Washington State Medicaid Transformation Project (MTP) demonstration
Section 1115 Waiver Quarterly Report (DY5 Q1)
Demonstration Year: 5 (January 1 to December 31, 2021)
Reporting Quarter: 1 (January 1 to March 31, 2021)

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Introduction

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

Over the five-year MTP period, Washington will:

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

The state will accomplish these goals through these programs:

- Transformation through Accountable Communities of Health (ACHs) Indian Health Care Providers (IHCPs)
- Long-Term Services and Supports (LTSS): Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA).
- Foundational Community Supports (FCS): Community Support Services (CSS) and Supported Employment – Individual Placement and Support (IPS).
- SUD IMD waiver: treatment services, including short-term services provided in residential and inpatient treatment setting that qualify as an institution for mental disease (IMD).
- Mental health (MH) IMD waiver: treatment Services, including short-term services provided in residential and inpatient treatment settings that qualify as an IMD.

Vision: a healthier Washington

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

Quarterly report: January 1–March 31, 2021

This quarterly report summarizes MTP activities from the first quarter of 2021: January 1 through March 31. It details MTP implementation, including stakeholder education and engagement, planning and implementation, and development of policies and procedures.

Summary of quarter accomplishments

- The state continues to await CMS' feedback on the one-year extension request. In anticipation of approval, the state continues to work on a longer-term renewal request. Submission of the longer-term renewal request is scheduled for the end of 2021, one year ahead of the expiration (pending approval of the one-year extension), as required by the special terms and conditions (STCs).
- During the reporting quarter, ACHs distributed more than $17.7 million to 269 partnering providers and organizations in support of project planning and implementation activities. The state distributed approximately $1.1 million in earned incentives to IHCPs in Q1 for achievement of IHCP-specific project milestones. In addition, seven of the nine ACH regions achieved the VBP adoption target for 2019 of 75 percent.
- HCA, in partnership with the Department of Social and Health Services (DSHS), submitted a one-year extension request and an MTP amendment request in early January 2021. The activities leading up to this submission were detailed in the 2020 Annual Report.
- New enrollees in LTSS for this reporting period: 35 MAC dyads, 323 TSOA dyads, and 525 TSOA individuals.
- Within FCS, the total aggregate number of people enrolled in services at the end of demonstration year (DY) 4 and quarter (Q) 4 includes 5,554 in IPS and 6,931 in CSS. The total unduplicated number of enrollments at the end of this reporting period was 10,338.
- The SUD and MH programs continued implementation efforts during the reporting quarter. The state continued working on the MH program monitoring protocol, including coordination with managed care organizations (MCOs) regarding the proposed metrics.

MTP-wide stakeholder engagement

During the reporting period, HCA moved all non-MTP-related content and webpages out of the Healthier Washington section of the HCA website and renamed it "Medicaid Transformation Project (MTP)." All content on this section focuses on MTP efforts, including:

- The one-year extension and amendment request.
- All five MTP initiatives.
- Individual pages for each ACH.
- Reports, news, events, and resources.
- How HCA tracks and measures success and works with partners.

View the MTP website section and read the announcement for more information. Throughout the remainder of this year, HCA will continue to update the remaining fact sheets, FAQs, and other documents that are posted online.

Statewide activities and accountability

Value-based purchasing (VBP)

New VBP website section

During the reporting quarter, HCA created a dedicated website section for VBP. This new section includes information about:

- VBP and value-based payment.
- How the state is advancing VBP through various activities, such as alternative payment models, contracting requirements, and more.
- How the VBP Roadmap and Apple Health Appendix are guiding the state's VBP efforts.
- How HCA tracks success through the annual Paying for Value surveys and works with partners.

Visit the VBP website section and read the announcement for more information.

VBP Roadmap and Apple Health Appendix

The VBP Roadmap describes HCA's VBP goals, purchasing and delivery system transformation strategies, innovation successes to date, and plans to accelerate the transition into value-based payment models. The appendix, in accordance with the STCs, describes how MTP supports providers and MCOs to move along the value-based care continuum. The roadmap establishes targets for VBP attainment and related Delivery System Reform Inventive Payment (DSRIP) incentives for MCOs and ACHs. HCA will update the roadmap and Apple Health Appendix in Q3 of DY5.

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 functions as the third-party assessor (TPA) of financial measures data submitted by MCOs as part of their contracts with HCA. HCA's contracts with the five MCOs established parameters for the VBP assessment process. The parameters include the financial performance measures, the timelines under which MCOs must submit data, and the review process (which includes third-party validation).

The IA completed validation of statewide and regional financial measure data submitted by MCOs in 2020. This accorded with the terms of MCO contracts with HCA. HCA began preparing for the VBP validation process in Q1 of 2021. This included scheduling check-ins with the IA for early Q2 to review lessons learned and begin preparations for the 2021 validation process. Next steps include updating the MCO templates, determining the sampling of provider contracts for each MCO, and creating a brief narrative for each MCO to complete summarizing activities done to achieve the performance targets.

Statewide progress toward VBP targets

HCA sets annual VBP adoptions targets for MCOs and ACH regions in alignment with HCA's state-financed purchasing goals. To track progress, HCA collects financial performance measure data from MCOs by ACH region through the VBP validation process and from commercial and Medicare payers and providers through an annual survey. HCA completed the analysis of this data in Q4 of 2020 and presented findings through a webinar in Q1 of 2021. HCA published a slide deck detailing results to the VBP webpage on HCA's website in Q1 of 2021.

Technical support and training

No updates for this reporting period.

Upcoming activities

HCA will begin preparations for the 2021 VBP validation and survey processes in Q2 of 2021.

Integrated managed care (IMC) progress

In 2014, state legislation directed a transition to integrate the purchasing of medical and behavioral health services for Apple Health (Medicaid) clients through an IMC system no later than January 1, 2020. Below are IMC-related activities for Q1.

- As directed by Senate Bill (SB) 6312, statewide integration was achieved in January 2020.
- With the support of ACHs, HCA continues to support behavioral health providers in their transition to managed care.
- Stabilizing the behavioral health provider network has continued to be a challenge because of the COVID-19 pandemic. Behavioral health workforce gaps have been of concern and ACHs have been exploring or implementing strategies to mitigate these issues.
- Since January 2021, HCA has focused attention in two areas specific to measuring clinical integration and bi-directional care, with the assistance of most of the ACHs around the state. During this reporting period:
    - HCA launched a short-term behavioral health performance measure project, which includes a series of regional provider meetings supported by the ACHs in most regions. These provider meetings included a presentation of behavioral health performance measures and a short survey. Most ACHs have participated in interviews for this project. Comagine Health (HCA's external quality review organization) will report out on this project at the end of June 2021.
    - An additional short-term project this quarter is a study of new clinical integration assessment methods. The ACHs and MCOs have worked together to identify a new set of assessment tools for pilot testing among several providers. The project also explores methods of collecting clinical integration progress from providers. This project will also include a report by the end of June 2021.

Health information technology (HIT)

The HIT Operational Plan is composed of actionable deliverables to advance HIT goals and vision articulated in the HIT Strategic Roadmap. This work supports the MTP work in the state. The HIT Strategic Roadmap and HIT Operational Plan focuses on three phases of transformation work: design, implementation and operations, and assessment. In the fall of 2020, HCA led months of conversations that resulted in identifying tasks for the 2021 HIT Operational Plan. These activities include 42 deliverables and tasks in areas including:

- Electronic health records (EHRs)
- MH IMD waiver
- SUD HIT Plan and Prescription Drug Monitoring Program (PDMP) enhancements
- Master Person Index (MPI)
- Provider directory
- Payment models and sources
- Data and governance
- Health information exchange (HIE) functionality
- Registries
- Clinical Data Repository (CDR)
- Tribal engagement

To view the 2021 HIT Operational Plan and other related reports, visit the Medicaid HIT Plan page.

Activities and successes

The HIT team spent much of the first quarter of 2021 continuing its focus on advancing multi-year initiatives involving HIT. During the past quarter, the state:

- Advanced its work with the CDR.
- Began implementation of a Master Person Index (MPI) to support the Department of Health (DOH)'s COVID-19 pandemic response, while continuing to plan activities for the Coalition MPI project. DOH efforts included contracting with Verato to provide MPI services. The Health and Human Services (HHS) Coalition agencies (DSHS, Department of Children, Youth, and Families (DCYF), DOH, Washington Health Benefit Exchange (HBE) and HCA) also reviewed Verato's functionality to determine whether it could meet the Coalition's MPI requirements.
- The HIT section presented an update on SDoH collection and activities in the state.
- HCA released a request for information for an e-consent management solution. This solution would support sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations.
- Continued coordination with ACHs and MCOs to support MTP activities in regions and plans across the state, including the use of HIT.
- Coordinated internally within HCA and DOH to support implementation of the HIT Plan requirements related to the PDMP and related requirements using funds made available through the Partnership Act/SUPPORT Act.
- Awarded three short-term contracts in support of the HIT requirements in the MH IMD waiver:
    - Telehealth: HCA contracted with the Behavioral Health Institute (BHI) to gather information from behavioral health and physical health providers, and others regarding how they are collecting and using SDoH data prior to and since the COVID-19 pandemic. This includes how the use of telehealth-delivered services and other technologies allow practices to gather and use SDoH data.
    - Closed loop referrals and e-referrals: HCA contracted with Comagine Health to gather information from behavioral health and physical health providers, ACHs and MCOs regarding factors that may be contributing to changes in key behavioral health performance measures (e.g., follow-up after in-patient hospitalization or emergency department (ED) visits for mental illness, MH treatment penetration rates for children with MH needs). Information gathered included the role HIT has in supporting transitions and referrals in care.
    - HIT to advance care coordination: HCA contracted with HealthierHere ACH to pilot and start development of an initial strategic implementation framework for statewide implementation of the Clinical Integration Assessment Tool (CIAT). The CIAT is comprised of two parallel self-assessment tools: one for physical health providers and the other for behavioral health (including MH and SUD providers). The CIAT will allow providers to identify and report on their level of integration across eight domains and track progress along a continuum of integration. For example, higher levels of integration reflect the use of HIT to support information exchange (e.g., electronic referrals).

HCA has been working to identify areas within the health care system that do not have adequate HIT or HIE capacity. This includes beginning an environmental scan of providers' electronic health record capacity, identifying community information exchange activities underway across regions in the state, and developing an approach to facilitate Fast Healthcare Interoperability Resources-based information exchange.

HCA continued work to design systems to implement requirements in the CMS interoperability rules. HCA engaged a contractor to support the development of (i) a Patient Facing Application Programming Interface (API) and (ii) Provider Directory API.

HCA staff monitored and provided feedback on legislative and budget proposals under consideration by the state legislature for the state's 2022-2023 biennium budget, including proposals related to the use of HIT. The state's budget decisions will determine which HIT efforts can advance.

DSRIP program implementation accomplishments

ACH project milestone achievement

Semi-annual reporting

ACHs report on their MTP activities, project implementation, and progress on required milestones. This is outlined in the Project Toolkit. Semi-annual reports are submitted every six months. The most recent set of ACH semi-annual reports (SARs) was submitted on February 1, 2021, for the July 1–December 31, 2020, reporting period.

Next steps

HCA and ACHs are coordinating across the state on scale and sustain strategies. In alignment with the timeline and expectations contained in the Project Toolkit, the most recent SAR introduced scale and sustain reporting. This information continues to inform planning tied to the MTP one-year extension request, along with considerations tied to the potential transition of DSRIP and/or a longer-term renewal application.

Annual VBP milestone achievement by ACHs

ACHs help assess and support provider VBP readiness and practice transformation by connecting providers to training and resources. ACHs continue to use several strategies to support regional providers in the transition to VBP.

Seven of the nine ACH regions achieved the VBP adoption target for 2019 of 75 percent. HCA and ACHs reviewed past progress and began preparations for DY5 activities in Q1 of 2021. ACHs continue to engage providers and share feedback regarding opportunities for continued VBP advancement, including interest among behavioral health providers and rural providers.

Financial executor (FE) portal activity

ACHs continue to distribute incentive funds to partnering providers through the FE portal. During the reporting quarter, ACHs distributed more than $17.7 million to 269 partnering providers and organizations in support of project planning and implementation activities. The state distributed approximately $1.1 million in earned incentive funds to IHCPs in Q1 for achievement of IHCP-specific project milestones.

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

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

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

DSRIP measurement activities

2019 marked the first pay-for-performance (P4P) year for the ACHs to be awarded based on achievement toward regional performance outcomes. The results for DY3 (January 1–December 31, 2019) of MTP have

been completed by the IA and provided to HCA. In 2019, ACHs made progress on 19 of 30 measures. Eleven measures declined during this year. Not all P4P targets were met. An overview of the ACHs' performance results and incentives earned for DY3 can be found here.

2019 statewide results

After reviewing the state's 2019 report, CMS confirmed the state achieved 100 percent of the performance targets for statewide quality improvement and adoption of VBP. This means the maximum payment amount will be available to ACHs based on regional performance results.

The approved CMS report of the statewide accountability results are available on the HCA website.

DSRIP program stakeholder engagement activities

During the reporting period, HCA continued to host weekly Transformation Alignment Calls (TACs) with ACHs, state partners, and others. HCA continued sending a weekly ACH email summarizing COVID-19 related communications HCA has sent out, along with other announcements and information from DOH, the Office of the Governor, Department of Commerce, the Coronavirus.wa.gov website, and others. HCA also began a new meeting series with MCOs to discuss the continuation of delivery system reform activities, including topics such as social investment, addressing SDoH, and CIE.

DSRIP stakeholder concerns

No stakeholder concerns were reported during the reporting period in the context of DSRIP. ACHs continued to hear from providers on telehealth limitations, billing and rate questions, and other new operational challenges emerging during the COVID-19 pandemic. ACHs continue to provide a unique regional coordination and triaging role partners surrounding emerging issue identification and mitigation.

Upcoming DSRIP activities

HCA and DSHS Research and Data Analysis (RDA) Division are planning to update technical specifications based on new updates to metric requirements from National Committee for Quality Assurance (NCQA). These changes will impact several metrics.

HCA and ACHs began to refine and narrow the scope of planning efforts in the first quarter of 2021. Themes have emerged surrounding community information exchange (CIE) and community-based care coordination (CBCC). The goal of these efforts is to seek alignment across ACHs regarding continuation of CIE and CBCC, building upon lessons learned and successes to-date. These planning efforts will continue into the second quarter of 2021 with an emphasis on identifying core functions that must continue to support a person-centered care coordination approach.

Tribal project implementation activities

Primary milestone: over $1,100,00 was distributed directly to IHCPs.

Tribal partner engagement timeline

January 5: participated in development of HCA's interoperability strategy.

January 6: participated a meeting with Social Finance to discuss an American Indian (AI)/Alaska Native (AN)-specific Pay-for-Success model.

January 7: participated in a tribal relations update meeting with Better Health Together (BHT) ACH to discuss the future of their Tribal Partners Leadership Council (TPLC), as their tribal liaison took a new position with a different organization.

January 13: presented the Community Health Access and Rural Transformation (CHART) grant opportunity at the Monthly Tribal Meeting (MTM) hosted by HCA and DOH.

January 21: participated in an all-day workshop facilitated by McKinsey & Company Inc. to develop an interoperability strategy that encompasses consideration of compliance with CMS/Office of the National Coordinator (ONC) interoperability rules as well as looking beyond compliance to build an interoperability foundation that provides the greatest benefit to clients, providers, and the health care community as needs evolve.

January 26: participated in an interview performed by the independent external evaluator (IEE), Oregon Health Science University's Center for Health System Effectiveness (CHSE) for MTP evaluation.

February 5: participated in a Behavioral Health Aide (BHA) Advisory Workgroup.

February 8: internal meeting regarding overlapping EHR efforts.

February 10: participated in BHT TPLC monthly meeting.

February 17: participated in the North Sound ACH Tribal Learning Series: Exploring the Contemporary Meaning of 'Two Spirit'.

February 25: met with Seattle Indian Health Board regarding Traditional Indian Medicine.

March 5: participated in the BHA Advisory Workgroup.

March 8: participated in the ACH Executive Only TAC.

March 8: met with members of the MTP team to discuss sustainability.

March 16: participated in HCA's internal SAR review.

March 17: participated in BHT's TPLC monthly meeting.

March 18: participated in a meeting between BHT and Confederated Tribes of the Colville Reservation.

March 31: met with Gevity (consultants hired to conduct an EHR Readiness Assessment) about work done to date regarding EHRs with IHCPs.

LTSS implementation accomplishments

This section summarizes LTSS program development and implementation activities from January 1 through March 31, 2021. Key accomplishments for this quarter include:

- Submitted a 1115 waiver extension request to CMS requesting a sixth year for Initiative 2 of MTP due to impacts of the COVID-19 pandemic. This request was part of the larger request to extend MTP through December 31, 2022.
- Submitted a 1115 waiver amendment to CMS, including a request to modify the definition of transportation under Initiative 2 to include travel—not only to waiver services but also travel into the community. This change is meant to decrease social isolation and support community integration.
- Continued collaboration with Area Agencies on Aging (AAA) partners and home care agency providers for sustainability planning for programs and services.

Network adequacy for MAC and TSOA

AAAs report continued challenges in recruiting new vendors for some services due to hesitancy of using ProviderOne; the complexity of the state's Medicaid payment system; and no guarantee of client referrals. A shortage of agency caregivers for in-home services continues to be an issue during the pandemic. AAAs report that some home care agencies have wait lists for clients needing in-home caregivers for personal care and respite care services.

Assessment and systems update

No major modifications to the assessment process or electronic tool were made this quarter. DSHS Home and Community Services (HCS) program managers continue to work with case management staff to identify efficiencies for the tool.

Staff training

MAC and TSOA program managers for HCS remain committed to providing monthly statewide training webinars on requested and needed topics during 2021. A staff survey was completed in late December 2020 to solicit feedback and topics from case management and financial staff.

Webinar trainings:

- February:
    - Review of policy and functionality of TCARE assessments and care plans in GetCare system
    - Assisting clients to receive necessary Durable Medical Equipment (DME) – bathroom equipment
- March:
    - Managing service enrollments and authorizations for MTP services
    - Overview of new utilization incentive service code
    - Review of changes in GetCare system with Quality Assurance Unit in preparation for 2021 audit cycle

Upcoming webinars:

- April – MTP policy and assessment system: open Q&A session

- May – Completing presumptive eligibility assessments/determining nursing facility level of care

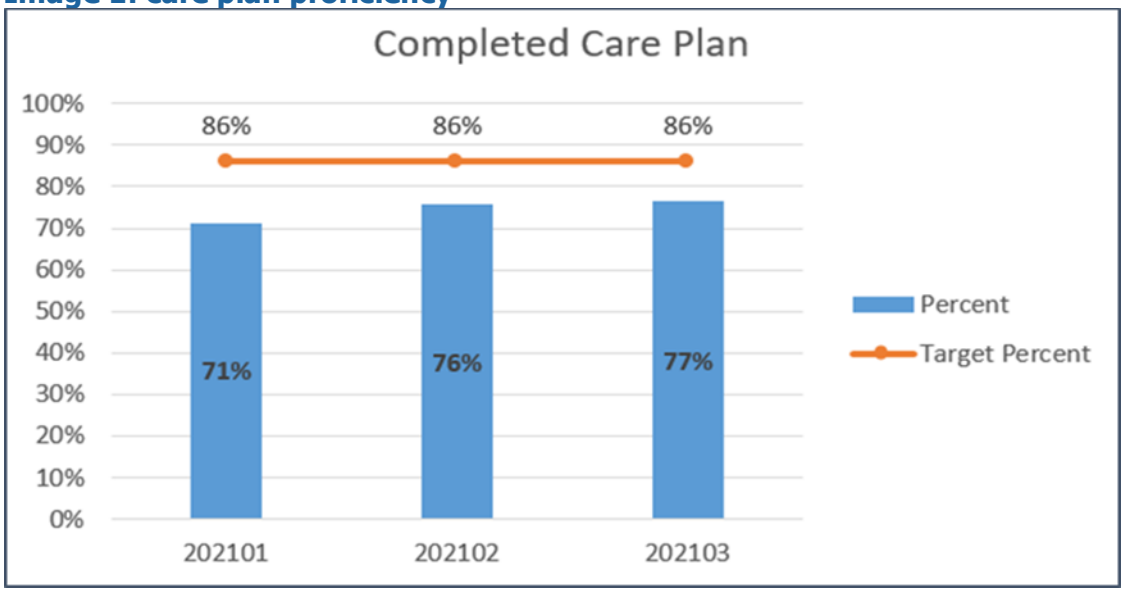
Data and reporting

Table 1: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of March 31, 2021	329	3279	6177
Number of new enrollees in quarter by program	35	323	525
Number of new person-centered service plans in quarter by program	*	*	177**
Number of beneficiaries self-directing services under employer authority	0	0	0

*Due to restructuring of the state's data report system, this information is currently unavailable. Updated information will be available in the next quarterly report.
**263 of the new enrollees do not require a care plan because they are still in the care planning phase and services have yet to be authorized.

Image 1: care plan proficiency



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

Tribal engagement

DSHS Aging and Long-Term Support Administration (ALTSA) continues to meet with tribes to discuss Medicaid services and Initiatives 2 and 3.

- February 8, 2021: ALTSA Region 1 HCS Office provided intake application packets, including MAC/TSOA information to the Yakama Nation.
- March 11, 2021: ALTSA Region 1 HCS Office, through the 7.01 planning meeting, reviewed and updated MAC/TSOA goals for the upcoming year.
- Created an outreach video for Tribal members. It will be unveiled and distributed at the Spring Tribal Summit in April.

Outreach and engagement

Outreach activities usually occur in a variety of settings, such as Community Resource Offices, community resource fairs, hospital social worker meetings, MCO virtual meetings, and virtual events at senior centers. Outreach activities continue to be virtual meetings and presentations as well as dissemination of program

publications/flyers. The volume and type of outreach activities are impacted by the COVID-19 pandemic and social distancing requirements. A few of the activities completed this quarter include:

- A new caregiver programs outreach flyer targeted specifically for senior meal sites and home-delivered meal vendors.
- A new virtual support group platform was used to create a support group targeted for unpaid family caregivers. The first session occurred during this quarter.

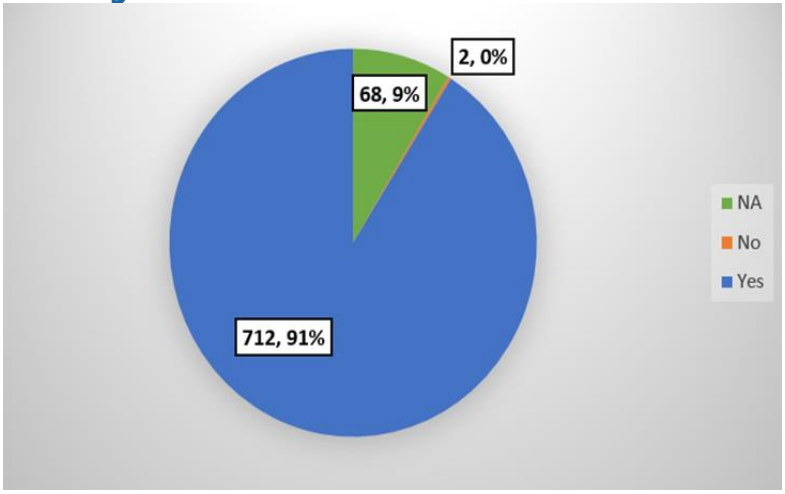
Table 2: outreach and engagement activities by AAA

	January	February	March
	Number of events held		
Community presentations and information sharing	16	17	7

Quality assurance

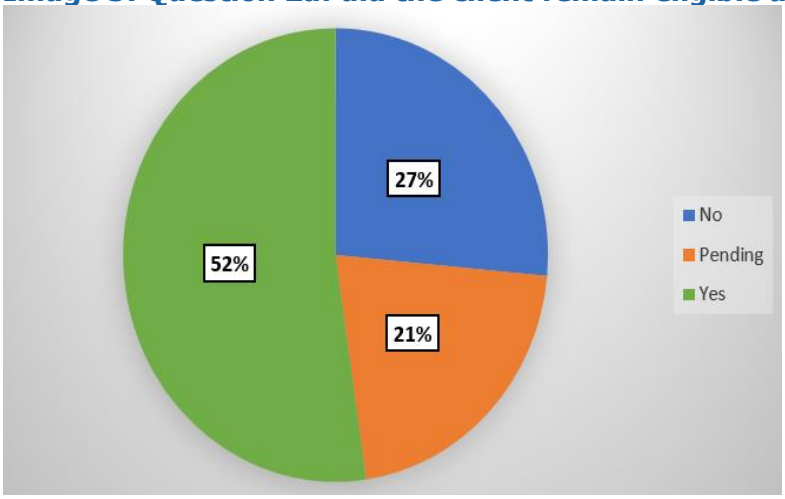
Results of the quarterly presumptive eligibility (PE) quality assurance review

Image 2: Question 1: was the client appropriately determined to be nursing facility level of care eligible for PE?



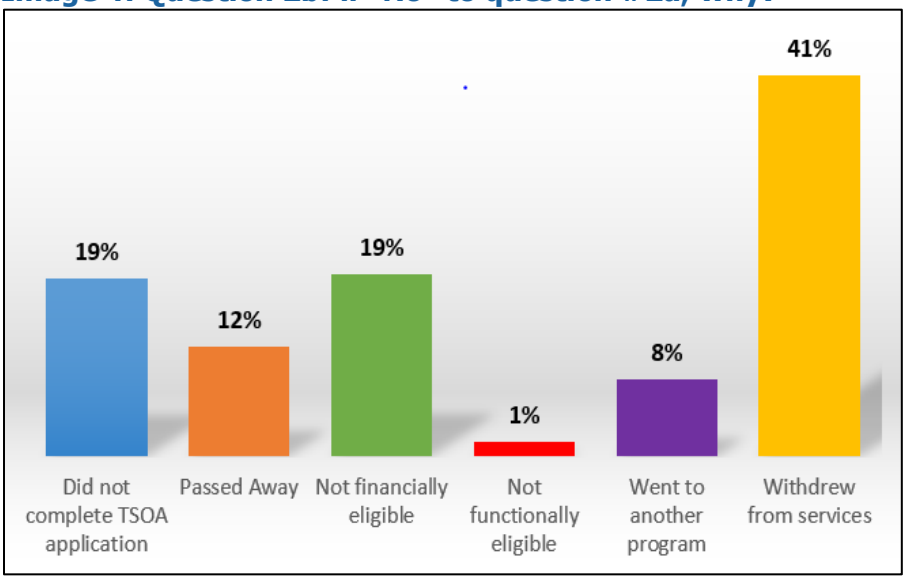
Note: The N/A represents clients who were part of the last quarter's review and the response to question #1 was "yes" but the response to question #2a was "pending".

Image 3: 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.

Image 4: Question 2b: if "No" to question #2a, why?



2021 quality assurance results to date

HCS' Quality Assurance unit began the 2021 audit cycle in April instead of January this year due to impacts of the COVID-19 pandemic. The audit cycle will conclude in October. Because of the late start of the audit cycle, there are no quality assurance results to report for the first quarter.

The statewide compliance review is conducted with all 13 AAAs. An identical review process is used in each AAA Planning and Service Area (PSA), using the same quality assurance tool and the same 19 questions (refer to the set of quality assurance questions). The quality assurance team reviews a statistically valid sample of case records. The sample size this year is 348 cases.

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

State rulemaking

There was no rulemaking activity during this quarter.

Upcoming activities

- Spring Tribal Summit will occur in April.
- Work begins in Q2 for moving HCS PE screening from CARE Production to HCS' new CARE Web system. Target date for completion is June 30, 2021.

LTSS stakeholder concerns

There were no stakeholder concerns submitted this quarter.

FCS implementation accomplishments

Initiative 3 provides evidence-based supportive housing and supported employment services to eligible Medicaid clients. This section summarizes the FCS program development and implementation activities from January 1 through March 31, 2021. Key accomplishments for the quarter include:

- Total aggregate number of people enrolled in FCS services at the end of DY5 Q1:
  - CSS: 6,931
  - IPS: 5,554
- There were 167 providers under contract with Amerigroup at the end of DY5 Q1, representing 461 sites throughout the state.

Note: CSS and IPS enrollment totals include 2,047 participants enrolled in both programs. The total unduplicated number of enrollments at the end of this reporting period was 10,338.

Network adequacy for FCS

Table 3: FCS provider network development

	January		February		March	
FCS service type	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
Supported Employment – Individual Placement Support (IPS)	39	83	39	81	39	78
Community Support Services (CSS)	18	44	18	44	18	44
CSS and IPS	105	331	110	339	110	339
Total	**162**	**458**	**167**	**464**	**167**	**461**

The number of contracted FCS providers grew overall in Q1 of 2021, including five new contracted providers serving individuals receiving both CSS and IPS services. Additional work by Division of Behavioral Health and Recovery (DBHR) training staff to onboard new providers focusing on FCS eligible populations with SUD is currently underway.

Additional incentives for new SUD providers to start FCS services will be made available in Washington through Substance Abuse and Mental Health Services Administration (SAMHSA) block grant funds in 2021. In addition to the 13 SUD agencies that either started IPS services or expanded their services in 2020, HCA intends to onboard eight new agencies in 2021 with these funds.

Client enrollment

Table 4: FCS client enrollment

	January	February	March
Supported Employment – Individual Placement and Support (IPS)	3,157	3,355	3,407
Community Support Services (CSS)	4,496	4,800	4,884
CSS and IPS	1,937	2,022	2,047
Total aggregate enrollment	**9,590**	**10,177**	**10,338**

Data source: RDA administrative reports

Table 5: FCS client risk profile

		Met HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
January	IPS	891 (17%)	.97	3.753 (74%)
	CSS	1.736 (27%)	1.32	4.392 (68%)
February	IPS	924 (17%)	.98	3.988 (74%)
	CSS	1.860 (27%)	1.32	4.685 (69%)
March	IPS	906 (17%)	.95	3.941 (72%)
	CSS	1.854 (27%)	1.27	4.608 (66%)

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

Table 6: FCS client risk profile, continued

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment needs flags
January	IPS	4,411	4,181 (95%)	2,779 (63%)	2,660 (60%)
	CSS	5,436	5,040 (93%)	4,084 (75%)	3,838 (71%)
February	IPS	4,656	4,392 (94%)	2,908 (62%)	2,771 (60%)
	CSS	5,760	5,303 (92%)	4,292 (75%)	4,006 (70%)
March	IPS	4,713	4,422 (94%)	2,902 (62%)	2,753 (58%)
	CSS	5,842	5,351 (92%)	4,314 (74%)	4,010 (69%)

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

Table 7: FCS client service utilization

		Medicaid only enrollees*	Long-term Services and Supports	Mental health services	SUD services (received in last 12 months)	Care + MH or SUD services
January	IPS	4,411	400 (9%)	3,495 (79%)	1,786 (40%)	366 (8%)
	CSS	5,436	680 (13%)	3,823 (70%)	2,443 (45%)	580 (11%)
February	IPS	4,656	432 (9%)	3,607 (77%)	1,829 (39%)	391 (8%)
	CSS	5,760	714 (12%)	3,924 (68%)	2,520 (44%)	598 (10%)
March	IPS	4,713	443 (9%)	3,554 (75%)	1,781 (38%)	402 (9%)
	CSS	5,842	726 (12%)	3,844 (66%)	2,481 (42%)	603 (10%)

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

Table 8: FCS client Medicaid eligibility

		CN blind/disabled (Medicaid only & full dual eligible)	CN aged (Medicaid only & full dual eligible)	CN family & pregnant woman	ACA expansion adults (nonadults presumptive)	Adults (nonadults presumptive) ACA expansion adults (SSI presumptive)	CN & CHIP children
January	IPS	1,384 (27%)	89 (2%)	633 (12%)	2,264 (44%)	597 (12%)	127 (2%)
	CSS	2,118 (33%)	292 (5%)	878 (14%)	2,094 (33%)	989 (15%)	62 (1%)
February	IPS	1,465 (27%)	94 (2%)	666 (12%)	2,401 (45%)	618 (11%)	133 (2%)
	CSS	2,218 (33%)	307 (5%)	926 (14%)	2,259 (33%)	1,050 (15%)	62 (1%)
March	IPS	1,491 (27%)	101 (2%)	669 (12%)	2,453 (45%)	606 (11%)	134 (2%)
	CSS	2,276 (33%)	317 (5%)	924 (13%)	2,301 (33%)	1047 (15%)	66 (1%)

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

Quality assurance and monitoring activity

FCS staff continued to work with the TPA to monitor the growth of the provider network and enrollments in the program. Enrollment in the FCS program continued to grow in Q1. Since the start of the program, more than 18,000 unique individuals have enrolled in FCS, including over 10,000 enrolled to receive CSS services. Enrollments of individuals in need of both CSS and IPS services also continued its steady growth trend, reaching over 2,000 enrollees in February.

The growth of the provider network continues to meet the demand for the number of individuals referred to receive FCS services. At this point, the program does not need to cap the number of enrollments.

The FCS training staff completed six fidelity reviews of contracted FCS providers. These reviews were completed virtually over two days with a review team made up of HCA staff and FCS providers. These reviews were designed to assess how well a provider aligns their services with the evidence-based practices of the IPS and Permanent Supportive Housing (PSH) model of services.

FCS staff also held four fidelity reviewers training events that teach FCS providers on the evidence-based practices and prepare their participation on review panels. HCA uses SAMHSA block grant funding to incentivize participation in a learning collaborative approach to the fidelity reviews.

Other FCS program activity

DBHR approved the applications of eight SUD treatment providers to become contracted FCS providers, utilizing SAMHSA block grant funds. The funds will enable the providers to hire staff, complete training on either IPS or CSS services, and contract with the TPA.

HCA continues to actively pursue the bulk purchase of pay-as-you-go mobile devices for FCS enrollees. FCS hired a new program manager to work with the ACHs to ensure a smooth distribution process between regional ACHs and FCS providers, then between FCS providers and FCS enrollees. The purchase and distribution of these devices is expected to be completed in the early part of Q2.

HCA continues to prepare for the Q2 launch of providing CSS services within IMD settings that meet the average length of stay requirement of 30 days or less established under MTP Initiatives 4 and 5. This also includes the development of a discharge planners toolkit to assist facilities to better connect vulnerable individuals with housing. FCS services will be highlighted in the toolkit, as well as HCA's partnership with housing resources through the homeless safety net under the Department of Commerce (Commerce).

HCA and Commerce were selected to participate on an SUD supportive housing learning collaborative with eight other states and the District of Columbia, sponsored by CMS. The state has greatly benefited from learning about the experiences of other states, as well as sharing lessons from implementing supportive housing through FCS.

During Q1, HCA and ALTSA co-presented information about FCS to benefit planners at a statewide Benefit Planner Forum. Additionally, HCA presented FCS information at the National Alliance to End Homelessness.

HCA released formal steps for nontraditional Medicaid providers to gain limited access to ProviderOne. This will allow these providers, who have not historically participated in Medicaid, to view an individual's Medicaid eligibility and enrollment in FCS prior to providing services.

Upcoming activities

DBHR staff will attend several virtual conferences in Q2, including the Region X Community Action Conference and Washington State Behavioral Health conference. HCA's participation in and sponsorship of the Region X Conference helps promote the role of Community Action Programs. HCA is also planning a presentation on the DOH to the Washington State Hospital Association that will take place later in Q2.

DBHR staff will be releasing contracts to incentivize FCS providers to either host or send staff to participate in fidelity reviews. This effort incorporates block grant funds from SAMHSA that will enhance HCA's effort to ensure quality services are delivered through FCS. Over the course of Q2, HCA aims to conduct 10 baseline fidelity reviews and 13 follow-up reviews of both CSS and IPS providers across Eastern and Western Washington. This work is central to promoting a culture of cross-collaboration and creating a learning community among FCS providers. More fidelity reviews will be conducted in Q3 and Q4 as more SAMSHA funds become available.

DBHR staff will launch the first round of targeted trainings to new SUD treatment providers in Q2. These providers will receive seed grants to start either CSS or IPS services, hire staff, and receive leadership and direct service staff training on the two evidence-based practice models, PSH and IPS.

FCS program stakeholder engagement activities

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

Table 9: FCS program stakeholder engagement activities

	January	February	March
	Number of events held		
Training and assistance provided to individual organizations	15	23	50
Community and regional presentations and training events	4	12	13
Informational webinars	2	10	11
Stakeholder engagement meetings	11	25	20
Total activities	**32**	**70**	**94**

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

Q1 topics included:

- Signs of vicarious trauma and compassion fatigue
- IMDs and supportive housing
- Introduction to virtual fidelity reviews
- Addressing practitioner burnout in vocational services
- Landlord learning community call
- Job developer community of practice
- Combating compassion fatigue and burnout
- Preparing for an FCS supportive housing fidelity review
- Web-based tools to identify interests and work values
- Career profile
- Best practices in clinical supervision

FCS stakeholder concerns

Amerigroup reported no provider grievances or appeals in Q1. HCA maintains ongoing collaboration with Amerigroup on assisting providers with billing, documentation, and accessing the state Medicaid database (ProviderOne).

FCS staff regularly receive feedback from the provider and stakeholder communities inquiring about the future of the program. With significant work underway to increase the number of provider groups focusing on populations with SUD, as well as expanding CSS services to IMD facilities, more questions are being raised about the status of the extension year application as we approach the end of the initial waiver period.

SUD IMD waiver implementation accomplishments

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

This section summarizes SUD IMD waiver development and implementation activities from January 1 through March 31, 2021. This quarter, work was primarily focused on the analysis of legislative initiatives, as the period covered the state's legislative session. Several bills impacting SUD services and treatment were considered.

Implementation plan

In accordance with the amended STCs, the state is required to submit an implementation plan for the SUD IMD waiver, incorporating six key milestones outlined by CMS. At the time of the waiver application, Washington met a number of these milestones based on its existing provision of SUD services. Where the state did not yet meet the milestones, CMS was engaged to confirm appropriate adjustments.

There are no changes or updates to the implementation plan to report on this quarter.

SUD HIT plan requirements

No updates for this reporting period.

Evaluation design

No updates for this reporting period.

Monitoring protocol

No updates for this reporting period.

Upcoming activities

HCA plans to continue work toward implementation of milestones.

MHIMD waiver implementation accomplishments

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

This section summarizes MH IMD waiver development and implementation activities from January 1 through March 31, 2021. During this reporting period, work was primarily focused on the analysis of legislative initiatives because of the state's legislative session. Several bills impacting behavioral health services and treatment were considered during this quarter to evaluate the impact on crisis services.

Implementation plan

In accordance with the amended STCs, the state is required to submit an implementation plan for the MH IMD waiver, incorporating key milestones outlined by CMS. At the time of the waiver application, the state met a number of these milestones in its provision of MH services. Where the state did not meet the milestones, CMS was engaged to confirm appropriate adjustments.

There are no changes or updates to the implementation plan to report on this quarter.

MH HIT plan requirements

This quarter, HCA initiated contracts related to the MH waiver HIT plan requirements. These contracts include work on:

- Telehealth: gathered information from behavioral health and physical health providers and others regarding how they collect and use DOH data prior to and since the COVID-19 pandemic. This includes how telehealth and other technologies support the collection and use of data.
- Closed loop referrals and e-referrals: gathered information regarding factors that may contribute to changes in key behavioral health performance measures (e.g., follow-up after in-patient hospitalization or ED visits for mental illness, or MH treatment penetration rates for children with MH needs). Information gathered includes the role of HIT in supporting transitions and referrals in care.
- HIT to advance care coordination: working on piloting and developing an initial strategic implementation framework for statewide implementation of the Clinical Integration Assessment Tool (CIAT). The CIAT allows providers to report on their level of integration along a continuum of integration (e.g., higher levels of integration reflect the use of HIT to support information exchange, such as electronic referrals).

Evaluation design

HCA is working to develop the MH IMD evaluation design, to be submitted in Q3.

Monitoring protocol

HCA is working to develop the MH IMD monitoring protocol, to be submitted in Q3.

Upcoming activities

Upcoming activities include continued work and finalization of the evaluation design and monitoring protocol.

Quarterly expenditures

The following table reflects quarterly expenditures for DSRIP, LTSS, and FCS during DY5 (2021). MCOs earned $8 million and ACHs earned $1.8 million for VBP incentives.

Table 10: DSRIP expenditures

	Q1	Q2	Q3	Q4	DY5 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
Better Health Together	$250,000					$125,000
Cascade Pacific Action Alliance	$35,053					$17,527
Elevate Health	$44,571					$22,286
Greater Columbia	$250,000					$125,000
HealthierHere	$250,000					$125,000
North Central	$250,000					$125,000
North Sound	$250,000					$125,000
Olympic Community of Health	$250,000					$125,000
SWACH	$250,000					$125,000
Indian Health Care Providers	$0					$0

Table 11: MCO-VBP expenditures

	Q1	Q2	Q3	Q4	DY5 Total
MCO-VBP	January 1–March 31	April 1–June 30	July 1–September 30	October 1–December 31	January 1–December 31
Amerigroup WA	$959,638.00				$959,638.00
CHPW	$1,233,495.00				$1,233,495.00
CCW	$946,640.00				$946,640.00
Molina	$3,889,269.00				$889,269.00
United Healthcare	$970,958.00				$970,958.00

Table 12: LTSS and FCS service expenditures

	Q1	Q2	Q3	Q4	DY5 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)	$4,975,602				$4,975,602
Medicaid Alternative Care (MAC)	$128,419				$128,419
MAC and TSOA not eligible	$0				$0
FCS	$5,465,921				$5,465,921

Financial and budget neutrality development issues

Financial

Below are the counts of member months eligible to receive services under MTP. Member months for non-expansion adults are updated retrospectively, based on the current caseload forecast council (CFC) medical caseload data. Actual caseload data for non-expansion adults is available through October 2020.

November 2020 through March 2021 member months for non-expansion adults are forecasted caseload figures from CFC. Actual member months data for the SUD populations is currently available through June 2020. Updated member months will be provided once data is available.

Image 5: member months eligible to receive services

Calendar month	Non-expansion adults only	SUD Medicaid disabled	SUD Medicaid non-disabled	SUD newly eligible	SUD American Indian/Alaska Native
Jan-17	376,321	0	0	0	0
Feb-17	375,218	0	0	0	0
Mar-17	374,751	0	0	0	0
Apr-17	373,605	0	0	0	0
May-17	373,150	0	0	0	0
Jun-17	373,054	0	0	0	0
Jul-17	372,144	0	0	0	0
Aug-17	371,878	0	0	0	0
Sep-17	370,614	0	0	0	0
Oct-17	370,417	0	0	0	0
Nov-17	370,250	0	0	0	0
Dec-17	370,275	0	0	0	0
Jan-18	370,313	0	0	0	0
Feb-18	368,939	0	0	0	0
Mar-18	368,719	0	0	0	0
Apr-18	367,432	0	0	0	0
May-18	367,746	0	0	0	0
Jun-18	366,996	0	0	0	0
Jul-18	366,699	5	19	91	113
Aug-18	366,067	8	17	95	458
Sept-18	365,037	4	19	80	356
Oct-18	364,990	4	22	93	401
Nov-18	364,498	3	27	93	315
Dec-18	363,899	4	17	96	201
Jan-19	363,802	12	57	167	416
Feb-19	362,040	12	50	163	394
Mar-19	361,692	19	65	164	426
Apr-19	361,226	24	60	178	526
May-19	360,709	17	52	185	534
June-19	359,923	28	63	227	572
Jul-19	360,369	29	89	312	628
Aug-19	359,937	32	117	362	482
Sep-19	359,510	34	105	380	408
Oct-19	358,994	34	111	411	469
Nov-19	358,130	40	94	404	574
Dec-19	358,451	28	96	432	555
Jan-20	358,883	29	110	488	502
Feb-20	358,798	23	123	455	437
Mar-20	360,477	28	116	419	424
Apr-20	363,943	32	87	326	302
May-20	366,361	23	91	346	312
Jun-20	369,143	26	89	329	176
Jul-20	371,851	0	0	0	0
Aug-20	374,725	0	0	0	0
Sep-20	377,004	0	0	0	0
Oct-20	379,103	0	0	0	0
Nov-20	380,309	0	0	0	0

Budget neutrality

HCA adopted CMS's budget neutrality monitoring tool and has been using the Performance Management Database and Analytics system to upload quarterly spreadsheets.

Designated state health programs (DSHP)

HCA has extended its contract with the IA to perform an independent audit based on agreed-upon procedures to validate the accuracy of DSHP claims reported on the CMS-64 for calendar year (CY) CY2019. HCA anticipates the audit and final report will be completed by June 2021.

Overall MTP development and issues

Operational/policy issues

The state Legislature authorized funding in support of HCA's application of a one-year extension of MTP. Further discussion of the application with our federal partners is anticipated as CMS considers approval of the one-year extension. The state continues work on a longer-term MTP application for renewal. Should CMS approve the one-year extension, submission of the longer-term renewal application would be submitted by the end of 2021, one year ahead of the expiration of MTP with a one-year extension, as required by the STCs.

Consumer issues

The state has not experienced any major consumer issues for DSRIP, FCS, LTSS, or the SUD and MH IMG waivers during this reporting period, other than general inquiries about benefits available through MTP.

The state continues to work on closed captioning services that might permit a hearing-impaired behavioral health counselor to perform counseling services over Zoom. When barriers like this are identified, state expertise is needed to achieve equity.

MTP evaluation

The IEE continued their active engagement on evaluation activities. The IEE's tenth rapid cycle report was delivered on March 31, 2021, in compliance with the contracted deliverable timeline. This report covers January 1 through March 31, 2021. It presents findings in three areas:

- **Washington state's Medicaid system performance through March 2020**, including key performance indicators in 10 measurement domains as well as examination of equity and disparities within measurement domains.
- **Progress toward MTP goals related to health equity in 2020**, including ACH-led equity activities and additional opportunities for state support or guidance.
- **ACH participation in the state's COVID-19 pandemic response and recovery in 2020,** including factors that facilitated ACHs' abilities to respond to community needs during the first year of the pandemic.

Key findings (extracted from the IEE's tenth rapid cycle report):

- **Washington State's Medicaid system performance:**
    - The IEE observed substantial and continued improvement in measures related to SUD and opioid use disorder – a trend that has continued since the Interim Evaluation Report. They also observed improvements in some preventive and wellness services, such as childhood immunizations and Body Mass Index (BMI) screenings, but worsening performance on others like well-child visits for children ages 3-6.
    - The IEE observed improvement in antidepressant medication management for adults, but other measures of MH care declined. Of concern, the 30-day rates of follow-up care after an ED visit or hospitalization for mental illness continued to worsen. Readmission rates for psychiatric conditions also increased. This is an important area for Washington State to monitor closely.
    - Measures related to SDoH, primary care access, and care for people with chronic conditions were mostly unchanged. Rates of utilization of EDs, acute hospital care, and institutional care remained unchanged.

- **Progress toward MTP goals related to heath equity in 2020:**
    - The ACH model provides framework for integrating equity into the health system transformation goals of MTP. There is evidence ACHs have sought to address equity in the areas commonly described as the core elements of the ACH model, such as community partnerships, shared definitions and language, and data sharing.
    - ACHs would benefit from increased support and guidance regarding health equity from HCA. Two distinct approaches have emerged among ACHs, one focused on racial equity and disparities, and the other focused on social needs. A comprehensive strategy would incorporate both approaches.
- **ACH participation in state COVID-19 response:**
    - ACHs have contributed to the state's COVID-19 response, leveraging their existing community partner networks and information exchange infrastructure to meet community needs during the pandemic. Specific federal and state actions supported ACHs' ability to adapt their operations toward the COVID-19 pandemic response.

Upcoming IEE activities:

- Data collection and analysis are ongoing. The IEE will continue to analyze and update performance measures as new administrative data becomes available.
- The IEE is currently interviewing MCO representatives to learn about MCO roles in MTP, the transition to IMC, value-based payment, and the impact of and response to the COVID-19 pandemic.

The IEE is also conducting additional interviews with primary care and hospital provider organizations. Recruitment for these interviews was slower than planned due to the COVID-19 pandemic, which severely impacted health care provider capacity and reduced interest and availability for participation.

Summary of additional resources, enclosures, and attachments

Additional resources

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

Summary of attachments

- Attachment A: state contacts
- Attachment B: Financial Executor Portal Dashboard, Q1 2021
- Attachment C: 1115 SUD Demonstration Monitoring Report – Part B

Attachment A: state contacts

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

Area	Name	Title	Phone
MTP and quarterly reports	Chase Napier	Manager, Medicaid Transformation	360-725-0868
DSRIP program	Chase Napier	Manager, Medicaid Transformation	360-725-0868
LTSS program	Kelli Emans	Integration unit manager, DSHS	360-725-3213
FCS program	Melodie Pazolt	Section manager, BH Programs and Recovery Support Services	360-725-0487
SUD IMD waiver	David Johnson	Federal Programs manager	360-725-9404
MH IMD waiver	David Johnson	Federal Programs manager	360-725-9404

For mail delivery, use the following address:

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

Attachment B: Financial Executor Portal Dashboard, Q1 2021

View this table on the HCA website, which shows all funds earned and distributed through the FE portal through March 31, 2021.

Attachment C: 1115 SUD Demonstration Monitoring Report – Part B

1115-SUD-Monitoring-Report-Template-v2.0

Trend Narrative Reporting

Updated 02/19/2021

Section	Topic	Prompt (check corresponding box)	State Response	Measurement Period First Reported	Related metric (if any)
1.2.1	Assessment of Need and Qualification for SUD Services	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	The monthly number of Medicaid beneficiaries with an SUD diagnosis has remained stable. However, continues to be a slight increase in the number of Medicaid beneficiaries with an OUD diagnosis. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#3: Medicaid beneficiaries with SUD diagnosis (monthly)
			The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#4: Medicaid beneficiaries with SUD diagnosis (annual)
			The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#5: Medicaid beneficiaries treated in an IMD for SUD

2.2.1	Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received any SUD treatment has remained stable over the last three months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#6: Any SUD Treatment
			The monthly number of Medicaid beneficiaries with an SUD diagnosis who received early intervention services has remained stable over the last three months. Research within the state has highlighted some barriers to billing for SBIRT, including but not limited to staff turnover and uncertainty around reimbursement. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#7: Early Intervention
			The monthly number of Medicaid beneficiaries with an SUD diagnosis who received outpatient SUD treatment has remained stable over the last three months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#8: Outpatient Services
			The number of residential and inpatient services has continued to decrease from the previous measurement period. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any	04/01/2019 – 06/30/2019	#10: Residential and Inpatient Services

			changes in trends should be interpreted with caution.		
			The monthly number of Medicaid beneficiaries with an SUD diagnosis who received withdrawal management services has remained stable over the last three months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#11: Withdrawal Management
			The monthly number of Medicaid beneficiaries with an SUD diagnosis who received medication assisted treatment has remained stable over the last three months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#12: Medication Assisted Treatment
			The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#36: Average Length of Stay in IMDs
3.2.1	Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)	The state has no metrics trends to report for this reporting topic.			
4.2.1	Use of Nationally Recognized SUD Program	The state has no metrics trends to report for this reporting topic.			

	Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)				
5.2.1	Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#13: SUD provider availability
			The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#14: SUD provider availability – MAT
6.2.1	Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2017 – 12/31/2017	#15: Initiation and Engagement of Alcohol and Other Drug Treatment
			The state has no metrics trends to report for this reporting topic this quarter.	01/01/2018 – 12/31/2018	#18: Use of Opioids at High Dosage in Persons without Cancer (modified by State)
			The state has no metrics trends to report for this reporting topic this quarter.	01/01/2018 – 12/31/2018	#21: Concurrent Use of Opioids and Benzodiazepines (modified by State)
			The state has no metrics trends to report for this reporting topic this quarter.	01/01/2018 – 12/31/2018	#22: Continuity of Pharmacotherapy for Opioid Use Disorder (modified by State)
7.2.1	Improved Care Coordination and Transitions between Levels of Care (Milestone 6)	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	The state has no metrics trends to report for this reporting topic this quarter.	01/01/2017 – 12/31/2017	#17(1): Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence
			The state has no metrics trends to report for this reporting topic this quarter.	01/01/2017 – 12/31/2017	#17(2): Follow-Up after Emergency Department Visit for Mental Illness

8.2.1	SUD Health Information Technology	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2017 – 06/30/2018	Q1: PDMP Statewide Fatal Drug Overdoses – All, All Opioids, Heroin, Prescription Opioids (excluding synthetic opioids), Synthetic Opioids (not Methadone)
			The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	Q2: Substance Use Disorder Treatment Penetration Rate
			The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential SUD Services
9.2.1	Other SUD-Related Metrics	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	The rate of Emergency Department Utilization for SUD has remained stable over the past three months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
			The rate of Inpatient Stays for SUD has remained stable over the past three months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries

			The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#25: Readmissions Among Beneficiaries with SUD
			The state has no metrics trends to report for this reporting topic this quarter.	07/01/2017 – 06/30/2018	#26: Overdose Deaths (count)
			The state has no metrics trends to report for this reporting topic this quarter.	07/01/2017 – 06/30/2018	#27: Overdose Deaths (Rate)
			The state has no metrics trends to report for this reporting topic this quarter.	01/01/2017 – 12/31/2017	#40: Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD.

State	Washington State
Demonstration name	Washington State Medicaid Transformation Project No. 11-W-00304/0
Approval date for demonstration	January 9, 2017
Approval period for SUD	July 1, 2018-December 31, 2021
Approval date for SUD, if different from above	July 17, 2018
Implementation date of SUD, if different from above	July 1, 2018
SUD (or if broader demonstration, then SUD - related) demonstration goals and objectives	Under Washington's 1115 demonstration waiver, the SUD program allows the state to receive Federal Financial Participation (FFP) for Medicaid recipients residing in institutions for mental disease (IMDs) under the terms of this demonstration for coverage of medical assistance including opioid use disorder (OUD)/substance use disorder (SUD) benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to ongoing chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. Expenditure authority will allow the state to improve existing SUD services and ensure the appropriate level of treatment is provided, increase the availability of medication assisted treatment (MAT), and enhance coordination between levels of care. The state will continue offering a full range of SUD treatment options using the American Society for Addiction Medicine (ASAM) criteria for assessment and treatment decision making. Medical assistance including opioid use disorder (OUD)/substance use disorder (SUD) benefits that would otherwise be matchable if the beneficiary were not residing in an IMD.

Executive Summary

Metrics submitted with this reporting period include data from July through September of 2020. COVID-19 likely impacted service delivery in a variety of ways—including challenges to service delivery brought about by infection control and social distancing measures. However, caution is advised when interpreting, as the full impact is still unclear as the pandemic continues.

Service decreases were observed in residential and inpatient services, however, numbers stabilized for withdrawal management, and medication-assisted treatment. Once again, it is not unreasonable to infer that the COVID-19 pandemic may have influenced trends and lead to "chop" in the data as individuals and providers reacted to COVID-19.

HCA staff monitored and provided feedback on legislative and budget proposals under consideration by the State Legislature for the state's 2022 - 2023 biennium budget, including proposals related SUD treatment and crisis services. Changes to SUD services in the wake of state court decisions were a major topic and changes will become clearer at the end of session which occurs in the next quarter.

Narrative information on implementation, by milestone and reporting topic

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
1.2 Assessment of Need and Qualification for SUD Services			
1.2.1 Metric Trends			
☒ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.**	The monthly number of Medicaid beneficiaries with an SUD diagnosis has remained stable. However, continues to be a slight increase in the number of Medicaid beneficiaries with an OUD diagnosis. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#3: Medicaid beneficiaries with SUD diagnosis (monthly)
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#4: Medicaid beneficiaries with SUD diagnosis (annual)
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#5: Medicaid beneficiaries treated in an IMD for SUD
☐ **The state has no metrics trends to report for this reporting topic.**			

1.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) The target population(s) of the demonstration.** **☐ ii) The clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration.**			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to assessment of need and qualification for SUD services.			
☒ The state has no implementation update to report for this reporting topic.			
2.2 Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)			
2.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received any SUD treatment has remained stable over the last three months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#6: Any SUD Treatment
	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received early intervention services has remained stable over the last three months. Research within the state has highlighted some barriers to billing for SBIRT, including but not limited to staff turnover and uncertainty around reimbursement. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#7: Early Intervention

	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received outpatient SUD treatment has remained stable over the last three months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#8: Outpatient Services
	The number of residential and inpatient services has continued to decrease from the previous measurement period. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#10: Residential and Inpatient Services
	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received withdrawal management services has remained stable over the last three months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#11: Withdrawal Management
	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received medication assisted treatment has remained stable over the last three months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#12: Medication Assisted Treatment
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#36: Average Length of Stay in IMDs
☐ The state has no metrics trends to report for this reporting topic.			
2.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to:			

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

3.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria** **☐ ii) Implementation of a utilization management approach to ensure (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, or (c) use of independent process for reviewing placement in residential treatment settings.**			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 2.			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state is not reporting metrics related to Milestone 2.			
4.2 Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)			
4.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3.			
☐ The state has no trends to report for this reporting topic.			
☒ The state is not reporting metrics related to Milestone 3.			

4.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards.** **☐ ii) State review process for residential treatment providers' compliance with qualifications standards.** **☐ iii) Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site.**			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 3.			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state is not reporting metrics related to Milestone 3.			
5.2 Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)			
5.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.			
☒ The state has no trends to report for this reporting topic.			

5.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care.**			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 4.			
☒ The state has no implementation update to report for this reporting topic.			
6.2 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)			
6.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 5.			
☒ The state has no trends to report for this reporting topic.			
6.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD.** **☐ ii) Expansion of coverage for and access to naloxone.**			
☒ The state has no implementation update to report for this reporting topic.			

☐ The state expects to make other program changes that may affect metrics related to Milestone 5.			
☒ The state has no implementation update to report for this reporting topic.			
7.2 Improved Care Coordination and Transitions between Levels of Care (Milestone 6)			
7.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 6.	No trends to report for Follow-Up after Emergency Department Use for Alcohol or Other Drug Dependence or for Mental Illness (only one measurement year available).		
☒ The state has no trends to report for this reporting topic.			
7.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ Implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports.**			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 6.			
☒ The state has no implementation update to report for this reporting topic.			
8.2 SUD Health Information Technology (Health IT)			
8.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its Health IT metrics.			

☒ The state has no trends to report for this reporting topic.			
8.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) How health IT is being used to slow down the rate of growth of individuals identified with SUD.** **☐ ii) How health IT is being used to treat effectively individuals identified with SUD.** **☐ iii) How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD.** **☐ iv) Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels.** **☐ v) Other aspects of the state's health IT implementation milestones.** **☐ vi) The timeline for achieving health IT implementation milestones.** **☐ vii) Planned activities to increase use and functionality of the state's prescription drug monitoring program.**			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Health IT.			
☒ The state has no implementation update to report for this reporting topic.			

9.2 Other SUD-Related Metrics			
9.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to other SUD-related metrics.	The rate of Emergency Department Utilization for SUD has remained stable over the past three months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
	The rate of Inpatient Stays for SUD has remained stable over the past three months. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.	04/01/2019 – 06/30/2019	#24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries
☐ The state has no trends to report for this reporting topic.			
9.2.2 Implementation Update			
☐ The state expects to make other program changes that may affect metrics related to other SUD-related metrics.			
☒ The state has no implementation update to report for this reporting topic.			
10.2 Budget Neutrality			
10.2.1 Current status and analysis			
☐ If the SUD component is part of a broader demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality. Describe the status of			

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

☐ ii) Delivery models affecting demonstration participants (e.g., Accountable Care Organizations, Patient Centered Medical Homes). ☐ iii) Partners involved in service delivery.			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state is working on other initiatives related to SUD or OUD.			
☒ The state has no implementation update to report for this reporting topic.			
☐The initiatives described above are related to the SUD or OUD demonstration (States should note similarities and differences from the SUD demonstration).			
☒ The state has no implementation update to report for this reporting topic.			
12. SUD Demonstration Evaluation Update			
12.1. Narrative Information			
☐ Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the			

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

implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.			
☒ The state has no updates on general requirements to report for this reporting topic.			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) The schedule for completing and submitting monitoring reports.** **☐ ii) The content or completeness of submitted reports and/or future reports.**			
☒ The state has no updates on general requirements to report for this reporting topic.			
☐ The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation			
☒ The state has no updates on general requirements to report for this reporting topic.			
13.1.2 Post-Award Public Forum			
☐ If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual report.			

☒ No post-award public forum was held during this reporting period and this is not an annual report, so the state has no post-award public forum update to report for this topic.			
14.1 Notable State Achievements and/or Innovations			
14.1 Narrative Information			
☐ Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.			
☒ The state has no notable achievements or innovations to report for this reporting topic.			

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

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