STATE OF WASHINGTON

March 10, 2022

Dear Members of the Joint Select Committee on Health Care Oversight:

SUBJECT: Quarterly Report on the Medicaid Transformation Project Demonstration

Pursuant to ESSB 5092, Sections 211 (2)(a)&(b), (3) and (4), enclosed please find two documents reporting on the activities, outcomes, financial status, and expenditures of the Medicaid Transformation Project Demonstration. The first is a copy of our recently submitted report to the federal Centers for Medicare and Medicaid Services (CMS). Under the terms of our agreement with CMS, the state is required to report quarterly on the activities and accomplishments of the Demonstration. Within the report is a quarterly expenditure and FTE report covering all three initiatives of the Demonstration. Given that the information contained in the report is the same as what we believe to be required under ESSB 5092, we respectfully suggest that the same report can fulfill both needs. However, please let us know if there is additional information you require.

The second document is a Medicaid Quality Improvement Program (MQIP) report is now included as a deliverable within our quarterly update. The MQIP report was required in the corresponding budget proviso.

The third document is an Accountable Communities of Health (ACH) activities report. This is also now included as a deliverable within our quarterly update.

If you have questions or require additional information, please do not hesitate to contact us.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Director
Health Care Authority

Jilma Meneses
Secretary
Department of Social and Health Services

Enclosures

By email

cc: Senate Ways and Means Committee, leadership and staff
Senate Health and Long-Term Care Committee, leadership and staff
House Appropriations Committee, leadership and staff
House Health Care and Wellness Committee, leadership and staff Joint
Select Committee on Health Care Oversight, leadership and staff Senate
and House, Democratic and Republican Caucus staff Governor's Office,
Senior Policy Advisors
Office of Financial Management, HCA Budget Assistants

Washington State Medicaid Transformation Project demonstration
Section 1115 Waiver Annual Report (DY5)/Quarterly Report (DY5 Q4)
Demonstration Year: 5 (January 1 to December 31, 2021)
Reporting Quarter: 4 (October 1 to December 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, called the Medicaid Transformation Project (MTP). MTP activities aim to improve the health and wellness systems' capacity to address local health priorities, deliver high-quality, cost-effective, whole-person care, and create a sustainable link between clinical and community-based services.

Over the MTP 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.

Annual report: demonstration year 5 (2021)

In accordance with special terms and conditions (STCs) 76 and 42 C.F.R. § 431.428, this report summarizes the activities and accomplishments for the fifth demonstration year (DY) of MTP (DY5). It documents accomplishments, project status, and operational updates and challenges.

Visit the Medicaid Transformation webpage to learn more about HCA's MTP work.

Policy and administrative updates

MTP in 2021

MTP programs continued COVID-19 response as the pandemic continued to impact organizations and communities across the state. In addition, the state and its partners continued preparations for the DY6 extension, including ongoing coordination with and CMS approving in December 2021.

The state worked on a five-year MTP renewal package during 2021, which included significant engagement with partners to explore enhancements to existing programs and consider lessons learned over the current MTP waiver This work will continue in 2022 and the state has received CMS approval for a delayed renewal application timeline of mid-2022.

MTP amendments

The state continues to coordinate with CMS regarding MTP amendment requests. Amendments relate to presumptive eligibility and transportation services within Initiative 2 and the adjustment of the value-based purchasing target from 90 percent to 85 for DY5.

Annual expenditures

Delivery System Reform Incentive Payment (DSRIP) program expenditures

During January 1 through December 31, 2021, **all nine** ACHs earned nearly **$83.1 million** in project incentives and integration incentives for demonstrating completion of required project and integration milestones during DY5. This includes the submission of implementation plans. During DY5, IHCPs earned nearly **$2.9 million** for IHCP-specific projects.

Table 1: 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	$0	$757,226	$9,112,622	$4,556,311
Cascade Pacific Action Alliance	$35,053	$6,345,933	$0	$688,388	$7,069,374	$3,534,687
Elevate Health	$44,571	$8,756,298	$0	$826,065	$9,626,934	$4,813,467
Greater Columbia	$250,000	$11,147,815	$0	$963,743	$12,361,558	$6,180,779
HealthierHere	$250,000	$13,081,240	$0	$1,514,452	$14,845,692	$7,422,846
North Central	$250,000	$3,873,065	$0	$344,194	$4,467,259	$2,233,630
North Sound	$250,000	$11,603,517	$0	$1,032,581	$12,886,098	$6,443,049
Olympic Community of Health	$250,000	$3,063,344	$0	$275,355	$3,588,699	$1,794,350
SWACH	$250,000	$5,541,304	$0	$481,871	$6,273,175	$3,136,588

Indian Health Care Providers	$0	$2,898,115	$0	$0	$2,898,115	$1,449,058

Table 2: 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				$959,638
CHPW	$1,233,495				$1,233,495
CCW	$946,640				$946,640
Molina	$3,889,269				$3,889,269
United Healthcare	$970,958				$970,958

Table 3: 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	$3,966,823	$5,461,087	$16,000,014
Medicaid Alternative Care (MAC)	$128,419	$137,639	$92,313	$141,788	$407,846
MAC and TSOA not eligible	$0	$573	$0	$27	$600
FCS	$4,304,004	$4,809,098	$4,407,602	$5,137,076	$18,657,780

LTSS data annual summary

Table 4: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of December 31, 2021	289	2178	4460
Number of new enrollees in 2021 by program	144	1073	1887
Number of new person-centered service plans in 2021 by program	78	415	916
Number of beneficiaries self-directing services under employer authority	0	0	0

FCS data annual summary

Reports are available on MTP reports page. These reports provide a month-by-month look at Medicaid clients enrolled in IPS and CSS since the programs began in January 2018.

Table 5: FCS client enrollment 2021

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Supported Employment – Individual	2,520	2,580	2,510	2,481	2,529	2,536	2,571	2,569	2,687	2,645	2,616	2,640

Placement and Support (IPS)												
Community Support Services (CSS)	3,710	3,857	3,800	3,835	3,962	3,988	4,032	4,081	4,283	4,234	4,225	4,288
CSS and IPS	1,485	1,390	1,237	1,211	1,254	1,307	1,347	1,611	1,596	1,644	1,674	1,675
Total aggregate enrollment	7,715	7,827	7,547	7,527	7,745	7,831	7,950	8,261	8,566	8,523	8,515	8,603

Data represents cumulative enrollment (number of individuals who had been enrolled at least one month during the life of the program). Month-to-month changes are because of client enrollment mix, not program impact. Some individuals may be enrolled in both IPS and CSS.

Data source: Research and Data Analysis (RDA) Division administrative reports

MTP evaluation

In 2018, HCA began working with an independent external evaluator, the Center for Health System Effectiveness (CHSE) at Oregon Health and Science University. CHSE is responsible for evaluating the overall success and effectiveness of MTP. In DY5, CSHE continued its active engagement.

Notable deliverables for the MTP evaluation in 2021 include:

Rapid-cycle Monitoring Reports

CHSE produces this report for the first three quarters as part of their evaluation, which highlights MTP quarterly activities, key findings (as available) from analyses, and a summary of MTP activities planned for the coming quarter. These reports also highlight the work and progress across all initiatives as implementation continues. Rapid-cycle Monitoring Reports are available on the Medicaid Transformation reports page.

The reports received in DY5 include:

- **Tenth Rapid-cycle Monitoring Report:** delivered on March 31, 2021, this report highlighted the COVID-19 impacts on data collection. Highlights and key findings for this report include:
    - Substantial and continued improvement in measures related to SUD and opioid use disorder (OUD) – a trend that has continued since the Interim Evaluation Report. Improvements were made in some preventive and wellness services, such as childhood immunizations and body mass index (BMI) screenings but showed worsening performance on others, such as well-child visits for children ages 3-6.
    - Improvement in antidepressant medication management for adults, other measures of mental health care declined. The 30-day rates of follow-up care after an emergency department visit or hospitalization for mental illness continued to worsen. Readmission rates for psychiatric conditions also increased. This is an important area for the state to monitor closely.
    - The ACH model provides a framework for integrating equity into the health system transformation goals of MTP. There is evidence that ACHs have sought to address equity in the areas that are commonly described as the core elements of the ACH model, such as community partnerships, shared definitions and language, and data sharing.
    - 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 COVID-19 response.

- **Eleventh Rapid-cycle Monitoring Report:** delivered on June 30, 2021, performance measures in this report reflected early impacts of COVID-19 on Washington's health care delivery system and Medicaid population. Highlights and key findings for this report include:
    - 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 facility closures and behavioral changes related to the pandemic rather than impacts of the MTP demonstration on service utilization.
    - Care for SUD, including opioids, improved during this period, continuing positive trends in prior periods. Improvements in selected measures related to medication use and medication management.
    - 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 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 managed care organizations (MCOs) continue to offer support to providers to address these challenges during the IMC transition.
- **Twelfth Rapid-cycle Monitoring Report:** delivered on September 30, 2021, performance measures in this report include the first six months of the COVID-19 pandemic in Washington State. Highlights and key findings for this report include:
    - Access to care changed in complex ways in 2020. Emergency department visits and hospitalizations declined sharply in the early months of COVID-19, as did access to oral health care. Declines in well-child visits for Medicaid members ages 3-6 were among the most dramatic changes in performance early in the pandemic. There were also decreases in access to primary care, preventive screenings, and mental health care.
    - Some care areas remained stable or improved in the early months of the pandemic. Chronic disease management services that could be delivered virtually, such as medication management, remained stable during this period. Timely prenatal care and SUD treatment continued to improve statewide.
    - Measures of access, quality, and utilization differed among Medicaid members. Rates of opioid prescribing to Black members remained markedly higher than for other enrollees, while access to OUD treatment was lower. Rates of emergency department utilization and hospitalizations were higher among American Indian (AI)/Alaska Native (AN) and Black members than for other groups. Rates of arrest and homelessness were relatively unchanged but occurred at higher rates among individuals with serious mental illness.
    - ACHs have played a fundamental role in promoting Domain One activities and overall progress. They have identified gaps, provided education and training, and primed their organizational partners for success. Nevertheless, ACHs face limitations in advancing Domain One efforts. ACHs do not have the finances or the authority to remove these barriers, making these essential areas for HCA involvement.

State legislative developments

The Washington State Legislature's 2021 session ran from January 11 to April 25, 2021. As anticipated, the operating budget provided continued spending authority for MTP. At the request of the Legislature, the state presented MTP updates to multiple legislative committees during 2021 and responded to targeted questions from legislators and staff. The state continued to discuss the DY6 extension and plans for the

five-year renewal request, including legislative direction related to MTP waiver strategies and related priorities that resulted from the 2021 legislative session.

MTP Public Forum

In mid-December, HCA held a virtual MTP Public Forum for DY5 to cover several topics:

- Overview of MTP and its initiatives
- Summary of ACHs' COVID-19 response activities
- Summary of this year's achievements and challenges, by initiative
- Update on the MTP one-year extension and amendment (January–December 2022)
- Update on the MTP five-year renewal (2023-2027)

There was also dedicated time at the end for Q&A with attendees. View the slide deck or watch the recording.

Summary of public comments received during DY5

The following public comments were received during DY5, organized by program:

DSRIP program public comments

Quarter 1

- No MTP stakeholder concerns were reported during.

Quarter 2

- No MTP stakeholder concerns were reported during.

Quarter 3

- No MTP stakeholder concerns were reported during.

Quarter 4

- ACHs and IHCPs raised concerns regarding the importance of the DY6 extension (prior to the state receiving CMS approval). In addition, comments focused on the need to begin planning even earlier for the five-year renewal to mitigate the loss of contracts, capacity, and overall progress on key strategies, such as community-based care coordination.

LTSS program public comments

Quarter 1

- There were no stakeholder concerns submitted this quarter

Quarter 2

- No stakeholder concerns were identified this quarter.

Quarter 3

- No stakeholder concerns were submitted during this quarter.

Quarter 4

- Stakeholders continued to share their concerns about the lack of available respite and personal care providers across the state.

FCS program public comments

Quarter 1

- The FCS program received no public comments or questions during Q1.

Quarter 2

- FCS program staff received questions regarding waiver sustainability and the future of FCS services.

Quarter 3

- The FCS team received feedback and questions regarding the extension year of the waiver and waiver renewal. Stakeholders expressed strong interested in continuing FCS services and opportunities for improvement.
- The FCS provider network expressed significant staffing shortages due to the COVID-19 pandemic, as well as local and federal vaccine mandates.

Quarter 4

- The FCS program continued to receive questions about extension-year approval and weighed in on opportunities for improving the program during the potential 5-year extension. Two different MCOs inquired about whether FCS would be extended under 1115 waiver authority or transitioned to managed care.

Quarterly report: October 1–December 31, 2021

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

Summary of quarter accomplishments

- In December 2021, CMS approved the state's one-year extension request, to extend MTP through December 31, 2022. The state worked quickly to amend applicable contracts and get work underway for 2022.
- The state continues work on a longer-term MTP application for renewal, and submission to CMS is anticipated in July of 2022. HCA will share renewal concepts and ideas with CMS during the months before submission.
- ACHs continue to distribute incentive funds to partnering providers through the financial executor (FE) portal. During the reporting quarter, ACHs distributed more than $27.7 million to 291 partnering providers and organizations in support of project planning and implementation activities. The state distributed approximately $1 million in earned incentive funds to IHCPs in Q4 for achievement of IHCP-specific project milestones.
- As of December 31, 2021, over 11,800 clients have received services and supports from the MAC and TSOA programs. New enrollees in LTSS for this reporting period include 30 MAC dyads, 217 TSOA dyads, and 461 TSOA individuals.
- Within FCS, the total aggregate number of people enrolled in services at the end of DY5 Q4 includes 4,315 in IPS and 5,963 in CSS. The total unduplicated number of enrollments at the end of this reporting period was 8.603.

MTP-wide stakeholder engagement

During the reporting period, HCA announced that CMS approved the state's MTP one-year extension. In addition, HCA updated The future of MTP, MTP renewal, and One-year extension and amendment pages to reflect DY6.

The agency will continue to update fact sheets, FAQs, and other online documents and publications to reflect this additional year and renewal efforts.

Statewide activities and accountability

Value-based purchasing (VBP)

In Q4, HCA began a series of strategy meetings to revisit VBP goals for 2022-2025, building on MTP and VBP priorities and focus areas and the original purchasing goal of achieving 90 percent of state-financed health care in value-based payment arrangements by the end of 2021. HCA expects to refine a new set of purchasing goals in Q2 or Q3 of DY6.

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 DSRIP incentives for MCOs and ACHs. HCA published the annual update to the Apple Health Appendix in Q4. HCA expects to update the VBP Roadmap in DY6 to capture HCA's strategic vision (published in Q4) and HCA's forthcoming purchasing goals for 2022-2025. HCA will request adjustments and will coordinate with CMS on a revised VBP incentive approach in DY6.

Validation of financial performance measures

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

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

The IA successfully completed the validation of MCO VBP data submissions. Upon completing the validation of MCO VBP performance on VBP adoption and provider incentives metrics, the IA delivered a final report to HCA and began disseminating formal communications to MCOs and ACHs about their performance.

The tables below provide details on the MCO and ACH incentives for VBP adoption provider incentives targets. They also include the partial earn-back where MCOs did not achieve the target.

Table 6: MCO achievement of VBP targets

MCO	% VBP	DY4 target	Target achieved	Partial earn-back
IMC				
Amerigroup	77%	85%	No	91%
Community Health Plan	87%	85%	Yes	N/A
Coordinated Care	85%	85%	Yes	N/A
Molina	80%	85%	No	94%
United Healthcare	87%	85%	Yes	N/A
IFC				
Coordinated Care	84%	85%	No	99%

Table 7: MCO achievement of quality targets

MCO	% incentives	DY4 target	Target achieved	Partial earn-back
IMC				
Amerigroup	1.37%	1.25%	Yes	N/A
Community Health Plan	2.84%	1.25%	Yes	N/A
Coordinated Care	4.57%	1.25%	Yes	N/A
Molina	3.85%	1.25%	Yes	N/A
United Healthcare	2.38%	1.25%	Yes	N/A
IFC				
Coordinated Care	2.65%	1.25%	Yes	N/A

Table 8: achievement of DSRIP-funded p4p incentives earned by MCOs and ACHs

	% VBP	DY4 target	Target achieved	MACRA A-APM arrangement**	% incentives earned*
MCO					
Amerigroup	77%	85%	No	No	TBD
Community Health Plan	87%	85%	Yes	Yes	TBD
Coordinated Care	85%	85%	Yes	No	TBD
Molina	80%	85%	No	Yes	TBD
United Healthcare	87%	85%	Yes	No	TBD
ACH					
Better Health Together	84%	85%	No	Yes	TBD
Cascade	79%	85%	No	Yes	TBD
Elevate Health	87%	85%	Yes	Yes	TBD
Greater Columbia	72%	85%	No	Yes	TBD
HealthierHere	85%	85%	Yes	Yes	TBD
North Central	83%	85%	No	Yes	TBD
North Sound	83%	85%	No	Yes	TBD
Olympic	75%	85%	No	Yes	TBD
SWACH	79%	85%	No	Yes	TBD

*Pending CMS determination on performance-weighting options.

**Medicare Access and CHIP Reauthorization ACT of 2015 (MACRA) Advanced Alternative Payment Model (A-APM)

Statewide progress toward VBP targets

HCA sets annual VBP adoption 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. HCA collected data from commercial and Medicare payers and providers through an annual survey. HCA completed the analysis of the health plan and provider Paying for Value surveys and will publish the results to the Tracking success page in Q1 of DY6. HCA will also present these findings publicly in Q1 of DY6.

Technical support and training

- No activities to report in Q4

Upcoming activities

- HCA will present findings from the paying for value survey in Q1 of DY6
- HCA will prepare for the 2022 MCO VBP validation process in Q2 of DY6

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 Q4:

- As directed by Senate Bill (SB) 6312, statewide integration was achieved in January 2020. With the support of ACHs, HCA continued 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. Updates for this reporting period include:
    - Earlier this year, HCA collaborated on a short-term behavioral health performance measure project, which included a series of regional provider meetings supported by 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.

HCA has partnered with the MCOs and ACHs to advance these recommendations and ongoing monitoring of these performance measures. HCA, in partnership with ACHs, have completed follow-up meetings in six of the 10 regions, with the remaining four regions scheduled for the first quarter of 2022. These meetings are facilitated discussions with the regional providers, MCOs, ACHs, and behavioral health administrative service organizations (BH-ASOs). Ongoing collaboration will help the state monitor these performance measures and advance improvements across the state.

Earlier in 2021, the state completed its research to identify a new clinical integration assessment tool to better support the advancement of bi-directional physical and behavioral health clinical integration in Washington state. The tool, called the WA Integrated Care Assessment (WA-ICA) will be completed by outpatient behavioral and physical health practices to track progress and to serve as a roadmap for practice teams in advancing integration. Domains and subdomains on the WA-ICA include screenings, referrals, care management, and sharing treatment information.

As reflected in the WA-ICA tool, as practices become more clinically integrated, the need for health information technology/electronic health records (EHR) tools increases. Throughout 2021, ACHs, MCOs and the HCA collaborated to select the assessment tool, pilot-test among a mix of providers, and begin development of an implementation strategy. This includes collecting, compiling, and analyzing the data, generating, and distributing reports, and technical and quality improvement coaching support that will be provided.

During the last quarter of 2021, methodology was introduced for identifying practice cohorts and an implementation schedule was developed. The communication workgroup continued to develop comprehensive set of strategies for outreach and engagement, including placing an Advancing clinical integration page on the HCA website and a panel discussion at the ACH Learning Symposium. Implementation will begin in July 2022 with an initial cohort of practices. Additional cohorts will begin to use the tool every six months, through July 2024.

Health information technology (HIT)

The HIT 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 focuses on three phases of Transformation work: design, implementation and operations, and assessment.

Q4 of 2021 focused heavily on planning for several health IT-related initiatives, including:

- 2022 Health IT Operational Plan
- Nationally required 988 crisis call line and the related and more expansive state requirements for a Crisis Call Center Hub System and a Behavioral Health Integrated Referral System
- Electronic Health Record as a Service (EHRaaS)
- Electronic Consent Management Solution

Work in these areas and additional tasks areas are described below.

Activities and successes

The HIT team spent much of Q4 2021 continuing its focus on advancing multi-year initiatives involving HIT. In Q4 HCA staff met with staff and leadership within and across state agencies to finalize the 2022 Health IT Operational Plan. The 2022 Plan includes 28 tasks spread across these 10 categories:

- EHRs
- Crisis call center and related activities
- MH IMD waiver
- Alternative payment models (APMs)
- Digital quality measures
- SDOH and Long Term Care (LTC)/social service data exchange
- CMS interoperability rules
- CDR functions
- MTP extension and renewal
- Tribal engagement

The ability to undertake many of these tasks (e.g., HIT tasks to support the MH IMD waiver HIT requirements) is contingent on the availability of funds.

- The Governor's Office submitted its budget proposal to the state legislature requesting funds to support the implementation of the HIT requirements for the MH IMD waiver, as requested in the HCA's decision package.
- HCA coordinated internally and with the Department of Health (DOH) to support implementation planning for the nationally required 988 crisis call system and the Crisis Call Center Hub System and the Behavioral Health Integrated Client Referral System required under state law. In addition, HCA led the development of the statutorily required Draft Technical and Operational Plan for these systems. The draft plan will be submitted to the Governor's Office and State Legislature in Q1 2022.
- The state completed the planning phase and started implementation of the Health and Human Services (HHS) Coalition Master Person Index (MPI) Project. This effort supports the development of client identity management across HHS Coalition programs and systems. An initial project phase focused on supporting the DOH's COVID-19 response. The project is currently developing the technical integration layer that will be used to connect coalition systems to the MPI. The MPI project is in the process of hiring two critical staff positions: MPI Governance Manager and MPI Architect.
- The Provider Directory and Patient Directory Application Programming Interfaces (APIs) went live in Q4.
- The state finalized the technical requirements needed for the cloud-based EHR solution that will be made available statewide to behavioral health, rural health, tribal health, and long-term care providers seeking to implement an EHR solution.
- The state will develop a request for proposals (RFP) for a lead organization to support the implementation of the statewide EHR solution as soon as funding is finalized.
- The state continued conversations with ACHs to identify and better understand activities underway related to community information exchange (CIE).
- HCA, in collaboration with ACHs and MCOs, continued preparing for the July 2022 implementation of the WA-ICA for the first cohort of outpatient primary care and behavioral health providers. The WA-ICA is a provider-level clinical self-assessment instrument and process to improve level of clinical integration. During this quarter, MCOs, ACHs, and the HCA identified HealthierHere (an ACH) as the entity to receive and analyze WA-ICA assessment results and generate reports for

providers, MCOs, and HCA regarding clinical integration. Planning for the initial implementation continues.

- HCA's Privacy Officer provided an update on the HIT Operational Plan during the bi-monthly meeting. They presented on the privacy requirements for health information access and exchange on behalf of a hypothetical person with co-occurring mental health and SUDs. The presentation provided an overview of federal privacy requirements (i.e., HIPAA and 42 CFR Part 2) and Washington State privacy requirements. The presentation discussed the applicability of these requirements in the context of several information exchange scenarios.
- HCA continued the collaboration with ACHs, MCOs, and Collective Medical (a technology vendor) to explore opportunities and barriers to advance health information exchange (HIE) on behalf of persons who receive behavioral health services, including persons being discharged from psychiatric hospital to community-based providers (i.e., primary care providers, mental health).

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 next set of ACH semi-annual reports (SARs) are due on January 31, 2022, for the July 1 – December 31, 2021, 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 state continues to review SARs and quarterly ACH activity repots to inform sustainability planning, including the MTP renewal effort and identified priorities related to health equity, community-based care coordination, and addressing SDOH.

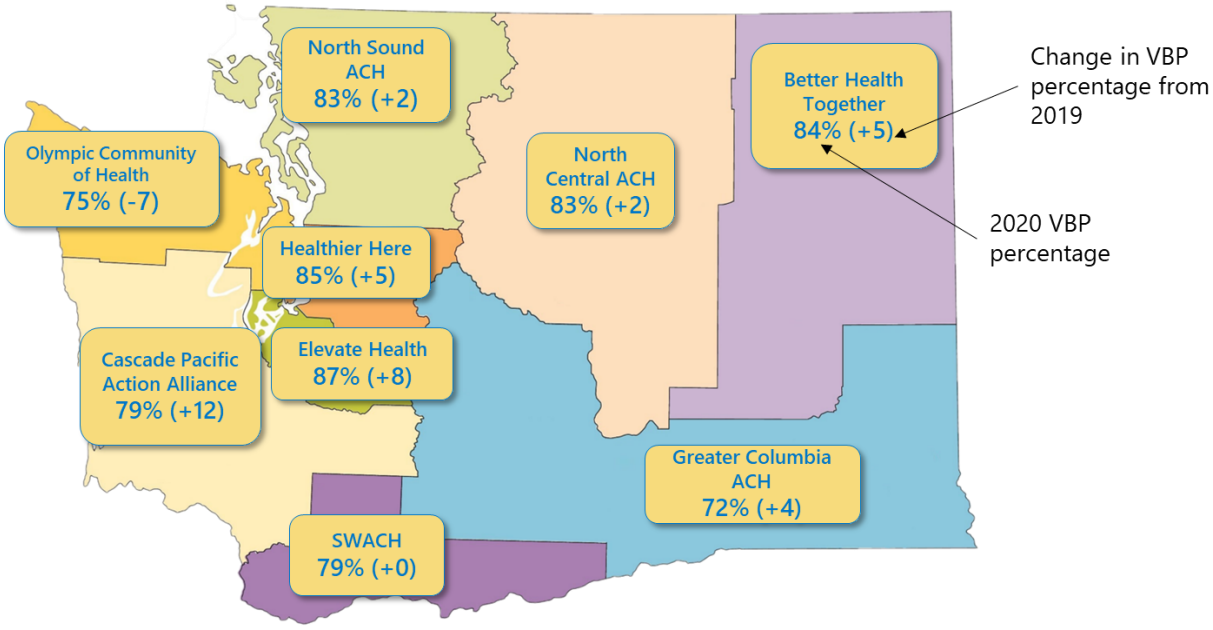
Annual VBP milestone achievement by ACHs

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.

Each ACH was instrumental in promoting and encouraging provider participation in the 2021 provider Paying for Value survey, which tracks progress and experience from calendar year 2020. A total of 62 unique provider organizations responded to the 2021 survey, down from 170 from the 2020 survey. Survey fatigue, general fatigue from system constraints in the pandemic, or a combination of the two could have contributed to the decline in survey participation. Additionally, HCA adopted a new survey platform in 2021, which could have led to confusion or presented a barrier to participation.

The figure below shows MCO VBP adoption for calendar year 2020 by ACH region, with the change from calendar year 2019 in parenthesis. Two of the nine ACH regions achieved the VBP adoption target for 2020 of 85 percent.

Figure 1: MCO VBP adoption for 2020 by ACH region



FE portal activity

ACHs continue to distribute incentive funds to partnering providers through the FE portal. During the reporting quarter, ACHs distributed more than $27.7 million to 291 partnering providers and organizations in support of project planning and implementation activities. The state distributed approximately $1 million in earned incentive funds to IHCPs in Q4 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 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 submitted revisions to foundational documents to support extension year operational performance requirements and changes, including a proposal to expedite incentive payments to ACHs and IHCPs in DY6. Additionally, HCA requested changes to DY5 performance measurement and updates to DY4 and DY5 rules to create more consistency between gap-to-goal and improvement-over-self-benchmark limits.

Statewide results

HCA submitted the DY4 statewide accountability report to CMS on December 29, 2021. Because of the COVID-19 pandemic, CMS waived the DY4 statewide accountability requirements. This includes the quality improvement and VBP adoption outcomes.

The VBP adoption for DY4 was 81.82 percent. MCOs did not collectively meet the target of 85 percent. With the current scoring methodology, the state's overall VBP adoption earnings would be 27 percent ($830,230) of the total at-risk dollars ($3,030,200) for DY4, and if not waived, total funds lost would have been 73 percent.

The state's performance toward the Quality Improvement Strategy (QIS) measures was 1.00, which the state met and exceeded the QIS threshold expectation of 20 percent. There were six measures that met the

quality or improvement score baseline requirement, providing a measure composite score to be weighted for the total QIS. Three measures did not improve from their previous baseline and received a zero (0) in the measure composite score, contributing only as a weight percentage against the total QIS.

DSRIP program stakeholder engagement activities

During the reporting period, HCA:

- Promoted the 2021 Learning Symposium. This included GovDelivery announcements (for external audiences, such as partners, providers, stakeholders, and other interested parties) and internal messaging to encourage HCA staff to attend. HCA also updated the Learning Symposium page.
- Announced that ACHs earned full incentives for January–June 2021.

DSRIP stakeholder concerns

Stakeholder concerns in Q4 2021 centered on the perceived uncertainty regarding CMS approval of the DY6 extension, but the state continued to assure partners that the state was working in close coordination with CMS and that approval was anticipated by end of year.

Upcoming DSRIP activities

Following approval of the DY6 extension, the state will submit several requested adjustments in Q1 2022 tied to reporting, performance, and funds flow. ACHs will extend contracts with providers in early 2022 to continue priority strategies while also continuing regional planning to transition investments and strategies as DSRIP ends.

The state and ACHs will continue to collaborate on the five-year renewal in Q1 2022. Weekly engagement with ACHs will continue and the focus will shift from DY6 preparation to even greater emphasis on renewal planning, including a concerted effort to refine the scope to emphasize health equity and addressing SDOH.

In Q4 2021, HCA received approval of the submitted Statewide Accountability Report. HCA is now coordinating with the IA to finalize ACH regional pay-for-performance (P4P) and high-performance pool (HPP) results for DY5. These results and corresponding regional earned incentives are expected to go out in Q2 DY5.

Tribal project implementation activities

Primary milestone: Distribution of $1,097,319 in IHCP-specific Projects incentives.

Tribal partner engagement timeline

October 1: hosted Roundtable on inclusion of Dental Health Aide Therapists (DHATs) as an 1115 waiver amendment

October 4: met internally to discuss the Primary Care Case Management entity (PCCMe) program and alignment with other HCA initiatives

October 4: hosted workgroup with the American Indian Health Commission (AIHC) for IHCPs to participate in the design of the PCCMe program

October 4: attended the North Sound ACH (NSACH) Tribal Alignment Committee meeting

October 8: meeting between the Governor's Indian Health Advisory Committee (GIHAC) and the Tribal Leaders Social Services Council (TLSSC), hosted by the Department of Social and Health Services (DSHS), to align work and reduce duplication

October 11: hosted workgroup with AIHC for IHCPs to participate in the design of the PCCMe program

October 13: participated in Better Health Together's (BHT's) Tribal Partners Leadership Council

October 13: hosted Consultation on inclusion of DHATs as an 1115 waiver amendment

October 14: participated in the EHR as a Service (EHRaaS) internal workgroup

October 18: hosted workgroup with AIHC for IHCPs to participate in the design of the PCCMe program

October 25: hosted workgroup with AIHC for IHCPs to participate in the design of the PCCMe program

October 26: hosted GIHAC meeting

October 27: participated in state-wide annual Centennial Accord meeting

November 1: hosted workgroup with AIHC for IHCPs to participate in the design of the PCCMe program

November 2-4: participated in the annual ACH/HCA Learning Symposium

November 5: participated in internal meeting regarding MTP renewal application, specifically Initiative 1

November 8: met with AIHC regarding the Biennial Indian Health Improvement Plan, a deliverable associated with GIHAC

November 8: hosted workgroup with AIHC for IHCPs to participate in the design of the PCCMe program

November 10: participated in BHT's Tribal Partners Leadership Council

November 15: met with AIHC to discuss Biennial Indian Health Improvement Plan

November 15: met with IHCP to discuss EHRaaS

November 15: hosted workgroup with AIHC for IHCPs to participate in the design of the PCCMe program

November 18: participated in the EHRaaS internal workgroup

November 22: hosted workgroup with AIHC for IHCPs to participate in the design of the PCCMe program

November 24: participated in internal meeting regarding MTP renewal application, specifically Initiative 1

November 29: hosted workgroup with AIHC for IHCPs to participate in the design of the PCCMe program

November 30: hosted meeting with other state agencies represented on GIHAC regarding the Biennial Indian Health Improvement Plan

December 3: participated in the Behavioral Health Aides Advisory Workgroup

December 6: participated in a joint meeting between the Northwest Washington Indian Health Board (NWWIHB) and North Sound ACH

December 6: hosted workgroup with AIHC for IHCPs to participate in the design of the PCCMe program

December 8: participated in BHT's Tribal Partners Leadership Council

December 8: participated in internal meeting regarding MTP renewal application, specifically Initiative 1

December 9: hosted GIHAC

December 9: participated in the EHRaaS internal workgroup

December 13: participated in internal meeting regarding MTP renewal application, specifically Initiative 1

December 13: hosted workgroup with AIHC for IHCPs to participate in the design of the PCCMe program

December 16: participated in internal meeting regarding MTP renewal application, specifically Initiative 1

LTSS implementation accomplishments

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

- As of December 31, 2021, almost 12,000 clients have received services and supports from the MAC and TSOA programs.

- Despite the pandemic, referrals, and enrollments for MAC and TSOA program have remained fairly steady over the past 3 months.

Network adequacy for MAC and TSOA

There is still a high usage of home-delivered meals and personal emergency response system (PERS). Area Agencies on Aging (AAAs) continue to work in their local areas to establish new contracts with providers in their areas. There have been continued challenges with having enough caregivers to support the demand for respite and personal care services this quarter, and there has been a corresponding focus to expand the network of providers. The state continues to provide COVID-related rate enhancements for home care agency providers.

Assessment and systems update

The team worked on development of a budget calculator tool in the GetCare system to assist case managers with management of clients' spending budgets. It should be released in the first quarter of 2022.

There were no major changes to assessments or assessment processes this quarter.

Staff training

MAC and TSOA program managers for Home and Community Services (HCS) remain committed to providing monthly statewide training webinars on requested and needed topics during 2021.

In December, a statewide survey was sent to MAC and TSOA case managers, supervisors, and financial workers requesting feedback regarding training sessions completed in 2021 and asking for training topics for 2022. Based upon the results, the upcoming webinar trainings for the first quarter of 2022 are:

- January: overview of the Quality Assurance process and the performance measures for 2022
- March: use of electronic forms and client notices in GetCare system

Data and reporting

Table 9: beneficiary enrollment by program for Q4

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of December 31, 2021	214	1451	3334
Number of new enrollees in quarter by program	30	217	461
Number of new person-centered service plans in quarter by program	13*	59**	169***
Number of beneficiaries self-directing services under employer authority	0	0	0

*16 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.

**152 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.

***285 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.

****The State will begin using individual providers after the Consumer Directed Employer is fully implemented for the 1915c and 1915k programs.

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

Tribal engagement

Washington State continues to be under a declared state of emergency. It has impacted all aspects of state, local, and tribal government operations. During this quarter, DSHS Aging and Long-Term Support Administration (ALTSA) met with several tribes to discuss Medicaid services and Initiative 2 and 3.

- September 17, 2021: Tribal Affairs staff shared information with Skokomish Tribal representatives, including MAC/TSOA and other in-home services.
- November 19, 2021: ALTSA MAC/TSOA staff presented information on MAC/TSOA as part of the bi-annual Tribal Summit, including a Tribal-focused video to be used for promotion of caregiver programs.
- ALTSA worked with Tribal program managers and developed a Tribal-focused placemat to be used in elder meal locations to promote family caregiver programs.

Recognizing a need to broaden marketing and outreach materials that are culturally appropriate, ALTSA continues to explore options to increase materials for use in multiple programs, including respite, kinship care, and MAC/TSOA.

Outreach and engagement

HCS developed a video commercial promoting caregiver programs which was advertised through Comcast in October, November, and December 2021. (Circle of Life commercial).

A second commercial video was presented at the Fall Tribal Summit and was distributed amongst the tribal communities for use in promoting caregiver programs. (Circle of Life Tribal Commercial).

During the quarter, HCS also resumed work on the placemat project, which was put on hold due to COVID-19 and congregate meal sights being closed. This project will provide family caregiving resources and MAC/TSOA program information on placemats that will be distributed to meal sights throughout the state as they begin to open in the upcoming year. The placemats can be used for other locations and venues, such as hospital cafeterias, senior housing dining rooms, etc.

AAAs continue to provide outreach and engagement activities in their local area to educate and promote MAC and TSOA programs.

Table 10: outreach and engagement activities by AAA

	Oct.	Nov.	Dec.
	Number of events held		
Community presentations and information sharing	14	53	16

The volume and type of outreach activities continue to be impacted by COVID-19 and social distancing requirements.

Quality assurance

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

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

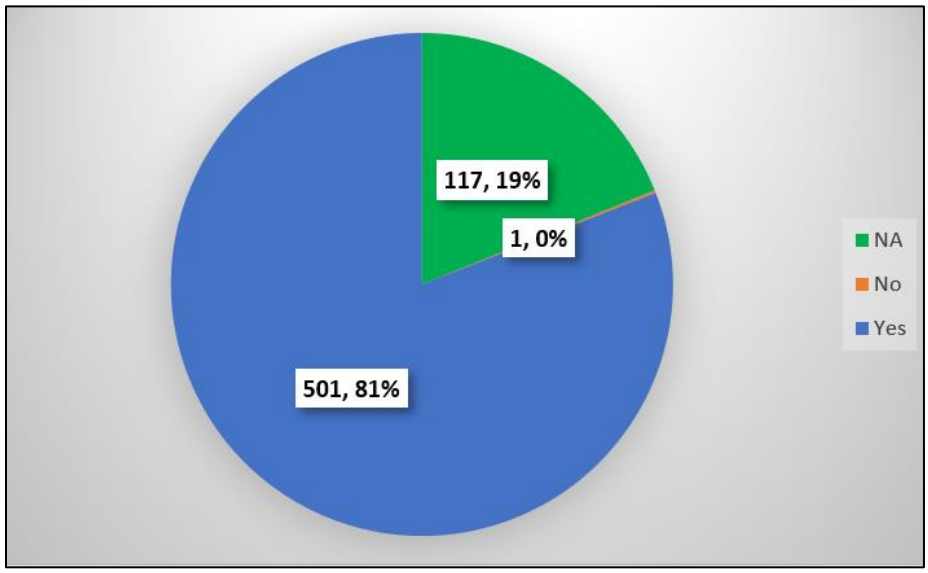


Figure 3: Question 2a: did the client remain eligible after the PE period?

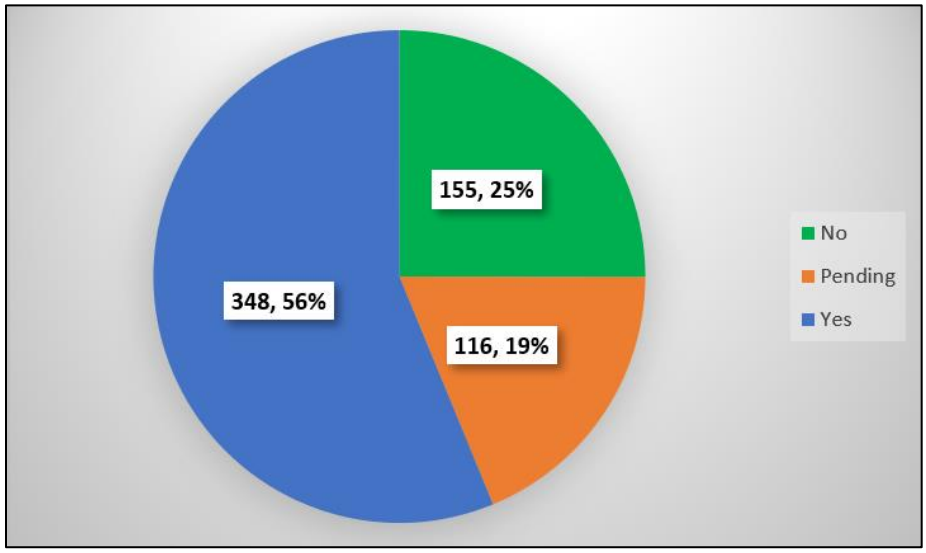
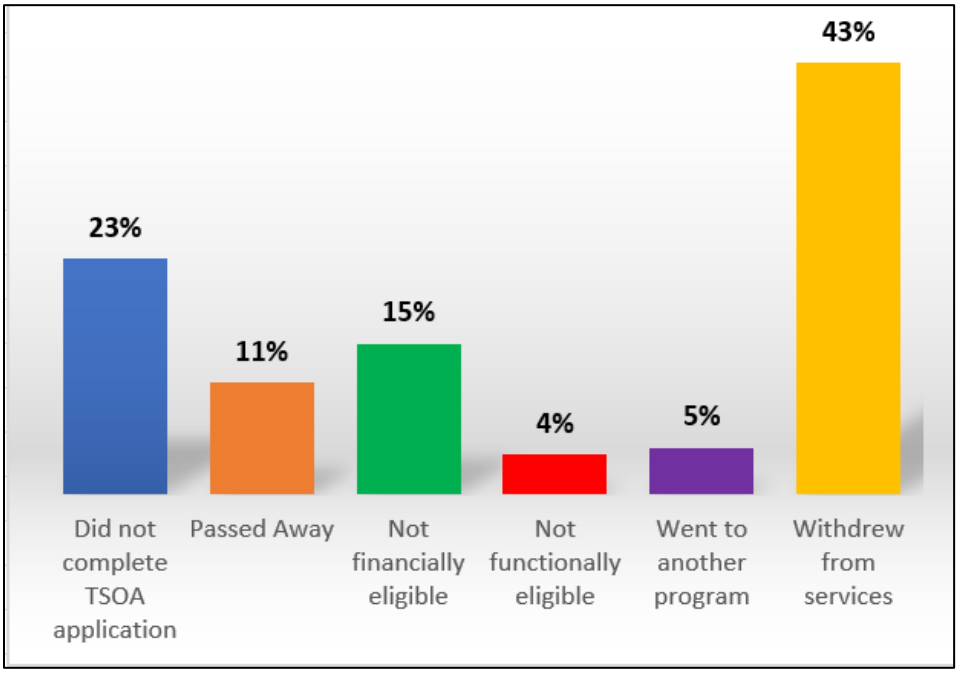


Figure 4: Question 2b: if "No" to question 2#a, why?



Note: These percentages represent the "No"population in the previous table (25%). For example, the 15% of PE clients found to be not financially eligible are 15% of the 25% illustrated in the Table for Question 2a.

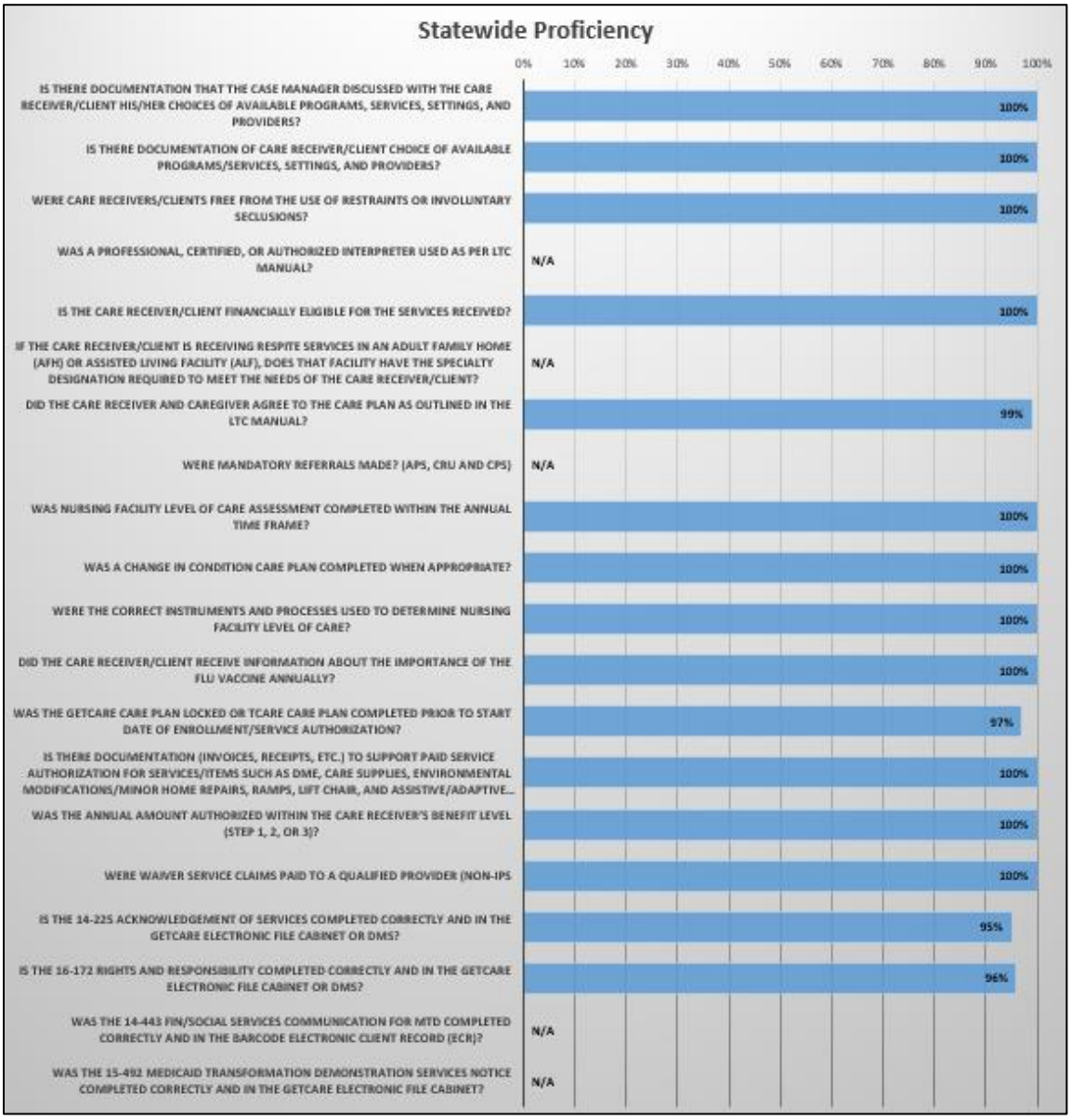
2021 quality assurance results to date

HCS' Quality Assurance unit began the 2021 audit cycle in April instead of January this year due to impacts of COVID-19. The audit cycle concluded in October.

The statewide compliance review of the MAC and TSOA performance measures was conducted with all 13 AAAs. An identical review process was used in each AAA Planning and Service Area (PSA), using the same quality assurance tool and the same 19 performance measures.

The Quality Assurance team reviewed a statistically valid sample of case records. The sample size in 2021 was 348 cases. This methodology is the same one used for the state's 1915(c) waivers and meets the CMS requirements for sampling. Each AAA's sample was determined by multiplying the percent of the total program population in that area by the sample size.

Figure 5: 2021 statewide proficiency



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

State rulemaking

There was no rulemaking activity this quarter.

Upcoming activities

- HCS, in collaboration with HCA, will continue preparations of the MTP renewal application for continuation of Initiative 2 services.
- The 2022 MAC and TSOA training sessions will begin in January with an overview of the Quality Assurance process and the performance measures that will be reviewed this year.
- The MAC and TSOA team at HCS Headquarters will review the enhancement list for systems and assessments to prioritize projects for 2022.

LTSS stakeholder concerns

Stakeholders continue to share their concerns about the lack of available respite and personal care providers across the state. DSHS was granted approval through its Money Follows the Person supplemental funding to hire positions that are dedicated to recruitment and retention of the direct care workforce.

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 October 1 through December 31, 2021. Key accomplishments for the quarter include:

- Total aggregate number of people enrolled in FCS services at the end of DY5 Q4:
  - CSS: 5,963
  - IPS: 4,315
- There were 167 providers under contract with Amerigroup at the end of DY5 Q4, representing 455 sites throughout the state.

Note: CSS and IPS enrollment totals include 1,675 participants enrolled in both programs. The total unduplicated number of enrollments at the end of this reporting period was 8,603.

Network adequacy for FCS

Table 11: FCS provider network development

	October		November		December	
FCS service type	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
Supported Employment – Individual Placement Support (IPS)	36	74	36	74	35	73
Community Support Services (CSS)	19	45	19	45	19	45
CSS and IPS	112	334	110	332	113	337
Total	167	453	165	451	167	455

The FCS provider network fluctuated slightly in DY5 Q4 and the number of contractors remained largely the same. The FCS program staff are actively looking for ways to reduce barriers for providers to join the network and increase overall capacity. From many of the monthly provider calls, concerns over staffing shortages exacerbated by the COVID-19 pandemic were commonly shared among providers.

Client enrollment

Table 12: FCS client enrollment

	October	November	December
Supported Employment – Individual Placement and Support (IPS)	2,645	2,616	2,640
Community Support Services (CSS)	4,234	4,225	4,288
CSS and IPS	1,644	1,674	1,675

Total aggregate enrollment	8,523	8,515	8,603

Data source: RDA administrative reports

Table 13: FCS client risk profile

		Met HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
October	IPS	611 (14%)	.95	3,118 (73%)
	CSS	1,406 (24%)	1.3	3,921 (67%)
November	IPS	594 (14%)	.95	3,055 (71%)
	CSS	1,364 (23%)	1.27	3,920 (66%)
December	IPS	567 (13%)	.75	2,900 (67%)
	CSS	1,357 (23%)	1.02	3,754 (63%)

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 14: FCS client risk profile, continued

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment needs flags
October	IPS	3,620	3,369 (93%)	2,216 (61%)	2,093 (58%)
	CSS	4,866	4,478 (92%)	3,584 (74%)	3,367 (69%)
November	IPS	3,626	3,331 (92%)	2,190 (60%)	2,056 (57%)
	CSS	4,867	4,431 (91%)	3,557 (73%)	3,320 (68%)
December	IPS	3,643	3,313 (91%)	2,164 (59%)	2,021 (55%)
	CSS	4,912	4,432 (90%)	3,548 (72%)	3,291 (67%)

Data source: RDA administrative reports

*Does not include individuals who are dual-enrolled.

Table 15: FCS client service utilization

		Medicaid only enrollees*	LTSS	MH services	SUD services (received in last 12 months)	Care + MH or SUD services
October	IPS	3,620	366 (10%)	2,707 (75%)	1,384 (38%)	324 (9%)
	CSS	4,866	579 (12%)	3,303 (68%)	2,154 (44%)	496 (10%)
November	IPS	3,626	372 (10%)	2,615 (72%)	1,347 (37%)	314 (9%)
	CSS	4,867	564 (12%)	3,178 (65%)	2,109 (43%)	471 (10%)
December	IPS	3,643	391 (11%)	2,542 (70%)	1,314 (36%)	321 (9%)
	CSS	4,912	579 (12%)	3,121 (64%)	2,069 (42%)	470 (10%)

(Aging CARE assessment in last 15 months)

Data source: RDA administrative reports

*Does not include individuals who are dual-enrolled.

Table 16: 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 (non-adults presumptive)	Adults (non-adults presumptive) ACA expansion adults (SSI presumptive)	CN & CHIP children
October	IPS	1,249 (29%)	83 (2%)	464 (11%)	1,929 (45%)	456 (11%)	108 (3%)
	CSS	2,003 (34%)	265 (5%)	733 (12%)	1,953 (33%)	868 (15%)	56 (1%)
November	IPS	1,259 (29%)	73 (2%)	467 (11%)	1,939 (45%)	438 (10%)	114 (3%)
	CSS	1,976 (33%)	269 (5%)	742 (13%)	1,993 (34%)	860 (15%)	59 (1%)
December	IPS	1,269 (29%)	73 (2%)	458 (11%)	1,980 (46%)	425 (10%)	110 (3%)
	CSS	2,010 (34%)	280 (5%)	742 (12%)	2,046 (34%)	824 (14%)	61 (1%)

ACA = Affordable Care Act

CHIP = Children's Health Insurance Program

CN = categorically needy

Data source: RDA administrative reports

Quality assurance and monitoring activity

The FCS third-party administrator (TPA), Amerigroup, reported no grievances or appeals during Q4, and reported no major concerns or issues regarding the FCS provider network. The decrease in the number of new enrollees observed in Q3 continued and then tapered off during Q4, primarily in CSS services. Overall, the total enrollments in FCS continue to grow and the decreases noted do not appear to be part of a larger trend.

As part of ongoing quality assurance activity, the FCS program worked with the TPA on moving from a quarterly disenrollment process to a monthly disenrollment process to increase the accuracy in enrollment data. This process helped clarify that the decreases observed were not part of an overall downward trend. This change in reporting will also provide more accurate enrollment figures in these quarterly reports and accounts for the difference in total aggregate enrollments between Q3 and Q4.

FCS training staff completed six fidelity reviews of contracted FCS providers, three for IPS service providers and three for CSS service providers. These reviews were completed virtually over two days with a review team of HCA staff and FCS providers. The FCS training staff are also bringing on fidelity reviewers from other state agencies, such as the Division of Vocational Rehabilitation (DVR) at DSHS to facilitate more cross-system collaboration.

FCS staff also held four fidelity reviewers training events that teach FCS providers and prospective reviewers the evidence-based practices and help prepare them for participation on review panels. These fidelity reviews use a learning collaborative approach and FCS providers can receive incentives through Substance Abuse and Mental Health Services Administration (SAMSHA) block grants to become reviewers or host a review.

Other FCS program activity

HCA continues to convene a monthly workgroup with DSHS staff to develop, discuss, and decide on key policies and practices necessary for the ongoing operation, improvement, and sustainability of the FCS program.

In partnership with DVR, HCA participates in a quarterly workgroup to improve consistency, collaboration, and employment outcomes for DVR customers with a behavioral health condition receiving supported employment services from DVR Supported Employment program and FCS.

FCS staff attended the annual Learning Symposium held jointly by HCA and ACHs.

Upcoming activities

- FCS staff continues to work with select providers operating various SUD and MH inpatient treatment facilities who are piloting the Discharge Planner's Toolkit that HCA is currently developing. The goal of this project is to create a web-based platform that aids discharge planners in connecting individuals exiting institutional settings with housing resources across the state.
- FCS staff will be presenting at the annual Housing First Partners Conference occurring in April 2022. The theme of the presentation focuses on FCS community support services working collaboratively with the mental health and correctional systems.
- FCS staff will continue to hold monthly workgroup meetings focused on the implementation of CSS services to support individuals transition out of inpatient behavioral health treatment settings. This work is largely aligned with MTP Initiatives 4 and 5 and coordinates similar efforts across other supportive housing programs.

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 17: FCS program stakeholder engagement activities

	October	November	December
	Number of events held		
Training and assistance provided to individual organizations	45	43	56
Community and regional presentations and training events	4	4	7
Informational webinars	13	12	16
Stakeholder engagement meetings	12	8	8
Total activities	74	667	87

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. Q4 topics included:

- Best Practices in Clinical Supervision
- Job Retention
- Landlord Outreach - supporting gender diverse individuals
- Networking with Employers in the remote environment
- Motivational Interviewing
- IPS in Urban vs Rural Settings
- IPS Justice Involved Job Seekers
- Cultural Humility in Housing
- Challenges of implementing IPS elements
- Weaving FCS into your services and Housing
- Marketing your Employment Services
- Landlord Outreach - skill building & psychological readiness
- Vicarious trauma and self-care techniques
- Practicing Self-care and building resiliency during stressful times
- When things fall apart: Supporting Consumers in Crisis management

- Housing Challenges: supporting consumers with navigating landlord and evictions issues
- Intro to Forensics in Supportive Housing
- Understanding Potential Employers' Diversity and Inclusion Practices
- The Restorative Function of Clinical Supervision
- Health Disparities and Mental Health Conditions: The Relationship of Social Determinants of Health to Provider Bias and Healthcare Deserts
- Helping Consumers Address Stigma & Ableism in the Workplace
- Preparing for a fidelity review
- Bolstering executive functioning skills
- Building a culturally competent IPS program
- Stand up to implicit bias

FCS stakeholder concerns

- The FCS program received questions about the MTP one-year extension approval and weighed in on opportunities for improving the program in preparation for the MTP renewal. Two different MCOs inquired about whether FCS would be extended under 1115 waiver authority or transitioned to managed care.
- FCS staff continue to work with providers on the transition from traditional grant-based housing support programs to billing FCS for housing case management services. Work is ongoing to explore ways to build provider capacity and increase caseload and service engagement.

SUD IMD waiver implementation accomplishments

This section summarizes SUD IMD waiver development and implementation activities from October 1 through December 31, 2021.

- Work continues on implementation of a new EHR that will be made available to behavioral health agencies, rural, and tribal providers to improve services and care coordination.

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. Below is an update on milestones under this initiative that the state must meet.

- **Milestone:** no updates to report at this time.
    - **Timeline:** no updates or changes to report during this reporting period.

SUD HIT plan requirements

During Q4 2021, the following SUD HIT related activities were undertaken:

- The Governor's Office submitted its budget proposal to the state legislature requesting funds to support the implementation of an electronic Consent Management Solution as requested in the Agency's Decision Package.
- HCA coordinated internally and with the Department of Health (DOH) to support implementation planning for the nationally required 988 crisis call system and the Crisis Call Center Hub System and the Behavioral Health Integrated Client Referral System required under State law. The Crisis Call Center Hub System and Behavioral Health Integrated Client Referral System will include a focus

on persons with SUD needs and systems and technology tools to support referrals to SUD (and other) providers.

- During its bi-monthly meeting providing an update on the HIT Operational Plan, the HCA Privacy Officer presented on the privacy requirements for health information access and exchange on behalf of a hypothetical person with co-occurring mental health and substance use disorders. The presentation provided an overview of federal privacy requirements (i.e., HIPAA and 42 CFR Part 2) and Washington State privacy requirements. The presentation discussed the applicability of these requirements in the context of several information exchange scenarios.

Evaluation design

- No updates

Monitoring protocol

- No updates

Upcoming activities

- Recovery Navigator Program is scheduled to go live by March 1
- Legislative funding for provider rate increases
- Legislature is exploring additional funding for crisis and SUD services

MH IMD waiver implementation accomplishments

This section summarizes MH IMD waiver development and implementation activities from October 1 through December 31, 2021.

- Efforts focused on finalizing evaluation designs and monitoring protocols and realizing HIT goals.

Implementation plan

- No updates to report at this time.

MH HIT plan requirements

HCA continued its efforts to provide outpatient EHR functionality to rural, behavioral health, and tribal providers. The goal of this EHR is to assist health care providers in their mission to provide better patient care at the point of care.

Evaluation design

- Evaluation design submitted to CMS on October 25, 2021.

Monitoring protocol

- Monitoring protocol materials submitted to CMS on October 25, 2021

Upcoming activities

- The upcoming legislative session will certainly include legislation addressing mental health and crisis services.

Quarterly expenditures

The following table reflects quarterly expenditures for DSRIP, LTSS, and FCS during DY5. During January 1 through December 31, 2021, **all nine** ACHs earned nearly **$83.1 million** in project incentives and VBP incentives. During DY5, IHCPs earned nearly **$2.9 million** for IHCP-specific projects.

Table 18: 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	$0	$757,226	$9,112,622	$4,556,311
Cascade Pacific Action Alliance	$35,053	$6,345,933	$0	$688,388	$7,069,374	$3,534,687
Elevate Health	$44,571	$8,756,298	$0	$826,065	$9,626,934	$4,813,467
Greater Columbia	$250,000	$11,147,815	$0	$963,743	$12,361,558	$6,180,779
HealthierHere	$250,000	$13,081,240	$0	$1,514,452	$14,845,692	$7,422,846
North Central	$250,000	$3,873,065	$0	$344,194	$4,467,259	$2,233,630
North Sound	$250,000	$11,603,517	$0	$1,032,581	$12,886,098	$6,443,049
Olympic Community of Health	$250,000	$3,063,344	$0	$275,355	$3,588,699	$1,794,350
SWACH	$250,000	$5,541,304	$0	$481,871	$6,273,175	$3,136,588
Indian Health Care Providers	$0	$2,898,115	$0	$0	$2,898,115	$1,449,058

Table 19: 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				$959,638
CHPW	$1,233,495				$1,233,495
CCW	$946,640				$946,640
Molina	$3,889,269				$3,889,269
United Healthcare	$970,958				$970,958

Table 20: 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

TSOA	$4,975,602	$5,563,325	$3,966,823	$5,461,087	$16,000,014
MAC	$128,419	$137,639	$92,313	$141,788	$407,846
MAC and TSOA not eligible	$0	$573	$0	$27	$600
FCS	$4,304,004	$4,809,098	$4,407,602	$5,137,076	$18,657,780

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 2021. November 2021 and December 2021 member months for non-expansion adults are forecasted caseload figures from CFC. Actual member months data for the SUD population is currently available through October 2021.

Table 21: member months eligible to receive services

Calendar month	Non-expansion adults only	SUD Medicaid disabled	SUD Medicaid non-disabled	SUD newly eligible	SUD AI/AN
Jan-17	376,307	0	0	0	0
Feb-17	375,204	0	0	0	0
Mar-17	374,734	0	0	0	0
Apr-17	373,588	0	0	0	0
May-17	373,132	0	0	0	0
Jun-17	373,037	0	0	0	0
Jul-17	372,126	0	0	0	0
Aug-17	371,860	0	0	0	0
Sep-17	370,594	0	0	0	0
Oct-17	370,399	0	0	0	0
Nov-17	370,228	0	0	0	0
Dec-17	370,256	0	0	0	0
Jan-18	370,295	0	0	0	0
Feb-18	368,922	0	0	0	0
Mar-18	368,731	0	0	0	0
Apr-18	367,472	0	0	0	0
May-18	367,838	0	0	0	0
Jun-18	367,118	0	0	0	0
Jul-18	366,861	5	19	91	113
Aug-18	366,263	8	17	95	458
Sept-18	365,267	4	19	80	356

Oct-18	365,265	4	22	93	401
Nov-18	364,799	3	27	93	315
Dec-18	364,252	4	17	96	201
Jan-19	364,172	36	135	438	417
Feb-19	362,491	32	120	413	395
Mar-19	362,125	43	150	426	426
Apr-19	361,626	57	136	473	526
May-19	361,078	44	125	483	534
June-19	360,263	65	150	577	573
Jul-19	360,674	65	197	679	628
Aug-19	360,213	66	243	746	482
Sep-19	359,739	75	214	780	408
Oct-19	359,188	74	237	884	469
Nov-19	358,287	82	190	813	574
Dec-19	358,575	58	213	940	559
Jan-20	358,991	32	129	531	505
Feb-20	358,889	24	125	478	441
Mac-20	360,596	33	133	484	428
Apr-20	364,087	42	109	382	304
May-20	366,527	25	97	377	318
Jun-20	369,311	46	157	552	198
Jul-20	371,996	25	84	337	31
Aug-20	374,843	28	107	352	38
Sep-20	377,066	34	100	333	46
Oct-20	379,086	26	93	368	43
Nov-20	380,008	28	87	376	25
Dec-20	381,502	38	100	444	24
Jan-21	382,657	16	57	224	30
Feb-21	382,706	25	89	294	18
Mar-21	384,048	21	85	315	28
Apr-21	385,365	25	98	366	14
May-21	386,553	31	85	309	25
Jun-21	387,611	17	36	160	19
Jul-21	389,200	25	101	365	16
Aug-21	391,258	19	90	317	14
Sep-21	392,684	16	80	307	5
Oct-21	394,012	16	75	238	0
Nov-21	395,171	0	0	0	0
Dec-21	396,462	0	0	0	0
Total	22,313,609	1,317	4,348	16,109	10,405

Budget neutrality

- HCA adopted CMS's budget neutrality monitoring tool and has been using Performance Management Database and Analytics system to upload quarterly spreadsheets.
- HCA is currently working on the data criteria for identifying expenditures and member months for serious mental illness (SMI) in IMDs. Once those criteria are finalized, HCA will be ready to report expenditures and member months for this population.

Designated state health programs (DSHP)

- HCA has continued to contract 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 calendar year (CY) 2020. Expected completion of the review is June 30, 2022.

Overall MTP development and issues

Operational/policy issues

The state appreciates CMS' efforts to approve the DY6 extension prior to the end of 2021. HCA will send proposed DSRIP reporting and performance and funds flow adjustments and looks forward to working with CMS on refinements in Q1 2022. These refinements relate to more equitable funding distribution across the state, reporting adjustments, repurposing VBP incentives, and P4P methodology adjustments to account for COVID-19.

The state continues work on a longer-term MTP application for renewal, and submission to CMS is now anticipated in mid-2022.

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. The state received general inquiries about benefits available through MTP and inquiries regarding the continuation of benefits and programs in 2022.

MTP evaluation

Prior to the extension of MTP, CHSE proposed to not submit a quarterly progress report (e.g., Rapid-cycle Monitoring Report") for DY5 Q4 because the final evaluation report was due in January 2022 and would have reported the same period of data. The MTP extension was not approved until the end of December 2021, which did not allow enough time for CHSE to get CMS approval of a Rapid-cycle Monitoring Report for Q4.

Upcoming IEE activities:

- A Rapid-cycle Monitoring Report is due March 2022, per the MTP evaluation reporting schedule.

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, Q4 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	Debbie Johnson	Initiative 2 Program Manager, DSHS	360-725-2531
FCS program	Matthew Christie	Program Administrator, FCS	360-489-2021
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, Q4 2021

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

Attachment C: 1115 SUD Demonstration Monitoring Report – Part B

1. **1115-SUD-Monitoring-Report-Template-v2.0**
   Trend Narrative Reporting
   Updated 02/19/2020

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.	Over the last six months, the monthly number of Medicaid beneficiaries with an SUD diagnosis has fluctuated slightly but overall remained stable. However, the upward trend in the number of beneficiaries with an OUD diagnosis observed in prior reporting periods remains. 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)
			Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state will report this metric next quarter.	07/01/2018 – 06/30/2019	#4: Medicaid beneficiaries with SUD diagnosis (annual)
			Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state will report this metric next 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 six months, with a slight increase in the last month of the reporting 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	#6: Any SUD Treatment
			The monthly number of Medicaid beneficiaries with an SUD diagnosis who received early intervention services has remained relatively stable, with a slight decrease in recent 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 an outpatient service decreased in the first few months of this reporting period, but has since returned to levels consistent with prior reporting periods. 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 monthly number of Medicaid beneficiaries with a SUD diagnosis who received a residential and inpatient service has been updated for the previous reporting period (see reporting issues tab for update on previously identified reporting issue and resolution of issue). The trend has stabilized. 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 six 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 six 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
			Due to potential issues with delays in claim submission, the state has delayed reporting for this metric.	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 Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)	The state has no metrics trends to report for this reporting topic.			
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.	Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state will report this metric next quarter.	07/01/2018 – 06/30/2019	#13: SUD provider availability
			Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state will report this metric next 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	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

		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(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.	Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state will report this metric next 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)
			Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state will report this metric next quarter.	07/01/2018 – 06/30/2019	Q2: Substance Use Disorder Treatment Penetration Rate
			Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state will report this metric next 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 relatively stable over the last six 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 last six 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
			Due to COVID, information on overdose deaths is not available at this time for the relevant reporting period.	07/01/2017 – 06/30/2018	#26: Overdose Deaths (count)
			Due to COVID, information on overdose deaths is not available at this time for the relevant reporting period.	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.

2. Executive Summary

Due to unexpected data infrastructure updates, some metrics/trends cannot be reported this quarter and will be reported next quarter. Of the trends that were available, numbers appear to be largely stable with a slight uptick in the monthly number of Medicaid beneficiaries receiving any SUD treatment in the last month, and a slight decrease in recent months for individuals with an SUD diagnosis who received early intervention services. Research within the state has indicated that there may be some barriers to billing for SBIRT related to staff shortages exacerbated by COVID pandemic related work shortages.

Trends for residential and inpatient services have stabilized and prior reporting has been updated following resolution of reporting issues.

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.**	Over the last six months, the monthly number of Medicaid beneficiaries with an SUD diagnosis has fluctuated slightly but overall remained stable. However, the upward trend in the number of beneficiaries with an OUD diagnosis observed in prior reporting periods remains. 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)
	Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state will report this metric next quarter.	07/01/2018 – 06/30/2019	#4: Medicaid beneficiaries with SUD diagnosis (annual)
	Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state will report this metric next 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 six months, with a slight increase in the last month of the reporting 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	#6: Any SUD Treatment
	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received early intervention services has remained relatively stable, with a slight decrease in recent 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	04/01/2019 – 06/30/2019	#7: Early Intervention

	these services is unknown. Any changes in trends should be interpreted with caution.		
	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received an outpatient service decreased in the first few months of this reporting period, but has since returned to levels consistent with prior reporting periods. 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 monthly number of Medicaid beneficiaries with a SUD diagnosis who received a residential and inpatient service has been updated for the previous reporting period (see reporting issues tab for update on previously identified reporting issue and resolution of issue). The trend has stabilized. 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 six 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 six 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
	Due to potential issues with delays in claim submission, the state has delayed reporting for this metric.	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.**	Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state will report this metric next quarter.	07/01/2018 – 06/30/2019	#13: SUD provider availability
☐ **The state has no trends to report for this reporting topic.**	Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state will report this metric next quarter.	07/01/2018 – 06/30/2019	#14: SUD provider availability —MAT
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 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 trends to report for this reporting topic.**	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)
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.**	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 trends to report for this reporting topic.**	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
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.	Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state will report this metric next 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 trends to report for this reporting topic.	Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state will report this metric next quarter.	07/01/2018 – 06/30/2019	Q2: Substance Use Disorder Treatment Penetration Rate

	Due to unexpected data infrastructure updates, the state has no metrics trends to report for this reporting topic this quarter. The state will report this metric next quarter.	07/01/2018 – 06/30/2019	Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential SUD Services
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 relatively stable over the last six 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 last six 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.**	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

	Due to COVID, information on overdose deaths is not available at this time for the relevant reporting period.	07/01/2017 – 06/30/2018	#26: Overdose Deaths (count)
	Due to COVID, information on overdose deaths is not available at this time for the relevant reporting period.	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.
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.			
☒ 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.	HCA adopted CMS's budget neutrality monitoring tool and has been using Performance Management Database and Analytics system to upload quarterly spreadsheets.		

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

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

anticipated barriers in achieving the goals and timeframes agreed to in the STCs.			
☒ The state has no SUD demonstration evaluation update to report for this reporting topic.			
☐ List anticipated evaluation-related deliverables related to this demonstration and their due dates.			
☒ The state has no SUD demonstration evaluation update to report for this reporting topic.			
13.1 Other Demonstration Reporting			
13.1.1 General Reporting Requirements			
☐ The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol.			
☒ The state has no updates on general requirements to report for this reporting topic.			
☐ The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.			
☒ The state has no updates on general requirements to report for this reporting topic.			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) The schedule for completing and submitting monitoring reports.**			

☐ ii) The content or completeness of submitted reports and/or future reports.			
☒ The state has no updates on general requirements to report for this reporting topic.			
☐ The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation			
☒ The state has no updates on general requirements to report for this reporting topic.			
13.1.2 Post-Award Public Forum			
☐ If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual report.			
☒ No post-award public forum was held during this reporting period, and this is not an annual report, so the state has no post-award public forum update to report for this topic.			
14.1 Notable State Achievements and/or Innovations			
14.1 Narrative Information			
☐ Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for			

populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.			
☒ The state has no notable achievements or innovations to report for this reporting topic.			

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

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

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

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

Washington State Health Care Authority

Medicaid Transformation Project

Health Care Authority	SFY 20-21 Budget	SFY 20 Expenditures to Date	SFY 21 Expenditures to Date	SFY 20-21 Total Expenditures	SFY 22 Budget	SFY 22 Expenditures to Date
Initiative 1 - DSRIP	**$165,082,000**	**$87,954,090**	**$34,465,720**	**$122,419,810**	**$65,830,000**	**$2,498,860**
Admin (GF-F)	$17,884,994	$10,262,223	$7,670,673	$17,932,896	$8,697,000	$2,498,860
DSRIP Incentives (GF-F)	$147,197,006	$77,691,867	$26,795,047	$104,486,914	$57,133,000	
Initiative 1 - DSRIP	**$112,949,000**	**$46,270,714**	**$26,795,047**	**$73,065,761**	**$57,133,000**	**$0**
DSRIP Incentives (GF-L)	$112,949,000	$46,270,714	$26,795,047	$73,065,761	$57,133,000	
Initiative 2 - DSHS MAC/TSOA**					**$25,891,000**	
MAC/TSOA (GF-F)					$12,945,000	
MAC/TSOA (GF-L)					$12,946,000	
Initiative 3 - FCS	**$67,896,000**	**$21,816,899**	**$21,516,448**	**$43,333,347**	**$55,102,000**	**$7,238,295**
FCS SE ADMIN (GF-F)	$1,771,200	$1,653,242	$1,318,295	$2,971,537	$1,312,000	$652,066
FCS SE ADMIN (GF-L)					$495,500	
FCS SE SERVICES (GF-F)	$21,428,700	$8,395,864	$6,993,108	$15,388,972	$12,164,800	$2,210,760
FCS SE SERVICES (GF-L)					$2,301,300	
FCS SH ADMIN (GF-F)	$3,243,600	$1,894,966	$2,852,324	$4,747,290	$2,842,000	$1,028,461
FCS SH ADMIN (GF-L)					$1,158,900	
FCS SH SERVICES (GF-F)	$41,452,500	$9,872,828	$10,352,720	$20,225,548	$28,976,000	$3,347,008
FCS SH SERVICES (GF-L)					$5,851,500	
Agency Admin (GF-F)	$0	$0	$0	$0	$0	$0
Initiative 3 - FCS**					**$384,000**	**$0**
DSHS FCS ADMIN (GF-F)					$192,000	$0
DSHS FCS ADMIN (GF-L)					$192,000	$0
DSHS - ALTSA	**SFY 20-21 Budget**	**SFY 20 Total Expenditures**	**SFY 21 Expenditures to Date**	**SFY 20-21 Total Expenditures**	**SFY 22 Budget**	**SFY 22 Expenditures to Date**
Initiative 2 - MAC and TSOA	**$79,799,000**	$25,173,683	$37,145,370	**$62,319,053**	**$29,292,000**	**$21,940,470**
Initiative 3 - FCS	**$2,525,000**	$645,823	$434,703	**$1,080,526**	**$624,000**	**$322,828**
DSHS and HCA (Community Behavioral Health)	**SFY 20-21 Budget**	**SFY 20 Total Expenditures***	**SFY 21 Expenditures to Date***	**SFY 20-21 Total Expenditures***	**SFY 22 Budget**	**SFY 22 Expenditures to Date***
Initiative 3 - FCS	**$15,358,000**	**$937,419**	**$1,334,054**	**$2,271,473**	**$1,454,000**	**$320,134**
FCS (GF-F)	$15,358,000	$937,419	$1,334,054	$2,271,473	$1,090,000	$320,134
FCS (GF-L)					$364,000	

*Administrative staff costs only. FCS admin and service expenditures (TPA costs) are paid from HCA's budget. As of SFY19, CBH merged with HCA.

**Per ESSB 5092, effective January 1, 2022 DSHS waiver expenditures (for Initiative 2 and 3) are appropriated under HCA's budget.

DSRIP - Delivery System Reform Incentive Payment

FCS - Foundational Community Supports

MAC and TSOA - Medicaid Alternative Care and Tailored Supports for Older Adults

Expenditures are reported on a cash basis and include liquidations.

Medicaid Quality Improvement Program
Report to Joint Select Committee on Health Care Oversight
Quarter 4: October 1, 2021 – December 31, 2021

1. Background

The Washington State Legislature authorized the Medicaid Quality Improvement Program (MQIP) during the 2020 legislative session to support the Medicaid Transformation Project. MQIP allows Washington State to implement quality improvement programs for people enrolled in Apple Health (Medicaid). Under MQIP, Medicaid managed care organizations (MCOs) are responsible for partnering with participating public hospitals to implement certain activities that:

- Reinforce the delivery of quality health care.
- Support community health.

Through MQIP, MCOs will receive incentive funds to share with participating public hospitals when they meet specific milestones.

2. Implementation status and results

The Association of Washington Public Hospital Districts (AWPHD) and University of Washington Medicine (UW Medicine) are state public hospitals participating under MQIP, in partnership with MCOs. During the fourth quarter of 2021, AWPHD and UW Medicine continued implementation of projects as outlined below.

AWPHD is working on a project that will:

- Support statewide efforts to prevent opioid dependency.
- Expand access to opioid use disorder treatments.
- Prevent opioid overdose in rural Washington.

UW Medicine is working on an initiative that focuses on care delivery sites, community engagement, and clinical quality. Under this initiative, UW will improve health care access and outcomes for all patients. Some activities in this initiative include:

- Development and expansion of new and existing clinical interventions to support access and whole-person care.
- Improving processes for data collection, analysis, and patient/provider access.
- Sharing guidelines, tools, clinical practice improvements, and other learnings with clinical providers and community partners outside of UW Medicine.

Payment for Milestone 2 occurred in December 2020, payment for Milestone 3 occurred in June 2021, payment for Milestone 4 occurred in December 2021, and payment for Milestone 5 is anticipated in June 2022 pending approval.

In addition to providing an implementation plan status report and an updated work plan, AWPHD and UW Medicine continue to submit performance data. This data will reflect selected project-specific measures of success that support program assessment and continuous improvement.

Below are several of the measures selected:

- Breast cancer screening rates for targeted populations.

- Change in access to Drug Enforcement Agency (DEA)-waivered providers in participating member facilities.
- Change in rate of opioid prescribing for individual providers.

MQIP partners reported a Milestone 3 2019 baseline of 60.6% breast cancer screening rate for the target population. Milestone 4 reported 2020 performance at a 66.7% screening rate with a goal of achieving 75%. MQIP partners continue to flag COVID-19 impacts and related data collection and measurement challenges that may impact future reporting on certain measures.

3. Expenditures

MQIP payments for Milestone 4 were released in December 2021. Below are the payment details. MQIP payments for Milestone 5 will be released in June 2022 following Milestone 5 completion.

MCO earned admin and payments to public hospitals (December 2021)						
	Amerigroup	**Community Health Plan**	**Coordinated Care**	**Molina**	**United Healthcare**	**Total**
Admin	$ 150,000	$150,000	$150,000	$150,000	$150,000	$750,000
UW Medicine	$1,218,159	$1,218,159	$1,218,161	$1,218,159	$1,218,159	$6,090,797
Evergreen Healthcare & Valley Medical Center	$267,995	$267,995	$267,995	$267,995	$267,994	$1,339,974
AWPHD	$769	$768	$768	$768	$769	$3,842
Public Hospitals Statewide	$35,776	$35,777	$35,776	$35,777	$35,777	$178,883
						$8,363,496

Accountable Communities of Health Quarterly Activity Report

Reporting period: October 1–December 31, 2021

Report to Joint Select Committee on Health Care Oversight

Introduction

This report reflects statewide and regional Accountable Community of Health (ACH) activities from October 1 to December 31, 2021. This report shares what ACHs are doing at the community level within and across regions to improve community health in Washington State.

Through their unique role, ACHs connect the health care delivery system and local community organizations. In addition to their Medicaid Transformation Project (MTP) activities, ACHs coordinate and support COVID-19 response. Statewide activities summarized below reflect the most recent quarter: (October 1–December 31, 2021).

Statewide ACH activities

COVID-19 response
ACHs continue to play a vital role in many aspects of COVID-19 response and recovery. Notably, ACHs are working with community organizations and clinical partners to increase vaccinations in hard-hit communities. ACHs are approaching this work with an equity lens, working closely with trusted messengers and local providers to address hot-spots and disparities.

Care coordination
ACHs continue to manage and participate in community-based care coordination efforts. These support people and their families in isolation and quarantine from COVID-19, those impacted by inclement weather events, vulnerable populations, and those with health-related social needs. ACHs contribute to meeting community needs by coordinating and supporting local organizations, prioritizing vulnerable populations and those experiencing health disparities, and building capacity for community information exchange.

Behavioral health
ACHs are working on an array of behavioral health activities, including installation of Naloxone vending machines, implementation of the Trueblood settlement, and training for providers and key staff in several settings, including K-12 education.

Individual ACH activities

Better Health Together (BHT)

Serving Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties

Behavioral health

- In November, board members allocated the remaining $1.5 million (approximately) in integrated managed care (IMC) incentive funds to behavioral health initiatives for 2022-23. Based on provider discussions, BHT identified five initiative categories to address behavioral health needs and build capacity:
    - Workforce Retention and Expansion
    - Training and Education - Peers and Community Health Workers
    - Training and Education - Evidence-based Practices
    - Staffing - Network Administrator and Program Manager
    - Emerging Opportunities
- BHT will use participatory budgeting to develop the specifics of the initiatives with partnering providers and impacted community members.

Telehealth

- BHT supports a School Based Telehealth (SBTH) pilot program in nine high-need Spokane Public Schools. This program is in partnership with CHAS Health, Providence Health Care, and Unify Community Health, which launched in fall 2021. Moving forward, BHT and partnering

providers are working together to develop communications to parents, data/measurements, and program sustainability.

- BHT allocated funding to support on-site primary care providers at four schools in the Newport School District to respond to the health care needs of students. In both school districts, providers have clinics close to the schools for any follow-up care.

Sustainability

- In October, the board approved a new governance structure and BHT began recruiting new board members. The new structure aims to foster and support regional readiness and serve as a model for anti-racist community health transformation. Combining alliances and community engagement strategies ensures BHT can focus on improving community health outcomes and that no single entity, sector, or person will dominate the decision-making or activities of BHT.

COVID-19 response

- BHT provided infrastructure for a COVID-19 Emergency Housing and Utility Assistance grant from the City of Spokane on behalf of smaller community-based organizations led by and serving Black, Indigenous, and People of Color (BIPOC). This funding ensures the entirety of the $2 million in grant funding can be provided to families struggling with housing costs, including rental and mortgage assistance. BHT worked collaboratively with partnering organizations to develop the program, which launched in December 2021.
    - With the support of BHT staff and waiver funding, partnering organizations directed the first $47,856 in assistance to seven COVID-impacted families for rent, mortgage, and utilities.

Tribal partnerships

- BHT continued to facilitate a discussion **with** three tribes and urban Indian health providers in the region. In December of 2021, the BHT Board allocated $1 **million** in Community Resiliency Funds to **the** Tribal Partners Leaders Council Collaborative to use a participatory budgeting process to allocate funds to the development of a whole**-**family health collaborative.

Cascade Pacific Action Alliance (CPAA)

Serving Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, and Wahkiakum counties

COVID-19 response

- CPAA organized 36 vaccination clinics, where a total of 1,488 adults and youth were vaccinated. Of those vaccinated, 691 (47 percent) were from BIPOC communities.
- CPAA launched the "Equity Circle Podcast," which has produced episodes featuring community leaders, elected officials, medical professionals, and county directors.
- CPAA created and shared 391 COVID-19 specific messages through social media, reaching an estimated audience of about 17,298 people per month, 12,932 monthly impressions, and 707 clicks per month.

Care coordination

- CPAA's Care Connect and CarePort community-based care coordination programs continue to address barriers to care. Besides helping families meet immediate needs (e.g., food support), the programs continue to address social determinants of health through sustainable "pathways".
    - In the 4th quarter, CPAA processed 362 grocery orders, distributed 254 care kits, and 182 food packs to people in need.
- CPAA's 14 passenger wheelchair-accessible van provides services to hard-to-reach populations.

Health equity

- Last quarter, CPAA conducted site visits and provided assistance to all 17 CPAA-funded health equity awardees across Central Western Washington. CPAA also convened a series of internal program manager-level meetings to review progress, identify best practices, and seek solutions to common challenges identified by partners during site visits.
- CPAA successfully organized a health equity mini summit where Dr. Lisa Wadell, Chief Medical Officer at the CDC Foundation was keynote speaker, alongside Vincent Perez, the Executive Director of the Equity Institute.
- The CDC Foundation is funding vaccine clinics, holding focus group discussions, and preparing podcast episodes for the benefit of minority and marginalized populations in the region.
- CPAA is also working with sovereign tribes, helping with vaccine clinics as requested.

Behavioral health

- CPAA held monthly IMC workgroup meetings and discussed with the AIMS Center of the University of Washington on type and content of technical assistance sought by partners.
- CPAA held meetings with select behavioral health organizations (BHOs) and with all Project 2a partners on sustainable solutions to mental and behavioral health needs in Wahkiakum and Pacific counties. The meetings generated interesting suggestions, including innovative integration models.
- CPAA continues to discuss with partners, including parents and school districts, the piloting of the Hope Squad program in schools to complement ongoing QPR (Question, Persuade, and Refer) Suicide Prevention trainings. Hope Squad is designed to reduce youth suicide through education, training, and peer intervention.

Elevate Health

Serving Pierce County

COVID-19 response

- Building on the success of the first two rounds of zero-interest bridge loans, OnePierce (Elevate Health's community investment arm) conducted another round of loan distributions in quarter (Q) 4 of 2021 to regional providers and partners for rental assistance. These bridge loans are essential to ensuring community-based organizations have responsive funding to meet emergent community needs prior to the reimbursement allocations of state and federal pandemic dollars.
- Elevate Health continued providing COVID-19 specific care coordination support to Pierce County. In the past three months, Elevate Health has worked to expand its partner network in response to the COVID-19 surges. Elevate Health added three new partners to the Care Connect Network, including Asia Pacific Cultural Center, Community Health Clinic, and Virginia Mason Franciscan Health.

Care coordination

- Common Spirit Health (CSH) awarded Elevate Health a $400,000 grant for a Maternity Support Pilot utilizing Pathways. The pilot is scheduled to go-live in Q2 of 2022. The Elevate Health team worked in concert with CSH to develop a proposed value-based payment model for Pathways, which will be piloted throughout the community-based network in 2022.
- Elevate Health applied for and was awarded a Bristol Myers Squibb Grant to apply the Pathways Community HUB Institute (PCHI) model to an "Atrial Fibrillation" trial cohort. The pilot will go live in Q3 of 2022.
- The Arcora Foundation and the Local Impact Network (Tacoma-Pierce County Health Department) selected Elevate Health to chair the Care Coordination sub-committee for oral health.

Health equity

- OnePierce held a "Behavioral Health Equity Grant Challenge" for distribution of $200,000 to expand access to behavioral health services and further behavioral health integration.
- Elevate Health has convened and organized local community partners, providers, managed care organizations (MCOs), and local government to address a gap in post-acute care delivery for populations experiencing homelessness by means of a "medical respite" initiative. Medical respite is intended to aid in recuperation and healing for unsheltered individuals whose conditions no longer warrant hospitalization, but render them too ill for a street or shelter environment. In response to this identified need, Elevate Health facilitated and established a regional Medical Respite Steering Committee in October. The committee meets bi-monthly for cooperative facility planning.

Behavioral health

- Elevate Health conducted bi-weekly planning meetings with the Opioid Task Force (OTF) for 2022 Opioid Summit in February. Elevate Health developed new charter for OTF and presented it for approval to the Executive Committee in December.
- Elevate Health completed a project collaboration with six emergency management system (EMS) fire districts under a $250,000 Cambia Foundation grant to equip behavioral health responders with behavioral health education. Elevate Health worked with Comprehensive Life Resource's Mobile Crisis Outreach Team (MCIRT) and Multicare Health System to provide first-responders with training around stigma, crisis management, stress management, and promoting connection to support services. The MCIRT team also created a short video series for providers that was shared on YouTube. Community trainings garnered nearly 100 percent participation from front-line fire district staff.

Greater Columbia ACH (GCACH)

Serving Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, and Yakima counties

Organizational changes

- GCACH Director Carol Moser is retiring, and GCACH hired Sharon Brown as the new Executive Director. As part of her outreach to elected officials, Carol has worked with Sharon over the past few years in her capacity as State Senator representing the 8th Legislative District.

COVID-19 response

- GCACH collaborated with Medical Teams International (MTI), the Tri-Cities Hispanic Chamber of Commerce, and seven community-based organizations, including housing agencies, food banks, churches, and free clinics to vaccinate targeted populations within Benton and Franklin Counties between August 12 to December 31st. Approximately 1,250 vaccinations were

provided to populations living in "hot spots" (census tracts with the lowest vaccination rates) using pop-up clinics staffed by MTI and Aristo Health Care.

Workforce development

- GCACH was awarded $146,667 per year for two years for a behavioral health pilot program funded through state legislation, House Bill 1504. Contracts were signed with seven community behavioral health agencies to support workforce needs related to reimbursement and incentives for supervision of interns and trainees in December. A total of 26 interns seeking certifications and degrees in substance use disorder and social work will be provided with training through the pilot. Nine interns will be seeking their master's degree in social work.
- GCACH sent out 75 letters of interest to Emergency Medical Services (EMS) First Responders in the GCACH service area in early December. The Emergency Medical Services Innovated (EMSI) program aims to bridge the gap between unmet health care needs, high-cost care, and access to care. EMSI prepares first responders to operate within a patient-center medical home model of care, learning the skills of population health management, data management, and sustainability.
- GCACH is funding a scholarship program to support Heritage University's newly developed Behavioral Health Aide (BHA) Certificate program: Indigenous Education Pathway for Tribal Nations. This proposed certificate seeks to create an indigenous BHA education pathway integrating the conceptual Traditional Indigenous Knowledge (TIK) framework. This framework includes dimensions of ceremony, tribal traditions, respect, connection, holism, trust, and spirituality as knowledge bundle systems.

Community information exchange

- GCACH is pursuing the development of a decentralized, open-source community information exchange (CIE). SiteSavvy is creating a resource directory for the GCACH service area, which will be finalized at the end of January 2022.
- GCACH is putting together a request for proposals (RFP) for the research, development, and implementation of a client data exchange for use by community-based organizations, human service agencies, and other non-clinical providers. GCACH is in early discussions with the Yakama Nation to pilot a potential Community Data Exchange (CDE) to connect their programs and services.

Multi-Payer Primary Care Transformation Model

- GCACH has been following the development of HCA's Multi-payer Primary Care Transformation Model (PCTM). PCTM closely aligns with the Patient-Centered Medical Home model of care, giving GCACH an opportunity to transition all provider sites into the HCA's PCTM, and providing the technical support needed to be successful under a value-based payment contract. GCACH is in close contact with HCA to find opportunities to help launch the PCTM model in 2023 as part of GCACH's scale and sustain strategy.

HealthierHere

Serving King County

CIE

- Together with clinical and community partners, HealthierHere leads the design and implementation of the Connect2 Community Network to strengthen care coordination in the region. HealthierHere created the Connect2 Community Network Catalyst Fund to enable interested organizations to use a closed-loop, bi-directional, referral technology via Unite Us. Over the past year, this critical investment enabled 49 clinical and social service organizations in King County to connect more than 500 community members directly to services using a shared technology. More than 55 percent of awardees are BIPOC-led, ensuring that community members can access culturally and linguistically competent care. Watch HealthierHere's animated video introducing the Connect2 Community Network.

- HealthierHere, in partnership with Global to Local and the YMCA of Greater Seattle, has received a $400,000 investment from Cambia Health Solutions to strengthen existing culturally and linguistically relevant referral and support services in south King County communities experiencing high health disparities. These investments will support and scale community health worker programs as well as the development of a comprehensive, up-to-date resource directory for Connect2 Community Network partners. Read more in the press release.

Health equity

- HealthierHere invested $1.1 million through partnerships with five Native-led, Native-serving organizations (Cowlitz Indian Tribe, Seattle Indian Health Board, Nakani Native Program, Unkitawa, and United Indians of All Tribes Foundation). This investment provides increased access to Traditional Medicine(s), focusing on equitable culturally appropriate, and culturally relevant and responsive activities to support physical, mental, emotional, and spiritual well-being for American Indian/Alaska Native/Indigenous communities.
- HealthierHere awarded a contract to Headwater People to evaluate the Traditional Medicine investments by looking at areas, such as the models, methodology, and exploring sustainability options for Traditional Medicine as an investment for MCO's and other non-health care payers.

Social determinants of health

- On December 7, HealthierHere hosted a panel that included Chris Klaeysen (Seattle Housing Authority), Jenny Le (King County Housing Authority), and Alex Ebrahimi (King County Regional Homelessness Authority) to share information and answer questions about Emergency Housing Vouchers (EHVs) available in the region. Nearly 100 participants tuned in to learn more about how they can connect to the regional access point and how community members can access the EHV program. EHVs are tenant-based vouchers allowing recipients to rent a unit from any landlord in a Public Housing Authorities jurisdiction.

Workforce

- HealthierHere co-sponsored a burnout prevention series for nursing and other health care professions in partnership with the Seattle and King County Health Industry Leadership Table (HILT). The series featured local and national community leaders, including Dr. Tatiana Sadak and Emily Ashado from the University of Washington and Dr. Amelia Schlak from Columbia University. Focused on unit/floor supervisors, human resource directors, and those responsible for direct patient care teams, the series was designed to help nurses and other critical staff cope in these ongoing unprecedented times.

North Central ACH

Serving Chelan, Douglas, Grant, and Okanogan counties

Behavioral health

- Working with the Central Washington Recovery Coalition, vending machines were installed in Wenatchee and Moses Lake on Nov. 5, 2021, providing free access to the life-saving Narcan naloxone nasal spray. The machines allow people to obtain Narcan anonymously for emergency preparedness without the need to go to a physician or pharmacy. These machines are the first of their kind in the state, and were funded by Beacon Health Options, which also purchased 1,800 packs of Narcan to supply the two machines. The machines have already been credited with saving lives since their installation.
- NCACH is assisting in the marketing of the San Poil Treatment Center, which held its grand opening on September 30. This work includes portions of investments toward public health and wellness capacity efforts that NCACH provided in 2021 to the Confederate Tribes of the Colville Reservation. This 46-bed treatment facility, located on the Colville Reservation in Keller, provides evidence-based residential substance abuse treatment that supports and integrates the traditional healing practices of indigenous people.

- About 25 recovery coaches in the region participated in a December 2021 training on "Ethical Considerations for Recovery Coaches." The NCACH Recovery Coaches Network now has nearly 100 members, more than a dozen of whom have also been hired to offer services through community-based agencies or clinical organizations.

Health equity

- The North Central Washington Equity Alliance kicked off a nine-month learning series, "Learning to People Better, Together," in October 2021 for 25 nonprofit organizations in the region. The series is designed to help nonprofit leaders and staff develop skills to improve diversity, equity, and inclusion work within their own organizations. NCACH is partnering in this pilot learning session with the Community Foundation of North Central Washington as well as the Leavenworth-based Icicle Fund.

Care coordination

- NCACH continues to invest in community-based care coordination models across the region. Models include recovery coaches targeting youth, coordinators embedded in schools, and partnerships between human service organizations and local fire districts to meet the needs of residents in outlying areas.
- An October 2021 meeting with Region 6 Health Home partners explored the status of information technology platforms used by various leads and brainstormed what the NCACH region could do to help move toward less data and platform fragmentation. The current state is creating significant burden for care coordination organizations.
- A meeting with North Central Washington (NCW) partners involved in various care coordination and community information exchange efforts in the region (such as Health Homes, Help Me Grow, 211, etc.) focused on respective efforts on resource directories and identifying potential alignment opportunities. One goal for staying coordinated is to integrate care coordination systems that currently exist within specific sectors into a more cohesive regional system.

Community engagement and outreach

- This fall, nearly 30 schools in the region will develop Hope Squad programs for their students. The peer-to-peer program for middle and high school students is designed to promote mental health resiliency and suicide prevention. About 45 staff members have been trained throughout the participating schools, and NCW has emerged as the third-largest area of Hope Squad programs in the entire nation. Regional work for Hope Squads was launched through funding from Cambia Health Solutions in 2021, with NCACH supplementing this effort with additional financing.

North Sound ACH (NSACH)

Serving Island, San Juan, Skagit, Snohomish, and Whatcom counties

Community engagement

- NSACH continued Partner Learning Sessions, including the Tribal & Equity Series. NSACH partners, Children of the Setting Sun Productions, shared 'Coast Salish Culture Through Film' in October, and Peacehealth shared examples of the power of belonging and civic muscle in December.
- Supported the second annual North Sound Indigenous Youth & Young Leaders Conference in November. Over 40 youth attended, with panel discussions, breakout learning groups, and keynote speaker Rena Priest, Washington State Poet Laureate.

COVID-19 response

- Continued support for COVID-19 care coordination across the region at the request of the local health jurisdictions, supplying COVID-positive individuals with care and food kits, and

providing both MTP and Department of Health (DOH) funding to support local public health and community-based organizations with personal protection equipment (PPE), rapid tests, and other COVID-19 needs.

- Partnered with organizations who are trusted messengers, community health workers (CHWs) and promotoras (who also acted as interpreters), navigators, and advocates for community members to have access to vaccines and testing sites. Also continued partnership with Kaiser Permanente and Medical Teams International to expand access to vaccines and oral health care in communities with lower rates of vaccination.

Emergency community response:

- In November 2021, Whatcom and Skagit counties were hit with massive flooding, and residents in rural areas were in need of emergency assistance.
    - Created a list of community partners and services for individuals impacted by the flood and distributed them via social media, through partner organizations, and directly to individuals.
    - Coordinated and paid for hotels, food, and cash gift cards for families who had lost their housing due to the floods. Also coordinated delivery of food from Bellingham Food Bank to these families.
    - Hosted and facilitated meetings between community-based organizations, emergency response agencies, nonprofits, and the cities to assist those impacted by flooding.
    - Provided emergency COVID-19 prevention tools to emergency shelters and those in hotels, including PPE, COVID-19 rapid antigen tests, and cleaning supplies.

Technical assistance

- Trained partners on Innovaccer software for CIE and provided technical assistance to partners on the platform, Hub program, and connections with referral partners.
- Care coordination and CHW support: the Care Coordination team noted that they had done significant work to set Care Coordination Agencies (CCAs) up in the Hub, train CHWs on software and provide support for billing and other technical assistance.
- Provided support for Tribal alignment work, requests for data, quality improvement information, information on value-based payments, information on maintaining staff well-being, resources for working with LGBTQ+ individuals, and information on behavioral health integration.

Sustainability

- Post-MTP, NSACH will begin its next phase, called the North Sound ACH Collaborative Action Network. The Collaborative Action Network will be open to all community members and organizations seeking to advance a just and inclusive culture and the necessary conditions required for all North Sound community members to thrive.

Olympic Community of Health (OCH)

Serving Clallam, Jefferson, and Kitsap counties

Community-based care coordination

- Care coordination is an important aspect to solving tough health issues in the Olympic region. By elevating community voices, we can better understand the challenges and strengths of care systems. OCH collaborated with regional partners to create and launch a video highlighting creative examples of partners coming together to support the individual needs of clients and patients. The video also highlights a story of Miranda Burger, OCH Program Manager, who

shares her experience as a new mother in rural Clallam County, navigating complex health care for her son.

Community engagement

- On November 15, 2021, OCH hosted over 60 partners from across the region at the 2021 Stronger Together Regional Convening, which took place at the Kiana Lodge. Several partners shared recent successes, OCH shared recent research about stigma of substance use disorder, and partners networked in-person for the first time since the start of the pandemic.

COVID-19 response

- In 2021, OCH funded seven projects across the region to support a strong recovery from COVID-19. Partners recently submitted reports about that work. Read the summary of these projects.

Community-clinical linkages

- Partners across the Olympic region are building strong partnerships between the clinical and community workforce to improve local health outcomes. OCH is inspired by the recent successes on local community-clinical linkage projects. Community-clinical linkages are connections between community and clinical sectors to improve population health. When clinical and community partners work together, better health outcomes are achievable for everyone.

SWACH

Serving Clark, Klickitat, and Skamania counties

Community-based care coordination:

- The Clark Cowlitz Fire Rescue (CCFR) Community Assistance Resource and Education Services (CARES) Program has established a Community Paramedicine based outreach, education, and navigation resource for Clark and Southern Cowlitz County. Utilizing an experienced Social Worker (MSW) and social work and Paramedic, the program delivers a wide variety of community outreach and resource referral activities with the goal of increasing safety and access to social services for vulnerable community members. The Community Paramedicine model gives a unique opportunity to intervene early and solve many medical, environmental, and social problems as early as possible. Value has been demonstrated through 911 usage reduction, appropriate resource utilization, integration into the whole person care model, and community member satisfaction.
    - Community Paramedicine partnerships were established with local Legacy and PeaceHealth hospitals to accept referrals through HealthConnect Hub and support patient post-discharge. This partnership supports improving hospital capacity during COVID-19 by supporting patients recovering from medical procedures or surgery if they can be at home with monitoring from Community Paramedicine.
- HealthConnect Hub is a common, integrated platform providing quality assurance, technical assistance, training and monitoring of care coordination models in the SWACH region. Leveraging evidence based care coordination models, HealthConnect Hub drives a Community Health Record platform where providers can refer community members in to address whole person needs to promote healthier outcomes. Pathways is an evidence-based care coordination model that centers community health workers (CHWs) to come along side community members, document self-identified health and social needs through an integrated assessment that identifies and supports modifiable risk to promote whole person wellness. Access to Health is a care coordination model which prioritizes simple care coordination techniques through trust building, referrals, and access coordination.
    - HealthConnect Hub provided care coordination supports, technical assistance, quality assurance, reporting and outcome-based payments for Pathways, Access to Health, Community Paramedicine, and Public Utility models during Q4. Pathways

served 284 individuals, Access to Health served 4 individuals, Community Paramedicine served 34 individuals, and Public Utility served 71 individuals through Community Based Workforce. Additionally, HealthConnect Hub trained seven new CHWs or Supervisors in the Pathways care coordination model during Q4.

Health equity:

- SWACH completed a digital equity project and creation of six brief "Technology Mindset" training videos in Spanish and English. The videos cover a variety of topics, ranging from supporting people in gaining familiarity with technology, accessing supports and services, and connecting with friends and family. These digital equity resources have now been championed and shared out by partner organizations to reach clients. These partner organizations include local public schools, DOH, and Area Agency for Aging and Disabilities of SW Washington.
- In December 2021, SWACH Board of Trustees voted to implement a two-year Racial Justice plan. The purpose of this plan is to identify and invest in areas of growth and transformation together with community, staff, and Board members. With staff and community involvement, the Board selected five areas of priority including:
    - Transforming within: Invest in a culture of learning and growth
    - Transforming together: Align community, staff, and board
    - Transforming outcomes: Center community voices in decision- and policymaking
    - Transforming outcomes: Invest in communities with most need
    - Transforming policies & systems: Culture of accountability and& psychological safety

Behavioral health:

- SWACH continued to support Trueblood in the region, as being a neutral convener remains a priority for SWACH. SWACH supports two monthly Trueblood meetings, bringing providers, systems, and others together with the goal to discuss their work and resources to better improve the Trueblood program.
- In its role as a convener across region and systems, SWACH continues to address regional opioid use impacts through convening of the Clark County Opioid Taskforce (CCOT) and participation in the Opioid Treatment Network. In Q4, the CCOT provided training by Eliza Powell Northwest High Density Drug Trafficking Areas (NW HIDTA). Eliza discussed an overdose response system and a tool used by first responders, called the OD Map, to find those needing Narcan.

COVID-19 response:

- HealthConnect Hub continues to provide critical COVID-19 resources throughout the region with trusted CHWs and a DOH Care Connect WA grant. The Southwest region experienced another significant surge of COVID-19 positive cases during Q4. The HealthConnect Hub Community Based Workforce (through CareConnect WA) served 961 households and provided 558 households with $659,615 in Household Assistance Requests and 488 fresh-food orders.
- As at home-testing options became more widely available in Q4, HealthConnect Hub provided important communication between CHWs, community members, and local health jurisdictions to give timely information and support people in receiving care options after testing positive for COVID-19.