.*
SMI/SED (or if broader demonstration, then SMI/SED - related) demonstration goals and objectives	*The intent of this demonstration is to support systemic changes to improve the lives of Washington Medicaid enrollees with SMI/SED service needs by: improving access, quality, oversight, crisis services and service coordination consistent milestones of the November 13th, 2018 SMDL letter*

[a] **SMI/SED demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SMI/SED demonstration approval. For example, if the state's STCs at the time of SMI/SED demonstration approval note that the SMI/SED demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SMI/SED demonstration. Note that the effective date is considered to be the first day the state may begin its SMI/SED demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on 12/15/2020, with an effective date of 1/1/2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SMI/SED demonstration:** The date the state began claiming federal financial participation for services provided to individuals in institutions of mental disease.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in the Monitoring Report Template provided by CMS and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested narrative information (with no modifications).

3. Annual Assessment of the Availability of Mental Health Services reporting

☒ The state will use data as of the following month and day of each calendar year to conduct its Annual Assessment of the Availability of Mental Health Services:

December 31

4. Acknowledgement of budget neutrality reporting requirements

☒ The state has reviewed the Budget Neutrality Workbook provided by the CMS demonstration team and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (with no modifications).

5. Retrospective reporting

The state is not expected to submit metrics data until after monitoring protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to monitoring protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

For a state that has monitoring protocols approved after one or more initial quarterly monitoring report submissions, it should report metrics data to CMS retrospectively for any prior quarters of the section 1115 SMI/SED demonstration that precede the monitoring protocol approval date. A state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data—in its second monitoring report submission that contains metrics. The retrospective report for a state with a first SMI/SED DY of less than 12 months should include data for any baseline period quarters preceding the demonstration, as described in Part A of the state's monitoring protocol (see Appendix B of the instructions for further guidance determining baseline periods for first SMI/SED DYs that are less than 12 months). If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its SMI/SED demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this information in Part B of its report submission (Section 3. Narrative information on implementation, by milestone and reporting topic). This general assessment is not intended to be a comprehensive description of every trend observed in metrics data. Unlike other

monitoring report submissions, for instance, the state is not required to describe all metrics changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for the state to provide context for its retrospective metrics data, to support CMS's review and interpretation of these data. For example, consider a state that submits data showing an increase in the utilization of telehealth services for mental health (Metric #15) over the course of the retrospective reporting period. The state may decide to highlight this trend to CMS in Part B of its monitoring report (under Milestone 3) by briefly summarizing the trend and providing context that during this period, the state implemented a grant to improve access to mental health treatment in rural areas through the use of telemedicine.

For further information on how to compile and submit a retrospective report, the state should review Section B of the Monitoring Report Instructions document.

☒ The state will report retrospectively for any quarters prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after monitoring protocol approval.

☐ The state proposes an alternative plan to report retrospectively for any quarters prior to monitoring protocol approval: *Insert narrative description of proposed changes to retrospective reporting. The state should provide justification for its proposed alternative plan.*

Attachment A: Monitoring Metric Supplemental Information

Medicaid Section 1115 SMI/SED Demonstration Monitoring Protocol – Additional Information to Support Monitoring Metric Specifications

Submitted March 1, 2022

Background and Introduction

The State will be leveraging multiple analytic teams to produce the required metric reporting. These analytic teams include the Health Care Authority's Analytics, Research, and Measurement team, the Health Care Authority's Finance and Medicaid Program Office of Integrity, and the Department of Social and Health Services Research and Data Analysis Division. Between the analytic teams, the State has an extensive existing data infrastructure that the State intends to leverage for the CMS reporting requirements. This existing infrastructure currently completes reporting for various entities, including the Adult and Child Common Measure Set and mental health related Substance Abuse Mental Health Services Administration (SAMHSA) reporting. This analytic infrastructure also supports a number of ongoing activities in the realm of health care transformation. These include, but are not limited to, Washington's movement towards the integration of behavioral and physical health care and all three initiatives of the initial Medicaid Transformation Project (Transformation through Accountable Communities of Health, Long-Term Services and Supports of the Aging Population, and Foundational Community Support Services).

The State analytic teams have reviewed the CMS provided specifications and reporting procedures. Per the instructions in the Monitoring Protocol, the State will explain any deviations from the CMS-provided specifications that are needed to match the health care context and data infrastructure within Washington State. The State created this attachment to minimize duplication of explanation of requested modifications which apply to multiple metrics, and to provide details on state-specified metrics that would not fit within the given metric workbook template.

The State thanks CMS for the opportunity to align the specifications with the State's health care context, data infrastructure, and existing 1115(a) demonstration. We welcome any questions or concerns from CMS regarding these requests.

Overview of 1115 SMI Demonstration Monitoring Metrics

This section describes the data sources the State will be drawing on, how the State will align the Serious Mental Illness (SMI) measurement periods with the State's broader 1115(a) demonstration reporting cycle, and will note the reporting level for all metrics.

Description of Data Sources

Integrated Client Databases and ProviderOne (MMIS). SMI demonstration monitoring metric production will leverage the integrated administrative data maintained in the Department of Social and Health Services Integrated Client Databases (ICDB) and ProviderOne (the state's Medicaid Management Information System). The ICDB was explicitly designed to support quasi-experimental evaluation of health and social service interventions in Washington State, and has been widely used in evaluation

studies published in peer-reviewed journals[1] and for the production of performance and monitoring measures. The underlying reporting arrays are regularly updated to align with State requirements. The State has analyzed completion factors based on the historical encounter data submitted to the State's MMIS by contracted MCOs responsible for SMI services. This completion factor analysis indicates that fewer than 90% of ultimately accepted encounters are uploaded and successfully accepted into the MMIS by five months from the month the service was provided to the client. Reporting with a 90-day lag would result in an even greater systematic undercount of services provided in the most recent reporting period. The State believes that reporting information that is known to be undercounted will negatively impact the IMD waiver program. The State requests a 6-month reporting lag to allow for reporting of information that is more complete. Even with the proposed 6-month reporting lag, we recommend provisions for updating information previously reported with more complete data when it becomes available.

The State also requests the ability to calculate the monthly metrics once per quarter. Per CMS' technical assistance document Reporting 1115 SMI Demonstration Monitoring Metrics "…if a state submits data on a quarterly basis, the submission should contain three monthly values for each monthly metric, each produced at the same time relative to their measurement periods." However, the underlying production schedule for the State's analytic environment is quarterly. The State is unable to change the global production cycle and fundamental infrastructure to accommodate this monitoring expectation. In addition, some of the data necessary for the monthly metrics is updated quarterly and would not be up to date for two months of each quarter. The State understands that part of CMS' reasoning for producing the monthly metrics at the same time relative to their measurement periods is due to the dynamic nature of Medicaid data. Observing a 6-month reporting lag mitigates this impact.

Measurement Period

Per CMS's instructions and in alignment with the Special Terms and Conditions (Schedule of State Deliverables for the Demonstration Period (XV), Washington will align the reporting cycles for the SMI Demonstration Amendment with the broader section 1115(a) demonstration quarterly and annual reporting cycles. Table 1 shows the current reporting cycle to the broader section 1115(a) demonstration.

Aligning to this reporting cycle will require a modification to the measurement periods in the technical specification document. The effective date of the Washington SMI demonstration is December 23, 2020. However, to align with this reporting structure, we will use January 1, 2021 as the start date for the measurement periods. This does not change the effective date of the demonstration. Washington is in favor of this modification, as it closely aligns with our current data infrastructure and reporting processes. For example, Medicaid enrollment is verified monthly in Washington, and thus all eligibility requirements will need to be based around calendar months. It would be impracticable for the State to make the substantial modifications to our current infrastructure that would be required to report on a different quarterly cycle.

[1] For a recent example, see Jingping Xing, Candace Goehring and David Mancuso. Care Coordination Program For Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs Care Coordination Program For Washington State. Health Affairs, 34, no.4 (2015):653-661.

TABLE 1.
Washington's 1115(a) Waiver Quarterly and Annual Reporting Cycle

Quarter/Annual Report Cycle	MTP Reporting Period	Report Due Date
DY4 Q4 (Annual Report DY4)	Jan 2020 – Dec 2020	03/01/2021
DY5 Q1	Jan 2021 – March 2021	06/01/2021
DY5 Q2	April 2021 – June 2021	09/01/2021
DY5 Q3	July 2021 – Sept 2021	12/01/2021
Final Report	Jan 2021 – Dec 2021	06/30/2022
DY5 Q4 (Annual Report DY5)	Jan 2021 – Dec 2021	03/01/2021
DY6 Q1	Jan 2022 – March 2022	06/01/2022
DY6 Q2	April 2022 – June 2022	09/01/2022
DY6 Q3	July 2022 – Sept 2022	12/01/2022
Final Report*	Jan 2022 – Dec 2022	06/30/2022

*The State will be submitting an 1115 renewal request. Should the request be approved, the additional quarterly and annual reporting cycles will be added.

In addition, this also aligns with reporting cycles for other related SMI projects and the Washington State fiscal year. The modified measurement periods for the monthly, quarterly, and annual metrics are described next and in the table below.

- For metrics with a monthly measurement period, the first monthly measurement period is the month the SMI demonstration began – January 1, 2021 to January 31, 2021. The second month is February 1, 2021 to February 28, 2021, and so forth.
- For metrics with a quarterly measurement period, the first quarter of the demonstration is the first three months of the demonstration – January 1, 2021 to March 31, 2021.
- For the CMS-constructed metrics with an annual measurement period, the first annual measurement period is the first twelve months of the demonstration – January 1, 2021 to December 31, 2021.
- For the established quality measures, the first annual measurement period is the calendar year in which the demonstration began – January 1, 2021 to December 31, 2021.

As previously discussed with CMS and consistent with the monitoring protocol for the SUD IMD waiver, the State believes setting the baseline to the year prior to the change in authorizing expenditure authority is needed to appropriately set demonstration targets, annual goals, and to ultimately respond to the demonstration hypothesis specific to the SMI amendment (STC 118). Thus, the State requests to define the baseline year as January 1, 2020 to December 31, 2020 for the CMS-constructed metrics (monthly, quarterly, and annual) and January 1, 2020 to December 31, 2020 for the established quality measures.

The State will begin reporting after a monitoring protocol has been agreed upon by the State and CMS, and sufficient time is provided to implement the metric specifications as stated in the agreed upon monitoring protocol. The requested reporting schedule in Table 2 below may change depending on when the monitoring protocol is approved. The reporting schedule also specifies a baseline reporting period of January 1, 2020 to December 31, 2020 for CMS constructed metrics and January 1, 2020 to December 31, 2020 for established quality measures. In addition, Table 2 employs the 6-month reporting lag that is necessary for the State to submit data that does not substantially undercount the

number of services provide. The proposed reporting schedule also aligns with the SMI/SED Demonstration Reporting Schedule in the Monitoring Protocol Workbook.

TABLE 2.

Proposed Reporting Schedule for Washington Metrics for SMI Demonstration

Dates of reporting quarter	WA's SMI DY: Jan - Dec	WA's broader 1115 DY: Jan 1 – Dec 31 (type of report)	Report due (per STCs schedule)	SMI metrics included in report	Reporting period of SMI metrics
Oct – Dec 2020	*waiver approved 12/23/2020*	DY4 Q4 (annual)	3/1/2021	N/A	N/A
Jan – Mar 2021	DY1 Q1	DY5 Q1 (quarterly)	6/2/2021	No SMI metrics reported. Monitoring protocol under development.	N/A
Apr – Jun 2021	DY1 Q2	DY5 Q2 (quarterly)	9/1/2021	No SMI metrics reported. Monitoring protocol under development.	N/A
Jul – Sept 2021	DY1 Q3	DY5 Q3 (quarterly)	12/1/2021	No SMI metrics reported. Monitoring protocol under development.	N/A
Oct – Dec 2021	DY1 Q4	DY5 Q4 (annual)	3/1/2022	No SMI metrics reported. Monitoring protocol under development.	N/A
Jan – Mar 2022	DY2 Q1	DY6 Q1 (quarterly)	6/2/2022	(1) Monthly metrics (2) Quarterly metrics (3) Established quality metrics (4) Other annual metrics	(1) Jan 2020 – Sept 2021 (2) Jan 2020 – Sept 2021 (3) January – December 2020 (4) January – December 2020
Apr – Jun 2022	DY2 Q2	DY6 Q2 (quarterly)	9/1/2022	(1) Monthly metrics (2) Quarterly metrics (3) Established quality metrics (4) Other annual metrics	(1) October – December 2021 (2) October – December 2021 (3) January – December 2021 (4) January – December 2021
Jul – Sept 2022	DY2 Q3	DY6 Q3 (quarterly)	12/1/2022	(1) Monthly metrics (2) Quarterly metrics	(1) January – March 2022 (2) January – March 2022
Oct – Dec 2022*	DY2 Q4	DY6 Q4 (annual)	3/1/2023	(1) Monthly metrics (2) Quarterly metrics	(1) April – June 2022 (2) April – June 2022

** Currently the SMI Demonstration ends on December 31, 2022. Data from July 1, 2022 to December 31, 2022 will not be available before the final annual report is due to CMS.*

Reporting Level

For each metric, the demonstration population is defined as the whole state. In addition, the State's SMI amendment is not focused on a particular geographic area or a specific subpopulation of Medicaid beneficiaries. Thus, per previous conversations with CMS, the State will not be reporting a separate model population.

Reporting 1115 SMI Demonstration Monitoring Metrics Defined by CMS

This section defines the subpopulations for metric reporting and provides additional information about the State's approach to metric calculation and reporting.

Subpopulation Definitions

- Standardized definition of SMI: Per the 1115_SMI_TechSpecsManualV2.pdf, Table B.1 for applicable value sets and Appendix E: Standardized Definition of SMI, the standardized definition of SMI will align with the NCQA definition.

- Age (children <16, transition age youth 16-24, adults 25-64, and older adults 65+): Age will be determined as of the first day of the measurement period. This is consistent with CMS provided instructions. Age breakouts will be reported for the cohort of beneficiaries that meet the CMS definition of SMI.
- Dual-eligible status (Medicaid only or Medicare-Medicaid eligible): Dual eligibility will be determined as of the first day of the measurement period. This is consistent with CMS provided instructions. Dual-eligible status breakouts will be reported for the cohort of beneficiaries that meet the CMS definition of SMI.

- State-specific definition of SMI: Per agreement with CMS, the state-specific definition of SMI/SED is under development.

Metric Calculation and Reporting

As CMS noted, Medicaid data is dynamic prior to reaching a data maturity threshold. For Washington State, that threshold is six-months. Observing a six-month data lag allows the State to represent the most complete data set for the measurement period. Any data lag less than six-months will result in potentially incomplete data and misrepresentative metric results. In addition, the six-month data lag allows for the inclusion of up to date information from data sources that are updated on a quarterly cadence, such as the Washington State Identification System arrest database, which the State will be using to define the "criminally involved" subpopulation as noted above.

Using a six-month data lag also allows the State to leverage the existing quarterly performance measurement processes to calculate the required metrics. Thus, required monthly reporting will be calculated at the same time once per quarter. All the data will be, at a minimum, matured to six-months thus minimizing the likelihood of any variability due to data completeness. This is consistent with the CMS approved monitoring protocol for the state's SUD IMD waiver.

Metric Specifications

This section provides additional detail on a subset of metric specifications. Other metric specification modifications are noted in the Monitoring Protocol 1115 SMI Metrics Workbook.

Metric # 36: Grievances Related to Services for SMI/SED

The State is requesting two modifications to Metric #36 to reflect the state-level process of reviewing grievances and existing reporting infrastructure. This metric will be restricted to Medicaid beneficiaries who are enrolled with a Managed Care Organization and will exclude fee for service Medicaid beneficiaries. All mental health service related grievances (includes both outpatient and inpatient related grievances) will be included in the metric. The State does not differentiate between SMI/SED and non-SMI/SED related grievances.

Metric #37: Appeals Related to Services for SMI/SED

Consistent with Metric #36, the State is requesting two modifications to Metric #37 to reflect the state-level process of reviewing appeals and existing reporting infrastructure. This metric will be restricted to Medicaid beneficiaries who are enrolled with a Managed Care Organization and will exclude fee for service Medicaid beneficiaries. All mental health service related appeals (includes both outpatient and inpatient related appeals) will be included in the metric. The State does not differentiate between SMI/SED and non-SMI/SED related appeals.

Metric #38: Critical Incidents Related to Services for SMI/SED

Consistent with Metric #36 and Metric #37, the State is requesting two modifications to Metric #38 to reflect the state-level process of the critical incident reporting infrastructure. This metric will be restricted to Medicaid beneficiaries who are enrolled with a Managed Care Organization and will exclude fee for service Medicaid beneficiaries. All critical incidents for Medicaid beneficiaries with a recent history of mental health treatment will be included. The State does not differentiate between SMI/SED and non-SMI/SED mental health related critical incidents.

HIT Metric Specifications

Q1: Community Based Psychiatric Hospitals Using HIT for Discharge Summaries. After reviewing the list of sample metrics provided by CMS, the State is proposing a process metric that will identify the percent of Medicaid participating community based psychiatric hospitals with access to technology tools to create and send discharge summaries.

Metric Description: This metric will report the percentage of community-based psychiatric hospitals that use Collective Medical (CM) technology tools for the creation and exchange of interoperable discharge summaries on behalf of individuals being discharged from the psychiatric hospital/psychiatric unit to the community based providers (e.g., primary care providers). The discharge summary would be created and exchanged using the Admission, Discharge, and Transfers (ADT) standard.

Data Source: Annual survey of psychiatric hospitals/psychiatric units.

Identification Window: Measurement year (January 1 – December 31)

Denominator: Total number of community-based psychiatric hospitals/psychiatric units that participate in Medicaid.

Numerator: Number of community-based psychiatric hospitals/psychiatric units that participate in a Medicaid that uses the CM system to create and send ADTs to the receiving community-based providers.

Q2: Mental Health Treatment Penetration Rate. After reviewing the list of sample metrics provided by CMS, the State was concerned about the limitations and uncertainties in technology adoption by providers treating individuals with SMI/SED. Thus, the State is proposing a metric that relies on the use of electronic claims/encounter data to identify individuals with a mental health treatment need who received a qualifying mental health service. This also aligns with HIT metric #2 in the state's SUD IMD waiver monitoring protocol (SUD treatment penetration rate). This metric includes mental health treatment services that are delivered via telehealth and allows the state to track the overall treatment penetration rate across service modalities. The state expects that improvements to information technology infrastructure for providers and recipients of telehealth mental health treatment will be reflected in this metric.

Metric Description: The percentage of Medicaid beneficiaries, 6 years of age and older, with a mental health service need identified within the past two years, who received at least one qualifying service during the measurement year.

Data Source: Administrative data.

Identification Window: Measurement year and the year prior to the measurement year.

Eligible Population	
Age	6 years and older. Age is as of the last day of the measurement year.
Gender	N/A
Minimum Medicaid enrollment	Measurement year. Enrollment must be continuous.
Allowable gap in Medicaid enrollment	One gap of one month during the measurement year.
Medicaid enrollment anchor date	Last day of measurement year.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid and beneficiaries with primary insurance other than Medicaid.

Denominator: Medicaid beneficiaries, aged 6 and older on the last day of the measurement year, with a mental health service need identified in either the measurement year or the year prior to the measurement year.

Mental health service need is identified by the occurrence of any of the following conditions:

- Receipt of any mental health service encounter meeting the numerator service criteria in the 24-month identification window
- Any diagnosis of mental illness (not restricted to primary) in the MI-Diagnosis code set in the 24-month identification window
- Receipt of any psychotropic medication listed in the Psychotropic-NDC code set in the 24-month identification window

Value sets required for denominator.

Name	Value Set
MI-Diagnosis code set	All value sets are available upon request.
Psychotropic-NDC code set	
MH-Proc1 value set	
MH-Taxonomy value set	
MH-Proc2 value set	
MH-Proc3 value set	
MI-Diagnosis	
MH-Proc4	
MH-Proc5	

Numerator: Beneficiaries must qualify for inclusion in the denominator to be eligible for inclusion in the numerator. Members receiving at least one mental health service meeting at least one of the following criteria, applied by claim line, in the 12-month measurement year:

- Receipt of an outpatient service with a procedure code in the MH-Proc1 value set (MCG 261)
  OR
- Receipt of an outpatient service with:
  - Servicing provider taxonomy code in the MH-Taxonomy value set (MCG262) AND
  - Procedure code in MH-Proc2 value set (MCG 4947) OR MH-Proc3 value set (MCG 3117) AND
  - Primary diagnosis code in the MI-Diagnosis value set

  OR
- Receipt of an outpatient service with:
  - Procedure code in MH-Proc4 value set (MCG 4491) AND
  - Any diagnosis code in the MI-Diagnosis value set

  OR
- Receipt of an outpatient service with:
  - Servicing provider taxonomy code in the MH-Taxonomy value set (MCG262) AND
  - Procedure code in MH-Proc5 value set (MCG 4948) AND
  - Any diagnosis code in the MI-Diagnosis value set

  OR
- Receipt of an outpatient service with:
  - Procedure code in MH-Proc3-MCG3117 AND
  - Primary diagnosis code in the MI-Diagnosis value set

Value sets required for numerator.

Name	Value Set
MI-Diagnosis code set	All value sets are available upon request.
Psychotropic-NDC code set	
MH-Proc1 value set	
MH-Taxonomy value set	
MH-Proc2 value set	
MH-Proc3 value set	
MI-Diagnosis	
MH-Proc4	
MH-Proc5	

Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential Mental health Service. After reviewing the list of sample metrics provided by CMS, the State was concerned about the limitations and uncertainties in technology adoption by providers treating individuals with SMI (e.g., lack of use of shared care plans, lack of connectivity between correctional health systems and community-based providers, limitations and variations in provider/resource directories). Thus, the State focused on developing a metric that links delivery of recovery supports provided through the Foundational

Community Supports (FCS) program (implemented as part of the Medicaid Transformation Program) to persons who had received mental health services in an inpatient or residential treatment facility. The metric relies on the use of electronic eligibility and claims/encounter data. This metric also aligns with the Q3 metric for the SUD IMD waiver monitoring protocol.

Metric Description: Percent of Foundational Community Supports (FCS) eligible Medicaid beneficiaries, age 18 and older, with a mental health related inpatient or residential treatment stay within the past two years, who enrolled in at least one FCS service during the measurement year.

Data Source: Administrative data.

Identification Window: Measurement year and the year prior to the measurement year.

Eligible Population	
Age	Age 18 and older. Age is as of the last day of the measurement year.
Gender	N/A
Minimum Medicaid enrollment	Measurement year. Enrollment must be continuous.
Allowable gap in Medicaid enrollment	One gap of one month during the measurement year.
Medicaid enrollment anchor date	Last day of measurement year.
Medicaid benefit and eligibility	Beneficiaries who qualify for Medicaid in any of the following categories: Categorically Needy Blind/Disabled, Categorically Needy Aged, Categorically Needy Apple Health for Workers with Disabilities (HWD), Categorically Needy Pregnant Women, Affordable Care Act Expansion Adults, Categorically Needy Family Medical, Categorically Needy Children, Children's Health Insurance Program (CHIP), Categorically Needy Children- Foster Care between 18 to 26 Years of Age

Denominator: Medicaid beneficiaries, who meet the eligibility requirements as stated above, with a mental health related inpatient or residential treatment stay within the measurement year or the year prior to the measurement year.

Numerator: Beneficiaries must qualify for inclusion in the denominator to be eligible for inclusion in the numerator. Include in the numerator all individuals who ever enrolled in at least one FCS service during the measurement year.

Attachment P
Presumptive Eligibility for Home and Community-Based Services Definitions

I. Qualified Entities

The state or qualified entity, on the basis of preliminary information and using a simplified methodology described STC Section 9 and this Attachment, will make a determination that the individual appears to meet functional and financial eligibility requirements.

A. *Qualified entity* – Presumptive eligibility will be determined by both the state and state designated qualified entities. A qualified entity is an entity that:
   1. Participates with the Department of Social and Health Services (DSHS) as an Area Agency on Aging (AAA), subcontractor of an AAA or as a state designated tribal entity to provide limited eligibility functions and other administrative functions as delegated in contract;
   2. Notifies the DSHS of its election to make presumptive eligibility determinations under this section, and agrees to make presumptive eligibility determinations consistent with State policies and procedures; and
   3. The state will include language specific to presumptive eligibility requirements to its existing contracts with qualified entities who shall conduct presumptive eligibility determinations.

B. *Qualified staff* – Presumptive eligibility shall be determined by staff of qualified entities who have met at least the following qualifications imposed by the state:
   1. A College degree and at least two years of social service experience or an equivalent level of education plus relevant experience;
   2. Complete PE training prior to determining PE; and
   3. The state will provide CMS the initial training curriculum and PE determination form for review and approval prior to program implementation. Subsequent content changes will be submitted to CMS for review at the time the change is made.

C. *Quality Assurance and Monitoring* – The state will monitor both state staff and qualified entities for adherence to policies applicable to presumptive eligibility determinations through contract monitoring and quality assurance reviews.
   1. Post implementation, the state will conduct a targeted review to validate PE determinations are being made in accordance with established criteria; and
   2. As part of the state's Quality Improvement Strategy, a sample of PE determinations will be reviewed yearly to determine that PE was established appropriately.

II. Presumptive Eligibility Requirements

A. *Presumptive Functional Eligibility* – Individuals will self-attest to meeting functional eligibility to determine if the individual appears to meet nursing facility level of care (NFLOC) or Medicaid Personal Care (MPC) level of care as defined in state rule.

1. Indicators for NFLOC, as described in WAC 388-106-0355, include:
    a. Does the individual need daily care provided or supervised by a registered nurse (RN) or licensed practical nurse (LPN); or
    b. Does the individual have an unmet or partially met need for assistance with 3 or more qualifying ADLs; or
    c. Does the individual have a cognitive impairment and require supervision due to one or more of the following: Disorientation, memory impairment, impaired decision making, or wandering and a need for assistance with 1 or more qualifying ADLs; or
    d. Does the individual have an unmet or partially met need for assistance with 2 or more qualifying ADLs; and
    e. Functional eligibility shall be confirmed by the State for ongoing program eligibility.
2. Indicators for MPC level of care include:
    a. The individual does not require the level of care furnished in a hospital or nursing facility, an intermediate care facility for intellectual disability, an institution providing community psychiatric services for individuals under the age of twenty-one, or an institution for mental disease for individuals age sixty-five or over; and
    b. The individual has an unmet or partially met need for assistance with 3 or more qualifying ADLs as defined in WAC 388-106-0210; or
    c. The individual has an unmet or partially met need for assistance with 1 or more qualifying ADLs as defined in WAC 388-106-0210;
    d. Functional eligibility shall be confirmed by the State for ongoing program eligibility.

B. *Presumptive Financial Eligibility* – individuals will self-attest to meeting financial eligibility requirements to determine if the applicant meets the eligibility requirements. The presumptive financial eligibility screen will determine if the applicant meets the following requirements:

1. For 1915(c) Home and Community-based Supports:
    a. State residency;
    b. Social Security Number (SSN)[1];
    c. Aged, Blind, or Self-Attestation of Disability;

[1] If an applicant does not have a SSN established it will not preclude the applicant from applying for 1915c Home and Community-based Supports PE, the state shall provide the individual with assistance applying for an SSN or getting the person's SSN, unless the individual meets the exception under WAC 182-503-0515 subsection (2)".

d. The individual's separate non-excluded monthly income is equal to or less than the Special Income Level (SIL) or net available income is no greater than the effective one-person medically needy income level (MNIL);
e. The individual's separate non-excluded resources are at or below $2,000 or, for a married couple, that non-excluded resources (calculated as of the first point at which the individual is deemed to have the status of an "institutionalized spouse") are at or below a combination of $2,000 plus the current state Community Spouse Resource Allowance, based on the individual's self-attested statement of their household resources.

2. For 1915(k) Home and Community-based Supports:
    a. The client is a current recipient of categorically needy or alternative benefit plan Medicaid coverage; or
    b. State residency;
    c. Social Security Number (SSN [2]);
    d. The applicant is Aged, Blind, or Self-Attests to Disability;
    e. The single individual's non-excluded monthly income is equal to or less than the Categorically Needy Income Level (CNIL) or, for a married couple with a non-institutional spouse, the individual's non-excluded income is equal to or less than the (CNIL) with spousal impoverishment protections;
    f. The individual's separate non-excluded resources are at or below $2,000 or, for a married couple with a non-institutional spouse, that non-excluded resources (calculated as of the first point at which the individual is deemed to have the status of an "institutionalized spouse") are at or below a combination of $2,000 plus the current state Community Spouse Resource Allowance, based on the individual's self-attested statement of their household resources.

3. For State Plan Medicaid Personal Care program:
    a. The client is a current recipient of categorically needy or alternative benefit plan Medicaid coverage.

[2] If an applicant does not have a SSN established it will not preclude the applicant from applying for 1915c Home and Community-based Supports PE, the state shall provide the individual with assistance applying for an SSN or getting the person's SSN, unless the individual meets the exception under WAC 182-503-0515 subsection (2)".

Attachment Q
Contingency Management Protocol

In accordance with the State's "Washington Medicaid Transformation Project 2.0 (MTP 2.0)" Section 1115(a) Demonstration Waiver and Special Terms and Conditions (STCs), this protocol provides additional detail regarding the distribution of motivational incentives to Apple Health beneficiaries receiving contingency management as required by STCs 13.3 and 13.4. The Washington State Health Care Authority (HCA) contingency management program is based on established clinical research demonstrating effective contingency management treatment and Washington's unique needs. The contingency management treatment program consists of a structured 24-week outpatient contingency management program, during which motivational incentives will be available. HCA' contingency management program may be provided to eligible Apple Health beneficiaries and is intended to complement other substance use disorder (SUD) treatment services already offered by Apple Health. Motivational incentives earned through the HCA contingency management program shall not be included as gross countable income for determining Apple Health eligibility.

I. Treatment Framework

A. **Beneficiary Eligibility and Participation.** Beneficiaries who meet the contingency management eligibility criteria detailed in STC 13.2 and who consent to treatment may participate in the contingency management program. Participation in contingency management will have no impact on beneficiary eligibility for, or obligation or right to use, other Apple Health services.

B. **Incentives.** Beneficiaries will receive motivational incentives, as defined in STC 13.3, for meeting the target behavior of stimulant-non-use as demonstrated by point-of-care drug tests. At the discretion of the State and consistent with STC 13.3, the definition of target behavior may be revised in accordance with the evidence-base for contingency management as a treatment intervention for SUD to include non-use of substances other than stimulants, and/or other target behaviors such as treatment/medication adherence. During the initial phase of the pilot, HCA shall set a maximum dollar amount of total incentives in a calendar year that participating beneficiaries will be able to receive for successful completion of the treatment protocol. HCA may adjust the total incentives in a calendar year to align with future federal guidance regarding taxable income thresholds and/or classification. As described in Attachment Q, Section IV below, and consistent with the guardrails described in STC 13.3, providers have no discretion to determine the size or distribution of motivational incentives.

Attachment Q, Sections I.C-F below describe an example of how HCA will implement the incentive delivery schedule and corresponding dollar amounts. The final delivery schedule and corresponding dollar amounts are subject to change by HCA.

C. **Treatment Schedule Overview**.

Contingency management treatment will consist of a 24-week outpatient program, during which motivational incentives will be available for meeting the target behavior of substance-non-use. Weeks 1–12 of contingency management treatment will serve as the escalation/reset/recovery period, and weeks 13–24 will serve as the maintenance period.

D. **Weeks 1-12: Escalation/Reset/Recovery Period.** During the initial 12 weeks of the contingency management treatment, participating beneficiaries will be asked to visit the treatment setting in person for a minimum of two treatment visits per week. Visits will be separated by at least 72 hours (e.g., Monday and Thursday/Friday, or Tuesday and Friday) to help reduce the risk that drug metabolites from the same drug use episode will not be detected in subsequent point-of-care drug test. Participating beneficiaries will be able to earn motivational incentives during each visit the drug test indicates they have a negative sample for stimulants (or other target behaviors, such as a negative sample for other substances, or treatment adherence/medication, as determined by the State and consistent with Section 13 of the STCs).

The initial motivational incentive value for the first sample negative for stimulants in a series is $10. For each week the participating beneficiary demonstrates non-use of stimulants (i.e., two consecutive point-of-care drug tests negative for stimulants), the value of the motivational incentive may be increased by up to $2.00 The maximum aggregate motivational incentive a participating beneficiary can receive during this initial 12-week period is $528.

When the participating beneficiary submits a positive sample or has an unexcused absence, the incentive for a subsequent negative sample will reset to the original incentive at the beginning of the incentive schedule.

A "recovery" of the pre-reset value will occur after two consecutive stimulant-negative urine or oral samples. At that time, the participating beneficiary will recover their previously earned motivational incentive level without having to restart the process.

E. **Weeks 13-24: Maintenance Period.** During weeks 13–24, participating beneficiaries will be asked to visit the treatment setting for testing a minimum of once a week. During weeks 13–24, the value of the motivational incentive for each visit may be increased by up to $2.00 compared to the prior visit. The maximum aggregate motivational incentive a participating beneficiary will be able to receive during weeks 13–24 is $564.

F. **Hypothetical Example: Incentive Delivery Schedule for Perfect Performance**. Table 1 illustrates an incentive delivery schedule for a participating beneficiary in a scenario where the beneficiary has a consistent attendance record and submits samples that are stimulant-negative during each visit over the 24-week period.

Table 1: Sample Incentive Schedule

Week	*Visit #*	*Incentive for Negative Test*
1	1	$10.00
1	2	$12.00
2	3	$12.00
2	4	$14.00
3	5	$14.00
3	6	$16.00
4	7	$16.00
4	8	$18.00

Table 1: Sample Incentive Schedule		
Week	***Visit #***	***Incentive for Negative Test***
5	9	$18.00
5	10	$20.00
6	11	$20.00
6	12	$22.00
7	13	$22.00
7	14	$24.00
8	15	$24.00
8	16	$26.00
9	17	$26.00
9	18	$28.00
10	19	$28.00
10	20	$30.00
11	21	$30.00
11	22	$32.00
12	23	$32.00
12	24	$34.00
13	25	$36.00
14	26	$38.00
15	27	$40.00
16	28	$42.00
17	29	$44.00
18	30	$46.00
19	31	$48.00
20	32	$50.00
21	33	$52.00
22	34	$54.00
23	35	$56.00
24	36	$58.00
TOTAL		$1092.00

Note: The incentive delivery schedule and corresponding dollar amounts in the section above are an illustrative example of how HCA will implement the contingency management program. This incentive delivery schedule and corresponding dollar amounts are subject to change by HCA.

II. Contingency Management Provider and Staffing Criteria

A. **Contingency Management Providers**. Eligible providers meeting the criteria detailed in STC 13.4 and other applicable STCs will be eligible to deliver the contingency management benefit.

B. **Contingency Management Coordinator.** At least two trained contingency management coordinators will administer the participating provider's contingency management program. The contingency management coordinator must meet the practitioner requirements listed in STC 13.4(c).

C. **Role of the Contingency Management Coordinator.** The contingency management

coordinator will be the main point of contact for all contingency management program participating beneficiaries and will be responsible for collecting point of care drug testing samples, inputting test results, and supporting the delivery of motivational incentives as described in Attachment Q, Section IV below.

III. Point-of-Care Drug Testing

During each visit, the contingency management coordinator will collect a urine sample or an oral sample from the participating beneficiary. Rapid, point-of-care tests must be CLIA-waived. The sample will be tested for stimulants, including cocaine, amphetamine and methamphetamine, as well as for opioids, to rapidly indicate whether recent stimulant use occurred (or other substance use defined by the State and consistent with STC 13.2). Positivity for the single target substance is the only determinant of whether an incentive is provided). Urine samples will be collected in a point-of-care test cup with specimen validity measures. Oral samples may be used for validated oral tests.

IV. Incentive Delivery

A. **Overview.** The contingency management coordinator will immediately inform the participating beneficiary of the results of the point-of-care drug test, and enter the results into a secure incentive management program that includes strict safeguards against fraud and abuse. The incentive management program will compute the appropriate motivational incentive earned according to the protocol detailed above in Attachment Q, Section I. The incentive amount can be immediately delivered electronically to participating beneficiaries via e-gift cards sent to participating beneficiaries' emails, sent to the provider to print the gift card, or delivered using other strategies developed by the incentive management program. The immediate delivery of the motivational incentive to the beneficiary following the determination of the motivational incentive amount earned by the incentive management program is a critical component of the contingency management benefit and consistent with the evidence-base.

B. **Incentive Calculations.** A secure incentive management program, REDCap, will automatically calculate the appropriate motivational incentive amount based on the point of care test, results with adjustments for the escalating value, reset and recovery features as described above in Attachment Q, Section I. REDCap prevents tampering with, modifying or overriding the protocol amounts. Upon each visit, the results of the point of care test will be entered into REDCap. REDCap will operate using an algorithm based on the motivational incentive delivery schedule described above. Using this algorithm, when a result is entered, REDCap will report the amount of any motivational incentive the participating beneficiary should receive per the protocol. A positive test for stimulants will result in the participating beneficiary receiving no motivational incentive. A negative test for stimulants (or other substances as defined at State discretion and consistent with STC 56) will result in an incentive amount as indicated by REDCap, considering escalations and resets.

C. **Oversight.** As a safeguard against fraud, waste and abuse, the contingency management coordinator, or other staff trained in the delivery of contingency management under the supervision of a Licensed Practitioner of the Healing Arts (LPHA) consistent with STC 57

when the contingency management coordinator is not available, will be permitted to enter the results of the participating beneficiary's point-of-care drug test into REDCap during the visit. On a recurring basis, the provider must conduct and document that a regular audit of the incentive delivery functions has been completed, including the software calculations recommended and incentive distributed. This provider audit must be conducted by an individual who has responsibility for overseeing the use of organizational funds (e.g., program or fiscal manager). The providers will be required to routinely submit the results of the audit to HCA.

D. **Incentive Delivery Method and Parameters.** After the motivational incentive amount is determined, REDCap will disburse the motivational incentive and will track all motivational incentives awarded to all participating beneficiaries, including the date the incentive was distributed and the amount of the motivational incentive.

E. **Incentive Types.** To redeem earned motivational incentives consistent with the protocol described in this Attachment Q, participating beneficiaries will be able to choose gift or debit cards from a range of retail outlet options to use or redeem the incentive balance, with restrictions placed on the incentives so they are not used to purchase weapons, cannabis, tobacco, alcohol, over-the-counter preparations containing possible intoxicants such as dextromethorphan, or pornographic material, or to participate in gambling (e.g., through the purchase of lottery tickets).

Attachment R

Service Definitions for the Reentry Demonstration Initiative

Covered Service	Definition
Community Health Worker (CHW) Services	CHW services will be provided in the period up to 90 days immediately prior to the expected date of release and is intended to support Health-Related Social Needs (HRSN) screening and planning for access to social services and other community supports based on identified HRSNs. CHW services may include coordination with case management services to ensure culturally competent planning and referral support.
Case Management	Case management will be provided in the period up to 90 days immediately prior to the expected date of release and is intended to facilitate reentry planning into the community in order to: (1) support the coordination of services delivered during the pre-release period and upon reentry; (2) ensure smooth linkages to social services and supports; and (3) ensure arrangement of appointments and timely access to appropriate care and pre-release services delivered in the community. Services shall include: • Conducting a health risk assessment, as appropriate; • Assessing the needs of the individual in order to inform development, with the client, of a discharge/reentry person-centered care plan, with input from the clinician providing consultation services and correctional facility's reentry planning team; ○ While the person-centered care plan is created in the pre-release period and is part of the case management pre-release service to assess and address physical and behavioral health needs and HRSN identified, the scope of the plan extends beyond release; • Obtaining informed consent, when needed, to furnish services and/or to share information with other entities to improve coordination of care; • Providing warm linkages to a care manager, which includes sharing discharge/reentry care plans with managed care plans upon reentry; • Ensuring that necessary appointments with physical and behavioral health care providers, including, as relevant to

Covered Service	Definition
	care needs, with specialty county behavioral health coordinators and managed care providers are arranged; • Making warm linkages to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, transportation, childcare, child development, and mutual aid support groups; • Providing a warm hand-off, as appropriate, to post-release case managers who will provide services under the Medicaid or CHIP state plan or other waiver or demonstration authority; • Ensuring that, as allowed under federal and state laws and through consent with the beneficiary, data are shared with managed care plans, and, as relevant, to physical and behavioral health/SMI/SUD providers to enable timely and seamless hand-offs; • Conducting follow-up with community-based providers to ensure engagement was made with individual and community-based providers as soon as possible and no later than 30 days from release; and • Conducting follow up with the individual to ensure engagement with community-based providers, behavioral health services, and other aspects of discharge/reentry planning, as necessary, no later than 30 days from release.
Physical and Behavioral Health Clinical Consultation Services	Physical and behavioral health clinical consultation services include targeted preventive, physical and behavioral health clinical consultation services related to the qualifying conditions. Clinical consultation services are intended to support the creation of a comprehensive, robust and successful reentry plan, including: conducting diagnosis, stabilization and treatment in preparation for release (including recommendations or orders for needed labs, radiology, and/or medications); providing recommendations or orders for needed medications and medical supplies, equipment, and appliances that will be needed upon release; and consulting with the pre-release care manager to help inform the pre-release care plan. Clinical consultation services are also intended to provide opportunities for clients to meet and form relationships with the community-based providers who will be caring for them upon release, including behavioral health providers, and enable information sharing and collaborative clinical care between pre-release providers and the providers who will be caring for the

Covered Service	Definition
	client after release, including behavioral health warm linkages. Services may include, but are not limited to: • Addressing service gaps that may exist in correctional care facilities; • Diagnosing and stabilizing individuals while incarcerated, preparing them for release; • Providing treatment, as appropriate, in order to ensure control of qualifying conditions prior to release (e.g. to suggest medication changes or to prescribe appropriate medical supplies, equipment, or appliances for post-release); • Supporting reentry into the community; and • Providing behavioral health clinical consultation which includes services covered in the State Plan rehabilitation benefit but is not limited to clinical assessment, patient education, therapy, counseling, and Peer Support services covered under the State Plan.
Laboratory and Radiology Services	Laboratory and radiology services will be provided consistent with the State Plan.
Medications and Medication Administration	Medications and medication administration will be provided consistent with the State Plan.
Medication-Assisted Treatment	• MAT for Opioid Use Disorders (OUD) includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders as authorized by the Social Security Act Section 1905(a)(29). • MAT for Alcohol Use Disorders (AUD) and Non-Opioid Substance Use Disorders includes all FDA-approved drugs and services to treat AUD and other SUDs. • Psychosocial services delivered in conjunction with MAT for OUD as covered in the State Plan 1905(a)(29) MAT benefit, and MAT for AUD and Non-Opioid Substance Use Disorders as covered in the State Plan 1905(a)(13) rehabilitation benefit, including assessment; individual/group counseling; patient education; prescribing, administering, dispensing,

Covered Service	Definition
	ordering, monitoring, and/or managing MAT.
Services Provided Upon Release	Services provided upon release include: • Covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with approved Medicaid or CHIP State Plan). • Medical supplies, equipment, and appliances consistent with Medicaid State Plan requirements.

Attachment S
Reentry Demonstration Initiative Implementation Plan

Washington State Reentry Implementation Plan
December 2024

Note: Washington previously submitted its Implementation Plan to CMS in April 2024 and is resubmitting the Plan to align with the CMS-released template on the Federal Register that incorporates changes from the public comment period. Contents of this Implementation Plan have been updated to conform with the new CMS template and to reflect updates to Washington's implementation approach.

Background

The implementation plan documents the state's approach to implementing a section 1115 Reentry demonstration and helps establish what information the state will report in its monitoring reports by describing whether and how the state will phase in implementation. The state must also submit a monitoring protocol that details its plans to conduct monitoring reporting. The implementation plan does not supersede or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments. For states covering the CAA population under the 1115 demonstration, the CAA-required operational protocol is satisfied by the reentry implementation plan.

The implementation plan outlines key information on the overall demonstration design, as well as actions related to the five milestones included in the State Medicaid Director Letter (SMDL) "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated" .

Reentry demonstration reporting topics
Implementation Settings
SMDL Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated
SMDL Milestone 2: Covering and ensuring access to the minimum set of pre-release services for individuals who are incarcerated to improve care transitions upon return to the community
SMDL Milestone 3: Promoting continuity of care
SMDL Milestone 4: Connecting to services available post-release to meet the needs of the reentering population
SMDL Milestone 5: Ensuring cross-system collaboration
Reducing Health Disparities
Reinvestment plan
Consolidated Appropriations Act Population
Appendix: Implementation Phase-In Approach (if applicable)

Implementation Settings

1. In the table below, report the total number of facilities anticipated for each facility type once the reentry demonstration is fully implemented. If the demonstration includes another facility type/s not listed in the table, add a column/s for the other facility type/s.
   - Does the state intend to phase in facilities? ☒ Yes ☐ No
     - ➢ If yes, provide the total estimated number of facilities for each facility type once the reentry demonstration is fully implemented, and estimate the number of facilities to be phased-in by demonstration year (DY).
     - ➢ If no, only provide the total estimated number of facilities for each facility type once the reentry demonstration is fully implemented.

	State Prisons	**County/Local Jails**	**Tribal Jails**	**Youth Correctional Facilities**
Total	**11**	**33**	**2**	**8**
DY 8				
DY 9				
DY 10	7	25	1	7
DY 11	4	8	1	1
DY 12				

2. Describe the state's plan for determining that participating facilities are ready to provide pre-release services to eligible beneficiaries. The description should address how the facilities will facilitate access into the correctional facilities for community health care providers (either in person or via telehealth). *(The information being requested here aligns with information required under Milestone 5.)*

   The Washington State Health Care Authority (HCA) is implementing a multi-stage readiness process to prepare facilities and validate that they meet the Initiative's requirements prior to going live with pre-release services. HCA has also tied distribution of capacity building funding to each stage of the readiness process to provide incentives for facilities to participate and ensure that they can access needed funding during the readiness process. Available funding is capped by the size of a facility. Key stages of the readiness process include submission of the following:

   - **Letter of intent** to participate in the Initiative, which requires facilities to identify their implementation cohort. Facilities may receive 10% of their total eligible capacity building funding upon submitting the letter of intent. This initial distribution of funding is intended to help facilities begin the work of planning for the next milestone.
   - **Capacity building application**, which requires facilities to attest to their current and/or planned readiness to support Initiative requirements, and to describe any technical assistance they will need from the state. The application also requires facilities to describe how they will use capacity building funding to support the readiness process. Facilities may receive up to 40% of their total eligible capacity-building funding upon approval of their application.
   - **Readiness assessment**, which requires facilities to describe how they will support the mandatory and possibly optional pre-release services. HCA will work with facilities to validate their responses and determine whether the facility is ready to go-live with pre-release services, which includes ensuring that facilities provide in-person and/or virtual access for

community-based service providers. Facilities may receive up to 40% of their total eligible capacity building funding upon approval of their assessment.

- **Interim and final progress reports**, which require facilities to report on key implementation measures defined by HCA (e.g., client utilization/outcomes, uses of capacity building funds). Facilities may receive up to 10% of their total eligible capacity building funding upon submission of the interim and final progress reports.

HCA is also providing ongoing technical assistance to participating facilities to further educate them on Initiative requirements, address policy and operational questions and issues, and collect feedback on implementation. Technical assistance activities include a statewide learning webinar series focused on key requirements (e.g., eligibility and enrollment, service delivery), as well as one-on-one technical assistance sessions with facilities. HCA is also in the process of procuring a Third-Party Administrator that will provide additional technical assistance resources to participating facilities (e.g., help desk, one-on-one learning sessions) starting in Spring 2025.

SMDL Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated.

3. Does the state currently suspend eligibility and benefits during incarceration? ☐ Yes ☒ No
   - If no, describe how the state will either effectuate a suspension strategy within two years from approval of the expenditure authority or implement an alternate plan that will ensure only allowable benefits are covered and paid for during incarceration, while ensuring coverage and payment of full benefits as soon as possible upon release.
     The State currently suspends Apple Health coverage (Medicaid and CHIP) for adults and youth in state prisons, juvenile rehabilitation facilities run by the Department of Children Youth and Families, and adult jails. Currently, Washington does not yet suspend coverage for individuals in tribal jails and local juvenile detention facilities, because there are not existing processes to share inmate rosters with the State. HCA is actively working with these facilities to establish manual processes to exchange inmate rosters to support suspension and reactivation of coverage at release.

4. Opportunity to enroll in Medicaid:
   ☒ The state attests that any Medicaid-eligible person who is incarcerated at a participating facility but not yet enrolled is afforded the opportunity to apply for Medicaid in the most feasible and efficient manner and is offered assistance with the Medicaid application process in accordance with 42 CFR 435.906 and 435.908, and anticipates using the following methods described at 42 CFR 435.907 to ensure enrollment:
   - ☒ Online application
   - ☒ by telephone
   - ☒ in person
   - ☒ via mail
   - ☐ common electronic means

   ☒ The state attests that all individuals who are incarcerated at a participating facility will be allowed to access and complete a Medicaid application and will be assisted in this process, including by providing information about where to complete the Medicaid application for

another state (e.g., relevant state Medicaid agency website), if the person plans to live in a different state after release.

☒ The state attests that all individuals enrolled in Medicaid during their incarceration will be provided with a Medicaid and/or managed care plan card or some other Medicaid and/or managed care enrollment documentation upon release, along with information on how to use their coverage.

5. Describe any challenges not already described in the milestone 1 items above that the state anticipates in meeting this milestone. For each challenge, describe the actions needed to overcome the challenge, as well as the associated timelines.

   - **Challenge:** Currently, tribal jails and locally run juvenile detention centers do not exchange inmate rosters with HCA to facilitate suspension and unsuspension of Medicaid coverage.
     - ***Mitigation Approach**:* HCA is working with participating locally run juvenile detention facilities and tribal jails to establish processes to share daily inmate roster files, when needed, to effectuate suspension and unsuspension. Processes for juvenile detention facilities consistent with the CAA will be implemented by the state July 1, 2025.
   - **Challenge:** HCA will need to update key systems and processes to ensure that individuals are transitioned to the appropriate benefits services package for reentry services during the 90-day service period. These systems changes will require careful consideration of the varying lengths of stay that individuals have across settings to ensure that individuals have access to the full 90-day benefit authorized under the Demonstration.
     - ***Mitigation Approach:*** HCA's policy and systems teams have developed processes and systems changes to assign the appropriate benefits services package to ensure that all reentry Medicaid benefits are accessible for individuals in a suspended status. HCA also continues to work with individual facilities to navigate situations when release dates may be unknown or evolving.

SMDL Milestone 2: Covering and ensuring access to the expected minimum set of pre-release services for individuals who are incarcerated, to improve care transitions upon return to the community.

6. Describe how, within two years from approval of the expenditure authority, the state will effectuate a policy to identify Medicaid and CHIP eligible individuals, or individuals who would be eligible for CHIP, except for their incarceration status. Include in the description how the state will implement a screening process to identify individuals who qualify for pre-release services in line with the qualifying criteria outlined in the state's STCs. *(The information being requested here aligns with information required under Milestone 1.)*

   Under Washington's Demonstration, individuals may qualify for pre-release services if they: 1) meet the definition of an inmate of a public institution, as specified by 42 CFR 435.1010, and are incarcerated in a state prison, county or city jail, tribal jail, or youth carceral facility; and, 2) are enrolled in Medicaid or CHIP or would otherwise be eligible for CHIP if not for their incarceration status. Accordingly, HCA will not require participating facilities to screen individuals for eligibility for pre-release services but will require them to screen for Medicaid/CHIP eligibility. Currently,

many carceral facilities, except for some local jails and juvenile detention facilities, already have processes in place to screen individuals and support them in applying for Medicaid regardless of the occurrence of an inpatient event. For example, all state-run prisons and juvenile rehabilitation facilities support Medicaid screening and applications, while there is wide variation in capabilities across local jails and juvenile detention facilities. Currently, tribal jails do not yet have standardized processes in place.

HCA will work with participating facilities to leverage existing screening processes where possible. For facilities that lack existing screening processes, HCA will support them in establishing new processes. To support the screening process, HCA will provide several options for facilities to look up whether an individual is already covered by Medicaid, including through Washington's ProviderOne and OneHealthPort systems. Based on the screening:

- If an individual is found to already be enrolled in Medicaid, the facility will provide and be reimbursed for all mandatory pre-release services during the pre-release period.
- If the individual is not enrolled in Medicaid, the carceral facility will support the individual in completing a Medicaid application through Washington Healthplanfinder for MAGI-based applications and through Washington Connections for non-MAGI applications. Facilities will support application submissions online, mail, in-person and via phone call. Facilities will also support individuals in selecting a Medicaid managed care plan using HCA guidance on plan selection (e.g., prioritizing plans in the individual's community, rather than the county of release). If a plan is not selected on the application, HCA will auto-assign one during the enrollment process.
    - Once an individual is enrolled in Medicaid, their coverage will be automatically suspended based on the individual's inclusion in the inmate roster. For individuals with stays lasting 90 days or less, the vast majority of jail stays in Washington, HCA will maintain coverage with their managed care organization to ensure continuity of care under a single payer.

7. Minimum pre-release benefit package:

☒ The state attests that Medicaid-eligible individuals who are identified as demonstration participants will have access to the minimum short-term pre-release benefit package, which, at a minimum, includes the services listed below. (Provide the Medicaid benefit category or authority for each service in the space provided.)

- Case management to assess and address physical and behavioral health needs, and health-related social needs (HRSN) (if applicable): Reentry Waiver Authority. Targeted Case Management State Plan and Medicaid managed care contract authority
    - Note: Targeted Case Management service will fulfill CAA requirements, but be available for all individuals served under the Initiative.
- Medication-assisted treatment (MAT) for all types of substance use disorder (SUD) as clinically appropriate with accompanying counseling: State Plan authority
- 30-day supply of medication (as clinically appropriate based on the medication dispensed and the indication) provided to the beneficiary immediately upon release: State Plan authority

8. Additional pre-release services:

- Does the state intend that Medicaid-eligible individuals who are identified as demonstration participants will have access to any pre-release services that are in addition to the minimum benefit services addressed in question 7? ☒ Yes ☐ No
  - ➢ If yes, list the additional pre-release services in the table below, along with the Medicaid benefit category or authority for each service:

Pre-release service	Medicaid Benefit Category or Authority
Physical and Behavioral Health Clinical Consultation Services	State Plan
Pre-Release Medications and adminstration	State Plan
Laboratory Services	State Plan
Radiology Services	State Plan
Community Health Worker Services	State Plan
Medical Equipment and Supplies at Release	State Plan

  - ➢ If no, skip down to question 9.

- If yes, does the state intend to phase-in the additional pre-release services? ☒ Yes ☐ No
  - ➢ If yes, complete the information in the Appendix A table template regarding participating facilities' Service Level selections and implementation timelines.

9. Describe any challenges not already described in the milestone 2 items above that the state anticipates in meeting this milestone. For each challenge, describe the actions needed to overcome the challenge, as well as the associated timelines.

- **Challenge:** Many facilities already have pharmacy capabilities, either through an onsite pharmacy or through an external partner (e.g., mail order pharmacy), as well as facility-specific formularies that may not completely align with the Medicaid formulary. Facilities will need to ensure that existing pharmacies and pharmacy partners are enrolled as Medicaid providers and that they have implemented a formulary that includes coverage of the medications in the Medicaid formulary.
  - ***Mitigation Approach:*** HCA will work with participating facilities to enroll their pharmacies as Medicaid pharmacies, where needed, and support them in updating their facility formularies to include coverage of all Medicaid formulary medications.
- **Challenge:** Some carceral facilities lack in-house pharmacies or established relationships with community providers to provide MAT and a 30-day supply of medications at release.
  - ***Mitigation Approach:*** HCA will provide technical assistance to facilities that lack MAT or pharmacy capabilities to develop solutions (e.g., partnering with a mail order pharmacy) and ensure that services align with the Apple Health formulary and meet Reentry Initiative requirements. The vast majority of participating facilities already have this provider capability, either in-house or through an external partner, so HCA expects this challenge to be limited to a small number of facilities.
- **Challenge:** Most carceral facilities do not have experience in billing Medicaid for services and those facilities who operate health care services with internal staff will be required to

enroll as Medicaid providers for the first time and do not have established billing and claiming processes.

  - ***Mitigation Approach:*** HCA will partner with a Third-Party Administrator to provide technical assistance to facilities for enrolling as Medicaid providers and to serve as a claims clearinghouse so that facilities have a single point of contact for submitting claims and addressing issues. HCA is also developing Medicaid billing guides for each of the pre-release services and will facilitate a series of learning webinars with facilities to further educate them on Medicaid billing processes. The vast majority of participating facilities do not intend to provide Medicaid services with in-house staff and intend to do so through an external partner, so HCA expects this challenge to be limited to a small number of facilities.

- **Challenge:** Many carceral facilities lack an electronic medical record (EMR) or have outdated systems that will limit their utility in the context of the reentry initiative.
  - ***Mitigation Approach:*** HCA will provide capacity building funding to participating facilities that they may use to support IT infrastructure needs, including adopting an EMR and/or upgrading existing systems.
- **Challenge:** Facilities will need to ensure that they establish an adequate network of pre-release case managers to serve their releasing population.
  - ***Mitigation Approach:*** HCA is actively working with participating facilities to assess provider network needs, including case managers. Facilities are required to document in their readiness assessments the volume of case managers they will need in their network to serve the anticipated size of the population. As part of this assessment, facilities will indicate whether they intend to leverage in-house case managers, partner with community-based providers or MCOs, or providers available through the Third-Party Administrator. In addition, HCA will provide access to technical assistance to support facilities in identifying needed providers and building their network. This approach gives facilities flexibility to leverage any existing partners they may already have, while also providing supplementary support to ensure an adequate network to meet demand.

SMDL Milestone 3: Promoting continuity of care.

10. Person-centered care plan: Describe the state's plan to ensure that, prior to release, individuals who are incarcerated will receive a person-centered care plan that addresses any physical and behavioral health needs, as well as HRSN (if applicable) and consideration for long term services and supports (LTSS) needs that should be coordinated post release. Include any existing requirements related to care plan content for reentering individuals.

    The person-centered care plan is a crucial and required component of HCA's overall pre-release case management requirements. The reentry care plan is an actionable person-centered tool that engages the individual at the center of decision-making to:

    - Support early identification and diagnosis of health conditions;
    - Connect to care and services; and,
    - Improve health stability post-release and beyond.

The reentry care plan is based on the information collected from treating clinicians and in needs identification in the Reentry Health Screening, Reentry Health Assessment, and any subsequent case management activities. The care plan will be prepared prior to release and include input from the correctional facility's reentry planning team. It is the responsibility of the case manager to decide the extent of detail required in the reentry care plan for each individual based on the complexity of their health and social service needs.

The reentry care plan may be created within one or multiple client interactions, but at minimum must include the following required components:

- Presenting diagnosis(es) and health problems, including:
  - Current and past physical, behavioral health, and HRSN needs and service utilization.
  - Known treating providers.
  - Social, educational and other underlying needs, such as vocational services or employment.
- An action plan, including:
  - Health goals developed with the client.
  - Services identified pre- or post-release to support goals achievement.
  - Referrals to post-release services, including long-term services and supports, as well as to the Community or Native Hubs to address HRSN needs if appropriate, such as housing, transportation, food, finance, education, and employment.
  - Plan to support client SUD engagement and counseling via:
    - Choice counseling using shared decision-making tools (e.g., OUD) and discussion of options/risks
    - Assessment of the stage of change and readiness to engage in treatment
    - Motivational interviewing to progress further in readiness
    - Referral to appropriate provider assessment visit for diagnosis and prescription of MOUD if appropriate, including clinical determination for amount of medication supply for SUD prescriptions to take-home in hand at release to meet the need between release and transition to community provider.
  - Supports Planning: A plan for engagement of identified supports for the member (e.g., family, friends, probation/community corrections officer, and other community supports as identified).
- Identification, monitoring and management of barriers.

Carceral facilities will assist in obtaining client engagement and informed consent for case management, informing the reentry care plan development, identifying needed referrals and appointments, and discussing any impact for changes in release date.

11. Case manager process and policies:

☒ The state attests to having processes and policies to ensure that case managers coordinate with providers of pre-release services and community-based providers (if they are different providers) and facilitate connections to community-based providers pre-release for timely access to services upon reentry in order to provide continuity of care.

☒ The state attests to having processes to facilitate coordination between case managers and community-based providers in communities where individuals will be living upon release or have the skills and resources to inform themselves about such providers for communities with which they are unfamiliar. *(This attestation additionally aligns with requirements under Milestone 2.)*

☒ The state attests to having policies to ensure that case managers have the necessary time needed to respond effectively to individuals who are incarcerated and transitioning back into the community. *(This attestation additionally aligns with requirements under Milestone 4.)*

12. Describe the state's policies to provide or to facilitate timely access to any post-release health care items and services, including fills or refills of prescribed medications and medical supplies, equipment, appliances or additional exams, laboratory tests, diagnostic, family planning, or other services needed to address the physical and behavioral health care needs, as identified in the person-centered care plan. The description should include how the policies will account for access across all implementation settings and for individuals with short-term sentences.

    Under the Demonstration, case managers and facilities will be required to anticipate and facilitate timely access to post-release health care items and services, including:

    - **Coordinating Post-Release Appointments and Medications:** The pre-release case manager must coordinate and schedule necessary post-release health care services, including but not limited to fills or refills of prescribed medications, diagnostic, family planning, primary care, specialty, mental health, substance use, dental, or other services. For medications at release, carceral facilities are required to provide at least a 30-day supply of prescribed medications. In addition to providing the medications in hand upon release, the carceral facility will be required to provide a prescription for any active medication to be fulfilled at a post-release pharmacy as appropriate and feasible so that the individual has access to refills. The care plan must also identify and facilitate any post-release health care items and services needed.
    - **Facilitating a Warm Handoff with Post-Release Case Manager:** Pre- and post-release case managers (if different) must conduct a warm handoff with the individual prior to release either virtually or in-person. For individuals with known release dates, the warm handoff meeting should occur at least 14 days prior to release. If it is not possible for the warm handoff to occur prior to the individual's release (e.g., if the individual is released by court order earlier than expected or has a very short stay), the pre- and post-release case managers must conduct the warm handoff in the community post-release within one week. At minimum, the warm handoff must include:
        - Sharing the reentry care plan and any other pertinent information with the post-release case manager (if different) and the individual's assigned managed care plan;
        - Scheduling and conducting an in-person or virtual warm handoff meeting that includes the individual (as appropriate) and both the pre- and post-release case

managers to begin establishing a trusted relationship, review the care plan and address questions, and identify any outstanding service needs and supports required for successful community reentry; and,

    - Coordinating with the individual's managed care plan and Community Hub to identify community-based providers and facilitate referrals for post-release services.

- **Coordinating Post-Release Case Management:** Once the individual has been released, the post-release case manager is required to:
    - Provide ongoing supports during the immediate post-release period, such as referrals and linkages to post-release providers;
    - Monitor and follow-up with the individual to ensure engagement with community-based providers; and,
    - Coordinate with Community Hub to coordinate needs for post-release HRSN services, as needed.

13. If the state is implementing the demonstration through managed care, please attest to the item below. If not, skip down to question 14.

    ☒ The state attests that the managed care plan contracts reflect clear requirements and processes for transfer of a member's relevant health information upon release to another managed care plan or, if applicable, state Medicaid agency (e.g., if the beneficiary is moving to region of the state served by a different managed care plan or to another state after release) to ensure continuity of coverage and care.

14. Describe any challenges not already described in the milestone 3 items above that the state anticipates in meeting this milestone. For each challenge, describe the actions needed to overcome the challenge, as well as the associated timelines.

- **Challenge:** Some facilities already have varying levels of case management services available to incarcerated individuals prior to release. Facilities will need to adapt and supplement these existing processes to meet the requirements of the Demonstration, including identifying additional case managers to ensure sufficient capacity to serve the eligible population.
    - ***Mitigation Approach:*** HCA will provide ongoing technical assistance to facilities to communicate the case management requirements for the Demonstration and support this availability with case managers via the managed care organizations. HCA will also contract with a Third-Party Administrator that will provide technical assistance to facilities that require support in building or expanding their network of case managers.

- **Challenge:** Individuals with short stays will likely pose challenges for ensuring delivery of pre-release case management and a warm handoff to the post-release case manager prior to release. For example, many individuals in jails are incarcerated for just a few days and/or are released earlier than anticipated.
    - ***Mitigation Approach:*** In situations where a warm handoff cannot occur prior to release, HCA will require that a warm handoff occur within one-week post-release, which will include sharing of the reentry care plan and other information about the individual's

needs and services with the post-release case manager. HCA will recommend that the pre- and post-release case managers meet with the individual in the community, if possible. HCA will further describe expectations for warm handoffs in short stay situations in the Policy & Operational Guide.

SMDL Milestone 4: Connecting to services available post-release to meet the needs of the reentering population.

15. Describe the state's plan for monitoring that contact between the reentering individuals and the case managers occurs within an appropriate timeframe. Include in the description the state's plan for ensuring ongoing case management.

    As described in SMDL Milestone 3, the pre- and post-release case managers will play a critical role in facilitating connections to post-release care, including monitoring the individual to ensure that they are able to connect with post-release service providers and access needed services. Prior to release, the care plan will be reviewed during the warm handoff meeting between the individual, pre-release case manager and post-release case manager. In the immediate post-release period, the post-release case manager is required to provide ongoing supports, follow-up with individuals, and coordinate with Community Hub to address the individual's HRSN needs.

    In addition, HCA will require participating facilities to submit interim and final progress reports, which will require details on how the facility supports the pre- and post-release case managers in facilitating warm handoffs prior to release. HCA will also require managed care plans and Community Hub to submit regular case management-related reports describing implementation progress, challenges, and technical assistance needs. Reports will include an HCA-defined set of metrics that provide further insight into implementation progress and outcomes (e.g., state-developed criminal justice performance measures measuring quality health outcomes, average time between the individual's release and engagement with a post-release case manager).

16. Describe any challenges not already described in the milestone 4 items above that the state anticipates in meeting this milestone. For each challenge, describe the actions needed to overcome the challenge, as well as the associated timelines.

    - **Challenge:** As noted in SMDL Milestone 3, some facilities already have varying levels of case management services and staff available to incarcerated individuals prior to release. Facilities will need to adapt their existing processes to align with Demonstration requirements and support warm handoffs to post-release case management.
        - ***Mitigation Approach:*** HCA's Capacity Building funding process allows carceral facilities to use Capacity Building funds to support the strengthening of the workforce and the development and implementation of protocols and procedures to support the care planning and warm handoff process.

SMDL Milestone 5: Ensuring cross-system collaboration.

17. Describe the system/s the state Medicaid agency and participating facilities will employ (for example, a data exchange, with requisite data-sharing agreements) to allow the state Medicaid agency to monitor individuals' access to and receipt of needed health care and HRSN (if applicable), both pre-

and post-release. Include in the description any anticipated data challenges and potential solutions, as well as details of the data-sharing agreements.

Carceral facilities, managed care plans and other implementation partners will need to establish new or enhanced information sharing processes to ensure effective reentry planning, including:

- **Sharing of inmate rosters and release dates:** Currently, the majority of facilities already have data exchange protocols and technological applications in place to share this information with HCA. HCA intends to leverage Washington's Jail Booking Reporting System (JBRS) utilized by jail facilities and the Offender Management Network Information (OMNI) used by Washington's Department of Corrections that provide carceral status and release date. HCA is actively engaging remaining facilities that lack technological infrastructure to these existing exchange systems to develop strategies to exchange this information to effectuate suspension/unsuspension and service delivery.
- **Sharing of care plans:** Pre-release case managers will need to exchange care plans and related information with post-release case managers and other partners (e.g., post-release service providers, MCOs). HCA is actively working with facilities to identify existing IT infrastructure and outstanding investment needs to address these challenges. Where needed, facilities and case managers will establish manual processes to exchange this information to support reentry.
- **Claims processing:** Most participating facilities lack experience with submitting Apple Health claims, so HCA is procuring a Third-Party Administrator to work directly with facilities to establish systems and processes to submit and process claims. The vendor will also provide direct technical assistance to facilities to support them in navigating the claims submission process.

In addition, HCA will establish a process to monitor the health care needs and HRSNs of individuals who are exiting carceral facilities, as well as overall implementation and impact of the Demonstration, in alignment with Federal and State monitoring priorities. Per the Demonstration requirements, HCA will submit to CMS a Monitoring Protocol after CMS releases the template to states. HCA will also produce Quarterly and Annual Monitoring Reports throughout the duration of the Demonstration and execute any necessary data sharing agreements with facilities and other implementation partners to gather needed data to support monitoring activities.

HCA's monitoring approach will include:

- **Robust implementation partner engagement.** HCA will engage carceral facilities and other partners to identify potential quality-of-care and health outcomes measures, in alignment with CMS guidance on the Health Equity Measure Slate. HCA will also consult with implementation partners to advise on anticipated data challenges related to the measures and mitigation strategies.

- **Capacity Building funding to support data infrastructure development.** HCA will provide Capacity Building program funding to carceral agencies/facilities to support needed IT investments, including implementation of case management technology and upgrading existing case management or Medicaid billing systems, which will support overall reporting and monitoring efforts.

- **Claims-based and Standardized reporting on key measures for each implementation milestone.** HCA will monitor individuals' access to and receipt of needed health care and HRSN services via claims-based monitoring of delivered services. Additionally, carceral

facilities will be asked to independently report on their provision of services, which may include:

- Number of individuals screened and enrolled in Medicaid, including applications submitted and denial/decline rates.
- Length of time that individuals receive pre-release services.
- Utilization of applicable pre-release services, such as: case management, medications for substance use disorder, physical or behavioral health consultations, laboratory and radiology services, and community-health worker services.
- The number of participants who received case management pre-release services and were enrolled in case management post-release.
- Utilization of post-release services, such as behavioral health and preventive care, emergency department visits and inpatient stays for serious mental illness.
- Outcomes measures (e.g., chronic condition management indicators).

18. Engagement of key entities:
    - Specify the types of key entities (e.g., correctional systems, community supervision entities, health care providers, managed care organizations, supported employment and supported housing agencies, etc.) the state intends to include in existing and future engagement for this demonstration.

    Implementation of Washington's Demonstration requires engagement and coordination across numerous entities and communities to ensure that Demonstration goals are achieved, including:

    - **Carceral facilities**, including state prisons, local jails, tribal jails, and youth correctional facilities.
    - **Medicaid managed care plans,** including Community Health Plan of Washington, Coordinated Care, Molina Healthcare of Washington, UnitedHealthcare Community Plan, and Wellpoint Washington.
    - **Community-based providers**, including pre- and post-release case management organizations, health care providers, and social services providers (e.g., housing agencies, employment providers).
    - **Third Party Administrator,** which HCA is procuring and will provide technical assistance and claims processing support for participating facilities.
    - **Post-release community organizations,** including Accountable Communities of Health and the Community/Native Hubs.
    - **Post-release supervision entities**, including local probation agencies.
    - **Tribal organizations** to provide input and feedback on Demonstration services delivered to tribal members.
    - **Individuals with lived experience** to provide input and feedback on Demonstration services.

- Describe the plan for the organizational level engagement, coordination, and communication between the state and the entities listed above.

  Shortly after CMS' approval of Washington's Demonstration, HCA formed a Reentry Initiative Steering Committee to coordinate planning and implementation. The Committee, currently comprised of team members from HCA, meets weekly and includes participation from senior leadership within HCA and other agencies, as needed.

  HCA has also established several forums for engaging with external implementation partners to communicate Demonstration requirements, gather feedback on emerging design decisions, and address questions. These forums include the following:

  - **Reentry Advisory Workgroup (RAW):** Formed in 2021 in response to SB 5304 and HB 1348, which directed HCA to suspend Medicaid coverage for individuals in carceral institutions. The RAW meets on a quarterly basis and includes participation from state and local carceral agencies and advises HCA on key policy and operational decisions that impact justice-involved individuals.
  - **Taking Action for Healthier Communities (TAHC) Task Force:** Originally launched under the MTP 2.0 Demonstration, the TAHC task force has evolved to include a focus on reentry-related issues. The task force meets in-person and includes participation from Accountable Communities of Health (ACHs), managed care plans, and state agencies.
  - **Implementation Workgroups**: In early 2024, HCA launched an implementation workgroup with the DOC and the DCYF to provide input on the planning and implementation of the Demonstration. HCA will form additional implementation workgroups throughout the year to engage in implementation planning with other facilities, including jails, tribal jails, and youth correctional facilities.
  - **One-on-One Facility Engagement:** As facilities submit letters of intent to participate in the Demonstration, HCA is establishing a regular cadence of one-on-one meetings with participating facilities to further assess implementation readiness, address facility questions, and provide direct technical assistance.
  - **Implementation Learning Webinars:** HCA is planning a series of public-facing learning webinars for implementation partners to provide additional guidance on Demonstration requirements and expectations, with a focus on key topics such as: client eligibility and enrollment, provider enrollment, and service delivery.

19. Describe the state's strategies for improving awareness about, and providing education on, Medicaid coverage and health care access among various stakeholders (e.g., individuals who are incarcerated, community supervision agencies, corrections institutions, health care providers, etc.).
    HCA has numerous existing forums that are used to engage with carceral facilities, managed care plans, ACHs, and other partners on opportunities to increase awareness and education about Medicaid coverage and health care. ACHs engage individuals with lived experience to perform outreach and assistance to county jails to provide connections to HRSN services.

Through the Demonstration, HCA will release guidance and resources for implementation partners on approaches to reentry that will improve awareness and education about Medicaid coverage and health care access, which will include:

- **Policy & Operational Guide** that will provide detailed guidance on expectations for communicating with justice-involved individuals, other implementation partners, or tribal nations on Medicaid coverage and access.
- **Formal direction to Medicaid managed care plans** describing expectations for their role in communicating with justice-involved members.
- **Updates to the Medicaid provider manual**, as needed.
- **Informal guidance** from HCA regarding the Demonstration, which HCA will announce through existing forums, as well as press releases, newsletters, social media, ACHs, and other distribution channels.

20. Describe any challenges not already described in the milestone 5 items above that the state anticipates in meeting this milestone. For each challenge, describe the actions needed to overcome the challenge, as well as the associated timelines.

Engagement of Key Entities & Community Members

- **Challenge:** Facilities are not required to participate in the Demonstration and, as such, HCA will rely on facilities opting to participate.
    - ***Mitigation Approach:*** HCA will continue to regularly and frequently engage with carceral agencies/facilities to provide information about the opportunity to participate in the Demonstration, including the opportunity to leverage Medicaid funding to support pre-release services and Capacity Building funding to support planning and implementation activities. HCA has seen high interest in the Reentry Demonstration to-date, with the majority of carceral facilities in the state joining the Initiative's Cohort 1.
- **Challenge:** Fostering coordination and collaboration across carceral, health care, managed care, and other implementation partners will, in many cases, require new relationships and lines of communication to be established.
    - ***Mitigation Approach:*** HCA will use Capacity Building funding to support carceral agencies/facilities in establishing processes to collaborate and communicate with implementation partners. HCA will also coordinate several stakeholder forums (e.g., TAHC) to collaborate statewide, which will complement efforts at the local level. ACHs will also play a significant role in facilitating connections between implementation partners and communities.

Reducing Health Disparities

21. Describe the state's strategies to drive positive changes in health care quality for all beneficiaries through the reentry demonstration, thereby reducing health disparities, and address how the strategies

will be integrated and how the state will meaningfully involve the population of focus into the demonstration implementation and the approach for monitoring and evaluation.

Standardizing the delivery of health care services to individuals in a carceral setting will assist in addressing health needs and reducing disparities. As described in SMDL Milestone 5, HCA will develop a robust monitoring and reporting process to assess implementation progress, service access and utilization, and individual outcomes. These activities will be critical to ensure that implementation partners are held accountable for driving positive changes in service access and quality, as well as reducing health disparities. HCA will continuously engage implementation partners and individuals with lived experience to inform the monitoring strategy, as well as strategies to address health disparities.

Reinvestment Plan

22. Describe the state's plan for reinvesting the total amount of federal matching funds received under the demonstration for any existing carceral health care services that are currently funded with state and/or local dollars. If the state already submitted this plan separately, please indicate this below.

    The state submitted its Reentry Initiative Reinvestment Plan to CMS on December 15, 2023, which analyzed the level of reinvestment needed per CMS requirements. Based on the analysis, HCA anticipates that the level of total planned investments in new services ($57,269,964) and the state share of the Reentry Capacity Building Program ($151,962,500) will exceed the level of required reinvestment associated with existing services ($53,528,237). Therefore, HCA does not project any excess required reinvestment.

Consolidated Appropriations Act Population

23. ☒ The state attests to complying with all requirements outlined in section 5121 of the CAA by including the population in the section 1115 demonstration.

    - If the state plans to partially cover the required population and services of the CAA as part of the section 1115 demonstration, please describe what populations and services will be included here:

      HCA intends to implement 5121 services July 2025 using Demonstration authority for the pre-release services.

24. ☒ The state attests to covering all or a portion of the optional CAA population outlined in section 5122 of the CAA by including the population in the section 1115 demonstration.

    - If the state plans to partially cover the optional population and services of the CAA as part of the section 1115 demonstration, please describe what populations and services will be included here:

      HCA intends to implement 5122 services using Demonstration authority for the pre-release services that overlap with 5122 services and use state plan amendment authority for the remaining services not covered by the Demonstration. The 5122 services will be available to facilities beginning July 1, 2025, with the support of the Demonstration and state plan amendment authority. For facilities not participating or not yet participating in

the Demonstration, coverage will be statewide through the authority of the state plan amendment.

- Additional Service for CAA-Eligible Youth Post-Adjudication (CAA 5121): Screening and diagnostic services for CAA-eligible children and youth supported by the Section 1115 Demonstration's approved "clinical consultation services"): State Plan authority

- Additional Services for CAA-Eligible Youth Pre-Adjudication (CAA 5122): Full Apple Health benefits, including all other Medicaid and CHIP services—not covered by the Demonstration—consistent with an enrollee's benefit package while the individual remains in pre-adjudication status. Also, full Apple Health benefits include any pre-adjudication services that are delivered outside of the Demonstration's 90-day duration for pre-release services. Implementation of Section 5122 includes all Washington State carceral facilities that serve the CAA population irrespective of participation in the Demonstration or achieving the Demonstration's readiness criteria. The 5122 services will be available to facilities beginning July 1, 2025. The services will be provided under State Plan authority through managed care organizations (MCOs) for enrollees enrolled in managed care and through fee-for-service coverage for client's who are not enrolled in managed care: State Plan Authority

25. Describe the state's internal operational plan for CAA populations and services that do not overlap with the section 1115 demonstration. The internal operational plan should include all the requirements outlined in "Section 5121 of the CAA, 2023 Internal Operational Plan" of the State Health Official Letter (SHO) #24-004.[1] If the state has already submitted this plan separately, please indicate below. Not applicable

[1] SHO# 24-004, "Provision of Medicaid and CHIP Services to Incarcerated Youth," is available in full here: https://www.medicaid.gov/federal-policy-guidance/downloads/sho24004.pdf.

Appendix A: Reentry Implementation Phase-in Approach Template

If a state is intending to phase-in additional pre-release services, provide the information below regarding the services in each Service Level, the number of facilities anticipated to provide each Service Level, the associated timeline for implementation, and any challenges and/or barriers that facilities may experience in providing a service/s or Service Level/s.

Service Level Description

1. In Table 1 below, provide the services included in each Service Level. Add more rows as necessary.

Table 1: Services in each service level.

Service Level	Services included in the Service Level
1 (Minimum benefit package)	• Case management to assess and address physical and behavioral health needs, and health-related social needs (HRSN): Reentry Waiver Authority, Targeted Case Management State Plan and Medicaid managed care contract authority • Medication-assisted treatment (MAT) for all types of substance use disorder (SUD) as clinically appropriate with accompanying counseling: State Plan authority • 30-day supply of medication (as clinically appropriate based on the medication dispensed and the indication) provided to the beneficiary immediately upon release: State Plan authority • CAA 5121: Screening and diagnostic services for CAA-eligible children and youth supported by the Demonstration's approved "clinical consultation services": State Plan authority • CAA 5122: Full Apple Health benefits for CAA-eligible children and youth while the individual remains in pre-adjudication status: State Plan Authority
2 (Optional services)	• Clinical assessment and evaluation for adults, including screening, evaluation, and diagnosis services • Pre-release medications, including all medications on the Apple Health pharmacy drug list • Laboratory services defined in the Medicaid benefit package • Radiology services defined in the Medicaid benefit package • Community Health Worker services to identify social service needs and make referrals to post-release services • Medical equipment and supplies at release, such as vision hardware and prosthetic/orthotic devices

2. Describe any anticipated challenges and/or barriers experienced by state prisons and other participating facilities in providing a service/s or service level/s.

    - **Challenge:** Correctional facilities vary widely in the scope of pre-release services that they provide. Many facilities provide these services with internal correctional staff who lack experience with Medicaid billing processes. As such, many facilities will need to expand their service delivery capacity and/or create new capacity to deliver the minimum services and any optional services they elect to provide.
        - ***Mitigation Approach:*** As noted previously, HCA will provide robust technical assistance support to facilities to educate them on the requirements for each pre-release service, as well as support them in planning to implement services. HCA will also provide Capacity Building funding to participating facilities to support them in planning and implementing the services. For optional services, HCA will permit facilities to select services on an a la carte basis as they demonstrate readiness to support selected services. This approach will provide maximum flexibility to facilities, while ensuring that facilities demonstrate full readiness to support optional services before going live with them.

Service Level Information by Facility Type

3. In Table 2 below, provide the requested information regarding the number of facilities anticipated to provide each service level, by facility type and demonstration year. Indicate the demonstration year (DY) for implementation, as well as the DYs following implementation, in the table, adding service level columns and types of facility rows as needed.

4. Describe any anticipated challenges and/or barriers experienced by facilities in providing a service/s or service level/s.

    HCA has identified the following challenges that it anticipates correctional facilities will experience and is currently working with facilities to develop mitigation strategies:

    - Enrolling as Medicaid providers and setting up new billing and claiming processes
    - Understanding the Medicaid program, which is new to the correctional facilities
    - Establishing new Medicaid eligibility and enrollment processes
    - Building new information sharing processes with pre- and post-release case managers

Table 2: By service level, total number of facilities, number of facilities anticipated to offer service level/s at implementation, and number of facilities anticipated to implement service level/s by DY.

Note: Below is a summary of the estimated number of facilities by type that will participate in the Demonstration. All participating facilities must support Service Level 1 (minimum benefit package), but HCA does not yet know which facilities will be able to provide additional, optional service levels by Demonstration Year.

		Service Level 1 (Minimum Benefit Package)	Service Level 2	Service Level 3	Service Level 4
State Prisons	Planned number of facilities offering each service level	***11***			
	Number of facilities anticipated to offer service level at implementation (during DY 8)				
	Number of facilities anticipated to implement service level, by DY				
	DY 9				
	DY 10	**7**			
	DY 11	**4**			
	DY 12				
County/Local Jails	Planned number of facilities offering each service level	**33**			
	Number of facilities anticipated to offer service level at implementation (during DY 8)				
	Number of facilities anticipated to implement service level, by DY				
	DY 9				
	DY 10	**25**			
	DY 11	**8**			
	DY 12				
Tribal Jails	Planned number of facilities offering each service level	**2**			

		Service Level 1 (Minimum Benefit Package)	Service Level 2	Service Level 3	Service Level 4
	Number of facilities anticipated to offer service level at implementation (during DY 8)				
	Number of facilities anticipated to implement service level, by DY				
	DY 9				
	DY 10	**1**			
	DY 11	**1**			
	DY 12				
Youth Correctional Facilities	Planned number of facilities offering each service level	**8**			
	Number of facilities offering service level at implementation (during DY 8)				
	Number of facilities anticipated to implement service level, by DY				
	DY 9				
	DY 10	**7**			
	DY 11	**1**			
	DY 12				

Attachment T
Placeholder for Reentry Demonstration Initiative Reinvestment Plan

Washington State Health Care Authority

Attachment U

Health-Related Social Needs (HRSN) Infrastructure Protocol

HRSN Infrastructure. The Washington State Health Care Authority is submitting the Health-Related Social Needs (HRSN) services infrastructure protocol for approval by the Centers for Medicare and Medicaid Services (CMS). The protocol addresses the requirements of infrastructure investments for the Health-Related Social Needs (HRSN) services program specified in Section 15.7 of the Special Terms and Conditions (STCs) of the Washington State Section 1115 Medicaid Demonstration waiver renewed on June 30, 2023. Over the duration of the Demonstration, the state is authorized to spend up to $270 million of infrastructure investments necessary to support the development and implementation of HRSN services.

The Washington State HRSN services program will allow qualifying Medicaid beneficiaries to receive evidence-based, non-medical services. The protocol specifies the proposed uses of HRSN infrastructure expenditures, types of entities that will receive funding, intended purposes of funding, projected expenditure amounts, and implementation timeline.

Under the terms of Washington's 1115 waiver, Accountable Communities of Health (ACHs), as Community Hubs, will provide services described in STC 15.2(c) to eligible Apple Health enrollees; provide vital HRSN service administration support to the HRSN fee-for-service program; and build HRSN service capacity across the state (see STC 15.4).

The Native Hub will provide similar navigation services and support. Although ACHs may limit their services to their respective regions, any qualifying individual in Washington may access community-based care coordination and services through any one of the 10 hubs.

HRSN Infrastructure

1. **Implementation timeline and approach**
    a. Timeline for disbursement of infrastructure funding
        i. The state may begin awarding infrastructure funds to eligible entities following approval of this document. The state will utilize a phased approach to disbursing infrastructure funds, initially focusing on capacity building to develop and implement the nine community hubs and statewide Native Hub, along with education, engagement, and outreach activities, and other investments for organizations participating in the delivery of HRSN services.
        ii. Eligible entities may apply for HRSN infrastructure funding on an ongoing basis, depending on availability of funds.
    b. Approach to infrastructure funding applications and disbursements
        i. The state will:
            1. Develop application processes for eligible entities seeking infrastructure funds from the state, including parameters that would apply to each Accountable Community of Health (ACH) under Section 1.b.ii
            2. Develop application processes for ACHs seeking infrastructure funds from the state to develop and implement community hubs
            3. Evaluate applications and allocate funds for activities to be performed in each of the four approved infrastructure categories
            4. Allocate funding to each ACH for regional distribution by the ACH to other eligible entities. Funding will be allocated based on Medicaid-covered lives in each region
        ii. Each of the ACHs will:

1. Develop application processes for other eligible entities seeking infrastructure funds
2. Evaluate applications from other eligible entities and award infrastructure funding based on the application process and HRSN service delivery prioritization established by the state
3. Disburse funding to awarded entities
4. Ensure that any HRSN fund disbursements are consistent with these STCs
5. Report to the state on the use of funds by ACH and regional partners, including alignment with percentage expenditures by allowable use category

c. Monitoring and oversight
The state will take action to address non-compliance, ensure non-duplication of funds, and perform other monitoring and technical assistance, as necessary.

2. **Eligible Entities**

In accordance with STC 15.4(d), this infrastructure funding is separate and distinct from the payment to the applicable managed care plans for delivery of HRSN services. The state will ensure that HRSN infrastructure expenditures described in STC 15.4(a) are not factored into managed care capitation payments and that there is no duplication of funds.

The following entities may be eligible to apply for and receive HRSN infrastructure funding:

a. ACHs
b. Native Hub participants
c. Providers of HRSN services, including, but not limited to:
    i. Community-based organizations (CBOs)
    ii. Social-services agencies
    iii. Housing agencies and providers
    iv. Food and nutrition service providers
    v. Case management providers
    vi. Traditional health workers
    vii. Child welfare providers
    viii. State, county, city, and local governmental agencies
    ix. Tribes and Indian health care providers (IHCPs)
    x. Physical and behavioral health care providers
d. Other entities supporting the infrastructure and delivery of HRSN services, such as technology and technical assistance providers,
e. State-contracted third-party administrator and/or financial executor to support HRSN contracting, implementation, and service delivery

3. **Intended purpose and proposed uses of HRSN infrastructure funding**
The state may claim federal financial participation (FFP) in infrastructure investments to support the development and implementation of HRSN services across the following domains in accordance with the categories specified in the STCs:

a. Technology
b. Development of business or operational practices
c. Workforce development
d. Outreach, education, and stakeholder convening

The state may provide infrastructure funding to eligible entities for activities in support of HRSN service delivery:

a. **Technology**
   i. Procuring IT infrastructure and data platforms needed to enable, for example:
      1. Authorization of HRSN services
      2. Referral to HRSN services
      3. HRSN service delivery
      4. HRSN service billing
      5. HRSN program oversight, monitoring, and reporting
   ii. Modifying existing systems (e.g., community information exchange) to support HRSN service delivery and closed loop referrals
   iii. Developing an HRSN services eligibility screening tool
   iv. Integration of data platforms, systems, and tools
   v. Supporting successful adoption of IT infrastructure and data platforms related to HRSN

b. **Development of business or operational practices**
   i. Development of policies and procedures related to:
      1. HRSN referral and service delivery workflows
      2. Billing and invoicing
      3. Data sharing and reporting
      4. Program oversight and monitoring
      5. Evaluation
      6. Privacy and confidentiality
   ii. Training and technical assistance on HRSN program roles and responsibilities
   iii. Administrative and/or overhead costs necessary to perform HRSN duties or expand HRSN service delivery capacity, including development and implementation of community hubs

c. **Workforce development**
   i. Cost of hiring staff
   ii. Cost of training staff members on HRSN policies and procedures.
   iii. Salary and benefits for staff that will have a direct role in overseeing, designing, implementing, or executing HRSN responsibilities prior to launch of delivery of HRSN services
   iv. Necessary certifications, training, technical assistance, or education for staff participating in the HRSN program (e.g., on culturally competent or trauma-informed care)
   v. Privacy and confidentiality training and/or technical assistance related to HRSN service delivery
   vi. Production costs for training materials and/or experts as it pertains to the HRSN program

d. **Outreach, education, and stakeholder convening**
   i. Development and production of materials necessary for marketing, outreach, training, or education
   ii. Translation of materials
   iii. Development of culturally competent materials
   iv. Planning for and facilitation of community-based outreach events to support awareness of HRSN services
   v. Planning for and facilitation of learning collaboratives or stakeholder convenings
   vi. Community engagement activities necessary to support HRSN program implementation and launch
   vii. Administrative or overhead costs associated with outreach, education, or convening

4. **Projected expenditure amounts**
The state estimated the infrastructure expenditure amounts for the Demonstration by allowable use category. In developing the estimates, the state used the annual infrastructure spending amounts specified in the STCs and an analysis of anticipated need across the state. For purposes of monitoring the infrastructure spending cap, the state will notify CMS if spending approaches 90 percent of the allowable infrastructure amount.

Allowable use category	Percent of spend	Estimated amount
Technology	35%	$94.5 M
Development of operational or business practices	25%	$67.5 M
Workforce development	25%	$67.5 M
Outreach, education, and stakeholder convening	15%	$40.5 M
Total	**100%**	**$270 M**

Washington State Health Care Authority

Health-Related Social Needs (HRSN) services protocol

The Washington State Health Care Authority is submitting the Health-Related Social Needs (HRSN) services protocol for approval by the Centers for Medicare and Medicaid Services (CMS). The protocol addresses the requirements for provision of HRSN services specified in Section 15.7 of the Special Terms and Conditions (STCs) of the Washington State Section 1115 Medicaid Demonstration waiver renewed on June 30, 2023.

The Washington State HRSN services program will allow qualifying Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. This protocol specifies the set of covered HRSN services under Washington's 1115 Medicaid Demonstration waiver, beneficiary eligibility, expected implementation settings and providers, screening tool(s), determination of medical appropriateness, care plan development, and closed loop referrals.

The state's ongoing design and implementation of HRSN services is informed, in part, by the Taking Action for Healthier Communities (TAHC) Task Force. The task force includes Washington's nine Accountable Communities of Health (ACHs), five managed care organizations (MCOs), and other state partners. Recommendations from the TAHC Task Force contribute to the implementation of HRSN services.

This document reflects the state's plans to date, and the state expects to amend or expand the information provided, as necessary.

Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services.

a. The state may choose to cover a subset of the HRSN services and/or beneficiary qualifying criteria specified in Attachment O. Changes to the state's service offerings and eligibility criteria, within what CMS has approved in Attachment O, do not require additional CMS approval. The state must follow the following process to notify CMS of any such HRSN service or qualifying criteria change:
    i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.
    ii. The state must provide public notice.
    iii. The state must submit a letter to CMS no less than 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.

b. In addition to the requirements in a. above, if the state seeks to implement additional clinical and social risk factors than what were included in approved Attachment O, the state must follow the process below to update the protocol:
   i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and social risk factors through the protocol process described in this STC if CMS determines the criteria are allowable and doing so would not increase the state's HRSN expenditure authority at the time of demonstration approval of the expenditure authority for HRSN services.
   ii. The state must receive CMS approval for the updated protocol prior to implementation of changes under this subpart (b).
   iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process outlined in this subpart (b). This restriction is not applicable to the process and scope of changes outlined in (a).

Waiver-funded HRSN Services

I. Introduction

This protocol covers the following set of HRSN services as specified in Section 15.7 of the STCs:

HRSN intervention: Nutrition Supports

- Nutrition counseling and education
- Medically tailored meals for up to 3 meals a day, for up to 6 months[1]
- Meals or pantry stocking for up to 3 meals a day, for up to 6 months[1]
- Fruit and vegetable prescriptions for up to 6 months[1]
- Short-term (no more than 30 days) grocery provision

HRSN intervention: Housing/Home Environment

- Recuperative care and short-term post-hospitalization housing
- Housing transition navigation services

[1] This intervention may be renewed for additional 6-month periods if the state determines the beneficiary still meets the clinical and needs-based criteria.

- Rent/temporary housing
- Community transition services
  - Transportation for non-emergency, non-medical needs
  - Personal care and homemaker services
- Stabilization centers
- Day habilitation programs
- Caregiver respite services
- Medically necessary environmental accessibility and remediation adaptations

HRSN intervention: Case management, outreach, and education

- Case management, outreach, and education

Washington envisions a blend of funding authorities for HRSN services, with the goal of delivering services across the state's entire Medicaid population. Consistent with Washington's special terms and conditions (STC), the state will claim federal financial participation (FFP) under the demonstration only for those individuals who are assessed and meet the approved clinical and social risk factors.

This implementation structure, in particular the establishment of nine Community Hubs, is made possible, in part, by the state's nine Accountable Communities of Health (ACHs). ACHs are independent non-profit organizations aligned with the state's Medicaid purchasing regions and covering all areas of the state. Under the terms of Washington's 1115 waiver, each ACH will establish a Community Hub to provide case management, outreach, and education. The hubs also will support the delivery of other approved HRSN services.

The state will work with tribes to create a single statewide Native Hub to provide similar navigation services and support. Although the nine Community Hubs may limit their services to their respective regions, any qualifying individual in Washington may access community-based care coordination and services through any one of the 10 hubs. The details of the Community Hubs and the Native Hub in the role of HRSN service delivery will be provided in a policy guide that the state is currently developing.

When appropriate, the state will coordinate with managed care organizations (MCOs) to seek parallel in lieu of service (ILOS) authority pursuant to 42 CFR 438.3(e)(2). ILOS will be the primary authority for HRSN services offered through Washington's managed care plans.

Pursuing both avenues for the provision of selected HRSN services will extend the availability of these services to the state's entire Medicaid population.

Regardless of funding authority, these services will be the choice of the individual. Individuals can opt out anytime, and providing these services does not absolve the state or MCO of responsibility to provide coverage for other medically necessary services.

Table 1 outlines the state's current assumptions about funding authority for the covered population(s) for each waiver approved HRSN service.

Table 1

HRSN service	Waiver authority population(s) served	ILOS authority population served
Nutrition supports	Fee-for-service	Managed care
Recuperative care and short-term post-hospitalization housing	Fee-for-service Managed care	N/A
Housing transition navigation services	Fee-for-service Managed care	N/A
Rent/temporary housing	Fee-for-service Managed care	N/A
Community transition services: Non-emergency, non-medical transportation	Fee-for-service Managed care	N/A
Community transition services	Fee-for-service	Managed care
Stabilization centers	Fee-for-service	Managed care
Day habilitation programs	Fee-for-service	Managed care
Care respite services	Fee-for-service	Managed care

Environmental accessibility and remediation adaptations	Fee-for-service	Managed care
Case management, outreach, and education (delivered through the community and Native hubs)	Fee-for-service Managed care	N/A

See Appendix B for further details about each service, including eligibility, expected implementation settings, and provider types.

II. Implementation timeline

Washington State anticipates initial implementation of selected HRSN services, including the launch of the Community Hubs, in mid-2024, and the launch of the Native Hub by early 2025. Further details on the expected timeline will be provided in the state's forthcoming implementation plan.

III. Member Eligibility Criteria

Individuals will need to meet the following eligibility criteria for HRSN services:

- Be enrolled in Apple Health (Medicaid) Have at least one of the **clinical risk factors** (listed in Appendix A)
- Have one of the **social risk factors** (listed in Appendix A) and
- Have the HRSN service be determined to be **medically appropriate** for the individual.

Additional HRSN service specific eligibility criteria may apply and are detailed in Appendix A.

Clinical Risk Factors

Individuals must meet one of the HRSN clinical risk factors listed in Appendix A based on assessment by service provider and included in the individual's care.

Social Risk Factors

Individuals must meet one of the HRSN Social risk factors listed in Appendix A based on assessment by service provider and included in the individual's care.

Medical Appropriateness

Title XIX or Title XXI eligibility is a mandatory prerequisite for participation in HRSN services covered under this waiver. The state currently defines medically appropriate care as:

"a requested service of setting for which care is intended to address the health needs of the individual, including physical, substance use, mental health, and HRSN. The service or setting, including the level or intensity, must be appropriate to the individual's health care needs, social needs, and condition. The service or setting must be reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the individual that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction."

This definition was developed as part of the state's recent submission for ILOS approval for intensive behavioral supports supervision (IBSS). Although ILOS is not part of the waiver-approved set of HRSN services, work to date provides background and structure for implementation of future HRSN services. As noted before, the state will seek parallel ILOS authority for waiver-funded HRSN services, when appropriate.

In addition to continuing to refine the definition of medical appropriateness, the state will develop a process for determining and documenting medical appropriateness. That process may apply to the provision of both ILOS and waiver-funded HRSN services and will be developed in partnership with ACHs, IHCPs, MCOs, and community and Native hubs, among others. The state anticipates having a pilot process in place by the beginning of Q3 2024, the earliest date hubs are expected to begin providing case management, outreach, and education under terms of the waiver.

The state will determine the appropriate mechanism for sharing medical appropriateness and other eligibility criteria among clinical providers, MCOs, ACHs, IHCPs, community and Native hubs, and community-based organizations (CBOs). That sharing may be used, in part, to identify appropriate HRSN services and make appropriate referrals. Shared information may include:

- Results of HRSN screening
- Medicaid eligibility and enrollment status
- Member utilization of Medicaid services to prevent duplication of benefits
- Others as identified by the state

Throughout the duration of the 1115 waiver, the state will continue to evaluate and revise criteria, as necessary.

IV. Publicly Maintained Criteria

The state will maintain all HRSN eligibility criteria, HRSN service, and medical appropriateness on public-facing webpages. The state will communicate any changes to CMS, and any changes must be approved by CMS prior to posting or implementation if they are inconsistent with the content of this protocol. The state will update its public facing content and will require MCOs, ACHs, community and Native hubs, and provider partners to make similar updates. In addition, the state will create and maintain publicly available policy guides for each approved service.

V. HRSN Services

The state will cover the menu list of HRSN services as defined in Appendix A.

Use of a Third-Party Administrator or Other Contracted Vendor

The state may contract with a Third-Party Administrator (TPA) or other contracted entity to perform administrative functions of HRSN services for both managed care and FFS members.

The procurement process for a contracted entity will be detailed in the HRSN implementation plan and takes into consideration the following administrative functions, among others:

- Training and technical assistance to HRSN providers
- Billing and claim process support as a centralized clearinghouse for billing some HRSN services

Conflict of interest

- Should the state contract with a TPA or other entity to perform administrative or training functions for the provision of HRSN services, the state will establish protocols to ensure that all activities are performed in a manner that guards against conflicts of interest in accordance with all applicable requirements.
- The state shall ensure appropriate protections against conflicts of interest in the service planning and delivery of HRSN services. The state agrees that appropriate separation of assessment, service planning and service provision functions are incorporated into the state conflict of interest policies.
- If the state contracts with Tribal organizations to perform HRSN service authorization and service planning for American Indian/Alaskan Native (AI/AN) enrolled in the state's FFS program, those Tribal organizations may also furnish HRSN services,

subject to protocols established by the state to ensure that assessment, service planning, and service provision are performed in a manner that guards against conflict of interest in accordance with all applicable requirements.

Providing culturally and linguistically appropriate services.

All HRSN services must be provided in a way that is culturally responsive, trauma-informed, and linguistically appropriate for Medicaid and FFS. HRSN service providers are required to support and follow established guidelines, such as:

- The National Standards for Culturally and Linguistically Appropriate Services (CLAS)
- The Centers for Disease Control's (CDC) Office of Readiness and Response (ORR), in collaboration with SAMHSA's National Center for Trauma-Informed Care (NCTIC)
- Any other national established guidelines

Nonduplication of services

- HRSN service will not be duplicative of a state or federally funded service or other HRSN service the member is already receiving.
- The state will work with federal, state, and local agencies to align and leverage existing federal, state, and local services and resources. Alignment with these partnerships will be provided in the implementation plan.
- The state will coordinate with cross-sector waiver-related initiatives.

VI. Provider Qualifications

Service providers will be required to meet the minimum qualifications described below to demonstrate the capacity and experience to provide HRSN services:

Providers will be required to meet minimum qualifications based on HRSN services, as detailed in Table 2 and Appendix A. Entities that contract with HRSN service providers (HCA, MCOs, Community Hubs, etc.) will be required to ensure that HRSN service providers meet and maintain compliance provider qualification requirements.

Table 2

HRSN intervention	Provider qualifications
Nutrition	• Nutrition services providers must have knowledge of principles, methods, and procedures of the nutrition services covered under the waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety.
Housing/Home Environment	• Housing services providers must have knowledge of principles, methods, and procedures of housing services covered under the waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing. • Providers of environmental accessibility and remediation adaptation services must maintain all credentials required by local, state, and federal law, including licensing and insurance, to perform relevant services. Environmental accessibility and remediation adaptation providers must have the ability to deliver services in a timely and appropriate manner.
Case management, outreach, and education	• HRSN case management, outreach, and education providers must have knowledge of principles, methods, and procedures of these services or comparable services meant to reach to and engage the populations covered under the waiver and connect them to benefits and services to meet their needs. • HRSN case management, outreach, and education providers must contract with the Community Hubs and Native Hub.

HRSN Provider Experience and Expertise: All HRSN services providers are expected to meet certain qualifications that ensure they are capable of providing high-quality services to members as well as have culturally specific expertise to connect with members of diverse populations. Qualifications may include, for example:

- Maintain sufficient hours of operation and staffing to serve the needs of HRSN participants.

- The ability to comply with applicable federal and state laws.
- The capacity to provide culturally and linguistically appropriate, responsive, and trauma-informed service delivery, including by ensuring their ability to:
    - Adhere to federal and state laws and requirements related to ensuring communication and delivery of services to members with diverse cultural and ethnic backgrounds
    - Meet cultural needs of the community for whom it provides service
    - Provide documentation of how cultural responsiveness and trauma informed care trainings are impacting organizational policies and staff practices
    - Document efforts to recruit and employ staff who reflect the HRSN Provider's region's Medicaid population, including individuals with similar demographics, lived experience, background and language fluency to the greatest extent possible.
- A history of responsible financial stewardship and integrity via state review or oversight and/or annual financial report(s). Community Hubs and the Native Hub will provide HRSN services to eligible Medicaid beneficiaries, regardless of tribal membership, race, or national/ethnic origin. The Native Hub will provide such services statewide, and the Community Hubs may limit services to their associated regions.

VII. Member Identification and Assessment of HRSN Service Need

Member Identification

The state is currently working with MCOs and other state partners during the monthly TAHC Task Force meetings to develop the process for member identification and assessment of HRSN services. The state will ensure that individuals can be identified for HRSN services through many different approaches and by different entities. Such approaches include, but are not limited to:

- Identify individuals through a review of encounter and/or claims data
- Contract with HRSN Service Providers to conduct HRSN Outreach and Engagement to identify individuals and make HRSN Recommendations (described further below)
- Identify individuals through the screening tool identified in Section VIII
- Identify individuals who engage with Community Hubs and/or the Native Hub
- Accept members' self-referral

The following are examples of eligible entities that may support identification and assessment of individuals in need of HRSN services.

- ACHs

- Native Hub participants
- Providers of HRSN services, including, but not limited to:
  - Community-based organizations (CBOs)
  - Social-services agencies
  - Housing agencies and providers
  - Food and nutrition service providers
  - Case management providers
  - Traditional health workers
  - Child welfare providers
  - State, county, city, and local governmental agencies
  - Tribes and Indian health care providers (IHCPs)
  - Physical and behavioral health care providers
- Other entities supporting the infrastructure and delivery of HRSN services, such as technology and technical assistance providers,
- State-contracted third-party administrator and/or financial executor to support HRSN contracting, implementation, and service delivery
- Correctional institutions
- Child welfare workers and other case managers
- Individuals who self-refer for HRSN services

HRSN service referrals

The state is currently working with MCOs and other state partners during the TAHC Task Force meetings to develop a referral process for HRSN services requests. An eligible entity initiating the HRSN service referral process will take into consideration the following:

- Confirmation of individual's Medicaid enrollment and/or eligibility
- Capturing data information pertaining to the individual's name, contact information, and recommended HRSN service
- Identification of one or more HRSN service needs the individual may need and/or the potential HRSN eligibility
- Identification of appropriate culturally, linguistically, and trauma-informed service for the individual
- Documentation of the attempts to collect the individual's information needed to determine eligibility for HRSN service
- Any other additional information the state may deem appropriate.

The state envisions a role for the Community Information Exchange (CIE) in the data collection and data-sharing necessary for the provision of requesting HRSN services by eligible HRSN service provider entities. Guidance for a HRSN service request process will be provided to HRSN service providers and eligibility entities in a publicly available policy guide.

Eligibility Determination and Services Approval

The state is currently working with ACHs, Tribes, IHCPs, MCOs, behavioral and physical health care providers, and other partners to develop processes that take into consideration the following:

- Upon receipt of the information regarding the individual's HRSN needs, the appropriate administrative entity will use reasonable efforts to obtain all other information necessary to 1)determine individual's eligibility for HRSN and 2)authorize the appropriate HRSN services.
- Documentation process for all the required information needed to make a HRSN service eligibility determination.
- Documentation process for all the required information needed to make a HRSN service approval or denial.

The state will require the appropriate administrative entity to:

- Notify the individual or HRSN service approval or denial and provide information about appeals and hearing rights.
- Any another additional information the state may deem appropriate.

Individuals have the option to decline the HRSN services, in which case the state will require the appropriate administrative entity to document the individual's request to decline the HRSN services.

VIII. Screening tool

Individuals may be identified as eligible for HRSN services through an initial screening process conducted by an eligible entity described in Section VII. Any screening tools used to assess beneficiaries for interventions involving pre/post hospitalization or post-transition housing must map to 24 CFR 91.5 definitions, and those used to screen beneficiaries for nutrition interventions must map to USDA's definition of food insecurity.

In collaboration with ACHs, Indian health care providers (IHCPs), the community and Native hubs, MCOs, community members, and others as appropriate, the state will select an approved screening tool that can be used by community and Native hubs, the community-based workforce, care managers, and clinical care providers, among others, to identify individuals with HRSN. The approved screening

tool(s) will be made publicly available and eligible entities have the option to use the state approved screening tool(s) or use the screening tool(s) of their choice. The state reserves the right to review any screening tool selected to ensure it meets minimum criteria.

The state will build on current efforts under way among ACHs, MCOs, clinical partners, and other participants in the Medicaid Quality Improvement Program (MQIP). Those entities are in the process of selecting, testing, and implementing evidence-based screening tools, including Care Coordination System (CCS), Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE), and USDA Food Security Survey, among others. As the state moves forward with its planned statewide community information exchange (CIE) and hub operations are further defined, the goal will be to create a unified screening approach with approved screening tool(s).

Results of the screening will be used to inform navigation services for the individual, the individual's care plan, and referrals to appropriate HRSN services or clinical care.

At minimum the screening to assess an individual's HRSN must include:

- Housing instability
- Food insecurity
- Financial insecurity
- The need for transportation assistance
- Family and community support
- Behavioral health
- Interpersonal safety and violence
- Other HRSN as identified by the state
- Other identified CMS HRSN screening guidelines

As appropriate, the state will develop guidelines for rescreening individuals or revising the screening tool(s).

IX. Care management, care plan and closed loop referrals

The state will establish a process for creating, sharing, and updating plans for individuals who screen positive for HRSN service needs, are Medicaid/CHIP eligible, and whose care meets the standards for medical appropriateness. The shared care plan will include services to

address HRSN and may include plans for physical or behavioral health care. The plan may be shared among community and Native hubs, community-based providers, MCOs, clinical providers, and other appropriate administrative entities to ensure continuity of care.

A shared care plan could require data- and information-sharing among MCOs, community and Native hubs, CBOs, behavioral and physical health care providers, and other appropriate administrative entities. The state will set guidelines for the sharing and protection of clinical and nonclinical information. The state also will continue to work with MCOs, ACHs, and community and Native hubs during the monthly TAHC Task Force to define the scope of clinical care coordination, community-based care coordination, and closed loop referrals. Those definitions will help ensure that coordination efforts complement, rather than duplicate, each other.

The state will determine care plan requirements. At a minimum, a care plan will:

- Be tailored to an individual's HRSN.
- Document the person-centered planning process, including dialogue and referrals between an individual and the care team, and a shared decision-making process.
- Refer the member to a HRSN provider for the approved services, and supporting member choice of provider, ensuring member needs are met by the Provider, including through regular communication with the individual and HRSN Provider delivering the service, and finding alternative providers if needed.
- Identify other HRSN services the member may need.
- Determine what other services the individual is receiving or may be eligible to receive under Medicaid or other programs.
- Coordinate with other social support services and care management the member is already receiving or becomes eligible for while receiving the HRSN service.
- Ensure closed loop referrals to community-based services and the community-based workforce.
- Provide continuity of care.
- Be reviewed at least once every 12 months, and revised upon reassessment of need, when individual's circumstances or needs change, or at the request of the individual.
- Ensure culturally appropriate and trauma-informed care by following established guidelines, such as those set by the Centers for Disease Control's (CDC) Office of Readiness and Response (ORR), in collaboration with SAMHSA's National Center for Trauma-Informed Care (NCTIC).
- Include documentation of resolution of conflict, grievances, or appeals.
- Be confidential.

As noted, the state is committed to creating a mechanism to ensure closed loop referrals, including an effort to establish a statewide CIE. A CIE would, among other things, support efforts to deliver HRSN services. In the interim, the state will work with ACHs, MCOs, and others to leverage their current information-exchange systems to promote continuity of care.

X. Payment

Washington is currently working with CMS to establish protocols for funding case management, outreach, and education services through a per member per month (PMPM) payment model.

For other HRSN services, service providers will submit invoices after providing HRSN services to individuals who meet HRSN social and clinical eligibility criteria. Depending on the individual's coverage, providers will bill either the state or the individual's managed care plan.

Currently the state is exploring the possibility of procuring a third-party administrator (TPA) or other administrative entity to help organizations meet Medicaid billing requirements. ACH and MCO partners, as well as the TAHC Task Force, are guiding the state in this work.

HRSN service providers will be reimbursed according to a fee schedule for HRSN services to be developed by the state.

As appropriate, the state will develop guidelines for payment schedules and will be provided in a policy guide.

Appendix A

Jump to:

- Nutrition supports
  - Nutrition counseling and education
  - Medically tailored meals
  - Meals or pantry stocking
  - Fruit and vegetable prescriptions
  - Short-term grocery provision
- Recuperative care and short-term, post-hospitalization housing
- Housing transition navigation services
- Rent/temporary housing
- Community transition services
- Stabilization centers
- Day habilitation programs
- Caregiver respite services
- Medically necessary environmental accessibility and remediation adaptation
- Case management, outreach, and education

Nutrition counseling and education

Description	Authorized by STC 15.2(a)(i). Any combination of educational strategies designed to motivate and facilitate voluntary adoption of food choices and other food and nutrition-related behaviors conducive to health and wellbeing. This service may consist of the following: 1. Provision of nutrition education or information to an individual or group that offers evidence based or evidence informed strategies on adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being and guidance on food and nutrition resources. 2. Meal preparation education in an individual or group setting. Nutrition education services may be supplemented with handouts, take-home materials, and other informational resources that support nutritional health and well-being. This service must: • Be provided in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate.
Eligible population	All individuals enrolled in Apple Health (Medicaid).
Social risk factors	Eligible population meeting the USDA definition of low food security, or very low food security.

Clinical risk factors	Individuals with chronic conditions (including but not limited to diabetes, cardiovascular disorders, chronic infectious diseases such as human immunodeficiency virus (HIV), cancer, chronic gastrointestinal disorders, respiratory conditions such as cystic fibrosis, eating disorders, and chronic behavioral health conditions).
Duration and frequency (if applicable)	N/A
Implementation setting	Beneficiaries may receive services at: • Clinical settings (inpatient and outpatient) • Food banks • Community centers • Farmers markets • Member residence • Others as approved by the state
Provider type	A Registered Dietitian Nutritionist (RDN) (preferred), qualified health care professional, or, if not available, a community health worker to develop a medically appropriate nutrition care plan.

Medically Tailored Meals (MTMs)

Description	Authorized by STC 15.2(a)(ii). Meals tailored to support individuals with health-related condition(s) for which nutrition supports would improve health outcomes. This service includes: 1. Initial assessment and reassessment, if needed, with a provider to develop a medically appropriate nutrition care plan.

2. The preparation and provision of the prescribed meals consistent with the nutrition care plan, up to 3 meals a day, for up to 6 months at a time; and
3. Delivery of the meal.

Each meal must contain sufficient food to support approximately one-third of an individual's daily nutritional need as indicated by the Dietary Reference Intakes and Dietary Guidelines. The meal may also include an accompanying fluid/drink and/or a supplementary food item to support meeting a member's nutrition needs between meals if medically appropriate (for example, to provide access to fluids and/or support taking medication accompanied by food). Meals may consist of fresh or frozen food.

This service may be provided for up to 6 months with an option for renewal for up to 6 months if clinical and social needs factors still apply.

Members cannot receive medically tailored meals, meals or pantry stocking, or short-term grocery provisions concurrently.

If the member is a pregnant/postpartum person, then the member may receive these services either throughout their pregnancy and up to 12 months postpartum. The timing of eligibility determination during pregnancy or postpartum period does not affect the allowable duration of benefit. The intervention may apply to subsequent pregnancies/postpartum periods during the demonstration period if the member meets the needs-based clinical criteria at the time of the subsequent pregnancies/postpartum periods.

If the member is a child/adolescent (0-21 years of age) or a pregnant person meeting needs-based criteria, additional meal support may be provided for the household.

The service must:

- Be provided in accordance with nutrition-related national guidelines, such as the Dietary Guidelines for Americans, or

	evidence-based practice guidelines for specific chronic diseases and conditions. • Follow food safety standards. • Consider an individual's personal and cultural dietary preferences.
Eligible population	All individuals enrolled in Apple Health (Medicaid).
Social risk factors	Eligible population meeting the USDA definition of low food security , or very low food security.
Clinical risk factors	Eligible population: • with chronic conditions (including but not limited to diabetes, cardiovascular disorders, chronic infectious diseases such as human immunodeficiency virus (HIV), cancer, chronic gastrointestinal disorders, respiratory conditions such as cystic fibrosis, eating disorders, and chronic behavioral health conditions), and • has been or is being discharged from institutional care, a hospital, or congregate settings ,within 6 months, such as skilled nursing facilities, large group homes, residential settings, Institutions of Mental Diseases, correctional facilities, and acute care hospitals; or at high risk of hospitalization or nursing facility placement.
Duration and frequency (if applicable)	Up to 3 meals a day for up to 6 months.
Implementation setting	N/A
Provider type	A Registered Dietitian Nutritionist (RDN) (preferred), or, if not available, a primary care provider to develop a medically appropriate nutrition care plan.

Meals or Pantry stocking

Description	Authorized by STC 15.2(a)(iii).

This service allows an individual to purchase an assortment of foods aimed at promoting improved nutrition for the individual. Individuals may pick up food from food retailers or have food delivered to the individual's home or private residence if delivery service is available. This service must be consistent with the nutrition care plan.

Examples of allowable foods include:

- Fruits and vegetables
- Meat, poultry, and fish
- Dairy products
- Breads and cereals
- Snack foods and non-alcoholic beverages
- Seeds and plants, which produce food for the household to eat

This service may:

- Take into account an individual's household size
- Be administered through, for example, a voucher or prepaid card to be used only at a food retailer for allowable purchases
- Be provided in conjunction with resources on the Dietary Guidelines for Americans to encourage healthy food selection

This service must:

- Be provided in accordance with evidence-based nutrition guidelines.
- Follow food safety standards.
- Be person-centered, consider dietary preferences, and be culturally appropriate.
- Not supplant or duplicate the work of other federal or state non-Medicaid agencies.

Eligible population

All individuals enrolled in Apple Health (Medicaid).

Social risk factors	Eligible population meeting the USDA definition of low food security, or very low food security.
Clinical risk factors	Eligible population with chronic conditions (including but not limited to diabetes, cardiovascular disorders, chronic infectious diseases such as human immunodeficiency virus (HIV), cancer, chronic gastrointestinal disorders, respiratory conditions such as cystic fibrosis, eating disorders, and chronic behavioral health conditions).
Duration and frequency (if applicable)	This service is available for up to 3 meals per day for up to 6 months. It may be renewed for additional 6-month periods if the state determines the beneficiary still meets all eligibility criteria. Members cannot receive medically tailored meals, meals or pantry stocking, or short-term grocery provisions concurrently.
Implementation setting	N/A
Provider type	N/A

Fruit and vegetable prescriptions

Description	Authorized by STC 15.2(a)(iv). This service allows an individual to purchase fruits and vegetables from participating food retailers and farms. Fruits and vegetables available for purchase through this service may be fresh, frozen, or canned. Individuals may pick up food from food retailers or have food delivered to where the individual resides if delivery service is available. This service may: • When the individual receiving the service is a child or pregnant individual, take into account an individual's household, using the SNAP definition of a household to determine the benefit level for these beneficiaries.

	• Be administered through, for example, a voucher or prepaid card to be used only at a food retailer for allowable purchases • Be provided in conjunction with resources on the Dietary Guidelines for Americans to encourage healthy food selection This service must: • Be provided in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate. • Not supplant or duplicate the work of other federal or state non-Medicaid agencies.
Eligible population	All individuals enrolled in Apple Health (Medicaid).
Social risk factors	Eligible population meeting the USDA definition of low food security, or very low food security.
Clinical risk factors	Eligible population with chronic conditions (including but not limited to diabetes, cardiovascular disorders, chronic infectious diseases such as human immunodeficiency virus (HIV), cancer, chronic gastrointestinal disorders, respiratory conditions such as cystic fibrosis, eating disorders, and chronic behavioral health conditions).
Duration and frequency (if applicable)	This service is available for up to 6 months. It may be renewed for additional 6-month periods if the state determines the beneficiary still meets all eligibility criteria.
Implementation setting	N/A
Provider type	N/A

Short-term grocery provisions

Description	Authorized by STC 15.2(a)(v). This service allows an individual to purchase an assortment of foods aimed at promoting improved nutrition for the individual. Individuals may pick up food from food retailers or have food delivered to the individual's home or private residence if delivery service is available. This service must be consistent with the nutrition care plan. Examples of allowable foods include: • Fruits and vegetables • Meat, poultry, and fish • Dairy products • Breads and cereals • Snack foods and • Non-alcoholic beverages • Seeds and plants, which produce food for the household to eat This service may: • Take into account an individual's household size If the member is a child/adolescent (0-21 years of age) or a pregnant person • Be administered through, for example, a voucher or prepaid card to be used only at a food retailer for allowable purchases • Be provided in conjunction with resources on the Dietary Guidelines for Americans to encourage healthy food selection This service must: • Be provided in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate.

	• Not supplant or duplicate the work of other federal or state non-Medicaid agencies.
Eligible population	All individuals enrolled in Apple Health (Medicaid).
Social risk factors	• Eligible population meeting the USDA definition of low food security, or very low food security.
Clinical risk factors	Eligible population who: • Is enrolled in LTSS and • has been or is being discharged within 6 months from the hospital or skilled nursing facility, or at high risk of hospitalization or nursing facility placement.
Duration and frequency (if applicable)	Individuals may stock up on groceries for 30 days, no more than once per calendar year. The cost of groceries for each instance of the service may not exceed 200% of the U.S. Department of Agriculture (USDA) SNAP Allowance for one month. Members cannot receive medically tailored meals, meals or pantry stocking, or short-term grocery provisions concurrently.
Implementation setting	N/A
Provider type	N/A

Recuperative care and short-term post-hospitalization housing

Description	Authorized by STC 15.2(b)(i). Recuperative care and short-term post-hospitalization housing settings provide a safe and stable place for eligible individuals to receive treatment on a short-term basis. This service is for individuals who are transitioning out of institutions and at risk of incurring other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits (as determined by a provider at the plan or network level).

	Eligible cost: • Room and board, food as well as food delivery costs, transportation, medical supplies Service may include: • Shelter • Clinical assessments • Behavior health screenings (for psychosocial needs) • Case management support in accessing benefits and housing • 24-hour bed rest and 24-hour wellness checks • Medical oversight that includes medication monitoring and ongoing assessments to determine whether or not treatments/care plans are effective • Minor clinical interventions (e.g. wound care, infection control, non-pharmacological pain management) • Medical case management for care coordination, transportation to medical appts, 3 meals per day • Safe storage for belongings, laundry • Cell phone for tele-health appointments
Eligible population	All individuals enrolled in Apple Health (Medicaid)
Social risk factors	• Eligible population who are homeless or at risk of homelessness, as defined by 24 CFR 91.5 with the exception of the annual income requirement in 24 CFR 91.5 (1)(i).
Clinical risk factors	Eligible population who is:

- At risk[2] of incurring other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits (as determined by clinicians at the plan or network level); and

- Meets at least one of the following three (3) health needs-based criteria:

  1) Individual assessed to have a behavioral health need, which is defined as one or both of the following criteria:

     a) Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or

     b) Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment.

  2) Individual assessed to have a need for assistance, demonstrated by the need for:

[2]. There is a predictive model, or a framework, being used by the National Institute for Medical Respite Care (NIMRC) which includes guiding principles, standards and models of care for medical respite. **https://nimrc.org/wp-content/uploads/2023/05/Framework-for-MRC-Delivery_-2023.pdf**

	a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388- 106-0010, one of which may be body care, and/or b) Hands-on assistance with one or more ADLs, one of which may be body care. 3) Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support).
Duration	Recuperative care: up to 90 days at a time and no more than 6 months per rolling 12-month period. Short-term post-hospitalization housing: up to six months once during the demonstration period. All section 1115 demonstration HRSN housing interventions with room and board are limited to global HRSN housing cap of a combined 6 months per rolling 12-month period.
Implementation setting	Implementation settings for recuperative care and short-term post-hospitalization housing must have appropriate clinicians who can provide medical and/or behavioral health care. The facility cannot be primarily used for room and board without the necessary additional recuperative support services. Medical respites without clinicians on site must work closely with Federally Qualified Health Centers (FQHCs) and provide care coordination through case management services. Implementation settings may include: • Hospitals, health centers, and other clinics • Wellness/respite centers • Social service centers • Skilled nursing facilities • Assisted living facilities

	• Residential group homes or small apartment buildings • Community centers • Adult family homes • Transitional housing facilities • Other as approved by the state Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g. gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from the demonstration.
Provider type	Providers may include: • Licensed physical health providers • Licensed behavioral health providers • Providers of transitional housing support • Case managers • Others as approved by the state
Specific provider qualifications	Both clinical and non-clinical staff with preferred experience consisting of registered nurses – patient care and admission coordinators, certified Community Health Workers and/or Peer specialists, Certified Medical Assistants (CMA), Mental Health Practitioner (Masters level SW or Licensed Mental Health Counselors), Behavioral Health Specialists (bachelor's level in psychology/sociology). Medical Respite providers should be following the guidelines of the National Institute of Medical Respite Care, meet the Standards for Medical Respite Care Programs, and complete HCA's Attestation for Respite Providers. Facility requirements: A facility that provides MRC services must meet local codes and ordinances for licensing, safety, and occupancy.

Housing transition navigation services

Description	Authorized by STC 15.2(b)(ii). Housing transition navigation services are services that aim to remove barriers to affordable housing including transition costs and housing deposits to assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to help a person establish a basic household. Short-term transition and moving costs necessary to establish a basic household such as: 1. Expenses needed to secure housing (i.e. security deposits, application fees, background checks); and first month's rent as required by landlord for occupancy. All section 1115 demonstration HRSN housing interventions with room and board are limited to global HRSN housing cap of a combined 6 months per rolling 12-month period. Room and board-only interventions are limited to a combined 6 months per household per demonstration period. 2. Utility set-up fees/deposits and up to six months of unresolved utility arrearages if necessary to set up services in new residence; and first month coverage of utilities, including water, garbage, sewage, recycling, gas, electric, internet and phone (inclusive of land line phone service and cell phone service), with a ceiling of up to six months in total retrospective/prospective payments of utilities per demonstration period. 3. Relocation expenses (i.e., moving, transportation to new residence, and storage costs) 4. Pantry stocking at move in (differs from meals and pantry stocking HRSN service)

	a. This service must be provided in conjunction with resources on the Dietary Guidelines for Americans to encourage healthy food selection b. Individuals may stock up on groceries for 30 days, no more than once per calendar year. The cost of groceries for each instance of the service may not exceed 200% of the U.S. Department of Agriculture (USDA) SNAP Allowance for one month. 5. Basic household goods and furniture, which may include appliances and utensils necessary for food consumption, bedding, furnishings, cribs, bathroom supplies, and cleaning supplies 6. Medically necessary environmental modifications including landlord approved and medically necessary home accessibility modifications, assistive technology, and devices to maintain healthy temperatures and clean air.
Eligible population	• All individuals enrolled in Apple Health (Medicaid).
Social risk factors	• Eligible population who are homeless or at risk of homelessness, as defined by 24 CFR 91.5 with the exception of the annual income requirement in 24 CFR 91.5 (1)(i); • For the service of pantry stocking, eligible population meeting the USDA definition of low food security, or very low food security.
Clinical risk factors	Eligible population who meets at least one of the following three (3) health needs-based criteria: 1) Individual assessed to have a behavioral health need, which is defined as one or both of the following criteria: a) Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or

b) Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment.

2) Individual assessed to have a need for assistance, demonstrated by the need for:

a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388- 106-0010, one of which may be body care, and/or

b) Hands-on assistance with one or more ADLs, one of which may be body care.

3) Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support).

Duration and frequency (if applicable)	Allowable expenditures may be covered up to a financial limit established by the state over the course of one 12-month period per instance, starting at the initial provision of services to support housing search, selection, and tenancy sustainability of individuals experiencing HRSN.
Implementation setting	N/A
Provider type	Any provider who is eligible to hold a contract with Washington State's Department of Social and Health Services (DSHS), HCA, and/or the Department of Commerce (Commerce) and any housing related contracts held through these contractors' awardees.

	Provider organizations must have demonstrated experience with providing housing-related services and supports and may include entities such as: • Vocational services agencies • Providers of services for individuals experiencing homelessness • Life skills training and education providers • County agencies • Public hospital systems • Mental health or substance use disorder treatment providers, including county behavioral health agencies • Social services agencies • Affordable housing providers • Supportive housing services providers • Permanent Supportive Housing operators • Peer Support service providers • Federally qualified health centers and rural health clinics • Others as approved by the state
Specific Provider qualifications	Any provider who is eligible to hold a contract with Health Care Authority, Department of Social and Health Services, and/or Department of Commerce and any housing-related contracts held through these contractors' awardees.

Rent/temporary housing

Description	Authorized by STC 15.2(b)(iii). Rent/temporary housing provides stable independent living situations for individuals transitioning out of institutional care or congregate settings who are homeless or at risk of homelessness. Payment may cover rent and/or short-term, temporary stays for up to six months including: • Rent payments for apartments, single room occupancy (SRO) units, single-family homes, multifamily homes, mobile home

	communities, accessory dwelling units (ADUs), co-housing communities, trailers, manufactured homes; or • Manufactured home lots, motel or hotel when it is serving as the individual's primary residence; or • Transitional and recovery housing including bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming. Rent/temporary housing 1. Rent payment (past due or forward rent but capped at six months of total rent payments per demonstration period). All section 1115 demonstration HRSN housing interventions with room and board are limited to global HRSN housing cap of a combined 6 months per rolling 12-month period. 2. Storage fees and movers' fees 3. Renter's insurance, if required by the lease 4. Landlord paid utilities that are part of the rent payment and not duplicative of other HRSN utility payments 5. Recurring utilities, including expenses for garbage, water, sewage, recycling, gas, electric, Internet, Phone (inclusive of land line phone service and cell phone service) , with a ceiling of up to six months in total retrospective/prospective payments of utilities per demonstration period. 6. Non-refundable, non-recurring utility set-up costs for utilities or restart costs if the service has been discontinued, and up to six months of arrears related to unpaid utility bills, but capped at six months of total arrears/prospective utility payments per demonstration.
Eligible population	All individuals enrolled in Apple Health (Medicaid).
Social risk factors	• Eligible population who are homeless or at risk of homelessness, as defined by 24 CFR 91.5 with the exception of the annual income requirement in 24 CFR 91.5 (1)(i);

Clinical risk factors	Eligible population who meets at least one of the following three (3) health needs-based criteria: 1) Individual assessed to have a behavioral health need, which is defined as one or both of the following criteria: a) Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or b) Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment. 2) Individual assessed to have a need for assistance, demonstrated by the need for: a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388- 106-0010, one of which may be body care, and/or b) Hands-on assistance with one or more ADLs, one of which may be body care. 3) Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support).
Duration and frequency (if applicable)	Up to six months once during the demonstration period.

Implementation setting	Services to be provided in independent living situations, such as in-home, and interim housing settings. Payments must be provided only in connection with dwellings that meet maintenance regulation code within the local jurisdiction for safety, sanitation, and habitability. Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g. gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from the demonstration.
Provider type	Provider organizations must have demonstrated experience with providing housing-related services and supports and may include entities such as: • Vocational services agencies • Providers of services for individuals experiencing homelessness • Life skills training and education providers • County agencies • Public hospital systems • Mental health or substance use disorder treatment providers, including county behavioral health agencies • Social services agencies • Affordable housing providers • Supportive housing services providers • Permanent supportive housing operators • Peer support service providers • Federally qualified health centers and rural health clinics • Others as approved by the state
Specific Provider qualifications	Any provider who is eligible to hold a contract with Health Care Authority, Department of Social and Health Services, and/or Department of Commerce and any housing-related contracts held through these contractors' awardees.

Community transition services

Description	Authorized by STC 15.2(b)(iv).

	Community transition services help individuals live in the community and avoid further institutionalization by providing:
	1. Transportation for nonmedical, non-emergency needs.
	2. Personal care and homemaker services.
	
	Personal Care and homemaker services are short-term care for individuals who do not qualify or no longer qualify for standard Home and Community Based services, have behavioral health conditions, and whose condition would be exacerbated by an unstable living environment. Access to this service would allow individuals to continue their community stabilization.
	
	At a minimum, the service will include meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:
	• Limited or short-term assistance with Instrumental Activities of Daily Living (IADLs) and/or Activities of Daily Living (ADLs), including:
	  ○ Personal care services (such as bowel and bladder care, bathing, grooming, transfer, and paramedical services);
	  ○ Medication management;
	  ○ House cleaning;
	  ○ Meal preparation;
	  ○ Laundry;
	  ○ Grocery shopping;
	  ○ Accompaniment to medical appointments.

Eligible population	All individuals enrolled in Apple Health (Medicaid) who are enrolled *in the Foundational Community Supports program*.
Social risk factors	• Eligible population who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5 with the exception of the annual income requirement in 24 CFR 91.5 (1)(i).

Clinical risk factors

Eligible population has been or is being discharged from institutional care, a hospital, or congregate settings such as skilled nursing facilities, large group homes, residential settings, Institutions of Mental Diseases, correctional facilities, and acute care hospitals; or at high risk of hospitalization or nursing facility placement; and

Eligible population who meets at least one of the following three (3) health needs-based criteria:

1) Individual assessed to have a behavioral health need, which is defined as one or both of the following criteria:

a) Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or

b) Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment.

2) Individual assessed to have a need for assistance, demonstrated by the need for:

a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388- 106-0010, one of which may be body care, and/or

b) Hands-on assistance with one or more ADLs, one of which may be body care.

	3) Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support).
Duration	N/A
Implementation setting	• The services are available in a home that is owned, rented, leased, or occupied by the individual or their caregiver. • For a home that is not owned by the individual, the individual must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).
Provider type	Providers may include: • Home health agencies • Area Agencies on Aging (AAA) • Foundational Community Supports providers • Other providers as approved by the state
Specific provider qualifications	Any provider who is eligible to hold a contract with Health Care Authority or Department of Social and Health Services.

Stabilization centers

Description	Authorized by STC 15.2(b)(v). Community Stabilization Centers are alternative destinations for individuals who are found to be publicly under the influence of substances, and/or recently experienced an overdose, and would otherwise be transported to the emergency department or jail. Stabilization centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to stabilize and access case management and other

	supportive services. Stays are limited to less than 24 hours. Service does not include room and board. Specific services may include, but are not limited to: • Behavioral and physical health screening • Case management to include referral to community supportive services • Basic medical services, to include staff who can screen individuals for medical and behavioral health needs. • Telehealth to include prescribing of medications for opioid use disorder • Peer Services • On-site shower and laundry services • Nutritional support
Eligible Population	All individuals enrolled in Apple Health (Medicaid).
Social risk factors	• Eligible population who are homeless or at risk of homelessness, as defined by 24 CFR 91.5 with the exception of the annual income requirement in 24 CFR 91.5 (1)(i)

Clinical risk factors	• Eligible population who are under the influence of substances or recently overdosed and report an active substance use disorder and
	  ○ are seeking services and support and are reluctant to seek care in a traditional clinical or emergency department setting; and
	  ○ are reluctant to seek care in a traditional clinical or emergency department setting; or
	  ○ who in the absence of a diversion alternative, would be taken to an emergency room or jail; or
	  ○ who are at risk of withdrawal or recurrent overdose symptoms.

Duration	Less than 24 hours.
Implementation setting	Provider facilities may include designated stabilization centers or other appropriate and allowable substance use disorder (SUD) facilities. This

	may include existing "diversion centers" which offer short-term placement and shelter to homeless individuals, diverting them away from the criminal court system. If shelter is provided, it is through the setting and not through this service. Clinical, behavioral health and navigation, coordination services are provided in this setting supported by nurses, mental health professionals, community health workers, and certified peer counselors. Induction on medications for opioid use disorder via on site or remote site prescribing provider.
Provider type	Providers may include: • Behavioral health agencies • Homelessness services agencies • Federally qualified health centers • Community Based Organizations • Others as approved by the state
Specific provider qualifications	Nurses, mental health professionals, and for care coordination/navigation services, community health workers and peer support specialists. Providers must have: • Experience and expertise with providing these services, assessment and management of acute intoxication and post overdose care; • Experience in working with unhoused or other marginalized populations; and • Experience working from a harm reduction, trauma informed philosophy. Services are provided under the supervision of a DEA registered provider.

Day habilitation programs

Description	Authorized by STC 15.2(b)(vi). Day habilitation programs help an individual acquire, retain, and improve self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. Day habilitation program services promote independence within the community and do not include room and board. Examples of program services may include: • Developing and maintaining interpersonal relationships • Education about the use of public transit and other transportation options • Behavioral health and physical health management skill development • Prevocational Services and Supports – services and supports to build skills necessary to perform compensated work in community integrated employment • Personal skills development in conflict resolution • Development of daily living skills (e.g., cooking cleaning, shopping, or money management) • Community resource awareness such as police, fire, or local services to support independence in the community. • Community participation Programs may include assistance with, but not limited to, the following • Seeking, selecting, securing housing • Settling disputes with landlord • Managing personal financial affairs and personal crisis planning • Seeking and securing employment • Accessing and navigating additional social services • Asserting civil and statutory rights through self-advocacy

	• Building and maintaining interpersonal relationships, including a circle of support • Coordination with Apple Health managed care plan to link member to any community supports and/or enhanced care management services for which the member may be eligible • Referral to housing resources if member does not meet current eligibility criteria • Assistance with income and benefits advocacy including Housing and Essential Needs (HEN), Supplemental Nutrition Assistance Program (SNAP), and SSI if member is not receiving these services and is eligible • Coordination with Apple Health managed care plan to link member to health care, mental health services, and substance use disorder services based on the individual needs of the member for members who are not receiving this linkage through other supports • Services may be provided in conjunction with but will not duplicate other related housing and employment supports and services.
Eligible population	All individuals enrolled in Apple Health (Medicaid).
Social risk factors	• Eligible population who are homeless or at risk of homelessness, as defined by 24 CFR 91.5 with the exception of the annual income requirement in 24 CFR 91.5 (1)(i);
Clinical risk factors	

Eligible population who meets at least one of the following three (3) health needs-based criteria:

1) Individual assessed to have a behavioral health need, which is defined as one or both of the following criteria:

a) Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning

(including ability to live independently without support) resulting from the presence of a mental illness; and/or

b) Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment.

2) Individual assessed to have a need for assistance, demonstrated by the need for:

a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388- 106-0010, one of which may be body care, and/or

b) Hands-on assistance with one or more ADLs, one of which may be body care.

3) Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support).

Duration and frequency (if applicable)	Less than 24 hours.
Implementation setting	Day habilitation program services are provided in an out-of-home, non-facility setting
Provider type	Providers of day habilitation services may include: • Behavioral health or substance use disorder treatment providers • Licensed psychologists • Registered nurses

	• Home health agency staff • Homeless services providers • Vocational skills agency staff • Peer support service providers • Clubhouse staff • Recovery Café staff • Others as approved by the state
Specific Provider qualifications	These services are often considered as peer mentoring or psycho-social rehabilitation services when provided by an unlicensed caregiver with the necessary training and supervision. Providers who offer the services include, but are not limited to: • Behavioral health or substance use disorder treatment providers • Licensed Psychologists • Licensed Certified Social Workers • Registered Nurses • Home health agencies • Homeless services providers, including housing and employment navigation services providers • Vocational skills agencies • Peer support service providers • Clubhouses • Recovery Cafes • Community Peer Run Organizations • Occupational Therapists • Other providers as approved by the state

Caregiver respite services

Description	Authorized by STC 15.2(b)(vii).

	Caregiver respite services provide intermittent temporary supervision on a short-term basis. Services provided to the individual are primarily non-medical and may include attending to the individual's basic self-help needs and other activities of daily living (ADL), including interaction, socialization, and continuation of usual daily routines that would ordinarily be performed by a caregiver. Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional placement. Services may include help with activities of daily living (bathing, dressing, etc.), daily housework (e.g., dishes, laundry, vacuuming), preparing meals, transportation to appointments, grocery shopping and assistance with yard and household maintenance, and general companionship. Respite services must be consistent with provider requirements and service requirements include: • Providing observation, direct support, and monitoring to meet the physical, emotional, social, and mental health needs of an individual consumer by someone other than the primary caregivers. • Service provided in a variety of settings such as the person's or caregiver's home, an organization's facilities, or in a respite worker's home, etc. • Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals. • Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals. • Services that attend to the member's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be

	performed by those persons who normally care for and/or supervise them. • Service provided in a manner necessary to provide relief for the person or caregivers. • Concurrent or auxiliary services may be provided by staff who are not assigned to provide respite care, such as recreational therapy, peer support, etc.
Eligible population	All individuals enrolled in Apple Health (Medicaid).
Social risk factors	• Eligible population whose unpaid caregivers require relief to avoid the enrollee being placed in an institution; and • Eligible population who self-identified current caregiver stress or fatigue or competing time commitment or scheduled vacation; and • Eligible population who self-identified challenge finding or affording alternative care.
Clinical risk factors	Individuals who live in the community and are compromised in their activities of daily living and/or have been assessed to have a behavioral health need that requires constant or near-constant supervision (e.g., a child with serious emotional disturbance (SED)) and whose unpaid caregivers require relief. The population eligible for caregiver respite services includes, but is not limited to, individuals who meet eligibility and criteria for or are enrolled in the following complex care services: • Health Home program • Intensive Outpatient and Partial Hospitalization Pilot Program (IOP/PH) • Mobile Crisis Response Services: • New Journey's First Episode Psychosis: • Program of Assertive Treatment (PACT): • Wraparound with Intensive Services (WISe): • Approved for Private Duty Nursing based on Apple Health criteria

	The client and caregiver meet at least one of the following: Client: • Clinical and/or physical decline that increases the client's medical or physical needs. • Complex clinical and/or behavioral needs (as described above) or placement on hospice. • Pregnant or recently postpartum. • Repeated emergency department use or multiple crisis encounters. Caregiver: • Medical needs (including but not limited to appointments, recovery after medical treatments or procedures, and having a contagious condition that would put the client at risk) • Needing additional rest to recover from a medical condition or event (including but not limited to injuries, pregnancy, and postpartum). • Requires services provided on an hour by hour basis due to the absence of or need for relief of those persons normally providing care to the individuals. • Requires services provided by the day/overnight on a short-term basis because of the absence of or relief need for those normally providing care to the individuals.
Duration and frequency (if applicable)	Eligible individuals may receive up to 336 hours of services per calendar year. The limit is inclusive of all in-home and in-facility services. Additional hours can be approved if the caregiver experiences an event, including medical treatment and hospitalization, that leaves an individual without their caregiver.
Implementation setting	Caregiver respite services are provided to the individual in their own home, health care facility, adult day care, or another location being used as the home. The service is inclusive of all in-home and in-facility services. Caregiver respite services cannot be provided virtually or via telehealth.

Provider type	Providers may include, but are not limited to: • Residential facility approved by the State • Providers contracted by county behavioral health • Behavioral health agencies • Home health agencies • Short-term Residential Therapeutic Program Providers or other care providers who are serving youth with complex needs • Respite facilities • Adult day cares • Adult Family Home • County Agencies • Residential Care Facility for the Elderly • Child Day Care Facility; Child Day Care Center; Family Child Care Home • Private Duty Nursing agencies • Licensed respite care agencies • Agencies providing meal services • Agencies providing housing for low-income clients • Crisis support agencies • Others as approved by the state

Specific Provider qualifications	Providers must have:
	• Experience and expertise with providing these unique services
	• Developmentally appropriate training for the population served
	Provided in under the supervision of the individuals service provider
	• Washington State registration as a licensed (RN, LPN, CNA, CMA, RMA, etc.), certified or registered caregiver or caregiver agency. Housing services provider, nutrition services provider, DME providers. Must be able to demonstrate:
	  ○ Sufficient staff to provide services as needed.
	  ○ Cultural competency.
	  ○ Credentialed by the appropriate Washington state agency with no restrictions.

- Signed Core Provider Agreement with the Washington Health Care Authority.

Environmental Accessibility, Remediation, and Adaptation

Description	Authorized by STC 15.2(b)(viii). Environmental accessibility, remediation and adaptation services provide physical changes to a home that are necessary to ensure the health, welfare, and safety of the individual or enable the individual to function with greater independence in the home. All services are subject to HCA approval. Services included are: • Accessibility Modifications • Remediation • Adaptation Home Devices ***Accessibility Modifications*** The provision of home/environmental accessibility modification services to eliminate known home-based health and safety risks and ensure the occupants' health and safety in the living environment. Examples of Accessibility Modifications include: • Ramps and grab-bars • Wheelchair access improvements like doorway widening, stair lifts, and roll-in showers • Installation of specialized electric and plumbing systems to accommodate medical equipment • Door and cabinet handles • Non-skid surfaces • Sound proofing • Overhead track systems • Stair lifts

- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower)
- Installation and testing of a Personal Emergency Response System (PERS) for individuals who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed)

Remediation

The provision of home/environmental remediation services to eliminate known home-based health and safety risks and ensure the occupants' health and safety in the living environment. Examples of Remediation include:

- Allergen-impermeable mattress and pillow dustcovers
- Ventilation improvements and air filters
- Integrated Pest Management (IPM) services
- De-humidifiers
- Minor mold removal and remediation services
- Carpet replacement
- Housing safety inspections
- Installation of washable curtains or synthetic blinds to prevent allergens

Adaptation Home Devices

1. The provision, service delivery, and installation as needed of a home device to individuals for whom such equipment is clinically appropriate as a component of treatment or prevention for a home-device specific medical indication (e.g., air conditioner for individuals at health risk due to significant heat or
   heaters for individuals at increased health risk due to significant cold)
2. Air filtration devices for individuals at health risk due to compromised air quality, and replacement air filters as needed
3. Refrigeration units for individuals who lack a working refrigeration unit or a unit that meets their medical needs

	4. Portable power supplies (PPS's) for individuals who need access to electricity-dependent equipment (e.g., ventilators, dialysis machines, intravenous equipment, chair lifts, mobility devices, communication devices, etc.) or are at risk of public safety power shutoffs that may compromise their ability to use medically necessary devices Modifications must be conducted in accordance with applicable State and local building codes. Modifications are payable up to a total lifetime maximum of $7,500. An enrollee may receive an exception to this maximum if their physical condition or living situation has changed so significantly that additional modifications are necessary to ensure their health, welfare, or independence.
Eligible population	All individuals enrolled in Apple Health (Medicaid).

Social risk factors	For each corresponding service, eligible population who is:
	
	• Accessibility modifications/Remediation
	  ○ An individual or family who requires a clinically appropriate home modification/ remediation service and the housing can either be modified or remediated cost-effectively, or the housing cannot be modified or remediated cost-effectively and the member needs a home inspection and/or to transition to another housing option.
	  ○ An individual or family who lives in housing that is physically inaccessible or unsafe due to a member's disability or medical condition and the housing can either be modified cost effectively, or the housing cannot be modified cost-effectively and the member needs a home inspection and/or to transition to another housing option.
	  ○ An individual or family who is living in housing that is negatively impacting their health, due to factors including but not limited to pests, mold, elements of the home are in

	disrepair, the member has exposure to pathogens/hazards, and/or the property is inadequately maintained, and the member either needs a home inspection or healthy home good, or the member needs to transition to another housing option. • Adaptation Home Devices: ○ Individuals at risk for institutionalization due to inaccessible living environments

Clinical risk factors	For each corresponding service, eligible population who has:
	
	• Accessibility modifications:
	  ○ Chronic health conditions causing physical limitations with inaccessible living environments
	
	• Remediation:
	  ○ Chronic health conditions for which remediation may be reasonably expected to improve health outcomes, such as (but not limited to) poorly controlled asthma, COPD, or other chronic respiratory conditions such as cystic fibrosis or interstitial lung disease
	
	• Adaptation Home Devices:
	  ○ Chronic health conditions for which devices may be reasonably expected to improve health outcomes and device specific medical indications for adaptation home devices, including:
	  ▪ Air conditioners for individuals at health risk due to significant heat;
	  ▪ Heaters for individuals at increased health risk due to significant cold;

	▪ Air filtration devices for individuals at health risk due to compromised air quality, and replacement air filters as needed; ▪ Refrigeration units for individuals who lack a working refrigeration unit or a unit that meets their medical needs (e.g., because it has inadequate temperature controls to meet their medication storage needs, etc.); or, ▪ Portable power supplies (PPS's) for individuals who need access to electricity-dependent equipment (e.g., ventilators, dialysis machines, intravenous equipment, chair lifts, mobility devices, communication devices, etc.) or are at risk of public safety power shutoffs that may compromise their ability to use medically necessary devices.
Duration	N/A
Implementation setting	The services are available in a home that is owned, rented, leased, or occupied by the individual or their caregiver. For a home that is not owned by the individual, the individual must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.). When authorizing services, the managed care plan must receive and document a current licensed health care provider's order specifying the requested services for the enrollee, a brief written evaluation specific to the enrollee describing how and why the service meets the needs of the individual; and that a home visit has been conducted to determine the suitability of any requested services. In most cases, enrollees and medical providers will need to work with a community-based organization that can conduct the home visit and

	support the enrollee through the choice and construction of services. These organizations may include Area Agencies on Aging and other community-based service organizations. In order to refer an enrollee for services, the medical provider may not have a financial relationship with the entities that conduct home visits or provide or install the determined service.
Provider type	Providers may include: • Home Health agencies • Medical equipment and supplies providers • Area Agencies on Aging (AAA) • Others as approved by the state
Specific provider qualifications	Providers must have experience and expertise in providing these unique services in a culturally and linguistically appropriate manner. • Qualified provider enrollment: For all Apple Health programs, providers are required to successfully complete the provider enrollment process and core provider agreements with HCA for health care services. For managed care, providers must also complete the credentialing process with each MCO. MCOs must ensure quality care is available through the provider, which may include onsite quality review as appropriate. • Qualified providers, acting within the scope of their license to practice and who are appropriately licensed and contracted, include: o Licensed and allowable providers. o Providers operating in Washington State must be licensed as above. • Providers of adaptation home devices during significant weather events (e.g., ACs during heat waves) must have knowledge and experience in providing such devices during significant weather events including the ability to store devices and distribute them prior to or

	during the event so that members have access to the devices when they need them most (i.e., while the event is taking place)

Case management, outreach, and education

Description	Authorized by STC 15.2(c). Community-Based Connector Services are case management, outreach, and education services which provide linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees. This service includes the following HRSN service navigation assistance activities: • Contacting and engaging individuals who belong to one or more HRSN Covered Populations and who may be eligible for HRSN services • Using multiple strategies for engagement, including in person meetings where the member lives, seeks care, or is accessible; community and street-level outreach; and mail, text, phone, and email; Working with the individual to provide the information necessary for assessment of HRSN service need, including through multiple engagements with the individual as needed • Helping the individual to enroll, re-enroll, or maintain enrollment in Apple Health • Providing help with securing and maintaining entitlements and benefits, such as TANF, WIC, SNAP, Social Security, Social Security Disability, and Veterans Affairs benefits, federal and state housing programs, and other federal and state benefits • Assisting in obtaining identification and other required documentation (e.g., Social Security card, birth certificate, prior rental history) needed to receive benefits and other supports

	• Connecting individuals to settings where basic needs can be met, such as access to shower, laundry, shelter, and food • Providing members who may have a need for medical, peer, social, educational, legal, and other related services with information and logistical support necessary to connect them with the needed resources and services • Providing application assistance and coverage of state and federal benefit programs' application fees as required for the services and activities listed above.
Eligible population	All individuals enrolled in Apple Health (Medicaid).
Social risk factors	Eligible populations who: • Are homeless or at risk of homelessness, as defined by 24 CFR 91.5 with the exception of the annual income requirement in 24 CFR 91.5 (1)(i); • Meet the USDA definition of low food security, or very low food security; • Experience poverty or near poverty, as defined by income below 200% of FPL; or • Screen positive for an HRSN.
Clinical risk factors	Eligible population with: • Complex behavioral health need: Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment. • Developmental disability need: An individual with an Intellectual Disability or Developmental Disability that requires services or supports to achieve and maintain care goals. • Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring

improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support). Examples may include chronic conditions such as: congenital anomalies that adversely impact health or function, blindness, disabling dental disorders, chronic neurological diseases, chronic cardiovascular diseases, chronic pulmonary diseases, chronic gastrointestinal diseases, chronic liver diseases, chronic renal diseases, chronic endocrine diseases, chronic hematologic disorders, chronic musculoskeletal conditions, chronic infectious diseases, cancers, autoimmune disorders, immunodeficiency disorders or chronic immunosuppression.

- Needs for Assistance with ADLs/IADLs or Eligible for LTSS: An individual who needs assistance with one or more Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (iADLs)
- Interpersonal Violence Experience: An individual who is experiencing or has experienced interpersonal violence (IPV), including domestic violence (DV), sexual violence (SV), or psychological violence
- Repeated Emergency Department Use and Crisis Encounters: An individual with repeated use of emergency department care (defined as two or more visits in the past six months or five or more visits within the past 12 months); with two or more crisis encounters in the past six months or five or more crisis encounters in the past 12 months, which represent an exacerbation of mental health distress, defined to include: receipt of crisis/outreach team services; use of behavioral health mobile crisis, crisis respite services, or school behavioral health crisis services; any length of stay in an adult jail or youth detention facility; or any length of stay in emergency foster care; and who was exited from a housing or behavioral healthcare program (e.g., shelter setting, day habilitation program, etc.) or from a school or an early childhood program in the past 12 months due to behaviors that are likely manifestations of health conditions, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect

	Pregnant/Postpartum: An individual who is currently pregnant or up to 12 months postpartum. • Children less than 6 years of age: A child who is less than six years of age and currently has, at least one of the following: - Malnutrition or at risk of developmental or growth delay or impairment as a result of insufficient nutrition as a clinical risk factor for case management related to nutrition services only. - Child maltreatment as defined by the CDC (https://www.cdc.gov/violenceprevention/pdf/CM_Surveillance-a.pdf) - Is a child with a special healthcare need (CYSHCN) as defined by HRSA (https://mchb.hrsa.gov/programs-impact/focusareas/children-youth-special-health-care-needs-cyshcn#i) - Low birth weight of <2500 grams - Mental health condition - Health conditions, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect. • Adults 65 years of age or older: An adult who is 65 years of age or over and currently has at least one of the following: - Two or more chronic health conditions - Social isolation placing at risk for early death, neurocognitive disorders, sleep disruption, cardiovascular disease, and elder abuse - Malnutrition as a clinical risk factor for case management related to nutrition services only. - Health conditions, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect
Duration and frequency (if applicable)	N/A

Implementation setting	Services may be initiated and provided in the home and community, community-based, or clinical settings and may include but are not limited to: • Physical and behavioral health care settings • Tribal clinics • Community-based organizations • Social service organizations • Food banks and farmers markets • Day habilitation settings • Stabilization centers • Carceral settings, including prisons and jails • Housing agencies • Home and community • Others as approved by the state
Provider type	The state will contract directly with community and Native hubs to provide HRSN services. Community and Native hubs will be the sole contractors for case management, outreach, and education service under this demonstration: • Nine Community Hubs, each operated by a regional ACH, will provide case management services to Apple Health managed care and fee-for-service individuals in their associated region. • The Native Hub will provide case management services to Apple Health individuals statewide in close coordination and partnership with Washington Tribes.

Attachment V
Provider Rate Increase Attestation Table

Washington HRSN Related Provider Payment Rate Increase Assessment – Attestation Table		
The reported data and attestations pertain to Health-Related Social Needs related provider payment increase requirements for the demonstration period of performance DY 8 thru DY 12.		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-Service Ratio**	**Medicaid Managed Care to Medicare Fee-for-Service Ratio**
Primary Care Services	73%	77%
	STC 16.5(b)	*STC 16.6(b)* *Data source: State's MMIS system (ProviderOne)* *Time period: January 1, 2022 to December 31, 2022.*
Obstetric Care Services	86%	89%
	STC 16.5(b)	*STC 16.6(b)* *Data source: State's MMIS system (ProviderOne)* *Time period: January 1, 2022 to December 31, 2022.*
Behavioral Health Care Services	87%	74%
	STC 16.5(b)	*STC 16.6(b)* *Data source: State's MMIS system (ProviderOne)* *Time period: January 1, 2022 to December 31, 2022.*

In accordance with STCs 16.1 through 16.14, including that the Medicaid provider payment rates used to establish the ratios do not reflect FFS supplemental payments or Medicaid managed care pass-through payments under 42 CFR § 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in the one service category in each delivery system, as applicable to the state's Medicaid or demonstration service delivery model, if for that delivery system the ratio is both the lowest ratio among the three and below 80 percent. Such provider payment increases for each service will be effective beginning on July 1, 2025 and will not be lower than the highest rate for that service code in Primary Care Services plus an amount necessary so that the Medicaid to Medicare ratio increases by at least two percentage points relative to the rate for the same or similar Medicare billing code through at least June 30, 2028. For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a FFS delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health care, and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition. The services that comprise any service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services. For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 16.6(b) will be based on Medicaid managed care provider payment rate and utilization data. [*Select the applicable effective date, must check either a. or b. below*] ☑a. The effective date of the rate increases is the first day of DY 10 and will be at least sustained, if not higher, through DY 12. ☐b. Washington has a biennial legislative session that requires provider payment approval and the timing of that session precludes the state from implementing the payment increase on the first day of DY 10. Washington will effectuate the rate increases no later than the CMS approved date of [*insert date*], and will sustain these rates, if not made higher, through DY 12.		
Washington does make Medicaid state plan FFS payments for the following categories of service for at least some populations: primary care, behavioral health care, and/or obstetric care. For any such payments, as necessary to comply with the Health-Related Social Need STCs, I agree to submit by no later than January 1, 2024 for CMS review and approval the Medicaid state plan FFS payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and		

Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new SPA, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than April 1, 2025.
Washington does include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care. For any such payments, as necessary to comply with the Health-Related Social Need STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 16.10 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than *April 1, 2025.*
If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 16.10, I attest that necessary arrangements will be made to assure that 100 percent of the two percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.
Washington further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC 16.
I, *Dr. Charissa Fotinos, State Medicaid Director*, attest that the above information is complete and accurate. *Signature* [redacted] *Charissa Fotinos* *Date* 03/21/2024

Table 5: Provider Rate Increase Attestation Table Template

Washington HRSN Related Provider Payment Rate Increase Assessment – Attestation Table		
The reported data and attestations pertain to Health-Related Social Needs related provider payment increase requirements for the demonstration period of performance DY 8 thru DY 12.		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-Service Ratio**	**Medicaid Managed Care to Medicare Fee-for-Service Ratio**
Obstetric Care Services	85%	90%
	STC 16.5(b)	*STC 16.6(b)* *Data source: State's MMIS system (ProviderOne)* *Time period: January 1, 2023 to December 31, 2023.*
Behavioral Health Care Services	84%	70%
	STC 16.5(b)	*STC 16.6(b)* *Data source: State's MMIS system (ProviderOne)* *Time period: January 1, 2023 to December 31, 2023.*

In accordance with STCs 16.1 through 16.14, including that the Medicaid provider payment rates used to establish the ratios do not reflect FFS supplemental payments or Medicaid managed care pass-through payments under 42 CFR § 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in the one service category in each delivery system, as applicable to the state's Medicaid or demonstration service delivery model, if for that delivery system the ratio is both the lowest ratio among the three and below 80 percent. Such provider payment increases for each service will be effective beginning on July 1, 2025 and will not be lower than the highest rate for that service code in Behavioral Health Care Services plus an amount necessary so that the Medicaid to Medicare ratio increases by at least two percentage points relative to the rate for the same or similar Medicare billing code through at least June 30, 2028.

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a FFS delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health care, and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise any service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 16.6(b) will be based on Medicaid managed care provider payment rate and utilization data.

[*Select the applicable effective date, must check either a. or b. below*]
☑a. The effective date of the rate increases is the first day of DY 10 and will be at least sustained, if not higher, through DY 12.
☐ b. Washington has a biennial legislative session that requires provider payment approval and the timing of that session precludes the state from implementing the payment increase on the first day of DY 10. Washington will effectuate the rate increases no later than the CMS approved date of [*insert date*], and will sustain these rates, if not made higher, through DY 12.

Washington does make Medicaid state plan FFS payments for the following categories of service for at least some populations: primary care, behavioral health care, and/or obstetric care. For any such payments, as necessary to comply with the Health-Related Social Need STCs, I agree to submit by no later than July 1, 2025 for CMS review and approval the Medicaid state plan FFS payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and
Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new SPA, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than July 1, 2025.
Washington does include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care. For any such payments, as necessary to comply with the Health-Related Social Need STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 16.10 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than *July 1, 2025.*
If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 16.10, I attest that necessary arrangements will be made to assure that 100 percent of the two percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.
Washington further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC 16.

I, *Dr. Charissa Fotinos, State Medicaid and Behavioral Health Medical Director*, attest that the above information is complete and accurate.

Signature [redacted]

Charissa Fotinos, MD, MSc

Date March 31, 2025

Attachment W
Placeholder for Monitoring Protocol

Health Related Social Needs Demonstration Initiative Implementation Plan

Introduction:
The Centers for Medicare & Medicaid Services (CMS) approved an extension of the state's section 1115 Medicaid demonstration waiver on June 30, 2023, for a period of July 1, 2023, through June 30, 2028. In the Special Terms and Conditions (STCs) of the extension, CMS approved a Health-Related Social Needs (HRSN) services demonstration initiative (Initiative). The Initiative authorized expenditure authority for Washington State to implement ten HRSN services. On December 8, 2023, CMS amended the extension for technical corrections. The corrections directed the state to develop an Implementation Plan for the HRSN Initiative.

Washington State is submitting the Health-Related Social Needs Services Implementation Plan (Implementation Plan) for approval by CMS. The Implementation Plan is drafted to fulfill STC 15.19, HRSN Implementation Plan. This excerpt guides the development of the Implementation Plan:

STC 15.19(a): The state is required to submit a HRSN Implementation Plan that will elaborate upon and further specify requirements for the provision of HRSN services and will be expected to provide additional details not captured in the STCs regarding implementation of demonstration policies that are outlined in the STCs. The Implementation Plan can be updated as initiatives are changed or added.

The Implementation Plan addresses, but is not limited to addressing, the specifications in STC 15.19(b) and STC 15.19(c). The Implementation Plan is organized by these milestones:

- Milestone 1: Strategic approach to implementing HRSN services
- Milestone 2: Key partnerships
- Milestone 3: Launching and operationalizing HRSN services
- Milestone 4: Technology, administrative services, and monitoring
- Milestone 5: Delivering HRSN services within an environment of support

For each milestone in the Implementation Plan, Washington describes the activities, key strategies, and timelines the state will advance to address them.

In addition to this Implementation Plan, the Washington State Health Care Authority (HCA) will release a "Policy & Operational Guide for Planning and Implementing HRSN Services" (Policy & Operational Guide). This Policy & Operational Guide will be available publicly and provide detailed policy requirements for partners, including, without limitation, Tribal organizations, Accountable Communities of Health (ACHs), Managed Care Plans (MCPs), providers, local and state agency partners, and community-based HRSN providers. The Policy & Operational Guide will be updated on an ongoing basis as implementation partners begin to operationalize HRSN services and provide experience-based feedback to the state.

Milestone 1: Strategic approach to implementing HRSN services (addresses STC 15.19(b))

STC 15.19(b): At a minimum, the Implementation Plan must provide a description of the state's strategic approach to implementing the policy, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The Implementation Plan does not need

to repeat any information submitted to CMS under the Protocols for HRSN Infrastructure and Services; however, as applicable, the information provided in the deliverables must be aligned and consistent with one another.

The state proposed and CMS approved a framework that extends existing and new expenditure authority for delivering HRSN services to fee-for-service (FFS) and managed care clients. STC 15, Health-Related Social Needs, provides a new authority to provide medically appropriate, waiver-funded HRSN services and to couple those services with existing in lieu of service (ILOS) authority in 42 CFR 438.3(e)(2) and 438.16 (recently finalized Medicaid managed care rule), with additional guidance published in a state Medicaid Director letter of January 4, 2023. ILOS will be the state's primary authority for delivering HRSN services to managed care clients. The state will provide waiver funded HRSN services for FFS clients and, for some HRSN services, managed care enrollees.

The state's strategy will be to develop services in a consistent manner regardless of authority, and couple them with employment and community support services renewed through the Foundational Community Supports (FCS) program. The current assumptions regarding funding authority and process for the covered populations of each waiver approved HRSN service are described in the HRSN Services Protocol and can be found in Table 1. The version of that protocol currently in review by CMS is in **Appendix 1**. ***This strategy was designed during the negotiation of the extension in Quarter 1 and Quarter 2 of 2023 and continues to be formulated to meet the needs of developing the delivery of HRSN services.***

Table 1

HRSN service	Waiver authority population(s) served	ILOS authority population served
Nutrition supports	Fee-for-service	Managed care
Recuperative care and short-term post-hospitalization housing	Fee-for-service Managed care	N/A
Housing transition navigation services	Fee-for-service Managed care	N/A
Rent/temporary housing	Fee-for-service Managed care	N/A
Community transition services: Non-emergency, non-medical transportation	Fee-for-service	Managed care
Community transition services: Personal care and homemaker services	Fee-for-service	Managed care
Stabilization centers	Fee-for-service	Managed care
Day habilitation programs	Fee-for-service	Managed care
Care respite services	Fee-for-service	Managed care
Environmental accessibility and remediation adaptations	Fee-for-service	Managed care

Case management, outreach, and education (delivered through the community and Native hubs)	Fee-for-service Managed care	N/A

The Initiative supports the state's strategy to address the Medicaid population's HRSNs via two funding authorities: ILOS and waiver funding. Access to both funding authorities will assist the state in meeting the needs of our entire Medicaid population. The strategy also heightens challenges the state will encounter as it continues to simultaneously employ and modify a strategy that coordinates both funding authorities for the delivery of HRSN services to FFS and managed care clients.

Key strategies for Milestone 1	
Taking Action for Healthier Communities (TAHC) Task Force	To develop a closer working relationship among ACHs and MCPs the state formed the Taking Action for Healthier Communities (TAHC) Task Force. Originated to provide advice to the state during the negotiation of the extension, the task force now focuses on developing a closer working relationship among ACHs and MCPs in the delivery of HRSN services. (ACHs and MCPs also assist the state's implementation of the reentry demonstration initiative through their work on the task force.) The advice of the task force is valuable to the development of HRSN services, and the task force will continue to meet on a regular cadence. The state will modify or phase out the task force if it determines that changes must be implemented to engage key partners through a different process.
DSHP Funding	The state is grateful for recent progress on DSHP funding and expeditiously expressed support for the funding amount communicated by CMS. The state is following guidance by CMS in taking the steps necessary to clarify DSHP funding programs for HRSN services and conclude the funding negotiations. The state will become more familiar with the expenditure pattern of each HRSN service, and through experience, will likely improve the accuracy of financial estimates, and thus, improve the communication of the expected funding of each HRSN service.
HRSN Workgroup	The state will develop a work plan and processes that enhance the ability to achieve the goal of simultaneously implementing an HRSN service for managed care and FFS clients. If the cadence of the simultaneous work does not coincide, and possibly extend the duration of development for managed care or FFS clients, then state leaders may need to determine an alternative implementation schedule. It is possible, for example, that implementing an HRSN service for FFS clients could provide information about the costs and benefits of implementing the same service through ILOS for managed care clients.

Milestone 2: Key partnerships (STC 15.19(c)(ii))

The state's strategy is to engage a diverse set of key partners in the design and implementation of HRSN services. To blend ILOS and waiver funded HRSN services authorities, initiatives, and programs, the state will need to rely upon key partners and further develop in-depth working relationships with them. Through focused engagements, the state will work with partners that will include, at a minimum, ACHs, MCPs, HRSN service providers, and state agencies.

2A. Accountable Communities of Health (ACH) partnership

Over the course of the previous demonstration, ACHs developed local partnerships, community networks, and expertise in community-based care coordination, navigation, and case management activities. ACH Community Hubs and the Native Hub (Hubs) are the "sole contracted providers" designated by the extension in STC 15.9(b) to operate the HRSN service case management, outreach, and education. Hubs are made up of nine regional ACH Community hubs and the statewide Native Hub. Hubs will provide essential linkages to the other waiver-approved HRSN services.

ACHs are tasked with developing and operating regional community hubs to perform community-based care coordination in their respective regions. Nine community hubs will be operated by ACHs, one in each of nine regions. The nine regional community hubs, along with the single statewide Native Hub, are a cornerstone of future HRSN service implementation. ACHs will utilize their advisory committees, whose membership consists of community member voices, for insights into designing hubs that best serve their respective communities. Further development of community hubs in each region is essential to delivering the other HRSN services.

Collectively, the ACHs have developed a set of alignment strategies that work toward standardizing important hub practices across all nine ACH regions. The state will continue to build upon the existing networks developed by ACHs, partnerships, and resources to provide case management of HRSN services.

The state will require ACHs to demonstrate community hub readiness to operationalize case-management services through a Hub. The state designed a readiness review process that will, in part, require ACHs to demonstrate a sufficient network of HRSN providers to meet the case management needs of Medicaid clients for non-clinical HRSN services. The review process will necessitate that hubs provide culturally and linguistically appropriate and responsive services.

The state meets weekly with ACH executives to collaborate on implementing the extension. Standing agenda items include the priorities and development of HRSN services, with an initial focus on community hubs; infrastructure funding and developing readiness criteria for the development of ACH community hubs; and contracting and various administrative items necessary to formalize agreements, progress, and monitoring. The weekly meetings with ACH executives will continue for the duration of this extension.

2B. Managed Care Plan (MCP) partnership

The state's authority couples funding of HRSN services with waiver-approved funds and funding offered through in lieu of services and settings (ILOSs) authority pursuant to 42 CFR 438.3(e)(2). ILOS is and will continue to be the primary authority for MCPs to provide allowable HRSN services to managed care enrollees. (MCPs also provide services that enhance clinical-community linkages through value-added benefits.)

For decades, MCPs have performed as an essential partner—providing coverage to 85% of the state's Medicaid clients. Throughout the extension, MCPs will now maintain and expand upon their pivotal role in addressing social and clinical care-based needs through the delivery of HRSN services. They will be integral in facilitating ILOS authority in the delivery of HRSN services for managed care clients. The distinction of HRSN services offered through ILOS authority is presented in the HRSN Services Protocol, Appendix 1.

MCPs have enhanced clinical-community linkages by facilitating relationships with community providers and ACHs. Expanding the delivery of HRSN services will depend upon MCPs continuing to build upon these relationships and defining roles that optimize an efficient delivery of HRSN services. Cross-sector collaboration is explored further in section 2E.

The state's close collaboration with MCPs has been developed and refined through the implementation of substantial projects such as the bi-directional integration of physical and behavioral health in the initial waiver. The state and MCPs maintain this collaboration through a commitment to frequent communication in multiple venues that will continue for the duration of this extension. The state alternates weekly meetings that discuss priorities, upcoming activities, and policies with MCP representatives: MCP and state policy and operational experts meet for in-depth policy discussions about implementing HRSN services, and the next week, state policy and operational experts provide updates on HRSN services and other extension topics for MCP executives and staff. The state hosts regular 1:1 meetings where MCP executives or staff check-in and collaborate and discuss topics about the extension relevant to that MCP. The state also schedules ad hoc meetings, typically to discuss an emerging policy issue of the extension, with all MCPs or with each MCP, separately.

2C. Partnership and engagement with Tribes

In the first year of the extension, HCA visited every federally recognized Tribe and the two Urban Indian Health Programs in the state. These visits included discussion on the Native Hub, along with the other major initiatives of the extension.

HCA heard again in these visits the unique position that Tribes and Indian Health Care Providers (IHCPs) are in when it comes to partnering on the implementation of the extension. Tribes and IHCPs run clinics, often operating in Health Professional Shortage Areas, address the opioid/fentanyl crisis, engage in government-to-government relationships with both the state and the Federal Government, and continue to promote and protect sovereignty and treaty rights.

Continuous updates and dialogue to discuss Tribal engagement and support are occurring in pre-established meetings, including:

- HCA Monthly Tribal Meeting
  - This is a long-standing meeting to discuss new programs, funding opportunities, changes in rules and laws, conference opportunities, etc.
- Governor's Indian Health Advisory Council (GIHAC)
  - A codified group of all Tribes, Urban Indian health programs, Health and Human Services state agencies, the Washington State House and Senate and the Governor's Office.
- American Indian Health Commission (AIHC) Quarterly Delegate meeting
  - The AIHC served as the Tribal Coordinating Entity in the initial waiver and is providing additional support under the extension. All Tribes, the two Urban Indian Health Programs and a few other Native-led, Native-serving organizations make up the delegates to AIHC.

2D. Taking Action for Healthier Communities (TAHC) Task Force

The TAHC Task Force was formed in late 2022 when the state was negotiating the renewal of the initial waiver with CMS. Recognizing the importance of multi-sector collaboration to deliver the expected suite of HRSN services, the state created the task force to "cultivate a partnership among MCOs and ACHs to operationalize HRSN services and community hubs, leveraging the strengths of each" with the purpose to "advise HCA on implementing TAHC operational policies or programs proposed in the [waiver] renewal application." The task force plays a significant role in assisting the state's efforts in establishing priorities for HRSN services.

The task force typically meets on a monthly cadence to determine best practices for operationalizing HRSN services. The task force also provides advice on how to blend HRSN services with the reentry demonstration initiative. The task force provides input on the current value of HRSN services for clients reentering their community and insights on where to continue investing HRSN services when enacting the reentry demonstration initiative. By meeting in person with the goal of implementing services, task force participants gain insight into each other's priorities and challenges and provide broad insight and perspective that carry into discussions and development activities outside of task force meetings.

The task force is proving to be a valuable addition to integrating the knowledge, ideas, and effort of key partners that cannot be achieved in separate discussions.

2E. Cross-sector collaboration and engagement

The state has developed cross-sector collaborations among state agencies and within divisions of the HCA. These collaborations encompass a wide range of partnerships aimed at enhancing the delivery of HRSN services.

- HCA's Eligibility Team is leading the work on the Medicaid/Children's Health Insurance Program (CHIP) continuous eligibility program. HCA continues to work towards programmatic cohesiveness that facilitates HRSN service delivery to this population, promoting equitable access to HRSN services.
- HCA has close relationships with Federally Qualified Health Centers and other providers with demonstrated success in delivering health care services to low-income populations. Some of these providers coordinate now with the ACH in their region and participate in arranging the delivery of HRSN services. HCA will continue to engage these providers as advisors as we develop how to scale up the delivery of HRSN services.
- Coordination and alignment among FFS, managed care, and FCS within HCA to coordinate seamless delivery of HRSN services across divisions within HCA and address critical needs for employment and shelter.
- HCA's reentry demonstration initiative team facilitates the reintegration of clients from carceral facilities by offering prerelease services. The state continues to work on programmatic alignment of HRSN services and the reentry demonstration to complement service delivery that encompasses a holistic approach to reentering the community.
- Long-Term Services and Supports (LTSS) administered by the Department of Social and Human Services (DSHS) ensures comprehensive care for individuals with long-term care needs. Community hubs will collaborate with Area Agencies on Aging to coordinate the provisions of essential HRSN services for clients receiving long-term services and supports.

- Washington State Department of Health (DOH) administers key public health services via the ACHs. HCA and DOH have established a close partnership to coordinate agency collaboration and enhance community hub services using data-driven, evidence-based practices.

After approval of the extension, the state formed a core HRSN work group of individuals with the expertise to design and implement the HRSN services. Program leads and subject matter experts are developing the processes and guidelines for the delivery of HRSN services. The HRSN work group has discussed a broad range of HRSN service delivery operational questions, including, but not limited to, the following:

- Defining the services to be delivered in each HRSN service.
- How best to communicate guidance for HRSN providers through the Policy & Operational Guide.
- Coordinating the delivery of the HRSN services for FFS and managed care clients.
- Alignment between HRSN and ILOS in later implementation phases of HRSN services.
- The role of HRSN services aligned with the reentry initiative.

These represent the initial partnerships to provide efficient HRSN services through public organizations established within the state. HCA will continue to build additional partnerships that contribute to the provision of HRSN services, underscoring the state's commitment to comprehensive and integrated approaches in addressing the social determinants of health for clients.

The state has identified several strategies associated with cohesive service delivery among key partners in the development of HRSN services.

Key strategies for Milestone 2	
TAHC Task Force	As noted above, the state will continue to lead the TAHC task force meetings in a fashion that develops a cohesive relationship among MCPs and ACHs. By the end of Quarter 4, 2024, the state should be identifying how best to memorialize the working relationship with both partners. The development of the Policy & Operational Guide in this same period will serve to clarify roles and responsibilities in the delivery of HRSN services.
HRSN Infrastructure Funding	In Quarter 1 and 2, 2024, the state designed and implemented a mechanism for distributing HRSN infrastructure funding. The mechanism provided the flexibility and accountability necessary to support the needs of each ACH in developing community hub services. In the same time period, the state also developed a readiness review process for community hubs that permitted each ACH to describe the readiness of its ability to launch and express how development of its regional hub will grow. The state will continue to refine these criteria and guide ACHs in hub development and service delivery. Further, the state will support the development and formalization of clear, coordinated workflows among the MCPs and ACHs.
Culturally appropriate care	The state will continue to make cultural appropriateness, trauma-informed, and linguistically appropriateness of service delivery a cornerstone of planning, process, and delivery of HRSN services and a distinctive requirement of the readiness criteria for HRSN service delivery. Moreover, the state has built a unique collaboration with tribal liaisons in recognizing sovereignty while facilitating a government-to-government relationship, the state will continue discussions with tribal members to enhance the implementation of HRSN service delivery. The state will continue to prioritize these relationships throughout the development and implementation of HRSN services.

Milestone 3: Launching and operationalizing HRSN services

Key decisions and the development of key operations are essential steps to the state's development of HRSN services for clients. In this section, the state describes progress to date and the next steps essential to launching and operationalizing HRSN services in Washington.

3A. Establish priorities for HRSN services

Prioritizing the services was a key tactical decision to begin the development of HRSN services. The state envisions developing the full scope of HRSN services authorized in the extension. It determined that fulfilling the full scope of HRSN services could best be accomplished by phasing the launch of the ten services. Illustration A presents the initial priorities established by the state.

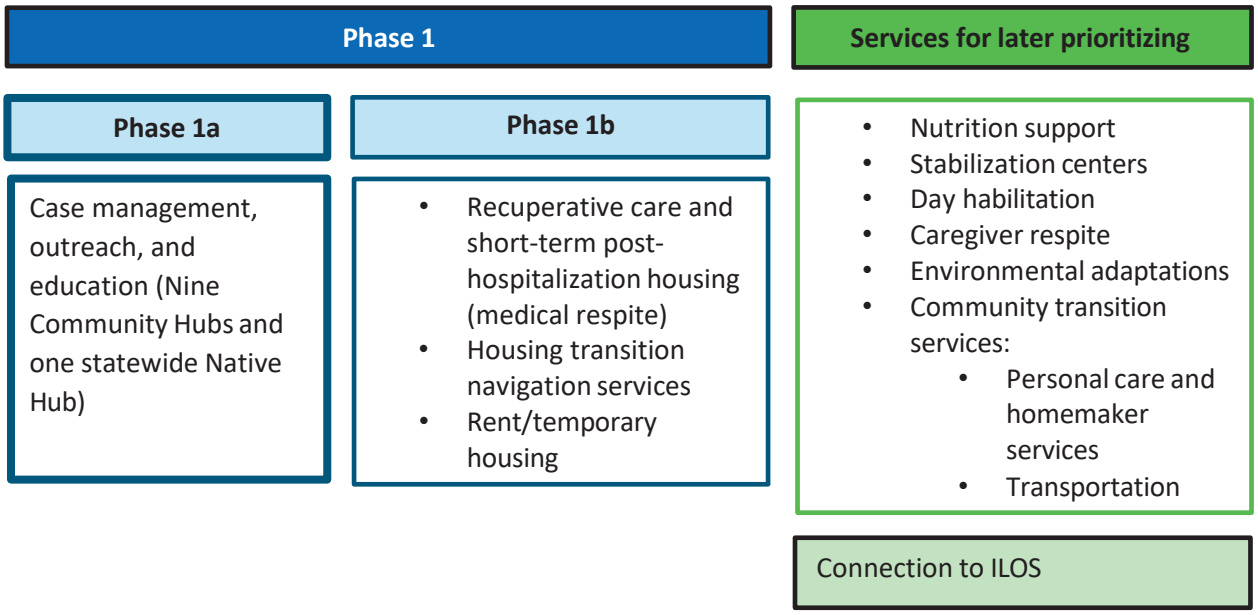
The state involved key partners, primarily the TAHC Task Force, in establishing priorities and selected to begin with the four HRSN services listed in Phase 1 of the illustration.

Hubs support the delivery of the other HRSN services, and the state selected to develop and implement Hubs as the top priority. Implementation of Hubs are scheduled to launch ***Quarter 3, 2024.***

The state also prioritized three additional HRSN services in Phase 1. The Phase 1b services were selected because waiver dollars fund their delivery for both FFS and managed care clients. Their implementation will begin in ***Quarter 3 and Quarter 4, 2024.***

The state will work with key partners to further develop this phased approach. The remaining HRSN services will be prioritized for implementation in a similar fashion as the decisions developed for Phase 1. The state expects to assess, discuss, and establish additional phases during ***Quarter 3 and Quarter 4, 2024.***

Illustration A: Phased approach to HRSN implementation



The state has succeeded in establishing initial priorities for the HRSN services initiative and the process of discussing priorities is now familiar, and yet, the state anticipates that establishing priorities may continue to be challenging.

The state recognizes that further complexities may need to be considered in establishing priorities of the remaining HRSN services. In this case, the state will need to lean heavily into methods that have been successful throughout the initial waiver extension: establish disciplined processes that involve partners and develop decision-making criteria that reflect the importance of the project and the perspectives of state leaders.

3B. Infrastructure investments that build capacity for HRSN services

The initial waiver supported ACHs and community-based organizations in clinical-community linkages prioritized within each region. A common emphasis upon providing HRSN services through Hubs necessitated additional investments in preparing Hubs, networks, and infrastructure to fill capacity in each region.

Infrastructure funding will support the capacity building necessary to deliver the suite of waiver approved HRSN services. The state's approved HRSN Infrastructure Protocol is included in Attachment U of the STCs. As outlined in Attachment U, infrastructure funding supports Four Categories of expenditures: technology; development of business or operational practices; workforce development; and outreach, education, and stakeholder convening.

Funding for HRSN infrastructure investments was approved in the extension. Annual limits of total computable expenditures for HRSN infrastructure are copied below from Table 4 of STC 15.4.

Table 4

	DY8	DY9	DY10	DY11	DY12
Total Computable Expenditures	$35,000,000	$75,000,000	$75,000,000	$65,000,000	$20,000,000

Unspent amounts will roll over to one or more demonstration years not to exceed this demonstration approval period and the state may claim the remaining amount in subsequent demonstration years.

Infrastructure funds support readiness for the delivery of HRSN services at each phase of implementation. The state has developed an application and review processes for infrastructure investments in DY8 (July 2023-June 2024) that will be administered by the state and will track expenditures across the Four Categories noted above in this section. Infrastructure funds will be distributed to ACHs in DY8 for infrastructure and capacity building of Hubs.

Eligible entities will provide the state with necessary information in the application process to receive infrastructure funding. The process includes, but is not limited to:

- Landscape assessment to determine readiness for supporting HRSN service delivery.
- Attestation including requirements on decision-making and management structures, tracking funds and oversight of funds, operations, data tracking and monitoring, and working relationships.
- Projected spending across the Four Categories.
- Actual spending across the Four Categories.
- Supplemental financial reports as required by the state.
- Readiness review criteria as defined by the state for additional HRSN services.

The state developed a separate process for distributing infrastructure investments in DY8 to accommodate retrospective investments in community hubs by ACHs. The state is developing a process for budgeting and distributing infrastructure investments prospectively for the remaining demonstration years of the extension. The prospective process for distributing infrastructure investments will be complete and in use in ***Quarter 3, 2024.***

The state established a process for distributing infrastructure funds and will continue to focus its work on administering the process in ways that verify value in the investments.

3C. HRSN readiness assessment

The initial set of readiness criteria established by the state in ***Quarter 2, 2024*** was developed to support the launching of Hubs. The state's criteria for Hub readiness are in Appendix 2.

The next set of readiness criteria in development by the state will ensure the readiness of each HRSN service before it is implemented. The criteria will be developed to begin assisting implementation of Phase 1b HRSN services in ***Quarter 3 and Quarter 4, 2024.*** At a minimum, the readiness criteria for each HRSN service will include the following:

- Ability of provider to deliver the service in accordance with the state's extension and the state's HRSN services protocol.
- Ability of provider to screen for an individual's HRSNs and make appropriate referrals.
- Ability of provider to develop and share care plans that are person-centered, developed in consultation with the individual, culturally responsive, and trauma informed.
- Ability of provider or administrative entity to initiate closed loop referrals.
- Ability of provider or administrative entity to meet data privacy standards.
- Ability of provider or administrative entity to provide member level data in accordance with STC 15.14(c).
- Ability of provider or administrative entity to track and report encounter data in accordance with STC 15.14(c).
- Approved rate methodology from CMS and appropriate public posting of rate changes.

Hubs will experience challenges as they implement innovative approaches that prepare them to deliver HRSN services. The state and Hubs will have to respond in tandem to successfully resolve the problems encountered.

Key strategies for Milestone 3	
Monitoring and Oversight	The state will implement robust oversight and monitoring mechanisms to track infrastructure funding that ensures compliance with spending guidelines and reporting requirements. The state will perform regular reviews to verify the accuracy and completeness of financial reports and identify any discrepancies or irregularities for corrective action. The state has established clear channels for communication and feedback with Hubs in the form of a project inbox for urgent communication and weekly meetings to stay on course. These channels of reporting and communication will enhance transparency of infrastructure investments and allow the Hubs and the state to highlight successful investments and best practices. The state will monitor the effectiveness of distributing infrastructure funds to assure that the process is supporting investments in HRSN services for each Hub. The state will review reports and use meetings to check in on investments resulting from the process. The meetings can be an essential forum for peer-to-

	peer learning among Hubs. The state may also modify the process if it is necessary to provide better support to ACHs with particular investment needs.
Ongoing ACH partnerships	The state will use the regular series of meetings to monitor and respond to current implementation challenges experienced by the ACHs. Hubs are essential to the delivery of HRSN services, and the state will have to remain nimble and respond jointly to the implementation challenges experienced by ACHs. The state and ACHs should leverage the common community hub standards developed by the ACHs as a helpful guide to resolving implementation issues.

Milestone 4: Technology, administrative services, and monitoring (addresses STC 15.19(c)(i) and STC 15.19(c)(iii))

The state envisions technology and administrative services playing crucial roles in supporting the delivery of HRSN services. The foundation of technological enhancements for HRSN services is the establishment of a Community Information Exchange (CIE) program that provides technological support to community hubs operated by ACHs. The state is also considering how a third-party administrator (TPA) may play a role in reducing administrative barriers in the provision of HRSN services.

4A. Community Information Exchange

Establishing and operating a series of community hubs for the clients of a region necessitates supporting each community hub with technology that helps deliver and manage HRSN services. Each ACH community hub will operate CIE technology that supports community-based care coordination for both the fee-for-service and managed care populations in a region. Throughout the extension, clinical care providers, MCPs, HRSN providers, and other community-based organizations across the state will leverage the CIE technology operated by ACHs to facilitate HRSN screening, closed loop referrals, data sharing among providers delivering HRSN services, and capturing and monitoring results. ACHs will also want to link CIE technology and share data on HRSN services among their regions. The enhanced level of seamless data-sharing will further collaboration among providers delivering HRSN services and enhance the effectiveness of each ACH community hub in delivering HRSN services.

The state is developing a CIE Program to support the implementation of CIE technology in each region and link CIE technology across regions to form an interoperable, statewide system. Central to beginning the CIE program is procurement of a lead organization to implement the vision the state has established for the program. The lead organization will develop, manage, and operate the CIE program. It will be responsible for developing a governance structure with an advisory board inclusive of partners that operate within and adjacent to community-based care, such as ACHs, MCPs, tribes, and partner agencies, such as Department of Children, Youth, and Families' Help Me Grow Washington system, and DOH's Care Connect Washington system.

The process to clarify the functionality of a lead organization and refine the solicitation process has been informed by eighteen responses in April of 2024 to a request for information (RFI) released by HCA. ***HCA anticipates releasing a request for proposals (RFP) in the Quarter 3 or Quarter 4 of 2024 with a lead organization identified by the end of 2024.***

The state has identified several challenges and mitigation strategies associated with procuring a lead organization for the CIE program:

- The state has concluded the RFI process. The information collected demonstrated that certain organizations in the marketplace could likely fulfill the role of lead organization for the CIE program. The RFI responses support moving forward in ***Quarter 3 and Quarter 4, 2024*** with an RFP for a lead organization and helped HCA comprehend how best to draft the RFP and evaluate responses.
- The state and lead organization will be faced with developing solutions due to differences in policies, technological processes, data standards, and privacy or other regulations.
- The state will emphasize that the lead organization focuses upon governance, facilitate disciplined policy discussions, and promote thoughtful implementation of technical expertise in performing interoperability. The state will also support collaboration and meaningful connections among partners that promote the development of trust and working relationships that lead to common policies and standards that ensure compliance with the STCs and technological requirements.

4B. Third Party Administrator (TPA)

HCA is considering a TPA or other contracted entity to play a key role in providing administrative support to HRSN service providers. The role would focus on providing a centralized clearinghouse for billing HRSN services, primarily supporting providers of HRSN services other than the Hubs. The TPA would also provide training and technical assistance for HRSN providers using the clearinghouse.

The TPA clearinghouse would support the billing of HRSN services for FFS clients. After reviewing the claim, the TPA would submit the claim to HCA for approval and payment to the HRSN service provider. The TPA could be a clearinghouse for managed care clients, too. MCP's, however, may find it more efficient to receive and pay claims directly to an HRSN service provider.

The state identified challenges and mitigation strategies associated with considering and moving forward with contracting for administrative services in support of delivering HRSN services.

The state concluded that third-party administrative services are necessary to implement the reentry demonstration initiative and has begun a solicitation process.

By the end of Quarter 4, 2024 the state will need to

- Determine if it should solicit for a TPA to exclusively support HRSN services.
- Determine if an organization exists that could effectively perform the administrative support necessary to assist the payment of claims for HRSN services.
- Identify and determine the appropriate technical support needed to develop network adequacy among HRSN service providers.
- Determine if an organization exists that could effectively perform administrative support to assist the payment of claims for HRSN services and provide technical support for network adequacy.

4C. Monitoring, oversight, and reporting

The state is building mechanisms of monitoring and oversight into an enhanced system of delivering HRSN services. The mechanisms emphasize clear accountability that starts with a joint commitment to collect, report, and review data. Discussing data informs the state and HRSN partners—ACHs, MCPs, and HRSN providers—and creates a collaborative environment for identifying and resolving problems. By investing in mechanisms of monitoring and oversight, the state is creating incentives and expectations

among its partners to stay informed and respond to issues in ways that maintain standards and program integrity. Developing this collaborative environment of accountability begins with the state leveraging investments in existing and new technology and developing new administrative partners. Primarily, the state will focus on the CIE program and TPA. They will assist the state in providing oversight through monitoring the delivery of HRSN services through mechanisms such as:

- Tracking HRSN infrastructure by use categories and reporting by funds flow.
- Requiring ACHs to report service delivery information by encounters.
- Tracking payment of HRSN services by provider and monitoring for abnormalities.
- Analyzing invoices to avoid payment irregularities.
- Reviewing accounts of HRSN services providers on a regular schedule.

HRSN partners will also report on key data elements related to HRSN service delivery. Key data elements will include, at a minimum:

- Number of clients referred to an HRSN provider.
- Number of clients receiving HRSN services.
- Demographic information on clients receiving HRSN services.
- Encounter-level data to identify service utilization.
- Data to support the independent evaluation of the HRSN initiative, including for example:
    - Housing status
    - Employment status
    - Utilization of health care services
    - Effect on Health

The state is demonstrating this early commitment to monitoring and oversight in two ways. First, the state continues to refine the scope of the evaluation, which consists of identifying data needs, with the independent external evaluator. Second, the state is currently developing the initial HRSN service: case management, outreach, and education (Hub services). The development began with the state creating and distributing HRSN infrastructure funds to be invested in Hubs. The state also developed a system of verifying and monitoring those investments. Next, the state created a readiness assessment—with an emphasis on delivering performance—to be completed before Hubs launch.

Key strategies for Milestone 4	
Project management and scope	The state recognizes the tight timeframes for implementing technology and administrative services in support of, primarily, the implementation of Hubs. The state has implemented vendors and technology within tight timeframes by relying on project management. The state will establish and manage a strict scope of work, focused on prioritizing the essential elements of each project.
Ensuring appropriate data collection	The state has been collaborating with ACHs on developing a rate methodology for community hub services. In the development of the rate methodology, the state has emphasized collecting and reporting performance data. The ACHs have been willing partners in developing a system that monitors the performance of the community hubs and the state anticipates reviewing initial data on the performance of community hubs by the end of 2024. As part of the readiness criteria for service delivery by community hubs, HCA will evaluate each hub's ability to support data collection and sharing as outlined in the implementation plan. To assist ACHs with lesser data capabilities, HCA will leverage the TPA to ensure the collection and sharing of key data elements before community hubs begin delivering HRSN services.

Milestone 5: Delivering HRSN services within an environment of support

The state is introducing HRSN services into an existing environment of support services for Medicaid clients. The state recognizes the necessity of combining HRSN services with the support clients now receive. Our goal is to integrate HRSN services within an environment of programs that assist clients in Washington.

The role of Hubs is central to coordinating services within the existing environment. ACH community hubs will be positioned in regions to directly connect clients to a service or provide assistance through a knowledgeable referral to another program. Hubs will use case management services to inquire about benefit enrollment and facilitate connections to appropriate community enrollment agencies with additional services for clients.

The integrated, multi-factor approach employed by the state should lead to an increased share of clients receiving referrals for housing assistance, food assistance from the Supplemental Nutrition Assistance Program (SNAP), the Supplemental Nutrition Program for Women, Infants, and Children (WIC), and Temporary Assistance for Needy Families (TANF). The state will develop and implement HRSN services as an initiative that fully utilizes available resources of their eligibility. The state will leverage existing relationships with partner agencies including the DOH and DSHS to better identify, refer, and track clients among programs providing services.

5A. Enhancements in technology

Enhancements in technology will play a role in connecting clients among these programs. The state is currently in year two of a 10-year benefit systems modernization plan known as the Integrated Eligibility

and Enrollment (IEE) Modernization Program. The IEE Modernization Program aims to create an integrated eligibility system for health and human services in Washington. The goal is to ensure easy access and a streamlined process. The program is led by a coalition of Washington State agencies, known as the Health and Human Services (HHS) Coalition. The HHS Coalition is comprised of the HCA, DSHS, DOH, the Department of Children, Youth, and Families, the Department of Corrections, the Washington Health Benefit Exchange (HBE), and Washington Technology Solutions. The HHS Coalition is providing oversight and guidance to the IEE Modernization Program project. The project is updating the Automated Client Eligibility System (ACES) system, the state's legacy system for determining eligibility, to allow for interoperability across benefits determinations. These changes will be instrumental in tracking and connecting clients to key benefits.

5B. Data tracking and monitoring

ACES is the state's connection point for eligibility information. Enrollment data for Medicaid, TANF, SNAP, and WIC are stored in ACES. The state will continue to maintain and upgrade the system to streamline eligibility processes and reduce system barriers to eligibility status within ACES. In support of efforts to track and increase client participation in services, the state will leverage its existing partnership with the Research and Data Analysis unit of DSHS to perform cross-program analysis to identify enrollees who are likely eligible but not enrolled in other key benefits.

Shown below are strategies associated with improving the share of Medicaid clients enrolled in federal and state programs that provide shelter.

Key strategies for Milestone 5	
Ensuring consistency across programs	Washington's current key benefits eligibility systems are fragmented, and different eligibility enrollment is housed in different state agencies. Washington will work collaboratively with other state agencies and the Research and Data Analysis division of DSHS to identify key benefit eligibility across different systems and provide notification to enrollees of their potential eligibility. Additionally, Washington will provide enrollees with resources for benefit connection. The state will collaborate with Hubs to establish expectations for consistent progress in integrating HRSN services within Washington's eligibility systems of services for clients. The expectations will be included in readiness assessments for the implementation of HRSN services.

HRSN Rate Methodology: The methodology submitted for community hub services is in **Appendix 3.**

HRSN Maintenance of Effort (MOE): The state submitted the HRSN MOE on December 19, 2023. Currently the state is in the process of revising the HRSN MOE following CMS review and feedback. The submission is in **Appendix 4.**

Appendix 2 | ACH Community Hub Readiness Criteria

In order to receive HRSN services funds to implement Case Management, Outreach, and Education services (STC15.2(c)), a community hub must meet the following readiness criteria. All responses must be submitted in writing to the Washington State Health Care Authority.

Please note that the following criteria are required for initial launch of the community hubs. Additional requirements may be added in later implementation phases of HRSN services.

1. Submit a membership list of a community hub advisory body. The advisory body may be the same as, or a subset of, an existing governing or advisory body.

2. Demonstrate, in a narrative submission, the necessary risk management, legal, and business experience and expertise to evaluate, develop, and execute contracts with partner organizations.

3. Submit written policies and procedures for
    - Providing or contracting for community-based care management services
    - Collecting and reporting data to HCA
    - Meeting the guidelines for collecting and reporting encounter data as outlined in STC 15.14(c):
      "When possible, this encounter data must include data necessary for the state to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts and subsequent efforts to mitigate health disparities undertaken by the state."
    - Maintaining data security

4. Submit a workplan describing steps to operate under a set of alignment criteria developed by the ACHs and approved by HCA. The plan should include methodology for measuring progress toward full compliance.

5. Submit a plan demonstrating a set of strategies to address equity, including strategies to incorporate of community-based health workforce voice and capacity to receive referrals from community partners.

6. Submit a plan outlining outreach efforts within your region.
    - If the plan includes outreach to a specific sub-population(s), please describe those efforts.

7. Demonstrate an approach to health-related social needs screening in alignment with other community hubs and in cooperation with network partners.
    - Submit HRSN screening tool(s) to be used by the hub. HCA understands the initial submission may be used on an interim basis and it may be replaced with a different screening tool as part of hub alignment.
        - Screening may include
            - Housing instability
            - Food insecurity
            - Financial insecurity
            - The need for transportation assistance
            - Family and community support
            - Behavioral health
            - Interpersonal safety and violence
            - Other HRSN identified by the hub or the state
    - Submit policies and procedures to support sharing screening results while protecting individual privacy and avoiding duplicate screening

8. Submit a plan for initiating closed-loop referrals to HRSN services and community providers based on the outcomes of screening. Include information about services that are culturally responsive and/or trauma-informed.
    - Submit process steps for warm hand-offs to network partners.

9. Demonstrate the ability to ensure there is a person-centered shared care plan for each individual served by the Hub, updated every 12-months or as needed, that is developed in consultation with the individual, culturally responsive, and trauma informed.

10. Submit a list of community partners accepting referrals to HCA and plans to expand your community network. If appropriate, include information about specific network expansion to serve target population(s).

Washington State Health Care Authority

Appendix 3 | Hub Case Management Rate Methodology

Hub Community-Based Case Management Prospective Payment Methodology

June 4, 2024

Background and Context

Central to the coordinated delivery of health-related social need (HRSN) services for Apple Health members will be Community Hubs and the Native Hub ("the Hubs"). Washington's nine Accountable Communities of Health (ACHs) will serve as the Community Hubs and a to-be-identified Tribal entity or entities will serve as the Native Hub. Over the past seven years, ACHs have actively fostered community partnerships and established connections, playing a vital role in addressing social drivers of health. Their community-led, community-driven approach is advancing health equity across their respective regions. To take on the role of the Hubs, ACHs and the Tribal entity will build on this strong foundation, expand existing community-based relationships, and develop and operate new capabilities and capacity.

Washington's Section 1115 Demonstration provides vital infrastructure funding to support the development of new capacity and capabilities for ACHs and the Tribal entity to serve as the Hubs. In recognition that the Hubs are by design entities typically with limited reserves and thin margins as funds are invested into the communities they serve, **Washington Health Care Authority (HCA) seeks to implement a prospective per-member per-month ([PMPM) payment methodology to the Hubs for case management, outreach, and education services ("community-based case management services")**.

The Hubs will be the sole providers of community-based case management services, which encompass activities to coordinate and refer Apple Health members (regardless of delivery system) to services that address health-related social needs and link Apple Health members to a variety of state and federal benefit programs. Community-based case management services are crucial to ensure Apple Health members with food, housing, financial insecurity, or other health-related social needs are supported in accessing the resources available in their communities. A prospective PMPM payment rather than fee-for-service approach would provide financial predictability and stability for the Hubs to support their ongoing operational costs.

Approach

- HCA is proposing a PMPM of $2.68 for community-based case management services.

Below are the calculations used to develop the PMPM rate. Please refer to the attached case management rates methodology for background assumptions.

		Estimated Hub Costs
Estimated # Medicaid Lives		220,000
Hub core staffing costs (fully loaded)	**$**	**1,312,500**
Community Hub Manager/ lead	*$*	*165,000*

Clinical Coordinator	*$*	*145,000*
Referral Coordinator	*$*	*240,000*
Training/ Quality Assurance lead	*$*	*140,000*
Data lead	*$*	*140,000*
CIO/IT staff	*$*	*230,000*
CFO/ Financial staff	*$*	*115,000*
ACH Exec. Director	*$*	*137,500*
CBO partner orgs/ CBHW Workforce Costs	**$**	**3,802,857**
CBHW est. cost (Fully loaded plus admin)	*$*	*90,000*
# of CBHWs for region		*42*
CBHW Travel costs	*$*	*31,429*
TA, Training, Learning Collaboratives for CBHWs	$	125,714
Hub staff training/ development	$	24,000
Communications/marketing	$	440,000
Technology Equipment		
Technology Platform	$	300,000
Privacy/ Security	$	40,000
Legal services	$	35,000
Evaluation / performance management	$	70,000
Sub-Total of Est. Actual Costs	$	6,150,071.43
Admin and other costs	$	922,510.71
TOTAL EST. ACTUAL COSTS	**$**	**7,072,582.14**
Annual Per Member Costs	$	32.15
Per Member Per Month Rate	$	2.68

Payments will be made quarterly to the Hubs.

- Accountability structure – Payments would be conditioned on the Hubs reporting appropriate encounter data on a quarterly basis.

Washington will explore feasibility of end-of-year reconciliation to validate services rendered and performance against the reported data/measures.

Washington State Health Care Authority

Appendix 4 | Maintenance of Effort Plan (MOE)

Maintenance of Effort Plan – Housing and Nutrition Programs

Introduction

According to the Medicaid Transformation Project (MTP 2.0) Special Terms and Conditions (STCs), section 15.16 Maintenance of Effort (MOE), the state must maintain a baseline level of state funding for ongoing social services related to housing transition supports and nutrition supports. This baseline is not intended to include one-time or non-recurring funding. This submission outlines the state's plan for determining baseline spending on these services throughout the state so that the state can monitor and report annual MOE as part of the Annual Monitoring Report described in STC 20.8.

Program Inclusion Criteria

For program inclusion, the state will use the following criteria:

1. Programs that provide housing or nutrition support in the state;
2. Fully funded by general fund state dollars;
3. Do not receive reoccurring federal funding; and
4. For a duration that is not considered time-limited, i.e., there is no known end date for program funding.

Federally funded programs are not included in the baseline due to the many factors that are outside of the state's control and beyond the intent of the MOE requirement.

Baseline Calculation Approach

Below are the parameters for baseline calculation:

1. The state will use the most recent historical expenditures, up to the five most recent years of expenditure data if available.
2. The historical annual expenditures will be used to establish an average for the baseline.
3. This approach will allow the state to establish an average annual expenditure amount to be included in the baseline while reducing the potential for the baseline to reflect an anomaly in the amount of general fund state expenditure authorization.

Programs to be Included in MOE Baseline

This section summarizes the programs the state plans to include in the baseline calculation based on initial research. The state will further validate program inclusion and may add additional programs based on the above criteria prior to reporting the official baseline as part of the first Annual Monitoring Report submission.

1. ***Foundational Community Supports Transitional Assistance Program (FCS TAP) – Health Care Authority (HCA)***

FCS TAP offers funding to FCS supportive housing enrollees as they take steps to achieve short and long-term housing goals. If an individual is actively receiving FCS-eligible Medicaid and they are authorized to receive FCS supportive housing (FCS-SH) services, eligibility for FCS TAP is presumed.

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

- IDs and other documentation (ID Card, Birth Certificates, SS Cards)
- Application Fees (Rental applications, background check, credit check)
- Transitional Housing Fees (Associated with entering certain housing)
- Moving Expenses (Moving rental and supplies)
- Home essentials and sustainability items (Small appliances, mattresses, cleaning supplies, light furnishings.)
- Items in arrears (Utilities, Rental, Storage)

FCS TAP is fully funded by general fund state dollars. The program was established in 2022, and the state has calculated an initial baseline of $3.05m in annual expenditures. Because this program was established in 2022, only three years of historical expenditure data is available to establish the baseline.

This baseline and any adjustments to the calculation will be included in the annual MOE as part of the Annual Monitoring Report described in STC 20.8.

2. Food Assistance Program (FAP) – Department of Social and Health Services (DSHS)

FAP is the state food assistance program that provides benefits to legal immigrants who are not eligible for the federal Supplemental Nutrition Assistance Program (SNAP), called Basic Food in Washington. Households that include a person eligible for FAP receive the same amount of food benefits they would receive for this person if they were eligible for SNAP. Benefits are based on household income and the number of eligible people in the home. Households can receive a mix of FAP and SNAP benefits depending on the citizenship or alien status of each person in the home. FAP consists of two distinct immigrant groups:

- Qualified aliens who have not met the requirements for age, work quarters, or 5-year time frame as a qualified alien, to be eligible for Basic Food benefits under the federal Supplemental Nutritional Assistance Program (SNAP). This population will cycle through FAP within 5 years or less and become eligible for federal benefits.
- Nonqualified aliens who are immigrants but will not be eligible for federal benefits unless they have an adjustment of their immigration status. These immigrants are referred to as Persons Residing Under Color of Law (PRUCOL).
    - Persons considered PRUCOL are legally in the U.S., but do not have an official status as a qualified alien with the U.S. Citizenship and Immigration Services. Immigrants, such as applicants for political asylum or withholding of deportation, who have not yet received a final order are considered PRUCOL.

1. ***Foundational Community Supports Transitional Assistance Program (FCS TAP) – Health Care Authority (HCA)***

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This baseline and any adjustments to the calculation will be included in the annual MOE as part of the Annual Monitoring Report described in STC 20.8.

2. ***Food Assistance Program (FAP) – Department of Social and Health Services (DSHS)***

FAP is fully funded by general fund state dollars. The program has been established for over 20 years, and the state has calculated an initial baseline of $18.9m in annual expenditures. The state used the five most recent years of historical data to establish the baseline.

This baseline and any adjustments to the calculation will be included in the annual MOE as part of the Annual Monitoring Report described in STC 20.8.

Attachment Y
Approved List of Designated State Health Programs (DSHPs)

The DSHP-eligible expenditures in this list exclude prohibited costs, in accordance with STC 23.2.

Program	Description	DSHP-Eligible Expenditures
Kidney Disease Program	The Kidney Disease Program (KDP) helps low-income residents with their high costs for treatment of end stage renal disease (ESRD), also known as kidney disease or kidney failure. The goal of the program is to assist Washington State residents with the extraordinary costs of chronic kidney disease.	$9,096,000
Nursing Homes, Community Residential, and Homecare	Medicaid services for non-Medicaid eligible elderly and disabled populations not meeting functional and/or financial requirements through the traditional Medicaid Long Term Services and Supports (LTSS) system. Services include in-home personal care, residential care, dementia care, behavioral support, and other in-home services, which may include personal response systems, equipment, and registered nurse delegation.	$50,216,000
Office of the Deaf and Hard of Hearing	The Office of the Deaf and Hard of Hearing encompasses several statewide programs that provide a wide range of services for Deaf, Deaf Blind, Deaf Disabled, Hard of Hearing, Late Deafened and Speech Disabled individuals, their families, and service providers in Washington State.	$9,952,000
Employment & Day and Other Community Services	Services provided to non-Medicaid eligible adults and children who have a developmental disability diagnosis, to allow them to thrive in their communities and have the typical day-to-day life of their peers. Individuals aged 21 and older may receive employment services.	$26,908,000
Community Residential & Homecare	Adults and children who have a developmental disability diagnosis receive services provided through contracts with for-profit and non-for-profit organizations. This allows them to remain in the community in the least restrictive setting that supports full engagement in their communities.	$25,060,000
Crisis and other non-Medicaid services	. Crisis and other non-Medicaid services are a broad range of services offered to qualified individuals, including children, youth, and families, experiencing behavioral health crisis 24/7/365 days per year.	$407,620,000

Program	Description	DSHP-Eligible Expenditures
Program of Assertive Community Treatment (PACT)	An evidence-based program for people with the most severe and persistent mental illness who experience significant difficulties with activities of daily living, with active symptoms and impairments, and who have not benefited from traditional outpatient programs. The program is a person-centered, recovery-oriented mental health service delivery model that has received substantial empirical support for reducing psychiatric hospitalizations, facilitating community living, and enhancing recovery.	$33,968,000
Outpatient and Support Services	Substance use disorder (SUD) outpatient and support services are a broad range of services provided in the community to non-Medicaid, low-income eligible individuals, often in partnership with drug courts and juvenile justice systems to ensure referrals to SUD treatment are medically appropriate and effectively managed.	$80,820,000
Total Allowable DSHP-Eligible Expenditures		$643,640,000
Total Allowable DSHP-Eligible Expenditures with Adjustment		$618,538,040
Total DSHP Cap. The state must not claim more than the capped amount of DSHP.		$592,000,000