



STATE OF WASHINGTON

May 30, 2019

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

**SUBJECT: Quarterly Report on the Medicaid Transformation Project Demonstration**

Pursuant to SSB 5883, Sections 213(1)(e)&(f), 204(3)(b), and 206(25)(a)&(b), 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. Given that the information contained in the report is the same as what we believe to be required under SSB 5883, 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 quarterly expenditure and FTE report covering all three initiatives of the Demonstration.

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

Cheryl Strange, LMHC, MPA  
Secretary  
Department of Social and Health Services

Enclosures

By email

cc: Senate Ways and Means Committee  
House Appropriations Committee  
Greg Attanasio, Counsel, Joint Select Committee on Health Care Oversight  
Chris Blake, Counsel, Joint Select Committee on Health Care Oversight  
Evan Klein, Counsel, Joint Select Committee on Health Care Oversight  
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**Medicaid Transformation Project**

Health Care Authority	SFY17 Budget	SFY17 Expenditures to Date	SFY18-SFY19 Budget	SFY18 Expenditures to Date	SFY19 Expenditures to Date	SFY18-19 Total Expenditures
<b>Initiative 1 - DSRIP</b>	\$127,336,000	\$11,496,394	\$486,683,000	\$359,157,956	\$7,415,321	\$366,573,276
<b>Initiative 3 - FCS</b>	\$14,992,000	\$0	\$38,425,000	\$543,281	\$1,060,129	\$1,603,410

DSHS - ALTSA	SFY17 Budget	SFY17 Expenditures to Date	SFY18-SFY19 Budget	SFY18 Expenditures to Date	SFY19 Expenditures to Date	SFY18-19 Total Expenditures
<b>Initiative 2 - MAC and TSOA</b>	\$3,680,000	\$353,365	\$41,388,000	\$8,707,502	\$14,995,903	\$23,703,405
<b>Initiative 3 - FCS</b>	\$1,221,000	\$45,725	\$2,200,000	\$513,509	\$654,744	\$1,168,253

DSHS and HCA (Community Behavioral Health)	SFY17 Budget	SFY17 Expenditures to Date	SFY18-SFY19 Budget	SFY18 Expenditures to Date*	SFY19 Expenditures to Date*	SFY18-19 Total Expenditures
<b>Initiative 3 - FCS</b>	\$883,000	\$0	\$13,098,000	\$129,743	\$547,371	\$677,114

\*Administrative staff costs only. FCS admin and service expenditures (TPA costs) are in HCA's budget.

As of July 1, 2018 - Behavioral Health integrated with HCA.

DSRIP - delivery system reform incentive payment

FCS - foundational community supports

MAC and TSOA - medicaid alternative care and tailored supports for older adults

Washington State Medicaid Transformation Project (MTP) demonstration  
Section 1115 Waiver Quarterly Report (DY 3 Q1)  
Demonstration Year: 3 (January 1 to December 31, 2019)  
Reporting Quarter: January 1 to March 31, 2019



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# Introduction

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

Over the five-year MTP period, Washington will:

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

The state will accomplish these goals through three programs:

- Transformation through Accountable Communities of Health (ACHs) and Delivery System Reform Incentive Payment (DSRIP) program.
- Long-term Services and Supports (LTSS) – Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA).
- Foundational Community Supports (FCS) – Community Support Services (CSS) and Supported Employment – Individual Placement and Support (IPS).

## The Healthier Washington initiative

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

Visit the [HCA website](#) to learn more about the Healthier Washington initiative.

# Quarterly report: January 1–March 31, 2019

This quarterly report summarizes MTP activities from January 1 through March 31, 2019. It details MTP implementation, including stakeholder education and engagement, planning and implementation, and development of policies and procedures.

## Summary of quarter accomplishments

- Within the DSRIP program, HCA continued engagement activities with ACHs and managed care organizations (MCOs) in ways that support a consistent feedback loop. Monthly MCO check-ins continued. Monthly calls with each ACH were added, providing dedicated time to focus on special circumstances of each ACH.
- Between the September 2017 implementation of LTSS and the end of demonstration year 3 (DY 3) quarter 1 (Q1), total enrollment reached 3,502, with an active enrollment of 1,966.
- At the end of DY 3 Q1, the total aggregate number of people enrolled in FCS included:
  - CSS: 1,991
  - IPS: 2,562
- HCA continued substance use disorder (SUD) program development and implementation, including incorporating CMS feedback into the SUD evaluation and design, and submitting the SUD monitoring protocol.
- HCA began implementation of its 2019 health information technology (HIT) Operational Plan. The plan identifies tasks that support implementation of health IT and health information exchange (HIE), and integrates the tasks in the SUD HIT plan.

## MTP-wide stakeholder engagement

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

- Program-specific, frequently asked questions were routinely updated in response to public inquiries. Questions were generated from a variety of forums—webinars, presentations, and stakeholder interaction—and used to clarify and define program development.
- Materials are continually developed and updated on the website, including information on ACH projects, earned incentives, and reports.
- Stakeholders received information about MTP-related activities through the Healthier Washington [email subscription list](#). More than 3,540 subscribers receive announcements and monthly newsletters. HCA also engages with stakeholders and the public through social media and blog posts.
- The FCS newsletter, Foundations (begun October 2018), continues to be well received among FCS stakeholders and partners, with more than 900 subscriptions at the time of this report.
- A new engagement feature—an enhanced “thank you for attending” email—was added to the Healthier Washington Webinar Series. This email now goes out to all registrants, instead of attendees only. It includes:
  - Answers to questions not addressed during the webinar because of time limits.
  - Links to the slides and to the webinar recording.
  - Links to programs or topics referred to in the webinar.
  - Information and registration links for future webinars and events.
  - Subscription links to the Healthier Washington and Foundation newsletters.
  - Links to HCA social media.

- HCA convened public and private sector stakeholders in monthly meetings to provide updates on tasks in the 2019 HIT Operational Plan.
- DSRIP guidance documents and ACH reporting documents, including independent assessor (IA) findings, continue to be available on HCA’s website. Also posted on the website are materials related to the ACH semi-annual reports submitted on January 31, 2019.

## Statewide activities and accountability

### Value-based payment (VBP)

#### Value-based Roadmap: Apple Health Appendix

The Apple Health Appendix, in accordance with the special terms and conditions (STCs), describes how MTP is supporting providers and MCOs to move along the value-based care continuum. It establishes targets for VBP attainment and related DSRIP incentives for MCOs and ACHs. The state received comments from CMS on the Appendix in December 2018. HCA submitted a written response to CMS questions in Q1 of 2019.

#### Validation of financial performance measures

In DY 1, HCA contracted with Myers and Stauffer to serve as the IA for MTP. In this role, the IA is the third-party assessor of financial measures data submitted by MCOs as part of their contracts with HCA. The state maintains contracts with the five MCOs. These contracts outline VBP attainment expectations, including the following parameters:

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

The IA completed validation of statewide and regional financial measure data submitted by MCOs in DY 2. HCA began preparing for the VBP validation process in Q1 of 2019, and scheduled check-ins with the IA for early Q2 to review lessons learned and begin preparations for the 2019 validation process.

#### Statewide progress toward VBP targets

According to 2017 MCO financial performance measure data, both MCO and ACH regions are currently ahead of the annual, state-financed VBP targets. In addition to the reported financial data, HCA issued two annual VBP surveys to:

- Track health plan and provider progress toward the state’s goal of paying for value.
- Identify barriers impeding desired progress.

Responses were collected through August 31, 2018. During Q3 of 2018, the state synthesized and analyzed results. In Q4 of 2018, a summary of key findings was made available to ACHs, stakeholders, and the public on the [Paying for value webpage](#). In Q1 of 2019, HCA presented region-specific results from the survey to North Central ACH, and extended the offer to other regions.

#### Technical support and training

In Q1 of 2019, HCA continued to work with Manatt to develop a VBP toolkit for providers. Tools and resources serve a variety of purposes, including:

- Providing baseline education.
- Developing necessary infrastructure and capabilities.
- Creating roadmaps for practice transformation and payment reform adoption.

Manatt is currently conducting key informant interviews to determine the utility and method of dissemination most appropriate for the tools and the toolkit itself. HCA will make a final document available to stakeholders in Q2 of 2019.

### Upcoming activities for the next quarter include:

- HCA reconvened a small group, facilitated by Manatt, to revisit VBP roles and expectations of various stakeholders. The stakeholders include HCA, providers, MCOs, and ACHs. HCA will further refine the roles and expectations of each stakeholder in Q2, and develop and implement a communications strategy to explain HCA's vision for VBP roles and expectations across the health system.
- The state will continue to convene discussions with ACHs, MCOs, and other partners to identify opportunities to support VBP readiness and attainment. These discussions will include coordinated efforts on the VBP toolkit containing technical assistance resources for providers. During DY 3 Q2, HCA will work with ACHs and MCOs on appropriate deployment mechanisms for the VBP toolkit technical assistance resource, including identification of where ACH and MCO support is most appropriate.
- HCA and Myers and Stauffer will continue preparations for the 2019 MCO VBP validation process.

### Integrated managed care (IMC) progress

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

- Hosted regular check-in calls with the 2019 mid-adopter regions for the first two months after IMC implementation to answer questions and identify/resolve immediate issues.
- Continued to monitor IMC implementation in the 2019 mid-adopter regions through regular participation in regional IMC workgroup meetings and through data collected for each region's Early Warning System.
- Monitored provider, MCO, and behavioral health-administrative services organization (BH-ASO) readiness activities in the North Sound region, and provided guidance/support to ensure the region is ready for IMC implementation by July 1, 2019.
- Continued extensive stakeholder engagement with the North Sound region and the on-time-adopter regions (the regions scheduled to implement IMC on January 1, 2020). This included continued participation in regional meetings and workgroups, and regular meetings with the MCOs and future BH-ASOs to address IMC issues, concerns, and questions.
- HCA will continue to engage stakeholders and beneficiaries regarding changes to managed care coverage in each region.

### HIT

The 2019 HIT Operational Plan includes tasks in several categories, including:

- Data and governance.
- Master Person Index (MPI) and provider directory.
- Payment models and sources.
- Health information exchange, including enhancing the functionality of the Clinical Data Repository (CDR), registries, tasks to expand the functionality, use, and users of the CDR.
- Engaging tribal partners in information exchange.
- Engaging behavioral health providers in health information exchange.
- Supporting exchange of SUD information and consent management.
- Tasks related to the SUD HIT plan, including enhancements to the prescription drug monitoring program (PDMP).

- Supporting a strategy and timeline for aligning multiple methods of HIE to support care and population health management. Information will be shared with ACHs (task 5-02).

In Q1, HCA implemented several tasks in the 2019 HIT Operational Plan in collaboration with other state agencies and organizations. This includes DOH; DSHS; Department of Children, Youth, and Families (DCYF); Health Benefit Exchange (HBE); OneHealthPort (OHP); ACHs; provider associations; and providers.

The HIT Operational Plan tasks implemented in Q1 include:

- HCA submitted the initial financial mapping report to CMS (task 1 in the SUD HIT plan; task 14-01 in the HIT Operational Plan).
- HCA submitted an Advance Planning Document (APD) to CMS requesting use of enhanced funding to develop, design, and implement a qualified PDMP as defined in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. Some tasks required for a qualified PDMP overlap with tasks in the SUD HIT plan. If approved, enhanced funding will also support implementation of some of SUD HIT plan tasks (tasks 06-02; 14-02 through 14-07).
- A State Enterprise Governance group has been formed to ensure coordination and resource alignment of information technology projects across state agencies and programs. This group is a multi-agency/organization workgroup (consisting of HCA, DSHS, DOH, DCYF, and HBE). One information technology project this group may consider is implementation of MPI. A white paper is under development that documents the lessons learned from other states and management efforts in Washington State. (See tasks 2-01, 14-08, and 14-09 in the HIT Operational Plan.)
- Division of Behavioral Health and Recovery (DBHR), now part of HCA, sponsored a survey of behavioral health providers' use of electronic health records (EHRs), including certified EHRs. (See task 12-01). Preliminary findings from the survey are:
  - 16 percent of respondents use paper records.
  - 48 percent of respondents use non-certified EHRs.
  - 36 percent of respondents use certified EHRs.
- HCA is identifying financial resources that could be used for behavioral health HIT/HIE (task 12-04). The timeline for developing the initial financial map (Q1) will be extended to Q2 and the maintenance of the map will be ongoing.
- HCA used APD funding to contract with OHP to advance the interoperable exchange of social determinants of health (task 9-07).

## 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 second set of semi-annual reports described ACH progress on projects from July 1 through December 31, 2018. The IA reviewed the projects and determined milestone completion and related eligibility for incentives.

After a rigorous independent assessment in Q1 2019, all nine ACHs demonstrated completion of milestones through the second half of 2018. All ACH regions earned incentive funds to continue their health transformation efforts. The IA notified ACHs of their achievements and incentive amounts in April 2019,

with earned funds distributed in DY 3 Q2. An [executive summary](#) of semi-annual report findings for Q3-4 2018 is available on MTP resources webpage.

In February 2019, the IA released guidance for reporting on upcoming project milestones (due Q3 2019).

## Next steps

Implementation of project activities is underway across the state. ACHs will continue to inform the state about project progress by submitting updated implementation plans that reflect progress during the reporting period. ACHs will also submit regional quality improvement strategies that:

- Detail how ACHs are supporting partnering providers in quality improvement.
- Define a feedback loop for partnering providers to report to the ACHs on progress.

## Integrated managed care (IMC) implementation milestone achievement

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

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

On January 1, 2019, [the following regions moved to IMC](#), achieving the phase 2 milestone:

- Greater Columbia (Greater Columbia ACH's corresponding regional service area (RSA), which includes Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, and Yakima counties).
- King (HealthierHere's corresponding RSA, which includes King County).
- Pierce (Pierce ACH's corresponding RSA, which includes Pierce County).
- Spokane (Better Health Together's corresponding RSA, which includes Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties).

In addition, implementation of IMC occurred in Okanogan (the transitional county of North Central ACH's corresponding RSA) and Klickitat (the transitional county of SWACH's corresponding RSA) counties. Incentives associated with phase 2 achievement will be distributed in Q2 of 2019.

## Annual VBP milestone achievement by ACHs

ACHs help assess and support provider VBP readiness and practice transformation by connecting providers to training and resources. As described in the second semi-annual report for 2018, ACHs used a number of strategies to support regional providers in the transition to VBP.

The independent assessment process in Q1 2019 found all nine ACHs showed progress on VBP milestones in DY 2. Several ACHs reported efforts to support behavioral health and rural providers. These efforts included notifying providers of VBP readiness tools, convening partners for workgroups and webinars, and supporting organizational assessments of strengths and opportunities for moving to VBP contracting. Incentives earned for VBP milestone achievement will be distributed in Q2 of 2019.

## Financial executor (FE) portal activity

The state's FE, Public Consulting Group, continued to provide direct technical assistance and resources to ACHs as they registered partnering providers and distributed payments to providers during this quarter. Additionally, HCA worked with the FE to gather feedback from ACHs on the successes and challenges of using the portal. During Q1, the FE made some process improvements to address ACH feedback about the portal's functionality. To support the implementation of process improvements, the FE made a test site available for ACHs to review and provide feedback on portal updates to ensure the adjustments supported ACH business needs.

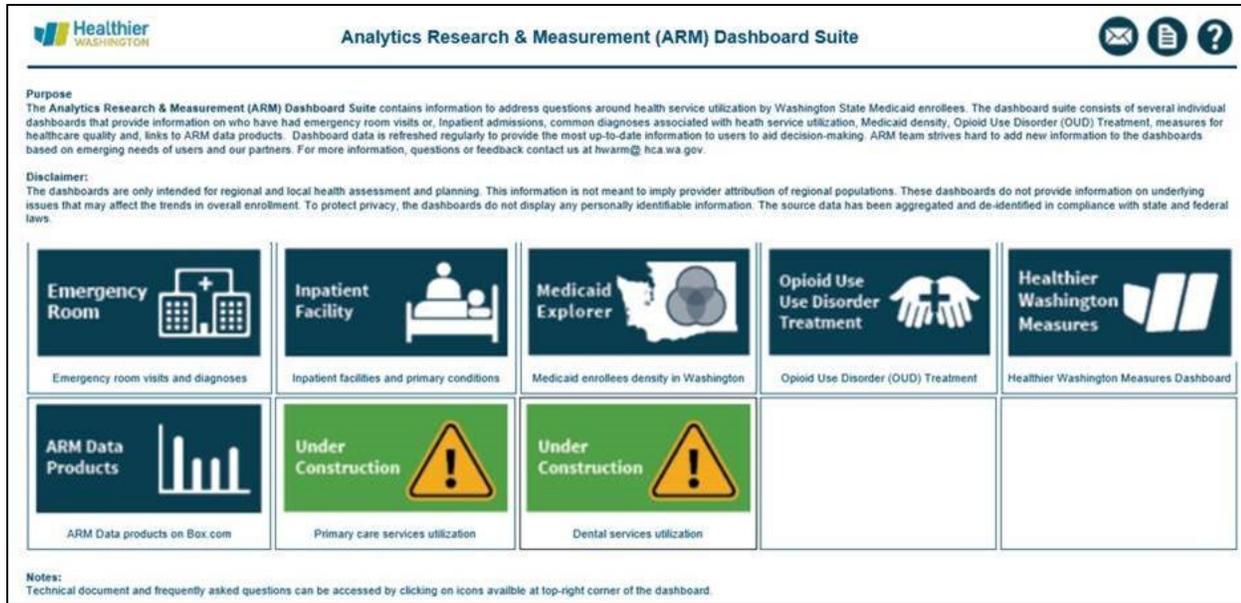
- ACHs continue to distribute incentive funds to partnering providers through the FE portal. During the reporting quarter, ACHs collectively distributed more than \$17.8 million to 247 partnering providers and organizations. These funds supported project planning and implementation activities. To date, ACHs collectively distributed more than \$155.6 million to 1,413 partnering providers.
- The state distributed approximately \$1.3 million in earned incentive funds to Indian Health Care Providers (IHCPs) in Q1 for achievement of IHCP-specific project milestones. To date, HCA distributed approximately \$9.6 million in earned incentive funds to IHCPs for achievement of IHCP-specific project milestones. [Attachment B](#) provides a detailed account of all funds earned and distributed through the FE portal.

## DSRIP measurement activities

### New data resources help ACH monitor regional health indicators

- The [Opioid Use Disorder \(OUD\) Treatment Dashboard](#) was published in February 2019 as part of HCA's Analytics, Research and Measurement (ARM) Data Dashboard Suite. The dashboard is a resource for ACHs to measure progress on opioid use. It contains data on how, and how effectively providers are treating OUD, and how well enrollees are responding to treatment. ARM will update the dashboard every quarter, and will add prevention indicators. See snapshot of dashboard below.

**Table 1: Analytics, Research, and Measurement Dashboard Suite**



- The refreshed [Healthier Washington Measures Dashboard](#) went live in early February 2019. This interactive dashboard allows people to explore Washington State population and measures data. It supports ACHs, local health jurisdictions, and communities by providing information to assess regional health needs for health improvement, and monitor outcomes over time. In addition to adding more data (based on claims from April 1, 2017–March 31, 2018), the refresh also includes:
  - More pay for performance (P4P) metrics.
  - Trends display for all claims-based metrics.
  - Additional cues to indicate the direction of improvement.

ACHs also received related derivative data products throughout Q1 to support regional analysis and monitoring efforts.

- A subset of project 3C P4P metrics were put on a shifted production timeline. This was because of the need for more capacity building and validation. This will not affect payment timelines during the performance year. In January 2019, baseline results and improvement targets were available for the remaining project 3C P4P metrics. ACHs that chose project 3C received an updated baseline report detailing baseline performance and DY 3 improvement targets. HCA also added metric results/improvement targets to the [2019 ACH improvement targets report](#).

### Pay for reporting (P4R) metric development

In Q1 2019, HCA continued P4R metric collection planning with ACH staff. The P4R metrics were developed and pre-tested with ACH-identified providers in spring of 2018. Adjustments were made to metric questions and [technical specifications](#) posted online in September 2018 (including a “[how-to-read](#)” guidance document).

During Q1, ACH staff asked questions about state expectations for P4R metric data collection and how the data will be used. HCA continues to partner with ACHs to ensure P4R metric data collection and processing is implemented in a way that works for ACHs, partnering providers, and HCA. For example, to address partnering provider concerns about submitting identifiable information with P4R metric responses, HCA will require ACHs to submit P4R metric responses in aggregate form through a template provided by HCA. The aggregated results will provide a holistic view of clinical integration progress across the state, and HCA

may be able to use this information to identify opportunities for specific technical assistance or resource needs.

## State measurement support

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

## DSRIP program stakeholder engagement activities

HCA has participated in many stakeholder engagement activities, including public forums, presentations, emails, webinars, and direct technical assistance. HCA continued to host weekly Transformation Alignment Calls with ACHs, state partners, and others who were invited or requested inclusion. The call format was adjusted to provide rotating agenda topics.

This change gave more continuity for planning and attendance. Over the course of Q1, HCA initiated monthly calls with staff from each ACH to allow for more targeted discussion and coordination. Topics this quarter included P4R developments; opportunities for strategy alignment; investments in HIT and HIE; and the importance of strengthening collaboration between ACHs, MCOs, and HCA on sustainable investments.

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

- **Ongoing:** The state supported numerous IMC readiness and educational activities during Q1.
- **February 14:** HCA hosted a webinar—part of the Healthier Washington Quarterly Webinar Series—on the future of the Healthier Washington initiative after the State Innovation Models (SIM) grant ended. It highlighted the continuance of MTP and other Healthier Washington initiative efforts. Community members, HCA and other state agency staff, ACHs, and other stakeholders attended this webinar.
- **March 5:** HCA hosted a call with MCO representatives who are actively engaged with ACHs and MTP efforts. The purpose of the call was to provide education about DSRIP VBP incentives for ACHs and MCOs, and the timing of the MCO P4R portion of the DY 2 incentive payments. The group agreed to use these calls, along with a quarterly in-person meeting, to discuss progress and challenges related to VBP and MTP.
- **March 7:** DOH repurposed the Practice Transformation Consortium, which ended at the close of the SIM grant, to include HCA, MCOs, and ACHs in discussing opportunities for training alignment with partners.

## DSRIP stakeholder concerns

Stakeholders continue to seek the most updated information about performance measures and outcomes. While these questions are likely to continue over the life of MTP, the questions provide opportunities to educate stakeholders about the MTP timeline, and the lag time of performance data. HCA has reinforced the value of the mid-point assessment and evaluation activities as ways to provide context, inform about lessons learned and early wins, and emphasize importance of local quality improvement strategies.

## DSRIP upcoming activities

- **Ongoing:** ACHs and partnering providers continue project implementation activities, further development of the regional quality improvement strategy, and first round of reporting on P4R metrics.

- **Q2:** The IA and HCA ramped up planning efforts during Q1 for the 2019 mid-point assessment.
- **Ongoing:** quarterly refresh of Healthier Washington Measures Dashboard.

## Tribal project implementation activities

**Primary milestone:** HCA, the Tribal Coordinating Entity (TCE), and the American Indian Health Commission of Washington State hosted an all-day, in-person meeting for ACHs to learn about what MTP looks like for IHCPs. Topics included:

- HCA and DBHR agency integration.
- Tribal 638 federally qualified health center (FQHC).
- Governor’s Indian Health Council.
- Community Health Aide Program Board and dental health aide therapists.
- Medicaid Transformation and HIT/HIE.
- Primary care case management (care coordination in the Washington State fee-for-service Medicaid program).

**Secondary milestone:** bi-weekly meetings hosted by HCA for tribal 638 FQHC and ACH tribal liaisons.

**Tertiary milestone:** payments were distributed through the FE portal for tribal projects, totaling \$1,345,672 for DY 3 Q1. These payments include both DY 1 planning funds and DY 2 earned funds.

## Tribal partner engagement

With the completion of site visits to all IHCPs and submission of the IHCP projects plan on October 1, 2018, HCA emphasized increasing awareness and understanding of how the IHCP projects plan fit within the context of MTP. This was done through state attendance and participation at the following events:

- **January 28:** HCA internal meeting about HIT/HIE.
- **February 1:** HCA met with HealthierHere (King County ACH) to further relationships and understanding about areas of overlap between tribes/IHCPs and ACHs.
- **February 13:** HCA participated in a call with Arizona, North Dakota, Wyoming, and Montana regarding claiming the 100 percent federal medical assistance percentages for services received through the Indian Health Service.
- **February 22:** HCA hosted an ACH tribal liaisons all-day, in-person meeting. Seven ACHs participated, along with the TCE and Commission.
- **February 26:** HCA presented to the Sauk-Suiattle Indian Tribe on IHCP-specific funds.
- **March 5:** HCA and the Commission held meeting to discuss what is tribal data sovereignty and how does it apply to the work of HIT/HIE under Medicaid Transformation.
- **March 6:** HCA participated in Manatt red flag monitoring.
- **March 11:** HCA and the Commission presented to the Olympic Community of Health ACH.

## LTSS implementation accomplishments

This section summarizes LTSS program development and implementation activities conducted from January 1 through March 31, 2019.

Key accomplishments for this quarter:

- As of March 29, 2019, the enrollment count is 3,502. The active enrollment count is 1,966.
- AARP Public Policy Institute [posted a publication](#) about MAC and TSOA programs in February 2019.

- The third issue of “What’s Up” newsletter for internal Aging and Long-Term Support Administration (AL TSA) and Area Agency on Aging (AAA) staff was published in February.

## Network adequacy for LTSS programs, MAC and TSOA

AAA contracts for 2019 have been submitted or have approved extensions. Network adequacy milestones are being developed and will be submitted according to their approved contract schedule. AL TSA and Home and Community Services (HCS) continue to monitor each AAA’s contract compliance.

## Assessment and systems update

- The electronic screening and assessment tools used for TSOA individuals were revised and released into the GetCare system on March 4, 2019. Some of the revisions included questions to be asked after the initial screening and assessments that will assist AL TSA with measuring outcomes and client satisfaction with the services/supports provided.
- The team worked on outlining revisions to the current care plan in GetCare. Development will begin next quarter.
- Plans continue for the integration of the current caregiver assessment into GetCare. This will streamline work and reduce the administrative burden on case managers who have to use multiple systems to implement MAC and TSOA services for dyads (caregiver/care receiver pairs).

## Staff training

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

- **January:** addition of vaccine and pneumonia questions to presumptive eligibility screening tool.
- **February:** policy and functionality of electronic exception to rule and policy requests in GetCare system.
- **March:** revisions to the TSOA individual screening and assessment tools.

Upcoming webinars include:

- **Statewide Health Insurance Benefits Advisors (SHIBA) training:** better understanding of general Medicare and learn about SHIBA as a resource for both case managers and MAC and TSOA clients.
- **Care plan training:** policy and system functionality.

## Data and reporting

**Table 2: beneficiary enrollment by program**

	MAC	TSOA
LTSS beneficiaries by program as of March 31, 2018	47	1,919
Number of new enrollees in quarter by program	21*	704**
Number of new person-centered service plans in quarter by program	3	261
Number of beneficiaries self-directing services under employer authority	0	0

\*13 of these new enrollees do not require a care plan because services have yet to be authorized.

\*\*339 of these new enrollees do not require a care plan yet. They are still in the care planning phase, and services have yet to be authorized.

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

## Outreach and engagement

Last quarter, it was noted there would be outreach “pilot” events during the first quarter of 2019 in several Community Services Offices (CSOs). The purpose was to promote caregiver programs and explain the different LTSS programs. Planning and coordination of these events took longer than expected. They are scheduled to occur in May and June of 2019.

Hospital association outreach continues to be a work in progress. AL TSA program management is meeting with the association in May to coordinate dates and locations for regional networking meetings around the state to promote caregiver programs.

**Table 3: outreach and engagement activities by AAA**

	January	February	March
	Number of events held		
Community presentations and information sharing	14	17	24

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

AL TSA met with a number of tribes to discuss Medicaid services and LTSS and FCS programs during Q1:

- **January 7:** planning meeting with Skokomish Tribe. Service descriptions included MAC/TSOA. (Government-to-government planning per [Administrative Policy 7.01.](#))
- **January 8:** Indian Policy Advisory Subcommittee meeting.
- **January 14:** planning meeting with Confederated Tribes of the Chehalis Reservation and Lewis-Mason-Thurston AAA. Service descriptions included MAC/TSOA. (Government-to-government planning per [Administrative Policy 7.01.](#))
- **January 22:** planning meeting with Squaxin Island Tribe. Service descriptions included MAC/TSOA. (Government-to-government planning per [Administrative Policy 7.01.](#))
- **January 23:** planning meeting with Confederated Tribes of the Chehalis Reservation and Olympic Area Agency on Aging. Service descriptions included MAC/TSOA. (Government-to-government planning per [Administrative Policy 7.01.](#))
- **January 24:** planning meeting with Quinault Nation. Service descriptions included MAC/TSOA. (Government-to-government planning per [Administrative Policy 7.01.](#))
- **February 20:** planning meeting with Hoh Tribe and Quileute Tribe. Service descriptions included MAC/TSOA.
- **February 22:** planning meeting with Nisqually Tribe. Service descriptions included MAC/TSOA.
- **February 28:** planning meeting with Makah Tribe. Service descriptions included MAC/TSOA.
- **March 6:** “Dear Tribal Leader” letter communicating update to Washington Administrative Code (WAC) for MAC/TSOA benefit levels. See attached letter below.



Dear Tribal Leader  
letter.pdf

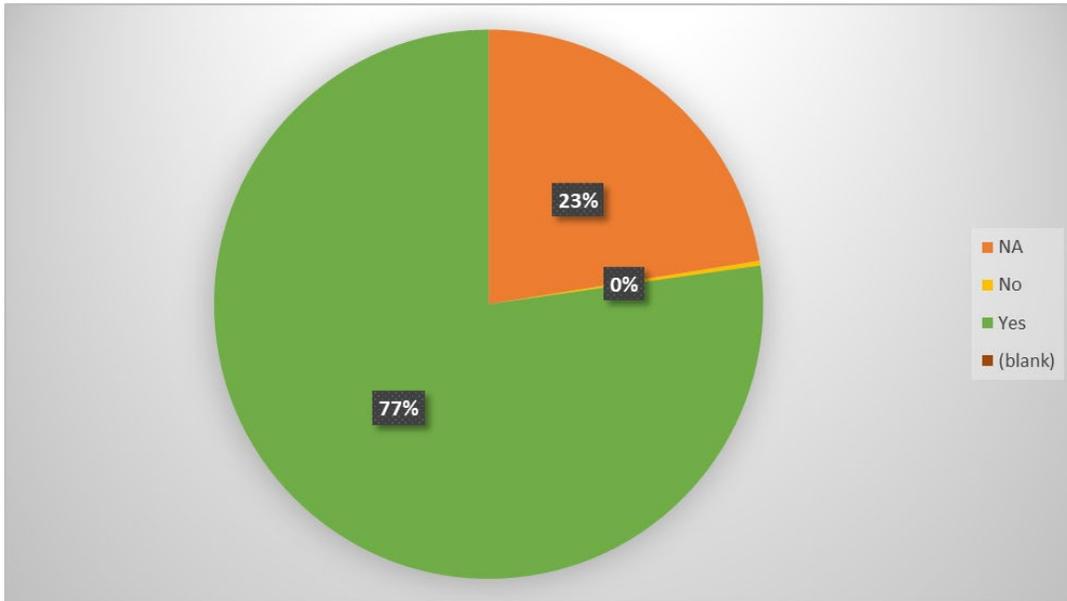
- **March 12:** Indian Policy Advisory Subcommittee meeting. Public notice of proposed rulemaking change shared.

- **March 12:** Planning meeting with Squaxin Island Tribe. Service descriptions included MAC/TSOA.
- **March 27:** Planning meeting with Lummi Nation. Service descriptions included MAC/TSOA.

## Quality assurance

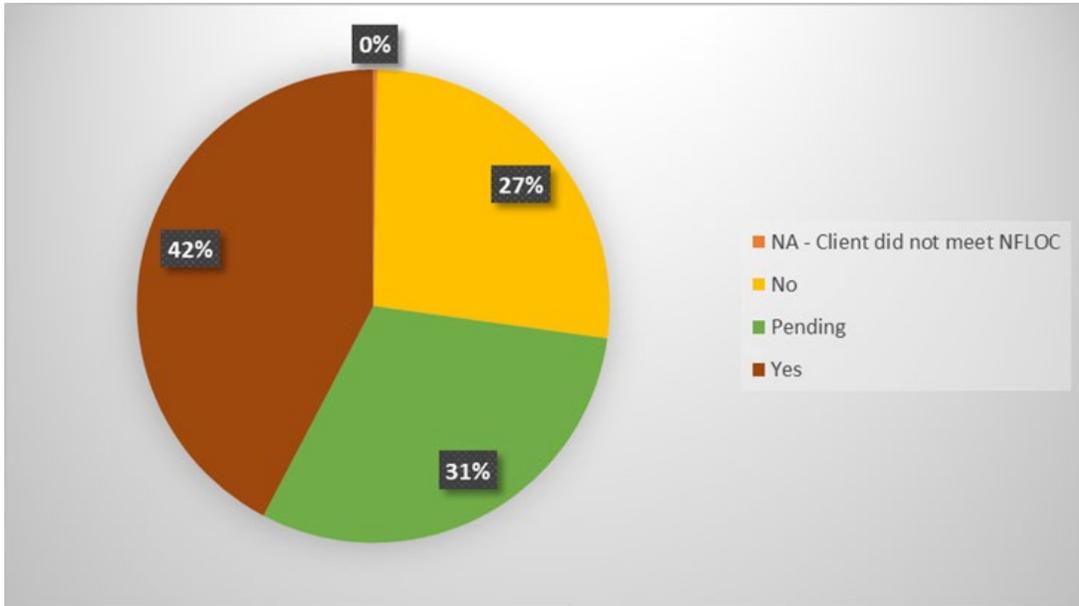
Results of the quarterly presumptive eligibility (PE) quality assurance review

**Table 4:** question 1: was the client appropriately determined to be nursing facility level of care eligible for PE?



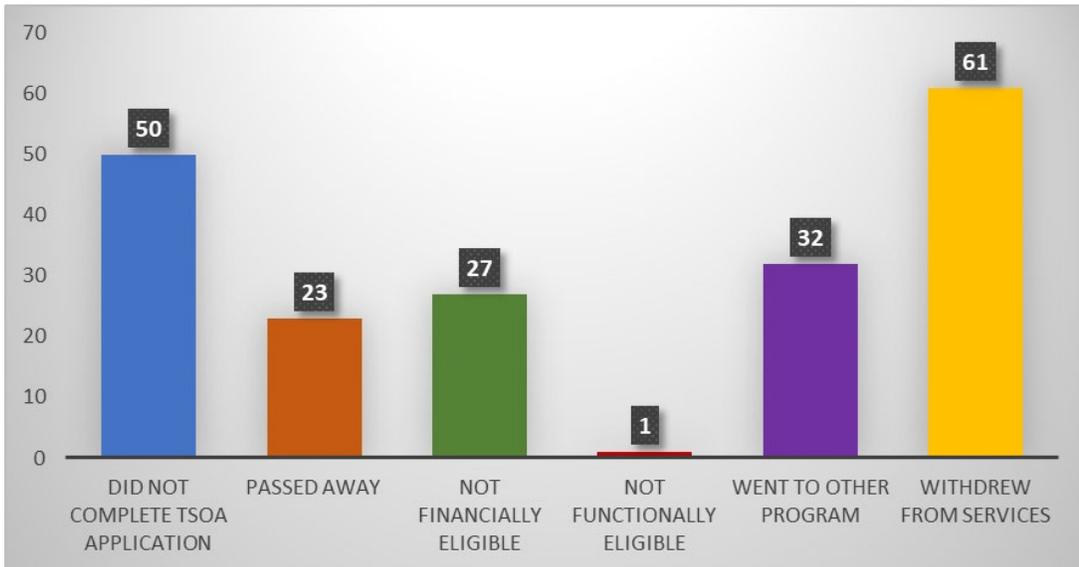
Note: the N/A represents clients who were part of the last quarter's review and the response to question #1 was "yes" but the response to question #2a was "pending".

**Table 5:** question 2a: did the client remain eligible after the PE period?



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

**Table 6:** question 2b: if "No" to question #2a, why?



## 2019 quality assurance results to date

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

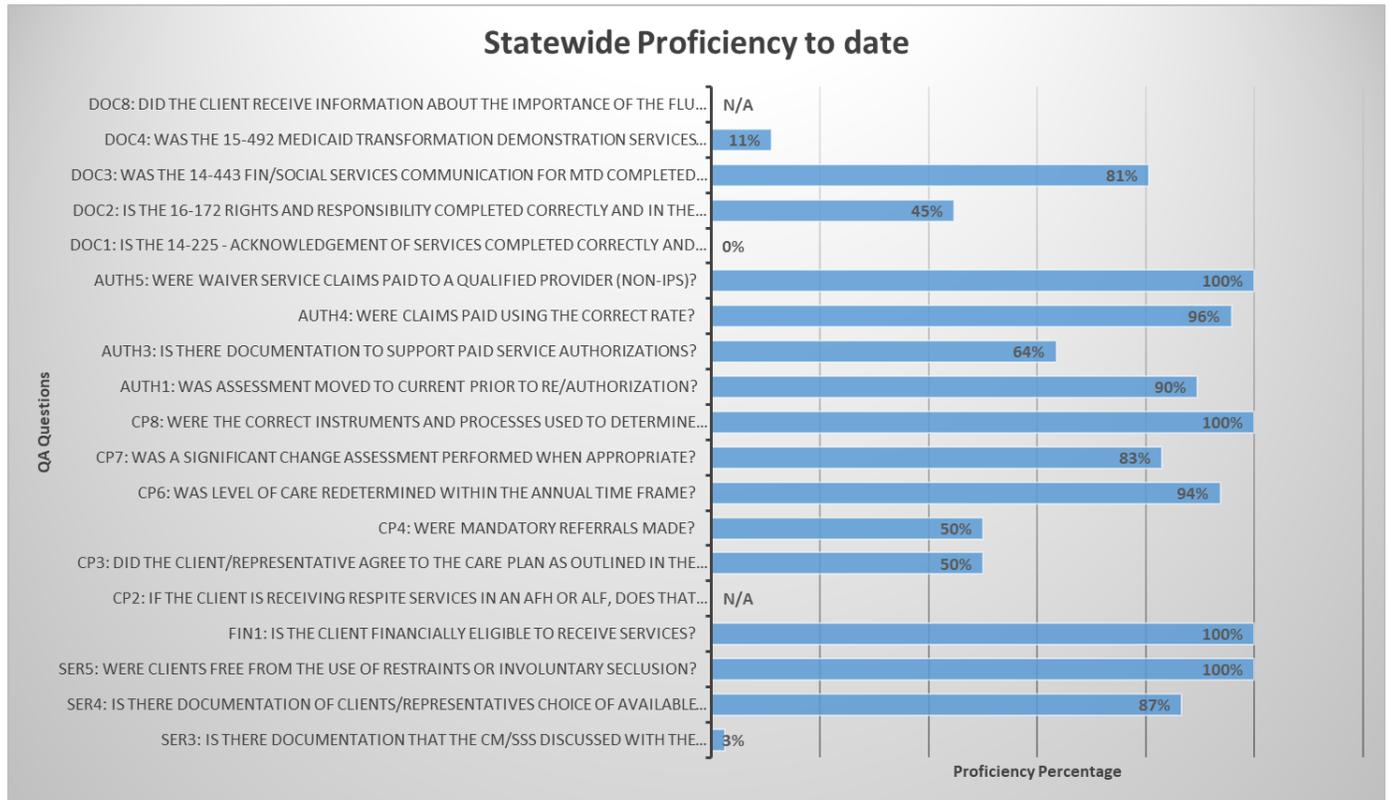


2019 MTD QA  
Questions.pdf

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

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

**Table 7: statewide proficiency to date**



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

## State rulemaking

**March 26:** a public hearing was held as part of the state rulemaking process for revisions related to the revised TSOA screening tool. No spoken comments were received. One entity submitted written comment regarding concerns that HCS’s published rates on the AL TSA website were only available in Excel format. AL TSA sought to address the comments received and evaluated the request to change. HCS rates are now available in both Excel and PDF formats. AL TSA is also seeking further feedback from clients on accessibility of rules.

**May 5:** rule for TSOA screening tool revisions becomes permanent.

## Upcoming activities

- The outreach project in the local CSOs has been delayed until May and June of 2019.
- HCS and AAA staff statewide are working on development of a performance improvement plan to increase dyad enrollments. Short-term, actionable tasks are being created and implemented next

quarter. Measuring success of these action items will occur monthly throughout the remainder of 2019.

- An outreach meeting is being scheduled for Q2 with statewide Health Home coordinators.
- Meeting with Medicare Advantage MCO partners to educate them about the MAC/TSOA programs and seek their partnership in spreading the word about available benefits to their members.

## LTSS stakeholder concerns

There are no concerns noted outside of rulemaking, which is addressed above.

# FCS implementation accomplishments

This section summarizes the FCS program development and implementation activities conducted from January 1 through March 31, 2019.

Key accomplishments for the quarter include:

- Total aggregate number of people enrolled in FCS services at the end of DY 3 Q1:
  - CSS: 1,991
  - IPS: 2,562
  - Note: The IPS and CSS caseloads include 318 people enrolled in both services.
- There were 99 providers under contract with Amerigroup at the end of DY 3 Q1, representing 299 sites throughout the state.
- Continuous quality improvement activities:
  - This quarter, FCS launched four events to train staff on how to participate in a fidelity review.
  - Three fidelity reviews were conducted this quarter, two on CSS and one on IPS.
  - Three additional FCS agencies participated in the fidelity reviews. This was an effort to create a cross-site learning collaborative approach to continuous quality improvement.
- Provider location data cleanup is occurring to prepare for the launch of the network map of provider sites.
- Training, technical assistance, stakeholder involvement, and information sharing continues through DBHR and ALISA partnerships. Thirteen webinars with more than 640 attendees occurred this quarter. They provided information, resources, or education about services related to CSS or IPS.

In July 2018, DBHR transitioned to HCA from DSHS. In December 2018, DBHR physically moved to HCA. Concurrently, FCS program manager Jon Brumbach left the agency. The oversight of the FCS program and contract management of the third-party administrator contract moved to DBHR. They are actively recruiting for the FCS program administrator position to replace Mr. Brumbach.

Enrollment for FCS continues to grow. Research and Data Analysis (RDA) in DSHS provides comprehensive demographic reports on enrollments, which are available on the [HCA website](#).

HCA continued to implement its continuous quality improvement strategy during this quarter. Four, daylong FCS fidelity reviewer trainings took place in Eastern and Western Washington. Two of the trainings focused on IPS services, and two focused on CSS.

The events were free for FCS providers, and provided in-depth training for providers to learn about:

- The FCS service fidelity models.
- How to conduct internal and external service fidelity reviews.
- FCS quality improvement resources and activities offered in the future.

HCA conducted three fidelity reviews of contracted FCS providers this quarter. Three FCS providers participated as reviewers.

## Network adequacy for FCS

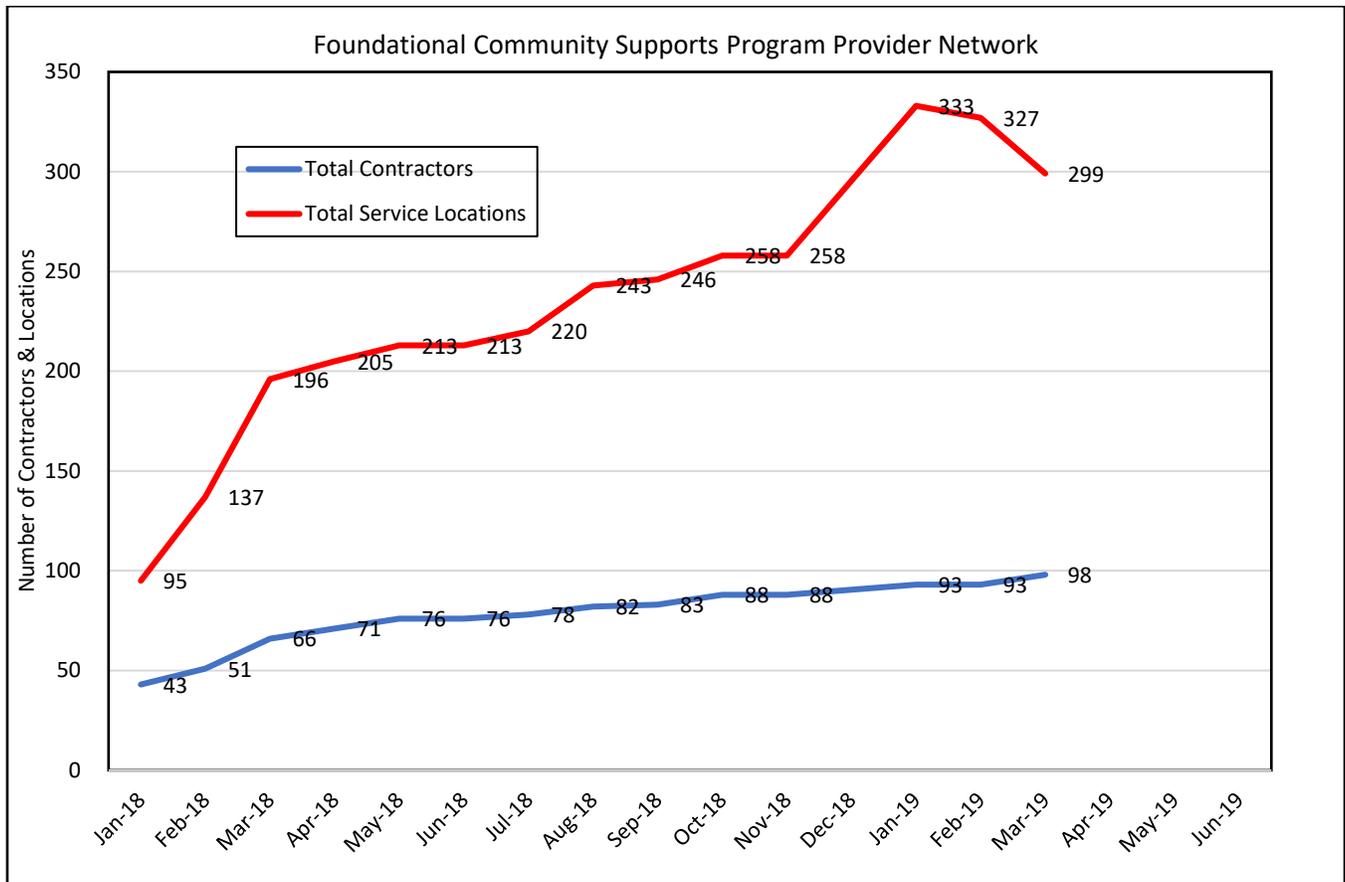
**Table 8: FCS provider network development**

FCS service type	January		February		March	
	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
Supported Employment – Individual Placement Support (IPS)	22	57	22	57	24	59
Community Support Services (CSS)	16	24	17	26	17	24
CSS and IPS	53	212	53	212	58	216
<b>Total</b>	<b>91</b>	<b>293</b>	<b>92</b>	<b>295</b>	<b>99</b>	<b>299</b>

Amerigroup continues to contract with new providers and refine the FCS contracted provider information. This is a final step toward network adequacy standards implementation, and the public launch of a tableau map of service locations and provider capacity. This refinement includes accurate reporting on the contracted providers’ site locations throughout the counties and regions. This resulted in what appears to be a reduction in service sites, but an increase in the number of agencies under contract with Amerigroup.

Amerigroup had one provider terminate its contract in February (Southwest Asthma and Allergy Associates), citing the rates were not enough to cover their costs. This is the only provider that has terminated its contract. FCS providers are required to report monthly on their capacity and outcomes, and changes to service locations, staff availability, and caseload.

**Table 9: FCS provider network**



## Client enrollment

The total number of clients enrolled in FCS increased from 3,116 at the end of DY 2 Q4 to 4,235 at the end of DY 3 Q1. FCS IPS continues to have the largest number of people enrolled, with 2,562 people enrolled at the end of Q1 of 2019 (including people enrolled in IPS and CSS), although the number of CSS enrollees continues to increase.

During DY 3 Q1, the state and Amerigroup invested significant staff resources in supporting CSS providers to build their client service capacity and provide quality services. HCA recognizes how challenging it can be to supervise (perhaps also carry a caseload), monitor service quality, and manage team performance. The state implemented a series of recurring calls, alternating months between IPS- and CSS-focused service delivery. The calls supported CSS provider supervisors and program leads in maintaining a strong workforce, reducing turnover, and achieving outcomes.

CSS client enrollment has increased at a slower rate than IPS client enrollment because CSS providers are typically smaller organizations and are non-traditional Medicaid providers. In addition, we continue to hear anecdotal concerns that some CSS providers are hesitant to add these services because of a lack of available housing stock.

**Table 10: FCS client enrollment**

	January	February	March
Supported Employment – Individual Placement and Support (IPS)	2,034	2,226	2,244
Community Support Services (CSS)	1,266	1,513	1,673
CSS and IPS	202	258	318
Total aggregate enrollment	<b>3,502</b>	<b>3,997</b>	<b>4,235</b>

Data source: RDA administrative reports

Additional information about the characteristics of FCS clients is included in the tables below. FCS continues to reach people with high rates of behavioral health diagnoses and people who are receiving services from multiple systems of care. A high rate (approximately 48 percent) of FCS enrollees continue to be Affordable Care Act Medicaid expansion adults. Capacity of FCS service providers continues to be addressed through multiple strategies:

- Providers report to Amerigroup monthly on staff capacity to provide services.
- The Amerigroup advisory council maintains this issue as a standing agenda item.
- New providers are sought through various recruitment efforts.
- Quarterly meetings on joint recruitment efforts are held in larger county systems, such as King County and southwest region.
- Opportunities for braiding resources are identified for agencies willing to expand capacity. Examples include:
  - The Vancouver Housing Authority dedicated up to 25 housing rental vouchers (called Community Choice Vouchers) to the FCS population.
  - In partnership with the Washington Community Behavioral Health Agency Council, DBHR issued Substance Abuse and Mental Health Service Administration (SAMHSA) grant funds to community behavioral health agencies willing to add FCS services.
  - DBHR also provided SAMHSA grant funding to FCS agencies for client support services. Through this funding, clients can receive interview clothing, work shoes, tools, have their food handler permit paid for, etc., so a person can be successful in employment.
- A Tableau map has been developed that incorporates contracted agencies and the counties they serve. The map also identifies which agencies are accepting referrals. The map was released for testing in February 2019 and will go live June 2019. Amerigroup continues to work with providers to help them report the most accurate information in their monthly capacity reports.

**Table 11: FCS client risk profile**

		Meet HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
January	IPS	235 (11%)	1.09	1,656 (74%)
	CSS	383 (26%)	1.75	1,116 (76%)
February	IPS	271 (11%)	1.08	1,824 (73%)
	CSS	476 (27%)	1.71	1,320 (75%)
March	IPS	289 (11%)	1.09	1,897 (74%)
	CSS	524 (26%)	1.76	1,482 (74%)

**HUD** = Housing and Urban Development

**PRISM** = Predictive Risk Intelligence System

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

Data source: RDA administrative reports

**Table 12: FCS client risk profile continued**

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment need flags
January	IPS	1,789	1,709 (96%)	1,044 (58%)	1,005 (56%)
	CSS	1,162	1,115 (96%)	913 (79%)	880 (76%)
February	IPS	2,000	1,906 (95%)	1,179 (59%)	1,133 (57%)
	CSS	1,407	1,345 (96%)	1,098 (78%)	1,058 (75%)
March	IPS	2,088	1,967 (94%)	1,226 (59%)	1,168 (56%)
	CSS	1,591	1,497 (94%)	1,218 (77%)	1,158 (73%)

**MH** = Mental health

**SUD** = Substance use disorder

Data source: RDA administrative reports

**Table 13: FCS client service utilization**

		Medicaid only enrollees*	Long-term Services and Supports	Mental health services	SUD services	Care + MH or SUD services
January	IPS	1,789	208 (12%)	1,454 (81%)	538 (30%)	166 (9%)
	CSS	1,162	166 (14%)	913 (79%)	490 (42%)	137 (12%)
February	IPS	2,000	227 (11%)	1,596 (80%)	595 (30%)	184 (9%)
	CSS	1,407	201 (14%)	1,054 (75%)	574 (41%)	164 (12%)
March	IPS	2,088	226 (11%)	1,601 (77%)	604 (29%)	182 (9%)
	CSS	1,591	211 (13%)	1,126 (71%)	634 (40%)	169 (11%)

**MH** = Mental health

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

(Aging CARE assessment in last 15 months)

Data source: RDA administrative reports

**Table 14: FCS client Medicaid eligibility**

		CN blind/disabled (Medicaid only & full dual eligible)	CN aged (Medicaid only & full dual eligible)	CN family & pregnant woman	ACA expansion adults	CN & CHIP children
January	IPS	719 (32%)	89 (4%)	242 (11%)	1,103 (49%)	83 (4%)
	CSS	579 (39%)	87 (6%)	146 (10%)	650 (44%)	<11
February	IPS	798 (32%)	92 (4%)	283 (11%)	1,229 (49%)	82 (3%)
	CSS	687 (39%)	109 (6%)	177 (10%)	790 (45%)	<11
March	IPS	806 (31%)	87 (3%)	280 (11%)	1,300 (51%)	89 (3%)
	CSS	770 (39%)	117 (6%)	197 (10%)	895 (45%)	12 (1%)

ACA = Affordable Care Act

CHIP = Children’s Health Insurance Program

CN = Categorically needy

Data source: RDA administrative reports

## Quality assurance and monitoring activity

Amerigroup conducts quarterly quality assurance reviews with 25 percent of their contracted providers. The purpose of the reviews is to ensure access to services occurs within an adequate timeframe, and to monitor claims and reporting compliance. Amerigroup conducts monthly question and answer sessions for all FCS contracted providers to address authorizations, claims, reporting, and documentation requirements. Contracted providers are required to complete a reauthorization assessment form to request additional service authorizations prior to the expiration date. Services provided outside the scope of the authorization period are not reimbursed.

HCA will evaluate network adequacy on a quarterly basis. The three network measures (statewide service availability, capacity to provide services, timeliness of services) are based on data from Amerigroup’s quarterly FCS Provider Network Report and FCS Enrollee Provider Assignment Report. The timeliness of service measure will also use information from Amerigroup’s service payment data. Finalizing these initial network adequacy measures has been delayed until a new FCS program administrator has been hired.

HCA sees fidelity reviews as a continuous quality improvement process to get the best outcomes of the services FCS contractors can provide. HCA launched a continuous quality improvement program to foster a learning collaborative approach to implementing the fidelity to the SAMHSA permanent supportive housing model and IPS model. Programs that adhere to an evidence-based model are more effective than those that do not. With the FCS program, HCA does not use fidelity reviews as audits or pass/fail certifications or exams. Fidelity to the model is reviewed so that the program can identify strengths as well as target efforts to the elements needing more support.

HCA is promoting a learning community approach to fidelity for CSS and IPS services. Participating in fidelity training and reviews with other agencies fosters a sharing environment focusing on “what works” rather than “gotcha.” Agencies may learn strategies from other agencies also experiencing the same challenges. Training events that promote the fidelity model share strategies about how to achieve good outcomes based on thoroughly researched models.

This quarter, three FCS contracted agencies hosted fidelity reviews at their organizations. Three other FCS contracted agencies sent staff to fidelity reviews. This approach fosters a learning community that supports

the successful implementation of FCS services, and provides guidance on handling the unique challenges faced by agencies delivering services.

### Other FCS program activity

HCA will be finalizing the automated, service-based enhancement in DY 3 Q2 through the ProviderOne claims system. FCS encounter data is currently submitted through the Amerigroup portal. Amerigroup has been providing administrative payments since fall of 2018. This is seen as the final step in fully operationalizing the FCS program.

### Upcoming activities

Recruitment and hiring for the FCS program administrator is active, with a potential hire in May 2019.

### FCS program stakeholder engagement activities

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

**Table 15: FCS program stakeholder engagement activities**

	January	February	March
	Number of events held		
Training and assistance provided to individual organizations	35	19	30
Community and regional presentations and training events	8	11	13
Informational webinars	4	6	6
Stakeholder engagement meetings	12	6	9
<b>Total activities</b>	<b>59</b>	<b>42</b>	<b>58</b>

Individual training and assistance provided to individual organizations increased significantly this quarter. The numbers include orientations by Amerigroup to newly contracted agencies.

Webinars are intended to inform, educate, and coordinate resources for FCS providers serving people who need housing and employment services, resources, and supports. Q1 topics included:

- Working Connections Child Care program
- Secure your oxygen masks - vicarious trauma and self-care techniques
- IPS basics - supervisor learning community
- The culture of work
- Utilizing the employment WIKI and Pathways to Employment sites
- Tenancy skills for community living
- The golden thread
- Supervisor learning community
- Collaborating with agencies/schools
- Everything you always wanted to know about FCS
- Pathways to Housing
- Importance of integration of CSS and IPS in treatment

## FCS stakeholder concerns

During Amerigroup's monthly question and answer session, contracted providers raised concerns about reauthorization processes, documentation standards, and the processes to request additional hours within the authorization period. Amerigroup described these processes in detail, and issued guidance on its provider website. Non-traditional providers, such as Community Action Councils, continue to learn the nuances of providing Medicaid reimbursable services and the expectations that accompany them. Amerigroup continues to report a significant amount of staff time dedicated to addressing these concerns, and providing technical assistance and training to FCS contractors.

## SUD program implementation accomplishments

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

This section summarizes SUD program development and implementation activities conducted January 1 through March 31, 2019. Accomplishments for the quarter include:

- Completing and including final changes to the billing guide in the April 1 (2019) version. Changes for this milestone are complete.
- Adding contract language that meets milestone 3 (medication-assisted treatment (MAT) in treatment) and milestone 5 (coordination of care) requirements in the draft July 1 (2019) contracts. The state responded to feedback from contractors (MCOs).
- Continuing to develop stakeholder training and technical assistance related to the rollout of milestones 3 and 6.
- Incorporating CMS feedback in the updated SUD evaluation and design.
- Submitting the SUD monitoring protocol. HCA responded to CMS questions and feedback regarding the submission.
- Submitting the financial map to CMS.

## Implementation plan

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

**Milestone 2:** Although the state met the requirement for an independent assessment prior to residential treatment in the managed care system, HCA agreed to change the assessment process for the fee-for-service (FFS) system. The FFS mainly affects American Indians and Alaska Natives (AI/AN) at this time. The state plans to update the FFS SUD billing guide to require an independent assessment, as outlined in the final STCs. A subgroup was formed to address these changes. HCA does not expect delays in making these changes to the billing guide.

- **Update:** Final changes to the billing guide were completed and are included in the April 1, 2019, version. Changes for this milestone are complete.

**Milestone 3:** The state will require all residential SUD agencies to provide or facilitate access to MAT. A sub-workgroup was formed, which meets regularly. The state expects to have the requirement in the July 1, 2019, managed care contracts.

- **Update:** The contract language was included in draft July 1, 2019, managed care contracts. The state received and responded to concerns from MCOs regarding the new requirements. The new language is on track for inclusion in the July 1, 2019, managed care contracts. The state initially offered a completion date of January 2020 for WAC changes related to this milestone. However, because these WACs are managed by another state agency, the change process may take longer than expected. HCA now expects the WAC changes to be complete by July 1, 2020.

**Milestone 4:** The state will assess the availability of MAT services across the state, including in both outpatient and residential agencies that provide MAT services, and their current ability to accept clients. A subgroup was formed to address this milestone. This subgroup includes both policy and data subject matter experts. At this time, the state is analyzing what data are available, and working on definitions for various data points. The overall assessment has proven to be complex, involving multiple state agencies, including DSHS, HCA, and DOH.

- **Update:** The milestone 4 workgroup continues to meet and clarify available data and other resources available to complete this milestone. The workgroup hopes to have the data available in May 2019, and at that time, begin the final assessment process. HCA initially offered a completion date of April 2019 for this milestone. Due to the complexity of the data elements involved, HCA expects to have this milestone complete by July 1, 2019.

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

- **Update:** The milestone 3 workgroup finalized the contract language, referenced above, and in this quarter began developing a statewide stakeholder and provider training on these changes. The contract language was included in draft July 1, 2019, managed care contracts. HCA received and responded to concerns from MCOs about the new requirements.

The new language is on track for inclusion in the July 1, 2019, managed care contracts. The state initially offered a completion date of January 2020 for WAC changes related to this milestone. However, because these WACs are managed by another state agency, the change process may take longer than expected. The state now expects the WAC changes to be complete by July 1, 2020.

## HIT

The state submitted the financial map to CMS, a deliverable required under task A of the SUD HIT plan. The financial map identifies several funding sources HCA could pursue. One of the identified funding sources are federal funds available under the SUPPORT Act. HCA requested to use SUPPORT Act funding for the tasks included in the SUD HIT plan. HCA is awaiting CMS feedback.

Tasks in the SUD HIT plan are contingent on funding. Washington State anticipates that financial mapping will be an ongoing activity and will require frequent updates as potential new sources of funding are identified, analyzed, and pursued.

## Evaluation design

CMS provided feedback and comments on the SUD evaluation design that HCA submitted on January 14, 2019. HCA, DSHS (Research and Data Analytics Division) and the independent external evaluator (IEE) developed responses to CMS comments and added additional detail as requested. HCA submitted the updated evaluation design on time to CMS (by April 27, 2019).

## Monitoring protocol

HCA submitted the SUD monitoring protocol and other documents in February 2019. CMS provided comments and feedback in March. The state is currently reviewing CMS comments and will seek additional clarification as needed.

## Upcoming activities

- Submit updated evaluation and design, incorporating SUD evaluation and design into the larger waiver.
- Submit final SUD Monitoring Protocol to CMS, pending approved language from CMS
- Provide additional provider training, technical assistance, and communication regarding milestones 3 and 6.
- Provide final approval of July 1, 2019, contract language implementing milestones 3 and 6.
- Obtain data related to the assessment of services and MAT availability statewide.
- Begin final narrative assessment related to milestone 4: assessment of MAT and SUD services statewide.

## Quarterly expenditures

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

**Table 16: DSRIP expenditures**

**Note:** HCA did not pay out any incentives during Q1 to ACHs; however, the state will pay DSRIP expenditures in Q2.

	Q1	Q2	Q3	Q4	DY 3 Total	Funding source
	January 1– March 31	April 1–June 30	July 1– September 30	October 1– December 31	January 1– December 31	Federal financial participation
<b>Accountable Communities of Health</b>						
<b>Better Health Together</b>	\$0					
<b>Cascade Pacific Action Alliance</b>	\$0					
<b>Greater Columbia</b>	\$0					
<b>HealthierHere</b>	\$0					
<b>North Central</b>	\$0					
<b>North Sound</b>	\$0					
<b>Pierce County</b>	\$0					
<b>Olympic Community of Health</b>	\$0					
<b>SWACH</b>	\$0					
<b>IHCP-specific projects</b>						
<b>Indian Health Care Providers</b>	\$0					

**Table 17: LTSS and FCS service expenditures**

	Q1	Q2	Q3	Q4	DY 3 Total
	January 1– March 31	April 1–June 30	July 1– September 30	October 1– December 31	January 1– December 31
<b>Tailored Supports for Older Adults</b>	\$1,669,673				
<b>Medicaid Alternative Care</b>	\$27,638				
<b>MAC and TSOA not eligible</b>	\$25				
<b>FCS<sup>1</sup></b>	\$0				

<sup>1</sup> HCA will be finalizing the automated, service-based enhancement in DY 3 Q2 through the ProviderOne claims system.

# Overall MTP development/issues

## Operational/policy issues

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

## Consumer issues

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

## Quality assurance and monitoring activity

See program-specific Q1 summary for quality assurance and monitoring activity updates.

- [LTSS](#)
- [FCS](#)

## MTP evaluation

The state executed its contract with the IEE, Oregon Health and Science University (OHSU), in Q3. From Q2 onward, the state supported the IEE's onboarding and introduction to all MTP initiatives. With this support, the IEE was able to quickly and actively engage in foundational work, which included:

- Attending in-person working sessions with the state's evaluation implementation team to define the first phase of data for the IEE's quantitative analysis.
- Obtaining documentation in support of the IEE's Washington State Institutional Review Board application and HCA's commitment to data support.
- Participating in fact-gathering meetings with subject matter experts to inform the IEE about MTP initiatives.
- Engaging in a meeting with state subject matter experts to support IEE's (draft) provider organization survey instruments for primary care clinics and hospitals.
- Attending additional in-person work sessions to continue determination of the next phase of administrative data needed for quantitative assessments of the ACHs' transformation projects.

The IEE provided three rapid-cycle monitoring reports that reflect [Q3](#) and [Q4](#) of 2018 and [Q1](#) of 2019 (Attachment C). The state initiated discussions with the IEE to determine how to expand the originally contracted scope of work to encompass evaluation of the SUD program, including the mid-point assessment, as required by the STCs.

The working relationship between HCA and the IEE is very active. The IEE's core project management team has regular bi-weekly phone conferences with the state's evaluation implementation team. The IEE participated in conference calls with ACH leadership following the release of each Rapid Cycle Monitoring Report. The IEE's reports are posted on the HCA website.

The IEE met the planned timeline for deliverables as defined in the contract with the state.

# Financial/budget neutrality development/issues

## Financial

HCA continues to work with partners at the State Auditor’s Office on a routine agency audit of MTP expenditures.

## Budget neutrality

HCA continues to respond to CMS requirements for budget neutrality monitoring, including adoption of the new budget neutrality monitoring tool. HCA provided additional background and analyses requested by CMS based on budget neutrality projections over the life of MTP.

HCA will continue to work on SUD budget neutrality reporting (including reporting SUD IMD member months) and will provide an update when available.

Below are the counts of member months eligible to receive services under MTP. Member months are updated retrospectively, based on the current Caseload Forecast Council (CFC) medical caseload data. November 2018 through March 2019 are forecasted caseload figures from CFC.

**Table 18: member months eligible to receive services**

Calendar month	Budget neutrality eligibility groups
Jan-17	375,822
Feb-17	374,596
Mar-17	374,147
Apr-17	372,994
May-17	372,558
Jun-17	372,483
Jul-17	371,611
Aug-17	371,360
Sep-17	370,128
Oct-17	369,963
Nov-17	369,815
Dec-17	369,842
Jan-18	369,900
Feb-18	368,521
Mar-18	368,365
Apr-18	367,079
May-18	367,421
Jun-18	366,687
Jul-18	366,420
Aug-18	365,846
Sept-18	364,852
Oct-18	364,859
Nov-18	364,739
Dec-18	364,527
Jan-19	363,489
Feb-19	362,480
Mar-19	361,872
Total	9,952,377

## Designated state health programs (DSHP)

There are no DSHP updates to provide this quarter.

# Summary of additional resources, enclosures, and attachments

## Additional resources

To learn more about Washington's MTP, [visit the HCA website](#).

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

## Summary of attachments

Attachment A: [State contacts](#)

Attachment B: [Financial Executor Portal Dashboard, Q1 2019](#)

Attachment C: [Independent External Evaluator Rapid-Cycle Report](#)

Attachment: MTD Questions and Answers



2019 MTD QA  
Questions.pdf

Attachment: Dear Tribal Leader letter



Dear Tribal Leader  
letter.pdf

# Attachment A: state contacts

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

Area	Name	Title	Phone
MTP and quarterly reports	Chase Napier	Manager, Medicaid Transformation	(360) 725-0868
DSRIP program	Chase Napier	Manager, Medicaid Transformation	(360) 725-0868
LTSS program	Kelli Emans	Managed Care Policy Analyst, DSHS	(360) 725-3213
FCS program	Melodie Pazolt	Deputy Director, DBHR	(360) 725-0487
SUD program	Richard VanCleave	Federal Programs Manager, DBHR	(360) 725-5274

**For mail delivery, use the following address:**

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

# Attachment B: Financial Executor Portal Dashboard, Q1 2019

This table shows all funds earned and distributed through the FE portal through March 31, 2019.

	Total	Better Health Together	Cascade Pacific Action Alliance	Greater Columbia	HealthierHere	North Central	North Sound	Olympic Community of Health	Pierce County ACH	SWACH	IHCP-specific projects
<b>Project description</b>											
Funds earned by ACH											
2A: Bi-directional integration of physical and behavioral health through care transformation	\$119,628,300	\$13,553,541	\$9,681,101	\$19,973,641	\$31,387,149	\$4,419,634	\$12,198,186	\$5,004,385	\$14,785,681	\$8,624,982	
2B: Community-based care coordination	\$43,493,398	\$9,318,060	\$6,655,758			\$3,038,497	\$8,386,254		\$10,165,156	\$5,929,674	
2C: Transitional care	\$31,549,257		\$3,932,947	\$8,114,291	\$12,751,029	\$1,795,476	\$4,955,514				
2D: Diversion interventions	\$8,784,021					\$1,795,476	\$4,955,514	\$2,033,032			
3A: Addressing the opioid use public health crisis	\$14,953,539	\$1,694,193	\$1,210,138	\$2,496,705	\$3,923,394	\$552,454	\$1,524,774	\$625,548	\$1,848,210	\$1,078,122	
3B: Reproductive and maternal/child health	\$4,200,573		\$1,512,672				\$1,905,966	\$781,935			
3C: Access to oral health services	\$1,612,742						\$1,143,580	\$469,162			
3D: Chronic disease prevention and control	\$29,907,073	\$3,388,385	\$2,420,275	\$4,993,410	\$7,846,787	\$1,104,908	\$3,049,547	\$1,251,096	\$3,696,421	\$2,156,245	
Behavioral health integration incentives	\$35,545,522	\$3,320,749		\$4,073,566	\$5,955,517	\$5,458,866	\$4,332,435		\$3,728,715	\$8,675,674	
VBP incentives	\$6,308,649		\$1,455,842			\$1,455,842	\$1,941,123	\$1,455,842			
IHCP-specific projects	\$10,979,000										\$10,979,000
High-performance pool											
<b>TOTAL FUNDS EARNED</b>	<b>\$306,962,074</b>	<b>\$31,274,928</b>	<b>\$26,868,733</b>	<b>\$39,651,613</b>	<b>\$61,863,876</b>	<b>\$19,621,153</b>	<b>\$44,392,893</b>	<b>\$11,620,998</b>	<b>\$34,224,183</b>	<b>\$26,464,698</b>	<b>\$10,979,000</b>
<b>Funds distributed by ACH</b>											
Administration	\$10,693,421	\$566,671	\$176,384	\$1,556,500	\$3,400,023		\$3,458,963	\$14,081	\$1,400,000	\$120,800	
Community health fund	\$6,588,952		\$940,715	\$740,033			\$3,408,204		\$1,500,000		
Health systems and community capacity building	\$13,612,702	\$1,010,001	\$381,295	\$9,732		\$430,349	\$6,317,632	\$110,000	\$4,685,693	\$118,000	\$550,000
Integration incentives	\$13,315,384	\$2,780,000		\$3,802,435	\$4,281,998	\$58,422	\$553,320		\$1,839,209		
Project management	\$2,891,211		\$999,510	\$890,500		\$588,324	\$216,877	\$196,000			
Provider engagement, participation and implementation	\$46,980,928	\$3,552,000	\$3,508,631	\$3,791,651	\$5,822,287	\$2,393,273	\$8,868,800	\$4,375,000	\$4,496,000	\$1,090,000	\$9,083,286
Provider performance and quality incentives	\$1,155,460		\$897,960			\$257,500					
Reserve/contingency fund	\$1,269,588		\$587,947				\$681,641				
Shared domain 1 incentives	\$68,739,027	\$7,561,293	\$6,873,903	\$9,623,464	\$15,122,587	\$3,436,951	\$10,310,855	\$2,749,561	\$8,248,683	\$4,811,732	
<b>TOTAL</b>	<b>\$165,246,673</b>	<b>\$15,469,964</b>	<b>\$14,366,345</b>	<b>\$20,414,315</b>	<b>\$28,626,895</b>	<b>\$7,164,819</b>	<b>\$33,816,290</b>	<b>\$7,444,642</b>	<b>\$22,169,585</b>	<b>\$6,140,532</b>	<b>\$9,633,286</b>
<b>Funds available</b>											
Total funds distributed to date	\$165,246,673	\$15,469,964	\$14,366,345	\$20,414,315	\$28,626,895	\$7,164,819	\$33,816,290	\$7,444,642	\$22,169,585	\$6,140,532	\$9,633,286
Total funds available for distribution	\$141,715,401	\$15,804,964	\$12,502,388	\$19,237,299	\$33,236,981	\$12,456,334	\$10,576,602	\$4,176,356	\$12,054,598	\$20,324,166	\$1,345,714
<b>% OF TOTAL FUNDS DISTRIBUTED</b>	<b>53.83 %</b>	<b>49.46 %</b>	<b>53.47 %</b>	<b>51.48 %</b>	<b>46.27 %</b>	<b>36.52 %</b>	<b>76.18 %</b>	<b>64.06 %</b>	<b>64.78 %</b>	<b>23.20 %</b>	<b>87.74 %</b>
<b>% of total funds distributed by ACH</b>											
Administration	6.47 %	3.66 %	1.23 %	7.62 %	11.88 %		10.23 %	0.19 %	6.31 %	1.97 %	
Community health fund	3.99 %		6.55 %	3.63 %			10.08 %		6.77 %		
Health systems and community capacity building	8.24 %	6.53 %	2.65 %	0.05 %		6.01 %	18.68 %	1.48 %	21.14 %	1.92 %	5.71 %
Integration incentives	8.06 %	17.97 %		18.63 %	14.96 %	0.82 %	1.64 %		8.30 %		

Project management	1.75 %		6.96 %	4.36 %		8.21 %	0.64 %	2.63 %			
Provider engagement, participation and implementation	28.43 %	22.96 %	24.42 %	18.57 %	20.34 %	33.40 %	26.23 %	58.77 %	20.28 %	17.75 %	94.29 %
Provider performance and quality incentives	0.70 %		6.25 %			3.59 %					
Reserve/contingency fund	0.77 %		4.09 %				2.02 %				
Shared domain 1 incentives	41.60 %	48.88 %	47.85 %	47.14 %	52.83 %	47.97 %	30.49 %	36.93 %	37.21 %	78.36 %	
<b>TOTAL</b>	<b>100.00 %</b>										

# Attachment C: Independent External Evaluator Rapid-Cycle Report

## Medicaid Transformation Project Evaluation

Rapid-Cycle Report

March 29, 2019

CENTER FOR HEALTH SYSTEMS EFFECTIVENESS



**Prepared for:**

Washington State Health Care Authority



# Medicaid Transformation Project

## Rapid-Cycle Report

### Overview

This report covers activities from CHSE's evaluation of Washington's Medicaid Transformation Project (MTP) from January 1 to March 29, 2019. In this period, CHSE collected and began to analyze the first data for the evaluation. These included qualitative data from 11 interviews with state agency key informants, and administrative data on demographics and metric results for the state's Medicaid population. We also laid groundwork for evaluation activities that will begin later this year, including identification of target populations for ACHs' health improvement projects and administration of primary care practice and hospital surveys.

### Accomplishments

#### Foundational Tasks

We applied and received approval for a study amendment from the Washington State Institutional Review Board (WSIRB) to cover important components of the evaluation. These included: the addition of primary care practice and hospital surveys for pilot testing and the use of primary care practice and hospital lists from the Washington All-Payer Claims Database (WA-APCD) for survey administration (described below); the addition of interview guides for use in primary care practice and hospital interviews; and the addition of new evaluation team members.

Another amendment will be needed to obtain detailed administrative data required to evaluate ACHs' health improvement projects. We plan to apply for the amendment in early April.

#### Document Analysis

We continued analyzing ACHs' semi-annual reports and other documents from ACHs and State agencies. We began using these documents to draft internal-facing summaries of MTP as a whole and summaries of ACHs' activities. These summaries will help the qualitative and quantitative teams understand MTP and interpret results from subsequent evaluation activities.

#### Key Informant Interviews

##### *State Agency Key Informants*

The qualitative team completed 11 Round 1 interviews with key informants from the Health Care Authority (HCA), the Department of Social and Health Services (DSHS), and other state employees from February through March, 2019. The initial state informants were purposively selected for subject-matter expertise in the following areas:

- Leadership and administration
- Health care transformation and policy
- Data and analytics
- Health information technology and exchange
- Value-based payment
- Workforce
- Long-term services and supports

- Foundational community supports

As part of each interview, participants were asked to recommend other experts to interview to get a deeper understanding or a different perspective on these issues. We will continue Round 1 interviews with state employees through early April, 2019, completing approximately 15 interviews. Data from these interviews will provide us with historical and contextual information to better understand the Medicaid Transformation Project (MTP) and help us plan and interpret results from subsequent evaluation activities.

Qualitative analysts began formally analyzing state-level interviews this quarter. Interviews were audio-recorded and professionally transcribed. Transcripts were reviewed for accuracy and uploaded into ATLAS.ti, an industry-standard text analysis tool, for data management and analysis. The qualitative team began meeting weekly to listen to the audio recordings, review the transcripts together, discuss key passages of text, and develop a list of codes reflecting topics and themes discussed by informants. Interview participants shared information about the following topics:

- Prior initiatives that influenced and preceded the MTP demonstration and Washington’s current vision for health care transformation
- Department and organization roles and responsibilities, and relationships between state partners and other stakeholders
- Successes and barriers to MTP implementation, experience with communication and engagement, ACH model design, and work related to MTP initiatives and domains

We will provide a summary of results from Round 1 interviews with state key informants in the next rapid-cycle report.

### *ACH Key Informants*

As a next step, we will interview leaders from each of Washington State’s ACHs between April and September, 2019. As with state key informants, we will ask ACH leaders to recommend other ACH stakeholders to interview. Informants may include board members, individuals with expertise in clinical care delivery, clinical quality measures, or domain 2 and 3 projects, and representatives of Medicaid managed care organizations. The qualitative team anticipates interviewing three to six stakeholders for each ACH. Our experience with regionally-based health care transformation in Oregon shows that in- person interviews can help establish relationships and build the foundation for future interviews. We plan to travel to each ACH region to conduct initial interviews and site visits in person.

### **Administrative Data Analysis**

We delivered a description of our proposed methods for identifying the target populations of each ACH’s health improvement projects using administrative data, and for attributing Medicaid members to provider organizations that partner with ACHs on these projects. These methods will be critical for categorizing Medicaid members into “treatment” and “comparison” groups for the purpose of evaluating the projects.

As a next step, we plan to refine these methods based on feedback from ACHs about their intended target populations. In addition, we continued to consult with State experts on means to identify ACHs’ target populations. For example, we presented options for identifying Medicaid members with specific chronic conditions using administrative data, since ACHs include chronic conditions in their definitions for some target populations. Also, we discussed options for identifying people served by the Pathways HUB model, since several ACHs using this model for Project 2B: Care Coordination.

We received an initial set of “Phase 1” administrative data needed to begin evaluating the impact of MTP on Washington State’s Medicaid system as a whole. The set consisted of a person-level enrollment file, several metric results files, and a health risk file. Our quantitative team began examining and plotting the data in order to understand trends and identify any unexpected features.

## **Primary Care Practice and Hospital Surveys**

### *Survey Development*

The primary care practice and hospital survey team finalized initial versions of two surveys that will be administered to a sample of primary care practices, and to all hospitals, at two points in time: mid-2019 and early 2021. The surveys will be used to answer evaluation questions about trends in value-based payment (VBP) adoption, health information technology (HIT) adoption, and workforce needs associated with MTP. In addition, we will use survey results to help select a subset of practices and hospitals for qualitative interviews, providing an in-depth understanding of factors driving these trends. We prepared initial versions of the surveys based on evaluation questions in the State's Evaluation Design, discussion with state key informants, and review of items on existing VBP, HIT, and workforce surveys, including some surveys administered by ACHs. The surveys are now ready for pilot testing.

We plan to carry out pilot testing and refinement of the surveys in April and May. For pilot testing, we will administer the surveys to administrative staff at a small group of primary care practices and hospitals in Washington State that volunteer to help test the surveys. The testing will allow us to determine how well they understood the questions, how much time they needed to complete the surveys, and where they may have been inclined to discontinue the surveys (i.e., "drop off"). This information will help us tailor question wording, survey length, and other aspects of the surveys to optimize response rates and obtain accurate results. In particular, limiting the total number of items and the time needed to complete the surveys will be critical to obtaining high response rates. Follow-up interviews with a subset of practices and hospitals identified through completion of the survey will enable us to obtain additional in-depth information on VBP adoption, HIT adoption, and workforce needs.

### *Survey Sampling and Administration*

In addition to finalizing the initial versions of the surveys, we submitted a data request to obtain lists of Washington State primary care practices and hospitals from the Washington All Payer Claims Database (WA-APCD). The WA-APCD will provide a comprehensive list of primary care practices and hospitals, along with their physical locations, approximate size (in terms of attributed patients for practices and discharges for hospitals), and Medicaid payer mix. These variables will be used to identify the sample of primary care practices selected for survey completion, and to analyze survey results by ACH region and practice or hospital characteristics.

Once we complete the pilot testing, we will finalize the survey. After we receive the list of practices and hospitals from Washington State, we can identify the sample of practices to survey. Since the dataset does not include the names and email addresses we need to administer the surveys, we will contact each selected practice and hospital to gather this information. With all of these steps completed, we can begin to administer the surveys with several reminders to ensure robust response rates.

## **SUD Amendment**

We continued to consult with the State about planning for evaluation of the substance use disorder (SUD) amendment to the Medicaid waiver. For example, we finalized a plan for the SUD midpoint assessment and provided input on cost analysis for the evaluation.

## **Key Decisions and Actions**

HCA agreed to extend the deadline for conducting and analyzing Round 1 interviews from May to September to allow adequate time to plan and conduct Round 1 interviews in person.