STATE OF WASHINGTON

March 10, 2025

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,

MaryAnne Lindeblad, BSN, MPH
Acting Director
Health Care Authority

Cheryl Strange
Acting Secretary
Department of Social and Health Services

Enclosures

By email

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

Washington State Health Care Authority

Washington State Medicaid Transformation Project (MTP 2.0)

Section 1115 demonstration waiver quarterly report

Demonstration Year (DY) 9 | Reporting Period 2:

October 1 – December 31, 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 (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 Care Hubs and one statewide Native Hub

Vision: A healthier Washington

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

Quarterly report: October 1 – December 31, 2024

This quarterly report summarizes activities from the third reporting period of MTP 2.0: October 1 through December 31, 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 $57,097,176.00 to partnering providers and organizations in support of project planning and implementation activities.
- During this reporting period, HCA has distributed $57,608,768.00 to ACHs for health-related social need (HRSN) infrastructure investments to support readiness for the delivery of Community Care Hub services.
- As of December 31, 2024, more than 19,350 clients and 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 4,503 clients.
- As of December 31, 2024, Long-Term Services and Supports (LTSS) presumptive eligibility (PE) has shown expected growth while in phase 1 (PE in Acute Care Hospital). On October 7th, Region 1 began testing phase 2 (statewide in-home applicants) to evaluate the impact of allowing all eligible participants wanting in-home LTSS services to pursue LTSS PE. On October 15, Aging and Long-Term Care of Eastern Washington (ALTCEW) Area Agency on Aging (AAA) also started offering LTSS PE as part of the phase 2 testing. They conducted 28 LTSS PE assessments this quarter.
- ALTSA completed the 2024 quality assurance cycle during this reporting period.
- Within Foundational Community Supports (FCS), the total aggregate number of people enrolled in services at the end of this reporting period includes 2,923 in IPS and 7,744 in Community Support Services (CSS). The total unduplicated number of enrollments at the end of this quarter reporting period is 13,632.
- On Continuous Apple Health enrollment for children ages 0 through 5, for this reporting period the number of new enrollments in October is 6,469; in November is 4,748; and in December is 3,419.
- On Apple Health postpartum coverage expansion, for this reporting period the number of new enrollments in October is 648; in November is 774; and in December is 847.
- Within the Reentry Initiative, 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. HCA received and reviewed 18 CBAs and established follow-up interviews for these facilities.
- For HRSN services, HCA received approval from CMS of payment rate methodologies for the HRSN services submitted for review: recuperative care and short-term post hospitalization housing; nutrition supports; medically necessary environmental accessibility and remediation adaptation; caregiver respite; and community transition services personal care and homemaker.

MTP 2.0-wide stakeholder engagement

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

- Hosting the 2024 MTP Public Forum
- Posting health-related social needs public comment notices

2024 MTP Public Forum

On December 11, 2024, HCA hosted the annual MTP Public Forum. The purpose of the forum was to provide the public with an update on our Medicaid waiver programs and share the next steps for MTP. The agenda included:

- An overview of MTP and its current position
- A deep dive into specific MTP initiatives

- A review of successes and challenges for the year

More than 300 people attended the forum this year – more than any previous MTP forum. Time was allotted for questions and answers, which yielded more questions than any previous year. Watch the recording and view the slide deck on the MTP meetings and materials page.

Health-related social needs public comments

In November, HCA posted the following public comment notices and associated fee schedules on HCA Public notices webpage:

- MTP 2.0 Rent and Temporary Housing Public Notice
- MTP Waiver Medical Respite Care Methodology under HRSN Public Notice
- MTP Nutrition Supports Rate Methodology Public Notice
- MTP Caregiver Respite Services Public Notice
- MTP Personal Care and Homemaker Services Public Notice
- MTP Home Accessibility and Remediation Services Public Notice

Collaboration and Shared Learning

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.

For this reporting period, there are no further updates on collaboration or shared learning activities.

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 October 1 through December 31, 2024.

MAC and TSOA

As of December 31, 2024, more than 19,350 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 4,503 clients.

Aging and Long-Term Support Administration (ALTSA) completed the 2024 annual quality assurance cycle during this review period.

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

Expansion highlights include:

- Utilizing the updated TSOA income eligibility criteria (400 percent of the federal benefit rate), 43 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), 17 additional participants in the expanded eligibility tier accessed TSOA services this quarter.

LTSS presumptive eligibility

As of December 31, 2024, LTSS) presumptive eligibility (PE) has shown expected growth while in phase 1 (PE in Acute Care Hospital). On October 7, Region 1 began testing phase 2 (statewide in-home applicants) to evaluate the impact of allowing all eligible participants wanting in-home LTSS services to pursue LTSS PE. In just over two weeks into testing, 257 intakes requesting LTSS PE were processed. The influx of those interested in pursuing LTSS PE was too overwhelming to manage region wide, so the testing area was narrowed down to Spokane County only. Although this brought the numbers down, a backlog of clients remained that needed to be processed by the Region 1 staff. Two new Social Service Specialist 2's (SSS2) were hired to work alongside the existing SSS2 in assessing for LTSS PE eligibility. Region 1 has conducted 252 LTSS PE assessments this quarter, which includes phase 1 and limited phase 2 testing within the region. While the remainder of the state continues operating under phase 1, Region 2 completed 50 LTSS PE assessments and Region 3 completed 28.

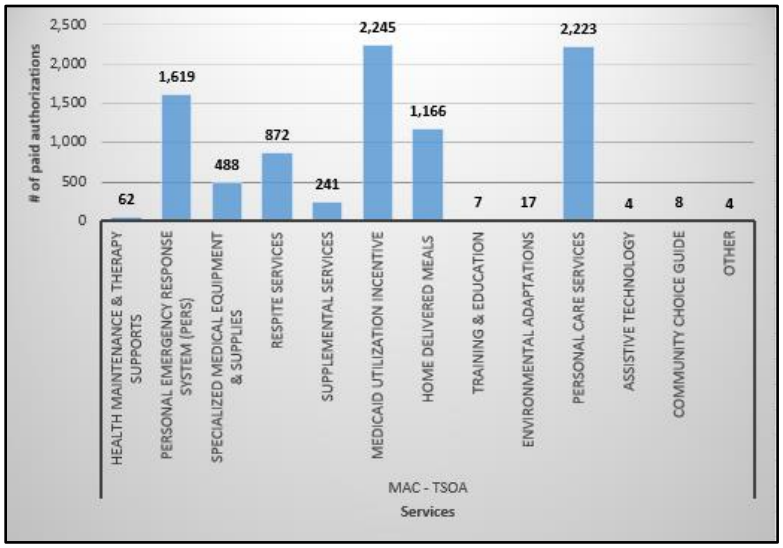
On October 15, Aging and Long-Term Care of Eastern Washington (ALTCEW) Area Agency on Aging (AAA) also started offering LTSS PE as part of the phase 2 testing. They conducted 28 LTSS PE assessments this quarter.

Regional staff have raised some concerns about the LTSS PE assessment functionality in phase 1, prompting collaboration with the CARE Web developers that led to enhancements this quarter.

Service utilization

MAC and TSOA service utilization

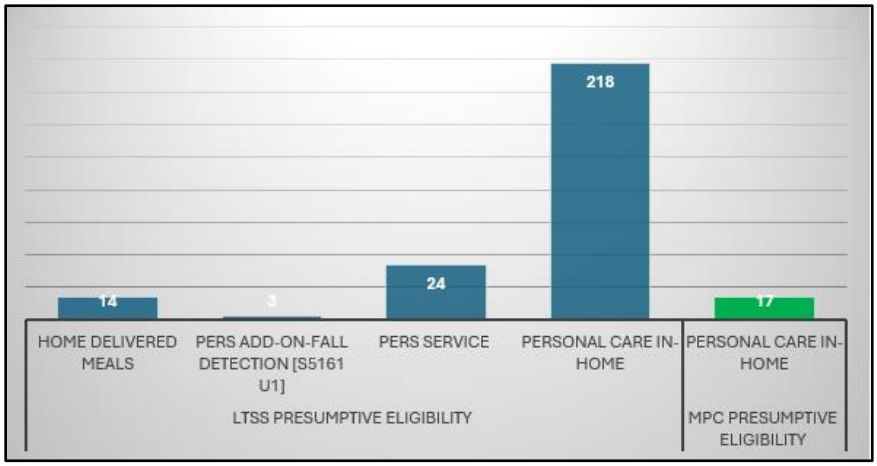
Figure 1: MAC and TSOA service utilization



LTSS PE service utilization

The chart below depicts the services that are currently being authorized during this quarter under LTSS PE. Please take note that the blue bars represent NFLOC services, where the green bar represents MPC personal care.

Figure 2: LTSS PE services utilization



Network adequacy for MAC and TSOA

The AAAs continue to monitor already established provider contracts as well as execute new contracts to expand their provider networks based on each planning service area's (PSA) identified needs.

The statewide direct care workforce shortage continues to impact the availability of respite and personal care providers. The MAC and TSOA programs successful implementation of the self-directed care model in June 2024 has proven invaluable, as it allows another option for care receivers to obtain respite and personal care, as identified in the person-centered care plan. Since the self-directed care model implementation, 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 the added provider option appears to be lessening the impact.

In addition to the self-directed care model, ALTSA also implemented the Remote Care Services pilot to help address the direct care workforce shortage which is an available option for MAC and TSOA participants when a direct care worker is unavailable.

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.

Assessment and systems update

MAC and TSOA

Collabrios (formally RTZ), 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 back to GetCare. During this quarter, continued troubleshooting and monitoring the system interface was necessary along with oversight and follow-up of referrals.

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 registration assistance process
- Implementation of a view option in GetCare for care receiver's eligibility status from WA State's payments system, ProviderOne.

ALTSA and community partners continue to work with TCARE Inc. to make needed 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, creating 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

In collaboration with CARE Web developers, CARE Web released the following updates for December 2024:

- LTSS: PE financial update for N-Series clients
- LTSS: Add weight, skin concerns, bedbound indicators to PE screenings
- LTSS: Add weight, skin concerns, bedbound indicators to LTSS PE Care Plan Form
- LTSS: Case-sharing ticklers
- Identify shared cases with a color tag
- LTSS PE Care Plan: keep accessible after LTSS PE Screening has been finalized/completed

An LTSS PE Data Report was built and placed into production this quarter. This report collects data from CARE Web and ProviderOne to pull real-time information and filter as necessary, such as by region, reporting unit, services authorized, date ranges, and when a client moves from LTSS PE to a core Medicaid program.

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:

- October 2024: Equity, Diversity, Access and Inclusion – Cultural Humility
- November 2024: Estate Recovery and Tribal Exemption
- December 2024: No offerings provided

Upcoming scheduled webinars include:

- January 2025: Quality Assurance Process Review for MTP 2024

HCA will schedule 2025 trainings based on staff feedback provided in the results of the 2024-2025 Training Survey.

LTSS PE

Region 1 hosts a weekly meeting to discuss any issues that have risen during the testing of Phase 2. Staff from the AAAs attend these meetings as they are case-sharing LTSS PE clients. Regional training materials, an implementation manual, workflows, and meeting agendas are all accessible on the TEAMS channel to facilitate continuous communication and review of relevant documents.

Two new Social Service Specialist 2's have been hired. They have completed training and are currently conducting LTSS PE assessments.

Data and reporting

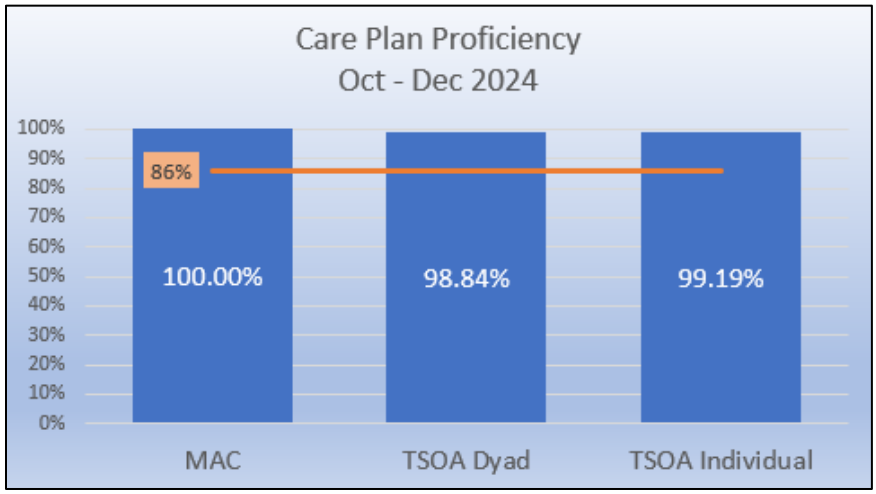
MAC and TSOA

Table 1: Beneficiary enrollment by program

	MAC dyads	TSOA dyads	TSOA individuals
LTSS beneficiaries by program as of December 31, 2024	304	1,388	3,276
Number of new enrollees in quarter by program	48	240	469
Number of new person-centered service plans in quarter by program	21	76	164
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	27	162	305
Number of beneficiaries self-directing services under employer authority*	12	30	105

*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

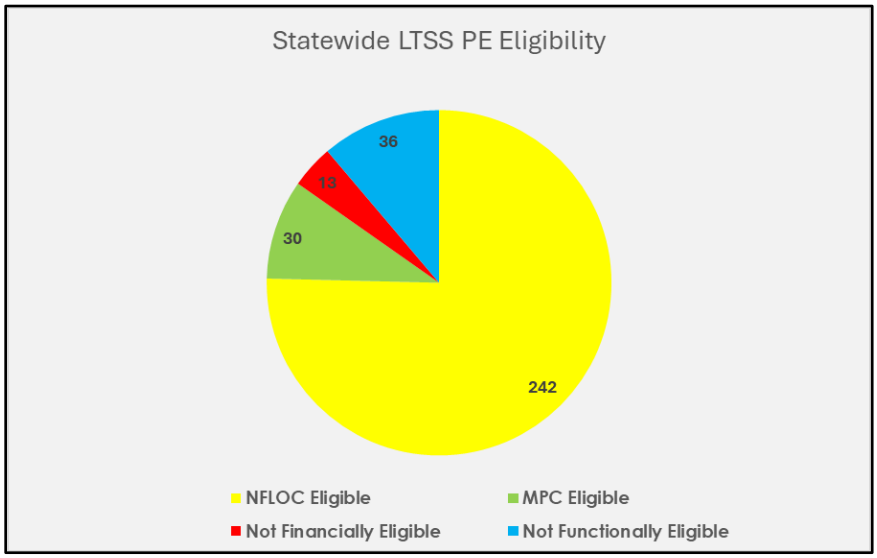


Note: The 86 percent line represents the CMS proficiency expectation.

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

LTSS PE

Figure 4: Statewide LTSS PE eligibility



Tribal engagement

MAC and TSOA

DSHS Aging and Long-Term Support Administration (ALTSA) Tribal Affairs team met with a number of tribes to discuss Medicaid services including the MAC and TSOA programs, Family Caregiver Support Program (FCSP) and Foundational Community Supports (FCS) services this quarter:

- **October:** No tribal engagement activities occurred. Tribal affairs continued working on developing Tribally focused MAC and TSOA materials.
- **November:** Tribal Affairs shared MAC and TSOA program information with Skokomish Tribe as part of a Health Homes presentation.

- **December:** Tribal Affairs engaged in a Health Homes discussion with Swinomish which included sharing information on the MAC and TSOA programs.

Tribal Affairs continues building relationships with Tribal Nations while sharing services supported by Money Follows the Person Tribal Initiative (MFPTI) including MAC and TSOA programs. During this quarter, Tribal Affairs participated in meetings with ALTSA MAC & TSOA program managers to increase culturally responsive materials to develop more culturally appropriate outreach materials for Tribal Nations. MAC and TSOA and other programs for unpaid caregivers continue to be a focus of Tribal Affairs outreach when working with Tribal partners. Developing outreach materials that provide concise, pertinent information for Tribal Nations should increase the utilization of the MAC and TSOA program for Tribal Nations. This effort will continue throughout 2025.

LTSS PE

There has been no Tribal outreach within LTSS PE this quarter.

Outreach and engagement

MAC and TSOA

ALTSA's MAC and TSOA program manager continues to seek indigenous volunteers to participate in interviews for an outreach video for the family caregiver programs and have begun partnering with ALTSA Tribal Affairs to create outreach materials which are tribal specific.

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

Table 2: Number of outreach and engagement activities held by AAAs

	October	November	December
Community presentations and information sharing	107	39	139

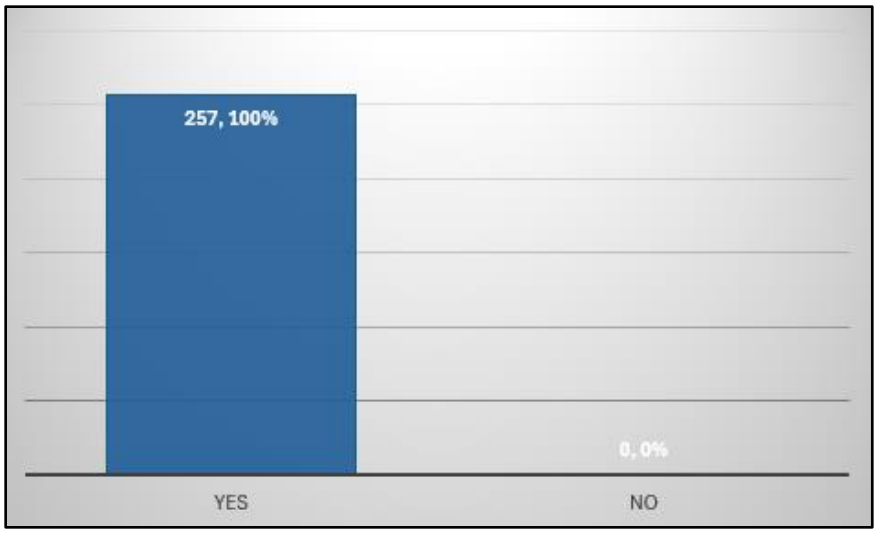
LTSS PE

There has been no planned outreach within LTSS PE this quarter, but as Region 1 tests Phase 2, they have partnered with the AAAs and their subcontractors, adding additional outreach through their organization.

Quality assurance

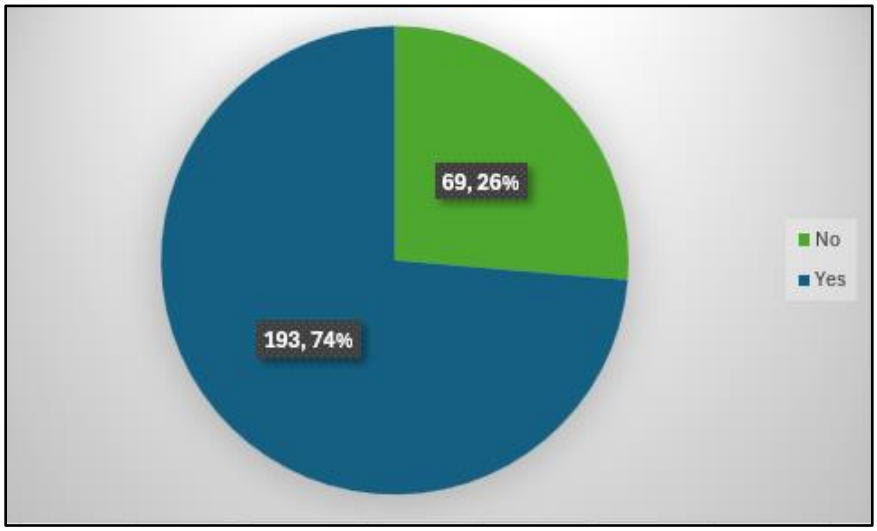
MAC and TSOA

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



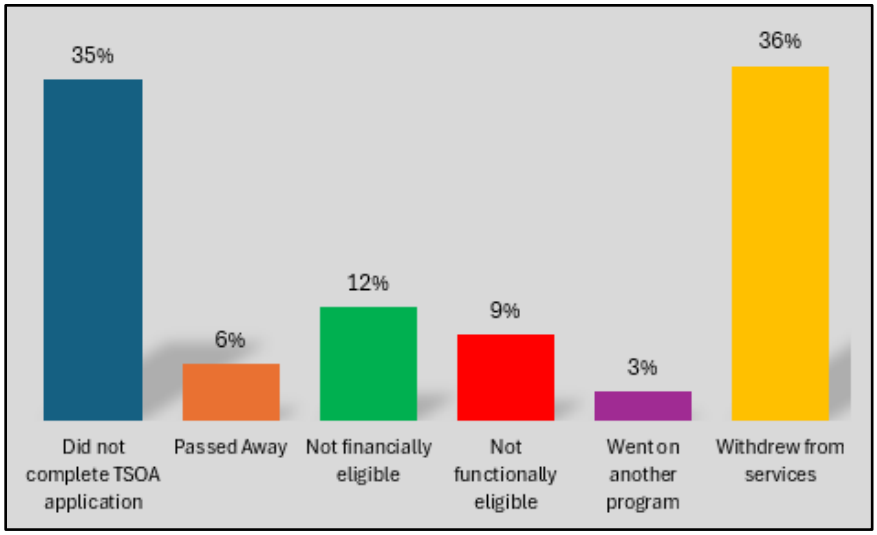
Note: 257 beneficiaries were appropriately determined NFLOC eligible with 100% success rate. 67 beneficiaries are not applicable as they have been reported on previously and the beneficiary's full eligibility determination occurred during this quarter.

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



Note: 193 beneficiaries (74%) transitioned from PE to full eligibility. 62 beneficiaries this quarter are still pending full eligibility and were therefore not applicable. 69 beneficiaries (26%) 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, 69 participants (26%) outlined above. For example, the 12 percent of PE clients found to be not financially eligible, are out of the 69 participants, who 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 Presumptive Eligibility period?

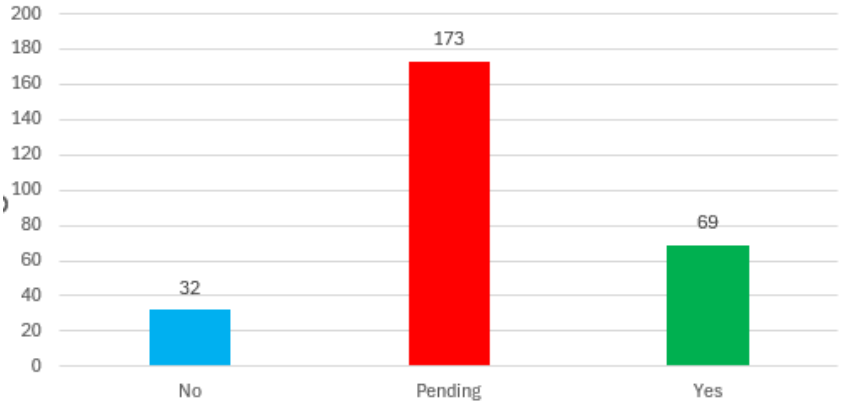


Figure 8: Question 1b: For those who with “No” responses, why?

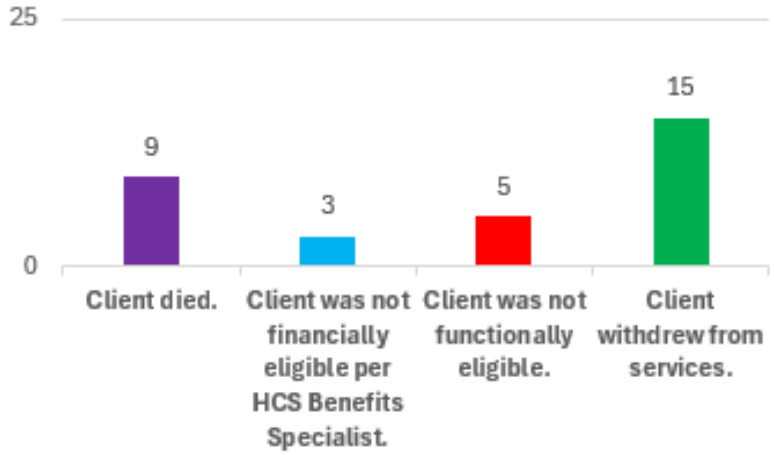


Figure 9: Question 2a: Did level of care remain the same from PE assessment to full CARE assessment? (Only applies to those who went onto in-home services)

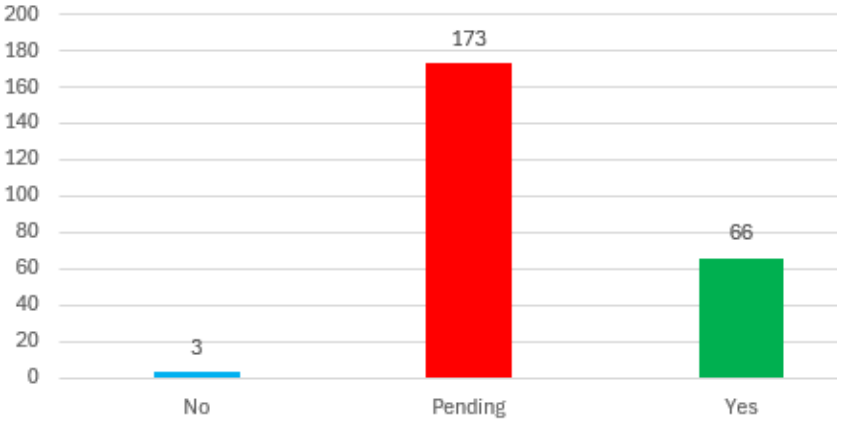
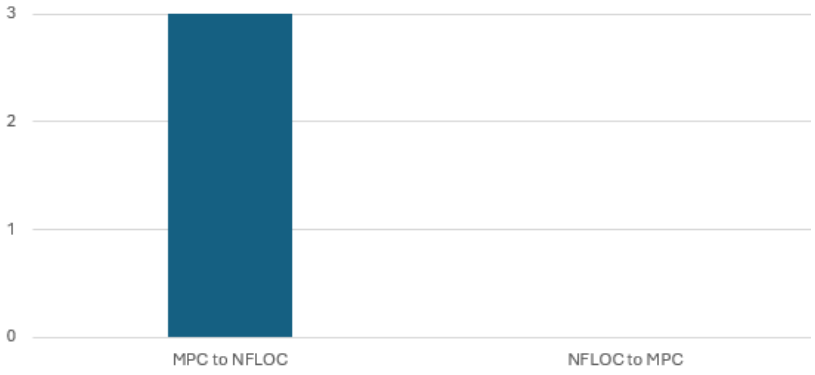


Figure 10: QA 2b: Did level of care remain the same from PE assessment to full CARE assessment? (Only applies to NO RESPONSE)



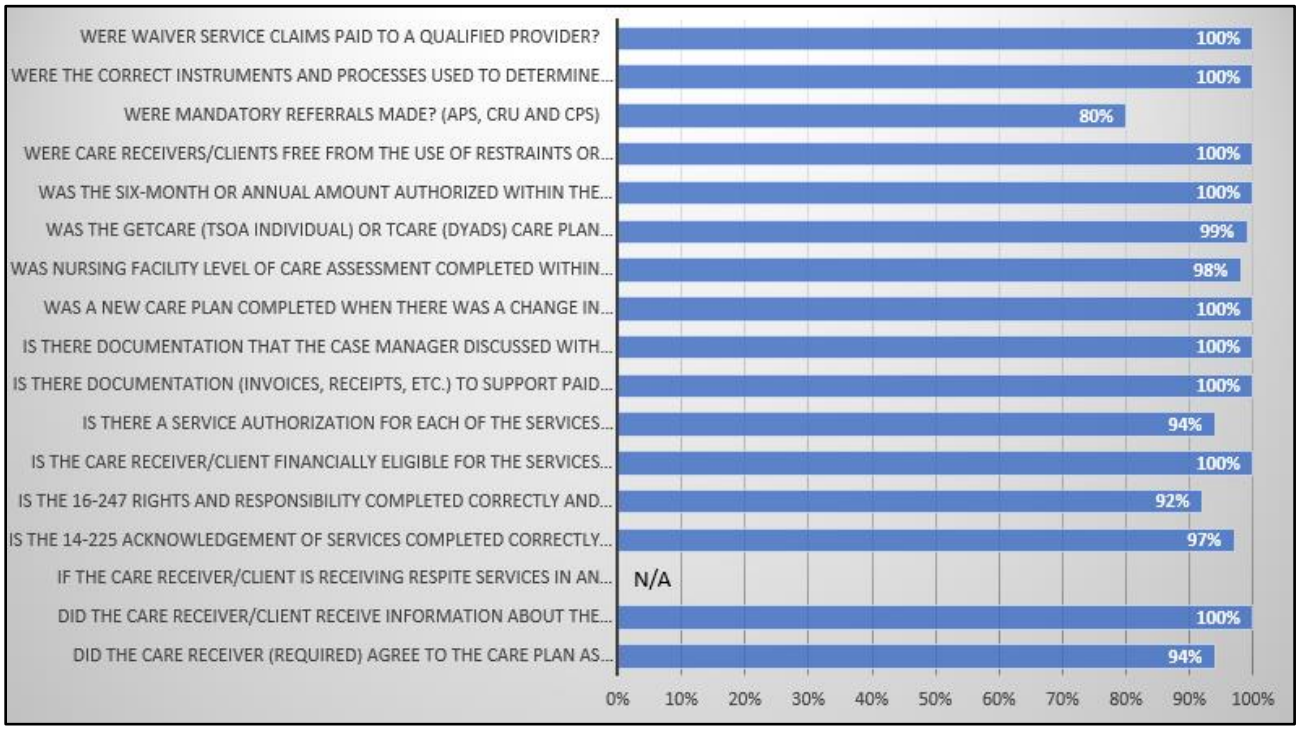
2024 quality assurance results to date

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 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 was 350 cases. The methodology used is the same for the state's 1915c waivers and meets the CMS requirements for sampling. Each AAA's sample was determined by multiplying the percent of the total program population in that area by the sample size.

Figure 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

Continue monitoring system infrastructure and referral processes regarding the recent implementation of the Consumer Direct Employer – self-directed care model.

LTSS PE

Within Region 1, HCS and AAAs agreed to initiate Phase 2 testing ahead of statewide implementation. This testing phase will continue through the next quarter, as we continue to collect data, evaluate staffing requirements, and refine the processes. The goal is to ensure that all obstacles have been adequately addressed before moving forward.

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 October 1 through December 31, 2024.

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

- CSS: 7,744
- IPS: 2,923

There were 238 providers under contract with Wellpoint at the end of the reporting period, representing 555 sites throughout the state.

Note: CSS and IPS enrollment totals include 2,965 participants enrolled in both programs. The total unduplicated number of enrollments at the end of this reporting period was 13,632.

Network adequacy for FCS

Table 3: FCS provider network development

	October		November		December	
FCS service type	Contracts	Service locations	Contracts	Service locations	Contracts	Service locations
Supported Employment – Individual Placement Support (IPS)	38	79	38	79	39	80
Community Support Services (CSS)	28	65	28	65	29	66
CSS and IPS	167	403	168	404	170	409
Total	233	547	234	548	238	555

Table 4: FCS client enrollment

	October	November	December
Supported Employment – Individual Placement and Support (IPS)	3118	3045	3217
Community Support Services (CSS)	8583	8169	8146
CSS and IPS	3203	3226	3259
Total aggregate enrollment	14904	14440	14622

Data source: RDA administrative reports

Table 5: FCS client risk profile

		Met HUD homeless criteria	Avg. PRISM risk score	Serious mental illness
October	IPS	810 (13%)	1.07	4409 (70%)
	CSS	2479 (21%)	1.29	7704 (65%)
November	IPS	815 (13%)	1.06	4356 (69%)
	CSS	2413 (21%)	1.28	7451 (65%)
December	IPS	844 (13%)	1.09	4531 (70%)
	CSS	2428 (21%)	1.29	7502 (66%)

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 6: FCS client risk profile continued

		Medicaid only enrollees*	MH treatment need	SUD treatment need	Co-occurring MH + SUD treatment needs flags
October	IPS	5422	4962 (92%)	3401 (63%)	3181 (59%)
	CSS	10088	9163 (91%)	7282 (72%)	6755 (67%)
November	IPS	5341	4870 (91%)	3306 (62%)	3093 (58%)
	CSS	9740	8856 (91%)	6970 (72%)	6485 (67%)
December	IPS	5438	4934 (91%)	3360 (62%)	3129 (58%)
	CSS	9743	8806 (90%)	6937 (71%)	6417 (66%)

Data source: RDA administrative reports

*Does not include individuals who are dual enrolled.

Table 7: 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
October	IPS	5422	750 (14%)	3932 (73%)	2211 (41%)	626 (12%)
	CSS	10088	980 (10%)	6766 (67%)	4480 (44%)	838 (8%)
November	IPS	5341	757 (14%)	3799 (71%)	2107 (39%)	634 (12%)
	CSS	9740	960 (10%)	6433 (66%)	4243 (44%)	815 (8%)
December	IPS	5438	837 (15%)	3795 (70%)	2095 (39%)	688 (13%)

	CSS	9743	968 (10%)	6313 (65%)	4158 (43%)	814 (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 8: 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
October	IPS	1732 (27%)	175 (3%)	756 (12%)	2572 (41%)	881 (14%)	192 (3%)
	CSS	3194 (27%)	699 (6%)	1475 (13%)	3997 (34%)	2266 (19%)	125 (1%)
November	IPS	1751 (28%)	181 (3%)	724 (12%)	2534 (40%)	888 (14%)	179 (3%)
	CSS	3120 (27%)	667 (6%)	1417 (12%)	3856 (34%)	2191 (19%)	116 (1%)
December	IPS	1877 (29%)	209 (3%)	733 (11%)	2564 (40%)	907 (14%)	172 (3%)
	CSS	3143 (28%)	674 (6%)	1408 (12%)	3843 (34%)	2187 (19%)	119 (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 Q1. 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 DY9 Q1, the FCS team conducted 2 formal reviews on FCS programs. Each of these agencies voluntarily participated and each review team consists of at least two other peer agencies. All in all, the learning collaborative aims to increase quality services is continuing to grow.

All of 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 at the end of DY7 and early DY8. The program maintained a waitlist for new enrollments that were managed on a first-come, first-served basis as space became available in the program. By the end of DY9 Q1, the pause was lifted and Wellpoint worked alongside FCS contracted agencies to ensure enrollment of all participants still in need of services. The waitlist backlog was processed by January 2025. There is no longer a waitlist for new FCS participants. 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. The disenrollment process was updated to more accurately track numbers of active enrollees in the future.

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. FCS trainers provided multiple webinars to offer information to regions without a similar coalition, the intent of which was to encourage development of FCS provider coalitions across the state.

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 Q1, this group is focusing 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, 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 to select Tenant-Based Rental Assistance (TBRA) awardees of the benefit in Q2 or Q3. In addition to TBRA vouchers, the first AHAH capital units became available for eligible FCS-SH enrollees to apply for in December 2024. AHAH is a benefit to FCS enrolled clients and provides project or tenant based rental subsidies to eligible enrollees.

The FCS Transition Assistance Program (TAP) serves 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, 2025, $1,350,000 was released to the TAP Provider Network. TAP expended funds for the first half of SFY25 as of Thursday, August 29, 2024, at 5pm. The additional $1,350,000 was made available January 1, 2025, for the remainder of SFY25. As of January 14, 2025, approximately $473,000 has been requested.

Upcoming activities

- Supported Employment Fidelity Reviewer Community of Practice: Lead Supported Employment Reviewer training was launched in 2024 to promote agency staff to become certified reviewers and expand the ability to conduct fidelity reviews across the state. Bimonthly sessions to strengthen the cadre will continue throughout 2025.
- 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 4 FCS trainers continue to provide training upon request of or as offered to current FCS provider agencies. Technical assistance provided may be to individual providers, a group of stakeholders, or statewide training. Training is provided either virtually or face to face.

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 9: Number of FCS program stakeholder engagement activities

	October	November	December
Training and assistance provided to individual organizations	78	106	78
Community and regional presentations and training events	7	3	3
Informational webinars	20	10	11

Stakeholder engagement meetings	27	13	12
Total activities	132	132	104

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
- Financial Wellness and Benefit Planning
- Providing and Documenting Medically Necessary Services

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 Q2 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 Section 1115 Medicaid demonstration waiver 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 institutions for mental diseases (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 October 1 through December 31, 2024. Accomplishments for this reporting period include:

- The state held its Co-occurring Disorders (COD) Conference, October 7-8.
- The Prevention Summit was October 30-31 in Seattle.

In October Kim Mount and Tony Walton from the Division of Behavioral Health and Resources (DBHR) Adult Substance Use Disorder Treatment section attended the Addiction Health Sciences Research conference in San Francisco. The conference was hosted by research partners at Stanford University. Kim presented at a symposium on HCA's role in SITT-MAT (Stagewise Implementation to Target – Medications for Addiction Treatment), a collaborative research project that aims to expand access to medications for opioid use disorder across Washington State. The symposium also featured behavioral health clinic providers and researchers involved in the project who shared their perspectives on this unique partnership.

The Joint Legislative Executive Committee (JLEC) continued to meet during this period and developed 4 subcommittees which met 3 times between 0ctober and December. They focused on:

- Community-based behavioral health and the behavioral health workforce
- Administrative and structural issues
- Prevention and early intervention
- Disparities and inequities

This work followed along and collaborated with other work going on to avoid duplication of efforts with other groups that included: CYBHWG, Washington Thriving, SURSAC, and CRIS committees.

A bed inventory was developed for JLED and an inventory of all BH Washington BH services will follow.

Implementation plan

In accordance with the amended STCs, the state is required to submit an implementation plan for the SUD IMD waiver, incorporating six key milestones outlined by CMS. At the time of the waiver application, Washington met a number of these milestones in its provision of SUD services. Where the state did not meet the milestones, CMS was engaged to confirm appropriate adjustments. There are no updates at this time to the state's SUD implementation plan.

SUD Health IT plan requirements

No updates to report at this time.

Evaluation design

No updates to report at this time.

Monitoring protocol

In preparing for reporting the SUD metrics this quarter, the state noticed an issue in the reporting for the prior quarter. To resolve this, we have re-reported the updated metric results from the prior quarter in the tab named "SUD Metrics (2)".Upcoming activities

No upcoming activities to report at this time.

MHIMD waiver implementation accomplishments

In November 2020, the state received approval of its Section 1115 Medicaid demonstration waiver 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 the mental health (MH) IMD waiver development and implementation activities from October 1 through December 31, 2024.

The Joint Legislative Executive Committee (JLEC) continued to meet during this period and developed 4 subcommittees which met 3 times between 0ctober and January. They focused on:

- Community-based behavioral health and the behavioral health workforce
- Administrative and structural issues
- Prevention and early intervention
- Disparities and inequities

This work followed along and collaborated with other work going on to avoid duplication of efforts with other groups that included: CYBHWG, Washington Thriving, SURSAC, and CRIS committees.

A bed inventory was developed for JLED and a inventory of all BH Washington BH services will follow.

Implementation plan

No updates to report this period.

MH health IT plan requirements

This quarter, HCA initiated contracts related to the MH waiver Health IT plan requirements. There are no updates to report at this time.

Evaluation design

No updates to report at this time.

Monitoring protocol

No updates to report at this time.

Upcoming activities

The legislative session begins in January and HCA anticipates that there will be work devoted to coverage of emergency services and behavioral health parity.

Contingency Management for SUD treatment implementation accomplishments

On July 1, 2023, Washington State received approval of its Section 1115 Medicaid demonstration waiver 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 October 1 through December 31, 2024.

Implementation progress

The project team has continued to meet and coordinate with stakeholders. The state completed the following activities during the reporting period:

- Prepared preliminary contract documents
- Developed communications for site notification

Upcoming activities

- The project team will complete communication with selected sites on implementation
- The project team will establish contracts with sites
- The project team will 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 Section 1115 Medicaid demonstration waiver 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 October 1 through December 31, 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 0-6.

Table 10: Number of new enrollments

	October	November	December
New enrollee between the ages of 0 and 1	4280	2996	1777
New enrollee age 1 through age 5 years	2189	1752	1642
Total	6469	4748	3419

Table 11: Number of unduplicated enrollments

	October	November	December
Unduplicated number between the ages of 0 and 1	43450	42832	41032
Unduplicated number age 1 through age 5 years	216190	216268	216201
Total	259640	259100	257233

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 12: Number of new enrollments

	October	November	December
Postpartum Care	648	774	847

Total distinct: 1053

Reentry from a carceral setting implementation accomplishments

On July 1, 2023, Washington State received approval of its Section 1115 Medicaid demonstration waiver 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 October 1 through December 31, 2024.

Implementation progress

Participation in the Reentry Initiative is based on carceral facilities meeting five key milestones.

Table 13: Reentry Initiative milestones by cohort

	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

Reentry Initiative milestones

1) Submit an Intent to participate form indicating the facility's intent to participate and select a cohort. In the Intent to Participate form, participating facilities will also choose which cohort they will go live. 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 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. For facilities intending to go live July 1, 2025 HCA extended the deadline for submitting CBAs to December 31, 2024.

HCA received and reviewed 18 CBAs and established follow-up interviews for these facilities.

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.
- Continued partnership with Washington Association of Sheriffs and Police Chiefs (WASPC). Held Reentry meetings with WASPC participants to communicate reentry roles, responsibilities, and provide technical assistance.
- Released a Request for Proposal (RFP) regarding a Third-Party Administrator's (TPA) role to support administrative and care management functions.
- Continued the development of a Policy and Operations Guide.
- Continued the development of a Learning Series to train facilities on subjects such as Medicaid 101, provider enrollment, client eligibility and enrollment, and pre-release service delivery.
- Facilitated the first training of the Learning Series with the goal of delivering one training every two weeks. The first of the series centered on Reentry 101 where participants learned about Medicaid, covered services, contracting and credentialing, roles and responsibilities for reentry.

Challenges

None to report at this time.

Upcoming activities

- Work with Cohort 2 facilities through monthly meetings to discuss ongoing activities.
- One-on-one meetings to address facility-specific questions.
- Technical assistance sessions.
- Continuing the Learning Series with a new subject every two weeks.
- Continue to review submitted Capacity Building Application, which includes an Implementation Plan and Readiness Assessment.
- Release Milestone 2 funding to facilities that successfully completed the CBA.
- Publish the Policy and Operations Guide to include an introduction, provider enrollment, client eligibility and enrollment, and pre-release service delivery sections.
- Align with courts and juvenile detention facilities concerning reentry.
- Continue collaboration with Managed Care Organizations (MCOs) and Accountable Communities of Health (ACHs)

Continued Engagement

HCA continues to engage several advisory groups, including the Washington Association of Sheriffs and Police Chiefs and the Re-entry Advisory Workgroup (RAW). RAW, initially mandated by legislation, offers guidance on reentry program design and implementation. It comprises representatives from state agencies, carceral facilities, associations, community-based organizations, and other justice-involved policy leaders. RAW collaborates to improve reentry services.

Furthermore, HCA ensures alignment with Reentry Initiative requirements through coordination with DOC, DCYF, and Juvenile Detention Facilities. Several implementation subgroups have been formed to work on various aspects such as facility and provider readiness, pharmacy, provider enrollment, system changes, care management continuity, pre-release and post-release, eligibility and enrollment, and benefit design for the pre-release period.

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.
- Complete an Operational Readiness Assessment template for facilities to attest to their current and/or planned readiness to support pre-release services.

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 Section 1115 Medicaid demonstration waiver for new programs.

- The **Community Care 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.
- **Health-related social needs (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 October 1 through December 31, 2024.

Community Care Hubs

Implementation progress

- HCA received CMS approval of the HRSN services protocol.
- HCA continues to work with and collaborate with ACHs on the implementation of Community Care Hubs.

Upcoming activities

HCA continues to collaborate with ACHs to develop a process for reporting requirements for hub services, the scope of work of the community health worker in a community hub setting, and the coordinating and aligning of hub services with other HRSN services and reentry.

Data and reporting

The state continues to work with the Community Care Hubs to build necessary infrastructure for data and reporting as defined by the STCs. Data will be collected after the service is fully operationalized.

Native Hub

This quarter, the Native Hub efforts have focused on two items:

- Presenting at the American Indian Health Commission's biannual Tribal and State Leaders Health Summit
- Infrastructure implementation

Implementation progress

Every two years, the American Indian Health Commission hosts the Tribal and State Leaders Health Summit. This event is attended by elected tribal leaders, Indian health care providers, the Governor's Office, and the heads of state agencies, such as the Health Care Authority, the Department of Social and Health Services and the Department of Health, as well as the staff who support Tribes and IHCPs at these agencies. There were four breakout sessions, with one focusing on the Native Hub.

Infrastructure implementation progress includes hiring a Native Hub Analyst and executing the technical assistance contract with the American Indian Health Commission.

Upcoming activities

HCA and the American Indian Health Commission will be hosting a standing meeting to establish an agreed upon plan for launching the Native Hub.

Data and reporting

Data will be captured when the services have been implemented.

Health related social needs (HRSN) services and infrastructure

Implementation progress

During this reporting period, HCA received CMS approval of the HRSN services protocol. HCA continues to work on HRSN services implementation through a phased approach:

- Phase 1a: Case management, outreach, and education (to establish the community and Native hubs) Washington State MTP 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. Washington's internal workgroup, along with sub-groups focused on specific services, continues to guide the planning and implementation of HRSN services

Partnership with existing housing agencies

The state will implement housing subsidies through HCA contracts and the Department of Social and Health Services (DSHS) 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

HCA continues to administer HRSN infrastructure payments to ACHs. HCA continues to work to develop an application process for other eligible entities to access infrastructure funds.

Upcoming activities

Washington continues to convene key external partners, notably ACHs and managed care organizations (MCOs), to design a collaborative process for delivering HRSN services. Washington continues to work on coordinating and aligning cross-initiatives work between HRSN services and the reentry initiative.

Data and reporting

Data collection and reporting will commence once the services are fully implemented.

Data sharing between partner entities

Data collection and reporting will commence once the services are fully 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 **$57,097,176.34** to **three** 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 pay for performance and High-Performance Pool (HPP) payments have been distributed to the nine ACHs. HCA and ACHs continue to partner on the transition from Delivery System Reform Incentive Payment (DSRIP) to the programs approved under MTP 2.0, including nine Community Care Hubs and one statewide Native Hub to support and deliver HRSN services.

The ACHs' formal responsibilities related to value-based purchasing (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

HCA has distributed $57,608,768 in HRSN infrastructure funds in DY9 to the Community Care Hubs (ACHs). Infrastructure investments support the development and implementation of HRSN services.

Table 14: 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	$2,977,691.00			$9,695,382.00
CHOICE	$5,996,358.44	$2,706,409.50			$8,702,767.94
Elevate Health	$7,323,482.50	$3,243,482.41			$10,566,964.91
Greater Health Now	$8,549,095.50	$3,789,095.50			$12,338,191.00
HealthierHere	$12,118,550.92	$5,742,420.91			$17,860,971.83
Thriving Together North Central Washington	$2,800,000.00	$1,100,000.00			$3,900,000.00
North Sound	$9,156,717.50	$4,056,716.31			$13,213,433.81

Olympic Community of Health	$2,331,148.00	$1,356,220.00			$3,687,368.00
SWACH	$4,272,565.00	$1,892,565.00			$6,165,130.00
Native Hub					

HRSN Services Expenditures

HCA will begin providing funds to ACH's for service expenditures in January 2025.

Table 15: Reentry Initiative planning and implementation

During Q2, HCA paid out a total of $250,000 to 2 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	$100,000			$600,000
Tier Two (50-249)	$875,000				$875,000
Tier Three (250-1,000)	$600,000	$150,000.00			$750,000.00
Tier Four (more than 1,000)	$0.00				$0.00
Total	$1,975,000	$250,000			$2,225,000

Table 16: 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	$7,041,894			11,049,104
Medicaid Alternative Care (MAC)	$155,792	$283,675			439,467
MAC and TSOA not eligible		$36,708			36,708
Presumptive Eligibility	$56,686	$98,018			56,686
FCS	$22,500,446	$9,379,527			31,879,973

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 17: 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	376,270	0	0	0	0	0	0	0	0
Feb-17	391,117	0	0	0	0	0	0	0	0
Mar-17	390,716	0	0	0	0	0	0	0	0
Apr-17	389,262	0	0	0	0	0	0	0	0
May-17	388,863	0	0	0	0	0	0	0	0
Jun-17	388,741	0	0	0	0	0	0	0	0
Jul-17	387,853	0	0	0	0	0	0	0	0
Aug-17	387,738	0	0	0	0	0	0	0	0
Sep-17	386,391	0	0	0	0	0	0	0	0
Oct-17	386,295	0	0	0	0	0	0	0	0
Nov-17	386,210	0	0	0	0	0	0	0	0
Dec-17	386,298	0	0	0	0	0	0	0	0
Jan-18	386,664	0	0	0	0	0	0	0	0
Feb-18	385,177	0	0	0	0	0	0	0	0
Mar-18	385,072	0	0	0	0	0	0	0	0
Apr-18	383,752	0	0	0	0	0	0	0	0
May-18	384,213	0	0	0	0	0	0	0	0
Jun-18	383,308	0	0	0	0	0	0	0	0
Jul-18	383,190	7	23	123	11	0	0	0	0
Aug-18	382,675	14	31	212	43	0	0	0	0
Sept-18	381,646	7	13	109	40	0	0	0	0
Oct-18	381,722	7	13	115	48	0	0	0	0
Nov-18	381,422	7	27	171	33	0	0	0	0
Dec-18	380,916	9	26	165	38	0	0	0	0
Jan-19	381,421	32	106	395	49	0	0	0	0
Feb-19	379,609	28	101	386	45	0	0	0	0
Mar-19	379,292	31	128	427	40	0	0	0	0
Apr-19	378,898	37	122	448	42	0	0	0	0
May-19	378,201	46	141	506	52	0	0	0	0
June-19	377,291	59	165	592	52	0	0	0	0
Jul-19	377,796	77	163	791	45	0	0	0	0
Aug-19	377,460	73	196	810	47	0	0	0	0
Sep-19	376,825	75	205	846	42	0	0	0	0
Oct-19	376,243	89	224	976	33	0	0	0	0
Nov-19	375,375	87	217	886	38	0	0	0	0
Dec-19	375,606	91	241	1074	44	0	0	0	0
Jan-20	376,122	78	188	1042	35	0	0	0	0

Feb-20	375,963	55	174	823	39	0	0	0	0
Mar-20	377,826	64	173	947	36	0	0	0	0
Apr-20	381,658	83	181	1148	16	0	0	0	0
May-20	384,328	58	220	817	17	0	0	0	0
Jun-20	387,317	74	232	1124	19	0	0	0	0
Jul-20	390,050	85	231	1256	19	0	0	0	0
Aug-20	393,069	51	203	870	29	0	0	0	0
Sep-20	395,345	67	205	1068	35	0	0	0	0
Oct-20	397,420	70	216	1220	22	0	0	0	0
Nov-20	398,429	36	188	755	18	0	0	0	0
Dec-20	400,008	47	209	863	24	47	22	60	6
Jan-21	401,136	43	222	843	25	2	2	13	6
Feb-21	401,141	26	87	294	15	107	38	173	7
Mar-21	402,575	22	82	309	14	109	38	171	6
Apr-21	403,863	20	73	286	13	108	38	172	4
May-21	404,967	32	86	311	22	111	39	171	4
Jun-21	405,980	20	31	163	20	111	38	168	3
Jul-21	407,384	26	101	375	18	109	38	168	5
Aug-21	409,278	20	92	320	15	107	38	173	4
Sep-21	410,426	18	80	313	15	111	38	173	6
Oct-21	411,625	17	78	261	15	110	39	171	5
Nov-21	413,356	15	77	293	12	111	39	170	6
Dec-21	413,650	8	40	214	12	112	38	171	5
Jan-22	415,210	4	13	88	8	107	36	178	4
Feb-22	416,361	36	179	649	10	78	21	144	2
Mar-22	418,025	40	176	657	20	77	21	144	2
April-22	420,328	41	182	663	15	82	21	140	4
May-22	421,714	44	197	732	14	86	21	141	3
Jun-22	424,097	46	194	746	24	84	22	142	6
Jul-22	426,161	43	195	787	14	109	39	227	3
Aug-22	429,043	79	259	1155	19	136	42	295	3
Sep-22	430,134	80	257	1161	20	140	41	297	3
Oct-22	431,916	80	260	1158	23	137	40	301	3
Nov-22	434,517	56	225	931	21	135	40	302	6
Dec-22	437,452	56	231	943	17	137	40	310	9
Jan-23	439,917	60	236	978	14	116	31	231	6
Feb-23	442,155	54	197	974	12	137	87	395	8
Mar-23	445,343	57	200	986	16	137	91	402	8
April-23	446,893	55	202	1006	17	137	90	410	8
May-23	447,187	84	292	1124	10	140	92	417	8
Jun-23	439,290	88	289	1125	17	133	94	419	5
Jul-23	430,393	94	316	1425	11	132	96	421	6
Aug-23	420,452	89	306	1429	11	132	89	416	7
Sep-23	418,153	91	310	1436	19	133	88	413	10
Oct-23	417,512	93	317	1471	19	134	89	416	9
Nov-23	416,810	74	288	1224	14	136	89	407	8
Dec-23	415,500	73	294	1223	19	139	85	395	4
Jan-24	414,007	77	306	1264	11	139	82	388	1
Feb-24	412,514	70	266	1124	18	72	60	186	4

March-24	411,884	71	273	1127	14	72	58	184	4
April-24	411,034	74	283	1160	7	73	58	181	6
May-24	409,711	83	344	1277	19	39	24	126	5
June-24	406,776	85	344	1308	22	42	24	125	6
July- 24	405,468	88	343	1375	16	46	24	134	3
Aug-24	403,878	79	341	1319	0	75	50	216	2
Sep-24	403,654	83	348	1373	6	76	47	206	2
Oct-24	405,187	81	345	1400	18	74	47	202	0
Total	37,691,120	4,119	14,419	61,745	1,762	4,877	2,324	11,265	235

Table 18: 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	21	600	2,372	250,002
Oct-24	34	648	2,387	253,465
Nov-24	48	774	2,396	252,982
Dec-24	50	847	2,370	251,123
Total	330	11,137	50,999	5,312,648

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)

DSHP was concluded 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.

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 evaluation design

The MTP 2.0 evaluation design was submitted for CMS approval in January of 2024. CMS provided feedback for changes in April of 2024. The evaluation design was returned to CMS June of 2024. CMS provided updated feedback in December of 2024. The new MTP 2.0 draft evaluation design is due back to CMS February of 2025.

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. In addition, the IEE is working to update the MTP 2.0 evaluation design based on CMS feedback.

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	360-280-4019
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 earned and distributed through the FE portal through December 31, 2024.

View this table on the HCA website, which shows all DSRIP funds earned and distributed through the FE portal through December 31, 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, 2028
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

At the state level, the number of Medicaid beneficiaries treated in an IMD for substance use disorder (SUD) continues to increase; 3,611 in SFY 2022, 5,358 in SFY 2023, and 5,496 in SFY 2024. Among the opioid use disorder (OUD) subpopulation, the number of Medicaid beneficiaries treated in an IMD for SUD increased from 2,108 in SFY 2022 to 3,158 in SFY 2023, and to 3,288 in SFY 2024.

Access to critical levels of care for OUD and other SUDs remained consistent and average lengths of stays in IMDs continue to decrease slightly, this trend was also seen in the OUD subpopulation.

The numbers of available providers improved for both SUD providers and medication assisted treatment (MAT) providers.

The rate of overdose deaths increased from 0.068% in SFY 2023 to 0.076% in SFY 2024 which underlines the continued need for this initiative.

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 has remained consistent with prior months.	04/01/2019 – 06/30/2019	#3: Medicaid beneficiaries with SUD diagnosis (monthly)
	The number of Medicaid beneficiaries with SUD diagnosis has increased slightly compared 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 5,358 in SFY 2023 at the state level. In SFY 2024, that number increased to 5,496. Among the OUD subpopulation, the number of Medicaid beneficiaries treated in an IMD for SUD increased from 2,108 in SFY 2022 to 3,158 in SFY 2023, and to 3,288 in SFY 2024.	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 number of individuals who received any SUD treatment has remained consistent with prior months.	04/01/2019 – 06/30/2019	#6: Any SUD Treatment
	The number of individuals who received SBIRT treatment has remained consistent with prior months.	04/01/2019 – 06/30/2019	#7: Early Intervention
	The number of individuals who received any outpatient SUD treatment has increased slightly over the last several months. However, the numbers are within the range of previously reported rates.	04/01/2019 – 06/30/2019	#8: Outpatient Services

	The number of individuals who received any residential or inpatient SUD treatment has decreased slightly compared with prior months.	04/01/2019 – 06/30/2019	#10: Residential and Inpatient Services
	The number of individuals who received withdrawal management has remained consistent compared with prior months.	04/01/2019 – 06/30/2019	#11: Withdrawal Management
	The number of individuals who received Medication Assisted Treatment has remained consistent compared with prior month.	04/01/2019 – 06/30/2019	#12: Medication Assisted Treatment
	The average length of stay in IMDs decreased from 11.48 days per client in SFY 2022 to 10.57 days per client in SFY 2023 at the state level. In SFY 2024, it further declined to 10.34 days per client. Among the OUD subpopulation, the rate decreased from 11.94 to 11.62 between SFY 2022 and SFY 2023. In SFY 2024, it further declined to 11.33.	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 number of available SUD providers increased from 10,876 in SFY 2023 to 11,388 in SFY 2024.	07/01/2018 – 06/30/2019

☐ **The state has no trends to report for this reporting topic.**	The number of available MAT providers increased from 4,666 in SFY 2023 to 5,487 in SFY 2024. This increase is likely due to existing SUD providers expanding to provide MOUD and the removal of the DATA waiver.	07/01/2018 – 06/30/2019	#14: SUD provider availability – MAT
5.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ **Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care.**			
☐ **The state has no implementation update to report for this reporting topic.**			
☐ **The state expects to make other program changes that may affect metrics related to Milestone 4.**			
☐ **The state has no implementation update to report for this reporting topic.**			
6.2 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)			
6.2.1 Metric Trends			
☐ **The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 5.**			
☒ **The state has no 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 statewide number of overdose deaths has increased from 1,408 in SFY 2023 to 1,692 in SFY 2024.	07/01/2017 – 06/30/2018	#26: Overdose Deaths (count)
	The statewide rate of overdose deaths has increased from 0.068% in SFY 2023 to 0.076% in SFY 2024.	07/01/2017 – 06/30/2018	#27: Overdose Deaths (Rate)

☐ **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, 2028
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

The number and rate of individuals aged eighteen and older who received follow up care within 30 and 7 days of hospitalization has increased slightly, this number decreased slightly for ages 6-17, but the overall rate slightly increased.

Utilization of inpatient MH, intensive outpatient, and partial hospitalization has remained consistent with prior months, with a very slight increase in outpatient mental health services compared to prior months.

Emergency department MH services increased compared with prior months, however this increase may be due to seasonality.

Utilization of telehealth mental health services has decreased compared to prior months, this likely continues the downward trend of telehealth utilization as COVID-19 exposure concerns wane.

The overall level of mental health service utilization has increased slightly compared to prior months.

Grievances, appeals, and critical incidents remained low/stable.

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 number of those ages 6-17 who received follow-up care within 30 and 7 days of hospitalization for mental illness has decreased slightly. However, the overall rate has slightly increased.* *The number and rate of those ages 18+ who received follow-up care within 30 and 7 days of hospitalization for mental illness have increased slightly.*	*Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)* *Follow-up After Hospitalization for Mental*

	Illness: Age 18 and Older (FUH-AD)
☐ 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 has remained consistent with prior months.* *The utilization level of intensive outpatient and partial hospitalization mental health services has remained consistent with prior months.* *The utilization level of outpatient mental health services has increased very slightly compared with prior months.* *The utilization level of emergency department mental health services has increased compared with prior months. However, it has been similar to the utilization level in Q2 CY 2023, suggesting that the increase may be due to seasonality.* *The utilization level of telehealth mental health services has 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 increased slightly compared with prior months.*	*Mental Health Services Utilization - Inpatient* *Mental Health Services Utilization - Intensive 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*
☐ 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.* *The percentage of patients with serious mental illness and diabetes who had hemoglobin A1c (HbA1c) in poor control (> 9.0%) has remained consistent with the prior year.*	*Count of Beneficiaries With SMI/SED (monthly)* *Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)*
☐ **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.*	*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: October 1, 2024–December 31, 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 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, 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

From July to September of 2023, HCA implemented a social needs screening survey (SNS) 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.

From October to December of 2023, all MQIP partners completed the survey to receive payments for Milestone 1. 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 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.

From January to March of 2024, MQIP partners created a SNS project proposal that works to standardize SNS practices across partnering public hospitals.

Recognizing the importance of social needs screenings for care coordination, efforts are currently underway to create consistency and reduce variability in social needs screenings 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

The project proposal was approved by HCA in May of 2024.

July to September 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.

October to December of 2024, MQIP partners continued implementation work, in preparation to submit baseline social needs screening data across provider networks 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, AWPHD and UW Medicine 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 released MQIP payments for Milestone 3 in December 2024 of more than $121,000,000 across MQIP partners.

Washington State Health Care Authority

Table 1: MCO-earned admin and payments to public hospitals (December 2024)

	Amerigroup	Community Health Plan	Coordinated Care	Molina	United Healthcare	Total
Admin	$150,000.00	$150,000.00	$150,000.00	$150,000.00	$150,000.00	$750,000.00
UW Medicine	$11,592,312.49	$13,524,365.	$11,592,313.	$47,335,278.	$12,558,339.	$96,602,607.49
Evergreen Healthcare & Valley Medical Center	$2,550,309.65	$2,975,360.00	$2,550,308.00	$10,413,762.00	$2,762,834.00	$21,252,573.65
AWPHD	$35,920.07	$41,907.00	$35,920.00	$146,674.00	$38,913.00	$299,334.07
Public Hospitals Statewide	$311,849.16	$363,824.00	$311,849.00	$1,273,385.00	$337,837.00	$2,598,744.16
Total	$14,640,391.37	$17,055,456.	$14,640,390.	$59,319,099.	$15,847,923.	$121,503,259.37

Washington State Health Care Authority

Medicaid Transformation Project

Health Care Authority	SFY 24-25 Budget	SFY 24 Expenditures to Date	SFY 25 Expenditures to Date	SFY 24-25 Total Expenditures
MTP 2.0	**$ 555,439,770**	**$37,116,541**	**$56,830,119**	**$93,946,660**
Admin (GF-F)	$ 12,621,650	$2,357,769	$1,410,518	$3,768,287
HRSN Infrastructure (GF-F)	$ 50,421,000	$16,200,503	$27,004,543	$43,205,047
HRSN Services (GF-F)	$ 279,080,406	$0	$0	$0
Admin (GF-L)	$ 12,621,650	$2,357,764	$1,410,515	$3,768,279
HRSN Infrastructure (GF-L)	$ 50,421,000	$16,200,503	$27,004,543	$43,205,047
HRSN Services (GF-L)	$ 150,274,065	$0	$0	$0
Initiative 1 - DSRIP	**$3,137,000**	**$875,625**	**$0**	**$875,625**
Admin (GF-F)	$3,137,000	$875,625	$0	$875,625
DSRIP Incentives (GF-F)	$0	$0	$0	$0
Initiative 1 - DSRIP	**$3,137,000**	**$875,624**	**$0**	**$875,624**
Admin (GF-L)	$3,137,000	$875,624	$0	$875,624
DSRIP Incentives (GF-L)	$0	$0	$0	$0
Re-entry	**$121,570,000**	**$0**	**$3,455,000**	**$3,455,000**
Re-entry (GF-F)	$60,785,000	$0	$1,727,500	$1,727,500
Re-entry (GF-L)	$60,785,000	$0	$1,727,500	$1,727,500
Initiative 2 - DSHS MAC/TSOA**	$101,367,000	$22,916,505	$7,196,729	$30,113,235
MAC/TSOA (GF-F)	$50,683,000	$11,559,387	$3,598,365	$15,157,752
MAC/TSOA (GF-L)	$50,684,000	$11,357,118	$3,598,365	$14,955,482
Initiative 3 DSHS PE	**$35,482,000**	**$56,353**	**$98,351**	**$154,704**
DSHS Presumptive Eligibility (GF-F)	$17,741,000	$28,176	$49,176	$77,352
DSHS Presumptive Eligibility (GF-L)	$17,741,000	$28,176	$49,176	$77,352
Initiative 3 - FCS	**$67,882,000**	**$48,312,018**	**$15,573,346**	**$63,885,364**
FCS SE ADMIN (GF-F)	$ 1,234,500.00	$750,612	$364,990	$1,115,602
FCS SE ADMIN (GF-L)	$ 1,234,500.00	$747,320	$364,990	$1,112,310
FCS SE SERVICES (GF-F)	$ 15,199,680.00	$9,303,354	$2,991,765	$12,295,119
FCS SE SERVICES (GF-L)	$ 6,208,320.00	$3,735,104	$1,173,174	$4,908,278
FCS SH ADMIN (GF-F)	$ 2,922,500.00	$1,880,986	$861,286	$2,742,272
FCS SH ADMIN (GF-L)	$ 2,922,500.00	$1,873,541	$861,286	$2,734,827
FCS SH SERVICES (GF-F)	$ 27,093,600.00	$21,111,849	$6,216,213	$27,328,062
FCS SH SERVICES (GF-L)	$ 11,066,400.00	$8,909,250	$2,739,643	$11,648,893
Agency Admin (GF-F)	$0	$0	$0	$0
Initiative 3 - FCS**	**$1,580,000**	**$947,609**	**$351,037**	**$1,298,646**
DSHS FCS ADMIN (GF-F)	$790,000	$473,805	$126,343	$600,148
DSHS FCS ADMIN (GF-L)	$790,000	$473,804	$126,343	$600,147

DSHS - ALTSA	SFY 24-25 Budget	SFY 24 Expenditures to Date	SFY 25	SFY 24-25 Expenditures to Date
Initiative 2 - MAC and TSOA	$ -		$0	**$0**
Initiative 3 - FCS	$0	$0	$0	**$0**

DSHS and HCA (Community Behavioral Health)	SFY 24-25 Budget	SFY 24 Expenditures to Date*	SFY 25 Expenditures to Date*	SFY 24-25 Expenditures to Date*
Initiative 3 - FCS	**$4,522,000**	**$1,196,211**	**$521,696**	**$1,717,907**
FCS (GF-F)	$2,261,000	$598,107	$260,848	$858,955
FCS (GF-L)	$2,261,000	$598,105	$260,848	$858,952

*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.