Washington State Medicaid Transformation Project (MTP) demonstration
Section 1115 Waiver Quarterly Report (DY 3 Q2)
Demonstration Year: 3 (January 1 to December 31, 2019)
Reporting Quarter: April 1 to June 30, 2019

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Introduction

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

Over the five-year MTP period, Washington will:

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

The state will accomplish these goals through several programs:

- Transformation through Accountable Communities of Health (ACHs) and Delivery System Reform Incentive Payment (DSRIP) program.
- Long-term Services and Supports (LTSS) – Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA).
- Foundational Community Supports (FCS) – Community Support Services (CSS) and Supported Employment – Individual Placement and Support (IPS).
- Substance Use Disorder (SUD) Program – Treatment Services, Including Short-term Services Provided in Residential and Inpatient Treatment Setting that Qualify as an Institution for Mental Disease (IMD).

The Healthier Washington initiative

The Washington State Health Care Authority (HCA) manages the MTP under the banner of the Healthier Washington initiative, a multi-sector partnership initiated by Governor Jay Inslee. The goals are to improve health, transform care delivery, and reduce costs. HCA's partner agencies are the departments of Health (DOH) and Social and Health Services (DSHS). Note: DSHS is the lead agency for the LTSS program.

Visit the HCA website to learn more about the Healthier Washington initiative.

Quarterly report: April 1–June 30, 2019

This quarterly report summarizes MTP activities from April 1 through June 30, 2019. It details MTP implementation, including stakeholder education and engagement, planning and implementation, and development of policies and procedures.

Summary of quarter accomplishments

- Within the DSRIP program, the first VBP incentives were distributed in the second quarter (Q2) to ACHs based on demonstration year (DY) two (DY2), pay for reporting (P4R) milestone achievement.
- The American Indian Health Commission of Washington State (the Commission), as the Tribal Coordinating Entity (TCE), hosted a kick-off regarding health information technology/health information exchange (HIT/HIE).
- By the end of June the state had served over 4,300 participants in MAC and TSOA programs.
- Total FCS program enrollment reached 5,147 by the end of June in DY3, Q2. This compares with 4,235 at the end of Q1.
- HCA submitted the final milestone 4 deliverable to CMS under the SUD program. The state provided a report on the availability of Medication Assisted Treatment (MAT) services across the state—in both outpatient and residential agencies that provide MAT services—and their current ability to accept clients.

MTP-wide stakeholder engagement

During the reporting quarter, HCA continued its robust stakeholder engagement and communication:

- On May 9, Healthier Washington presented the second in the Quarterly Webinar Series: Health Care Transformation in Indian Country. Over 300 people registered. The follow-up email included:
    - Answers to questions not addressed during the webinar because of time limits.
    - Links to the slides and the webinar recording.
    - Links to topical information referred to in the webinar.
    - Information and registration links for future webinars and the upcoming Healthier Washington 2019 Public Forum (September 12 and 26 in Wenatchee and Vancouver, respectively).
    - Subscription links to the Healthier Washington and Foundation newsletters.
    - Links to HCA social media.
- Healthier Washington continued to publish two monthly newsletters: the Healthier Washington Newsletter (3,638 subscribers) and Foundations: the newsletter for Foundational Community Supports (1,194 subscribers). Subscriber numbers have increased for both publications, particularly for Foundations, which was first published in October 2018.
- Healthier Washington communications continued to maintain the Health Systems Transformation calendar, a shared resource for the state and ACHs. The calendar is populated with MTP-related events of interest to a broad array of stakeholders throughout the state. The purpose is to be a single source of MTP-related events information for planning, scheduling and for reporting.

Statewide activities and accountability

Value-based payment (VBP)

Value-based Roadmap: Apple Health Appendix

The Apple Health Appendix, in accordance with the special terms and conditions (STCs), describes how MTP is supporting providers and Managed Care Organizations (MCOs) to move along the value-based care continuum. It establishes targets for VBP attainment and related DSRIP incentives for MCOs and ACHs. In

Q2 of 2019, the state and CMS discussed follow-up questions from CMS relating to VBP and the Apple Health Appendix.

Validation of financial performance measures

In DY1, HCA contracted with Myers and Stauffer to serve as the Independent Assessor (IA) for MTP. In this role, the IA is the third-party assessor of financial measures data submitted by MCOs as part of their contracts with HCA. The state maintains contracts with the five MCOs. These contracts outline VBP attainment expectations, including the following parameters:

- Financial performance measures
- Timelines under which MCOs must submit data
- Review process, which includes third-party validation

In collaboration with HCA, the IA prepared the VBP validation packets in Q2, including data entry templates and provider contract samplings for each MCO, for release.

Statewide progress toward VBP targets

According to 2017 MCO financial performance measure data, both MCO and ACH regions are currently ahead of the annual, state-financed VBP targets. In DY3 Q2, HCA prepared its annual Paying for Value surveys to:

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

HCA requires each MCO to respond to the annual survey to provide information and data on their non-Medicaid books of business in Washington State.

Technical support and training

In DY3 Q2, HCA continued to work with Manatt on VBP-related topics. Manatt further refined the VBP toolkit and conducted key informant interviews with select ACHs and MCOs. This was to understand the utility of the tools referenced by the toolkit and the capacity of various stakeholders to use them. HCA and Manatt revisited an attempt to define the roles and expectations of various stakeholders relative to VBP. In Q2, HCA presented to ACHs the final draft of a document that defines these roles and expectations.

Upcoming activities for the Q3 include:

- Release of annual Paying for Value survey to Washington State health plans and provider organizations.
- IA validation of MCO VBP and quality performance for 2018.
- Updates to the annual Value-based Roadmap and Apple Health Appendix.

Integrated managed care (IMC) progress

In 2014, state legislation directed a change — to integrate the purchasing of medical and behavioral health services for Apple Health clients through an Integrated Managed Care (IMC) system no later than January 1, 2020. In Q2, the state:

- Continued to monitor IMC implementation in the 2019 mid-adopter regions through regular participation in regional IMC workgroup meetings and through data collected for each region's Early Warning System.
- Monitored provider, MCO, and behavioral health–administrative services organization (BH-ASO) readiness activities in the North Sound region, and provided guidance/support to ensure the region was ready for IMC implementation by July 1, 2019.
- Continued extensive stakeholder engagement with the North Sound region and the on-time-adopter regions (the regions scheduled to implement IMC on January 1, 2020). This included continued

participation in regional meetings and workgroups, and regular meetings with the MCOs and future BH-ASOs to address IMC issues, concerns, and questions.
- Provided guidance on HCA's updated service encounter reporting instructions and answered questions from providers, MCOs, and BH-ASOs on this topic.

HCA will continue to engage with stakeholders and beneficiaries about changes to managed care coverage in each region.

Health IT

The quarterly report for the Health IT Operational Plan is now packaged with this report. Highlights include:

- A Clinical Data Repository (CDR) data governance group was established to review and approve clinical data uses.
- HCA submitted to CMS an updated State Medicaid Health Information Technology Plan (SMHP), which identifies the current state of health information technology (HIT) in Washington State, articulates the desired future state, and outlines the roadmap to realize the future state.
- Developed a white paper on implementing a *Master Person Index*. The paper was presented to the Health and Human Services (HHS) coalition leadership group, which is comprised of secretary level leaders from Washington state HHS agencies. The HHS coalition voted to prioritize this work in the coming years.
- The CDR went live with a Problems, Allergies, Medications and Immunizations (PAMI) Plus report.
- HCA, in collaboration with DOH, submitted to CMS a planning/implementation advance planning document (P/I APD) funding request for a qualified prescription monitoring program (PMP) system (required in the SUPPORT Act).
- HCA finalized its guidance for sharing substance use disorder (SUD) information in a method aligned with 42 CFR part 2.

DSRIP program implementation accomplishments

Financial executor (FE) portal activity

- ACHs continue to distribute incentive funds to partnering providers through the FE portal. During the reporting quarter, ACHs distributed over $31.6 million to 284 partnering providers and organizations, in support of project planning and implementation activities.
- To date, ACHs distributed over $215.8 million to 506 partnering providers.
- The state distributed approximately $336 thousand in earned incentive funds to Indian Health Care Providers (IHCPs) in Q2 for achievement of IHCP-specific project milestones.
- To date, the state distributed approximately $9.9 million in earned incentive funds to IHCPs for achievement of IHCP-specific project milestones.
- Attachment B provides a detailed account of all funds earned and distributed through the FE portal to date.

The state's FE, Public Consulting Group (PCG), continued to provide direct technical assistance and resources to ACHs as they used the portal to register and distribute payments to providers this quarter. HCA worked with the FE to gather feedback from ACHs on the successes and challenges of using the portal.

ACH project implementation

Project implementation progress

Implementation of project activities is underway across the state. This past quarter, the nine ACHs hired a contractor to provide statewide support to ACHs. The focus of this work is on alignment and shared learning, with the goal of cultivating statewide strategies for continued implementation. For example, the contractor has gathered information from each ACH regarding common HIT/HIE strategies to further align HIT investments and supports throughout the state. The contractor has been facilitating monthly ACH convenings to foster conversations and strategies.

Next Steps

ACHs will submit the third semi-annual report for period January – June 2019 in Q3 DY3 (July 31, 2019). ACHs will continue to notify the state of project progress by submitting updated implementation plans that reflect advancements and changes during the reporting period. The semi-annual report includes results from the P4R metric data gathered by ACHs from partnering provider sites.

ACHs will also submit regional quality improvement strategies that detail how ACHs are supporting partnering providers in quality improvement, and create a feedback loop for partnering providers to report to the ACHs on progress.

Integrated managed care (IMC) implementation milestone achievement

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

- Phase 1**:** binding letter(s) of intent
- Phase 2**:** implementation of integrated managed care

As previous reported, on January 1, 2019, the following regions moved to IMC, achieving the Phase 2 milestone:

- Greater Columbia
- King
- Pierce
- Spokane

IMC implementation also occurred in two transitional counties that were on a delayed implementation schedule:

- Okanogan – the transitional county of North Central ACH's corresponding regional service area (RSA)
- Klickitat – the transitional county of SWACH's corresponding RSA

Integration incentives were paid out for the regions that transitioned on January 1. All incentives associated with Phase 2 achievement were distributed in May of 2019 except for incentives for NSACH, due to the July 1 implementation date.

Value Based Payment (VBP) implementation milestone achievement

Incentives earned by ACHs for the VBP pay-for-reporting (P4R) milestone achievement were distributed in Q2 DY3. ACHs are expected to continue efforts to promote VBP readiness tools, convene partners for VBP-related education or shared learning, and support organizations as they respond to readiness assessments.

MCO VBP P4R milestone achievement will be validated in Q3 DY3 following MCO data submission in August. Earned incentives are expected to be distributed in September.

DSRIP measurement activities

Analytics, Research and Measurement (ARM) Support and Data Products

The refreshed Healthier Washington Measures Dashboard went live in early May 2019. This interactive dashboard allows people to explore Washington State population and measures data. It supports ACHs, local health jurisdictions, and communities by providing information to assess regional health needs and monitor outcomes. In addition to adding more data (based on claims from July 1, 2017 – June 30, 2018), the refreshed dashboard includes:

- New measures for maternal and child health.
- Updates on time periods for some measures as well as changes in layout, and updates on documentation.

ACHs also received related, derivative data products throughout Q2 to support regional analysis and monitoring efforts.

The ARM team provided multiple technical assistance (TA) sessions to support ACHs.

- On the June 10, 2019 TA session, ARM shared some potential use cases for dental and maternal child health measures on the Healthier Washington Measures Dashboard. This session was to assist ACHs in Project 3B (reproductive & maternal/child health) and Project 3C (access for oral health services).
- On the July 15, 2019 TA session, ARM provided an overview of:
    - All opioid related metrics available on all public-facing dashboards.
    - The critical differences between the public-facing dashboards.
    - How data can help inform ACH practice in Project 3A (addressing the opioid use public health crisis).

Pay for performance (P4P) metrics specification review

Metric specifications can change yearly. As measure-stewards retire or alter metric specifications— to reflect clinical care guidelines changes, treatment recommendations, or current health care practices— metric modifications will be reviewed and incorporated as appropriate. On an annual basis, the state will monitor changes in how to calculate results for the DSRIP quality and outcome metrics as part of a continuous quality improvement and monitoring process.

During Q2, state performance metric producers reviewed all proposed updates to DSRIP quality and outcome metrics. All updates to specifications were adopted into the DSRIP measurement program. Summary of changes are limited to changes that directly affect P4P metrics or sub-metrics. Other unrelated, changes may have occurred for each metric. HCA will publish revised metric specifications on the Medicaid Transformation metrics webpage by end of August 2019, along with a summary of metric updates.

Pay for reporting (P4R) metrics submission guidance

In May, HCA released additional guidance to ACHs about P4R metrics reporting intent and process for reporting, and published an updated P4R metrics reporting template to the Medicaid Transformation webpage. ACHs will submit P4R metric data gathered from partnering provider sites in aggregate form. ACHs are also required to submit a succinct breakdown of site respondents' site-level characteristics. This is due to the IA on July 31 with the rest of the Semi-annual Report (SAR) components.

State measurement support

HCA continues to monitor stakeholder questions about project P4R/P4P metrics, the Measurement Guide, and metric technical specifications. HCA will update documents to capture DSRIP program development, and participate in ACH-led calls and forums to address DSRIP measurement questions.

DSRIP program stakeholder engagement activities

HCA has participated in many stakeholder engagement activities, including public forums, presentations, emails, webinars, and direct technical assistance. HCA continued to host weekly Transformation alignment calls with ACHs, state partners, and others who were invited or requested inclusion. The call format was adjusted to provide a forum, once a month, for strategic planning with ACH Executives.

Additionally, the following engagement activities occurred during the reporting quarter:

- Ongoing: The state supported numerous IMC readiness and educational activities during Q2.
- April 23: HCA hosted its quarterly meeting with MCOs to discuss Healthier Washington and Medicaid Transformation. The meeting focused on updates surrounding VBP monitoring and technical assistance efforts, VBP incentives under DSRIP, and data sharing and data requests.
- June 11: HCA launched a new workgroup, the MT Priorities work group, that includes HCA, ACHs and MCOs to discuss Medicaid Transformation priorities, and specific strategies that would benefit from more collaboration to define roles, align investments, and explore sustainability levers. Monthly meetings are planned; the first priority topic is care coordination.

DSRIP stakeholder concerns

ACHs and stakeholders continued to express the need to clarify roles for care coordination within the Medicaid program. This need includes the alignment of ACH-supported activities and investments, e.g., Pathways Community Based Care Coordination, HIE, and Closed Loop Referral Systems. HCA, MCOs and ACHs will prioritize this topic for discussion in the newly formed MT Priorities work group. As implementation efforts are underway and new issues and opportunities are emerging, the goal is to reach a common understanding of the care coordination vision, roles, scope, levers and investments.

DSRIP upcoming activities

- ACHs to submit the third SAR, July 2019
    - Includes updated implementation plan and demonstration of milestone achievement, standard reporting requirements, regional quality improvement strategy, partnering provider site-level roster, P4R metric information.
- HCA to publish annual update to Measurement Guide, August 2019
- HCA to publish updated technical specifications for DSRIP quality and outcome metrics, August 2019
- HCA release of ACH project P4P improvement targets for DY 4, October 2019

Tribal project implementation activities

Due to the complexity of the Indian health care system, MTP has a separate set of guidelines and funding protocols for IHCP-specific projects. Incentive payments under this portion of MTP are awarded for achieving milestones that reflect the development of more effective health systems and greater capacity within IHCPs. Goals include better coordination of physical and behavioral health care and social services for Medicaid clients, and helping IHCPs to reduce unnecessary use of intensive services and settings by Medicaid clients without impairing health outcomes.

HCA is working with tribal governments and IHCPs on a tribal FQHC alternative payment model, in addition to several other IHCP specific projects. HCA works closely with ACHs in this work. Implementation and engagement highlights for DY3 Q2 are included in this timeline:

- April 5: HCA hosted the standing ACH tribal liaisons call
- April 9: HCA presented to Muckleshoot on the tribal FQHC APM
- April 12: HCA presented at the North Central ACH annual summit on the topic of addressing the road blocks to whole person health
- April 15: HCA participated in the North Sound ACH Tribal Alignment Committee

- April 23: HCA participated in a meeting between Yakama Nation Behavioral Health and Greater Columbia ACH regarding the Health Commons Project
- April 26: HCA hosted the Tribal FQHC workgroup
- April 30: HCA participated in the Commission's insurance fair
- May 8: HCA participated in the Commission's HIT/HIE day
- May 16: HCA participated in the Better Health Together Tribal Partnership Council
- May 24: HCA hosted the Tribal FQHC workgroup
- May 29: HCA participated in a meeting between Yakama Nation Behavioral Health and Greater Columbia ACH regarding the Health Commons Project
- June 11: HCA hosted a meeting for managed care organizations and ACHs to discuss sustainability
- June 13: HCA received approval from CMS for Washington State plan amendment #19-0009
- June 18: HCA participated in the North Sound ACH Tribal Alignment Committee
- June 19: HCA participated in the integration kickoff for Yakama Nation
- June 20: HCA participated in the Better Health Together Tribal Partnership Council
- June 21: HCA participated in the HealthierHere event, "Building Bridges: Foundations for Successful Community-Clinical Partnerships"
- June 28: HCA hosted the standing ACH tribal liaisons call
- June 28: HCA met with Pierce County ACH to discuss working with local tribe

Tribal partner engagement

Primary milestone: The Health Care Authority received approval from CMS for State Plan Amendment #19-0009. This authorizes an alternative payment methodology (APM) for any outpatient health program or facility operated by a tribe or tribal organization under the Indian Self Determination and Education Assistance Act that elects to enroll in Washington Medicaid as a Federally Qualified Health Center.

Secondary milestone: The Commission, as the Tribal Coordinating Entity (TCE), hosted a kick-off regarding HIT/HIE.

Long-term Services and Supports (LTSS) implementation accomplishments

This section summarizes LTSS program development and implementation activities conducted from April 1 through June 30, 2019.

Key accomplishments for this quarter:

- By the end of June, the state had served over 4,300 participants in MAC and TSOA programs.
- A statewide work group began development of a Lean process improvement to increase the number of newly enrolled dyads.

Network adequacy for LTSS programs, MAC and TSOA

Aging and Long-Term Support Administration (ALTSA) and DSHS Home and Community Services (HCS) continue to monitor contract compliance for each of the thirteen area agency on aging (AAA). Network adequacy milestones will be developed and submitted by each AAA per their approved contract schedule. The state is monitoring for any access issues.

Assessment and systems update

- Enhancements to the GetCare care plan used primarily for TSOA individuals were completed and released during the quarter. These enhancements will allow the state to better capture personal goals and tasks recorded in the care plan.

- A major system change involving GetCare and the caregiver assessment tool, TCARE, is developing a streamlined workflow for using these systems, collecting necessary data from each system.

Staff training

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

- April 30 – Understanding the importance and policy requirements for creating care plans for MAC and TSOA enrollees.
- May 6 and 23 – Two Health Insurance Benefits Advisors (SHIBA) webinar trainings were conducted in order for case managers to gain a better understanding of Medicare and learn about SHIBA as a resource for both themselves and for the clients being supported in ALTSA programs including MAC and TSOA.
- June 26– How to resolve authorization errors in GetCare.

Upcoming webinars include:

- July 8 – Using the newly revised GetCare care plan.
- August 21 – New functionality – service line "reviewing" status.
- September – Updates to warm hand off (WHO) protocols and seamless transitions.

Data and reporting

Table 2: Beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of June 30, 2019	69	688	1572
Number of new enrollees in quarter by program	25*	300**	491***
Number of new person-centered service plans in quarter by program	5	88	197
Number of beneficiaries self-directing services under employer authority	0	0	0

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

The state continues to monitor and assist AAAs with compliance in timely completion of care plans for enrollees. Statewide care plan training was conducted on April 30, 2019.

Outreach and engagement

Pilot outreach events in several community service offices (CSO) to promote caregiver programs and explain the available LTSS programs have been in the planning and coordination stage for the last several months. Once approved by the CSO managers/directors, we will move forward with scheduling these events. We anticipate receiving approval in July. Events will occur in August and September.

Hospital association outreach continues to be a work in progress. ALTSA program management had planning meetings with the association in May and June. Coordination with AAA that will be co-facilitating these outreach events will occur in July. Three to four regional networking events with the hospitals and medical clinics to promote caregiver programs will be occurring late summer of 2019.

Table 3: Outreach and engagement activities by AAA

	April	May	June
	Number of events held		
Community presentations and information sharing	68	109	50

The state saw a significant increase in AAA outreach and engagement activities focused on caregiver support program/services including MAC/TSOA benefits in this quarter. This is due in part to a request for better tracking and reporting and increased attention on local outreach as an action item resulting from the statewide performance improvement project.

Outreach activities occurred in a variety of settings, such as community resource fairs, hospital social worker meetings, MCO meetings, public library events, senior centers, and 55+ housing communities.

ALTSA met with a number of tribes to discuss Medicaid services and LTSS and FCS programs during Q2:

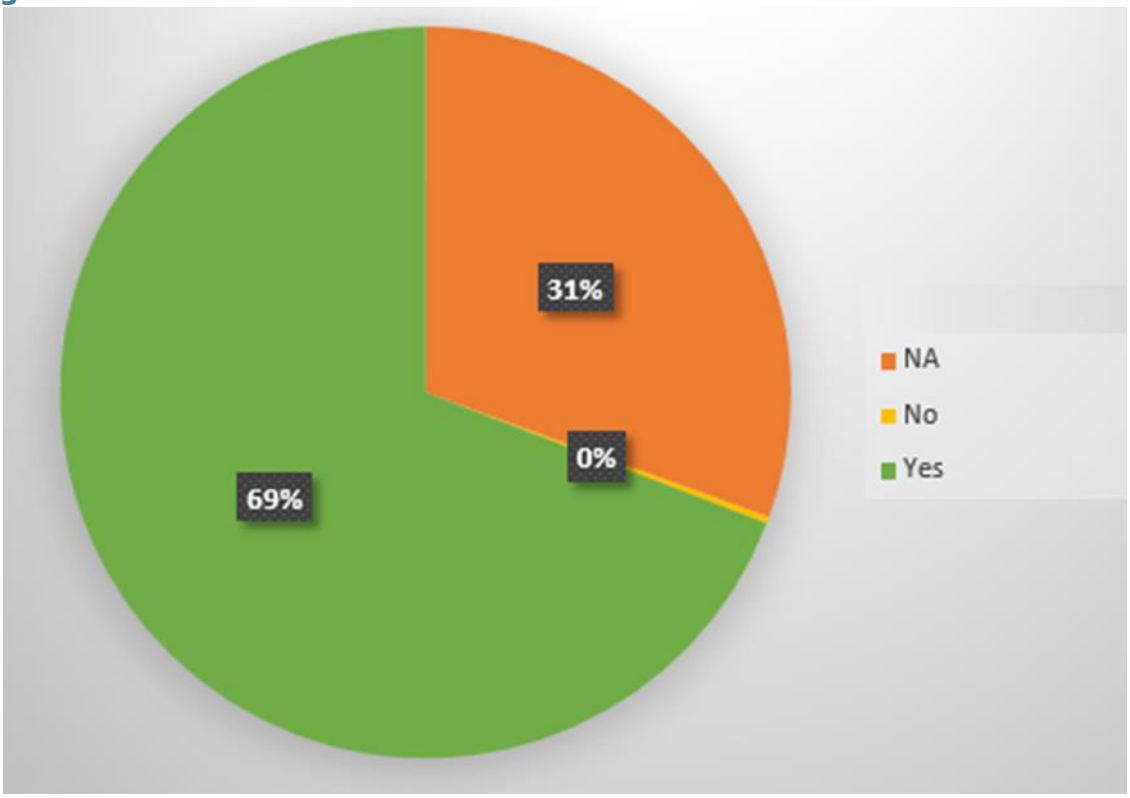
- April 16, 2019: Service discussion with Muckleshoot Tribe in-home services department. Service descriptions included MAC/TSOA.
- June 6-7, 2019: Tribal Summit held in Eastern Washington. Representatives from tribes, tribal organizations, AAAs, state agencies and contractors joined in a two-day meeting to discuss issues including how to improve outreach to Indians and Alaska Natives. MAC and TSOA were a featured presentation at this event.
- June 28, 2019: 7.01 planning meeting with Makah Tribe. Service descriptions included MAC/TSOA. ALTSA is engaged in conversations to explore mechanisms to enhance culturally relevant outreach for MAC/TSOA services.

Tribal liaisons and program staff continued research with tribes on communication methods that will enhance understanding of MAC/TSOA services.

Quality assurance

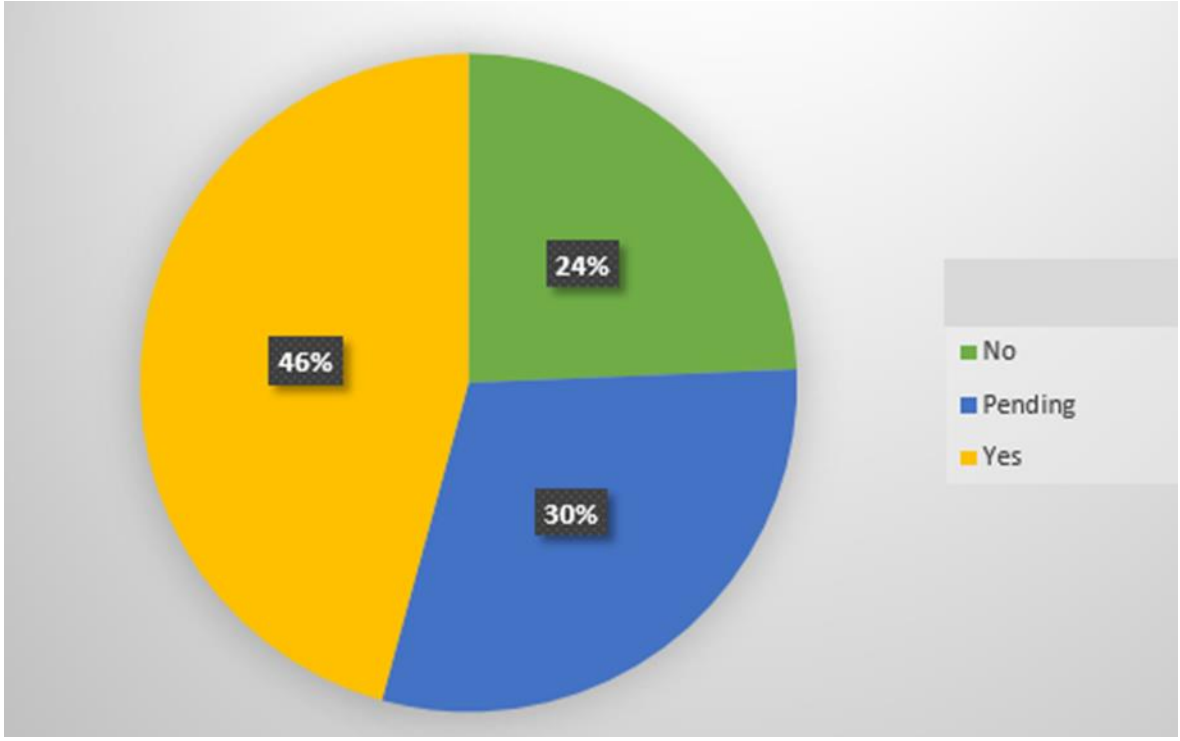
Results of the quarterly presumptive eligibility (PE) quality assurance review:

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



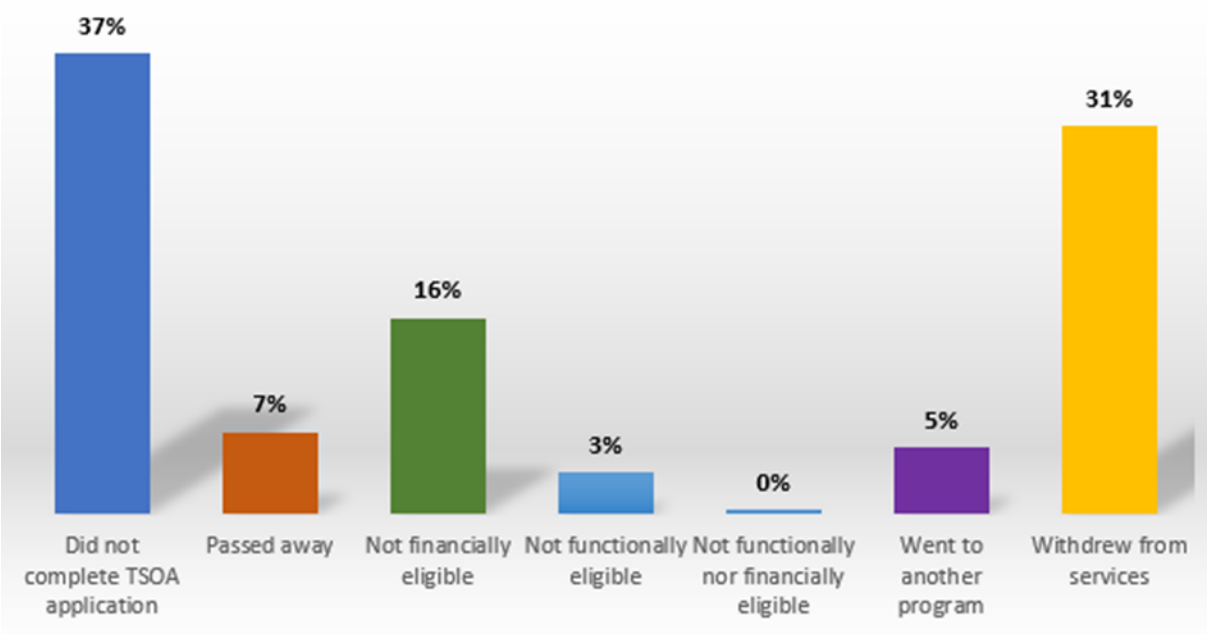
Note: the N/A represents clients who were part of the last quarter's review and the response to question 1 was "yes" but the response to question 2a was "pending."

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



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

Table 6: Question 2b: if "no" to question 2a, why?



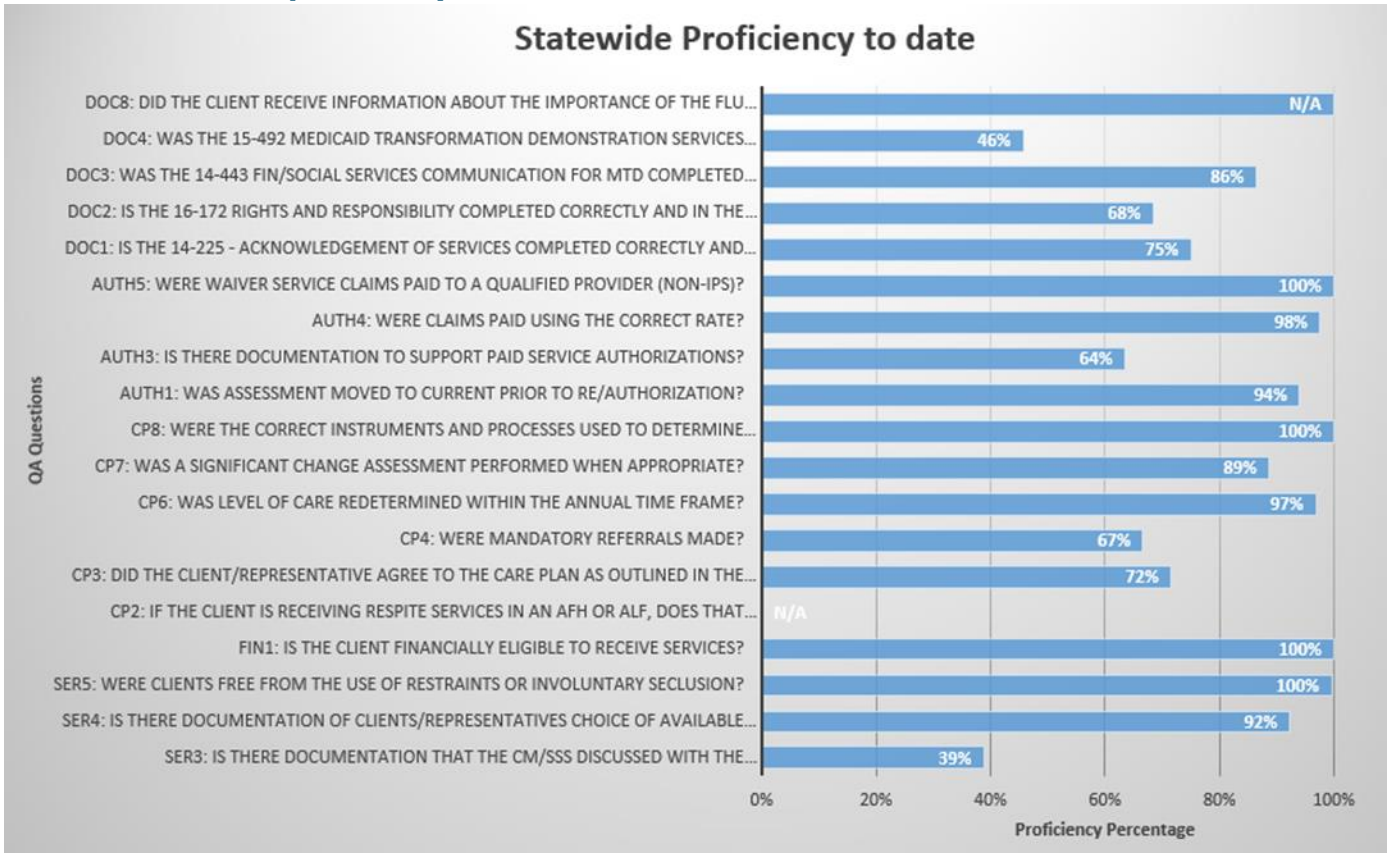
2019 quality assurance results to date

Home and Community Service (HCS) quality assurance unit began the 2019 audit cycle in January, and is expected to end in October. The statewide compliance review will be conducted in all 13 AAAs. An identical review process is used in each AAA planning and service area (PSA), using the same quality assurance tool and the same 19 questions (see attachment, below). The quality assurance team reviews a statistically valid sample of case records.

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

The results below include the eight PSAs that have completed the initial, quality assurance compliance review in 2019. Each subsequent quarterly report will add the results from the additional PSAs compliance reviews. The comparison chart reflects the statewide proficiency to date for each of the audit questions.

Table 7: Statewide proficiency to date



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

State rulemaking

There was no rulemaking activity during this quarter.

Upcoming activities

- CSO outreach events are expected to occur August and September.
- An outreach meeting has been scheduled for August with statewide Health Home coordinators.
- Three outreach events with attendees from the Washington State Hospital Association and the Federally Qualified Health Clinics will be co-facilitated with the AAAs and ALTSA/HCS staff in late summer 2019.

LTSS stakeholder concerns

No stakeholder concerns were raised during this quarter.

Foundational Community Supports (FCS) implementation accomplishments

This section summarizes the FCS program development and implementation activities conducted from April 1 through June 30, 2019.

Key accomplishments for the quarter include:

- Total aggregate number of people enrolled in FCS services at the end of DY 3 Q2:
  - Community Support Services (CSS): 2096 (through June 2019)
  - Individual Placement Support (IPS): 2499 (through June 2019)
  - Note: CSS and IPS enrollment totals include 552 people enrolled in both services. During DY 2, IPS enrollments exceeded CSS by considerable margins. By the end of DY 3 Q2, however, enrollment totals were nearly equal.

Amerigroup, the third party administrator for FCS, has contracted with 108 providers as of the end of DY 3 Q2. This represents 319 sites throughout the state. A Tableau provider map was released to the public in July. This responsive dashboard map shows the locations and service capacity of all contracted network providers. It will be updated as providers come under contract. The map can be found here: https://fortress.wa.gov/hca/tableau/t/51/views/FCSProviderMap/Dashboard

- Continuous quality improvement activities:
  - HCA conducted five fidelity reviews on the IPS model and Permanent Supportive Housing (PSH) model of services that were delivered by contracted FCS providers this quarter (3 IPS fidelity reviews – 2 PSH fidelity reviews). Eleven other FCS providers sent staff members to participate in fidelity reviews conducted at the host agencies. This cross-pollination between FCS providers supports HCA's continued effort to foster a learning community committed to continuous quality improvement.
  - HCA and DSHS Research and Data Analysis (RDA) continue to work with Oregon Health Sciences University (OHSU) on an external review of FCS program efficacy.
  - HCA hired a new FCS program administrator, Greg Claycamp, to replace Jon Brumbach. The administrator oversees the contract with Amerigroup, and interacts with internal and external stakeholders to ensure the initiative conforms to the protocol established by the Washington State and CMS.
  - In addition, HCA also hired a new FCS program manager, Matt Christie, to manage data acquisition and use, and FCS communications.

Network adequacy for FCS

Table 8: FCS provider network development

	April		May		June	
FCS service type	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
Supported Employment – Individual Placement Support (IPS)	27	70	28	65	30	66
Community Support Services (CSS)	18	32	17	30	16	29
CSS and IPS	60	243	60	221	62	224
Total	**105**	**345**	**105**	**316**	**108**	**319**

Network participation was largely static during the second quarter. Amerigroup, HCA, and partners continue to engage new prospective providers.

Amerigroup continues to contract with new providers and refine the FCS contracted provider information by narrowing the sites associated with the agency that is providing FCS services. This is a final step toward network adequacy standards implementation. This refinement includes accurate reporting on the contracted providers' site locations throughout the counties and regions. The reporting resulted in what appears to be a reduction in service sites, but an increase in the number of agencies under contract with Amerigroup.

Client enrollment

Total program enrollment reached 4862 by the end of May in DY3 Q2. This compares with 4235 at the end of Q1. We continue to monitor and assess the contracted provider network to ensure enrollment parity and capacity between CSS and IPS providers. During the latter half of DY3, we will begin assessing engagement and use—the percentage and characteristics of clients who advance from enrollment to sustained services engagement, versus those who discharge from service enrollment.

Enrollment for FCS continues to grow. Additional information about the characteristics of FCS clients is included in the tables below. FCS continues to reach people with high rates of behavioral health diagnoses and people who are receiving services from multiple systems of care. A high number of FCS enrollees continue to be Affordable Care Act Medicaid expansion adults. The DSHS RDA provides comprehensive enrollment demographic reports that are available on the HCA website.

Table 9: FCS client enrollment

	April	May	June
Supported Employment – Individual Placement and Support (IPS)	2111	2343	2499
Community Support Services (CSS)	1783	2003	2096
CSS and IPS	452	516	552
Total aggregate enrollment	4346	4862	5147

Data source: RDA administrative reports

Table 10: FCS client risk profile

		Meet HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
April	IPS	320 (12%)	1.06	1882 (73%)
	CSS	581 (26%)	1.68	1604 (72%)
May	IPS	338 (12%)	1.06	2140 (75%)
	CSS	605 (24%)	1.68	1826 (72%)
June	IPS	357 (12%)	1.1	2326 (76%)
	CSS	636 (24%)	1.7	1924 (73%)

HUD = Housing and Urban Development

PRISM = Predictive Risk Intelligence System

Note: Month-to-month changes are due to client enrollment mix, not program impact

Data source: RDA administrative reports

Table 11: FCS client risk profile continued

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment need flags
April	IPS	2144	2059 (96%)	1305 (61%)	1262 (59%)
	CSS	1798	1717 (95%)	1392 (77%)	1339 (74%)
May	IPS	2396	2310 (96%)	1436 (60%)	1393 (58%)
	CSS	2026	1929 (95%)	1561 (77%)	1505 (74%)
June	IPS	2548	2458 (96%)	1495 (59%)	1450 (57%)
	CSS	2134	2031 (95%)	1640 (77%)	1581 (74%)

MH = Mental health

SUD = Substance use disorder

Data source: RDA administrative reports

Table 12: FCS client service utilization

		Medicaid only enrollees*	Long-term Services and Supports	Mental health services	SUD services	Care + MH or SUD services
April	IPS	2144	222 (10%)	1784 (83%)	781 (36%)	186 (9%)
	CSS	1798	272 (15%)	1378 (77%)	814 (45%)	223 (12%)
May	IPS	2396	250 (10%)	1991 (83%)	851 (36%)	207 (9%)
	CSS	2026	301 (15%)	1539 (76%)	903 (45%)	248 (12%)
June	IPS	2548	265 (10%)	2108 (83%)	875 (34%)	222 (9%)
	CSS	2134	328 (15%)	1594 (75%)	929 (44%)	273 (13%)

MH = Mental health

SUD = Substance use disorder (services received in the last 12 months)

(Aging CARE assessment in last 15 months)

Data source: RDA administrative reports

Table 13: FCS client Medicaid eligibility

		CN blind/disabled (Medicaid only & full dual eligible)	CN aged (Medicaid only & full dual eligible)	CN family & pregnant woman	ACA expansion adults	CN & CHIP children
April	IPS	763 (30%)	72 (3%)	269 (10%)	1368 (53%)	91 (4%)
	CSS	850 (38%)	132 (6%)	215 (10%)	1024 (46%)	14 (<1%)
May	IPS	850 (30%)	83 (3%)	301 (11%)	1531 (54%)	94 (3%)
	CSS	962 (38%)	156 (6%)	246 (10%)	1142 (45%)	13 (<1%)
June	IPS	921 (30%)	90 (3%)	300 (10%)	1634 (54%)	106 (3%)
	CSS	1017 (38%)	163 (6%)	265 (10%)	1190 (45%)	13 (<1%)

ACA = Affordable Care Act

CHIP = Children's Health Insurance Program

CN = categorically needy

Data source: RDA administrative reports

Quality assurance and monitoring activity

HCA launched a continuous quality improvement program to foster a learning collaborative approach to implementing fidelity to two definitive models: the SAMHSA Permanent Supportive Housing (PSH) model, and IPS model. Participation in fidelity training and reviews fosters a sharing environment focused on "what works" rather than on what agencies are doing wrong. Agencies that are experiencing similar challenges can learn from each other.

Training events that promote the fidelity model provide outcomes-based strategies derived from thoroughly researched models. HCA sees fidelity reviews as a continuous quality improvement process. They help FCS contractors get the best services outcomes possible. Programs that adhere to an evidence-based model are more effective than those that do not. HCA does not use fidelity reviews as pass/fail exams, but as a way to identify strengths, and direct support most effectively.

Continuous quality improvement activities included:

- This quarter, HCA conducted four fidelity review training events for FCS agencies: 2 – IPS; 2 – PSH
- Training, technical assistance, stakeholder engagement, and information sharing continued this quarter. FCS hosted 23 webinars with more than 700 attendees. Amerigroup conducts quarterly quality assurance reviews with 25 percent of their contracted providers. The purpose of the reviews is to ensure access to services occurs within an adequate timeframe, and to monitor claims and reporting compliance. Amerigroup conducts monthly question and answer sessions for all FCS contracted providers to address authorizations, claims, reporting, and documentation requirements. Contracted providers are required to complete a reauthorization assessment form to request additional service authorizations prior to the expiration date. Services provided outside the scope of the authorization period are not reimbursed.

Other FCS program activity

In addition to activities described elsewhere in this report, we continue to build partnerships with service providers and other entities that manage strategically allied resources. These include tribal governments, housing authorities, and other affordable housing providers. Presentations at multiple state conferences occurred this quarter:

- Washington State Behavioral Health Conference
- Region X Public Housing Conference
- TANF – WorkFirst State Conference
- IPS International Learning Collaborative meeting in Denver, Colorado
- "Saying it out loud" State Conference
- Region X Community Action Program Conference

Washington has received inquiries from multiple states about the FCS program. Several conference calls have occurred this quarter with state agencies as well as national technical assistance organizations such as the Center for Health Care Strategies to learn more about the FCS history and launch.

Upcoming activities

- Additional fidelity reviews with IPS and CSS providers are scheduled this next quarter in both Eastern and Western Washington.
- Interviewers from OHSU will participate.
- Consideration of targeted outreach to new providers is based upon analysis of network adequacy.

FCS program stakeholder engagement activities

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

Table 14: FCS program stakeholder engagement activities

	April	May	June
	Number of events held		
Training and assistance provided to individual organizations	39	36	54
Community and regional presentations and training events	15	19	22
Informational webinars	8	7	8
Stakeholder engagement meetings	8	9	11
Total activities	**70**	**71**	**95**

Training and assistance activities to individual organizations continued to increase this quarter, as did the number of community and regional presentations and webinars.

Webinars are intended to inform, educate, and coordinate resources for FCS providers serving people who need housing and employment services, resources, and supports. Examples of the webinar topics covered this quarter:

- IPS principles: leadership support and expectations
- Landlord outreach and engagement: understanding hoarding disorders
- Tips for employer relationship building
- Overview of the basic food employment and training program
- Overview of the source of income discrimination law
- PATH Intentional Program services and FCS overview
- Supported education for individuals in first episode psychosis programs
- Supervisor responsibilities in collaborating with DVR
- How one SUD agency implemented IPS services
- Basic CSS supervision
- One provider's experience (ability employment assistance) with claims and billing

FCS stakeholder concerns

Amerigroup did not report any instances of provider grievances or appeals during this quarter. Some providers did report challenges to timely payment of submitted claims. When these challenges arise, Amerigroup appears to be responsive to provider concerns. Contracted providers have also raised concerns about reauthorization processes, documentation standards, and the processes to request additional hours within the authorization period, which may be affecting reimbursement for claims. Amerigroup described these processes in detail during their monthly question and answer session, and provided guidance on its provider website. Non-traditional providers, such as community action councils, continue to learn the nuances of providing Medicaid reimbursable services and the expectations that accompany these services. Amerigroup continues to report a significant amount of staff time dedicated to addressing concerns and providing technical assistance and training to FCS contractors. There are no systemic issues at this time, although there have been some challenges resulting from provider errors in submitting claims; other challenges may require system improvements at Amerigroup or HCA.

Stakeholders continue to express concerns about a lack of affordable housing in both rural and urban areas. We continue to work with allied stakeholders to improve client access to affordable housing. HCA-DBHR staff members worked with the Department of Commerce's Housing Trust Fund team, making presentations throughout the state. The goals of these presentations were to disseminate information and promote stronger partnerships among capital funding sources, builders, and FCS services.

SUD program implementation accomplishments

In July 2018, Washington State received approval of its 1115 waiver amendment, allowing the state to receive federal funding for SUD treatment services, which include short-term services provided in residential and inpatient treatment settings that qualify as IMDs. An IMD is a facility with more than 16 beds, in which at least 51 percent of the patients receive mental health or substance use treatment.

This section summarizes SUD program development and implementation activities conducted April 1 through June 30, 2019. Accomplishments for the quarter include:

- A revised SUD monitoring protocol submitted to CMS.
- A revised evaluation design submitted to CMS.
- Additional contract language for milestone 3c, ensuring residential treatment facilities offer MAT on-site, or ensure access to MAT off-site.
- Additional contract language for milestone 6 to include policies for linking beneficiaries with community-based services and supports following a residential or inpatient facility stay.
- Technical assistance and provider training for milestones 3 and 6.

Implementation plan

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

- **Milestone 3c:** Requirement that residential treatment facilities offer MAT on-site or facilitate access off-site
    - Update: MCO contracts for January 2020 include language for this requirement.

- **Milestone 4:** Sufficient provider capacity at critical levels of care – MAT for Opioid Use Disorder (OUD)
    - Update: Submitted final milestone 4 deliverable to CMS. The state provided a report on the availability of MAT services across the state—in both outpatient and residential agencies that provide MAT services—and their current ability to accept clients. A subgroup was formed to address this milestone. This group included both policy and data subject matter experts. The overall assessment has proven to be complex, involving multiple state agencies, including DSHS, HCA, and DOH.

- **Milestone 6:** The state will require residential and outpatient providers to improve coordination between levels of care. A sub-workgroup was formed and meets regularly. HCA expects to have the requirement in the July 1, 2019, managed care contracts.
    - Update: MCO contracts for January 2020 include language for this requirement.

HIT

The SUD IMD waiver requires the state to implement a HIT plan that includes requirements to 1) enhance the functionality and use of the prescription drug monitoring program (PDMP), 2) develop patient identifiers to properly match patients receiving opioid prescriptions with patients in the PDMP. These SUD IMD waiver HIT plan requirements align with many of the requirements in Section 5042 of the SUPPORT

Act in the PARTNERSHIP Act, which requires the development and implementation of a qualified-PDMP (Q-PDMP).

During this quarter, HCA collaboration with the DOH to submit to CMS P/I APD requesting funds to implement a Q-PDMP, which will support implementation of many of the required HIT plan tasks in the SUD IMD waiver.

The SUD IMD waiver HIT plan requires the state to enhance interstate data sharing to better track patient specific prescription data. During this quarter, Washington State established a memorandum of understanding (MOU) with Oregon to facilitate sharing data between each of the state's prescription monitoring programs (PMPs). Additionally, DOH entered into an MOU with the National Association of Boards of Pharmacy (NABP) for NABP to provide Washington with NABP PMP InterConnect System services. Washington will use this system to address the lack of interoperability with other state PMPs that are not fully connected or operable with Washington's PMP. It will provide Washington with access to out-of-state PMP information to further support the lawful purpose of such programs. (Lawful purpose: purposes that are consistent and not in conflict with Washington's laws, chapter 70.225 RCW, and the rules adopted thereunder.) Idaho also has an agreement with NABP, which will allow Washington to meet its qualified PMP requirement to connect to contiguous states and share data between PMP systems.

The SUD IMD waiver HIT plan requires that the state support use of a master person index (MPI) (or master data management service, etc.) in support of SUD service delivery. During this quarter, HCA submitted an MPI white paper for decision making by the HHS multi-agency enterprise governance (EG) process. This involves HCA, DOH, DSHS, Department of Children, Youth and Families (DCYF), and the Health Benefits Exchange (HBE). The draft MPI white paper takes into account the need for a master patient index (MPI) for the PDMP and other purposes. State agency leadership has prioritized this work and a new multiagency workgroup will be convened in the third quarter.

Evaluation design

HCA submitted a revised evaluation design to CMS on April 24. This included additional detail on the cost analyses to be conducted by the Independent External Evaluator (IEE), Oregon Health Sciences University (OHSU) and received feedback from CMS on May 17, 2019. The state re-submitted the final evaluation design revision to CMS in early July.

An amendment to the contract with OHSU was drafted to include the SUD program work. The statement of work was updated to include OHSU responsibility for performing the mid-point assessment activities and report. Planning activities for the mid-point assessment will begin early in the next reporting period. At the end of this reporting period, the contract was out for final review by OHSU and the HCA leadership.

Monitoring protocol

HCA received comments from CMS on the SUD monitoring protocol and supporting documents from CMS in late March. The state reviewed and responded to CMS's comments with additional information and re-submitted the monitoring protocol on June 21, 2019.

Upcoming activities

- Presentation to tribal members at monthly tribal meeting
- Evaluation engagement and collaboration with partners

Quarterly expenditures

The following table reflects quarterly expenditures for DSRIP, LTSS, and FCS during DY 3 (2019).

Table 15: DSRIP expenditures

	Q1	Q2	Q3	Q4	DY 3 Total	Funding source
	January 1–March 31	April 1–June 30	July 1–September 30	October 1–December 31	January 1–December 31	Federal financial participation
Accountable Communities of Health						
Better Health Together	$0	$17,396,295				$8,698,148
Cascade Pacific Action Alliance	$0	$11,313,792				$5,656,896
Greater Columbia	$0	$21,829,660				$10,914,830
HealthierHere	$0	$33,463,618				$16,731,809
North Central	$0	$6,130,010				$3,065,005
North Sound	$0	$16,820,688				$8,410,344
Pierce County	$0	$19,109,624				$9,554,812
Olympic Community of Health	$0	$4,705,518				$2,352,759
SWACH	$0	$8,136,037				$4,068,019
IHCP-specific projects						
Indian Health Care Providers	$0	$0				

Table 16: LTSS and FCS service expenditures

	Q1	Q2	Q3	Q4	DY 3 Total
	January 1–March 31	April 1–June 30	July 1–September 30	October 1–December 31	January 1–December 31
Tailored Supports for Older Adults (TSOA)	$1,669,673	$2,117,045			
Medicaid Alternative Care (MAC)	$27,638	$39,598			
MAC and TSOA not eligible	$25	$0			
FCS[1]	$0	$324,645			

[1] HCA will be finalizing the automated, service-based enhancement in DY 3 Q2 through the ProviderOne claims system.

Overall MTP development/issues

Operational/policy issues

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

Consumer issues

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

Quality assurance and monitoring activity

See program-specific, Q2 summary for quality assurance and monitoring activity updates.

- DSRIP
- LTSS
- FCS

MTP evaluation

The state executed its contract with the IEE in 2018, Q3. Recent key activities include the following:

- Submission of the fourth Rapid Cycle Monitoring Report (June 30, 2019), including the first substantive analysis by Center for Health Systems Effectiveness (CHSE).
- Completion of first round of key informant interviews and initial analysis of data from the interviews
- Recruitment of key informants from ACHs and initial site visits with three ACHs.
- Submission of study amendment to the Washington State Institutional Review Board (WA IRB) to add additional administrative data for quantitative analysis.
- Receipt of first cycle administrative data, and initial activity to organize the data into an evaluation database
- Pilot testing completion for primary care practice and hospital surveys.
    - Follow up meeting on June 28, 2019 with HCA subject matter experts for final review. This resulted in HCA receiving approval to move the survey instruments forward to WA IRB for approval.
- Finalization and agreement with HCA on SUD amendment mid-point assessment statement of work and budget.

Highlights from the fourth Rapid Cycle Monitoring Report includes results from the first substantive analysis by CHSE. The report summarizes findings from round 1 state agency key informant interviews with 14 staff members. The report covers methodology, and includes a narrative summary assessment on the following research aims:

- Overall Medicaid system performance: Washington did not start from scratch; it built the MTP from the "seeds" of the State Innovation Model (SIM) grant and other initiatives and state policy changes.
- Progress toward meeting VBP penetration targets: MCOs are meeting VBP goals, but providers need more support.
- Impact of MTP on workforce capacity needed for transformation goals: Washington is pursuing partnerships to address workforce shortages, as well as other initiatives such as loan repayment.
- Impact of MTP on provider adoption and use of health information activity: The state plays a critical role in improving and promoting reliable tools for information exchange and population health capacity.

- Implementation and effect of LTSS: LTSS leverages previous programs and shows promising improvements. Reaching caregivers is challenging. Aligning LTSS with other MTP initiatives may support the state's broader goals.
- Implementation and impact of FCS: FCS is using evidence-based models; HCA is monitoring fidelity. Beneficiaries can find services through multiple pathways. Partners are experiencing a steep learning curve. Housing availability affects enrollment.

Upcoming key activities:

- Completing "phase 3" administrative data set needed for the quantitative evaluation of Initiative 2 (LTSS), Initiative 3 (FCS), and Initiative 4 (SUD amendment); submission of WA IRB amendment to approve the additional data.
- Continued round 1 key informant interviews.
    - Next step: ACH key informants.
- Meetings with key ACH staff to discuss ACH project target population selection.
- Continuation of qualitative analysis from round 1 key informant interview.
- Continued building of the evaluation database for quantitative analysis.
- Launching of primary care provider and hospital survey instrument.
- Initiation of activities for SUD mid-point assessment, including collaboration with tribes, MCO representatives, SUD treatment providers and other partners for design, planning and conducting the assessment.

The IEE provided four rapid-cycle monitoring reports that reflect Q3 and Q4 of 2018, Q1 and Q2 of 2019.

Financial/budget neutrality development/issues

Financial

HCA has posted solicitation to procure for an independent auditor to validate the claims submitted on the CMS-64 Designated State Health Program (DSHP) expenditure report.

Budget neutrality

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

Below are the counts of member months eligible to receive services under MTP, including non-expansion adults and SUD populations. Member months for non-expansion adults are updated retrospectively, based on the current caseload forecast council (CFC) medical caseload data. March 2019 through June 2019 for non-expansion adults are forecasted caseload figures from CFC. Data are not yet available to report June's SUD member months.

Table 17: member months eligible to receive services

Calendar month	Non-expansion adults only	SUD Medicaid disabled	SUD Medicaid Non-disabled	SUD newly eligible	SUD American Indian/Alaskan Native
Jan-17	376,040	0	0	0	0
Feb-17	374,812	0	0	0	0
Mar-17	374,306	0	0	0	0
Apr-17	373,100	0	0	0	0
May-17	372,614	0	0	0	0
Jun-17	372,483	0	0	0	0
Jul-17	371,616	0	0	0	0
Aug-17	371,362	0	0	0	0
Sep-17	370,132	0	0	0	0
Oct-17	369,957	0	0	0	0
Nov-17	369,808	0	0	0	0
Dec-17	369,847	0	0	0	0
Jan-18	369,905	0	0	0	0
Feb-18	368,536	0	0	0	0
Mar-18	368,370	0	0	0	0
Apr-18	367,110	0	0	0	0
May-18	367,466	0	0	0	0
Jun-18	366,753	0	0	0	0
Jul-18	366,531	0	0	0	0
Aug-18	365,945	0	0	0	0
Sept-18	364,950	0	0	0	0
Oct-18	364,944	0	0	0	0
Nov-18	364,476	0	0	0	0
Dec-18	363,932	0	0	0	0
Jan-19	363,827	0	0	0	0
Feb-19	362,101	0	0	0	0
Mar-19	361,797	0	0	0	0
Apr-19	361,457	0	0	0	0
May-19	361,645	0	0	0	0
June-19	360,858	0	0	0	0
Total	11,036,681	0	0	0	0

Designated state health programs (DSHP)

No DSHP updates to provide this quarter.

Summary of additional resources, enclosures, and attachments

Additional resources

To learn more about Washington's MTP, visit the HCA website.

Receive notifications about MTP-related activities, new materials, and opportunities for public comment through the Healthier Washington email subscription list.

Summary of attachments

Attachment A: State contacts

Attachment B: Financial Executor Portal Dashboard, Q2 2019

Attachment C: Health IT Operational Quarterly Report

Attachment D: Independent External Evaluator Rapid-Cycle Report

Attachment A: state contacts

Area	Name	Title	Phone
MTP and quarterly reports	Chase Napier	Manager, Medicaid Transformation	(360) 725-0868
DSRIP program	Chase Napier	Manager, Medicaid Transformation	(360) 725-0868
LTSS program	Kelli Emans	Managed Care Policy Analyst, DSHS	(360) 725-3213
FCS program	Melodie Pazolt	Section Manager, DBHR	(360) 725-0487
SUD program	Louise Nieto	Supervisor Administrative Programs, DBHR	(360) 725-5278

For mail delivery, use the following address:

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

Attachment B: FE portal dashboard, Q2 DY3

This table shows all funds earned and distributed through the FE portal through June 30, 2019.

	Total	Better Health Together	Cascade Pacific Action Alliance	Greater Columbia	HealthierHere	North Central	North Sound	Olympic Community of Health	Pierce County ACH	SWACH	IHCP-specific projects
Project description											
Funds earned by ACH											
2A: Bi-directional integration of physical and behavioral health through care transformation	$171,474,477.88	$19,427,564.48	$13,876,829.96	$$28,630,096.27	$44,990,149.35	$6,335,076.96	$17,484,806.31	$7,173,253.79	$21,193,704.84	$12,362,995.92	
2B: Community-based care coordination	$62,343,173.55	$13,356,450.60	$9,540,322.57			$4,355,363.48	$12,020,804.14		$14,570,672.74	$8,499,560.02	
2C: Transitional care	$45,222,514.26		$5,637,463.25	$11,630,976.13	$18,277,247.35	$2,573,623.88	$7,103,203.65				
2D: Diversion interventions	$12,590,963.08					$2,573,623.88	$7,103,203.65	$2,914,135.55			
3A: Addressing the opioid use public health crisis	$21,434,312.50	$2,428,446.29	$1,734,604.92	$3,578,761.27	$5,623,768.57	$791,884.27	$2,185,601.66	$896,657.02	$2,649,214.31	$1,545,374.19	
3B: Reproductive and maternal/child health	$6,021,077.25		$2,168,255.40				$2,732,001.33	$1,120,820.52			
3C: Access to oral health services	$2,311,693.51						$1,639,200.00	$672,493.51			
3D: Chronic disease prevention and control	$42,868,616.99	$4,856,889.58	$3,469,206.84	$7,157,523.54	$11,247,537.13	$1,583,768.54	$4,371,202.32	$1,793,314.03	$5,298,426.64	$3,090,748.37	
Behavioral health integration incentives	$61,612,839.00	$8,301,872.00		$10,183,916.00	$14,888,792.00	$5,781,980.00	$4,332,435.00		$9,321,788.00	$8,802,056.00	
VBP incentives	$2,700,000.00	$300,000.00	$300,000.00	$300,000.00	$300,000.00	$300,000.00	$300,000.00	$300,000.00	$300,000.00	$300,000.00	
IHCP-specific projects	$10,979,000.00										$10,979,000.00
Project Plan bonus	$6,308,649.00		$1,455,842.00			$1,455,842.00	$1,941,123.00	$1,455,842.00			
TOTAL FUNDS EARNED	**$445,867,317.02**	**$48,671,222.95**	**$38,182,524.94**	**$61,481,273.21**	**$95,327,494.40**	**$25,751,163.01**	**$61,213,581.06**	**$16,326,516.42**	**$53,333,806.53**	**$34,600,734.50**	**$10,979,000.00**
Funds distributed by ACH											
Administration	$15,944,574.38	$1,464,657.22	$335,891.00	$1,556,500.00	$6,117,865.95		$4,677,634.12	$14,081.37	$1,400,000.00	$377,944.72	
Community health fund	$9,905,634.23		$2,358,557.00	$1,395,201.87			$4,651,875.36		$1,500,000.00		
Health systems and community capacity building	$20,182,319.91	$4,475,201.00	$787,879.75	$1,198,937.92	$42,582.00	$976,131.01	$6,428,467.31	$110,000.00	$4,756,663.00	$856,457.92	$550,000.00
Integration incentives	$16,592,754.97	$2,810,000.00		$4,132,434.89	$4,292,645.42	$58,421.66	$553,320.00		$4,745,933.00		
Project management	$3,752,740.30		$1,903,385.00	$890,500.00		$423,002.71	$318,417.39	$196,000.00		$21,435.20	
Provider engagement, participation and implementation	$60,313,674.84	$3,614,500.00	$6,465,901.00	$4,799,534.00	$7,553,074.00	$2,413,273.26	$15,077,235.00	$5,968,867.01	$3,756,000.00	$1,245,586.57	$9,419,704.00
Provider performance and quality incentives	$9,688,833.40		$1,958,520.00	$340,662.00		$592,500.00			$5,217,952.80	$1,579,198.60	
Reserve/contingency fund	$2,404,473.07		$1,474,098.00				$930,375.07				
Shared domain 1 incentives	$87,005,581.00	$9,570,613.50	$8,700,558.00	$12,180,782.00	$19,141,228.50	$4,350,278.00	$13,050,837.50	$3,480,224.00	$10,440,668.50	$6,090,391.00	
TOTAL	**$225,790,586.10**	**$21,934,971.72**	**$23,984,789.75**	**$26,494,552.68**	**$37,147,395.87**	**8,813,606.64**	**$45,688,161.75**	**$9,769,172.38**	**$31,817,217.30**	**$10,171,014.01**	**$9,969,704.00**
Funds available											
Total funds distributed to date	$225,790,586.10	$21,934,971.72	$23,984,789.75	$26,494,552.68	$37,147,395.87	$8,813,606.64	$45,688,161.75	$9,769,172.38	$31,817,217.30	$10,171,014.01	$9,969,704.00
Total funds available for distribution	$220,076,730.92	$26,736,251.23	$14,197,735.19	$34,986,720.53	$58,180,098.53	$16,937,556.37	$15,525,419.31	$6,557,344.04	$21,516,589.23	$24,429,720.49	$1,009,296.00
% OF TOTAL FUNDS DISTRIBUTED	**50.64 %**	**45.07 %**	**62.82 %**	**43.09 %**	**38.97 %**	**34.23 %**	**74.64 %**	**59.84 %**	**59.66 %**	**29.40 %**	**90.81 %**
% of total funds distributed by ACH											
Administration	7.06 %	6.68 %	1.40 %	5.87 %	16.47 %		10.24 %	0.14 %	4.40 %	3.72 %	
Community health fund	4.39 %		9.83 %	5.27 %			10.18 %		4.71 %		
Health systems and community capacity building	8.94 %	20.40 %	3.28 %	4.53 %	0.11 %	11.08 %	14.07 %	1.13 %	14.95 %	8.42 %	5.52 %
Integration incentives	7.35 %	12.81 %		15.60 %	11.56 %	0.66 %	1.21 %		14.92 %		
Project management											

Provider engagement, participation and implementation											
Provider performance and quality incentives											
Reserve/contingency fund											
Shared domain 1 incentives											
TOTAL	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**

Attachment C: HIT operational quarterly report DY3

Washington State Medicaid Transformation Project demonstration
Section 1115 Waiver Quarterly Health IT Operational Report
Demonstration Year 3: (January 1, 2019 to December 31, 2019)
Federal Fiscal Quarter: Second Quarter (April 1, 2019 to June 30, 2019)

Q2 DY 3, April 1, 2019 – June 30, 2019

The HIT operational plan is composed of actionable deliverables to advance the HIT goals and vision articulated in the HIT Strategic Roadmap (https://www.hca.wa.gov/assets/program/health-information-technology-strategic-roadmap.pdf). This work supports the MTP. The HIT roadmap and operational plan focuses on three phases of MTP work: design, implementation/operations, and assessment. In 2018, HCA led months of conversations that resulted in identifying tasks for the 2019 HIT operational plan.

These activities include 64 deliverables and tasks in areas including:

- SUD IMD waiver
- Data and governance
- Master person Index
- Provider directory
- Payment models and sources
- Enhancing HIE functionality, including enhancing the CDR
- Registries
- Tribal engagement
- EHRs
- Behavioral health integration

Washington has advanced work on these tasks and deliverables during Q 2 DY3, including beginning implementation of several of these activities.

Success stories

The HIT team spent much of the Q3 DY 3 establishing governance to move HIT initiatives forward. This includes:

- Establishing a CDR data governance group (task 01-01) to review and approve clinical data uses
- Building the HHS enterprise coalition governance process (task 01-03) to identify, prioritize, and oversee multi-agency initiatives affecting the five HHS agencies:
    - HCA
    - DOH
    - DSHS
    - DCYF
    - HBE

Additionally, the HCA has initiated a process to incorporated successes from evaluation work from the SIM grant and MTP.

In April, HCA submitted an updated SMHP, which identifies Washington's current state of HIT, articulates the desired future state, and outlines the roadmap. The SMHP also aligned with other HIT plans, including the HIT operational plan required in the MTP, and the SUD HIT plan required as a component of the SUD IMD waiver.

During Q2, HCA also led a multi-agency workgroup to identify use cases for a master person index. This group interviewed many states to understand their master person index efforts and identified lessons learned. The workgroup produced a white paper (task 02-01) that was presented to the HHS coalition leadership group. The group prioritized implementing a master person index in the coming years.

The CDR went live with a PAMI Plus report. This summarizes clinical information for providers, and is accessible through the CDR. The state is currently advancing other information reporting.

Washington recently established a MOU with Oregon for sharing data between each of the state's PMPs. DOH also entered an MOU with the National Association of Boards of Pharmacy (NABP) for NABP to provide Washington with the NABP PMP InterConnect System services. Washington will use this system to address the lack of interoperability with other state PMPs that are not fully connected or operable with Washington's PMP. It will provide Washington with access to out-of-state PMP information to further support the lawful purpose of such programs. (Lawful purpose: purposes that are consistent and not in conflict with Washington's laws, chapter 70.225 RCW, and the rules adopted, thereunder) Idaho also has an agreement with NABP that will allow Washington to meet its qualified PMP requirement to connect to contiguous states and share data between PMP systems. Washington was able to satisfy the requirement under the PARTNERSHIP Act, described in Section 5042 of the SUPPORT Act that the state enter into data sharing agreements with contiguous states as a result of the MOU with Oregon and the agreements that Idaho and Washington have with the NABP.

During Q2, the HCA, in collaboration with DOH, submitted a P/I APD requesting funding to implement a PMP system with enhanced functionality required under the PARTNERSHIP Act, described in Section 5042 of the SUPPORT Act. The P/I APD also requested funding for:

- Electronic consent management.
- The availability of additional clinical data sources.
- Reporting for clinical and case management.

The enhancements will support Washington's efforts to combat the opioid crisis through integrating the data in the PMP and CDR, and allow providers to make more informed treatment decisions. In addition, the activities of this P/I APD will support some of the tasks required in the IMD waiver SUD HIT plan.

During the Q2, HCA finalized its guidance for sharing SUD information using a method aligned with 42 CFR, part 2. This is the result of work initiated in 2018 that involved considerable consultation with multiple state agencies, physical and behavioral health care providers, managed care organizations, ACHs, and others. The guidance is titled *Sharing Substance Use Disorder Information – A Guide for Washington State*. (https://www.hca.wa.gov/assets/billers-and-providers/60-0015-sharing-substance-use-disorder-information-guide.pdf) This guide with inform future work regarding eConsent management.

Progress to date

During Q2 DY 3, Washington advanced its HIT operational plan. This work included:

- Coordinating with tribes and ACHs on state and national HIE resources.
- Continuing to support the HIT plan requirements of the SUD IMD waiver.
- Initiating meetings of the CDR Data Governance Committee that provides guidance and develops policies and processes for clinical and claims data and role-based access for clinical, social and claims data for the CDR.
- Drafting the Multiple Methods of HIE whitepaper (currently under final review).

While there was substantial progress made on several deliverables in Q2 DY 3, there were four deliverables that were scheduled to be completed during this quarter:

Description of task 01-04 Using the SIM evaluation and MTP independent external evaluation outcomes regarding data analysis and HIT/HIE, develop routine communication to share successes for regular program improvement. This includes communications to ACHs for dissemination to providers and program/pilot implementation as applicable. **This task was completed** with the development of a process to disseminate early findings from state evaluations and by encouraging external partners to use findings from the MTP IEE's rapid cycle report.
Description of task 02-01 Draft an MPI white paper for decision making for the HHS multi-agency enterprise EG process (involving HCA, DOH, DSHS, DCYF, HBE). The draft MPI white paper will take into account need for MPI (e.g., use of an MPI in eligibility and enrollment and the PDMP (see tasks 06-03 and 14-08)) and will take into account input from non-state entities selected by HCA for an advisory role, based on their work on similar MPI efforts. Develop project implementation plan with key decision points. **This task was completed** and state agency leadership made advancement of this project a priority. Work has entered a new phase, with a new multiagency workgroup being convened in Q3, and a legislative funding request being convened.
Description of task 09-05 HCA, in collaboration with OHP and clinical users, will determine the best method(s) for finding and distributing CDR data (e.g., developing an interface for the CDR for BH/LTC providers and correctional health service providers (such as a PAMI+ report) **This task was completed** and the PAMI+ report is currently available to users of the CDR.
Description of task 13-01 Guidance on complying with 42 CFR, part 2 HCA will disseminate provider guidance on complying with 42 CFR part 2 and consent form that could be used at the point of care to obtain patient consent to share information that is subject to 42 CFR, part 2. **This task was completed** in May 2019 with the broad dissemination of sharing SUD information guidance issued by HCA.

Washington continues to work on remaining deliverables in all major categories.

Challenges

While substantial progress has been made, there are two deliverables that are at-risk, and six that were re-planned for 2019. These include the following at-risk deliverables:

Task number	Task	Comment
05-02	Multiple Methods of HIE	We have drafted the Multiple Methods of HIE white paper and are currently in the review process. Due to multiple competing priorities the review process has been delayed and we anticipate the due date for this task will be in Q3 2019.
09-06	Design/develop smart form use cases.	HCA solicited feedback from agency partners and outside stakeholders in the attempt to identify Smart Form use cases that could be designed and developed.

		Unfortunately, there was very little interest in identifying use cases at this point.

Changes in HIT operational plan

There were 12 items that were re-planned for 2019 due to pending decisions, resource constraints and to align with other activities:

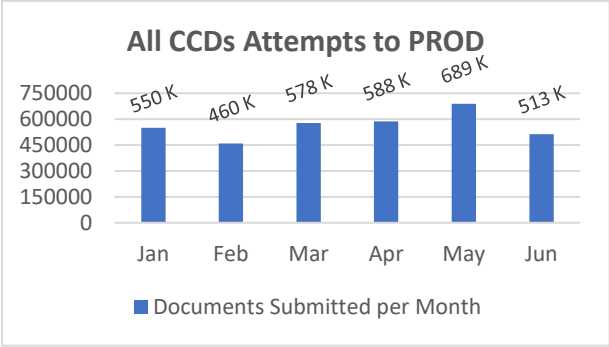
Task number	Task	Comment
01-01	Policies/guidance regarding clinical and claims data, including data in the CDR.	Adjusted the end date of this effort to 9/30/19 due to ongoing decisions regarding CDR policies
01-02	Role-based access policies for clinical, social, and claims data	Adjusted the end date of this effort to 9/30/19 due to ongoing discussions regarding access to data for individuals outside State government.
05-05	Strategy for Community/Consumer Engagement on HIE, including the CDR	Adjusted the end date of this effort to 12/31/19
05-06	Security practices for HIT/HIE	Adjusted the end date of this effort to 12/31/19
05-06	Telehealth	Adjusted the end date of this effort to 9/30/19
09-06	Design/Develop Smart Form Use Cases.	Due to little interest in designing Smart Forms, we are closing this task.
10-02	Assist Tribes exploring EHR replacement and system integration	Adjusted end date of this task to 12/31/19
12-02	SUPPORT Act: EHR Incentive Payments to BH providers	Closing this task as we've been informed by CMS that, at this time, the federal government will not be pursuing an EHR incentive payment program for behavioral health providers
12-05	Streamline SAMHSA reporting	Adjusted end date of this task to 9/30/19. Currently working on incorporating new language to support this effort in MCO contracts
14-06	G: Develop enhanced provider workflow / business processes to better support clinicians' access to the PDMP prior to prescribing an opioid or other controlled substance (timeline: 12 months)	Adjusted end date of this task to 12/31/19 to align with other SUPPORT ACT related activities
14-07	H: Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions through the PMP—prior to the issuance of an opioid prescription (timeline: 24+ months)	Adjusted end date of this task to 12/31/21 to align with other SUPPORT ACT related activities

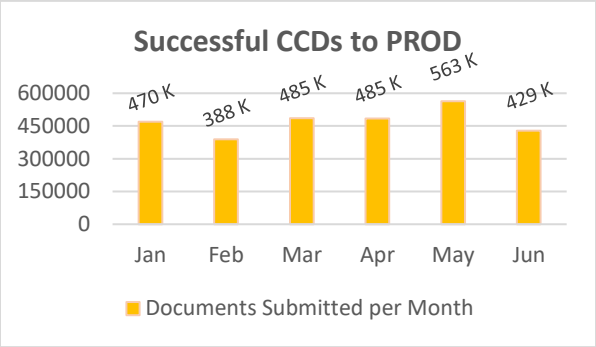
Next Steps

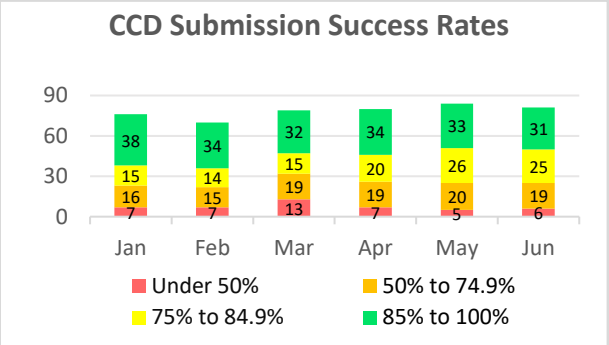
Washington continues to implement the 2019 HIT operational plan. With the recent approval of the P/IAPD under the PARTNERSHIP Act, described in Section 5042 of the SUPPORT Act, we will focus on planning and beginning implementation activities for those related items during Q3. Additionally, the state will draft a supplemental funding request for the legislature regarding the Master Person Index.

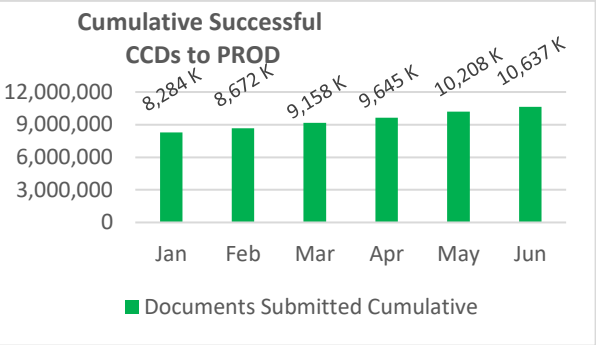
CDR sponsor dashboard

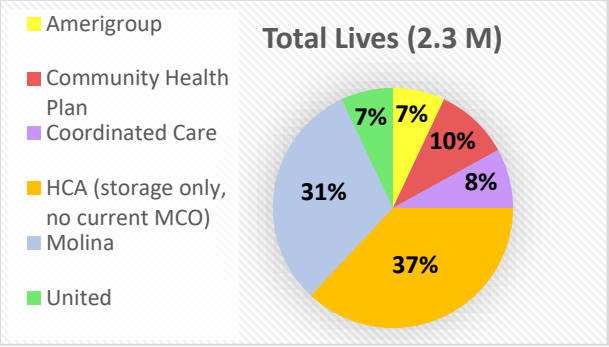
(prepared for executive sponsors – July 08, 2019)

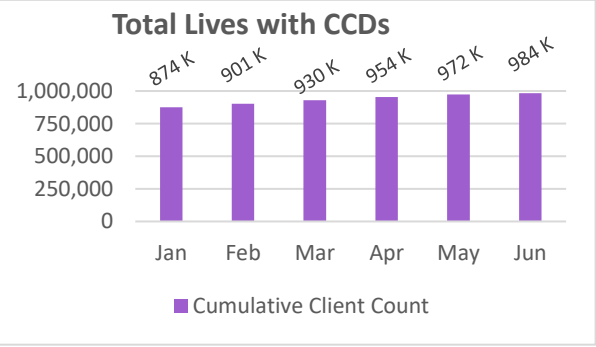












Top 20 Organizations by total successful CCD submissions

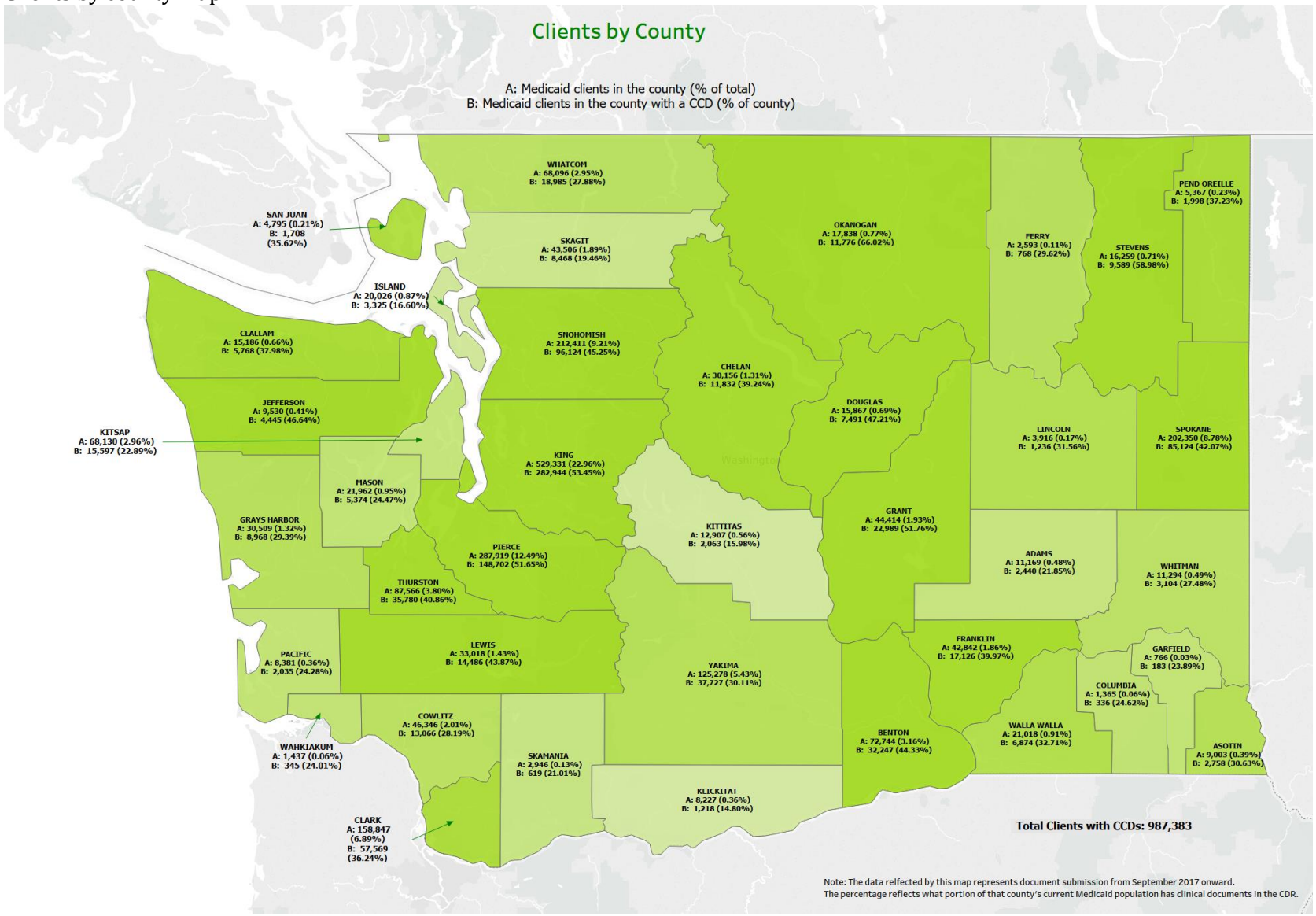
Rank	Org Name	CCD Count	Rank	Org Name	CCD Count
1.	University of Washington	87,420	11.	Community Health Care	12,016
2.	Multicare	74,992	12.	PeaceHealth	11,910
3.	Health Point CHC	31,354	13.	Community Health Care	8,632
4.	Neighborcare Health	26,620	14.	Providence Health and Services	8,183
5.	Swedish Medical Center	24,768	15.	Sea Mar Community Health Center	6,250
6.	Confluence Health	21,400	16.	Tri-Cities Community Health	5,728
7.	Kadlec Regional Medical Center	20,711	17.	Country Doctor	5,465
8.	The Vancouver Clinic	15,731	18.	The Everett Clinic	4,245
9.	Yakima Neighborhood Health Services	14,467	19.	Moses Lake Community Health Center	3,970
10.	Seattle Children's	13,373	20.	The Polyclinic	3,449

Number of provider organizations in UAT in last month: 4
CDR tickets at HCA: 7 and CDR tickets at OHP: 46

CDR sponsor dashboard

(prepared for executive sponsors – July 08, 2019)

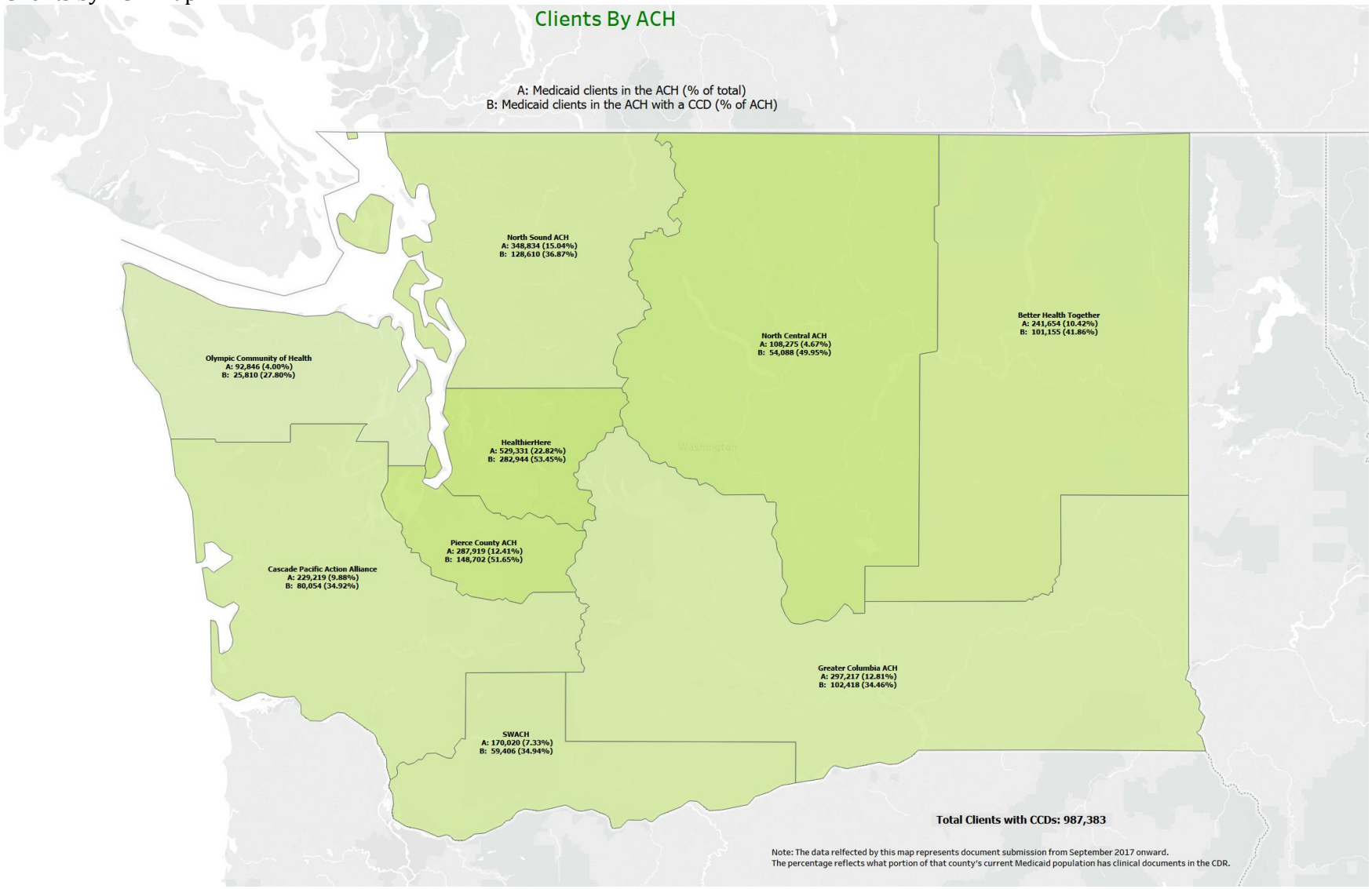
Clients by county map



CDR sponsor dashboard

(prepared for executive sponsors – July 08, 2019)

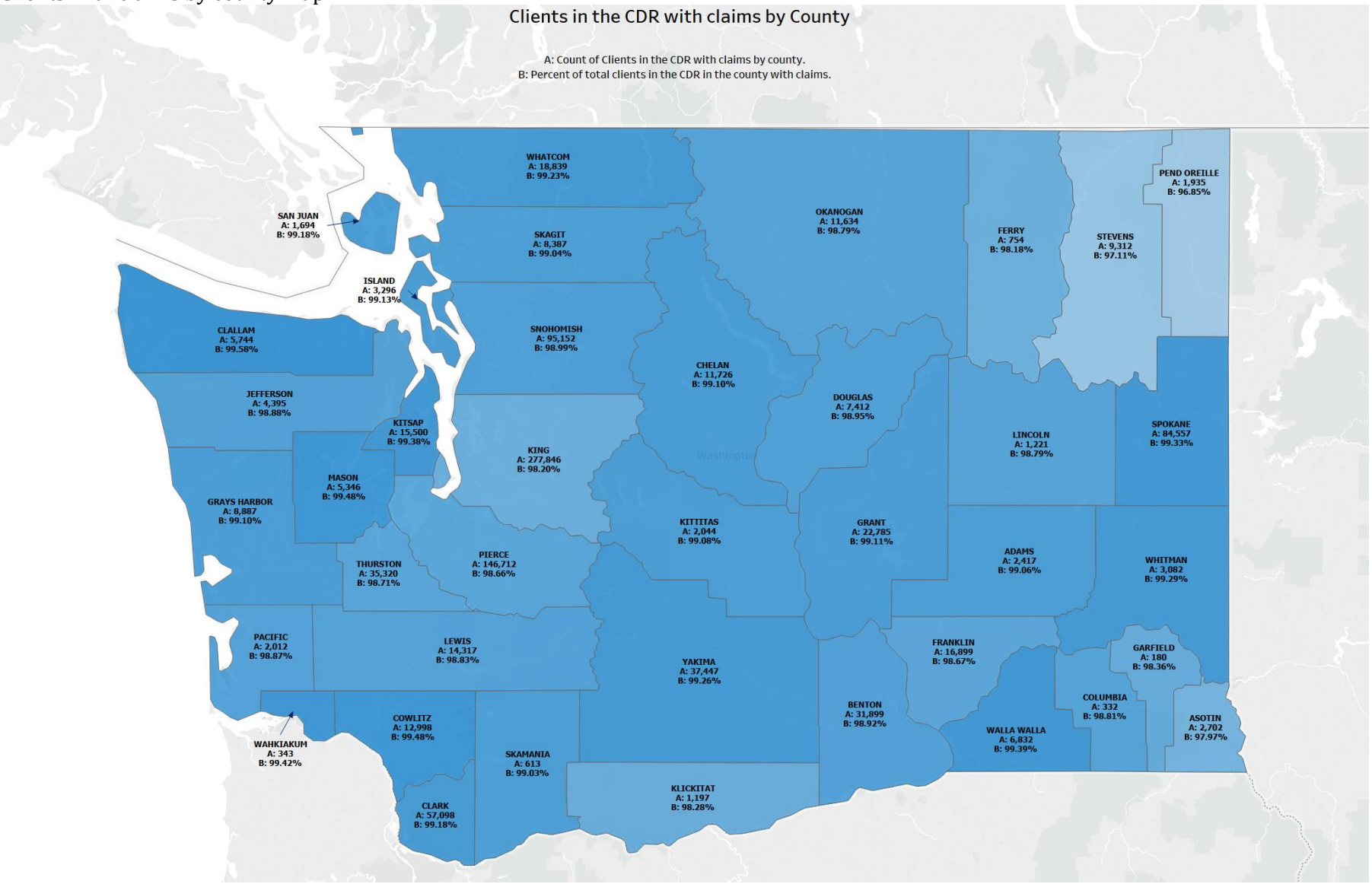
Clients by ACH map



CDR sponsor dashboard

(prepared for executive sponsors – July 08, 2019)

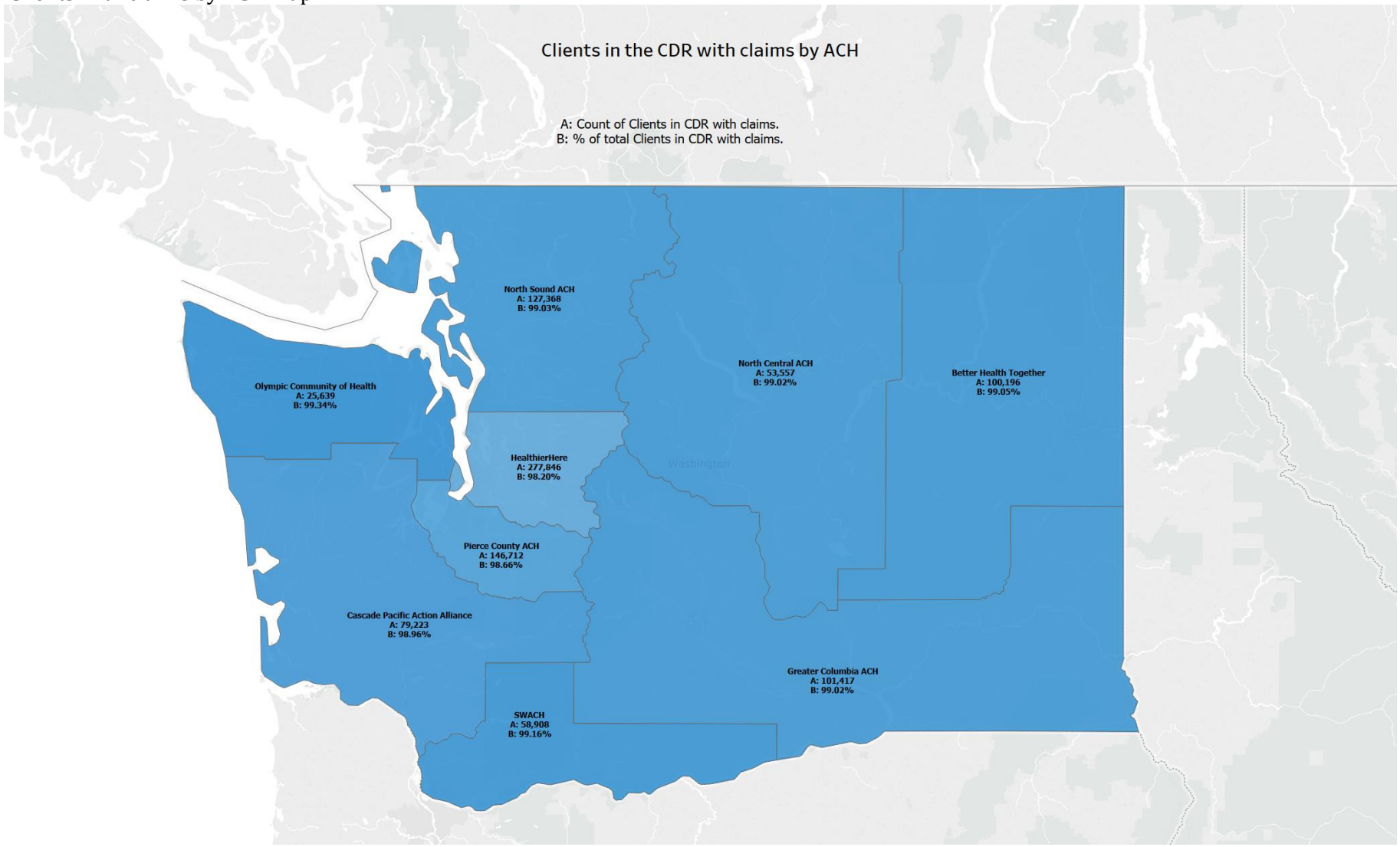
Clients with claims by county map



CDR sponsor dashboard

(prepared for executive sponsors – July 08, 2019)

Clients with claims by ACH map



Task number	% complete	Start date	Due date	Name	Year/quarter end date	Status	Category
1-01	75	1/2/19	9/30/19	Policies/guidance regarding clinical and claims data, including data in the CDR.	Q2	On Track	Data and Governance
1-02	25	1/2/19	9/30/19	Role-based access policies for clinical, social, and claims data	Q2	On Track	Data and Governance
1-03	75	12/31/19	12/31/19	Build out Enterprise Governance structure	Q4	On Track	Data and Governance
1-04	100	1/2/19	9/30/19	Develop process for incorporating successes from evaluation work (SIM, MTP, etc.)	Q3	Complete	Data and Governance
2-01	100	1/2/19	12/31/19	Draft MPI White Paper and Implementation Plan for Enterprise Governance decision making	Q4	Complete	Master Person Index
3-01	0	1/2/19	12/31/19	Draft Provider Directory white paper and implementation plan for Enterprise Governance decision making	Q4	On Track	Provider Directory
3-02	25	7/1/19	12/31/19	Time and distance standards for provider networks	Q4	On Track	Provider Directory
4-01	25	7/1/19	12/31/19	Provider Assignment/Provider Attribution	Q4	On Track	Payment Models and Sources
4-02	25	4/1/19	9/30/19	MCO HIE incentives	Q3	On Track	Payment Models and Sources
4-03	50	1/2/19	9/30/19	VBP Models and HIT/HIE	Q3	On Track	Payment Models and Sources
4-04	0	1/2/19	12/31/19	Implement Payment Model 2-Rural Multipayer Payment Model	Q4	On Track	Payment Models and Sources
4-05	0	4/1/19	9/30/19	Public/Private Partnerships	Q3	On Track	Payment Models and Sources
5-01	0	1/2/19	12/31/20	Identify and Synthesize Planned ACH and State HIT/HIE Investments	2020	On Track	Health Information Exchange functionality, including enhancing the CDR

Task number	% complete	Start date	Due date	Name	Year/quarter end date	Status	Category
5-02	75	1/2/19	6/28/19	Multiple Methods of HIE	Q2	At Risk	Health Information Exchange functionality, including enhancing the CDR
5-03	0	7/1/19	12/31/19	Closed loop referral and Population Health Management	Q4	On Track	Health Information Exchange functionality, including enhancing the CDR
5-04	50	1/2/19	12/31/20	Strategy for Community/Provider Engagement on HIE, including the CDR	2020	On Track	Health Information Exchange functionality, including enhancing the CDR
5-05	50	1/2/19	12/31/19	Strategy for Community/Consumer Engagement on HIE, including the CDR	Q2	On Track	Health Information Exchange functionality, including enhancing the CDR
5-06	25	1/2/19	12/31/19	Security practices for HIT/HIE	Q2	On Track	Health Information Exchange functionality, including enhancing the CDR

Task number	% complete	Start date	Due date	Name	Year/quarter end date	Status	Category
5-07	0	1/2/19	9/30/19	Telehealth	Q2	On Track	Health Information Exchange functionality, including enhancing the CDR
6-01	50	7/1/14	9/30/21	Administer Public Health Registry Onboarding	2021	On Track	Registries
6-02	50	10/1/18	6/28/19	SUPPORT Act: PDMP	Q2	On Track	Registries
6-03	100	10/1/18	6/28/19	Support Access to PDMP through CDR	Q2	Complete	Registries
6-04	25	10/1/18	12/31/19	Support Act: PDMP Guidance	Q4	On Track	Registries
6-05	0	7/1/19	9/30/21	Integrate Other Public Health Registries	2021	On Track	Registries
7-01	25	7/1/19	6/30/20	Enable Addition of FFS Clients to CDR	2020	On Track	Adding Clients to CDR
8-01	50	7/1/19	12/31/19	CDR onboarding	Q4	On Track	Adding CDR Users
8-02	25	7/1/19	12/31/19	Jail Transition Services	Q4	On Track	Adding CDR Users
8-03	0	8/1/19	9/30/19	1st responders/Community Paramedicine	Q3	On Track	Adding CDR Users
9-01	0	1/2/19	9/30/19	Update HIE Roadmap	Q3	On Track	Adding CDR Functions/ Quality
9-02	25	10/1/18	12/31/19	Deploy Reporting Features in CDR	Q4	On Track	Adding CDR Functions/ Quality
9-03	0	10/1/18	12/31/19	Deploy Query and API functionality in CDR	Q4	On Track	Adding CDR Functions/ Quality
9-04	0	7/2/18	12/31/19	Data Quality Improvement Efforts	Q4	On Track	Adding CDR Functions/ Quality
9-05	100	4/1/19	6/28/19	PAMI+ Report for Healthcare Providers	Q3	Complete	Adding CDR Functions/ Quality

Task number	% complete	Start date	Due date	Name	Year/quarter end date	Status	Category
9-06	0	4/1/19	9/30/19	Design/Develop Smart Form Use Cases.	Q3	On Track	Adding CDR Functions/ Quality
9-07	25	4/1/19	9/30/19	SDOH data and CDR	Q3	On Track	Adding CDR Functions/ Quality
9-08	0	7/1/19	12/31/20	Develop Standardized Shared Care Management Tools/Functions	2020	On Track	Adding CDR Functions/ Quality
9-09	25	4/2/18	6/30/20	Develop Standardized Discharge Summary	2020	On Track	Adding CDR Functions/ Quality
9-10	0	1/2/19	12/31/19	Medication Prior Authorization	Q4	On Track	Adding CDR Functions/ Quality
9-11	100	7/2/18	9/30/19	Increase DDA Client Data in CDR	Q2	Complete	Adding CDR Functions/ Quality
10-01	100	4/2/18	12/31/19	Have conversations with Tribes about Exchanging Health Information	Q4	Complete	Tribal Engagement
10-02	50	4/2/18	12/31/19	Assist Tribes exploring EHR replacement and system integration	Q2	On Track	Tribal Engagement
10-03	0	7/1/19	12/31/19	Support Tribal Adoption of CDR	Q4	On Track	Tribal Engagement
11-01	50	1/3/11	9/29/23	Administer EHR Incentive Project	2023	On Track	EHRs
12-01	100	1/2/19	3/29/19	BH providers' EHR/CEHRT adoption	Q1	Complete	Behavioral Health Integration
12-02	100	4/1/19	6/28/19	SUPPORT Act: EHR Incentive Payments to BH providers	Q2	Closed	Behavioral Health Integration
12-03	25	4/1/19	12/31/19	Technical Assistance to BH Providers on CEHRT adoption and use	Q4	On Track	Behavioral Health Integration
12-04	50	1/2/19	12/31/20	Develop and Maintain a Financial Map of Funds for BH HIT/HIE	2020	On Track	Behavioral Health Integration

Task number	% complete	Start date	Due date	Name	Year/quarter end date	Status	Category
12-05	75	4/1/19	9/30/19	Streamline SAMHSA Reporting	Q2	On Track	Behavioral Health Integration
13-01	100	1/2/19	6/28/19	Guidance on complying with 42 CFR Part 2	Q2	On Track	Substance Use Disorder Health IT
13-02	0	4/1/19	12/31/21	eConsent Management Tool	2021	On Track	Substance Use Disorder Health IT
14-01	100	10/1/18	3/31/19	A. Financial map for SUD HIT Plan	2019	On Track	SUD HIT Plan and PDMP Enhancements
14-02	75	4/1/19	6/30/20	B. Enhanced interstate data sharing in order to better track patient specific prescription data	2019	On Track	SUD HIT Plan and PDMP Enhancements
14-03		7/1/19	6/30/20	C. Enhanced "ease of use" for prescribers and other state and federal stakeholders	2019	On Track	SUD HIT Plan and PDMP Enhancements
14-04		7/1/19	6/30/21	D. Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange (Timeline 24+ months)	2019	On Track	SUD HIT Plan and PDMP Enhancements
14-05		7/1/19	6/30/20	E. Enhance identification of long-term opioid use correlated to clinician prescribing patterns	2019	On Track	SUD HIT Plan and PDMP Enhancements
14-06		1/1/19	12/31/19	G. Develop enhanced provider workflow / business processes to better support clinicians' access to the PDMP prior to prescribing an opioid or other controlled substance (Timeline: 12 months)	2019	On Track	SUD HIT Plan and PDMP Enhancements
14-07		1/1/20	12/31/21	H: Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions through the PMP— prior to the issuance of an opioid prescription (Timeline: 24+ months)	2020	On Track	SUD HIT Plan and PDMP Enhancements
14-08		7/1/19	6/30/20	F. Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query)	2019	On Track	SUD HIT Plan and PDMP Enhancements
14-09		7/1/19	6/30/20	I: Enhance MPI (or master data management service, etc.) in support of SUD care delivery	2019	On Track	SUD HIT Plan and PDMP Enhancements

Attachment D: IEE Rapid-Cycle Report

Healthier Washington Medicaid Transformation evaluation

Rapid-Cycle Report

June 28, 2019

CENTER FOR HEALTH SYSTEMS EFFECTIVENESS

Prepared for:
Washington State Health Care Authority

OHSU

JUNE 28, 2019

Healthier Washington Medicaid Transformation Rapid-Cycle Report

Overview

This report covers activities from CHSE's evaluation of Washington's Medicaid Transformation Project (MTP) from April 1 to June 30, 2019. In this period, CHSE completed the first round of interviews with key informants from Washington State agencies. In addition, we began recruiting and conducting interviews with key informants from Washington State's accountable communities of health (ACHs), and made progress on initiating administrative data analysis and provider organization surveys.

Following a summary of our accomplishments in this period, this report summarizes findings from the first round of state agency key informant interviews.

▶ KEY FINDINGS:

- *Previous initiatives and legislation in Washington provided a foundation for MTP and health system reform efforts.*
- *Managed care organizations are meeting value-based payment (VBP) goals but providers, especially smaller provider organizations, need more support to adopt VBP models.*
- *MTP has encouraged a coordinated approach to addressing workforce capacity in the state, and state administrators are considering various strategies to enhance training and address workforce shortages.*
- *More support is needed from the state to enhance population health management and the use of health information technology (HIT) and health information exchange (HIE). Many HIT and HIE tools exist and are being used, which poses challenges to information exchange and interoperability.*
- *Long-Term Supports and Services (LTSS) is showing promise and leverages the state's history and experience in addressing long-term needs. LTSS remains somewhat separated from the other MTP activities, and alignment with the other initiatives may support the success of this program and the state's vision.*
- *Foundational Community Services (FCS) has roots in legislative direction, and MTP provided a way to fund this work. FCS is using evidence-based models to deliver the benefits and Division of Behavioral Health and Recovery is monitoring the model fidelity. Beneficiaries are able to access FCS benefits from multiple points of access to improve reach to those who need services. Partners involved in FCS, which are generally community-serving or community-based organizations, had little experience with Medicaid and its billing structures. With no planning phase, there was a steep learning curve to deliver these benefits. Lack of available housing limits the ability to help beneficiaries find and keep housing using FCS benefits, which in turn limits the capacity to properly staff employees to provide the housing benefits.*

Accomplishments

Foundational Tasks

CHSE submitted a study amendment request to the Washington State Institutional Review Board (WSIRB) for additional administrative data needed to carry out the evaluation, and received approval for the request from WSIRB. In addition, CHSE amended its data confidentiality agreement to use the additional data with assistance from WSIRB.

Key Informant Interviews

The qualitative team completed the first round of interviews with key informants from Washington State agencies, including the Health Care Authority (HCA) and the Department of Social and Health Services (DSHS), and began analyzing data from the interviews. In addition, the qualitative team began recruiting key informants from ACHs, and conducted initial site visits with three ACHs. Site visits enable the qualitative team to collect preliminary information about an ACH and schedule follow-up interviews with ACH staff and stakeholders. The qualitative team will continue to recruit and conduct interviews through fall 2019.

Administrative Data Analysis

Following WSIRB approval for use of additional administrative data and amendment of the confidentiality agreement, the quantitative team received the data and began organizing the data into an evaluation database. Within the next three months, the quantitative team will begin using these data to analyze trends in performance metrics for ACH regions and subgroups of Medicaid members, and to identify the target populations of ACHs' health improvement projects in order to evaluate the impact of these projects.

Primary Care Practice and Hospital Surveys

CHSE completed pilot testing of the surveys at four sites, including two primary care practices and two hospitals in Washington State. Using feedback from pilot testing, we revised the surveys and prepared web versions for final review and approval by HCA and DSHS. In addition, we received lists of Washington State primary care practices and hospitals from the Washington All Payer Claims Database that we will use to administer the surveys and began finalizing our methodology for creating the sample of primary care practices to survey. Using information from the list, we began contacting hospitals to identify staff who should receive the survey. We anticipate beginning to contact staff at primary care practices in August, after creating the practice sample. We plan to use ACHs' partnering provider rosters submitted in July to ensure that our sample contains a sufficient number of practices working with ACHs on health improvement projects.

Findings from Key Informant Interviews

Overview

This report summarizes findings from Round 1 interviews with 14 state agency key informants who have knowledge of and experience with MTP. The report will cover our qualitative methodology and provide a narrative summary that begins to address the following evaluation research aims:

- Aim 1: Assess overall Medicaid system performance
- Aim 2: Assess progress toward meeting value-based payment (VBP) targets
- Aim 3: Assess the impact of MTP on workforce capacity needed to support health system transformation
- Aim 4: Assess the impact of MTP on the adoption and use of health information technology (HIT)
- Aim 6: Assess implementation and impact of Initiative 2, Long-Term Services and Supports (LTSS)
- Aim 7: Assess implementation and impact of Initiative 3, Foundational Community Supports (FCS)

Methods

We consulted the Washington State Health Care Authority (HCA) to develop an initial list of key informants and their contact information. We aimed to select people across diverse departments and with a range of perspectives. As part of each interview, we asked interviewees to recommend other experts we should talk with for a deeper understanding of issues or a different perspective. We used an iterative sampling strategy to achieve a maximum variation sample. Our team moved between selecting some key informants for interviews, conducting interviews and analyzing the data, and then using insights from interviews to inform subsequent sample selection. The process of moving between selection, data collection, and analysis helped ensure that a full range of ideas and perspectives surfaced.

Semi-structured interviews with 14 key stakeholders were conducted between January and April, 2019. Interviews were approximately one hour and were conducted using video software or over the phone. During the interviews participants shared their perspectives on state priorities and MTP efforts. We explored influential state policy, contextual history, and vision for MTP, which provided context for Aim 1. The topic areas of VBP, workforce capacity, HIT, data analytics, LTSS, and FCS informed our understanding of the other aims.

Interviews were professionally transcribed, and transcripts were de-identified and entered into Atlas.ti (Version 8, Atlas.ti Scientific Software Development GmbH, Berlin, Germany) for data management and analysis. Data were analyzed using an immersion-crystallization approach. The qualitative team reviewed the data together and built a code list. Team members listened to the audio recordings, read the transcripts, and met weekly as a group to discuss emerging findings. Then team members reviewed the collected text that was tagged with specific codes, identified patterns, and summarized the high-level findings below.

Aim 1: Assess Overall Medicaid System Performance

Through interviews, we identified initial conditions that were in place in Washington prior to the start of MTP. Previous initiatives and changes to the state's organizational structure informed the state administrators' approach to MTP, provided contextual information important for understanding the region at baseline, and will inform our understanding of performance changes over time.

Previous Initiatives: Washington Did Not Start from Scratch

Prior to MTP, Washington State enacted Healthier Washington, a statewide initiative focused on health care transformation and improving population health. Through Healthier Washington and other efforts (grants, legislative action, and advocacy), several organizations and state staff were already implementing changes to foster whole-person care, aging in place, and supportive employment and housing. Heathier Washington set the stage for the state's focus on health care transformation in the state. The $65 million State Innovation Model (SIM) grant from the Center for Medicare and Medicaid Innovation (CMMI) was especially influential, as it was used to develop the Accountable Communities of Health (ACHs), conduct the Regional Health Needs Inventory to assist data-informed decision making, and help launch alternative payment models in regions of the state. The legislative mandate to fully integrate behavioral and physical health by 2020 was also critical for signaling the state's prioritization of integrated care. Key informants described MTP as a funding source, but also as a catalyst that energized and continued existing efforts and demonstrated to the legislature that these programs were worthwhile and effective.

"[SIM] … became the seeds for the Medicaid transformation work." (State Participant 11).

Through legislative direction, the Department of Social and Human Services (DSHS) and HCA underwent an organizational restructure. The Division of Behavioral Health and Recovery (DBHR), which was formerly under DSHS, moved to the HCA. Medicaid purchasing was previously transferred from DSHS to the HCA in 2011, consolidating the state's purchasing power. MTP required leaders across multiple departments (HCA, DSHS, and the Department of Health) to work together. The multi-agency initiative and state reorganization were foundational steps in working toward the state's vision of integrating behavioral health and providing whole-person care. State interviewees anticipate that legislative direction will continue to play a role in sustaining and supporting MTP.

Aim 2: Assess Progress Toward Meeting VBP Penetration Targets

Managed Care Organizations (MCOs) are Meeting VBP Goals

Under SIM, HCA established contractual arrangements with MCOs and began incentivizing VBP adoption through an annual withhold program that continued with MTP. Performance measures were informed by the Health Care Payment and Learning Action Network (HCP-LAN) Alternative Payment Model framework. MTP requires that 90 percent of dollars paid by MCOs to providers be paid through VBP arrangements that meet the HCP-LAN categorization of 2C (i.e., Rewards for Performance) or higher by 2021. Interviews with state-level staff revealed that MCOs were essential to VBP adoption. One interviewee reported that in 2017, MCO performance or adoption was approximately 30 percent, 10 percent higher than the anticipated target, and the adoption rate was about 50 percent, which also outpaced HCA's annual goals.

Providers Need More Support

Interviews suggest that while MCOs are exceeding targets for VBP adoption, providers, particularly smaller providers (including behavioral health providers), need more resources to assume the risks of VBP adoption (i.e., billing, contracting, and establishing VBP arrangements with MCOs). Larger providers are more apt to have greater resources and greater capacity to implement change and assume risk. These providers tend to be the first ones to contract with MCOs, but they are insufficient for meeting the 90 percent goal. While the HCA has begun to develop VBP technical assistance support for providers, the support offered is limited, according to interviews. Additional VBP support may be offered through the ACHs, which we will continue to explore in our upcoming ACH site visits.

> *"We haven't really provided a lot [of support to providers]. We're exploring a lot of, how could we support—what are the needs, but even if we mapped [it] out, here's everything that's needed, we don't currently have the resources or capacity identified to fulfill that." (State Participant 7)*

Aim 3: Assess the Impact of MTP on the Development of the Workforce Capacity Needed to Support Health System Transformation

Medicaid Transformation Elicits a Coordinated Approach to Workforce Development

Prior to SIM and MTP, the state lacked coordination around workforce issues. The SIM demonstration provided an opportunity for the state to coordinate efforts across stakeholders. HCA established the Washington Health Workforce Sentinel Network (Sentinel Network), which included HCA, the state's Workforce Training and Education Coordinating Board, and the University of Washington Center for Health Workforce Studies.

Since MTP began, the state has formed a number of partnerships in the region, especially through the Health Workforce Council, which is comprised of people from professional associations, including the Hospital Association, the Medical Association and the Nurses Association. Through these partnerships, Washington is pursuing opportunities to address workforce shortages across the state and create opportunities for education, training and career development. We will continue to follow these efforts, as most of the state's work has focused on convening and engaging stakeholders, and the opportunities described below are only considerations.

> *"The health workforce activities here tend to be focused through an entity called the Health Workforce Council. It…develop[s] clear pathways and act[s] on priorities to address what was originally termed in the legislation as shortages, but we are trying to get it expanded to say health professions, so we can be broader in refining what people do and refining competencies." (State Participant 8)*

The State is Pursuing Various Opportunities to Enhance Training and Address Demand and Shortages

HCA aims to build workforce capacity during MTP by recruiting and retaining health professionals at various levels, from paraprofessionals to nurses and physicians. There are a number of initiatives under consideration, including loan repayment, scholarship opportunities, alternative career pathways (i.e., apprenticeships), and rural health recruitment.

The state is exploring workforce reciprocity and enhancing the role of paraprofessionals to address workforce shortages. With workforce reciprocity, the state would enter into reciprocal agreements with other states to hire health professionals with an out-of-state licensure. Recent proposed legislation to join the Nursing Licensure Compact failed due to concerns about the changes to time requirements for gaining state nursing licensure. Workforce reciprocity also has implications for providing telehealth services to rural and underserved communities, and this approach will likely return to future legislative sessions.

"We knew there was a growth of paraprofessional roles, medical assistants, a growing demand for community health worker kinds of roles, use of peer support specialists in behavioral health, but there was no real structure to look at education training." (State Participant 8)

Paraprofessionals (i.e., community health workers, peer counselors) were also identified as a solution to the workforce shortages; however, these roles lack standardized education and training. Establishing standards, consistency, and a set of skills and competencies that are focused on team-based care may be needed in order to thoughtfully deploy this group of individuals into the workforce.

Aim 4: Assess the Impact of MTP on Provider Adoption and Use of Health Information Technology

The State Plays a Critical Role in Improving and Promoting Consistency in Tools for Information Exchange and Population Health Management Capacity

Providers across the state use a variety of different electronic health record (EHR) and information exchange tools, including EDIE, PreManage, CommonWell, and Carequality. However, these tools are not used consistently across regions, and more work is needed to increase their use and create alignment. The state's investments in the Clinical Data Repository (CDR), which aims to connect disparate EHR platforms and aggregates clinical information in one location, may facilitate greater use of these data. However, at this time, the CDR is not mature enough to generate aggregate clinical data to support the ACHs with their population health management needs.

ACHs have developed plans for supporting information exchange and monitoring the heath of their populations, but some may additional support to develop greater analytic capacity and sophistication. Some analytic support is currently provided by HCA, DSHS, and Providence CORE. HCA also reviewed ACH implementation plans in an effort to their need around population health management and information exchange. However, interviewees suggested that the state could play a greater role in guiding the ACHs and addressing data gaps, as population health data gaps have the potential to pose risks in the ability to evaluate which efforts are effective.

"As the ACHs were maturing and creating their own data teams, we were very proactive in connecting with their data teams. We actually stepped up biweekly meetings with their data teams. We started to hear from them either direct data requests or in conversations." (State Participant 11).

Aim Six: Assess implementation and impact of Initiative 2, Long-Term Services and Supports

LTSS Leverages Previous Programs and Shows Promising Improvements

Compared to other states, Washington has as long history of emphasizing home and community- based services as part of its long-term care approach. This includes the Family Caregiver Program, which began prior to MTP and had limited funding. The Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) programs were intended to expand the Family Caregiver Program, and through the TSOA program, target individuals who were not financially eligible for Medicaid and prevent them from spending down their assets in order to access Medicaid-funded long-term care services. Interviewees reported that these programs are showing promising reductions in cost and emergency department utilization rates. We will evaluate change in these and other outcomes associated with LTSS as part of our quantitative evaluation of MTP.

Reaching Caregivers is Challenging

Despite high demand and referrals for services, interviewees shared challenges reaching unpaid family caregivers because these individuals often do not identify as a caregiver or may not be accustomed to seeking services and help. Interviewees believe there are more eligible caregivers who have not yet engaged and enrolled in the programs. Another unanticipated outcome is that MAC and TSOA outreach efforts have increased reach and connected the Area Agencies on Aging to individuals who may benefit from LTSS programs other than MAC and TSOA.

"It's hard to help people even realize that they are a caregiver to people. They have roles. 'I'm a mom.' 'I'm a sister.' 'I should be doing this.' [We are] helping people to see that it's okay to accept help, and it can actually help them be healthier, be a better caregiver, and be better in that role." (State Participant 3)

Aligning LTSS with Other MTP Initiatives May Support the State's Broader Goals

TSOA and MAC appear separate from the other initiatives. Exclusion of dually-eligible beneficiaries from the target population for Initiative 1 may be driving this separation. Dually-eligible and Medicare beneficiaries represent a significant proportion of the LTSS-eligible population. LTSS is also paid using fee-for-service models, which may further isolate it from Initiative 1, which emphasizes value-based payment models. The growing aging population has ramifications for workforce needs, health care costs and emergency department utilization, so expanding alignment efforts across the initiatives may be beneficial and help support the state's broader goals.

Aim Seven: Assess Implementation and Impact of Initiative 3, Foundational Community Supports

Legislation Directed the Foundational Community Supports Program

Foundational Community Supports (FCS) are a set of Medicaid benefits which aim to help individuals with complex health needs obtain and maintain housing and employment stability. Prior to MTP, the legislature directed the DBHR to begin measuring homelessness and employment among the behavioral health population. A subsequent bill directed implementation of supportive housing and supported employment services and the use of evidence-based promising practices for achieving those outcomes. While these bills provided legislative direction to implement these services, it did not include funding to pay for additional services, and DBHR applied for the 1115 waiver to implement these services.

FCS is using Evidence-Based Models and DBHR is Monitoring Fidelity

The models for supported employment and supportive housing are based on evidence-based programs that were recommended by Washington State Institute for Public Policy (WSIPP), and the state has leveraged formal toolkits for these programs that were developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). DBHR's current role is to oversee the program and ensure quality assurance and fidelity to the evidence-based models.

Beneficiaries Can Access Services Through Multiple Pathways

Beneficiaries can enroll in FCS programs through a variety of health care and community serving providers in the region. Amerigroup, the third-party administrator, is currently contracted with over 100 agencies with more than 300 sites across the state. FCS providers are paid using a fee-for-service billing infrastructure, and all FCS providers must be credentialed Medicaid providers.

Partners Experienced a Steep Learning Curve

Several FCS provider organizations are community-serving organizations that had little experience with the health care system and had never contracted with Medicaid prior to this program. These organizations needed additional support and assistance with contracting, understanding benefit rules and regulations, and developing a fee-for-service billing infrastructure. There was little time to plan for implementation, and these community serving organizations encountered a steep learning curve as they built the infrastructure to provide and bill for these services.

Housing Availability Impacts Enrollment and Staffing Structure

Interviewees reported that enrollment in supportive employment has been higher than supportive housing. This may be related to limited housing availability that is needed to accompany the supportive housing benefit, as FCS does not create more affordable housing or pay for housing infrastructure that is needed to successfully house an individual. Interviews described an ongoing need for partnerships, especially with the Department of Commerce, as they are critical partners in creating affordable housing that's needed to pair with the supportive housing FCS benefit.

"We can provide the services to pay for or to help somebody obtain and maintain that housing, but we still need the subsidies to be able to pay the rent. We've developed a strong relationship with the Department of Commerce, but they really actually need the funds to be able to pay those rents. That's been some focus of the legislature this year." (State Participant 2)

The lack of affordable housing availability also impacts organizations' ability to staff individuals to provide the supportive housing benefit. For example, if an organization only has two housing openings a month, and a caseload of two FCS beneficiaries, then the revenue generated from those two cases is not enough to sustain a staff member, requiring organizations to pay for those positions through philanthropic dollars or other resources.

Next Steps

The qualitative team has begun recruiting and conducting interviews with the ACHs. Each site visit to an ACH begins with an informal call with the Executive Director or Chief Executive Officer of the ACH to discuss the logistics of our visit and allow an opportunity for us to learn more about the ACH. During this call, we also cover recommendations on who we should interview to cover topics related to our research questions. We plan on conducting approximately three to six in-person interviews with each ACH and will continue to recruit and conduct interviews through the fall of 2019.