



WASHINGTON STATE MEDICAID TRANSFORMATION WAIVER APPLICATION

Washington State Health Care Authority
and Department of Social and Health Services

August 24, 2015



STATE OF WASHINGTON
HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

August 24, 2015

Victoria Wachino
Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
200 Independence Avenue, Southwest
Washington, DC 20201

Dear Ms. Wachino:

SUBJECT: Request for Approval of Section 115 Waiver Demonstration

The Washington State Health Care Authority (HCA) is pleased to submit a formal request for a Section 1115 Waiver Demonstration - the Washington State Medicaid Transformation Waiver. With technical assistance from the National Governor's Association (NGA) Policy Academy in facilitating preliminary conversations with the Centers for Medicare and Medicaid Services (CMS), we propose a dynamic five-year demonstration beginning January 1, 2017, preceded by a nine-month "year zero" in which the federal-state partnership supports achievement of structural milestones needed to operationalize the demonstration. We are committed to the intensive dialog needed to reach mutual agreement of Special Terms and Conditions by April 2016.

With support from a State Innovation Model (SIM) planning grant, Washington developed its State Health Care Innovation Plan as the blueprint for continued innovation in pursuit of the Triple Aim in Washington. That work continues through a subsequent SIM test grant, providing initial "down-payment" investments in Washington's infrastructure over the next four years to advance multi-payer and population health transformation. The State readily took advantage of opportunities under the Affordable Care Act, and on January 1, 2014, expanded its Medicaid program to serve the new adult population, helping cut the State's uninsured rate from 16.8 percent in 2013 to 6.4 percent in early 2015. This success has been driven in large part by the expansion of Medicaid which now covers an additional 554,000 newly eligible adults, most of whom previously lacked health insurance.

We must now turn our attention to the more difficult challenge - that 80 percent of overall population health is determined by factors and social determinants outside the traditional health care and public health sectors. For the health and productivity of our state and the growing ranks of Medicaid beneficiaries, there are really no options. The State must proactively address systemic Medicaid problems, strengthen clinical and community linkages that mitigate the

Victoria Wachino
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effects of social determinants of health, and move in a direction that evidence shows can improve outcomes and decrease projected per capita cost growth. Our alternative, under straining state budgets, will be a future retrenchment to the classic reactive approaches to cost containment—reducing benefits, shrinking enrollment, and cutting reimbursement.

This Section 1115 demonstration waiver is an exceptional opportunity to pursue the bold, unique solutions needed to establish a sustainable path to improving the lives of Medicaid beneficiaries – the children, families, adults, and elderly individuals we serve. Conversations initiated under the SIM grants have sparked statewide interest, engagement, and ideas for reform. Through the release of the Medicaid Transformation Waiver concept paper and draft application, this statewide interest has grown in magnitude and urgency. During the public comment period we received over 200 pages of thorough comments, questions, and letters of support. In addition, the Tribal consultations, webinars, public forums, and standing stakeholder meetings generated additional thoughtful input. We have addressed many of the questions and comments in our submitted demonstration application; more will be incorporated in ongoing work as we pursue approval and define further operational details.

The historical federal-state partnership has achieved much for low-income vulnerable populations in Washington State. We thank you for the opportunity to build on the accomplishments and look forward to continuing to work with Centers for Medicare and Medicaid Services (CMS) and the federal review team as we advance common objectives through the Medicaid Transformation Waiver.

Sincerely,



MaryAnne Lindeblad, BSN, MPH
Medicaid Director

Enclosure

cc: Dorothy Teeter, Director, HCA
Kevin Quigley, Secretary, DSHS
MaryAnne Lindeblad, Medicaid Director, HCA
Jane Beyer, Assistant Secretary, BHSIA, DSHS
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JAY INSLEE
Governor



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August 24, 2015

Vicki Wachino, Director
Center for Medicaid and State Operations
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Dear Ms. Wachino:

Implementation of my plan for a Healthier Washington began early in 2014 after hundreds of people from the public and private sectors were asked to share their ideas on how the health system might be transformed to produce better health and better care at lower cost.

The Washington State Health Care Innovation Plan was produced as a result of that work. I introduced and signed HB 2572 to authorize and support the implementation of this plan. Through the plan we will improve how we pay for services, ensuring that we reward providers when they achieve good outcomes. We will ensure that health care focuses on integrated care and coordination with community services to operationalize a “whole-person” philosophy. And we will leverage a broad collaborative regional approach to build healthier communities by targeting health determinants at the local level.

The partnerships we have built with the Department of Health and Human Services, and the Centers for Medicare and Medicaid Services (CMS) in particular, have been key to the success of historic innovation in the state’s Medicaid program, known as Apple Health. Improvement in health plan performance, health care quality and health outcomes continue to be key objectives as we transition Apple Health towards full integration of medical, mental health and substance use disorder services by 2020.

It is my pleasure to support the state’s application for a section 1115 Medicaid Transformation Demonstration waiver. It is a critical tool for continuing to improve health care system and community service linkages for Washington’s vulnerable populations as my Healthier Washington plan is implemented. Through our Medicaid expansion we have been proactive in establishing a continuum of affordable coverage for the majority of Washingtonians. We now must be proactive in ensuring that Apple Health delivers the array of coordinated care and services needed to sustain the health and recovery of its beneficiaries. At the same time, we must



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be proactive in preparing for the aging of our population and the looming threat to the viability of our rebalanced long-term care system.

I look forward to your favorable consideration of Washington State's request to partner in delivery system transformation that will ensure the sustainability of Apple Health. My office's lead in health reform implementation – Bob Crittenden, MD, MPH - is available if you have questions about our involvement and support.

Very truly yours,



Jay Inslee
Governor

cc: Jane Beyer, Assistant Secretary, Behavioral Health and Service Integration Administration, DSHS
Bob Crittenden, Special Assistant for Health Reform, Governor's Office
Nathan Johnson, Director, Policy Planning and Performance, HCA
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Rich Pannkuk, Senior Budget Assistant, Human Services, OFM
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Washington State Legislature

August 25, 2015

Vikki Wachino, Director
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Dear Ms. Wachino:

We are writing to express our support for Washington state's application to the Centers for Medicare and Medicaid Services for a section 1115 Medicaid Transformation Demonstration waiver.

With bipartisan leadership from our colleagues on the House and Senate health care committees, the State Legislature has established transformational policy direction for the Medicaid program. Legislation in 2013 established standard measures of performance and accountability across Medicaid delivery systems and in 2014 we set our state on course to achieve full integration of physical and behavioral health services by 2020. In addition, we have directed the Health Care Authority and Department of Social and Health Services to implement value-based purchasing, with the goal of having 80% of all state health care dollars in such contracts by 2020.

We believe this waiver is an important tool for achieving the broad and transformative aims that have been established for Washington's Medicaid program. In our state, Medicaid has grown at a significant rate due to the expansion. The delivery system is stretched and must transform to ensure the sustainability of the program. The looming age wave threatens the viability of our rebalanced long-term care system if proactive steps are not taken soon.

Washington state has a long tradition of initiatives that have reformed health care delivery through evidence-based practices, expanded access to coverage and care for vulnerable populations, and embraced value-based purchasing principles. Our state is prepared to take on this new challenge of transforming and preserving the Medicaid program for the over 1.7 million people we now serve.

To move Washington forward on its mission to create better health, better care at a lower cost for Medicaid enrollees, we urge CMS to enter negotiations with the state as soon as possible. We will be following the progress closely and stand ready to support this effort through any available means.

Sincerely,


Representative Eileen Cody, Chair
House Health Care and Wellness


Senator David Frocht, Ranking
Senate Health Care Committee



Representative Paul Harris, Member
House Health Care and Wellness

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PREFACE

The year is 2020. John is a Medicaid enrollee, now 27 years old and living in the north Puget Sound area of Washington State. As a teenager, his parents worried about his mood swings, but attributed it to adolescence. To fit in, John started smoking in high school. At 22, he seemed to have found his passion and was doing well in his first year of community college, pursuing an IT certification. He has recently gained weight, and during a visit to an urgent care clinic following a visit for bronchitis, John was diagnosed with Type 2 diabetes. He didn't have a consistent primary care provider and wasn't sure how to manage his illness, so maintaining his blood sugars became an ongoing challenge.

During his second quarter of community college, John began to experience extreme mood and behavior changes. This change seemingly came out of nowhere, stunning his family and friends. After a particularly frightening blow-up, he was hospitalized and diagnosed with bipolar disorder.

During his discharge from the hospital, John and his family were surprised to learn he qualified for Medicaid, and successfully signed him up with hopes that his health care needs would be met. After his release, John was diligent at first about following his discharge plan—taking his medications, meeting with his therapist as well as a primary care physician (PCP). Though he continued to see his PCP to manage his diabetes, he did not understand the importance of talking about his ongoing mental health treatments or prescribed medications. As a result, John's PCP remained in the dark about this co-occurring disorder.

For a little while, John was doing much better. However, he soon discovered that when he took his medications as prescribed, the side effects would often make him feel even worse—so sometimes he wouldn't take any of them. Before long, John's life—and his family's life—became a roller coaster. Multiple case managers were attempting to help John navigate a delivery system designed primarily for episodic interventions for acute and chronic illness, and crisis, but that was leading to some serious unintended consequences. Everyone wanted to help, but John wasn't getting any better.

John experienced intermittent periods of stability, but a cloud of anxiety and depression never fully dissipated. Meanwhile, John was not consistent with his medication and appointments. John's family felt he was getting lost in a web of well-meaning providers and interventions that were targeted to the presenting symptoms and not his whole person needs. Unbeknownst to John, the lack of communication between his providers often resulted in duplicate lab tests and, at times, the prescribing of more medications than he needed. John dropped out of school and remained unemployed. He continued to struggle with his weight and would drink heavily to self-medicate on his bad days. During manic episodes, John became agitated and reclusive, eventually alienating himself from his friends and avoiding his family.

John's parents arranged to pay his rent directly to his landlord so he could remain housed, but because John had become so withdrawn and unwilling to accept their help, they were unable to do more. John was frustrated with having so many different providers and felt overwhelmed by

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the frequency of appointments. He did not feel that he had any control over his own care or future. There were plenty of people telling John what was best for him, but no one to really listen or, more importantly, to ask John what he really wanted.

Halfway through the year, John has been to the emergency room five times for physical and mental health concerns. Each time the hospital has been paid for stabilization services while he awaits the next in an array of costly health interventions.

The year is 2020. Washington's systems have failed John. We are left with a burning question: Could we have done better?

In this application, Washington proposes a 21st century health transformation approach for John and others served within the Medicaid system. This approach builds on the foundation that successfully engaging people in improving their health and supporting their recovery requires that we move beyond the traditional medical care system.

SECTION I - PROGRAM DESCRIPTION

Overview of Transformation in Washington State

Washington has a long tradition in reforming its health care delivery system; expanding access for pregnant women and children in the 1990's and transitioning to managed care to purchase health care for most of its beneficiaries during the same time period. The State readily took advantage of opportunities under the Affordable Care Act, and on January 1, 2014, expanded its Medicaid program to serve the new adult population, helping to cut the State's uninsured rate from 16.8 percent in 2013 to 6.4 percent in early 2015.¹

As a result of the Medicaid expansion, Washington's Medicaid program that historically served children, families and people with disabilities has expanded by forty-four percent. Twenty-five percent of Washington's population - 1.8 million low-income people - obtains health care through the Medicaid program. It now provides insurance coverage to approximately 554,000 new adults, a population with different care needs and utilization patterns. For the Indian health system, comprised of Indian Health Service (IHS) facilities, tribal 638 health programs, and urban Indian health organizations (together, the ITUs), Medicaid expansion has had mixed results. ITUs have experienced significant increases in Medicaid reimbursements for services to newly eligible Medicaid enrollees but the interaction of Medicaid and IHS rules has introduced complexity and unintended consequences.

Looking forward, Washington anticipates an "age wave" that, without new approaches to service delivery and caregiver support, threatens the viability of the long-term care system which has been rebalanced toward home and community based services. By 2040, Washington's population aged 65 and older is projected to reach 1.8 million—an increase of just over one million persons since 2010. The majority of Washingtonians are not insured for long-term services and supports (LTSS), have no affordable options for LTSS coverage, and have no practical financial way to prepare for their LTSS needs except the path to impoverishment and reliance on Medicaid.

The current health system is fraught with preexisting gaps, silos and duplication in care delivery, and frayed or nonexistent linkages to critical support services. These issues impact all Medicaid populations – adults, families, children and the elderly. Integration of physical and behavioral health services is a critical priority for meeting the whole person needs of beneficiaries across the age spectrum. Yet providers find they are often challenged in their ability to share patient information necessary to ensure quality, integrated care or simply to determine appropriate course of treatment; because of both perceived and real regulatory barriers.

¹ Witters, Dan. "In U.S., Uninsured Rates Continue to Drop in Most States." *Gallup*. 10 August 2015. <http://www.gallup.com/poll/184514/uninsured-rates-continue-drop-states.aspx>

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In this Demonstration proposal the State includes key investments to address these issues and the 80/20 challenge— that 80% of overall population health is determined by factors and social determinants outside the health care delivery system. Per the Healthy People 2020 vision,² *“Determinants of health reach beyond the boundaries of traditional health care and public health sectors; sectors such as education, housing, transportation, agriculture, and environment can be important allies in improving population health.”* Washington’s Medicaid Transformation Demonstration not only addresses the costliness of the 20% through more effective delivery of health care services, it builds operational linkages to the non-health sectors that define the 80%, through specific investments in new, multidisciplinary workforce capacity, delivery system reform and population health improvement.

Washington envisions a delivery system for all its Medicaid beneficiaries – children, families, adults and the elderly - that proactively assesses need, manages health services and drives population health improvement. This transformation requires a fundamental shift in the health care delivery system from reliance on clinical silos, institutional settings, and treating episodes of illness, to becoming fully integrated, community-driven, and focused on providing high quality, cost effective, and well-coordinated care and recovery supports. Table 1 summarizes the impact of the Medicaid Transformation from the perspective of a beneficiary as we move from the current state to a transformed system.

Table 1. Vision for System Change

Current System	Transformed System
Fragmented clinical and financial approaches to care delivery	Integrated systems that deliver whole person care
Disjointed care and transitions	Coordinated care and transitions
Disengaged clients	Activated clients who are connected to the care they need and empowered to take a greater role in their health
Capacity limits in critical service areas	Optimal access to appropriate services throughout the state
Individuals impoverish themselves to access long term services and supports (LTSS) and Caregiver burnout leads to out of home placement	Timely supports that delay or divert need for Medicaid LTSS
Inconsistent measurement of delivery system performance	Standardized performance measurement with accountability for improved health outcomes
Volume-based payment	Value-based payment that rewards quality of care and improved outcomes

² <http://www.healthypeople.gov/2020/topics-objectives/topic/vision>

Building Blocks for Transformation

This Demonstration proposal is a critical component of the vision for a Healthier Washington. It will help ensure that over the next five years, the State will complete the evolution of statewide integrated purchasing of physical and behavioral health care and incorporate broad community engagement in effective models of care and service delivery. Washington has taken the first steps toward transforming its health care system as part of its broader Healthier Washington initiative, captured in the 2013 State Health Care Innovation Plan and endorsed by a bipartisan legislature in 2014 through Governor-request legislation, HB 2572 and SB 6312.³

Regional Integrated Medicaid Purchasing

The State is reforming its purchasing for physical and behavioral health care services through a new regional approach to Medicaid managed care contracting. With a legislative mandate of transitioning to full financial and administrative integration by 2020 it will launch two initiatives early in 2016; financial and administrative integration of physical and behavioral health services through managed care organizations (MCOs) in the southwest region of the State, and integration of mental health and substance use disorder services through behavioral health organizations (BHOs) in the balance of the State. MCOs that primarily deliver physical health services will collaborate and coordinate with BHOs in regions where the transition to fully integrated managed care health systems has not yet occurred.

State Innovation Model Test

To support Healthier Washington, the State applied for and received a State Innovation Model (SIM) grant that is making initial “down-payment” investments in Washington’s infrastructure over the next four years to advance multi-payer and population health transformation.

Central to Washington’s vision for transformation is the formation of nine regional Accountable Communities of Health (ACHs) that serve the State. The fundamental premise of ACHs is a paradigm shift that recognizes the integral role and influence of regional multi-sector partners in shaping Washington’s health systems to respond to local population health and health care delivery needs while addressing social determinants of health. Importantly, ACHs are not risk-bearing entities and are not intended to displace the role of managed care plans. ACHs are regional collaboratives that bring together public and private entities to form multi-sector partnerships that work on shared health goals. ACHs are Washington’s structured approach to incorporating social determinants of health in all aspects of health transformation across public and private payers and delivery settings. For example, many Medicaid beneficiaries face life challenges that prevent them from managing their own health – housing stability being a major challenge for high-risk Medicaid populations. ACHs will guide clinical-community linkages to make sure all sectors recognize the many factors and opportunities that affect health.

³ [Engrossed Second Substitute House Bill 2572](#) (2013)—“Better Health Care Purchasing”; [Second Substitute House Bill 6312](#) (2013)—“Treating the Whole Person”.

With support from its SIM grant, Washington is making investments in ACH formation. By the end of 2015 we expect to have officially designated ACHs in each of the nine regions shown in Figure 1.⁴ The two noted as “Pilots”—North Sound and Cascade Pacific Action Alliance—were formally designated on July 1, 2015. ACHs, known as Communities of Health prior to their designation, will support transformation projects across the State’s 39 counties. To achieve designation ACHs must demonstrate readiness for leading future activities by meeting minimum requirements related to governance, ACH membership, community engagement, backbone organizational functions, sustainability planning, progress on regional health assessments, and emerging priorities for a regional health plan that is responsive to state priorities.

Figure 1: Washington’s Accountable Communities of Health



ACH members may include providers (i.e., medical, behavioral, oral health), hospitals, MCOs and BHOs, LTSS providers, social services, public health, county and local governments, social determinants and supports (e.g., housing, education, criminal justice and early learning), economic and workforce development (e.g., businesses, commerce and job training agencies), philanthropy, community members (e.g., consumers and populations with health disparities),

⁴ The Cascade Pacific Action Alliance currently supports counties that encompass two Medicaid purchasing regions.

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federally recognized Tribes, community-based organizations, and other partners critical to the collaborative achievement of the triple aim.

With broad multi-sector membership and inclusive governance, ACHs provide a forum for engaging the wider community in promoting whole health for all while amplifying the community voice in shaping decisions related to health system transformation. For example, as the “early adopter” southwest region of Washington transitions to fully integrated managed care purchasing of physical and behavioral health in 2016, ACH members are fully engaged with the State in advising on procurement documents and in building a community and provider-based transition plan with an early warning system for post implementation monitoring.

ACHs drive more extensive transformation than possible through managed care purchasing or health care delivery system interaction alone —with enormous potential benefits to Medicaid beneficiaries, the MCOs and BHOs, health care and community service providers, State and communities. During a recent summit meeting with ACHs to discuss connections between their current path and development for the Medicaid transformation proposed in the draft waiver application, the question was posed – “*How do ACHs drive toward system change in a manner that impacts individual beneficiaries?*” The discussion is best captured through one example of regional efforts to design better coordinated and cost-effective systems to serve “*Familiar Faces.*”

The Familiar Faces Initiative, a Triple Aim-focused, individual level strategy of the King County Health and Human Services Transformation Plan, is a broad-scale systems improvement design effort for adults who are booked into the County jail four or more times in a 12-month period and who also have a mental health and/or substance use disorder condition. These individuals also have high levels of chronic medical conditions, housing instability and many experience chronic homelessness and unemployment. Many became newly eligible for Medicaid under the Medicaid expansion, while many others who were previously covered by Medicaid recently shifted from a fee-for-service to managed care delivery system.

The initiative’s work is an example of a regionally defined project with strong potential for further scale and spread under the Medicaid transformation proposal. From the perspective of an individual beneficiary, appendix 1 captures the complex multi-sector engagement in the current system. It also offers a pictorial draft of the future vision in which systems have been redesigned with the health and recovery of an individual “Familiar Face” at the center.

Other SIM initiatives that operate in partnership with the Demonstration to maximize its effect include:

- **Practice Transformation Support Hub.** Focused on practice transformation as a necessary complement to payment reform, the Hub will leverage statewide and community-level technical assistance and practice coaching to support provider practice redesign.

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- **Plan for Improving Population Health.** Leveraging an existing effort to forge stronger links between public health and the delivery system, Washington will develop a statewide strategy to improve population health, and more broadly infuse health equity and population health into delivery system and payment reforms.
- **Workforce expansion.** Focused on non-traditional workforce growth for community health workers (CHWs), including peer support specialists, a CHW Task Force is now in the process of making actionable recommendations to the state and its SIM partners around the role of CHWs in a transforming delivery system.
- **Statewide analytics, interoperability and measurement.** New analytical infrastructure for monitoring and reporting on health system performance will support broad deployment of common statewide performance measures to guide health care purchasing. New information exchange capacity, the development of a clinical data repository, will be leveraged to support care delivery, clinical-community linkages and improved health outcomes.

LTSS Rebalanced System

Washington has garnered national recognition for its achievements in shifting long-term services and supports (LTSS) from institutional to home and community-based settings.⁵ Eighty-four percent (84%) of individuals receiving Medicaid funded LTSS are now served in their own home or a community residential setting. To sustain that position in the face of coming demographic changes calls for a “next generation” of system redesign which focuses on outcomes, encourages individual empowerment and resilience and provides better links to a reformed healthcare system. While ACHs will be responsible for leading local transformation efforts, collaboration with the entities responsible for authorization and payment of LTSS is also a critical component of the state’s vision to transform service delivery and outcomes for Medicaid beneficiaries.

Parallel Indian Health System

In conjunction with other initiatives, transformation will have significant impacts on the Indian health system. ITUs operate under a unique and complex body of laws that require specific attention to ensure the needs of American Indian and Alaska Natives (AI/AN) are addressed and unintended consequences are avoided. The federal government has a trust responsibility and treaty obligations to provide for all health care needs of every AI/AN. The federal government provides for these health care needs primarily through IHS. IHS appropriations, which support the IHS facilities and the tribal 638 facilities (together, the Tribal Health Programs) and to a lesser extent the urban Indian health organizations, meet less than 60% of identified AI/AN health care needs, based on federal Level of Need Funded calculations.⁶ Given the trust

⁵ According to the 2014 AARP Scorecard on LTSS for older adults, people with physical disabilities and family caregivers, Washington’s system is ranked 2nd in the nation for its high performance at the same time as the state’s ranking for cost is 34th.

⁶ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035886/pdf/AJPH.2013.301682.pdf>

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responsibility and IHS appropriations over the years, Tribal Health Programs manage the health care coverage for their AI/AN clients under global budgets with Medicaid reimbursement as an increasingly important supplemental funding source.

Washington state maintains a government-to-government relationship with the tribes, supported by consultation obligations to the tribes and the ITUs. Since 1989, the state and tribes have been parties to the Centennial Accord, an agreement between co-equal sovereigns to respect each other's sovereignty and to work together to improve the services delivered to people by the parties. In 2012, the state enacted chapter 43.376 RCW, which requires every state agency to make reasonable efforts to collaborate with Indian tribes in the development of policies, agreements, and program implementation that directly affect tribes and to develop a consultation process that is used by the agency for issues involving tribes. In accordance with this statute and CMS requirements, the state's single state Medicaid agency has implemented a consultation policy that requires respectful, constructive communication in a cooperative process that works toward a consensus before a decision is made or an action taken.

Within these federal and state constructs Medicaid transformation impacts on the Indian health system must recognize that ITUs in Washington are not comprehensive health care providers – there are no inpatient facilities in the Washington Indian health system⁷ and some Tribal Health Programs do not have any health care providers on staff. As a result, their global budgets are increasingly subject to the market dynamics of the non-ITU system – which continues to be driven to a significant extent by fee-for-service payments. As the non-ITU health system moves toward a more rational value-based payment model, the State will need to ensure that changes do not undermine Tribal Health Programs.

Demonstration Goals and Initiatives

The initial Medicaid purchasing initiatives and SIM grant-financed activities, while an essential platform, are not enough to ensure that the State's health care system can fully transform to a system that focuses on the needs of an individual as a whole person.

As a result, through this Demonstration proposal, the State is seeking a federal investment of \$3 billion and the authority necessary to use that critical investment to achieve four key goals:

- Reduce avoidable use of intensive services and settings such as acute care hospitals, nursing facilities, psychiatric hospitals, traditional LTSS and jails.
- Improve population health, with a focus on prevention and management of diabetes, cardiovascular disease, pediatric obesity, smoking, mental illness, substance use disorders and oral health; that is coordinated and whole-person centered.
- Accelerate the transition to value-based payment, while ensuring that access to specialty and community services outside the Indian Health system are maintained for Washington's tribal members.

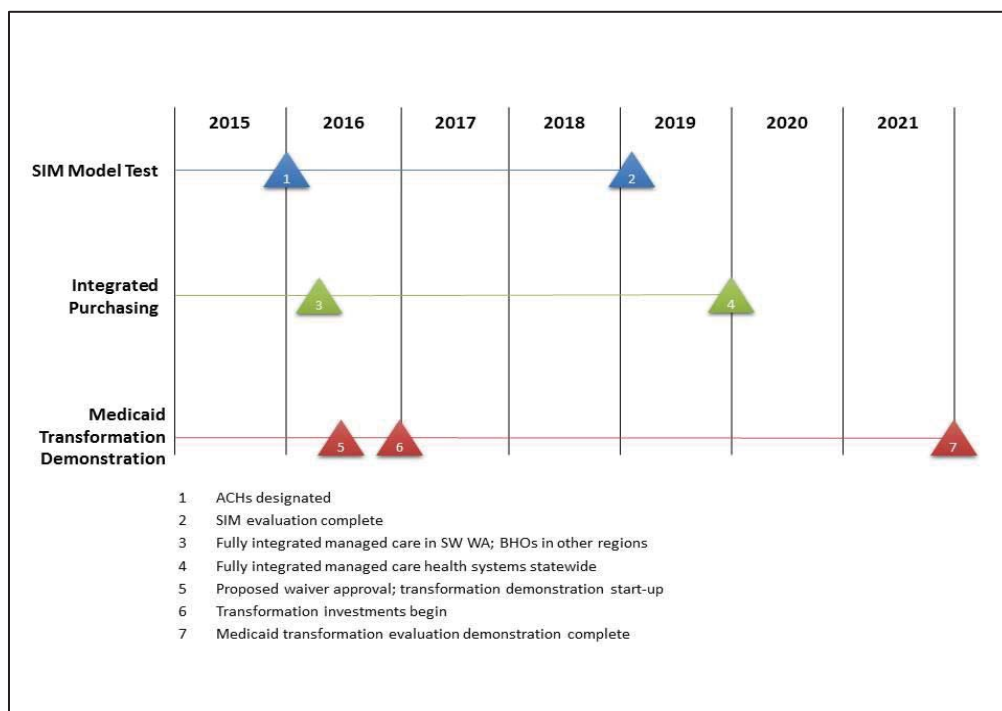
⁷ In fact, most specialty care is provided outside the ITU system.

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- Ensure that Medicaid per-capita cost growth is two percentage points below national trends.

These goals will be achieved through three initiatives that are presented as independent but will be operationalized to maximize their collective impact through projects that link across the initiatives. For example, opportunities may arise to link initiatives in regions with cross-cutting statewide priorities. By 2019, our intent is that the advancement of purchasing towards fully integrated managed health system contracts for physical and behavioral health, complemented by SIM investments and Demonstration support, will result in 80 percent of State financed health care (Medicaid and Public Employees) being purchased through value-based payment.

Figure 2. Complementary Building Block Timeline



Initiative 1: Transformation through Accountable Communities of Health (ACHs).

To effectively transform the health system, ACHs will be central to organizing local services, managing the financing and implementation of transformation projects, and building and brokering clinical-community linkages to establish effective models of coordinated care. Statewide adoption of key transformation projects can be informed through regionally diverse ACHs which provide a critically important understanding of how implementation efforts are most likely to succeed. ACHs provide the structure for formal engagement between the State and each regional service area. They are a vehicle uniquely positioned to integrate disparate clinical and community support systems with local decision making to direct evidence-based interventions and investments where they can have the greatest local impact.

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This robust community engagement in coordination with the Indian health system differentiates Washington's Demonstration from Medicaid transformation efforts in other states. In their public comment letter, appendix 9, the American Indian Health Commission for Washington State confirms the interest of the tribes and the urban Indian health organizations in partnering with the state to form a Tribal-centric coordinating entity that would review, approve, and support transformation opportunities across all tribes in addition to the opportunities afforded by their regional ACH engagement.

Although ACHs do not deliver services, they are comprised of leading clinical and community service providers in the region. As a result they bring a local and diverse perspective on system transformation needs and priorities. As a collective body of providers in the broadest sense they will be fundamental to:

- ***Defining the transformation investment menu.*** The State and its partners are developing a menu of prioritized transformation investments (projects) described further in Section IV, Delivery System and Payment. Categorized under three investment domains, *Health Systems Capacity Building, Care Delivery Redesign and Population Health Improvement*, projects will incorporate performance expectations that align with core statewide measures of performance established through stakeholder-driven efforts over the last two years, and continue to evolve as data collection and measurement capacity improve. Investments will be prioritized based on evidence- and research-based success in Washington State. This will ensure that the Demonstration finances providers who undertake transformation projects that advance the State's goals and that have been shown to produce positive outcomes. The State will also consider promising practices—those that indicate potential for success based on a well-established theory or preliminary testing,—especially where they address health disparities and improve health for minorities or Tribal communities that have not fully benefited from pilots or research to date. The State expects that a core set of priority projects will be implemented across the State with room for regional flexibility based on a community needs assessment. Projects form a portfolio of potential investments that, when undertaken collectively and across provider systems and community based organizations, will drive performance improvement.
- ***Coordinating Transformation Projects:*** Beyond their formal start-up designation requirements, ACHs will undergo a qualification process by the State to lead Medicaid transformation projects approved by the State under Initiative 1. As ACHs are evolving, opportunities for varying coordinating entity arrangements are becoming apparent. Later this fall, the State will work with ACHs to define options most likely to be successful initially and over the course of the Demonstration.

To apply for Demonstration financing ACHs will coordinate selection of transformation projects from a menu of evidence- and research-based transformation projects to be finalized by the State in discussion with CMS. The State will require common interventions with flexibility for selected projects to be informed by individual regional needs

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assessments.⁸ ACH members will collectively lead project implementation through the following key functions:

- Complete periodic regional assessments and planning (initially funded through SIM)
 - In conjunction with a core set of statewide projects, identify opportunities for targeted transformation projects based on the needs of the communities in each region.
 - Align multi-sector members to submit applications for regional transformation project investments.
 - Build and broker clinical-community linkages to establish effective models of coordinated care.
 - In alignment with value-based payment efforts, establish performance agreements with providers that will participate in transformation projects.
 - Receive funds from the State for approved transformation projects and distribute performance-based payments to participating providers and other partners.
 - Oversee and report on process and performance measures and project status.
 - Work with the State to make course corrections as needed to meet performance expectations.
- **Assuring Accountability for Results:** As described in Section 4, Delivery System and Payment Rates for Services, transformation projects will incorporate relevant performance measures that apply across investment projects and managed care entities to support consistent Medicaid priorities and quantify their impact on quality, access, cost of care, and improvement in population health status. These measures reflect the State's commitment to a transition toward consistent, standardized performance measure sets across health systems and related transformation efforts.⁹

Beyond the Demonstration period, most ACHs can be expected to perform one or more of the following functions that sustain momentum for continued innovation and quality improvement towards the Triple Aim:

- Identify value-added regional transformation projects proven effective during the Demonstration that should be continued.
- Define, capture, and reinvest savings accruing across ACH members based on an agreed-upon approach to be developed.¹⁰

⁸ ACHs are responsible for conducting a comprehensive regional health needs assessment referenced as a community needs assessment in this document.

⁹ For additional information on the development of a Statewide Common Core Set of Measures, see http://www.hca.wa.gov/hw/Pages/performance_measures.aspx. Previous work completed to establish standard Medicaid measures across delivery systems is summarized here: http://www.hca.wa.gov/documents_legislative/ServiceCoordinationOrgAccountability.pdf

¹⁰ Section V describes expectations for a “workgroup” process through which discussions will be needed to operationalize elements of the proposed Demonstration. Shared savings and reinvestments are fundamental areas for further collaboration.

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- Identify gaps and deploy resources to assist providers with the move to value-based payments, in alignment with statewide practice transformation investments.
- Provide an early warning system for access and quality issues impacting Medicaid beneficiaries.

Initiative 2: Broaden Array of Service Options that Enable Individuals to Stay at Home and Delay or Avoid Need for More Intensive Care.

Statewide, Washington seeks to better tailor long-term care benefits to the needs of our aging population by building upon the state’s well established infrastructure and expertise in providing high quality, self-directed and cost effective community based care options. The state seeks to provide services and supports to family caregivers who have chosen to take on the responsibility, without compensation, of supporting their loved ones to remain in their own homes. This population currently falls through the cracks of Medicaid LTSS leading to burnout, out of home placements and increased state and federal costs. These innovations require federal authority to target and supplement the current comprehensive community based Medicaid long-term care benefit package, reduce the need for families to impoverish themselves to access needed care and to more effectively target nursing home services to individuals who need that level of care.

- First, Washington will create a new benefit package—Medicaid Alternative Care (MAC) — for individuals eligible for Medicaid but not currently receiving Medicaid-funded long-term care services and supports (LTSS). This benefit package will provide another community based option for clients and their families to choose from and will primarily support unpaid family caregivers, avoiding or delaying the need for more intensive Medicaid-funded services.¹¹
- Second, Washington will establish a new eligibility category and limited benefit package— Tailored Supports for Older Adults (TSOA) —for individuals “at risk” of future Medicaid LTSS use who do not currently meet Medicaid financial eligibility criteria.
- Third, Washington will revise the functional eligibility criteria for nursing home services so that those beneficiaries with the lowest needs do not qualify for nursing home services. Functional eligibility for current State Plan and 1915(c) LTSS waiver services will not change and low needs individuals currently receiving services in nursing facilities will continue to be eligible in those settings.

The State will administer these new programs (MAC and TSOA) and manage the delinking of the nursing facility level of care from the HCBS level of care. The State will engage stakeholders in the process of developing the LTSS initiatives including outreach, beneficiary information and program implementation.

¹¹ After expanding a targeted State-funded family caregiver supports program in fiscal year 2012, individuals benefiting from the program were 20% less likely to use Medicaid long-term care services in a given year.

Initiative 3: Provision of Targeted Foundational Community Supports.

Addressing the social determinants of health is a key component of the broader shift to focusing on managing health and recovery. These foundational community supports will improve and maintain the health of vulnerable beneficiaries and ensure they are not accessing avoidable institutional care. Homelessness is traumatic, cyclical, and puts people at risk for complex behavioral health and long term care problems. Homelessness and constant recycling through institutional and residential resources interferes with engagement in services, and jeopardizes the chances for successful recovery. For example, individuals without stable housing are less likely than others to have a usual source of care and are more likely to postpone needed medical care and to use the emergency department.

Housing and employment are two key social determinants health that are amenable to intervention. Homelessness is traumatic, cyclical, and puts people at risk for complex behavioral health and long term care problems. Homelessness and repeated recycling through institutional and residential resources interferes with engagement in services and jeopardizes the chances for successful recovery. For example, individuals without stable housing are less likely than others to have a usual source of care and are more likely to postpone needed medical care and to use the emergency department.

There is also substantial evidence about the link between [un]employment and poor physical and mental health outcomes, even in the absence of pre-existing conditions. A deep research base supports the development of effective strategies for people with significant psychiatric disabilities,¹² notably the development of Individual Placement and Support (IPS).¹³ Supported Employment-IPS has been found effective for numerous populations, including people with many different diagnoses, educational levels, and prior work histories; long-term Social Security beneficiaries; young adults; older adults; veterans with post-traumatic stress disorder or spinal cord injury; and people with co-occurring mental illness and substance use disorders.¹⁴ The Demonstration project begins to address issues that may impede dealing with chronic unemployment and poverty through policy and services.

Through the Demonstration Washington will develop criteria to target supportive housing and supported employment services to Medicaid beneficiaries who are most likely to benefit from the services. By meeting beneficiaries' needs for stable housing, meaningful daily activity and income the State, community and beneficiary are better able to focus on achieving health outcome goals. In their public comment letter, appendix 9, the American Indian Health Commission for Washington State also confirms the interest of tribes and the urban Indian health organizations in offering supportive housing and supported employment services to AI/AN Medicaid beneficiaries. Due to their unique status in managing and providing for the care of AI/ANs and to AI/AN health disparities, the federal government and the state will need to

¹² Haslett, Drake, Bond, et al., 2011; Bond, 2004

¹³ (ICI, 2015 unpublished report

¹⁴ Dartmouth, 2014

work with the tribes and urban Indian health programs to deliver the same or analogous supportive housing and supported employment services as those delivered outside the Indian health system.

Transformation Sustainability Post-Demonstration

As described, under the Healthier Washington plan, the State intends that 80% of State-financed health care (i.e., Medicaid and public employees) will incorporate value-based payments to providers by 2019. (See section IV for further details.) The Demonstration will accelerate this transition by building providers' experience in coordinating across systems of care, by deepening relationships among providers and community-based supports and by building providers' capacity to accept value-based payments and report performance. Over the course of the Demonstration, some transformation projects will generate savings and improve quality, demonstrating the "business case" for continuing the project after the Demonstration ends¹⁵.

To sustain the transformation, the State must ensure that savings generated during the Demonstration are reinvested in a way that offers incentives for MCOs/BHOS, providers, and community-based organizations to participate fully in the transformed system. For example, reducing hospitalizations by working with community-based organizations to increase social supports for patients will save MCOs and BHOs money but will also reduce hospital revenues. An effective reinvestment strategy must therefore share savings with plans, providers, hospitals, and community-based organizations to assure aligned incentives to reduce avoidable intensive care. Similarly, behavioral health care and long term care service providers may make investments to expand capacity and collaborate with other providers, but the savings may accrue to physical health. The reinvestment strategy must align incentives across systems of care and the participants involved in achieving care goals. At a minimum, this will require Washington State and CMS to rethink methodologies for Medicaid rate setting. This could occur in two ways.

- First, transformation initiatives that yield a positive return on investment could be continued after the Demonstration via waiver or other authority needed to offer the services through managed care contracting and State administered benefits, without the need for additional federal funding.
- Second, under managed care rate setting rules MCOs have the ability to invest "savings" in non-state plan services. If savings in covered services are achieved in one year, and removed from the MCO or BHO rates the next year, this opportunity to invest is greatly constrained and discouraged. A shared savings mechanism must be incorporated into rate

¹⁵ To respect the federal trust responsibility for AI/ANs and to avoid unintended consequences to the Indian health system, the methodology for calculating savings under the Demonstration will need to exclude all amounts paid for services provided by tribes or ITUs to AI/ANs.

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setting to provide incentives for investments in nontraditional services or programs that yield sustainable, improved performance.¹⁶

Additionally, throughout the Demonstration, the State and its ACH partners will collaborate with members and payers (i.e., both MCOs and BHOs) to develop a plan for funding and sustaining the transformation. ACHs are currently required through their contracts with the State to develop a long-term sustainability plan. This will feed a planning process for continuing successful transformation activities as the Demonstration proceeds. Since regions have different needs and ACHs may have different capabilities, it will be critical to allow flexibility in local planning. A collaborative workgroup process, as noted in Section V, will be essential to getting this right.

For state administered innovation initiatives, sustainability planning will require an assessment of effect over the course of the Demonstration to ascertain return-on-investment opportunities that would support State investment over the long term.

Preservation and enhancement of the culturally responsive health care delivery system for AI/AN populations will also be an essential component of long-term Medicaid sustainability planning. The state will ensure that federal legal protections for AI/AN populations and I/T/Us remain intact. The state will also need to work with the tribes and urban Indian health programs to address their concerns regarding access in the fee-for-service system to specialty care (and to primary care for those tribes that do not have a medical clinic.) To sustain transformations achieved in Indian country, savings of Medicaid dollars under the Demonstration, whether due to tribal-centric transformations or tribal involvement in other transformations, will need to be reinvested in the Indian health system. To support these sustainability efforts, the state requests that the federal government not adjust IHS appropriations, including future requests and allocations, as a result of any savings achieved under the Demonstration.

Emerging Challenges Threaten Medicaid's Strength and Sustainability

Today's health care system is driven by financial incentives that favor episodic volume-based diagnosis and treatment over health promotion. Individuals often delay seeking care until they have a health emergency. Providers often work in silos, delivering fragmented care with limited understanding of, or access to, tools that could help address social factors that impact health. Once a beneficiary's condition has seriously deteriorated, it can be difficult, if not impossible, to fully restore his or her health to prior levels. Often the best outcome is to manage clinical decline over a course of relapses and incomplete recoveries. Even for LTSS, as presently configured, the State's Medicaid program engages only when an individual's health and finances are compromised. At that point the individual may be unable to maintain quality of life

¹⁶ Preliminary work is underway on this front to consider methods applicable in regions that are "early adopters" of fully integrated managed care for physical and behavioral health services. This is a Legislative directive to support the policy of integrated care.

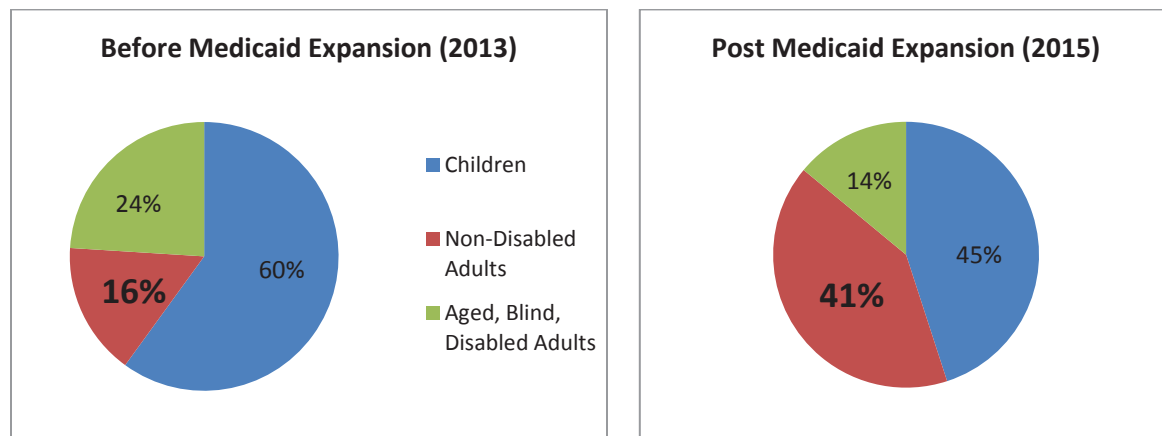
or remain in their home because they can no longer manage daily living tasks or afford the maintenance and upkeep of living independently. The result is a move to high-cost residential or institutional care, with little likelihood of long-term improvement, funded primarily by Medicaid.

These systemic issues are exacerbated by growing challenges that require Washington to rethink how Medicaid can sustain delivery of high-quality, cost-effective care and services in the future.

Expansion Population Is Stretching System Capacity

By expanding Medicaid to cover the new adult group, Washington has increased its Medicaid enrollment by 44% in less than two years. Prior to expansion, 60% of Washington State’s Medicaid enrollees were children, 16% were non-disabled adults and 24% were aged, blind or disabled adults. After expansion, 45% are children, 41% are non-disabled adults and 14% are aged, blind or disabled adults.¹⁷ The Medicaid program now serves a population that is primarily adults, about 56% of whom are new to Medicaid and often have previously unmet health care needs. This population is different from traditional Medicaid adults.

Figure 3. Washington’s Medicaid Classic and New Adult Populations



The new adult group has significant rates of behavioral health needs (often with co-morbidities): 22 percent have a mental health condition, and 14 percent have a substance use disorder.¹⁸ And while the new adult group has generally lower hospital admission rates than other non-disabled adults, inpatient stays average 50 percent longer.¹⁹

¹⁷ Comparison of June 2013 vs. June 2015 Medicaid enrollment, HCA.

¹⁸ CY 2014 Newly Eligible Adult Population summary of clients with at least 6 months of newly eligible adult coverage in CY2014, Research and Data Analysis, DSHS, June 2015.

¹⁹ Inpatient cost and utilization measures by eligibility coverage group, Research and Data Analysis, DSHS, June 2015.

Furthermore, Medicaid expansion has significantly increased the proportion of persons leaving local jails and state correctional facilities who are enrolling in Medicaid upon release. About half of released inmates who enroll in Medicaid have significant mental health needs, and about two-thirds of persons released from local jails have an indication of a substance use disorder. Prior to Medicaid expansion in CY 2013, fewer than 20 percent of inmates released from Washington State Department of Corrections facilities were enrolled in Medicaid upon release; post expansion more than 60 percent secure Medicaid coverage after release. Similar improvements have been observed for persons released from local jail facilities.

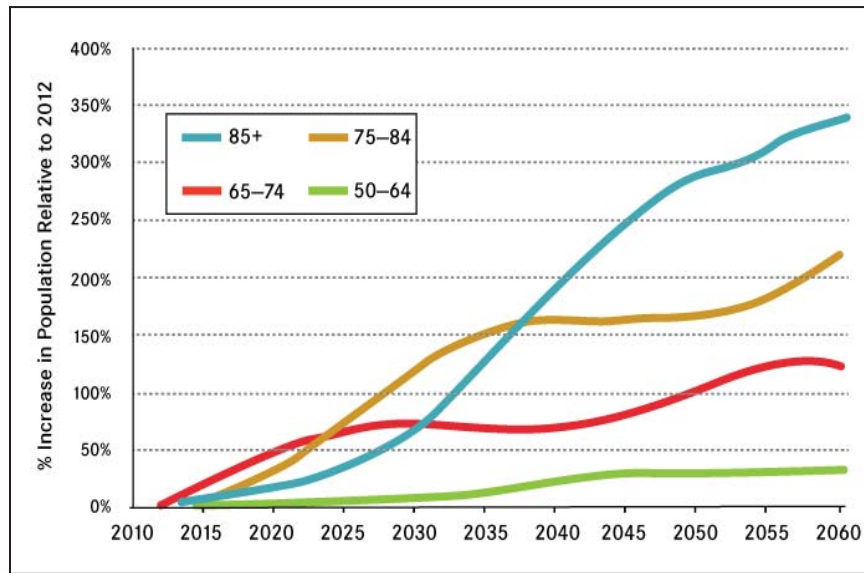
Like many other states, Washington has shortages of providers in areas of the state and, even where sufficient capacity exists, not all providers accept Medicaid patients. Faced with an unprecedented increase in demand, Medicaid providers are struggling to keep up. After expansion, psychiatric readmission rates rose among all adult Medicaid enrollees with mental illness (including new adults and traditionally eligible adults). For adults with either mental illness or substance use disorders, the rate of emergency department use likewise rose—reversing the multi-year decline in emergency department use for this population. These and additional challenges in serving Medicaid beneficiaries are summarized in appendix 2, along with the Washington-specific research that underscores the opportunities for transforming the system.

“Age Wave” Threatens Long-Term Sustainability of Program.

National data indicate that 70% of individuals who reach age 65 will need LTSS during their lifetime. By 2035, the population age 75 and above will have risen by roughly 150%. The number of Medicaid beneficiaries with complex cognitive challenges will also increase dramatically by 2040 relative to 2010: a 181% increase in Medicaid beneficiaries over age 65 with Alzheimer’s, a 152% increase in Medicaid beneficiaries over age 70 with dementia, and a 152% increase in the number of Medicaid beneficiaries over age 75 with serious cognitive difficulties.²⁰ Although Washington is a national leader in delivering high quality, client-directed and cost-effective community-based long-term services and supports, current demographic projections indicate that the demands for LTSS will rapidly become unsustainable in a state where rebalancing has already occurred. Over the next ten years alone, expenditures on long-term care in Washington are expected to double. The rising demand will stretch the State’s capacity to deliver community-based care unless we can target upstream supports to unpaid family caregivers who provide approximately 85% of LTSS in Washington State.

²⁰ Data provided by Research and Data Analysis, DSHS, June 2015.

Figure 4. Projected Growth in Washington’s Elderly Population, 2010-2050



Source: Washington State Department of Social and Health Services, Research and Data Analysis Division

As the “age wave” begins to crest, Washington will be under continued pressure to deliver cost-effective, community-based care that is tailored to meet the diverse needs of an elderly population. Over the past 20 years, the State has been able to serve the growing older adult population by rebalancing from costly care in institutional settings to preferred and more cost-effective care in home and community-based settings. New strategies are now necessary to ensure we have the provider capacity, service access and funding to meet the needs of an aging population.

To avoid a fiscal cliff and to continue delivering high-quality care, Washington State must develop new approaches to meeting the needs of its aging population, building upon its successes in providing choice in how individuals’ needs for LTSS are addressed. Washington has been successful in creating an entitlement for receiving home and community-based LTSS through Medicaid and to date has not experienced wait lists in its 1915c waivers. Washington has also increased access to care through its policies of allowing family and friends to be hired by clients and paid through Medicaid funding. Although it is possible to add services and supports for unpaid family caregivers under existing Home and Community-Based Services (HCBS) authorities, current federal regulations would require that these services add to state plan and waiver services the individual may be eligible for. To serve a larger Medicaid-eligible population with increased choice and flexibility for clients and families in need of LTSS, the State is seeking authority to create a new benefit package that would be offered as a choice in lieu of existing Medicaid funded LTSS. A second benefit package would also be created for individuals who are at risk of spending down to Medicaid LTSS eligibility. Ensuring that there are nursing homes available for individuals who need that level of care is also a critical factor in the state’s transformation efforts. Serving individuals with lighter care needs in the community will help to ensure capacity in nursing homes for individuals who need access to rehabilitative, skilled nursing and higher levels of care in a 24-hour care setting.

Rethinking Medicaid is Critical

Washington’s Medicaid program is at a critical juncture. It can affirmatively address the emerging challenges of its growing, changing, and aging Medicaid population and the complex system dynamics as it moves to more fully integrated managed care for physical and behavioral health. Conversely, it can delay until sustainability becomes a crisis that returns the State to classic reactive approaches to cost containment—reducing benefits, shrinking enrollment, and cutting reimbursement. For the health and productivity of our state there are really no options; the State must proactively address systemic Medicaid problems, strengthen clinical and community linkages that address the social determinants of health, and move in a direction that evidence shows can improve outcomes and decrease projected per capita cost growth.

In a transformed system, the Medicaid program, MCOs, BHOs, LTSS, health care and community service providers, and beneficiaries will have incentives to work together, leveraging the resources of the larger community to address clinical and social determinants of health. By intervening before individuals become seriously ill, the new system will be better able to support a return to health and sustained recovery to avoid (or at least delay) a downward spiral. The Healthier Washington initiative, with the support of the Medicaid Transformation Demonstration, will reduce fragmentation in administration while improving care coordination, service delivery, and financing of services for Medicaid beneficiaries.

Evaluation Plan and Hypotheses to be Tested

Washington’s Demonstration will test the following hypotheses:

- Whether community-based collaborations that define community health needs can (1) support redesigned care delivery, (2) expand health system capacity, and (3) improve individual and population health outcomes - resulting in a reduction in the use of avoidable intensive services, a reduction in use of intensive service settings, bringing spending growth below national trends, and accelerating value-based payment reform.
- Whether providing limited scope LTSS to individuals “at risk” for Medicaid and to Medicaid beneficiaries who are not currently receiving Medicaid-funded LTSS and de-linking eligibility for optional state plan or waiver HCBS from nursing facility level of care criteria will avoid or delay eligibility for and use of full Medicaid LTSS benefits while preserving quality of life for beneficiaries and reducing costs for the state and federal government.
- Whether the provision of foundational community supports - supportive housing and supported employment - will improve health outcomes and reduce costs for a targeted subset of the Medicaid population.

Washington currently has extensive, nationally recognized data and analytic capacity for evaluation of Medicaid transformation initiatives. The availability of the State’s Integrated Client Database, described in appendix 3, analyzed by a skilled team of State agency researchers in partnership with university-affiliated staff, provides a unique opportunity to evaluate the impact of the three waiver-financed initiatives. Specifically the database enables the State to assess an array of access, quality, and cost metrics to evaluate whether

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Demonstration initiatives have been successful. In addition, the database supports tools such as PRISM,²¹ which offer sophisticated predictive modeling and data integration support to facilitate care management for high-risk Medicaid beneficiaries.

Within 120 days of approval of the terms and conditions for the Demonstration, Washington will develop a comprehensive draft evaluation plan for CMS’s review. No later than 60 days after receiving comments on the draft evaluation plan from CMS, the State will submit its final evaluation plan. We will look to CMS for technical assistance in structuring the evaluation plan and performance monitoring to align with the SIM Test Model valuation. Our challenge will be in measuring cross-cutting system integration and sector effects (including LTSS); our currently siloed systems have resulted in little opportunity and incentive to do this effectively. We also recognize that evaluation hypotheses need to target the most important effects that can in fact be measured. Preliminary thoughts on our evaluation are included in table 2.

Table 2. Demonstration Evaluation Questions, Hypotheses and Approach

Evaluation Question	Hypothesis	Evaluation Approach
What are the effects of implementation of transformation projects by community-based collaborations?	Medicaid beneficiaries, such as those with physical and behavioral health co-morbidities, will have higher quality of care after the transformation projects are implemented.	Measure intervention impacts on trends in targeted HEDIS and state-defined health care quality and outcome measures using Washington State’s Integrated Client Database (ICDB). ²²
	Total cost of care for individuals with multiple chronic conditions will be lower after the transformation projects are implemented.	Measure intervention impacts on health and social service cost measures using the ICDB and quasi-experimental evaluation techniques. ²³
	The rate of avoidable use of intensive services and settings, including use of community hospitals, psychiatric hospitals, skilled nursing facilities and jails, will be reduced after the transformation projects are implemented.	Measure intervention impacts on utilization of inpatient and institutional services using the ICDB and quasi-experimental evaluation techniques. ²⁴

²¹ PRISM (Predictive Risk Intelligence System) is Washington State’s web-based, clinical decision support data tool that identifies individuals with physical and behavioral health co-morbidities.

²² In a quasi-experimental design, the research substitutes statistical "controls" for the absence of physical control of the experimental situation. For an example, see Mancuso, D. and Felver, B. Managed Medical Care for Persons with Disabilities and Behavioral Health Needs. <https://www.dshs.wa.gov/sesa/rda/research-reports/managed-medical-care-persons-disabilities-and-behavioral-health-needs>.

²³ For an example, see: Xing, J., Goehring, C., and Mancuso, D. Care Coordination Program for Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs. Health Affairs. April 2015.

²⁴ Ibid.

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Evaluation Question	Hypothesis	Evaluation Approach
What are the effects of modifying eligibility criteria and benefit packages for long-term services and supports?	Individuals receiving the limited scope benefit will better maintain quality of life, as compared to before the Demonstration.	Measure intervention impacts on functional indicators using the ICDB and quasi-experimental evaluation techniques.
	The rate of growth in Medicaid enrollment for full scope long-term services and supports will be lower than projections created before the Demonstration.	Measure intervention impacts on utilization of Medicaid-paid long-term services and supports using the ICDB and quasi-experimental evaluation techniques. ²⁵
	Low needs individuals served in a home setting who are not eligible for nursing home services under new eligibility have health and safety needs met in the community	Measure impacts of change in nursing home criteria on utilization of institutional services using the ICDB and quasi-experimental evaluation techniques.
What are the effects of providing foundational community supports for targeted populations?	Individuals receiving supportive housing or supported employment services will have better outcomes than a comparable population.	Measure intervention impacts on health and social service costs, homelessness, and employment rates using the ICDB and quasi-experimental evaluation techniques.

²⁵ For an example, see: Lavelle, B., Mancuso, D., Huber, A. and Felver, B. Expanding Eligibility for the Family Caregiver Support Program in SFY 2012. <https://www.dshs.wa.gov/sesa/rda/research-reports/expanding-eligibility-family-caregiver-support-program-sfy-2012>

SECTION II – DEMONSTRATION ELIGIBILITY

Demonstration Population Overview

The Demonstration will not alter the eligibility criteria or income standards for the 1.8 million individuals enrolled in Washington’s Medicaid program or the Medicaid eligibility groups they represent. Nonetheless, investments in transformation projects funded through the Demonstration could improve care delivery for all these individuals. In that sense all Medicaid enrollees are technically “Demonstration eligible.” This includes children, although they were not specifically called out in the earlier discussion of Washington’s emerging challenges.

Further estimates are being developed to refine population estimates for specific Demonstration initiatives and transformation investments. Design work continues to refine specific eligibility standards and methods related to *Initiative 2: Broaden Array of Service Options that Enable Individuals to Stay at Home and Delay or Avoid Need for More Intensive Care* and *Initiative 3: Provision of Targeted Foundational Community Supports*. Eligibility standards and methodologies applicable to the Demonstration are summarized below.

Targeted Long-Term Services and Supports

Future Functional Eligibility for Nursing Home Services

The Demonstration will increase the functional eligibility criteria to qualify for nursing home services in the future, so that individuals with low level of need for activities of daily living will not qualify to receive services in that setting. Individuals currently receiving nursing home services will be “grandfathered” to ensure they do not have to meet the new higher standard. The lower institutional level of care criteria, in place prior to the approval of the Demonstration, will continue as the eligibility criteria for PACE and HCBS offered through the state plan or a 1915(c) waiver.

Option to Choose Medicaid Alternative Care

Currently eligible Medicaid beneficiaries who are eligible for, but have chosen not to receive, Medicaid-funded LTSS will be eligible for a new Medicaid Alternative Care (MAC) benefit package. These individuals do not constitute a new Medicaid eligibility group. The Demonstration allows them a benefits choice that will enable them to remain in their homes for a longer period. Proposed eligibility criteria include:

- Age 55 or older;
- Income at or below 150% of the Federal Poverty Level;
- Eligible for Categorically Needy (CN) services;
- Meet functional eligibility criteria for HCBS as determined through an eligibility assessment (these individuals would not need to meet the higher functional eligibility criteria that will be established under the Demonstration for nursing facility care);

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- Have not chosen to receive the LTSS Medicaid benefit currently available under optional state plan or HCBS authorities. We propose that individuals being served through the classic HCBS services could opt out of that benefit to choose the lesser MAC benefit package as long as they meet the other proposed MAC criteria.

Washington will not apply post-eligibility treatment of income to the MAC population. Because the cost of this benefit package is also relatively low and the eligibility threshold is high, the assigned amount of participation may exceed the actual benefits value. If this were the case there would be no incentive to use the program and beneficiaries would resort to more intensive and costly services. Individuals receiving MAC will also not be subject to estate recovery or post-eligibility treatment of income.

Individuals served in nursing facilities at the time of waiver approval will continue to be eligible under the functional eligibility criteria in place upon their admission to the facility. To be admitted to a nursing facility at any period during the Demonstration, Medicaid beneficiaries must meet the increased functional eligibility requirements.

The lower institutional level of care criteria in place prior to the approval of the Demonstration will remain the eligibility criteria to qualify for PACE or HCBS offered through the state plan or a 1915(c) waiver.

Eligibility Expansion for Medicaid “At Risk” Population

In addition, as indicated in table 3, the Demonstration will establish a ***new eligibility expansion category*** for individuals who are “at risk” of becoming eligible for Medicaid in order to access LTSS. This is the “At Risk” or “Tailored Supports for Older Adults” (TSOA) eligibility group who would not meet the financial eligibility for Medicaid without this waiver. Under the Demonstration, these individuals may access a new LTSS benefit package that will preserve their quality of life while delaying their need (and the financial impoverishment) for full Medicaid benefits.

Table 3: Demonstration Eligibility Expansion Populations

Eligibility Group Name	Social Security and CFR Sections	Income Level
“At risk” for Medicaid - also known as Tailored Supports for Older Adults (TSOA)	n/a	Income up to 300% of the Federal Benefit Rate

To qualify for the Tailored Supports for Older Adults (TSOA) benefits which support those “at risk” for Medicaid, we propose that beneficiaries:

- Be age 55 or older;
- Not be currently eligible for Medicaid;

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- Meet functional eligibility criteria for HCBS as determined through an eligibility assessment (these individuals would not need to meet the higher functional eligibility criteria that will be established under the Demonstration for nursing facility care);
- Have income up to 300% of the Federal Benefit Rate.

To determine eligibility for TSOA services we propose to only consider the income of the applicant, not their spouse/dependents, when determining if gross income is at or below the 300% Federal Benefit Rate limit.

To determine income, Washington will use the Social Security Income (SSI)-related income methodologies currently in use for determining eligibility for Medicaid LTSS. No post-eligibility treatment of income will apply and eligibility will be determined using only the applicant's income. Individuals receiving the TSOA benefit would not be subject to estate recovery. Like the MAC population, Washington will not apply post-eligibility treatment of income to the TSOA populations. Because the cost of this benefit package is relatively low and the eligibility threshold is high, the assigned amount of participation may exceed the actual benefits value. If this were the case there would be no incentive to use the program and beneficiaries would resort to more intensive and costly services.

Preliminary modeling suggests that approximately 270,000 individuals in the State may meet eligibility criteria for the TSOA services. Some of these individuals may be Medicaid-eligible individuals who have not applied for Medicaid benefits. We predict that about 35% of those eligible may choose to participate in the program. To ensure that funding for the Demonstration is equitably distributed across LTSS transformation initiatives, enrollment limits may be imposed on eligibility for TSOA benefits.

Foundational Community Supports

Washington intends to offer access to supportive housing and supported employment, to a targeted group of individuals. Preliminary modeling suggests that approximately 7,500 individuals would be eligible for supportive housing services, with about 40%, or 3,000, engaged on a monthly basis. We estimate that 40% of the engaged population would be Medicaid expansion new adults. As work proceeds to refine the definition of eligibility and benefits, modeling results will be revised.

SECTION III – DEMONSTRATION BENEFITS AND COST SHARING REQUIREMENTS

Demonstration Benefits Overview

Under the Demonstration, most Medicaid enrollees will receive the same benefits they currently receive under the State Plan and existing waiver authorities. Details of Washington’s Alternative Benefit Plan, which is available to “expansion adults,” are described in the State Plan.²⁶ Premium assistance for employer sponsored coverage is not included in the Demonstration.

Washington will offer two new limited-scope packages of long-term services and supports to individuals:

- who meet current eligibility standards, but who choose not to access Medicaid-funded long-term care services and to
- those “at risk” of needing Medicaid coverage.

Medicaid adult beneficiaries, who meet additional criteria established by the State as described in the previous section, may also receive foundational community supports (i.e., supportive housing and/or supported employment benefits).

Eligibility groups and the new benefit packages that apply are summarized in table 4. The CMS- Requested Long Term Services and Supports Form and the Benefit Specifications and Qualification Forms are included as appendices 4, 5, and 6.

Table 4: Additional Demonstration Benefits by Eligibility Group

Eligibility Group	Benefits
Aged, Disabled, or Both	Medicaid Alternative Care (MAC)
“At risk” for Medicaid	Tailored Supports for Older Adults (TSOA)
Targeted sub-population of Medicaid beneficiaries (adult categories)	Supportive housing Supported employment

Long term services and supports that will be provided include those marked X in the list provided by CMS:

- Homemaker
- Case Management
- Adult Day Health Services (TSOA program)
- Habilitation – Supported Employment
- Habilitation – Day Habilitation

²⁶ <http://www.hca.wa.gov/medicaid/medicaidsp/Pages/index.aspx>

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- Habilitation – Other Habilitative
- Respite
- Psychosocial Rehabilitation
- Environmental Modifications (Home Accessibility Adaptations)
- Non-Medical Transportation
- Home Delivered Meals Personal
- Emergency Response
- Community Transition Services
- Day Supports (non-habilitative) (TSOA program)
- Supported Living Arrangements
- Assisted Living
- Home Health aide
- Personal Care Services (TSOA program)
- Habilitation – Residential Habilitation
- Habilitation – Pre-Vocational
- Habilitation – Education (non-IDEA Services)
- Day Treatment (mental health service)
- Clinic Services
- Vehicle Modifications
- Special Medical Equipment (minor assistive devices)
- Assistive Technology
- Nursing Services
- Adult Foster Care
- Supported Employment
- Private Duty Nursing
- Adult Companion Services
- Supports for Consumer Direction/Participant Directed Goods and Services
- Other: Education and training, health maintenance and therapies.

Medicaid Alternative Care (MAC)

Administered by the State, the MAC benefit package will be offered through a participant-directed budget to individuals who are Aged, Disabled, or Both and Not Currently Receiving Medicaid-Funded LTSS. Participants may allocate their budget among the covered services listed in table 5, up to the amount and duration covered by their budget. Preliminary modeling is underway to inform budget parameters. Individuals receiving MAC would also be eligible for Medicaid-funded Medical services but would not be eligible for other Medicaid funded optional state plan or 1915(c) waiver LTSS benefits. MAC is an alternate benefit package that individuals may choose so they can remain in their home with care provided through their unpaid family caregiver. If an eligible individual chooses to access state plan or 1915(c) waiver LTSS benefits, they would no longer be eligible to receive MAC services.

Table 5: Benefits - Medicaid Alternative Care

Benefit	Description of Amount, Duration, and Scope
Caregiver Assistance Services	<p>Services that take the place of those typically performed by the unpaid caregiver in support of unmet needs the care receiver has for assistance with activities of daily living and instrumental activities of daily living. Services include but are not limited to :</p> <ul style="list-style-type: none"> • Housework/errands • Transportation(only in conjunction with the delivery of a service) • Respite • Home delivered meals
Training & Education	<p>Services and supports to assist caregivers with gaining skills and knowledge to implement services and supports needed by the care receiver to remain at home or skills needed by the caregiver to remain in their role. Services include but are not limited to :</p> <ul style="list-style-type: none"> • Support groups • Group training • Caregiver coping/skill building training • Consultation on supported decision making • Caregiver clinical training
Specialized Medical Equipment & Supplies	<p>Goods and supplies needed by the care receiver that are not covered under the state plan, Medicare or private insurance. Services include but are not limited to :</p> <ul style="list-style-type: none"> • Supplies • Specialized Medical Equipment • Personal emergency response system
Health Maintenance & Therapies	<p>Clinical or therapeutic services that assist the care receiver to remain in their home or the caregiver to remain in their caregiving role and provide high quality care.</p> <p>Services are provided for the purpose of preventing further deterioration, improving or maintaining current level of functioning. Supports and services categorized here include those typically performed or provided by people with specialized skill, certification or licenses.</p> <p>Services include but are not limited to :</p> <ul style="list-style-type: none"> • Adult day health • RDAD and EB exercise programs • Health Promotion Services • Counseling

Tailored Supports for Older Adults

Administered by the State, the TSOA benefit package will be offered to individuals determined to be “at risk” for Medicaid (as described in the previous section), through a participant-directed budget. Participants may allocate their budget between the covered services listed in table 6 up to the amount and duration covered by their budget. Preliminary modeling is

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underway to inform budget parameters. Individuals receiving TSOA services would **not** be eligible for Medicaid-funded Medical services or other Medicaid-funded optional state plan or 1915(c) waiver LTSS benefits. Individuals who later become Medicaid eligible will no longer be eligible for TSOA services.

Table 6: Benefits - Tailored Supports for Older Adults (TSOA)

Benefit	Description of Amount, Duration, and Scope
Caregiver Assistance Services	<p>Services that take the place of those typically performed by the unpaid caregiver in support of unmet needs the care receiver has for assistance with activities of daily living and instrumental activities of daily living. Services include but are not limited to :</p> <ul style="list-style-type: none"> • Housework/errands • Transportation(only in conjunction with the delivery of a service) • Respite • Home delivered meals
Training & Education	<p>Services and supports to assist caregivers with gaining skills and knowledge to implement services and supports needed by the care receiver to remain at home or skills needed by the caregiver to remain in their role. Services include but are not limited to :</p> <ul style="list-style-type: none"> • Support groups • Group training • Caregiver coping/skill building training • Consultation on supported decision making • Caregiver clinical training
Specialized Medical Equipment & Supplies	<p>Goods and supplies needed by the care receiver that are not covered under the state plan, Medicare or private insurance. Services include but are not limited to :</p> <ul style="list-style-type: none"> • Supplies • Specialized Medical Equipment • Personal emergency response system
Health Maintenance & Therapies	<p>Clinical or therapeutic services that assist the care receiver to remain in their home or the caregiver to remain in their caregiving role and provide high quality care. Services are provided for the purpose of preventing further deterioration, improving or maintaining current level of functioning. Supports and services categorized here include those typically performed or provided by people with specialized skill, certification or licenses. Services include but are not limited to :</p> <ul style="list-style-type: none"> • Adult day health • RDAD and EB exercise programs • Health Promotion Services • Counseling
Personal Assistance Services	<p>Supports involving the labor of another person to help waiver participants carry out everyday activities they are unable to perform independently. Services may be provided in the person's home or to access community resources. Services include but are not limited to :</p>

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Benefit	Description of Amount, Duration, and Scope
	<ul style="list-style-type: none"> • Personal Care • Nursing delegation • Adult day care • Transportation(only in conjunction with the delivery of a service) • Home delivered meals

Foundational Community Supports

Preliminary definition of benefits for statewide supportive housing and supported employment are described in tables 7 and 8. These will be refined as work proceeds in the Fall 2015.

Table 7: Benefits - Foundational Community Supports

Benefit	Description of Amount, Duration, and Scope
Supportive Housing	<p>Housing-related activities (Individual Housing Transition Services, Individual Housing and Tenancy Sustaining Services) that include a “to be defined” range of flexible services and supports available to Medicaid enrollees age 18 and older,²⁷ who require tenancy supports to access and maintain community housing. To be eligible, individuals must meet one or more of the following criteria:</p> <ol style="list-style-type: none"> 1. Meet HUD definition of chronically homeless (see below) <p>Or</p> <ol style="list-style-type: none"> 2. Have frequent or lengthy institutional contacts (emergency room visits, nursing facility stays, hospital, psychiatric hospital stays, jail stays). Frequency, length and acuity to be determined. <p>Or</p> <ol style="list-style-type: none"> 3. Have frequent or lengthy adult residential care stays: Adult Residential Treatment Facilities (RTF), Adult Residential Care (ARC), Enhanced Adult Residential Care (EARC), Assisted Living (AL), Adult Family Home (AFH), Expanded Community Services (ECS)) or Enhanced Service Facilities (ESF). Frequency, length and acuity to be determined. <p>Or</p> <ol style="list-style-type: none"> 4. Have frequent turnover of in-home caregivers or providers. Frequency, length and acuity to be determined by ALISA CARE assessment. <p>Or</p> <ol style="list-style-type: none"> 5. Meet specific risk criteria (PRISM risk score of 1.5 or above) <p style="text-align: center;">HUD Chronically Homeless Definition.</p> <p>The definition of “chronically homeless” currently in effect for the CoC Program is that which is defined in the CoC Program interim rule at 24 CFR 578.3, which states that a chronically homeless person is:</p> <p>(a) An individual who:</p> <ol style="list-style-type: none"> i. Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and ii. Has been homeless and living or residing in a place not meant for human habitation, a

²⁷ While this population may be predominantly adults, it also would include transitioning youth – those coming out of foster care, homelessness, or JRA facilities for example.

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Benefit	Description of Amount, Duration, and Scope
	<p>safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and</p> <p>iii. Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;</p> <p>(b) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition [as described in Section I.D.2.(a) of this Notice], before entering that facility; or</p> <p>(c) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition [as described in Section I.D.2.(a) of this Notice, including a family whose composition has fluctuated while the head of household has been homeless.</p>
Supported Employment	<p>Supported Employment related services will be available to Medicaid working age enrollees (16 and up) who, because of their disabilities, need intensive ongoing support to obtain and maintain an individualized job in competitive or customized employment or self-employment, in an integrated work setting in the general workforce for which and individual is compensated at or above the minimum wage. Medicaid working age enrollees (16 and up) eligible for this benefit will meet one or more of the following criteria:</p> <ul style="list-style-type: none"> • Severe and persistent mental illness, moderate to severe substance use disorder or severe emotional disturbance <p>Or</p> <ul style="list-style-type: none"> • Behavioral health and or traumatic Brain injury and or physical disabilities who are eligible for LTSS <p>AND</p> <ul style="list-style-type: none"> • Wish to become employed <p>Upon full implementation, average monthly service need is estimated at about 4-5 hours per user. Based on experience with fidelity reviews of providers in Oregon, we estimate that it will take 48 months to reach full program capacity.</p>

Copayments Applicable to “At Risk” Population

For those individuals who are “at risk’ for Medicaid LTSS but not currently Medicaid eligible, we are considering an option for a sliding scale based on income to define applicable copayments for TSOA benefits. Coinsurance and deductibles will not apply. Consistent with federal regulations, American Indians/Alaska Natives would be exempt from any copayment requirements.

Table 8: Copayments - Tailored Supports for Older Adults

Eligibility Group	Benefit	Copayment Amount
“At risk” for Medicaid (TSOA)	Respite, personal care, household and errands	Sliding Scale – to be determined based on income

SECTION IV – DELIVERY SYSTEM AND PAYMENT RATES FOR SERVICES

Delivery System Transformation Overview

Washington intends to transform Medicaid over the next five years to improve its delivery and payment system and sustain the program in the face of a growing, aging, predominantly adult, Medicaid population. All facets of Washington’s transformation strategy share a common theme—the need to grow competency in health improvement and recovery strategies. This will allow Washington to deliver higher value care that meets each beneficiary’s range of needs, thereby decreasing the use of avoidable intensive and costly services.

Beneficiaries will continue to access care during the Demonstration through delivery systems defined in the State Plan, section 1932, 1915 (b), 1915 (c), 1915 (k) and other waivers in place during the 1115 waiver period. They include those noted with an X below:

- Managed care
 - Managed Care Organization (MCO)
 - Prepaid Inpatient Health Plans (PIHP)
 - Prepaid Ambulatory Health Plans (PAHP)
- Fee-for-service (including Integrated Care Models) Primary Care Case Management (PCCM)
- Other (N/A)

Beneficiaries not receiving coverage through managed care health systems (MCOs and BHOs) will continue to receive services through the fee-for-service Medicaid program and, in the case of the AI/AN population, through the Indian health system. LTSS benefits will continue to be delivered through 1915(c), 1915(k) and optional state plan authorities under fee-for-service arrangements.

Enrollment in the Demonstration will be “mandatory” in that the care delivered to all Medicaid beneficiaries could be affected by the Demonstration. For example, an individual receiving physical and mental health services could find that, after the Demonstration is implemented, they are able to see a nurse practitioner regarding their high blood pressure during a visit to a community mental health center. The Demonstration, however, does not affect how beneficiaries enroll in (or change enrollment in) MCOs or BHOs. It also does not affect current legal protections for the AI/AN population, including encounter rate reimbursement applicable to the Indian health delivery system in Washington.

The Demonstration will not alter the State’s approach to assuring choice of MCOs, access to care, and adequacy of provider networks. These fundamental Medicaid requirements will continue to be addressed in the manner set forth in the State Plan and the State’s waiver authorities. The State will also continue to follow the process for selecting and procuring managed care providers that is outlined in the State Plan.

In the Demonstration preface and afterword to this document, Washington’s current and transformed delivery systems are described through the lens of one beneficiary, John. Changes to the delivery system that are supported through the Demonstration are described below through the lens of the three Medicaid transformation initiatives.

Initiative 1: Transformation through Accountable Communities of Health

As earlier stated, ACHs are not service delivery organizations in themselves. However, based on approved applications they will receive performance-based payments to distribute to providers and community-based organizations undertaking defined transformation projects.

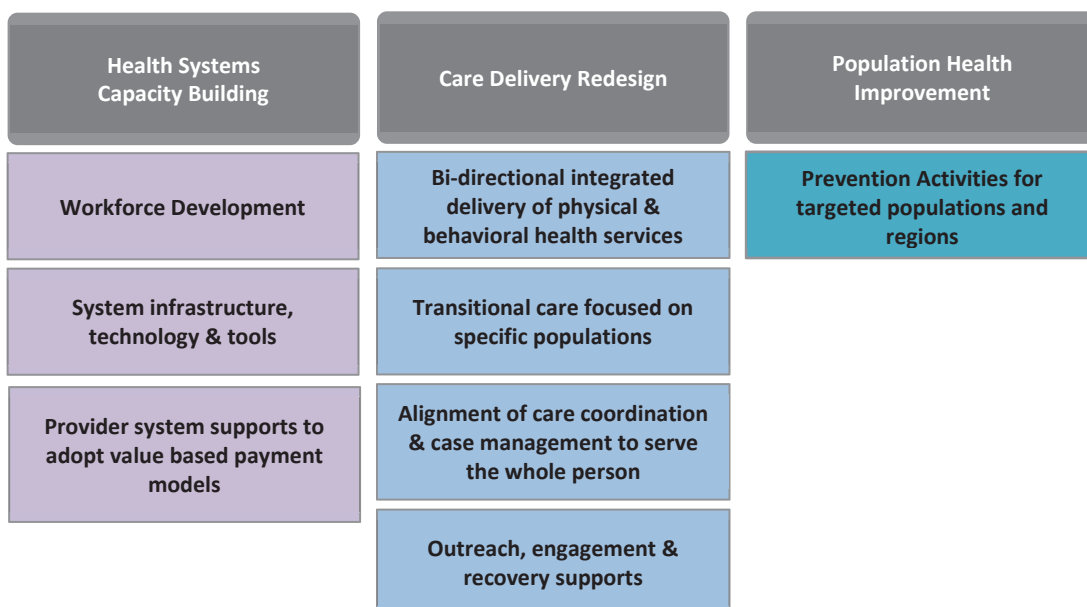
Transformation projects will require providers in a region to collaborate across systems of care, build clinical–community linkages, and implement population health initiatives. Based on the success (or limitations) of transformation projects, the State and its key partners will be able to assess the business case for sustaining the transformation projects after the Demonstration.

Transformation Projects

The menu of transformation projects has not been fully developed. As indicated in Section V, we anticipate the need for a comprehensive workgroup effort to complete this, beginning this Fall. This has been a clear theme from public comments, stakeholder engagement and Tribal Consultation in recent weeks. For the purposes of this initiative, the number of enrolled Medicaid beneficiaries residing in each ACH must be determined in order to establish transformation project valuation and to monitor quality and performance expectations. We anticipated that beneficiaries will be attributed to the ACH regional service area in which they reside, regardless of the site of care delivered. The State will provide data on numbers of enrolled beneficiaries to ACHs.

Sample transformation projects have been categorized under three investment domains as shown in Figure 5.

Figure 5: Transformation Project Domains



- **Health Systems Capacity Building** encompasses projects designed to build providers' capabilities to succeed and effectively operate in a transformed system. It includes projects designed to develop current workforce capacity, support the expansion and redefinition of workforce, and support work flow redesign to optimally meet the needs of Medicaid beneficiaries. For example, projects that increase health information exchange capabilities across provider types would be considered, as well as projects that support the development of care teams connected to the community or that aim to increase the ability of providers to meet the complex, often intertwined needs of beneficiaries. Additionally, telemedicine programs that extend limited resources, and increase beneficiary engagement and support workforce development to increase the care skills of long-term services and supports, will be considered.

Projects in this domain will be largely influenced by needs assessments coordinated through the ACH in order to address regional gaps that would otherwise hinder providers from participating in the Demonstration. In addition, some projects may need to support ACHs in meeting the financial and administrative demands of serving as the coordinating entity for transformation projects in their region.

Demonstration funds will also help build the capabilities for providers to succeed under value-based payment arrangements.²⁸ MCOs and BHOs will be contractually required to enter into value-based purchasing arrangements with providers by 2019. However, providers currently vary considerably in their readiness to accept risk for the cost of care delivered to beneficiaries. For example, larger hospitals and health systems are more likely to have the resources and infrastructure in place to accommodate risk-based contracts than smaller community-based providers. ACHs will draw on the expertise of their hospital and health system members, as well as MCOs, BHOs, and others, to reach readiness across the network of Medicaid providers in the region. Over the course of the Demonstration, ACHs will assist providers in accessing technical assistance available through the SIM-financed Practice Transformation HUB to help develop administrative, financial and legal capacity to adopt more integrated and accountable models of care and payment.

- **Care Delivery Redesign** focuses on scaling, spreading, and sustaining care delivery models that integrate systems of care and supports to address the health and recovery needs of the whole person, across the state. To this end it also supports development of clinical-community linkages. Effective and innovative models of integrated physical and behavioral health care currently operate in Washington State and can more readily be brought to scale with assistance from the SIM Test Model practice transformation Hub.²⁹ Adapted from the

²⁸ An important comment made during the public comment period offered a reminder that payment reform methodologies will need to accommodate small, culturally-based agencies that have strong capacity for reaching target populations although operating margins are small.

²⁹ Models include Collaborative Care primary care sites evaluated in the IMPACT study, as well as behavioral health models such as those exemplified by Kitsap Mental Health Services—a CMMI Innovation Award Grantee—and Asian Counseling and Referral Services, DESC and NAVOS, all SAMHSA-HRSA Center for Integrated Health Solutions

Healthier Washington Innovation Plan blueprint, Figure 6 provides an overview of elements of effective models currently operating in Washington state. Transformation projects that target integration of primary care and behavioral health will be core state priorities.

Figure 6. Bi-Directional Integrated Care Examples

BEHAVIORAL HEALTH CENTER	COMMUNITY HEALTH CENTER
<ul style="list-style-type: none"> ■ Behavioral health (BH) center— psychiatric consultation for primary care providers (PCPs) supports rapid diagnostic, medical management and training. ■ Behavioral health provider serves community PCP offices for low/ moderate BH needs and to coordinate access as needed to specialty BH services. ■ Primary care provider co-located in behavioral health center supports patients who prefer PCP services at the behavioral health center. ■ Team-based approach to clientele identified as having chronic health conditions in addition to BH needs. Team includes medical assistants and focus on improving health status. 	<ul style="list-style-type: none"> ■ Primary care clinic (Federally Qualified Health Center)—Regularly scheduled, technology-supported, psychiatric consultation for primary care providers supports rapid mental health diagnosis and treatment (including psychiatric medications), and training. ■ On-site, behavioral health provider serves patients at the community PCP offices for low/ moderate BH needs and to coordinate access as needed to specialty BH services. ■ Services provided are patient-centered, promote evidence-based practices, and have a primary focus on improving clinical outcomes. Regular, proactive screening and monitoring assures that patients are treated to achieve clinical goals and do not “fall between the cracks.”

In cases of currently effective bi-directional models, innovations are occurring to stimulate improved connections between community-based primary care and other providers with mental health and substance use disorder expertise. This is a “Community-Based Model” of bi-directional care, oriented towards sustaining recovery outside intensive service settings and ensuring that primary care providers, for example, have information and technical assistance readily available to support beneficiaries with complex health care needs in the least restrictive environment they choose.

Opportunities to build better transitions of care, especially with respect to transitions from jails to the community, require consideration of alternative approaches to sustaining connection to the Medicaid program (e.g., in suspension mode) so that beneficiaries are not totally disconnected from their traditional MCO/BHO and care team when they are discharged. This was a topic of repeated focus in public comments.

Primary and Behavioral Healthcare Integration Program awardees. Peninsula Community Health Services is a recipient of the Social Innovation Fund Grant through the John Hartford Foundation. Many of these innovation leaders are following practices developed and elaborated by the University of Washington AIMS Center, following the principles of measurement-based care, treatment to target, stepped care, and other aspects of the chronic illness care model developed by Edward Wagner and colleagues at the Group Health Research Institute MacColl Center for Healthcare Innovation, also located in Seattle, Washington.

- **Population Health Improvement** incorporates transformation projects that focus on prevention and health promotion for Medicaid beneficiaries consistent with the goals of the Demonstration.

Projects will target clinical and community prevention—specifically oriented towards diabetes, cardiovascular disease, pediatric obesity, smoking, mental illness, substance use disorders and oral health—that is coordinated and whole-person centered. The delivery system needs to be more flexible, rethinking approaches to engage individuals in personal health behavior change based on their needs and service preferences at the time. Since clinical services and community prevention efforts are critically linked in many areas, this presents an opportunity for mutually reinforcing effects and attention to increasing health equity.

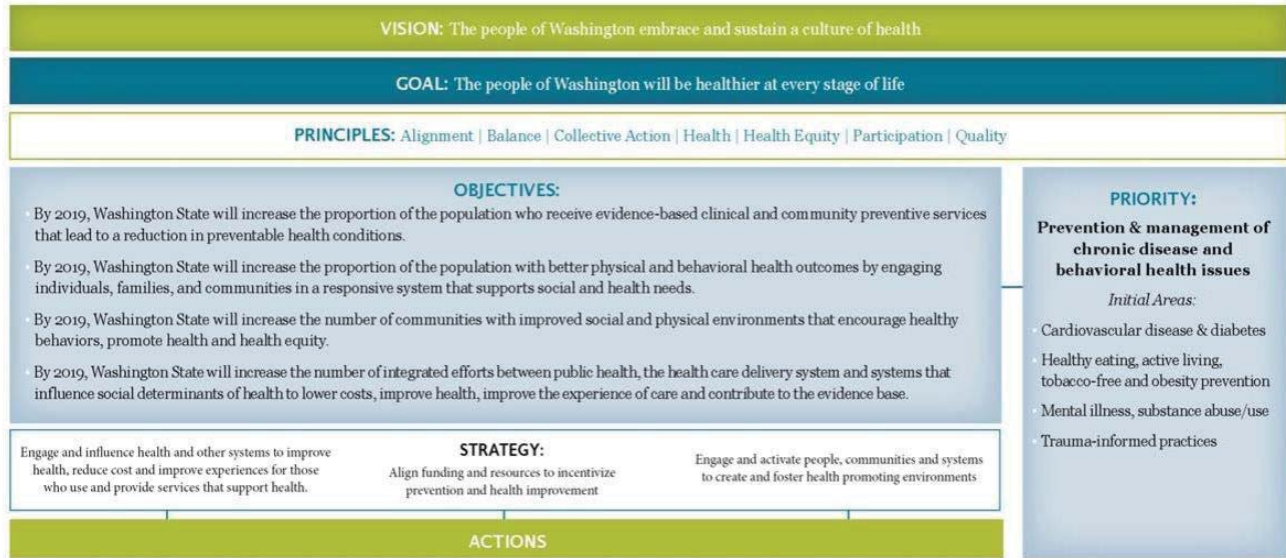
Maternal and child health is one pressing focus for the Medicaid program given that it funds more than half the births in the state and provides coverage to nearly half of all Washington's children. The Nurse Family Partnership (NFP) model offers one example of proven population health interventions in Washington state that could be further scaled to achieve the goals of this Demonstration.

NFP has a nearly four-decade track record of proven effectiveness in improving health outcomes and lowering costs for children and mothers. The Washington State Institute for Public Policy shows a nearly 3 to 1 return on investment associated with the program.³⁰ Through home visits from registered nurses, beginning early in pregnancy until the child reaches age two, NFP clients receive the care and support needed to have a healthy pregnancy, provide responsible and competent care for their children, and become economically self-sufficient. The NFP model combines case management with preventive services, including nursing assessments and screenings, incidental direct services, referrals to needed health services and health education and guidance within the scope of practice of a registered nurse.

Population health projects will dovetail with projects prioritized in the Care Delivery Redesign domain and will need to be informed in the fall by continued SIM Model Test build-out of the Plan for Improving Population Health. This is based on the earlier public-private multi-sector partnership to develop a comprehensive Prevention Framework, figure 7, as a blueprint for population health improvement.

³⁰ <http://www.wsipp.wa.gov/BenefitCost/Program/35>

Figure 7. Prevention Framework



Role of the MCO/BHO

Current and emerging models of ACH governance recognize the vital role of Managed Care Organizations (MCOs) and Behavioral Health Organizations (BHOs) as ACH members. They will play an essential role in the identification of community needs, participating in the transformation project selection process and supporting successful project implementation. Outside their ACH collaboration, MCOs and BHOs also have contractual obligations to manage and measure care outcomes and to initiate quality improvement programs targeted to improving their Medicaid members’ health – under their service contracts with the state. Comments received during the public comment period raised questions about alignment of the traditional MCO and BHO roles defined under current contract with the state and the implications of the intended role of ACHs in Medicaid purchasing.

One important consideration is to balance the need for MCOs to participate in multiple differing ACH transformation projects. Priorities for ACH led transformation projects will be consistent with MCO or BHO contracted expectations to maximize the value to Washington’s health system transformation. In particular, we anticipate that Performance Improvement Projects (PIPs) required in Medicaid MCO contracts will complement regional transformation projects. MCOs will benefit from active participation in transformation projects that yield reductions in utilization of more costly institutional, crisis, or specialty health care services. Ideally, with federal flexibility, MCOs and BHOs would be able to use participation in ACH-lead transformation projects to meet their PIP requirements.

The state intends to address managed care and ACH alignment under this initiative through the use of common performance measures that ensure mutual, cross-sector accountability and clear contractual expectations that are transparent to all entities. Process and performance measures for transformation projects will align with relevant performance measures to be

included in MCO and BHO contracts. This is explained further in the section on Value-Based Payments.

Continued workgroup activity in the lead up to “Year 0” will assist in achieving greater clarity.

Ensuring that Demonstration funds are used effectively

For transformation funding to be approved, the State will ensure the readiness and competency of each ACH to administer, coordinate and oversee transformation project investments. Project applications will need to include a funds flow plan, detailing the project budget and the expected distribution of funds. Understanding domain-specific reporting requirements will help to engage providers and optimize investments.

Through its contract with the State, each ACH will retain responsibility for implementing the transformation projects and for monitoring project related provider performance with an approach for remedial action if required. ACHs will separately enter into agreements with providers and community-based organizations in the region to establish the roles and responsibilities of the providers and organizations and define the process for addressing variation in provider performance.

The State will establish maximum total payments for each ACH, taking into account such factors as the number of Medicaid beneficiaries residing in each ACH region, the relative value of transformation projects being undertaken, and the quality and reach of the application. Once an ACH has met required process milestones or outcome metrics, the State will release funds to the ACH for distribution among members contracted to implement the funded projects. The State will require that most payments target providers with a Medicaid caseload volume above a threshold (yet to be defined) for the region.

During the first two years of the Demonstration, Washington expects that ACH payments will be tied to process milestones, such as transformation project selection and application for funding, defining related protocols, and discreet infrastructure investments needed to carry out transformation projects. These might include purchasing tools that link medical and community interventions, hiring patient-centered medical home consultants, and retraining and developing workers, such as community health workers/peer support counselors. ACHs will also retain a portion of the Demonstration funds to cover their own costs to implement the transformation projects (e.g., hiring core staff to support transformation-related ACH governance committees and to analyze data.)

Over the course of the Demonstration, incentive payments to reward high-performing providers and organizations will become increasingly important. Beginning in Demonstration Year 3, ACH project participants will receive payments contingent on attaining specified outcome metrics that demonstrate improvement over prior performance. For example, an ACH project participant might only receive a payment if it met an established benchmark for the psychiatric hospitalization readmission rate or alcohol and drug treatment retention, assuming

they were appropriate measures for the transformation project undertaken. To standardize the State's focus on common goals, process and performance measures for payments for transformation projects will align with relevant performance measures to be included in Medicaid MCO and BHO contracts.

Initiative 2: Broaden Array of Service Options that Enable Individuals to Stay at Home and Delay or Avoid Need for More Intensive Care

Delivery Reforms

Washington is a national leader in providing LTSS in the community. But currently individuals either qualify for all Medicaid-funded LTSS or do not qualify at all. To lead the next phase of LTSS delivery innovation, Washington needs flexibility to offer a broader array of targeted benefits to provide the appropriate level of services to individuals to meet their needs. Rather than an "all or nothing" approach to community-based long-term care, the State will offer an expanded, tiered benefit structure with access managed through the state's current service delivery structure, Home and Community Services and Area Agencies on Aging (AAA). Based on the assessment of need and the individual's informed consent, the State/AAAs would authorize and pay for MAC or TSOA services as summarized in the following categories of tiered benefits.

- Individuals new to Medicaid LTSS post waiver who meet the new, higher functional eligibility criteria will be eligible to receive services in skilled nursing facilities or home and community based settings.
- Individuals who currently receive or choose to receive Medicaid-funded home and community based services through 1915(c) waivers or state plan services will receive the same comprehensive set of services they receive today.
- Individuals who: (1) are eligible for Medicaid, (2) meet the current functional eligibility criteria to receive LTSS, and (3) do not choose to receive the Medicaid-funded LTSS described above, will be eligible for MAC benefits. These services will target supports needed by unpaid family caregiver(s) to ensure that they can continue caring for the Medicaid beneficiary safely at home. Beneficiaries will receive Medicaid-funded medical services, and individuals will be able to shift to (or from) service categories if they choose to do so.
- Individuals who are "At Risk" for Medicaid. While they meet functional eligibility to receive LTSS, they do not yet meet current financial eligibility criteria for Medicaid services. Under the Demonstration, Washington will offer these individuals an option for TSOA services. If the individual is eligible and chooses to receive benefits under Medicaid, they will no longer be eligible for TSOA.

Impact on Quality and Value

Providing targeted services and supports to unpaid family caregivers and individuals at risk of Medicaid spend down will increase the quality of the care and access to services that delay or prevent the need for more intensive supports. Unpaid caregivers will have access to caregiver

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screening and assessment designed to identify causes of stress and burden and individualized care plans will be developed to address the needs of the caregiver and care receiver.

Caregivers will be able to tailor services to increase their skills and knowledge of how to care for their loved one, how to manage caregiving tasks and have access to services that will reduce stress and burden. It is well documented that maintaining the ability to age in place increases quality of life and individuals are most comfortable receiving care from someone who is not a stranger.

Caregivers who receive ongoing family caregiver support through state funded programs show statistically significant improvements in indicators of health and well-being and there is a statistically significant delay in the use of Medicaid long term services and supports for the individual receiving care.

- Early intervention is key to improving the ability of individuals to maintain levels of functioning and to prevent future decline. Assisting individuals to create plans of care that are cost effective and meet basic needs will decrease the need for more intensive supports.
- Washington is working to maintain its standing as a leader in innovative delivery of long term services and supports and is ready to model the next evolution of a rebalanced delivery system through providing targeted services that will divert and delay the need for more intensive services.

Individuals receiving LTSS benefits for unpaid family caregivers or under the “at risk” population will self-direct their service budget among the services available in their benefit package. Personal care, household and errands (home maker) and respite services provide a self-directed employer option.

The state will use the fee-for-service rates identified in the State Plan for State Plan covered services, which include personal emergency response systems, home delivered meals and adult day services. The state will use the fee-for-service rates and the provider types identified in the state plan for personal care (which will also include respite, housework and errands). In the case of Individual Providers, rates are established through Collective Bargaining Agreement. Fee for service rates for LTSS not otherwise covered in the state plan are negotiated at the local level and must be within ranges published by the State for each service. Payment cannot exceed 1) the prevailing charges in the locality for comparable services under comparable circumstances, or 2) the rates charged by Area Agencies on Aging for comparable services funded by other sources. Written procedures for determining rates that are reasonable and consistent with market rates must be in place. Acceptable methods for determining rates include periodic market surveys, cost analysis and price comparison.

Initiative 3: Provision of targeted foundational community supports.

Supportive Housing

Supportive housing and supported employment services described in Section III will initially be implemented statewide to a targeted population through a flexible payment methodology with payments through MCOs and BHOs and fee for service for individuals eligible for LTSS. This delivery approach is currently proposed to continue through the first 2-3 years of the Demonstration while the model is fully developed and proven. A rough estimate of the service cost, including administrative costs, is \$600 per engaged client per month. This excludes the cost of already covered behavioral health and long term supports.

Washington will leverage the Chronic Homeless Policy Academy, the Money Follows the Person Demonstration and national technical assistance received through SAMHSA and HUD to further develop the strategic planning processes and strengthen relationships and agreements with state and local housing, community development agencies and HUD. Creation of the licensing requirements for supportive housing services is underway. Processes to assess licensing and/or contractual requirements within the long term care system are yet to be determined. Pilot and grant-funded projects in Washington State have demonstrated the need for, as well as, the success of supportive housing services. Replication and dissemination of the service model would be accomplished through the Demonstration, potentially linked with Initiative 1 to support capacity development. Data collection and outcome evaluation as well as facilitating stronger relationships with proprietors of affordable housing stock will be implemented through various policy academy and other workgroups, webinars and conference presentations.

Indisputable evidence of the beneficial effects of evidence based supported employment coupled with the clearly delineated deleterious effects of long term unemployment offers strong fiscal and therapeutic rationale for a targeted supported employment Medicaid benefit. Washington has been chosen to participate in a SAMHSA sponsored Olmstead policy academy to improve employment outcomes for individuals with psychiatric disabilities as well as the Dartmouth Psychiatric Research Center's Supported Employment Learning Collaborative. Supported employment pilot and grant-funded projects currently underway in Washington State exemplify models to assist in scaling and replicating supported employment services as a statewide Medicaid benefit. Initiatives to implement anti-stigma campaigns, education on the culture of work as well as fidelity-based supported employment services based on the Individual Placement and Support model are currently underway through federal grant funding. Facilitating and developing stronger relationships and agreements with Vocational Rehabilitation and Workforce Innovation Opportunity Act (WIOA) one-stop systems will be the focus of the next year. Opportunities may arise to link with other (initiative 1) transformation projects in regions where these services are a priority. Once sufficient experience has been established, we anticipate that the benefit cost and delivery of services would be integrated into MCO and BHO rates and a flexible payment method established for AI/AN populations served in the Indian Health system and individuals eligible for LTSS.

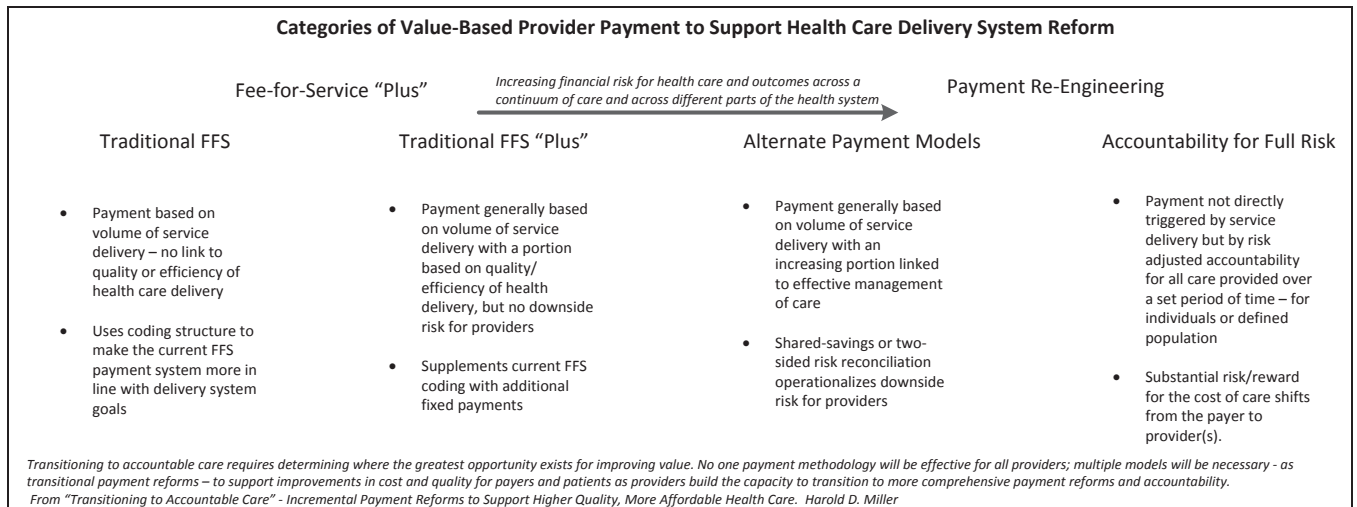
Value-Based Payments

In general, managed care payments will be consistent with the State Plan. However, transformation projects will drive movement from traditional fee-for-service-based provider payments toward reengineered payment systems in which there is increasing financial risk for health care and outcomes across a continuum of care and across different parts of the health system. ACHs will maximize the value-based payment effect by bringing to bear the impact of community service linkages on measurable health system outcomes.

During the State’s 2013 State Health Care Innovation planning, the blueprint for Healthier Washington, we asked MCOs about their payment arrangements with providers serving physical health care needs of Medicaid clients. Barely 24% of care was provided within a specific “budget” in which payment was not directly triggered by service delivery, but rather by responsibility for the care of a beneficiary (regardless of the volume of services). As previously noted, through current transformation initiatives and with the assumption of waiver and SIM Model Test investments, 80% percent of State financed health care (Medicaid and public employees) is intended to be purchased through value-based payment arrangements, by 2019. In subsequent years a key goal of Healthier Washington is to support providers in taking additional steps towards such arrangements as refined payment models take root to incent, reward and sustain delivery system transformation. We expect that the adoption of value-based payment methods by MCOs and BHOs will reinforce, and be reinforced by, the impact of innovations proposed in the Demonstration.

Our rudimentary classification of value-based payment arrangements is shown below in Figure 8. It reflects an array of payment models, most of which are employed to some degree in the current marketplace.

Figure 8. Value-Based Payment Arrangements



We fully anticipate that a roadmap to value-based payment would be an essential milestone in Special Terms and Conditions for an approved Medicaid Transformation Demonstration. Technical assistance from CMS will be important in building a road-map that recognizes the

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intersecting paths we are undertaking – see Figure 2 as a reminder of the complementary transformation building block timeline. The State will need to work with CMS to build an appropriate methodology for establishing quality-based supplemental payments for high-performing ACHs and providers. We anticipate that any Medicaid-centric value-based payment methodology will be based on the evolution of common performance measures that apply across ACHs, MCOs, BHOs and AAAs in support of State priorities.

The Healthier Washington Statewide Common Core Set of measures, including the workgroup activities for ongoing development of measures is available at:

http://www.hca.wa.gov/hw/Pages/performance_measures.aspx.

Earlier work to identify critical behavioral health and community support service measurement is described in a report to the Legislature available at:

http://www.hca.wa.gov/documents_legislative/ServiceCoordinationOrgAccountability.pdf.

These measures reflect the State’s commitment to standardized performance measurement across multi-payer public and private health delivery systems, a fundamental principle in the State’s Healthier Washington initiatives. For example, in 2016 contracts, common performance metrics will include:

- Alcohol or Drug Treatment Retention*
- Alcohol/Drug Treatment Penetration*
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
- Childhood Immunization Status
- Comprehensive Diabetes Care
- First Trimester Care
- Mental Health Treatment Penetration*
- Plan All-Cause Readmission Rate
- Psychiatric Hospitalization Readmission Rate*
- Well Child Visits

Note that asterisked measures represent the subset that will be included in BHO contracts.

In the future, we also anticipate inclusion of the Home and Community-Based Service Utilization or Reduction in avoidable use of institutions (hospital, nursing home) performance measure in the MCO, BHO and AAA contracts to help ensure additional cross system coordination.

Performance, which will drive value-based payments, must be based on metrics that ACHs, MCOs, BHOs, AAAs, and providers in general can jointly influence by improving care coordination and collaboration and by demonstrating improved beneficiary outcomes. For Tribes, the Government Performance and Results Act (GPRA) measures unique to the Tribal Health system will need to be recognized.

By necessity, measures pertinent to the Demonstration would initially target development of processes and procedures to affect change. Later, incentive payments would be available based

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on meeting performance goals for quality and outcome measures. Over time the incentive structure could evolve to a risk-based shared savings model taking both quality and financial performance into account. The value of such a model is referenced in the earlier description of Demonstration sustainability.

SECTION V – IMPLEMENTATION OF DEMONSTRATION

Complementary Transformation Paths

Prior to the start-up and during the Demonstration we will continue to align Demonstration efforts with work on the parallel SIM Model Test, State regional integrated purchasing, and other transformative paths. We are committed to ensuring that system improvement efforts and infrastructure capacity-building being undertaken as a result of Demonstration investments do not duplicate these evolving efforts. In particular we will ensure alignment with (a) Medicaid-contracted managed care health systems in which services, quality improvement projects and administrative functions are accounted for in capitation rates, (b) the SIM Test Model genesis of Accountable Communities of Health, development of value-based payment models, the infrastructure for a practice transformation support Hub and improved performance analytics, and (c) federal SAMHSA and Money Follows the Person grant activities that have demonstrated the need for and success of supportive housing and supported employment.

Based on the proposed Demonstration timeline, Figure 9 provides an overview of connections among key Healthier Washington initiatives.

Figure 9: Alignment of Demonstration and Other Transformation Initiatives

	Demonstration 2017-2021	SIM 2015-Jan 2019	Integrated Purchasing 2016-2019
Determine Regional Service Areas		✓ 2015	✓ 2015
Support formation of ACHs		✓ 2015	
Build ACH (Coordinating Entity) Role	✓ 2015-2016		
Develop sustainability plan	✓ 2017-2019	✓ 2016	
Establish practice transformation hub		✓ 2016	
Integrate purchasing contracts for behavioral health (MCOs and BHOs)		✓ 2016	✓ 2016-2019
Leverage practice transformation hub	✓ 2017-2019	✓ 2017-2018	
Build integrated physical and behavioral health delivery systems	✓ 2017-2021		✓ 2016-2019
Leverage State/Regional measures	✓	✓	✓
Evaluation Planning and Execution	✓ 2018-2021	✓ 2015-2018	✓ 2015-2016 (early warning system)

To implement the Medicaid Transformation Demonstration we propose a “dynamic” process with a 9 month “year zero” in which the federal-state partnership supports achievement of

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structural milestones necessary for operationalizing the Demonstration. Our goal is to leverage connections with regional integrated purchasing, SIM Test Model interventions and the existing LTSS infrastructure for caregiver services, to expedite Medicaid transformation. To that end, we are committed to the intensive dialog needed to reach mutual agreement of Special Terms and Conditions in April 2016 to allow the five-year Demonstration proposed to begin January 1, 2017.

Demonstration Implementation Schedule

Workgroups Serving Medicaid Transformation Development

To support the State’s readiness for “Year 0,” several workgroups are anticipated to inform development of Special Terms and Conditions and to build out details for operationalizing the Demonstration. Although specific workgroups have not been defined as yet – some topics may be combined - substantive conversation content is described in Table 9, consistent with many comments received during the public comment period. At present, the workgroup focus should not be interpreted to mean independent workgroups and many discussions will continue into “Year 0.”

Table 9: Topical Workgroups for Demonstration Support

Workgroup Focus	Potential Topics	Anticipated Start
Coordinating entities	Definition of coordinating entity options for partnerships, functions, shared learning, and legal considerations Definition of partnership role in Medicaid purchasing and outreach	Leverage current ACH engagement in fall 2015 Southwest WA fully integrated purchasing effort providing useful early lessons for purchasing partnership
Tribal Implications	Implications and opportunities for Washington State’s 29 Tribes and 2 Urban Indian Health Organizations Alignment with non-ITU marketplace, data reporting / performance measurement (tie with GPRA measures)	Tribal workgroup initiated in Spring 2015
Transformation Projects	Assist State in developing menu (toolkit) of transformation projects, selection parameters and measurement targets Regional project application guidance	Begin fall 2015 - leverage SIM Prevention Framework follow-up, ongoing performance measurement workgroups, ACH and State regional needs assessments Begin early Spring 2016
Sustainability	Planning for Post Demonstration – informed by similar activities for SIM Test Model	Begin Demonstration Year 1 - leverage SIM Test Model planning

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Workgroup Focus	Potential Topics	Anticipated Start
Payment Reform	Shared savings, re-investment loop, and connections with value-based payment models ACH performance accountability and funds flow processes	Begin Demonstration Year 1 - leverage SIM Test Model efforts from planning related to Medicaid Regional Integrated Purchasing and other payment redesign
LTSS	Program design, budget modeling, evaluation and reporting, system/IT impacts, staff and provider readiness, client outreach and education	Leverage AAA experience in family caregiver support, Older Americans Act, Initiated activities summer 2015
Supportive Housing and Supported Employment	Final eligibility criteria and benefit design, role of community health workers/peer supports Cross sector provider collaboration, training, education, provider network development, policy/procedures, reporting requirements	Leverage ongoing Chronic Homeless Policy Academy and Olmstead Policy Academy
Managed Care Health Systems	PIPs/transformation project alignment, integrated purchasing transition	Managed Care Policy workgroup and RSN-BHO have standing meetings
Joint Select Committee on Health Care Oversight	Legislative grounding on cross-initiative fiscal and policy connections Status of engagement with CMS and federal review team	Ongoing as requested by the Legislature
Healthier WA Core Team	Cross-cutting policy and operational alignment for all agencies engaged in the broad Healthier WA effort – the Medicaid Transformation Demonstration is a key tool.	Group has been meeting weekly since early 2015

Initiative 1: Transformation through Accountable Communities of Health

YEAR 0: During the first six-nine months after approval, Washington will conduct several key implementation activities, including the following:

- **Build State infrastructure and technical assistance capacity for managing Demonstration.**
- **Formalize menu of transformation projects.** Washington will continue to collaborate with ACHs, MCOs, BHOs, clinicians, subject matter experts, advocates, policymakers, and Tribes to identify the menu of transformation projects to be funded through the Demonstration. Comments received during initial stakeholder discussions, Tribal-specific workgroups, and preliminary reviews with ACHs suggest

that agreement with CMS on parameters for setting boundaries for transformation projects is critical for expediting the Demonstration. The State is expected to identify which transformation project an ACH must select, as well as other parameters that inform selection of transformation projects (e.g., a maximum number of total projects or the minimum number of projects from each domain).

- **Develop readiness assessment for ACHs.** The State will work closely with stakeholders and CMS to identify criteria to evaluate when an ACH has sufficient administrative capacity to serve as the coordinating entity for implementation of transformation. To support a rigorous certification process for coordinating entity status, draft readiness assessments will be released for stakeholder feedback.
- **Develop application for ACHs.** The State will develop an application for ACHs to submit in order to qualify for Demonstration funds. At a minimum, the application will require an explanation of how the ACH and its member organizations will implement the projects selected, how the ACH anticipates distributing Demonstration funds among its member organizations, and how it will hold providers receiving Demonstration funding accountable for their performance.
- **Review and approve applications submitted by ACHs.** The State will review and, if appropriate, approve the applications that the ACHs submit.
- **Distribute initial payments.** Once the ACHs meet the initial process milestones, the State will distribute the initial payments of Demonstration funds to the ACHs.

YEARS 1 and 2: During the first two years of the Demonstration, the State will make payments contingent on the ACHs meeting process milestones. The State will also ensure that ACHs are collaborating with their members and payers (MCOs/BHOs) to begin developing plans for sustaining transformation post-Demonstration.

YEARS 3–5: Washington will begin linking payments of Demonstration funds to outcomes measures, increasing the proportion of outcomes measures over time. Prior to the beginning of Year 5, the State will require that ACHs submit their plans for sustaining successful transformation projects after the waiver. Options will be constructed in partnership with the State.

Initiative 2: Broaden Array of Service Options that Enable Individuals to Stay at Home and Delay or Avoid Need for More Intensive Care.

YEAR 0: During the first six-nine months after approval, Washington will begin several key implementation activities to assure operational readiness. A compressed timeline for implementing initiative 2 may be possible such that “Year 0” may be phased differently than other initiatives. Implementation activities will include the following at a minimum:

- ***Build State infrastructure and technical assistance capacity for managing Demonstration activities.*** The State will use information received in public forums

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and comment periods as well as additional ways to communicate and collaborate with stakeholders to identify potential needs and gaps in infrastructure and capacity.

- **Update eligibility and other systems.** The state will update its eligibility systems to reflect eligibility changes to nursing facility level of care and the eligibility criteria for the new “At Risk” eligibility group. Nursing home eligibility will be developed through a workgroup including involvement from impacted stakeholders and there will be opportunity for review and comment by LTSS stakeholders prior to finalization.
- **Modify IT systems to accommodate benefits.** The State will modify its IT systems to account for two new LTSS benefit packages, link Medicaid beneficiaries with their choice of benefit packages and pay for services provided.
- **Leverage experience in State and Federal programs in designing MAC and TSOA.** The State will continue to collaborate closely with Tribes, Area Agencies on Aging, existing provider networks and interested stakeholders in design of MAC and TSOA.
- **Plan and implement stakeholder education.** The State will hold webinars open to the public to publicize the new options for long term care services.
- **Develop and implement training for LTSS social workers/case managers.** The State will develop training materials to train Senior Information and Assistance/Aging and Disability Resource Center, state, and Area Agency on Aging staff on the new benefit levels, eligibility, authorization and qualification of providers.
- **Develop reporting and evaluation framework specific to LTSS Demonstration.** The State will coordinate with efforts of the 1519/5732 workgroup on performance measures and work with DSHS Research and Data Analysis on evaluation framework.
- **Develop evaluation framework.**

YEAR 1: Washington will begin enrolling individuals in the new limited scope LTSS benefit packages. The State will also hold public meetings after the second quarter of Year 1 to collect feedback from stakeholders on the program.

YEARS 2–5: Washington will administer the program and conduct an ongoing evaluation of the Demonstration project outcomes.

Initiative 3: Provision of Targeted Foundational Community Supports

YEAR 0: The State will finalize criteria for individuals eligible to receive targeted foundational community supports, determine benefit design, develop contract language for MCO or BHO contracts, determine payment rates and methodologies for the services, and make the systems changes needed to effectuate providing coverage for those benefits. Requirements for American Indian and Alaska Natives, who may choose to obtain these services through the Indian Health System, will need to be determined in accordance with the State Centennial Accord. For other individuals who access services through the LTSS system continuation of the fee-for-service system will be

needed. As with initiative 2, a compressed timeline for implementation may be possible and “Year 0” would be phased differently than other initiatives. Implementation activities will include the following at a minimum

- **Plan and implement administrative processes.** Washington will finalize eligibility criteria for targeted supportive housing and/or supported employment services, determine benefit design, develop contract language for MCO and BHO contracts, LTSS, determine payment methodologies for the services. Fidelity review processes will be established utilizing national learning collaborative models through the Dartmouth Psychiatric Research Center for supported employment services.
- **Finalize licensing requirements.** The state will finalize licensing requirements for supportive housing and supported employment categories and disseminate information to MCOs and BHOs as well as their provider network.
- **Update eligibility and other systems.** Washington will update its eligibility systems to reflect the eligibility criteria for sub-populations to access the benefits.
- **Modify IT systems to accommodate benefits.** Data systems will be modified to include supportive housing and supported employment service encounter codes.
- **Stakeholder education and training:** Washington will conduct stakeholder and broad provider, LTSS, MCO and BHO training.
- **Client Outreach and education:** Building upon other federally funded homeless outreach efforts such as the Projects for Assistance in Transition from Homelessness (PATH) program, individuals will be identified and notified of the benefit.

YEARS 1–5: The State will administer the program. Washington will begin providing services to individuals who meet the eligibility criteria. Baseline fidelity assessments will be conducted.

YEAR 3: The State will begin to incorporate payment for services in the development of rates for evolving managed health care systems through which the State purchases integrated physical and behavioral health services. Indian Health System linkages must continue. The state will continue to offer LTSS through FFS arrangements.

Marketing and Outreach

Initiative 1: Transformation through Accountable Communities of Health

The State will develop an outreach plan in collaboration with ACHs and their members to ensure that Medicaid beneficiaries understand how they can benefit from Demonstration projects. For outreach to AI/ANs with respect to the services available under the Demonstration, the state will work with the tribes and urban Indian health programs as they have the expertise and competence for communicating with the AI/AN population.

Initiative 2: Broaden Array of Service Options that Enable Individuals to Stay at Home and Delay or Avoid Need for More Intensive Care.

The State will develop an outreach plan for individuals who may meet the Tailored Supports for Older Adults (TSOA) eligibility criteria and for current Medicaid beneficiaries who may qualify for Medicaid Alternative Care (MAC). The plan will include, among other things, outreach to advocates, public advertising, and targeted mailings to individuals currently participating in the state-funded Family Caregiver Supports program.

To be enrolled in the Tailored Supports for Older Adults (TSOA) group, individuals must apply. Once an individual is determined eligible through an assessment process, he or she will work with the State and Area Agency on Aging staff to develop a service plan.

Enrolled Medicaid beneficiaries will also need to apply to receive Medicaid Alternative Care (MAC) in lieu of their current long term care benefits. As part of the assessment process, the beneficiary will receive counseling on the long term care options available to them, including the MAC benefit, and can choose to participate.

Initiative 3: Provision of Targeted Foundational Community Supports

After the State finalizes, and CMS approves, the criteria for receiving targeted supportive housing and supported employment benefits, the State (or an MCO/BHO, if applicable) will send notices to Medicaid beneficiaries who may be eligible to request the services and who have apparently stable mailing addresses. Beneficiaries may be required to submit additional information to establish that they meet the criteria to receive a specific targeted benefit. Once the State (or an MCO/BHO, if applicable) has determined that a person meets the criteria to receive the targeted benefit, the State (or an MCO/BHO, if applicable) will send to the individual a notice that provides more information on how to access the benefit.

Recognizing that some people eligible for these benefits will lack a stable mailing address, Washington will also work closely with advocates and providers to reach out to eligible Medicaid beneficiaries regarding the new benefit.

SECTION VI – DEMONSTRATION FINANCING AND BUDGET NEUTRALITY

Budget Neutrality – Overall Methodology

To manage expenditures in the Medicaid Transformation Demonstration, Washington proposes to use a per capita methodology defined by broad Medicaid eligibility group concepts rather than an aggregate federal spending approach. Our proposal estimates that annual federal costs under the waiver will not exceed what they would be absent the waiver. The Transformation Investment fund will be financed through a portion of savings accrued to the federal government as a result of strategies employed to constrain the rate of per-capita Medicaid spending.

Washington is proposing a shared-risk provision in which, during the course of the Demonstration:

- “Without waiver” (WOW) program base-year per-capita costs are trended forward by an agreed upon Medicaid per-capita cost trend factor, without any discount generated via transformation projects.
- “With waiver” (WW) program base-year per-capita costs are trended forward by the agreed upon WOW Medicaid per-capita cost trend factor, discounted by 2 percentage points.
- CMS and Washington State will share the financial cost of caseload changes in the Medicaid program.
- Federal liability remains a calculation of actual enrollments over the Demonstration period multiplied by the federal share of the actual per-capita costs.
- CMS and Washington State will share the financial cost based upon anticipated per-capita trends. If total computable per-capita costs were above “without waiver” estimates, the excess would be borne by the State. If total computable per-capita costs were below the budget neutrality limit, federal liability is reduced to the lower, actual per-capita costs. In either case, our approach ensures that Washington does not supplant state funds with federal funds.

Based on CMS guidance a budget neutrality Excel workbook will be provided to include:

- Historical enrollment, trends and expenditures.
- Estimated enrollment, trends, and expenditures for Medicaid enrollees under the Medicaid program *without the waiver*.
- Estimated enrollment, trends, and expenditures for Medicaid enrollees and hypothetical populations under the Medicaid program *with the waiver*.
- Budget neutrality summary of costs *with and without* the waiver.

The proposed model for determining base year (CY 2015) and Demonstration year calculations of per-capita costs and enrollment is as follows. Average monthly caseload estimates have been

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provided in table 10 to give an order-of-magnitude to the broad Medicaid eligibility group concept we propose. Average annual aggregate historical expenditures and estimates of Demonstration expenditures “with” and “without” are appended to table 10. These have been constructed using the proposed methodology, with demonstration year calculations based on option 1 as described below.

Budget Neutrality – Proposed Base Year Calculations

Base year (CY 2015) estimates are comprised of per-capita costs and enrollments for five broad Medicaid eligibility coverage groups:

- (1) Disabled Adults and Children,
- (2) Non-Disabled Children,
- (3) Non-ABD 'Classic' Adults,
- (4) ACA Expansion Adults, and
- (5) Aged.

This classification concept allows for more transparency with respect to changes in caseload composition over time. The actual populations included in the calculations are limited to only those clients with full scope Title XIX or Title XXI coverage.

Base year enrollment numbers are adjusted to reflect the most up-to-date projections from Washington State’s Caseload Forecast Council.³¹ The Caseload Forecast Council is statutorily authorized by the State to provide the official Medical caseload forecasts used in all Washington State’s budgeting estimations.

Base year per-capita costs for each of the coverage groups are based on historical total costs and enrollment for all Medicaid services provided under Washington’s State Plan for the populations described above.

- **Time frame:** CY 2004 through CY 2008
- **Service modalities:** Medical, Long-term services and supports, Mental health, & Substance use disorder services
- **Costs adjustments:** implementation of Medicare Part D in January 2006 is simulated retroactively to January 2004 in order to create consistent time series

Total costs are divided by total member months within each coverage group for an entire year in order to calculate a yearly average per-member per-month (PMPM) cost for each of the five years captured in the historical data. An average annual percentage change in the PMPM cost is then derived for each eligibility group. Base year PMPM costs are derived by trending the last historical year PMPM (2008) forward to the base year by the average annual growth rate in each coverage group.

³¹ <http://www.cfc.wa.gov/default.htm>

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Estimated per-capita costs for the Demonstration time period will depend on the “*without waiver*” trend rate. The “*with waiver*” trend rate will simply be a 2% reduction off the “*without waiver*” trend. Therefore the remainder of the discussion is focused on the “*without waiver*” trend. Typically, data from the State’s most recent five year experience would be used as one option for calculating this trend. Taking this approach however would capture experience from an anomalous severe economic downturn that would not be reflective of the proposed Demonstration time period. Therefore, Washington proposes that there are two viable options to consider for the estimation of the “*without waiver*” trend factor.

- Option 1 would use data from an historical period untouched by the recent economic downturn. The most recent five years of experience that would meet this criterion are CY2004-2008. This time frame is the basis for our base year estimates and we propose to continue to use trend factors from this time period in the Demonstration period.
- Option 2 would use a nationally recognized forecasted Medicaid per-capita growth rate such as CMS’s National Health Expenditures; CMS’s Actuary Office’s forecasts, or the President’s trend

The proposed model is consistent with CMS analysis of health spending growth published in late July.³² It recognizes that while growth rates in health spending over the last six years have been historically low, the projection of Medicaid spending for the foreseeable future primarily reflects the effects of the coverage expansion, stronger economic growth relative to the recent past, and the aging of the population.

³² <http://content.healthaffairs.org/content/34/8/1407> and <http://healthaffairs.org/blog/2015/07/28/health-affairs-web-first-health-spending-growth-to-remain-moderate-compared-to-pre-recession-highs/>

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Table 10 – Part A. Average Monthly Caseloads by Calendar Year

Shaded cells represent populations for whom projection modeling is not complete.

Initiative 1: Medicaid program average monthly caseloads represent the population that could be served by investments in Initiative 1 transformation projects.																
Medicaid Population	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Children - Disabled	16,553	16,956	17,096	17,360	17,760	18,259	18,712	18,889	18,297	18,331	18,409	18,508	18,605	18,704	18,844	18,902
Children Non-Disabled	520,073	527,408	553,858	616,213	669,301	693,734	700,376	703,385	740,514	784,985	809,497	832,252	855,905	880,231	916,932	930,976
Adults - Disabled	112,162	114,199	117,560	122,569	129,875	136,066	138,538	140,565	133,123	132,651	133,363	134,075	134,785	135,498	136,512	136,936
Adults Non-ABD	128,286	121,009	120,499	130,427	141,211	143,833	142,720	142,319	166,940	173,145	177,817	181,498	185,626	189,848	196,361	198,582
Aged	62,251	62,171	62,566	63,945	65,450	66,972	68,540	70,064	71,578	73,494	75,259	76,991	78,773	80,595	83,267	84,367
Expansion Adults	29,958	30,842	33,197	36,382	37,909	32,344	29,875	33,349	405,337	551,352	569,149	576,317	580,894	583,816	586,267	587,177
Initiative 2: Medicaid program average monthly caseloads represent the population that could be served by investments in alternative LTSS benefits.																
MAC adults (currently accounted for in the Aged and Disabled Medicaid populations)																
"At Risk" of Medicaid Demonstration Expansion Population																
Initiative 3: Medicaid program average monthly caseloads represent the population that could be served by investments in supportive housing and supported employment benefits.																
Supportive housing target population																
Supported employment target population																
Total Caseload to be Served through the Demonstration – current Medicaid eligibility groups and Demonstration expansion group																
DEMONSTRATION																
TOTAL																

Table 10 – Part B. Average Aggregate Expenditures by Calendar Year

Budget Neutrality Summary	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Without-Waiver Total Expenditures	\$14,379,201,978	\$15,382,410,590	\$16,425,598,568	\$17,546,188,514	\$18,732,435,932	\$82,465,835,582
With-Waiver Total Expenditures	\$14,105,976,818	\$14,803,366,129	\$15,506,851,806	\$16,249,991,492	\$17,018,841,139	\$77,685,027,384
VARIANCE	\$273,225,160	\$579,044,461	\$918,746,761	\$1,296,197,022	\$1,713,594,793	\$4,780,808,197
	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	5-YEARS
Historical Expenditures	\$3,855,115,133	\$4,084,752,617	\$4,176,083,964	\$4,455,529,884	\$4,876,995,047	\$21,448,476,645

Financing the Non-Federal Share

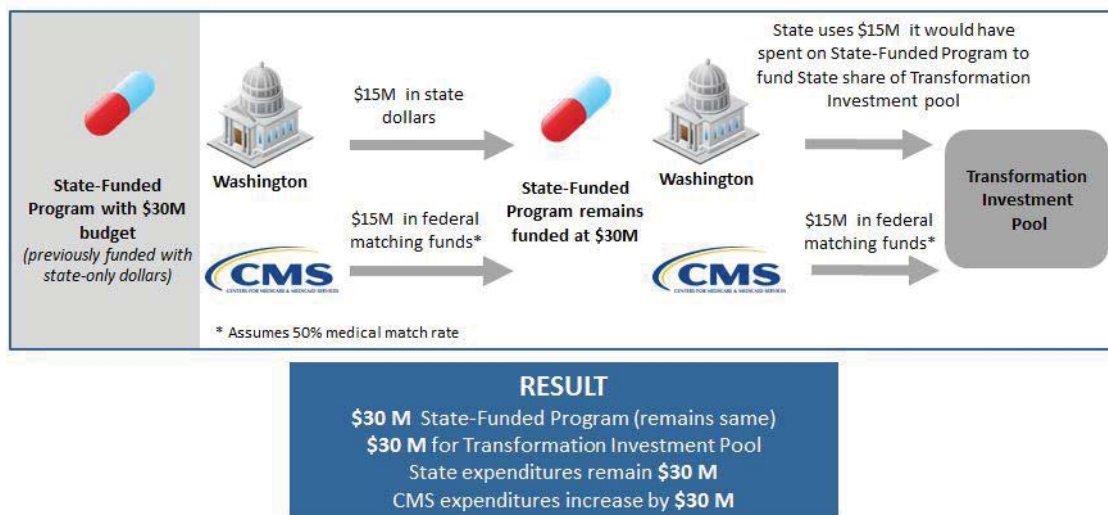
To finance the non-federal share of the Demonstration, Washington intends to use a combination of intergovernmental transfers and general fund dollars generated through approved designated state health programs (DSHP).

DSHP protocol guidelines from CMS indicate 3 approval categories. Washington is currently assessing options for programs that we anticipate will qualify as the primary source of non-federal funding. Examples are:

- **Medicaid Services for Non-Medicaid eligible people** - Nursing home services for non-Medicaid eligible clients; Continuity of care payments for people who cycle frequently on-and-off Medically Needy Spend-down programs; Washington residents who meet the medical, income and asset requirements set by KDP; Private duty nursing services to individuals living in community based settings, Medical aid for injured workers; vocational support for offender community re-entry and stabilization services
- **Non-Medicaid service for Medicaid people** - PACT wrap around services for individuals with complex mental health needs; WIC Services/activities for pregnant and breastfeeding women, infants, and children under age five who are at nutritional risk; Limited emergent needs once per year, related to raising a child/ren outside the formal child welfare system; crisis intervention (mental health stabilization) services to avoid institutionalization
- **Medicaid provider stabilization** - Hold Harmless grants paid for deficiencies in hospital payments provided under the Certified Public Expenditure program to ensure complete funding for hospital services to Medicaid clients

Figure 10 illustrates DSHP financing flow using a generic state-funded program.

Figure 10. DSHP Financing Overview



Standard CMS Funding Questions

Responses to standard questions that apply to **all payments made to all providers** under Attachments **4.19-A** of the State Plan are submitted to CMS with each State Plan amendment. Current questions and responses are included below. Additional questions necessary for the Demonstration may require further CMS guidance.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State Plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

State response: Providers receive and retain the total Medicaid expenditures claimed by the State.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per Diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the State to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
 - (i) a complete list of the names of entities transferring or certifying funds;
 - (ii) the operational nature of the entity (state, county, city, other);
 - (iii) the total amounts transferred or certified by each entity;
 - (iv) clarify whether the certifying or transferring entity has general taxing authority; and,

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- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

State response: Each share of each type of Medicaid payment is from appropriations from the legislature to the Medicaid agency.

- 3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved state plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

State response: No supplemental or enhanced payments are made.

- 4. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

State response: No governmental provider receives payments that in the aggregate exceed their reasonable costs of providing services.

SECTION VII –PROPOSED WAIVER AND EXPENDITURE AUTHORITIES

Washington’s Medicaid program currently operates under a number of Medicaid waivers – 1932, 1915(b), 1915(c) and 1915(k). At CMS’ recommendation, these are not being consolidated under the proposed section 1115 Medicaid Transformation Demonstration waiver. We propose that they continue but operate by reference within the section 1115 waiver authority to ensure that the populations, benefits and delivery systems they authorize are fully connected to the Demonstration.

Request for Waiver and Expenditures Authorities

At a minimum, the State requests the following waiver authorities:

- § 1902(a)(1). Authority to operate the Demonstration on a less-than-statewide basis.
- § 1902(a)(10)(B). Authority to vary the amount, duration, and scope of benefits provided to the TSOA population.
- §1902(a)(10)(B). Authority to vary the amount, duration, and scope of benefits for individuals who meet current eligibility criteria for Medicaid funded long term care services, but who wish to receive MAC benefits in lieu of more intensive services.
- §1902(a)(10)(B). Authority to vary the amount, duration, and scope of benefits for individuals who wish to receive supportive housing and supported employment services.
- §1902(a)(10)(B). Authority to limit housing-based case management to certain targeted groups of Medicaid beneficiaries..
- § 1902(a)(17). Authority to allow ACHs to target transformation projects to different sub-populations.
- § 1902(a)(17). Authority to target certain state-administered benefits to sub-populations.
- § 1902(a)(17). Authority to apply a more liberal income and resource standard for individuals determined to be “At Risk” for future Medicaid enrollment.
- § 1902(a)(17). Authority to provide the TSOA benefit package to the “At Risk” for Medicaid group.
- § 1902(a)(17). Authority to provide the MAC benefit package to individuals meeting current eligibility criteria for LTSS, but who are not currently receiving and do not choose more intensive Medicaid-funded nursing facility “most intensive” services.

In addition, the State requests the following expenditure authorities:

- § 1903. Authority to receive federal matching dollars for designated state health programs.
- § 1903. Authority to receive federal matching dollars for payments related to transformation projects made under the Demonstration.
- § 1903. Authority to receive federal matching dollars for services provided to the “At Risk” for Medicaid group.
- § 1903. Authority to allow the reinvestment of state-designated shared savings towards applicable Demonstration expenditures. The amount of savings available for use under

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this authority will be based on the difference between the actual expenditures under the Demonstration and pre-established agreed to per capita amounts.

- § 1903(m) and 42 CFR §438.60. Authority to allow direct payments to managed care providers or supportive housing and supported employment services.
- § 1903. Authority to allow for reimbursement for specific managed care plan, provider, behavioral health organization and system payments that support performance, quality, system alignment and whole-person care coordination to the extent not otherwise allowed. This may include fee-for-service and managed care-based incentive payments, and expenditures that support value-based payment evolution.

The State also requests technical guidance to identify authorities needed to:

- Leverage the SIM Model Test evaluation plan in building and reporting on outcomes in the Demonstration so that effects are consistently measured across the innovation investments.
- Develop fully integrated systems of coordinated care and recovery supports that are able to share information for effective treatment planning in compliance with privacy protections afforded to substance use disorder patient records.
- Align requirements for ACH transformation investment projects with managed care health system’ programs of performance improvement projects (PIPs) to understand clinical and non-clinical system-wide effects without duplicating reporting and evaluation requirements.

With respect to the Indian health system, the state requests technical assistance from the Department of Health and Human Services, including the Indian Health Service and the Centers for Medicare and Medicaid Services, to determine the expenditure authorities necessary, if any, for the ITUs to participate in the Demonstration.

Waiver and expenditure authorities and the reasons for Washington’s requests are described further in Tables 11 and 12.

Table 11. Waiver Authority and Reason for Request

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(1)	To permit the State to operate the Demonstration on a less-than-statewide basis.	ACHs in different regions will likely select different transformation projects, meaning that each transformation activity will not be carried out on a statewide basis.
§ 1902(a)(10)(B)	To permit the State to establish a limited scope benefit, Tailored Supports for Older Adults (TSOA), open only to the “At Risk” for	Individuals in the “At Risk” for Medicaid group established under the Demonstration will have access to a more limited set of benefits

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Waiver Authority	Use for Waiver	Reason for Waiver Request
	Medicaid population.	than other beneficiaries who qualify for Medicaid-funded long term services and supports.
§ 1902(a)(10)(B)	To permit the State to establish a limited scope benefit package, Medicaid Alternative Care(MAC) open to Medicaid beneficiaries meeting current eligibility criteria for long term care coverage, but who are not currently receiving Medicaid-funded long term care.	Individuals who are enrolled in Medicaid and who meet the eligibility criteria to receive long term care but do not currently receive such services will receive a limited benefit package of long term services and supports.
§ 1902(a)(17)	To permit the State to allow ACHs to target transformation projects to different sub-populations.	ACHs will target particular transformation projects to different populations, based on the populations' needs.
§ 1902(a)(17)	To permit the State to target certain services, supportive housing and supported employment, to different sub-populations.	The State will offer supportive housing and supported employment benefits to beneficiaries meeting criteria established by the State.
§ 1902(a)(17)	To enable the State to apply a more liberal income and resource standard to individuals found to be "at risk" for future enrollment in Medicaid.	The State will establish a new eligibility category for individuals who do not currently meet financial or clinical eligibility criteria but who are identified as being at risk for future enrollment in Medicaid.
§ 1902(a)(17)	To permit the State to establish a limited scope benefit package open only to the "At Risk" for Medicaid population.	Individuals in the "At Risk" for Medicaid group established under the Demonstration will have access to a more limited set of benefits than other beneficiaries who qualify for Medicaid-funded long term services and supports.
§ 1902(a)(17)	To permit the State to establish a limited scope benefit package open to Medicaid beneficiaries meeting current eligibility criteria for long term care coverage, but who are	Individuals who are enrolled in Medicaid and who meet the eligibility criteria to receive long term care but do not currently receive such services will receive a

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Waiver Authority	Use for Waiver	Reason for Waiver Request
	not currently receiving Medicaid-funded long term care.	limited benefit package of long term services and supports.

Table 12. Expenditure Authority and Reason for Request

Expenditure Authority	Use for Waiver	Reason for Waiver Request
§ 1903	To permit the State to receive federal matching dollars for specified designated state health programs.	This expenditure authority will enable the State to fund a portion of the non-federal share for payments under the Demonstration using designated state health programs.
§ 1903	To permit the State to receive federal matching dollars for payments made under the Demonstration for transformation projects.	This expenditure authority will allow the State to make payments to ACHs for achieving specific milestones and metrics related to transformation projects undertaken to support the Demonstration vision.
§ 1903	To permit the State to receive federal matching dollars for the limited scope benefit delivered to the “At Risk” for Medicaid population.	This expenditure authority will allow the State to receive federal matching payments for services delivered to the “At Risk” for Medicaid population.

SECTION VIII – PUBLIC NOTICE AND TRIBAL CONSULTATION

Implementation of the plan for a Healthier Washington began early in 2014 after hundreds of people from the public and private sectors were asked to share their ideas on how the system might be transformed to produce better health, better care and lower cost. The Washington State Health Care Innovation Plan was produced as a result of that work. The document now drives the collaborative work of 11 state agencies and many tribal, county and local governments; health care organizations (non-profit and for-profit); individual providers; insurance plans; university health experts; consumers; private businesses and more to achieve a Healthier Washington.

Over the past six months, the State has continued this collaborative engagement in earnest to gain input and insight into how Medicaid transformation can support the vision for a Healthier Washington. This effort began formally with a webinar on March 10, 2015 to engage stakeholders in the exploration of Medicaid transformation through a potential Section 1115 Demonstration Waiver. Public input was further solicited with the release of the initial concept paper on May 29, 2015 and a subsequent public webinar on June 15, 2015. All supporting documents and presentations were made available on the Medicaid Transformation website, http://www.hca.wa.gov/hw/Pages/medicaid_transformation.aspx.

The web page includes a copy of the waiver concept paper, executive summary, waiver application draft, materials from public hearings, recordings of past webinars and instructions on how to submit comments on the waiver application draft.

Public Comment Period

The public comment period for Washington's proposed waiver Demonstration was from Thursday, July 23, 2015 until Monday, August 24, 2015 at 5 p.m. (Pacific Time). The State provided public notices about the Demonstration as follows:

- The full public notice was posted on the State's website beginning July 24, 2015. See appendix 7 for a copy of the public notice.
- The Washington State Health Care Authority provided hard copies of the draft Demonstration application for public review, upon request.
- An abbreviated public notice was published in two newspapers with large circulation, The Seattle Times and the Spokesman Review, on Friday, July 24, 2015.
- The abbreviated public notice was e-mailed to the Healthier Washington Feedback e-mail distribution list.
- The State invited comment on the draft Waiver application from the public and interested stakeholders through a dedicated inbox: medicaidtransformation@hca.wa.gov as well as a physical address made available on the Medicaid Transformation website.

The State gathered stakeholder input through a required public notice process that included six public hearings, five of which included web capability to maximize accessibility. At each public

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hearing, attendees heard from four State leaders and time was apportioned for small group break-out sessions and a question and answer session. Approximately 250 individuals attended the public hearings and 45 individuals participated by webinar. The public hearings and additional public opportunities were held as follows:

- **Pierce County—Monday, August 3, 2015**
Time: 8:00 am – 10:00 am
Pierce College
9401 Farwest Drive SW
Lakewood, WA
- **Snohomish County—Monday, August 3, 2015**
Time: 1:00 pm – 3:00 pm
Everett Community College—Jackson Conference Center
2000 Tower St
Everett, WA
- **Yakima County—Tuesday, August 4, 2015**
Time: 8:00 am – 10:00 am
Yakima Valley Community College— Deccio Higher Education Center
South 16th Ave & Nob Hill Blvd
Yakima, WA
- **Franklin County—Tuesday, August 4, 2015**
Time: 2:00 am – 4:00 pm
Columbia Basin College—Gjerde Center
2600 N 20th Ave
Pasco, WA
- **Spokane County—Wednesday, August 5, 2015**
Time: 10:00 am – 12:00 pm
Spokane Regional Health District Administrative Office
1101 W College Ave
Spokane, WA
- **Medicaid Title XIX Advisory Committee – Friday, July 31, 2015**
Time: 8:30 am – 9:40 am
Courtyard Marriott Seattle/SouthCenter
16038 West Valley Highway
Tukwila, WA
- **Joint Select Committee on Health Care Oversight – Wednesday, July 22, 2015**
Time: 9:00am – 11:00 am

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State Capital Campus – John L. O’Brien Building
Olympia, WA

- **Medicaid Transformation Waiver Application Public Webinar – Friday, August 14, 2015**
Time: 8:00 am – 9:30 am
Webinar; audio recording and presentation slides available online

In addition to the public hearings, workgroups have met regularly for many months to discuss various topics related to the Demonstration proposal. Staff members met individually with stakeholder groups and advocates, including, but not limited to the following:

- Accountable Communities of Health (ACHs)
- Managed Care Organizations (MCOs)
- Fiscal and Policy Legislative Staff
- Washington Association of Area Agencies on Aging (W4A)
- Washington Mental Health Council
- Statewide Advisory Council on Homelessness (SACH)/Interagency Council on Homelessness (ICH)
- Washington State Hospital Association (WSHA)
- Washington State Medical Association (WSMA)
- Northwest Health Law Advocates (NoHLA)
- State Council on Aging (SCOA)
- Healthy Washington Coalition
- Community Health Centers (CHC)
- Regional Support Network Administrators (RSN)
- Downtown Emergency Service Center (DESC)
- Local Government Entities

Tribal Engagement

Washington State is home to twenty-nine federally recognized tribal governments and two urban Indian health organizations. In accordance with 42 CFR 431.408(b), on May 29, 2015, the State notified tribes, urban Indian health organizations, and other tribal parties of its intent to pursue a Section 1115 waiver Demonstration and request for a tribal consultation on August 12, 2015. Please refer to appendix 8.

Over the last 3 months, state staff met with representatives and staff from tribes and urban Indian health organizations in a variety of contexts to foster mutual understanding of the Demonstration and determine the implications and potential benefits for tribes and urban Indian health organizations:

- Quarterly meetings of the American Indian Health Commission for Washington State on May 14, 2015 and August 13, 2015
- Tribal workgroup meetings on June 11, 2015; June 25, 2015; July 17, 2015; and August 7, 2015

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- Tribal roundtable on July 22, 2015

Additionally, the State held a tribal forum on August 5, 2015 at the NATIVE Project in Spokane to discuss the content of the draft waiver application. Forty-three representatives from tribes, urban Indian health organizations, IHS, and tribal organizations attended in person or via webinar. The substance of the discussions in these meetings is reflected in a letter from the American Indian Health Commission for Washington State (see Appendix 9). The letter provided the framework for discussion during the formal consultation, held on August 12, 2015, with a total of 23 representatives of tribes, urban Indian health organizations, IHS, and tribal organizations attending in-person or via webinar. Discussion from the Consultation has been incorporated in the application.

Public Input

The stakeholder engagement process has been extremely robust and the State is committed to extensive and transparent engagement moving forward. Comments received in response to the release of the concept paper along with comments within 30 days of the posting of the draft application were reviewed and considered for revisions. Stakeholder input provided to the State has also been posted on the Medicaid Transformation website. A summary of comments received by the State during the 30-day public notice period are included in Appendix 10. Additionally, the State categorized all questions and comments received during that time and will address common questions through the Frequently Asked Questions document available of the designated Demonstration webpage.

SECTION IX – DEMONSTRATION ADMINISTRATION

Please provide the contact information for the state’s point of contact for the Demonstration application.

Name and Title: MaryAnne Lindeblad, Washington State Medicaid Director

Telephone Number: 360-725-1040

Email Address: maryanne.lindeblad@hca.wa.gov

AFTERWORD

Five years following his diagnosis of bipolar disorder, John finds himself re-enrolled in community college, pursuing that no longer distant dream of receiving an IT certification. Shortly after recovering from his last hospital stay, John was connected to a supported employment program that is now providing regular assistance and support services to ensure his academic and career progress.

John now feels more capable of managing his health, has more control over his life, and can focus on what is important to him. Although John remains diagnosed with bipolar disorder and Type 2 diabetes, and is still a regular smoker, these are no longer total impediments to his life. He has a greater understanding of his diagnoses and is able to better manage his condition in partnership with his care team. With just one single care plan, John no longer feels completely overwhelmed. Additionally, he knows that there are plenty of other services available if he ever needs them. He has even set a goal to reduce his smoking and is optimistic that he will be successful. John may continue to experience episodes of depression and mania in the future, but now he feels empowered about how and where he receives his care. He has found a set of providers who work to understand what is important to him; they have developed a person-centered care plan including a medication regimen that helps control his symptoms without disabling side effects. As a result John is taking his medication regularly. When he has bad days or questions about his care, he knows there is someone he can call who understands all his needs as well as his goals.

Over five years, the reclusive, overweight 22 year-old has transformed into a motivated young professional, hardly distinguishable from his peers. John and his family speak regularly. Without the added strain of John's unmanaged bipolar disorder, their relationship has greatly improved, and now when he calls it is not because he is in a crisis.

The once paralyzing symptoms and accompanying stigma of a mental health diagnosis is now being leveraged as an opportunity. John volunteers once a week at the local Community Mental Health center as a peer support specialist, helping others just like him understand how to work as part of a coordinated, connected care team to prioritize and reach their health goals, even with a serious mental illness. For John, this work is tremendously important. As he transitioned out of the hospital, a peer specialist was a huge factor in facilitating John's successful path forward by helping to break down barriers and working with him on engaging with other services. That lived experience showed John that recovery was possible and how significant it was to have a peer involved in his care.

Stabilization and recovery is not an easy path. However, with support from an entire community, it is more likely to be achieved. An interdisciplinary team of health care professionals and peer support specialists has been with John through the ups and downs, ensuring that his physical and behavioral health needs are met. While a carefully coordinated treatment regimen was important, his access to career training and supported employment has

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made all the difference between an almost certain track to permanent disability to one that is likely to maintain his quality of life and ability to achieve his goals. A transformed, accountable, and connected system provided the necessary supports and incentives to allow John to recover fully. Statistics tell us that compared to someone with a similar diagnosis; John has avoided at least two psychiatric inpatient stays and seven emergency room visits over the last two years. His average annual cost of care would have been \$12,000 for those two years; instead it has been \$5,500. Today, John receives the care he needs in addition to the support that keeps him headed toward his life goals. There will be ups and downs, but John and his family now have a community supporting them and a delivery system that has been transformed to be better connected, person-centered, and focused on the overall 'health' of the patients it serves, not just the treatment of illness and disease.

Apply John's story to the thousands of others like him who today fall through the cracks, ending up incarcerated or institutionalized, and on a fast track to permanent disability. There are significant family and societal costs to doing nothing. Washington's approach to Medicaid transformation is the chance to ensure that newly eligible or longer term Medicaid beneficiaries don't have to endure the status quo approach that results in a shortened life span or permanent disability, with an exhausted family left in its wake. It is the opportunity to form partnerships for meeting individual and family needs, a pressing case that we have heard from our safety net providers for decades. It also forces action and mutual accountability at a local level between health plans, providers and other community members, where health improvement is most likely to occur.

The year is 2015—we are not willing to accept a 2020 that resembles the status quo.

APPENDICES

APPENDIX 1

Familiar Faces Value Stream v.3.5 DRAFT

Legend

- Wait or delay
- ± Sequence of steps varies
- * All jail clients get this step
- § Not all providers do/use this
- FF: Familiar Face
- MH: Mental Health
- SUD: Substance Use Disorder
- VAT: Vulnerability Assessment Tool
- Unless otherwise specified, all data is for 2013

Process Step

- Subprocess
- Timeline
- Data-base

FF are defined as adults (≥18 years old) with:

- ≥4 jail bookings in King county in a year
- Substance use and/or mental health issues

Familiar Faces Population

Across both years:
 2013: 1,273
 2014: 1,252

85% had mental health issue(s)
 91% had SUD issue(s)

FF could have contact with First Responders at any point

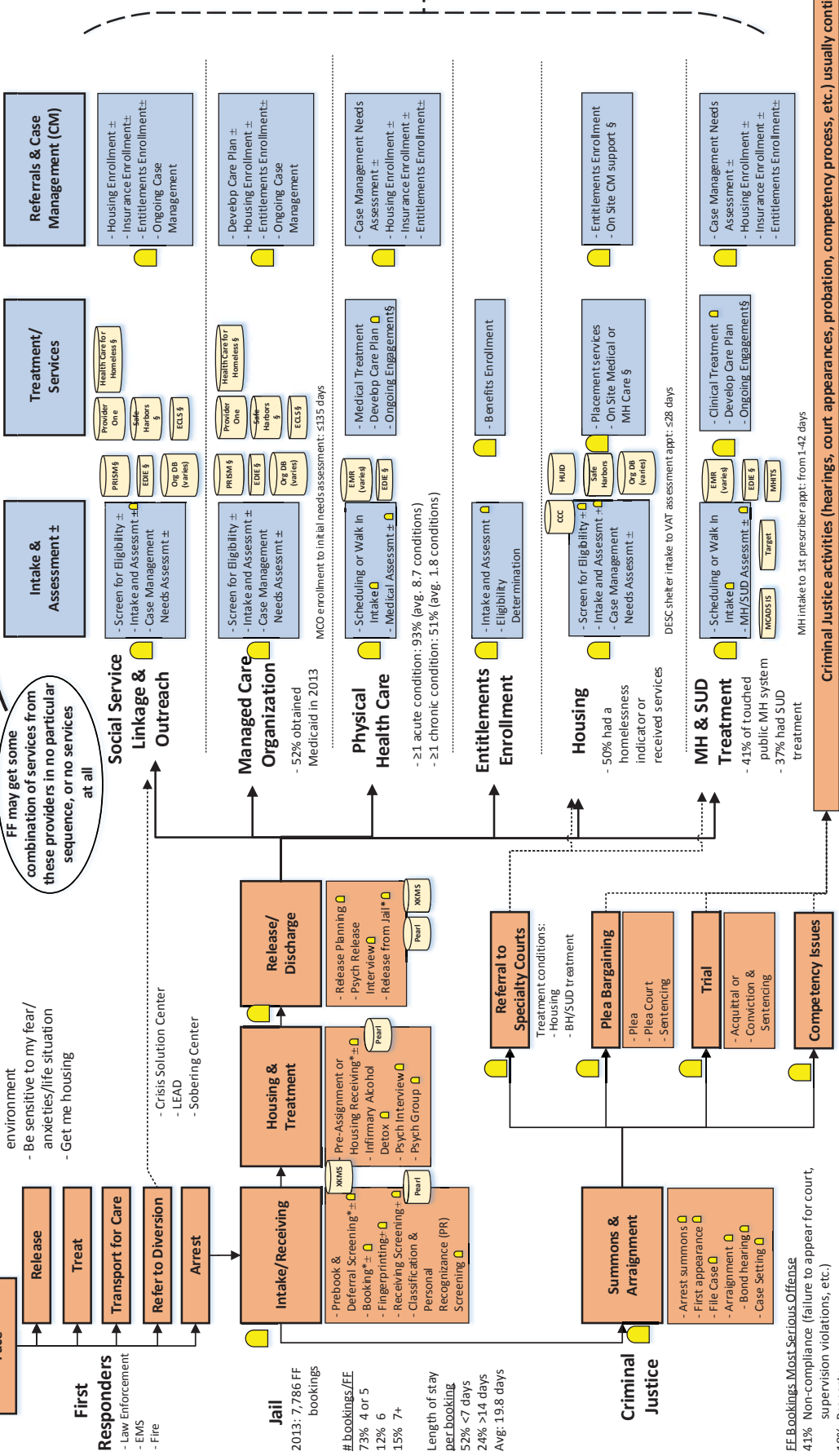
FF Customer Requirements:

- I want the right care/access to environment
- Be sensitive to my fear/anxieties/life situation
- Get me housing

FF may get some combination of services from these providers in no particular sequence, or no services at all

Database Legend

- § Does not apply to all agencies/orgs
- CCC: Client Care Coordination database
- ECS: Extended Client Lookup System
- EDI: Emergency Department Information Exchange
- EMR: Electronic Medical Record
- HMS: Homeless Management Information System (Federal)
- MHTS: Mental Health Integration database
- Org DB: Agency or organization's in house database
- Pearl: Jail Health's electronic medical record
- PRISM: Predictive Risk Intelligence System
- ProviderOne: State Medicaid database
- Safe Harbors: State database of homelessness data
- Target: State database of SUD data
- XKMS: Jail inmate management system



FF Bookings Most Serious Offense

- 41% Non-compliance (failure to appear for court, supervision violations, etc.)
- 18% Property
- 13% Drugs

Criminal Justice activities (hearings, court appearances, probation, competency process, etc.) usually continue

Who Is Involved in the Familiar Faces Value Stream **DRAFT**

Legend
 ACH: Accountable Communities of Health
 KC: King County
 EMS: Emergency Medical Responders (First Responders)
 DAJD: Dept. of Adult & Juvenile Detention
 DPH: Dept. of Public Health
 DCHS: Dept. of Community and Human Services
 DSHS: Washington State Dept. of Social & Health Services
 RSN: Regional Support Networks

Familiar Faces Population
 Defined as adults (≥18 years old) with:
 - ≥4 jail bookings in King county in a year
 - Substance abuse and/or mental health issues

Service Providers
 - Evergreen Treatment Services REACH/HEET/LEAD*
 - KC DPH Community Health Services
 - Downtown Emergency Service Center (DESC)*
 - RSN/Diversion and Reentry (FACT/FISH)
 - YWCA Opportunity Place & Women's Referral Center
 - Amerigroup*
 - Community Health Plan of Washington*
 - Coordinated Care*
 - Molina*
 - United Health Care*

Other Initiatives Underway
 - City of Seattle Multi-Disciplinary Team (MDT)
 - KC Mental Illness & Drug Dependency Action Plan (MIDD)
 - KC Veterans & Human Services Levy
 - KC Communities of Opportunity
 - KC Accountable Communities of Health (ACH)

Other Initiatives Underway

- KC Accountable Communities of Health (ACH)

Managed Care Organization

- United Health Care*
 - KC DPH Public Health Clinics
 - Harborview Pioneer Square Clinic*
 - Community Health Centers
 - KC DPH Mobile Medical Van*
 - Edward Thomas Medical Respite*
 - Neighborcare*
 - Pike Market Clinic
 - Country Doctor
 - Health Point
 - Sea Mar
 - 45th St Clinic
 - International Community Health Services (IHS)
 - Other community care providers

Physical Health Care Provider

- Health Care for the Homeless
 - KC Communities of Opportunity
 - KC Recidivism Reduction & Re-entry Strategic Planning
 - KC Accountable Communities of Health (ACH)

Diversion
 - Crisis Solution Center
 - LEAD (Law Enforcement Assisted Diversion)
 - Sobering Center

Jail
 - KC DPH Jail Health Services*
 - KC DAJD*

Entitlements Enrollment

- DSHS
 - Catholic Community Services (Other providers assist with applications)
 - KC DCHS Release Planning*
 - Plymouth Housing*
 - Catholic Community Services (CCS)
 - Compass Human Service Alliance
 - Pioneer Human Services*
 - Downtown Emergency Service Center (DESC)*
 - Faith-based transitional housing and shelters (multiple)
 - Other non-profit human services providers (multiple)

Housing

- Communities of Opportunity
 - Committee to End Homelessness
 - Plan to End Veterans' Homelessness
 - Coordinated Entry & Assessment Alignment for all populations (youth/young adults, adults, families) & Reentry)
 - Criminal Justice Initiatives (NOW Diversion & Reentry)
 - Veterans Justice Initiative
 - 25 Cities
 - Medicaid Supportive Human Service Benefit
 - DCHS Housing Line of Business (LOB)

Criminal Justice
 - KC Prosecuting Attorney's Office*
 - KC Dept. Public Defense*
 - KC District Court
 - KC Superior Court*
 - KC Specialty Courts (Mental Health & Drug Court)*
 - City of Seattle Municipal Court*
 - Other jurisdictions that contract for services at KCCF and MRJC

- Second Chance Act

MH & SUD Treatment

Mental Health
 - Sound Mental Health*
 - Community Psychiatric clinic (CPC)
 - Pioneer Human Services*
 - Evergreen Treatment Services* REACH and LEAD
 - KC DPH Mobile Medical Van*
 - Downtown Emergency Service Center (DESC)*
 - Substance Use Disorder (SUD)
 - Downtown Emergency Service Center (DESC)*
 - Evergreen Treatment Services*
 - Sobering Center/Detox
 - State contracted in patient SUD treatment providers

APPENDIX 2

Challenges and Opportunities for Waiver-Supported Transformation of Washington State's Medicaid Health Service Delivery Systems

Washington State has long been a national leader in implementing successful Medicaid program innovations. Examples include:

- Expansion of Medicaid under the Affordable Care Act, adding more than a half million newly eligible adults to the Medicaid coverage since January 2014.
- Expansion of access to home- and community-based LTSS services through savings achieved by rebalancing LTSS services from a system previously reliant on institutional nursing facility care.
- Reductions in ED utilization through multiple initiatives including the “ER is for Emergencies” program.
- Implementation of cost-effective care management interventions for high-risk Medicaid beneficiaries and Medicare-Medicaid dual eligibles through the Health Homes program, supported by nationally recognized predictive modeling and data integration technologies.¹

However, in spite of this past success, several critical challenges lie immediately ahead.

- Cost containment strategies driven by fiscal constraints during the Great Recession – including provider rate reductions, rate freezes and paying physical and behavioral health plans at the low end of the actuarial rate range – have led to erosion of provider capacity, especially in the areas of mental health treatment, substance use disorder treatment and specialty medical care.
- The addition of more than a half million newly eligible adults to Medicaid coverage since January 2014 has placed even greater stress on already constrained provider capacity. Although the expansion population is on average somewhat healthier than the adult population previously covered by Medicaid, many in the new adult population have significant physical and behavioral health needs. For example, Medicaid expansion has massively increased the proportion of persons leaving correctional facilities who are enrolling in Medicaid upon release, adding tens of thousands of Medicaid beneficiaries with high prevalence of substance use problems and mental illness.² This subset of the

¹ For more information, see: Xing J, Goehring C, and Mancuso D. Care Coordination Program for Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs. Health Affairs. April 2015.

² Prior to Medicaid expansion in CY 2013, fewer than 20 percent of inmates released from Washington State Department of Corrections facilities were enrolled in Medicaid upon release. Since expansion, more than 60 percent secured Medicaid coverage after release. Similar improvements have been observed for persons released

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Medicaid expansion population is also a large consumer of local criminal justice and emergency response resources.

- There is a great opportunity through broader clinical integration of physical and behavioral health care to significantly improve rates of beneficiary engagement in needed mental health and substance use disorder treatment services. To fill existing gaps in national quality measure standards (e.g., NCQA HEDIS) in the area of behavioral health, Washington State has developed performance metrics measuring access to mental health and substance use disorder treatment services.³ These performance metrics indicate that significant improvements in access to behavioral health services are possible. Impact evaluations using these metrics have demonstrated that access to behavioral health services is associated with savings in physical health care costs and reduced risk of criminal justice involvement.⁴
- Housing instability and homelessness continue to be major challenges for high-risk Medicaid populations. Homelessness is frequently experienced by persons with serious mental illness and/or substance use disorders, and developing services to stably house persons with these conditions presents a significant opportunity to reduce potentially avoidable health service utilization and interaction with criminal justice systems. Homelessness is also a major risk for persons leaving institutional settings and youth

from local jail facilities. About half of released inmates who enroll in Medicaid have significant mental health needs, and about two-thirds of persons released from local jails have an indication of a substance use disorder.

³ For more detail, see: Mancuso D and Felver B. Managed Medical Care for Persons with Disabilities and Behavioral Health Needs. <https://www.dshs.wa.gov/sesa/rda/research-reports/managed-medical-care-persons-disabilities-and-behavioral-health-needs>.

⁴ In SFY 2014, a third of adult Medicaid enrollees with mental illness received mental health therapy or related services through the Regional Support Network (RSN) service delivery system, and about half received mental health services through the RSN system or through their medical managed care organization. Medical cost offset studies conducted by RDA have shown that persons with mental illness who receive outpatient therapy experience better health outcomes than persons who receive medication alone or who remain untreated. Similarly, about a third of adult Medicaid enrollees with an indication of substance use disorder (SUD) received Medicaid-funded SUD treatment services. RDA's medical cost offset studies have demonstrated the significant impact that substance disorder treatment services have on medical service costs, nursing facility service costs, and criminal justice involvement. Studies include:

- (1) Estee S and Mancuso D, Washington State Mental Health Services: Cost Offsets and Client Outcomes. <https://www.dshs.wa.gov/sesa/rda/research-reports/washington-state-mental-health-services-cost-offsets-and-client-outcomes>.
- (2) Wickizer, T. M., Krupski, A., Stark, K. D., Mancuso, D., & Campbell, K. (2006). The effect of substance abuse treatment on Medicaid expenditures among general assistance welfare clients in Washington State. *Milbank Q*, 84(3), 555-576. <http://www.milbank.org/840304.html>.
- (3) Mancuso D and Felver B. Chemical Dependency Treatment, Public Safety. <https://www.dshs.wa.gov/sesa/rda/research-reports/chemical-dependency-treatment-public-safety>.
- (4) Mancuso D, Nordlund D and Felver B. The Impact of Substance Abuse Treatment Funding Reductions on Health Care Costs for Disabled Medicaid Adults in Washington State. <https://www.dshs.wa.gov/sesa/rda/research-reports/impact-substance-abuse-treatment-funding-reductions-health-care-costs-disabled-medicaid-adults-washington-state>

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emancipating from foster care, and interventions designed for these populations could produce significant long-term improvements in health outcomes, with attendant cost savings.⁵

- Employment rates for Medicaid beneficiaries – especially persons with disabilities – are low. Employment supports present a strategic opportunity to engage or re-engage beneficiaries in the labor market, with the potential to improve health outcomes and quality of life, and to help some beneficiaries move into employer-based commercial health care coverage.⁶
- The coming Age Wave and the forecast growth in the number of elders and persons with disabilities with significant functional, cognitive and behavioral needs will place increasing stress on Medicaid-funded long-term services and supports. Absent investments in services to delay the need for more costly Medicaid-funded LTSS services, including nursing facility care, pressure on LTSS budgets will increase dramatically into the foreseeable future.⁷
- There are significant disparities in access, quality and health outcomes across populations in the state. These disparities exist across racial and ethnic groups, and across counties and regions. Washington is building into its performance measurement infrastructure the ability to track access, quality and outcome metrics across regions and population groups, supporting establishment of performance goals and monitoring of progress towards achieving improved health outcomes for all and reductions in health disparities.

Washington State is uniquely situated to support evaluation of the impact of waiver-related innovations and to monitor a broad range of outcomes potentially impacted by waiver investments across health, social service and local government (e.g., criminal justice) systems. The Research and Data Analysis Division of the Department of Social and Health Services is a national leader in the integration and analysis of integrated social and health service data. The

⁵ See the following studies for more information about the housing challenges facing these populations:

- (1) Shah MF et al. Youth at Risk of Homelessness. <https://www.dshs.wa.gov/sesa/rda/research-reports/youth-risk-homelessness>.
- (2) Shah MF and Felver B. The Housing Status of Individuals Leaving Institutions and Out-of-Home Care. <https://www.dshs.wa.gov/sesa/rda/research-reports/housing-status-individuals-leaving-institutions-and-out-home-care>.
- (3) Shah MF et al. Achieving Successful Community Re-Entry upon Release from Prison. <https://www.dshs.wa.gov/sesa/rda/research-reports/achieving-successful-community-re-entry-upon-release-prison>

⁶ See Mancuso D. Employment Monitoring Reports for RSN Clients. <https://www.dshs.wa.gov/sesa/rda/research-reports/employment-monitoring-reports-rsn-clients>.

⁷ See Lavelle B, Mancuso D, Huber A and Felver B. Expanding Eligibility for the Family Caregiver Support Program in SFY 2012. <https://www.dshs.wa.gov/sesa/rda/research-reports/expanding-eligibility-family-caregiver-support-program-sfy-2012>.

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Analytics, Interoperability and Measurement (AIM) interagency team supported by SIM grant funding will deepen and broaden the State's capabilities in this area. SIM-supported investments in the centralized Clinical Data Repository and All Payer Claims Database will further broaden the State's ability to measure health care quality and health outcomes across both Medicaid and commercial coverage.

APPENDIX 3

DSHS Integrated Client Database

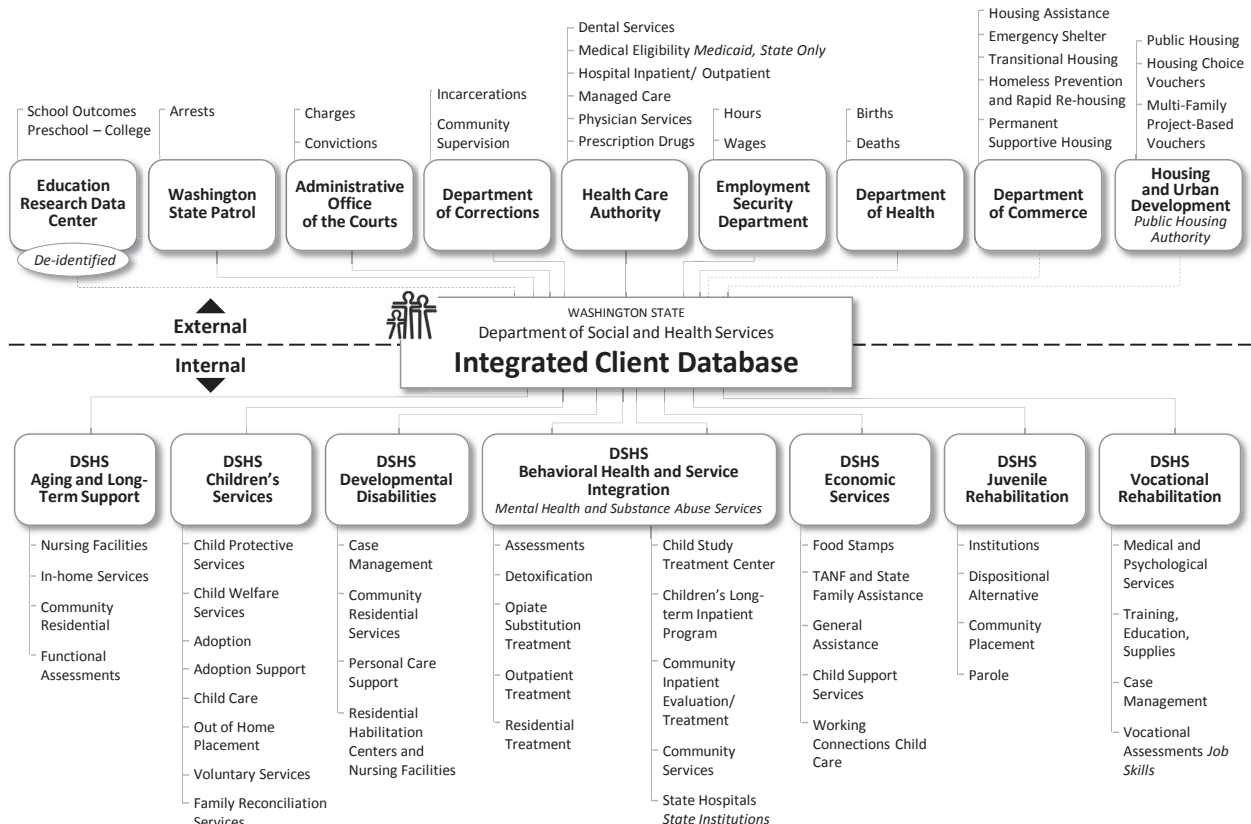
DSHS' INTEGRATED CLIENT DATABASE (ICDB) is a longitudinal client database containing over a decade of detailed service risks, history, costs, and outcomes. ICDB is used to support cost-benefit and cost offset analyses, program evaluations, operational program decisions, geographical analyses and in-depth research. DSHS serves almost 2.4 million clients a year. *The ICDB is the only place where all the client information comes together.* From this central DSHS client database, we get a current and historical look into the life experiences of residents and families who encounter the state's social service system.

The ICDB draws information from over 30 data systems across and outside of DSHS. It is created by extracting and matching client records for DSHS clients from administrative data collected by DSHS and other state agencies in their ongoing work with Washington residents. The ICDB includes the following for each client, by date: identifiers, service history and service cost across DSHS, demography, geography of residence and service, risk indicators, outcomes, birth and death records, medical diagnoses, medical costs, prescription drug use, alcohol and drug problems, mental illness indicators, homelessness, functional disability status, chronic health conditions, criminal justice encounters, incarcerations, employment status, and wages. ICDB information is monitored for consistency and accuracy.

Strict client confidentiality. Strict confidentiality standards are in place to ensure protection of personal client information. Strict adherence to human subjects review applies to all research conducted from this central client database. Data management is HIPAA compliant.

Washington State Social and Health Services Integrated Client Database

Established and Maintained by the DSHS Research and Data Analysis Division



In detail. Service histories, life events, risks and outcomes include:

- Service spans and costs
- Residential history
- Sex, race/ethnicity and citizenship
- Births to Washington residents and parent/child links through Support Enforcement
- Length and type of social services received and their costs
- Medical coverage
- Health status, medical encounters and prescriptions
- Mental health status and services
- Alcohol and drug problems and treatment
- Developmental disability services
- Severity of health problems, functional health status
- Economic services and child support enforcement
- Out-of-home placement episodes and events
- Adult and juvenile criminal justice events (arrests, convictions, and incarcerations)
- Juvenile rehabilitation services
- Employment information (wages, hours and industry type)
- Vocational rehabilitation services
- Disabling health conditions and long-term care services
- Status and spells of homelessness
- Death and its causes

Population estimates and geography. Population estimates are available for any of ICDB's standard geographic areas, such as counties, cities, legislative districts, school districts, and zip codes. ICDB also has geospatial boundary data for each of these geographic areas, which are used to determine the precise location of each client's residence. The population and geospatial data make flexible reporting of client services, expenditures, and outcomes possible. The information can be used to generate counts and use rates by age, race, gender, and poverty levels for any geographic area, enhancing our ability to make regional and local comparisons for policy purposes.

Technology behind the system. ICDB obtains interface files from source systems and processes these files on a weekly or monthly basis. Each month ICDB receives an average of 90 files. Every quarter, ICDB creates special files for reporting. The process involves resolution and unduplication of client and residential address information, which includes adding new clients, and assigning unique client identifiers where appropriate. Internal to the system are about 89 thousand lines of pl/sql code. The SAS processes consist of 50 main program files and 303 supporting code files containing about 40,000 lines of code. These have produced over 204 gigabytes of data files including 487 SAS data sets and 325 Excel spreadsheets, which are available on request. The RDBMS is Oracle (version 11.2), with partitioning and spatial options. The system includes a design repository, a testing environment, an enterprise management repository, a backup catalog, and the production database. Oracle forms provide interface for running batch jobs and metadata administration. The current size of the production database, measured by the amount of allocated space, is about 900 gigabytes. The system has over 800 hundred tables. The largest table, containing client services, is about 40 gigabytes.

CONTACT: David Mancuso, PhD
Director, Research and Data Analysis Division
Olympia, Washington
360.902.7557

www.dshs.wa.gov/rda/

APPENDIX 4

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Long Term Services and Supports Form

Please complete this form if you indicated in Section III that the Demonstration will provide long term services and supports (LTSS).

Indicate the Population(s) that the following long-term services and support description applies to:

Enter Populations Here: *The populations served will be the Tailored Supports (TSOA) for Older Adults group and the Medicaid Alternative Care (MAC) group*

Administration of the Long Term Services and Supports Program

Will the LTSS component of the Demonstration be operated by one or more State agencies other than the Medicaid agency? Yes No

If yes, please provide the contact information of the key contacts at those agencies, including name, title, name of agency, address, telephone number, email address and fax number. Also describe the specific sub-population associated with the contact:

*Bill Moss. Assistant Secretary
Aging and Long Term Support Administration
P.O. Box 45600
Olympia, WA 98504-5600
360-725-2311
MossBD@dshs.wa.gov
Fax: 360-407-0304*

Do other State agencies, that are not part of the Single State Medicaid Agency, perform Demonstration operational and administrative functions on behalf of the Medicaid agency?

Yes No

Do any contracted entities, including managed care organizations, perform Demonstration operational and administrative functions on behalf of the Medicaid agency or the waiver operating agency (if applicable)?

Yes No

Do any local or regional non-state entities perform Demonstration operational and administrative functions?

Yes No

If yes to any of the questions above, specify the types of State agencies, contracted

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entities and/or local/regional non-state entities and describe the specific functions that they perform. This includes individual enrollment, management of any enrollment or expenditure limits, level of care evaluation, review of service plans, prior authorization of services, utilization management, provider enrollment and agreements, rate methodologies, rules, policies and procedures, and quality assurance and improvement activities. Please describe how the Single State Agency oversees the performance of these non-State entities:

Function	State Medicaid Agency	Operating Agency (ALTSA)	Local or regional non-state entity (AAAs)
Individual Enrollment		X	X
Management of any enrollment or expenditure limits		X	
Level of care evaluation		X	X
Review of service plans		X	X
Prior authorization of services		X	X
Utilization management		X	X
Provider enrollment and agreements	X	X	X
Rate methodologies		X	X
Policies and procedures	X	X	
Quality assurance and improvement activities		X	X

Operating Agency: The Aging and Long Term Support Administration (ALTSA) is located within the Washington State Department of Social and Health Services (DSHS). Through a cooperative agreement, the State Medicaid Agency has delegated operation of the LTSS waiver programs to DSHS.

Local or regional non-state agencies: The operating agency contracts with Area Agencies on Aging (AAAs) to perform certain operational and administrative functions at the local level. The operating agency has a contract that sets forth the responsibilities and performance requirements of the AAAs. The contract is available through the operating agency.

Oversight by the Single State Agency: Schedule A5 of the Cooperative Agreement delegates the following functions to the operating agency:

- Submission of all necessary application, renewal and amendment materials to CMS in order to secure and maintain approval of all proposed and existing waivers
- Responsibility for the operation, management, and reporting of allowable Medicaid administrative activities for approved federal waivers
- Developing regulations, MMIS policy changes, and provider manuals

The Cooperative Agreement is reviewed and updated when needed as issues are identified.

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The Medicaid agency is responsible for approving rules, regulations and policies that govern how waivers are operated and retains the authority to discharge its responsibilities for the administration of the Medicaid program pursuant to 42 CFR § 431.10(e). The assigned operational and administrative functions are monitored as part of ALTSA's annual Quality Assurance (QA) Review Cycle. Final QA outcome reports are provided to the Medicaid agency for review and follow-up. The State Medicaid Agency receives annual Quality Assurance Review reports and meets with the operating agency at the conclusion of the QA cycle to review results and provide input into the quality improvement activities.

Consolidation of Existing Waivers or Authorities into the Demonstration

Are existing State waivers or programs operating under other authorities being consolidated into the Demonstration Program?

Yes No

If yes, identify the existing waiver(s) (1915(b),(c),(d),(e) or State Plan authorities (1915(a), (i), (j), (k), 1932) that are being consolidated into the 1115 Demonstration, including the names of the waivers or programs and identifying waiver numbers. Also indicate the current status of these waivers or authorities.

Describe how individuals in these programs will be transitioned to the 1115 Demonstration program and assured a comparable level of services, quality and continuity of care.

Level of Care to Qualify for the Program

This Demonstration is requested in order to provide LTSS to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which should be reimbursed under the approved Medicaid state plan:

Indicate and describe the level of care criteria for participants in the Long Term Services and Supports Demonstration program, such as hospital, nursing facility, ICF-MR, IMD-hospital, IMD-nursing facility, or needs-based criteria. Identify which entity performs the initial and subsequent level of care evaluations and the frequency of such reevaluations:

Through the Demonstration waiver, the state seeks to de-link eligibility for home and community based services from eligibility for nursing facility services. The state will retain the current NFLOC criteria as the criteria for HCBS. The state will revise and heighten the criteria for nursing facility services. The level of care required for both the TSOA and MAC groups is Community Based Level of Care, which was previously termed Nursing Facility Level of Care (NFLOC) and is still described that way in state rule. Upon waiver approval State rule will be updated to reflect the new terminology and eligibility levels and criteria.

The level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool is fully specified in WAC 388-106-0355 and is summarized here:

Level of Care is based on the following factors:

1. The state uses a standardized electronic assessment tool to determine LOC. Functional criteria for LOC mean one of the following applies:

(1) Care is required to be provided by or under the supervision of a registered nurse or a licensed practical nurse on a daily basis;

(2) The individual has an unmet or partially met need with at least three of the following activities of daily living. For each ADL a minimum level of assistance is required in self performance and/or support provided (self performance and support provided is defined below).

The minimum level of assistance required for each ADL is:

-Eating - Support provided is setup; or

-Toileting and bathing - Self performance is supervision; or

-Transfer, bed mobility, and ambulation - Self performance is supervision and support provided is setup; or

-Medication management - Self performance is assistance required; or

-If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility; or

(3) The individual has an unmet or partially met need with at least two of the following activities of daily living:

The minimum level of assistance required for each ADL is:

-Eating - Self performance is supervision and support provided one person physical assist; or

-Toileting - Self performance is extensive assistance and support provided is one person physical assist; or

-Bathing - Self performance is limited assistance and support provided is one person physical assist; or

-Transfer and Mobility - Self performance is extensive assistance and support provided is one person physical assist; or

-Bed Mobility – includes limited assistance in self performance and the need for turning and repositioning; and support provided is one person physical assist;

-Medication Management – Assistance required daily in self performance; or

-If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility; or

(4) The individual has a cognitive impairment and requires supervision due to one or more of the following: Disorientation, memory impairment, impaired decision making, or wandering and have an unmet or partially met need with at least one or more of the following:

The minimum level of assistance required for each ADL is:

- Eating - Self performance is supervision and support provided one person physical assist; or**
- Toileting - Self performance is extensive assistance and support provided is one person physical assist; or**
- Bathing - Self performance is limited assistance and support provided is one person physical assist; or**
- Transfer and Mobility - Self performance is extensive assistance and support provided is one person physical assist; or**
- Bed Mobility – includes limited assistance in self-performance and the need for turning and repositioning; and support provided is one person physical assist; or**
- Medication Management – Assistance required daily in self-performance; or**
- If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility.**

"Self-performance for ADLs" means what the individual actually did in the last seven days before the assessment, not what he/she might be capable of doing. Coding is based on the level of performance that occurred three or more times in the seven-day period. Self-performance definitions and assessments are consistent with that used under the Minimum Data Set (MDS). This provides a common set of clinical data across all long term care settings. Self-performance level is scored as:

- (a) Independent if the individual received no help or oversight, or if the individual needed help or oversight only once or twice;**
- (b) Supervision if the individual received oversight (monitoring or standby), encouragement, or cueing three or more times;**
- (c) Limited assistance if the individual was highly involved in the activity and given physical help in guided maneuvering of limbs or other nonweight bearing assistance on three or more occasions. For bathing, limited assistance means physical help is limited to transfer only;**
- (d) Extensive assistance if the individual performed part of the activity, but on three or more occasions, the individual needed weight bearing support or the individual received full performance of the activity during part, but not all, of the activity. For bathing, extensive assistance means the individual needed physical help with part of the activity (other than transfer);**
- (e) Total dependence if the individual received full caregiver performance of the activity and all subtasks during the entire seven-day period from others. Total dependence means complete nonparticipation by the individual in all aspects of the ADL; or**

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(f) Activity did not occur if the individual or others did not perform an ADL over the last seven days before the individual's assessment. The activity may not have occurred because:

- (i) The individual was not able (e.g., walking, if paralyzed);**
- (ii) No provider was available to assist; or**
- (iii) The individual declined assistance with the task.**

"Support provided" means the highest level of support provided to the individual by others in the last seven days before the assessment, even if that level of support occurred only once.

- (a) No set-up or physical help provided by others;**
- (b) Set-up help only provided, which is the type of help characterized by providing the individual with articles, devices, or preparation necessary for greater self performance of the activity. (For example, set-up help includes but is not limited to giving or holding out an item or cutting food);**
- (c) One-person physical assist provided;**
- (d) Two- or more person physical assist provided; or**
- (e) Activity did not occur during entire seven-day period.**

Washington uses an automated assessment to evaluate and reevaluate level of care criteria required by the waiver. The assessment tool is available to CMS upon request through the Medicaid agency.

Individual Cost Limits

Do individual cost limits apply when determining whether to deny LTSS or entrance to the Demonstration to an otherwise eligible individual? Yes No

If yes, indicate the type of cost limit that applies and describe any additional requirements pertaining to the indicated limit:

- Cost Limit in Excess of Institutional Costs. The State refuses entrance to the Demonstration to any otherwise eligible individual when the State reasonably expects that the cost of the LTSS furnished to that individual would exceed the cost of a level of care specified for the Demonstration up to an amount specified by the State.
- Institutional Cost Limit. The State refuses entrance to the Demonstration to any otherwise eligible individual when the State reasonably expects that the cost of the LTSS furnished

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to that individual would exceed 100% of the cost of the level of care specified for the waiver.

- Cost Limit Lower Than Institutional Costs. The State refuses entrance to the Demonstration to any otherwise qualified individual when the State reasonably expects that the cost of LTSS furnished to that individual would exceed an amount specified by the State that is less than the cost of a level of care specified for the Demonstration. Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of Demonstration individuals.

Long Term Services and Supports – Outreach, Education, Enrollment and Screening Describe the Demonstration program’s approach to Outreach, Education, Enrollment and Screening, including any coordination with a Money Follows the Person program. Include a description of the roles of the State and other entities in the processes.

Public outreach media and materials will be delivered in conjunction with multiple partners: ADRCs, State Council on Aging, Senior Lobby and Alzheimer’s groups etc. Education will be developed by State Unit on Aging staff and will be disseminated through the thirteen Area Agencies on Aging within the state of Washington. 1115 Demonstration program information will be mailed to current constituents. The AARP will be asked to assist with dissemination of information through their current Town Hall by Phone strategy.

This demonstration will take lessons learned from the state’s successful Money Follows the Person grant regarding enrollment, outreach and screenings and apply relevant best practices that will be incorporated throughout services, from front door to long term care services at Home and Community Services and Aging and Disability Resource Centers.

Person-Centered Planning

Indicate who is responsible for collaborating with the individual in developing the Demonstration's person-centered service plan and for its final development:

- Case Manager Social Worker
- Other (please describe, include qualifications)

Supporting the Participant in Service Plan Development

Specify: (a) the supports and information that are made available to the individual (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the individual’s authority to determine who is included in the process.

The person-centered planning (PCP) approach is a process that is driven by the person with long-term support needs, and may also include a representative whom the

person has freely chosen or is legally authorized. The PCP approach identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual.

In some cases, caregivers may be the individuals seeking assistance. Person-centered planning will be offered to caregivers to assist in determining their desire for caregiver support which might include: supportive services, communication strategies, ways to reduce caregiver stress, and understanding the importance of individual self-determination. It is essential to support caregivers while also protecting the rights of individuals to self-determine.

Participants, families and representatives are supported to direct and be actively engaged in the service plan process by:

- **Receiving information about the process and programs in advance of service planning**
- **Choosing a time and location of the service plan meeting that is convenient to them**
- **Receiving encouragement to identify goals that are meaningful to the care receiver and care recipient when developing the service plan.**
- **Receiving full information from the case manager about all available choices and service options included in the benefit package from the case manager**

(b.) Participants are welcome to invite others of their choosing to participate in service plan development.

Service Plan Development Process

Describe the process that is used to develop the person-centered service plan, including:

- (a) who develops the plan, what individuals are expected to participate in the plan development process;

The plan is developed by the participant, the participant's chosen representative and/or legal representative, the caregiver (when there is one), and others who have been invited by the participant.

- (b) the timing of the plan, how and when it is updated, including mechanisms to address changing circumstances and needs (and expectations regarding scheduling and location of meetings to accommodate individuals receiving services);

Assessment and service planning occurs at times and locations convenient to the caregiver and care receiver. Assessments occur at least every 12 months, when the participant or unpaid caregiver's circumstances or needs change significantly, or at the request of the participant. Assessments may result in an update to the service plan. The service plan can also be updated at any time to reflect changes such as; new or discontinued goals, changes in providers, changes in living situations, or changes in preferences.

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- (c) the types of assessments that are conducted to support the service plan development process, including securing information about the individual's needs, preferences and goals, and health status;

The state will use the TCARE assessment and the Comprehensive Assessment Reporting Evaluation (CARE) assessment tools to support the service plan development process.

The Comprehensive Assessment Reporting Evaluation (CARE) tool is used by case managers during a face-to-face visit with the participant to document functional ability, determine eligibility for long-term care services and supports, and develop the person-centered service plan and includes needs, preferences and goals. The CARE tool is designed to be an automated, participant-entered assessment system that is the basis for comprehensive person-centered care planning.

The TCARE assessment focuses on the needs, preferences and goals of the unpaid caregiver to help the caregiver sustain their role. TCARE also gathers information on the care receiver/client, related to cognitive status, behaviors, activities of daily living, instrumental activities of daily living and primary diagnoses in order to support the plan of care.

- (d) how the individual is informed of the services that are available under the Demonstration;

Individuals receive information in advance of the service plan development. This information is provided through online outreach materials on AAA, AL TSA and DSHS websites and in print at ADRC and AAA offices. During the service planning meeting, information about all services available through the demonstration is provided by the case manager.

- (e) how the plan development process ensures that the service plan addresses the individual's goals, needs (including health care needs), and preferences.

The CARE and TCARE assessments capture information about care receiver and caregiver goals and needs including health goals and preferences. The case manager facilitates the discussions regarding caregiver goals, strategies and preferred services.

The TCARE algorithm produces recommendations based on the caregiver's goals and cultural preferences.

The CARE assessment captures goals, strengths, weaknesses, preferences.

- (f) how Demonstration and other services are coordinated;

Case managers assist the participant to develop a

comprehensive service plan that outlines both demonstration services and other services available to the caregiver and care receiver. Case managers assist in the coordination of these services. The case manager's role in the person-centered planning process is to enable and assist the person to identify and access a personalized mix of paid and non-paid services. The individual's personally-defined outcomes, preferred methods for achieving them, training supports, therapies, and other services needed to achieve those outcomes become part of a written care plan.

Case managers assist in the coordination of these services by offering information on how to be an employer and how to find caregivers or respite providers. The care plan will identify who will act to achieve the identified services or outcomes.

- (g) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan;

The service plan identifies who is responsible for implementing service plan activities and services as directed by the service recipient within the service budget amount. The plan is monitored during routine contact with participants, providers or unpaid caregivers.

- (h) Indicate how and when the plan is updated, in addition to when the individual's needs change;

Service plan updates occur at least every 12 months, or when the participant or unpaid caregiver's circumstances or needs change significantly, or at the request of the participant or unpaid caregiver.

- (i) indicate the frequency with which the service plan is reviewed and the service delivery oversight process; and

The service plan is reviewed during regular client contacts, at least every 12 months, when the participant's circumstances or needs change significantly, or at the request of the participant or unpaid caregiver. Service verification occurs through quality assurance activities.

Indicate whether the Demonstration allows for self-direction by budget, hire/fire authority or both.

The Demonstration allows for self-direction of the service budget and employer authority for those beneficiaries using Individual Providers for personal care or respite.

Criminal History and/or Background Investigations

Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide Demonstration services:

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Long term care workers are required to pass Background checks(name and date of birth) prior to contracting, every two years from the date of the last background check, and at any time upon request of the department. Long term care workers are also required to pass a national fingerprint-based background check if hired after 1-7-12, if they have lived outside of the state since the last fingerprint check and at any time upon request of the department.

For a list of automatically disqualifying convictions and pending charges refer to [WAC 388-113-0020](#). For the list of HCS Negative Actions that are disqualifying, See [WAC chapter 388-71](#).

Are criminal history and/or background investigations required? Yes
 No

If yes, indicate the types of positions for which such investigations must be conducted:

- Administrative Staff Transport Staff
 Staff, providers and others who have direct contact with the individual
 Others (please describe)

Indicate the scope of such investigations:

- National (FBI) criminal records check State criminal records check
 Other (please describe) **National FBI fingerprint based checks**

Abuse Registry Screening

Does the State maintains an abuse registry and requires the screening of individuals through this registry? Yes No

If yes, specify the entity (entities) responsible for maintaining the abuse registry:
Indicate the types of positions for which abuse registry screenings must be conducted:

- Administrative Staff Transport Staff
 Staff, providers and others who have direct contact with the individual
 Others (please describe) **All staff and contractors who have unsupervised contact with participants**

Allowable Settings

Are Demonstration services provided in facilities subject to §1616(e) of the Act?

Washington State Medicaid Transformation Waiver Application

Yes No

If yes, indicate the types of facilities where Demonstration services may be provided, any capacity limits for such facilities, the home and community based services that may be provided in such facilities, and how a home and community character is maintained in these settings:

Individual Rights

In addition to fair hearings, does the State operate other systems for dispute resolution, grievances or complaints concerning the operation of the Demonstration program's home and community-based services component?

Yes No

Quality Improvement Strategies

Provide a description of the quality improvement strategies to be employed in the operation of the Demonstration. In particular describe strategies to ensure the health and welfare of individuals to be served with Home and Community-Based Services, including the prevention of abuse, neglect and exploitation (e.g., critical incident management system, utilization review, case management visits, etc.), the single State Medicaid Agency oversight and involvement.

Please also include the self-direction strategy if the Demonstration allows for self-direction.

The Quality Improvement Strategy for Waiver Administration and Oversight

The Health Care Authority (HCA), the State Medicaid agency, has ultimate approval authority for the design and implementation of this waiver. HCA approves all changes to the waiver through the Waiver Amendment process. HCA retains the authority to discharge its responsibilities for the administration of the Medicaid program pursuant to 42 CFR 431.10(e). The Health Care Authority delegates the operational authority for LTSS provided through the waiver to the Department of Social Health Services (DSHS). Operational and administrative functions are performed by the Aging and Long Term Support Administration (AL TSA), an administration within DSHS.

The Medicaid agency is responsible for approving rules, regulations and policies that govern how waivers are operated and retains the authority to discharge its responsibilities for the administration of the Medicaid program pursuant to 42 CFR § 431.10(e). The assigned operational and administrative functions are monitored as part of AL TSA's annual Quality Assurance (QA) Review Cycle. At the end of each QA Review Cycle, a final report is generated which includes detailed data on a state-wide level. These results are analyzed and incorporated into a statewide Performance Improvement Plan (PIP).

Final QA outcome reports are provided to the Medicaid agency for review and follow-up through the Medicaid Waiver Management Committee.

The Medicaid Waiver Management Committee includes representatives from divisions within the operating agency; HCS and RCS, as well as two other DSHS administrations: Developmental Disabilities Administration and Behavioral Health and Service Integration Administration. The committee meets quarterly to review all functions delegated to the operating agency, current quality assurance activity, pending waiver activity (e.g. amendments, renewals, etc.), potential waiver policy and rule changes and quality improvement activities.

The Operating Agency contracts with 13 Area Agencies on Aging (AAAs) to perform certain operational and administrative functions at the local level. The Operating Agency is responsible for assessing the performance of the AAAs.

The Home and Community Services Division (HCS) Quality Assurance (QA) Unit performs a variety of monitoring activities each 12 month review cycle. The focus of each review cycle is determined by an analysis of the previous year's monitoring results to ensure remediation and system improvement. Reviews also focus on ensuring that the CMS protocols are addressed and Washington is in compliance with state and federal regulations. The sample size is determined based on accepted statistical sampling methods. Final QA outcome reports are provided to the Medicaid agency for review and input into the development of the PIP. Monitoring results are also reviewed with the Medicaid Agency Waiver Management Committee.

The Quality Improvement Strategy for Health and Welfare Reporting of Incidents

The State requires the following types of critical events or incidents be immediately reported for review and follow-up action by an appropriate authority:

- Abandonment
- Abuse (including sexual, physical and mental)
- Exploitation
- Financial exploitation
- Neglect
- Self-neglect

Monitoring of Adult Protective Services (APS)

APS is a state wide program within the State Operating Agency. The intakes, investigations and protective services performed by APS are continuously monitored at both the state and the regional levels. For example:

1. **Regional supervisors and program managers conduct on-going quality assurance audits of APS case records.**
2. **The APS program has implemented a new statewide QA monitoring process that includes record reviews and a formal in-person skills evaluation conducted by a supervisor during an actual APS investigation.**

Washington State Medicaid Transformation Waiver Application

3. **Several reports based on data pulled from the statewide APS data base are routinely generated and evaluated no less than annually by program managers and upper management at the state office.**
4. **The regions have and use a report system tool that enables them to create customized reports pulled from the statewide data base to track, monitor and evaluate implementation of APS in their region.**
5. **APS also routinely reports some aspects of program performance to the Governor for her review (Government Management Accountability and Performance).**
6. **Reports are available from the new TIVA (Tracking Incidents for Vulnerable Adults) system that allows RCS and HCS management to review the intakes and investigations by program, by type, and by facility for tracking and trending purposes.**
7. **Data is used to develop statewide training for case managers and the community on adult protective services and how to recognize and prevent instances or reoccurrences of abuse, neglect and exploitation.**

Information and findings are communicated to the Medicaid agency via the quarterly Medicaid Agency Waiver Management Committee.

Self-Direction Strategy

Participants receive a yearly service budget and direct and manage their waiver services within their yearly budget amount. Each participant develops a Participant Centered Plan which addresses the needs identified in the comprehensive assessment. The plan identifies which goods and services will be purchased to meet the assessed needs and the qualified provider of each good and service. Case management to all waiver participants is provided as an administrative activity. Case managers support participants to develop and implement the participant centered plan, manage their service budget and authorize waiver services to qualified providers.

APPENDIX 5

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: **Supportive Housing Services**

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Supportive Housing Services are a specific intervention for people who, but for the availability of services, do not succeed in housing and who, but for housing, do not succeed in services. Supportive Housing Services include activities that assist a homeless or unstably housed individual to live with maximum independence in community integrated housing.

1) Services that support an individual's ability to prepare for and transition to housing, such as:

- Screening and housing assessment for individuals' preferences and barriers**
- Developing an individual housing support plan: identifying goals, addressing barriers, establishing approaches to meet their goals, including identifying available services/resources**

- Assisting with housing application and search processes**

- Identifying resources for modifications; one-time move-in needs**

- Assisting in arranging for and supporting details of the move**

- Developing housing support crisis plan**

2) Services to support individuals to maintain tenancy once housing is secured, such as:

- Early intervention for behaviors that might jeopardize housing, e.g., late rent payment; lease violations**

- Training on roles, responsibilities, rights of tenant and landlord**

- Coaching on relationship-building with landlords, managers, and neighbors, and assisting in dispute resolution**

- Linking with community resources to prevent eviction**

- Assisting with housing recertification process**

- Coordinating with the individual to review, update, and modify their housing support and crisis plans**

- On-going training and support in household management, et**

3) Activities that support collaborative efforts across public agencies and the private sector that assist a state in identifying and securing housing resources, such as:

- Developing formal/informal collaborations between services and housing agencies**

- Participating in planning processes of housing agencies, for example, by providing demographic, housing need, and other relevant data**

- Working with housing partners to create and identify housing options, such as coordinating housing locator systems; developing services data and tracking systems to include housing.**

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 5 hours per Day Week Month Year

Other, describe:

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration:

The duration of service will be determined based on a systematic review of individualized clinical information.

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:

Provider Specifications and Qualifications

Provider Category(s):

Individual (list types) Agency (list types of agencies)

The service may be provided by a:

Licensed and certified behavioral health agency that provides chemical dependency or mental health treatment services. Staff qualifications correlate with the Provider Types listed in the service encounter reporting instructions and the state plan or under the supervision of, a mental health professional.

(1) Mental health professional means:

- (A) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapter 71.05 and 71.34 RCW;**
- (B) A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;**
- (C) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.**
- (D) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or**
- (E) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-265.**

Legally Responsible Person Relative/Legal

Guardian Description of allowable provider

Specify the types of providers of this benefit or service and their required qualifications:

Mental Health State Plan Provider Descriptions:

"Psychiatrist" means a person having a license as a physician in this state who has completed residency training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and is board eligible or board certified in psychiatry.

"Psychologist" means a person who has been licensed as a psychologist pursuant to chapter

"Social worker" means a person with a master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary;

"Child psychiatrist" means a person having a license as a physician and surgeon in this state, who has had graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

"Psychiatric nurse" means a registered nurse who has a bachelor's degree from an accredited college or university, and who has had, in addition, at least two years experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional. "Psychiatric nurse" shall also mean any other registered nurse who has three years of such experience.

"Counselor" means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee.

(2) "Mental Health Care Provider" means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, A.A. level with two years experience in the mental health or related fields.

(3) "Peer Counselor" means the individual who: has self-identified as a consumer or survivor of mental health services; has received specialized training provided/contracted by the Mental Health Division; has passed a written/oral test, which includes both written and oral components of the training; has passed a Washington State background check; has been certified by the Mental Health Division; and is registered as a counselor with the

Department of Health.

Chemical Dependency Treatment State Plan Provider Qualifications:

(A) The outpatient chemical dependency service treatment center and program must be certified by DBHR, ensuring it meets all standards and processes necessary to be a certified chemical dependency service provider (treatment program) according to DBHR WAC.

(B) The residential treatment facility in which the care is provided and program must be certified by DBHR and licensed by DOH, ensuring it meets:

(I) All health and safety standards for licensure and operations for residential treatment facilities according to DOH WAC; and

(II) All standards and processes necessary to be a certified chemical dependency treatment program according to DBHR WAC.

1. Provider Type:

License Required:

Yes No

Certificate Required: Yes No
Describe:

Other Qualifications Required for this Provider Type (please describe):

2. Provider Type:

License Required: Yes No

Certificate Required: Yes No
Describe:

Other Qualifications Required for this Provider Type (please describe):

3. Provider Type:

License Required: Yes No

Certificate Required: Yes No
Describe:

Other Qualifications Required for this Provider Type (please describe):

4. Provider Type:

License Required: Yes No

Certificate Required: Yes No
Describe:



Other Qualifications Required for this Provider Type (please describe):

APPENDIX 6

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: **Supported Employment Services**

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Supported Employment -Individual Placement and Support services are the ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported employment - Individual Placement and Support services may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, asset development and career advancement services, and other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 4-5 hours per Day Week Month Year

Other, describe:

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration:

The duration of service will be determined based on a systematic review of individualized clinical information.

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:

Provider Specifications and Qualifications

Provider Category(s):

- Individual (list types) Agency (list types of agencies)

The service may be provided by a:

Licensed and certified behavioral health agency that provides chemical dependency or mental health treatment services. Staff qualifications correlate with the Provider Types listed in the service encounter reporting instructions and the state plan or under the supervision of, a mental health professional.

(1) Mental health professional means:

- (A) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapter 71.05 and 71.34 RCW;**
- (B) A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;**
- (C) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.**
- (D) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or**
- (E) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-265.**

- Legally Responsible Person Relative/Legal

Guardian Description of allowable provider

Specify the types of providers of this benefit or service and their required qualifications:

Mental Health State Plan Provider Descriptions:

"Psychiatrist" means a person having a license as a physician in this state who has completed residency training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and is board eligible or board certified in psychiatry.

"Psychologist" means a person who has been licensed as a psychologist pursuant to chapter

"Social worker" means a person with a master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary;

Other Qualifications Required for this Provider Type (please describe):

2. Provider Type:

License Required: Yes No

Certificate Required: Yes No
Describe:

Other Qualifications Required for this Provider Type (please describe):

3. Provider Type:

License Required: Yes No

Certificate Required: Yes No
Describe:

Other Qualifications Required for this Provider Type (please describe):

4. Provider Type:

License Required: Yes No

Certificate Required: Yes No
Describe:

Other Qualifications Required for this Provider Type (please describe):

APPENDIX 6



Public Notice: Medicaid Transformation Waiver Application

Washington State Health Care Authority (HCA) and Department of Social and Health Services, working together, are seeking Section 1115 Demonstration Waiver authority to support transformation of the state's Medicaid (Apple Health) program.

Background

Since January 1, 2014, Washington has expanded its Medicaid program by nearly 50 percent, providing coverage to more than 550,000 new adult enrollees, cutting the state's uninsured rate in half. The program—which previously provided services only to children, pregnant women, families, and people with disabilities—is now serving a brand new population with different care needs, utilization patterns, and pent-up demand. At the same time, Washington is anticipating an “age wave”: by 2040, Washington's population aged 65 and older is projected to reach 1.8 million—an increase of just over one million persons since 2010. The majority of Washingtonians are not insured for long term services and supports (LTSS), have no affordable options for LTSS coverage, and have no practical financial way to prepare for their LTSS needs except the path to impoverishment and reliance on Medicaid.

Today's health care system is driven by financial incentives that favor episodic volume-based diagnosis and treatment over health promotion. Individuals often delay seeking care until they have a health emergency. Providers often work in silos, delivering fragmented care with limited understanding of, or access to, tools that could help address social factors that impact health. Once a Medicaid beneficiary's condition has seriously deteriorated, it can be difficult, if not impossible, to fully restore his or her health to prior levels. Often the best outcome is to manage the beneficiary's decline over a course of relapses and incomplete recoveries. As presently configured, the State's Medicaid program does not cover needed LTSS until an individual's health and finances are seriously compromised. At this point they may be unable to maintain quality of life or remain in their homes because they can no longer afford the maintenance and upkeep. The result is a move to high-cost residential or institutional care funded primarily by Medicaid.

This five-year Demonstration proposal is a critical component of the vision for a Healthier Washington to ensure that over the next five years the State will have a multi-pronged pathway to support the evolution of Medicaid purchasing, community engagement and models of care and service delivery. In a transformed system, the Medicaid program, Managed Care Organizations (MCOs) and Behavioral Health Organizations (BHOs), providers, and beneficiaries will have incentives to work together, leveraging the resources of the larger community to address social determinants of health. By intervening before a person becomes seriously ill, the system will be better able to return the beneficiaries to their prior health level, avoiding (or at least delaying) a downward spiral. The Healthier Washington initiative, with the support of this Demonstration waiver, will reduce fragmentation in administration while improving care coordination, service delivery, and financing of services for Medicaid beneficiaries.

Central to Washington's vision for transformation is the formation of Accountable Communities of Health (ACHs) in nine regions of the State. With support from its State Innovation Models (SIM) grant, Washington is currently making investments in ACH formation. The first two of nine ACHs have been designated and we anticipate that ACHs covering the remainder of the State will be designated by the end of 2015, with plans developed to identify regional transformation priorities.

ACH members include providers, hospitals, MCOs and BHOs, social services, public health, county and local governments, housing, education, early learning, philanthropy, consumers, businesses, federally recognized Tribes, and other community-based organizations critical to the collaborative achievement of the triple aim – better care, better health and lower costs. With broad membership and inclusive governance, ACHs provide a forum for engaging the wider community in promoting whole health. They will drive more extensive transformation than possible through managed care purchasing alone—with enormous potential benefits to Medicaid beneficiaries, the MCOs and BHOs, the providers, State and communities. ACHs will play a key role in Medicaid transformation.

Overview

The initial Medicaid purchasing initiatives and SIM grant-financed activities, while an essential platform, are not enough to ensure that the State's health care system can fully transform to a system that serves the whole person. As a result, through this Demonstration proposal, the State is seeking a federal investment of \$3 billion and the authority necessary to use that critical investment to achieve four key goals:

- Reduce avoidable use of intensive services, such as acute care hospitals, nursing facilities, psychiatric hospitals and traditional long term services and supports (LTSS).
- Improve population health on specific measures.
- Accelerate the transition to value-based purchasing.
- Ensure that Medicaid cost growth is two percentage points below national trends.

These goals will be achieved through three initiatives:

- **Initiative 1: Transformation through Accountable Communities of Health (ACHs).**
To effectively transform the health system, ACHs will be central to organizing local services, defining community health needs, implementing transformation projects, and building clinical-community linkages. This robust community engagement in coordination with the Indian health system differentiates Washington's Demonstration from Medicaid transformation efforts in other states. The State will require common interventions with flexibility for selected projects to be informed by individual regional needs assessments. ACHs will assume accountability for results, reporting on achievement of milestones and metrics, and developing plans, with their members, for sustaining successful Medicaid transformation projects once the five-year demonstration period ends.

- **Initiative 2: Provision of Targeted Long-Term Services and Supports to Individuals at Risk of Utilizing more Intensive Care.** Washington seeks to better tailor long-term care benefits to the needs of our aging population. This requires federal authority to supplement the current comprehensive community based Medicaid long-term care benefit package with two additional limited benefit packages and to more effectively target nursing home services to those people with the most intensive care needs. The new benefit packages will be: (1) Medicaid Alternative Care (MAC)—this benefit package, for individuals eligible for Medicaid but not currently receiving Medicaid-funded long-term care services and supports (LTSS), will primarily support unpaid family caregivers, avoiding or delaying the need for more intensive Medicaid-funded services. (2) Tailored Supports for Older Adults (TSOA)—a new eligibility category and limited benefit package for individuals “at risk” of future Medicaid LTSS use who do not currently meet Medicaid financial eligibility criteria.
- **Initiative 3: Provision of Targeted Foundational Community Supports.** Addressing the social determinants of health by providing foundational community supports—specifically, linkages to supportive housing and supported employment—will improve and maintain the health of vulnerable beneficiaries and ensure they are not accessing avoidable institutional care. Through the Demonstration Washington will target supportive housing and supported employment services to Medicaid beneficiaries who are most likely to benefit from the service.

Public Input

Your comments, suggestions, and questions are important to us. HCA has posted its Medicaid Transformation Waiver application for public comment on its Healthier Washington website – <http://www.hca.wa.gov/hw/>. A hard copy of the application may be requested by contacting HCA at the mailing or e-mail address provided in the Public Comment section (below); you can also pick up copies at the HCA front desk at 626 8th Ave. SE, Olympia.

After gathering the public’s ideas and comments about the proposal, the agency will make changes to the application, include comments in an addendum, and submit the revised application to the Centers for Medicare and Medicaid Services (CMS).

The public comment period for the Medicaid Transformation Demonstration Waiver application is from **Friday, July 24** until **Sunday, August 23 at 5 p.m. PST**. Comments received within 30 days of the posting of this notice will be reviewed and considered for revisions to or inclusion in the application. You can provide comments by:

- Attending a public forum on the Medicaid Transformation Waiver Application (see dates and locations on the following pages).
- E-mailing comments to medicaidtransformation@hca.wa.gov

- Mailing comments to:
Health Care Authority
Attn: Medicaid Transformation
PO Box 42710
Olympia, WA 98504

If CMS decides to enter into negotiations with Washington State, there will be an additional 30-day federal public comment period. We expect the negotiations with CMS to extend over several months. During this period of negotiations and conversations with CMS, we will continue conversations with our stakeholders, partners, Tribes and the general public. We will be looking for your input and suggestions throughout this process and in the early design and implementation stages that follow.

Public Meetings

We are hosting five public meetings to provide an overview of the Medicaid Transformation Demonstration Waiver and gather public comments. In addition, the Medicaid Transformation Demonstration Waiver will be on the agenda for the Title XIX Medicaid Advisory Committee Meeting. See details below.

Public Meetings

Monday, August 3, 2015

Pierce County

Time: 8:00 – 10:00 a.m.

Location: Pierce College-Ft. Steilacoom
9401 Farwest Dr SW, Lakewood

RSVP to medicaidtransformation@hca.wa.gov. Let us know in your e-mail that you plan to attend the Lakewood forum.

Check our website (<http://www.hca.wa.gov/hw/>) to see if there will be a call-in/webinar option for this webinar.

Snohomish County

Time: 1:00 – 3:00 p.m.

Location: Everett Community College
2000 Tower St, Everett

RSVP to medicaidtransformation@hca.wa.gov. Let us know in your e-mail that you plan to attend the Everett forum.

To register for the webinar, go to: <https://attendee.gotowebinar.com/register/5994499279769883138>

Tuesday, August 4, 2015

Yakima County

Time: 8:00 – 10:00 a.m.

Location: Yakima Valley Community College
South 16th Ave & Nob Hill Blvd, Yakima

RSVP to medicaidtransformation@hca.wa.gov. Let us know in your e-mail that you plan to attend the Yakima forum.

Check our website (<http://www.hca.wa.gov/hw/>) to see if there will be a call-in/webinar option for this webinar.

Franklin County

Time: 2:00 – 4:00 p.m.

Location: Columbia Basin College
2600 N 20th Ave, Pasco

RSVP to medicaidtransformation@hca.wa.gov. Let us know in your e-mail that you plan to attend the Tri-Cities forum.

Check our website (<http://www.hca.wa.gov/hw/>) to see if there will be a call-in/webinar option for this webinar.

Wednesday, August 5, 2015

Spokane County

Time: 10:00 a.m. – Noon

Location: Spokane Regional Health District Administrative Office
1191 W College Ave, Spokane

RSVP to medicaidtransformation@hca.wa.gov

Please let us know in your e-mail that you plan to attend the Spokane forum.

To register for the webinar, go to: <https://attendee.gotowebinar.com/register/1963960132203542530>

Medicaid Title XIX Advisory Committee Meeting

Friday, July 31, 2015

Time: 8:30 – 9:40 a.m.

Location: Courtyard by Marriott Hotel
16038 West Valley Highway, Tukwila

Webinar option is preferred for this meeting since limited seating is available.

To register for the webinar, go to: <https://attendee.gotowebinar.com/register/6298442776594102786>

RSVP to medicaidtransformation@hca.wa.gov to attend in person.

To get up-to-date information on public comment opportunities, go to: <http://www.hca.wa.gov/hw>.

Additional Information

Hypothesis and Evaluation Parameters

Washington's Demonstration will test the following hypotheses:

- Whether community-based collaborations that define community health needs can (1) support redesigned care delivery, (2) build health system capacity, and (3) improve individual and population health outcomes resulting in a reduction in the need for more intensive services, bringing spending growth below national trends, and accelerating value-based payment reform.
- Whether providing limited scope LTSS to individuals "at risk" for Medicaid and to Medicaid beneficiaries who are not currently receiving Medicaid-funded LTSS and de-linking eligibility for optional state plan or waiver HCBS from nursing facility level of care criteria will avoid or delay eligibility for and use of full Medicaid LTSS benefits while preserving quality of life for beneficiaries and reducing costs for the state and federal government.
- Whether the provision of foundational community supports, such as supportive housing and supported employment, will improve health outcomes and reduce costs for a targeted subset of the Medicaid population.

Impact to Eligibility Requirements, Benefit Coverage, and Cost Sharing

The Demonstration will not change the eligibility of any populations currently eligible for Medicaid in Washington. However, it will establish a new eligibility category for individuals who are "at risk" of becoming eligible for Medicaid in order to access LTSS. Under the Demonstration, individuals in the "at risk" for Medicaid group may choose to access a limited LTSS benefit package that will preserve their quality of life while delaying their need for full Medicaid benefits. Preliminary modeling suggests that approximately 270,000 individuals in the State may meet eligibility criteria for the TSOA services offered in Initiative 2. Some of these individuals may be Medicaid-eligible individuals who have not applied for Medicaid benefits. We predict that about 35% of those eligible would participate in the program.

The Demonstration will also increase the functional eligibility criteria to qualify for nursing home services so that only individuals that need the level of services provided in a nursing home receive services in that setting. Individuals currently receiving nursing home services will be "grandfathered" to ensure they do not have to meet the new higher standard. The lower institutional level of care criteria, in place prior to the approval of the demonstration, will remain the eligibility criteria to qualify for PACE and HCBS offered through the state plan or a 1915(c) waiver.

Financing and Budget Neutrality

Washington proposes to use a per capita methodology defined by Medicaid eligibility groups rather than an aggregate federal spending approach. As required by CMS, our proposal ensures that annual federal costs under the waiver are not more than they would be absent the waiver. The Transformation Investment fund will be financed through a portion of savings accrued to the federal government as a

result of strategies employed to constrain the rate of Medicaid spending. Through providing managed care choices for 90 percent of Medicaid enrollees, and rebalancing the long term care system from nursing homes to community based settings, Washington has achieved significant federal savings and anticipates increased federal cost avoidance through 2021.

Federal Waiver and Expenditure Authorities Requested

The State requests the following waiver authorities:

- § 1902(a)(1). Authority to operate the Demonstration on a less-than-statewide basis.
- § 1902(a)(10)(B). Authority to vary the amount, duration, and scope of benefits provided to the TSOA population.
- § 1902(a)(10)(B). Authority to vary the amount, duration, and scope of benefits for individuals who meet current eligibility criteria for Medicaid funded long term care services, but who wish to receive MAC benefits in lieu of more intensive services.
- § 1902(a)(17). Authority to allow ACHs to target transformation projects to different sub-populations.
- § 1902(a)(17). Authority to target certain state-administered benefits to sub-populations.
- § 1902(a)(17). Authority to apply a more liberal income and resource standard for individuals determined to be “At Risk” for future Medicaid enrollment.
- § 1902(a)(17). Authority to provide the TSOA benefit package to the “At Risk” for Medicaid group.
- § 1902(a)(17). Authority to provide the MAC benefit package to individuals meeting current eligibility criteria for LTSS, but who are not currently receiving and do not choose more intensive Medicaid-funded nursing facility “most intensive” services.

The State requests the following expenditure authorities:

- § 1903. Authority to receive federal matching dollars for designated state health programs.
- § 1903. Authority to receive federal matching dollars for payments related to transformation projects made under the Demonstration.
- § 1903. Authority to receive federal matching dollars for services provided to the “At Risk” for Medicaid group.

Medicaid Transformation Waiver Application Available for Public Comment

Dear Feedback Network member,

Washington's draft application for a Medicaid Transformation Demonstration Waiver is now available for public comment.

This plan, part of Healthier Washington, will transform the delivery system for the 25% of Washington's population served by Medicaid, engaging and supporting Apple Health clients, providers, and communities in achieving improved health, better care, and lower costs.

The waiver will provide flexibility to fund nontraditional services for targeted populations and allow the state to use federal savings to finance qualified health transformation projects and accelerate change across systems. We also propose new flexibilities and investments for individuals receiving long-term services and supports to maintain their independence and quality of life.

Your feedback and comments inform our work

Before submitting the application to our federal partners, we want to know what you think. The public comment period for the application is from Friday, July 24, until Sunday, August 23, at 5:00 p.m.

In August, we will be holding a series of public meetings across Washington (see schedule below).

Monday, Aug. 3

- 8 – 10 a.m. Pierce College-Ft. Steilacoom
Lakewood
- 1 – 3 p.m. Everett Community College
Everett

Tuesday, Aug. 4

- 8 – 10 a.m. Yakima Valley Community College
Yakima
- 2 – 4 p.m. Columbia Basin College
Pasco

Wednesday, Aug. 5

- 10 a.m. – noon Spokane Regional Health District
Spokane

To read the application and learn more about how to provide comments at a public forum or through other avenues, visit the Healthier Washington website (<http://www.hca.wa.gov/hw/Pages/default.aspx>) and go to [Medicaid Transformation](#).

After gathering ideas and comments from our partners, stakeholders, Tribes, and the public, we will submit a revised application to the Centers for Medicare and Medicaid Services (CMS).

Submission of the waiver application to CMS marks the beginning, not the end, of an extensive process toward approval and implementation of the demonstration project. We look forward to continued conversations with you as the process gets under way.

The State of Washington Health Care Authority (HCA), working with the Department of Social and Health Services, is seeking Section 1115 Waiver authority to support transformation of its Medicaid program.

AFFIDAVIT OF PUBLICATION

STATE OF WASHINGTON County of Spokane} ss

The Demonstration will focus on three initiatives:

- Developing investments to transform the delivery system through health systems capacity building, delivery system transformation, and population health improvements.
Implementing tiered eligibility for long-term services and supports by creating two new LTSS eligibility and benefit packages, and revising the criteria for nursing facility care.
Providing targeted benefits for social supports- supportive housing and supported employment services- for individuals who are most in need of these services; Criteria for benefit eligibility will be established by the State.

A link to the full public notice for the Medicaid Transformation Waiver application can be found at: http://www.hca.wa.gov/hw.

The public comment period for the Medicaid Transformation Waiver application is from Friday, July 24 until Sunday, August 23 at 5 p.m. PST. You can e-mail comments to medicaidtransformation@hca.wa.gov or mail comments to: Washington State Health Care Authority, Attn: Medicaid Transformation, PO Box 42710, Olympia, WA, 98504.

HCA will accept verbal and/or written comments at the meetings listed below.

Title XIX Advisory Committee Meeting Friday, July 31, 8:30-9:40 a.m. Courtyard by Marriott Hotel, Tukwila Call-in option preferred; limited seating available. To attend in person, RSVP to medicaidtransformation@hca.wa.gov

Public Forums

Monday, August 3, 8-10 a.m. Pierce College-Ft. Steilacoom, Lakewood

Monday, August 3, 1-3 p.m. Everett Community College, Everett

Tuesday, August 4, 8-10 a.m. Yakima Valley Community College,

Name: WA St. Health Care Authority Client ID: 9021050
PO No. SR29709 No. Lines: 104
Total Cost: \$442.34 Order No. 193310

I, Jean Robinson do solemnly swear that I am the Principal Clerk of The Spokesman-Review, a newspaper established and regularly published, once each day in the English language, in and of general circulation in the City of Spokane County, Washington; and in the City of Coeur d'Alene, Kootenai County, Idaho; that said newspaper has been so established and regularly published and has had said general circulation continuously for more than six (6) months prior to the 23rd day of July, 1941; that said newspaper is printed in an office maintained at its place of publication in the City of Spokane, Washington; that said newspaper was approved and designated as a legal newspaper by order of the Superior Court of the State of Washington for Spokane County on the 23rd day of July, 1941, and that said order has not been revoked and is in full force and effect; that the notice attached hereto and which is a part of the proof of publication, was published in said newspaper one time(s), the publication having been made once each time on the following dates:

July 24, 2015

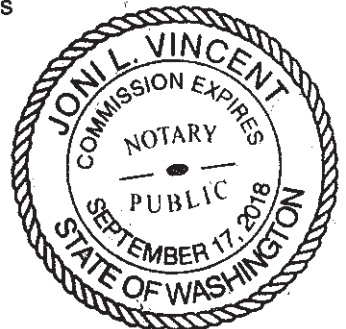
That said notice was published in the regular and entire issue of every number of the paper during the period of time of publication, and that the notice was published in the newspaper proper and not in a supplement.

Jean Robinson

Subscribed and sworn to before me at the City of Spokane, this 24th day of July, 2015.

Joni L. Vincent

Notary Public in and for the State of Washington, residing at Spokane County, Washington



Notary Stamp

Paper Affidavits.xls

APPENDIX 7



STATE OF WASHINGTON
HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

May 29, 2015

Dear Tribal Leader:

SUBJECT: Global 1115 Waiver Application

In accordance with section 1902(a)(73)(A) of the Social Security Act regarding the solicitation of advice prior to the submission of any Medicaid State Plan Amendment (SPA) or waiver likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations, the Health Care Authority (the Agency) hereby seeks your advice on the following matter.

Purpose

The Agency intends to submit an application for a Global 1115 Waiver in September 2015. Please see the enclosed concept paper for information about the waiver and the State's objectives in applying for this waiver. To prepare the waiver application, the Agency and the Department of Social and Health Services (DSHS) will be soliciting input from Tribes and Urban Indian Organizations (see below) as well as stakeholders throughout the State.

Request for Consultation

We respectfully request a consultation with the Tribes, Tribal Organizations, Indian Health Programs, and Urban Indian Organizations on the Global 1115 Waiver application. We have reserved the following date, time, and place for this consultation:

Date: August 12, 2015
Time: 10:30 a.m. – 3:00 p.m.
Location: Cherry Street Plaza,
626 8th Avenue SE
Olympia, WA 98501
Sue Crystal Conference Center

Health Care Authority Director Dorothy Teeter, Medicaid Director MaryAnne Lindeblad, and Chief Policy Officer Nathan Johnson, as well as our DSHS partners, will participate in the consultation. For anyone who is unable to attend in person but who wishes to participate remotely, we will offer webinar access.

To RSVP, please send an email to tribalaffairs@hca.wa.gov or call Jessie Dean by telephone at 360-725-1649.

Preparation of Waiver Application

With the release of the enclosed concept paper, the Agency and our DSHS partners are beginning the process of soliciting input from Tribes and Urban Indian Organizations, as well as

stakeholders throughout the State, on how this Global 1115 Waiver should support the pursuit of more holistic, whole person care in Washington State. At the request of the American Indian Health Commission for Washington State, the Agency is convening a workgroup that will be charged with exploring opportunities for this waiver to support more holistic care for American Indians/Alaska Natives. This workgroup will meet weekly beginning in mid-June. If any Tribal or Urban Indian Organization representative would like to participate in this workgroup, please send an email to tribalaffairs@hca.wa.gov or call Jessie Dean by telephone at 360-725-1649.

The Agency and DSHS will use the input from Tribes and Urban Indian Organizations, as well as stakeholders, to prepare a draft application for the Global 1115 Waiver. We anticipate distributing the draft application for your review in early August – before the requested consultation on August 12.

Comments and Questions

Even if you or your representative cannot participate in the consultation or workgroup, the Agency would appreciate any input or concerns that you wish to share regarding this waiver application. To submit any comments or questions, please contact Jessie Dean, Administrator, Tribal Affairs and Analysis, by telephone at 360-725-1649 or via email at tribalaffairs@hca.wa.gov with a courtesy copy to Ann Myers, State Plan Coordinator, at ann.myers@hca.wa.gov by August 12, 2015.

Please forward this information to any interested party.

Sincerely,



MaryAnne Lindeblad, BSN, MPH
Medicaid Director

Enclosure

- cc: Dorothy Frost Teeter, Director, HCA
Kevin Quigley, Secretary, DSHS
Nathan Johnson, Chief Policy Officer, PPP, HCA
Jane Beyer, Assistant Secretary, BHSIA, DSHS
Bill Moss, Assistant Secretary, ALISA, DSHS
Bea Alise Rector, Director, HCS, DSHS
David Reed, Acting Office Chief, ADSA/DBHR, DSHS
Jenny Hamilton, Senior Policy Analyst, PPP, HCA
Kat Latet, Senior Policy Analyst, PPP, HCA
Ann Myers, State Plan Coordinator, LAS, HCA
Jessie Dean, Administrator, Tribal Affairs and Analysis, PPP, HCA



APPENDIX 8

American Indian Health Commission for Washington State “Improving Indian Health through Tribal-State Collaboration”

August 10, 2015

Dorothy Teeter, Director
Washington State Health Care Authority
626 8th Avenue SE
P.O. Box 45502
Olympia, Washington 98504-5502

Re: AIHC Comments RE Washington State Medicaid Transformation Waiver Application

Dear Ms. Teeter:

The American Indian Health Commission for Washington State (AIHC), serving as an advocate for twenty-nine tribes and two urban Indian health organizations in Washington, is providing comments in response to the Health Care Authority’s (HCA) “Washington State Medicaid Transformation Waiver Application” submitted for public comment on July 23, 2015. The purpose of this letter is to (1) identify tribal implications of the global waiver implementation; (2) provide recommendations for addressing American Indian/Alaska Native (AI/AN) issues within the application as well as draft AI/AN specific standard terms and conditions (STCs) for the upcoming waiver process (see attached); and (3) address state and federal consultation requirements for Waiver submissions. The AIHC requests the HCA to provide the following list of the tribal/urban implications for the global waiver as well as the attached AI/AN STCs for further input and consideration by the tribes and urban Indian health organizations (UIHOs) at the upcoming August 12, 2015 HCA Tribal Consultation.

I. Impacts of 1115 Medicaid Transformation Waiver Implementation upon Tribes and Urban Indian Organizations

As stated in the Medicaid Transformation Waiver Application, “transformation will have significant impacts on the Indian health care delivery system.” Many of these impacts have the potential to provide significant benefits to Indian country including the provision of Long-Term Services and Supports (LTSS) to individuals at risk of utilizing additional intensive care and the provision of targeted foundational community supports.

However, several components of the waiver have implications for the Indian health care delivery system that require special attention in order to avoid unintended consequences. These potential effects include the following: (1) degradation of the fee-for-service system utilized by many AI/AN who also utilize the Indian health care delivery system; (2) ineffective and inefficient design and implementation of transformation projects by entities or organizations lacking knowledge and competence in the complex area of the Indian health care delivery system; and (3) lack of or inappropriate coordination of Regional Accountable Communities of Health (ACHs) with member tribes and urban Indian organizations.

Chair

Stephen Kutz
Cowlitz Tribe

Vice-Chair

Cheryl Sanders
Lummi Tribe

Treasurer

Marilyn Scott
Upper Skagit Tribe

Secretary

Leslie Wosni
Suquamish Tribe

Member-at-Large

Aren Sparck

Executive Director

Vicki Lowe

Member Tribes:

Chehalis
Colville
Cowlitz
Jamestown S’Klallam
Kalispel
Lower Elwha Klallam
Lummi
Makah
Muckleshoot
Nisqually
Nooksack
Port Gamble S’Klallam
Puyallup
Quileute
Quinault
Samish
Sauk-Suiattle
Shoalwater Bay
Skokomish
Snoqualmie
Spokane
Squaxin Island
Stillaguamish
Suquamish
Swinomish
Tulalip
Upper Skagit
Yakama

Member Organizations:

Seattle Indian Health Board
NATIVE Project of Spokane



A. Tribal/Urban Implications of Expansion of Managed Care on Indian Health Care Delivery System

HCA acknowledges within the application, “beneficiaries not receiving coverage through managed care will continue to receive services through the fee-for-service Medicaid program, and in the case of AI/AN population, through the Indian health system.” However, the proposed transformation of the state Medicaid program will undoubtedly have direct and substantial impacts on the Indian health care delivery system. Medicaid coverage for AI/AN is a fundamental piece of the Indian health care delivery system, and any large scale efforts to change the statewide system will have repercussions for Tribes, urban Indian organizations, and the AI/AN population served by Medicaid. Excluding IHS funding, Medicaid is the largest public health insurance program for Indian people and the second largest source of health coverage altogether.¹ As of 2013, at least 29% of AI/AN are enrolled in Medicaid in Washington State.² With Medicaid Expansion, it is likely that this percentage is higher. The significance of Medicaid within Indian country is largely a result of the federal trust responsibility to provide health care. Indian Health Services is funded at 55% of the level of need. The Purchased and Referred Care (PRC) program (formerly known as Contract Health Services) where AI/AN access specialty care and inpatient services is severely underfunded. Federal law requires Indian health care providers to utilize all resources including Medicaid before accessing PRC funds. In order to address IHS funding shortfalls, Washington’s Tribes have aggressively sought third party payment strategies. All but one of the Tribes have tribal health clinics contract with the state Medicaid agency to be providers to access Medicaid financing to help provide health services to tribal members.

As we have seen with the Regional Support Networks (RSN), expansion of managed care has caused further degradation of the fee-for-service reimbursement system that the Indian health care delivery system utilizes. While AI/AN can technically opt out of managed care, many have no choice but to receive critical services from the managed care system such as mental health services through the RSN. Since the Pacific Northwest does not have an IHS hospital, all inpatient care and the vast majority of specialty care comes from outside the Indian health care delivery system. According to the 2013 Tribal-Centric Behavioral Health Report to the Legislature, in 2011, 72% of AI/AN received mental health services through the RSN system.

The transition to managed care has created a severe lack of access to specialty and primary care for AI/AN who have the highest rate of chronic health conditions. The RSN system has had additional negative implications for Indian health care providers and AI/AN enrollees. The Tribal Centric Health Report described RSNs and tribes as having a “disjointed” relationship resulting in insufficient to no response whatsoever from designated mental health providers; lack of discharge coordination; lack of culturally responsive services; and disregard for tribal mental health professionals. In addition, the report recommended corrective actions and penalties for those RSNs who do not ensure that AI/AN consumers are afforded the same access, rights and benefits available to all other Medicaid beneficiaries.

Recommendations. The fee-for-service system in Indian country will remain substantially different from the HCA’s proposed transformed Medicaid system which will be largely managed care. Nonetheless, health care delivery issues within the two systems will intersect as highlighted in the RSN example. Careful and thoughtful planning in coordination with tribal leaders and tribal health experts will avoid unnecessary

¹ Report to the Legislature, Tribal-Centric Behavioral Health Report, November 30, 2013.

² Tribal-Centric Behavioral Health Report.



and often costly negative impacts of poor implementation of systematic changes to the health care delivery system. As reported by the Tribal-Centric Behavioral Health Workgroup, ***“a Managed Care system without a requirement to acknowledge and constructively work with Tribal Governments cannot adequately respond to, and appropriately serve, American Indians and/or Alaskan Natives (AI/AN).”***³

HCA needs to take special measures to improve AI/AN access to primary and specialty care such as examining the potential benefits or “renting” a network for the fee-for-service system. In order to address the tribal implications of the managed care system, the AIHC recommends HCA develop, in coordination with the tribes and UIHOs, AI/AN specific STCs that require stronger enforcement of federal protections for AI/AN and Indian health services-operated programs, 638 tribal contracted and compacted programs and urban Indian health programs (I/T/Us) who interact with the managed care system. In addition, the attached AI/AN STCs provide for full faith and credit for referrals from I/T/Us as if all I/T/U providers were authorized in any given managed care entity.

The HCA should also implement the Tribal-Centric Behavioral Health Workgroup recommendations provided in the Tribal-Centric Behavioral Health Report. Specifically, the HCA should create a mechanism to coordinate planning activities between the workgroup, the State Health Care Innovation Plan (SHCIP) team, HCA staff, and the Behavioral Health and Service Integration Administration (BHSIA). Such coordination among the agencies and workgroups will reduce duplicative efforts and avoid the conflicting statements from various state agencies regarding implementation of the waiver.

B. Tribal/Urban Implications for Design and Implementation of Regional ACHs and Transformation Projects

Regional ACHs will be charged with several functions that will directly effect the tribes and UIHOs located within their geographical designations. These functions include selecting and implementing transformation projects in their region and facilitating the transition to a value-based purchasing system. Transformation projects include three major domains: (1) Health Systems Capacity Building; (2) Delivery System Transformation; and (3) Population Health Improvement.

Transformation projects will have significant impact on tribes and UIHOs who currently conduct many of these activities, some of which have been practiced for decades. Unique from any other provider in Washington State, tribal experience in these three specific areas is largely based on their multifaceted role of serving as police departments, court systems, schools, social service agencies, employers, public health departments, water and sewage departments, natural resources, and Indian health organizations providing medical, dental, mental health, and chemical dependency services. In addition, most all Indian health providers have expertise in performance measures that monitor population health outcomes. An added dimension to the Indian health system is the engagement of tribal governments with neighboring cities, counties, and regions when addressing health issues of their community and individual tribal members. Given the multi-layered system of Indian health, tribes should play a key role in the selection and implementation of these projects.

Another significant implication of these projects is that they are intended to address population health outcomes that are most prevalent in Indian country. According to the Department of Health’s most recent report on “The Health of Washington State, “American Indians and Alaska Natives appear to have

³ Tribal-Centric Behavioral Health Report.



poorest measures of health compared to other groups.”⁴ The report presents an alarming degree of health care disparities among AI/AN.⁵ In almost every category of health risk, the AI/AN population had the highest rate of incidence, including the following:

- Highest rate of smoking
- Higher rate of obesity
- Highest rates of disabilities
- Highest rates of drug induced deaths
- Highest rate of infant mortality
- Highest rate of coronary heart disease
- Highest rate of asthma
- Highest rate of colorectal cancer
- Highest rate of diabetes
- Highest rate of stroke
- Highest rate of suicide
- Highest rate of alcohol and abuse disorders
- Highest rate of poor mental health
- Highest rate of adult tooth loss

During 2009–2011 combined, AI/AN had the highest age adjusted death rates—significantly higher than any other population.⁶ Conversely, AI/AN during this same period had the shortest life expectancy of 72 years compared the overall population average of 80. Consistent with the spirit and intent of the Healthier Washington Initiative, the Department of Health has stated the following:

Mortality rates and life expectancy can be improved by reducing specific causes of diseases and **eliminating disparities**, as discussed in other chapters of this report. **Some of the underlying causes of mortality are amenable to public health interventions.** Chief among these are reducing tobacco use, unhealthy diets, physical inactivity, and excessive alcohol consumption.⁷ *Emphasis added.*

In order to achieve the demonstration’s goals of reducing the need for more intensive services and bringing spending growth below national trends, the State will need to specifically target the population with the highest rates of chronic conditions – the AI/AN population. The State will more effectively use limited resources by creating tribal/urban-led efforts to address these disparities and reduce costly medical interventions. Tribes and urban Indian health organizations are keenly aware of these staggering health care disparities and have been implementing intervention strategies for decades. These health care disparities and the complex legal framework of the Indian health system support the need for extensive tribal/urban engagement and the utilization of tribal/urban technical expertise in implementing these transformation activities.

Recommendations. The AIHC requests that specific measures to address the impacts outlined above be included in the waiver application. These measures should include at a minimum tribal/urban ACH(s) comprised of tribal representatives and tribal health experts to provide competent analysis,

⁴ *The Health of Washington State*, 2007, General Health Status, Washington State Department of Health, section 2.1.1.

⁵ *The Health of Washington State*, Washington State Department of Health, 2007 with updates from 2008-2014.

⁶ *The Health of Washington State*, Mortality and Life Expectancy, Washington State Department of Health, 2013, p. 4-5.

⁷ *The Health of Washington State*, Mortality and Life Expectancy, Washington State Department of Health, 2013, p. 4-5.



planning and technical assistance to assure that HCA adequately addresses the needs of AI/AN and the Indian health delivery system in Washington. The formation of tribal/urban ACH(s) will assist the State in (1) preservation of the current Indian health care delivery system including the Fee-for-Service Model and the encounter rate reimbursement; (2) improving managed care organization compliance with federal legal protections for AI/AN and I/T/Us and improved coordination with the Indian health care delivery system; (3) determination and implementation of transformation projects; and (4) ensuring the regional accountable communities of health are designed and implemented in a parallel, complementary and coordinated manner with the Indian health care delivery system.

Regional ACHs will need to be fully informed and educated about the Indian health care delivery system in order to effectively engage tribes and urban Indian organizations. In addition, the State should ensure that all Regional ACHs have membership from each of the tribes and urban Indian organizations within their designated areas. As sovereign entities, tribes should have the option of participating within their Regional ACHs.

C. Tribal/Urban Implications for Methodology for Incentive Payments to Providers and ACHs and Collection of Data

As part of the sustainability for the proposed transformation, the State of Washington intends to provide incentive payments to plans, providers, and community-based organizations. Section IV, Question 10 of the application addresses the methodology the State will use for establishing quality-based supplemental payments for high-performing ACHs and providers. The methodology will be based on common performance measures that apply across ACHs, MCOs and BHOs in support of State priorities. The State's integrated Client Database will be used to assess quality and cost metrics of the Demonstration's three initiatives.

Recommendations. First, the HCA should extend to tribes and UIHOs the same opportunity as other providers and ACHs to receive incentive payments for transformation activities and measurement of population health outcomes provided by Indian health care providers. Tribes and UIHOs have been providing the same proposed transformation activities with minimal levels of funding for many years. In addition, many tribes and UIHOs, unlike most providers, have monitored the quality of their clinical care through the comprehensive performance measures of the Government Performance and Results Act (GPRA). The goal of GPRA, much like Healthier Washington, is to improve health outcomes by promoting a strong focus on results, service, quality, and customer satisfaction. GPRA measures include clinical measures, such as various diabetes measures, cancer screening and others; quality of care; prevention, such as immunizations and injury prevention; and infrastructure, such as access to or improved sanitation facilities. Given the distinct components of the health care delivery system and disproportionate level of health care disparities within the AI/AN population, the HCA will need to coordinate with tribes and UIHOs to develop a separate methodology to determine supplemental payments to Indian health care providers. The State should ensure within the waiver that tribes and UIHOs will continue to use their own performance measuring methodologies and that the State will not impose any additional reporting requirements upon the tribes nor require participation in the value-based payment system.

D. Tribal/Urban Implications for Community Foundational Support System

Initiative three of the waiver application will provide foundational community supports to improve and maintain the health of vulnerable beneficiaries through supportive housing and supported



employment services. This initiative will have significant implications for tribes and UIHOs. The 2014 DOH Health of Washington State reports that AI/AN have the highest rate of poverty over any other population in Washington State. Indian health care providers are acutely aware of the impacts of homelessness and unemployment on the health of their patients and many times are working in conjunction with the tribal housing and local community housing programs to stabilize their patients living conditions. Conversely, many tribal housing programs are already providing similar supportive services to their residents.

Recommendations. Tribes and UIHOs can provide key strategies for effective implementation of Initiative 3 for the AI/AN population. One critical component of implementation will be ensuring that the reimbursement methodology is compatible with Indian country. The application states the cost of the benefit and delivery of services would be integrated into MCO and BHO rates. We are requesting that HCA provide an AI/AN exception to this provision.

II. Consultation and Notice Requirements

We appreciate the HCA's acknowledgement that the Global Medicaid Transformation Medicaid Waiver will have a significant impact on the Indian health care delivery system. However, the tribes and UIHOs have yet to receive notification regarding the anticipated impacts on tribes and urban Indian organizations as required by State Plan Amendment (SPA) Transmittal Number 11-025. We hope that this letter as well as earlier letters provided by AIHC and the Northwest Portland Area Indian Health Board provides some guidance as to what these tribal implications are.

The HCA has held several tribal workgroup meetings in order to seek input into the draft waiver application. While these tribal workgroup meetings are important, they do not constitute consultation. While the tribes were given a high level introduction to the concept behind the global Waiver, tribes and UIHOs first consultation on Waiver Application will be occurring on August 12, 2015 with comments due on August 23, 2015. We understand the enormous undertaking of drafting such a waiver, but request that the HCA incorporate the comments provided by the tribes, UIHOs, AIHC and NPAIHB within the Global Waiver application and begin to further develop the proposed AI/AN STCs with input and consideration from the tribes and UIHOs.

III. Conclusion

Productive engagement with the tribes and urban Indian health organizations is essential to achieving the State's "triple aim" of improved health status, better care, and lower costs, by maximizing existing capacity and expertise and minimizing duplication of efforts. Recommendations for inclusion of the attached AI/AN STCs and formation of tribal/urban ACH(s) are based on three factors: (1) AI/AN have the highest level of health care disparities of any other population and that these disparities need to be addressed in order to improve population health outcomes; (2) the enormous operational and legal complexities of the Indian health care delivery system necessitates specific attention and utilization of tribal/urban technical expertise; and (3) the sovereign status of the 29 tribes and their government-to-government relationship with the State requires a higher level of coordination and consultation than with stakeholders. The examples of success in Indian country stem from tribes possessing full authority to determine and implement their own health care strategies. Conversely, failures and wasted state resources occur as the result of lack of seeking expertise from tribes and urban Indian organizations and providing tribal and urban opportunities to lead the way in improving health outcomes for their communities and AI/AN members.



We look forward to working with the State on implementation of the Global Transformation Medicaid Waiver and facilitating consultation with the tribes and UIHOs. If you have questions regarding this proposed AI/AN section, please contact AIHC Executive Director, Vicki Lowe at vicki.lowe.aihc@outlook.com or 360-477-4522. We look forward to our continued partnership to ensure effective and meaningful tribal and urban Indian health program participation in the Plan's design and implementation.

Sincerely,

A handwritten signature in black ink, which appears to read 'Stephen Kutz'. The signature is written in a cursive style with a horizontal line above it.

Stephen Kutz, Chair
American Indian Health Commission for Washington State

Attachments

cc:

Kitty Marx, Director CMS Division of Tribal Affairs
Cecile Greenway, CMS Medicaid Region 10 Program Branch Manager
Tribal Leaders
Tribal Health Directors
Urban Indian Health Organization Directors
AIHC Delegates
Nathan Johnson, HCA Policy Director
MaryAnn Lindeblad, HCA Medicaid Director
Jessie Dean, HCA Tribal Liaison
Joe Finkbonner, NPAIHB Executive Director
Jim Roberts, NPAIHB Policy Analyst
Heather Erb, AIHC Legal Consultant

DRAFT AI/AN STANDARD SPECIAL TERMS AND CONDITIONS

1. Tribal Consultation. As required by both federal and state law, HCA will consult and coordinate with the Indian health care delivery system in the design and implementation of its Global Waiver. In meeting its requirement to consult and coordinate with the twenty-nine tribes and two urban Indian health programs, the state will invest in competent analysis, planning and technical assistance to assure that HCA adequately addresses the needs of AI/AN and the Indian health delivery system in Washington. Under the HCA's consultation requirements, I/T/Us and tribes will be provided the opportunity and resources to be fully informed of Healthier Washington and ACH implementation and their impacts on the Indian health care delivery system and tribal and urban Indian communities. I/T/Us will have sufficient information in order to determine whether to function as their own ACHs or how they will function with Regional ACHs.
2. State will enforce American Indians/Alaska Natives exclusion from mandatory managed care per Section 1932(a)(2)(c). Individuals identified as AI/AN shall be excluded from this demonstration unless an individual chooses to opt into the demonstration and access coverage pursuant to all the terms and conditions of this demonstration. Individuals who are AI/AN and who have not opted in to a managed care plan will receive the health benefits generally available to enrollees of the managed care plan in which they are enrolled.
3. State will enforce of ARRA 5006(a) Cost Sharing, Premium, and Reimbursement Protections. AI/AN individuals who receive services directly by an I/T/U or through referral under Purchased/Referred Care services shall not be imposed any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing or similar charges, and payments to an I/T/U or a health care provider through referral under Purchased/Referred care services for services provided to an eligible AI/ AN shall not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing or similar charges. Under Section 206 of the Indian Health Care Improvement Act, (IHCA), I/T/U facilities are entitled to payment notwithstanding network restrictions.
4. State will improve Managed Care Plan Network Adequacy, Contracting, Reimbursement, and Coordination of Care.
 - a. MCOs will be required to contract with all I/T/Us and use the Indian Addendum
 - b. MCO coordination of care and prior authorization requirements must be consistent with I/T/U system's coordination of care requirements (e.g. referrals). Full faith and credit will be given for referrals from I/T/Us as if all I/T/U providers were authorized in any given managed care entity
 - c. Increased access to specialty and primary care
 - d. Improved wraparound supplemental payment system
 - e. Requirement that MCOs participate in Indian health care delivery system training and tribal roundtables
 - f. Utilize the tribal assister program model used by the Washington Health Benefit Exchange and the Office of Insurance Commissioner to assist with coverage and access questions for AI/AN beneficiaries

5. Managed Care Organization compliance with the following ARRA 5006(d) protections. The managed care plans must comply with federal legal protections for AI/AN and I/T/Us and improved coordination with the Indian health care delivery system including the following provisions:
 - a. Permit any Indian who is enrolled in a non-Indian managed care entity and eligible to receive services from a participating I/T/U provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services;
 - b. Require each managed care entity to demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers;
 - c. Require that I/T/U providers, whether participating in the network or not, be paid for covered Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either (1) at a rate negotiated between the managed care entity and the I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider; and
 - d. Provide that the managed care entity must make prompt payment to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations at 42 CFR sections 447.45 and 447.46.
6. Preservation of FFS System within Indian Health Programs.
 - a. Those Indian health programs as defined by the Indian Health Care Improvement Act¹ shall continue to be eligible for Fee-for-Service reimbursement at the established Office of Management and Budget's federal encounter rate or the established FQHC rate
 - b. HCA will prevent degradation of FFS by increasing access to specialty care
 - c. Community Support Foundational Support System will provide exclusion for AI/AN in managed care.
7. No Auto Assignment for AI/AN individuals. Auto-assignment will not apply to AI/ANs unless they have opted in to participate in a managed care plan.
8. Notices. The notice must include information explaining that AI/ANs are excluded from the demonstration unless they opt-in, and that AI/ANs who have not opted in may still receive the health benefits available from the managed care plans through a FFS system, with access to covered benefits through I/T/U facilities.
9. Health Performance Measures. Utilization of GPRA measures or other IHS clinical data to reduce duplication and over reporting by I/T/Us.
10. Implementation of the 2013 Tribal Centric Behavioral Health Report Recommendations and Coordination with the I/T/U Chemical Dependency in the Development of the Behavioral Health

¹ U.S.C. 25 § 1603(12).

Organizations. The State will implement the recommendations provided in the 2013 Tribal Centric Behavioral Health Report. The State in coordination with the tribes and urban Indian organizations will provide further analysis of the complications that the integration of Substance Abuse services with the mental health managed care services may have on the tribal and urban behavioral health program service needs of American Indian/Alaska Natives of Washington. The Tribal centric behavioral health system needs to be implemented and harmonized with the medical and behavioral health integration set forth in state law and embraced in the Plan.

11. Accountable Communities of Health.

- a. Create tribal/urban ACHs for determining and implementing transformation projects and addressing tribal/urban implications for waiver transformation activities
- b. Development of ACHs in a manner that is parallel, complimentary, and coordinates with the Indian health care delivery system.
 - i. Ensure the design and implementation of Healthier Washington and ACHs meets the needs of the AI/AN communities in Washington state through I/T/U engagement
 - ii. All Regional ACH will receive training on the Indian health care delivery system with a particular focus on their local I/T/U systems and the needs of Tribal and urban Indian populations

12. Uncompensated care waiver. The State will provide for a tribal uncompensated waiver to make uncompensated care payments for optional services eliminated from the state plan provided by Indian Health Service (IHS) Tribal health programs to IHS-eligible Apple Health beneficiaries.

Appendix 9

Summary of Public Comments and Responses

The State received over 200 pages of comments, questions, and letters of support in response to the draft waiver application. Although not every comment could be addressed in the application, the State is committed to continued engagement and discussion with stakeholders, tribes, and other partners. We anticipate that greater detail and clarity will be achieved in the coming months through additional Frequently Asked Questions (FAQ) documents, focused statewide workgroups, further webinars and ongoing general conversations regarding the Medicaid program.

The following summarizes the comments received during the 30-day public notice period and the State's response.

Demonstration Elements

- 1. Several commenters expressed urgency for the State to take advantage of the federal invitation, a July 27, 2015 letter to state Medicaid directors, to incorporate an IMD waiver for chemical dependency into its Transformation Request.**

We agree with the importance of responding to this invitation and will explore opportunities with CMS.

- 2. One commenter noted that we must ensure sufficient planning is undertaken to ready all systems to "go live." They recommended that the State request a one-year implementation period to expand needed resources and services.**

We agree that an implementation period is essential to assure operational readiness and critical to the success of this demonstration. We have proposed a nine month implementation period, referred to as "Year 0" throughout the application.

- 3. One commenter stated, "In the post-Affordable Care Act world, the patient population we serve and the needs of those patients have changed. We believe that Washington's Medicaid Transformation can achieve the goal of a Healthier Washington through care integration, engaged patients, demonstrated care quality, and aligned incentives for providers."**

We thank the commenter and look forward to working with our stakeholders and partners to transform and strengthen our Medicaid program.

Eligibility for Incentive Payments

- 4. One commenter asked, "with regard to the proposal that the state will require that most payments target providers with a Medicaid volume above a State-defined threshold for the region. Draft Application p. 31. What is the purpose of this threshold and how will it be developed? What is the process for HCA to determine the "state-defined threshold"? We are**

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concerned that whatever factors underlie this proposal, they could undermine access and quality of care.”

A threshold is necessary to ensure that transformation projects are aimed at the Medicaid population and the providers serving that population. We will provide further clarification in an updated FAQ document.

Complementary SIM Initiatives

- 1. Several commenters would like additional information on how the Demonstration proposal would intersect with the Practice Transformation Hub.**

We expect that SIM initiatives such as the Practice Transformation Hub (Hub) will operate in partnership with this Demonstration to maximize its effect. Over the course of the Demonstration, ACHs will assist providers in accessing technical assistance available through the Hub to help develop administrative, financial and legal capacity to adopt more integrated and accountable models of care and payment [See p. 10, 37]

Managed Care Entities

- 1. One commenter offered support for the recognition that rate-setting practices conducted by CMS and its contracted actuaries will need to be more flexible in establishing Medicaid rates.**

We thank the commenter and will work with CMS on this issue.

- 2. Several questions involved specific details regarding the roles and responsibilities of managed care entities.**

Managed care plans play a central role in the delivery of Medicaid services, and we are committed to continuing the Managed Care policy workgroup to address implementation and other demonstration-related issues.

- 3. One commenter asked for further clarification regarding the relationship of the MCOs to the ACHs: “The waiver application initially characterizes MCOs as members of the ACH, and later asserts that ACHs “must work in partnership” with MCOs. To be a “member of” or “a partner of “are associated with different expectations.”**

We see these roles as complementary. As a “member” of an ACH, an MCO will have an opportunity to have a meaningful role in influencing the ACH’s activities and focus. At the same time, as a “partner”, the MCO can collaborate with the ACH in assuring that the delivery of health care in the community is consistent with those activities and focus. This partnership/membership distinction is not unique to managed care plans and is a role already quite visible in the work of ACH members. [See p. 40]

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Performance Measures

- 1. One commenter urged that CMS consider adopting the Starter Set of measures that the statewide Performance Measures Coordinating Committee worked to complete under legislative direction.**

We are committed to leveraging the PMCC common core set of measures in addition to the Medicaid measures framework developed under Engrossed House Bill 1519 (EHB 1519) and Second Substitute Senate Bill 5732 (2SSB 5732). [See p. 15]

For additional information on the development of a Statewide Common Core Set of Measures, see http://www.hca.wa.gov/hw/Pages/performance_measures.aspx. Previous work completed to establish standard Medicaid measures across delivery systems is summarized here: http://www.hca.wa.gov/documents_legislative/ServiceCoordinationOrgAccountability.pdf.

Measures are evolving as data collection, federal guidance on standards, and measurement techniques improve.

- 2. It was recommended that the application clarify how qualitative methods will supplement evaluation.**

We have yet to determine the details but qualitative methods will apply to the process milestones anticipated in the initial years of the Demonstration.

- 3. One commenter requested a crosswalk outlining the common set of measures across ACHs, MCOs and BHOs, as well as any additional measures that apply to only one, or some, of these entities.**

We believe a crosswalk of the measures would be a valuable reference and will be publishing this document over the coming weeks.

Value-Based Payment

- 1. One commenter asked “If VBP arrangements need to be in place by 2019 but the waiver may not be fully operational until the end of 2016 or later, will there be enough time to build capacity of providers to enter into these arrangements?”**

As many commenters noted, providers are already engaged in the full continuum of VBP arrangements across payers. In 2014, HCA released a Request for Information on the state of value-based payments and received responses from virtually all leading plans and health systems in Washington showing significant intent, some progress but a major opportunity for further advancement in this area. We see the waiver as a vital tool in achieving the Healthier Washington goal of having 80% of state health care purchasing under value-based arrangements by 2019 and believe there is sufficient time to achieve this goal.

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Transformation Projects

- 1. Several commenters asked about the process for developing a project toolkit for proposed initiative 1. There is great stakeholder interest in partnering with the State to identify transformation projects and contribute to the guiding principles for the menu of options.**

We recognize that stakeholders have significant experience and expertise to shape the menu of projects and want to leverage that feedback for building the transformation toolkit. Many examples of potential projects were offered in public comments – see #11 below. We anticipate the formation of a statewide workgroup structure will occur this fall to begin building out the details of the toolkit. Additionally, draft versions of a project toolkit will be released for public comment. The application has been updated to more fully reflect this process. [See p. 49-50]

- 2. One commenter proposed that ACHs leverage existing regionally-based needs assessments, including Community Health Needs Assessments, in order to complete required Regional Health Needs Assessments which will serve as a critical tool for identifying regionally-based projects to fund through this Demonstration.**

It is expected that the State and ACHs will take existing needs assessments into consideration as they complete this process. A common methodology will be important.

- 3. Several commenters felt the population health strategies appeared to be aimed at “targeted” populations only and should apply more broadly to the Medicaid population overall.**

We appreciate the comment and clarified language in the application. The waiver is intended to incorporate transformation projects that focus on prevention and health promotion for Medicaid beneficiaries consistent with the goals of the Demonstration. Projects will target clinical and community prevention - specifically oriented towards diabetes, cardiovascular disease, pediatric obesity, smoking, mental illness, substance use disorders and oral health – that is coordinated and whole-person centered. [See p. 39]

- 4. Many commenters provided feedback that the proposal lacks focus on Children’s health and while children continue to be a significant percentage of the Medicaid population, the application did not mention preventive strategies that would move us upstream to prevent poor health outcomes down the road, in adulthood. It was also recommended that the State consider two overarching investments for all children enrolled in Medicaid: improving access to care and assuring preventive standard of care.**

Although children had not been specifically called out in the discussion of Washington’s emerging challenges, this demonstration does include children covered by Medicaid. Investment areas will be further defined through the formation of dedicated workgroups to develop the project toolkit over the coming months. The waiver is intended to incorporate transformation projects that focus on prevention and health promotion for Medicaid beneficiaries consistent with the goals of the Demonstration. [See p. 39]

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- 5. One comment stated that performance of regionally-based transformation projects must also recognize benefits in other areas, including savings accrued in the criminal justice system.**

We agree that cross sector reinvestment is a significant opportunity, and as all things in this area of focus, deserves much further discussion at a local and statewide level.

- 6. It was recommended that this waiver require child care centers to provide active, outdoor play time.**

Pediatric obesity is an area of focus under the population health domain and the updated application reflects this as a key investment. However, there are limitations to what Medicaid can and will pay for.

- 7. One commenter emphasized the need for investments in infrastructure to support patient care including: building systems that share information across hospitals and with other local partners, work force training and development, and telemedicine.**

We thank the commenter for the recommendation and have captured the need for investments in infrastructure in the Health Systems Capacity Building domain of Initiative 1. Further detail of transformation projects and investments will be developing over the coming months. [See p. 36-39].

- 8. One commenter suggested investing in the needed resources to various health care education and training programs to ensure that providers understand the value of providing integrated care and are comfortable providing care in this setting.**

This suggestion is consistent with the intent across several of the potential investment domains under Initiative 1. There is a significant provider training aspect in all elements of delivery system reform, and especially for purposes of driving integrated care delivery. To this end, we anticipate that the assistance of the SIM-financed Hub will be invaluable.

- 9. One commenter suggested that language regarding telemedicine programs should be revised to include, “workforce development projects that increase the care skills of long-term services and supports.”**

We have incorporated this suggestion. [See p. 37]

- 10. Several commenters highlighted the absence of oral health in the draft application.**

We agree that oral health is essential to successfully address whole-person care. This will need to be recognized during the development of the project toolkit.

- 11. Many commenters provided suggestions for transformation projects, including:**
 - a. Community-based asthma interventions**
 - b. Oral health**
 - c. HIV/AIDS/STD/Chronic Hepatitis C**

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- d. Violence and injury prevention (including falls prevention for older adults)
- e. Unintended pregnancy prevention
- f. Moving-related assistance
- g. Stabilization services and eviction prevention
- h. Assessment of and modification to the home environment to reduce asthma triggers
- i. Pediatric behavioral health
- j. Early identification for transition age youth experiencing a first episode of psychosis

We are appreciative of the enthusiasm and support for suggested projects. A stakeholder driven process in the development of the transformation toolkit is the next available forum for advancing this discussion.

Accountable Communities of Health

1. **Several commenters asked for clearer connections around proposed projects and initiatives in addressing health disparities. It was proposed that the State needs to incent each ACH to focus on improving the health of the overall population as well as increasing health equity and that criterion for ACH readiness should include a plan for addressing health equity.**

We anticipate that some projects, to be identified through workgroups, will be centered on increasing health equity. Additionally, we appreciate and will consider the recommendation to include a plan for addressing health equity as an element for determining ACH readiness as the coordinating entity. The details for determining ACH readiness to serve as the coordinating entity will be developed over the coming months.

2. **Several commenters expressed concerns that ACHs will not meet readiness criteria unless additional resources and technical assistance is provided.**

Initial state funding and current SIM investments provide a solid foundation for ACH design, but we recognize the additional capacity needed for coordinating entity readiness. Under an approved waiver we expect that ACHs will be able to obtain additional resources for initial planning and ongoing administrative functions to perform the coordinating entity functions and further develop the infrastructure to set the foundation for success. One commenter offered examples of coordinating entity functions to consider for potential resourcing through initial planning funds:

1. *ACH education of provider staff*
2. *Stakeholder and public education on 1115 waiver*
3. *Funds flow development*
4. *Contracting and legal*
5. *Project implementation and management*
6. *Steering, clinical, IT and other workgroups*
7. *Assess and build IT infrastructure needs for the region to implement 1115 projects. Develop timely, accurate, and actionable reports that can be analyzed for rapid process improvement*

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Finally, this topic has been further described in the Frequently Asked Questions document released on July 20, 2015 and is available on our website for review:

http://www.hca.wa.gov/hw/Documents/waiver_faq.pdf.

- 3. One commenter suggested that certification for ACHs to serve as the coordinating entity should be more rigorous around community engagement and multi-sector participation than the readiness proposal required of all ACHs to achieve designation status. It was also recommended that the State consider a “process milestone” that would trigger payment for ACHs establishing a mechanism for community voice to promote broad participation and substantive engagement with social determinants.**

We are committed to a rigorous certification process for coordinating entity status and will take these comments under full consideration. [See p. 51]

- 4. It was recommended that the State support a centralized webpage for ACH information, including key links to ACH websites and/or charter and meeting documents.**

We understand and support this idea. The State and most ACHs do maintain a webpage and we will look at options to help centralize information and guidance.

- 5. One commenter asked what type of legal structure will be required of ACHs in order to serve as the coordinating entity.**

Further details on requirements to serve as the coordinating entity will be defined over the coming months through additional discussions with ACHs, stakeholder groups, and CMS.

- 6. One commenter requested that managed care entities be a required member of the ACH governance structure.**

It is already the expectation that managed care organizations are represented in each ACH governance structure. The State recognizes that Health Plans are vital ACH partners. Additional information regarding ACH-MCO partnership expectations is available on our website:

http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx.

- 7. A few commenters requested a uniform operational ACH framework for serving as the coordinating entity to avoid too much “variation.”**

We appreciate the need to achieve this balance between regional flexibility and operational uniformity. The current ACH evaluation framework outlines statewide process measures and serves as the starting point for operational uniformity across all ACHs, where appropriate. We are, and will remain, committed to carefully striking this balance as coordinating entity criteria are further developed.

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Shared Savings

- 1. One commenter stated that the waiver application should outline the ways in which it is anticipated that waiver-derived savings will be measured and recouped from the various organizations playing a role in the waiver's various programs. They asked for further details on how shared savings are likely to be redirected to health system participants and how they will be phased out.**

We recognize that more details around shared savings strategies are necessary and will leverage the formation of a workgroup to consider options for how savings should be defined, measured, captured and reinvested. Additionally, we expect to address this issue in partnership with technical assistance provided by CMS.

Long-Term Supports and Services

- 1. Many commenters sought further clarification regarding how the State will operationalize the proposed new benefit packages in Initiative 2.**

Some responses will be reflected in a forthcoming FAQ document to clearly articulate how the LTSS initiatives relate to existing LTSS Medicaid services. Additionally, the State has convened workgroups to address details of how these benefits will be operationalized alongside the existing LTSS benefits.

- 2. Several commenters expressed concerns regarding an individual's choice of full scope vs. targeted benefits**

The new benefit packages are not a replacement of existing services that an individual would be eligible for but instead offer an additional choice through person centered planning. We have added additional language throughout the waiver application, and specifically in Section 1, to make clear that there is choice between traditional LTSS and the new benefit plans. The State will work with advocates and interested stakeholders to develop outreach and enrollment materials to ensure individuals are given a choice of available benefits and services packages.

- 3. Multiple commenters wanted to know what is changing with the existing LTSS delivery system.**

The waiver application states that the new benefits are in addition to the existing LTSS delivery system. In the overview section of the application, and throughout, the statement is made that these new benefits will build on the existing LTSS system not replace it. Revisions have been made in the waiver application to provide a greater degree of clarity.

- 4. Many comments reflected the need for ongoing stakeholder engagement and involvement in the long term services and support initiative. There was particular emphasis on outreach, education, informed consent and client rights**

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The State is committed to engaging stakeholders in the process of further development of the LTSS initiatives including outreach, beneficiary information, and program implementation. Language has been added in Section V of the application to address stakeholder engagement and involvement.

5. Commenters requested additional clarification on what the revised NFLOC will be.

A workgroup has convened to evaluate and recommend revisions to the current NFLOC criteria and to develop recommendations to address areas of public comment. DSHS will seek comment from broad representation of stakeholder on revised eligibility criteria. Language has been added in Section 5 of the application to address stakeholder engagement and involvement.

6. A commenter inquired about the inclusion of Cost Sharing within the proposed TSOA LTSS benefit package:

The State will consider whether it is feasible to include cost sharing in the TSOA program. This program is targeted to individuals who are not yet financially eligible for Medicaid, but are at risk of spending down. Consistent with federal Medicaid regulation, cost-sharing would not apply to American Indian or Alaska Native populations. The application language has been changed from 'will' to 'may' include cost sharing.

7. One commenter requested clarification as to whether Medicare Advantage beneficiaries will be eligible for the proposed LTSS benefits.

We do not anticipate excluding any Medicare groups from these new services.

8. Commenters asked if we would be creating new provider types for existing services in the new benefit packages for personal care and respite.

Clarification was added to the application in Section 4 to state that "The state will use the fee-for-service rates and the provider types identified in the state plan for personal care (which will also include respite, housework and errands)." [See p. 43]

Supportive Housing

1. Many commenters provided letters for support for the Supportive Housing Medicaid benefit given there is strong evidence that supportive housing is effective in helping people who are chronically homeless to access and retain permanent housing with regular and appropriate levels of health services.

We thank the commenters for their support.

2. Several comments reflected concern regarding the HUD Chronic Homeless definition restrictiveness.

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The State has convened workgroups to address the details of eligibility for the Supportive Housing benefit and will leverage the cross sector collaboration through the Chronic Homeless Policy Academy and Olmstead Policy Academy to clarify and finalize eligibility criteria and benefit design.

3. Commenters expressed concern over the usage and lack of clarity around utilizing the PRSIM Risk Score.

The State has convened workgroups to address the details of eligibility for the Supportive Housing benefit and will leverage the cross sector collaboration through the Chronic Homeless Policy Academy and Olmstead Policy Academy to clarify and finalize eligibility criteria and benefit design. Further clarification regarding the use of PRISM as an eligibility determination tool is included in Appendix 5 of the application.

4. Several commenters reflected that there was a lack of clarity around projected case load and penetration.

The State has convened workgroups to address the details of eligibility for the Supportive Housing benefit and will leverage the cross sector collaboration through the Chronic Homeless Policy Academy and Olmstead Policy Academy to clarify and finalize eligibility criteria and benefit design. Further eligibility information is included in Appendix 5 of the application. As the design parameters are confirmed, modeling of projected case load and penetration will be revised and published.

5. Many commenters shared the challenges related to bricks and mortar/rental subsidy resources.

Convening partnerships with affordable housing providers and community resources will play an important role in identifying other non-Medicaid funded sources to support the services. In addition to developing future workgroups to engage stakeholders in developing that partnership, Section V of the application incorporates strategies and action steps to address this issue. It is essential to note here that CMS will not approve Medicaid financing for investment in actual bricks and mortar.

6. Several comments expressed concern between the intersection of supportive housing services and linkage to primary care.

Supportive Housing services should not take away the importance of providing linkages to primary care but enhance the capacity of service providers to specifically address housing obtainment and maintenance and its impact on health. The State will work with stakeholders in multiple systems to incorporate strategies and action steps to address this issue.

7. Several commenters expressed concern about notification processes for benefit availability.

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The State will work with stakeholders in multiple systems to incorporate outreach strategies to notify and engage individuals about the benefit. Section V of the application incorporates strategies such as the use of Projects to Assist in Transition from Homelessness (PATH) teams to conduct some of the outreach efforts.