



Washington State Medicaid Transformation Project (MTP) demonstration
Section 1115 Waiver Quarterly Report (DY5 Q2)
Demonstration Year: 5 (January 1 to December 31, 2021)
Reporting Quarter: 2 (April 1 to June 30, 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) and 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: April 1–June 30, 2021

This quarterly report summarizes MTP activities from the second quarter of 2021: April 1 through June 30. It details MTP implementation, including stakeholder education and engagement, planning and implementation, and development of policies and procedures.

Summary of quarter accomplishments

- Further discussion of the application with federal partners is anticipated as CMS considers approval of the state’s application for a one-year extension. The state continues work on a longer-term MTP application for renewal, and submission to CMS is anticipated by the end of 2021. The state will continue policy development and legislative engagement in anticipation of legislative authorization of expenditure authority starting in 2023.
- HCA and ACHs are coordinating across the state on scale and sustain strategies. The next semi-annual report (SAR) will be submitted on July 31, 2021. This information continues to inform planning tied to the MTP one-year extension request and the transition of DSRIP through a longer-term renewal application. HCA continues to engage ACHs and MCOs to discuss waiver renewal concepts, ongoing partnership opportunities, and strategies for sustainability of critical whole-person care efforts and health related services.
- During the reporting quarter, ACHs distributed more than \$20.7 million to 277 partnering providers and organizations in support of project planning and implementation activities. The state distributed approximately \$2.8 million in earned incentives to IHCPs in Q2 for achievement of IHCP-specific project milestones.
- New enrollees in LTSS for this reporting period: 42 MAC dyads, 293 TSOA dyads, and 488 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 6,080 in IPS and 7,835 in CSS. The total unduplicated number of enrollments at the end of this reporting period was 11,616.

The SUD and MH programs continued implementation efforts during the reporting quarter. Both the evaluation design and monitoring plan for the MH program were submitted to CMS.

MTP-wide stakeholder engagement

During the reporting period, HCA updated or created various MTP-related fact sheets, frequently asked questions (FAQs), and other documents. These include:

- [One-pager about MTP](#)
- [One-pager about MTP and ACHs](#)
- [FAQ on LTSS](#)
- [Fact sheet on FCS](#)
- [FAQ on SUD IMD](#)
- [FAQ on mental health IMD](#)
- [Fact sheet on independent external evaluator \(IEE\)](#)
- [Fact sheet on difference between independent assessor and IEE](#)

Throughout the remainder of this year, HCA will continue to update documents/publications that are posted on the website.

Statewide activities and accountability

Value-based purchasing (VBP)

During the reporting period, HCA prepared for the annual Paying for Value surveys. This included the creation of the surveys, developing a communications plan and materials, and coordinating messaging about the surveys.

- The survey for **health plans/payers** helps HCA track progress toward the state's VBP goals, identify barriers impeding desired progress, and gain insight into nonstate purchased health care programs. This year's survey aims to capture responses from all Washington State health plans participating in the individual, small and large group, and Medicare markets.
- The survey for **health care providers** provides valuable insight into the challenges providers face as they consider adopting new payment arrangements. This year's survey aims to capture more responses and measure results against last year.

New VBP website section

At the end of the reporting period, HCA updated the [Tracking success page](#) with links and information about the 2021 Paying for Value surveys.

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 special terms and conditions (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 Incentive Payment (DSRIP) program incentives for managed care organizations (MCOs) and ACHs. HCA continues to refine the long-term strategic vision for VBP and will update the roadmap and appendix in Q3.

Validation of financial performance measures

In DY1, HCA contracted with Myers and Stauffer, LC to serve as the independent assessor (IA) for MTP. In this role, the IA functions as the third-party assessor of financial measures data submitted by MCOs as part of their contracts with HCA. HCA's contracts with the five MCOs establish parameters for the VBP assessment process. These parameters include the financial performance measures, the timelines under which MCOs must submit data, and the review process, which includes third party validation.

- HCA began preparing for the VBP validation process in Q1 of 2021 (DY5). In Q2, HCA and the IA reviewed "lessons learned" and updated the VBP validation process and MCO reporting templates, including adjusting the templates to align with the refreshed Health Care Payment Learning & Action Network (HCP-LAN) Framework. The MCOs will also include a brief narrative in their completed templates summarizing activities done to achieve the performance targets.

Statewide progress toward VBP targets

HCA sets annual VBP adoption targets 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 requires each MCO to respond to the annual survey to provide information and data on their non-Medicaid health care coverage in Washington State. HCA updated the survey template and released the health plan survey on July 1, 2021.

Additionally, HCA developed and released the provider survey on July 1, 2021.

Technical support and training

- The IA will join an HCA-MCO conference call in Q3 to answer questions MCOs may have related to the VBP Validation process.
- Manatt Health facilitated two working sessions with HCA and MTP leadership to refine the strategic vision related to VBP in anticipation of, and planning for MTP waiver renewal.

Upcoming activities

- HCA will continue refining the long-term VBP strategic vision and refine priorities for MTP waiver renewal.
- MCOs will complete the VBP validation templates and work with the IA to address any discrepancies in Q3. The IA will coordinate with HCA on the analysis and final reporting of MCO progress to-date.
- Providers and health plans (including MCOs) will complete HCA's Paying for Value Survey by August 31, 2021, and HCA will start analysis in Q3.
- HCA will update the VBP Roadmap for 2021, aiming for release in early Q4.
- HCA will provide a "VBP 101" presentation to two ACHs, Greater Columbia ACH and Cascade Pacific Action Alliance, in July (Q3) 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 Q2.

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 a major concern and ACHs have been exploring and implementing strategies to mitigate these issues.
- Since April 2021, HCA has maintained focus 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 completed a short-term behavioral health performance measure project, which included 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 participated in interviews for this project. At the end of June 2021, Comagine Health (HCA's external quality review organization) provided a final report on this project and HCA is in the process of determining next steps.
 - An additional short-term project this quarter was the completion of a study of a new clinical integration assessment tool. The ACHs and MCOs have worked together to identify an assessment tool to pilot testing among several providers. The project also explored methods of collecting clinical integration progress from providers. This project concluded in June 2021 and HCA is in the process of determining next steps.

Health information technology (HIT)

The Health IT Operational Plan is composed of actionable deliverables to advance the health IT goals and vision articulated in the [Health IT Strategic Roadmap](#). This work supports MTP in Washington State. The Health IT Roadmap and Operational Plan focus on three phases of Transformation work: design, implementation and operations, and assessment. In fall 2020, HCA led months of conversations that

resulted in identifying tasks for the 2021 Health IT Operational Plan. These activities include 42 deliverables and tasks in areas including:

- Electronic health records (EHRs)
- Mental health 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 functionality
- Registries
- Clinical Data Repository (CDR)
- Tribal engagement

Activities and successes

The HIT team spent much of the second 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.
- The state began implementation of a MPI to support the Department of Health's (DOH's) COVID-19 response while continuing planning activities for the Coalition MPI project. DOH continues to build its infrastructure to support connecting to the Verato MPI solution. Additionally, the Health and Human Services (HHS) Coalition agencies (Department of Social and Health Services (DSHS), Department of Children, Youth, and Families (DCYF), DOH, Washington Health Benefit Exchange (HBE) and HCA) determined Verato would be a central element of the broader Coalition's MPI solution. The Coalition allocated funds to begin implementation of the MPI solution. The State also successfully completed a Security Design Review with Verato to support the MPI implementation.
- The Provider Directory API Product Guide was recently approved to support the CMS Interoperability Rules. The provider directory group is conducting design sessions and an implementation date is expected by the end of 2021.
- The state completed an environmental scan of provider readiness to adopt EHR to determine readiness of behavioral health, Indian health care, and rural health care providers to adopt or change an EHR solution.
- The state contracted with an organization to identify key characteristics of a lead organization to support an EHR solution in Washington State.
- HCA completed a Request for Information for an e-consent management solution, identifying potential vendors and options to support electronic consent management.
- The state continued coordination with the nine ACHs and MCOs to support MTP activities in regions and plans across the state, including the use of health IT. For example, HCA summarized activities underway across ACHs to implement community information exchange to support the exchange of social determinants of health information. HCA is working with ACHs to update this information.
- The HCA coordinated internally and with DOH to support implementation of the HIT plan requirements related to the Prescription Drug Monitoring Program (PDMP) and related requirements using funds made available through the Partnership Act/SUPPORT Act.
- Three HCA funded projects were completed. The projects support some of the HIT requirements under the MH IMD waiver and focused on:
 - Behavioral health performance measure study
 - Social determinants of health and telehealth
 - Clinical Integration Assessment Tool

- HCA initiated a new contract to continue planning for statewide implementation of the Clinical Integration Assessment Tool
- HCA continued internal discussions regarding how to fund and support implementation of the HIT requirements under the MD IMD waiver.

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

HCA continued work to design systems to implement requirements in the CMS Interoperability Rules. HCA continued its implementation of (i) a Patient Facing Application Programming Interface (API) and (ii) Provider Directory API.

The 2021 legislative session concluded with the passage of several provisions for the next biennium that could be supported by using health IT. HCA staff completed an initial assessment of the state budget and identified the key items involving health IT to ensure coordination across program and agency. A key legislative provision that includes the use of health IT, requires the state to establish crisis call center hubs, expand the crisis response system, and implement the national 988 suicide hotline. HCA, in collaboration with other state agencies, continues to plan for the coordinated implementation of these requirements.

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. During this reporting period, ACHs worked on the content of their SARs for the January 1–June 30, 2021 reporting period.

Next steps

HCA and ACHs are coordinating across the state on scale and sustain strategies. The next SARs will be submitted on July 31, 2021. This information continues to inform planning tied to the MTP one-year extension request and the transition of DSRIP through a longer-term renewal application.

HCA continues to engage ACHs and MCOs to discuss waiver renewal concepts, ongoing partnership opportunities, and strategies for targeting ongoing investments as the state looks ahead to sustainability of critical whole-person care efforts and health related services.

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. ACHs also help recruit provider participation in HCA's Paying for Value survey. As the state moves beyond initial implementation of IMC, ACHs and MCOs continue to support providers in appropriate VBP readiness activities. This includes specific support surrounding integration assessment and behavioral health provider capacity building.

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 \$20.7 million to 277 partnering providers and organizations in support of project planning and implementation activities. The state distributed approximately \$2.8 million in earned incentive funds to IHCPs in Q2 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

HCA's Analytics, Research, and Measurement (ARM) team continues efforts to provide quarterly production and visualization updates to the Healthier Washington dashboard based on updated performance data. The Healthier Washington dashboard is a publicly available data resource that provides

data on populations, health indicators and Healthcare Effectiveness Data and Information Set (HEDIS) measures for Washington State. The dashboard supports ACHs and partnering providers by providing actionable data on population health and social determinants of health. ACHs and other users have provided feedback regarding functionality and improvements to the dashboard.

The National Committee for Quality Assurance (NCQA) HEDIS® updated four measures that required HCA to revise the measures based on the changes provided. These changes were submitted to CMS for approval and presented at a monthly monitoring call. The changes include the following:

- Replace the children’s and adolescent’s access to primary care practitioners (CAP) with an alternative measure: child and adolescent well-care visits (CWV), to align with NCQA HEDIS recommendations. All three age-based submetrics will be included in the achievement value calculation for project 2A and 3D. Given that this is a new metric, and no national benchmark is available for the baseline period (CY 2018), the achievement value will be calculated using the improvement-over-self-approach.
- Replace the well-child visits in the 3rd, 4th, 5th, and 6th years of life with an alternative measure: child and adolescent CWV, to align with NCQA HEDIS recommendations. Only the 3-11 years old age band will be included in the achievement value calculation for Project 3B to align with the intent of the original metric. Given that this is a new metric, and no national benchmark is available for the baseline period (CY 2018), the achievement value will be calculated using the improvement-over-self-approach. Similarly, this replacement measure and specifications will apply to statewide accountability. The same improvement-over-self-approach will be used in the Quality Improvement (QI) scoring model for statewide accountability.
- Updated the well-child visits in the first 15 months of life with an alternative measure: well-child visits in the first 30 months of life, to align with NCQA HEDIS recommendations. Given that this is a new metric, and no national benchmark is available for the baseline period (CY 2018), the achievement value will be calculated using the improvement-over-self-approach.
- Replace the comprehensive diabetes care: medical attention for nephropathy with an alternative measure: kidney health evaluation with patients with diabetes, to align with NCQA HEDIS recommendations. Given that this is a new metric, and no national benchmark is available for the baseline period (CY 2018), the achievement value will be calculated using the improvement-over-self-approach.

Per state statute, the six-month data lag time was completed, July for DY 4 (pay-for-performance (P4P)). The ARM team will start running aggregation of the performance data for P4P, high-performance, and statewide accountability P4P based on parameters of the measure specifications.

HCA continues to provide technical assistance surrounding project pay-for-reporting (P4R)/P4P metrics, the DSRIP Measurement Guide, and metric technical specifications. HCA also continues to update documents to capture DSRIP program development and participate in ACH-led calls and forums to address DSRIP performance and measurement questions. Related resources, including the measurement guide, are available on the Medicaid Transformation metrics page.

DSRIP program stakeholder engagement activities

During this reporting period, HCA [sent out an announcement](#) highlighting the 2019 results for statewide and regional performance results for ACHs. HCA also [sent out an announcement](#) about ACHs earning full incentives for the second half of DY4 (July–December 2020).

In addition, HCA continued to host weekly Transformation Alignment Calls 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.

DSRIP stakeholder concerns

No stakeholder concerns were reported during the reporting period in the context of DSRIP. ACHs continue to triage communications with partners surrounding emerging issue identification and mitigation and COVID-19 related opportunities.

Upcoming DSRIP activities

HCA and DSHS Research and Data Analysis (RDA) Division continue to update and finalize technical specifications based on new updates to metric requirements from NCQA. This includes upcoming coordination with the IA as DY4 performance results are finalized. Coordination with ACHs, MCOs, and other partners will continue as the state develops its waiver renewal concepts surrounding future delivery system reform and SDOH efforts.

Tribal project implementation activities

Primary milestone: Development of a payment model for Tribes/IHCPs and American Indian (AI)/Alaska Natives (AN)

Tribal partner engagement timeline

April 6: participated in and presented at CMS Training on IHCPs.

April 6: participated in a meeting on adopting a Clinical Integration Assessment Tool with HCA staff, ACH staff and MCO staff

April 8: participated in a meeting between BetterHealthTogether (BHT) and the Confederated Tribes of the Colville Reservation regarding participation in BHT work

April 8: met with Seattle Indian Health Board (SIHB) regarding Traditional Indian Medicine

April 12: held an internal meeting regarding Behavioral Health Aides (BHAs) as part of the Community Health Aide Program (CHAP) and Medicaid reimbursement for BHAs

April 14: participated in BHT's Tribal Partnership Leadership Council (TPLC) monthly meeting

April 15: prepared communication materials regarding a new payment model for Tribes/IHCPs and AI/ANs

April 19: participated in annual meeting of the CHAP Program and BHA advisory workgroup, hosted by the Northwest Portland Area Indian Health Board (NPAIHB)

April 22: presented internally on new payment model for Tribes/IHCPs and AI/ANs

April 27: participated in meeting to prepare for national consultation on CHAP

April 28: met internally to work on BHA Medicaid reimbursement

April 30: met internally to work on BHA Medicaid reimbursement

May 4: met with SIHB regarding 100 percent Federal Medical Assistance Percentage (FMAP)

May 4: presented internally on new payment model for Tribes/IHCPs and AI/ANs

May 5: participated in the American Indian Health Commission's (the Commission) Quarterly Delegate meeting

May 6: presented internally on new payment model for Tribes/IHCPs and AI/ANs

May 6: met internally to work on BHA Medicaid reimbursement

May 12: participated in BHT's TPLC monthly meeting

May 14: presented internally to leadership on new payment model for Tribes/IHCPs and AI/ANs

May 19: attended the National Indian Health Board's presentation on Medicaid and Medicaid agencies

May 21: met with representatives from CMS regarding new payment model

June 1: discussed internally other state's 1115 efforts as related to Tribes/IHCPs and AI/ANs

June 2: participated in North Sound ACH's Tribal Alignment Committee meeting

June 3: presented internally on new payment model for Tribes/IHCPs and AI/ANs

June 4: participated in the BHA Advisory Workgroup, hosted by the NPAIHB

June 7: participated in an internal meeting with the Federally Qualified Health Center team to discuss 100 percent FMAP for Urban Indian Health Centers

June 10: met with BHT executive leadership to discuss future alignment with the Office of Tribal Affairs at HCA

June 10: participated in internal meeting regarding the 1115 renewal application

June 14: presented internally to leadership on new payment model for Tribes/IHCPs and AI/ANs

June 14: met with NPAIHB and the Commission to discuss BHAs and Medicaid reimbursement

June 14: met with the Commission to discuss the new payment model for Tribes/IHCPs and AI/ANs

June 16: met internally to discuss IHCP projects for 1115 renewal

June 17: met internally to work on BHA Medicaid reimbursement

LTSS implementation accomplishments

This section summarizes LTSS program development and implementation activities from April 1 through June 30, 2021. Key accomplishments for this quarter include:

- The statewide average Quality Proficiency was 100 percent for Q2.
- Case management staff reported a significant increase in referrals for MAC and TSOA programs and services this quarter as state and county COVID-related restrictions lift and vaccine uptake increases. Primary services requested continue to be personal care, respite care, personal emergency response system (PERS), and home-delivered meals.
- Home and Community Services (HCS) created and conducted a survey with Area Agency on Aging (AAA) case management staff requesting feedback about the MAC and TSOA programs and current benefit packages. This information will be shared with AAA directors to solicit their input and will inform decisions made by HCS and HCA management regarding the MTP renewal request.

Network adequacy for MAC and TSOA

AAAs continue to work in their local service areas to establish new contracts with providers. There continues to be statewide challenges in having enough in-home agency caregivers to support the demand for respite and personal care services, especially in smaller rural communities and culturally diverse communities. The pandemic has exacerbated the direct care workforce shortage. Statewide strategies are being implemented through the ‘Money Follows the Person’ infrastructure funding, targeted toward direct care worker recruitment and retention efforts.

Assessment and systems update

Updates and refinement to assessment tracking tools and custom reporting within the MAC and TSOA case management and assessment system (GetCare) were made to enable front line staff and their supervisors to more efficiently track the status of care receivers and caregivers, as well as streamline care planning, assessment, and authorization activities across case management teams.

Staff training

MAC and TSOA program managers for HCS remain committed to providing monthly statewide training webinars on requested and needed topics in 2021. Below are the webinar trainings that occurred this quarter:

- April 14 – Recipient Aid Category (RACs), Authorizations and Errors
- May 19 – Completing PE assessments/Determining Nursing Facility Level of Care (NFLOC)

Upcoming webinars:

- July 21 – Using the Barcode System for MAC and TSOA programs
- September 15 – Diversity and Inclusion in MAC, TSOA, and Family Caregiver Support Programs

Data and reporting

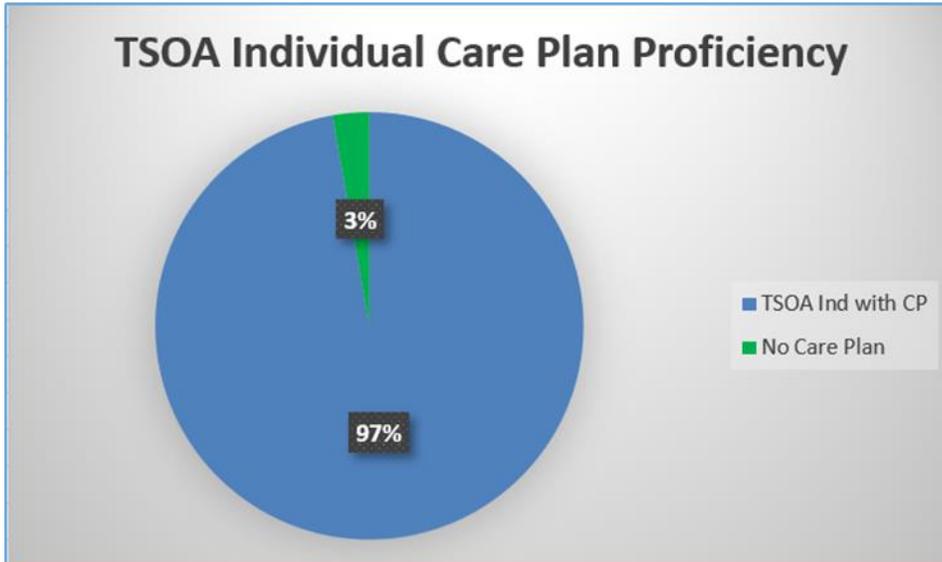
Table 1: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of June 30, 2021	371	3544	6631
Number of new enrollees in quarter by program	42	293	488
Number of new person-centered service plans in quarter by program	*	*	242***
Number of beneficiaries self-directing services under employer authority	0	0	0

* Due to restructuring of the state's data report system, the service plan data for dyads is currently unavailable. Updated information for the first and second quarter will be available in the next quarterly report.
***233 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.

Figure 1: TSOA Individuals - Care Plan Proficiency

Due to the issue above regarding the state's data report system, the state is only able to report the care plan proficiency for TSOA individuals this quarter. In the next quarterly report, the state will report care plan proficiency for all programs since January 2021.



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

Tribal engagement

- April 1 through June 30, 2020: DSHS Aging and Long-Term Support Administration (AL TSA) met with several Tribes to discuss Medicaid services and MTP initiatives 2 and 3.
- February - March 2021: Tribal Affairs staff shared information with Cowlitz Tribe Elder Services about MAC/TSOA.
- April 6, 2021: AL TSA Tribal Affairs staff met with Northwest Portland Area Indian Health Board (NWPIHB) CDC BOLD grantee to discuss CDC grant deliverables and WA State Dementia support programs, including MAC/TSOA.
- April 2021: Olympic Area Agency on Aging (O3A), American Indian Health Commission (AIHC) and regional Tribes met to discuss service access. Tribes requested more information on MAC/TSOA. O3A is planning a follow-up meeting to share in-depth information.
- May 20, 2021: Virtual Tribal-AL TSA-HCS-AAA Spring Summit workshop on MAC/TSOA. Estimated attendance was about 83 people.
- June 14, 2021: HCA and AL TSA formally replied to the NPAIHB and AIHC letter to CMS concerning the MTP 1115 Waiver extension request. The response included information on the ability of Tribes to contract with the state to provide a variety of MAC/TSOA approved services.

Outreach and engagement

Outreach activities continue to be primarily virtual meetings and presentations as well as dissemination of program publications/flyers and use of social media advertisements. The volume and type of outreach

activities continue to be impacted by the COVID-19 pandemic and social distancing requirements. A few of the activities completed this quarter include the following:

- HCS Headquarters (HQ) coordinated production of a new commercial video promoting caregiver programs which was released as a [Comcast advertisement this quarter](#).
- In addition to advertising through Facebook and YouTube, HCS finished up a second commercial video that will be presented at a Tribal meeting for final review and then distributed to tribal communities to promote caregiver programs. The video will be presented at the Tribal Fall Summit.
- A new virtual platform was used to create a support group for unpaid family caregivers. The first session occurred during this quarter.

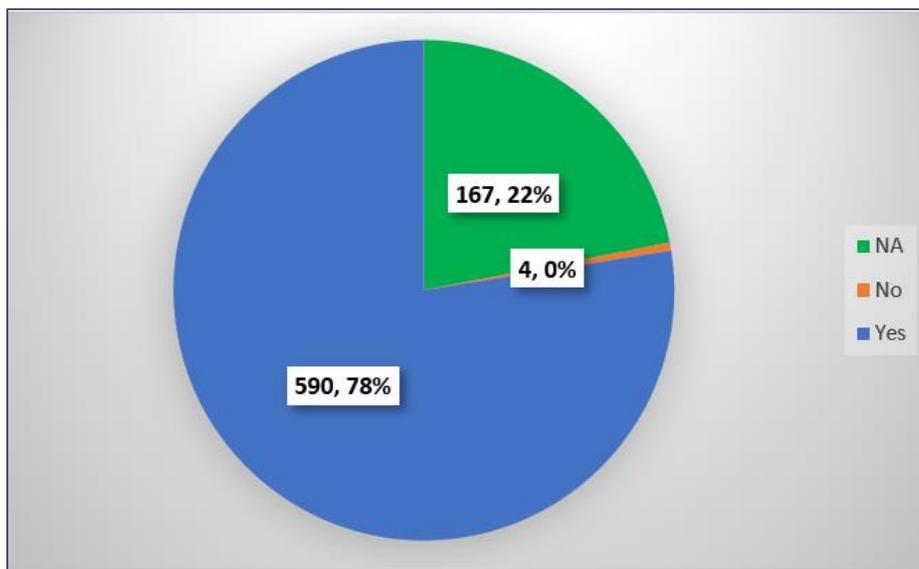
Table 2: outreach and engagement activities by AAA

	April	May	June
	Number of events held		
Community presentations and information sharing	46	25	47

Quality assurance for presumptive eligibility

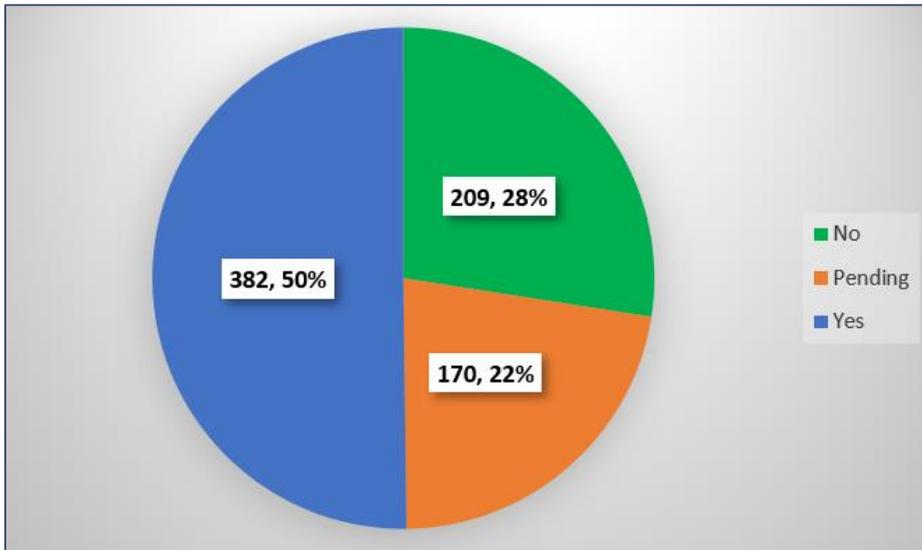
The presumptive eligibility (PE) quality assurance review was conducted for Q2. The sample size is 100 percent of the participants enrolled under PE. Results show that more than 99 percent of participants of were appropriately determined to meet nursing facility level of care.

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



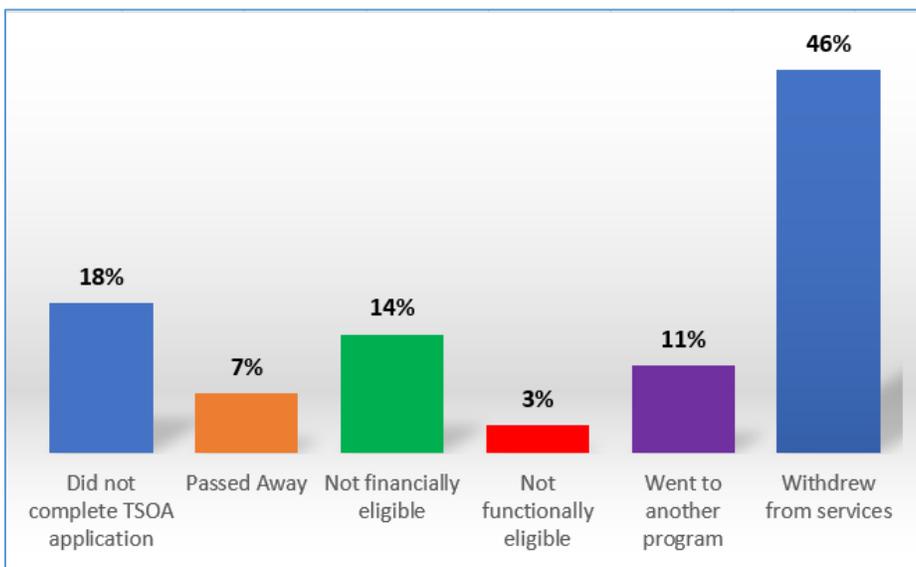
Note: The N/A represents clients who were part of the last quarter’s review and the response to question #1 was “yes” but the response to question #2a was “pending”.

Figure 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.

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



Note: These percentages represent the "No" population in the previous table (28%). For example, the 14% of PE clients found to be not financially eligible is 14% of the 28% illustrated in the Table for question 2a, which is 29 people.

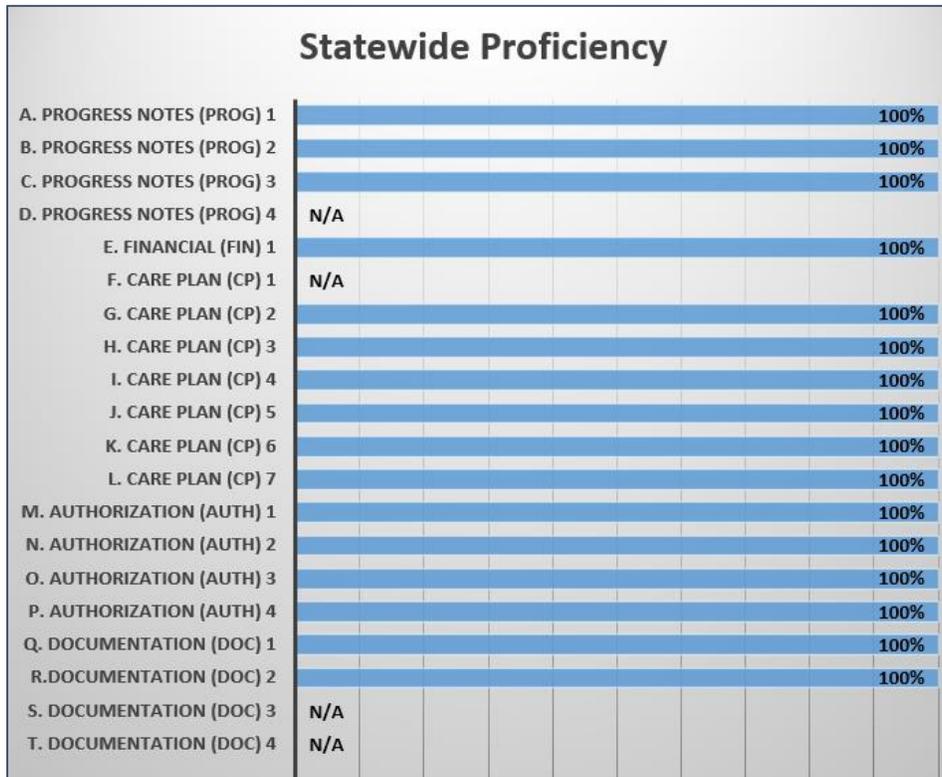
2021 quality assurance (QA) measures results to date

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

The statewide compliance review of the MAC and TSOA performance measures 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. These [questions are available online](#).

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.

Figure 5: statewide proficiency to date



State rulemaking

- There was no rulemaking activity related to MAC and TSOA programs during this quarter.

Upcoming activities

- Finalize development of another Tribal commercial video, working with Yakama Nation.
- Prepare for the upcoming Fall Tribal Summit.
- Continue analysis of current MAC and TSOA benefit packages and cost projections related to MTP renewal.

LTSS stakeholder concerns

- No stakeholder concerns were identified 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 April 1 through June 30, 2021. Key accomplishments for the quarter include:

- Total aggregate number of people enrolled in FCS services at the end of DY5 Q2:
 - CSS: 7,835
 - IPS: 6,080
- There were 166 providers under contract with Amerigroup at the end of DY5 Q2, representing 451 sites throughout the state.

Note: CSS and IPS enrollment totals include 2,299 participants enrolled in both programs. The total unduplicated number of enrollments at the end of this reporting period was 11,616.

Network adequacy for FCS

Table 3: FCS provider network development

FCS service type	April		May		June	
	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
Supported Employment – Individual Placement Support (IPS)	36	74	36	74	36	74
Community Support Services (CSS)	18	44	18	44	19	45
CSS and IPS	109	328	110	330	111	332
Total	163	446	164	448	166	451

The FCS provider network continued to grow month over month in Q2. Division of Behavioral Health and Recovery (DBHR) staff completed trainings to onboard SUD treatment providers who will start either CSS or IPS services or expand services to a new service location.

Client enrollment

Table 4: FCS client enrollment

	April	May	June
Supported Employment – Individual Placement and Support (IPS)	3,567	3,722	3,781
Community Support Services (CSS)	5,254	5,489	5,536
CSS and IPS	2,215	2,291	2,299
Total aggregate enrollment	11,036	11,502	11,616

Data source: RDA administrative reports

Table 5: FCS client risk profile

		Met HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
April	IPS	938 (16%)	N/A*	N/A*
	CSS	1,984 (27%)	N/A*	N/A*
May	IPS	952 (16%)	.96	4,436 (74%)
	CSS	2,058 (26%)	1.29	5,262 (68%)
June	IPS	969 (16%)	.96	4,444 (73%)
	CSS	2,096 (27%)	1.3	5,289 (68%)

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)

*Note: Data unavailable due to error in RDA data system

Table 6: FCS client risk profile, continued

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment needs flags
April	IPS	4,892	4,658 (95%)	3,113 (64%)	2,998 (61%)
	CSS	6,189	5,767 (93%)	4,651 (75%)	4,400 (71%)
May	IPS	5,088	4,827 (95%)	3,225 (63%)	3,096 (61%)
	CSS	6,453	5,994 (93%)	4,843 (75%)	4,570 (71%)
June	IPS	5,123	4,844 (95%)	3,231 (63%)	3,094 (60%)
	CSS	6,470	5,973 (92%)	4,821 (75%)	4,531 (70%)

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
April	IPS	4,892	457 (9%)	3,857 (79%)	1,988 (41%)	418 (9%)
	CSS	6,189	760 (12%)	4,303 (70%)	2,797 (45%)	649 (10%)
May	IPS	5,088	482 (9%)	3,957 (78%)	2,034 (40%)	438 (9%)
	CSS	6,453	778 (12%)	4,407 (68%)	2,901 (45%)	669 (10%)
June	IPS	5,123	489 (10%)	3,873 (76%)	2,009 (39%)	439 (9%)
	CSS	6,470	788 (12%)	4,288 (66%)	2,857 (44%)	673 (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
April	IPS	1,529 (26%)	106 (2%)	681 (12%)	2,582 (45%)	645 (11%)	128 (2%)

Washington State Medicaid Transformation Project demonstration

Approval period: January 9, 2017 through December 31, 2021

	CSS	2,349 (31%)	335 (4%)	969 (13%)	2,474 (33%)	1,127 (15%)	77 (1%)
May	IPS	1,589 (26%)	112 (2%)	706 (12%)	2,669 (44%)	686 (11%)	138 (2%)
	CSS	2,462 (32%)	344 (4%)	996 (13%)	2,586 (33%)	1,175 (15%)	79 (1%)
June	IPS	1,614 (27%)	117 (2%)	707 (12%)	2,721 (45%)	670 (11%)	136 (2%)
	CSS	2,495 (32%)	350 (4%)	997 (13%)	2,621 (33%)	1,158 (15%)	77 (1%)

ACA = Affordable Care Act

CHIP = Children's Health Insurance Program

CN = categorically needy

Data source: RDA administrative reports

QA and monitoring activity

RDA released their second evaluation of the FCS program at the end of Q2. This evaluation period includes data from the January 2018 through September 2019. This 18-month period highlights the outcomes of individuals enrolled in the FCS program compared to a statistically matched comparison group of Medicaid beneficiaries not enrolled in the FCS program. The [full report](#) is available on HCA's website.

Updated IPS findings include:

- Uniformly positive impacts on employment rates for both HCA and ALTSA populations.
- Modest increases in earnings and average hours worked among the HCA population.
- No statistically significant impacts on emergency department (ED) or inpatient utilization for ALTSA or HCA clients.

CSS findings include:

- Significant positive impacts on transitions out of homelessness for the HCA population.
- Statistically significant increases in the percentage of clients housed in housing projects funded by the Department of Commerce.
- Statistically significant increases in receipt of in-home services.
- No statistically significant impacts on ED utilization for ALTSA or HCA clients or community residential placements for ALTSA clients.
- Statistically significant increases in IP utilization and nursing facility placements.

The state continues to identify ways to build on the early success of the program. FCS staff will work with providers and the third-party administrator (TPA) to focus on the quality of services and engagement of enrollees with the services to increase service utilization in areas of the state where engagement is lower.

FCS program staff are working with RDA on an FCS metric that takes a closer look at service engagement by region and county to identify areas where there is an increased need for both enrollment and services. This tool will also provide data that will help inform decisions on ways to improve program outcomes and identify areas for improvement.

HCA staff also met regularly with the TPA to monitor the growth of the provider network and enrollment trends in the program. In Q2, the program saw an additional 2,000 enrollments, bringing the total number of enrollments to more than 20,000 unique individuals since the start of the program.

The FCS training staff completed 20 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) service models.

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

Other FCS program activity

HCA successfully procured 3,000 mobile phones with six months of bonus service for FCS enrollees. The phones were shipped to ACHs for distribution to the individual FCS providers in their area, as requested. Resources for obtaining additional services were provided to FCS providers to share with the enrollees. Through this partnership, HCA has distributed over 1,000 pay-as-you-go cell phones for FCS enrollees. FCS staff are actively engaging with providers on proper documentation and assistance with the mobile devices to ensure enrollees in need of a phone can receive one. HCA will continue to distribute the phones until they are fully dispersed in Q3 and Q4.

DBHR staff attended and presented about FCS at the Region X Community Action Conference and the Washington State Behavioral Health Care Conference.

FCS staff worked with other DBHR housing support programs to create an electronic toolkit to help discharge planners connect people exiting inpatient and other institutional settings with housing resources. This project was selected by Results Washington as a public performance project that aims to foster partnerships and focus on measurable outcomes to reduce homelessness.

HCA anticipates an initial pilot to launch in August 2021 before the finalized toolkit becomes readily available by early Q4. HCA will measure the increase in referrals to FCS and other recovery support and supportive housing programs in an effort to reduce the number of individuals discharging and returning to homelessness.

DBHR staff released requests for applications for two projects that support FCS providers: Ongoing funds that will incentivize FCS providers to either host or send staff to participate in fidelity reviews, and incentive funds that will allow up to 10 SUD treatment providers to become FCS providers of IPS or CSS services or expand these services to a new location.

Upcoming activities

DBHR will begin recruitment for the new FCS housing subsidy program manager early in Q3. The position will manage short-term housing subsidy funds allocated to HCA by the Washington State Legislature for the 2022-2023 biennium. These housing subsidies are to support people eligible for the FCS program in obtaining housing while receiving wraparound CSS supports. Similarly, the Department of Commerce received additional funds to support FCS enrollees in receiving long-term housing subsidies with the goal of maintaining permanent housing.

In Q3, FCS and Technical Assistance Collaborative staff will take part in a national webinar, part of the CMS learning collaborative focused on SUD supportive housing. Also, in Q3, DBHR and DSHS staff will jointly present updates on FCS at the statewide Conference on Ending Homelessness.

FCS program stakeholder engagement activities

HCA continues to receive inquiries about the FCS program from organizations and agencies both in and out of the state, including Washington’s ACHs and MCOs. HCA responds readily to these inquiries, usually by teleconference. During the reporting quarter, staff from HCA, AL TSA, and Amerigroup supported a variety of stakeholder engagement activities. DBHR-led training events in Q2 reached approximately 2,602 individuals from contracted provider agencies across the state.

Table 9: FCS program stakeholder engagement activities

	April	May	June
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	Number of events held		
Training and assistance provided to individual organizations	42	45	43
Community and regional presentations and training events	5	9	16
Informational webinars	10	12	12
Stakeholder engagement meetings	11	12	18
Total activities	68	78	88

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.

Q2 topics included:

- Work incentives
- Supported employment and supported education
- Building relationships with employers
- Landlord outreach learning community - harm reduction
- Career change in an upheaval
- Trauma informed care - disillusionment
- Marketing supported employment services to your agency
- Staff retention and rehiring
- The assessment process and prioritizing areas of need
- ISP components and goal development
- Enhancing equity, inclusion, and collaboration through person first language
- Applying the SMART framework
- Coordination of care in supportive housing
- Tools to utilize motivational interviewing
- Photovoice
- Benefits planning

FCS stakeholder concerns

HCA did not receive any stakeholder concerns during Q2. However, FCS program staff continue to address questions raised about waiver sustainability and the future of the FCS program. FCS staff engage on a weekly and monthly cadence with various provider groups and other program stakeholders to gather feedback and hear about program impacts.

SUD IMD waiver implementation accomplishments

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

This section summarizes SUD IMD waiver development and implementation activities from April 1 through June 30, 2021.

- The fiscal year 2021-2023 legislative session ended with some significant investments for behavioral health. For SUD services this included:
 - \$45 million in funding for recovery navigator programs.
 - More than \$42 million in funding to expand SUD services and supports including outreach, treatment, and recovery support services.
 - \$15.5 million in increased funding for Tribal residential SUD treatment providers.
 - \$5 million in funding for medication for opiate use disorder (MOUD) treatment in city, county, regional and Tribal jails.
 - Continued funding for rate increases to behavioral health providers.
 - Funding to enhance medication for medications for opiate use disorder (MOUD) tracking.
 - Funding for SUD family navigators.
 - Funding to support overdose prevention medications, such as Naloxone.
 - Funding to improve behavioral telehealth standards.
 - Funding for homeless outreach teams.

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. These changes, included in the state's SUD implementation plan, are described below:

- **Milestone 6:** The state will require residential and outpatient providers to improve coordination between levels of care.
 - **Updated:** Updated Washington administrative code (WAC) language was filed on 5/25/2021 with an effective date of 7/1/2021. WAC 246-341-1050 specifically requires that inpatient and residential SUD treatment providers:
 - g) Must develop and provide to the individual a discharge summary that must include:
 - (i) A continuing care recommendation; and
 - (ii) Scheduled follow-up appointments, including the time and date of the appointment(s).

SUD HIT plan requirements

- The HCA coordinated internally and with 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.

Evaluation design

- There were no updates during this reporting period.

Monitoring protocol

- There were no updates during this reporting period.

Upcoming activities

- Washington will join other Region X states in participating in the Region X Opioid Summit August 3-5.

Mental health IMD 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 April 1 through June 30, 2021.

- The fiscal year 2021-2023 legislative session ended with some significant investments for behavioral health. For mental health services this included:
 - Over \$64 million in funding to increase local behavioral health mobile crisis response team capacity to ensure response for calls coming into a new 988 crisis hotline.
 - Expanded clubhouse services.
 - Funding for homeless outreach teams.
 - Funding for peer support and recruitment.
 - \$20 million in additional funding of expanded mental health services and supports.
 - Additional funding for behavioral health Medicaid personal care services.
 - Crisis co-responder grants.
 - Short-term behavioral health housing supports.

Implementation plan

- There were no updates during this reporting period.

MH HIT plan requirements

- This quarter, the three HCA funded projects were completed. The projects support the HIT requirements under the MH IMD waiver and focused on:
 - Behavioral health performance measure study
 - Social determinants of health and telehealth
 - Clinical Integration Assessment Tool

Evaluation design

- Evaluation plan was submitted on 6/21/2021.

Monitoring protocol

- Monitoring plan was submitted on 6/24/2021.

Upcoming activities

- Bed registry work group
- Expanding use of HIT

Quarterly expenditures

The following table reflects quarterly expenditures for DSRIP, LTSS, and FCS during DY5 (2021). MCOs earned \$8,000,000 and ACHs earned \$3,179,624 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	\$8,105,396				\$4,177,698
Cascade Pacific Action Alliance	\$35,053	\$6,345,933				\$3,190,493
Elevate Health	\$44,571	\$8,756,298				\$4,400,435
Greater Columbia	\$250,000	\$11,147,815				\$5,698,908
HealthierHere	\$250,000	\$13,081,240				\$6,665,620
North Central	\$250,000	\$3,873,065				\$2,061,533
North Sound	\$250,000	\$11,603,517				\$5,926,759
Olympic Community of Health	\$250,000	\$3,063,344				\$1,656,672
SWACH	\$250,000	\$5,541,304				\$2,895,652
Indian Health Care Providers	\$0	\$2,898,115				\$1,449,058

Table 11: MCO-VBP 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
MCO-VBP					
Amerigroup WA	\$959,638	\$0			
CHPW	\$1,233,495	\$0			
CCW	\$946,640	\$0			
Molina	\$3,889,269	\$0			
United Healthcare	\$970,958	\$0			

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	\$5,563,325			
Medicaid Alternative Care (MAC)	\$128,419	\$137,639			
MAC and TSOA not eligible	\$0	\$573			
FCS	\$5,465,921	\$6,542,310			

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 February 2021. March 2021 through June 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 April 2021.

Table 13: 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	376,313				
Feb-17	375,210				
Mar-17	374,742				
Apr-17	373,596				
May-17	373,141				
Jun-17	373,045				
Jul-17	372,135				
Aug-17	371,869				
Sep-17	370,605				
Oct-17	370,408				
Nov-17	370,239				
Dec-17	370,266				
Jan-18	370,305				
Feb-18	368,932				
Mar-18	368,741				
Apr-18	367,482				
May-18	367,843				
Jun-18	367,123				
Jul-18	366,832	5	19	91	113
Aug-18	366,198	8	17	95	458
Sept-18	365,170	4	19	80	356
Oct-18	365,123	4	22	93	401
Nov-18	364,634	3	27	93	315
Dec-18	364,034	4	17	96	201
Jan-19	363,936	34	133	411	417
Feb-19	362,181	31	115	392	395
Mar-19	361,800	42	144	398	426
Apr-19	361,299	54	131	427	526
May-19	360,741	40	117	441	534
June-19	359,925	60	141	534	573
Jul-19	360,368	60	185	608	628
Aug-19	359,936	63	224	666	482
Sep-19	359,502	69	202	712	408
Oct-19	358,986	38	126	473	469

Nov-19	358,115	40	95	407	574
Dec-19	358,440	29	115	506	558
Jan-20	358,869	32	129	517	504
Feb-20	358,795	24	124	472	440
Mar-20	360,483	32	133	475	428
Apr-20	363,953	39	108	377	304
May-20	366,362	24	97	371	318
Jun-20	369,128	46	156	547	198
Jul-20	371,803	25	84	336	30
Aug-20	374,630	26	107	346	33
Sep-20	376,826	32	100	331	42
Oct-20	378,821	26	92	362	36
Nov-20	379,740	28	86	374	19
Dec-20	381,281	38	100	444	21
Jan-21	382,493	16	57	220	24
Feb-21	382,648	25	87	291	14
Mar-21	383,920	21	82	301	10
Apr-21	385,157	12	51	168	0
May-21	385,885				
Jun-21	386,638				
Total	19,946,647	1034	3442	12455	10255

Budget neutrality

- HCA adopted CMS's budget neutrality monitoring tool and has been using the Performance Management Database and Analytics (PMDA) system to upload quarterly spreadsheets. The annual budget neutrality report was recently submitted through PMDA at the end of June 2021.
- HCA is currently working on the data criteria for identifying expenditures and member months for the mental health IMD. HCA is planning on reporting costs related to SMI IMDs on the CMS-64 by quarter ending September 30, 2021.

Designated state health programs (DSHP)

- HCA contracted with Myers & Stauffer to perform an independent audit based on agreed-upon procedures to validate the accuracy of DSHP claims reported on the CMS-64 for CY 2019. Attached is a final report issued by Myers and Stauffer. HCA has also included a corrective action plan addressing the associated findings from the report.

Overall MTP development and issues

Operational/policy issues

Further discussion of the application with federal partners is anticipated as CMS considers approval of the state's application for a one-year extension. The state continues work on a longer-term MTP application for renewal, and submission to CMS is anticipated by the end of 2021. The state will continue policy development and legislative engagement in anticipation of legislative authorization of expenditure authority starting in 2023.

Consumer issues

The state has not experienced any major consumer issues for DSRIP, FCS, LTSS, or the SUD and MH IMD waivers during this reporting period, other than general inquiries about benefits available through MTP. Stakeholders and consumers continue to raise questions regarding the timing of feedback from CMS on the extension application and anticipated timeline for approval.

MTP evaluation

The IEE continued their active engagement on evaluation activities. The IEE's eleventh rapid cycle report was delivered on June 28, 2021, in compliance with the contracted deliverable timeline.

This report covers the IEE's activities from April 1 through June 30, 2021. The data analyzed includes measure results through June 2020. It presents findings in these areas:

Washington State's Medicaid system performance through June 2020, including key performance indicators in 10 measurement domains as well as an examination of equity and disparities within measurement domains. The report provides an early look at how the COVID-19 pandemic may have impacted health care and quality in Washington. The data for this report spans July 2019 through June 2020. While that time span includes the onset of the pandemic, a large portion of each metric's measurement year predates the pandemic.

- **Implementation findings** related to the transition to IMC and response to COVID-19. This section provides a progress update on the transition to IMC, integration support provided by MCOs and ACHs, and bi-directional integration efforts in behavioral health and primary care settings. Qualitative data was collected through key informant interviews and publicly available documents produced by HCA and the ACHs.

Key findings (extracted directly from the report):

We observed stark declines in emergency department utilization and hospital care, as well as preventive services such as well-child visits and oral health care. These changes likely reflect closures and behavioral changes related to the pandemic rather than impacts of the MTP demonstration on service utilization.

Notably, care for substance use disorders, including opioids, improved during this period, continuing positive trends in prior periods. We observed improvements in selected measures related to medication use and medication management.

Our ongoing evaluation of the state's transition to Integrated Managed Care (IMC) suggests that behavioral health provider organizations continue to experience delayed payments while also facing new administrative burdens and a need for a new health information technology infrastructure. Some progress toward clinical integration of primary care and behavioral health services has occurred, though behavioral health providers have been slower than physical health organizations to implement changes. ACHs and MCOs continue to offer support to providers to address these challenges during IMC transition.

Overall evaluation progress

In this reporting period, the IEE completed evaluation activities to support the ongoing evaluation of the MTP. These included:

- Quantitative analysis of Medicaid data, with the regular cyclic data production from HCA and RDA.
- Key informant interviews, including representatives from the state, ACHs and one interview with each of the five MCOs in Washington.
- Provider interviews, with primary care practice and hospital provider organizations selected from the provider survey administered from September 2019 through January 2020.
- Continued updating the ACH analytic case summaries, to develop a deeper understanding of ACH approaches, activities, and experiences.

Upcoming IEE activities

Evaluation activities are ongoing. Future reports will continue to present quantitative updates and assessments of performance metrics of MTP in 2021.

In future periods, the qualitative team will focus collection efforts on the FCS program. An initial sampling plan, interview guides and recruitment materials have been developed. Recruitment will begin in Q3 2021.

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, Q2 2021](#)
- Attachment C: [DSHP independent audit report for CY2019](#)
- Attachment D: [CY2019 audit corrective action plan](#)

Note: per CMS instructions (as of July 15, 2021), Washington State will not be submitting an 1115 SUD Demonstration Monitoring Report Part B (monitoring protocol) this quarter. The state anticipates resuming reporting next quarter after receiving updated technical specifications.

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	Debbie Johnson	Initiative 2 Program Manager, DSHS	360-725-2531
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, Q2 2021

[View this table on the HCA website](#), which shows all funds earned and distributed through the FE portal through June 30, 2021.

Attachment C: DSHP independent audit report for CY2019

[View this report on the HCA website.](#)

Attachment D: CY2019 audit corrective action plan

[View this document on the HCA website.](#)