STATE OF WASHINGTON

April 9, 2026

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

SUBJECT: Quarterly Report on the Medicaid Transformation Project

Pursuant to Senate Bill (SB) 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 (MTP). Washington State's Section 1115 Medicaid demonstration waiver. The first enclosure is a copy of our recently submitted report to the federal Centers for Medicare & Medicaid Services (CMS).

Under the terms of our agreement with CMS, the state is required to report quarterly on the activities and accomplishments of MTP. Within the report is a quarterly expenditure and FTE report covering three of five MTP initiatives. Given that the information contained in the report is the same as what we believe to be required under SB 5092, we respectfully suggest that the same report can fulfill both needs. However, please let us know if there is additional information you require. Please note, this will be the last quarterly report produced as we have moved to annual reporting to CMS and intend to mimic that cadence for legislative reporting.

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

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

Sincerely,

Ryan Moran, DrPH, MHSA Director Health Care Authority	Angela Ramirez 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 Health Care Authority

Washington State Medicaid Transformation Project (MTP 2.0)

Section 1115 Medicaid Demonstration Waiver

Annual Monitoring Report

Demonstration Year 9: July 1, 2024, through June 30, 2025

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Introduction

On June 30, 2023, the Centers for Medicare & Medicaid Services (CMS) approved Washington State's request for a Section 1115 Medicaid demonstration waiver, titled Medicaid Transformation Project (MTP 2.0). 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 MTP 2.0 period, Washington will:

- Expand coverage and access to care, ensuring that people can get the care they need.
- Advance whole-person primary, preventive, and home- and community-based care.
- Accelerate care delivery and payment innovation focused on health-related social needs.

The state will accomplish these goals through these continuing or new programs:

- **Long-Term Services and Supports (LTSS):** Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) and Presumptive Eligibility (PE)
- **Foundational Community Supports (FCS):** Community Support Services (CSS) and Supported Employment – Individual Placement and Support (IPS)
- **Substance use disorder (SUD) IMD waiver:** Treatment services, including short-term services provided in residential and inpatient treatment settings, 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
- **Contingency Management (CM) for SUD treatment:** Evidence-based intervention for SUD
- **Continuous enrollment (CE):** Continuous Apple Health enrollment for children ages 0 through 5 and Apple Health postpartum coverage expansion
- **Reentry from a carceral setting (Reentry Initiative):** Services to individuals beginning up to 90 days prior to their expected release and continuing into their reentry to their communities
- **Health-related social needs (HRSN) services:** Evidence-based, non-medical services that address social needs that affect health. HRSN services are coordinated in part by nine Community Care Hubs and one statewide Native Hub.

Vision: A healthier Washington

The Washington State Health Care Authority (HCA) is the lead agency for MTP 2.0, and many other agencies and partners play an important role in improving Washington's health and wellness systems. Together, we are working to create a healthier Washington, where people can receive better health, better care, and at a lower cost.

Annual Monitoring Report overview

Each state with an approved Section 1115 Medicaid demonstration is expected to utilize a monitoring report workbook to complete its monitoring reports, per the demonstration's Special Terms and Conditions requirement. In the monitoring report, the state will submit information on monitoring metrics, qualitative summaries of metrics trends, and implementation updates associated with waivers and expenditure authorities approved in its Section 1115 demonstration.

This Annual Monitoring Report summarizes MTP 2.0 activities for the Demonstration Year (DY) 9 reporting period, **July 1, 2024-June 30, 2025**. It details MTP 2.0 implementation, partner engagement, planning and development, and program policies and procedures.

This document is an accessibility-compliant version of the Excel report template required by and submitted to in January 2026. The content is the same.

Executive Summary

This section provides a brief overview of the key achievements, highlights, challenges, and/or risks identified during the DY9 reporting period.

Health-Related Social Needs Services (HRSNs)

In DY9, HCA received approval of the HRSN services protocol and payment rate methodologies from CMS. HRSN services implementation followed a phased approach:

HRSN Case Management, Outreach, and Education

The case management, outreach, and education service was soft launched in July 2024 and formally launched in January 2025. HCA continues to collaborate with ACHs on the implementation of Community Care Hubs. In DY9, HCA finalized Hub service activities and Community Health Worker training requirements and memorialized them in contract. HCA also worked collaboratively with Hubs to develop a process for reporting on service provision. HCA has facilitated a series of referral conversations between Hubs and other waiver-funded providers, including FCS providers and carceral facilities. HCA continued to administer HRSN infrastructure payments to ACHs and worked with the ACHs to define requirements for sharing infrastructure funds with HRSN service providers. From January to June 2025, there were 6,326 total referrals for both social needs (especially housing, food access, transportation) and health needs (behavioral health and primary care). The Native Hub is being co-developed between HCA and the 29 federally recognized Tribes and two Urban Indian health programs in Washington State.

HRSN Recuperative care and short-term hospitalization housing (medical respite)

During this reporting period, the state continued work to implement the medical respite care service via the MCOs for a July 2025 launch date. Further information on MRC implementation, success, and challenges will be included in the following DY10 Annual Monitoring Report.

HRSN Nutrition Supports, Caregiver Respite, Home Accessibility

HCA is partnering with DSHS to administer nutrition supports, caregiver respite, and home accessibility, remediation, and adaptation services under the waiver. DSHS will provide these services through their network of Area Agencies on Aging (AAA), as well as via providers contracted with the Developmental Disabilities Community Services (DDCS). Washington is working with AAAs, ACHs, and MCOs to establish referral networks to these services for clients in need.

HRSN Infrastructure Payments

HRSN Infrastructure funding supported several programs, including ACH and additional HRSN providers, the CIE program and FCS. The CIE infrastructure will knit together CIE technologies currently used by the ACHs into a statewide system under the direction of the Health and Human Services Enterprise Coalition (HHS Coalition). These technologies include capabilities such as resource directories, client management systems, and closed-loop referrals, among others.

HRSN Housing Transition Navigation and Rent/Temporary Housing

Beginning in February 2025, housing subsidies were implemented through DSHS and provided support to 395 unique individuals through June 30,2025. The state is continuing work to implement housing subsidies through FCS, and selected Spokane Housing Authority to contract with landlords and other Housing Authorities to make rental payments on behalf of FCS participants.

Reentry Initiative

In DY9, Reentry key achievements included conducting a series of Reentry Initiative learning webinars for carceral facilities, providers, ACHs and MCOs, webpage redesign, developing and implementing Capacity Building Applications and Operational Readiness Assessments for carceral facilities to complete, contracting with a Third-Party Administrator to support billing, and publishing the Reentry Policy & Operations Guide and Reentry Targeted Case Management Billing

Guide. In DY10, eight facilities are poised to launch from Cohort 1 on July 1, 2025, and twelve additional carceral facilities are poised to launch in late 2025 and early 2026.

Contingency Management

In DY9, HCA developed a cohort of providers to launch the Contingency Management program. Primary activities were collecting readiness assessments, selecting providers, and beginning the contracting process. Twenty providers are planning to participate in this cohort, with site preparation and training set to begin in in February 2026 and implementation beginning in April 2026 (DY10).

Foundational Community Supports (FCS)

For July 1, 2024 – June 30, 2025, the total number of unduplicated FCS enrollments was 26,427. This included 12,864 Supported Employment enrollees, and 20,783 Supportive Housing enrollees. These programs include the clients accessing permanent supportive housing units for CSS-eligible individuals under the Apple Health and Homes initiative, which was launched in Q3. Certain Apple Health and Homes clients are receiving both supportive housing services and HRSN rent/temporary housing as they move into housing.

In DY9, the FCS training staff continued to provide support to FCS providers and administered a provider survey to gain more insight into opportunities for system improvements.

Long-Term Services and Supports Presumptive Eligibility (LTSS PE)

During DY9, approximately 1,204 clients were found eligible to receive LTSS PE services. A considerable number of LTSS PE clients have successfully transitioned to in-home services following a thorough evaluation of their functional and financial eligibility. Washington has strategic plans to broaden access to LTSS PE. Region 1, consisting of counties in western Washington, is currently testing program effectiveness before statewide implementation. Efforts in this region have included continuous dialogues with management, regional personnel, and the Area Agencies on Aging (AAAs) to optimize workforce, facilitate case sharing, provide training, track data effectively, and pinpoint potential challenges. Consequently, there has been a formal request to adopt a Lean methodology, which seeks to standardize and streamline LTSS PE processes, ensuring efficient access to services across all regions. Regional staff feedback in Region 1 has initiated a collaborative effort with the Comprehensive Assessment Reporting & Evaluation web developers to implement future enhancements

Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)

In DY9, 5,742 clients, in addition to their family caregivers, received services and supports through the Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) programs. Utilizing the updated TSOA income eligibility criteria (400 percent of the federal benefit rate), there were 235 new participants in the expanded eligibility tier this DY. Utilizing the updated resource standard (six months of the current private nursing facility rate), there were 84 additional participants in the expanded eligibility tier this year.

The state exceeded the expenditure authority for MAC/TSOA services in DY9. Although outside the DY9 reporting period, the state has implemented a waitlist as of December 1, 2025, for the Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) program. Enrollment into MAC and TSOA will reopen when program expenditures fall below the expenditure authority within a future DY.

Substance Use Disorder Institutions for Mental Disease (SUD IMDs)

The state continues to meet all aspects of its SUD and SMI IMD implementation plan. In August 2024, permanent rules were adopted in the Washington Administrative Code (WAC) relating to the establishment

and certification of 23-hour crisis relief centers. The state maintains robust contract requirements in its state dollar funded wrap around contracts with managed care organizations related to coordination and discharge planning for state hospitals, state psychiatric care facilities, and long-term civil commitment (LTCC) facilities. Washington state continues

to promote the availability and use of early intervention services through screenings, structured assessments and brief initial interventions Activities to increase access to and utilization of crisis stabilization services in DY9 included enhancing crisis response services through co-response integration and support and planning for a statewide Administrative Services Organization for AI/AN enrollees.

Continuous Enrollment

With the addition of Continuous Enrollment for Children's Health Insurance Program (CHIP) in January 2025, the state has implemented a manual process to ensure continuous coverage for CHIP children under the age of six and planning full system support for CHIP continuous eligibility in DY10 and continues outreach to families in the meantime. The Continuous Enrollment for CHIP enrollment numbers for DY9 (Federal RACs only) were 10,761. The state also continues to outreach people about Apple Health postpartum coverage. The DY9 enrolment numbers for Post Partum (RAC 1276 only) were 2,152.

Implementation Updates

This section summarizes demonstration progress by remarking on contextual factors, initiatives, and state activity related to the goals and objectives of the overall demonstration. CMS provided specific narrative prompts for each reporting topic. CMS' narrative prompts are included below, followed by HCA's responses.

Demonstration Operations and Policy

Using the subsection prompts below, highlight critical demonstration implementation, operations, or policy considerations that might have affected (positively or negatively) eligibility and participation in demonstration programs, access to services, timely provision of services, or any other areas affecting beneficiaries. Summarize any related state activity that may have either a positive or negative effect on achieving the demonstration's approved goals or objectives.

Summarize implementation, operations, or policy considerations that may affect the demonstration or its beneficiaries, including eligibility and participation in the demonstration.

HCA has made several eligibility scoping decisions for our HRSN services to maximize benefits for clients experiencing homelessness. The majority of HRSN services currently being implemented, including medical respite care, nutrition supports, environmental modifications, housing navigation and rent/temporary housing have been scoped to cover FCS-enrolled clients.

To deliver a service to clients as soon as possible, HCA has made progress on the following implementations:

Department of Social and Health Services (DSHS) began implementing the rent and temporary housing benefit for Home and Community Services (HCS) clients as of 2/1. The state will implement rent and temporary housing services for FCS clients, with a portion going to those eligible for the AHAH benefit, starting in 2026. The state will also begin to administer housing transition navigation services in 2026 through the existing Transition Assistance Program (TAP) in 2026.

The state is partnering with DSHS to also administer nutrition supports, caregiver respite, and home accessibility, remediation, and adaptation services under the waiver. These services are set to launch in 2026.

During this reporting period, the state continued work to implement medical respite care for a July 2025 launch date.

The state launched the first cohort of carceral facilities participating in the Reentry Initiative on July 1, 2025, and is providing ongoing TA to facilities preparing to go live with services. HCA has scoped the reentry population to be as broad as possible to serve any Medicaid-eligible individual during the high-risk period of reentering into the community ensuring connections to community-based organizations increasing the likelihood of a successful transition.

Describe activities under the below topics as they pertain to the demonstration:

Organizational, administrative, or service delivery changes.

HCA has largely utilized a fee for service delivery system to implement waiver programs, using FFS as an on-ramp for new to Medicaid community-based providers that may have more limited or no experience billing Medicaid. Community care hubs and housing navigation and rent/temporary housing are being implemented following this FFS payment model. Given provider experience billing Medicaid, the Reentry Initiative and medical respite care have been implemented via managed care organizations who are assisting in implementation by educating providers on contracting and billing processes. HCA has also utilized Third Party Administrators to assist new to Medicaid providers with understanding Medicaid requirements and with billing processes. Over DY9, HCA procured a Third-Party Administrator for the Reentry Initiative and has continued to use a Third-Party Administrator to support providers contracted to provide services to FCS-enrolled clients.

Legislative activities.

HCA has not been subject to any new legislation that would impact the waiver. Existing legislation has supported the major components of the waiver, including supportive housing and employment, Accountable Communities of Health, and the Reentry Demonstration.

Fiscal changes and related processes or definitions that would result in changes in access, benefits, populations, enrollment, etc.

No fiscal changes occurred in DY9 that resulted in changes in access, benefits, populations, or enrollment.

Litigation activities.

HCA has had no litigation activities related to the waiver.

Summarize other contextual factors (e.g., emergencies or disasters), initiatives (e.g., notable innovations), or state activity (e.g., system-wide Medicaid enrollment changes, stakeholder communications, and/or unexpected achievements or outcomes) that may accelerate or create delays in achieving the goals and objectives of the overall demonstration and its individual authorities.

WA did not experience any emergencies or disasters in DY9 that would impact our ability to implement the waiver.

Data Infrastructure and Health IT

Provide updates to data infrastructure, IT, or any other system changes or enhancements relevant to the demonstration, including any activities since the state's last update. Include information on system changes affecting demonstration eligibility and enrollment processing, MMIS, how IT is being used to support demonstration initiatives to identify and effectively treat and serve individuals in the demonstration, etc. In addition, include details on adoption and enhancement of IT systems to support data sharing between state Medicaid agencies, participating service providers and facilities, or partner entities assisting in the administration of the demonstration. Describe activities, challenges, and any remediation steps to establishing or maintaining the state's capacity for reporting key demographic data.

The state continues to work across teams and agencies to make changes needed to existing data systems to track utilization of services. In addition, data teams are working to create the analytic infrastructure that will be used for monitoring and evaluation of implemented programs.

The state also made progress on implementing the statewide Community Information Exchange (CIE) in DY9. The CIE infrastructure will knit together CIE technologies currently used by the ACHs into a statewide system under the direction of the Health and Human Services Enterprise Coalition (HHS Coalition). These technologies include capabilities such as resource directories, client management systems, and closed-loop referrals, among others. In May 2025, Washington state released the request for proposal (RFP) for the Lead organization contract and is positioned to begin the procurement process in DY10.

Demonstration Evaluation

Provide an update on evaluation efforts. The state should also provide CMS with any information on challenges related to executing the evaluation, such as independent evaluator procurement and data availability, completeness, and quality. The state should include similar updates, as applicable, for any other post-approval assessments (e.g., mid-point assessments or annual availability assessments). If applicable, the state should include an attachment to report the results of beneficiary satisfaction surveys conducted during the year.

Progress on evaluation efforts continues. CMS approved Washington's independent external evaluation design in June of 2025. Since that approval, Oregon Health & Science University (OHSU), Washington's independent external evaluator, has conducted stakeholder engagement meetings with state subject matter experts (SME) on Foundational Community Supports (FCS), Health-Related Social Needs (HRSN), Contingency Management, and

the Reentry initiatives. OHSU has shared detailed analytic plans for HRSN and Reentry. The State's next deliverable, the mid-point assessment, is due to CMS August 28, 2026. While work on the mid-point assessment has begun, the State awaits the full CMS mid-point assessment guidance to ensure compliance. The State continues to collaborate with OHSU to ensure sufficient data availability to support the interim evaluation, due to CMS on June 30, 2027.

In parallel with OHSU's evaluation activities, the State's internal performance monitoring efforts are also progressing. The State is working with CMS to address differences between CMS's annual monitoring report timeline and the State's data maturation timeline. Additionally, the State continues to identify relevant data sources, particularly for HRSN, and to build the reporting infrastructure necessary to support ongoing monitoring and evaluation activities.

Post-Award Public Forum

Provide a summary of the most recent annual post-award public forum indicating any resulting action items or issues. Include a summary of the public comments for the period during which the forum was held.

Washington held the MTP 2.0 Public Forum on December 11, 2024, via a one-hour virtual webinar. The forum included an overview of all projects under the Section 1115 waiver, with deeper dives into the Reentry Demonstration Initiative, HRSN services, Foundational Community Supports, and Long-Term Services and Supports. 293 people attended the event.

The webinar also provided the opportunity for the public to comment and ask questions. Most of the comments were on the Reentry Demonstration Initiative, health-related social needs (HRSN) services, and FCS. During the Q&A period, the HCA team answered questions about how MTP is funded and detailed the total budget allocated for the programs. HCA also answered questions about implementation timelines for the waiver programs. Additionally, there were questions from Medicaid clients and providers about how to connect with the HRSN services. These questions gave us the opportunity to explain the role of the Accountable Communities of Health and describe the screening and referral pathways via Community Care Hubs.

Our primary action item from the forum was to expand the educational materials and resources on our MTP public facing website to further address the questions

Provider Payment Rate Increase

Attest that any required FFS and managed care provider rate increases for primary care services, obstetric care services, and behavioral health services, subject to the STCs, were at least sustained from, if not higher than, the previous year.

The state attests that the provider rate increases for primary care services and behavioral health services were sustained and higher from the prior year.

Collecting and Providing Eligibility Information for Beneficiaries who Qualify for Continuous Eligibility

Describe successes and challenges related to activities to annually update beneficiary contact information, provide beneficiaries reminder of continued eligibility, verify beneficiary residency, and confirm that the beneficiary is not deceased, for all beneficiaries who qualify for a continuous eligibility period that exceeds 12 months.

Children under the age of six enrolled in Medicaid and CHIP are eligible for continuous coverage periods that exceed 12 months. System support is vital in facilitating annual reminders and verifications. Annually, an ex parte renewal is completed for these children, automatically reviewing their eligibility by comparing application information with data sources such as the Federal Hub and the Public Assistance Reporting Information System (PARIS). This process confirms that the beneficiary maintains state residency and is not deceased. Following this verification, a notice and pre-populated renewal form are sent to the family, allowing them to update contact information and provides a reminder of the child's continued eligibility.

Additional processes are in place when returned mail is received or when a child appears in the quarterly PARIS report. For returned mail, staff use multiple modalities to verify and update the family's address and residency. For children identified through the PARIS report, an information request letter is sent to the family to confirm the child's Washington State residency.

SMI/SED MOE Funding Outpatient Community-Based Mental Health Services

Provide the dollar amount, including the level of state appropriations and local funding for outpatient community-based mental health services, for the most recently completed state fiscal year (specify the start and end dates as MM/DD/YYYY).

$29,215,969 for SFY25 (07/01/2024 – 06/30/2025)

Describe and explain any reductions in the MOE dollar amount below the amount provided in the state's application materials. If true, the state should confirm that it did not move resources to increase access to treatment in inpatient or residential settings at the expense of community-based services.

There was no reduction.

Activities to Support Early Intervention in SMI/SED

Describe activities to promote the availability and use of early intervention services such as screenings, structured assessments, and brief initial interventions. Discuss any challenges encountered and changes in the approach outlined in past monitoring reports, if applicable.

There are no changes in the approach. Washington state continues to promote the availability and use of early intervention services through screenings, structured assessments and brief initial interventions with robust managed care contract requirements which ensure all of contracted PCPs are offered training for screening of behavioral health conditions with age-appropriate tools, brief intervention and referral to treatment for enrollees aged 13 and older, application of evidence based and promising practices for behavioral health conditions commonly occurring in primary care, and identification of individuals with first episode psychosis.

Bi-Directional behavioral and physical health integration continues to be emphasized with progress tracked at 6-month intervals. Washington continues to expand access to screening and early intervention through Washington State's crisis system, and Partnership Access Lines (PALS) which can provide advice to PCPs for children's mental health care, additional PALs include the Mental Health Referral Service for Children and Teens PAL, and the Psychiatry Consultation Line (PCL) which connects PCPs in Washington seeking clinical advice for patients 18 and older with faculty psychiatrists at UW Medicine. Statewide access to the New Journey's first-episode psychosis program continues to expand.

Activities to Support Crisis Stabilization Services

Describe activities to increase access to and utilization of crisis stabilization services, specifically crisis stabilization services for mental health and substance use disorders, including mobile crisis units, crisis observation and assessment centers, crisis stabilization units, and coordinated community crisis response teams. Discuss any challenges encountered and changes in the approach outlined in past monitoring reports, if applicable.

Activities to increase access to and utilization of crisis stabilization services in DY9 included enhancing crisis response services through co-response integration and support and planning for a statewide Administrative Services Organization for AI/AN enrollees. No challenges or changes in approach.

Case Management and Care Coordination

Describe activities to connect beneficiaries to services, including primary or behavioral health (specifically, mental health and substance use disorder) care or services to address health-related social needs, including for beneficiaries transitioning from institutional settings, if applicable. Discuss any challenges encountered, changes in the approach outlined in the implementation plan(s), and any changes to the timeline, if applicable.

HRSN

Under the waiver's HRSN services, there is an approved case management, outreach, and education service, which Washington is referring to as the HRSN screening and referral service publicly. This service is provided by the Community Care Hubs (CCH), established by the Accountable Communities of Health (ACHs), and includes screening, referral, and community-based care coordination of health-related social needs services and community resources for individuals to improve and manage their health. With the approval of the HRSN infrastructure protocol, ACHs received infrastructure funding for developing CCHs starting July 2023.

Several challenges occurred during implementation. The first was a delay in the service start date. Though originally planned for a go-live date of July of 2024, delays in the HRSN services protocol approval led to a delayed implementation of January of 2025. Another challenge that arose during implementation stemmed from CCHs utilizing five different client management systems across the nine Hubs. While each system is sufficiently sophisticated to track regional outcomes, assessing performance on a statewide scale has proven difficult. Each system has different designations used to denote key transition points within a client journey. To address these challenges, the State has built a nuanced performance and monitoring strategy to ensure compliance. Throughout 2025, the State worked with CCHs to standardize key definitions and measure reporting specifications to monitor performance. The State conducted 1:1 technical assistance with each CCH to better understand each client management system in operation and build a template for individual-client level reporting. The State also onboarded the community care hubs into the State's claim submission technology, ProviderOne. Onboarding Community Care Hubs into ProviderOne took eight months from start to finish. The go-live date for ProviderOne is planned for November 1, 2025.

SMI

The state maintains robust contract requirements in its state dollar funded wrap around contracts with managed care organizations related to coordination and discharge planning for state hospitals, state psychiatric care facilities, and long-term civil commitment (LTCC) facilities and requires MCOs to link enrollees to appropriate community providers as soon after admission as possible to support timely discharge and participate in discharge planning which supports timely discharge in accordance with the Enrollee preferences, including Enrollee choice to live in their own home or in the most integrated community setting appropriate for their needs. State hospitals have recently rolled out a new electronic Transfer, Discharge, Planning System or TDPS, it has shifted communication from paper forms to electronic transmittals for discharge planning coordination between state hospitals and managed care entities.

Implementation Planning and Capacity Building Expenditures

Describe activities undertaken, as well as any deviations from the STCs, post-approval protocols, and/or implementation plan, as may be applicable, regarding intended uses, amounts, and recipients of allowable implementation planning, capacity building, infrastructure, and transitional non-service expenditures, including any applicable changes to the timeline. In case of any deviation from previous reporting, include a discussion of corrective steps the state has implemented or will implement.

HRSN

In DY9, HCA administered infrastructure payments to all 9 ACHs, totaling $54,883,273 with an additional $1.75 million to distribute to Medical Respite Care providers. Eligible entities that deliver an HRSN service can apply to receive these funds directly from ACHs to support activities related to provider standup. Additionally, $595,644 was set aside in infrastructure funding to support the Community Information Exchange program (CIE).

In DY9, the CIE program established foundational program elements (sponsorship, charter, staffing, etc.) in preparation for the next phases of the initiative. Since its 2022 landscape assessment, HCA has updated its understanding of any changes related to the establishment of CCHs and their supporting technology to implement HRSN services. The CIE program developed and released a procurement for a lead organization

partner in May 2025, with selection and contracting expected to be completed in October 2025. The lead organization will be tasked with establishing community governance, standards for CIE data exchange, and implementing technology for statewide CIE.

Reentry

The carceral facilities will start providing services in DY10, phasing in with three cohorts. DY9 was a critical year for planning and capacity building. Capacity building funds were provided to facilities as they completed milestones such as completing an intent to participate form and contractual agreement with HCA, completing a Capacity Building Application (CBA) including an implementation plan and budget, and completing a readiness assessment attesting to the facility's current and/or planned readiness to support pre-release services.

In DY9, the twelve carceral facilities in Cohort 1 accomplished these milestones and HCA released the capacity building funds allocated to support planning and implementation. These funds were used for technology and IT services, hiring and training of staff, and development of protocols and procedures. The Cohort 1 start for implementation will be in DY10 (July 1, 2025). Cohort 2 accomplished milestones 1 and 2, and Cohort 3 accomplished milestone 1. These cohorts also received capacity building funds to support planning and implementation. In DY9, HCA received and reviewed a total of thirty-four CBAs for Cohorts 1 and 2 and established follow-up interviews for these facilities. HCA also conditionally approved the readiness assessments for twelve facilities in June 2025 to start services in DY10 as part of Cohort 1.

Partnerships with Providers and Other Key Entities

Describe coordination among key entities participating in the demonstration, including activities to establish and sustain informal or formal partnerships (such as through a contract, memorandum of understanding, or letter of agreement). For example, for demonstrations with an SDOH/HRSN policy, describe partnerships with health care providers, health plans, and SDOH/HRSN providers, including details on enrolling qualified providers to provide SDOH/HRSN services in the demonstration. For demonstrations with a reentry policy, describe coordination and communication among corrections systems, including the probation and parole system, health care providers and provider organizations, the State Medicaid Agency, and supported employment and supported housing agencies or organizations. Discuss any challenges encountered and any changes to the key entities, approach, or timeline outlined in the implementation plan or other protocols required by the STCs.

HRSN

Starting February 2025, Department of Social and Health services began implementing HRSN Rent and Temporary Housing for Home and Community Services (HCS) clients. The state will continue to implement housing subsidies through HCA contracts and DSHS contracts to administer up to 6 months of rental assistance and/or temporary housing on behalf of eligible participants. HCA accepted applications for a public housing authority (PHA) to administer the rental subsidies service on behalf of participants enrolled in the Foundational Community Supports program and chose Spokane Housing Authority (SHA) for this role. Participants will be determined to be eligible for FCS CSS through standard eligibility processes managed by the TPA, Wellpoint. Additional screening by FCS CSS providers and/or the Community Care Hubs will inform HCA of additional need for housing support offered through the rent and temporary housing benefit. SHA will contract with landlords and other PHAs to make rental payments on behalf of eligible participants authorized by HCA. HCA also aims to enter into an interlocal agreement with the Washington State Department of Commerce to administer a portion of the rent and temporary housing benefit for certain individuals who are eligible for the Apple Health and Homes (AHAH) housing benefit and create referral pathways for the Community Behavioral Health Rental Assistance Program (CBRA) benefit. These state-funded long-term subsidies provide certain HRSN-eligible enrollees with an opportunity to obtain permanent housing and/or a long-term housing subsidy that prioritizes the FCS-enrolled or eligible population (in the case of CBRA beneficiaries) based on their health-based needs and social risk factors.

The state is partnering with DSHS to also administer nutrition supports, caregiver respite, and home accessibility, remediation, and adaptation services under the waiver. HCA will be amending current contracts with DSHS to provide these services with waiver funds and expand existing services through the network of Area Agencies on Aging (AAA), as well as providers contracted with the Developmental Disabilities Community Services (DDCS)s. Clients must meet the appropriate social and clinical risk factors for a given service administered by providers contracted with AAAs or DDCS. Additional nutrition supports, caregiver respite, and home accessibility, remediation, and adaptation services will be expanded to broader priority populations (not eligible for LTSS or DDCS services), including post-acute care clients, FCS-enrolled clients, and individuals recently released from incarceration, later in DY10.

Reentry

Throughout DY9, HCA continued to engage several advisory groups, including the Washington Association of Sheriffs and Police Chiefs and the Re-entry Advisory Workgroup (RAW). RAW, initially mandated by legislation, offers guidance on reentry program design and implementation. It comprises representatives from state agencies, carceral facilities, associations, community-based organizations, and other justice-involved policy leaders. RAW collaborates to improve reentry services. Furthermore, HCA ensures alignment with Reentry Initiative requirements through coordination with DOC, DCYF, and Juvenile Detention Facilities. Several implementation subgroups have been formed to work on various aspects such as facility and provider readiness, pharmacy, provider enrollment, system changes, care management continuity, pre-release and post-release, eligibility and enrollment, and benefit design for the pre-release period.

Starting in January 2025, the MTP team hosted a learning series for carceral facilities interested in participating in Cohort 1 and Cohort 2 of the Reentry Initiative. The webinars covered specific Reentry-related topics to assist facilities in understanding the initiative. On average, over 115 attendees from across the state joined the webinars each week. Other MTP stakeholders, such as managed care organizations (MCOs), Department of Corrections (DOC), and Department of Children, Youth, and Families (DCYF) also attended these webinars. In DY9, HCA updated the MTP public-facing webpage focusing on the Reentry Initiative to include the learning series webinars, and new materials available to assist facilities participating in the Reentry Initiative.

Beneficiary Engagement

Describe the activities that the state undertook to solicit input from Medicaid beneficiaries to identify barriers to participation and inform decisions about implementation, monitoring, and evaluation of the SDOH/HRSN and/or reentry demonstration(s).

HRSN

Health Care Authority has engaged with various stakeholders to inform service development and implementation for various HRSN services. In DY9, the Medicaid Transformation Project team partnered with the HCA Division of Behavioral Health and Recovery to engage with the Washington Family Youth System Partner Round Table (which convenes families, youth, system partners, and community members to improve behavioral health services and supports for children, youth, and their families) on the development and implementation of HRSN caregiver respite services. HCA is engaged with various housing workgroups including the Permanent Supportive Housing Advisory Council, and the Foundational Community Supports advisory council, which both include past, current, and prospective participants in various Medicaid-funded services. These groups routinely provide input on access to services, provider quality, and service quality to inform the state of opportunities for improved coordination and monitoring of waiver funded services.

Reentry

In December 2024, information on the Reentry Initiative was presented at the MTP 2.0 Annual Public Forum and questions fielded from providers, facilities, and beneficiaries. In DY9, HCA updated the MTP public-facing

webpage focusing on the Reentry Initiative to include educational materials on the program and progress towards implementation for Medicaid clients and the public.

Phasing-In of Services

Describe any changes to the state's plan for phasing-in of services, regions, or facilities, if applicable. Discuss any challenges encountered, changes in the approach outlined in the implementation plan, and any changes to the timeline, if applicable.

HRSN

Washington State identified a three-part approach to phasing in HRSN services. The first phase of services leveraged existing state resources to expand work related to housing supports, Community Care Hubs, and Recuperative Care and Post-Hospitalization Housing -- known as Medical Respite Care. These initiatives built off existing waiver services or state-only investments (in the case of Medical Respite Care) with a clear implementation pathway once the HRSN Services Protocols were approved. The second phase of services focused on Nutrition Supports, Home Modifications, and Caregiver Respite services, leveraging existing infrastructure with the Department of Social and Health Care Services and their contracts with Area Agencies on Aging and Developmental Disabilities Community Services providers to serve long-term care and developmental disability clients. HCA anticipates launching the second phase of services early to mid DY10, followed by the third phase of services at the start of DY11. This third phase would include the Managed Care Organizations administering nutrition supports, home accessibility, remediation, and adaptation services, as well as caregiver respite services for clients who don't qualify for LTSS or DD services. This work is currently under development.

Reentry

During DY9, Washington State was more clearly able to define the implementation timeline for the TPA, including delays associated with the IT security review and data sharing agreements. The Claims Clearinghouse function was estimated to be ready on November 1, 2025. Therefore, in DY9, Washington State identified two groups within Cohort 1: facilities that had the capacity to go-live without a TPA and therefore implement as planned on July 1, 2025, and facilities that would need the TPA to implement claims processing and therefore would shift to a Nov 1 go-live date. Other than this split of Cohort 1 into two groups, there were no other changes to the state plan.

SDOH/HRSN Activities to Assist Beneficiaries in Obtaining Non-Medicaid Funded Housing and Nutrition Supports

Describe the activities the state has undertaken to assist beneficiaries in obtaining non-Medicaid funded housing and nutrition supports, including progress made since the state's last reporting. The state should describe whether and to what extent beneficiaries are accessing the non-Medicaid funded supports. Include discussion of any deviations from the Implementation Plan or the Protocol for SDOH/HRSN Services, including any changes to the timeline, if applicable, and information about mitigation steps the state has implemented or will implement to address any such deviation.

The state has taken careful consideration when developing connections with non-Medicaid funded housing services. The design of the rent/temporary housing service intentionally supports clients eligible for long-term, state-funded rental assistance programs including the Apple Health and Homes initiative and rental assistance available through DSHS Home and Community Services (HCS). In February 2025, the first recipients to receive HRSN rental assistance were authorized through HCS. Many of these clients will be eligible to receive state-funded rental assistance as they transition off of the HRSN benefit, while others will transition to other non-Medicaid funded housing.

HCA anticipates the launch of the Apple Health and Homes initiative in Q1 of DY10. This initiative provides state-funded rental assistance for certain individuals enrolled in Foundational Community Supports. HCA designed

the HRSN housing services eligibility criteria to match the AHAH initiative, intentionally aligning the benefits and assist program participants find and maintain stable housing using Medicaid funded services and supports, while state-funded subsides provide support for longer-term housing.

HCA and DSHS continue to assess similar pathways to transition clients from Medicaid funded nutrition supports to other longer-term resources. Currently, no HRSN nutrition supports are available to Medicaid clients, however, the state aims to create similar connections to longer-term resources as part of the planning and implementation of the nutrition support services.

SDOH/HRSN MOE Funding Housing and/or Nutrition Programs

Provide the dollar amount of state funding for social service programs related to housing supports and/or nutrition supports for the most recently completed state fiscal year (specify the start and end dates as MM/DD/YYYY). For annual reporting, the state should use the same methodology used in the baseline MOE report whenever possible. Otherwise, the state should provide an explanation for the deviation from the baseline methodology.

SFY25 (07/01/2024 - 06/30/2025) $66,121,848

Describe and explain any reductions in the MOE dollar amount below the amount provided in the baseline spending submission. If accurate, the state should confirm that it did not move resources to increase access to approved Medicaid section 1115 housing supports and/or nutrition supports that address SDOH/HRSN at the expense of pre-existing social services in those categories. This may involve explaining any deviations from the methodology used in the baseline MOE report.

There were no reductions in the MOE dollar amount. The state did not move resources to increase access to approved Medicaid section 1115 housing supports and/or nutrition supports.

Summary of additional resources, enclosures, and attachments

To learn more about MTP 2.0, **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: 1115 Waiver Demonstration Metrics Workbook**
- **Attachment C: MTP Expenditure Report**

Attachment A: State contacts

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

Area	Name	Title	Phone
MTP and quarterly reports	Emma Oppenheim	Director, Medicaid Transformation Project	360-725-0868
DSRIP program	Kahlie Dufresne	Deputy Policy Director, SPI	360-280-4019
LTSS program	Resa Lee-Bell	MTP Waiver Program Manager, DSHS	360-725-2531
FCS program	Rayan Orbom	Program Administrator, Foundational Community Supports	360-725-5286
SUD IMD waiver	David Johnson	Federal Programs manager	360-725-9404
MH IMD waiver	David Johnson	Federal Programs manager	360-725-9404
Continuous Eligibility	Maggie Clay	EPICS Deputy Section manager	360-725-1079
HRSN	Matt Christie	HRSN Manager, Medicaid Transformation Project	360-725-2078
Native Hub	Lena Nachand	Tribal Liaison, Office of Tribal Affairs	360-725-1386
Reentry	Tyron Nixon	Transformation Implementation Manager, MPD	360-725-9711
Contingency Management	Lora Weed	Acting Project Director, State Opioid Response Grant, State Opioid Response Treatment Manager	360-725-1998

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: 1115 Waiver Demonstration Metrics Workbook

The **MTP Annual Monitoring Report DY9 Metrics Workbook** that Washington submitted to CMS is available as an Excel workbook. CMS provided one tab for base metrics, one tab for each possible demonstration policy, and a tab for state-specific metrics. The metric tabs in this workbook include:

- Base Metrics
- SMI-SED Metrics
- SUD Metrics
- State-Specific Metrics
- Metrics Context

Attachment C: MTP Expenditure Report

The **MTP Expenditure Report for 2025** is available.

Washington State Health Care Authority

Medicaid Transformation Project

Health Care Authority	SFY 24-25	SFY 24	SFY 25	SFY 24-25	SFY 26-27	SFY 26	SFY 27	SFY 26-27
	Budget	Expenditures to Date	Expenditures to Date	Total Expenditures	Budget	Expenditures to Date	Expenditures to Date	Total Expenditures
MTP 2.0	**$ 555,439,770**	**$37,116,541**	**$141,026,420**	**$178,142,960**	**$ 845,509,300**	**$48,501,568**	**$0**	**$48,501,568**
Admin (GF-F)	$ 12,621,650	$2,357,769	$3,427,678	$5,785,448	$ 5,801,000	$630,630	$0	$630,630
HRSN Infrastructure (GF-F)	$ 50,421,000	$16,200,503	$28,724,527	$44,925,030	$ 57,245,000	$23,613,855	$0	$23,613,855
HRSN Services (GF-F)	$ 279,080,406	$0	$40,174,334	$40,174,334	$ 584,871,250	$6,300	$0	$6,300
Admin (GF-L)	$ 12,621,650	$2,357,764	$3,427,670	$5,785,434	$ 5,801,000	$630,628	$0	$630,628
HRSN Infrastructure (GF-L)	$ 50,421,000	$16,200,503	$28,724,527	$44,925,030	$ 57,245,000	$23,613,855	$0	$23,613,855
HRSN Services (GF-L)	$ 150,274,065	$0	$36,547,684	$36,547,684	$ 134,546,050	$6,300	$0	$6,300
DSHP	**$0**	**$0**	**$0**	**$0**	**$335,000,000**	**$15,792,288**	**$0**	**$15,792,288**
Admin (GF-F)	$0	$0	$0	$0	$335,000,000	$15,792,288	$0	$15,792,288
Re-entry	**$121,570,000**	**$0**	**$44,520,189**	**$44,520,189**	**$156,579,000**	**$6,403,383**	**$0**	**$6,403,383**
Re-entry Admin (GF-F)	$60,785,000	$0	22,203,937.98	$22,203,938	$62,261,000	$3,075,570	$0	$3,075,570
Re-entry Admin (GF-L)	$60,785,000	$0	22,316,251.26	$22,316,251	$62,261,000	$3,075,570	$0	$3,075,570
Re-entry Service (GF-F)					$27,523,000	$203,778	$0	$203,778
Re-entry Service (GF-S)					$4,534,000	$48,465	$0	$48,465
Initiative 2 - DSHS MAC/TSOA**	$101,367,000	$22,967,374	$40,529,663	$63,497,037	$122,440,000	1,340,707.62	$0	$1,340,708
MAC/TSOA & Staffing(GF-F) Admin	$50,683,000	$11,584,822	$20,264,832	$31,849,654	$28,682,000	109,998.22	$0	$109,998
MAC/TSOA & Staffing (GF-L) Admin	$50,684,000	$11,382,552	$20,264,831	$31,647,383	$28,683,000	109,998.21	$0	$109,998
Mac & Tsoa (GF-F) Service					$32,531,000	560,355.60	$0	$560,356
Mac & Tsoa (GF-L) Service					$32,544,000	560,355.59	$0	$560,356
Initiative 3- FCS	$1,580,000	$947,609	$2,823,508	$3,771,118	$2,740,000	$43,918		$43,918
DSHS FCS ADMIN (GF-F)	$790,000	$473,805	$645,016	$1,118,821	$1,370,000	$21,959	$0	$21,959
DSHS FCS ADMIN (GF-L)	$790,000	$473,804	$645,016	$1,118,820	$1,370,000	$21,959	$0	$21,959
Presumptive Eligibility	**$14,141,000**	**$56,353**	**$4,210,325**	**$4,266,677**	$74,561,000	$628,844		$628,844
Presumptive Eligibility (GF-F)	$7,070,000	$28,176	$2,105,163	$2,133,340	$37,280,000	$314,422	$0	$314,422
Presumptive Eligibility (GF-L)	$7,071,000	$28,176	$2,105,162	$2,133,338	$37,281,000	$314,421	$0	$314,421
Rental Subsidies			$1,427,390		$32,620,000	$42,987		$42,987
Rental Subsidies (GF-F)			$713,695		$16,310,000	$21,493	$0	$21,493
Rental Subsidies (GF-L)			$713,695		$16,310,000	$21,493	$0	$21,493
Coordinated Personal Care					$57,912,000			
Coordinated Personal Care (GF-F)					$28,956,000			
Coordinated Personal Care (GF-L)					$28,956,000			
Guardianship / Informed Decision Making					$2,292,000			
Guardianship / Informed Decision Making (GF-F)					$1,146,000			
Guardianship / Informed Decision Making (GF-L)					$1,146,000			
Initiative 3 - FCS	**$67,882,000**	**$48,395,675**	**$39,834,332**	**$88,230,007**	**$190,620,000**	**$10,266,515**	**$0**	**$10,266,515**
FCS SE ADMIN (GF-F)	$ 1,234,500.00	$749,307	$896,867	$1,646,174	$ 2,348,000.00	$294,559	$0	$294,559
FCS SE ADMIN (GF-L)	$ 1,234,500.00	$746,016	$896,867	$1,642,882	$ 2,348,000.00	$294,559	$0	$294,559
FCS SE SERVICES (GF-F)	$ 15,199,680.00	$9,538,476	$10,473,898	$20,012,374	$ 42,089,510.00	$2,387,068	$0	$2,387,068
FCS SE SERVICES (GF-L)	$ 6,208,320.00	$3,874,661	$4,243,060	$8,117,721	$ 17,191,490.00	$953,654	$0	$953,654
FCS SH ADMIN (GF-F)	$ 2,922,500.00	$1,878,516	$1,945,304	$3,823,820	$ 6,311,500.00	$590,594	$0	$590,594
FCS SH ADMIN (GF-L)	$ 2,922,500.00	$1,871,071	$1,945,304	$3,816,375	$ 6,311,500.00	$590,594	$0	$590,594
FCS SH SERVICES (GF-F)	$ 27,093,600.00	$20,895,225	$13,689,790	$34,585,015	$ 80,954,200.00	$3,663,317	$0	$3,663,317
FCS SH SERVICES (GF-L)	$ 11,066,400.00	$8,842,403	$5,743,244	$14,585,646	$ 33,065,800.00	$1,492,170	$0	$1,492,170
Agency Admin (GF-F)	$0	$0	$0	$0	$0	$0	$0	$0
AHAH & Transition & Rent	**$34,653,000**	**$0**	**$0**	**$0**	**$106,750,000**	**$0**	**$0**	**$0**
Transition and Rent (GF-F)	$10,050,000			$0	$29,313,000	$0	$0	$0
Transition and Rent (GF-L)	$10,050,000			$0	$29,312,000	$0	$0	$0
Apple Health and Homes Admin (GF-F)	$914,000			$0	$2,398,500	$0	$0	$0
Apple Health and Homes Admin (GF-L)	$914,000			$0	$2,398,500	$0	$0	$0
Apple Health and Homes Services (GF-F)	$9,035,000			$0	$30,763,500	$0	$0	$0
Apple Health and Homes Services (GF-L)	$3,690,000			$0	$12,564,500	$0	$0	$0

DSHS and HCA (Community Behavioral Health)	SFY 24-25	SFY 24	SFY 25	SFY 24-25	SFY 26-27	SFY 26	SFY 27	SFY 24-25
	Budget	Expenditures to Date*	Expenditures to Date*	Expenditures to Date*	Budget	Expenditures to Date*	Expenditures to Date*	Expenditures to Date*
Initiative 3 - FCS	**$4,522,000**	**$1,204,439**	**$1,062,114**	**$2,266,552**	**$4,732,000**	**$231,998**	**$0**	**$231,998**
FCS (GF-F)	$2,261,000	$602,220	$531,057	$1,133,278	$2,366,000	$115,999	$0	$115,999
FCS (GF-L)	$2,261,000	$602,218	$531,056	$1,133,275	$2,366,000	$115,999	$0	$115,999

*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.

Base Metrics Data and Trends

Technical specifications manual version: [Enter Technical Specifications Manual Version Number]

Metric Number	Metric Name	Metric Description	Data Source	Desired Directionality	Metric Trends and Explanation	Measurement Period	Dates Covered by Measurement Period	Demonstration Numerator or Count	Demonstration Denominator	Demonstration Rate/Percentage
EXAMPLE: BA_1 ***(Do not delete or edit this row)***	*EXAMPLE: Total Eligibility for the Demonstration*	*EXAMPLE: The unduplicated number of beneficiaries eligible for the demonstration and not suspended at any time during the measurement period. This indicator is the total number of unduplicated individuals in the overall demonstration. It includes those newly eligible for the demonstration during the measurement period and those whose eligibility continues from a prior period. This indicator is not a point-in-time count. It captures beneficiaries who were eligible for the demonstration for at least one day during the measurement period. For certain demonstration programs, this metric may capture the count of total program participation instead of count of individuals eligible for the program.*	*EXAMPLE: Administrative records*	*EXAMPLE: Consistent*	*EXAMPLE: This metric decreased by 5 percent due to an increase in eligibility redeterminations during Unwinding of continuous eligibility, resulting in more people being disenrolled from Medicaid and finding coverage in the Marketplace.*	*EXAMPLE: Month 1*	*EXAMPLE: 01/01/2024-01/31/2024*	*EXAMPLE: 650*	*EXAMPLE: n.a.*	*EXAMPLE: n.a.*
BA_1	Total Eligibility for the Demonstration	The unduplicated number of beneficiaries eligible for the demonstration and not suspended at any time during the measurement period. This indicator is the total number of unduplicated individuals in the overall demonstration. It includes those newly eligible for the demonstration during the measurement period and those whose eligibility continues from a prior period. This indicator is not a point-in-time count. It captures beneficiaries who were eligible for the demonstration for at least one day during the measurement period. For certain demonstration programs, this metric may capture the count of total program participation instead of count of individuals eligible for the program.	Administrative records	Decrease	*The total number of beneficiaries eligible for the demonstration remained consistent throughout the measurement year.Counts for April - June 2025 are likely undercounted because the data are not full mature. The data for this time period should be considered preliminary.*	Demonstration month 1	07/01/2024 - 07/31/2024	1,932,344		
						Demonstration month 2	08/01/2024 - 08/31/2024	1,928,148		
						Demonstration month 3	09/01/2024 - 09/30/2024	1,925,452		
						Demonstration month 4	10/01/2024 -10/31/2024	1,932,276		
						Demonstration month 5	11/01/2024 - 11/30/2024	1,932,481		
						Demonstration month 6	12/01/2024 - 12/31/2024	1,933,866		
						Demonstration month 7	01/01/2025 - 01/31/2025	1,932,764		
						Demonstration month 8	02/01/2025 - 02/29/2025	1,922,985		
						Demonstration month 9	03/01/2025 - 03/31/2025	1,919,598		
						Demonstration month 10	04/01/2025 - 04/30/2025	1,915,552		
						Demonstration month 11	05/01/2025 - 05/31/2025	1,902,405		
						Demonstration month 12	06/01/2025 - 06/30/2025	1,892,714		
BA_2	Appeals, Eligibility	Number of appeals filed by demonstration beneficiaries during the measurement period regarding Medicaid eligibility.	Administrative records	Decrease	*A total of 821 appeals related to Medicaid eligibility were filed by beneficiaries during the measurement year.*	Demonstration Year	07/01/2024 - 06/30/2025	*821*		
BA_3	Appeals, Benefits	Number of appeals filed by demonstration beneficiaries during the measurement period regarding benefits.	Administrative records	Decrease	*A total of 10,903 appleas related to benefits were filed by beneficiaries during the measurement period.*	Demonstration Year	07/01/2024 - 06/30/2025	*10,903*		
BA_4	Grievances	Number of grievances filed by demonstration beneficiaries during the measurement period.	Administrative records	Decrease	*Beneficiaries filed 24,893 grievances during the measurement period.*	Demonstration Year	07/01/2024 - 06/30/2025	*24,893*		
BA_5	Emergency Department Utilization, All Use	Total number of ED visits per 1,000 demonstration beneficiary months during the measurement period.	Claims and encounters; other administrative records	Decrease	*ED visits per 1,000 member months increased from 48 in Q3 2024 to 53 in Q1 in 2025. Counts for April - June 2025 are likely undercounted because the data are not full mature and the data is unavailable for this report.*	Demonstration quarter 1	07/01/2024 - 09/30/2024	*222,519*	*4,674,851*	47.60
						Demonstration quarter 2	10/01/2024 - 12/31/2024	*235,875*	*4,658,493*	50.63
						Demonstration quarter 3	01/01/2025 - 03/31/2025	*245,006*	*4,627,346*	52.95
						Demonstration quarter 4	04/01/2025 - 06/30/2025	*[Insert value here.]*	*[Insert value here.]*	#VALUE!
BA_6	Inpatient Admissions	Total number of inpatient admissions per 1,000 demonstration beneficiary months during the measurement period.	Claims and encounters and other administrative records	Decrease	*Inpatient admissions per 1,000 member months remained stable at approximately 8 admissions per 1,000 member months during the measurement period. Counts for April - June 2025 are likely undercounted because the data are not fully mature. The data for this time period is unavailable.*	Demonstration quarter 1	07/01/2024 - 09/30/2024	*37,182*	*4,674,851*	7.95
						Demonstration quarter 2	10/01/2024 - 12/31/2024	*37,259*	*4,658,493*	8.00
						Demonstration quarter 3	01/01/2025 - 03/31/2025	*38,203*	*4,627,346*	8.26
						Demonstration quarter 4	04/01/2025 - 06/30/2025	*[Insert value here.]*	*[Insert value here.]*	#VALUE!
BA_7	Plan All-Cause Readmissions (PCR-AD) [NCQA; CMIT# 561; Medicaid Adult Core Set; Adjusted HEDIS specifications]	For beneficiaries aged 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:	Claims and encounters	Decrease	*The observed 30-day readmission rate was approximately 9 percent during calendar year 2024. The observed-to-expected ratio was 1.04, indicating slightly more readmissions than expected given the case mix. Six percent of beneficiaries were identified as outliers.*	Calendar Year				
BA_7.1	Plan all-cause readmissions - index hospital stays	1. Count of Index Hospital Stays (IHS)		n.a	n.a		01/01/2024 - 12/31/2024	48113		
BA_7.2	Plan all-cause readmissions - observed 30 day readmissions	2. Count of Observed 30-Day Readmissions		n.a	n.a		01/01/2024 - 12/31/2024	4499		
BA_7.3	Plan all-cause readmissions - expected 30 day readmissions	3. Count of Expected 30-Day Readmissions		n.a	n.a		01/01/2024 - 12/31/2024	4288.89		
BA_7.4	Plan all-cause readmissions - beneficiaries in demonstration population	4. Count of beneficiaries in demonstration population		n.a	n.a		01/01/2024 - 12/31/2024	40,265		
BA_7.5	Plan-all cause readmissions - number of outliers	5. Number of outliers		n.a	n.a		01/01/2024 - 12/31/2024	2419		
BA_c_7a	Plan all-cause readmissions - observed 30-day readmission rate <<This Rate is Autocalculated>>	c_7a. Count of observed 30-day readmissions divided by the count of index hospital stays (BA_7.2 / BA_7.1)*100		n.a	n.a		blank	4499.00	48113.00	9%
BA_c_7b	Plan all-cause readmissions - expected readmission rate <<This Rate is Autocalculated>>	c_7b. Count of expected 30-day readmissions divided by the count of index hospital stays (BA_7.3 / BA_7.1)*100		n.a	n.a		blank	4288.89	48113.00	9%

Metric Number	Metric Name	Metric Description	Data Source	Desired Directionality	Metric Trends and Explanation	Measurement Period	Dates Covered by Measurement Period	Demonstration Numerator or Count	Demonstration Denominator	Demonstration Rate/Percentage
BA_c_7c	Plan all-cause readmissions - observed-to-expected ratio <<This Rate is Autocalculated>>	c_7c. Count of observed 30-day reasmissions divided by count of expected 30-day readmissions (BA_7.2 / BA_7.3)		n.a	n.a		blank	4499.00	4288.89	1.049
BA_c_7d	Plan all-cause readmissions - outlier rate <<This Rate is Autocalculated>>	c_7d. Number of outliers divided by count of beneficiaries in demonstration population (BA_7.5 / BA_7.4)*1,000		n.a	n.a		blank	2419.00	40265.00	6.008

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CMS = Centers for Medicare & Medicaid Services; CMIT = CMS Measures Inventory Tool; ED = emergency department; HEDIS = Healthcare Effectiveness Data and Information Set; NCQA = National Committee for Quality Assurance.
end of worksheet