



WASHINGTON STATE MEDICAID TRANSFORMATION WAIVER APPLICATION

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

July 23, 2015

This draft application is available for public comment to the citizens of Washington State from Friday, July 24, 2015 until Sunday, August 23, 2015 at 5:00 p.m. Comments can be e-mailed to medicaidtransformation@hca.wa.gov or mailed to: Washington State Health Care Authority, Attn: Medicaid Transformation, PO Box 42710, Olympia, WA, 98504. To learn more, go to: www.hca.wa.gov/hw.

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 multiple infections, 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

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).

The Need for 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. 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, cutting the State's uninsured rate in half. We now provide insurance coverage to more than 550,000 new adults.

As a result of the Medicaid expansion, Washington's Medicaid program that historically served children, families and people with disabilities has expanded by fifty percent and is being stretched to now serve a brand new population with different care needs, utilization patterns and pent-up demand. The current health system has a shaky foundation with preexisting gaps and silos in care delivery and frayed or nonexistent linkages to critical support services.

At the same time, Washington anticipates an "age wave" that, without new approaches to eligibility and care, threatens the viability of the already rebalanced long-term care 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.¹ Eighty-six percent (86%) 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 more individual stability, less dependence and more resilience, and better linkage to a reformed healthcare system.

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 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.

In this Demonstration proposal the State includes key investments to address the 80/20 proposition—more closely tying 80% of health determinants that exist outside the clinical health care system to the 20% of delivery system outputs that impact overall health. Washington envisions a delivery system for its Medicaid beneficiaries that proactively manages

¹ 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.

health and drives population health improvement. This transformation requires a fundamental shift in the health care delivery system from being clinically siloed, institution-based, and focused on treating illness, to becoming fully integrated, community-driven, and focused on providing high quality cost effective and well-coordinated care.

Building Blocks for the Transformation

This 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. Washington has taken the first steps towards 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 the legislature and governor in 2014 in HB 2572 and SB 6312.² To support Healthier Washington, the State applied for and received a State Innovation Model (SIM) grant that is initiating investments in Washington's infrastructure over the next four years to advance multi-payer and population health transformation.

The State also is reforming its purchasing for physical and behavioral health care services through a new regional approach for Medicaid. With a goal 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. By 2019, through advancement of these initiatives and with complementary SIM investments and Demonstration support, 80 percent of State financed health care (Medicaid and Public Employees) will be purchased through value-based payment arrangements.

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 SIM grant, Washington is 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. 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. With broad membership and inclusive governance,

² [Engrossed Second Substitute House Bill 2572](#) (2013)—“Better Health Care Purchasing”; [Second Substitute House Bill 6312](#) (2013)—“Treating the Whole Person”.

ACHs provide a forum for engaging the wider community in promoting whole health and will amplify the voice of the community in shaping decisions related to health system transformation. They also 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.

At the same time, transformation will have significant impacts on the Indian health care delivery system. The Indian Health Service (IHS)/Tribally-operated health programs/urban Indian health programs (I/T/U) 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.

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 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, 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. ACHs will be fundamental to:
 - **Transformation Projects:** ACHs will undergo qualification by the State to lead collaborative efforts among their members to define community health needs and implement approved Medicaid transformation projects. To apply for Demonstration financing they 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 assessments.³ ACH members will collectively lead

³ ACHs are responsible for conducting a comprehensive regional health needs assessment referenced as a community needs assessment in this document.

project implementation by identifying targeted interventions and essential community supports, assessing necessary capacity development, and analyzing outcome data.

- **Accountability for Results:** As described in Section 4, Delivery System and Payment Rates for Services, transformation projects will incorporate relevant performance and outcome measures that apply across ACHs, MCOs and BHOs to support consistent Medicaid priorities. These measures reflect the State's commitment for consistent, standardized performance measure across health systems and initiatives.⁴

Through these measures the State will ensure ACH functional and financial accountability for the success of transformation project milestones and ultimate outcomes achieved by responsible providers and other entities. Clear mechanisms will be developed to address unsatisfactory performance. ACHs and involved providers and entities will be held responsible for implementing transformation projects by, for example, conditioning State payment to ACHs on the achievement of defined milestones and metrics. As a condition of receiving Demonstration funds, ACHs must work in partnership with providers, managed care organizations (MCOs), behavioral health organizations (BHOs), the existing aging and long term supports infrastructure, and others to develop a plan for sustaining successful Medicaid transformation projects after the Demonstration ends. To that end, ACHs will support providers in developing the relationships and capabilities necessary to manage risk, ensuring that providers are well-positioned for success under longer-term value-based payment by MCOs and BHOs. Technical assistance provided through the Practice Transformation infrastructure being developed under the SIM grant (i.e., the HUB)⁵ will strengthen these efforts.

- **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.

⁴ 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

⁵ The Practice Transformation Hub will provide training, tools, and technical assistance to primary care, behavioral health, and other providers. The hub will coordinate dissemination of evidence-based tools that promote integrated care models, clinical decision support, and clinical-community linkages.

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- First, Washington will create a new limited 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 primarily support unpaid family caregivers, avoiding or delaying the need for more intensive Medicaid-funded services.⁶
 - 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.
- **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. 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.⁷ 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 service. 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.⁸ Access to these benefits for some of the highest risk/highest cost individuals in their communities will provide ACHs with critical additional tools to complement regional transformation projects.

Sustainability of the System

By implementing its proposed Demonstration, Washington will have a system that reduces the need for more intensive services, thereby generating savings to the State, counties, ACHs, and their partner organizations. Savings will be reinvested in a way that offers incentives to plans, providers, and community-based organizations to participate fully in the transformed system.

⁶ 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.

⁷ Kushel, M.B., Gupta, R., Gee, L., and Haas, J.S. *Housing instability and food insecurity as barriers to health care among low-income Americans*. Journal of General Internal Medicine. Volume 21, Issue 1, pages 71–77, January 2006.

⁸ *Ibid.*

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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, hospitals, and community-based organizations to assure aligned incentives to reduce inpatient stays. Similarly, behavioral health care providers may make investments to expand capacity and collaborate with other providers, but the savings may accrue on the physical health side. Again, the reinvestment strategy must align incentives across systems of care and the continuum of providers and organizations involved in achieving care goals.

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 federal legal protections for AI/AN populations and I/T/Us remain intact.

Through the Demonstration, the State will develop its reinvestment strategy both at a statewide and regional level. The State will work with CMS and ACH members, which includes MCOs, BHOs, providers, community-based organizations, and others to develop a comprehensive, statewide reinvestment strategy that rewards organizations invested in the delivery system for improving the efficiency of the health care system on which Medicaid beneficiaries rely. Among other approaches, the State is committed to modifying the managed care rate setting methodology to reward MCOs, BHOs, and providers for generating savings in a manner that is consistent with federal requirements. At a regional level, the ACHs will work with their members, including a wide range of providers, MCOs, BHOs, long term care service providers, local public health agencies, and community-based organizations, to develop regional priorities and resources for reinvestment.

2) Include the rationale for the Demonstration.

Washington's Medicaid program is at a critical juncture: it can affirmatively address the emerging challenges of its growing, changing, and aging Medicaid population or it can put off reform until sustainability becomes a crisis that drives us back into classic reactive approaches to cost containment—cutting benefits, enrollment, and reimbursement. The State must proactively address quality and outcome problems embedded in our Medicaid system and move in a direction that evidence shows can improve care and outcomes, and decrease projected costs. Through the Demonstration, the State seeks to invest in innovative eligibility for LTSS, new targeted benefits, proven care delivery models, workforce expansion, and population health interventions that will fundamentally change the way care is delivered and paid for.

Emerging Challenges Threaten Medicaid's Strength and Sustainability

Growing challenges require that Washington rethink how Medicaid can continue to deliver high-quality, cost-effective care in order to sustain the program 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.⁹ 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.

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.

- **The New Adult Population is Different.** Compared to the pre-expansion Medicaid populations overall, the new adult group is characterized by higher rates of behavioral health needs (often with co-morbidities): 22 percent have a mental health condition, and 14 percent have a substance use disorder.¹⁰ And while the new adult group has generally lower hospital admission rates than other non-disabled adults, inpatient stays average 50 percent longer.¹¹
- **“Age Wave” Threatens Long-Term Sustainability of the Program.** 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 necessary to ensure we are able to meet the needs of an aging population.

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

⁹ Comparison of June 2013 vs. June 2015 Medicaid enrollment, HCA.

¹⁰ 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.

¹¹ Inpatient cost and utilization measures by eligibility coverage group, Research and Data Analysis, DSHS, June 2015.

over age 70 with dementia, and a 152% increase in the number of Medicaid beneficiaries over age 75 with serious cognitive difficulties.¹² Although Washington is a national leader in delivering high quality and cost-effective community-based long-term services and supports, current demographic projections indicate that the demands for LTSS will rapidly become unsustainable. 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 the State is able to target upstream supports for unpaid family caregivers who provide approximately 85% of LTSS in Washington State.

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. 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 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.

Rethinking Medicaid: Key Elements of the Demonstration

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 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.

In a transformed system, the Medicaid program, MCOs and 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

¹² Data provided by Research and Data Analysis, DSHS, June 2015.

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 waiver, will reduce fragmentation in administration while improving care coordination, service delivery, and financing of services for Medicaid beneficiaries. The Demonstration will reconfigure care relationships within care systems to improve whole health.

3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.

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.

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, 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 Demonstration initiatives have been successful. In addition, the database supports tools such as PRISM¹³, 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 evaluation plan for CMS's review. No later than 60 days after

¹³ PRISM (Predictive Risk Intelligence System) is Washington State's data tool that identifies individuals with physical and behavioral health co-morbidities. This web-based, clinical-decision support application offers sophisticated predictive modeling and data integration, which facilitates care management for high-risk Medicaid beneficiaries.

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receiving comments on the draft evaluation plan from CMS, the State will submit its final evaluation plan.

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Evaluation Question	Hypothesis	Evaluation Approach
What are the effects of implementation of transformation projects by community-based collaborations?	Individuals with multiple chronic conditions 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). ¹⁴
	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. ¹⁵
	The rate of avoidable use of intensive services, including use of medical/surgical hospitals, psychiatric hospitals, and skilled nursing facilities 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. ¹⁶
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 activities of daily living, instrumental activities of daily living, and related 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. ¹⁷
	The rate of long term nursing home utilization will decrease with change in clinical criteria for nursing home care, as compared to before the Demonstration.	Measure impacts of change in nursing home criteria on utilization of institutional services using the ICDB and quasi-experimental evaluation techniques.

¹⁴ 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>.

¹⁵ 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.

¹⁶ Ibid.

¹⁷ 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>

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Evaluation Question	Hypothesis	Evaluation Approach
What are the effects of providing foundational community supports?	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.

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate.

Each of the three initiatives of the Demonstration will operate statewide:

- Initiative 1: Accountable Communities of Health (ACHs).** By the end of 2015 Washington State expects to have officially designated ACHs in each of the nine regions shown in Figure 1.¹⁸ The two noted as “Pilots”—North Sound and Cascade Pacific Action Alliance—were 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.

Figure 1: Washington ACH Regions



¹⁸ The Cascade Pacific Action Alliance currently supports counties that encompass two Medicaid purchasing regions.

2. **Initiative 2: Provision of Targeted Long-Term Services and Supports to Individuals at Risk of Utilizing more Intensive Care.** The State will administer the limited caregiver support benefit programs (MAC and TSOA) and de-link nursing facility level of care from the HCBS level of care on a statewide basis.
3. **Initiative 3: Targeted Foundational Community Supports.** The State will offer supportive housing and supported employment benefits to targeted populations on a statewide basis.

5) Include the proposed timeframe for the Demonstration.

As is further discussed in Section V, the Demonstration will be implemented as soon as possible after approval of the terms and conditions. The Demonstration will continue for a five-year period, plus an initial six-month implementation period.

6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

The Demonstration will not affect components of the State's current Medicaid program outside of eligibility, benefits, cost-sharing, or delivery systems. However, changes are needed to make value-based purchasing by MCOs and BHOs successful. The State must ensure that savings generated through the transformation projects are reinvested in part through the plans' capitation rates, requiring Washington to rethink its approach to rate setting. This is further discussed in Section IV.

Section II – Demonstration Eligibility

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration (an example is provided below; note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included).

Please refer to Medicaid Eligibility Groups: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf> when describing Medicaid State plan populations, and for an expansion eligibility group, please provide the state name for the groups that is sufficiently descriptive to explain the groups to the public.

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 access a limited LTSS benefit package that will preserve their quality of life while delaying their need for full Medicaid benefits.

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.

Eligibility Chart
Mandatory State Plan Groups

Eligibility Group Name	Social Security and CFR Sections	Income Level

Optional State Plan Groups

Eligibility Group Name	Social Security and CFR Sections	Income Level

Expansion Populations

Eligibility Group Name	Social Security and CFR Sections	Income Level
Tailored Supports for Older Adults (TSOA)	n/a	Income up to 300% of the Federal Benefit Rate

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan.

Tailored Supports for Older Adults (TSOA)

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
- 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 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.

Medicaid Alternative Care (MAC)

Currently eligible Medicaid beneficiaries who are eligible for, but have chosen not to receive, Medicaid-funded LTSS will be eligible for the limited Medicaid Alternative Care (MAC) benefit package if they meet the following proposed criteria:

- 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.)
- 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.

Individuals receiving MAC would 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 during the Demonstration period, 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.

3) Specify any enrollment limits that apply for expansion populations under the Demonstration.

To ensure that funding for the Demonstration is equitably distributed across transformation initiatives, enrollment limits may be imposed on eligibility for TSOA benefits.

4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.

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.

Through Initiative 3, Washington will offer foundational community supports, such as 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 will be Medicaid expansion new adults.

Additionally, although the Demonstration will not alter the eligibility criteria or standards for populations currently eligible for coverage in Washington, the investments in transformation projects funded through the Demonstration could improve care delivery for the entire Washington Medicaid population of approximately 1.8 million enrollees.

Further estimates are being developed to refine population estimates for specific Demonstration initiatives.

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State).

Washington will not apply post-eligibility treatment of income to the TSOA or MAC populations. Because the cost of these benefit packages is relatively low and the eligibility threshold are high, the assigned amount of participation may exceed the actual benefits value. If this were

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the case there would be no incentive to use the program and beneficiaries would resort to more intensive and costly services.

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.

6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).

The State will not implement new eligibility procedures under the Demonstration.

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.

N/A

Section III – Demonstration Benefits and Cost Sharing Requirements

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

☒ Yes ☐ No (if no, please skip questions 3 – 7)

Most individuals will receive the same benefits they currently receive under the State Plan. Medicaid beneficiaries who meet additional criteria established by the State will also receive targeted foundational community supports, such as supportive housing or supported employment. Washington will offer two new limited-scope packages of long-term services and supports:

- Medicaid Alternative Care (MAC): A limited scope LTSS benefit package for individuals who meet current eligibility standards, but who are not accessing Medicaid-funded long-term care services.
- Tailored Supports for Older Adults (TSOA): A limited scope LTSS benefit package for those “at risk” for Medicaid.

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

☒ Yes ☐ No (if no, please skip questions 8 - 11)

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration (an example is provided):

Benefit Package Chart

Eligibility Group	Benefit Package
Aged, Disabled, or Both	Medicaid Alternative Care (MAC)
“At risk” for Medicaid	Tailored Supports for Older Adults (TSOA)
Targeted Sub-population in need of foundational community supports	Supportive housing Supported employment

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:



- ☐ Federal Employees Health Benefit Package
- ☐ State Employee Coverage
- ☐ Commercial Health Maintenance Organization
- ☐ Secretary Approved

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Washington's Alternative Benefit Plan is described in its State Plan.

5) In addition to the Benefit Specifications and Qualifications form:
<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf>, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan, (an example is provided).

Benefit Chart: Targeted Foundational Community Supports for Supportive Housing and Supported Employment

Benefit	Description of Amount, Duration, and Scope	Reference
Supportive Housing	<p>Housing-related activities (Individual Housing Transition Services, Individual Housing & Tenancy Sustaining Services, State-level Housing-Related Collaborative Activities) that include a range of flexible services and supports available to individuals who meet the HUD definition of chronically-homeless and meet specific risk criteria (PRISM risk score of 1.5 or above). This will include individuals with behavioral health conditions, individuals utilizing LTSS who meet additional specific eligibility guidelines, and those exiting inpatient-institutional settings.</p> <p>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.</p>	<p>CMCS Information Bulletin 6.15</p>  <p>CMS Bulletin Medicaid Housing Services CIE</p>
Supported Employment	<p>Individual employment support services to Medicaid participants (16 and up) with serious and persistent mental illness or severe emotional disturbance, and individuals eligible for LTSS, who 1) wish to become employed and 2) 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 an individual is compensated at or above the minimum wage.</p> <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 capacity.</p>	<p>CMCS Information Bulletin 9.16.11</p>  <p>CMS Information Bulletin 9.16.11.pdf</p>

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Benefit Chart: Medicaid Alternative Care (MAC) for Individuals who are Aged, Disabled, or Both and Not Currently Receiving Medicaid-Funded LTSS

The benefit package will be offered through a participant-directed budget. Participants may allocate their budget among the covered services listed in this table up to the amount and duration covered by their budget.		
Benefit	Description of Amount, Duration, and Scope	Reference
Respite care	Relief for unpaid family members or other unpaid caregivers.	
Caregiver Screening & Assessment	Screening and assessment provided to unpaid family caregivers using the Tailored Caregiver Assessment and Referral application (TCARE) developed by the University of Wisconsin. Identifies stress, burden, and uplifts associated with caregiving, as well as needs of care receiver.	
Caregiver Support Groups	Caregiver or condition/disease-specific focused groups.	
Caregiver Training	Assist caregivers with coping and/or building caregiving skills, or providing the care receiver with training for up to 2 hours per week.	
Caregiver Consultation	Clinical and therapeutic services that assist unpaid caregivers in implementing treatments and supports needed by the care receiver to remain at home.	
Personal Emergency Response System	An electronic device that enables participants to secure help in an emergency. Includes installation and monthly service fee.	
Supplies	Limited to supplies not covered under State Plan, Medicare or private insurance.	
Housework & Errands	Services needed to maintain the home in a clean, sanitary, and safe environment, and assistance with essential shopping.	
Evidence-Based Programs	Star-C, RDAD, Powerful Tools for Caregiving, Memory Care, Wellness Adult Day Program.	

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.

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Benefit Chart: Tailored Supports for Older Adults (TSOA): “At Risk” for Medicaid Population

The benefit package will be offered through a participant-directed budget. Participants may allocate their budget between the covered services listed in this table up to the amount and duration covered by their budget.

Benefit	Description of Amount, Duration, and Scope	Reference
Personal Care	Assistance to enable participants to accomplish tasks of daily living.	Optional 1905(a)(24), 42CFR 440.170 42 CFR §440.167 1915 (c)
Respite care	Relief for unpaid families or other unpaid caregivers.	Optional 1905(a)(24), 42CFR 440.170 42 CFR §440.167 1915 (c)
Caregiver Screening & Assessment	Screening and assessment provided to unpaid family caregivers using the Tailored Caregiver Assessment and Referral application (TCARE) developed by the University of Wisconsin. Identifies stress, burden, and uplifts associated with caregiving, as well as needs of care receiver.	
Caregiver Support Groups	Caregiver or condition/disease-specific focused groups.	
Caregiver Training	Assist caregivers with coping and/or building caregiving skills, or providing the care receiver with training.	
Caregiver Consultation	Clinical and therapeutic services that assist unpaid caregivers in implementing treatments and supports needed by the care receiver to remain at home.	
Personal Emergency Response System	An electronic device that enables waiver participants to secure help in an emergency. Includes installation and monthly service fee.	
Supplies	Limited to supplies not covered under Medicare or private insurance.	
Housework & Errands	Services needed to maintain the home in a clean, sanitary and safe environment, and assistance with essential shopping.	
Home Delivered Meals	Meals delivered to the beneficiary’s home.	
Adult Day Services	Adult Day Health and Adult Day Care	

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.

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Benefits Not Provided

Benefit	Description of Amount, Duration, and Scope	Reference
	Individuals receiving these services would not be eligible to receive Medicaid-funded HCBS waiver or optional state plan services.	

6) Indicate whether Long Term Services and Supports will be provided.

 X Yes (if yes, please check the services that are being offered) No

In addition, please complete the: <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf>, and the: <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf>.)

- ☒ Homemaker
- ☐ Case Management
- ☒ Adult Day Health Services (TSOA program)
- ☐ Habilitation – Supported Employment
- ☐ Habilitation – Day Habilitation
- ☐ Habilitation – Other Habilitative
- ☒ Respite
- ☐ Psychosocial Rehabilitation
- ☐ Environmental Modifications (Home Accessibility Adaptations)
- ☐ Non-Medical Transportation
- ☒ Home Delivered Meals Personal (TSOA program)
- ☒ 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

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- ☐ Nursing Services
- ☐ Adult Foster Care
- ☐ Supported Employment
- ☐ Private Duty Nursing
- ☐ Adult Companion Services
- ☒ Supports for Consumer Direction/Participant Directed Goods and Services
- ☒ Other (please describe): Caregiver screening & assessment; caregiver support groups; caregiver training; caregiver consultation; supplies.

7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

___ Yes (if yes, please address the questions below)

X No (if no, please skip this question)

a) Describe whether the state currently operates a premium assistance program and under which authority, and whether the state is modifying its existing program or creating a new program.

b) Include the minimum employer contribution amount.

c) Describe whether the Demonstration will provide wrap-around benefits and cost-sharing.

d) Indicate how the cost-effectiveness test will be met.

8) If different from the State plan, provide the premium amounts by eligibility group and income level.

N/A

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan (an example is provided):

Copayment Chart

Eligibility Group	Benefit	Copayment Amount
TSOA	Respite, personal care, household and errands	Sliding Scale – to be determined based on income

10) Indicate if there are any exemptions from the proposed cost sharing.

N/A

Section IV – Delivery System and Payment Rates for Services

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

☒ Yes

☐ No (if no, please skip questions 2 – 7 and the applicable payment rate questions)

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

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.

In the Demonstration application preface and afterword, Washington's current and transformed delivery systems are described in terms of their support for one beneficiary, John. Changes to the delivery system that are supported through the Demonstration are described in reference to Washington's three transformation initiatives.

Initiative 1: Transformation through Accountable Communities of Health

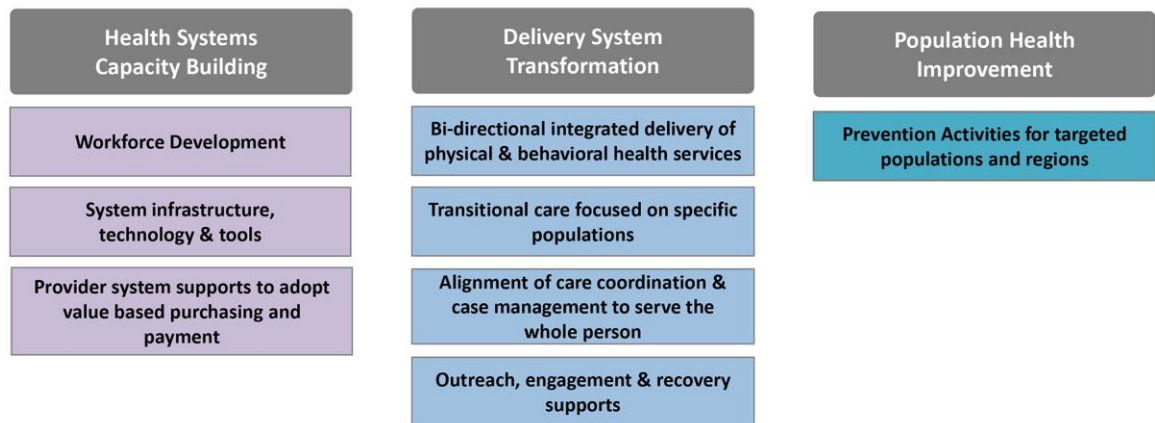
Washington will use Demonstration funds to make performance-based payments to ACHs to be shared with providers and community-based organizations undertaking state-defined transformation projects. Transformation projects will require providers in a region to collaborate across systems of care, build clinical–community linkages, and implement population health initiatives. Based on the success (or limitations) of transformation projects, the State, ACHs, MCOs and BHOs, providers, and community-based organizations will be able to assess the business case for sustaining the transformation projects after the Demonstration. Key operational elements are addressed below:

- **Defining the projects providers will undertake to enable transformation.** The State is developing a menu of transformation projects to be funded through the Demonstration. Transformation projects will be aligned with performance measures included in MCO and BHO contracts beginning in 2016. Transformation projects will be prioritized based on evidence- and research-based success in Washington State. This will ensure that the Demonstration finances transformation projects that will advance the State's goals and that have been shown to promote desirable 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 affect minority or Tribal communities that have not fully benefited from pilots or research to date. The State expects that standard 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 transformation.

Figure 2 provides an overview of transformation projects categorized under three investment domains in which sample transformation priorities are included.

Figure 2: Transformation Project Domains



1. *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 which extend limited resources and increase beneficiary engagement 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. Some projects will also support ACHs in meeting the additional fiduciary and administrative demands of serving as the coordinating entity for transformation projects in their region.

2. *Care Delivery Redesign* focuses on scaling, spreading, and sustaining care delivery models across the State that integrate systems of care and supports to address the needs of the whole person. To this end it will also support development of clinical-community linkages. For example, projects will invest in scaling and spreading effective and innovative models of integrated physical and behavioral health care currently operating in Washington State.¹⁹

Bi-Directional Integrated Care Examples	
<p>KITSAP MENTAL HEALTH CENTER</p> <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. 	<p>VALLEY VIEW HEALTH CENTER</p> <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.”

¹⁹ 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 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.

3. *Population Health Improvement* incorporates transformation projects that focus on prevention and health promotion for targeted populations of Medicaid beneficiaries. Projects will focus on both clinical and community prevention. Since clinical services and community prevention efforts are critically linked in many areas, this presents an opportunity for mutually reinforcing effects. Population health projects will dovetail with projects prioritized in the Care Delivery Redesign domain.

In addition to the discrete transformation projects described above, providers—with support from ACHs—will also use Demonstration funds to build the capabilities necessary to succeed under value-based purchasing arrangements. By developing the prerequisite skills, relationships, and processes for value-based purchasing during the Demonstration, providers will be well-positioned to manage increasing levels of risk post-Demonstration.

- ***Role of the ACHs.*** ACHs play a key role in ensuring that the 80/20 proposition related to determinants of health is addressed.

Through the Demonstration, Washington will broaden the envisioned role of ACHs to include coordination, selecting and deploying particular transformation projects funded through the Demonstration, as well as partnering with providers to build the capabilities that are prerequisites for value-based purchasing. For example, mental health providers caring for the severely mentally ill need to coordinate their care with the physical health providers, substance use disorder providers, housing providers and other social supports at the local level to get optimal outcomes. Likewise, long term care service providers must have avenues to provide services to individuals who do not meet current eligibility criteria or choose not to receive behavioral health services but whose functional capacity is limited. Since the ACHs can draw on the expertise and capabilities of their diverse membership, Washington expects that the ACHs' activities will reflect a more balanced focus leading to a richer set of community-based resources and tools that achieve whole person health.

Specifically, ACHs will:

- Determine which of the transformation projects identified by the State (as described above) will be funded in their region.
- Align their members to submit applications for regional transformation projects that represent diverse sectors.
- Establish performance agreements with providers chosen to be funded for project implementation.
- Receive funds from the State and distribute performance-based payments to project participants.

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- 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.

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 for 2016.

These measures currently 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

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

Through the investment of Demonstration funds, ACHs will enable providers to move toward more integrated and accountable models of care. The State anticipates that value-based purchasing arrangements between MCOs/BHOs and providers will be the primary mechanism for sustaining the shift to managing health. Through the Demonstration, the State will ensure that MCOs, BHOs, and providers are ready to enter into these arrangements. 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, as presented in Figure 3. 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 ensure 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, fiduciary and legal capacity to adopt more integrated and accountable models of care.

- ***The role of the MCO/BHO.*** Current 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. MCOs and BHOs have contractual obligations to manage and measure care outcomes and to initiate quality improvement programs targeted to improving their Medicaid members' health. One important consideration is to balance the need for MCOs to participate in multiple differing ACH transformation projects. Priorities for ACH lead 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 this when their active participation in transformation projects can yield reductions in utilization of more costly institutional, crisis, or specialty health care services.
- ***Ensuring that Demonstration funds are used effectively.*** At the outset and prior to distribution of Demonstration funds, the State will ensure the readiness and competency of each ACH to administer, coordinate and oversee transformation project investments, through formalized phases of ACH certification. In addition, to ensure that Demonstration funds are used to support and advance transformation in the Medicaid delivery system, the State will require shared accountability for performance among ACH members, including participating MCOs and BHOs. Through its contract with the State, each ACH will retain responsibility for implementing the transformation projects and for monitoring related provider performance with an approach for corrective action if required. ACHs will separately enter into contracts 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 provider underperformance.

The State will establish maximum total payments for each ACH, taking into account the number of Medicaid beneficiaries residing in each ACH region and the value of transformation projects being undertaken. Once an ACH has reached the required process milestones or outcome metrics, the State will release funds to the ACH. The ACH will then distribute funds among members contracted to implement the funded projects. The State will require that most payments target providers with a Medicaid volume above a State-defined threshold 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, ACHs will receive payments contingent on attaining specified outcome metrics that demonstrate improvement over prior performance. For example, an ACH 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.

- ***Ensuring the sustainability of transformation.*** As part of the State’s overarching Healthier Washington plan, the State aims for 80% of State-financed health care (i.e., Medicaid and public employees) to incorporate value-based payments to providers by 2019. Washington expects that the Demonstration will accelerate this shift toward value-based purchasing by building providers’ experience in coordinating across systems of care and by deepening relationships among providers and community-based supports. The State anticipates that 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 ends. For example, if a transformation project promoting bi-directional integration of physical and behavioral health services achieves cost avoidance and improves patient outcomes, there would be a strong case for continuing the intervention after the Demonstration ends. The State will contractually require MCOs/BHOs to enter into value-based purchasing arrangements with providers.

For value-based purchasing by MCOs and BHOs to be successful, the State must ensure that savings generated through transformation projects are reinvested in part through the plans’ capitation rates. This will require Washington State and CMS to rethink methodologies for Medicaid rate setting. This could occur in two ways.

- First, transformation projects and foundational support services 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, 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 incorporated into rate setting would provide incentives for

investments in nontraditional services or programs that yield improved performance.

Additionally, throughout the Demonstration, the State, along with its ACH partners will collaborate with its members and payers (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, and the State will also require that the ACHs incorporate a path for continuing the successful transformation activities in their broader sustainability plan. Since regions have different needs and ACHs may have different capabilities, Washington believes it is critical that each ACH have considerable flexibility when designing their sustainability plans. In other words, the role of the ACHs post-Demonstration likely will differ across the State. But Washington expects that most ACHs will perform one or more of the following functions during and after the Demonstration:

1. Identify value-added regional transformation projects proven effective during the Demonstration that should be continued.
2. Develop an approach to define, capture, and reinvest savings accruing across ACH members.
3. Administer and deploy shared resources needed for successful implementation of value-based payments.
4. Monitor on the ground service to Medicaid beneficiaries as an early warning system for access and quality issues.

In addition to crafting a plan for post-Demonstration sustainability, over the course of the demonstration, transformation projects will be aimed at building delivery system capabilities to bear risk through value-based purchasing arrangements. By focusing during the Demonstration on developing the relationships and infrastructure required for successful value-based purchasing, ACHs and providers will ensure that providers are ready to move toward more integrated and accountable models of care through their contracts with MCOs and BHOs by the end of the Demonstration.

Initiative 2: Provide targeted long-term services and supports to individuals at risk of utilizing more intensive services. 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, the State/AAAs would authorize and pay for MAC or TSOA services as summarized in the following categories of tiered benefits.

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- 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 a limited scope LTSS. 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 the benefit package does not adequately address their needs.
- 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 a limited scope LTSS benefit only.
- **Initiative 3: Provision of targeted foundational community supports.** Supportive housing and supported employment services described in Section III will initially be implemented statewide to a targeted population with payment through MCOs and BHOs initially under a case rate. 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. Opportunities may arise to link with transformation projects in regions where these services are considered a priority. Once sufficient experience has been established, the cost of the benefit and delivery of services would be integrated into MCO and BHO rates.

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- ☒ **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)**
- ☐ **Health Homes**
- ☐ **Other (please describe)**

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently

authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option:

The Demonstration will not affect how the State pays for services delivered to Medicaid beneficiaries. Beneficiaries will continue to access care during the Demonstration as described in the State Plan and under existing waiver authorities. Most beneficiaries will continue to be served through MCOs and BHOs. Beneficiaries not receiving coverage through managed care 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. Foundational community supports such as supportive housing and supported employment will also be delivered via fee-for-service arrangements until they can be incorporated into MCO and BHO rates over the course of the Demonstration.

5) If the Demonstration will utilize a managed care delivery system:

a) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations?

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.

b) Indicate whether managed care will be statewide, or will operate in specific areas of the state.

Managed care will continue to be provided statewide, consistent with the State Plan.

c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state).

Managed care is currently provided statewide for behavioral and physical health and will remain so during the Demonstration.

d) Describe how the state will assure choice of MCOs, access to care and provider network adequacy.

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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.

e) Describe how the managed care providers will be selected/procured.

The State will continue to follow the process for selecting and procuring managed care providers that is outlined in the State Plan.

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

For each initiative, proposed delivery systems are as described above.

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration

☒ **Yes**
☐ **No**

Individuals receiving limited scope LTSS benefits will allocate their service budget among the services available in their benefit package.

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.

The state will use the fee-for-service rates identified in the State Plan for State Plan covered services, which include personal care, personal emergency response systems, home delivered meals and adult day services.

The state will determine case rates for Targeted Foundational Community Supports to provide these services to beneficiaries until they are incorporated in MCO and BHO rates.

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 reasonable rates include periodic market surveys, cost analysis and price comparison.

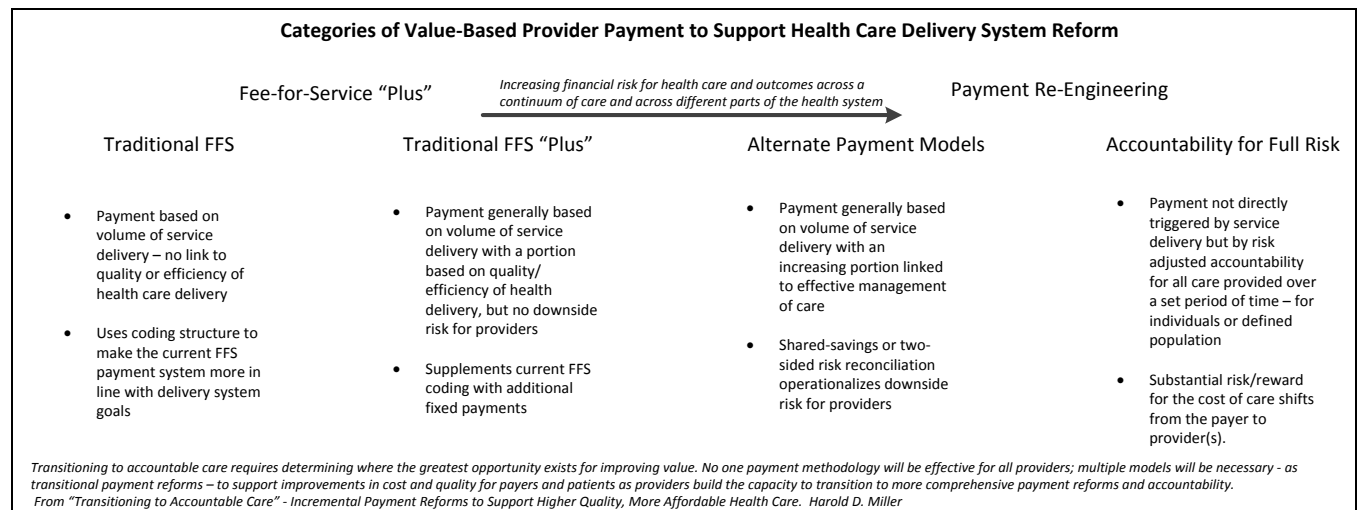
9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.

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 purchasing 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 transformation, we asked managed health care organizations 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). Through current transformation initiatives and with the assumption of waiver and State Innovation Model (SIM) investments, by 2019, 80% percent of State financed health care (Medicaid and public employees) will be purchased through value-based payment arrangements.

Our classification of value-based purchasing arrangements is shown below in Figure 3. It reflects an array of payment models, most of which are employed to some degree in the current marketplace.

Figure 3. Value-based purchasing arrangements



In developing the sustainability plan, the State in partnership with ACH members, including MCOs and BHOs, will need to build an effective reinvestment strategy that defines, measures,

and captures shared savings resulting from interventions financed through the waiver. Critical in this will be the assurance that MCOs, BHOs and health and community service providers are not financially penalized when delivery transformations result in higher value of care and social supports for Medicaid enrollees. We envision that this will require the State to revise its approach for establishing managed health care system rates. With CMS approval, we expect that flexibility in payment reform will encourage continued investments of savings realized in ongoing improvements without the option to return to historical service patterns once waiver investments end.

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.

The State will work with CMS to build an appropriate methodology 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. 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. The 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.

Section V – Implementation of Demonstration

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.

The Demonstration will be implemented as soon as is feasible after approval. The Demonstration will continue for a five-year period, plus an initial six-month implementation period. A separate implementation timeline for each Demonstration component is outlined below.

Initiative 1: Transformation through Accountable Communities of Health

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

- ***Establish 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 projects, if any, 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 whether an ACH has sufficient administrative capacity to serve as the coordinating entity for implementation of transformation projects or whether a separate organization must assume that backbone administrative function.
- ***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 for State approval their plan for sustaining successful transformation projects after the waiver.

Initiative 2: Provision of Targeted Long term Services and Supports to Individuals “At Risk” of Utilizing more Intensive Care

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

- ***Update eligibility systems.*** Washington will update its eligibility systems to reflect the eligibility criteria for the new “At Risk” for Medicaid group.
- ***Modify eligibility framework.*** Modify LTSS eligibility systems to ensure that 1) the functional eligibility criteria to qualify for HCBS offered through the State Plan or a 1915(c) waiver is delinked from the new, higher criteria for nursing facility services, 2) individuals receiving nursing facility services prior to the Demonstration approval will be evaluated under the original, lower functional eligibility criteria for nursing facility services, and 3) individuals seeking nursing facility services after the demonstration approval will be evaluated under the new, higher functional eligibility criteria for nursing facility services.
- ***Modify IT systems to accommodate benefits.*** Washington will modify its IT systems to account for two new limited scope LTSS benefit packages.
- ***Plan stakeholder education.*** The State will develop a plan for educating advocates and consumers about the new Medicaid eligibility group and new benefit packages.
- ***Begin 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 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: 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 case rates for the services, and make the systems changes needed to effectuate providing coverage for those benefits.

YEARS 1–5: The State will administer the program.

YEAR 3: The State will begin to incorporate payment for services in MCO and BHO rate development.

2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.

Initiative 1: Transformation through ACHs. For the purposes of this initiative, the number of enrolled Medicaid beneficiaries residing in each ACH must be determined in order to establish total valuation and to monitor quality for transformation projects. 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.

Initiative 2: Limited Scope LTSS Benefits. 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.

Currently 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

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available to them, including the MAC benefit. Based upon the individual's choice, they can switch to the new MAC package.

Initiative 3: 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. 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. Washington will also work with advocates and providers to inform them of the new benefit and the criteria for accessing the benefit.

3) If applicable, describe how the state will contract with insurance carriers to provide Demonstration benefits, including whether the state needs to conduct a procurement action.

N/A

Section VI – Demonstration Financing and Budget Neutrality

Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion. The Financing Form:

[http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf)

[Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf) includes a set of standard financing questions typically raised in new section 1115 demonstrations; not all will be applicable to every demonstration application. The Budget Neutrality form and spreadsheet: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf> includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.

Budget Neutrality

Washington proposes to use a per capita methodology defined by Medicaid eligibility groups rather than an aggregate federal spending approach. 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.

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

- “With waiver” program base-year per-capita costs are trended forward by nationally accepted trend factors for Medicaid (e.g., the President’s budget) discounted by 2 percentage points.
- “Without waiver” program base-year per-capita limits are trended forward by nationally accepted trend factors for Medicaid (e.g., the President’s budget) without any discount generated by transformation projects. Historical service expenditures are being analyzed to define baseline expenditures and trends including the effects of unique economic events in Washington State in recent years.
- CMS and Washington State share the financial cost for caseload changes in the Medicaid program so that federal liability remains a calculation of actual enrollment for the period multiplied by the per-capita cost and FMAP for the period.
- CMS and Washington State share the financial cost per-capita based on trends anticipated. 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

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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.

Historical enrollment and future caseload projections are provided in Figure 4, however they do not yet include projections for the hypothetical population of “at risk” individuals addressed by Initiative 2. We will work with CMS to refine the budget neutrality methodology and enrollment projections for Washington’s demonstration will be refined to reflect the most up-to-date projections from the State’s Caseload Forecast Council.²⁰

Based on CMS guidance following submission of this application, a budget neutrality Excel workbook will be provided - [WA 1115 Medicaid Transformation Waiver - BN&Historical Exp.xlsx](#). It will 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.

²⁰ <http://www.cfc.wa.gov/default.htm>

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Figure 4. Average Monthly Caseloads by Calendar Year

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

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.

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

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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,
- (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 – List of Proposed Waivers and Expenditure Authorities

1) Provide a list of proposed waivers and expenditure authorities.

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.

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2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

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 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)(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, such as 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.

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Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 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 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.

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

1) Start and end dates of the state’s public comment period.

[TO BE COMPLETED AFTER PUBLIC NOTICE PROCESS]

2) Certification that the state provided public notice of the application, along with a link to the state’s web site and a notice in the state’s Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

[TO BE COMPLETED AFTER PUBLIC NOTICE PROCESS]

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

[TO BE COMPLETED AFTER PUBLIC NOTICE PROCESS]

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.)

[TO BE COMPLETED AFTER PUBLIC NOTICE PROCESS]

5) Comments received by the state during the 30-day public notice period.

[TO BE COMPLETED AFTER PUBLIC NOTICE PROCESS]

6) Summary of the state’s responses to submitted comments, and whether or how the state incorporated them into the final application.

[TO BE COMPLETED AFTER PUBLIC NOTICE PROCESS]

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state’s approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

[TO BE COMPLETED AFTER PUBLIC NOTICE PROCESS]

Section IX – Demonstration Administration

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

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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 clinic 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.

Recovery was no easy path. However, it was a path in which there was support from the entire community. 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 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.