STATE OF WASHINGTON

December 30, 2024

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.

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,

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

Jilma Meneses
Secretary
Department of Social and Health Services

Enclosures

By email

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

Washington State Health Care Authority

Washington State Medicaid Transformation Project 2.0 (MTP 2.0) demonstration

Section 1115 Waiver Quarterly Report

Demonstration Year (DY) 9 Reporting Period 1: July 1 through September 30, 2024

Table of contents

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 2.0 (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).
- 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.
- Contingency Management (CM) for SUD treatment: evidence-based intervention for SUD.
- Continuous enrollment: Continuous Apple Health enrollment for children ages 0 through 5 and Apple Health postpartum coverage expansion.
- Reentry from a carceral setting: 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 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.

Quarterly report: July 1–September 30, 2024

This quarterly report summarizes MTP activities from the third reporting period of MTP 2.0: July 1 through September 30, 2024. It details MTP implementation, including stakeholder education and engagement, planning and implementation, and development of policies and procedures, and continues the demonstration reporting as demonstration year 9 (DY9).

Summary of quarter accomplishments

- Accountable Communities of Health (ACHs) continue to distribute incentive funds to partnering providers through the Financial Executor (FE) portal. During the reporting quarter, ACHs distributed more than $39,549,523 to 14 partnering providers and organizations in support of project planning and implementation activities.
- During Q1, HCA has distributed $59,265,608 to ACHs for health-related social need (HRSN) infrastructure investments to support readiness for the delivery of Community Hub services.
- As of September 30, 2024, more than 18,560 clients, in addition to their family caregivers, have received services and supports through the Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) programs. The average caseload for the quarter was 4,394 clients. New enrollees for Long-Term Services and Supports (LTSS) for this quarter reporting period include 55 MAC dyads, 270 TSOA dyads, and 488 TSOA individuals.
- Within Foundational Community Supports (FCS), the total aggregate number of people enrolled in services at the end of this reporting period includes 5,508 in IPS and 10,411 in CSS. The total unduplicated number of enrollments at the end of this quarter reporting period is 12,814.
- Within Reentry from a carceral setting, HCA welcomed facilities into Cohort 1 and engaged in monthly meetings with participating facilities, one-on-one meetings to address facility-specific questions, and provided technical assistance sessions.

MTP 2.0-wide stakeholder engagement

During the reporting quarter, HCA continued its stakeholder engagement efforts:

Reentry Initiative engagement

HCA continues to foster relationships with carceral facilities, which includes state prisons, city and county jails, Tribal jails, and youth correctional facilities. This quarter, HCA launched a Cohort 1 discussion series to answer outstanding questions and to aid facilities that submitted the intent to participate form. The discussion series has provided participating facilities the opportunity to ask questions about next steps, timelines, and requirements. The following resources are available on the **Reentry Initiative webpage**:

- View the **September 23 slide deck**
- Watch the **July 23 recording**

This quarter, HCA has increased engagement and understanding of the Reentry Initiative by updating and posting new content on the Reentry Initiative webpage. New resources include:

- **Cohort 1 section of the webpage** with information such as Introduction to the Capacity Building Application (CBA), Attestations form, links to infrastructure budget funds, and initial participation requirements
- Successful reentry from incarceration infographic (see below)
- Updated **Reentry FAQ document**

Infographic 1: Successful reentry from incarceration

Housing and employment engagement

There were two public comment periods for HRSN services this quarter. See methodology and rate schedules below:

- Case management rate methodology and rate schedule
- Housing transition navigation services rate methodology and rate schedule

Learning Symposium

Although HCA no longer holds a formal learning collaborative/symposium once per year, HCA ensures ongoing opportunities for collaboration and shared learning among the nine ACHS and HCA staff. Weekly conference calls with ACH leadership provide a venue for updates from HCA, plus a forum for ACHs to provide feedback and share information with each other. In addition, quarterly calls with each ACH allow for more detailed, region-specific discussion. ACH leaders include staff in the quarterly calls at their discretion.

LTSS implementation accomplishments

This section summarizes Long-Term Services and Supports (LTSS) program development and implementation activities for Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) programs from July 1–September 30, 2024. Key accomplishments for this quarter include:

MAC and TSOA

As of September 30, 2024, more than 18,560 clients, in addition to their family caregivers, have received services and supports through the MAC and TSOA programs. The average caseload for the quarter was 4,394 clients.

Aging and Long-Term Support Administration (ALTSA) continues with the 2024 annual quality assurance cycle.

Expansion under 1115 demonstration waiver renewal, MTP 2.0, to further develop innovative projects, activities, and services for MTP participants was successfully implemented.

Expansion highlights include:

- Utilizing the updated TSOA income eligibility criteria (400 percent of the federal benefit rate), 67 new participants in the expanded eligibility tier accessed TSOA services this quarter.
- Utilizing the updated resource standard (six months of the current private nursing facility rate), 25 additional participants in the expanded eligibility tier accessed TSOA services this quarter.
- Increased utilization by care receivers for MTP 2.0 additional services include Pest Eradication, Specialized Deep Cleaning, and Community Choice Guiding services.

LTSS PE

As of September 30, 2024, LTSS PE has shown steady progress in phase 1, with approximately 290 clients seeking services and about 94% of those found eligible. A majority of LTSS PE eligible clients have transitioned to in-home services after assessing their functional and financial eligibility.

As phase 2 approaches with plans to expand access to LTSS PE, Region 1 has agreed to test phase 2 prior to statewide rollout. Concentrated efforts within Region 1 have included ongoing discussions with management, regional staff, and the Area on Aging Agency (AAA) to focus on staffing/caseload management, case sharing, training, data tracking, and identifying/resolving possible obstacles.

Regional staff raised concerns about the LTSS PE assessment functionality in phase 1, prompting collaboration with the CARE Web developers that led to enhancements including:

- Caregiver instructions
- Printing all collateral contacts on to the LTSS PE care plan
- Voice signature for LTSS PE care plan
- Case-sharing between HCS and the AAAs

Network adequacy for MAC and TSOA

AAAs continue to monitor already established contracts as well as continuing to execute additional contracts in relation to the MTP 2.0 additional services (Pest Eradication, Specialized Deep Cleaning and Community Choice Guide services). After recent policy and contract enhancements for non-medical Transportation, AAAs also continue to work on contracting with Transportation service vendors.

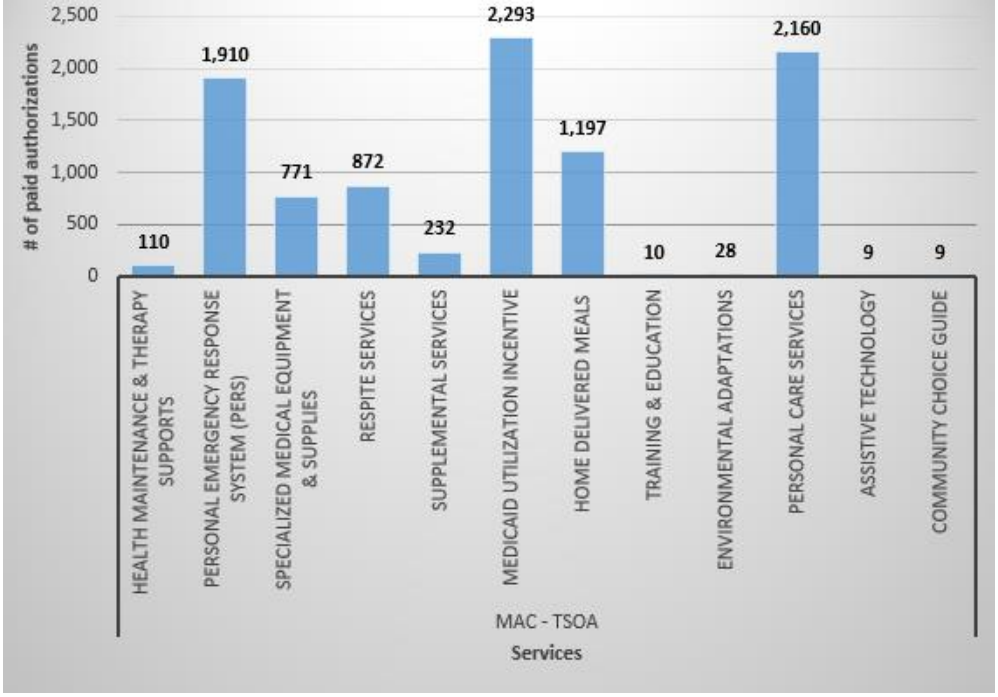
The statewide direct care workforce shortage continues to impact the availability of Respite and Personal Care providers. The MAC and TSOA programs successfully implemented the self-directed care model in June 2024 which has proven invaluable as it allows another option for care receivers to obtain their Respite and Personal Care needs. Since implementation of the self-directed care model, the MAC and TSOA programs have seen numerous successful referrals to Consumer Direct Care of Washington (CDWA) which is the contracted CDE (Consumer Directed Employer) provider for Washington state and appears to be lessening the impact of the shortage.

The MAC and TSOA programs continue to see utilization of alternative services and providers as a bridge when Personal Care or Respite workers are in short supply. Continued utilization of other services in the MTP service benefits package to meet participants needs include but are not limited to home delivered meals, personal emergency response systems, adult day care, and environmental modifications.

Service utilization

MAC and TSOA

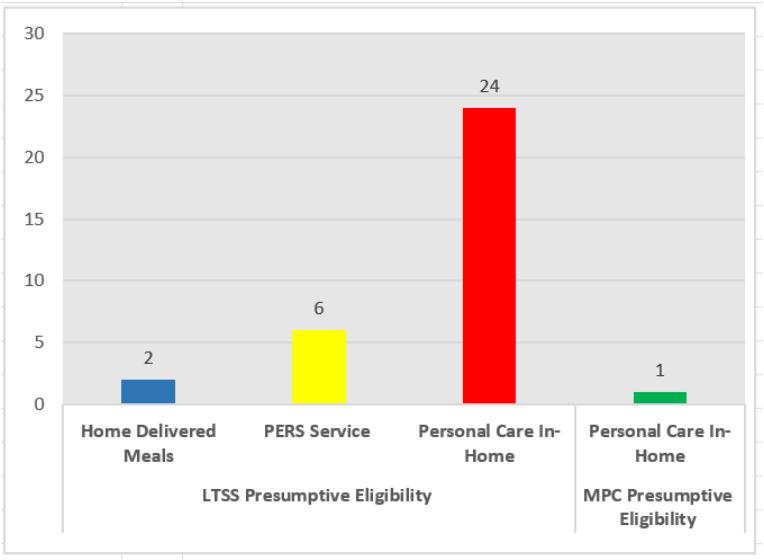
Figure 1: MAC and TSOA service utilization



LTSS PE

The graph below depicts the services that are currently being utilized during this quarter under LTSS PE. Please take note that the red bar represents NFLOC personal care, where the green bar represents MPC personal care.

Figure 2: LTSS PE services utilization



Assessment and systems update

MAC and TSOA

RTZ Systems, GetCare' s administrator, completed the interface between the GetCare case management system and CDWA's provider management system in June 2024. This interface allows case managers to send and receive required documents, as part of the referral process, to CDWA. The interface also allows CDWA to send pertinent case management notifications. During this quarter, continued system enhancements occurred with the interface data exchange, documents, and case manager notifications.

Expected future system updates include:

- Improvements to the person-centered care planning tools,
- Reduced processing time of recipient aid categories through the system interfaces,
- Streamlining Voter's Registration assistance process, and
- Implementation of a view option in GetCare for care receiver's eligibility status from WA State's payments system, ProviderOne.

ALTSA and community partners have recently started a project assisting TCARE Inc. to make necessary equity and inclusion changes to their evidence-based assessment process which is utilized for unpaid family caregivers in the MAC and TSOA programs. Project participants identified words and concepts in the TCARE assessment process that are either unknown in some cultures or are sensitive in nature, that would create an adverse situation for family caregivers who speak English as a second language or are non-English speaking who participate in Washington's Family Caregiver programs.

LTSS PE

During this quarter, the following CARE Web enhancements were completed:

- Caregiver instructions
- Printing all collateral contacts on to the LTSS PE care plan
- Voice signature for LTSS PE care plan
- Case-sharing between HCS and the AAAs

Future CARE Web enhancements that are being considered/developed include:

- Identifying shared cases with color tag
- Adding weight/skin concerns and bedbound indicators
- Case-sharing tickler notifications
- Keep the "Services" section of the Care Planning enabled
- LTSS financial updated for clients receiving MAGI-based health coverage

Staff training

MAC and TSOA

MAC and TSOA program managers for Home and Community Services are committed to providing monthly statewide training webinars on requested and needed topics during the report period. Below are the webinar trainings that occurred during this reporting period:

- July 2024: Open Office Hours – CDWA Systems and Functionality Training
- August 2024: Open Office Hours – CDWA Implementation Follow-up and Open Forum, Carina Information Training
- September 2024: No offerings provided

LTSS PE

Regular Q&A meetings are held with region 1 in preparation for testing phase 2. Region 1 specific meetings address case managers who have questions regarding the assessment process. HCS - Region 1 has arranged regular meetings with the AAAs to answer questions and provide LTSS PE documents, desk aids, workflows, and training materials. This information is also shared through a shared Teams channel for ongoing reference. Shadowing opportunities between HCS and AAA has been proposed to provide cross-training and support.

Region 1 has requested additional staff to conduct the LTSS PE assessment, as phase 2 will allow more people to be eligible for services. One staff has been hired/trained, and two more positions are being considered.

Data and reporting

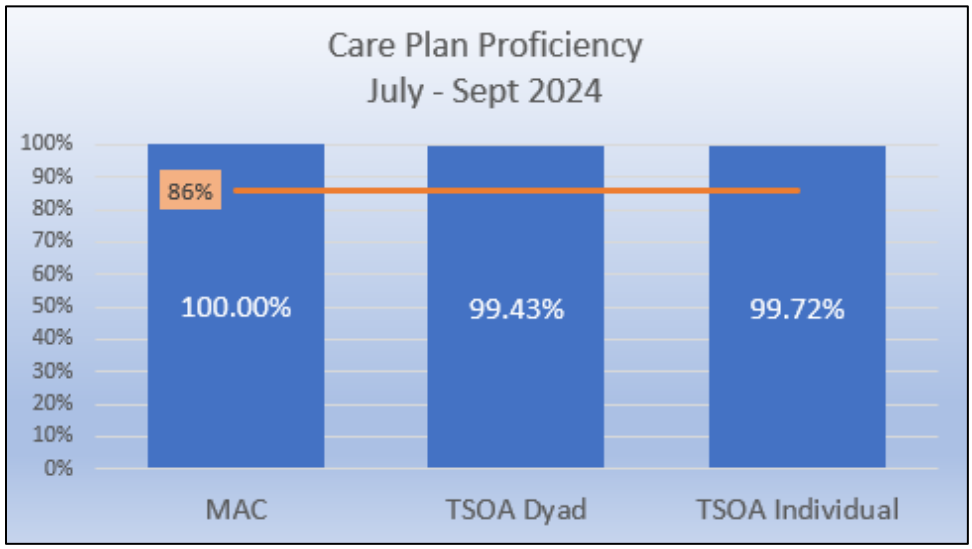
MAC and TSOA

Table 1: Beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of September 30, 2024	279	1,424	3,157
Number of new enrollees in quarter by program	55	270	488
Number of new person-centered service plans in quarter by program	21	85	191
Number of new enrollees who do not require a care plan because they are still in the care planning phase and services have yet to be authorized	34	185	298
Number of beneficiaries self-directing services under employer authority*	1	10	31

*The state has successfully implemented all necessary system enhancements for CDE for the MAC and TSOA programs. Effective June 26, 2024, MAC and TSOA participants have the option of self-directed services.

Figure 3: Statewide care plan proficiency to date



Note: The 86 percent line represents the CMS proficiency expectation.

The AAAs compliance with timely completion of care plans for enrollees continues to exceed proficiency.

LTSS PE

Table 2: Beneficiary enrollment by program

Month/Year of Service	LTSS Presumptive Eligibility (NFLOC)	MPC Presumptive Eligibility
July 2024 –September 2024		
Grand Total	27	2

Note: LTSS PE continues in phase 1. Totals reflect all three regions for those individuals who were found eligible for LTSS PE services during this quarter.

Tribal engagement

MAC and TSOA

DSHS Aging and Long-Term Support Administration (ALTSA) continues to meet with tribes to discuss Medicaid services including the MAC, TSOA, and FCS programs from July 1–September 30, 2024.

- July: ALTSA Tribal Affairs is currently contracting with Samish nation for Money Follows the Person Tribal Initiative (MFPTI) and completing quarterly check-ins which include reviewing available resources for unpaid caregivers in their community. This includes MAC & TSOA programs.
- August: ALTSA Tribal Affairs partnered with Yakama nation to provide a culturally responsive trauma informed care workshop for paid and unpaid caregivers. Information regarding MAC & TSOA programs was shared.
- September: ALTSA Tribal Affairs presented position information and MFPTI program goals at Long-Term Care initiative meeting including supportive role of MAC & TSOA programs. This is a milestone as it is the first time Tribal Affairs has participated at this meeting.

ALTSA Tribal Affairs continues building relationships with Tribal nations while sharing services supported by MFPTI including MAC & TSOA programs. Tribal Affairs has participated in meetings with MAC & TSOA program managers to

increase culturally responsive materials regarding MAC & TSOA to develop outreach for Tribal nations. MAC & TSOA and other programs for unpaid caregivers continue to be a focus when working with Tribal partners. Developing outreach materials that provide concise pertinent information for Tribal nations should increase the utilization of this program for Tribal nations. This effort will continue into 2025.

Outreach and engagement

MAC and TSOA

ALTSA's MAC and TSOA Program Manager continues to seek indigenous volunteers to participate in interviews for the Caregivers Program video and are hoping to work with ALTSA Tribal Affairs soon to create outreach materials which are tribal specific.

In conjunction with a department wide rebranding refresh, ALTSA staff will continue to collaborate with the AAAs on updating outreach materials and brainstorming ideas for new publications to engage community members.

Table 3: Number of outreach and engagement activities held by Area Agencies on Aging

	July	August	September
Community presentations and information sharing	87	109	78

There was an overall increase in outreach and engagement activities though the volume and type of outreach activities continues to fluctuate.

LTSS PE

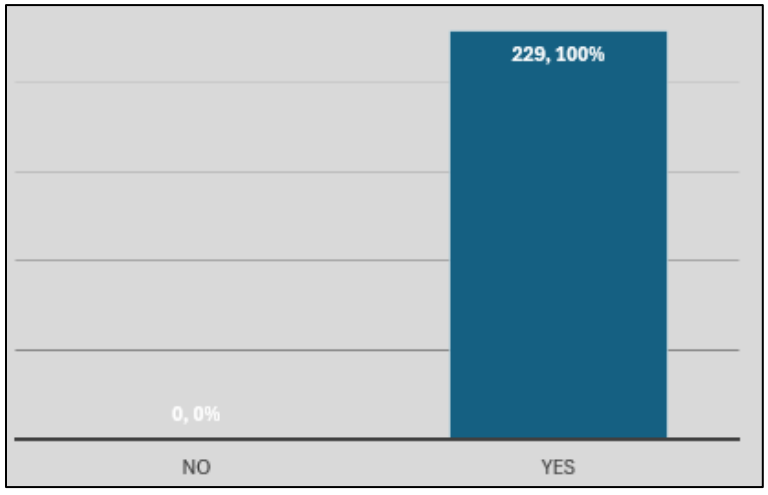
ALTSA's LTSS presumptive eligibility (PE) program manager attended the Indian Policy Advisory Committee (IPAC) for ALTSA on July 9, 2024. Education was delivered regarding eligibility criteria and the services available through LTSS PE, along with a fact sheet intended for distribution to interested individuals or organizations.

Quality assurance

Results of the quarterly PE quality assurance review are outlined below:

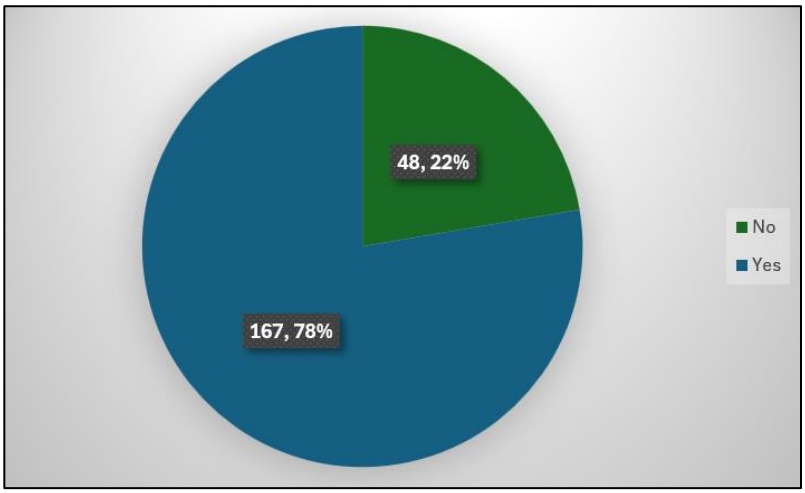
MAC and TSOA

Figure 4: Question 1: Was the client appropriately determined to be nursing facility level of care eligible for PE?



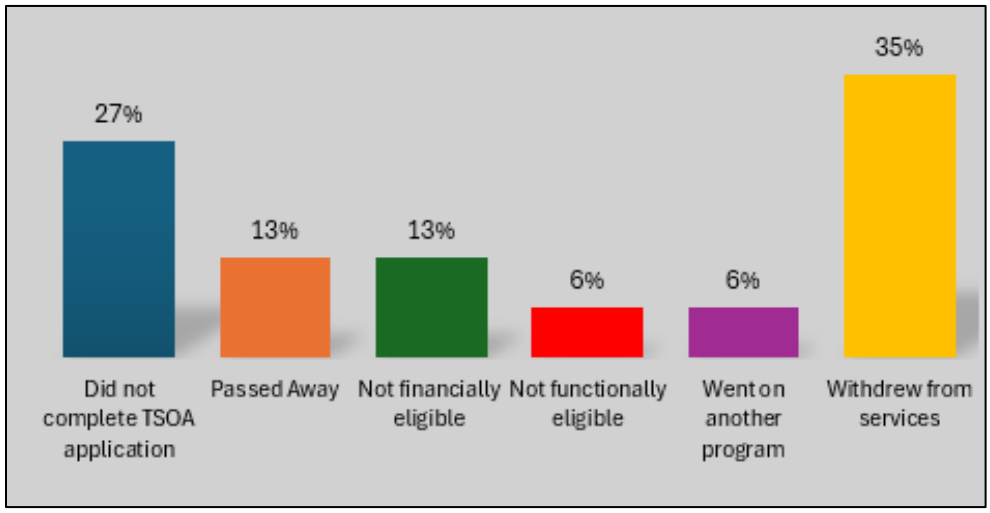
Note: 229 beneficiaries were appropriately determined NFLOC eligible with 100% success rate. 57 beneficiaries are not applicable as they have been reported on previously and the beneficiary's full eligibility determination occurred during this quarter.

Figure 5: Question 2a: Did the client remain eligible after the PE period?



Note: 167 beneficiaries (78%) transitioned from PE to full eligibility. 71 beneficiaries this quarter are still pending full eligibility and were therefore not applicable. 48 beneficiaries (22%) did not remain eligible after the PE period.

Figure 6: Question 2b: If "No" to Question 2a, why?



Note: These percentages represent the "No" population in the previous table, 48 participants (22%) outlined above. For example, the 13 percent of PE clients found to be not financially eligible, are out of the 48 participant, whom did not remain eligible after the PE period illustrated in the Table for Question 2a.

LTSS PE

Figure 7: Question 1a: Did the client remain eligible for in-home services after the PE period?

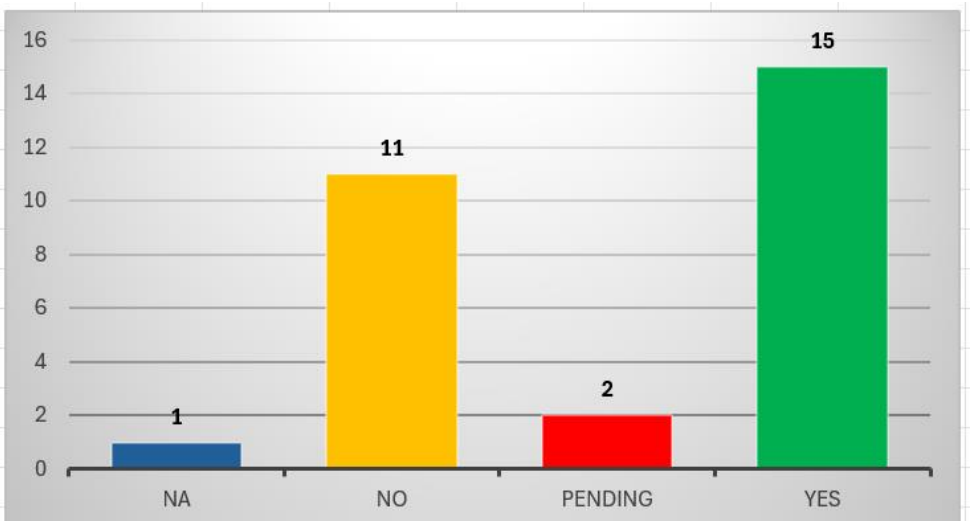


Figure 8: Question 1b: For those who with "No" responses, why?

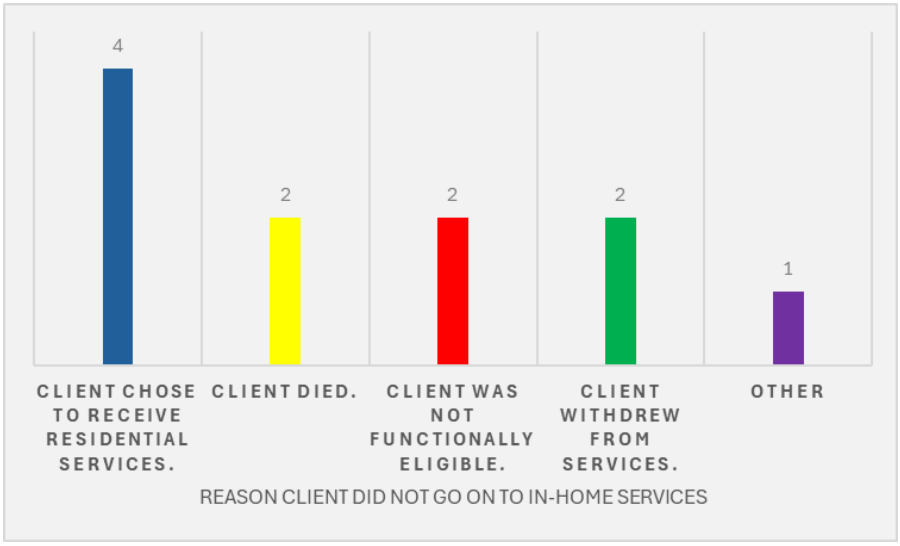
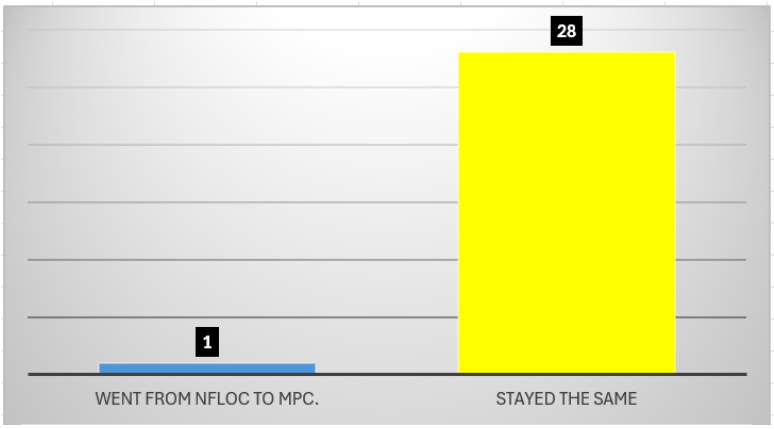


Figure 9: Question 2a: Did level of care remain the same from PE assessment to full CARE assessment?

(Only applies to those who went onto in-home services)

Figure 10: Question 2b: Did level of care remain the same from PE assessment to full CARE assessment?

(Only applies to NO RESPONSE)



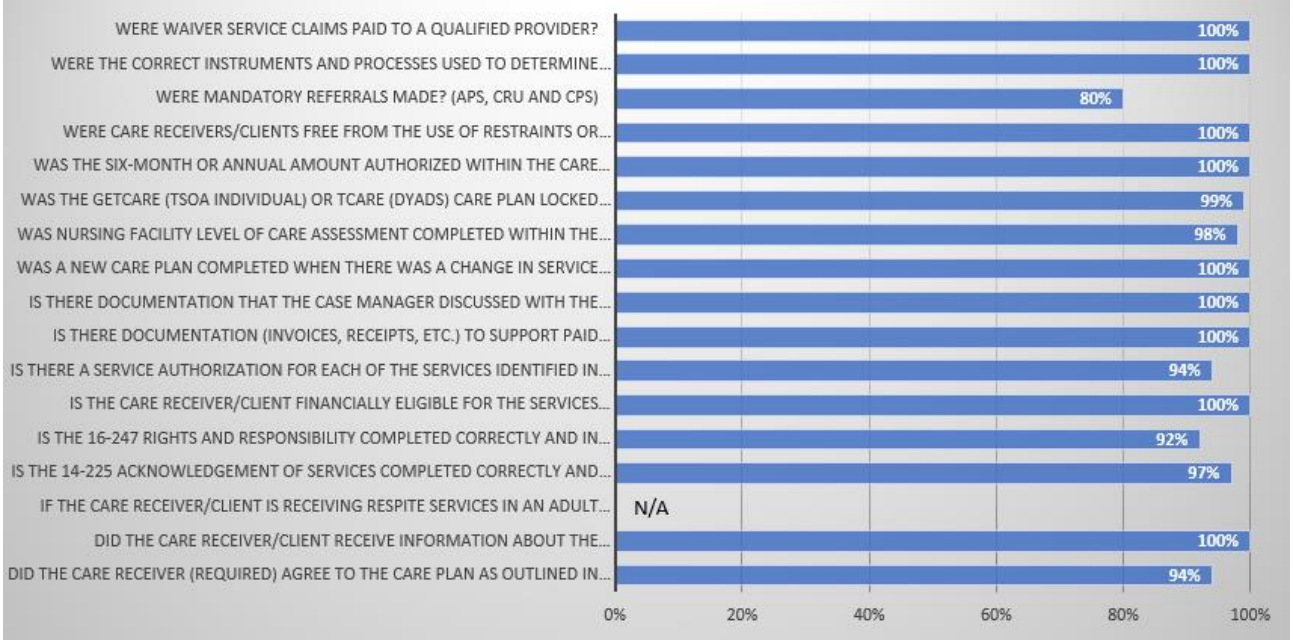
2024 quality assurance results to date

MAC and TSOA

HCS's 2024 Quality Assurance cycle began in January. The statewide compliance review of the 17 applicable MAC and TSOA performance measures is conducted with all 13 AAAs. An identical review process is applied in each AAA Planning and Service Area (PSA), using the same quality assurance tool and the same performance measures.

The Quality Assurance team reviews a statistically valid sample of case records. The sample size for 2024 is 350 cases. The methodology used is the same for the state's 1915c waivers and meets the CMS requirements for sampling. Each AAAs sample was determined by multiplying the percent of the total program population in that area by the sample size.

Figure 11: Statewide proficiency to date



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

State rulemaking

MAC and TSOA

No state rulemaking specific to MAC and TSOA occurred during this quarter.

LTSS PE

No state rulemaking specific to LTSS PE occurred during this quarter.

Upcoming activities

MAC and TSOA

The state will continue monitoring system infrastructure and referral processes regarding the recent implementation of the Consumer Direct Employer self-directed care model.

The Remote Care Services pilot launched in May to help address the work force shortage being experienced with direct care workers. As the pilot progresses, this may be an option for MAC and TSOA participants utilizing Personal Care and Respite services.

LTSS PE

Region 1 has agreed to initiate phase 2 testing beginning October 2024, ahead of the statewide implementation. This testing phase will also involve the AAA's, allowing individuals to access services in accordance with the "no wrong door" philosophy. During the phase 2 testing, Region 1 will have the opportunity to gather data, assess staffing needs, enhance the intake process, and provide training and support to the AAA's as they become familiar with the details of this waiver program.

LTSS stakeholder concerns

MAC and TSOA

There are no community partner concerns to report this quarter.

LTSS PE

There are no community partner concerns to report this quarter.

FCS implementation accomplishments

Foundational Community Supports (FCS) 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–September 30, 2024. Key accomplishments for the quarter include:

Total aggregate number of people enrolled in FCS services at the end of this reporting period:

- Community Support Services (CSS): 10,411
- Individual Placement Support (IPS): 5,508

There were 231 providers under contract with Wellpoint at the end of the reporting period, representing 543 sites throughout the state.

Note: CSS and IPS enrollment totals include 3,105 participants enrolled in both programs. The total unduplicated number of enrollments at the end of this reporting period was 12,814.

Network adequacy for FCS

Table 4: 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)	37	77	37	77	37	77
Community Support Services (CSS)	28	65	28	65	28	65
CSS and IPS	165	402	165	401	165	401
Total	230	544	231	543	231	543

Table 5: FCS client enrollment

	July	August	September
Supported Employment – Individual Placement and Support (IPS)	2,781	2,517	2,403
Community Support Services (CSS)	8,102	7,360	7,306
CSS and IPS	3,169	2,906	3,105
Total aggregate enrollment	14,052	12,783	12,814

Data source: RDA administrative reports

Table 6: FCS client risk profile

		Met HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
July	IPS	730 (12%)	1.07	4,144 (70%)
	CSS	2,355 (21%)	1.29	7,267 (64%)
August	IPS	668 (12%)	1.08	3,762 (69%)
	CSS	2,106 (21%)	1.3	6,674 (65%)
September	IPS	730 (13%)	1.07	3,833 (70%)
	CSS	2,146 (21%)	1.28	6,807 (65%)

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 7: FCS client risk profile continued

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment needs flags
July	IPS	5,123	4,583 (89%)	3,055 (60%)	2,797 (55%)
	CSS	9,639	8,514 (88%)	6,575 (68%)	5,954 (62%)
August	IPS	4,651	4,134 (89%)	2,705 (58%)	2,464 (53%)
	CSS	8,730	7,664 (88%)	5,844 (67%)	5,275 (60%)
September	IPS	4,725	4,156 (88%)	2,749 (58%)	2,487 (53%)
	CSS	8,854	7,705 (87%)	5,819 (66%)	5,237 (59%)

Data source: RDA administrative reports

*Does not include individuals who are dual enrolled.

Table 8: 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	5,123	711 (14%)	3,513 (69%)	2,073 (40%)	584 (11%)
	CSS	9,639	965 (10%)	5,929 (62%)	4,017 (42%)	785 (8%)
August	IPS	4,651	663 (14%)	3,089 (66%)	1,816 (39%)	532 (11%)
	CSS	8,730	881 (10%)	5,244 (60%)	3,520 (40%)	695 (8%)

September	IPS	4,725	659 (14%)	3,018 (64%)	1,821 (39%)	517 (11%)
	CSS	8,854	893 (10%)	5,132 (58%)	3,479 (39%)	688 (8%)

(Aging CARE assessment in last 15 months)

(Aging CARE assessment in last 15 months)

Data source: RDA administrative reports

*Does not include individuals who are dual-enrolled.

Table 9: FCS client Medicaid eligibility

		CN blind/disabled (Medicaid only & full dual eligible)	CN aged (Medicaid only & full dual eligible)	CN family & pregnant woman	ACA expansion adults (nonadults presumptive)	Adults (nonadults presumptive) ACA expansion adults (SSI presumptive)	CN & CHIP children
July	IPS	1,638 (28%)	157 (3%)	670 (11%)	2,471 (42%)	833 (14%)	171 (3%)
	CSS	3,106 (28%)	674 (6%)	1,407 (12%)	3,876 (34%)	2,061 (18%)	125 (1%)
August	IPS	1,538 (28%)	151 (3%)	600 (11%)	2,191 (40%)	781 (14%)	150 (3%)
	CSS	2,889 (28%)	629 (6%)	1,274 (12%)	3,426 (33%)	1,909 (19%)	112 (1%)
September	IPS	1,543 (28%)	154 (3%)	633 (11%)	2,232 (41%)	791 (14%)	144 (3%)
	CSS	2,891 (28%)	648 (6%)	1,282 (12%)	3,502 (34%)	1,954 (19%)	108 (1%)

ACA = Affordable Care Act

CHIP = Children's Health Insurance Program

CN = categorically needy

Data source: RDA administrative reports

Quality assurance and monitoring activity

FCS staff collaborated with Wellpoint, the third-part administrator (TPA), to oversee FCS. No significant concerns or problems were identified through the 18 quality assurance reviews that occurred during this reporting period. The TPA has confirmed the absence of any significant grievances or appeals throughout this period, however, did receive three supportive housing grievances related to individual provider internal processes and Wellpoint is directly monitoring.

FCS staff continued work to identify processes to decrease the need for reconnecting enrollees who experience changes in their Medicaid coverage. FCS is not an entitlement benefit, and enrollment is accomplished through a manual process requiring weekly workflows to enroll and re-enroll (or reconnect) eligible individuals to the program. The reconnection process necessitates conducting a historical eligibility screening to identify gaps in coverage that may have occurred due to changes in Medicaid type, incarceration, or other modifications in the ProviderOne database that automatically

disconnect an individual from FCS. The FCS team at HCA and the TPA have identified a potential solution and are currently working to establish data processes that address this need.

The FCS team conducted two more virtual comprehensive fidelity reviewer trainings, which were divided into two sessions. One two-part training centered on supported employment, while the other training was dedicated to supportive housing. The purpose of the training events was to equip FCS providers and potential reviewers with knowledge about the evidence-based practices; ultimately, enhancing the quality of the services they offer.

The training aimed to prepare agency staff for their active participation in review panels while also raising their knowledge of fidelity measurement. The fidelity reviews adopt a collaborative learning approach. In this reporting period, the FCS team conducted two formal reviews on FCS programs. Each of these agencies voluntarily participated and each review team consists of at least two other peer agencies. Overall, the learning collaborative aims to increase quality services is continuing to grow.

These engagements intend to create and maintain high quality service delivery by investing in foundational knowledge and supportive guidance regarding evidence-based practice fidelity adherence.

Other FCS program activity

Effective April 22, 2024, HCA implemented a temporary pause to new FCS program enrollments due to projected budgetary overspend and to preserve the services of existing program participants. Growth in the program exceeded previously projected enrollment forecast in the end of DY7 and early DY8. The program will maintain a waitlist for new enrollments to be managed on a first-come, first-served basis as space becomes available in the program. By the end of this reporting period, the pause was lifted, and Wellpoint has been working alongside FCS contracted agencies to ensure enrollment of all participants still in need of services. This pause also accounts for the noticeable decrease in program enrollments between July and August 2024, where disenrollments from the program (due to service authorizations ending) were not replaced by new enrollments in the benefit.

HCA continues to maintain an ongoing monthly workgroup with our partnering state departments. Monthly, the ALTSA team and DSHS's Research and Data Analysis (RDA) staff meets to develop, discuss, and adopt key policies and practices necessary for the continued operation, improvement, and long-term success of the FCS program. The HCA FCS team meets independently with ALTSA as well to ensure alignment and inclusion of all populations in service delivery and design.

Additionally, the FCS team continues to hold bi-monthly meetings with providers, coordinated by King County, the most populous county in Washington State. Spokane County also initiated a similar space for providers. These meetings offer FCS providers in the county regular engagement with the FCS trainers, the opportunity to share experiences, exchange ideas, and learn from one another about effective practices when administering FCS benefits.

In partnership with the DSHS's Division of Vocational Rehabilitation (DVR), HCA actively engages in a quarterly workgroup. This workgroup's primary goal is to improve consistency, foster collaboration, and optimize employment outcomes for DVR customers with behavioral health conditions who are receiving supported employment services through the DVR Supported Employment program and FCS. In this reporting period, this group focused on increasing confidence in supported employment programs and retaining employment specialists as well as individual program monitoring best practices.

FCS has continued to provide a funding opportunity, referred to as Glidepath to Supported Employment, which is intended to provide formal benefit planning and employment services. Ten agencies were awarded contracts and will support individually identified regions. These state-only funds are intended to partner FCS IPS providers with Housing and Essential Needs program to provide up to nine months of additional rental assistance as a bridge period for IPS-enrolled individuals who would otherwise be financially unsupported due to increasing income through employment.

Additionally, the FCS team is rolling out the Apple Health and Homes (AHAH) program which, after additional planning and contracting to ensure sound data practices between partner agencies, will be hosting its first lottery for awardees of

the benefit in the upcoming reporting periods. AHAH is a benefit to FCS enrolled clients and provides project or tenant based rental subsidies to eligible enrollees.

Lastly, the FCS Transition Assistance Program (TAP) launched in May of 2022. TAP aims to serve Washington's most vulnerable population with complex care needs. TAP supports FCS CCS eligible individuals obtain and maintain safe, stable and affordable housing. FCS TAP has a network of 130 providers under contract through Wellpoint.

The Washington State Legislature appropriated $3,109,000 of the general fund for State Fiscal Year 2025. Funding was split into two disbursals for the fiscal year. As of July 1, 2024, $1,350,000 was released to the TAP Provider Network. The TAP expended funds for the first half of SFY25 as of Thursday, August 29, 2024, at 5pm. An additional $1,350,000 will be available January 1, 2025, for the remainder of SFY25.

Upcoming activities

Supportive Housing Institute (SHI) applications were announced during this reporting period. The SHI is a collaboration with the Corporation for Supportive Housing to directly prepare agencies to build new permanent supportive housing units within Washington State. HCA will accept ten agencies to receive intensive and comprehensive technical assistance for 6 months. Accepted applications will be announced in the next reporting period.

The FCS team continued to maintain regular meetings with the Department of Commerce (COM) to discuss the planning and development of two programs. These programs include the collaboration of COM, DSHS, and HCA to establish permanent supportive housing units for CSS-eligible individuals under the name "Apple Health and Homes." The program has been diligently working to launch its first lottery for a long-term subsidy and hope to launch during Q2 or Q3 of FY 2025.

FCS program stakeholder engagement activities

HCA continues to receive inquiries from other states and entities regarding the FCS program. HCA responds readily to these inquiries, usually by teleconference. During the reporting quarter, staff from HCA, ALTSA, and Wellpoint supported a variety of stakeholder engagement activities.

A significant portion of the stakeholder engagement activities during this quarter were related to the temporary pause to new enrollments. The FCS program staff held monthly meetings with providers and other key stakeholders to solicit feedback related to the pause and how the waitlist will be managed.

Lastly, the FCS team has developed an FCS provider survey to gain more insight into program challenges and how system improvements could be made to increase program efficiency and their confidence in providing FCS services.

Table 10: Number of FCS program stakeholder engagement activities held

	July	August	September
Training and assistance provided to individual organizations	49	41	41
Community and regional presentations and training events	8	5	7
Informational webinars	14	11	6
Stakeholder engagement meetings	7	6	7
Total activities	78	63	61

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.

During this reporting period, topics included:

- Client Engagement Strategies and Best Practices
- Peer Services in Supported Employment and beyond
- Care Coordination Best Practices
- Back to the Basics: resumes, interviews, and cover letters
- Intersection of Housing and Healthcare
- Transition Assistance Program Updates and Discussion

FCS stakeholder concerns

The FCS team has been receiving feedback about the challenges faced by providers who are new to billing Medicaid when submitting claims as well as the FCS enrollment pause. In response, HCA is offering additional one-on-one technical assistance, a series of pre-recorded budget webinars to support providers in adopting the best practices and aligning with other Medicaid billing processes, as well as a Provider Survey to understand implementation and billing challenges. The FCS team additionally developed a New Provider Orientation presentation to assist these agencies with the intricacies of billing FCS services.

FCS agencies have been actively providing feedback and insights on FCS services. Providers share, at a minimum, during a quarterly Advisory Council meeting. The FCS provider survey will be active in the next reporting period and HCA intends to analyze and publish the results within the same quarter. Some of the issues that have been previously raised were the need to increase understanding about systems used to verify eligibility of enrollees, examining reasons for application denials, and decreasing confusion through updating provider-facing documents.

To keep constituents informed, the FCS team regularly provides updates and opportunities during the quarterly Advisory Council meetings, as well as hosts webinars with specific and relevant information. The FCS team is also currently examining the establishment of a formal feedback loop to increase the prevalence and timeliness of hearing stakeholder perspectives.

SUD IMD waiver implementation accomplishments

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

This section summarizes SUD IMD waiver development and implementation activities from July 1 through September 30, 2024. Accomplishments for this reporting period include:

In August, permanent rules were adopted in the Washington Administrative Code (WAC) relating to the establishment and certification of 23-hour crisis relief centers. A 23-hour crisis relief center means:

- A community-based facility or portion of a facility which is licensed or certified by the department of health
- Open 24 hours a day, seven days a week
- Offers access to mental health and substance use care for no more than 23 hours and 59 minutes at a time per patient
- Accepts all behavioral health crisis walk-ins, drop-offs from first responders, and individuals referred through the 988 system regardless of behavioral health acuity
- Meets the requirements under RCW 71.24.916

Implementation plan

In accordance with the amended special terms and conditions (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 in its provision of SUD services. Where the state did not meet the milestones, CMS was engaged to confirm appropriate adjustments. These changes, included in the state's SUD implementation plan, are described below:

No updates.

SUD Health IT plan requirements

No updates to report this period.

Evaluation design

No updates to report this period.

Monitoring protocol

No updates to report this period.

Upcoming activities

- Washington Co-occurring Disorders & Treatment Conference – October 6-8, 2024
    - This will promote information sharing and provide education about system changes.

MHIMD 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, 2024.

In August, permanent rules were adopted in the Washington Administrative Code (WAC) relating to the establishment and certification of 23-hour crisis relief centers and endorsement standards for Community-Based Crisis Teams (CBCT) and Mobile Rapid Response Crisis Teams (MCRT).

A 23-hour crisis relief center means:

- A community-based facility or portion of a facility which is licensed or certified by the department of health
- Open 24 hours a day, seven days a week
- Offers access to mental health and substance use care for no more than 23 hours and 59 minutes at a time per patient
- Accepts all behavioral health crisis walk-ins, drop-offs from first responders, and individuals referred through the 988 system regardless of behavioral health acuity
- Meets the requirements under RCW 71.24.916

Mobile rapid response crisis team (MRRCT): means a team that provides professional, on-site, community-based interventions such as outreach, de-escalation, stabilization, resource connection, and follow-up support for people who are experiencing a behavioral health emergency. A MRRCT must:

- Include certified peer counselors as a best practice to the extent practical based on workforce availability; and
- Meet standards for response times established by the authority's contracted BH-ASO.

Implementation plan

No updates to report this period.

MH Health IT plan requirements

No updates to report this period.

Evaluation design

No updates to report this period.

Monitoring protocol

No updates to report this period.

Upcoming activities

Work is ongoing on the development of inpatient and residential treatment resources.

Contingency Management for SUD treatment implementation accomplishments

On July 1, 2023, Washington State received approval of its 1115 waiver (MTP 2.0) for new programs. Contingency Management is an evidence-based behavioral intervention for stimulant use disorder. It provides incentives to individuals contingent upon objective evidence of the target behavior, such as a negative urine drug test, in order to increase the likelihood of these behaviors, which are essential components and outcomes of effective treatment.

This section summarizes the Contingency Management program development and implementation activities from July 1 through September 30, 2024.

Implementation progress

Since our last progress report, the project team has continued to meet and coordinate with stakeholders. The state completed the following activities during the reporting period:

- Collected site selection/readiness surveys from interested sites across the state and analyzed the results
- Identified eligible sites and selected the first ten sites that best meet the criteria for implementation

Upcoming activities

- Communicate and coordinate with selected sites on implementation
- Establish funding and payment processes for contingency management

Data and reporting

No updates to report for this quarter. Data on enrollment numbers and incentives will be reported upon implementation of Contingency Management and when data is available.

Aftercare and treatment services

No updates to report for this quarter. Information on aftercare and treatment services will be reported upon implementation of Contingency Management and when data is available.

Continuous Enrollment implementation accomplishments

On July 1, 2023, Washington State received approval of its 1115 waiver (MTP 2.0) for new programs:

- The **Continuous Apple Health enrollment for children, ages 0 through 5,** program provides continued benefits for eligible children, ages 0 through the end of the month in which they turn 6 years old.
- The **Apple Health Postpartum coverage expansion** program provides continued benefits for individuals from the end of pregnancy through 12 months postpartum.

This section summarizes the Continuous Enrollment programs development and implementation activities from July 1 through September 30, 2024.

Continuous Apple Health enrollment for children, ages 0 through 5

Implementation progress

Since the approval date in April 2023, the state has provided continuous coverage for children on Medicaid, ages 0 through 5. Initially, the state utilized a manual process to ensure continuous coverage, reinstating benefits for any children under the age of six who may have lost coverage under the yearly redetermination process.

Full system support to provide continuous eligibility through automatic annual renewals was implemented in March 2024.

Upcoming activities

The state continues to outreach to families on continuous Apple Health enrollment.

Data and reporting

Below are monthly enrollments for continuous Apple Health for children, ages 0 through 5.

Table 11: Number of new enrollment

	July	August	September
New enrollee between the ages of 0 and 1	3,671	3,697	3,083
New enrollee age 1 through age 5 years	1,612	1,855	1,891
Total	5,283	5,552	4,974

Table 12: Number of unduplicated number

	July	August	September
Unduplicated number between the ages of 0 and 1	43,484	43,475	42,728
Unduplicated number age 1 through age 5 years	215,558	215,462	215,464
Total	259,042	258,937	258,192

Apple Health Postpartum coverage expansion

Implementation progress

The state implemented postpartum extension coverage in June 2022 under the American Rescue Plan Act (ARPA) and with state plan approval, Washington provides full coverage to those who were on Medicaid or CHIP during their pregnancy. With waiver approval, Washington state is authorized to provide coverage to those who were not previously enrolled in Medicaid or CHIP during their pregnancy with income up to 193 percent of the FPL until 12 months after their pregnancy ends.

Since July 2024, this coverage group enrolls into managed care to be consistent with the other postpartum programs in Washington.

Upcoming activities

The state continues to outreach to people about Apple Health Postpartum coverage.

Data and reporting

Below is the total monthly enrollment for the waiver approved postpartum coverage.

Table 13: Number of new enrollment

	July	August	September
Postpartum Care	579	599	606

Reentry from a carceral setting implementation accomplishments

On July 1, 2023, Washington State received approval of its 1115 waiver (MTP 2.0) for new programs. The reentry from a carceral setting program provides individuals pre-release services up to 90 days prior to the expected date of release to their communities.

This section summarizes the program development and implementation activities from July 1 through September 30, 2024.

Implementation progress

Table 14: Reentry Initiative participation based on carceral facilities meeting milestones

	1) Intent to Participate form	2) Implementation Plan	3) Readiness Assessment	Go-live with pre-release services	4) Interim Progress Report	5) Final Progress Report
Cohort 1	June 1, 2024	Oct. 1, 2024	March 1, 2025	**July 1, 2025**	May 1, 2026	Oct. 1, 2026
Cohort 2	Nov. 1, 2024	April 1, 2025	Sept. 1, 2025	**Jan. 1, 2026**	Dec. 1, 2026	May 1, 2027
Cohort 3	May 1, 2025	Oct. 1, 2025	March 1, 2026	**July 1, 2026**	May 1, 2027	Oct. 1, 2027

1) Submit an Intent to participate form indicating the facility's intent to participate and participation cohort. In the Intent to Participate form, participating facilities will also choose which cohort they will go-live with. Facilities that want to go live July 1, 2025, submitted their Intent to Participate form to HCA by June 1, 2024. Submitting this document signals a facility's:

- Agreement to participate in the initiative
- Completion of Milestone 1 (fill out and submit the Intent to Participate form)
- Ability to receive capacity building funding
- Complete a contractual agreement with HCA expressing willingness and ability to receive capacity funds to support the planning for and implementation of the initiative.

2) Complete a Capacity Building Application which includes an Implementation Plan. This plan describes how the facility will support pre-release services and a detailed budget that:

- Covers planned expenses
- Requests capacity building funding

3) Complete a Readiness Assessment attesting to the facility's current and/or planned readiness to support pre-release services. HCA will provide a template for the assessment and review and approve submitted assessments in order for the facility to go-live with pre-release services.

4) Submit Interim Progress Report on initial implementation progress on implementation.

5) Submit Final Progress Report on overall implementation progress and outcomes

Milestone accomplishment

HCA extended an official invitation to all carceral facilities in Washington to support the state's reentry initiative.

Intent to Participate:

- For facilities planning to go live on July 1, 2025, the Intent to Participate form was due by June 1, 2024. HCA received 42 responses.

- HCA established contractual relationships with the entities willing and able to receive capacity funds to support the planning and implementation of the initiative.

Cohort 1 Activities: HCA welcomed facilities into Cohort 1 and engaged in multiple activities during this reporting period, including:

- Monthly meetings to discuss ongoing activities for participating facilities.
- One-on-one meetings to address facility-specific questions.
- Technical assistance sessions.

HCA developed a Capacity Building Application (CBA), which includes an Implementation Plan and Readiness Assessment. This assessment helps facilities attest to their current abilities and provides HCA with information on their needs. The application is due back to HCA by October 1, 2024.

Other Activities:

- Continued to update a frequently asked questions document for distribution.
- Responded to emails from a designated inbox for questions.
- Continued bi-weekly joint meetings with the Department of Children, Youth, and Family (DCYF) and Department of Corrections (DOC) to align efforts on the reentry initiative.
- Reviewed information from a Request for Information (RFI) regarding a third-party administrator's (TPA) role to support administrative and care management functions. From the feedback of the RFI HCA started drafting an RFP to be released in November.

Challenges

Carceral facilities are in the process of completing a CBA. One of the goals for this CBA is to identify gaps and challenges that facilities identify. Information will be reported as soon as this information becomes available.

Upcoming activities

Cohort 2: HCA plans to support Cohort 2 over the next year with the following activities:

- Monthly meetings to discuss ongoing activities
- One-on-one meetings to address facility-specific questions
- Technical assistance sessions
- Guidance on the CBA, which includes an Implementation Plan and Readiness Assessment
- Development of a Policy and Operations Guide
- Development of a learning series to train facilities on subjects such as Medicaid 101, provider enrollment, and eligibility

Continued Engagement

HCA continues to engage several advisory groups, including the Washington Association of Sheriffs and Police Chiefs and the Reentry 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.

Priority Planning Efforts

HCA continues to work on several priority planning efforts, including:

- Care management design, including pre-release and immediate post-release continuity of care.
- Benefit design for mandatory and secondary services, including parameters for progression from mandatory to secondary services by facility.
- Enrollment and plan assignment pre-release and post-release, including implications on the TPA role and Medicaid billing.

Data and reporting

We currently do not have data on these services for this quarter. However, data collection will commence as soon as the services are implemented.

Health-related social needs (HRSN) implementation accomplishments

On July 1, 2023, Washington State received approval of its 1115 waiver (MTP 2.0) for new programs.

- The **Community Hubs** focus on community-based care coordination, including screening patients, determining patient needs, connecting patients to community organizations that can provide those needs, and more.
- The **Native Hub** is a statewide network of Indian health care providers, tribal social service divisions, and Native-led, Native-serving organizations focused on whole-person care coordination.
- **HRSN services** include nutrition, housing, rental subsidies, transportation, and other non-medical HRSN services that help a person live their healthiest life.
- **HRSN Infrastructure** provides infrastructure investments to support the readiness for HRSN service delivery. Investments include technology, planning, workforce development, and convening.

This section summarizes the HRSN development and implementation activities from July 1 through September 30, 2024.

Community Hubs

Implementation progress

HCA began administering HRSN infrastructure funds to ACHs to support readiness for the delivery of hub services. In addition, HCA evaluated all 9 ACH submissions of hub readiness criteria and approved all submissions to launch their hubs upon CMS approval of the HRSN services protocol. Implementation of HRSN services is still pending CMS approval of the HRSN services protocol.

Upcoming activities

HCA will develop a process for reporting requirements for hub services. The state also continues to work on coordinating and aligning hub services with other HRSN services, reentry, and walking through CMS review of the HRSN service protocols.

Data and reporting

Data will be captured when service is implemented.

Native Hub

The Native Hub is being co-developed between HCA and the 29 federally recognized Tribes and 2 Urban Indian health programs in Washington State.

Implementation progress

The American Indian Health Commission (AIHC) hosted a tribal caucus so that Tribes and IHCPs could speak freely without the Office of Tribal Affairs (OTA)/HCA present. Per their report:

“The American Indian Health Commission (AIHC) held a Tribal/IHCP Leaders Caucus on September 10th, 2024. The caucus included 20 participants representing 12 Tribes. The current Washington Medicaid 1115 Waiver distinguishes a ‘Native Hub’ to address the health-related social needs (HRSN) of the American Indian/Alaska Native Medicaid population. The September 10th Tribal Caucus gave Tribal Leaders an opportunity to voice existing gaps, needs, concerns and ideas to address HRSN. This discussion focused on those Medicaid eligible AI/AN served through Indian Health Care Providers. Items discussed included gaps in resources and services for Case/Care management, enable billing for Traditional Medicine, streamlining billing and improving Electronic Health Record systems.”

“The Tribal Leaders attending this caucus provided decades of lived knowledge and experience in the Indian Health Care System. While health care payment models are evolving, the Medicaid 1115 waiver Native Hub model provides a valuable opportunity to demonstrate how IHCPs can and do provide informed ‘whole person’ health and wellness services, that do address health related social needs, to the AI/AN population if adequate funding mechanisms are in place.”

OTA is heartened by this feedback and is looking forward to next steps with Tribes and IHCPs.

Upcoming activities

HCA and the American Indian Health Commission will be hosting a one- to two-day work session for the Tribes and IHCPs to further refine and develop the Native Hub.

Data and reporting

Data will be captured when the services have been implemented.

HRSN services and infrastructure

Implementation progress

Following CMS feedback about Washington's initial HRSN services protocol submission, the state has submitted its revised HRSN services protocol. The state has also submitted its HRSN implementation plan last quarter. With input from an internal workgroup and the Taking Action for Healthier Communities (TAHC) Task Force, the state has determined the initial phasing of HRSN service implementation:

- **Phase 1a:** case management, outreach, and education (to establish the community and Native hubs) Washington State Medicaid Transformation Project 2.0 demonstration Approval period: July 1, 2023, through June 30, 2028
- **Phase 1b:** Recuperative care and short-term post-hospitalization housing (medical respite), Housing transition navigation services, Rent/temporary housing
- **Later phases:** Nutrition support, stabilization centers, day habilitation, caregiver respite, environmental adaptations the state's internal workgroup, along with sub-groups focused on specific services, continues to guide the planning and implementation of HRSN services

The state's internal workgroup, along with sub-groups focused on specific services, continues to guide the planning and implementation of HRSN services. Implementation of HRSN services is still pending CMS approval of the HRSN services protocol.

Partnership with existing housing agencies

The state will implement housing subsidies through HCA contracts and The Department of Social and Health Services contracts to administer up to 6 months of rental assistance and/or temporary housing on behalf of program participants. HCA continues to look into options for a public housing authority (PHA) to administer the rental subsidies service on behalf of participants enrolled in the Foundational Community Supports program participants will be determined eligible for FCS CSS through standard eligibility processes managed by the TPA, Wellpoint. Additional screening by FCS CSS providers and/or the Community Hubs will inform HCA of additional need for housing support offered through the Rent and temporary housing benefit. The role of the PHA will be to contract with landlords and other PHAs to make rental payments on behalf of eligible participants authorized by HCA. The state plans to release a letter of interest to the Washington Association of Housing Authorities in DY9 Q2.

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. This state-funded long-term subsidy provides certain FCS CSS-eligible enrollees with an opportunity to obtain permanent housing and/or a long-term housing subsidy that prioritizes the FCS target population based on their health-based needs and social risk factors. AHAH will be the first long-term subsidy closely aligned with the HRSN rent and temporary housing benefit for the FCS-eligible population. The state will continue to explore avenues for additional alignment with other long-term housing subsidies and vouchers over the course of DY9.

Partnership with existing nutrition agencies

The state continues to meet and partner with statewide nutrition agencies to inform nutrition supports services implementation.

Infrastructure Investments

Starting in September, HCA began to administer HRSN infrastructure payments to ACHs. HCA will work with ACHs to develop an application process for eligible entities to access infrastructure funds.

Upcoming activities

The state continues to convene key external partners—notably the ACHs and MCOs—to design a collaborative process for delivering HRSN services. The state continues to work on coordinating and aligning cross-initiatives work between HRSN services and reentry.

Data and reporting

Data will be captured when the services have been implemented.

Data sharing between partner entities

Data will be captured when service is implemented.

Quarterly expenditures

Financial executor (FE) portal activity

ACHs continue to distribute incentive funds to partnering providers through the FE portal. During the reporting quarter, ACHs distributed more than **$39,549,523** to **14** partnering providers and organizations in support of project planning and implementation activities.

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.

DSRIP program implementation accomplishments

The program is sunsetting as the final P4P and High-Performance Pool (HPP) payments have been distributed to the nine ACHs. HCA and ACHs continue to partner on the transition from DSRIP to the programs approved under MTP 2.0, including nine Community Hubs and one statewide Native Hub to support and deliver HRSN services.

The ACHs' formal responsibilities related to VBP will be phased out with the sunsetting of DSRIP performance accountability. ACHs can stay up to date with HCA's VBP goals and progress on the HCA website.

HRSN Infrastructure Expenditures

During Q1, HCA has distributed $59,265,608 to ACHs for HRSN infrastructure investments.

Table 15: HRSN infrastructure payments to ACHs and Native Hub

	Q1 (July 1– September 30)	Q2 (October 1 – December 31)	Q3 (January 1- March 31)	Q4 (April 1 – June 30)	DY9 Total (July 1 – June 30)
Better Health Together	$6,717,691.00				$6,717,691.00
CHOICE	$5,996,358.44				$5,996,358.44
Elevate Health	$8,549,095.50				$8,549,095.50
Greater Health Now	$12,118,550.92				$12,118,550.92
HealthierHere	$2,800,000.00				$2,800,000.00
Thriving Together North Central Washington	$9,156,717.50				$9,156,717.50
North Sound	$2,331,148.00				$2,331,148.00
Olympic Community of Health	$7,323,482.50				$7,323,482.50
SWACH	$4,272,565.00				$4,272,565.00
Native Hub	$0.0				$0.0
Total	$59,265,608.86				$59,265,608.86

Table 16: Reentry Demonstration Initiative planning and implementation

During Q1, HCA paid out a total of $1,975,000 to 16 facilities for Planning and Implementation.

Carceral Facility by Tier (based on average daily population)	Q1 (July 1– September 30)	Q2 (October 1 – December 31)	Q3 (January 1- March 31)	Q4 (April 1 – June 30)	DY9 Total (July 1 – June 30)
Tier One (1-49)	$500,000				$500,000
Tier Two (50-249)	$875,000				$875,000
Tier Three (250-1,000)	$600,000				$600,000
Tier Four (more than 1,000)	$0.00				$0.00
Total	$1,975,000				$1,975,000

Table 17: LTSS and FCS service expenditures

	Q1 (July 1– September 30)	Q2 (October 1 – December 31)	Q3 (January 1- March 31)	Q4 (April 1 – June 30)	DY9 Total (July 1 – June 30)
Tailored Supports for Older Adults (TSOA)	$4,007,210				$4,007,210
Medicaid Alternative Care (MAC)	$155,792				$155,792
MAC and TSOA not eligible	$0.0				$0.0
Presumptive Eligibility	$56,686				$56,686
FCS	$22,500,446				$22,500,446

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.

Table 18: Member months eligible to receive services

Calendar month	Non-expansion adults only	SUD Medicaid disabled	SUD Medicaid non-disabled	SUD newly eligible	SUD AI/AN	SMI Medicaid Disabled IMD	SMI Medicaid non-disabled IMD	SMI Newly eligible IMD	SMI AI/AN
Jan-17	376,273	0	0	0	0	0	0	0	0
Feb-17	391,119	0	0	0	0	0	0	0	0
Mar-17	390,719	0	0	0	0	0	0	0	0
Apr-17	389,265	0	0	0	0	0	0	0	0
May-17	388,866	0	0	0	0	0	0	0	0
Jun-17	388,744	0	0	0	0	0	0	0	0
Jul-17	387,856	0	0	0	0	0	0	0	0
Aug-17	387,741	0	0	0	0	0	0	0	0
Sep-17	386,394	0	0	0	0	0	0	0	0
Oct-17	386,298	0	0	0	0	0	0	0	0
Nov-17	386,213	0	0	0	0	0	0	0	0
Dec-17	386,303	0	0	0	0	0	0	0	0
Jan-18	386,669	0	0	0	0	0	0	0	0
Feb-18	385,183	0	0	0	0	0	0	0	0
Mar-18	385,076	0	0	0	0	0	0	0	0
Apr-18	383,756	0	0	0	0	0	0	0	0
May-18	384,217	0	0	0	0	0	0	0	0
Jun-18	383,313	0	0	0	0	0	0	0	0
Jul-18	383,195	7	23	123	11	0	0	0	0
Aug-18	382,680	14	31	212	43	0	0	0	0
Sept-18	381,652	7	13	109	40	0	0	0	0
Oct-18	381,728	7	13	115	48	0	0	0	0
Nov-18	381,428	7	27	171	33	0	0	0	0
Dec-18	380,922	9	26	165	38	0	0	0	0
Jan-19	381,426	32	106	395	49	0	0	0	0
Feb-19	379,613	28	101	386	45	0	0	0	0
Mar-19	379,296	31	128	427	40	0	0	0	0
Apr-19	378,902	37	122	448	42	0	0	0	0
May-19	378,205	46	141	506	52	0	0	0	0
June-19	377,295	59	165	592	52	0	0	0	0
Jul-19	377,800	77	163	791	45	0	0	0	0
Aug-19	377,466	73	196	810	47	0	0	0	0
Sep-19	376,830	75	205	846	42	0	0	0	0
Oct-19	376,250	89	224	976	33	0	0	0	0
Nov-19	375,380	87	217	886	38	0	0	0	0
Dec-19	375,611	91	241	1074	44	0	0	0	0

Jan-20	376,128	78	188	1042	35	0	0	0	0
Feb-20	375,969	55	174	823	39	0	0	0	0
Mar-20	377,832	64	173	947	36	0	0	0	0
Apr-20	381,666	83	181	1148	16	0	0	0	0
May-20	384,336	58	220	817	17	0	0	0	0
Jun-20	387,325	74	232	1124	19	0	0	0	0
Jul-20	390,058	85	231	1256	19	0	0	0	0
Aug-20	393,077	51	203	870	29	0	0	0	0
Sep-20	395,355	67	205	1068	35	0	0	0	0
Oct-20	397,431	70	216	1220	22	0	0	0	0
Nov-20	398,440	36	188	755	18	0	0	0	0
Dec-20	400,019	47	209	863	24	47	22	60	6
Jan-21	401,147	43	222	843	25	2	2	13	6
Feb-21	401,152	26	87	294	15	107	38	173	7
Mar-21	402,586	22	82	309	14	109	38	171	6
Apr-21	403,874	20	73	286	13	108	38	172	4
May-21	404,977	32	86	311	22	111	39	171	4
Jun-21	405,990	20	31	163	20	111	38	168	3
Jul-21	407,394	26	101	375	18	109	38	168	5
Aug-21	409,289	20	92	320	15	107	38	173	4
Sep-21	410,432	18	80	313	15	111	38	173	6
Oct-21	411,625	17	78	261	15	110	39	171	5
Nov-21	413,343	15	77	293	12	111	39	170	6
Dec-21	413,588	8	40	214	12	112	38	171	5
Jan-22	415,123	4	13	88	8	107	36	178	4
Feb-22	416,224	36	179	649	10	78	21	144	2
Mar-22	417,889	40	176	657	20	77	21	144	2
April-22	420,190	41	182	663	15	82	21	140	4
May-22	421,575	44	197	732	14	86	21	141	3
Jun-22	423,957	46	194	746	24	84	22	142	6
Jul-22	426,017	43	195	787	14	109	39	227	3
Aug-22	428,901	79	259	1155	19	136	42	295	3
Sep-22	429,986	80	257	1161	20	140	41	297	3
Oct-22	431,772	80	260	1158	23	137	40	301	3
Nov-22	434,409	56	225	931	21	135	40	302	6
Dec-22	437,375	56	231	943	17	137	40	310	9
Jan-23	439,870	60	236	978	14	116	31	231	6
Feb-23	442,134	54	196	974	12	137	87	395	8
Mar-23	445,324	57	200	985	16	137	91	402	7
April-23	446,868	55	201	1005	17	137	90	410	8
May-23	447,143	84	291	1122	10	140	92	417	8
Jun-23	439,236	88	289	1124	17	133	94	419	5
Jul-23	430,316	94	315	1424	11	132	96	421	6
Aug-23	420,347	89	305	1428	11	132	89	416	7
Sep-23	418,045	91	309	1435	18	133	88	413	10
Oct-23	417,394	93	316	1469	19	134	89	416	9
Nov-23	416,743	74	288	1223	14	136	89	407	8
Dec-23	415,408	73	294	1222	19	139	85	395	4

Jan-24	413,864	77	305	1263	11	139	82	388	0
Feb-24	412,358	70	265	1121	18	72	60	185	3
March-24	411,736	70	270	1124	12	72	58	184	3
April-24	410,772	71	277	1149	5	73	58	180	5
May-24	409,439	81	336	1259	13	39	24	126	3
June-24	406,488	80	329	1240	8	39	24	121	1
July- 24		80	316	1196	0				
Total	36,069,620	3,857	13,317	57,358	1,697	4,640	2,180	10,613	216

Table 19: Member months eligible to receive services

(Presumptive Eligibility, Post-Partum, Continuous Enrollment for Children)

Calendar month	Presumptive Eligibility	CE Post-Partum Individuals	CE Children Disabled	CE Children Non-Disabled
Apr-23	0	0	2,663	254,888
May-23	0	0	2,624	254,776
Jun-23	0	0	2,610	253,331
Jul-23	0	563	2,610	252,404
Aug-23	0	545	2,457	252,417
Sep-23	0	548	2,441	253,965
Oct-23	0	571	2,430	254,304
Nov-23	0	592	2,433	254,627
Dec-23	4	624	2,389	254,631
Jan-24	10	640	2,385	254,191
Feb-24	25	622	2,359	253,622
Mar-24	25	620	2,338	251,771
Apr-24	32	635	2,352	254,311
May-24	25	591	2,352	252,328
Jun-24	22	545	2,327	249,605
Jul-24	16	576	2,334	252,288
Aug-24	18	596	2,370	251,617
Sep-24	8	600	2,372	250,002
Total	185	8,868	43,846	4,555,078

Budget neutrality

HCA adopted CMS's budget neutrality monitoring tool and has been using Performance Management Database and Analytics system to upload quarterly spreadsheets.

Designated state health programs (DSHP)

HCA continues to respond to DSHP questions from CMS during this past quarter. No new updates to provide

Overall MTP development and issues

Operational/policy issues

HCA and agency partners continue to work with the Washington State Legislature to answer questions, provide implementation updates, and support budget development aligned with the MTP 2.0 CMS approval.

Consumer issues

The state has not experienced any major consumer issues for DSRIP, FCS, LTSS, or the SUD IMD waiver during this reporting quarter, other than general inquiries about benefits available through MTP, , including new and continuing programs.

MTP evaluation

The MTP independent external evaluator's (IEE) quarterly rapid cycle report was put on hold to allow the following activities:

- MTP 1.0 Summative Evaluation Report
- MTP 2.0 Evolution design

The MTP 2.0 evaluation design was submitted for CMS approval to in January of 2024. CMS provided feedback for changes in April of 2024. The evaluation design was returned to CMS June of 2024.

MTP 1.0 Summative Evaluation Report was submitted July of 2024.

Upcoming IEE activities

The IEE is working with state data teams to update contracts, data sharing agreements, and IRB applications to extend their work through the duration of MTP 2.0.

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**
- Attachment C: **1115 SUD Demonstration Monitoring Workbook – Part A**
- Attachment D: **1115 SUD Demonstration Monitoring Report – Part B**
- Attachment E: **1115 SMI/SED Demonstration Monitoring Workbook – Part A**
- Attachment F: **1115 SMI/SED 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	Emma Oppenheim	Director, Medicaid Transformation Project	360-725-0868
DSRIP program	Michael Arnis	Deputy Policy Director, SPI	360-725-0868
LTSS program	Debbie Johnson	Initiative 2 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: Financial Executor Portal Dashboard

View this table on the HCA website, which shows all HRSN funds distributed through the FE portal through September 30, 2024.

View this table on the HCA website, which shows all DSRIP funds earned and distributed through the FE portal through September 30, 2024.

Attachment C: 1115 SUD Demonstration Monitoring Workbook – Part A

A public workbook (which does not contain the full workbook) is available on the HCA website.

Attachment D: 1115 SUD Demonstration Monitoring Report – Part B

1. Title Page for the State's SUD Demonstration or SUD Components of Broader Demonstration

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-June 30, 2023
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

The number of Medicaid beneficiaries with substance use disorder diagnosis (SUD) remained consistent with the prior year. The number of Medicaid beneficiaries treated in an IMD for SUD increased from 3,611 in State fiscal year (SFY 2022 to 4,630 in SFY 2023 statewide. The number of Medicaid beneficiaries treated in an IMD for SUD increased from 2,108 in SYF 2022 to 2,604 in SYF 2023 among the opioid use disorder (OUD) subpopulations.

The average length of stay in IMDs decreased from 11.48 days per client in SFY 2022 to 10.01 days per client in SFY 2023 statewide. Among the OUD subpopulation, the rate decreased from 11.94 to 10.53.

3. 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.**	The number of Medicaid beneficiaries with SUD diagnosis remained consistent with the prior year.	07/01/2018 – 06/30/2019	#4: Medicaid beneficiaries with SUD diagnosis (annual)
	The number of Medicaid beneficiaries treated in an IMD for SUD increased from 3,611 in SFY 2022 to 4,630 in SFY 2023 at the state level. The number of Medicaid beneficiaries treated in an IMD for SUD increased from 2,108 in SFY 2022 to 2,604 in SFY 2023 among the OUD subpopulations.	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 average length of stay in IMDs decreased from 11.48 days per client in SFY 2022 to 10.01 days per client in SFY 2023 at the state level. Among the OUD subpopulation, the rate decreased from 11.94 to 10.53.	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.**
5.2.2 Implementation Update
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ **Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care.**
☐ **The state has no implementation update to report for this reporting topic.**
☐ **The state expects to make other program changes that may affect metrics related to Milestone 4.**
☐ **The state has no implementation update to report for this reporting topic.**

6.2 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)
6.2.1 Metric Trends
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 5.
☒ The state has no 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 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.**
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 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.

Attachment E: 1115 SMI/SED Demonstration Monitoring Workbook – Part A

A public workbook (which does not contain the full workbook) is available on the HCA website.

Attachment F: 1115 SMI/SED Demonstration Monitoring Report – Part B

1. 1115-SMI/SED Demonstration-Monitoring-Report Trend Narrative Reporting

State	Washington
Demonstration name	Washington State Medicaid Transformation Project No. 11-W-00304/0
Approval date for demonstration	January 9, 2017
Approval period for SMI/SED	July 1, 2018-June 30, 2023
Approval date for SMI/SED, if different from above	November 6. 2020
Implementation date of SMI/SED, if different from above	December 23, 2020
SMI/SED (or if broader demonstration, then SMI/SED - related) demonstration goals and objectives	This demonstration amendment will provide authority for the state to receive FFP for delivering treatment to Medicaid beneficiaries diagnosed with SMI while they are short-term residents in settings that qualify as IMDs, primarily to receive treatment for SMI. The goal of this amendment is for the state to maintain and enhance access to mental health services, and continue delivery system improvements to provide more coordinated and comprehensive treatment for beneficiaries with SMI. With this approval, beneficiaries will have access to a continuum of services at new settings that, absent this amendment, would be ineligible for payment for most Medicaid enrollees.

2. Executive Summary

As noted below, the state is unable to report several metrics this quarter due to a delay in metric production.

We can report that the utilization level of inpatient mental health services remained consistent with prior months during this reporting period. The utilization levels of outpatient, intensive outpatient, partial hospitalization mental health services decreased compared with prior months. However, the utilization is similar to the utilization in Q1 CY 2022 and 2023, suggesting that the decrease may be due to seasonality. Likewise the utilization level of emergency department mental health services decreased compared with prior months. However, the utilization has been lower in Q1 of the previous years , suggesting that the decrease may be due to seasonality.

The utilization level of telehealth mental health services decreased compared with prior months. This is likely a continuation of the downward trend of telehealth utilization as concerns around COVID-19 exposures waned.

The overall level of mental health service utilization has decreased compared with prior months.

The number of beneficiaries with SMI/SED treated in an IMD for mental health increased approximately 10% compared to CY 2022.

The monthly count of beneficiaries with SMI/SED remained consistent with prior months.

The number of grievances related to services for SMI/SED remained low. The number of appeals related to services for SMI/SED remained low. The number of critical incidents related to services for SMI/SED remained in the general range seen in prior years.

3. **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 Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings (Milestone 1)			
1.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.			
☒ 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 licensure or accreditation processes for participating hospitals and residential settings** **☐ii) The oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements** **☐ iii) The utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay** **☐ iv) The program integrity requirements and compliance assurance process**			

☐ **v) The state requirement that psychiatric hospitals and residential settings screen beneficiaries for comorbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions** ☐ **vi) Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings**
☐ **The state has no implementation update to report for this reporting topic.**
☐ **The state expects to make the following program changes that may affect metrics related to Milestone 1.**
☐ **The state has no implementation update to report for this reporting topic.**
2.2 Improving Care Coordination and Transitions to Community-Based Care (Milestone 2)
2.2.1 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 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) Actions to ensure that psychiatric hospitals and residential treatment settings carry out intensive predischarge planning, and include community-based providers in care transitions** ☐ **ii) Actions to ensure psychiatric hospitals and residential settings assess beneficiaries'**

housing situations and coordinate with housing services providers **☐ iii) State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers within 72 hours post discharge** **☐ iv) Strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers)** **☐ v) Other State requirements/policies to improve care coordination and connections to community based 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 2.			
☐ The state has no implementation update to report for this reporting topic.			
3.2 Access to Continuum of Care, Including Crisis Stabilization (Milestone 3)			
3.2.1 Metric Trends			
☒ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3.	• *The utilization level of inpatient mental health services remained consistent with prior months.* • *The utilization level of intensive outpatient and partial hospitalization mental health services decreased compared with prior months. However, the utilization is similar to the utilization in Q1 CY 2022 and 2023, suggesting that the decrease may be due to seasonality.* • *The utilization level of intensive outpatient mental health services decreased compared with prior months.*	*01/01/2021-03/31/2021*	*Mental Health Services Utilization - Inpatient* *Mental Health Services Utilization - Intensive*

	However, the utilization is similar to the utilization in Q1 CY 2022 and 2023, suggesting that the decrease may be due to seasonality. • *The utilization level of emergency department mental health services decreased compared with prior months. However, the utilization has been lower in Q1 of the previous years, suggesting that the decrease may be due to seasonality.* • *The utilization level of telehealth mental health services decreased compared with prior months. This is likely a continuation of the downward trend of telehealth utilization as concerns around COVID-19 exposures waned.* • *The overall level of mental health service utilization has decreased compared with prior months.* • *The number of beneficiaries with SMI/SED treated in an IMD for mental health increased approximately 10% compared to CY 2022.*	*Outpatient and Partial Hospitalization* *Mental Health Services Utilization - Outpatient* *Mental Health Services Utilization - ED* *Mental Health Services Utilization - Telehealth* *Mental Health Services Utilization - Any Services* *Beneficiaries With SMI/SED Treated in an IMD for Mental Health*

☐ **The state has no trends to report for this reporting topic.**			
3.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ **i) State requirement that providers use an evidenced-based, publicly available patient assessment tool to determine appropriate level of care and length of stay** ☐ **ii) Other state requirements/policies to improve access to a full continuum of care including crisis stabilization**			
☐ **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.**			
4.2 Earlier Identification and Engagement in Treatment, Including Through Increased Integration (Milestone 4)			
4.2.1 Metric Trends			
☒ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.**	• *The monthly count of beneficiaries with SMI/ED remained consistent with prior months.*	*01/01/2021/ - 03/31/2021*	*Count of Beneficiaries With SMI/SED (monthly)*
☐ **The state has no trends to report for this reporting topic.**			
4.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to:			

☐ **i) Strategies for identifying and engaging beneficiaries in treatment sooner (e.g., with supported education and employment)** ☐ **ii) Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment** ☐ **iii) Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED** ☐ **iv) Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people**
☐ **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.**
5.2 SMI/SED Health Information Technology (Health IT)
5.2.1 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.**
5.2.2 Implementation Update
Compared to the demonstration design and operational details, the state expects to make the following changes to:

☐ **i) The three statements of assurance made in the state's health IT plan** ☐ **ii) Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider and/or physician/mental health provider to community based supports** ☐ **iii) Electronic care plans and medical records** ☐ **iv) Individual consent being electronically captured and made accessible to patients and all members of the care team** ☐ **v) Intake, assessment and screening tools being part of a structured data capture process so that this information is interoperable with the rest of the health IT ecosystem** ☐ **vi) Telehealth technologies supporting** **collaborative care by facilitating broader availability of integrated mental health care and primary care** ☐ **vii) Alerting/analytics** ☐ **viii) Identity management**
☐ **The state has no implementation update to report for this reporting topic.**
☐ **The state expects to make the following program changes that may affect metrics related to health IT.**
☐ **The state has no implementation update to report for this reporting topic.**
6.2 Other SMI/SED-Related Metrics
6.2.1 Metric Trends

☒ **The state reports the following metric trends, including all changes (+ or -) greater than two 2 percent related to other SMI/SED-related metrics.**	• *The number of grievances related to services for SMI/SED remained low.* • *The number of appeals related to services for SMI/SED remained low.* • *The number of critical incidents related to services for SMI/SED remained in the general range seen in prior years.*	*01/01/2021 – 03/01/2021*	*Grievances Related to Services for SMI/SED* *Appeals Related to Services for SMI/SED* *Critical Incidents Related to Services for SMI/SED*
☐ **The state has no trends to report for this reporting topic.**			
6.2.2 Implementation Update			
☐**The state expects to make the following program changes that may affect other SMI/SED-related metrics.**			
☐ **The state has no implementation update to report for this reporting topic.**			
7.1 Annual Assessment of the Availability of Mental Health Providers			
7.1.1 Description Of Changes To Baseline Conditions And Practices			
☐ **Describe and explain any changes in the mental health service needs (for example, prevalence and distribution of SMI/SED) of Medicaid beneficiaries with SMI/SED compared to those described in the Initial Assessment of Availability of Mental Health Services.** **Recommended word count is 500 words or less.**			

☐ **This is not an annual report, therefore the state has no update to report for this reporting topic.**
☐**Describe and explain any changes to the organization of the state's Medicaid behavioral health service delivery system compared to those described in the Initial Assessment of Availability of Mental Health Services. Recommended word count is 500 words or less.**
☐ **This is not an annual report, therefore the state has no update to report for this reporting topic.**
☐ **Describe and explain any changes in the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state compared to those described in the Initial Assessment of Availability of Mental Health Services. At minimum, explain any changes across the state in the availability of the following services: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning. Recommended word count is 500 words or less.**
☐ **This is not an annual report, therefore the state has no update to report for this reporting topic.**
☐**Describe and explain any changes in gaps the state identified in the availability of mental health services or service capacity while completing the Availability Assessment compared to those described in the Initial Assessment of Availability of Mental Health Services.** **Recommended word count is 500 words or less.**
☐**This is not an annual report, therefore the state has no update to report for this reporting topic.**
7.1.2 Implementation Update

☐ **Compared to the demonstration design and operational details, the state expects to make the following changes to:**

☐ **i) The state's strategy to conduct annual assessments of the availability of mental health providers across the state and updates on steps taken to increase availability**

☐ **ii) Strategies to improve state tracking of availability of inpatient and crisis stabilization beds**

☐ **The state has no implementation update to report for this reporting topic.**

8.1 SMI/SED Financing Plan

8.1.1 Implementation Update

Compared to the demonstration design and operational details, the state expects to make the following changes to:

☐ **i) Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves law enforcement and other first responders**

☐ **ii) Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model**

☐ **The state has no implementation update to report for this reporting topic.**
9.2 Budget Neutrality
9.2.1 Current Status and Analysis
☐ **If the SMI/SED component is part of a broader demonstration, the state should provide an analysis of the SMI/SED-related budget neutrality and an analysis of budget neutrality as a whole. Describe the current status of budget neutrality and an analysis of the budget neutrality to date.**
9.2.2 Implementation Update
☐ **The state expects to make the following program changes that may affect budget neutrality.**
☐ **The state has no implementation update to report for this reporting topic.**
10.1 SMI/SED-Related Demonstration Operations and Policy
10.1.1 Considerations
☐ **States should highlight significant SMI/SED (or if broader demonstration, then SMI/SED-related) demonstration operations or policy considerations that could positively or negatively impact 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 SMI/SED 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 topic.**
10.1.2 Implementation Update
☐ **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 SMI/SED.**
☐**The state has no implementation update to report for this reporting topic.**
☐**The initiatives described above are related to the SMI/SED demonstration as described (States should note similarities and differences from the SMI/SED demonstration).**
☐**The state has no implementation update to report for this reporting topic.**
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**

☐ iv) The state Medicaid agency's Memorandum of Understanding (MOU) or other agreement with its mental health services agency
☐The state has no implementation update to report for this reporting topic.
11 SMI/SED Demonstration Evaluation Update
11.1. Narrative Information
☐ Provide updates on SMI/SED 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 SMI/SED demonstration evaluation update to report.
☐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 SMI/SED demonstration evaluation update to report.
☐List anticipated evaluation-related deliverables related to this demonstration and their due dates.
☐The state has no SMI/SED demonstration evaluation update to report.
12.1 Other Demonstration Reporting
12.1.1 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 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 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 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 topic.**
12.1.2 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.**

13.1 Notable State Achievements and/or Innovations
13.1 Narrative Information
☐ **Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SMI/SED (or if broader demonstration, then SMI/SED 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 topic.**

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

The MPT, FUH-CH, FUH-AD, FUA-AD, FUM-AD, AAP, APM, and APC measures (metrics #13, 14, 15, 16, 17, 18, 7, 8, 9, 10, 26, 29, 31) 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 Serious Mental Illness/Serious Emotional Disturbance 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 Quality Improvement Program

Report to Joint Select Committee on Health Care Oversight

Reporting period: July 1, 2024–September 30, 2024

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 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. 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.
HCA worked with MQIP partners throughout Q2 of 2023 to discuss new program parameters for MQIP 2.0 to correspond with the launch of MTP 2.0 effective July 1, 2023. The milestones under MQIP 2.0 will restart at Milestone 1 based on the new parameters being established.

Under MQIP 2.0, the Health Care Authority (HCA) will focus on improving social needs screening rates and reporting to help address inequities and social determinants of health. To do this, HCA will engage collaboratively with MCOs and their network providers to design a strategy to improve social needs screening rates and reporting.

The initial design of MQIP 2.0 was focused on alignment with the new National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measure, Social Need Screening and Intervention (SNS-E). However, after partnering providers completed Milestone 1, the focus of MQIP 2.0 shifted to pursue social needs screening projects more broadly. MCOs and their network providers will screen patients for three types of social needs: food, housing, and transportation.

Implementation status and results

During Q3 of 2023, HCA implemented a social needs screening survey as a required deliverable for all MQIP partners. This survey captures information regarding SNS-E readiness, current practices regarding social needs screening and interventions, and information regarding screening categories and tools used.

All MQIP partners completed the survey to receive payments for Milestone 1 in Q4 of 2023. These survey results informed discussions regarding social needs screening, appropriate screening categories and tools, and alignment between SNS-E requirements and other agency priorities such as health-related social needs (HRSN) services under MTP 2.0.

Key results from the survey included the following:

- The top three tools used for social needs screenings were the following: PREPARE, Accountable Health Communities, Hunger Vital Sign.
- Other HRSN categories identified were financial resources, social connectedness, and safety.
- Most social needs screenings occur upon enrollment within an MCO or entry into a provider facility.

- The top barriers identified in implementing SNS-E project changes were billing coding issues, data infrastructure and fragmentation, and capacity issues with both providers and community-based organizations to address positives social needs screenings.

During Q1 of 2024, MQIP partners created a SNS-E project proposal that works to standardize SNS-E practices across partnering public hospitals. HCA approved MQIP partners project proposal in early Q2 of 2024.

Recognizing the importance of social needs screenings for care coordination, efforts are currently underway to create consistency and reduce variability in SNS-E across both UW Medicine and AWPHD's health delivery systems. Practices are being developed locally by individual clinics or facilities. Currently, there is no uniform referral practice, but efforts are in progress to align practices and goals. Referrals are primarily internal, facilitated through limited social worker outreach, with each entity having its own resources and processes to support patients in meeting their social needs. Much of this variation is due to geographical differences and the availability of external resources.

There is a continuous effort to create and maintain a shared set of resources by health systems or hospitals. However, access to and availability of various resources remains limited.

To address the current state and streamline social needs screening and referral practices, MCOs and partnering providers will seek to:

- Reduce variation and support resource alignment across provider networks
- Develop shared screening policies and procedures
- Develop shared referral processes and procedures

In Q3 of 2024, MQIP partners worked on implementation infrastructure needed to undertake a project of this scale. These activities include convening stakeholders across provider networks, defining shared tools and measure sets available in current electronic health record systems, and selecting and implementing pilot sites for future milestones. In Q4 of 2024, MQIP partners will continue implementation work, in preparation to submit baseline SNS-E data across provider networks beginning in 2025.

Milestones, payment, and improvement measures

Reporting periods occur every six months and each reporting period represents a milestone for approval and payment.

As part of achieving a milestone, UW Medicine and AWPHD submit an implementation plan status report, updated work plan, or other required deliverables based on parameters established by HCA. Data from Milestone 1 survey completion will be reported in future MQIP reports once those results have been synthesized.

Expenditures

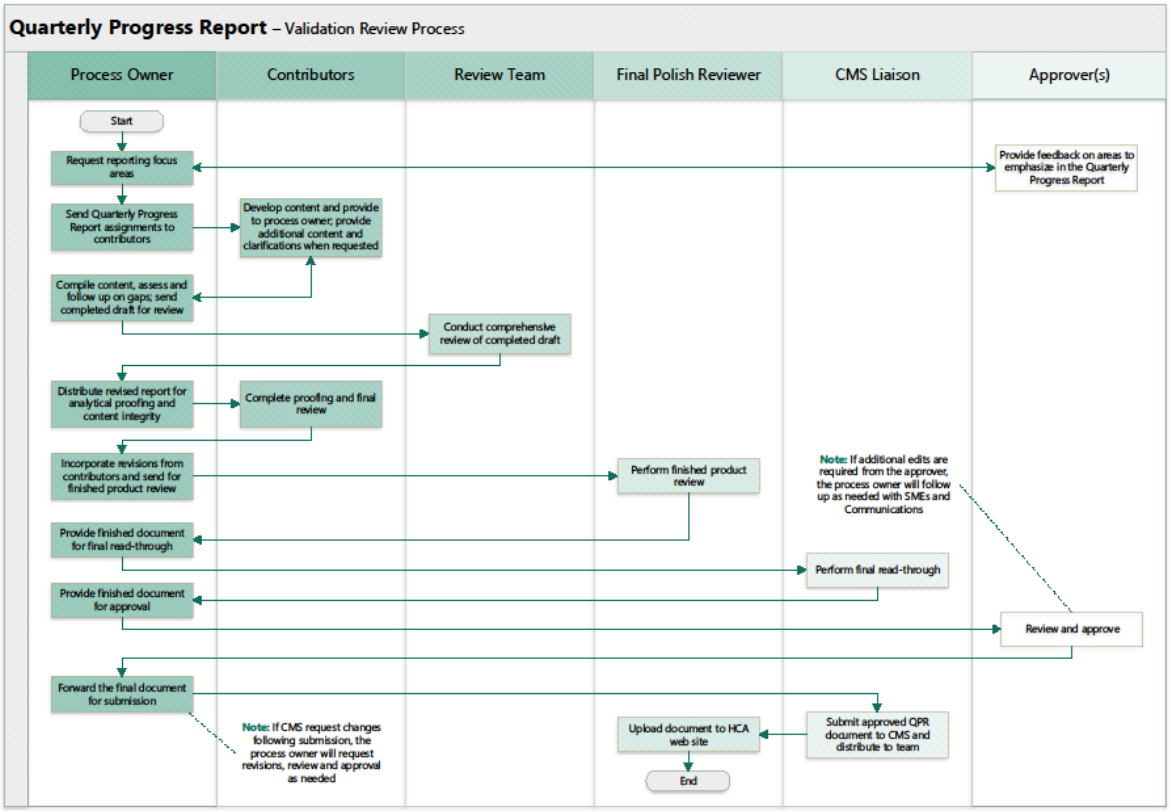
HCA anticipates releasing MQIP payments for Milestone 3 in December 2024, and the estimated payment amount is $121 million across MQIP partners. HCA made no payments to MCOs this quarter.

Quarterly Progress Report with MQIP Quarterly Report / Quarterly Legislative Report - Validation Review Process

Quarterly Progress Report Overview:

The Quarterly Progress Report is created to meet a Special Terms and Conditions (STC) requirement for CMS. It is a compilation of activities, accomplishments and updates covering the previous quarter of the Medicaid Transformation Project. Key tasks include content development, compilation, review and approval.

Process Flow:



Quarterly Progress Report with MQIP Quarterly Report / Quarterly Legislative Report - Validation Review Process

Role Assignments:

Process Owner:	Cassidy Farrow
Contributors:	Policy, MPD, Finance, LTSS, FCS and SUD program leads, HIT, IMC, VBP, Tribal Affairs, Communications, and ARM
Review Team:	Emma Oppenheim/Sagung Colina
CMS Liaison:	Emma Oppenheim
QA:	MTP team
Final Polish Reviewer(s):	Lyndsay Fluharty, Rachelle Alongi
Approver(s):	Mich'l Needham, Michael Arnis

Process Steps:

Role	Step	Description/Best Practices	Time to complete	Example dates
Process Owner	Send Quarterly Progress Report assignments to contributors	Create a template with pre-populated sections assigned to contributors. (To avoid confusion, the template should not include a table of contents.) Send assignments a few days before the end of the reporting quarter to give the contributors as much time as possible. Include in the email: • Report templates (MQIP and Quarterly Progress Report) • High level schedule Update high-level tasks in the MTP Operations work plan in Clarizen to track the status of the quarterly report.	2 days	10/16 – 10/18
Contributors	Develop content and provide to process owner; provide additional content and clarifications when requested	Develop the reports. (Additional content is required when developing the combined Quarterly/Annual Progress Report.) Assignments are included in the report template. See **best practices** for what the review teams will look for.	(+/-) 3 weeks	10/18 – 11/8
Process Owner	Compile content, assess and follow up on gaps; send completed draft for review	Compile content as it is provided. An additional 3 days is given to compile content after the contributor's deadline. To streamline formatting, clear formatting from incoming content before compiling into the new report. Before handing off, conduct a huddle with the review team to coordinate logistics, special updates, timing, and roles.	1 day	11/8
Review Team	Conduct comprehensive review of completed draft	The review team are content SMEs that transition the draft into a completed documents. The documents can be provided back to the process owner when all tracked changes have been accepted. See **best practices** for what to look for when reviewing the consolidated draft report.	3 days	11/8 – 11/12
Process Owner	Distribute revised report for analytical proofing and content integrity; include leadership team	Request a follow-up review from the report contributors to ensure the meaning is intact and analytical information is accurate. Include a reminder to the contributors to seek input from their leadership as needed.	1 day	11/12

Quarterly Progress Report with MQIP Quarterly Report / Quarterly Legislative Report - Validation Review Process

Role	Step	Description/Best Practices	Time to complete	Example dates
Contributors	Complete proofing and final review	This step provides the opportunity to ensure the meaning is intact and the analytical information in charts, graphs and tables is correct. Contributors provide the report to their leadership to incorporate their input as needed before the report is final. This may include leaders from ALTSA, BHA, DBHR, FSD, MSA and the DSRIP Program Team. 1115 SUD Demonstration Monitoring Workbook – Part A completed (delay due to metric production cycles). 1115 SUD Demonstration Monitoring Report – Part B metric narrative completed (other elements of the monitoring report to be completed during step 5: initial compilation of content).	5 days	11/12 – 11/18
QA	Perform initial quality assurance review	Perform initial quality assurance review	1 day	11/18
Final Polish Reviewer	Perform formatting review	Communications provides the final finished product review, making edits and formatting changes directly to the documents. The review takes into account overall readability and style. See **best practices** for what this review includes.	3 days	11/18 – 11/20
Process Owner	Provide finished document for final read-through	Provide the finished documents to the CMS Liaison for a final read-through.	1 day	11/20
CMS Liaison	Perform final read-through	Review the final documents before sending for approval.	1 day	11/20
Process Owner	Provide finished documents for approval (Quarterly Progress Report and MQIP Quarterly Report)	Once the read-through is complete, email the finished documents to the approvers for final review.	1 day	11/20
Approver(s)	Review and approve	This step provides the final approval of the finished product. Note: If additional edits are required, the process owner follows up with content providers, SMEs and Communications, as needed.	3 days	11/20 - 11/22
Process Owner	Forward the final document for submission	Send the Quarterly Progress Report and the 1115 SUD Demonstration Monitoring Report Workbook (unsuppressed) to the CMS Liaison for final submission to CMS. • Upload the final version to SharePoint • Send the Quarterly Progress Report to the Final Polish Reviewer to post the document to the HCA website. Also send the MQIP report to the CMS Liaison.	1 day	11/22
CMS Liaison	Submit approved Quarterly Progress Report to CMS and distribute to the team	Save the Quarterly Progress Report as a PDF and email to CMS. Quarterly Progress reports are due: • Q1 – June 1 of each year	1 day	11/22

Commented [CF1]: Goal to submit early since a lot of people will be OOO Thanksgiving week

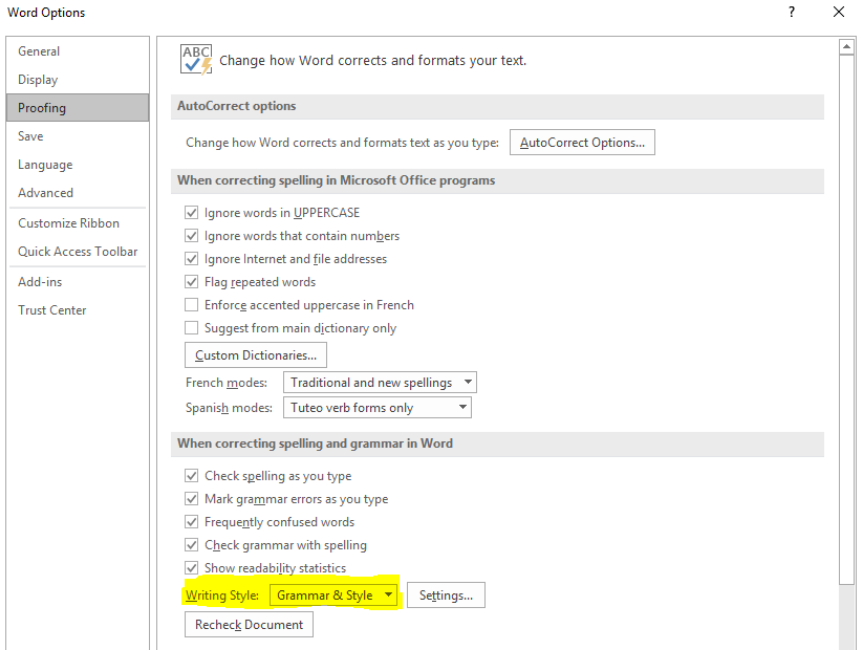
Quarterly Progress Report with MQIP Quarterly Report / Quarterly Legislative Report - Validation Review Process

Role	Step	Description/Best Practices	Time to complete	Example dates
		• Q2 – September 1 of each year • Q3 – December 1 of each year • Quarterly/Annual Progress Report – March 1 of each year Example Quarterly Progress Report name: WA MTP DYQ3 Quarterly_ Report_vF Example Quarterly / Annual Progress Report name: WA MTP DY2Q4 Quarterly_DY 2 Annual Progress Report_vF Forward the submitted Quarterly Progress Report, as well as the MQIP Quarterly Report to the Healthier Washington team. Also forward to the Quarterly Legislative Report process owner.		
Final Polish Reviewer	Upload the document to HCA website	Following the submission to CMS, post the document to the HCA website and post the final word version of the report to an internal site.	6 days	11/25 – 12/2
Documents returned for changes from CMS				
Process Owner (Chase)	Revise and reissue	This step only occurs when CMS request revisions to a submitted report. In this event, the process owner and other potentially impacted contributors make the requested revisions and move the document through a round of review and approval as needed.	TBD	TBD

Best practices for content development and review:

Best practices (overall):

- Plain talking, including using simple terms and making sentences as short as possible (about 18-20 words maximum per sentence). The longer the word, the more difficult the word is to understand (e.g. instead of "surreptitious" write "sneaky" or "sly.")
- Using an active voice (e.g. instead of "*it was decided* to not buy any more Girl Scout cookies" write "*we decided* to not buy any more Girl Scout cookies"). If you want to know when you're using passive voice in Microsoft Word, click on File > Options > Proofing > under *When correcting spelling and grammar in Word* section, select Grammar and Style." See below. This tool will prompt you to change to active voice. Using an active voice will make your writing more clear, understandable, and credible.



- Level of detail / what to share with audience.
- Using an active voice
- Level of detail / what to share with audience
- Standard terminology, standard program names, use of acronyms (a list of acronyms and program names will be included in the Quarterly Progress Report for reference)
- Providing titles for figures/exhibits/tables
- Providing editable tables where possible (to allow changes, if needed)
- Specifying footnotes and ensuring links work

Review Team will look for:

- (above)

- Message and tone
- Evenness across content areas / level of detail
- Links go with content

Communications will look for:

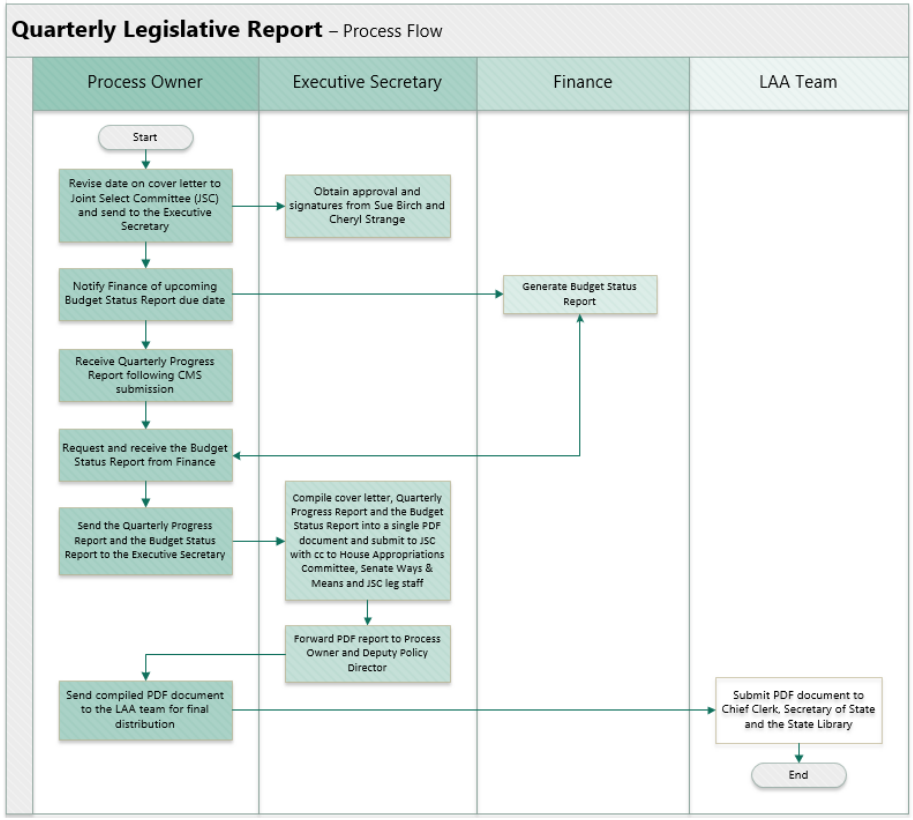
- (above)
- Sentence structure
- Using Word readability statistics (measures passive sentences, Flesch reading ease, and Flesch-Kincaid grade level and tells you how easy a document is to understand)
- Adding indexing for figures/exhibits/tables
- Adding table of contents
- Use of footnotes and hyperlinks/URLs
- Use of capitalization, headings, margins, spacing, document headers and footers, footnotes
- Visual appearance (fonts, colors, spacing, etc.)

Quarterly Progress Report with MQIP Quarterly Report / Quarterly Legislative Report - Validation Review Process

Quarterly Legislative Report Overview:

The Quarterly Legislative Report includes the Quarterly Progress Report and a financial report provided by the Finance team. A pre-defined cover letter is updated to accompany the submission. The process is initiated two weeks in advance of the CMS submission of the Quarterly Progress Report and completes approximately two weeks following submission.

Process Flow:



Role Assignments:

Quarterly Progress Report with MQIP Quarterly Report / Quarterly Legislative Report - Validation Review Process

Process Owner: Keah Hardy/Tokina Brown
Executive Secretary: Michelle Cleary
Finance: Mary Hughes
LAA Team: Evan Klein and Staff

Process Steps:

Role	Step	Description/Best Practices	Time to complete (business days)
Process Owner	Revise date on cover letter to Joint Select Committee (JSC) in preparation of the final report.	Initiate the process approximately ten business days before the scheduled submission of the Quarterly Progress Report (QPR). In addition to the cover letter date, review cc's and make appropriate changes. Reference http://leg.wa.gov/legislature/Pages/CommitteeListing.aspx or ask Evan Klein (or legislative staff) for update of names to include.	1 day
Process Owner	Notify Finance of upcoming Budget Status Report due date		1 day
Finance	Generate Budget Status Report	Finance requests ten business days advance notice to generate the report.	10 days
Process Owner	Receive Quarterly Progress Report following CMS submission	The CMS liaison provides the quarterly progress report and the MQIP quarterly report when it is submitted to CMS. The Quarterly Progress reports are submitted: • Q1 – June 1 of each year • Q2 – September 1 of each year • Q3 – December 1 of each year • Quarterly/Annual Progress Report – March 1 of each year Example Quarterly Progress Report name: WA MTP DY2Q3 Quarterly_ Report_vF Example Quarterly/Annual Progress Report name: WA MTP DY2Q4 Quarterly_DY 2 Annual Progress Report_vF	1 day
Process Owner	Request and receive the Budget Status Report from Finance.	Provide advanced notice to Mary as needed. Example Budget Status Report name: JSC quarterly leg report through 12.31.2018	3 days
Process Owner	Compile the cover letter, Quarterly Progress Report, MQIP quarterly report and the Budget Status Report into a single PDF document and submit to the Executive Assistant for signature	This activity happens about a week following submission of the Quarterly Progress Report to CMS. Include House Appropriations Committee staff, House Health Care and Wellness Committee staff, and Senate Ways & Means Committee staff.	2 day

Quarterly Progress Report with MQIP Quarterly Report / Quarterly Legislative Report - Validation Review Process

Role	Step	Description/Best Practices	Time to complete (business days)
Process Owner/Policy Administrative assistant	Compile cover letter, Quarterly Progress Report, MQIP quarterly report and the Budget Status Report into a single PDF document and submit to JSC with cc to House Appropriations Committee, Senate Ways & Means and JSC leg staff	This activity happens about a week following submission of the Quarterly Progress Report to CMS. Include House Appropriations Committee staff, House Health Care and Wellness Committee staff, and Senate Ways & Means Committee staff.	2 days
Executive Secretary	Forward PDF report to Process Owner and Deputy Policy Director	Forward submitted document to the Policy Director and the Process Owner (Michael Arnis and Judy Beckler).	1 day
Process Owner	Send SIGNED compiled PDF document to Chase, Sagung, Tamarra and Lucy (LAA Team) for final distribution		1 day
LAA Team	Submit PDF document to Chief Clerk, Secretary of State and the State Library		1 day

Washington State Health Care Authority

Medicaid Transformation Project

Health Care Authority	SFY 22-23 Budget	SFY 22 Expenditures to Date	SFY 23 Expenditures to Date	SFY 22-23 Total Expenditures	SFY 24-25 Budget	SFY 24 Expenditures to Date	SFY 25 Expenditures to Date	SFY 24-25 Total Expenditures
MTP 2.0	**$0**	**$0**	**$0**	**$0**	**$ 342,123,056**	**$2,357,769**	**$562,688**	**$2,920,458**
Admin (GF-F)	$0	$0	$0	$0	**$ 12,621,650**	$2,357,769	$562,688	$2,920,458
HRSN Infrastructure (GF-F)	$0	$0	$0	$0	$ 50,421,000	$16,200,503	$13,432,301	$29,632,804
HRSN Services (GF-F)	$0	$0	$0	$0	$ 279,080,406	$0	$0	$0
MTP 2.0	**$88,813,000**	**$40,640,750**	**$11,803,229**	**$52,443,980**	**$ 213,316,715**	**$18,558,268**	**$13,994,988**	**$32,553,256**
Admin (GF-L)	$6,259,500	$2,095,400	$2,698,013	$4,793,413	**$ 12,621,650**	$2,357,764	$562,687	$2,920,451
HRSN Infrastructure (GF-L)	$0	$0	$0	$0	$ 50,421,000	$16,200,503	$13,432,301	$29,632,804
HRSN Services (GF-L)	$82,553,500	$38,545,351	$9,105,217	$47,650,567	$ 150,274,065	$0	$0	$0
Initiative 1 - DSRIP	**$93,094,000**	**$42,934,419**	**$12,037,457**	**$54,971,876**	**$3,137,000**	**$875,625**	**$0**	**$875,625**
Admin (GF-F)	$10,540,500	$4,389,068	$2,932,241	$7,321,309	$3,137,000	$875,625	$0	$875,625
DSRIP Incentives (GF-F)	$82,553,500	$38,545,351	$9,105,217	$47,650,567	$0	$0	$0	$0
Initiative 1 - DSRIP	**$88,813,000**	**$40,640,750**	**$12,037,453**	**$52,678,204**	**$3,137,000**	**$875,624**	**$0**	**$875,624**
Admin (GF-L)	$6,259,500	$2,095,400	$2,932,237	$5,027,637	$3,137,000	$875,624	$0	$875,624
DSRIP Incentives (GF-L)	$82,553,500	$38,545,351	$9,105,217	$47,650,567	$0	$0	$0	$0
Re-entry Services	**$0**	**$0**	**$0**	**$0**	**$121,570,000**	**$0**	**$1,980,000**	**$1,980,000**
Re-entry Services (GF-F)					$60,785,000	$0	$990,000	$990,000
Re-entry Services (GF-L)					$60,785,000	$0	$990,000	$990,000
Initiative 2 - DSHS MAC/TSOA**	$79,456,000	$22,281,245	$36,606,249	$58,887,494	$116,654,000	$22,730,088	$20,870	$22,750,958
MAC/TSOA (GF-F)	$39,728,000	$11,140,623	$17,942,783	$29,083,406	$58,321,000	$11,466,179	$10,435	$11,476,614
MAC/TSOA (GF-L)	$39,728,000	$11,140,622	$18,663,466	$29,804,089	$58,333,000	$11,263,909	$10,435	$11,274,344
Initiative 3 DSHS PE	**$0**	**$0**	**$0**	**$0**	**$35,482,000**	**$50,995**	**$5,692**	**$56,686**
DSHS Presumptive Eligibility (GF-F)	$0	$0	$0	$0	$17,741,000	$25,497	$2,846	$28,343
DSHS Presumptive Eligibility (GF-L)	$0	$0	$0	$0	$17,741,000	$25,497	$2,846	$28,343
Initiative 3 - FCS	**$57,244,000**	**$22,205,645**	**$45,518,634**	**$67,724,279**	**$65,148,000**	**$45,642,693**	**$6,362,120**	**$52,004,814**
FCS SE ADMIN (GF-F)	$1,046,500	$837,747	$631,095	$1,468,842	$ 1,106,000.00	$785,855	$256,688	$1,042,543
FCS SE ADMIN (GF-L)	$1,046,500	$320,018	$631,095	$951,113	$ 1,106,000.00	$785,854	$256,688	$1,042,543
FCS SE SERVICES (GF-F)	$14,919,690	$6,099,491	$7,993,457	$14,092,948	$ 17,705,980.00	$8,646,591	$993,279	$9,639,870
FCS SE SERVICES (GF-L)	$6,094,810	$1,190,489	$4,206,682	$5,397,170	$ 7,232,020.00	$3,432,669	$371,220	$3,803,889
FCS SH ADMIN (GF-F)	$1,853,000	$1,372,013	$1,470,392	$2,842,405	$ 2,002,500.00	$1,960,806	$611,962	$2,572,769
FCS SH ADMIN (GF-L)	$1,852,000	$609,300	$1,470,392	$2,079,692	$ 2,002,500.00	$1,960,806	$611,962	$2,572,768
FCS SH SERVICES (GF-F)	$21,605,550	$9,652,068	$18,924,423	$28,576,491	$ 24,135,030.00	$19,663,497	$2,273,488	$21,936,985
FCS SH SERVICES (GF-L)	$8,825,950	$2,124,519	$10,191,097	$12,315,616	$ 9,857,970.00	$8,406,615	$986,832	$9,393,447
Agency Admin (GF-F)	$0	$0	$0	$0	$0	$0	$0	$0
Initiative 3 - FCS**	**$1,170,000**	**$615,387**	**$493,594**	**$1,108,981**	**$1,580,000**	**$947,609**	**$50,060**	**$997,670**
DSHS FCS ADMIN (GF-F)	$585,000	$307,694	$246,797	$554,490	$790,000	$473,805	$22,184	$495,989
DSHS FCS ADMIN (GF-L)	$585,000	$307,693	$246,797	$554,490	$790,000	$473,804	$22,184	$495,989

DSHS - ALTSA	SFY 22 Budget	SFY 22 Expenditures to Date		SFY 22 Expenditures to Date	SFY 24-25 Budget	SFY 24 Expenditures to Date	SFY 25	SFY 24-25 Expenditures to Date
Initiative 2 - MAC and TSOA	**$29,292,000**	$27,344,798	$0	**$27,344,798**	$ -		$0	**$0**
Initiative 3 - FCS	**$624,000**	$350,546	$0	**$350,546**	$0	$0	$0	**$0**

DSHS and HCA (Community Behavioral Health)	SFY 22-23 Budget	SFY 22 Expenditures to Date*	SFY 23 Expenditures to Date*	SFY 22- 23 Expenditures to Date*	SFY 24-25 Budget	SFY 24 Expenditures to Date*	SFY 25 Expenditures to Date*	SFY 24-25 Expenditures to Date*
Initiative 3 - FCS	**$3,364,000**	**$937,771**	**$752,540**	**$1,690,311**	**$4,367,000**	**$1,147,285**	**$276,421**	**$1,423,706**
FCS (GF-F)	$2,104,000	$711,715	$376,218	$1,087,933	$2,183,500	$573,643	$138,210	$711,854
FCS (GF-L)	$1,260,000	$226,056	$376,322	$602,377	$2,183,500	$573,642	$138,210	$711,852

*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.