Summary of one-year amendment request

Overview

Washington State's Medicaid program

In Washington State, Medicaid is called Apple Health. Washington's Medicaid program, including both managed care and fee-for-service, is managed by the Washington State Health Care Authority.

As of August 2020, there were a total of 1,924,079 Apple Health eligible clients in Washington State. Of these, about 85% of clients are enrolled in a managed care plan, with the remaining 15% in the fee-for-service program. Slightly less than half, (44.49 percent) of clients, were age 19 or under. While about 30% of Washingtonians identify as non-white, over 40% of Apple Health clients are people of color and therefore more likely to experience health inequities.

Apple Health program enrollment has increased considerably in the last several months due to economic implications of the COVID-19 pandemic. From March 2020 through August, just under 100,000 new individual clients were enrolled in the program.

Amendment request

The Washington State Health Care Authority (HCA) is requesting an amendment to the Medicaid Transformation Project Demonstration section 1115 waiver, which is scheduled to expire on December 31, 2021. This amendment request addresses three components:

1. Delivery System Reform Incentive Payment (DSRIP) Value-Based Payment (VBP) adoption target for Demonstration Year (DY) 5
2. DSRIP VBP Improvement Score Methodology
3. Long-Term Services and Supports (LTSS) Presumptive Eligibility (PE)
4. LTSS Transportation Services

Goals of the amendment request

1. VBP Adoption Change

Due to COVID-19, Washington State is requesting an amendment to adjust the 2021 MCO VBP adoption target to 85%. This means the target will not change from 2020 to 2021. Washington State is seeking an adjustment so that MTP targets align with the Apple Health Appendix and state VBP adjustments in light of COVID-19.

2. VBP Improvement Score Methodology Change

The current “improvement score” methodology applies to Statewide Accountability, MCO VBP incentives, and ACH VBP incentives. The state is requesting an improvement to the way the score is calculated so that improvement is rewarded even if the target is not met.

3. Presumptive Eligibility (PE) Change

Initiative 2 focuses on expanding options for people receiving long-term services and supports (LTSS) so they can stay at home and delay or avoid the need for more intensive services. Initiative 2 also supports families in caring for loved ones while increasing the well-being of caregivers.

Washington State is requesting an amendment to extend the PE process to clients discharging from acute care hospitals and who are diverting from community psychiatric hospitals and need to access LTSS. WA state hospitals face considerable barriers in discharging certain patients because they need community supports related to functional impairments due to mental health issues, dementia, and other diagnoses, resulting in patients remaining in hospital beds for long lengths of stay beyond medical necessity for treatment.

Extending PE to cover individuals discharging or diverting from our hospitals to LTSS would mean patients would be able to access immediate, essential services prior to a final financial eligibility determination and a full functional eligibility assessment by Department of Social and Health Services (DSHS) staff. Importantly, this would include access to appropriate long term services and supports through Community First Choice and 1915(c) waivers.

Current assessment data shows approximately 2640 assessments are completed per year for clients in hospital settings. Approximately 75% of those assessments require an initial eligibility determination for long term services and supports. This is a relatively low volume of overall applications for long term services and supports. This limited hospital population combined with our extremely high accuracy rate in making PE determinations for the TSOA population exemplifies the minimal risk to the state and our federal partners due to inaccurate eligibility determinations.

4. Transportation Services Change for MAC and TSOA

Washington State is seeking a definition change for transportation to authorize transportation to community events that are not authorized in conjunction with the delivery of a service. The revision would expand the transportation services beyond those provided in conjunction with the delivery of a waiver service. Through this amendment, Washington State will offer transportation in accordance with the participant’s service plan to facilitate their access to waiver and other community services, activities and resources as specified by the participant’s service plan.

Currently, many clients have access to services such as meal programs that are provided in the community but they are often unable to attend or receive these supports because they do not have transportation. We cannot provide the transportation under the current definition limits because it is not directly in conjunction with the delivery of a waiver service. The ability to extend transportation as

part of a participant's service plan will greatly increase access to critical supports and community resources.

Eligibility

Washington's amendment request does not impact the MTP eligibility criteria that is already approved. Eligibility and enrollment information is different for each MTP initiative:

Initiative	Eligibility criteria
Initiative 1: Delivery system transformation	Benefits all Medicaid clients through large scale delivery system and payment reform projects implemented by ACHs and IHCPs.
Initiative 2: Long term services and supports	Medicaid Alternative Care (MAC): • 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. Tailored Supports for Older Adults (TSOA) • 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.
Initiative 3: Foundational Community Supports	Individuals must be 18 years or older for Supportive Housing services and 16 years or older for Supported Employment services and be Medicaid eligible. Individuals must meet at least one assessed heath needs-based criteria and is expected to benefit from community support services: • Mental health need where there is need for improvement, stabilization or prevention of deterioration of functioning resulting from the presence of a mental illness (receiving services through a behavioral health organization [BHO] or integrated managed care [IMC]) • Need for outpatient substance use disorder (SUD) treatment (receiving services through BHO or IMC)

	• Need for assistance with three or more activities of daily living (ADL) (receiving long-term care [LTC] services) • Need for hands-on assistance with one or more ADL (receiving LTC services) • Complex physical health need, which is a long continuing or indefinite physical condition requiring improvement, stabilization or prevention of deterioration of functioning Individuals must also meet at least one of the following risk factors: • Supportive housing services serves clients who experience: o Chronic homelessness (as defined by the U.S. Department of Housing and Urban Development) o Frequent or lengthy institutional contacts o Frequent or lengthy stays in adult residential care o Frequent turnover of in-home caregivers o Predictive Risk Information System (PRISM) Risk score of 1.5 or above • Supported employment services serves clients who: o Are enrolled in the Aged, Blind or Disabled Program or the Housing and Essential Needs Program o People diagnosed with severe and persistent mental illness (SPMI), substance use disorder (SUD), or co-occurring mental illness and SUD o Vulnerable youth and young adults with behavioral health needs o People who receive long-term services and supports
Initiative 4: Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD)	Individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).
Initiative 5: Residential and Inpatient Treatment for Individuals with Serious Mental Illness (SMI)	Individuals who are primarily receiving treatment for serious mental illness who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

Benefits and cost-sharing

Washington state is not requesting any changes to benefits as approved in the original waiver application. The Medicaid Transformation project does not have any cost sharing requirements.

Initiative 1:

Benefits all Medicaid clients through large scale delivery system and payment reform projects implemented by ACHs and IHCPs. In addition, care transition, care coordination, chronic-disease self-management and other prevention activities target some of the state's most vulnerable populations, including those facing the greatest health disparities and co-morbidities.

Initiative 2:

1. Medicaid Alternative Care (MAC) - Creation of a benefit package for individuals who are eligible for Medicaid but not currently accessing Medicaid-funded LTSS. This benefit package will provide services to unpaid caregivers designed to assist them in getting supports necessary to continue to provide high-quality care and to focus on their own health and well-being.
2. Tailored Supports for Older Adults (TSOA) – A separate eligibility category and benefit package for individuals "at risk" of future Medicaid LTSS use who currently do not meet Medicaid financial eligibility criteria. This is designed to help individuals avoid or delay impoverishment and the need for Medicaid-funded services. The TSOA benefit package provides services and supports to unpaid family caregivers as well as services and supports to individuals without unpaid caregivers.

MAC and TSOA include the following benefits:

- Caregiver Assistance Services: Services that take the place of those typically performed by unpaid caregiver.
- Training and Education: Assist caregivers with gaining skills and knowledge to care for recipient.
- Specialized Medical Equipment & Supplies: Goods and supplies needed by the care receiver.
- Health maintenance & therapies: Clinical or therapeutic services for caregivers to remain in role or care receiver to remain at home.
- Personal Assistance Services: Supports involving the labor of another person to help the recipient (TSOA individuals only).

Initiative 3:

Foundational Community Supports (FCS) provides a set of Home and Community Based Services (HCBS), including Community Support Services (also called Supportive Housing) and Supported Employment Services (also called Individual Placement and Support Services). Supportive housing and supported employment services work with employers and property owners to match individuals with the right environment while providing ongoing support. These services do not pay for housing or for wages or wage enhancements.

Initiative 4 provides extended treatment services in participating facilities for clients with serious mental health conditions.

Initiative 5 *(pending approval)* provides extended treatment services in participating facilities for clients with serious mental health conditions.

Enrollment

Presumptive Eligibility for discharges/diversions from acute care hospitals and community psychiatric hospitals: The state anticipates approximately 1500 applicants per year will utilize the LTSS PE process to receive in-home LTSS services.

MAC and TSOA transportation utilization for community engagement: The state anticipates that approximately 10% of the MAC and TSOA caseload (450) per month will utilize transportation for community engagement. The state does not expect waiver expenditures as there will not be an increase in the participant's monthly budget limit.

VBP adoption change mitigates at-risk funding but does not impact the projected budget neutrality or established DSRIP limits. Although not a likely scenario, the largest possible impact due to the change from 90 to 85% VBP adoption for DY5 would be the entirety of VBP at-risk for DY5: $4,968,401. The IS methodology and weighting adjustments would impact the mechanisms for distribution but would not impact the total incentives distributed to ACHs and MCOs.

Health care delivery system

Washington state is not requesting changes to our original delivery system transformation plan approved under the current 1115 waiver. Washington intends to continue transforming Medicaid across all initiatives, including this amendment, to improve its delivery and payment system and sustain the program in the face of a growing and aging 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.

Annual costs and budget neutrality

The state does not expect an increase in waiver expenditures as there will not be an increase in the participant's monthly budget limit. As a result, the state does not anticipate an impact on budget neutrality.

The state is projecting to be within our limits authorized for DY01-DY05. The total STC limit for MAC and TSOA is $133.3M across the 5 years and our current projections is $83.9M.

Below is a summary table of our with-waiver expenditures across the five years:

With-Waiver Total Expenditures

		DEMONSTRATION YEARS (DY)					Total
		1	2	3	4	5	
Medicaid Per Capita							
Non-Expansion Adults Only		$4,127,090,476	$4,588,372,995	$2,650,967,700	$2,516,458,778	$2,467,964,560	
Medicaid Aggregate - WW only							
DSHP		$192,631,562	$181,206,690	$117,008,060	$76,543,710	$98,879,556	
DSRIP		$242,100,000	$231,700,000	$187,180,434	$151,510,022	$71,250,000	
TOTAL		**$4,561,822,038**	**$5,001,279,685**	**$2,955,156,194**	**$2,744,512,510**	**$2,638,094,116**	**$17,900,864,543**

Evaluation Design

Washington state proposes to continue its current evaluation of all five initiatives the Medicaid Transformation Project Demonstration section 1115 waiver. This amendment will be evaluated under the initiative(s) approved for (Initiatives 1 and 2) but will not require substantive changes to the evaluation design. Washington state proposes to evaluate the impacts specific to this amendment under the following hypothesis of the approved evaluation design:

Below are the parameters from the evaluation design that apply to this amendment:

Specific testable hypotheses will include:	• Do caregivers show change from baseline to 6-month follow-up in survey/self-report measures of: - Caregiving burden - Physical/mental health status - Quality of life • Do care receivers, including TSOA individuals without unpaid caregivers, show change from baseline to 6-month follow-up in survey/self-report measures of: - Physical/mental health status - Quality of life • Are caregivers and care receivers satisfied with their experience with the program? • Do MAC program participants show similar health outcomes to comparable recipients of traditional Medicaid LTSS services? • Following implementation of the MAC and TSOA programs, are Medicaid-paid LTSS cost trends lower than expected based on forecasts derived from baseline Medicaid-paid LTSS utilization rates and the observed changes in per cap costs and the composition of the Washington State population?
Data Sources	• Participant Self-Report Data • Self-Reported Administrative Assessment Data • Survey Data
Measures	**Survey and administrative self-report measures.** As detailed above, administrative assessment data is expected to capture measures related to caregiver characteristics and issues; caregiver condition/circumstances, and LTSS placement intentions. Many of these measures are part of the evidence-based, validated TCARE® screening and assessment system, which has been a component of numerous recognized evidence-based assessments. Survey instruments will be designed to complement the information available in administrative data, and collect additional key data and more in-depth data. As detailed above, the first survey wave is designed to inform program implementation and operation, rather than to measure program impacts on caregiver and care receiver experiences and outcomes. Measures of participant experiences and potential impacts on quality of life, caregiver burdens and health, and participant satisfaction with program participation will be derived from data captured in the second and third survey waves, described above. The precise specifications of wave 2

	and wave 3 survey instruments are expected to be determined in consultation with the independent external evaluator. **Comparisons between MAC clients and recipients of traditional Medicaid LTSS services.** This component of the evaluation will focus on health service utilization and related outcomes, including: • Outpatient Emergency Department Visits per 1000 Member Months (NCQA HEDIS® EDU or similar state-defined alternative) • Inpatient Admissions per 1,000 Member Months (NCQA HEDIS® IHU or similar state-defined alternative) • Plan All-Cause 30-Day Readmission Rate (NCQA HEDIS® PCR) • Nursing facility entry rate (state-defined measure derived from nursing home claim data currently integrated into the State's ICDB) • Mortality rates (state-defined measure derived from death certificate records currently integrated into the State's ICDB **Overall LTSS utilization and cost impact estimates.** Estimates of impacts on Medicaid-paid LTSS utilization and costs will be derived using the "synthetic estimation projection" approach described in the next section. This analysis will rely on measures of Medicaid-paid LTSS service costs and utilization derived from state agency administrative data, combined with Washington State population data derived from US Census Bureau data products (e.g., the American Community Survey), as reflected in the County Population Estimation Model maintained by the OFM Forecasting and Research Division.

List of waiver and expenditure authorities that are being requested

Washington state is not requesting any changes to federal expenditure and waiver authorities already approved in the Medicaid Transformation Project Demonstration.

Previously approved expenditure authorities:
ƒ § 1903. Authority to receive federal matching dollars for designated state health programs.
ƒ § 1903. Authority to receive federal matching dollars for payments related to transformation projects made under the Demonstration.
ƒ § 1903. Authority to receive federal matching dollars for services provided to the "At Risk" for Medicaid group.
ƒ § 1903. Authority to allow the reinvestment of state-designated shared savings towards applicable Demonstration expenditures. The amount of savings available for use under this authority will be based on the difference between the actual expenditures under the Demonstration and pre-established agreed to per capita amounts.

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

Previously approved waiver authorities:
ƒ § 1902(a)(1). Authority to operate the Demonstration on a less-than-statewide basis.
ƒ § 1902(a)(10)(B). Authority to vary the amount, duration, and scope of benefits provided to the TSOA population.
ƒ §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.
ƒ §1902(a)(10)(B). Authority to vary the amount, duration, and scope of benefits for individuals who wish to receive supportive housing and supported employment services.
ƒ §1902(a)(10)(B). Authority to limit housing-based case management to certain targeted groups of Medicaid beneficiaries.
ƒ § 1902(a)(17). Authority to allow ACHs to target transformation projects to different sub-populations.
ƒ § 1902(a)(17). Authority to target certain state-administered benefits to subpopulations.
ƒ § 1902(a)(17). Authority to apply a more liberal income and resource standard for individuals determined to be “At Risk” for future Medicaid enrollment.
ƒ § 1902(a)(17). Authority to provide the TSOA benefit package to the “At Risk” for Medicaid group.
ƒ § 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.