Washington State Health Care Authority

Washington State Medicaid Transformation Project (MTP 2.0)

Section 1115 demonstration waiver quarterly report

Demonstration Year (DY) 9 | Reporting Period 3:

January 1 through March 31, 2025

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Introduction

On June 30, 2023, the Centers for Medicare & Medicaid Services (CMS) approved Washington State's request for a Section 1115 Medicaid demonstration waiver, titled Medicaid Transformation Project (MTP 2.0). The activities are targeted to improve the system's capacity to address local health priorities, deliver high-quality, cost-effective, whole-person care, and create a sustainable link between clinical and community-based services.

Over the MTP 2.0 period, Washington will:

- Expand coverage and access to care, ensuring that people can get the care they need.
- Advance whole-person primary, preventive, and home- and community-based care.
- Accelerate care delivery and payment innovation focused on health-related social needs.

The state will accomplish these goals through these continuing or new programs:

- **Long-Term Services and Supports (LTSS):** Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) and Presumptive Eligibility (PE)
- **Foundational Community Supports (FCS):** Community Support Services (CSS) and Supported Employment – Individual Placement and Support (IPS)
- **Substance use disorder (SUD) IMD waiver:** Treatment services, including short-term services provided in residential and inpatient treatment settings, that qualify as an institution for mental disease (IMD)
- **Mental health (MH) IMD waiver:** Treatment services, including short-term services provided in residential and inpatient treatment settings, that qualify as an IMD
- **Contingency Management (CM) for SUD treatment:** Evidence-based intervention for SUD
- **Continuous enrollment (CE):** Continuous Apple Health enrollment for children ages 0 through 5 and Apple Health postpartum coverage expansion
- **Reentry from a carceral setting (Reentry Initiative):** Services to individuals beginning up to 90 days prior to their expected release and continuing into their reentry to their communities
- **Health-related social needs (HRSN) services:** Evidence-based, non-medical services that address social needs that affect health. HRSN services are coordinated in part by nine Community Care Hubs and one statewide Native Hub.

Vision: A healthier Washington

The Washington State Health Care Authority (HCA) is the lead agency for MTP 2.0, and many other agencies and partners play an important role in improving Washington's health and wellness systems. Together, we are working to create a healthier Washington, where people can receive better health, better care, and at a lower cost.

Quarterly report: January 1 – March 31, 2025

This quarterly report summarizes MTP activities from the third reporting period of MTP 2.0: January 1 through March 31, 2025. It details MTP implementation, including stakeholder education and engagement, planning and implementation, and development of policies and procedures, and continues the demonstration reporting as "demonstration year 9" (DY9).

Summary of quarter accomplishments

- Accountable Communities of Health (ACHs) continue to distribute HRSN infrastructure funds to partnering providers. During the reporting quarter, ACHs received $86,130,209.49 in HRSN infrastructure funds for the development and implementation of the Community Care Hubs and capacity-building of HRSN partnering providers in their communities.
- As of March 31, 2025, more than 22,284 clients, in addition to their family caregivers, have received services and supports through the Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) programs. The average caseload for the quarter was 4,751 clients.
- As of March 31, 2025, Long-Term Services and Supports (LTSS) presumptive eligibility (PE), approximately 514 clients were found eligible to receive services.
- Within Foundational Community Supports (FCS), the total aggregate number of people enrolled in services at the end of this reporting period includes 4,126 in Individual Placement Support (IPS) and 9,422 in Community Support Services (CSS). The total unduplicated number of enrollments at the end of this quarter reporting period is 16,852.
- On Contingency Management, 7 providers are expected to participate in the program during Cohort 1.
- On Continuous Apple Health enrollment for children ages 0 through 5, for this reporting period the number of new enrollments in January is 5,320; in February is 4,025; and in March is 3,102.
- On Apple Health postpartum coverage expansion, for this reporting period the number of new enrollments in January is 868; in February is 859; and in March is 831.
- Within the Reentry Initiative, the state received 24 Capacity Building Applications (CBA) and has distributed more than $4 million Capacity Building Funding to 10 facilities.
- For HRSN services, HCA received approval of the HRSN services protocol and payment rate methodologies for HRSN services.

Stakeholder engagement

During this reporting quarter, HCA continued its stakeholder engagement efforts through:

- Reentry Initiative learning series webinars
- Reentry from a carceral setting webpage redesign

Reentry Initiative learning series

Starting in January 2025, the MTP team hosted a learning series for carceral facilities interested in participating in Cohort 1 and Cohort 2 of the Reentry Initiative. The webinars ran January 6 – March 19 with each week of the series covering a specific Reentry-related topic to assist facilities in understanding the initiative. On average, over 115 attendees from across the state joined the webinars each week. There was time allotted for questions at the end of each presentation. Each learning series webinar was recorded and posted on the Reentry from a carceral setting webpage along with a PDF of the presentation.

Other MTP stakeholders, such as managed care organizations (MCOs), Department of Corrections (DOC), and Department of Children, Youth, and Families (DCYF) also attended these webinars.

Reentry from a carceral setting webpage

This quarter, HCA updated the MTP webpage focusing on the Reentry Initiative to include the learning series webinars, and new materials available to assist facilities participating in the Reentry Initiative. The Reentry from a carceral setting webpage now includes detailed information about each milestone, along with the forms facilities need to submit for each milestone. Examples of the new materials include:

- Facilities' milestone progress in the Reentry Initiative
- Reentry Initiative Policy and Operations Guide
- Milestone 3: Readiness Assessment form

Collaboration and shared learning

HCA ensures ongoing opportunities for collaboration and shared learning among the nine Accountable Communities of Health (ACHs) and HCA staff. Weekly conference calls with ACH leadership provide a venue for updates from HCA, plus a forum for ACHs to provide feedback and share information with each other. In addition, quarterly calls with each ACH allow for more detailed, region-specific discussion. ACH leaders include staff in the quarterly calls at their discretion.

For this reporting period, there are no further updates on collaboration or shared learning activities.

LTSS implementation accomplishments

This section summarizes Long-Term Services and Supports (LTSS) program development and implementation activities for Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) programs, as well as LTSS presumptive eligibility (PE) from January 1 – March 31, 2025. Key accomplishments for this quarter include:

MAC and TSOA

As of March 31, 2025, more than 22,284 clients, in addition to their family caregivers, have received services and supports through the MAC and TSOA programs. The average caseload for the quarter was 4,751 clients.

Aging and Long-Term Support Administration (ALTSA) has started the 2025 annual quality assurance cycle during this review period.

HCA successfully implemented MTP 2.0 expansions under the Section 1115 demonstration waiver renewal to further develop innovative projects, activities, and services for MTP participants.

Expansion highlights include:

- Utilizing the updated TSOA income eligibility criteria (400 percent of the federal benefit rate), 59 new participants in the expanded eligibility tier accessed TSOA services this quarter.
- Utilizing the updated resource standard (six months of the current private nursing facility rate), 24 additional participants in the expanded eligibility tier accessed TSOA services this quarter.

LTSS PE

During this quarter, the LTSS PE demonstrated notable progress, with approximately 514 clients found eligible to receive services. A considerable number of LTSS PE clients have successfully transitioned to in-home services following a thorough evaluation of their functional and financial eligibility. As we approach phase 2, there are strategic plans to broaden access to LTSS PE. Region 1 is currently testing phase 2 to ensure effectiveness before statewide implementation. Efforts in this region have included continuous dialogues with management, regional personnel, and the Area on Aging Agency (AAA). These discussions aim to optimize workforce, facilitate case sharing, provide training, track data effectively, and pinpoint potential challenges. Consequently, there has been a formal request to adopt a lean methodology, which seeks to standardize and streamline LTSS PE processes, ensuring equitable and efficient access to services across all regions.

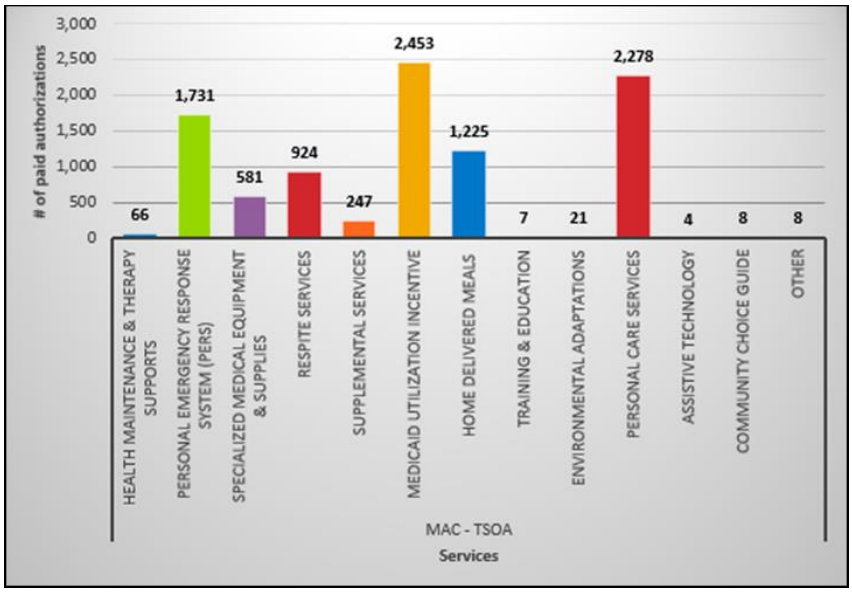
Regional staff expressed concerns regarding the functionality of the LTSS PE assessment during Phase 1. This feedback has initiated a collaborative effort with the CARE Web developers to implement future enhancements.

Service Utilization

MAC and TSOA service utilization

The chart below depicts the number of paid authorizations for services offered under the MAC and TSOA programs this quarter.

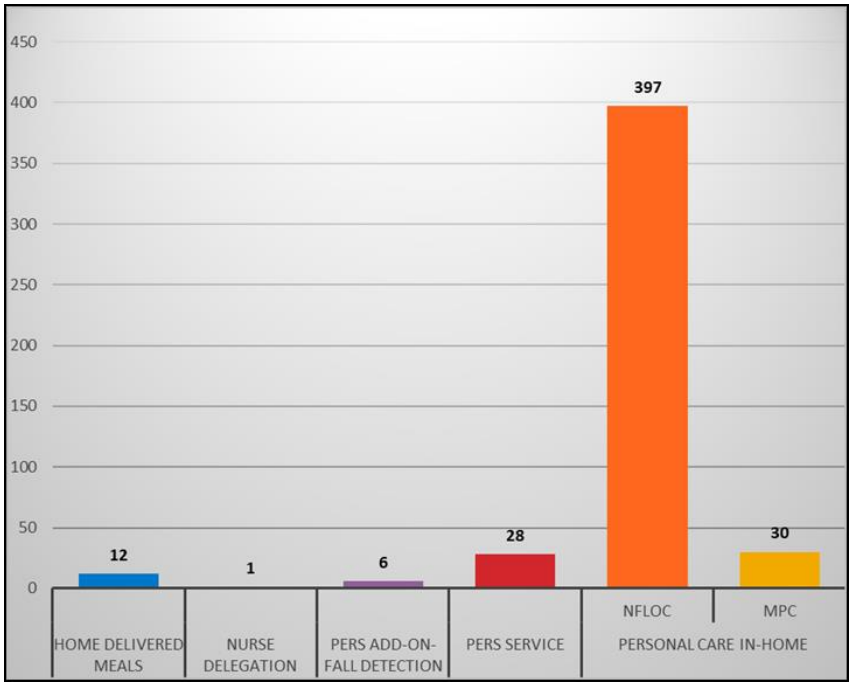
Figure 1: MAC and TSOA service utilization



LTSS PE

The chart below depicts services that are current in this quarter under LTSS PE.

Figure 2: LTSS PE service utilization



Network adequacy for MAC and TSOA

The Area on Aging Agencies (AAAs) continue to monitor already established provider contracts as well as execute new contracts to expand their provider networks based on each planning service area's (PSA) identified needs.

The statewide direct care workforce shortage continues to impact the availability of respite and personal care providers. The MAC and TSOA programs successful implementation of the self-directed care model in June 2024 has proven invaluable, as it allows another option for care receivers to obtain respite and personal care, as identified in the person-centered care plan. Since the self-directed care model implementation, the MAC and TSOA programs have seen numerous successful referrals to Consumer Direct Care of Washington (CDWA) which is the contracted Consumer Directed Employer (CDE) provider for Washington State and the added provider option appears to be lessening the direct care workforce shortage impact.

In addition to the self-directed care model, ALTSA also implemented the Remote Care Services pilot to help address the direct care workforce shortage which is an available option for MAC and TSOA participants when a direct care worker is unavailable.

The MAC and TSOA programs continue to see utilization of alternative services and providers as a bridge when personal care or respite workers are in short supply. Continued utilization of other services in the MTP service benefits package to meet participants' needs include but are not limited to home delivered meals, personal emergency response systems, adult day care, and environmental modifications.

Assessment and systems update

MAC and TSOA

Collabrios (formally RTZ), GetCare's administrator, completed the interface between the GetCare case management system and Consumer Direct Care of Washington (CDWA's) provider management system in June 2024. This interface allows case managers to send and receive required documents, as part of the referral process, to CDWA. The interface also allows CDWA to send pertinent case management notifications back to GetCare. During this quarter, continued troubleshooting and monitoring the system interface was necessary along with oversight and follow-up of referrals.

Collabrios and the CARE team successfully upgraded the interface between GetCare and CARE to ProviderOne, Washington State's Medicaid Management Information System (MMIS), which is the system used by all Medicaid providers to submit claims to be paid for services provided. The enhancement included reduction in processing time of recipient aid categories through the system interfaces which has positively impacted workflow and timely delivery of services.

Further instructions were provided in regard to streamlining the voter's registration assistance process to help with troubleshooting some of the system and policy requirements.

Expected future system updates include:

- Improvements to the person-centered care planning design and tool.
- Implementation of a view option in GetCare for care receiver's eligibility status in ProviderOne.

After collaborating with community partners, ALTSA has started working with TCARE Inc. and Collabrios to incorporate cultural and language equity changes to TCARE, which is the assessment tool used for Washington's Family Caregiver Programs.

LTSS PE

In collaboration with CARE Web developers, HCA completed the following CARE Web enhancements this quarter:

- Identifying shared cases with color tag
- Adding weight/skin concerns and bedbound indicators

- Case-sharing tickler notifications
- Keep the "Services" section of the Care Planning enabled
- Modify financial screening questions for N-series clients in LTSS PE determination

Future CARE Web enhancements that are being considered/developed include:

- Skin Observation Protocol triggers
- Social Service Specialist/Case Manager signature electronically applied

Staff training

MAC and TSOA

MAC and TSOA program managers for home and community services are committed to providing bi-monthly statewide training webinars on requested and needed topics during the report period. Below is the webinar training that occurred during this reporting period:

- January 2025: Quality Assurance Process Review for MTP 2025

HCA has compiled data and feedback from the 2024-2025 training survey that went out statewide to AAAs, MTP social services staff, and HCS public benefits specialists. HCA will use the information gathered to create the 2025 training calendar which should be published in the next quarter.

LTSS PE

As Phase 1 continues to be implemented throughout the state, there has been a minimal need for staff training. In October of 2024, Region 1 started testing Phase 2 in an effort to gain valuable insight before a statewide rollout.

With the testing of Phase 2 in region 1, additional staff have been hired, allowing for three (3) full-time LTSS PE assessors. As testing continues, scheduled Q&A meetings are conducted with the Spokane HCS office and the AAA's serving the region 1 area. These specific meetings focus on case managers who have questions about the assessment process, transfer protocols between HCS and the AAAs, or any technical barriers that they face. Although shadowing opportunities between HCS and the AAAs have been proposed to facilitate cross-training support, the information made available through a shared Teams channel for ongoing reference has provided sufficient information to support clients through either agency. These reference materials include LTSS PE specific documents, desk aids, workflows, and PowerPoint presentations.

Data and reporting

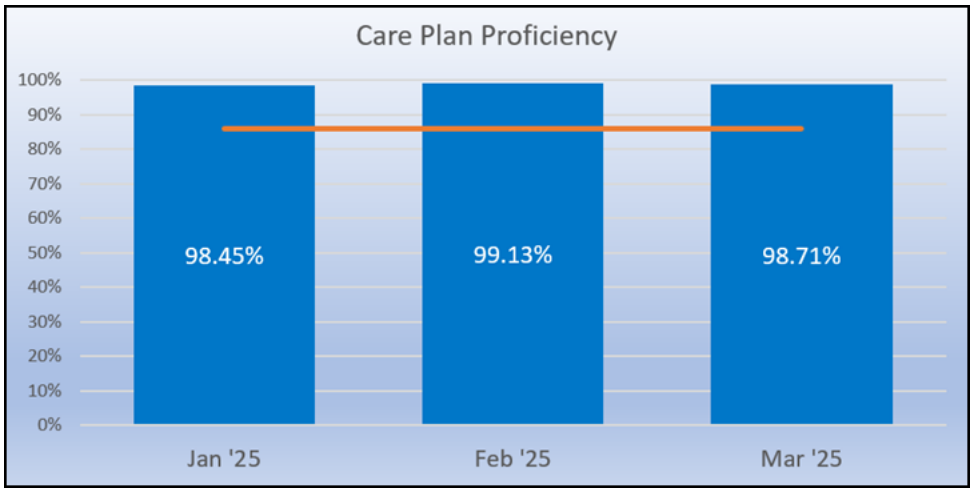
MAC and TSOA

Table 1: Beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of March 31, 2025	324	1461	3544
Number of new enrollees in quarter by program	43	303	630
Number of new person-centered service plans in quarter by program	20	94	215
Number of new enrollees who do not require a care plan because they are still in the care planning phase and services have yet to be authorized	22	203	411
Number of beneficiaries self-directing services under employer authority*	24	39	230

*The state has successfully implemented all necessary system enhancements for CDE for the MAC and TSOA programs. Effective June 26, 2024, MAC and TSOA participants have the option of self-directed services.

Figure 3: Statewide care plan proficiency to date



Note: The orange 86 percent line represents the CMS proficiency expectation.

The AAAs compliance with timely completion of care plans for enrollees continues to exceed proficiency.

LTSS PE

Month/Year of Service	LTSS Presumptive Eligibility Beneficiary (NFLOC)	MPC Presumptive Beneficiary Eligibility
January – March 2025 Grand Total	437	49

LTSS PE continues in Phase 1 and includes the region 1 area that is testing Phase 2. Totals reflect all three regions for those individuals who were found eligible for LTSS PE services during this quarter.

Tribal engagement

MAC and TSOA

Department of Social and Health Services (DSHS) Aging and Long-Term Support Administration (ALTSA) Tribal Affairs team met with a number of Tribes this quarter to discuss Medicaid services including the MAC and TSOA programs, Family Caregiver Support Program (FCSP) and Foundational Community Supports (FCS) services.

January: Tribal Affairs attended Muckleshoot Tribe 7.01 planning meeting and shared MAC & TSOA program information. Outreach was also provided to Port Gamble S'Klallam during the 7.01 and the tribe was encouraged to reach out to learn more about the MAC & TSOA programs.

February: Tribal Affairs met with Lummi nation to discuss contracting for MFPTI (Money Follows the Person Tribal Initiative) and shared MAC and TSOA program information.

March: State Unit on Aging (SUA) program manager presented the MAC and TSOA program information to the Indian Policy Advisory Committee (IPAC) with six Tribes in attendance.

Tribal Affairs continues building relationships with Tribal Nations while sharing services supported by MFPTI, including the MAC and TSOA programs. Tribal Affairs has participated in meetings with MAC and TSOA program managers to increase the creation and development of culturally responsive materials regarding MAC and TSOA for Tribal nations. MAC, TSOA, and other programs for unpaid caregivers continue to be a focus when working with Tribal partners. Tribal Affairs continues to collaborate with ALTSA program managers to develop outreach materials that provide concise pertinent information for Tribal nations to increase the utilization of this program for Tribal nations. This effort will

continue throughout 2025. SUA program manager will attend periodic IPAC meetings to share MAC and TSOA information as well as collaborate with Tribal nations.

LTSS PE

There has been no tribal engagement provided or requested this quarter.

Outreach and engagement

MAC and TSOA

In conjunction with a department wide rebranding refresh, ALTSA staff will continue to collaborate with the AAAs and Tribal Affairs on updating outreach materials and brainstorming ideas for new publications to engage community members.

Table 2: Number of outreach and engagement activities held by Area Agencies on Aging

	January	February	March
Community presentations and information sharing	124	105	188

LTSS PE

Home and Community Services (HCS) will continue to collaborate with the Aging & Long-Term Care of Eastern Washington (ALTCEW) to prepare for participation in Phase 2.

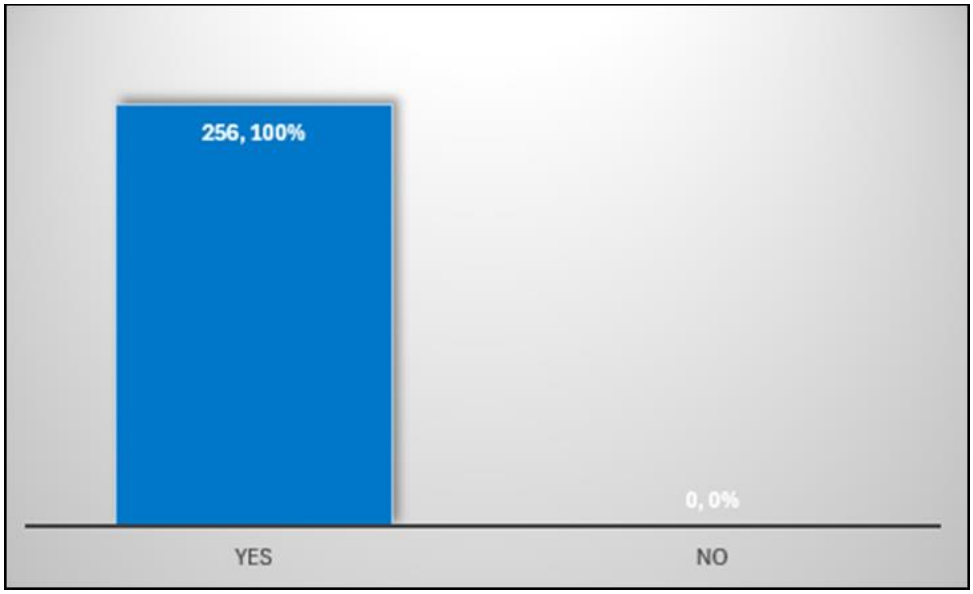
In February 2025, AARP Public Policy Institute partnered with ATI Advisory to interview HCS to better understand how presumptive eligibility could improve timely access to Medicaid Home and Community Based Services (HCBS) and reduce the need for institutional care. This interview allowed ATI Advisory to gain perspective on operational approaches to developing these programs, the impacts in our state, as well as the barriers and challenges to program implementation that other states considering presumptive eligibility may have.

Quality assurance

This section provides the results of the quarterly presumptive eligibility (PE) quality assurance review.

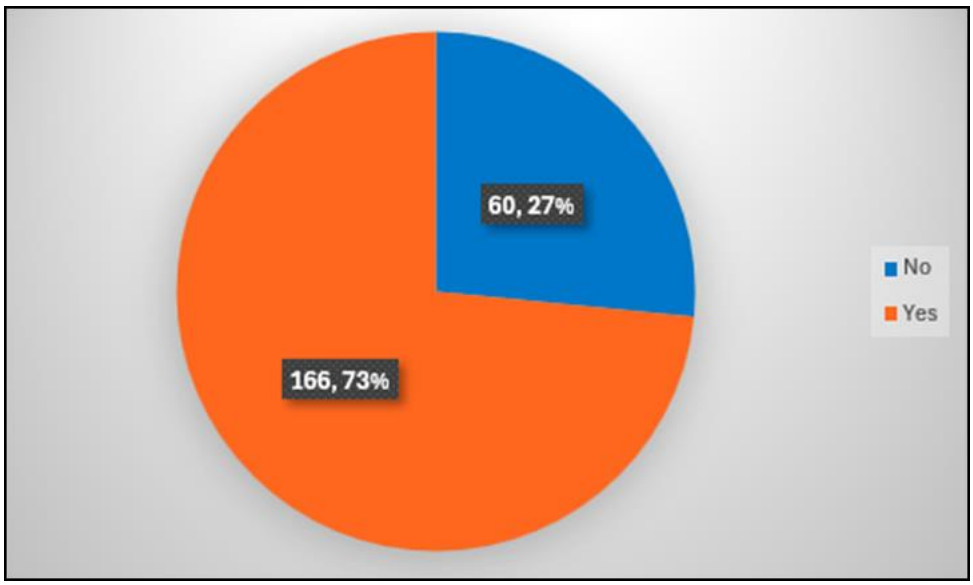
MAC and TSOA

Figure 4: Question 1: Was the client appropriately determined to be nursing facility level of care eligible for PE?



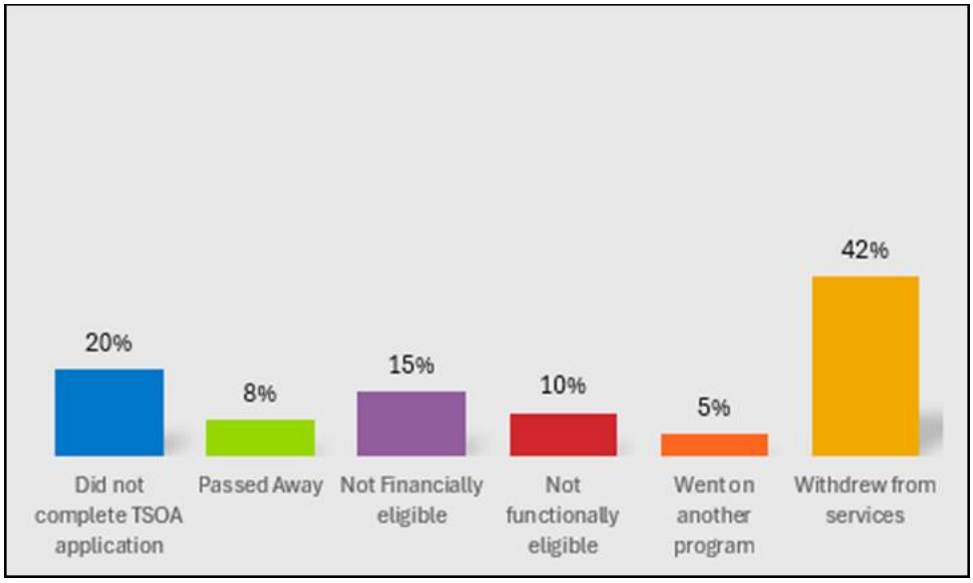
Note: 256 beneficiaries were appropriately determined NFLOC eligible with 100% success rate. 62 beneficiaries are not applicable as they have been reported on previously and the beneficiary's full eligibility determination occurred during this quarter or full eligibility is still pending.

Figure 5: Question 2a: Did the client remain eligible after the PE period?



Note: 166 beneficiaries (73%) transitioned from LTSS PE to full eligibility. 92 beneficiaries this quarter are still pending full eligibility and were therefore not applicable. 60 beneficiaries (27%) did not remain eligible after the PE period.

Figure 6: Question 2b: If "No" to question #2a, why?



Note: These percentages represent the "No" population in the previous table, 60 participants (27%) outlined above. For example, the 15 percent (9 participants) of PE clients found to be not financially eligible, are out of the 60 participants, who did not remain eligible after the PE period illustrated in the Table for Question 2a.

LTSS PE

Figure 7: Question 1a: Did the client remain eligible for in-home services after the PE period?

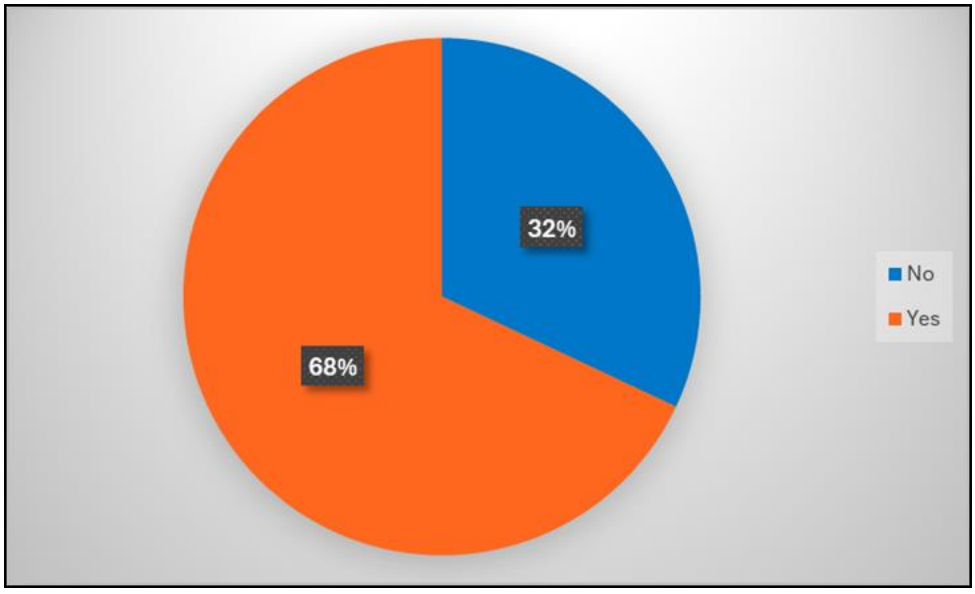


Figure 8: Question 1b: For those who with “No” responses, why?

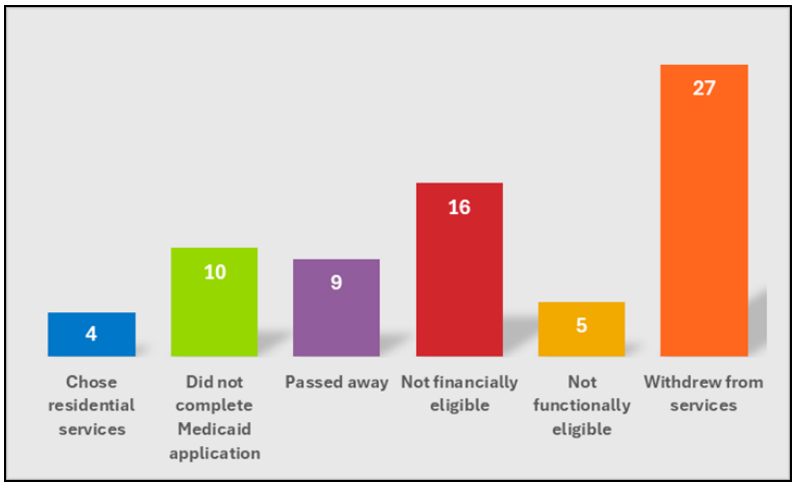


Figure 9: Question 2a: Did level of care remain the same from PE assessment to full CARE assessment?

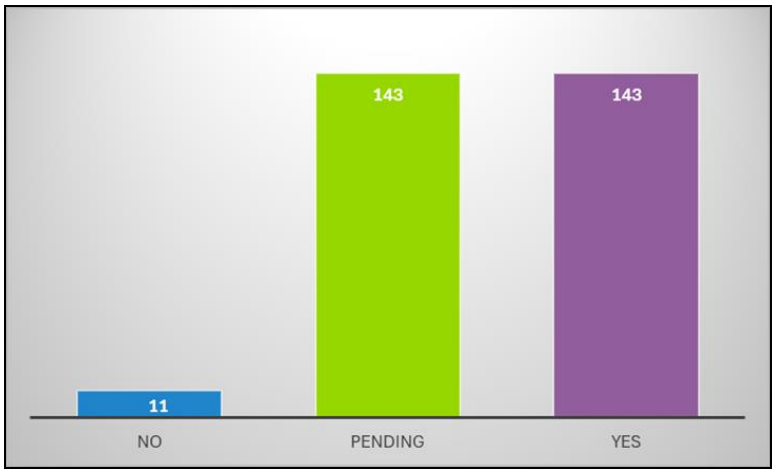
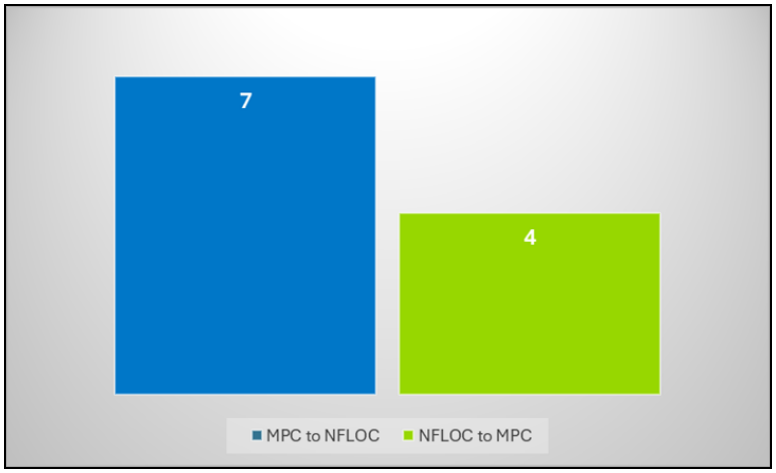


Figure 10: Question 2b: Did level of care remain the same from PE assessment to full CARE assessment? (Only applies to NO RESPONSE)



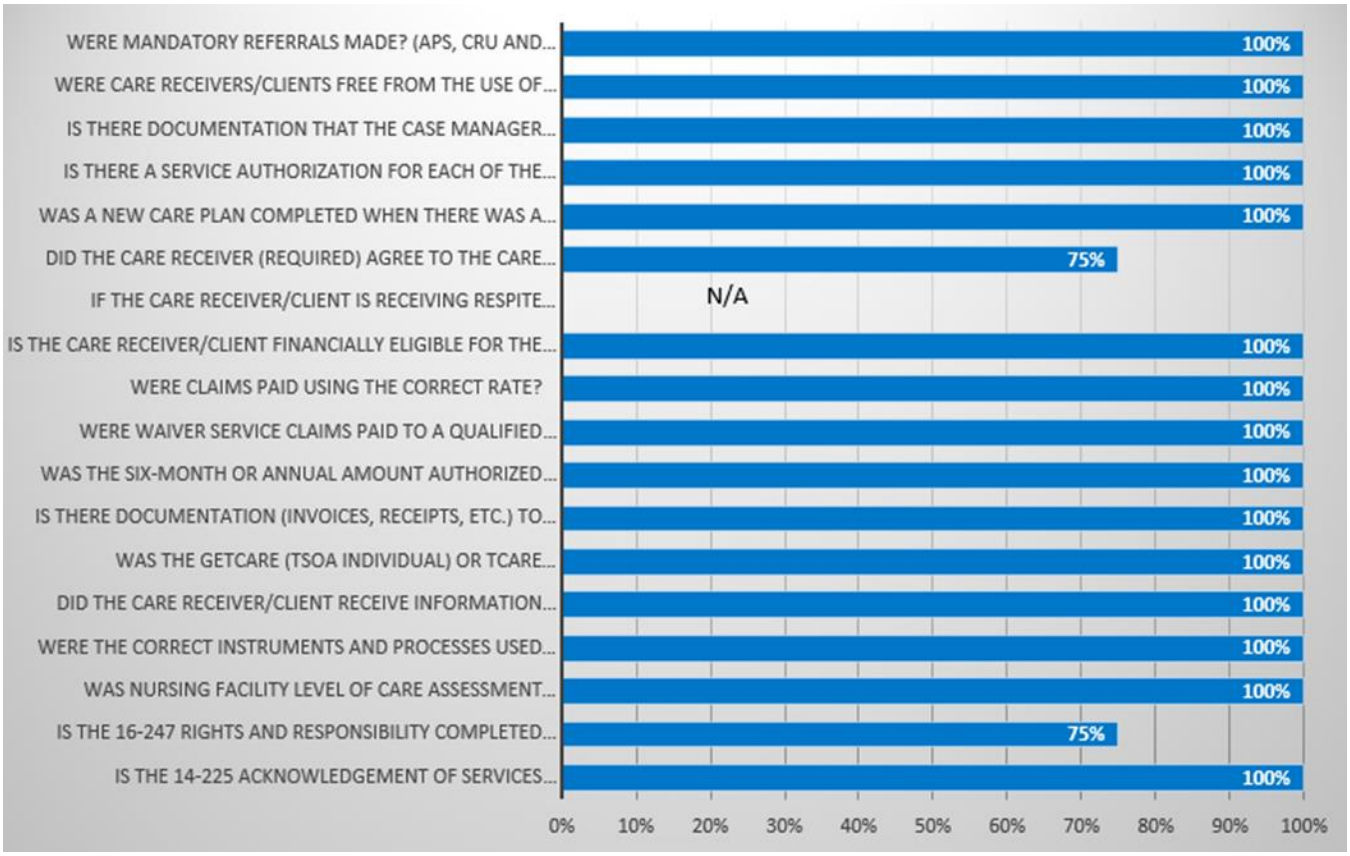
2025 quality assurance results to date

MAC and TSOA

HCS's 2025 Quality Assurance cycle began in January. The statewide compliance review of the 18 applicable MAC and TSOA performance measures is conducted with all 13 AAAs. An identical review process is applied in each AAA using the same Quality Assurance tool and the same performance measures.

The Quality Assurance team reviews a statistically valid sample of case records. The sample size for 2025 was 354 cases. The methodology used is the same for the state's 1915c waivers and meets the CMS requirements for sampling. Each AAA's sample was determined by multiplying the percent of the total program population in that area by the sample size.

Figure 11: Statewide proficiency to date



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

State rulemaking

MAC and TSOA

No state rulemaking specific to MAC and TSOA occurred during this quarter.

LTSS PE

No state rulemaking specific to LTSS PE occurred during this quarter.

Upcoming activities

MAC and TSOA

Continuation of monitoring system infrastructure and referral processes regarding 2024 implementation of the Consumer Direct Employer – self-directed care model.

LTSS PE

There has been a general interest to pursue a lean project prior to implementing Phase 2 statewide. This project would address effective communication and align teams, improve process flow and effectiveness, identify waste, and facilitate continuous quality improvement. As further talk continues, a date to proceed with this project will be set in the near future.

Discussions have emerged regarding the potential expansion of Phase 2 testing to include an additional county within region 1. While this has not yet been implemented, we are actively exploring options and will make a careful decision before moving forward.

LTSS stakeholder concerns

MAC and TSOA

There are no community partner concerns to report this quarter.

LTSS PE

There are no community partner concerns to report this quarter.

FCS implementation accomplishments

Foundational Community Supports (FCS) provides evidence-based supportive housing and supported employment services to eligible Medicaid clients. This section summarizes the FCS program development and implementation activities from January 1 – March 31, 2025.

Total aggregate number of people enrolled in FCS services at the end of this reporting period:

- CSS: 9,422
- IPS: 4,126

There were 241 providers under contract with Wellpoint at the end of the reporting period, representing 559 sites throughout the state.

Note: CSS and IPS enrollment totals include 4,047 participants enrolled in both programs. The total unduplicated number of enrollments at the end of this reporting period was 16,852.

Network adequacy for FCS

Table 3: FCS provider network development

	January		February		March	
FCS service type	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
Supported Employment – Individual Placement Support (IPS)	38	79	38	79	38	79
Community Support Services (CSS)	29	66	29	66	30	67
CSS and IPS	172	411	172	411	173	413
Total	239	556	239	556	241	559

Table 4: FCS client enrollment

	January	February	March
Supported Employment – Individual Placement and Support (IPS)	3356	3608	3856
Community Support Services (CSS)	8369	8624	8949
CSS and IPS	3430	3704	4047
Total aggregate enrollment	**15155**	**15936**	**16852**

Data source: RDA administrative reports

Table 5: FCS client risk profile

		Met HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
January	IPS	1003 (13%)	1.07	5310 (70%)
	CSS	2767 (21%)	1.26	8489 (66%)
February	IPS	1082 (13%)	1.07	5608 (70%)
	CSS	2932 (22%)	1.25	8843 (65%)
March	IPS	1134 (14%)	1.07	5663 (70%)
	CSS	2980 (22%)	1.25	8857 (66%)

HUD = Housing and Urban Development

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

Table 6: FCS client risk profile continued

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment needs flags
January	IPS	6415	5912 (92%)	4088 (64%)	3838 (60%)
	CSS	11167	10165 (91%)	8101 (73%)	7534 (67%)
February	IPS	6832	6277 (92%)	4352 (64%)	4083 (60%)
	CSS	11693	10605 (91%)	8453 (72%)	7844 (67%)
March	IPS	6892	6315 (92%)	4322 (63%)	4048 (59%)
	CSS	11608	10490 (90%)	8322 (72%)	7705 (66%)

Data source: RDA administrative reports

*Does not include individuals who are dual enrolled.

Table 7: FCS client service utilization

		Medicaid only enrollees*	Long-term Services and Supports	Mental health services	SUD services (received in last 12 months)	Care + MH or SUD services
January	IPS	6415	964 (15%)	4710 (73%)	2619 (41%)	806 (13%)
	CSS	11167	1042 (9%)	7535 (67%)	5064 (45%)	901 (8%)
February	IPS	6832	1029 (15%)	4895 (72%)	2784 (41%)	845 (12%)
	CSS	11693	1098 (9%)	7744 (66%)	5283 (45%)	946 (8%)
March	IPS	6892	1048 (15%)	4811 (70%)	2734 (40%)	847 (12%)
	CSS	11608	1093 (9%)	7502 (65%)	5188 (45%)	925 (8%)

Data source: RDA administrative reports (Aging CARE assessment in last 15 months)

*Does not include individuals who are dual-enrolled.

Table 8: FCS client Medicaid eligibility

		CN blind/ disabled (Medicaid only & full dual eligible)	CN aged (Medicaid only & full dual eligible)	CN family & pregnant woman	ACA expansion adults (nonadults presumptive)	Adults (nonadults presumptive) ACA expansion adults (SSI presumptive)	CN & CHIP children
January	IPS	2094 (28%)	237 (3%)	858 (11%)	3094 (41%)	1077 (14%)	200 (3%)
	CSS	3388 (26%)	708 (5%)	1661 (13%)	4480 (35%)	2513 (19%)	143 (1%)
February	IPS	2207 (27%)	251 (3%)	918 (11%)	3289 (41%)	1164 (14%)	204 (3%)
	CSS	3519 (26%)	736 (5%)	1730 (13%)	4759 (35%)	2594 (19%)	144 (1%)
March	IPS	2250 (28%)	267 (3%)	924 (11%)	3284 (40%)	1196 (15%)	207 (3%)
	CSS	3523 (26%)	742 (6%)	1714 (13%)	4672 (35%)	2612 (19%)	141 (1%)

ACA = Affordable Care Act

CHIP = Children's Health Insurance Program

CN = categorically needy

Data source: RDA administrative reports

Quality assurance and monitoring activity

FCS staff collaborated with Wellpoint, the third-party administrator (TPA), to oversee the FCS program. In Q3, one issue arose with a provider who was unable to receive payments with a backlog of Exception to the Rule (ETR) requests. FCS staff collaborated with Wellpoint to resolve the problem and provide technical assistance to the agency weekly. Additionally, the ETR process is being updated to incorporate lessons learned and ensure future issues are addressed more effectively.

To support timely National Provider Identifier (NPI) revalidation and reduce processing delays, FCS implemented a proactive notification process. Providers now receive an initial courtesy email prompting them to review and confirm their contact information in ProviderOne before the HCA sends the official revalidation notice. This step helps ensure that revalidation letters are sent to the correct address, minimizing disruptions in service delivery and preventing potential lapses in billing or payment due to outdated provider information.

FCS staff continued work to identify processes to decrease the need for reconnecting enrollees who experience changes in their Medicaid coverage. FCS is not an entitlement benefit, and enrollment is accomplished through a manual process requiring weekly workflows to enroll and reenroll (or reconnect) eligible individuals to the program. The reconnection process necessitates conducting a historical eligibility screening to identify gaps in coverage that may have occurred due to changes in Medicaid type, incarceration, or other modifications in the ProviderOne database that automatically

disconnect an individual from FCS. The FCS team at HCA and the TPA have identified a potential solution and are currently working to establish data processes that address this need.

To ensure all members of the FCS team are fully trained in conducting both supportive housing and supported employment fidelity reviews, especially in light of new staff onboarding and evolving team roles, the FCS team began internal fidelity reviewer training in Q3. This initiative is designed to build internal capacity and ensure consistency in review standards across the team. While the team had previously focused on training external provider agencies, this shift reflects a commitment to strengthening internal fidelity expertise and enhancing review quality.

Due to statewide budget restrictions and an HCA travel freeze, the FCS team was unable to conduct in-person fidelity reviews through Q3. However, plans are underway to resume in-person reviews in Q4, with scheduling already in progress. Despite the travel limitations, the team remains focused on maintaining the integrity of fidelity assessments and supporting continuous quality improvement across FCS programs.

The FCS team is currently collaborating with National TA to implement a provider proficiency assessment. This assessment aims to evaluate whether new or existing providers are delivering services in alignment with FCS standards. If providers are not meeting the evidence-based practices intended by FCS, they will be connected with our training team to engage in targeted training and technical assistance. Additionally, the team is exploring options to expand fidelity measures and incorporate them into FCS provider contracts. This will help ensure that all contracted providers adhere to fidelity standards and participate in ongoing fidelity reviews throughout the duration of their service provision.

All of these engagements intend to create and maintain high quality service delivery by investing in foundational knowledge and supportive guidance regarding evidence-based practice fidelity adherence.

Other FCS program activity

Effective April 22, 2024, HCA temporarily stopped accepting new FCS program enrollments due to projected budgetary overspend and the need to preserve services for existing participants. Program growth exceeded the previously projected enrollment forecast at the end of DY7 and into early DY8. During this time, a waitlist was established for new enrollments and managed on a first-come, first-served basis as capacity allowed. By the end of Q1 DY9, new enrollments resumed, and Wellpoint worked in coordination with FCS-contracted agencies to ensure individuals still in need of services were enrolled. The waitlist backlog was cleared by January 2025, and there is no longer a waitlist for new FCS participants. This enrollment hold also accounts for the noticeable decrease in program enrollment between July and August 2024, when disenrollments (due to expiring service authorizations) were not offset by incoming participants. The disenrollment process was subsequently updated to more accurately track the number of active enrollees. As of the end of Q1, FCS had 11,591 total enrollees, compared to 16,852 at the end of Q3.

HCA continues to maintain an ongoing monthly workgroup with our partnering state departments. Monthly, the ALTSA team and DSHS's Research and Data Analysis (RDA) staff meets to develop, discuss, and adopt key policies and practices necessary for the continued operation, improvement, and long-term success of the FCS program. The HCA FCS team meets independently with ALTSA as well to ensure alignment and inclusion of all populations in service delivery and design.

The FCS team continues to hold bi-monthly meetings with providers, coordinated by King County, the most populous county in Washington State. Spokane County also initiated a similar space for providers. These meetings offer FCS providers in the county regular engagement with the FCS trainers, the opportunity to share experiences, exchange ideas, and learn from one another about effective practices when administering FCS benefits. FCS trainers provided multiple webinars to offer information to regions without a similar coalition, the intent of which was to encourage development of FCS provider coalitions across the state.

Additionally, HCA staff, trained fidelity reviewers, and supportive housing service providers meet monthly for in-depth discussions relating to PSH fidelity and problem-solving around barriers to providing services. Topics often include fidelity review sustainability and long-term planning, deep dives on dimensions of the PSH principles, and how to increase engagement among providers.

In partnership with the DSHS's Division of Vocational Rehabilitation (DVR), HCA actively engages in a quarterly workgroup. This workgroup's primary goal is to improve consistency, foster collaboration, and optimize employment outcomes for DVR customers with behavioral health conditions who are receiving supported employment services through the DVR Supported Employment program and FCS.

FCS has continued to provide a funding opportunity, referred to as Glidepath to Supported Employment, which is intended to provide formal benefit planning, Supported Employment services, and support funds to reduce barriers to going back to work or school. Nine agencies were awarded contracts and will support individually identified regions. These state-only funds are intended to partner FCS IPS providers with Housing and Essential Needs program to provide up to nine months of additional rental assistance as a bridge period for IPS-enrolled individuals who would otherwise be financially unsupported due to increasing income through employment. Regional Glidepath providers are collecting data and reporting back to HCA quarterly on program participant demographics and outcomes.

Additionally, the FCS team is rolling out the Apple Health and Homes (AHAH) program. AHAH is a benefit to FCS enrolled clients and provides project or tenant based rental subsidies to supportive housing eligible enrollees. After additional planning and contracting to ensure sound data practices between partner agencies, hosted its first lottery to select Tenant-Based Rental Assistance (TBRA) awardees of the benefit in March 2025. Through this lottery, 59 vouchers were awarded across 10 regions in WA. A second AHAH-TBRA lottery will take place in Q4. In addition to TBRA vouchers, the first AHAH capital units became available for eligible FCS-SH enrollees to apply for in December 2024. Since then, with support from Wellpoint sending available unit notifications to the provider network, properties have begun implementing their Tenant Selection Plans (TSP) to fill available units.

The FCS Transition Assistance Program (TAP) serves Washington's most vulnerable population with complex care needs. TAP supports FCS CCS eligible individuals obtain and maintain safe, stable and affordable housing. FCS TAP has a network of 142 providers under contract through Wellpoint.

The Washington State Legislature appropriated $3,109,000 of the general fund for State Fiscal Year 2025. Funding was split into two disbursals for the fiscal year. As of July 1, 2025, $1,350,000 was released to the TAP Provider Network. TAP expended funds for the first half of SFY25 as of Thursday, August 29, 2024, at 5pm. The additional $1,350,000 was made available January 1, 2025, for the remainder of SFY25. As of February 13, 2025, TAP funds were depleted entirely.

Upcoming activities

Based on provider feedback, a series of nine training courses aiming to increase tenant engagement, clarify roles and responsibilities, and increase the state's housing inventory was offered in 2024, in addition to the FCS team's traditional Supportive Housing Institute in 2025. Training was launched in 2024 to promote agency staff to become certified reviewers and expand the ability to conduct fidelity reviews across the state. Bimonthly sessions to strengthen the cadre will continue throughout 2025.

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

The FCS trainers continue to provide training upon request of or as offered to current FCS provider agencies. Technical assistance provided may be to individual providers, a group of stakeholders, or statewide training. Training is provided either virtually or face to face.

To enhance onboarding and ongoing support for new providers, the FCS team is developing pre-recorded trainings focused on program fundamentals and billing practices. These training courses will provide accessible, on-demand guidance covering key topics such as service delivery expectations, documentation standards, and accurate billing procedures in ProviderOne. By offering consistent, standardized training content, FCS aims to improve provider confidence, reduce common billing errors, and ensure alignment with program requirements across all participating agencies.

Using general state funds, the FCS team is planning to partner with Tribal HUBs across Washington to expand access to supportive services for individuals who would otherwise qualify for FCS but are ineligible due to their Medicaid status. This initiative prioritizes Tribal members and allows Tribal HUBs to directly deliver services that are similar in scope to FCS—such as supportive housing and employment—while respecting Tribal sovereignty and allowing for culturally responsive approaches that may differ from standard FCS delivery models. To support implementation, FCS plans to create a service manual and referral guide, enabling Tribal HUBs to operate independently of Wellpoint while continuing to serve their communities.

Additionally, FCS is in the contracting process for multiple Housing-Related Social Needs funding projects. Notably, in Q3, the FCS team hosted informational sessions for Public Housing Authorities (PHAs) across Washington State to encourage applications to serve as the rent payer for rental assistance funds. These sessions provided an overview of the program's goals, responsibilities of the rent payer, and the application process. Following the sessions, the FCS team conducted a thorough review of submitted LOIs and ultimately selected the Spokane Housing Authority to carry out this critical role. This partnership will help ensure timely and accurate rental payments on behalf of eligible individuals receiving housing services.

In addition to this work, FCS will be managing contracts for:

- Apple Health and Homes Rental Assistance Program (AHAH-RAP): HRSN funds will be used for up to six months of rental assistance per AHAH tenant. Rent will be paid directly to landlords on behalf of tenants by the Department of Commerce's Office of Apple Health and Homes. COM will submit a monthly invoice to FCS to be reimbursed for rents paid for those within 6 months of utilizing the benefit, totaling approximately $10,032,550 through June 2028.
- Transition Assistance Program (TAP): HRSN Housing Transition Navigation Funds will enhance existing FCS TAP services as well as provide additional benefits. FCS TAP assists enrollees experiencing complex behavioral health needs obtain quality affordable places to call home by lowering financial barriers to housing security. Common costs covered by the FCS TAP program have included first and last month's rent, security deposits, rental and utility arrears, identification cards, credit checks, relocation fees and more. HRSN funds will add pantry stocking and utility set-up fees to the suite of services, increase the total allowance for many of the categories and implement utilization of HUD's FMR tool to determine equitable rental and utility payments. The total amount of funding is approximately $46,500,000 through June 2028.

FCS program stakeholder engagement activities

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

A significant portion of the stakeholder engagement activities during this quarter were related to the temporary pause to new enrollments. The FCS program staff held monthly meetings with providers and other key stakeholders to solicit feedback related to the pause and how the waitlist will be managed. Other stakeholder engagement events have included shared technical assistance and program alignment activities.

Lastly, the FCS team has developed an FCS provider survey to gain more insight into program challenges and how system improvements could be made to increase program efficiency and their confidence in providing FCS services.

Table 9: Number of FCS program stakeholder engagement activities held

	January	February	March
Training and assistance provided to individual organizations	99	115	102

Community and regional presentations and training events	3	3	4
Informational webinars	12	12	11
Stakeholder engagement meetings	9	9	11
Total activities	123	139	128

Training and assistance activities to individual organizations continued to increase this quarter. Webinars are intended to inform, educate, and coordinate resources for FCS providers serving people who need housing and employment services, resources, and support.

During this reporting period, topics included:

- Client Engagement Strategies and Best Practices
- Peer Services in Supported Employment and Beyond
- Care Coordination Best Practices
- Back to the Basics: Resumes, Interviews, and Cover Letters
- Intersection of Housing and Health care
- Transition Assistance Program Updates and Discussion
- Financial Wellness and Benefit Planning
- Providing and Documenting Medically Necessary Services
- FCS 101 for New and Existing Providers

FCS stakeholder concerns

The FCS team has been receiving feedback about the challenges faced by providers who are new to billing Medicaid when submitting claims as well as the FCS enrollment pause. In response, HCA is offering additional one-on-one technical assistance, a series of pre-recorded budget webinars to support providers in adopting the best practices and aligning with other Medicaid billing processes, as well as a Provider Survey to understand implementation and billing challenges. The FCS team additionally developed a New Provider Orientation presentation to assist these agencies with the intricacies of billing FCS services.

FCS agencies have been actively providing feedback and insights on FCS services. Providers share, at a minimum, during a quarterly Advisory Council meeting. The FCS provider survey will be active in Q2, and HCA intends to analyze and publish the results within the same quarter. Some of the issues that have been previously raised were the need to increase understanding about systems used to verify eligibility of enrollees, examining reasons for application denials, and decreasing confusion through updating provider-facing documents. The FCS team continued to monitor results from this survey in Q3 and will be working on increasing provider survey submissions across the network through Q4.

To keep constituents informed, the FCS team regularly provides updates and opportunities during the quarterly Advisory Council meetings, as well as hosts webinars with specific and relevant information. The FCS team is also currently examining the establishment of a formal feedback loop to increase the prevalence and timeliness of hearing stakeholder perspectives.

SUD IMD waiver implementation accomplishments

In July 2018, Washington State received approval of its Section 1115 demonstration waiver amendment to receive federal financial participation for substance use disorder (SUD) treatment services. This includes short-term residential services provided in residential and inpatient treatment settings that qualify as an institution for mental diseases (IMD). An IMD is a facility with more than 16 beds where at least 51 percent of the patients receive mental health or substance use treatment.

This section summarizes SUD IMD waiver development and implementation activities from January 1 – March 31, 2025. Accomplishments for this reporting period include:

- Washington State entered its 69th legislature's 2025 regular session on January 13, 2025. While behavioral health investments continue to be a priority for the legislature, legislators grappled with significant revenue shortfalls.
- Significant legislative attention was focused on
    - Children's crisis services
    - Implementation of ASAM 4 criteria
    - Certified peer support specialists
    - Enhancing Crisis services
    - Improving behavioral health care access
    - Complex cases of children in crisis
    - Legal representation for persons under involuntary treatment orders

Implementation plan

The state continues to meet all aspects of its implementation plan.

SUD Health IT plan requirements

No updates to report at this time.

Evaluation design

No updates to report at this time.

Monitoring protocol

During a routine review of the code and data tables used to calculate the SUD utilization metrics, the state identified an issue with how co-occurring SUD and SMI claims were handled. The issue was corrected and has resulted in identifying a significant number of additional claims. SUD outpatient and residential/inpatient services were particularly impacted as were the total number of individuals identified with a SUD diagnosis. The state has included updated information for the SUD utilization metrics back to July 2023.

Upcoming activities

The legislative session will end late April at which point HCA will have a better understanding of what initiatives have been funded, we expect that the legislature will try to maintain the system despite fiscal pressures.

MHIMD waiver implementation accomplishments

In November 2020, the state received approval of its Section 1115 demonstration waiver amendment to receive federal financial participation for serious mental illness (SMI)/serious emotional disturbance (SED) treatment services with a start date of January 1, 2021. This includes acute inpatient services provided in residential and inpatient treatment settings that qualify as an IMD.

This section summarizes MH IMD waiver development and implementation activities from January 1 – March 31, 2025.

- Washington State entered its 69th legislature's 2025 regular session on January 13, 2025. While behavioral health investments continue to be a priority for the legislature, legislators grappled with significant revenue shortfalls.
- Significant legislative attention was focused on
    - Children's crisis services
    - Implementation of ASAM 4 criteria
    - Certified peer support specialists
    - Enhancing Crisis services
    - Improving behavioral health care access
    - Complex cases of children in crisis
    - Legal representation for persons under involuntary treatment orders

Implementation plan

The state continues to meet the milestones of its implementation plan.

MH health IT plan requirements

No updates to report at this time.

Evaluation design

No updates to report at this time.

Monitoring protocol

HCA has made several refinements to the calculation of the SMI IMD finance metrics. As such, updated numbers are being reported for the six finance metrics for measurement periods CY 2021 and CY 2022. The refinement to the IMD expenditure calculations were made to ensure only provider NPIs associated with SMI IMDs were included in the calculation. This resulted in a decrease in the total cost and per capita totals for both measurement periods. The inpatient and residential expenditure calculations was refined to capture the full range of relevant expenditures and allowed for the required additional time for claims to fully mature. As previously noted, using a shorter than two-year data lag for costs results in a substantial undercount of the costs. The updated inpatient and residential cost metrics have grown due to these factors. In addition, the member month calculation for all service types was refined to more accurately reflect the distribution across service types.

Upcoming activities

The legislative session will end late April at which point HCA will have a better understanding of what initiatives have been funded, we expect that the legislature will try to maintain the system despite fiscal pressures.

Contingency Management for SUD treatment implementation accomplishments

On July 1, 2023, Washington State received approval of its Section 1115 demonstration waiver for new programs. Contingency Management is an evidence-based behavioral intervention for stimulant use disorder. It provides incentives to individuals contingent upon objective evidence of the target behavior, such as a negative urine drug test, in order to increase the likelihood of these behaviors, which are essential components and outcomes of effective treatment.

This section summarizes the Contingency Management program development and implementation activities from January 1 – March 31, 2025.

Implementation progress

The project team has continued to meet and coordinate with stakeholders. The state completed the following activities during the reporting period:

Cohort 1

- Notified 12 providers they had been selected to participate in the Contingency Management (CM) Section 1115 demonstration waiver program
- Processed intake forms for providers who confirmed their interest in participating in the program
- Initiated contract process – seven providers are expected to participate in the program

Cohort 2

- Sent message requesting parties interested in participating in the next cohort of providers to apply by submitting a Readiness Assessment
- Actively collecting Readiness Assessments

HCA established a funding and payment process for initial cohorts.

Upcoming activities

- Continue to establish contracts with Cohort 1
- Start selection process for Cohort 2
- Start to develop Contingency Management benefits through managed care organizations

Data and reporting

No updates to report for this quarter. Data on enrollment numbers and incentives will be reported upon implementation of Contingency Management and when data is available.

Aftercare and treatment services

No updates to report for this quarter. Information on aftercare and treatment services will be reported upon implementation of Contingency Management and when data is available.

Continuous Enrollment implementation accomplishments

On July 1, 2023, Washington State received approval of its Section 1115 demonstration waiver for new programs, which includes:

- The **Continuous Apple Health enrollment for children, ages 0 through 5,** program provides continued benefits for eligible children, ages 0 through the end of the month in which they turn 6 years old.
- The **Former Foster Care Youth from another State** program provides continued benefits to eligible former foster care youth under age 26, regardless of the state they had Medicaid when they turned 18.
- The **Apple Health Postpartum coverage expansion** program provides continued benefits for individuals from the end of pregnancy through 12 months postpartum.

This section summarizes the Continuous Enrollment programs development and implementation activities from January 1 – March 31, 2025.

Continuous Apple Health enrollment for children, ages 0 through 5

Implementation progress

Since the April 2023 approval date, the state has provided continuous Medicaid coverage for children, ages 0 through 5. Initially, the state utilized a manual process to ensure continuous coverage, reinstating benefits for any children under the age of six who may have lost coverage under the yearly redetermination process.

Full system support to provide continuous Medicaid eligibility through automatic annual renewals was implemented in March 2024.

With the addition of Continuous Enrollment for Children's Health Insurance Program (CHIP) in January 2025, the state has implemented a manual process to ensure continuous coverage for CHIP children under the age of six.

Upcoming activities

The state is planning full system support for CHIP continuous eligibility by July 2025 and will continue to outreach to families in the meantime.

Data and reporting

Below are monthly enrollments for continuous Medicaid enrollment, ages 0-5.

Table 10: Number of new Medicaid enrollment

	January	February	March
New enrollee between the ages of 0 and 1 year	3510	2692	1822
New enrollee age 1 through age 5 years	1810	1333	1280
Total	5320	4025	3102

Table 11: Number of unduplicated Medicaid enrollment

	January	February	March
Unduplicated number between the ages of 0 and 1	43650	42775	41201
Unduplicated number age 1 through age 5 years	216198	215515	215156

Total	259848	258290	256357

Former foster care youth from another state

Implementation progress

The state provides Medicaid coverage to former foster care youth from another state when they:

- Are under age 26
- Turned 18 on or before December 31, 2022
- Were in foster care and enrolled in Medicaid upon attaining age 18
- Applied for Apple Health in Washington

System support provides an online application pathway for former foster care youth to apply for Medicaid in Washington and remain continuously enrolled through their 26th birthday.

Upcoming activities

The state continues to outreach to families on continuous Apple Health.

Apple Health postpartum coverage expansion

Implementation progress

The state implemented postpartum extension coverage in June 2022 under the American Rescue Plan Act (ARPA) and with state plan approval, Washington provides full coverage to those who were on Medicaid or CHIP during their pregnancy. With waiver approval, Washington State is authorized to provide coverage to those who were not previously enrolled in Medicaid or CHIP during their pregnancy with income up to 193 percent of the FPL until 12 months after their pregnancy ends.

Since July 2024, this coverage group enrolls into managed care to be consistent with the other postpartum programs in Washington.

Upcoming activities

The state continues to outreach to people about Apple Health postpartum coverage.

Data and reporting

Below is the total monthly enrollment for the waiver approved postpartum coverage.

Table 12: Number of new enrollments

	January	February	March
Postpartum care	868	859	831

Total distinct: 1080

Reentry from a carceral setting implementation accomplishments

On July 1, 2023, Washington State received approval of its Section 1115 demonstration waiver for new programs. The reentry from a carceral setting program (Reentry Initiative) provides individuals pre-release services up to 90 days prior to the expected date of release to their communities.

This section summarizes the program development and implementation activities from January 1 – March 31, 2025.

Implementation progress

Participation in the Reentry Initiative is based on carceral facilities meeting five key milestones.

Table 13: Reentry Initiative milestones by cohort

	1) Intent to Participate form	2) Implementation Plan	3) Readiness Assessment	Go-live with pre-release services	4) Interim Progress Report	5) Final Progress Report
Cohort 1	June 1, 2024	Oct. 1, 2024	April 4, 2025	**July 1, 2025**	May 1, 2026	Oct. 1, 2026
Cohort 2	Nov. 1, 2024	April 1, 2025	Sept. 1, 2025	**Jan. 1, 2026**	Dec. 1, 2026	May 1, 2027
Cohort 3	May 1, 2025	Oct. 1, 2025	March 1, 2026	**July 1, 2026**	May 1, 2027	Oct. 1, 2027

Reentry Initiative milestones

1) **Submit an Intent to participate form** indicating the facility's intent to participate and select a cohort in which they will go live. Submitting this document signals a facility's:

- Agreement to participate in the Reentry Initiative
- Completion of Milestone 1 (fill out and submit the Intent to Participate form)
- Ability to receive capacity building funding
- Complete a contractual agreement with HCA expressing willingness and ability to receive capacity funds to support the planning for and implementation of the initiative

2) Complete a Capacity Building Application which includes an Implementation Plan. This plan describes how the facility will support pre-release services and a detailed budget that:

- Covers planned expenses
- Requests capacity building funding

3) Complete a Readiness Assessment attesting to the facility's current and/or planned readiness to support pre-release services. HCA will provide a template for the assessment and review and approve submitted assessments in order for the facility to go-live with pre-release services.

4) Submit Interim Progress Report on initial implementation progress on implementation.

5) Submit Final Progress Report on overall implementation progress and outcomes.

Milestone accomplishment

HCA launched a comprehensive Readiness Assessment process that requires facilities to demonstrate their ability to comply with all waiver requirements prior to going live with authorized services. Through this process, HCA is also requiring facilities to demonstrate readiness to support related requirements through the Consolidated Appropriations Act, 2023.

HCA received and reviewed 24 CBAs and established follow-up interviews for these facilities. So far, Washington has distributed more than $4 million in Capacity Building Funding to 10 facilities to support their planning efforts to participate in the Reentry Initiative.

Several implementation subgroups were formed to work on various aspects such as facility and provider readiness, pharmacy, provider enrollment, contracting and credentialing, system changes, care management continuity, pre-release and post-release, eligibility and enrollment, and benefit design for the pre-release period.

Technical Assistance and learning initiatives

Starting in December 2024 and continuing every two weeks through June 2025, HCA conducted training through a webinar learning series. These webinars covered key topics and provided valuable insights into fulfilling the requirements of the Reentry Initiative. The learning series includes sessions on:

- Medicaid 101
- Roles and responsibilities
- Managed care organization (MCO) contracting and credentialing
- Provider enrollment
- Client eligibility and enrollment
- Consolidated Appropriations Act (CAA), 2023 for eligible juveniles
- Reentry Initiative benefits
- HCA web resources
- Data exchange requirements

Policy and Operations Guide

To accompany the learning series topics, HCA produced and published a Reentry Initiative Policy and Operations Guide. This comprehensive written guide outlines the various program requirements in detail to ensure clarity and understanding.

Managed care organizations (MCO)

HCA repurposed its monthly MCO engagement meetings to weekly occurrences. The main purpose is to be aligned for the July 1, 2025, launch. Weekly agendas include contracting and credentialing, eligibility, screening and case management, CAA, pharmacy benefits, Reentry Targeted Case Management (rTCM), reentry benefits, and billing and claiming.

Third-party administrator

HCA plans to use a third-party administrator (TPA) to support application support for providers, provider enrollment, and billing and claims payment clearinghouse services. A vendor was selected through a robust Request for Proposal Process. Currently, HCA is conducting onboarding activities to include contract, weekly meetings, aligning reentry goals and project framework and plans.

Challenges

None to report at this time.

Upcoming activities

- Work with Cohort 2 and Cohort 3 facilities through monthly meetings to discuss ongoing activities
- One-on-one meetings to address facility-specific questions
- Technical assistance sessions
- Continue to review submitted Capacity Building Application, which includes an Implementation Plan and Readiness Assessment
- Release Milestone 2 funding to facilities that successfully completed the CBA
- Continue to align with courts and juvenile detention facilities concerning the Reentry Initiative and CAA

- Continue collaboration with MCOs and Accountable Communities of Health (ACHs)
- Continue collaborations with Department of Corrections, Department of Children, Youth and Families, and the Washington Association of Sheriffs and Police Chiefs

Continued engagement

HCA continues to engage several advisory groups, including the Washington Association of Sheriffs and Police Chiefs and the Reentry Advisory Workgroup (RAW). RAW, initially mandated by legislation, offers guidance on reentry program design and implementation. It comprises representatives from state agencies, carceral facilities, associations, community-based organizations, and other justice-involved policy leaders. RAW collaborates to improve reentry services. Furthermore, HCA ensures alignment with Reentry Initiative requirements through coordination with DOC, DCYF, and juvenile detention facilities. Several implementation subgroups have been formed to work on various aspects such as facility and provider readiness, pharmacy, provider enrollment, system changes, care management continuity, prerelease and post-release, eligibility and enrollment, and benefit design for the pre-release period.

Priority planning efforts

HCA continues to work on several priority planning efforts, including:

- Care management design, including pre-release and immediate post-release continuity of care
- Benefit design for mandatory and secondary services, including parameters for progression from mandatory to secondary services by facility.
- Enrollment and plan assignment pre-release and post-release, including implications on the TPA role and Medicaid billing
- Complete an Operational Readiness Assessment template for facilities to attest to their current and/or planned readiness to support pre-release services

Data and reporting

We currently do not have data on these services for this quarter. However, data collection will commence as soon as the services are implemented.

Health-related social needs (HRSN) implementation accomplishments

On July 1, 2023, Washington State received approval of its Section 1115 demonstration waiver for new programs, which includes:

- The **Community Care Hubs** focus on community-based care coordination, including screening patients, determining patient needs, connecting patients to community organizations that can provide those needs, and more.
- The **Native Hub** is a statewide network of Indian health care providers, tribal social service divisions, and Native-led, Native-serving organizations focused on whole-person care coordination.
- **Health-related social needs (HRSN) services** include nutrition, housing, rental subsidies, transportation, and other non-medical HRSN services that help a person live their healthiest life.
- **HRSN Infrastructure** provides infrastructure investments to support the readiness for HRSN service delivery. Investments include technology, planning, workforce development, and convening.

This section summarizes the HRSN development and implementation activities from January 1 – March 31, 2025

Community Care Hubs

Implementation progress

- HCA received CMS approval of the HRSN services protocol and payment methodologies.
- HCA continues to work with and collaborate with ACHs on the implementation of Community Care Hubs.

Upcoming activities

HCA developed a process for reporting requirements for hub services and continues to collaborate with ACHs to develop the scope of work of the community health worker in a Community Care Hub setting and the coordinating and aligning of hub services with other HRSN services and reentry.

Data and reporting

During this reporting period, ACHs prepared their first aggregate measure reporting as part of the Community Care Hub service. Results of the first reporting period will be finalized for the next reporting period.

Native Hub

The Native Hub is being co-developed between HCA and the 29 federally-recognized Tribes and 2 Urban Indian health programs in Washington State.

This reporting period, the Native Hub efforts have focused on two items:

- Hosting an all-day work session on the Native Hub
- Hiring and on-boarding additional staff to support the implementation of the Native Hub

Implementation progress

The Office of Tribal Affairs (OTA) at HCA and the American Indian Health Commission hosted an all-day work session on January 7, 2025. At that session, a tribal elected official directed OTA to provide a plan for launch at the first Governor's Indian Health Advisory Council (GIHAC) meeting of the year. GIHAC meetings are required to be scheduled outside of the Washington State Legislative Session, and the first one of 2025 is scheduled for June 11. At this meeting, OTA will present a plan to launch the Native Hub.

Infrastructure implementation progress includes onboarding a Native Hub Analyst.

Upcoming activities

On June 11, 2025, OTA will present the plan to launch the Native Hub at the first GIHAC meeting of the year.

Data and reporting

Data will be captured when the services have been implemented.

Health-related social needs (HRSN) services and infrastructure

Implementation progress

HRSN services implementation through a phased approach:

- **Phase 1a:** Case management, outreach, and education (to establish the community and Native hubs) Washington State MTP 2.0 demonstration approval period: July 1, 2023, through June 30, 2028
- **Phase 1b:** Recuperative care and short-term post-hospitalization housing (medical respite), housing transition navigation services, rent/temporary housing
- **Later phases:** Nutrition support, stabilization centers, day habilitation, caregiver respite, environmental adaptations. Washington's internal workgroup, along with sub-groups focused on specific services, continues to guide the planning and implementation of HRSN services

Partnership with existing housing agencies

Starting in February, housing subsidies have begun implementation through the state's contract with Department of Social and Health Services (DSHS). The state will continue to implement housing subsidies through HCA contracts and DSHS contracts to administer up to 6 months of rental assistance and/or temporary housing on behalf of program participants. HCA accepted applications for a public housing authority (PHA) to administer the rental subsidies service on behalf of participants enrolled in the Foundational Community Supports program and has chosen Spokane Housing Authority (SHA) for this role. Participants will be determined to be eligible for FCS CSS through standard eligibility processes managed by the TPA, Wellpoint. Additional screening by FCS CSS providers and/or the Community Care Hubs will inform HCA of additional need for housing support offered through the rent and temporary housing benefit. The role of SHA will be to contract with landlords and other PHAs to make rental payments on behalf of eligible participants authorized by HCA.

HCA also aims to enter into an interlocal agreement with the Washington State Department of Commerce to administer a portion of the rent and temporary housing benefit for certain individuals who are eligible for the Apple Health and Homes (AHAH) housing benefit and the Community Behavioral Health Rental Assistance Program (CBRA) benefit. These state-funded long-term subsidies provide certain HRSN-eligible enrollees with an opportunity to obtain permanent housing and/or a long-term housing subsidy that prioritizes the FCS-enrolled or eligible population (in the case of CBRA beneficiaries) based on their health-based needs and social risk factors.

Partnership with existing agencies

The state is partnering with DSHS to administer nutrition supports, caregiver respite, and home accessibility, remediation, and adaptation services under the waiver. HCA will be amending current contracts with DSHS to provide these services with waiver dollars by expanding existing work contracted statewide through the network of Area Agencies on Aging (AAA), as well as providers contracted with the Developmental Disabilities Administration (DDA). This gives DSHS an opportunity to expand current services approved under the Section 1115 demonstration waiver around nutrition supports and increase the reach of those currently being served with caregiver respite and home modification services.

Clients must meet the appropriate social and clinical risk factors for a given service administered by providers contracted with AAAs or DDA. Additional nutrition supports, caregiver respite, and home accessibility, remediation, and adaptation services will be expanded to broader target populations (not eligible for LTSS or DDA services) predominantly served by HCA later in DY10. HCA is currently developing the scope of services and target populations with partners across divisions

including HCA's Division of Behavioral Health and Recovery (DBHR), Medicaid Programs Division (MPD), and Clinical Quality and Care Transformation (CQCT).

Infrastructure Investments

HCA continues to administer HRSN infrastructure payments to ACHs. HCA continues to work with ACHs to develop an application process for other eligible entities to access infrastructure funds.

Upcoming activities

Washington continues to convene key external partners to design a collaborative process for delivering HRSN services. The state continues to work on coordinating and aligning cross-initiatives work between HRSN services and the Reentry Initiative.

Data and reporting

Data collection and reporting will commence once the services are fully implemented.

Data sharing between partner entities

Data collection and reporting will commence once the services are fully implemented.

Data sharing between partner entities/Community Information Exchange

Data collection and reporting will commence once the services are fully implemented.

Quarterly expenditures

HRSN infrastructure expenditures

HCA has distributed **$86,130,209.49** in HRSN infrastructure funds in DY9 to Community Care Hubs (ACHs). Infrastructure investments support the development and implementation of HRSN services.

Table 14: Infrastructure payments to ACHs and Native Hub

	Q1 (July 1–September 30, 2024)	Q2 (October 1–December 31, 2024)	Q3 (January 1–March 31, 2025)	Q4 (April 1–June 30, 2025)	DY9 Total (July 1, 2024–June 30, 2025)
Better Health Together	$ 6,717,691	$2,977,691.00	$0.0	$0.0	$9,695,382.00
CHOICE	$5,996,358.44	$2,706,409.50	$0.0	$0.0	$8,702,767.94
Elevate Health	$7,323,482.5	$3,243,482.41	$0.0	$0.0	$10,566,964.91
Greater Health Now	$8,549,095.5	$3,789,095.50	$0.0	$0.0	$12,338,191.00
HealthierHere	12118550.92	$5,742,420.91	$0.0	$0.0	$17,860,971.83
Thriving Together North Central Washington	$2,800,000	$1,100,000.00	$0.0	$0.0	$3,900,000.00
North Sound	$9,156,717.5	$4,056,716.31	$0.0	$0.0	$13,213,433.81
Olympic Community of Health	$2,331,148	$1,356,220.00	$0.0	$0.0	$3,687,368.00
SWACH	$4,272,565	$1,892,565.00	$0.0	$0.0	$6,165,130.00
Native Hub	$0.0	$0.0	$0.0	$0.0	$0.0

HRSN service expenditures

HCA has distributed **$51,954,526.43** in HRSN services funds in DY9 to Community Care Hubs (ACHs). HRSN services payments supports the provision and delivery of HRSN services.

Table 15: HRSN services payments to ACHs and Native Hub

	Q1 (July 1–September 30, 2024)	Q2 (October 1–December 31, 2024)	Q3 (January 1–March 31, 2025)	Q4 (April 1–June 30, 2025)	DY9 Total (July 1, 2024–June 30, 2025)
Better Health Together	$0.0	$0.0	$5,558,635.00	$0.0	$5,558,635.00
CHOICE	$0.0	$0.0	$5,104,323.32	$0.0	$5,104,323.32
Elevate Health	$0.0	$0.0	$6,493,981.68	$0.0	$6,493,981.68
Greater Health Now	$0.0	$0.0	$7,135,362.50	$0.0	$7,135,362.50
HealthierHere	$0.0	$0.0	$11,812,098.32	$0.0	$11,812,098.32

Thriving Together North Central Washington	$0.0	$0.0	$2,645,696.68	$0.0	$2,645,696.68
North Sound	$0.0	$0.0	$7,910,364.18	$0.0	$7,910,364.18
Olympic Community of Health	$0.0	$0.0	$1,552,676.43	$0.0	$1,552,676.43
SWACH	$0.0	$0.0	$3,741,388.32	$0.0	$3,741,388.32
Native Hub	$0.0	$0.0		$0.0	

Reentry Initiative expenditures

During Q3, HCA paid a total of **$8,107,000** to 9 facilities for planning and implementation.

Table 16: Reentry Initiative planning and implementation

Carceral Facility by Tier (based on average daily population)	Q1 (July 1–September 30)	Q2 (October 1–December 31)	Q3 (January 1-March 31)	Q4 (April 1 – June 30)	DY9 TOTAL (July 1 – June 30)
Tier One (1-49)	$500,000	$100,000	$1,000,000		$1,600,000
Tier Two (50-249)	$875,000		$2,607,000		$3,482,000
Tier Three (250-1,000)	$600,000	$150,000	$3,300,000		$4,050,000
Tier Four (more than 1,000)	$ -		$1,200,000		$1,200,000
Total	$1,975,000	$250,000	$8,107,000		$10,332,000

LTSS and FCS expenditures

Table 17: LTSS and FCS service expenditures

	Q1 (July 1–September 30, 2024)	Q2 (October 1–December 31, 2024)	Q3 (January 1–March 31, 2025)	Q4 (April 1–June 30, 2025)	DY9 Total (July 1, 2024–June 30, 2025)
Tailored Supports for Older Adults (TSOA)	$4,007,210	$7,041,894	$6,738,771.17	$0.0	$17,787,875.40
Medicaid Alternative Care (MAC)	$155,792	$283,675	$280,712.19	$0.0	$720,179.32
MAC and TSOA not eligible	$0.0	$36,708	$0.0	$0.0	$36,707.94
Presumptive Eligibility	$56,686	$98,018	422,458.64	$0.0	$577,162.16
FCS	$11,205,757	$9,379,527	$7,322,170.00	$0.0	$27,907,454

Financial and budget neutrality development issues

Financial

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

Table 18: Member months eligible to receive services

Calendar month	Non-expansion adults only	SUD Medicaid disabled	SUD Medicaid non-disabled	SUD newly eligible	SUD AI/AN	SMI Medicaid Disabled IMD	SMI Medicaid non-disabled IMD	SMI Newly eligible IMD	SMI AI/AN
Jan-17	376,270	0	0	0	0	0	0	0	0
Feb-17	391,117	0	0	0	0	0	0	0	0
Mar-17	390,716	0	0	0	0	0	0	0	0
Apr-17	389,262	0	0	0	0	0	0	0	0
May-17	388,863	0	0	0	0	0	0	0	0
Jun-17	388,741	0	0	0	0	0	0	0	0
Jul-17	387,853	0	0	0	0	0	0	0	0
Aug-17	387,738	0	0	0	0	0	0	0	0
Sep-17	386,391	0	0	0	0	0	0	0	0
Oct-17	386,295	0	0	0	0	0	0	0	0
Nov-17	386,210	0	0	0	0	0	0	0	0
Dec-17	386,298	0	0	0	0	0	0	0	0
Jan-18	386,664	0	0	0	0	0	0	0	0
Feb-18	385,177	0	0	0	0	0	0	0	0
Mar-18	385,072	0	0	0	0	0	0	0	0
Apr-18	383,752	0	0	0	0	0	0	0	0
May-18	384,213	0	0	0	0	0	0	0	0
Jun-18	383,308	0	0	0	0	0	0	0	0
Jul-18	383,190	7	23	123	11	0	0	0	0
Aug-18	382,675	14	31	212	43	0	0	0	0
Sept-18	381,646	7	13	109	40	0	0	0	0
Oct-18	381,722	7	13	115	48	0	0	0	0
Nov-18	381,422	7	27	171	33	0	0	0	0
Dec-18	380,916	9	26	165	38	0	0	0	0
Jan-19	381,421	32	106	395	49	0	0	0	0
Feb-19	379,609	28	101	386	45	0	0	0	0
Mar-19	379,292	31	128	427	40	0	0	0	0
Apr-19	378,898	37	122	448	42	0	0	0	0
May-19	378,201	46	141	506	52	0	0	0	0
June-19	377,291	59	165	592	52	0	0	0	0
Jul-19	377,796	77	163	791	45	0	0	0	0
Aug-19	377,460	73	196	810	47	0	0	0	0
Sep-19	376,825	75	205	846	42	0	0	0	0
Oct-19	376,243	89	224	976	33	0	0	0	0
Nov-19	375,375	87	217	886	38	0	0	0	0

Dec-19	375,606	91	241	1074	44	0	0	0	0
Jan-20	376,122	78	188	1042	35	0	0	0	0
Feb-20	375,963	55	174	823	39	0	0	0	0
Mar-20	377,826	64	173	947	36	0	0	0	0
Apr-20	381,658	83	181	1148	16	0	0	0	0
May-20	384,328	58	220	817	17	0	0	0	0
Jun-20	387,317	74	232	1124	19	0	0	0	0
Jul-20	390,050	85	231	1256	19	0	0	0	0
Aug-20	393,069	51	203	870	29	0	0	0	0
Sep-20	395,345	67	205	1068	35	0	0	0	0
Oct-20	397,420	70	216	1220	22	0	0	0	0
Nov-20	398,429	36	188	755	18	0	0	0	0
Dec-20	400,008	47	209	863	24	47	22	60	6
Jan-21	401,136	43	222	843	25	2	2	13	6
Feb-21	401,141	26	87	294	15	107	38	173	7
Mar-21	402,575	22	82	309	14	109	38	171	6
Apr-21	403,863	20	73	286	13	108	38	172	4
May-21	404,967	32	86	311	22	111	39	171	4
Jun-21	405,980	20	31	163	20	111	38	168	3
Jul-21	407,384	26	101	375	18	109	38	168	5
Aug-21	409,278	20	92	320	15	107	38	173	4
Sep-21	410,426	18	80	313	15	111	38	173	6
Oct-21	411,625	17	78	261	15	110	39	171	5
Nov-21	413,356	15	77	293	12	111	39	170	6
Dec-21	413,650	8	40	214	12	112	38	171	5
Jan-22	415,210	4	13	88	8	107	36	178	4
Feb-22	416,361	36	179	649	10	78	21	144	2
Mar-22	418,025	40	176	657	20	77	21	144	2
April-22	420,328	41	182	663	15	82	21	140	4
May-22	421,714	44	197	732	14	86	21	141	3
Jun-22	424,097	46	194	746	24	84	22	142	6
Jul-22	426,161	43	195	787	14	109	39	227	3
Aug-22	429,043	79	259	1155	19	136	42	295	3
Sep-22	430,134	80	257	1161	20	140	41	297	3
Oct-22	431,916	80	260	1158	23	137	40	301	3
Nov-22	434,517	56	225	931	21	135	40	302	6
Dec-22	437,452	56	231	943	17	137	40	310	9
Jan-23	439,917	60	236	979	14	116	31	231	6
Feb-23	442,155	54	197	975	12	137	87	395	9
Mar-23	445,343	57	200	988	16	137	91	402	8
April-23	446,893	55	202	1007	17	137	90	410	8
May-23	447,187	84	292	1126	10	140	92	417	8
Jun-23	439,290	88	289	1125	17	133	94	419	5
Jul-23	430,393	94	316	1426	11	132	96	421	6
Aug-23	420,452	89	306	1429	11	132	89	416	7
Sep-23	418,153	91	310	1436	19	133	88	413	10
Oct-23	417,512	93	318	1472	19	134	89	416	9

Nov-23	416,810	74	289	1225	14	136	89	407	8
Dec-23	415,500	73	295	1223	20	139	85	395	4
Jan-24	414,007	77	306	1264	11	139	82	388	1
Feb-24	412,514	70	267	1125	18	72	60	186	4
March-24	411,884	71	273	1130	15	72	58	184	4
April-24	411,034	74	283	1162	9	73	58	181	6
May-24	409,711	83	344	1281	19	39	25	126	5
Jun-24	406,776	85	345	1313	24	42	25	125	6
Jul- 24	405,468	89	345	1389	16	46	26	136	3
Aug-24	403,878	82	346	1418	22	76	51	220	4
Sep-24	403,654	84	353	1412	23	76	48	210	6
Oct-24	405,187	84	359	1462	18	76	51	220	3
Nov-24		52	295	1215	17	70	49	250	2
Dec-24		52	291	1200	3	69	48	243	3
Jan-25		50	283	1159	0	69	46	234	0
Feb-25									
Mar-25									
Total	37,691,120	4,281	15,319	65,558	1,827	5,088	2,477	12,020	250

Table 19: Member months eligible to receive services (Presumptive Eligibility, Post-Partum, Continuous Enrollment for Children)

Calendar month	Presumptive Eligibility	CE Post-Partum Individuals	CE Children Disabled	CE Children Non-Disabled
Apr-23	0	0	2,663	254,888
May-23	0	0	2,624	254,776
Jun-23	0	0	2,610	253,331
Jul-23	0	563	2,610	252,404
Aug-23	0	545	2,457	252,417
Sep-23	0	548	2,441	253,965
Oct-23	0	571	2,430	254,304
Nov-23	0	592	2,433	254,627
Dec-23	4	624	2,389	254,631
Jan-24	10	640	2,385	254,191
Feb-24	25	622	2,359	253,622
Mar-24	25	620	2,338	251,771
Apr-24	32	635	2,352	254,311
May-24	25	591	2,352	252,328
Jun-24	22	545	2,327	249,605
Jul-24	17	576	2,334	252,288
Aug-24	19	596	2,370	251,617
Sep-24	21	600	2,372	250,002
Oct-24	34	648	2,387	253,465
Nov-24	51	774	2,396	252,982
Dec-24	81	847	2,370	251,123

Jan-25	117	868	2,351	253,788
Feb-25	154	859	2,346	252,477
Mar-25	130	832	2,345	250,205
Total	767	13,696	58,041	6,069,118

Budget neutrality

HCA is waiting to upload our quarterly budget neutrality (BN) monitoring reports, pending a new BN monitoring template from CMS.

Designated state health programs (DSHP)

With the recent CMS approval of DSHP funding, HCA will soon begin outreach and communication to the programs that were approved and eligible to receive federal financial participation through the Section 1115 demonstration authority. We will provide additional updates in the next quarter on the status of DSHP implementation.

Overall MTP development and issues

Operational/policy issues

HCA and agency partners continue to work with the Washington State Legislature to answer questions, provide implementation updates, and support budget development aligned with the MTP 2.0 CMS approval.

Consumer issues

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

MTP evaluation

The MTP independent external evaluator's (IEE) quarterly rapid cycle report was put on hold to allow the following activities:

- MTP 1.0 Summative Evaluation Report
- MTP 2.0 evaluation design

The MTP 2.0 evaluation design was submitted for CMS approval to in January of 2024. CMS provided feedback for changes in April of 2024. The evaluation design was returned to CMS June of 2024. CMS provided updated feedback in December of 2024. The updated MTP 2.0 draft evaluation design was submitted in February 2025.

MTP 1.0 Summative Evaluation Report was submitted July of 2024. The State received CMS feedback in March 2025. The updated response will be submitted May 16, 2025.

Upcoming IEE activities

The IEE is working with the state data teams to update contracts, data sharing agreements, and IRB applications to extend their work through the duration of MTP 2.0. In addition, the IEE is working on updated response to the MTP 1.0 Summative Evaluation Report and has begun quarterly meetings with subject matter experts related to MTP 2.0 programs to develop an enhanced understanding of the implementation within each of the projects under the MTP 2.0 Section 1115 demonstration waiver.

Summary of additional resources, enclosures, and attachments

Additional resources

To learn more about MTP 2.0, **visit the HCA website**. Receive notifications about MTP-related activities, new materials, and other information through HCA's **email subscription list**.

Summary of attachments

- Attachment A: State contacts
- Attachment B: Financial Executor Portal Dashboard
- Attachment C: 1115 SUD Demonstration Monitoring Workbook – Part A
- Attachment D: 1115 SUD Demonstration Monitoring Report – Part B
- Attachment E: 1115 SMI/SED Demonstration Monitoring Workbook – Part A
- Attachment F: 1115 SMI/SED Demonstration Monitoring Report – Part B

Attachment A: State contacts

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

Area	Name	Title	Phone
MTP and quarterly reports	Emma Oppenheim	Director, Medicaid Transformation Project	360-725-0868
DSRIP program	Michael Arnis	Deputy Policy Director, SPI	360-280-4019
LTSS program	Debbie Johnson	Initiative 2 Program Manager, DSHS	360-725-2531
FCS program	Rayan Orbom	Program Administrator, Foundational Community Supports	360-725-5286
SUD IMD waiver	David Johnson	Federal Programs manager	360-725-9404
MH IMD waiver	David Johnson	Federal Programs manager	360-725-9404
Continuous Eligibility	Maggie Clay	EPICS Deputy Section manager	360-725-1079
HRSN	Matt Christie	HRSN Manager, Medicaid Transformation Project	360-725-2078
Native Hub	Lena Nachand	Tribal Liaison, Office of Tribal Affairs	360-725-1386
Reentry	Tyron Nixon	Transformation Implementation Manager, MPD	360-725-9711
Contingency Management	Lora Weed	Acting Project Director, State Opioid Response Grant, State Opioid Response Treatment Manager	360-725-1998

For mail delivery, use the following address:

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

Attachment B: Financial Executor Portal Dashboard

View this table on the HCA website, which shows all HRSN funds earned and distributed through the FE portal through March 31, 2025.

View this table on the HCA website, which shows all DSRIP funds earned and distributed through the FE portal through March 31, 2025.

Attachment C: 1115 SUD Demonstration Monitoring Workbook – Part A

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

Attachment D: 1115 SUD Demonstration Monitoring Report – Part B

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

State	Washington State
Demonstration name	Washington State Medicaid Transformation Project No. 11-W-00304/0
Approval date for demonstration	January 9, 2017
Approval period for SUD	July 1, 2018-June 30, 2028
Approval date for SUD, if different from above	July 17, 2018
Implementation date of SUD, if different from above	July 1, 2018
SUD (or if broader demonstration, then SUD -related) demonstration goals and objectives	Under Washington's 1115 demonstration waiver, the SUD program allows the state to receive Federal Financial Participation (FFP) for Medicaid recipients residing in institutions for mental disease (IMDs) under the terms of this demonstration for coverage of medical assistance including opioid use disorder (OUD)/substance use disorder (SUD) benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to ongoing chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. Expenditure authority will allow the state to improve existing SUD services and ensure the appropriate level of treatment is provided, increase the availability of medication assisted treatment (MAT), and enhance coordination between levels of care. The state will continue offering a full range of SUD treatment options using the American Society for Addiction Medicine (ASAM) criteria for assessment and treatment decision making. Medical assistance including

	opioid use disorder (OUD)/substance use disorder (SUD) benefits that would otherwise be matchable if the beneficiary were not residing in an IMD.

2. Executive Summary

During a routine review of the code and data tables used to calculate the SUD utilization metrics, the state identified an issue with how co-occurring SUD and SMI claims were handled. The issue was corrected and has resulted in identifying a significant number of additional claims. SUD outpatient and residential/inpatient services were particularly impacted as were the total number of individuals identified with a SUD diagnosis. The state has included updated information for the SUD utilization metrics back to July 2023.

The number of Medicaid beneficiaries with SUD diagnosis has increased slightly compared with the prior quarter and the number of individuals who received any SUD treatment has remained consistent with prior months. The number of individuals who received screening, brief intervention and referral to treatment has remained consistent with prior months and the number of individuals who received any outpatient SUD treatment has remained consistent with prior months.

The number of individuals who received any residential or inpatient SUD treatment has decreased slightly compared with prior months but the number of individuals who received withdrawal management has remained consistent compared with prior months.

The number of individuals who received Medication Assisted Treatment has increased slightly compared with prior months, The overall SUD treatment rate has increased slightly compared with the previous measurement period.

The overall rate of emergency department utilization and inpatient stays for SUD has remained consistent compared with the previous measurement period. The overall rate of access to preventive/ambulatory health services remained consistent compared with the previous measurement period. The number of beneficiaries with SUD who had access to preventive/ambulatory health services declined compared with the previous measurement period due to Medicaid unwinding.

3. Narrative Information on Implementation, by Milestone and Reporting Topic

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
1.2 Assessment of Need and Qualification for SUD Services			
1.2.1 Metric Trends			
☒ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.**	The number of Medicaid beneficiaries with SUD diagnosis has increased slightly compared with the prior quarter.	04/01/2019 – 06/30/2019	#3: Medicaid beneficiaries with SUD diagnosis (monthly)
	Not reported this quarter.	07/01/2018 – 06/30/2019	#4: Medicaid beneficiaries with SUD diagnosis (annual)
	Not reported this quarter.	07/01/2018 – 06/30/2019	#5: Medicaid beneficiaries treated in an IMD for SUD
☐ **The state has no metrics trends to report for this reporting topic.**			
1.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to:			

☐ **i) The target population(s) of the demonstration.** ☐ **ii) The clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration.**			
☐ **The state has no implementation update to report for this reporting topic.**			
☐ **The state expects to make other program changes that may affect metrics related to assessment of need and qualification for SUD services.**			
☐ **The state has no implementation update to report for this reporting topic.**			
2.2 Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)			
2.2.1 Metric Trends			
☒ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.**	The number of individuals who received any SUD treatment has remained consistent with prior months.	04/01/2019 – 06/30/2019	#6: Any SUD Treatment
	The number of individuals who received SBIRT treatment has remained consistent with prior months.	04/01/2019 – 06/30/2019	#7: Early Intervention
	The number of individuals who received any outpatient SUD treatment has remained consistent with prior months.	04/01/2019 – 06/30/2019	#8: Outpatient Services
	The number of individuals who received any residential or inpatient SUD treatment has decreased slightly compared with prior months.	04/01/2019 – 06/30/2019	#10: Residential and Inpatient Services

	The number of individuals who received withdrawal management has remained consistent compared with prior months.	04/01/2019 – 06/30/2019	#11: Withdrawal Management
	The number of individuals who received Medication Assisted Treatment has increased slightly compared with prior month.	04/01/2019 – 06/30/2019	#12: Medication Assisted Treatment
	Not reported this quarter.	07/01/2018 – 06/30/2019	#36: Average Length of Stay in IMDs
☐ The state has no metrics trends to report for this reporting topic.			
2.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes: **☐ i) Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g., outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management).** **☐ ii) SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and**			

medication assisted treatment services provided to individuals in IMDs.
☐ The state has no implementation update to report for this reporting topic.
☐ The state expects to make other program changes that may affect metrics related to Milestone 1.
☐ The state has no implementation update to report for this reporting topic.
3.2 Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)
3.2.1 Metric Trends
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2.
☒ The state has no trends to report for this reporting topic.
☐ The state is not reporting metrics related to Milestone 2.
3.2.2 Implementation Update
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria** **☐ ii) Implementation of a utilization management approach to ensure (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are**

appropriate for the diagnosis and level of care, or (c) use of independent process for reviewing placement in residential treatment settings.
☐ The state has no implementation update to report for this reporting topic.
☐ The state expects to make other program changes that may affect metrics related to Milestone 2.
☐ The state has no implementation update to report for this reporting topic.
☐ The state is not reporting metrics related to Milestone 2.
4.2 Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)
4.2.1 Metric Trends
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3.
☒ The state has no trends to report for this reporting topic.
☐ The state is not reporting metrics related to Milestone 3.
4.2.2 Implementation Update
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) Implementation of residential treatment provider qualifications that meet the ASAM**

Criteria or other nationally recognized, SUD-specific program standards. **☐ ii) State review process for residential treatment providers' compliance with qualifications standards.** **☐ iii) Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site.**			
☐ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 3.			
☐ The state has no implementation update to report for this reporting topic.			
☐ The state is not reporting metrics related to Milestone 3.			
5.2 Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)			
5.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.	Not reported this quarter.	07/01/2018 – 06/30/2019	#13: SUD provider availability, #14: SUD provider availability – MAT
☐ The state has no trends to report for this reporting topic.			

5.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care.**			
☐ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 4.			
☐ The state has no implementation update to report for this reporting topic.			
6.2 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)			
6.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 5.	Not reported this quarter.	01/01/2017 – 12/31/2017	#15: Initiation and Engagement of Alcohol and Other Drug Treatment
	Not reported this quarter.	01/01/2018 – 12/31/2018	#18: Use of Opioids at High Dosage in Persons without

	Cancer (modified by State) #21: Concurrent Use of Opioids and Benzodiazepines (modified by State) #22: Continuity of Pharmacotherapy for Opioid Use Disorder (modified by State)
☐ The state has no trends to report for this reporting topic.	
6.2.2 Implementation Update	
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD.** **☐ ii) Expansion of coverage for and access to naloxone.**	

☐ **The state has no implementation update to report for this reporting topic.**			
☐ **The state expects to make other program changes that may affect metrics related to Milestone 5.**			
☐ **The state has no implementation update to report for this reporting topic.**			
7.2 Improved Care Coordination and Transitions between Levels of Care (Milestone 6)			
7.2.1 Metric Trends			
☒ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 6.**	Not reported this quarter.	01/01/2017 – 12/31/2017	#17(1): Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence #17(2): Follow-Up after Emergency Department Visit for Mental Illness
☐ **The state has no trends to report for this reporting topic.**			
7.2.2 Implementation Update			

Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ Implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports.**			
☐ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 6.			
☐ The state has no implementation update to report for this reporting topic.			
8.2 SUD Health Information Technology (Health IT)			
8.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its Health IT metrics.	N/A the state is not reporting this quarter due to a change in the source system data.	07/01/2017 – 06/30/2018	Q1: PDMP Statewide Fatal Drug Overdoses – All, All Opioids, Heroin, Prescription Opioids (excluding synthetic opioids), Synthetic Opioids (not Methadone)

	The overall SUD treatment rate has increased slightly compared with the previous measurement period.	07/01/2018 – 06/30/2019	Q2: Substance Use Disorder Treatment Penetration Rate
	N/A the state is not reporting this quarter due to a delay in metric processing.	07/01/2018 – 06/30/2019	Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential SUD Services
☐ The state has no trends to report for this reporting topic.			
8.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) How health IT is being used to slow down the rate of growth of individuals identified with SUD.** **☐ ii) How health IT is being used to treat effectively individuals identified with SUD.**			

☐ iii) How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD. **☐ iv) Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels.** **☐ v) Other aspects of the state's health IT implementation milestones.** **☐ vi) The timeline for achieving health IT implementation milestones.** **☐ vii) Planned activities to increase use and functionality of the state's prescription drug monitoring program.**			
☐ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Health IT.			
☐ The state has no implementation update to report for this reporting topic.			
9.2 Other SUD-Related Metrics			
9.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to other SUD-related metrics.	The overall rate of ED utilization for SUD has remained consistent compared with the previous measurement period.	04/01/2019 – 06/30/2019	#23: Emergency Department Utilization for SUD per 1,000 Medicaid

			Beneficiaries
	The overall rate of IP stays for SUD has remained consistent compared with the previous measurement period.	04/01/2019 – 06/30/2019	#24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries
	Not reported this quarter.	07/01/2018 – 06/30/2019	#25: Readmissions Among Beneficiaries with SUD
	Not reported this quarter.	07/01/2017 – 06/30/2018	#26: Overdose Deaths (count)
			#27: Overdose Deaths (Rate)
	The overall rate of access to preventive/ambulatory health services remained consistent compared with the previous measurement period. The number of beneficiaries with SUD who had access to preventive/ambulatory health services declined compared with the previous measurement period due to Medicaid unwinding.	01/01/2017 – 12/31/2017	#40: Access to Preventive/ Ambulatory Health Services for Adult Medicaid

Beneficiaries with SUD.
☐ **The state has no trends to report for this reporting topic.**
9.2.2 Implementation Update
☐ **The state expects to make other program changes that may affect metrics related to other SUD-related metrics.**
☐ **The state has no implementation update to report for this reporting topic.**
10.2 Budget Neutrality
10.2.1 Current status and analysis
☐ **If the SUD component is part of a broader demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality. Describe the status of budget neutrality and an analysis of the budget neutrality to date.**
10.2.2 Implementation Update
☐ **The state expects to make other program changes that may affect budget neutrality**
☐ **The state has no implementation update to report for this reporting topic.**
11.1 SUD-Related Demonstration Operations and Policy

11.1.1 Considerations
☐ **States should highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively affect beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.**
☐ **The state has no related considerations to report for this reporting topic.**
11.1.2 Implementation Update
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ **i) How the delivery system operates under the demonstration (e.g., through the managed care system or fee for service).** ☐ **ii) Delivery models affecting demonstration participants (e.g., Accountable Care Organizations, Patient Centered Medical Homes).** ☐ **iii) Partners involved in service delivery.**
☐ **The state has no implementation update to report for this reporting topic.**

☐ **The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.**
☐ **The state has no implementation update to report for this reporting topic.**
☐ **The state is working on other initiatives related to SUD or OUD.**
☐ **The state has no implementation update to report for this reporting topic.**
☐**The initiatives described above are related to the SUD or OUD demonstration (States should note similarities and differences from the SUD demonstration).**
☐ **The state has no implementation update to report for this reporting topic.**
12. SUD Demonstration Evaluation Update
12.1. Narrative Information
☐ **Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.**
☐ **The state has no SUD demonstration evaluation update to report for this reporting topic.**
☐ **Provide status updates on deliverables related to the demonstration evaluation and**

indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.
☐ The state has no SUD demonstration evaluation update to report for this reporting topic.
☐ List anticipated evaluation-related deliverables related to this demonstration and their due dates.
☐ The state has no SUD demonstration evaluation update to report for this reporting topic.
13.1 Other Demonstration Reporting
13.1.1 General Reporting Requirements
☐ The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol.
☐ The state has no updates on general requirements to report for this reporting topic.
☐ The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.
☐ The state has no updates on general requirements to report for this reporting topic.

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

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

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

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

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

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

Attachment E: 1115 SMI/SED Demonstration Monitoring Workbook – Part A

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

Attachment F: 1115 SMI/SED Demonstration Monitoring Report – Part B

1. 1115-SMI/SED Demonstration-Monitoring-Report Trend Narrative Reporting

State	Washington
Demonstration name	Washington State Medicaid Transformation Project No. 11-W-00304/0
Approval date for demonstration	January 9, 2017
Approval period for SMI/SED	July 1, 2018-June 30, 2028
Approval date for SMI/SED, if different from above	November 6. 2020
Implementation date of SMI/SED, if different from above	December 23, 2020
SMI/SED (or if broader demonstration, then SMI/SED - related) demonstration goals and objectives	This demonstration amendment will provide authority for the state to receive FFP for delivering treatment to Medicaid beneficiaries diagnosed with SMI while they are short-term residents in settings that qualify as IMDs, primarily to receive treatment for SMI. The goal of this amendment is for the state to maintain and enhance access to mental health services, and continue delivery system improvements to provide more coordinated and comprehensive treatment for beneficiaries with SMI. With this approval, beneficiaries will have access to a continuum of services at new settings that, absent this amendment, would be ineligible for payment for most Medicaid enrollees.

2. Executive Summary

HCA has made several refinements to the calculation of the SMI IMD finance metrics. As such, updated numbers are being reported for the six finance metrics for measurement periods CY 2021 and CY 2022. The refinement to the IMD expenditure calculations was made to ensure only provider NPIs associated with SMI IMDs were included in the calculation. This resulted in a decrease in the total cost and per capita totals for both measurement periods. The inpatient and residential expenditure calculations was refined to capture the full range of relevant expenditures and allowed for the required additional time for claims to full mature. As previously noted, using a shorter than two-year data lag for costs results in a substantial undercount of the costs. The updated inpatient and residential cost metrics have grown due to these factors. In addition, the member month calculation for all service types was refined to more accurately reflection the distribution across service types.

The utilization level of inpatient mental health services has remained consistent with prior months, but the utilization level of intensive outpatient and partial hospitalization mental health services has decreased slightly compared with prior months.

The utilization level of outpatient mental health services has increased very slightly compared with prior months. The utilization level of emergency department mental health services has decreased slightly compared with prior months.

The utilization level of telehealth mental health services has remained consistent with prior months.

The overall level of mental health service utilization has remained consistent with prior months. The monthly count of beneficiaries with SMI/ED has decreased slightly compared with prior months.

The number of grievances, and appeals related to services for SMI/SED have remained low. The number of critical incidents related to services for SMI/SED remained in the general range seen in prior years.

3. **Narrative information on implementation, by milestone and reporting topic**

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
1.2 Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings (Milestone 1)			
1.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.			
☒ The state has no metrics trends to report for this reporting topic.			
1.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) The licensure or accreditation processes for participating hospitals and residential settings** **☐ii) The oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements** **☐ iii) The utilization review process to ensure beneficiaries have access to the appropriate**			

levels and types of care and to provide oversight on lengths of stay **☐ iv) The program integrity requirements and compliance assurance process** **☐ v) The state requirement that psychiatric hospitals and residential settings screen beneficiaries for comorbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions** **☐ vi) Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings**
☐ The state has no implementation update to report for this reporting topic.
☐ The state expects to make the following program changes that may affect metrics related to Milestone 1.
☐ The state has no implementation update to report for this reporting topic.
2.2 Improving Care Coordination and Transitions to Community-Based Care (Milestone 2)
2.2.1 Metric Trends
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2.
☒ The state has no metrics trends to report for this reporting topic.
2.2.2 Implementation Update
Compared to the demonstration design and operational details, the state expects to make the following changes to:

☐ **i) Actions to ensure that psychiatric hospitals and residential treatment settings carry out intensive predischarge planning, and include community-based providers in care transitions** ☐ **ii) Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers** ☐ **iii) State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers within 72 hours post discharge** ☐ **iv) Strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers)** ☐ **v) Other State requirements/policies to improve care coordination and connections to community based care**
☐ **The state has no implementation update to report for this reporting topic.**
☐ **The state expects to make other program changes that may affect metrics related to Milestone 2.**
☐ **The state has no implementation update to report for this reporting topic.**
3.2 Access to Continuum of Care, Including Crisis Stabilization (Milestone 3)
3.2.1 Metric Trends

☒ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3.**	The utilization level of inpatient mental health services has remained consistent with prior months.	Mental Health Services Utilization - Inpatient
	The utilization level of intensive outpatient and partial hospitalization mental health services has decreased slightly compared with prior months.	Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization
	The utilization level of outpatient mental health services has increased very slightly compared with prior months.	Mental Health Services Utilization - Outpatient
	The utilization level of emergency department mental health services has decreased slightly compared with prior months.	Mental Health Services Utilization - ED
	The utilization level of telehealth mental health services has remained consistent with prior months.	Mental Health Services Utilization - Telehealth

	The overall level of mental health service utilization has remained consistent with prior months.	Mental Health Services Utilization - Any Services
☐ **The state has no trends to report for this reporting topic.**		
3.2.2 Implementation Update		
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) State requirement that providers use an evidenced-based, publicly available patient assessment tool to determine appropriate level of care and length of stay** **☐ ii) Other state requirements/policies to improve access to a full continuum of care including crisis stabilization**		
☐ **The state has no implementation update to report for this reporting topic.**		
☐ **The state expects to make other program changes that may affect metrics related to Milestone 3.**		
☐ **The state has no implementation update to report for this reporting topic.**		

4.2 Earlier Identification and Engagement in Treatment, Including Through Increased Integration (Milestone 4)		
4.2.1 Metric Trends		
☒ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.**	The monthly count of beneficiaries with SMI/ED has decreased slightly compared with prior months.	Count of Beneficiaries With SMI/SED (monthly)
☐ **The state has no trends to report for this reporting topic.**		
4.2.2 Implementation Update		
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ **i) Strategies for identifying and engaging beneficiaries in treatment sooner (e.g., with supported education and employment)** ☐ **ii) Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment** ☐ **iii) Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED** ☐ **iv) Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people**		
☐ **The state has no implementation update to report for this reporting topic.**		

☐ **The state expects to make other program changes that may affect metrics related to Milestone 4.**
☐ **The state has no implementation update to report for this reporting topic.**
5.2 SMI/SED Health Information Technology (Health IT)
5.2.1 Metric Trends
☐ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its health IT metrics.**
☒ **The state has no trends to report for this reporting topic.**
5.2.2 Implementation Update
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ **i) The three statements of assurance made in the state's health IT plan** ☐ **ii) Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider and/or physician/mental health provider to community based supports** ☐ **iii) Electronic care plans and medical records** ☐ **iv) Individual consent being electronically captured and made accessible to patients and all members of the care team** ☐ **v) Intake, assessment and screening tools being part of a structured data capture process**

so that this information is interoperable with the rest of the health IT ecosystem **☐ vi) Telehealth technologies supporting** **collaborative care by facilitating broader availability of integrated mental health care and primary care** **☐ vii) Alerting/analytics** **☐ viii) Identity management**		
☐ The state has no implementation update to report for this reporting topic.		
☐ The state expects to make the following program changes that may affect metrics related to health IT.		
☐ The state has no implementation update to report for this reporting topic.		
6.2 Other SMI/SED-Related Metrics		
6.2.1 Metric Trends		
☒ The state reports the following metric trends, including all changes (+ or -) greater than two 2 percent related to other SMI/SED-related metrics.	The number of grievances related to services for SMI/SED remained low.	Grievances Related to Services for SMI/SED
	The number of appeals related to services for SMI/SED remained low.	Appeals Related to Services for SMI/SED
	The number of critical incidents related to services for SMI/SED remained in the general range seen in prior years.	Critical Incidents Related to Services for SMI/SED

☐ **The state has no trends to report for this reporting topic.**
6.2.2 Implementation Update
☐**The state expects to make the following program changes that may affect other SMI/SED-related metrics.**
☐ **The state has no implementation update to report for this reporting topic.**
7.1 Annual Assessment of the Availability of Mental Health Providers
7.1.1 Description Of Changes To Baseline Conditions And Practices
☐ **Describe and explain any changes in the mental health service needs (for example, prevalence and distribution of SMI/SED) of Medicaid beneficiaries with SMI/SED compared to those described in the Initial Assessment of Availability of Mental Health Services.** **Recommended word count is 500 words or less.**
☐ **This is not an annual report, therefore the state has no update to report for this reporting topic.**
☐**Describe and explain any changes to the organization of the state's Medicaid behavioral health service delivery system compared to those described in the Initial Assessment of Availability of Mental Health Services. Recommended word count is 500 words or less.**
☐ **This is not an annual report, therefore the state has no update to report for this reporting topic.**
☐ **Describe and explain any changes in the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state compared to those described in the Initial Assessment of Availability of Mental Health Services. At minimum, explain any changes**

across the state in the availability of the following services: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning. Recommended word count is 500 words or less.
☐ This is not an annual report, therefore the state has no update to report for this reporting topic.
☐Describe and explain any changes in gaps the state identified in the availability of mental health services or service capacity while completing the Availability Assessment compared to those described in the Initial Assessment of Availability of Mental Health Services. **Recommended word count is 500 words or less.**
☐This is not an annual report, therefore the state has no update to report for this reporting topic.
7.1.2 Implementation Update
☐ Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) The state's strategy to conduct annual assessments of the availability of mental health providers across the state and updates on steps taken to increase availability** **☐ ii) Strategies to improve state tracking of availability of inpatient and crisis stabilization beds**
☐ The state has no implementation update to report for this reporting topic.
8.1 SMI/SED Financing Plan

8.1.1 Implementation Update
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves law enforcement and other first responders** **☐ ii) Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model**
☐ The state has no implementation update to report for this reporting topic.
9.2 Budget Neutrality
9.2.1 Current Status and Analysis
☐ If the SMI/SED component is part of a broader demonstration, the state should provide an analysis of the SMI/SED-related budget neutrality and an analysis of budget neutrality as a whole. Describe the current status of budget neutrality and an analysis of the budget neutrality to date.
9.2.2 Implementation Update

☐ **The state expects to make the following program changes that may affect budget neutrality.**
☐ **The state has no implementation update to report for this reporting topic.**
10.1 SMI/SED-Related Demonstration Operations and Policy
10.1.1 Considerations
☐ **States should highlight significant SMI/SED (or if broader demonstration, then SMI/SED-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SMI/SED demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.**
☐**The state has no related considerations to report for this topic.**
10.1.2 Implementation Update
☐ **The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.**
☐ **The state has no implementation update to report for this reporting topic.**

☐**The state is working on other initiatives related to SMI/SED.**
☐**The state has no implementation update to report for this reporting topic.**
☐**The initiatives described above are related to the SMI/SED demonstration as described (States should note similarities and differences from the SMI/SED demonstration).**
☐**The state has no implementation update to report for this reporting topic.**
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ **i) How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service)** ☐ **ii) Delivery models affecting demonstration participants (e.g. Accountable Care Organizations, Patient Centered Medical Homes)** ☐ **iii) Partners involved in service delivery** ☐ **iv) The state Medicaid agency's Memorandum of Understanding (MOU) or other agreement with its mental health services agency**
☐**The state has no implementation update to report for this reporting topic.**
11 SMI/SED Demonstration Evaluation Update
11.1. Narrative Information
☐ **Provide updates on SMI/SED evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and**

the timing for the demonstration. See report template instructions for more details.
☐ The state has no SMI/SED demonstration evaluation update to report.
☐Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.
☐The state has no SMI/SED demonstration evaluation update to report.
☐List anticipated evaluation-related deliverables related to this demonstration and their due dates.
☐The state has no SMI/SED demonstration evaluation update to report.
12.1 Other Demonstration Reporting
12.1.1 General Reporting Requirements
☐The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol.
☐ The state has no updates on general requirements to report for this topic.
☐ The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.
☐ The state has no updates on general requirements to report for this topic.

☐ **The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation.**
☐ **The state has no updates on general requirements to report for this topic.**
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ **i) The schedule for completing and submitting monitoring reports** ☐ **ii) The content or completeness of submitted reports and/or future reports**
☐ **The state has no updates on general requirements to report for this topic.**
12.1.2 Post-Award Public Forum
☐ **If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual report.**
☐ **No post-award public forum was held during this reporting period, and this is not an annual report, so the state has no post-award public forum update to report for this topic.**
13.1 Notable State Achievements and/or Innovations
13.1 Narrative Information
☐ **Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the**

hypotheses of the SMI/SED (or if broader demonstration, then SMI/SED related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.
☐ **The state has no notable achievements or innovations to report for this topic.**

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

The MPT, FUH-CH, FUH-AD, FUA-AD, FUM-AD, AAP, APM, and APC measures (metrics #13, 14, 15, 16, 17, 18, 7, 8, 9, 10, 26, 29, 31) are Healthcare Effectiveness Data and Information Set

("HEDIS®") measures that are owned and copyrighted by the National Committee for Quality Assurance ("NCQA"). NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications.

The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not validated the adjusted measure specifications but has granted CMS permission to adjust.

Calculated measure results, based on the adjusted HEDIS specifications, may be called only "Uncertified, Unaudited HEDIS rates."

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