STATE OF WASHINGTON

December 3, 2021

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 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

Donald Clintsman
Acting 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 (MTP) demonstration

Section 1115 Waiver Quarterly Report (DY5 Q3)

Demonstration Year: 5 (January 1 to December 31, 2021)

Reporting Quarter: 3 (July 1 to September 30, 2021)

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Introduction

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

Over the five-year MTP period, Washington will:

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

The state will accomplish these goals through these programs:

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

Vision: a healthier Washington

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

Quarterly report: July 1–September 30, 2021

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

Summary of quarter accomplishments

- The state looks forward to continuing discussions with CMS leading up to approval of the state's one-year MTP extension. The state also continues work on a longer-term MTP application for renewal, and submission to CMS is now anticipated in 2022. This additional time will allow the state to continue stakeholder engagement and development of key concepts to be supported through the long-term renewal period.
- ACHs continue to distribute incentive funds to partnering providers through the financial executor (FE) portal. During the reporting quarter, ACHs distributed more than $16.7 million to 267 partnering providers and organizations in support of project planning and implementation activities. The state distributed approximately $819,000 in earned incentive funds to IHCPs in quarter (Q) 3 for achievement of IHCP-specific project milestones.
- As of September 24, 2021, over 11,360 clients have received services and supports from the MAC and TSOA programs. New enrollees in LTSS for this reporting period: 31 MAC dyads, 261 TSOA dyads, and 452 TSOA individuals.
- Within FCS, the total aggregate number of people enrolled in services at the end of demonstration year (DY) 5 and Q3 includes 6,836 in IPS and 5,157 in CSS. The total unduplicated number of enrollments at the end of this reporting period was 9,940.
- HCA continues to monitor the distribution of 3,000 mobile phones procured for FCS enrollees. The phones are distributed through a partnership between ACHs and individual FCS providers in their area. At the end of Q3, more than 2,294 phones had been distributed to FCS enrollees.
- The state held its annual Co-occurring Disorder Treatment Conference via teleconferencing on October 4 and 5, with sessions tailored to helping adjust to treatment current realities.

MTP-wide stakeholder engagement

MTP continuation

During the reporting period, HCA created two new pages: the future of MTP and MTP renewal, and made significant updates to the one year extension and amendment page. These new pages share information and resources about next steps for, and the continuation of, the state's MTP work.

HCA staff began meeting internally to strategize and plan immediate next steps in communicating about the MTP renewal. Staff discussed the best ways to loop in HCA leadership, inform the Legislature, support MTP partners, and notify stakeholders and the public about the MTP renewal.

Dental Health Aide Therapist (DHAT) amendment

HCA held two public notice webinars on the DHAT amendment to inform potential submission of the DHAT amendment to CMS later this year. The announcement provided details about the amendment, when the webinars would occur (including a Zoom link), and how people could share public comment. Webinar participation was limited, but HCA will also engage Tribes in formal consultation regarding this amendment. Through Tribal Consultation and Roundtables, HCA will receive guidance from Tribal partners regarding the DHAT amendment and whether to continue with submission to CMS.

Statewide activities and accountability

Value-based purchasing (VBP)

In Q3, HCA concluded a series of strategy meetings with MTP leadership and program staff to identify key VBP priorities and focus areas for the MTP renewal period.

VBP Roadmap and Apple Health Appendix

The VBP Roadmap describes HCA's VBP goals, purchasing and delivery system transformation strategies, innovation successes to date, and plans to accelerate the transition into value-based payment models. The appendix, in accordance with the special terms and conditions (STCs), describes how MTP supports providers and managed care organizations (MCOs) to move along the value-based care continuum. The roadmap establishes targets for VBP attainment and related MCO and ACH incentives in the Delivery System Reform Incentive Payment (DSRIP) program.

In Q3, HCA continued to refine the long-term strategic vision for VBP and will publish an update to the Apple Health Appendix in Q4. HCA intends to delay the update to the VBP Roadmap to capture and align with updates from a leadership-level strategic vision in development.

Validation of financial performance measures

In DY1, HCA contracted with Myers and Stauffer to serve as the independent assessor (IA) for MTP. In this role, the IA is the third-party assessor of financial measures and data submitted by the five MCOs as part of their contracts with HCA. The state maintains contracts with 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 disseminated VBP validation packets to each MCO, including MCO-specific provider contract sampling requests and data entry templates in June of 2021. Each MCO successfully completed the template and provided the requested contract samples to the IA.

The IA began reviewing the templates and contract samples and initiated the write-back process with each MCO to validate each plan's data. HCA expects the IA to complete the review by the end of October 2021.

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 and from commercial and Medicare payers and providers through the annual Paying for Value survey.

Each MCO must complete the survey for its non-Medicaid books of business in Washington State as a condition of the managed care contract. HCA updated the survey template and released the health plan survey on July 1, 2021. Each MCO completed and submitted the survey to HCA in August 2021.

Additionally, HCA developed and released the provider survey, through ServiceNow, on July 1, 2021. HCA closed the Paying for Value survey on August 31, 2021 and began the analysis to track and plan provider progress relating to VBP adoption and to identify barriers to progress. HCA expects to conclude the analysis and publish results in Q4.

Paying for Value survey communications

During this reporting period, HCA sent out three announcements about the annual Paying for Value survey for providers. These announcements shared information about VBP goals, the purpose of the survey, and the importance of provider feedback.

In addition to sending out announcements to providers, HCA sent out direct emails to MCOs, health care plans, and providers. HCA also asked partners, including ACHs and medical associations, to help spread the word and encourage their provider networks to participate in the survey.

Technical support and training

- No activities in Q3

Upcoming activities

- Complete MCO VBP validation process.
- Complete and publish the analysis of the Paying for Value surveys.
- Calculate 2020 VBP adoption: by ACH, MCO, statewide managed care, by statewide HCA (MCO and Employee and Retiree Benefits programs) health care spend.

Integrated managed care (IMC) progress

In 2014, state legislation directed a transition to integrate the purchasing of medical and behavioral health services for Apple Health (Medicaid) clients through an IMC system no later than January 1, 2020. Below are IMC-related activities for Q3.

- As directed by Senate Bill (SB) 6312, statewide integration was achieved in January 2020. With the support of ACHs, HCA continues to support behavioral health providers in their transition to managed care.
- Stabilizing the behavioral health provider network has continued to be a challenge because of the COVID-19 pandemic. Behavioral health workforce gaps have been a major concern and ACHs have been exploring and implementing strategies to mitigate these issues.
- Since April 2021, HCA has maintained focus in two areas specific to measuring clinical integration and bi-directional care, with the assistance of most of the ACHs around the state. 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 the ACHs in most regions. These provider meetings included a presentation of behavioral health performance measures and a short survey.

    Most ACHs participated in interviews for this project. At the end of June 2021, Comagine Health (HCA's external quality review organization) provided a final report on this project. HCA reviewed this report internally and will be partnering with MCOs and ACHs over the next several months to review the recommendations and discuss next steps.
  - Earlier this year, the state completed the study of a new clinical integration assessment tool, the WA Integrated Care Assessment (WA-ICA). ACHs and MCOs have worked together to identify an assessment tool and have pilot-tested this tool among several providers. The project also explored methods of collecting clinical integration progress from providers. This initial pilot project concluded in June 2021 and now is moving forward with broader implementation.

    The WA-ICA implementation plan proposes that the first cohort of providers will begin using this tool by end of June 2022. The WA-ICA will be used by out-patient primary care and behavioral health practices to assess their level of clinical 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 IT/electronic health records (EHR) tools increases.

    Visit the advancing clinical integration page for more information.

Health information technology (HIT)

The Health IT Operational Plan is composed of actionable deliverables to advance the health IT goals and vision articulated in the Health IT Strategic Roadmap. This work supports Medicaid transformation in Washington State.

The Health IT Roadmap and Operational Plan focuses on three phases of transformation work: design, implementation and operations, and assessment. In fall 2020, the HCA led months of conversations that resulted in identifying tasks for the 2021 Health IT Operational Plan. These activities include 42 deliverables and tasks in several areas:

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

The third quarter of 2021 focused on addressing the COVID-19 pandemic by supporting provider use of telehealth. Washington State also started planning for the implementation of the nationally required 9-8-8 system and a behavioral health integrated client referral system required under state law; continued work to implement the CMS interoperability requirements related to Patient Access and Provider Directory Application Programming Interfaces (APIs); and started development of the 2022 Health IT Operational Plan, which will continue critical work and focus on meeting health IT needs to better serve Medicaid clients.

Activities and successes

The Health IT team spent the third quarter of 2021 continuing its focus on multi-year and shorter-term initiatives involving HIT. During the past quarter:

- The state continued its implementation process of the Health and Human Services (HHS) Coalition Master Person Index (MPI) Project. This effort has focused on supporting the Department of Health's COVID-19 response. In September, the coalition approved expanding the implementation to develop the coalition infrastructure to support connections from all coalition agencies (the departments of Health (DOH), Social and Health Services (DSHS), Children, Youth, and Families (DYCF), HCA, and Washington Health Benefit Exchange.)
- The Provider Directory API is currently under development and expected to go live in Q4 2021.
- The Patient Access API is also under development and expected to go live in early Q4 2021.
- The state identified the key functionalities/modules needed for an EHR solution that, contingent on funding, could be made available statewide to behavioral health, rural health, and Tribal health care providers seeking to implement an EHR solution (or upgrade their current system).
- The state identified key characteristics of a lead organization that, contingent on funding, would support implementation of the statewide EHR solution.
- The state continued coordination with ACHs and MCOs to support Medicaid transformation activities in regions and plans across the state, including the use of HIT. For example:
    - HCA summarized activities and opportunities across ACHs to implement HIT, health information exchange (HIE), and community information exchange (CIE):

    - Several ACHs support implementation of DOH's CareConnect platform for information sharing with social service agencies on behalf of persons who have tested positive for COVID-19.
    - Two ACHs continue to make investments in HIT/HIE and CIE platforms to support information sharing across the care continuum.
- HCA advanced funding requests to the Governor's Office to support implementation of:
    - HIT requirements in the MH IMD waiver.
    - An electronic consent management solution to support the exchange of information subject to 42 CFR Part 2.
    - Statewide CIE.
- HCA hosted a meeting providing an update on the Health IT Operational plan that discussed the CMS Interoperability Rules, implementing the Community Health Access and Rural Transformation (CHART) Model, and federal and state funding opportunities to advance the use of broadband by health care providers in Washington State.
- HCA continued work to identify areas within the health care system that do not have adequate HIT or HIE capacity. This included conducting an environmental scan of providers' EHR needs.

DSRIP program implementation accomplishments

ACH project milestone achievement

Semi-annual reporting

ACHs report on their MTP activities, project implementation, and progress on required milestones. This is outlined in the Project Toolkit. Semi-annual reports are submitted every six months. The most recent set of ACH semi-annual reports (SARs) was submitted on July 31, 2021, for the January 1–June 30, 2021, reporting period.

The IA reviewed the projects, determined milestone completion, and related eligibility for incentives. After a rigorous independent assessment in Q3 2021, all nine ACHs demonstrated completion of milestones, including COVID-19-related reporting requirements, through the first half of 2021. All ACH regions will receive incentive funds in Q4 to continue their health transformation efforts.

Next steps

HCA and ACHs are coordinating across the state on scale and sustainability strategies that are in alignment with the timeline and expectations contained in the Project Toolkit. HCA continues to work closely with ACHs and MCOs regarding extension year planning and how to transition and sustain activities beyond DY5. These conversations will also inform pay-for-reporting (P4R) expectations in DY6 in anticipation of the extension year approval.

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 many strategies to support regional providers in the transition to VBP and provide a unique forum for providers to identify opportunities and can mitigate challenges locally and/or coordinate with MCOs and HCA as needed.

Each ACH promoted and encouraged provider participation in the 2021 Paying for Value survey. HCA provided periodic updates to ACHs on regional response rates throughout the duration of the survey.

FE portal activity

ACHs continue to distribute incentive funds to partnering providers through the FE portal. During the reporting quarter, ACHs distributed more than $ 16.7 million to 267 partnering providers and organizations in support of project planning and implementation activities. The state distributed approximately $819,000 in earned incentive funds to IHCPs in Q3 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

During the reporting period, HCA updated core documents that provide project and incentive valuations. These documents were submitted to CMS and are awaiting approval. Updates included new VBP adoption methodology, improvement scoring achievement value updates and Healthcare Effectiveness Data and Information Set (HEDIS) measure updates to drive pay-for-performance (P4P) incentives.

- The project toolkit was updated to reflect changes to ACH P4P performance accountability in alignment with the national measure steward.
- The Funding and Mechanics protocol was updated to reflect changes to the ACH High-Performance Pool (HPP) measures in alignment with the national measure steward.
- The DSRIP Measurement Guide was updated to reflect requested changes submitted to CMS as well as routine annual updates.

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

DSRIP program stakeholder engagement activities

2021 Learning Symposium

HCA and ACHs continued to collaborate and plan the 2021 HCA/ACH Learning Symposium. Artemis, an ACH contractor, helped guide this work. Like last year, HCA played a more supportive, consultative role while ACHs determined the topics, speakers, and overall theme of the symposium.

HCA updated the Learning Symposium page and sent out an announcement and social media post encouraging people to register and attend the event. The Learning Symposium is November 2-4, 2021.

DSRIP stakeholder concerns

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

Upcoming DSRIP activities

DY4 P4P performance results will be finalized in Q4. This encompasses regional P4P, high-performance pool, statewide accountability, and VBP performance outcomes for the state, ACHs, and MCOs.

One area of focus among HCA, MCOs, and ACHs is the transition of current integration assessment activities to a new standard integration assessment approach to be implemented beginning in DY6. A workgroup

continues to meet and develop recommendations to inform ACH provider arrangements and future implementation to be supported through the extension year and potentially through a long-term MTP renewal.

Tribal project implementation activities

- **Primary milestone:** distribution of $818,939 in IHCP-specific Projects incentives.

Tribal partner engagement timeline

July 8: prepared to present to the Governor's Indian Health Advisory Council (GIHAC) regarding HIE and the work of the HHS Coalition.

July 16: met internally to discuss the development of a statewide clinical integration assessment tool.

July 16: met with other state agency Tribal liaisons in advance of the GIHAC meeting to discuss the meeting, the Biennial Indian Health Improvement Report, and information technologies.

July 19: met with an MCO to discuss a pilot regarding managed care and IHCPs.

July 19: met internally to discuss the potential for a DHAT 1115 waiver amendment.

July 21: GIHAC meeting.

July 21: met internally regarding how the fee-for-service population, primarily made up of American Indian/Alaska Natives (AI/ANs), will be included in the 1MTP renewal application.

July 27: met with two other MCOs separately to discuss a pilot regarding managed care and IHCPs.

July 29: met internally to discuss the Initiative 1 concept for the MTP waiver renewal application.

August 17: met internally to discuss concepts for AI/ANs and IHCPs additions to the 1MTP renewal application.

August 18: met with another MCO to discuss a pilot regarding managed care and IHCPs.

August 25: met internally to further define and clarify assumptions around a potential 1115 waiver addition, self-attestation.

August 25: participated in an internal meeting regarding 1115 waiver visioning.

September 1: participated in the clinical integration assessment tool workgroup.

September 2: met internally to discuss the Tribe/IHCP portion of the MTP renewal application.

September 7: presented on the concept of an expanded Primary Care Case Management (PCCM) program for IHCPs.

September 9: presented at the quarterly delegates' meeting of the American Indian Health Commission on the PCCM payment model.

September 14: participated in a demonstration of Epic for IHCPs.

September 17: met internally to discuss the timeline for public engagement in the MTP renewal application and tribal consultation.

September 22: participated in a listening session for IHCPs regarding a statewide EHR project.

September 24: met with North Carolina Medicaid to discuss the PCCM program they recently started with the Eastern Band of Cherokee Indians (EBCI).

September 29: participated in the clinical integration assessment tool workgroup.

LTSS implementation accomplishments

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

- As of September 24, 2021, over 11, 360 clients have received services and supports from the MAC and TSOA programs.
- Statewide care plan proficiency reached a record high of 93 percent this quarter.
- 2022 quality assurance measures for MAC and TSOA programs were revised and approved.
- MTP program managers completed the 2021 MTP Training series for Home and Community Services (HCS) and Area Agencies on Aging (AAA) case management staff and supervisors.

Network adequacy for MAC and TSOA

AAAs across the state continue to contract with new service providers including, but not limited to, massage therapy, acupuncture, residential respite services, and housework/errand providers. Network adequacy milestones for each AAA are on track.

AAAs continue to report shortage of in-home service (respite and personal care) providers across the state.

Assessment and systems update

- Program managers began drafting business requirements for adding a client budget management tool into the GetCare application for case management use.
- Program staff explored and prioritized modifications to GetCare and CARE systems to increase case manager efficiencies and fine-tuned minor system bugs that occurred.
- A COVID-19 vaccine question was added to the Presumptive Eligibility Screen and Annual Nursing Facility Level of Care (NFLOC) Assessment.

Staff training

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

- July 21 – MTD Barcode Training (Barcode is the Medicaid program eligibility database and is the tool used for social service case managers to communicate electronically with financial public benefit specialists)
- September 15 – Cultural Considerations

Data and reporting

Table 1: beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of September 24, 2021	413	3768	7028
Number of new enrollees in quarter by program	31	261	452
Number of new person-centered service plans in quarter by program	*16	91**	208***
Number of beneficiaries self-directing services under employer authority**	0	0	0

*13 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.

**148 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.

***236 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

DSHS Aging and Long-Term Support Administration (ALTSA) met with several Tribes to discuss Medicaid services and MTP Initiatives 2 and 3 during the reporting period.

- August 8: Tribal Affairs staff shared information with Cowlitz Tribe at Cowlitz Health Symposium, including MAC/TSOA and other in-home services.
- August 9: ALTSA Kinship Care staff shared a variety of respite and service information with Cowlitz Tribe at Cowlitz Health Symposium, including MAC/TSOA.
- Recognizing a need to broaden marketing and outreach materials that are culturally appropriate, ALTSA began exploring options to increase materials for use in multiple programs, including respite, kinship care and MAC/TSOA.

Outreach and engagement

Outreach activities continue to be primarily virtual meetings and presentations as well as dissemination of program publications/flyers and use of social media advertisements. The volume and type of outreach activities continue to be impacted by the COVID-19 pandemic and social distancing requirements.

Table 2: outreach and engagement activities by AAA

	July	August	September
	Number of events held		
Community presentations and information sharing	42	35	45

Last quarter, the state reported the development of a caregiver outreach video/advertisement to be utilized on Comcast, Facebook, and YouTube. The state is extremely pleased with the results from these ads. The Comcast ad ran in several counties (Ferry, Stevens, Thurston, King, Yakima, Benton, and Franklin). Data indicates there were 125,551 impressions delivered (how often the ad was shown). In addition, reports showed that there were 905 hours of interaction with the 30-second ad.

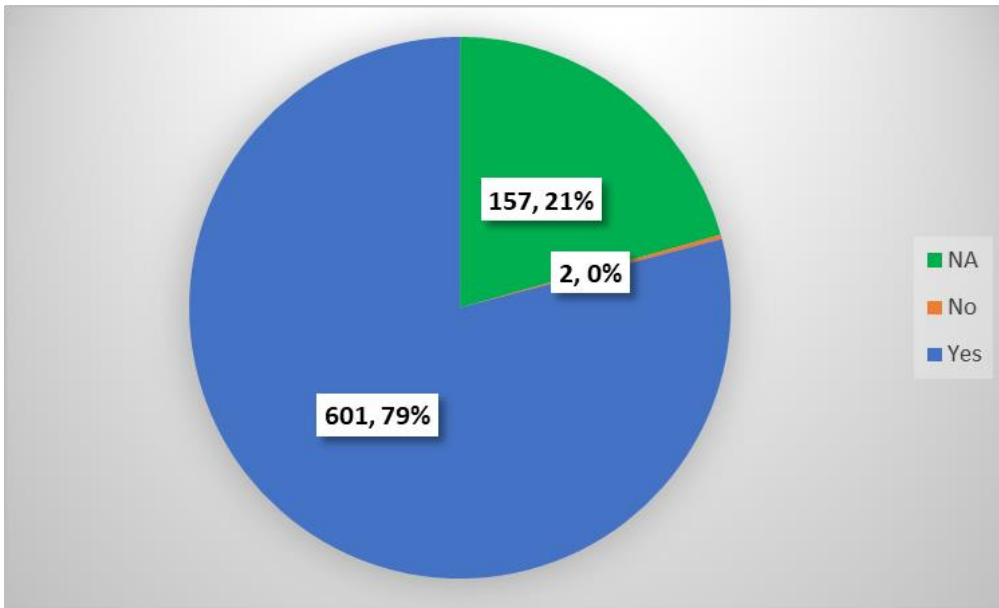
During this quarter, there was an increase in referrals across the state as well as an increase in dyads during July and August. Since this ad ran, there has also been an increase in dyad enrollment in the targeted AAAs that historically had a low percentage of dyad to TSOA individual enrollments.

The same ad, deployed on Facebook and YouTube from July 21 through August 23, showed similar results. There were 346,000 impressions and 174,000 views (how often people watched the video). This has been the most viewed video/ad DSHS has produced and advertised in the history of DSHS video ads.

Quality assurance for presumptive eligibility

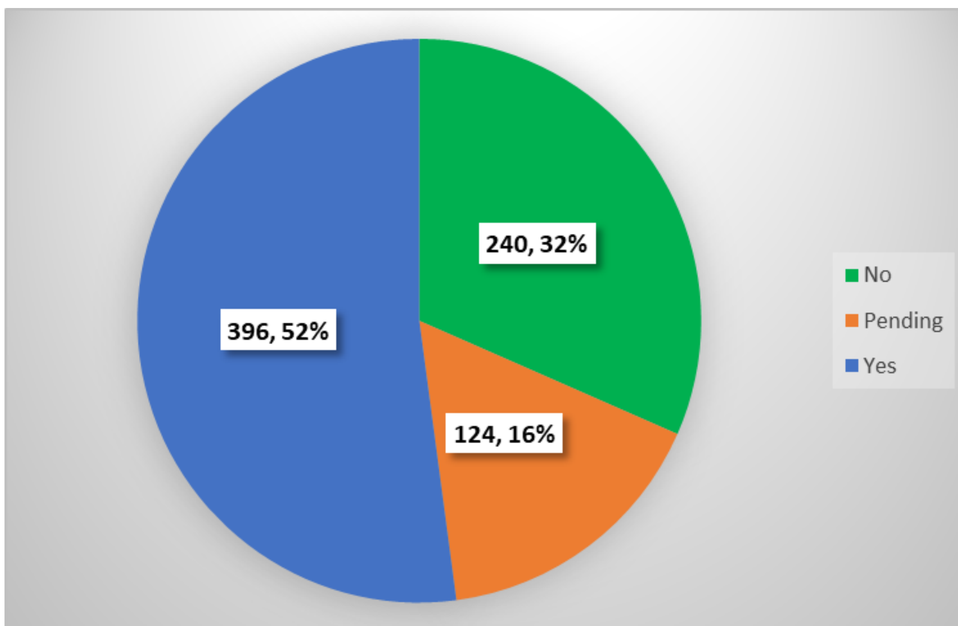
The results of the quarterly presumptive eligibility (PE) quality assurance review were conducted for Q3. The sample size is 100 percent of the participants enrolled under PE during the quarter. Results show that more than 99 percent of participants were appropriately determined to meet nursing facility level of care.

Table 3: Question 1: was the client appropriately determined to be nursing facility level of care eligible for PE?



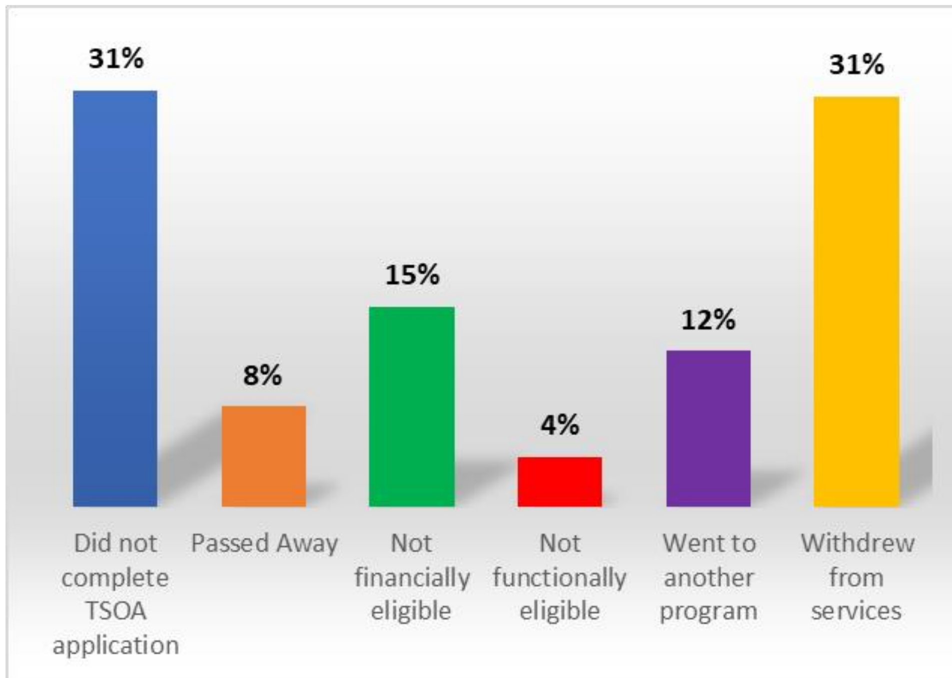
Note: The N/A represents clients who were part of the last quarter's review and the response to question #1 was "yes" but the response to question #2a was "pending".

Table 4: 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 5: Question 2b: if "No" to question #2a, why?



Note: These percentages represent the "No"population in the previous table (32%). For example, the 15% of PE clients found to be not financially eligible is 15% of the 32% illustrated in the Table for question 2a.

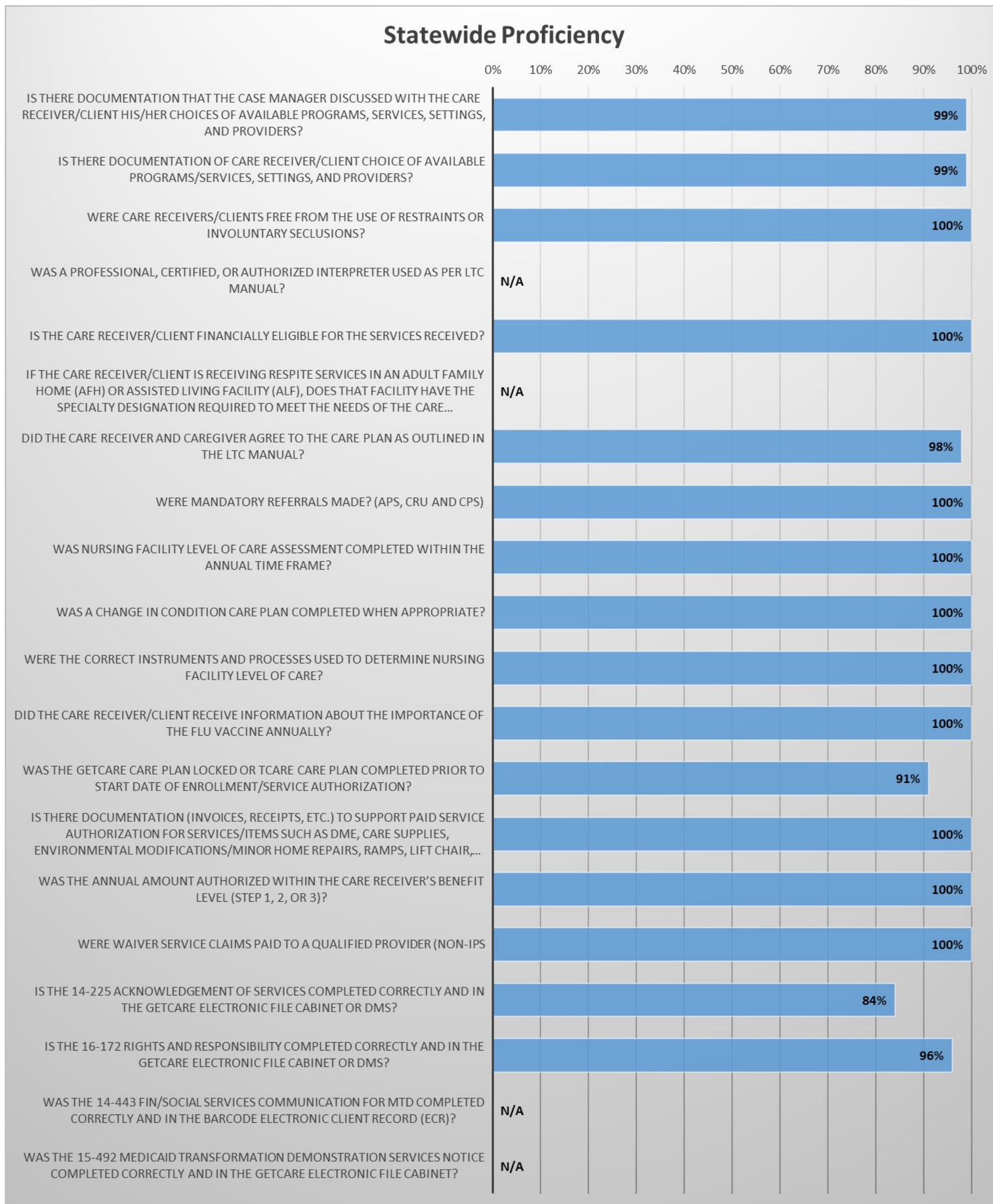
2021 program quality assurance measure results to date

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 concludes in October.

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

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

Table 6: statewide proficiency to date



As reported in Q1 and Q2, the state's data reporting system was undergoing re-development. This was because of identified issues with data exchange between two applications and the state was not able to provide the care plan proficiency data. The reporting system work has been completed and the proficiency data for the first three quarters of 2021 are below.

Table 7: statewide care plan proficiency – Q3

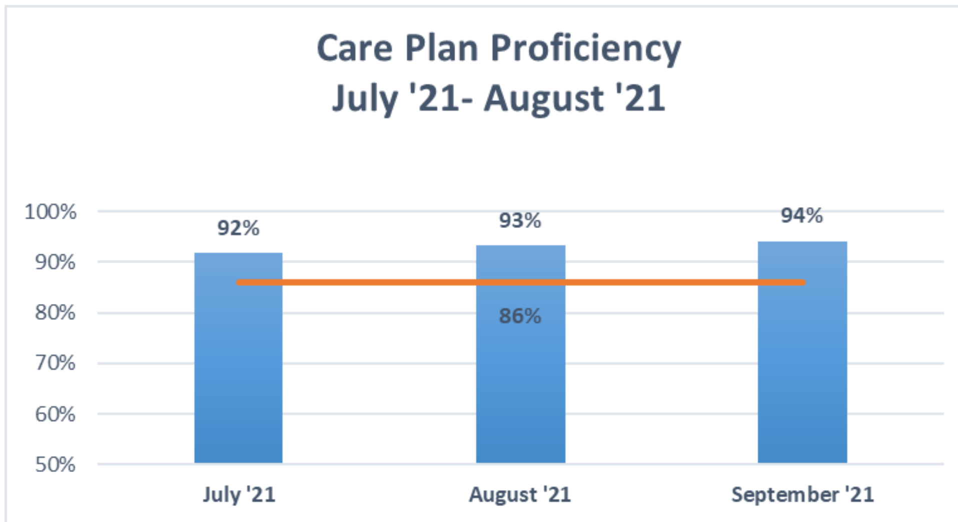


Table 8: statewide care plan proficiency – Q2

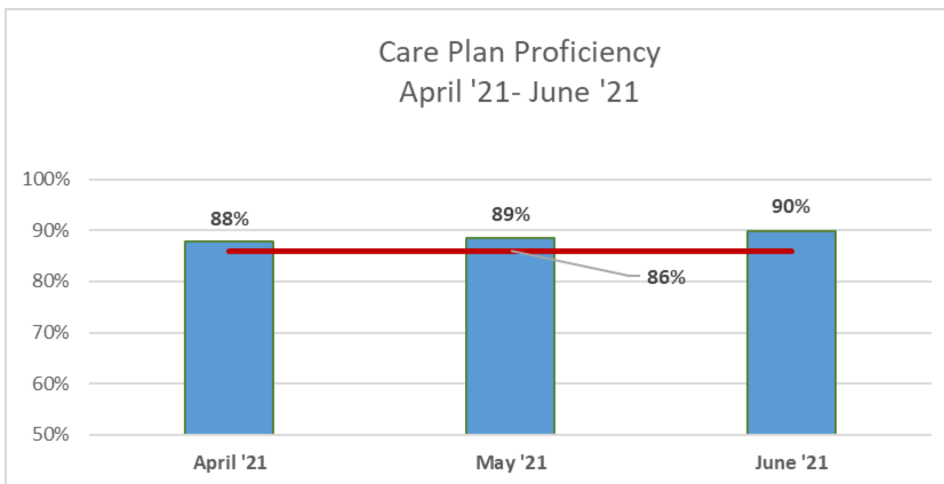
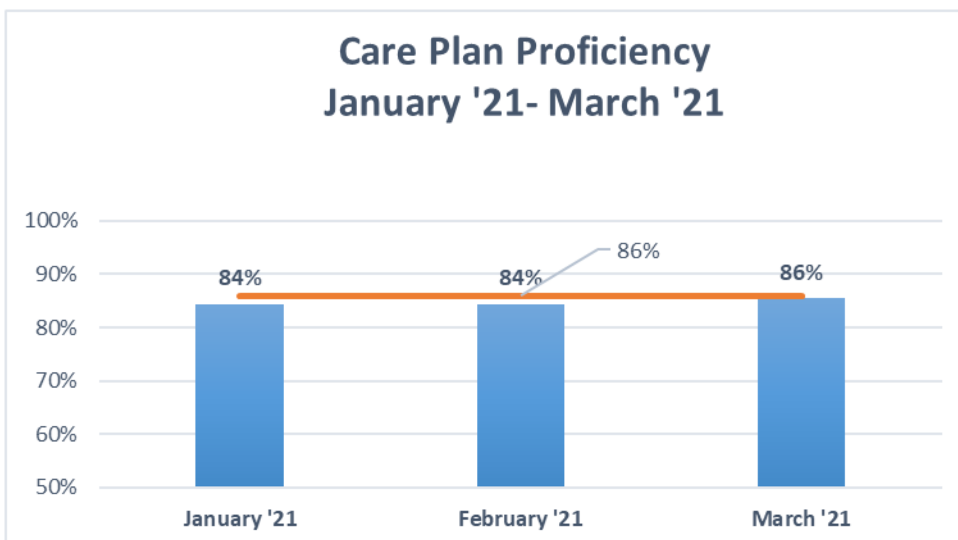


Table 9: statewide care plan proficiency – Q1



State rulemaking

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

Upcoming activities

- The Fall Tribal Summit will be held virtually on November 18-19.
- A training survey will be sent out in December to Home and Community Services (HCS) and AAA staff to gather feedback regarding 2021 training events and to solicit requests for 2022 training topics.
- HCS will hold stakeholder meetings in October and November to provide an update on the MAC and TSOA extension request, and the amendment submitted to CMS early in January. The meetings will also share information related to the upcoming work for the MTP renewal.

LTSS stakeholder concerns

- No stakeholder concerns were submitted during this quarter.

FCS implementation accomplishments

Initiative 3 provides evidence-based supportive housing and supported employment services to eligible Medicaid clients. This section summarizes the FCS program development and implementation activities from July 1 through September 30, 2021. Key accomplishments for the quarter include:

- Total aggregate number of people enrolled in FCS services at the end of Q3:
  - CSS: 6,836
  - IPS: 5,157
- There were 167 providers under contract with Amerigroup at the end of Q3, representing 453 sites throughout the state.

Note: CSS and IPS enrollment totals include 2,053 participants enrolled in both programs. The total unduplicated number of enrollments at the end of this reporting period was 9,940.

Network adequacy for FCS

Table 10: FCS provider network development

	July		August		September	
FCS service type	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
Supported Employment – Individual Placement Support (IPS)	36	74	36	74	36	74
Community Support Services (CSS)	19	45	19	45	19	45
CSS and IPS	111	333	112	334	112	334
Total	**166**	**452**	**167**	**453**	**167**	**453**

The FCS provider network remained largely the same during Q3, with a new contracted provider joining in July to start both CSS and IPS services.

Client enrollment

Table 11: FCS client enrollment

	July	August	September
Supported Employment – Individual Placement and Support (IPS)	2927	3112	3104
Community Support Services (CSS)	4505	4825	4783
CSS and IPS	1793	2121	2053
Total aggregate enrollment	9225	10058	9940

Data source: Research and Data Analytics (RDA) administrative reports
*August enrollment count overcounted due to changes in the disenrollment process. Updated enrollment counts will be reflected in following reports.

Table 12: FCS client risk profile

		Met HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
July	IPS	693 (15%)	.94	3435 (73%)
	CSS	1553 (25%)	1.28	4195 (67%)
August	IPS	771 (15%)	.95	3808 (73%)
	CSS	1682 (24%)	1.28	4642 (67%)
September	IPS	746 (14%)	.95	3776 (73%)
	CSS	1655 (24%)	1.29	4567 (67%)

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 13: FCS client risk profile, continued

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment needs flags
July	IPS	4023	3796 (94%)	2494 (62%)	2394 (60%)
	CSS	5262	4870 (93%)	3908 (74%)	3689 (70%)
August	IPS	4480	4187 (93%)	2777 (62%)	2651 (59%)
	CSS	5801	5341 (92%)	4303 (74%)	4058 (70%)
September	IPS	4397	4095 (93%)	2689 (61%)	2564 (58%)
	CSS	5694	5208 (91%)	4187 (74%)	3927 (69%)

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

Table 14: FCS client service utilization

		Medicaid only enrollees*	Long-term Services and Supports	Mental health services	SUD services (received in last 12 months)	Care + MH or SUD services
July	IPS	4023	385 (10%)	3106 (77%)	1567 (39%)	339 (8%)
	CSS	5262	632 (12%)	3556 (68%)	2343 (45%)	542 (10%)
August	IPS	4480	432 (10%)	3358 (75%)	1718 (38%)	374 (8%)
	CSS	5801	674 (12%)	3838 (66%)	2540 (44%)	574 (10%)
September	IPS	4397	425 (10%)	3245 (74%)	1625 (37%)	366 (8%)
	CSS	5694	652 (11%)	3669 (64%)	2407 (42%)	546 (10%)

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

Table 15: FCS client Medicaid eligibility

		CN blind/disabled (Medicaid only & full dual eligible)	CN aged (Medicaid only & full dual eligible)	CN family & pregnant women	ACA expansion adults (nonadults presumptive)	Adults (nonadults presumptive) ACA expansion adults (SSI presumptive)	CN & CHIP children
July	IPS	1347 (29%)	87 (2%)	520 (11%)	2125 (45%)	527 (11%)	114 (2%)
	CSS	2070 (33%)	290 (5%)	767 (12%)	2128 (34%)	974 (15%)	69 (1%)
August	IPS	1460 (28%)	95 (2%)	618 (12%)	2381 (45%)	553 (11%)	126 (2%)
	CSS	2247 (32%)	312 (4%)	880 (13%)	2391 (34%)	1045 (15%)	71 (1%)
September	IPS	1451 (28%)	94 (2%)	586 (11%)	2353 (46%)	551 (11%)	122 (2%)
	CSS	2227 (33%)	307 (4%)	863 (13%)	2335 (34%)	1038 (15%)	66 (1%)

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

QA monitoring activity

The third-party administrator (TPA) reported no major concerns or issues during Q3 regarding the FCS provider network. However, a decrease in the number of new enrollments was observed in September. Ongoing analysis is currently underway on addressing the decrease in new assessments for the program. FCS staff are meeting with the TPA regularly to monitor provider capacity and identify areas where additional training and support are needed.

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

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

Other FCS program activity

HCA hired Scott Tankersley for the newly established FCS Housing Subsidy Program Manager position to manage short-term housing subsidy funds allocated to HCA by the Washington State Legislature for the

2022-2023 biennium. The housing subsidies aim to cover transition costs that support people eligible for the FCS program in obtaining housing while receiving wraparound CSS supports and while waiting to be connected to longer-term housing resources.

HCA continues to monitor the distribution of 3,000 mobile phones procured for FCS enrollees. The phones are distributed through a partnership between ACHs and individual FCS providers in their area. At the end of Q3, more than 2,294 phones had been distributed to FCS enrollees.

HCA and DSHS staff jointly presented updates on FCS at the statewide Conference on Ending Homelessness. Additional presentations were made at the conference by Division of Behavioral Health and Recovery (DBHR) FCS staff on Fidelity and Photo Voice.

HCA established 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 DSHS Division of Vocational Rehabilitation (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 worked with RDA on the development of an FCS enrollment report across the different ACHs to better integrate cross-initiative efforts to expand the program's reach. Work is also underway to assess the need for a similar report focused on the FCS enrollment across the five MCOs in Washington State.

Upcoming activities

- During Q4, FCS staff will continue planning for the potential MTP extension-year. Work is underway to plan the various trainings, webinars, and work groups that aim to support the FCS provider network and improve the experience of program participants.
- FCS staff will attend the annual Learning Symposium held jointly by HCA and ACHs.
- FCS staff will continue 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 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 16: FCS program stakeholder engagement activities

	July	August	September
	Number of events held		
Training and assistance provided to individual organizations	24	64	65
Community and regional presentations and training events	3	4	11
Informational webinars	6	6	6
Stakeholder engagement meetings	6	10	13
Total activities	**39**	**84**	**95**

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. Q3 topics included:

- Housing resources and coordination of care
- Landlord outreach and engagement
- Combating compassion fatigue and burnout
- How to increase referrals
- Supportive housing basics
- FCS contract process
- FCS treatment planning
- FCS implementation questions
- Supportive housing 101
- Supportive housing 201
- IPS principles
- Adding supported employment to book of business
- Collaboration with Department of Services for the Blind
- Human center poverty reduction workgroup
- HEN enhancements
- Leveraging FCS for new housing
- Work is a critical part of recovery: intersection of SUD and supported employment
- Supportive housing and SUD
- Supporting people with hoarding behaviors and excessive clutter
- Offering constructive feedback to job seekers in a positive way
- Motivational interviewing and matching vocational interventions to stage of change

FCS stakeholder concerns

- The FCS team continues to receive feedback and respond to questions regarding the MTP extension year renewal. Stakeholders, including other state agencies, providers, and MCOs have expressed their strong interest in seeing continuity in FCS services, as well as provided feedback for areas where they see opportunities for improvement.
- FCS staff across DBHR and ALTSA have listened to concerns from the provider network around significant staffing challenges due to the COVID-19 pandemic, as well as local and federal vaccine mandates. Workforce shortages continue to be a recurring theme during stakeholder meetings and monthly calls with providers.

SUD IMD waiver implementation accomplishments

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

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

- Contracting for recovery navigator programs as well as SUD family navigator programs began in earnest.

Implementation plan

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

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

SUD HIT plan requirements

The state continued its implementation process of the HHS Coalition Master Person Index Project. In September, the coalition approved expanding the implementation to develop the coalition infrastructure to support connections from all coalition agencies (DSHS, DCYF, DOH, HBE and HCA). The MPI Project is in the process of hiring two critical staff positions: MPI Governance Manager and MPI Architect.

HCA advanced funding requests to the Governor's office to support implementation of an electronic consent management solution to support the exchange of information subject to 42 CFR Part 2.

Evaluation design

- There were no updates to report during this reporting period.

Monitoring protocol

- Per CMS instructions (as of July 15, 2021), the state is submitting two quarters of reporting. In the monitoring protocol workbook, the tab titled "SUD metrics_DY5Q2" includes the reporting for DY5Q2 that was delayed due to implementing updated technical specifications. The tab titled "SUD metrics_DY5Q3" contains the current quarter (DY5Q3) reporting. The state also notes that Technical Specifications Manual Version 4.0 was used for both reporting quarters. However, there is no option to select Version 4.0 in the dropdown options.

Upcoming activities

- The state will hold its annual Co-occurring Disorder Treatment Conference again via teleconferencing on October 4-5. Session will focus on helping attendees adjust to treatment current realities.

MH IMD waiver implementation accomplishments

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

This section summarizes MH IMD waiver development and implementation activities from July 1 through September 30, 2021.

- Bed registry work groups commenced. Stakeholders included representatives from:

- Behavioral Health-Administrative Services Organizations
- DSHS's Behavioral Health Agency
- Department of Health
- Designated Crisis Responder Association
- Governor's Office
- HCA
- Law Enforcement
- Managed Care Organizations
- Persons with Lived Experience
- SUD Residential Providers
- Washington American College of Emergency Physicians
- Washington National Alliance on Mental Illness
- Washington State Hospital Association
- Washington Behavioral Health Council
- Washington State Medical Association

The focus of the first stakeholder meeting was to learn about how each respective stakeholder organization would intersect with a bed registry, hear from national subject matter experts on what other state have learned about implementing bed registries, and review the bills and federal regulations related to this work.

The focus of the second stakeholder meeting was to learn from stakeholders regarding the need for a bed registry and what problem a bed registry would solve from them. We have also had individual meetings with the Washington State Hospital Association and Counties.

Implementation plan

- There were no updates or changes to report during this reporting period.

MH HIT plan requirements

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

- Collaboration with ACHs, MCOs, and Collective Medical (a technology vendor) to explore opportunities to advance HIE on behalf of persons that receive behavioral health services, including persons being discharged from psychiatric hospital to community-based providers (i.e., primary care providers, mental health).

Evaluation design

- There were no updates to report during this reporting period.

Monitoring protocol

- There were no updates to report during this reporting period.

Upcoming activities

- Evaluation design will be submitted to CMS on October 25, 2021.
- Monitoring protocol materials will be submitted to CMS on October 25, 2021.

Quarterly expenditures

The following table reflects quarterly expenditures for DSRIP, LTSS, and FCS during DY5 (2021). No incentives were paid out in the third quarter.

Table 17: 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		$8,355,396	$4,177,698
Cascade Pacific Action Alliance	$35,053	$6,345,933	$0		$6,380,986	$3,190,493
Elevate Health	$44,571	$8,756,298	$0		$8,800,869	$4,400,435
Greater Columbia	$250,000	$11,147,815	$0		$11,397,815	$5,698,908
HealthierHere	$250,000	$13,081,240	$0		$13,331,240	$6,665,620
North Central	$250,000	$3,873,065	$0		$4,123,065	$2,061,533
North Sound	$250,000	$11,603,517	$0		$11,853,517	$5,926,759
Olympic Community of Health	$250,000	$3,063,344	$0		$3,313,344	$1,656,672
SWACH	$250,000	$5,541,304	$0		$5,791,304	$2,895,652
Indian Health Care Providers	$0	$2,898,115	$0		$2,898,115	$1,449,058

Table 18: 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 19: 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		$14,505,750

Medicaid Alternative Care (MAC)	$128,419	$137,639	$92,313		$358,371
MAC and TSOA not eligible	$0	$573	$0		$573
FCS	$5,465,921	$6,542,310	$4,933,158		$16,941,389

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 June 2021.

July 2021 through September 2021 member months for non-expansion adults are forecasted caseload figures from CFC. Actual member months data for the SUD populations are currently available through June 2021.

Table 20: member months eligible to receive services

Calendar month	Non-expansion adults only	SUD Medicaid disabled	SUD Medicaid non-disabled	SUD newly eligible	SUD American Indian/Alaska Native
Jan-17	376,313	0	0	0	0
Feb-17	375,210	0	0	0	0
Mar-17	374,741	0	0	0	0
Apr-17	373,595	0	0	0	0
May-17	373,139	0	0	0	0
Jun-17	373,044	0	0	0	0
Jul-17	372,133	0	0	0	0
Aug-17	371,867	0	0	0	0
Sep-17	370,602	0	0	0	0
Oct-17	370,407	0	0	0	0
Nov-17	370,236	0	0	0	0
Dec-17	370,263	0	0	0	0
Jan-18	370,302	0	0	0	0
Feb-18	368,929	0	0	0	0
Mar-18	368,736	0	0	0	0
Apr-18	367,477	0	0	0	0
May-18	367,843	0	0	0	0
Jun-18	367,123	0	0	0	0
Jul-18	366,866	5	19	91	113
Aug-18	366,268	8	17	95	458
Sept-18	365272	4	19	80	356
Oct-18	365269	4	22	93	401
Nov-18	364779	3	27	93	315
Dec-18	364183	4	17	96	201
Jan-19	363083	36	135	438	417
Feb-19	362325	32	119	413	395
Mar-19	361947	43	149	425	426

Apr-19	361453	56	136	473	526
May-19	360901	43	125	483	534
June-19	359,083	65	150	575	573
Jul-19	360,493	65	197	678	628
Aug-19	359,028	66	243	744	482
Sep-19	359,957	75	214	779	408
Oct-19	358004	73	237	884	469
Nov-19	358,135	81	190	812	574
Dec-19	358,470	58	213	940	558
Jan-20	358,909	32	129	529	504
Feb-20	358,845	24	125	476	440
Mac-20	360,547	33	133	482	428
Apr-20	363,030	41	109	380	304
May-20	366,464	25	97	375	318
Jun-20	369,240	46	157	552	198
Jul-20	371,625	25	84	337	30
Aug-20	374,758	27	107	352	36
Sep-20	376,971	32	100	333	45
Oct-20	378,980	26	93	368	41
Nov-20	379,892	28	87	376	23
Dec-20	381,368	38	100	444	24
Jan-21	382,486	16	57	223	29
Feb-21	382,529	25	89	294	18
Mar-21	383,871	21	85	315	26
Apr-21	385,168	25	98	366	12
May-21	386395	31	85	302	17
Jun-21	387,519	17	29	146	6
Jul-21	389,613				
Aug-21	391,174				
Sep-21	392,116				
Total	21,123,875	1233	3993	14842	10333

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 MH IMDs. Due to a delay with documenting the MH IMD waiver definition, HCA has not been able to report MH IMD expenditures on the CMS-64.

Designated state health programs (DSHP)

- HCA 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 looks forward to continuing discussions with CMS leading up to approval of the state's application for a one-year extension. The state continues work on a longer-term MTP application for renewal, and submission to CMS is now anticipated in 2022.

This additional time will allow the state to continue stakeholder engagement and development of key concepts to be supported through the long-term renewal period. The state will continue policy development and legislative engagement while advancing the case for legislative authorization of expenditure authority for the long-term renewal starting in 2023.

Consumer issues

The state has not experienced any major consumer issues for DSRIP, FCS, LTSS, or the SUD and MH IMD waivers during this reporting period, other than general inquiries about benefits available through MTP. Providers and partners continue to raise questions regarding the timing of the extension year approval from CMS, including general concerns surrounding uncertainty of future funding and contract extensions tied to the pending approval.

MTP evaluation

The independent external evaluator (IEE) continued their active engagement on evaluation activities. The IEE's twelfth rapid cycle report was delivered on September 29, 2021, in compliance with the contracted deliverable timeline. This report covers July through September 2021. It presents findings in these areas:

- **Washington State's Medicaid system performance through September 2020**, including key performance indicators in ten measurement domains as well as examination of equity and disparities within measurement domains.
- **Progress toward implementation of MTP Domain 1 activities related to Health Systems and Community Capacity Building**, including delivery system transformation through ACHs, value-based payment, workforce development, and HIT expansion.

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

The performance measures in this report include the first six months of the COVID-19 pandemic in Washington State. Effects of the pandemic will likely become more pronounced over time.

- Access to care changed in complex ways in 2020. Emergency department visits and hospitalizations declined sharply in the early months of the pandemic, 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. We also observed decreases in access to primary care, preventive screenings, and mental health care.

- In contrast, 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.
- As in prior periods, 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 opioid use disorder treatment was lower. Rates of emergency department utilization and hospitalizations were higher among AI/AN and Black members than for other groups. Rates of arrest and homelessness were relatively unchanged but occurred at higher rates among individuals with SMI.

Upcoming IEE activities:

- Evaluation efforts are ongoing, and future reports will continue to present updates and assessments of MTP in 2021.
- The IEE qualitative analysts continue to analyze data collected in round 2 of state, ACH, and MCO interviews and rounds 1 and 2 of provider organization interviews on different topics (e.g., Domain 1, project implementation, and COVID-19 impacts).
- The qualitative team plans to collect data about the FCS program by interviewing HCA and DSHS leaders and staff and representatives from provider organizations that deliver supportive housing and employment services.
- Qualitative analysts have begun to analyze data from the first two focused FCS interviews and will continue to analyze subsequent interviews.

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, Q3 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, Foundational Community Supports	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, Q3 2021

View this table on the HCA website, which shows all funds earned and distributed through the FE portal through September 30, 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)
			The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#4: Medicaid beneficiaries with SUD diagnosis (annual)
			The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#5: Medicaid beneficiaries treated in an IMD for SUD

2.2.1	Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received any SUD treatment has remained stable over the last 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

			In the early months of this reporting period the number of Medicaid beneficiaries who received residential or inpatient services increased considerably before decreasing significantly. At this point the state is still reviewing the data to determine whether this is trend is reflective of a change in service delivery or a data quality issue. All data points in the current 6 month reporting period should be considered preliminary pending additional state review. 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

			The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#36: Average Length of Stay in IMDs
3.2.1	Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)	The state has no metrics trends to report for this reporting topic.			
4.2.1	Use of Nationally Recognized SUD Program 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.	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#13: SUD provider availability
			The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#14: SUD provider availability – MAT
6.2.1	Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	There has been an increase in initiation and engagement of alcohol and other drug treatment from 2019 to 2020. All three sub metrics (alcohol, opioid, and other) saw an increase, as well as the total number of Medicaid beneficiaries initiating and engagement in AOD treatment. 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.	01/01/2017 – 12/31/2017	#15: Initiation and Engagement of Alcohol and Other Drug Treatment

			The use of opioids at high dosages in persons without cancer continues to decline from 2019 to 2020. 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.	01/01/2018 – 12/31/2018	#18: Use of Opioids at High Dosage in Persons without Cancer (modified by State)
			The concurrent use of opioids and benzodiazepines continues to decline from 2019 to 2020. 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.	01/01/2018 – 12/31/2018	#21: Concurrent Use of Opioids and Benzodiazepines (modified by State)
			Continuity of pharmacotherapy for opioid use disorder continues to increase with an almost three percentage point increase from 2019 (50.7%) to 2020 (53.28%). 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.	01/01/2018 – 12/31/2018	#22: Continuity of Pharmacotherapy for Opioid Use Disorder (modified by State)
7.2.1	Improved Care Coordination and Transitions between Levels of Care (Milestone 6)	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	The rate of follow-up after emergency department use for alcohol or other drug dependence increased slightly for both the 7 day and 30-day metrics from 2019 to 2020 despite a significant increase in the number of qualifying emergency department visits. 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.	01/01/2017 – 12/31/2017	#17(1): Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence

			The rate of follow-up after emergency department use for mental illness has remained stable from 2019 to 2020 despite a significant increase in the number of qualifying emergency department visits. 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.	01/01/2017 – 12/31/2017	#17(2): Follow-Up after Emergency Department Visit for Mental Illness
8.2.1	SUD Health Information Technology	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2017 – 06/30/2018	Q1: PDMP Statewide Fatal Drug Overdoses – All, All Opioids, Heroin, Prescription Opioids (excluding synthetic opioids), Synthetic Opioids (not Methadone)
			The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	Q2: Substance Use Disorder Treatment Penetration Rate
			The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential SUD Services
9.2.1	Other SUD-Related Metrics	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	The rate of emergency department utilization for SUD has remained relatively 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	#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
			The state has no metrics trends to report for this reporting topic this quarter.	07/01/2017 – 06/30/2018	#26: Overdose Deaths (count)
			The state has no metrics trends to report for this reporting topic this quarter.	07/01/2017 – 06/30/2018	#27: Overdose Deaths (Rate)
			The rate of access to preventive/ambulatory health services for adult Medicaid beneficiaries with an SUD diagnosis decreased slightly from 2019 to 2020. However, the absolute number of Medicaid beneficiaries with an SUD diagnosis who had a qualifying visit indicating that while the overall percentage decreased, more individuals were accessing qualifying services. Note: This measurement period occurred during the COVID-19 pandemic. The impact of COVID-19 on the receipt of these services is	01/01/2017 – 12/31/2017	#40: Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD.

			unknown. Any changes in trends should be interpreted with caution.		

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:**
   This measurement period occurred during the beginning months of the COVID-19 pandemic. Trends were largely stable. That said, a decrease and return to levels consistent with prior reporting periods was noted in the monthly number of Medicaid beneficiaries with an SUD Diagnosis who received outpatient services. At the start of this reporting period, the number of Medicaid beneficiaries receiving residential or inpatient services increased significantly before decreasing significantly. We are reviewing the accuracy of the data to determine if the numbers are accurate or if there is a data quality issue. All data points in the current 6 month reporting period should be considered preliminary pending additional state review. The impact of COVID-19 on the receipt of these services is unknown. Any changes in trends should be interpreted with caution.

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)
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#4: Medicaid beneficiaries with SUD diagnosis (annual)
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#5: Medicaid beneficiaries treated in an IMD for SUD
☐ **The state has no metrics trends to report for this reporting topic.**			

1.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ **i) The target population(s) of the demonstration.** ☐ **ii) The clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration.**			
☒ **The state has no implementation update to report for this reporting topic.**			
☐ **The state expects to make other program changes that may affect metrics related to assessment of need and qualification for SUD services.**			
☒ **The state has no implementation update to report for this reporting topic.**			
2.2 Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)			
2.2.1 Metric Trends			
☒ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.**	The monthly number of Medicaid beneficiaries with an SUD diagnosis who received any SUD treatment has remained stable over the last 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 Interventio n

	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
	In the early months of this reporting period the number of Medicaid beneficiaries who received residential or inpatient services increased considerably before decreasing significantly. At this point the state is still reviewing the data to determine whether this trend is reflective of a change in service delivery or a data quality issue. All data points in the current 6 month reporting period should be considered preliminary pending additional state review. 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
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#36: Average Length of

			Stay in IMDs
☐ **The state has no metrics trends to report for this reporting topic.**			
2.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ **i) Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g., outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management).** ☐ **ii) SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication assisted treatment services provided to individuals in IMDs.**			
☒ **The state has no implementation update to report for this reporting topic.**			
☐ **The state expects to make other program changes that may affect metrics related to Milestone 1.**			
☒ **The state has no implementation update to report for this reporting topic.**			
3.2 Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)			
3.2.1 Metric Trends			
☐ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2.**			

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

☒ The state has no trends to report for this reporting topic.			
☐ The state is not reporting metrics related to Milestone 3.			
4.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: **☐ i) Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards.** **☐ ii) State review process for residential treatment providers' compliance with qualifications standards.** **☐ iii) Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site.**			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 3.			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state is not reporting metrics related to Milestone 3.			

5.2 Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)			
5.2.1 Metric Trends			
☐ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.**			
☒ **The state has no trends to report for this reporting topic.**	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#13: SUD provider availability
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	#14: SUD provider availability – MAT
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.**	There has been an increase in initiation and engagement of alcohol and other drug treatment from 2019 to 2020. All three sub metrics (alcohol, opioid, and other) saw an increase, as well as the total number of Medicaid beneficiaries initiating and engagement in AOD treatment. Note: This measurement period occurred	01/01/2017 – 12/31/2017	#15: Initiation and Engageme nt of Alcohol

	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.		and Other Drug Treatment
	The use of opioids at high dosages in persons without cancer continues to decline from 2019 to 2020. 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.	01/01/2018 – 12/31/2018	#18: Use of Opioids at High Dosage in Persons without Cancer (modified by State)
	The concurrent use of opioids and benzodiazepines continues to decline from 2019 to 2020. 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.	01/01/2018 – 12/31/2018	#21: Concurrent Use of Opioids and Benzodiazepines (modified by State)
	Continuity of pharmacotherapy for opioid use disorder continues to increase with an almost three percentage point increase from 2019 (50.7%) to 2020 (53.28%). 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.	01/01/2018 – 12/31/2018	#22: Continuity of Pharmacotherapy for Opioid Use Disorder (modified by State)
☐ **The state has no trends to report for this reporting topic.**			
6.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ **i) Implementation of opioid prescribing guidelines and other**			

interventions related to prevention of OUD. **☐ ii) Expansion of coverage for and access to naloxone.**			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 5.			
☒ The state has no implementation update to report for this reporting topic.			
7.2 Improved Care Coordination and Transitions between Levels of Care (Milestone 6)			
7.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 6.	The rate of follow-up after emergency department use for alcohol or other drug dependence increased slightly for both the 7 day and 30-day metrics from 2019 to 2020 despite a significant increase in the number of qualifying emergency department visits. 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.	01/01/2017 – 12/31/2017	#17(1): Follow-Up after Emergency Departmen t Visit for Alcohol or Other Drug Dependenc e
	The rate of follow-up after emergency department use for mental illness has remained stable from 2019 to 2020 despite a significant increase in the number of qualifying emergency department visits. 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.	01/01/2017 – 12/31/2017	#17(2): Follow-Up after Emergency Departmen t Visit for Mental Illness
☐ The state has no trends to report for this reporting topic.			
7.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to:			

☐ **Implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports.**			
☒ **The state has no implementation update to report for this reporting topic.**			
☐ **The state expects to make other program changes that may affect metrics related to Milestone 6.**			
☒ **The state has no implementation update to report for this reporting topic.**			
8.2 SUD Health Information Technology (Health IT)			
8.2.1 Metric Trends			
☐ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its Health IT metrics.**			
☒ **The state has no trends to report for this reporting topic.**	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2017 – 06/30/2018	Q1: PDMP Statewide Fatal Drug Overdoses – All, All Opioids, Heroin, Prescription Opioids (excluding synthetic opioids), Synthetic Opioids (not Methadone)
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	Q2: Substance Use

			Disorder Treatment Penetration Rate
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2018 – 06/30/2019	Q3: Foundational Community Supports Beneficiaries with Inpatient or Residential SUD Services
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, 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	#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
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2017 – 06/30/2018	#26: Overdose Deaths (count)
	The state has no metrics trends to report for this reporting topic this quarter.	07/01/2017 – 06/30/2018	#27: Overdose Deaths (Rate)
	The rate of access to preventive/ambulatory health services for adult Medicaid beneficiaries with an SUD diagnosis decreased slightly from 2019 to 2020. However, the absolute number of Medicaid beneficiaries with an SUD diagnosis who had a qualifying visit indicating that while the overall percentage decreased, more individuals were accessing qualifying services. 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.	01/01/2017 – 12/31/2017	#40: Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD.
☐ **The state has no trends to report for this reporting topic.**			
9.2.2 Implementation Update			
☐ **The state expects to make other program changes that may affect metrics related to other SUD-related metrics.**			
☒ **The state has no implementation update to report for this reporting topic.**			
10.2 Budget Neutrality			
10.2.1 Current status and analysis			
☐ **If the SUD component is part of a broader demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of**			

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

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

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

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

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

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

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	SFY 20	SFY 21	SFY 20-21	SFY 22	SFY 22
	Budget	Expenditures to Date	Expenditures to Date	Total Expenditures	Budget	Expenditures to Date
Initiative 1 - DSRIP	**$165,082,000**	**$87,950,571**	**$30,995,795**	**$118,946,366**	**$65,830,000**	**$640,366**
Admin (GF-F)	$17,884,994	$10,258,703	$7,642,686	$17,901,389	$8,697,000	$640,366
DSRIP Incentives (GF-F)	$147,197,006	$77,691,867	$23,353,110	$101,044,977	$57,133,000	$0
Initiative 1 - DSRIP	**$112,949,000**	**$46,270,714**	**$23,353,110**	**$69,623,824**	**$57,133,000**	**$0**
DSRIP Incentives (GF-L)	$112,949,000	$46,270,714	$23,353,110	$69,623,824	$57,133,000	$0
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**	**$21,820,078**	**$21,222,898**	**$43,042,976**	**$55,102,000**	**$2,569,812**
FCS SE ADMIN (GF-F)	$1,771,200	$1,729,575	$1,456,576	$3,186,150	$1,312,000	$593,914
FCS SE ADMIN (GF-L)					$495,500	
FCS SE SERVICES (GF-F)	$21,428,700	$8,338,990	$6,839,377	$15,178,367	$12,164,800	$471,258
FCS SE SERVICES (GF-L)					$2,301,300	
FCS SH ADMIN (GF-F)	$3,243,600	$1,917,684	$3,010,900	$4,928,584	$2,842,000	$868,929
FCS SH ADMIN (GF-L)					$1,158,900	
FCS SH SERVICES (GF-F)	$41,452,500	$9,833,830	$9,916,045	$19,749,875	$28,976,000	$635,712
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**	**SFY 20**	**SFY 21**	**SFY 20-21**	**SFY 22**	**SFY 22**
	Budget	**Total Expenditures**	**Expenditures to Date**	**Total Expenditures**	**Budget**	**Expenditures to Date**
Initiative 2 - MAC and TSOA	**$79,799,000**	$25,173,683	$37,494,762	**$62,668,445**	**$29,292,000**	**$11,829,811**
Initiative 3 - FCS	**$2,525,000**	$645,823	$431,530	**$1,077,353**	**$624,000**	**$152,190**
DSHS and HCA (Community Behavioral Health)	**SFY 20-21**	**SFY 20**	**SFY 21**	**SFY 20-21**	**SFY 22**	**SFY 22**
	Budget	**Total Expenditures***	**Expenditures to Date***	**Total Expenditures***	**Budget**	**Expenditures to Date***
Initiative 3 - FCS	**$15,358,000**	**$937,420**	**$1,359,442**	**$2,296,862**	**$1,454,000**	**$141,889**
FCS (GF-F)	$15,358,000	$937,420	$1,359,442	$2,296,862	$1,090,000	$141,889
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 3: July 1, 2021 – September 30, 2021

Washington State Health Care Authority

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 third quarter of 2020, 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 of 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.

Health Care Authority (HCA) approved reporting for the third milestone (Milestone 3) in Q2 2021 and payment occurred in June 2021. Milestone 4 is tied to payment and will be completed in Q4 of 2021.

In addition to providing an implementation plan status report and an updated work plan with additional project detail, Milestone 4 requires AWPHD and UW Medicine to submit data on 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 baseline of 60.6% breast cancer screening rate for the target population. Milestone 4 will include an update and we will compare to the baseline and expect to see an increase in screening rates over time.

3. Expenditures

MQIP payments for Milestone 4 will be released in December 2021. The estimated payment amount is $8.3 million.

Washington State Health Care Authority

Accountable Community of Health (ACH) Quarterly Activity Report

Reporting period: July 1–September 30, 2021

Report to Joint Select Committee on Health Care Oversight

Washington State Health Care Authority

Introduction

This report reflects statewide and regional Accountable Community of Health (ACH) activities from July 1 to September 30, 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 have been coordinating and supporting COVID-19 response.

Statewide ACH activities

- ACHs are still very involved in COVID-19 response, including hosting vaccine clinics for hard-to-reach populations and communities, supporting testing efforts, participating in Department of Health's (DOH) CareConnect Hub program for individuals and families in isolation/quarantine, and other vital efforts.
- ACHs planning for the future in partnership with the communities they serve. ACHs are conducting strategic planning exercises, community engagement efforts, grant writing, and other activities to determine how to continue to support the health of communities. ACHs are also working closely with the Health Care Authority (HCA) to plan for MTP one-year extension and five-year renewal efforts, which include ACHs.
- ACHs are distributing funds to regional organizations and partners to conduct a host of activities—from health equity work to community-based organization support and social determinants of health.
- ACHs are actively engaged in behavioral health and whole-person care efforts across their regions. This includes participating in multi-sector groups to advance a standard behavioral health integration assessment and installing Naloxone vending machines to address high rates of suicidality in youth.

Individual ACH activities

Better Health Together (BHT)

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

COVID-19 response

- BHT partnered with several local organizations, including Latinos en Spokane, The NATIVE Project, Planned Parenthood, Martin Luther King Jr. Family Outreach Center, and Spokane Pride to support COVID-19 vaccination efforts. Partners provided 6,800 vaccinations at 46 vaccination clinics and events. The fully vaccinated rates within BHT's six counties increased for all demographics since the project launched in April 2021. The fully vaccinated rate increased for American Indian (AI) and Alaska Natives (AN) from 10 percent to 39 percent, Asian and Pacific Islanders from 9 percent to 40, Black community members from 7 percent to 33, and across all demographics from 17 percent to 47. To support these efforts, BHT invested $450,000 in MTP funds.
- Starting in February 2021, BHT convened a workgroup of community stakeholders, including Spokane and Mead school districts, Providence, Multicare, NATIVE Project, Unify Community Health, WA School-Based Health Alliance, Kaiser Permanente, and Washington State University (WSU) Spokane to explore ways to support students' primary care using

school-based telehealth services. This fall, a pilot program is launching with CHAS Health, Unify Community Health, and Providence Health Care at nine Spokane School District elementary schools to support acute primary care services. BHT allocated $360,000 in MTP funds to support this. The group will continue to develop a sustainable funding model, additional point of care tests, and over-the-counter medication management.

- In May, the City of Spokane awarded BHT a $2 million contract to support Black, Indigenous, People of Color (BIPOC) community organizations to distribute rental assistance. Several BIPOC lead organizations approached BHT to act as an intermediary in providing financial support to allow smaller community-based organizations the capacity to contract for rental and housing assistance. BHT contributed $50,000 MTP funds to support BHT's infrastructure to this program and allow all $2 million to fund partnering organization capacity and maximize rental assistance.

Care coordination

- The COVID-19 Care Coordination Hub (CareConnect Hub, supported by DOH) provided $217,740 in housing assistance and $36,941.89 in food assistance to community members experiencing financial hardships while quarantining for COVID-19. The Care Connect Hub has served 1,594 clients since its launch on January 10, 2021.

Sustainability

- BHT has been planning for post-MTP activities over the last two years. This year, BHT is focused on developing strategies that link health care and social determinants of health, embed an equity focus on health system transformation, and further develop access to behavioral health services. This fall, BHT hosted Community Participatory Design sessions, launched with their Community Voices Council (comprised of Medicaid beneficiaries with lived experience) and Tribal Partners Leadership Council. Additional sessions are with Trusted Messenger, Behavioral Health, Primary Care, and social determinants of health partners.

Cascade Pacific Action Alliance (CPAA)

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

COVID-19 response

- CPAA is working directly with MTP partners and public health departments across the seven counties in organizing vaccine clinics and conducting focus group discussions to tackle concerns, misinformation, myths, and falsehoods fueling vaccine hesitancy and resistance. CPAA has contracted with additional partners to expand this outreach, targeting more rural areas as well as communities of color.
- CPAA has integrated COVID-19 work with MTP programs and platforms, such as Local Forum and Community CarePort platforms. We plan to make naloxone available at COVID-19 events.
- Our efforts have been augmented by two new grants through CHOICE: $100,000 from the CDC Foundation to accelerate COVID-19 vaccine uptake in communities of color and a $973,914 grant to strengthen the community-based organization workforce to help manage the continued pandemic.

Care coordination

- CPAA's activities through Community CarePort and Washington CareConnect programs remain strong. CPAA continues to put more individuals and families on different pathways to success.
- CPAA is fully engaged and committed to having a strong, effective, and coordinated response to the danger of wildfires. CPAA staff attend and participate on relevant weekly calls and are a regional hub and resource for care packs.

Health equity

- Seventeen partners were selected and are being funded to implement health equity initiatives across the region for a total of $170,000. CPAA dollars are also being braided with CDC Foundation funds to bring health equity perspective to COVID-19 support in Central Western.
- In September, CPAA launched the "Equity Circle Podcast", a communication tool for covering a range of issues, including COVID-19 and whole-person care through a health equity lens.
- A workgroup meets weekly to plan for a CPAA Health Equity convening that will take place in December 2021.

Behavioral health

- CPAA continues to facilitate monthly integrated managed care (IMC) workgroup calls.
- CPAA has held several meetings around behavioral health needs in Wahkiakum and Pacific counties with the goal of supporting a pilot mobile clinic.
- CPAA is working to address the high incidence of suicide and suicidality among young people and are planning to implement a Hope Squad program in schools.

Social determinants of health

- CPAA used Health Resources & Services Administration (HRSA) funding to acquire a 14-seater wheelchair accessible van to help meet transportation needs for rural, hard-to-reach communities. CPAA will deploy this van on MTP outreach activities and in delivering care packages through Community CarePort.
- CPAA funded a feasibility study and preliminary financial model for an outpatient medication-assisted treatment (MAT) facility with an optional pharmacy component for the Chehalis Tribe for $137,205.

Elevate Health

Serving Pierce County

COVID-19 response

- Elevate Health signed a 2022 contract for DOH Washington CareConnect program as the Regional Hub for COVID-19 Care Coordination response services. During the reporting period, Elevate Health added two new network partners for the Care Connect work: Virginia Mason Franciscan Health (VMFH)/Rainier Health Network (RHN) and Asia Pacific Cultural Center. The network now has a total of six community-based organizations assisting with COVID-19 response.

Care coordination

- Elevate Health received a $400,000 two-year grant from Common Spirit Health (CSH) for a Pathways Maternity Pilot. The operational plan was completed in collaboration with CSH and VMFH for a pilot launch in quarter 1 of 2022. Contracting for this pilot is underway.
- Elevate Health completed a demonstration of Health Homes protocols with Pierce County Aging and Disability Services. Pierce County is preparing to engage in contract discussions with Elevate Health to join the Innovaccer platform and utilize established workflows.

Health equity

- OnePierce, Elevate Health's community resilience fund, approved a short-term project financing loan of $800,000 for the development of affordable housing for first-time homeowners.
- OnePierce launched its Behavioral Health Equity Challenge, calling for applications for grants of up to $50,000 for organizations improving access to behavioral health services or promoting the integration of behavioral health with physical health. It received applications requesting five times the amount of funding available. Awards were announced in November.

Behavioral health

- Elevate Health facilitated collaboration and coordination with six Emergency Management System (EMS) districts to provide community behavioral health crisis education services facilitated by Trueblood co-responders and Pierce County's Mobile Community Intervention Response Team throughout the county (with funding from Cambia Health Foundation).
- Elevate Health participated in launch of Pierce County's Regional System of Care Committee (the planning of which began in 2019). Elevate Health's Sr. Director of Integration and Transformation was appointed to the Regional System of Care Committee (RSCC) Advisory Board.

Social determinants of health

- Elevate Health initiated work with technology partner, Innovaccer, to begin stacking and aggregating social determinant of health data sets with Elevate Health's instance for purposes of descriptive and prescriptive analysis. Prepared first use case.
- Elevate Health has initiated a new podcast production entitled *Community Care Conversations*, which raises awareness around social determinant and health needs. The intent of the podcast lends a voice to collaborative community partnerships promoting wellness in Pierce County.

Greater Columbia ACH (GCACH)

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

COVID-19 response

- GCACH is collaborating with Medical Teams International and coordinating with community partners to provide COVID-19 vaccinations, especially in identified "hot spots" (those census tracts with the lowest vaccination rates) within Benton and Franklin counties. To date, 11 events have occurred and 219 people have been vaccinated.

Workforce development

- GCACH was awarded $146,667 per year for two years for a behavioral health pilot program introduced through legislation; House Bill 1504. This bill aligns closely with the behavioral health preceptorship program that GCACH introduced in June of 2020. Applications for funding will be sent out in early October to community behavioral health providers, with an anticipated program start of January 2022.
- GCACH kicked off its first Community Health Worker (CHW) cohort on August 24. A series of trainings, identified by the partnering provider organizations is being implemented to help CHWs adjust to their working environments and understand their roles within their organizations. Thirteen CHWs have finished the DOH core CHW training and started working in primary care and behavioral health organizations.

Community information exchange (CIE)

- Staff from the HealthierHere presented on their approach to building a CIE for their community at the September Leadership Council meeting. HH shared that CIE is a technology tool that connects the relationship between our social and health care providers. How the CIE will be implemented in GCACH is in the planning stages, but preliminary feedback from the Local Health Improvement Networks suggests smaller regional exchanges as opposed to one regional hub.

Health equity

- GCACH has teamed with the Tri-Cities Regional Chamber of Commerce's Inclusion Council and the Rotary Clubs in Benton and Franklin counties to deliver a series of speaking engagements on justice and diversity, equity, and inclusion (DEI). The goal of the project is to determine the level of understanding about DEI in the community.

Community engagement

- The Practice the Pause media campaign officially ended in July; however, GCACH continues to provide trainings and materials to community organizations, schools, and providers. The campaign promoted tools for resilience among all ages with resources grounded in the COPE, CALM, CARE framework developed by Dr. Kira Mauseth, an expert in behavioral health and disaster recovery.

HealthierHere

Serving King County

Whole-person care

- HealthierHere launched a small, shared care plan pilot with HealthPoint as the lead agency and Valley Cities as a partner. The primary activity of the Shared Care Plan Pilot is to test the sharing of patient information across a federally qualified health center (FQHC)-behavioral health agency (BHA) network with a population that includes medically and behaviorally complex individuals to facilitate coordination of care.
- Building on the work of Phase 1, HealthierHere, in collaboration with HCA, all five managed care organizations (MCOs), and ACHs continued to build out the framework for implementing a new statewide tool and strategy for assessing integration among physical and behavioral health providers: the Washington Integrated Care Assessment (WA-ICA).

- Work included soliciting input from providers and relevant representative/professional associations (i.e., Washington State Hospital Association (WSHA), Washington State Medical Association (WSMA), Washington Association for Community Health, Washington Council for Behavioral Health, etc.) on what communication and change management strategies would prove beneficial as the statewide partners make this transition.
- The final report provides a multi-year strategy for ensuring that all eligible physical and behavioral health practices (N > 5000) would be transitioned to the new assessment. Multiple communication tools and guidelines for data management and strategy were included in the final report, which will soon be available on the HCA website.

Care coordination

- Following a highly competitive application process, a review committee of partners and HealthierHere staff selected a collaborative team from Mathematica and Comagine Health to conduct a regional landscape analysis of current care coordination activities and requirements in the King County region.
    - The initial assessment of the current state is an important step toward defining a shared vision for a future system of care coordination that will be responsive to the needs of all people in King County. The landscape analysis will provide insights and opportunities to collectively transform from a fragmented system of sector-specific care coordination to a community-based care coordination model optimized for whole-person care.

CIE

- HealthierHere launched a technology request for proposals (RFP) on August 2 for the CIE. The purpose of this RFP is to identify and select a vendor or vendors to build and operate the Connect2 Community Unified Network Infrastructure (UNI) as a managed service. The UNI will serve as a "network of networks" connecting technology platforms used by organizations participating in the Connect2 Community Network.

Health equity

- HealthierHere invested a total of $1.1 million in five tribal health care and native-led/native-serving community-based organizations to provide access to traditional medicine. The Traditional Medicines Investment is a decolonized investment approach to wholistic health care that is community centered and culturally relevant. The investment includes an evaluation component to create a pathway for sustainability of traditional medicine as part of the health care system.

North Central ACH (NCACH)

Serving Chelan, Douglas, Grant, and Okanogan counties

Whole-person care

- Through recently expanded support by Beacon Health Options, NCACH will now be placing a third naloxone (Narcan®) vending machine in the North Central region to help reduce opioid overdose deaths. This vending machine is expected to be placed next spring at the

Family Health Center in Okanogan, following the installation of the first two machines that will appear by the end of 2021 at sites in Wenatchee and Moses Lake.

- A training in August for 25 emergency department recovery coaches has boosted the number of recovery coaches in North Central Washington to nearly 100 people. Of the 94 currently trained recovery coaches, 16 are presently employed in community-based agencies or clinical organizations in the region. All the coaches also provide voluntary recovery assistance in their communities.

North Sound ACH (NSACH)

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

Social determinants of health

- A recent pilot project launched in Skagit Valley to address vulnerable families impacted by the pandemic and provide culturally appropriate and nourishing food to migrant farmworkers and the Latinx community. With support from NSACH, Northwest Agricultural Business Center (NABC), and seven Skagit Valley farmers, 115 families were served with fresh food boxes in September. "The reactions from the families have been phenomenal. They asked if we are doing this every month or every week. They are shocked to see so many of the vegetables that they love to cook with to make traditional sauces, hot sauce or soups," NABC Project Manager Alex Perez said via email. "The participating farmers are also filled with joy with these projects, they get to share their delicious produce locally with a lot of pride!" NABC and partners worked with farmers in Skagit Valley to select organic produce for the families in need, including peppers, chilies, potatoes, corn, tomatoes, and strawberries.

Whole-person care

- Behavioral and physical health providers have been completing the MeHAF for three years, intended to measure the level of integration of practice and care. During 2021, a work group comprised of ACHs, HCA, and all five MCOs worked collaboratively to recommend steps to advance this assessment process in a consistent manner statewide. After coming to consensus on a tool, six sites piloted the tool, including two that practice in the North Sound region (Skagit Pediatrics and Ideal Option). NSACH chief executive officer and two project managers are on the work group that is recommending how this tool can scale and spread.

COVID-19 response

- In June 2021, NSACH began a COVID-19 vaccine accelerator project sponsored by Kaiser Permanente of Washington. This project leverages the ACH networks across the state and connects them to Medical Teams International's (MTI) dental, vaccine and testing teams. To date, this project has completed 50 vaccine clinics. In the North Sound region, these clinics have been at food banks, churches, shelters, parking lots, and schools.
- NSACH secured a Clinical Laboratory Improvement Amendment (CLIA) waiver that enabled them to administer and support COVID-19 rapid tests. This effort began following conversations with community partners who were expressing little to no access to COVID-19 tests and community testing options. Now, there are nearly 60 organizations that the ACH team is supporting to stand up their own internal testing programs. The CLIA waiver also allows NSACH to support mobile testing events. We are currently supporting the Tri-

Parish Food Bank, adding drive-thru testing options for the families who come weekly to pick up food.

- A photography project featuring migrant farmworker youth in Skagit Valley has been shown in galleries in New York, Portland, and Seattle, and was featured in the Mexican Consulate's virtual MEXAM NW Festival on Oct. 7 with some of the youth and NSACH Project Manager Marco Morales. Morales was one of the organizers of the project, along with the students in the Migrant Leaders Club at Mount Vernon High School, Underground Writing in Mount Vernon, and photographer Marilyn Montufar. "The project bridges photography with youth writing to address how Latinx communities have been deeply impacted by the COVID-19 pandemic due to lack of resources, healthcare accessibility, and language barriers," according to Montufar's interview with the Frye Museum.

Olympic Community of Health (OCH)

Serving Clallam, Jefferson, and Kitsap counties

Sustainability

- The Board of Directors for OCH adopted a new five-year strategic plan in September. Key elements of the plan include:
    - Value Proposition: Stronger Together: Foster a region of healthy people, thriving communities.
    - Overarching Goal: Improve individual and population health and advance equity by addressing the determinants of health.
    - Focus areas for 2022-2026: Long-term, affordable, quality housing; Access to the full spectrum of care; Individual needs are met timely, easily, and compassionately; Reduced substance misuse and abuse.

Community engagement

- In August, OCH brought partners together for an opportunity to connect on lessons learned and to discuss future opportunities around **value-based payments**. Regional partners from hospitals, primary care, behavioral health, and community-based organizations were joined by representatives from HCA, Community Health Plan of Washington (CHPW), Coordinated Care, United Healthcare, and Molina Healthcare for a collaborative and open conversation about challenges and possibilities.
- This summer, OCH staff visited with implementation partners, both virtually and in-person, to hear how partners continue to go above and beyond for the health of their communities. By listening to partner experiences, successes, and challenges, and fostering relationships with partner staff, OCH can cater upcoming activities and opportunities to the unique needs of the region.

Whole-person care

- OCH took a targeted universalism approach to addressing local behavioral health needs. OCH engaged implementation partners to embark on an activity of their choice to support the local behavioral health needs of their communities, going above and beyond their standard efforts. The region has the benefit of caring, dedicated, and talented partners addressing both long-standing and current behavioral health needs. OCH intentionally provided partners with the freedom to get creative and think outside the box to best cater projects to the needs of their clients and communities while maximizing strengths.

SWACH

Serving Clark, Klickitat, and Skamania counties

Health equity

- SWACH contributed $120,000 to Community Foundation for Southwest Washington's Social Justice and Resiliency Fund. These funds will support 1) capacity-building for organizations to invest in equity work and address the disparities within their organization and/or programming, 2) investments in organizations focused on systemic change, policy, and advocacy efforts; and/or, 3) operating support for organizations led by BIPOC, culturally specific organizations and coalitions seeking to reimagine the systems they work in. A member of SWACH staff is participating in the grants review committee.
- SWACH staff finalized its proposed Racial Justice Plan based on organizational equity assessment to be reviewed by its Board of Trustees in December.
- SWACH staff completed training series/facilitated discussion on white dominant culture as well as continued engaging in equity discussions as part of its monthly book club.

Behavioral health

- SWACH supported the Trueblood Collaboration Taskforce. This includes a separate shared learning and integration meeting for direct service providers across Trueblood contracted and state agencies. This allows for direct service partners to bring individual issues and cases for staffing with partners across agencies.
- SWACH collaborated with its partners to apply for and received $162,000 Beacon COVID-19 block grant funds to implement five naloxone vending machines.
- Supported development of a co-responder model for behavioral health crisis response to include community paramedicine and connection to community care coordination supports.

COVID-19 response

- SWACH was awarded $1 million HRSA grant focused on local community-based workforce to increase COVID-19 vaccine access. Implementation of this project began in August.
- Between July 1 and September 30, HealthConnect received 881 household referrals for the Care Connect WA (CCW) program needing COVID-19+ supports.
    - Referral follow ups connected community-based workers to approximately 3,500 COVID-19 impacted individuals.
    - HealthConnect Hub provided 376 households with $439,529.47 in household assistance and 414 grocery orders worth $80,657.73 in fresh food orders in Clark County. Klickitat and Skamania counties community health workers served households with over $10,000 in fresh food orders.