CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: **No. 11-W-00304/0**

TITLE: **Washington State Medicaid Transformation Project**

AWARDEE: **Washington State Health Care Authority**

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list or identified as not applicable in the accompanying expenditure authorities and/or these STCS, shall apply to the demonstration project.

The following waivers are granted under the authority of section 1115(a)(1) of the Social Security Act ("the Act") and shall enable the state to implement the Washington State Medicaid Transformation Project (MTP) section 1115 demonstration subject to the approved Special Terms and Conditions (STC).

These waivers are effective beginning January 9, 2017 through December 31, 2021and none of these waivers apply to the Substance Use Disorder (SUD) component of this demonstration.

1. Statewideness/Uniformity **Section 1902(a)(1)**
42 CFR §431.50

To the extent necessary to enable the state to make delivery system reform incentive payments—based on a regional needs assessment–that vary regionally in amount and purpose.

2. Reasonable Promptness **Section 1902(a)(8)**

To enable the state to limit the number of individuals receiving benefits through the Medicaid Alternative Care (MAC) or Tailored Support for Older Adults (TSOA) program.

To enable the state to limit the number of individuals who receive foundational community supports benefits under the demonstration.

3. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable the state to restrict freedom of choice of provider for individuals receiving benefits through the Medicaid Alternative Care (MAC) or Tailored Support for Older Adults (TSOA) program.

To the extent necessary to enable the state to restrict freedom of choice of provider for

individuals receiving who receive foundational community supports benefits under the demonstration.

4. Amount, Duration, Scope and Service **Section 1902(a)(10)(B)**

To permit the state to provide benefits for the Tailored Supports for Older Adults (TSOA) expansion population that are not available in the standard Medicaid benefit package.

To permit the state to provide benefits not available in the standard Medicaid benefit package to individuals who have elected and enrolled to receive Medicaid Alternative Care (MAC) benefits.

To permit the state to provide benefits not available in the standard Medicaid benefit package to populations specified by Accountable Communities of Health (ACH).

To permit the state to offer a varying set of benefits to beneficiaries eligible for the Foundational Community Support program.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **No. 11-W-00304/0**

TITLE: **Washington State Medicaid Transformation Project**

AWARDEE: **Washington State Health Care Authority**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall, for the period beginning January 9, 2017 through December 31, 2021, unless otherwise specified, be regarded as matchable expenditures under the state's Medicaid state plan.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Washington ("state") to operate its section 1115 Medicaid demonstration. These expenditure authorities promote the objectives of title XIX in the following ways:

a. Increase access to, stabilize, and strengthen, providers and provider networks available to serve Medicaid and low-income populations in the state;
b. Improve health outcomes for Medicaid and other low-income populations in the state; and
c. Increase efficiency and quality of care through initiatives to transform service delivery networks.

1. **Delivery System Reform Incentive Payments (DSRIP) to Accountable Communities of Health (ACH) and Partnering Providers**
   Expenditures for performance-based incentive payments to regionally-based Accountable Communities of Health (ACH) and their partnering providers to address health systems and community capacity; financial sustainability through participation in value-based payment; Bi-directional integration of physical and behavioral health; community-based whole person care; improve health equity and reduce health disparities.

2. **Delivery System Reform Incentive Payments (DSRIP) to Managed Care Organizations**
   Expenditures for DSRIP payments to managed care organizations.

3. **Medicaid Alternative Care (MAC) Unpaid Caregiver Supports**
   Expenditures for costs to support unpaid caregivers serving individuals who are receiving MAC benefits.

4. **Medicaid Alternative Care (MAC) Services for Eligible Individuals**
   Expenditures for individuals age 55 and older who are eligible for the standard Medicaid benefit package, meet the functional eligibility criteria for HCBS under the state plan, but elect, instead, to receive MAC services specified in Section VI.

5. **Tailored Support for Older Adults (TSOA) Unpaid Caregiver Supports**
   Expenditures for costs to support unpaid caregivers serving individuals who are receiving TSOA benefits.

6. **Tailored Support for Older Adults (TSOA) for Eligible Individuals**
   Expenditures for services that are an alternative to long-term care services and supports for individuals age 55 or older who are not otherwise eligible for CN or ABP Medicaid, meet functional eligibility criteria for HCBS under the state plan, and have income up to 300 percent of the supplemental security benefit rate established by section 1611(b)(1) of the Act.

7. **Presumptive Eligibility for MAC and TSOA**
   Expenditures for each individual presumptively determined to be eligible for MAC or TSOA services, during the presumptive eligibility period described in STC 54. In the event the state implements a waitlist, the authority for presumptive eligibility terminates.

8. **Designated State Health Programs (DSHP)**
   Expenditures for the Designated State Health Programs (DSHP) specified in STC 91.

9. **Foundational Community Supports**
   Expenditures for home and community-based services (HCBS) and related services as described in Section VII.

10. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD).** Effective as of the date of the SUD demonstration amendment approval letter through December 31, 2021, expenditures for otherwise covered services furnished to otherwise eligible 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).

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00304/0

TITLE: Washington State Medicaid Transformation Project

AWARDEE: Washington State Health Care Authority

I. PREFACE

The following are the Special Terms and Conditions (STC) for the Washington State Medicaid Transformation Project (MTP) section 1115(a) Medicaid demonstration (hereafter "MTP" or "demonstration") to enable the Washington State (hereafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of certain Medicaid requirements, and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs further set forth in detail the nature, character, and extent of federal involvement in the demonstration, the state's implementation of the expenditure authorities and the state's obligations to CMS during the demonstration period. The effective date of the demonstration is January 9, 2017 and is approved through December 31, 2021unless otherwise stated. The Substance Use Disorder (SUD) component of this demonstration is effective as of the date of the SUD demonstration amendment approval letter through December 31, 2021.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description And Objectives
III. General Program Requirements
IV. Populations Affected by the Demonstration
V. Delivery System Reform Program
VI. Long Term Services & Supports
VII. Foundation Community Supports
VIII. General Reporting Requirements
IX. Substance Use Disorder Program and Benefits
X. General Financial Requirements
XI. Designated State Health Programs (DSHP)
XII. Monitoring Budget Neutrality
XIII. Evaluation of the Demonstration
XIV. Schedule of State Deliverables for the Demonstration Period
Attachment A: Quarterly Report Template
Attachment B: DSHP Claiming Protocol
Attachment C: DSRIP Planning Protocol
Attachment D: DSRIP Program Funding & Mechanics Protocol

Attachment E: Value-Based Roadmap (Original)
Attachment F: Financial Executor Role
Attachment G: Intergovernmental Transfer (IGT) Protocol
Attachment H: Tribal Engagement and Collaboration Protocol
Attachment I: Foundational Community Supports Protocol
Attachment J: Evaluation Design
Attachment K: SUD Implementation Plan Protocol
Attachment L: Reserved for SUD Monitoring Protocol
Attachment M: Health IT Protocol

II. PROGRAM DESCRIPTION AND OBJECTIVES

This demonstration aims to transform the health care delivery system through regional, collaborative efforts led by Accountable Communities of Health (ACH). It will test changes to payment, care delivery models and targeted services.

Over the next five years, Washington will:

- Integrate physical and behavioral health purchasing and service delivery to better meet whole person needs;
- Convert 90 percent of Medicaid provider payments to reward outcomes instead of volume;
- Support provider capacity to adopt new payment and care models;
- Implement population health strategies that improve health equity; and
- Provide new targeted services that address the needs of the state's aging populations and address key determinants of health

The demonstration will provide up to $994 million (total computable) in the form of incentive payments to providers tied to projects coordinated by ACHs, based on achievement of milestones and outcomes. Delivery System Reform Incentive Payment (DSRIP) incentives under this demonstration are time-limited and the project design will reflect a priority for financial sustainability beyond the demonstration period.

ACHs are regionally situated, self-governing organizations with non-overlapping geographic boundaries that also align with Washington's regional service areas for Medicaid purchasing. ACHs are composed of managed care, provider, and many other community organizations and are focused on improving health and transforming care delivery for the populations that live within their region. ACHs are not new service delivery organizations and do not provide direct services nor are they a replacement of managed care. ACHs will lead strategies consistent with the transformation objectives based on a regional needs assessment. ACHs will be responsible for certifying achievement of milestones and performance metrics for payment to partnering providers. Managed care organizations (MCO) will continue to serve the majority of Medicaid enrollees in the provision and coordination of State Plan services and will be incentivized to implement value based payment strategies.

The state will also offer a new Medicaid Alternative Care (MAC) benefit package for individuals eligible for Medicaid but not currently receiving Medicaid-funded long-term services and

supports (LTSS). This benefit package will provide another community-based option for clients and their families to choose, which will help them avoid or delay more intensive Medicaid-funded services by supporting their unpaid caregivers. In addition to the MAC benefits, the State will also engage in activities to support unpaid family caregivers who serve MAC beneficiaries. Similar to the MAC benefit package, the state will also establish a new eligibility category and limited benefit package termed Tailored Supports for Older Adults (TSOA). TSOA will be for individuals "at risk" of future Medicaid LTSS use and who do not currently meet Medicaid financial eligibility criteria.

The State will offer a Foundational Community Supports Program to eligible beneficiaries. Under this program, the state will provide a set of HCBS that includes one-time community transition services to individuals moving from institutional to community settings and those at imminent risk of institutional placement, in addition to HCBS that could otherwise be provided to the individual under a 1915(c) waiver or 1915(i) SPA.

In addition, the state will implement initiatives to improve existing substance use disorder services. Initiatives will ensure the appropriate level of treatment is provided, increase the availability of medication assisted treatment (MAT), and enhance coordination between levels of care. The State will continue offering a full range of substance use disorder (SUD) treatment options using American Society for Addiction Medicine (ASAM) criteria for assessment and treatment decision making.

On [date], CMS approved a Corrective Action Plan (CAP) which included, among other changes, revised expenditure limits beginning in 2019 (see Section X and Attachment N).

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (which are a part of these terms and conditions), must apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, court order, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
   a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures

made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.

b) If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **Changes Subject to the Amendment Process**. Changes related to demonstration features such as eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these demonstration elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 6 below.

6. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS in writing for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

   a) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

   b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure limit;

   c) An explanation of the public process used by the state consistent with the requirements of STC 14; and

   d) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

7. **Extension of the Demonstration**. States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 Code of Federal Regulations (CFR) §431.412(c) or a transition and

phase-out plan consistent with the requirements of STC 8.

8. **Demonstration Phase Out.** The state may only suspend or terminate this demonstration, in whole or in part, at any time prior to the date of expiration consistent with the following requirements:
   a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the effective date and reason(s) for the suspension or termination. At least six months before the effective date of the demonstration's suspension or termination, the state must submit to CMS its proposed transition and phase-out plan, together with intended notifications to demonstration enrollees. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with the requirements of STC 14. Once the 30-day public comment period has ended, the state must provide a summary of public comments received, the state's response to the comments received, and how the state incorporated the comments received into the transition and phase-out plan submitted to CMS.
   b) Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently enrolled or determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.
   c) Phase-out Plan Approval: The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.
   d) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, §431.210 and §431.213. In addition, the state must assure all appeal and hearing rights are afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as found in 42 CFR §435.916.
   e) Exemption from Public Notice Procedures 42 CFR §431.416(g): CMS may expedite federal and state public notice requirements in accordance with the circumstances described in 42 CFR §431.416(g).
   f) Enrollment Limitation during Demonstration Phase-Out: If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended.
   g) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs

associated with terminating the demonstration including services and administrative costs of disenrolling participants.

9. **CMS Right to Amend, Suspend, or Terminate.** CMS may amend, suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing, that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the amendment, suspension or termination, together with the effective date.

10. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in an amount up to $5,000,000 per deliverable (federal share) when deliverables are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. The state does not relinquish its rights to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

    a) Thirty days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

    b) The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

    c) For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Should CMS agree to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

    d) When the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in the STCs, the deferral(s) will be released.

    e) As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for extension, amendment or renewal, or for a new demonstration.

    f) If applicable, CMS will consider with the state an alternative set of operational steps for implementing the intended deferral associated with this demonstration to align the process with any existing deferral process the state is undergoing (e.g., the quarter the deferral applies to and how the deferral is released).

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

12. **Withdrawal of Waiver/Expenditure Authority.** CMS reserves the right to amend or withdraw waiver and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the state in writing of the determination and the reasons for the amendment or withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems applicable to the demonstration; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

14. **Public Notice, Tribal Consultation and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR §431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the public notice procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

    A state with Federally-recognized Indian Tribes, Indian Health Programs, and/or Urban Indian Health Organizations must comply with the tribal consultation requirements set forth in section 1902(a)(73) of the Act and implemented in regulation at 42 CFR §431.408(b) or the tribal consultation requirements contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 6 or extension, are proposed by the state.

15. **Federal Financial Participation (FFP).** No federal matching for administrative or medical assistance payments for services provided under this demonstration will take effect until the effective date identified in the CMS demonstration approval documents.

IV. POPULATIONS AFFECTED BY THE DEMONSTRATION

16. **Eligibility Groups Affected By the Demonstration.** All individuals eligible under the Medicaid State Plan are affected by the demonstration. Such individuals derive their eligibility through the Medicaid State Plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived in this demonstration and described in these STCs. In addition, this demonstration extends eligibility to one demonstration expansion population. Specifically, this demonstration affects:

    a. All individuals who are currently eligible under the state's Medicaid State Plan; and

b. Individuals eligible for Tailored Supports for Older Adults (TSOA) who are not otherwise eligible for CN or ABP Medicaid, age 55 or older, meet functional eligibility criteria for Home and Community Based Services (HCBS) under the state plan or 1915(c), and have income up to 300% of the supplemental security benefit rate established by section 1611(b)(1) of the Act.

V. DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM

This demonstration authorizes Accountable Communities of Health (ACHs) to coordinate and oversee regional projects aimed at improving care for Medicaid beneficiaries with a focus on building health systems capacity, care delivery redesign, prevention, and health promotion, and preparing for value-based payments.

ACHs are self-governing organizations with multiple community representatives defined in STC 20, that address care in regions with non-overlapping boundaries that also align with Washington's regional service areas for Medicaid purchasing. They are focused on improving health and transforming care delivery for the populations that live within the region. ACHs are not new service delivery organizations, do not provide direct services, nor are they a replacement of managed care. ACHs must be headquartered in the region they serve and include in their governing bodies representatives of managed care organizations, health care providers, and other relevant organizations within the region (see STC 20). Managed care organizations (MCOs) will continue in their current roles, serving the majority of Medicaid enrollees in the provision and coordination of State Plan services and will be incentivized to implement value-based payment strategies.

ACHs, through their governing bodies, are responsible for managing and coordinating the partnering providers. The ACHs must meet the qualifications set forth in STCs 19-22 and must meet certain targets to earn incentive payments. In addition, they will certify whether or not the partnering providers have met the milestones as required for earning incentive payments within their region. The ACH will certify to the independent assessor (see STC 18) whether or not partnering providers have achieved the milestones. The independent assessor will review the ACH's certification and make recommendations to the state related to distribution of payment. Once the state affirms the recommendations from the independent assessor, the state will send them to the financial executor to distribute incentive payments to the partnering ACH providers.

Incentive payments for partnering providers and the ACHs will transition from pay-for-reporting to outcome-based over the course of the demonstration. The performance of this initiative will be measured at the statewide and regional ACH level, and incentive payments will be paid out accordingly. The maximum allowable expenditures available for total ACH incentive payments are enumerated in STC 43 below (see Table 2). The state will allocate total funds across the ACHs based on a CMS-approved methodology to be submitted in the DSRIP Program Funding and Mechanics Protocol (Attachment D). Each regional ACH includes a coalition of partnering providers, and the ACH primary decision-making body will apply on behalf of partnering providers for such incentive payments as a single ACH.

17. **Role of Independent Assessor.** The state will contract with an independent assessor to review ACH project proposals using the state's review tool and consider anticipated project performance. The independent assessor has no affiliation with the ACHs or their partnering providers. The independent assessor shall make recommendations to the state regarding approvals, denials or recommended changes to project plans to make them approvable. This entity (or another entity identified by the state) will also assist with the mid-point assessment and any other ongoing reviews of ACH Project Plan.

    a. **Review tool**. The state will develop a standardized review tool that the independent assessor will use to review ACH Project Plans and ensure compliance with these STCs and associated protocols. The review tool will be available for public comment according to the timeframe specified in the Program Funding and Mechanics Protocol (Attachment D). The review tool will define the relevant factors, assign weights to each factor, and include a scoring for each factor.

    b. **Mid-point assessment.** During DY 3, the state's independent assessor shall assess project performance to determine whether ACH Project Plans merit continued funding and provide recommendations to the state. If the state decides to discontinue specific projects, the project funds may be made available for expanding successful project plans in DY 4 and DY 5, as described in the Program Funding and Mechanics Protocol (Attachment D).

18. **ACH Management.** Each ACH must identify a primary decision-making process, a process for conflict resolution and structure (e.g., a Board or Steering Committee) that is subject to the outlined composition and participation guidelines. The primary decision-making body will be the final decision-maker for the ACH regarding the selection of projects and participants based on the regional needs assessment. Each ACH and the state will collaborate and agree on each ACH's approach to its decision-making structure for purposes of this demonstration. The overall organizational structure established by the ACH must reflect capability to make decisions and be accountable for the following five domains, at a minimum. The ACH must demonstrate compliance with this STC in the ACH Project Plan.

    a. *Financial*, including decisions about the allocation methodology, the roles and responsibilities of each partner organization, and budget development.
    b. *Clinical*, including appropriate expertise and strategies for monitoring clinical outcomes. The ACH will be responsible for monitoring activities of providers participating in care delivery redesign projects and should incorporate clinical leadership, which reflects both large and small providers and urban and rural providers.
    c. *Community*, including an emphasis on health equity and a process to engage the community and consumers.
    d. *Data*, including the processes and resources to support data-driven decision making and formative evaluation.
    e. *Program management and strategy development.* The ACH must have organizational capacity and administrative support for regional coordination and communication on behalf of the ACH.

19. **ACH Composition and Participation.** At a minimum, each ACH decision-making body must include voting partners from the following categories:

a. One or more primary care providers, including practices and facilities serving Medicaid beneficiaries;
b. One or more behavioral health providers, including practices and facilities serving Medicaid beneficiaries;
c. One or more health plans, including but not limited to Medicaid Managed Care Organizations; if only one opening is available for a health plan, it must be filled by a Medicaid Managed Care Organization;
d. One or more hospitals or health systems;
e. One or more local public health jurisdiction;
f. One or more representatives from the tribes, IHS facilities, and UIHPs in the region, as further specified in STC 22;
g. Multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in the region. This includes, but is not limited to, transportation, housing, employment services, education, criminal justice, financial assistance, consumers, consumer advocacy organizations, childcare, veteran services, community supports, legal assistance, etc.

The ACHs must create and execute a consumer engagement plan as part of the ACH Project Plan. The consumer engagement plan will detail the multiple levels of the decision-making process to ensure ACHs are accurately assessing local health needs, priorities and inequities. As part of the ACH Project Plan ACHs must provide documentation of at least two public meetings held for purposes of gathering public comment and must also provide details for how their submitted project plan incorporates feedback from the public comment process.

To ensure broad participation in the ACH and prevent one group of ACH partners from dominating decision-making, at least 50 percent of the primary decision-making body must be non-clinic, non-payer participants. In addition to balanced sectoral representation, where multiple counties exist within an ACH, a concerted effort to include a person from each county on the primary decision-making body must be demonstrated.

20. **American Indians/Alaska Natives (AI/AN) Managed Care Protections.** This section 1115 demonstration will not alter the statutory exemption of AI/ANs from requirements to enroll in managed care, or alter the requirements for the state and managed care entities to come into compliance with the Medicaid Managed Care Regulations published April 26, 2016, including the Indian-specific provisions at 42 CFR §438.14.

21. **Indian Health Care Providers.**

1. The state will assure compliance by the state itself and by any managed care or ACH contractor with the requirements of section 1911 of the Social Security Act and 25 U.S.C. § 1647a(a)(1), to accept an entity that is operated by IHS, an Indian tribe, tribal organization, or urban Indian health program as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as

any other provider qualified to participate as a provider of health care services under the program, if the entity attests that it meets generally applicable State or other requirements for participation as a provider of health care services under the program.

2. The state will assure compliance by the state itself and by any managed care or ACH contractor with the requirements of 25 U.S.C. § 1621t, to licensed health professionals employed by the IHCP shall be exempt from the Washington State licensure requirements if the professionals are licensed in another state and are performing the services described in the contract or compact of the Indian health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

22. Tribal Engagement and Collaboration Protocol. The state, with tribes, IHS facilities, and urban Indian Health Programs, must develop and submit to CMS for approval a Tribal Engagement and Collaboration Protocol (Attachment H) no later than 60 calendar days after demonstration approval date. Once approved by CMS, this document will be incorporated as Attachment H of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved expenditure and waiver authorities and STCs.

ACHs will be required to adopt either the State's Model ACH Tribal Collaboration or Communication Policy or a policy agreed upon in writing by the ACH and every tribe and Indian Health Care Provider (IHCP) in the ACH's region. The model policy establishes minimum requirements and protocols for the ACH to collaborate and communicate in a timely and equitable manner with tribes and Indian healthcare providers.

In addition to adopting the Model ACH Tribal Collaboration and Communication Policy, ACH governing boards must make reasonable efforts to receive ongoing training on the Indian health care delivery system with a focus on their local tribes and IHCPs and on the needs of both tribal and urban Indian populations.

Further specifications for engagement and collaboration in Medicaid transformation between (a) tribes, IHS facilities, and urban Indian health programs and (b) ACHs and the state, will be described by the Tribal Engagement and Collaboration Protocol (Attachment H). At a minimum, the Tribal Engagement and Collaboration Protocol must include the elements listed below:

a. Outline the objectives that the state and tribes seek to achieve tribal specific interests in Medicaid transformation; and
b. Specify the process, timeline and funding mechanics for any tribal specific activities that will be included as part of this demonstration, including the potential for financing the tribal specific activities through alternative sources of non-federal share.

23. Tribal Coordinating Entity. The federal government and the State have federal trust responsibility to support tribal sovereignty and to provide health care to tribal members and their descendants. Part of this trust responsibility involves assessing this demonstration for impacts, including unintended consequences, on affected IHCPs and AI/AN. The state will

facilitate a tribal coordinating entity (TCE) controlled by tribes and Urban Indian Organizations (as defined in 25 U.S.C. § 1603(29)) for purposes of facilitating appropriate engagement and coordination with tribal governments and communicating advice and feedback from Indian Health Care Providers (IHCPs) (as defined in 42 C.F.R. § 438.14(a)) to the state on matters related to this demonstration. The state will work with the TCE:

1. To provide opportunity to review programs and projects implemented through delivery system reform efforts within this demonstration;
2. For the TCE to coordinate with affected tribes and IHCPs to provide an assessment of potential impacts as a result of delivery system reform activities within this demonstration on affected IHCPs and AI/AN populations and report these assessments to CMS, the ACHs, and the State;
3. To coordinate with tribes and IHCPs to establish a cross-walk of statewide common performance measures to the GPRA measures used by tribes and IHCPs; and
4. To support other tribal-specific projects implemented through this demonstration to the extent appropriate.

24. Tribal Specific Projects. Consistent with the government-to-government relationship between the tribes and the State, tribes, IHCPs, or consortia of tribes and IHCPs can apply directly through the State to receive funding for eligible tribal specific projects. Tribes and IHCPs will not be required to apply for tribal specific projects through ACHs or the TCE, and the TCE and ACHs will not participate in the approval process for tribal specific projects.

1. Indian Health Care Provider Health Information Technology Infrastructure. The state will work with the tribes and IHCPs to develop a tribal specific project, subject to CMS approval, that will enhance capacity to: (i) effectively coordinate care between IHCPs and non-IHCPs, (ii) support interoperability with relevant State data systems, and (iii) support tribal patient-centered medical home models (e.g., IHS IPC, NCQA PCMH, etc.).

2. Other Tribal Specific Projects. The state will work with tribes on tribal specific projects, subject to CMS approval, that align with the objectives of this demonstration, including requirements that projects reflect a priority for financial sustainability beyond the demonstration period.

3. The Tribal Engagement and Collaboration Protocol (Attachment H) will provide further specifications for process, timeline and funding mechanics for any tribal specific projects that will be included as part of this demonstration. To the extent applicable, the Tribal Engagement and Collaboration Protocol must align with project requirements set forth in these STCs.

25. Financial Executor. In order to assure consistent management of and accounting for the distribution of DSRIP funds across ACHs, the state shall select through a procurement process a single Financial Executor. The Financial Executor will be responsible for administering the funding distribution plan for the DSRIP that specifies in advance the methodology for distributing funding to providers partnering with the ACHs. The funding

methodology will be described in the DSRIP Program Funding and Mechanics Protocol (Attachment D) and submitted to CMS for approval.

1. The Financial Executor will perform the following responsibilities: (a) provide accounting and banking management support for DSRIP incentive dollars; (b) distribute earned funds in a timely manner to participating providers in accordance with the state approved funding distribution plans; (c) submit scheduled reports to the state on the actual distribution of transformation project payments, fund balances and reconciliations; and (d) develop and distribute budget forms to participating providers for receipt of incentive funds (see Attachment G).[1] Financial Executor performance will be subject to audit by the state.

2. The distribution of funds must comply with all applicable laws and regulations, including, but not limited to, the following federal fraud and abuse authorities: the anti-kickback statute (sections 1128B(b)(1) and (2) of the Act); the physician self-referral prohibition (section 1903(s) of the Act); the gainsharing civil monetary penalty (CMP) provisions (sections 1128A(b)(1) and (2) of the Act); and the beneficiary inducement CMP (section 1128A(a)(5) of the Act). State approval of an ACH funding distribution plan does not alter the responsibility of ACHs to comply with all federal fraud and abuse requirements of the Medicaid program.

26. Attribution Based On Residence. The state will use defined regional service areas, which do not have overlapping boundaries, to determine populations for each ACH. Determination will be made based on beneficiary residence. There is only one ACH per regional service area, as described in the DSRIP Program Funding and Mechanics Protocol (Attachment D).

27. ACH Provider Agreements under DSRIP. In addition to the requirements specified in the DSRIP Program Funding and Mechanics Protocol (Attachment D), ACHs must establish a partnership agreement between the providers participating in projects.

28. Project Objectives. ACHs will design and implement projects that further the objectives, which are elaborated further in the DSRIP Planning Protocol (Attachment C).

a. *Health Systems and Community Capacity.* Creating appropriate health systems capacity in order to expand effective community based-treatment models; reduce unnecessary use of intensive services and settings without impairing health outcomes; and support prevention through screening, early intervention, and population health management initiatives.

b. *Financial Sustainability through Participation in Value-based Payment.* Medicaid transformation efforts must contribute meaningfully to moving the state forward on value-based payment (VBP). Paying for value across the continuum of Medicaid services is necessary to assure the sustainability of the transformation projects undertaken through the Medicaid Transformation Demonstration. For this reason, ACHs will be required to design project plan activities that enable the success of Alternative Payment Models

[1] For a comprehensive description of the Financial Executor role, see Attachment G.

required by the state for Medicaid managed care plans (see Table 1 under STC 40 for the APM goals per DY).

c. *Bi-directional Integration of physical and behavioral health.* Requiring comprehensive integration of physical and behavioral health services through new care models, consistent with the state's path to fully integrated managed care by January 2020. Projects may include: co-location of providers; adoption of evidence-based standards of integrated care; and use of team-based approaches to care delivery that address physical, behavioral and social barriers to improved outcomes for all populations with behavioral health needs. Along with directly promoting integration of care, the projects will promote infrastructure changes by supporting the IT capacity and protocols needed for integration of care, offering training to providers on how to adopt the required changes; and creating integrated care delivery protocols and models. The state will provide increased incentives for regions that commit to and implement fully integrated managed care prior to January 2020.

d. *Community-based Whole-person Care.* Use or enhance existing services in the community to promote care coordination across the continuum of health for beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health. In addition, develop linkages between providers of care coordination by utilizing a common platform that improves communication, standardizes use of evidence-based care coordination protocols across providers, and to promote accountable tracking of those beneficiaries being served. Projects will be designed and implemented to promote evidence-based practices that meet the needs of a region's identified high-risk, high-needs target populations.

e. *Improve Health Equity and Reduce Health Disparities.* Implement prevention and health promotion strategies for targeted populations to address health disparities and achieve health equity. Projects will require the full engagement of traditional and non-traditional providers, and project areas may include: chronic disease prevention, maternal and child health, and access to oral health services, and the promotion of strategies to address the opioid epidemic.

29. Project Milestones. Progress towards achieving the goals specified above will be assessed based on achievement of specific milestones and measured by specific metrics that are further defined in the DSRIP Planning Protocol (Attachment C). These milestones are to be developed by the state in consultation with stakeholders and members of the public and approved by CMS. Generally, progress milestones will be organized into the following categories:

1. *Project planning progress milestones.* This includes plans for investments in technology, tools, stakeholder engagement, and human resources that will allow ACHs to build capacity to serve target populations and pursue ACH project goals in accordance with community-based priorities. Performance will be measured by a common set of process milestones that include project development plans, consistency with statewide goals and

metrics, and demonstrated engagement from relevant providers who commit to participate in project plan activities.

2. *Project implementation progress milestones*. This includes milestones that demonstrate progress towards process-based improvements, as established by the state, in the implementation of projects consistent with the demonstration's objectives of building health and community systems capacity; promoting care delivery redesign through bi-directional integration of care and care coordination; and fostering health equity through prevention and health promotion. Examples of progress milestones include: identify number of providers and practices implementing evidence-based and promising practices for integration; complete a plan for regional implementation of fully integrated managed care. In addition, performance will be monitored by project-level and system-wide outcome measures consistent with the objectives of the demonstration outlined in STC 29 and specific project area.

3. *Scale and sustain progress milestones.* This includes milestones that demonstrate project implementation progress, as established by the state, related to efforts to scale and sustain project activities in pursuit of the demonstration objectives. Performance will be monitored by project-level and system-wide outcome measures consistent with the objectives of the demonstration outlined in STC 29 and specific project areas. The state will identify a sub-set of project-level and system-wide measures that will transition to pay for performance. The identification of measures that transition and the timing of transition to pay for performance will be outlined in the DSRIP Planning Protocol (Attachment C).

30. ACH Performance Indicators and Outcome Measures. The state will choose performance indicators and outcome measures that are connected to the achievement of the goals identified in STC 29 and in the DSRIP Planning Protocol (Attachment C). The DSRIP performance indicators and outcome measures will comprise the list of reporting measures that the state will be required to report under each of the DSRIP projects.

The state and CMS will accept GPRA measures in lieu of comparable statewide common performance measures when such substitution will reduce duplicative reporting and avoid excessive administrative burdens on tribes and IHCPs.

31. MCO Role in DSRIP. Managed care organizations are expected to serve in leadership or supportive capacity in every ACH. This ensures that delivery system reform efforts funded under this demonstration are coordinated from the beginning across all necessary sectors – those providing payment, those delivering services and those providing critical, community-based supports. Managed care organizations have the following roles and responsibilities under this demonstration:

a. Continue to meet all contractual requirements for the provision and coordination of Medicaid state plan services, including utilization management, care coordination and any new requirements consistent with the Medicaid transformation demonstration.
b. Participate in the design and implementation of delivery system reform projects

c. Actively provide leadership in every Accountable Community of Health where a MCO is providing services, whether through participation in governance or other supportive capacity.
d. Collaborate with provider networks to implement value-based payment models, aligned to the HCP-LAN framework and report on the status of those arrangements to the state when requested,
e. Ensure business approaches evolve to sustain new models of care delivery and population health management, during and beyond the five-year demonstration.

MCOs are expected to participate in delivery system reform efforts as a matter of business interest and contractual obligation to the state, and for this reason, do not receive incentive payments for participation in ACH-led transformation projects, with one exception. A portion of delivery system reform incentives is uniquely set aside to reward managed care plan attainment of value-based payment models, consistent with STC 40a). The incentive amounts are further defined in the DSRIP Planning Protocol (Attachment C), the DSRIP Program Funding and Mechanics Protocol (Attachment D) and the Roadmap (Attachment F).

32. DSRIP Planning Protocol. The state must develop and submit to CMS for approval a DSRIP Planning Protocol no later than 60 calendar days after the demonstration approval date. CMS has 60 calendar days to review and approve the protocol. Once approved by CMS, this document will be incorporated as Attachment C of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved expenditure authorities and STCs. Changes to the protocol will apply prospectively unless otherwise indicated in the protocols. The DSRIP Planning Protocol must:

a. Outline the global context, goals and outcomes that the state seeks to achieve through the combined implementation of individual projects by ACHs;
b. Detail the requirements of the ACH Project Plans, consistent with STC 35, which must include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance;
c. Specify a set of outcome measures that must be reported at the ACH level, regardless of the specific projects that they choose to undertake;
d. Include required baseline and ongoing data reporting, assessment protocols, and monitoring/evaluation criteria aligned with the evaluation design and the monitoring requirements in section XI of the STCs.
e. Include a process that allows for potential ACH Project Plan modification (including possible reclamation, or redistribution, pending state and CMS approval) and an identification of circumstances under which a plan modification may be considered, which shall stipulate that the state or CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved.
f. When developing the DSRIP Planning Protocol, the state should consider ways to structure the different projects and demonstrate that it will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation

Design required in section XII of the STCs. Participating ACHs will use the same metrics for similar projects to enhance evaluation and learning experience between ACHs.

33. DSRIP Program Funding and Mechanics Protocol. The state must develop a DSRIP Program Funding and Mechanics Protocol to be submitted to CMS for approval no later than 60 days after the demonstration approval date. CMS has 60 days to review and approve the protocol. Once approved by CMS, this document will be incorporated as Attachment D of these STCs and, once incorporated, may be altered only with CMS approval, and only to the extent consistent with the approved expenditure authorities and STCs. Changes to the protocol will apply prospectively, unless otherwise indicated in the protocols. DSRIP payments for each ACH partnering provider are contingent on the partnering providers fully meeting project metrics defined in the approved ACH Project Plan. In order for providers to receive incentive funding relating to any metric, the ACH must submit all required reporting, as outlined in the DSRIP Program Funding and Mechanics Protocol (Attachment D). In addition, the DSRIP Program Funding and Mechanics Protocol must:

1. Describe and specify the role and function of a standardized ACH report to be submitted to the state on a quarterly basis that outlines a status update on the ACH Project Plan, as well as any data or reports that ACHs may be required to submit baseline information and substantiate progress. The state must develop a standardized reporting form for the ACHs to document their progress.
2. Specify an allocation formula across ACHs based on covered Medicaid lives per ACH, scale of project, type of project, level of impact on beneficiaries, number of providers, and other factors;
3. Specify parameters for an incentive payment formula to determine DSRIP incentive payments commensurate with the value, impact, and level of effort required, to be included in the ACH budget plan.
4. Specify that an ACH failure to fully meet a performance metric or non-compliance under its ACH Project Plan within the time frame specified will result in a forfeiture of the associated incentive payment.
5. Include a description of the state's process to develop an evaluation plan for DSRIP as a component of the draft evaluation design as required by STC 116.
6. Ensure that payment of funds allocated in an ACH Project Plan to outcome measures will be contingent on the ACH certifying and reporting DSRIP performance indicators to the state via the independent assessor and on the ACH meeting a target level of improvement in the DSRIP performance indicator relative to baseline. A portion of the funds allocated in DSRIP Year 3 and DSRIP Year 4, and a majority of funds allocated in DSRIP Year 5, must be contingent on meeting a target level of improvement. ACH partnering providers may not receive credit for metrics achieved prior to approval of their ACH Project Plans.
7. Require that, for DSRIP years 4 and 5, all incentive dollars are contingent upon the state achieving fully integrated managed care by January 2020 for physical and behavioral health services. The state will report on progress toward this outcome on its annual report.
8. Include criteria and methodology for project valuation, including a range of available incentive funding per project.
9. Include pre-project plan milestones for capacity-building incentive payments.

34. ACH Project Plans. ACHs must develop a Project Plan that is consistent with the transformation objectives of this demonstration and describes the steps the ACH will take to achieve those objectives. The plan must be based on the DSRIP Planning Protocol (Attachment C), and further developed by the ACH to be directly responsive to the needs and characteristics of the communities that it serves. In developing its ACH Project Plan, an ACH must solicit and incorporate community and consumer input to ensure it reflects the specific needs of its region. ACH Project Plans must be approved by the state and may be subject to additional review by CMS. In accordance with the schedule outlined in these STCs and the process described further in the DSRIP Program Funding and Mechanics Protocol (Attachment D), the state and the assigned independent assessor must review and approve ACH Project Plans in order to authorize DSRIP funding for DY1 and DY 2 and must conduct ongoing reviews of ACH Project Plans as part of a mid-point assessment in order to authorize DSRIP funding for DY 3-5. The state is responsible for conducting these reviews for compliance with approved protocols. The independent assessor recommendations should be considered final and not subject to CMS review. The DSRIP Planning Protocol (Attachment C) will provide a structured format for ACHs to use in developing their ACH Project Plan submission for approval. At a minimum, it will include the elements listed below.

a. Each ACH Project Plan must identify the target populations, projects, and specific milestones for the proposed project, which must be chosen from the options described in the approved DSRIP Planning Protocol (Attachment C).
b. Goals of the ACH Project Plan should be aligned with each of the objectives as described in STC 29 of this section.
c. Milestones should be organized as described above in STCs 28-29 of this section reflecting the overall goals of the demonstration and subparts for each goal as necessary.
d. The ACH Project Plan must describe the needs being addressed and the proposed period of performance, beginning after January 9, 2017.
e. Based on the proposed period of performance, the ACH must describe its expected outcome for each of the projects chosen. ACHs must also describe why the ACH selected the project drawing on evidence for the potential for the interventions to achieve these changes.
f. The ACH Project Plan must include a description of the processes used by the ACH to engage and reach out to stakeholders including a plan for ongoing engagement with the public, based on the process described in the DSRIP Planning Protocol (Attachment C).
g. ACHs must demonstrate how the projects support sustainable delivery system transformation for the target populations. The projects must implement new, or significantly enhance existing, health care initiatives.
h. For each stated goal or objective of a project, there must be an associated outcome metric that must be reported in all years. The initial ACH Project Plan must include baseline data on all applicable quality improvement and outcome measures.
i. ACH Project Plans must include an ACH Budget Plan, which specifies the allocation of funding proposed for each metric and milestone. ACHs may not receive credit for metrics achieved prior to approval of their ACH Project Plans.

35. **Monitoring.** The independent assessor and the state will be actively involved in ongoing monitoring of ACH projects, including but not limited to the following activities.

    a. **Review of milestone achievement.** At least two times per year, ACHs seeking payment for providers under the DSRIP program shall submit reports to the state demonstrating progress on each of their projects as measured by project-specific milestones and metrics achieved during the reporting period. The reports shall be submitted using the standardized reporting form approved by the state. Based on the reports, the Independent Assessor will calculate the incentive payments for the progress achieved according to the approved ACH Project Plan. The Independent Assessor's determination shall be considered final. The ACH shall have available for review by the state, upon request, all supporting data and back-up documentation. These reports will serve as the basis for authorizing incentive payments to providers for achievement of DSRIP milestones.

    b. **Quarterly DSRIP Operational Protocol Report**. The state shall provide quarterly updates to CMS and the public on the operation of the DSRIP program. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration and whether there has been progress toward the goals of the demonstration. The reports will document key operational and other challenges, to what they attribute the challenges and how the challenges are being addressed, as well as key achievements and to what conditions and efforts they attribute the successes.

    c. **Learning collaboratives.** With funding available through this demonstration, the state will support regular learning collaboratives, which will be a required activity for all ACHs.

    d. **Additional progress milestones for at risk projects**. Based on the information contained in the ACH semi-annual report or other monitoring and evaluation information collected, the state may identify particular projects as being "at risk" of not successfully completing its ACH project in a manner that will result in meaningful delivery system transformation. Projects that remain "at risk" are likely to be discontinued at the midpoint assessment.

    e. **Annual discussion.** In addition to regular monitoring calls, the State shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned.

36. **Data.** The state shall make the necessary arrangements to assure that the data required from the ACHs and from other sources, are available as required by the CMS approved DSRIP Planning Protocol (Attachment C).

37. **Health IT.** The state will use Health Information Technology ("Health IT") to link services and core providers across the continuum of care to the greatest extent possible. The state is expected to achieve minimum standards in foundational areas of Health IT and to develop its

own goals for the transformational areas of Health IT use. The state will discuss how it plans to meet the Health IT goals/milestones outlined below in the DSRIP Planning Protocol (see STC 34 and Attachment C). Through quarterly reporting, the state will further enumerate how it has, or intends to, meet the stated goals

1. The state must have plans with achievable milestones for Health IT adoption or health information exchange for providers both eligible and ineligible for the Medicaid Electronic Health Records (EHR) Incentive Programs and execute upon that plan.
2. The state shall create a pathway, or a plan, for the exchange of clinical health information for Medicaid consumers statewide to support the demonstration's program objectives.
3. The state shall advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing state policies—and in all applicable state procurements (e.g. including managed care contracts).

    1. Where there are opportunities at the state and provider level to leverage federal Medicaid funds that could use a standard referenced in 45 CFR §170, the state must adopt it.
    2. Where there are opportunities at the state and provider level to leverage federal Medicaid funds that could use a standard not already referenced in 45 CFR §170 but are included in the ISA, the state should attempt to use the federally-recognized ISA standards barring no other compelling state interest.

4. The state shall require the electronic exchange of clinical health information, utilizing the Consolidated Clinical Document Architecture (C-CDA), with all members of the interdisciplinary care. The state will provide a Health IT strategy by April 1, 2017 that details existing HIT capabilities that support this goal, and develop a mutually-agreed upon timeframe between CMS and the state for any identified enhancements.
5. The state shall ensure a comprehensive Medicaid enterprise master patient index that supports the programmatic objectives of the demonstration. The state will provide a Health IT strategy by April 1, 2017 that details existing HIT capabilities that support this goal, and develop a mutually-agreed upon timeframe between CMS and the state for any identified enhancements.
6. The state shall ensure a comprehensive provider directory strategy that supports the programmatic objectives of the demonstration. The state will provide a Health IT strategy by April 1, 2017 that details existing HIT capabilities that support this goal, and develop a mutually-agreed upon timeframe between CMS and the state for any identified enhancements.
7. The state will pursue improved coordination and improved integration between Behavioral Health, Physical Health, Home and Community Based Providers and community-level collaborators for Improved Care Coordination (as applicable) through the adoption of provider-level Health IT infrastructure and software—to facilitate and improve integration and coordination to support the programmatic objectives of the demonstration. The state will provide a Health IT strategy by April 1, 2017 that details existing HIT capabilities which support this goal, and develop a mutually-agreed upon timeframe between CMS and the state for any identified enhancements.

8. The State shall ensure a comprehensive Health IT-enabled quality measurement strategy that support the programmatic objectives of the demonstration. The state will provide a Health IT strategy by April 1, 2017 that details existing HIT capabilities which support this goal, and develop a mutually-agreed upon timeframe between CMS and the state for any identified enhancements.

38. Value-based Roadmap. Recognizing that the DSRIP investments must be sustained through new payment methods, and that managed care plans will play a critical role in the long-term sustainability of this effort, the state must take steps to plan for and reflect the impact of DSRIP in managed care business approaches.

Within 60 days of STC approval, and subsequently, by October 1st of each demonstration year, the state must submit an updated Value-based Roadmap ("Roadmap") which establishes targets for VBP attainment, related incentives under DSRIP for MCOs and ACHs, a description of how managed care is transforming to support new models of care, and Medicaid MCO contract changes being made to align with the Medicaid Transformation Demonstration project. The state will also address the payment mechanism, including an implementation plan detailing when the state will submit any required documentation in order to meet payment timelines.

The Roadmap will be updated annually to ensure that best practices and lessons learned can be incorporated into the state's overall vision of delivery system reform. This Roadmap will describe what the state and its stakeholders consider the payment reforms required for a high quality and a financially sustainable Medicaid delivery system.

Recognizing the need to formulate this plan to align with the stages of DSRIP, this will be a multi-year plan. It will necessarily be flexible to properly reflect future DSRIP progress and accomplishments. Progress on the Roadmap will also be included in the quarterly DSRIP report.

The Roadmap shall address the following:

a. Targets for regional ACH and statewide MCO attainment of VBP Goals, per STC 39.
b. Approaches that MCOs and the state will use with providers to encourage practices consistent with DSRIP objectives and metrics and the VBP targets.
c. Use of DSRIP measures and objectives by the state in their contracting strategy approach for managed care plans.
d. MCO contract amendments to include any necessary reporting of DSRIP objectives and measures.
e. Alternative payment models deployed between MCOs and providers to reward performance consistent with DSRIP objectives and measures.
f. Measurement of MCOs based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans.
g. Evolution toward further alignment with MACRA and other advanced APMs.

39. Models of Value-Based Payment. The state has established VBP goals consistent with the HCP-LAN *Alternative Payment Models* (APM) Framework[2] and the Quality Payment Program (QPP) under MACRA, further defined in Table 1. The goals are in alignment with broader U.S. Department of Health and Human Services' (HHS) delivery system reform goals.

Under DSRIP, regional and managed care plan-level incentives will be established. Specifically, the state agrees to VBP target thresholds at or above which incentive payments can be earned by partnering ACH providers and MCOs. *See Table 1*. The state will ensure both improvement from baseline and attainment are taken into consideration in the development of the VBP incentive program. The thresholds will be further defined in the DSRIP planning protocol (Attachment C) and Roadmap (Attachment F).

Table 1: Percentage of Provider Payments in HCP-LAN APM Categories at or above which Incentives are Provided to Providers and MCOs under DSRIP

VBP Goals (consistent with HCP-LAN Framework)*					
	DY1	**DY2**	**DY3**	**DY4**	**DY5**
HCP LAN Category 2C – 4B	30%	50%	75%	85%	90%
Subset of goal above: HCP LAN Category 3A-4B	-	10%	20%	30%	50%
Payments in Advanced APMs			TBD*	TBD*	TBD*

a. Starting in DY 1, VBP incentives will be based on the percentage of provider payments in categories 2C-4B of the HCP-LAN Framework, with progressive targets throughout the demonstration.
b. By DY 2, the state will implement in its Roadmap (Attachment F) additional criteria that incentivizes ACH and MCO attainment of upside/downside provider risk arrangements (HCP-LAN categories 3A-4B). The incentive structure will be further defined in the DSRIP Planning Protocol (Attachment C) and Roadmap (Attachment F).
c. By DY 3, the additional targets (*) outlined in Table 1 above to be defined in the Roadmap, will incentivize implementation of MACRA Advanced APMs in provider contracts.
d. Beginning in DY 4, to be eligible for any region or plan-level incentives under the Roadmap, at least 30 percent of all provider payments must meet or exceed category 3A of the HCP-LAN framework with additional incentives provided for meeting categories 3B through 4B with the following elements:

    i. Shared upside and downside risk (where entities will be required to bear more than a nominal risk for monetary losses)

[2] Available at https://hcp-lan.org/groups/apm-fpt/apm-framework/

ii. Payment tied to provider improvement and attainment of quality performance metrics from the Washington Statewide Common Measure set, using HCA Quality Improvement Model or similar tool.
iii. Care transformation requirements consistent with ACH-led DSRIP activities, including appropriate recognition of state level best practice recommendations, such as the Bree Collaborative.[3]
iv. Use of certified EHR technology and health information exchange services in support of VBP methods.

e. The state will submit annually, by no later than October 1 of each demonstration year, an updated Roadmap (Attachment F) to meet the specifications of this section and to ensure the roadmap aligns with evolving MACRA and other state-based payment models. All thresholds for VBP incentive payments exclude payments for services provided by or through Indian health care providers.
f. The Roadmap will describe how the state will validate and categorize value-based arrangements using a third-party validator.
g. Contractual obligations for MCOs are integral to this demonstration, including requirements that MCOs attain defined levels of value-based payment with their provider networks while achieving quality improvement across a core set of quality metrics to be included in the managed care contracts. A premium withhold has been established to incentivize improved quality performance, and that withhold will increase over the five years of the demonstration. These value-based purchasing targets and quality measures align to the DSRIP program structure and will change to adapt to future requirements and protocols developed throughout this demonstration.

40. Challenge and Reinvestment Pools. Under DSRIP, the state will set aside no more than 15 percent of annually available DSRIP funds to reward MCO and ACH partnering providers for provider-level attainment of VBP targets stipulated in STC 39. Two pools are created to facilitate incentive payments:

a. *Challenge Pool.* An annual budget, not to exceed 5 percent of total available DSRIP funding, is established as incentive payments for MCO attainment and progression toward VBP targets. In addition, if unearned incentives from the MCO premium withholds and DSRIP funding for MCO VBP attainment (see STC 40(g)) remain after the annual performance period, any remaining funds will be used for incentive payments for MCOs meeting exceptional standards of quality and patient experience, based on a subset of measures to be defined in the DSRIP planning protocol (Attachment C) and Roadmap (Attachment F).

[3] Bree Collaborative is a public-private consortium established in 2011 by the Washington State Legislature "to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State." Annually, the Bree identifies up to three areas where there is substantial variation in practice patterns and/or high utilization trends that do not produce better care outcomes. Recommendations from the Bree are sent to the Health Care Authority to guide state purchasing for programs such as Medicaid and Public Employees Benefits Board (PEBB).

b. *Reinvestment Pool*. An annual budget, not to exceed 10 percent of total available DSRIP funding, is established to reward ACH partnering providers (regional) attainment and progression toward VBP targets. To the extent unearned incentives remain after the annual performance period from ACH Projects or VBP unearned incentives, any remaining funds will be used for incentive payments to the ACH for performance against a core subset of measures to be defined the DSRIP planning protocol (Attachment C) and Roadmap (Attachment F). These funds must be spent on demonstration objectives.

41. Federal Financial Participation (FFP) for DSRIP. The state may claim, as authorized expenditures under the demonstration, up to $994 million total computable for five years, performance-based incentive payments to ACH partnering providers or MCOs that support change in how care is provided to Medicaid beneficiaries through payment and delivery system reforms. DSRIP payments are an incentive for successfully meeting associated metrics and outcomes rather than payment of claims for the provision of medical care. For this reason, DSRIP payments shall not be considered patient care revenue for purposes of offsetting allowable uncompensated care costs under the DSRIP Funding and Mechanics Protocol under demonstration authority.

1. DSRIP payments are not direct reimbursement for expenditures or payments for services. DSRIP payments are intended to support and reward ACHs and their partnering providers for delivery system transformation efforts and are eligible for federal matching at the administrative rate and not as medical assistance. DSRIP payments are not considered patient care revenue, and shall not be offset against disproportionate share, MCO expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) or other allowable administrative expenses.

2. The state may not claim FFP for DSRIP until after CMS has approved the DSRIP Planning Protocol (Attachment C) and DSRIP Funding and Mechanics Protocol (Attachment D). Once approved, the state may receive FFP for expenditures beginning January 1, 2017.

3. The state may not claim FFP for DSRIP payments in each year for DSRIP Year 1 through DSRIP Year 5 until the state has concluded whether or not the ACHs, MCOs, and partnering providers have met the performance indicated for each payment. The state must inform CMS of the funding of all DSRIP payments through a quarterly payment report to be submitted to CMS within 60 days after the end of each quarter. ACH and MCO reports must contain sufficient data and documentation to allow the state and CMS to determine if the ACH, MCO, and partnering providers have fully met the specified metric or VBP goal, and ACHs and MCOs must have available for review by the state or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to approved DSRIP activities.

4. The non-federal share of payments to ACHs, MCOs, and partnering providers may be funded by state general revenue funds, intergovernmental transfers, designated state health programs, or any other allowable source of non-federal share consistent with

federal law. The funding will flow to the participating providers according to the methodology specified in the DSRIP Funding and Mechanics Protocol.

5. The state must inform CMS of the funding of all DSRIP payments to providers through quarterly reports submitted to CMS within 60 calendar days after the end of each quarter, as required in STC 73. This report must identify the funding sources associated with each type of payment received by each provider.

42. DSRIP Funding. The amount of demonstration funds available for the DSRIP Program is shown in Table 2 below.

Table 2: DSRIP Funding and At-Risk Percentages

	DY1	**DY2**	**DY3**	**DY4**	**DY5**
	01/01/17-12/31/17	**01/01/18-12/31/2018**	**01/01/19 - 12/31/19**	**01/01/20 - 12/31/20**	**01/01/21 - 12/31/21**
Maximum Allowable Funds	$242,100,000	$240,600,000	$235,900,000	$151,510,022	$124,210,022
Percent At Risk for Performance	0%	0%	5%	10%	20%
Dollar Amount at Risk for Performance	N/A	N/A	$11,795,000	$15,151,002	$24,842,004

Funding At Risk for VBP and Quality Improvement Goals under DSRIP. A share of total DSRIP funding will be at risk if the state fails to demonstrate progress toward meeting the demonstration's VBP goals as outlined in STC 40, Table 1 and quality measures to be defined in the DSRIP Planning Protocol (Attachment C). The percentage at risk will gradually increase from 0 percent in DY 1-2 to 5 percent in DY 3 to 10 percent in DY 4 and 20 percent in DY 5. The at-risk outcome measures will be developed by the state and included in the DSRIP Planning Protocol for approval by CMS. They must be statewide and measure progress toward the state's Medicaid transformation goals.

43. Life Cycle of the Five-Year DSRIP Program. Synopsis of anticipated activities planned for this demonstration and the corresponding flow of funds.

1. ***Demonstration Year 1- Planning and Design:*** In the first year of the demonstration, the state will undertake implementation activities, including the following:

   i. *Submit the DSRIP Planning Protocol (Attachment C) and* DSRIP *Program Funding and Mechanics Protocol (Attachment D).* Working closely with stakeholders and CMS, the state will submit the two required protocols in accordance with STCs 32 and 33 by March 9, 2017.

   ii. *Develop and oversee certification process for ACHs.* The state will develop a process for ACHs to be certified to lead Medicaid transformation projects. Certification will require, among other things, that the ACHs: (1) describe their governance plan and process to ensure compliance with principles outlined in the STCs; and (2) describe

the stakeholder, tribal engagement, and public processes that will be used to solicit community input.

iii. *Develop and oversee project plan application process for ACHs.* The state will develop a project plan application in accordance with the approved DSRIP Planning Protocol (Attachment C) and the DSRIP Program Funding and Mechanics Protocol (Attachment D). The ACHs must complete the project plan applications within the timeframe determined by the state.

iv. *Review and approve project plans submitted by ACHs.* Once the ACHs submit project plans and they are reviewed by the independent assessor, the state will approve applications in accordance with the DSRIP Funding and Mechanics Protocol (Attachment D).

v. *Establish Statewide Resources To Support ACHs.* The demonstration will also support ACHs with statewide resources. Specifically, ACHs will be provided with technical assistance and the opportunity to participate in learning collaboratives that facilitate the sharing of best practices and lessons learned across ACHs. The statewide resources will be developed to coordinate with other ongoing and emerging delivery system reform efforts in the state.

2. ***Demonstration Years 2-4: Implementation, Performance Measurement and Outcomes*:**

i. In these years, the state will move the distribution of DSRIP payments to more outcome-based measures, making them available over time only to those ACH partnering providers that meet performance metrics.

3. ***Demonstration Year 5: Performance Measurement and Sustainability:***

i. DSRIP investments that meet the demonstrations objectives will continue through value-based payment objectives, led by MCOs and supported by ACHs and the provider community.

VI. LONG TERM SERVICES AND SUPPORTS

44. 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 a new Medicaid Alternative Care (MAC) benefit package. These individuals *do not* constitute a new MEG. The demonstration allows them a benefits choice that will enable them to remain in their homes for a longer period. Eligibility criteria include:

a. Age 55 or older;
b. Eligible for Categorically Needy (CN) or Alternative Benefit Plan (ABP) services; and
c. Eligible to receive the LTSS Medicaid benefit currently available under optional State Plan 1915(k) or HCBS authorities—but have chosen to receive services under MAC instead.

The state will not apply post-eligibility treatment of income to the MAC population because they will not be receiving LTSS.

45. MAC Benefits Package. Administered by the state, or its delegate, the MAC benefit package will be offered through a person-centered planning process where services from one or more of the service categories in STC 45(a) through (d) are identified in a plan of care—up to a specified limit as defined in state rule—to individuals who are age 55 or older and eligible for CN or ABP coverage,—and not currently receiving Medicaid-funded LTSS. Beneficiaries receiving MAC would also be eligible for Medicaid medical services but would not be eligible for other Medicaid optional state plan or 1915(c) LTSS benefits at the same time. MAC is an alternate benefit package that individuals may choose so they can remain in their home with care provided through their unpaid family caregiver. If an eligible individual chooses to access state plan or 1915(c) LTSS benefits, they would no longer be eligible to receive MAC services. With the exception of services authorized under presumptive eligibility, services offered under this benefit will not duplicate services covered under the state plan, Medicare or private insurance, or through other federal or state programs. The following are the MAC benefits with corresponding descriptions:

1. Caregiver Assistance Services. Services that take the place of those typically performed by the unpaid caregiver in support of unmet needs the care receiver has for assistance with activities of daily living (ADL) and instrumental ADL. Services include:
   i. Housework/errands/yardwork
   ii. Transportation (only in conjunction with the delivery of a service)
   iii. Respite (in home and out of home)
   iv. Home delivered meals
   v. Home safety evaluation
   vi. Minor home modifications and repairs required to maintain a safe environment

2. Training and Education. Services and supports to assist caregivers with gaining skills and knowledge to implement services and supports needed by the care receiver to remain at home or skills needed by the caregiver to remain in their role. Services include:
   i. Support groups
   ii. Group training
   iii. Caregiver coping/skill building training
   iv. Consultation on supported decision making
   v. Caregiver training to meet the needs of the care receiver
   vi. Financial or legal consultation
   vii. Health and wellness consultation

3. Specialized Medical Equipment & Supplies. Goods and supplies needed by the care receiver. Goods and supplies include:
   i. Supplies
   ii. Specialized Medical Equipment (includes durable medical equipment and adaptive equipment)
   iii. Personal emergency response system

iv. Assistive Technology

4. Health Maintenance & Therapy Supports. Clinical or therapeutic services that assist the care receiver to remain in their home or the caregiver to remain in their caregiving role and provide high quality care. Services are provided for the purpose of preventing further deterioration, improving or maintaining current level of functioning. Supports and services categorized here include those typically performed or provided by people with specialized skill, certification or licenses. Services include:
   i. Adult day health
   ii. RDAD and EB exercise programs
   iii. Health Promotion and Wellness Services
   iv. Counseling

46. Tailored Supports for Older Adults (TSOA). The demonstration also establishes a new eligibility expansion category for individuals who are "at risk" of becoming eligible for Medicaid in order to access LTSS. This "At Risk" or "Tailored Supports for Older Adults" (TSOA) eligibility group is comprised of individuals that could receive Medicaid State Plan benefits under 42 CFR §435.236 and §435.217. Under the Demonstration, these individuals may access a new LTSS benefit package that will preserve their quality of life while delaying their need (and the financial impoverishment) for full Medicaid benefits. The individuals must:

a. Be age 55 or older;
b. Be a U.S. citizen or in eligible immigration status;
c. Not be currently eligible for CN or ABP Medicaid;
d. Meet functional eligibility criteria for NFLOC as determined through an eligibility assessment; and
e. Have income up to 300% of the SSI Federal Benefit Rate.
   i. To determine eligibility for TSOA services, the state will consider the income of the applicant, not their spouse/dependents, when determining if gross income is at or below the 300% SSI Federal Benefit Rate limit; and
   ii. 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. Like the MAC population, Washington will not apply post-eligibility treatment of income to the TSOA populations.
   iii. The individual's separate non-excluded resources are at or below $53,100 or, for a married couple, that non-excluded resources (calculated as of the first point at which the individual is deemed to have the status of an "institutionalized spouse") are at or below a combination of $53,100 plus the current state Community Spouse Resource Allowance, based on the individual's verified household resources.
      1. To determine resources, the State will us the Social Security Income (SSI)-related resource rules currently in use for determining eligibility for Medicaid LTSS with the following exceptions:
      2. Transfer of asset penalties do not apply
      3. Excess home equity provisions do not apply

47. TSOA Benefits Package. Administered by the state or its delegate, the TSOA benefit package will be offered to individuals determined to be "at risk" for Medicaid (as described in the previous section) will be offered through a person-centered planning process where services from one or more of the service categories are identified in a plan of care up to a specified limit as defined in state rule. Individuals receiving TSOA services will not be eligible for CN or ABP Medicaid-funded medical services or other Medicaid-funded optional State Plan or 1915(c) LTSS benefits. Individuals who later become CN or ABP Medicaid-eligible will no longer be eligible for TSOA services. Individuals receiving MN Medicaid-funded medical services or are eligible for a Medicare Savings Program (MSP) are eligible for TSOA services. With the exception of services authorized under presumptive eligibility, services offered under this benefit will not duplicate services covered under the state plan, Medicare or private insurance, or through other federal or state programs. The following are the TSOA benefits with corresponding descriptions:

a. TSOA Benefits. The TSOA benefits include all the same benefits outlined in STC 46(a) through (d).
b. Personal Assistance Services. Supports involving the labor of another person to help demonstration participants carry out everyday activities they are unable to perform independently. Services may be provided in the person's home or to access community resources. Services include but are not limited to:
   i. Personal Care
   ii. Nursing delegation
   iii. Adult day care
   iv. Transportation (only in conjunction with the delivery of a service authorized for this specific program)
   v. Home delivered meals
   vi. Home safety evaluation
   vii. Home modifications and repairs (associated with the home modifications) required to maintain a safe environment

48. Person Centered Planning. The state agrees to use person-centered planning processes to identify participants', applicants' and unpaid caregivers' LTSS needs, the resources available to meet those needs, and to provide access to additional service and support options as needed. The state assures that it will use person centered planning tools that will be in compliance with the characteristics set forth in 42 CFR 441.301(c)(1)-(3).

49. Self-Directed Supports. The state agrees to provide resources to support participants or their proxies (e.g., a surrogate, parent or legal guardian/representative) in directing their own care when that care is provided by an individual provider. This support assures, but is not limited to, participants' compliance with laws pertaining to employer responsibilities and provision for back-up attendants as needs arise. The state agrees to assure that background checks on employees and their results are available to participants. State policies and guidelines will include, but not be limited to: criteria for who is eligible to self-direct, a fiscal agent/intermediary, and training materials to assist participants with learning their roles and

responsibilities as an 'employer' and to ensure that services are consistent with care plan needs and allocations.

a. Program enrollees will have full informed choice on the requirements and options to: self-direct services; have a qualified designated representative direct services on their behalf, or select traditional agency-based service delivery. State and provider staff will receive training on these options.

50. Conflict of Interest. The state agrees that the entity responsible for assisting the individual with development of the person-centered service plan may not be an LTSS service provider, unless that service planning entity is the only qualified and willing entity available to conduct the service. If a service planning entity is the only willing and qualified entity to conduct the service, the state must establish firewalls between the service provision and planning functions to ensure conflict of interest protections. The state assures that conflict of interest protections will be in compliance with the characteristics set forth in 42 CFR 441.301(c)(1)(v)(vi). The state also assures that the independent evaluation and determination of eligibility for LTSS is performed by an agent that is independent and qualified as defined in 42 CFR 441.730.

51. Home and Community-Based Setting Requirements. The state will assure compliance with the characteristics of home and community-based settings in accordance with 42 CFR 441.301(c)(4), for those services that could be authorized under sections 1915(c) and 1915(i).

52. Quality Measures. The state will develop a Quality Improvement System (QIS) that includes:

a. Performance measurement and reporting in accordance with the quality reporting and review standards outlined in *Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers* guidance issued March 12, 2014, and reporting timelines outlined in *Revised Interim Procedural Guidance* issued February 6, 2007.

1. Performance measures should address the following areas:
   i. Identification of needs and goals, and access to services (Level of Care/Functional assessment and Person-Centered Plan of Care at least annually);
   ii. Services are delivered in accordance with the Person-Centered Plan of Care
   iii. Providers meet required qualifications;
   iv. Settings meet the home and community-based setting requirements for those services that could be authorized under 1915(c) and 1915(i);
   v. Number of substantiated incidents of neglect, exploitation or abuse and average time to resolution;
   vi. The State Medicaid Agency (SMA) retains authority and responsibility for program operations and oversight; and
   vii. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1115 participants by qualified providers.

b. Ongoing quarterly/annual reporting that includes:
   i. Number of LTSS beneficiaries broken out by program (MAC and TSOA);
   ii. Number of new MAC and TSOA person-centered service plans;
   iii. Percent of MAC and TSOA level of care re-assessments annually; and
   iv. Number of people self-directing services under employer authority

53. Critical Incident Reporting. The state has a system as well as policies and procedures in place through which providers must identify, report and investigate critical incidents that occur within the delivery of MAC and TSOA. Provider contracts reflect the requirements of this system. The state also has a system as well as policies and procedures in place through which to detect, report, investigate, and remediate abuse, neglect, and exploitation. Providers and participants are educated about this system. Provider obligations include specific action steps that providers must take in the event of known or suspected abuse, neglect or exploitation.

54. Presumptive Eligibility. The state will provide the MAC and TSOA services outlined in STCs 45 and 47 to individuals during a presumptive eligibility (PE) period following a determination by the state or a qualified entity—on the basis of preliminary information—that the individual appears to meet functional and financial eligibility requirements, using simplified methodology prescribed by the state and approved by CMS. In the event the state implements a waitlist, the authority for presumptive eligibility terminates.

a. *Qualified entity* – Presumptive eligibility will be determined by both the state and state designated qualified entities. A qualified entity is an entity that:
   i. Participates with the Department of Social and Health Services (DSHS) as an Area Agency on Aging (AAA), subcontractor of an AAA or as a state designated tribal entity to provide limited eligibility functions and other administrative functions as delegated in contract;
   ii. Notifies the DSHS of its election to make presumptive eligibility determinations under this section, and agrees to make presumptive eligibility determinations consistent with State policies and procedures; and
   iii. The state will include language specific to presumptive eligibility requirements to its existing contracts with qualified entities who shall conduct presumptive eligibility determinations.

b. *Qualified staff* – Presumptive eligibility shall be determined by staff of qualified entities who have met at least the following qualifications imposed by the state.
   i. A College degree and at least two years of social service experience or an equivalent level of education plus relevant experience;
   ii. Complete PE training prior to determining PE; and
   iii. The state will provide CMS the initial training curriculum and PE determination form for review and approval prior to program implementation. Subsequent content changes will be submitted to CMS for review at the time the change is made.

c. *Quality Assurance and Monitoring* – The state will monitor both state staff and qualified entities for adherence to policies applicable to presumptive eligibility determinations through contract monitoring and quality assurance reviews.
   i. Post implementation the state will conduct a targeted review of implementation to validate PE determinations are being made in accordance with established criteria; and
   ii. As part of the state's Quality Improvement Strategy, a sample of PE determinations will be reviewed yearly to determine that PE was established appropriately.

d. *Presumptive Functional Eligibility* **–** The following information will be collected as part of the presumptive functional eligibility assessment to determine if the individual appears to meet nursing facility level of care as defined in state rule. Indicators include:
   i. Does the individual need daily care provided or supervised by a registered nurse (RN) or licensed practical nurse (LPN); or
   ii. Does the individual have an unmet or partially met for assistance with 3 or more qualifying ADLs; or
   iii. Does the individual have a cognitive impairment and require supervision due to one or more of the following: Disorientation, memory impairment, impaired decision making, or wandering and a need for assistance with 1 or more qualifying ADLs; or
   iv. Does the individual have an unmet or partially met need for assistance with 2 or more qualifying ADLs; and
   v. Functional eligibility shall be confirmed by the State for ongoing program eligibility.

e. *Presumptive Financial Eligibility* **–** Presumptive financial eligibility will be determined by a financial screen, based on application attestation, to determine if the applicant meets the following requirements:

   i. For TSOA:

      1. State resident;
      2. Social Security Number (SSN);[4]
      3. The individual's separate non-excluded income is equal to or less than the Special Income Level (SIL).
      4. The individual's separate non-excluded resources are at or below $53,100 or, for a married couple, that non-excluded resources (calculated as of the first point at which the individual is deemed to have the status of an "institutionalized spouse") are at or below a combination of $53,100 plus the current state Community Spouse Resource Allowance, based on the individual's self-attested statement of their household resources.

   ii. For MAC:

[4] If an applicant does not have a SSN established it will not preclude the applicant from applying for TSOA or MAC, the state shall provide the individual with assistance applying for an SSN or getting the person's SSN.

1. The state or qualified entity will confirm the individual is presumptively eligible in a categorically needy or alternative benefit plan program that offers healthcare coverage to the target population using the state's eligibility and enrollment data system.

f. *Period of Presumptive Eligibility* – Period of presumptive eligibility means a period that begins on the date on which a qualified entity determines that an applicant is presumptively eligible[5] and ends with the earlier of:

i. In the case of an individual on whose behalf a Medicaid or TSOA application has been filed, the day on which a decision is made on that application; or
ii. In the case of an individual on whose behalf a Medicaid or TSOA application has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made.

g. *Presumptive Eligibility Service Level* –As part of the presumptive eligibility determination the state shall assess the individual for both functional eligibility (NFLOC) and financial eligibility concurrently.

55. Estate Recovery. Participants in MAC and TSOA are exempted from Medicaid estate recovery requirements due to:

a. Scope of Medicaid estate recovery;
b. Limitation on access to Medicaid-funded state plan or demonstration HCBS for MAC participants;
c. Services available to MAC participants are outside the scope of services generally defined by CMS as HCBS; and
d. TSOA is a non-Medicaid population.

56. Wait List. The state may institute a waitlist for those who are eligible for MAC or TSOA services but are unable to access the services because funding for services under the demonstration is not available. If the state determines expenditures for this program will exceed the expenditure authorities 3-6 within a given demonstration year, the state may impose a wait list. The state will implement the waitlist and ensure that no existing beneficiaries lose services as a result of the waitlist. In the event the state implements a waitlist, the authority for presumptive eligibility terminates.

VII. FOUNDATIONAL COMMUNITY SUPPORTS

57. Foundational Community Supports Program. Under this program, the state will provide a set of HCBS for eligible individuals.

[5] To receive services past the PE period, the state must have completed a full financial eligibility determination and/or a NFLOC assessment.

58. **Foundational Community Supports Services 1**. One-time community transition services to individuals moving from institutional to community settings and those at imminent risk of institutional placement.

59. **Foundational Community Supports Eligibility 1.** Eligible individuals include those who would be eligible under a section 1915(c) waiver program who, but for the Foundational Community Supports Program, would be in an institutional placement. (For example, those at imminent risk of institutionalization include those individuals with a disabling condition who meet an institutional level of care.)

60. **Post Approval Protocol 1**. The post-approval protocol (Attachment I), which will be subject to CMS approval, will include the service definitions for the one-time transition services and payment methodologies.

61. **Foundational Community Supports Services 2**. HCBS that could be provided to the individual under a 1915(c) waiver or 1915(i) SPA.

62. **Foundational Community Supports Eligibility 2.** Eligibility for these services include individuals who could be eligible under a section 1915(c) waiver or 1915(i) SPA program.

63. **Post Approval Protocol 2.** The post-approval protocol (Attachment I), which will be subject to CMS approval, will include the content that would otherwise be documented in a 1915(c) waiver and/or 1915(i) SPA, and will include service definitions, payment methodologies, and the administrative approach.

64. **Submission of Post Approval Protocol**. The state will submit the protocol for services identified in STC 60 and STC 63 above to CMS for review within 60 days following demonstration approval, and will not provide services under the program until receiving CMS approval.

65. **Wait List.** The state may institute a waitlist for those who are eligible for the Foundational Community Supports Program but are unable to access the services because funding for services under the demonstration is not available. If the state determines expenditures for this program will exceed the expenditure authority within a given demonstration year, the state may impose a wait list. The state will implement the waitlist and ensure that no existing beneficiaries lose services as a result of the waitlist.

VIII. GENERAL REPORTING REQUIREMENTS

66. **General Financial Reporting Requirements.** The state must comply with all general financial requirements under title XIX of the Act in section IX of the STCs.

67. **Electronic Submission of Reports.** The state must submit all monitoring and evaluation report deliverables required in these STCs (e.g., quarterly reports, annual reports, evaluation reports) electronically, through CMS' designated electronic system.

68. **Compliance with Managed Care Reporting Requirements.** The state must comply with all managed care reporting regulations at 42 CFR §438 et. seq. except as expressly waived or identified as not applicable in the expenditure authorities incorporated into these STCs.

69. **Reporting Requirements Relating to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality as set forth in section IX of the STCs, including the submission of corrected budget neutrality data upon request.

70. **Monthly Monitoring Calls.** CMS will convene monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration, including planning for future changes in the program. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda prior to the calls. Topics to be discussed include, but are not limited to:

    a. Operations and performance;
    b. Stakeholder concerns, audits, and lawsuits;
    c. Related legislative developments in the state; and
    d. Any demonstration changes or amendments the state is considering.

71. **Annual Discussion with CMS.** In addition to regular monitoring calls, the state will hold an annual discussion with CMS during which it will present information on the implementation progress of the demonstration, progress toward the Medicaid goals, key challenges, achievements, and lessons learned. The call may also include a discussion regarding issues that CMS may raise.

72. **Quarterly Operational Reports.** The state must submit progress reports in the format specified by CMS, as per the prescribed schedule in Section XIII. The intent of these reports is to present the state's analysis and the status of the various operational areas in reaching the goals of the DSRIP activities. These quarterly reports, using the quarterly report guideline outlined in Attachment A, must include, but are not limited to the following reporting elements:

    a. Summary of quarterly expenditures related to ACHs, ACH Project Plans, and the DSRIP Funds;
    b. Updated budget neutrality spreadsheets
    c. Summary of all public engagement activities, including, but not limited to the activities required by CMS;
    d. Summary of activities associated with the ACHs, ACH Project Plans, and the DSRIP Fund. This shall include, but is not limited to, reporting requirements in STC 35 of this section and the DSRIP Planning Protocol (Attachment C):
    e. Updates on state activities, such as changes to state policy and procedures, to support the administration of the DSRIP Funds,
    f. Updates on provider progress towards the pre-defined set of activities and associated milestones that collectively aim towards addressing the state's goals;

g. Summary of state's analysis of ACH Project Plans;
h. Summary of state analysis of barriers and obstacles in meeting milestones;
i. Summary of activities that have been achieved through the DSRIP Fund;
j. Summary of transformation and clinical improvement milestones and that have been achieved; and
k. Evaluation activities and interim findings.
l. SUD Health IT. The state will include a summary of progress made in regards to SUD Health IT requirements outlined in STC 78(f).

73. Rapid Cycle Assessments. The state shall specify for CMS approval a set of performance and outcome metrics, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment of ACH projects, performance indicators and outcomes, and for monitoring and evaluation of the demonstration.

74. Annual Report. The state must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. This report must also contain a discussion of the items that must be included in the quarterly operational reports required under STC 72. The state must submit the draft annual report no later than March 1 of each year. Within 60 calendar days of receipt of comments from CMS, a final annual report must be submitted.

75. Final Report. Within 120 calendar days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 calendar days after receipt of CMS' comments.

76. Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Protocol and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

77. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

IX. SUBSTANCE USE DISORDER PROGRAM AND BENEFITS

78. Opioid Use Disorder/Substance Use Disorder Program. Effective upon CMS' approval of the OUD/SUD Implementation Plan Protocol, the demonstration benefit package for Washington Medicaid recipients will include OUD/SUD treatment services, including short term residential services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD), which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Washington Medicaid recipients residing in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Washington will aim for a statewide average length of stay of 30 days in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in Section VIII below, to ensure short-term residential treatment stays. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

The extension of coverage to services for all recipients while they are in short-term residential treatment for OUD/SUD will expand the available settings and allow the state to offer a full continuum of care for recipients with OUD/SUD (see Table 3). Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Table 3: Washington OUD/SUD Benefits Coverage with Expenditure Authority

SUD Benefit	Medicaid Authority	Expenditure Authority
Outpatient Services	*State plan (Individual services covered)*	Services provided to individuals in an IMD
Intensive Outpatient Services	*State plan (Individual services covered)*	Services provided to individuals in an IMD
Residential Treatment	*State plan (Individual services covered)*	Services provided to individuals in an IMD
Medically Supervised Withdrawal Management	*State plan*	Services provided to individuals in an IMD
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	*State Plan*	N/A
Medication-Assisted Treatment (MAT)	*State plan*	Services provided to individuals in an IMD

The state attests that the services indicated in Table 3, above, as being covered under the Medicaid state plan authority are currently covered in the Washington Medicaid state plan.

a. **SUD Implementation Plan Protocol.** The state must submit an OUD/SUD Implementation Plan Protocol within 90 calendar days after approval of the SUD program under this demonstration. The state may not claim FFP for services provided in IMDs until CMS has approved the Implementation Plan Protocol. Once approved, the SUD Implementation Plan Protocol will be incorporated into the STCs, as Attachment K, and once incorporated, may be altered only with CMS approval. After approval of the Implementation Plan Protocol, FFP will be available prospectively, not retrospectively. Failure to submit an Implementation Plan Protocol will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the OUD/SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral.

At a minimum, the SUD Implementation Plan Protocol will describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of the SUD component of this demonstration program:

i. **Access to Critical Levels of Care for OUD and other SUDs:** Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of OUD/SUD program demonstration approval;

ii. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other comparable assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;

iii. **Patient Placement:** Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of SUD program demonstration approval;

iv. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in Washington Administrative Code regulations: WAC 388-877.[6] The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other comparable, nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of OUD/SUD program demonstration approval;

v. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval;

[6] http://apps.leg.wa.gov/wac/default.aspx?cite=388-877

vi. **Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval;

vii. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for OUD:** An assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval;

viii. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

ix. **SUD Health IT Plan:** Implementation of the milestones and metrics as detailed in STC 78(f) and Attachment M; and

x. **Improved Care Coordination and Transitions between levels of care:** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports, including tribal services and supports, following stays in these facilities within 24 months of SUD program demonstration approval.

b. **SUD Monitoring Protocol.** The state must submit a SUD Monitoring Protocol within 150 calendar days after approval of SUD program under this demonstration. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment L. At a minimum, the SUD Monitoring Plan Protocol will include reporting relevant to each of the program implementation areas listed in STC 78(a). The protocol will also describe the data collection, reporting and analytic methodologies for performance measures identified by the state and CMS for inclusion. The SUD Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 72 of the demonstration. In addition, for each performance measure, the SUD Monitoring Protocol will identify a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points.

   Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements. Progress on the performance measures identified in the Monitoring Protocol will be reported via the quarterly and annual monitoring reports.

c. **Mid-Point Assessment.** The state must conduct an independent mid-point assessment (December 31, 2020 of the SUD component of this demonstration. The assessor must collaborate with tribes and key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-point assessment. The assessment will include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Protocol, and toward closing the gap between baseline and target each year in performance measures as approved in the SUD Monitoring Protocol. The assessment will also include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and about the risk of possibly missing those milestones and performance targets. The mid-point assessment will also provide a status update of budget neutrality requirements. For each milestone or measure target at medium to

high risk of not being met, the assessor will provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The assessor will provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. A copy of the report will be provided to CMS. CMS will be briefed on the report.

For milestones and measure targets at medium to high risk of not being achieved, the state will submit to CMS modifications to the SUD Implementation Protocol and SUD Monitoring Plan Protocols for ameliorating these risks subject to CMS approval.

d. **SUD Evaluation.** The OUD/SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as listed in sections VIII (General Reporting Requirements) and Section XII (Evaluation of the Demonstration of the STCs).

e. **SUD Evaluation Design.** The state must submit, for CMS comment and approval, a revision to the Evaluation Design to include the SUD program with implementation timeline, no later than one hundred eighty (180) days after the effective date of these amended STCs. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state must use an independent evaluator to develop the draft Evaluation Design.

   i. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Quarterly and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

   ii. **Evaluation Questions and Hypotheses Specific to OUD/SUD Program.** The evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

f. **SUD Health Information Technology (Health IT).** The state will provide CMS with an assurance that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration—or it will submit to CMS a plan to develop the infrastructure/capabilities. This "SUD Health IT Plan," or assurance, will be included as a section of the state's "Implementation Plan Protocol" (see STC 78(a)) to be approved by CMS. The SUD Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of SUD health IT ecosystem improvement.

i. The SUD Health IT section of the Implementation plan will include implementation milestones and dates for achieving them (see Attachment K).

ii. The SUD Health IT Plan must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) "Health IT" Plan.

iii. The SUD Health IT Plan will describe the state's goals, each DY, to enhance the state's prescription drug monitoring program's (PDMP)[7]

iv. The SUD Health IT Plan will address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[8] This will also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan will describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

v. The SUD Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

vi. The SUD Health IT Plan will describe how the activities described in (a) through (e) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.[9]

vii. In developing the Health IT Plan, states should use the following resources.

1. States may use resources at Health IT.Gov (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/) in "Section 4: Opioid Epidemic and Health IT."

2. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration.

g. The state will include in its Monitoring Plan (see STC 78(b)) an approach to monitoring its SUD Health IT Plan which will include performance metrics provided by CMS or State defined metrics to be approved in advance by CMS.

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[7] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

[8] *Ibid*.

[9] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

h. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Reports (see STC 74).

i. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

    1. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.
    2. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

X. GENERAL FINANCIAL REQUIREMENTS

79. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the expenditures as specified in section IX of the STCs.

80. Reporting Expenditures Under the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality agreement:

a. Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number (11-W-00304/0) assigned by CMS, including the project number extension which indicates the Demonstration Year (DY) in which services were rendered.

b. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

c. Pharmacy Rebates. When claiming these expenditures the state may refer to the July 24, 2014 CMCS Informational Bulletin which contains clarifying information for quarterly reporting of Medicaid Drug Rebates in the Medicaid Budget and Expenditures (MBES) (http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-24-2014.pdf). The state

must adhere to the requirement at section 2500.1 of the State Medicaid Manual that all state collections, including drug rebates, must be reported on the CMS-64 at the applicable Federal Medical Assistance Percentage (FMAP) or other matching rate at which related expenditures were originally claimed. Additionally, we are specifying that states unable to tie drug rebate amounts directly to individual drug expenditures may utilize an allocation methodology for determining the appropriate Federal share of drug rebate amounts reported quarterly. This information identifies the parameters that states are required to adhere to when making such determinations.

Additionally, this information addresses how states must report drug rebates associated with the new adult eligibility group described at 42 CFR §435.119. States that adopt the new adult group may be eligible to claim drug expenditures at increased matching rates. Drug rebate amounts associated with these increased matching rates must be reported at the same matching rate as the original associated prescription drug expenditures. Pharmacy rebates are to be reported on Form CMS-64.9 base, Service Category Line 7.

d. Use of Waiver Forms. For each demonstration year, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver names listed below. Expenditures should be allocated to these forms based on the guidance which follows.

1. **DSHP:** Expenditures authorized under the demonstration for the Designated State Health Programs (DSHP).
2. **Non-Expansion Adults:** Expenditures authorized under the demonstration for Medicaid beneficiaries specified in STC 18 (excluding SUD IMD expenditures).
3. **MAC:** Expenditures authorized under the demonstration for beneficiaries receiving Medicaid Alternative Care (MAC) services.
4. **TSOA:** Expenditures authorized under the demonstration for beneficiaries receiving Tailored Supports for Older Adults (TSOA) services.
5. **Foundational Community Supports 1:** One-time community transition services to individuals moving from institutional to community settings and those at imminent risk of institutional placement.
6. **Foundational Community Supports 2:** HCBS that could be provided to the individual under a 1915(c) waiver or 1915(i) SPA.
7. **HepC:** Expenditures for prescription drugs ("HepC Rx") related to a diagnosis of Hepatitis C for individuals affected by or eligible under the demonstration.
8. **MAC and TSOA Not Eligible:** Expenditures authorized under the demonstration for beneficiaries receiving presumptive eligibility for TSOA and MAC services and determined ineligible.
9. **SUD IMD (individual waiver names are listed in 10(a) through 10(d) below):** All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD.
    a. Medicaid Disabled IMD;
    b. Medicaid Non-Disabled IMD;
    c. Newly Eligible IMD; and
    d. American Indian/Alaskan Native IMD.

81. Expenditures Subject to the Budget Neutrality Agreement. For purposes of this section, the term "expenditures subject to the budget neutrality agreement" means expenditures for the MEGs outlined in section IX of the STCs, except where specifically exempted. All expenditures that are subject to the

budget neutrality agreement (including those authorized in the Medicaid State Plan, through section 1915(b) and 1915(c) waivers) are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

82. Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality agreement (except for (a) below), but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver. Expenditures should be allocated to these forms based on the guidance which follows.

a. **DSRIP – Incentive Pmts:** Costs authorized under the demonstration for delivery system transformation.
b. **DSRIP – ADM:** Administrative costs associated with the operation of the DSRIP.
c. **Foundational Community Supports 1 – ADM:** Administrative costs associated with the operation of the FCS Initiative 1.
d. **Foundational Community Supports 2 – ADM:** Administrative costs associated with the operation of the FCS Initiative 2.
e. **MAC – ADM:** Administrative costs associated with providing beneficiaries MAC services.
f. **TSOA – ADM:** Administrative costs associated with providing TSOA services.

83. Claiming Period. All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms, in order to properly account for these expenditures in determining budget neutrality.

84. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

a. For the purpose of calculating the budget neutrality agreement and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 72 the actual number of eligible member months for the populations affected by this demonstration as defined in STC 22. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

b. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

c. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.

d. The state must report member months according to the MEGs defined below. There are two categories of member months:

i. **Non-Expansion Adults Only (less SUD IMD)**: These are member months that are inclusive of those noted in STC 16, but exclusive of SUD IMD Member Months.

ii. **SUD IMD:** SUD IMD Member Months are months of Medicaid eligibility during which the individual is an inpatient in an IMD under terms of the demonstration for any day during the month and must be reported separately for each SUD IMD MEG, as applicable.

1. Medicaid Disabled IMD
2. Medicaid Non-Disabled IMD
3. Newly Eligible IMD
4. American Indian/Alaskan Native IMD

85. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (TC and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each FFY on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and state and Local Administrative Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 calendar days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

86. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole for the following, subject to the limits described in Section IX of the STCs:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State Plan; and

c. Net medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration period.

87. Sources of Non-Federal Share. The state provides assurance that the matching non-federal share of funds for the demonstration is state/local/tribal monies. The state further assures that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. The CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the demonstration shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid State Plan.

88. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.

b. To the extent, the state utilizes certified public expenditures (CPE) as the funding mechanism for title XIX payments, including expenditures authorized under a section 1115 demonstration, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR §433.51 used to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority other than this waiver demonstration, those federal matching funds received cannot then be used as the state share needed to receive other federal matching funds under 42 C.F.R. § 433.51(c). The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match;

d. The state may use intergovernmental transfers (IGT) to the extent that such funds are derived from state, tribal, or local monies and are transferred by units of government within the state. The state must submit an IGT Protocol (Attachment E) for CMS approval prior to using IGT for the non-federal share of demonstration expenditures.

e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 C.F.R §447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

89. Monitoring the Demonstration. The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

90. Program Integrity. The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

X. DESIGNATED STATE HEALTH PROGRAMS

91. Designated State Health Programs (DSHP). Funding of DSHPs is to ensure the continuation of vital health care and provider support programs while the state devotes increased state resources during the period of this demonstration for DSRIP initiatives that will positively impact the Medicaid program, and result in savings to the federal government that will exceed the DSHP funding. Expenditures are claimed in accordance with CMS-approved claiming and documentation protocols to be specified in the DSHP Claiming Protocol (Attachment B). In order to ensure achievement of the demonstration's goals, the total annual expenditure authority is subject to the requirements of STC 92. CMS has approved expenditure authority for DSHP with the agreement that this one-time investment of DSHP funding would be phased down over the demonstration period. FFP may be claimed for expenditures made for the DSHPs enumerated in Table 4 beginning January 9, 2017 through December 31, 2021 in accordance with an approved DSHP claiming protocol as described in STC 92.

Table 4: Approved DSHP through December 31, 2021

Agency	Program
HCA	Kidney Disease Program (KDP)
ALTSA	Nursing Homes, Community Residential, and Homecare
ALTSA	State Family Caregiver Support
ALTSA	Senior Citizen's Services Act (SCSA)
ALTSA	Office of the Deaf and Hard of Hearing
DDA	Employment & Day and Other Community Services
DDA	Community Residential & Homecare
BHA	Crisis and other non-Medicaid services
BHA	Program of Assertive Community Treatment (PACT)
BHSIA	Offender Re-entry Community Safety Program
BHA	Spokane Acute Care Diversion
BHA	Psychological Evaluations
BHA	Outpatient and Support Services
BHA	Residential Services
BHA	Parent in Reunification
BHA	Problem Gambling Services
DOC	Mental health transition services
DOC	ORCS (Offender Reentry Community Safety)
DOC	Medications for Releasing Offenders
DOC	Community-supervised violator medical treatment
DOH	Tobacco and Marijuana Prevention and Education
DOH	Family Planning Non-Title X
DOH	HIV/AIDS Prevention
Other	Health Professional Loan Repayments (WA Student Achievement Council)
Other	Street Youth Service (Department of Commerce)
Other	"County Levy" Health Programs (see Attachment B)

92. **Limit of FFP for DSHP.** The amount of FFP that the state may receive for DSHP may not exceed the limits described below. If upon review, the amount of FFP received by the state is found to have exceeded the applicable limit, the excess must be returned to CMS as a negative adjustment to claimed expenditures on the CMS-64.

    a. The state may claim up to $748,431,326 million TC for DSHP expenditures incurred through December 31, 2021. The TC DSHP amount for DY1 will not exceed $240 million.

    b. The state may continue receiving FFP each DY for the difference between the Maximum Allowable DSHP and the Maximum Allowable DSRIP spending (see "Difference DSHP & DSRIP" in Table 5 below). For the differences listed each DY, as long as the state has another allowable (non-DSHP) source of non-federal share, the state may claim FFP for those additional expenditures.

Table 5: DSHP Annual Limits: Total Computable and At-Risk Percentages

	DY1 01/01/17-12/31/2017	DY2 01/01/18-12/31/18	DY3 01/01/19-12/31/19	DY4 01/01/20-12/31/20	DY5 01/01/21-12/31/21
Maximum Allowable DSHP	$240,000,000	$216,000,000	$117,008,060	$76,543,710	$98,879,556
Maximum Allowable DSRIP	$242,100,000	$240,600,000	$235,900,000	$151,510,022	$124,210,022
Difference DSHP & DSRIP	$2,100,100	$24,600,000	$118,891,940	$74,966,312	$25,330,466

93. **DSHP Claiming Protocol.** The state will develop a CMS-approved DSHP claiming protocol with which the state will be required to comply in order to draw down DSHP funds for the demonstration and submit the protocol no later than 60 calendar days after the demonstration approval date. State expenditures for the DSHP listed above must be documented in accordance with the protocols. The state is not eligible to receive FFP until an applicable protocol is approved by CMS. Once approved by CMS, the protocol becomes Attachment B of these STCs, and thereafter may be changed or updated with CMS approval. Changes and updates are to be applied prospectively. For each DSHP, the protocol must contain the following information:

    a. The sources of non-federal share revenue, full expenditures and rates.
    b. Procedures to ensure that FFP is not provided for any of the following types of expenditures:

        i. Grant funding to test new models of care
        ii. Construction costs (bricks and mortar)
        iii. Room and board expenditures
        iv. Animal shelters and vaccines
        v. School based programs for children
        vi. Unspecified projects
        vii. Debt relief and restructuring

viii. Costs to close facilities
ix. HIT/HIE expenditures
x. Services provided to undocumented individuals
xi. Sheltered workshops
xii. Research expenditures
xiii. Rent and/or Utility Subsidies that are normally funded by the United States Department of Housing and Urban Development and United States Department of Agriculture (USDA) or other state/local rental assistance programs
xiv. Prisons, correctional facilities, services for incarcerated individuals and services provided to individuals who are civilly committed and unable to leave
xv. Revolving capital fund
xvi. Expenditures made to meet a maintenance of effort requirement for any federal grant program
xvii. Administrative costs
xviii. Cost of services for which payment was made by Medicaid or CHIP (including from managed care plans)
xix. Cost of services for which payment was made by Medicare or Medicare Advantage
xx. Funds from other federal grants
xxi. Needle-exchange programs
xxii. Abortions that would not be allowable if furnished under Medicaid or CHIP
xxiii. Costs associated with funding federal matching requirements.

To assure DSHP expenditures from responsible entities of "County Levy" Health Programs (Attachment B) do not include coverage of services to undocumented individuals, the state will reduce each reported "County Levy" program costs by 3.6% unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS.

94. DSHP Claiming Process. Documentation of each designated state health program's expenditures, as specified in the DSHP Protocol, must be clearly outlined in the state's supporting work papers and be made available to CMS. In order to assure CMS that Medicaid funds are used for allowable expenditures, the state will be required to supply summary DSHP expenditure information with the CMS-64 by account coding at the same level as information is currently provided to support the CMS-64.

Federal funds must be claimed within two years following the calendar quarter in which the state disburses expenditures for the DSHP. Federal funds are not available for expenditures disbursed before January 1, 2017, or after December 31, 2021.

Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the DSHP listed above, they shall not be used as a source of non-federal share. The administrative costs associated with the DSHP listed above, and any others subsequently added by amendment to the demonstration, shall not be included in any way as demonstration and/or other Medicaid expenditures. Any changes to the DSHP listed above

shall be considered an amendment to the demonstration and processed in accordance with STC 7 in Section III.

95. **Reporting DSHP Payments**. The state will report all expenditures for DSHP payments to the programs listed above on the forms CMS-64.9 Waiver and/or 64.9P Waiver under the waiver name "DSHP" as well as on the appropriate forms.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

96. **Budget Neutrality Effective Date.** Notwithstanding the effective date specified in section I of the STCs or in any other demonstration documentation, all STCs, waivers, and expenditure authorities relating to budget neutrality shall be effective beginning January 1, 2017.

97. **Limit on Title XIX Funding**. The state will be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by the state using the procedures described in section X, STCs 84 and 88. The data supplied by the state to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the Form CMS-64.

98. **Risk.** The state shall be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, the state will not be at risk for changing economic conditions which impact enrollment levels. However, by placing the state at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

99. **Expenditures Included in the Calculation of the Annual Budget Neutrality Limit.** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, by multiplying the predetermined PMPM cost for each EG (shown on the table in STC 101 by the corresponding actual member months total, and summing the results of those calculations. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by Composite Federal Share 1, which is defined in STC 104 below. The demonstration expenditures subject to the budget neutrality limit are those reported under the following Waiver Names (DSHP, DSRIP, Non-Expansion Adults, MAC

and TSOA Not Eligible), plus any excess spending from the Supplemental Tests described in STC 102.

100. Impermissible DSH, Taxes, or Donations.[10]

101. Main Budget Neutrality Test. The trend rate and PMPM limit for the demonstration's main MEG (i.e. not "hypothetical" MEGs listed in the "Supplemental Tests" in STC 102) for each year of the demonstration is listed in Table 6 below. The single PMPM expenditure limit is based on actual aggregated state historical Medicaid spending for the corresponding MEGs, trended forward using the lower of state historical trend rate(s) or the President's Budget Medicaid trend rate(s).

Table 6: PMPM Expenditure Limits by Demonstration Year

MEG	Trend Rate[11]	DY1 PMPM	DY2 PMPM	DY3 PMPM	DY4 PMPM	DY5 PMPM
Non-Expansion Adults Only	4.0%	$1,012.82	$1,046.24	$694.38	$722.16	$751.05

102. Supplemental Tests. Budget neutrality agreements may also include optional Medicaid populations and/or services that could have been eligible for FFP under the state plan–or other title XIX authority—but have not been and are not included in current expenditures. These expenditures are termed "hypothetical expenditures" and the budget neutrality agreement does not permit accumulation or access to budget neutrality "savings" from hypothetical spending. A prospective per capita cap on federal financial risk is established for these groups based on the costs that the population is expected to incur under the demonstration.

a. **Supplemental Budget Neutrality Test 1: MAC and TSOA.**

i. The MEGs listed in the table below are the hypothetical groups included in the calculation of the Supplemental Budget Neutrality Test 1 Hypotheticals Cap.

	Trend Rate	DY1	DY2	DY3	DY4	DY5
MAC and		$5,979,600	$19,327,770	$23,039,000	$35,493,000	$49,451,000

[10] Replaced by STC 105 with CAP.

[11] Beginning in DY3, the MEG's trend rate was revised to reflect the terms of the CAP approved on [date]. Prior to the CAP's approval, the MEG's PMPM trend rate was 3.3 percent.

TSOA[12]						

ii. The Supplemental Budget Neutrality Test 1 Hypotheticals Cap is equal to the sum of the aggregate amounts in the table above. The federal share of the Supplemental Budget Neutrality Test 1 Hypotheticals Cap is obtained by multiplying the Supplemental Budget Neutrality Test 1 Hypotheticals Cap by Composite Federal Share 2.

iii. The Supplemental Budget Neutrality Test 1 is a comparison between the federal share of the Supplemental Budget Neutrality Test 1 Hypotheticals Cap and total FFP reported by the state for hypothetical groups under the following Waiver Names (MAC, TSOA).

iv. If total FFP for hypothetical groups should exceed the federal share of the Supplemental Budget Neutrality Test 1 Hypotheticals Cap, the difference must be reported as a cost against the budget neutrality limit described in STCs 103 and 105 of these STCs

b. Supplemental Budget Neutrality Test 2: HepC Rx. Expenditures *in aggregate* for prescription drugs related to a diagnosis of Hepatitis C ("HepC Rx") for demonstration enrollees will be separately tabulated but, since they are covered services under the approved state plan, will be treated as hypothetical for the purpose of budget neutrality. The state will not accrue budget neutrality savings if actual HepC Rx expenditures are less than projections and expenditures above projections will be treated as hypothetical for the purpose of budget neutrality. Additionally, the state will reconcile the projected, to actual, HepC Rx costs and provide an analysis of yearly HepC Rx spending in the *Annual Budget Neutrality Report* described in STC 111 below.

	Trend Rate	**DY1**	**DY2**	**DY3**	**DY4**	**DY5**
HepC Rx		$131,821,200	$136,171,300	$140,664,952	$145,306,896	$150,102,023

c. Supplemental Budget Neutrality Test 3: Foundational Community Supports 1&2. Expenditures *in aggregate* for the services described in Section VII and Attachment I.

i. The MEGs listed in the table below are the hypothetical groups included in the calculation of the Supplemental Budget Neutrality Test 3 Hypotheticals Cap.

[12] Excludes expenditures for individuals who received TSOA and MAC services during the presumptive eligibility period and determined ineligible.

	Trend Rate	DY1	DY2	DY3	DY4	DY5
Foundational Community Supports 1 & 2		$14,992,000	$33,226,000	$27,346,190	$39,155,919	$42,494,053

ii. The Supplemental Budget Neutrality Test 3 Hypotheticals Cap is equal to the sum of aggregate amounts in the table above. The federal share of the Supplemental Budget Neutrality Test 1 Hypotheticals Cap is obtained by multiplying the Supplemental Budget Neutrality Test 1 Hypotheticals Cap by Composite Federal Share 3.

iii. The Supplemental Budget Neutrality Test 1 is a comparison between the federal share of the Supplemental Budget Neutrality Test 1 Hypotheticals Cap and total FFP reported by the state for hypothetical groups under the following Waiver Names (Foundational Community Supports 1, Foundational Community Supports 2).

iv. If total FFP for hypothetical groups should exceed the federal share of the Supplemental Budget Neutrality Test 3 Hypotheticals Cap, the difference must be reported as a cost against the budget neutrality limit described in STCs 103 and 105 of these STCs.

d. **Supplemental Budget Neutrality Test 4: Substance Use Disorder Expenditures.** Expenditures *as PMPMs* for services provided as described in State Medicaid Director #17-003, *Strategies to Address the Opioid Epidemic*, the state may receive FFP for all Medicaid state plan services—including those for the continuum of services to treat OUD and other SUDs—provided to Medicaid enrollees who are short-term residents in an IMD primary for a diagnosis of SUD. These "SUD Services" are, or could be, state plan services that would be eligible for reimbursement if not for the IMD exclusion; therefore, they are being treated as hypothetical as described above. The state may claim FFP via demonstration authority for all state plan services provided to Medicaid enrollees in and IMD—including those specifically listed in Table 3.

i. The MEGs listed in the table below are the hypothetical groups included in the calculation of the Supplemental Budget Neutrality Test 4 Hypotheticals Cap.

SUD MEG	TREND	DY 1 - PMPM	DY 2 PMPM	DY 3 PMPM	DY 4 PMPM	DY 5 PMPM
Medicaid Disabled	3.4%	-	$1,084	$1,142	$1,149	$1,189

Medicaid Non-Disabled	3.6%	-	$292	$300	$311	$322
Newly Eligible	4.7%	-	$462	$478	$500	$524
American Indian/Alaskan Native	3.1%	-	$3,009	$3,079	$3,174	$3,273

ii. The Supplemental Budget Neutrality Test 4 Hypotheticals Cap calculated by taking the PMPM cost projection for each group and in each DY times the number of eligible member months for that group in that DY, and adding the products together across groups and DYs. The federal share of the Supplemental Budget Neutrality Test 4 Hypotheticals Cap is obtained by multiplying the Supplemental Budget Neutrality Test 4 Hypotheticals Cap by Composite Federal Share 4.

iii. The Supplemental Budget Neutrality Test 4 is a comparison between the federal share of the Supplemental Budget Neutrality Test 4 Hypotheticals Cap and total FFP reported by the state for hypothetical groups under the following Waiver Names (SUD IMD).

iv. If total FFP for hypothetical groups should exceed the federal share of the Supplemental Budget Neutrality Test 4 Hypotheticals Cap, the difference must be reported as a cost against the budget neutrality limit described in STCs 101 and 105 of these STCs

103. Expenditures Excluded From Budget Neutrality Test. Regular FMAP will continue for costs not subject to budget neutrality limit tests. Those exclusions include:

a. All other non-MMIS payments, such as DSH, GME, Medicaid Quality Incentive Payments (MQIP), Proportionate Share Payments (ProShare), gross adjustments, reconciliations, and other settlement payments; and
b. Administrative expenditures and collections.

104. Composite Federal Share Ratio. The federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C, with consideration of additional allowable demonstration offsets such as, but not limited to premium collections and pharmacy rebates, by TC demonstration expenditures for the same period as reported on the same forms. Composite Federal Share 1 is based on the following MEGs: Non-Expansion Adults. Composite Federal Share 2 is based on the following MEGs: MAC, TSOA. Composite Federal Share 3 is based on the following MEGs: Foundational Community Supports 1, Foundational Community Supports 2. Composite Federal Share 4 is based on the following MEGs: SUD IMD. For the purpose of interim monitoring of budget neutrality,

a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method.

105. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.
b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.
c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

106. Enforcement of Budget Neutrality. CMS shall enforce the budget neutrality agreement over the life of the demonstration, rather than on an annual basis. The state shall submit to CMS an annual report to determine if/how the state is meeting its expenditure goals (see STC 107. If the state exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified in Table 7 below for any of the demonstration years (DY), the state must submit a corrective action plan to CMS for approval.

Table 7: Maximum Budget Neutrality Caps

Demonstration Year	Cumulative Target Definition	Percentage
DY1	Cumulative Budget Neutrality Limit Plus:	2.0 percent
DY1 through DY2	Cumulative Budget Neutrality Limit Plus:	1.5 percent
DY1 through DY3	Cumulative Budget Neutrality Limit Plus:	1.0 percent
DY1 through DY4	Cumulative Budget Neutrality Limit Plus:	0.0 percent
DY1 through DY5	Cumulative Budget Neutrality Limit Plus:	0.0 percent

In addition, the state shall be required to submit a corrective action plan if an analysis of the expenditure data in relationship to the budget neutrality expenditure cap indicates a possibility that the demonstration will exceed the cap.

107. Annual Budget Neutrality Report. On or before July 1, 2018 , and on July 1 of each year thereafter, the state shall submit to CMS an Annual Budget Neutrality Monitoring Report, which will include an assessment of the demonstration's budget neutrality status based on actual expenditures to-date (including complete or nearly complete actual expenditures for the immediately preceding DY), the cumulative budget neutrality limit to-date, and updated projections for both the budget neutrality limit and WW expenditures through the end of the current approval period. If the state's actual expenditures are found to have exceeded the cumulative budget neutrality limit by more than the percentages described in Table 8 above, or if the state's projections show that that actual cumulative spending will exceed the budget neutrality limit for the approval period, the state must include corrective actions to ensure budget neutrality for the demonstration, with priority given to reduction of planned DSHP and/or DSRIP spending. As outlined in STC 101(b), the state will also report expenditures related to HepC Rx.

108. Budget Neutrality Monitoring Tool. The state and CMS will jointly develop a budget neutrality monitoring tool (using a mutually agreeable spreadsheet program) for the state to use for quarterly budget neutrality status updates including established baselines and member months and other in situations when an analysis of budget neutrality is required. The tool will incorporate the "C Report" for monitoring actual expenditures subject to budget neutrality. A working version of the monitoring tool will be sent by the end of calendar year 2018

109. Exceeding Budget Neutrality. If the budget neutrality expenditure limit has been exceeded at the end of the demonstration period, the excess federal funds must be returned to CMS using the methodology outlined in STC 104, composite federal share ratio. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

XII. EVALUATION OF THE DEMONSTRATION

110. Submission of a Draft Evaluation Design Update. The state must submit to CMS for approval a draft evaluation design no later than 120 calendar days after CMS' approval date of the demonstration. At a minimum, the draft evaluation design must include a discussion of the goals, objectives, and evaluation questions specific to the entire delivery system reform demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population, specific testable hypothesis, including those that focus on target populations for the demonstration and more generally on beneficiaries, providers, plans, market areas and public expenditures. The draft design should be described in sufficient detail to determine that it is scientifically rigorous. The data strategy must be thoroughly documented. It must discuss the data sources, including the use of Medicaid encounter data,

and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring within the state (i.e. SIM grant). However, it is understood that the transformation initiatives under the demonstration inherently build upon the State Health Care Innovation Plan and other ongoing transformation efforts in Washington, and the summative evaluation design will reflect this. The state commits to the development of a draft evaluation design that directly reflects the demonstration domains of focus, and will ensure separate evaluations of federally funded efforts. The draft design must describe the state's process to select an outside contractor for the evaluation.

The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results. Information from the external quality review organization (EQRO) may be considered for the purposes of evaluation, as appropriate.

The state must acquire an independent entity to conduct the evaluation. The evaluation design must describe the state's process to contract with an independent evaluator, including a description of the qualifications the entity must possess, how the state will ensure no conflict of interest, and budget for evaluation activities.

111. Demonstration Hypotheses. The state will test the following hypotheses in its evaluation of the demonstration.

a. Whether community-based collaborations that define community health needs can (1) support redesigned care delivery, (2) expand health system capacity, and (3) improve individual and population health outcomes - resulting in a reduction in the use of avoidable intensive services, a reduction in use of intensive service settings, bringing spending growth below national trends, and accelerating value-based payment reform.
b. Whether providing limited scope LTSS to individuals "at risk" for Medicaid and to Medicaid beneficiaries who are not currently receiving Medicaid-funded LTSS 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.
c. Whether the provision of foundational community supports - supportive housing and supported employment - will improve health outcomes and reduce costs for a targeted subset of the Medicaid population.
d. Whether federal funding of DSHPs enabled the state to leverage Medicaid spending to support delivery system reforms that resulted in higher quality care and in long term federal savings that exceeded the federal DSHP funding.
e. Whether authorizing expenditure authority for services in IMDs will increase Medicaid beneficiary access to inpatient and residential SUD treatment services as part of an effort to provide the full continuum of treatment services, and increase the likelihood that

Medicaid beneficiaries receive SUD treatment in the setting most appropriate for their needs.

112. Domains of Focus. The Evaluation Design must, at a minimum, address the research questions listed below. For questions that cover broad subject areas, the state may propose a more narrow focus for the evaluation.

a. Was the DSRIP program effective in achieving the goals of better care for individuals (including access to care, quality of care, health outcomes), better health for the population, or lower cost through improvement through the implementation of transformation projects by community-based collaborations? To what degree can improvements be attributed to the activities undertaken under DSRIP?

b. To what extent has the DSRIP enhanced the state's health IT ecosystem to support delivery system and payment reform? Has it specifically enhanced these four key areas through ACHs and provider partners: governance, financing, policy/legal issues and business operations?

c. To what extent has the DSRIP program improved quality, efficiency and effectiveness of care processes through care delivery redesign, including bi-directional integration of behavioral, physical and SUD services, alignment of care coordination, and coordination between providers, including bi-directional integrated delivery of physical, behavioral health services, SUD services, and transitional care services, and alignment of care coordination and to serve the whole person?

d. What are the effects of modifying eligibility criteria and benefit packages for long-term services and supports?

e. What is the effectiveness of the providing foundational community supports, described in Section VII in terms of health, quality of life, and other benefits to the Medicaid program?

113. Evaluation Design Process: Addressing the research questions listed above will require a mix of quantitative and qualitative research methodologies. When developing the DSRIP Planning Protocol, the state should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design. From these, the state must select a preferred research plan for the applicable research question, and provide a rationale for its selection.

To the extent applicable, the following items must be specified for each design option that is proposed:

a. Quantitative or qualitative outcome measures;
b. Baseline and/or control comparisons;
c. Process and improvement outcome measures and specifications;
d. Data sources and collection frequency;

e. Robust sampling designs (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses);
f. Cost estimates;
g. Timelines for deliverables.

114. Levels of Analysis: The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups. In its review of the draft evaluation plan, CMS reserves the right to request additional levels of analysis.

115. Final Evaluation Design and Implementation. CMS shall provide comments on the draft Evaluation Design within 60 calendar days of receipt, and the state shall submit a final Evaluation Design within 60 calendar days after receipt of CMS comments. The state shall implement the Evaluation Design and submit its progress in each of the quarterly and annual reports.

116. Evaluation Reports.

a. **Interim Evaluation Report.** The state must submit a Draft Interim Evaluation Report 12 months prior to the expiration of the demonstration. The purpose of the Interim Evaluation Report is to present preliminary evaluation findings, and plans for completing the evaluation design and submitting a Final Evaluation Report according to the schedule outlined in (b). The state shall submit the final Interim Evaluation Report within 60 calendar days after receipt of CMS comments.

b. **Final Evaluation Report.** The state must submit to CMS a draft of the Final Evaluation Report by January 30, 2022. The state shall submit the final evaluation report within 60 calendar days after receipt of CMS comments.

c. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully, to the greatest extent possible, with CMS or the independent evaluator selected by CMS. The state must submit the required data to CMS or the contractor. Requests for information and data from CMS or the independent evaluator selected by CMS shall be made in a timely manner and provide the state with an adequate timeframe to provide the information as agreed to by CMS and the state.

XIII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION PERIOD

Date	Deliverable	STC
Administrative		
30 calendar days after approval date	State acceptance of demonstration STCs and Expenditure Authorities	Approval letter
Post Approval Protocols		
60 calendar days after approval date	Submit Draft DSRIP Planning Protocol (Attachment C) and DSRIP Program Funding & Mechanics Protocol (Attachment D)	STCs 32, 33
60 calendar days after approval date	Submit Draft DSHP Claiming Protocol (Attachment B)	STC 93
90 calendar days after approval date	Submit Tribal Engagement and Collaboration Protocol (Attachment H)	STC 22
October 1, 2017 and due on October 1 of each year annually thereafter	Submit Value-Based Roadmap (Original) (Attachment F)	STC 39
120 calendar days after approval date.	Submit Intergovernmental (IGT)Transfer Protocol (Attachment E)	STC 88
60 calendar days after approval date	Submit Financial Executor Role (Attachment G)	STC 25
60 calendar days after approval date	Submit Foundational Community Supports Protocol (Attachment I)	STC 60
90 days after SUD program approval date	SUD Implementation Protocol	STC 78(a)
150 days after SUD program approval date	SUD Monitoring Protocol	STC 78(b)
Evaluations		
120 calendar days after approval date	Submit Draft Design for Evaluation Report	STC 110
One year prior to the expiration of the demonstration	Submit Draft Interim Evaluation Report	STC 116
60 calendar days after receipt of CMS comments	Submit Final Interim Evaluation Report	STC 116
January 31, 2022	Submit Draft Final Evaluation Report	STC 116
60 calendar days after receipt of CMS comments	Submit Final Evaluation Report	STC 116
December 31, 2020	Submit Draft SUD Mid-point Assessment	STC 78

60 calendar days after receipt of CMS comments	Submit Final SUD Mid-point assessment	STC 78
Quarterly/Annual/Final Reports		
Quarterly Deliverables, except 4th quarter: Quarter 1 report: June 1 of each demonstration year Quarter 2 report: September 1 of each demonstration year Quarter 3 report: December 1 of each demonstration year	Quarterly Progress Reports	STC 72
Quarterly Expenditure Reports (CMS-64) are due 60 calendar days after the end of each quarter.	Quarterly Expenditure Reports (CMS 64)	STC 79
March 1 of each subsequent demonstration year.	Draft Annual Report	STC 74
Annual Budget Neutrality Reports due on or before July 1, 2018 , and on July 1 of each year thereafter	Annual Budget Neutrality Reports	STC 107
Final Report due 120 days after the end of the demonstration	Final Report	STC 75

ATTACHMENT A
Quarterly Report Template

Quarterly Report Template

Pursuant to STC 74 (Quarterly Operational Reports), the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

NARRATIVE REPORT FORMAT:

Title Line One**:** Washington State Medicaid Transformation Project (MTP) Section 1115 Waiver Demonstration

Title Line Two: Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period: ***[Example: Demonstration Year: 1 (1/1/2016– 12/31/2016)***
Federal Fiscal Quarter:
Footer: Date on the approval letter through end of demonstration period]

Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

Accountable Communities of Health (ACH) and Delivery System Reform Information

Discuss the following:

1. Trends and any issues related to access to care, quality of care, care integration and health outcomes, including progress toward statewide fully integrated managed care.

2. Information about each regional ACH, including the number and type of participating providers, and efficiencies realized through ACH development and maturation.

3. Information about the state's Health IT ecosystem, including improvements to governance, financing, policy/legal issues, business operations and bi-directional data sharing with ACHs.

4. Information about progress made toward demonstration objectives: health systems and community capacity, financial sustainability through participation in VBP, bidirectional integration of physical and behavioral health, community-based whole person care and improved health equity and reduced health disparities.

Please complete the following table that outlines number of beneficiaries residing in each region under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

Attribution by Residence Counts for Quarter and Year to Date

Note: Enrollment counts should be unique enrollee counts by *each* regional ACH, not member months

Name of ACH	Current Enrollees (year to date)

VI. Operational/Policy/Systems/Fiscal Developments/Issues

A status update that identifies all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, health plan contract changes and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

IX. Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state's actions to address these issues.

XI. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

XII. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

XIII. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

XIV. Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

XV. State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

ATTACHMENT B
DSHP Claiming Protocol

I. Review of DSHPs included in STCs

To support the goals of health system transformation, the state may claim Federal Financial Participation (FFP) for actual expenditures related to Designated State Health Programs (DSHP), subject to a maximum 5-year capped amount of $748,431,326 (total computable; see Section X). As described in these STCs, DSHP expenditures may be claimed for the period beginning January 9, 2017 and ending December 31, 2021. The state's programs that will serve as DSHPs are described in Table A below (see also STC 90, Table 3) and the limits and timelines under which the state may claim matching funds for these expenditures are described in Table B (see also STC 91, Table 4). This protocol describes the methodology and guidelines by which the state may claim FFP for DSHP expenditures.

Table A. Designated State Health Programs (DSHP) List

Number	Responsible Entity	Program
A	Health Care Authority (HCA) or successor	Kidney Disease Program (KDP)
B	Aging and Long-Term Support Administration (ALTSA) or successor	Nursing Homes, Community Residential, and Homecare
C	Aging and Long-Term Support Administration (ALTSA) or successor	State Family Caregiver Support
D	Aging and Long-Term Support Administration (ALTSA) or successor	Senior Citizen's Services Act (SCSA)
E	Aging and Long-Term Support Administration (ALTSA) or successor	Office of the Deaf and Hard of Hearing
F	Development Disabilities Administration (DDA) or successor	Employment & Day and Other Community Services
G	Development Disabilities Administration (DDA) or successor	Community Residential & Homecare
H	Behavioral Health Administration (BHA) or successor	Crisis and other non-Medicaid services
I	Behavioral Health Administration (BHA) or successor	Program of Assertive Community Treatment (PACT)
J	Behavioral Health Administration (BHA) or successor	Offender Re-entry Community Safety Program

K	Behavioral Health Administration (BHA) or successor	Spokane Acute Care Diversion
L	Behavioral Health Administration (BHA) or successor	Psychological Evaluations
M	Behavioral Health Administration (BHA) or successor	Outpatient and Support Services
N	Behavioral Health Administration (BHA) or successor	Residential Services
O	Behavioral Health Administration (BHA) or successor	Parent in Reunification
P	Behavioral Health Administration (BHA) or successor	Problem Gambling Services
Q	Department of Corrections (DOC) or successor	Mental health transition services
R	Department of Corrections (DOC) or successor	ORCS (Offender Reentry Community Safety)
S	Department of Corrections (DOC) or successor	Medications for Releasing Offenders
T	Department of Corrections (DOC) or successor	Community-supervised violator medical treatment
U	Department of Health (DOH) or successor	Tobacco and Marijuana Prevention and Education
V	Department of Health (DOH) or successor	Family Planning Non-Title X
W	Department of Health (DOH) or successor	HIV/AIDS Prevention
X	Other or successor	Health Professional Loan Repayments (WA Student Achievement Council)
Y	Other or successor	Street Youth Service (Department of Commerce)
Z	Other or successor	"County Levy" Health Programs (see Attachment B)

Table B. DSHP Limits

Demonstration Year (DY)	DSHP Total
DY1 (1/9/2017-12/31/2017)	$240,000,000
DY2 (1/1/2018 – 12/31/2018)	$216,000,000
DY3 (1/1/2019 – 12/31/2019)	$117,008,060
DY4 (1/1/2020 – 12/31/2020)	$76,543,710
DY5 (1/1/2021 – 12/31/2021)	$98,879,556
Total	**$748,431,326**

II. Documentation of Expenditures for General DSHP

In claiming DSHP expenditures, the state will provide CMS with a summary Excel worksheet by Responsible Entity and program in an orderly format, or other CMS-approved alternative, so that CMS may review and test underlying supporting documentation as detailed in this claiming protocol.

A. For all DSHPs claimed, the state will make available to CMS for quarterly DSHP expenditures the following information:

- Responsible Entity
- Program
- Total amount paid to date
- Certified Public Expenditure (CPE) Documentation

B. Documentation of expenditures for each DSHP will be clearly outlined in supporting documents and be made available to CMS in accordance with this claiming protocol.

III. Unallowable DSHP Expenditures

In accordance with STC 92(b), DSHP expenditures submitted to CMS will not include:

- Grant funding to test new models of care;
- Construction costs (bricks and mortar);
- Room and board expenditures;
- Animal shelters and vaccines;
- School-based programs for children;
- Unspecified projects;
- Debt relief and restructuring;
- Costs to close facilities;
- HIT/HIE expenditures;
- Services provided to undocumented individuals;
- Sheltered workshops;
- Research expenditures;
- Rent and utility subsidies normally funded by the United States Department of Housing and Urban Development;
- Prisons, correctional facilities, and services provided to individuals who are civilly committed and unable to leave;
- Revolving capital fund;
- Expenditures made to meet a maintenance of effort requirement for any federal grant program;

- Administrative costs;
- Cost of services for which payment was made by Medicaid or CHIP (including from managed care plans);
- Cost of services for which payment was made by Medicare or Medicare Advantage;
- Funds from other federal grants;
- Needle-exchange programs;
- Abortions that would not be allowable if furnished under Medicaid or CHIP; and
- Costs associated with funding federal matching requirements.

IV. Background on Washington's Financing and Accounting Systems

The Financial Services Division (FSD), within the Health Care Authority (HCA), is responsible for accounting and financial management services that include accounts payable, accounts receivable, billing, data management and financial reporting and analysis. The FSD is responsible for the draw-down of federal funds in accordance with the Cash Management Improvement Act (CMIA). Additionally, financial managers of the various DSHPs are responsible for identifying costs eligible and allowable for federal match at the state-specific Federal Medical Assistance Percentages (FMAP) for federal reimbursement, and proper reporting.

A. Agency Financial Reporting System (AFRS)

The Agency Financial Reporting System (AFRS) is the state's official accounting system. This system is used to process accounting transactions (pay bills, record revenue and general ledger). The integrity of all accounting processes is audited as part of the state's Single Audit performed by the Washington State Auditor's Office, in accordance with OMB Circular A-133. This independent audit of internal control systems, financial records, financial statements, and federal award transactions and expenditures over federally funded programs is to ensure compliance with federal regulations.

B. Sources of Non-Federal Share

Federal Financial Participation for DSHP expenditures, as described above, is time-limited and phases down each year of the demonstration, as described in STC 91, Table 4. The state provides assurance that the non-federal share of funds for the demonstration is consistent with STC 86. The state further assures that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law.

For purposes of expenditures claimed under this protocol, the state will use certified public expenditures (CPE) as the funding mechanism to claim federal match for the approved state and local DSHPs as identified in STC 87(c). In addition to certifying that expenditures are eligible for FFP under the DSHP provisions of the demonstration

project, the contributing Responsible Entities must certify that the sources of the non-federal share comply with the terms of this paragraph, excluding the types of program costs that are not eligible for FFP as defined in STC 92(b).

Certified Public Expenditure Process

For each DSHP, the state must perform the following steps to determine the amount of the DSHP expenditures eligible for FFP. The payments and associated claimed expenditures must be commensurate with actual program services delivered and actual allowable program expenditures. DSHPs with claims processed through ProviderOne[13] are based on an approved unit rate.

For each demonstration year, the Responsible Agency with an approved DSHP will complete an annual form to be provided to HCA. The annual form is for HCA's internal budgeting, monitoring and reporting and is not used to inform or support federal claiming. This form will include:

- Name of Responsible Entity
- Name of Program
- Program account coding
- Budget for the demonstration year
- Estimated expenditures by month for the demonstration year
- Certification and attestation by the Responsible Entity CFO or designee

On a monthly basis, HCA will collect from Responsible Entities with an approved DSHP the following information for federal claiming purposes

- Actual monthly costs spent for the approved DSHP
- Cost documentation to support the Responsible Entity DSHP expenditures

Certification and attestation by the Responsible Entity CFO or designee. The Responsible Entity will attest to the following specific attributes:

- information submitted is true, accurate, and complete
- information submitted is prepared in accordance with governing law and HCA instructions
- acknowledge that all information submitted in the CPE application is subject to audit by HCA or its authorized designee
- unallowable expenditures as defined in STC 92(b) are excluded from certified expenditures, only net expenditures are being claimed

The State will perform the following steps in order to provide reasonable assurance that the CPE expenditures are accurate and allowable:

[13] ProviderOne is Washington's Medicaid Management Information System (MMIS).

- Review the CPE form and supporting documentation for accuracy.
- Ensure the Responsible Entity's CFO or designee's attestation is obtained
- Inquire with the Responsible Entity if any discrepancies are discovered on the application or supporting documentation
- If discrepancies exist, ensure that the Responsible Entity submits a revised CPE form

Using the CPE funding mechanism, the state will claim the federal share on its quarterly CMS 64 based on the actual total computable expenditures certified by the Responsible Entity with an approved DSHP.

HCA will maintain all CPE records and other supporting documentation. HCA will prepare and submit the CMS-64 Quarterly Expense Report, identifying the expenditures allowable for federal claiming.

HCA will contract with an independent auditor to annually validate the accuracy of the federal claim. Each of the Responsible Entities with an approved DSHP will be required to provide full cooperation with the independent auditor.

V. DSHP Program Details

General DSHP expenditures will be claimed for the following programs, as listed in Table A. A description of each of these programs and the procedures used to document expenditures for these programs are included below.

A. Program Title: Kidney Disease Program (KDP)

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

The Kidney Disease Program (KDP) is a state-funded program that helps low-income residents with their high costs for treatment of end stage renal disease (ESRD), also known as kidney disease or kidney failure. Undocumented individuals are not eligible for KDP services. HCA contracts with kidney centers to provide ESRD services to KDP clients. Services include:

- In-center dialysis
- In-home dialysis
- Medications
- Anti-rejection medication for transplant patients
- Home helper costs
- Equipment and home supplies

- Transportation
- Pre-transplant dental work (with prior authorization)

HCA also reimburses the client's share of the following expenses:

- Insurance premiums
- Medicare premiums
- Co-insurance and co-pays

Eligible Population:

Gross household income must be at or below 220 percent of Federal Poverty Level and must satisfy resource limitations and medical and residential criteria.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in the STCs. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b)(i) through (xxiii). All expenditures on these contracts are related to treating the client's costs for ESRD. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

B. Program Title: Nursing Homes, Community Residential and Homecare
Funding Sources: General Fund State, Medicaid.

These programs receive Medicaid funding; however, only General Fund State expenditures will be claimed.

Brief Description:

Medicaid services for non-Medicaid eligible elderly and disabled populations not meeting functional and/or financial requirements through the traditional Medicaid Long Term Services and Supports (LTSS) system. Services include in-home personal care, residential care, dementia care, behavioral supports, and other in-home services, which may include personal response systems, equipment, and registered nurse delegation. Clients receive services based on their individual assessment, which measures their level of need with activities of daily living (ADL) in addition to other supports/needs.

Eligible Population:

Generally, any individual normally served under Medicaid Community First Choice (CFC), but who has fallen out of eligibility (temporarily). These costs exclude those receiving services under the Alien Emergency Medical program.

Residential Care Discharge Allowance (RCDA): individuals eligible for residential discharge allowance:

- Receive long-term care services from home and community services;
- Are being discharged from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to your own home;
- Do not have other programs, services, or resources to assist with these costs;
- Have needs beyond what is covered under the Community Transition Services (under Community First Choice); and
- DDA clients who are being discharged from Nursing Facilities only.

Washington Roads:

There are three cohorts of individuals eligible for Washington Roads. Clients who are recipients in the N05 Medicaid coverage group in ACES are eligible for WA Roads when cohort-specific criteria are met:

- Cohort 1. Individuals eligible for WA Roads while in an institution are:
  - People age 18 and older with a continuous 30-day or longer stay in a hospital or nursing facility; and
  - Medicaid recipients in the institution for at least one day or Fast Track eligible; and
  - Functionally and financially eligible (or Fast Tracked) for waiver/state plan home and community based services (HCBS), which currently include Community First Choice (CFC), Medicaid Personal Care (MPC), Alternative Benefit Plan – Medicaid Personal Care (ABP-MPC), Community Options Program Entry System (COPES), Residential Support Waiver (RSW) and New Freedom.
- Cohort 2. Individuals eligible for WA Roads while living in the community are functionally and financially eligible for waiver/state plan HCBS AND have any one of these characteristics:
  - Unstable residential or in-home settings
  - Frequent institutional contacts (ER visits, SNF stays, hospital admits, etc.)
  - Frequent turnover of caregivers
  - Multiple systems involvement (DOC, psychiatric institutions, etc.)

- Is interested in obtaining employment through the Steps to Employment (S2E) project and the project is available in the individual's geographical area.

- Cohort 3. Individuals living in subsidized housing that have been coordinated through ALTSA (including NED, Bridge, 811, etc.), regardless of whether they are currently eligible for, or receiving, waiver/state plan HCBS.

  Individuals who are not eligible for WA Roads are:

  - Clients residing in Intermediate Care Facilities for the Intellectually Disabled (ICF/IIDs) or Residential Habilitation Centers (RHCs).
  - Clients enrolled in managed long-term care programs such as PACE.
  - Clients enrolled in programs for non-citizens (Alien LTC)

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in the Special Terms & Conditions of the demonstration. Any unallowable expenditures identified for the items listed in STC 92(b)(i) through (xxiii) will be excluded from claiming. Controls exist within ProviderOne and IPOne[14] to identify those expenditures that should be excluded. Expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

C. Program Title: State Family Caregiver Support

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Supportive services for the unpaid caregivers of non-Medicaid enrolled elderly and disabled adults to delay or divert the care recipient from entering or spending down to the more expensive traditional Medicaid long-term care system. Services include respite, consultation and options counseling, training, equipment, and evidence based interventions. The current state program will continue in its current form; however, initiative two of the waiver proposes a significant program expansion to serve additional caregivers.

[14] The Individual Provider One (IPOne) is the online, electronic payment system that allows individual providers to submit timesheets, receive pay for hours worked for in home clients, and allows providers to manage claims.

Eligible Population:

Any income level. Individuals with higher income levels will be asked to participate towards the cost of care for respite based on a sliding fee basis. Eligible individuals must be adults 18 or older caring for adults 18 or older.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in the Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organization to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that such services are not provided to undocumented individuals.

D. Program Title: Senior Citizen's Services Act (SCSA)

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Supportive services for the elderly population who are not receiving Medicaid LTSS paid services or who need services not payable through Medicaid funds to delay entry into the Medicaid long-term care system. Services are administered and/or delivered by the Area Agencies on Aging (AAA) and are provided to restore or maintain each client's ability to maintain living in the community. Services vary by AAA and include information and referrals, foot care, bath assistance, adult day health/day care, transportation, meals, Family Caregiver Support, Long-Term Care Ombudsman, and health promotion. AAAs also use SCSA funding to support their planning, coordination, and administrative functions but these expenditures will not be claimed as DSHP.

Eligible Population:

Clients must be either (a) 65 or older or (b) 60 and older and unemployed or working less than 20 hours per week. Clients must be at risk of not being able to remain in their home with an income at or below 40 percent of state median income and resources of less than $10,000 single or $15,000 household of two. People with higher incomes may participate using a sliding fee basis.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these STCs. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

E. Program Title: Office of the Deaf and Hard of Hearing
Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

The Office of the Deaf and Hard of Hearing provides Medicaid-eligible services to Medicaid and non-Medicaid eligible individuals who are deaf, hard of hearing, and deaf-blind. Services include information, referral, advocacy, sign language interpreter services, telecom equipment distribution, relay services, and assistive community technology.

Eligible Population:

Any state resident who is deaf, hard of hearing, deaf-blind, or speech-disabled and hearing are eligible. Hearing parents with deaf babies or children are also eligible.

There are no income limits for Social and Human Services and Communication Access Services.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in the Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

F. Program Title: Employment & Day and Other Community Services
Funding Sources: General Fund State, Medicaid

These programs receive Medicaid funding; however, only General Fund State expenditures will be claimed.

Brief Description:

Services provided to non-Medicaid eligible adults and children who have a developmental disability diagnosis, to allow them to thrive in their communities and have the typical day-to-day life of their peers. Individuals age 21 and older may receive employment services. Contractors, including counties and non-profits, provide services in the traditional state Developmental Disabilities Administration service system, including individualized and group supported employment; community access; individualized technical assistance; respite individual providers; enhanced respite; medical and psychological evaluation/consultation; and crisis intervention.

Eligible Population:

Individuals who:

- Are age 21 and over, meet the other requirements contained in Chapter 388-823, and have evidence of the following:
    - A developmental disability (RCW 71A.10.020(3) attributable to intellectual disability, cerebral palsy, epilepsy, autism, or another neurological or other condition found by DDA to be closely related to intellectual disability or requiring treatment similar to that required for individuals with intellectual disability;
    - Originate prior to age eighteen;
    - Be expected to continue indefinitely; and
    - Result in substantial limitations to the individual's adaptive functioning.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these STCs of the demonstration. Any unallowable expenditures identified for the items listed in STC 92(b) i through xxiii will be excluded from claiming. Controls exist within ProviderOne and IPOne to identify those expenditures that should be excluded. Expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

G. Program Title: Community Residential & Homecare
Funding Sources: General Fund State, Medicaid

These programs receive Medicaid funding; however, only General Fund State expenditures will be claimed.

Brief Description:

Medicaid and Non-Medicaid adults and children who have a developmental disability diagnosis receive services provided through contracts with for-profit and non-for-profit organizations. This allows them to remain in the community in the least restrictive setting that supports full engagement in their communities. Services include: group homes; child foster group care; alternate living; companion home; companion home respite; client evaluation; supported living; residential transportation; staff add-ons; nurse delegation; HCBS care Individual Providers (IP); HCBS care parent provider; personal care IP child non-waiver; personal care IP adult non-waiver; personal care agency child non-waiver; personal care adult family homes; personal care transportation non-waiver; personal care IP training wages non-waiver; personal care residential arc; Children's Administration shared funding for personal care; caregiver training; residential provider training; client allowance; and, attendant care. Only services paid with state only funding will be claimed as DSHP expenditures.

Eligible Population:

Clients must be enrolled and eligible clients of the Developmental Disabilities Administration, and have been assessed as needing community residential and homecare services to meet their health and welfare needs.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in the STCs of the demonstration. Any unallowable expenditures identified for the items listed in STC 92(b) i through xxiii will be excluded from claiming. Controls exist within ProviderOne and IPOne to identify those expenditures that should be excluded. Expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

H. Program Title: Crisis and other non-Medicaid services
Funding Sources: General Fund State, Medicaid

These programs receive Medicaid funding; however, only General Fund State expenditures will be claimed.

Brief Description:

Short-term crisis services stabilize non-Medicaid and Medicaid -eligible individuals. These are provided in the community and at home by traditional designated mental health professionals. Services may be provided in partnership with the court system to ensure that referrals are medically appropriate and effectively managed.

Eligible Population:

Services are provided based on resources and access standards defined by each Behavioral Health Organization.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these STCs of the demonstration. Any unallowable expenditures identified for the items listed in STC 92(b) i through xxiii will be excluded from claiming. Controls exist within ProviderOne and IPOne to identify those expenditures that should be excluded. Expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

I. Program Title: Program of Assertive Community Treatment (PACT)
Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

An evidence-based program for people with the most severe and persistent mental illness who experience significant difficulties with activities of daily living, with active symptoms and impairments, and who have not benefited from traditional outpatient programs. The program is a person-centered, recovery-oriented mental health service delivery model that has received substantial empirical support for reducing psychiatric hospitalizations, facilitating community living, and enhancing recovery. Services are designed to avoid the frequent access of inpatient services and jails and are provided by traditional Mental Health Professionals using a wraparound approach.

Eligible Population:

Services are provided based on resources and access standards set by each Behavioral Health Organization.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these STCs of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. In addition, any expenditures associated with services provided in an IMD setting will be excluded. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

J. Program Title: Offender Re-entry Community Safety Program

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Public safety enhancement through additional mental health treatment, including short-term counseling and discharge planning for dangerously mentally ill and/or intellectually disabled individuals to avoid intensive hospitalization upon release from prison. Clients participating in the program receive services such as pre-engagement, intensive case management, needs assessment, mental health services and treatment, sex offender treatment, chemical dependency treatment, medical and other non-medical treatment supports. Once designated into the program and released into the community, the offender is eligible for up to 60 months of support including Enhanced Mental Health Treatment; Chemical Dependency Treatment, Care Management, and Educational/Vocational Services.

Eligible Population:

Population is determined by Department of Corrections/Department of Social and Health Services screening committee. Participants must have been incarcerated in DOC facility.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. In addition, any expenditures associated with services provided pre-release will be excluded. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

K. Program Title: Spokane Acute Care Diversion

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Evaluation and treatment services that divert clients with complex mental health issues from long-term stays at hospitals that are IMDs. This expenditure is for a non-IMD inpatient facility serving non-Medicaid clients.

Eligible Population:

Services are provided based on resources and access standards set by each Behavioral Health Organization.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

M. Program Title: Outpatient and Support Services

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Substance use disorder (SUD) outpatient and support services provided in the community to non-Medicaid, low income eligible individuals, often in partnership with drug courts and juvenile justice systems to ensure referrals to SUD treatment are medically appropriate and effectively managed. Services are provided by traditional chemical dependency providers who also provide State Plan Medicaid services and include assessments, opiate substitution treatment, detox, case management and outreach for adults, youth, and pregnant and parenting women.

Eligible Population:

Services are provided based on resources and access standards set by each BHO. Clients must be ten years of age or older.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

N. Program Title: Residential Services

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Residential (non-IMD) treatment services for low income adults, youth and women who are pregnant or postpartum and women with dependent children.

Eligible Population:

Services are provided based on resources and access standards set by each Behavioral Health Organization.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

P. Program Title: Problem Gambling Services

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

This program funds problem and pathological gambling prevention efforts. Activities include elder awareness, literature distribution, and problem gambling prevention activities targeting young adults. Training specific to problem and pathological gambling

is provided for chemical dependency professionals, licensed mental health counselors, psychologists, and agency affiliated counselors. A 24-hour helpline for problem and pathological gambling assists people with referrals to treatment providers and crisis stabilization.

Eligible Population:

Clients must be eighteen years of age or older and Medicaid eligible and/or Low Income (not able to afford treatment).

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

Q. Program Title: Mental Health Transition Services

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Two Psych Associates located at two separate Community Justice Centers in the community to provide mental health transitional services. These staff work one on one with offenders with identified mental health needs in the community after release from prison to help coordinate transition of care to community providers and assure those individuals are linked to the appropriate entities to address their needs and assist in a successful transition back into the community.

Eligible Population:

Any releasing offender with identified mental health transition assistance needs.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the

program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

R. Program Title: Offender Reentry Community Safety(ORCS)
Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

As part of the reentry process, a multisystem care planning team (MSCPT) works with the offender to identify, release and transition needs, which include housing, treatment for mental health and/or chemical dependency, community supports, transportation, and other specialized treatment services. Members of the MSCPT may include the Department of Corrections staff (ORCS transition mental health counselor, classification counselor, community corrections officers, and primary therapist), community mental health professional, chemical dependency professional and community support people, including family members. The MSCPT and offender complete a 48-hour transition plan that identifies appointments and activities to be completed during the first 48-hours of release. One of the main components of the program is to connect the offender with a community mental health provider prior to releasing to create a more successful link to services in the community.

Eligible Population:

Seriously mentally ill offenders transitioning back into the community.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

S. Program Title: Medications for Releasing Offenders
Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Offenders who are on medications at the time of release are provided a 30-day supply of their medications to maintain health care stability while they get accustomed to life in the community. It is more beneficial for the offender to leave with the prescription in hand and provides better assistance to transition back into the community from prison by allowing the offender time to get established with a community provider without needing to worry to get a prescription filled immediately after release.

Eligible Population:

All releasing offenders who have a current prescription as of the date of release.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

T. Program Title: Community-supervised Violator Medical Treatment
Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Payment for medical costs for supervised offenders residing in the community. Supervision includes a regular designated check-in time with the assigned Community Corrections Officers, along with any number of court-ordered stipulations (e.g., no drug use, maintaining employment, no travel out of state).

Eligible Population:

All violators under Department of Corrections jurisdiction on the date of service.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the

program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

U. Program Title: Tobacco and Marijuana Prevention and Education

Funding Sources: Dedicated Marijuana Account (State), Tobacco Control Program (Federal)

These programs receive federal funding; however, only State expenditures will be claimed.

Brief Description:

The Tobacco and Vapor Product Prevention and Control Program works with diverse partners statewide to implement policies, systems and environmental changes to prevent underage use of tobacco, promote our Tobacco Quitline, reduce second-hand smoke, and reduce disparities in our priority populations (Latino/Hispanic, LGBTQ, American Indian/Alaska Native, Asian/Pacific Islander and Black/African American). The Marijuana Prevention and Education Program works with diverse partners statewide to implement policies, systems and environmental changes to prevent underage use of marijuana, reduce second-hand smoke, and reduce disparities in our priority populations (Latino/Hispanic, LGBTQ, American Indian/Alaska Native, Asian/Pacific Islander and Black/African American).

Eligible Population:

The Washington State Tobacco Quitline (1-800-QUIT-NOW) serves all of Washington and triages callers to their health plan. About 40 percent of the calls are transferred to Medicaid or a private insurance plan. DOH covers people who are uninsured and the underinsured (callers with a health plan with no telephone counseling or nicotine replacement benefit). The Quitline does not collect income information.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

V. Program Title: Family Planning Non-Title X

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Access to family planning services, supplies, and information to all who want and need them. Family planning services are a critical part of basic healthcare that allows men and women to plan the size and spacing of their families, prepare for the birth of healthy children, and prevent unplanned pregnancies. Priority is given to people from low-income families. We do not ask about citizenship status when providing these services.

Eligible Population:

Individuals of reproductive age, with reproductive capacity, who want family planning services and are uninsured, under-insured, at or below 250 percent FPL, OR require confidential services.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above, are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

W. Program Title: HIV/AIDS Prevention
Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Supplies antiretroviral medications (Pre-Exposure Prophylaxis; PrEP) in an effort to accelerate reductions in new HIV infections for high-risk individuals by covering the full cost of Truvada® for those who are uninsured (on case by case basis) and providing co-pay assistance for Truvada® for those who are insured. The program purchases insurance for a limited amount of enrollees through the Health Benefit Exchange.

Eligible Population:

HIV-negative, insured, state residents at high risk of becoming infected with HIV. There is no income requirement.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these STCs. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

X. Program Title: Health Professional Loan Repayments (WA Student Achievement Council)

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

Financial assistance - loan repayments and conditional scholarships - to encourage licensed primary care health professionals to provide primary health care in rural or underserved urban areas with designated shortages.

Eligible Population:

Health professionals serving rural or underserved urban areas.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above, are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

Y. Program Title: Street Youth Service (Department of Commerce)

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

State-funded outreach program for unaccompanied homeless youth to connect them to health and housing services.

Eligible Population:

Unaccompanied homeless youth under the age of 18.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

Z. Program Title: "County Levy" Health Programs (see Attachment B)
Funding Sources: General Fund Private/Local

Brief Description:

Sales and use tax distributed for chemical dependency or mental health treatment services or therapeutic courts to support communities in implementing cost containment measures dealing with eliminating chronic jail recidivism, assuring substance abuse and mental health treatment for vulnerable populations, and gaining appropriate use of community safety and emergency services. Twenty-two (of 39) counties and 1 city (Tacoma) levied the tax in FY14. Nine counties and one city are included in this DSHP.

Eligible Population:

Eligibility and target populations vary from county to county; however, specific programs identified largely apply to financially needy populations who are otherwise ineligible for Medicaid, or provide needed services not covered by Medicaid to Medicaid beneficiaries.

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above, are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

ATTACHMENT C
DSRIP Planning Protocol

I. Preface

On January 9, 2017, the Centers for Medicare & Medicaid Services (CMS) approved Washington State's request for a section 1115(a) Medicaid demonstration entitled *Medicaid Transformation Project* demonstration (hereinafter MTP or "demonstration"). Part of this demonstration is a Delivery System Reform Incentive Payment (DSRIP) program, through which the state will make performance-based funding available to regionally-based Accountable Communities of Health (ACH) and their partnering providers. The demonstration is currently approved through December 31, 2021.

The Special Terms and Conditions (STC) of the demonstration set forth in detail the nature, character, and extent of federal involvement in the demonstration, the state's implementation of the expenditure authorities, and the state's obligations to CMS during the demonstration period. The DSRIP requirements specified in the STCs are supplemented by two attachments to the STCs. The DSRIP Planning Protocol (this document, Attachment C) describes the ACH Project Plans, the set of outcome measures that must be reported, transformation projects eligible for DSRIP funds, and timelines for meeting associated metrics.

This protocol is supplemented by a Project Toolkit and Project Measure and Performance Table. The toolkit provides additional details and requirements related to the ACH projects and will assist ACHs in developing their Project Plans.

In accordance with STC 34, the state may submit modifications to this protocol for CMS review and approval. Any changes approved by CMS will apply prospectively unless otherwise specified by CMS.

II. ACH Project Plan Requirements

a. Introduction

ACH Project Plans will provide an outline of the work that an ACH, through its partnering providers, will undertake. The plans must be developed in collaboration with community stakeholders and be responsive to community needs. The plans will provide details on how the selected projects respond to community-specific needs and further the objectives of the demonstration. The

plans also will describe the ACH's capacities, composition and governance structure. In order to be eligible to receive DSRIP incentive payments, an ACH must have an approved Project Plan.

There are three steps for ACH Project Plan approval:

1. ACHs must satisfy a two-phase certification process that will confirm the ACHs are prepared to submit Project Plan applications. Completion of each phase will qualify the ACHs for Project Design funding. Certification criteria will be set forth by the state, and ACHs will submit both phases of certification information to the state within the required time frames. The state will review and approve each certification phase prior to distribution of Project Design funds for that phase.

    a. Phase 1 certification requirements must be submitted to the state by May 15, 2017.
    b. Phase 2 certification requirements must be submitted to the state by August 14, 2017.

    Certification criteria are described further below.
2. ACHs must develop and submit a Project Plan application for approval. The components of the Project Plan are described in STC 36 and further detailed in this protocol. Completed Project Plan applications are due to the state by November 16, 2017.
3. The state and its contracted Independent Assessor will evaluate and (if appropriate) approve ACH Project Plans. ACHs with approved Project Plans are eligible to receive performance-based incentive payments. The state and the Independent Assessor will approve Project Plans as early as November 20, 2017, and no later than December 22, 2017.

The state will develop and post a draft Project Plan Template for public feedback prior to releasing a final version. Design funds attached to each certification phase will support ACHs as they address specific requirements and submit their Project Plans. As ACHs develop Project Plans, they must solicit and incorporate community and consumer input to ensure that Project Plans reflect the specific needs of the region. After the Project Plans are submitted to the state, they will be reviewed by an Independent Assessor contracted by the state. The Independent Assessor will review and make recommendations to the state for approval of Project Plans. The state must approve of Project Plans in order to authorize DSRIP incentive funding. Project Plans may be subject to additional review by CMS.

b. ACH Certification Criteria

The certification process is intended to ensure that each ACH is prepared to serve as the lead entity and single point of accountability to the state for the transformation projects in its region. The certification application solicits information to ensure that: (a) the ACH is qualified to fulfill the role of overseeing and coordinating regional transformation activities; (b) the ACH meets the composition standards outlined in STC 23; and (c) the ACH is eligible to receive project design funds. There are two phases to the certification process. According to a timeline developed by the state, each ACH must complete both phases and receive approval from the state before submitting a Project Plan application.

Phase 1 Certification: Each ACH must demonstrate compliance and/or document how it will comply with state expectations in the following areas, at a minimum:

1. Governance and Organizational Structure, including compliance with principles outlined in STC 22 and decision-making expectations outlined by the state.
2. Initiation or continuation of work with regional Tribes, including adoption of the Tribal Engagement and Collaboration Policy or alternate policy as required by STC 24.
3. Community and Stakeholder Engagement to demonstrate how the ACH is accountable and responsive to the community.
4. Budget and funds flow, including how design funds will support project plan development.
5. Clinical capacity and engagement to demonstrate engagement and input from clinical providers.
6. Other requirements as the state may establish.

Phase 2 Certification: Each ACH must demonstrate that it is in compliance with state expectations in the following areas, at a minimum:

1. Governance and Organizational Structure, including compliance with principles outlined in STC 22 and decision-making expectations outlined by the state. ACHs will describe whether any developments or adjustments have occurred since Phase 1 Certification.
2. Tribal Engagement and Collaboration describing specific activities and events that further the relationship between the ACH and Tribes.
3. Community and Stakeholder Engagement to describe concrete actions that have occurred since Phase 1 Certification. Provide details for how

the ACH will satisfy public engagement requirements for Project Plan development outlined in STC 23.

4. Budget and funds flow to summarize strategic use of funding and decision making processes regarding incentive funding distribution.
5. Data-informed decision making strategies, including processes for applying available data to project selection and implementation planning.
6. Transformation project planning to describe progress on project selection processes.
7. Other requirements as the state may establish.

c. ACH Project Plan Requirements

As part of this demonstration, each ACH and its regional participating providers will be responsible for implementing a set of projects selected from the Project Toolkit. The Project Plan:

- Provides a blueprint of the work that each region, coordinated by the ACH, will undertake through the implementation of these projects.
- Explains how the regional work responds to community-specific needs, relates to the mission of the ACH, and furthers the objectives of the demonstration.
- Provides details on the ACH's composition and governance structure, specifically any adjustments to refine the model based on initial lessons learned.
- Demonstrates ACH compliance with the terms and conditions of participation in the demonstration.
- Incorporates the voice and perspective of the community and consumers through outreach and engagement.

Each ACH will submit a Project Plan to the state for review. The Project Plans will be used by the state to assess ACH preparedness in planning and implementing its local demonstration program and the regional alignment with the demonstration's overall objectives and requirements. The state's contracted Independent Assessor will review and evaluate Project Plans and make recommendations to the state for approval/remediation of each Plan. In addition, commitments made by an ACH in its Project Plan must be consistent with the terms of a contract between the state and the ACH, outlining the requirements and obligations of the ACH as the lead and other partnering providers in the ACH in order to be eligible to receive DSRIP incentive funding.

The Project Plan Template will provide a structured format and outline the information required to be submitted by each ACH as part of its Project Plan. The template will be divided into two main sections and will include scoring criteria. Section I will focus on how the ACH, through its partnering providers, is being directly responsive to the needs and characteristics of the community it serves. It will include details regarding the ACH's overall programmatic vision, composition, and decision-making processes. Section II will ask ACHs to provide detailed project-specific plans. The state may add additional requirements to the Project Plan application in addition to what is outlined below.

The categories for Section I of the Project Plan template will include:

1. *ACH Theory of Action and Alignment Strategy*: Rationale explaining how the ACH plans to improve the quality, efficiency, and effectiveness of care processes in its community.

2. *Governance*: Description of how the ACH complies with the state's governance and decision-making expectations.

3. *Regional Health Needs Inventory:* Description of how the ACH used available data to identify target populations and ensure that project selection responds to community-specific needs, aims to reduce health disparities, and furthers the objectives of the demonstration.

4. *Community and Consumer Engagement and Input*: Evidence of public input into the project plans, including consumer engagement. ACHs must demonstrate that they solicited and incorporated input from community members and consumers. The plan must also describe the processes the ACHs will follow to engage the public and how such engagement will continue throughout the demonstration period.

5. *Tribal Engagement and Collaboration*: Demonstration that the ACH has complied with the Tribal Engagement and Collaboration requirements.

6. *Budget and Funds Allocation*: Description of how decisions about the distribution of funds will be made, the roles and responsibilities of each partner in funds distribution and a detailed budget for the remaining years of the demonstration.

7. *Value-based Payment Strategies:* Description of the regional strategies to support attainment and readiness of statewide VBP targets.

For each selected project, Section II requires, that ACHs provide details regarding:

1. *Partnering Organizations*: Description of the partnering providers, both traditional and non-traditional, that have committed to participate in projects. Partnering providers must serve and commit to continuing to serve the Medicaid population. ACHs must ensure that together, these partnering providers serve a significant portion of Medicaid covered lives in the region and represent a broad spectrum of care and related social services that are critical to improving how care is delivered and paid for. Additional details on recommended implementation partners will be provided in Project Toolkit guidance documents.

2. *Relationships with Other Initiatives:* The ACH will attest to securing descriptions of any initiatives that its partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place and ensuring these projects are not duplicative of DSRIP projects. In DY 2, partnering providers will be required to provide descriptions and attest that DSRIP projects are not duplicative of other funded projects and do not duplicate the deliverables required by the former project(s). If projects are built on one of these other projects, or represent an enhancement of such a project, that may be permissible but the ACH will be required to explain how the DSRIP project is not duplicative of activities already supported with other federal funds.

3. *Monitoring and Continuous Improvement*: Description of the ACH's plan for monitoring project implementation progress and continuous improvement or adjustments in alignment with Section V (Process for ACH Project Plan Modification).

4. *Expected Outcomes*: Description of the outcomes the ACH expects to achieve in each of the project stages, in alignment with the metrics and parameters provided by the state.

5. *Sustainability:* Description of how the projects support sustainable delivery system transformation for the target population.

6. *Regional Assets, Anticipated Challenges and Proposed Solutions*: Description of the assets that the ACH and partnering providers bring to the delivery system transformation efforts, and the challenges or barriers they expect to confront in improving outcomes and lowering costs for the target populations. For identified challenges, the ACH must describe how

it expects to mitigate the impact of these challenges and what new capabilities will be required to be successful.

7. *Implementation Approach and Timing*: Explanation of the planned approach to accomplishing each set of required project milestones for each of the selected projects.

III. Project Toolkit

a. Overview of Project Categories

Each ACH, through its partnering providers, is required to implement at least four transformation projects and participate in statewide capacity building efforts to address the needs of Medicaid beneficiaries. These projects will be spread across the following three domains:

1. Health Systems and Community Capacity Building
2. Care Delivery Redesign (at least two projects)
3. Prevention and Health Promotion (at least two projects)

The Domains, and the strategies defined within each Domain, are interdependent. Domain 1 is focused on systemwide planning and capacity-building to reinforce transformation projects. Domain 1 strategies are to be tailored to support efforts in Domain 2 and Domain 3; projects in Domain 2 and Domain 3 integrate and apply Domain 1 strategies to the specified topics and approaches.

ACHs will develop detailed implementation plans. As described in Section IV, project progress will be measured based on state-defined milestones and metrics that track project planning, implementation, and sustainability.

b. Description of project domains

i. Health Systems and Community Capacity Building

This domain addresses the core health system capacities to be developed or enhanced to transition the delivery system according to Washington's Medicaid Transformation demonstration. Domain 1 does not outline individual projects, but rather three required focus areas to be implemented and expanded across the delivery system, inclusive of all provider types, to benefit the entire Medicaid population. The three areas of focus are: financial sustainability through value-based payment, workforce, and systems for population health management. Each of these

areas will need to be addressed progressively throughout the five-year timeline to directly support Domain 2 and Domain 3 transformation project success.

ii. Care Delivery Redesign

Transformation projects within this domain focus on innovative models of care that will improve the quality, efficiency, and effectiveness of care processes. Person-centered approaches and integrated models are emphasized. Domain 2 includes one required project and three optional projects. ACHs will be required to select at least one of the optional projects for a minimum of two Domain 2 projects in total.

iii. Prevention and Health Promotion

Transformation projects within this domain focus on prevention and health promotion to eliminate disparities and achieve health equity across regions and populations. Domain 3 includes one required project and three optional projects. ACHs will be required to select at least one of the optional projects for a minimum of two Domain 3 projects in total.

Table 1. Menu of Transformation Projects

#	Project	Description
Health Systems and Community Capacity Building		Foundational activities that address the core health system capacities to be developed or enhanced to transition the delivery system in accordance with the demonstration's goals and transformation objectives.
Financial sustainability through value-based payment		Paying for value across the continuum of care is necessary to ensure the sustainability of the transformation projects undertaken through this demonstration. A transition away from paying for volume may be challenging to some providers, both financially and administratively. As not all provider organizations are equipped at present to successfully operate in these payment models, providers may need assistance to develop additional capabilities and infrastructure.
Workforce		The health services workforce will need to evolve to meet the demands of the redesigned system of care. Workforce transformation will be supported through the provision of training and education services, hiring and deployment processes, and integration of new positions and titles to support transition to team-based, patient-centered care and ensure the equity of care delivery across populations.
Systems for population health management		The expansion, evolution, and integration of health information systems and technology will need to be supported to improve the speed, quality, safety, and cost of care. This includes linkages to community-based care models. Health data and analytics capacity will need to be improved to

		support system transformation efforts, including combining clinical and claims data to advance VBP models and to achieve the triple aim.
Care Delivery Redesign		Strategies that focus on innovative models of care to improve the quality, efficiency, and effectiveness of care processes. Person-centered approaches and integrated models are emphasized.
2A	**Bi-directional integration of physical and behavioral health through care transformation**	The Medicaid system aims to support person-centered care that delivers the right services in the right place at the right time. Primary care services are a key gateway to the behavioral health system, and primary care providers need additional support and resources to screen and treat individuals for behavioral health care needs, provide or link with appropriate services, and manage care. Similarly, for persons not engaged in primary care services, behavioral health settings can be equipped to provide essential primary care services. Integrating mental health, substance use disorder, and primary care services has been demonstrated to deliver positive outcomes and is an effective approach to caring for people with multiple health care needs. Through a whole-person approach to care, physical and behavioral health needs will be addressed in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through managed care organizations, for people enrolled in Medicaid.
2B	**Care coordination**	Care coordination is essential for ensuring that children and adults with complex health service needs are connected to the evidence-based interventions and services that will improve their outcomes. Appropriately coordinated care is especially important for high-risk populations, such as those living with chronic conditions, those impacted by the social determinants of health such as unstable housing and/or food insecurity, the aging community, and those dependent on institutionalized settings. Communities are challenged to leverage and coordinate existing services, as well as establish new services to fill gaps. Without a centralized approach to "coordinating the coordinators," a single person might be assigned multiple care coordinators who are unaware of one another, potentially provide redundant services, and risk creating confusion for the individual.
2C	**Transitional care**	Points of transition out of intensive services/settings, such as individuals discharged from acute care, inpatient care or from jail or prison into the community are critical intervention points in the care continuum. Transitional care services provide opportunities to reduce or eliminate avoidable admissions, readmissions and jail use. Individuals discharged from intensive settings may not have a stable environment to return to or may lack access to reliable care. Transitions can be especially difficult on beneficiaries and caregivers when there are substantial changes in

		medications or routines or an increase in care tasks. This project includes multiple care management and transitional care approaches.
2D	**Diversion interventions**	Diversion strategies provide opportunities to re-direct individuals away from high-cost medical and legal avenues and into community-based health care and social services that can offer comprehensive assessment, care/case planning and management to lead to more positive outcomes. This strategy promotes more appropriate use of emergency care services and also supports person-centered care through increased access to primary care and social services, especially for medically underserved populations.
Prevention and Health Promotion		Projects focus on prevention and health promotion to eliminate disparities and achieve health equity across regions and populations.
3A	**Addressing opioid use public health crisis**	The opioid epidemic affects communities, families, and overwhelms law enforcement, health care and social service providers. Opioid use disorder is a devastating and life-threatening chronic medical condition and access to treatments that support recovery and access to lifesaving medications to reverse overdose needs to be improved. This project will support strategies focused on addressing prevention, treatment, overdose prevention and recovery supports aimed at supporting whole-person health
3B	**Reproductive and maternal/child health**	Focusing on the health of women and children is a primary focus for the Medicaid program as Medicaid funds more than half of the births in the state and provides coverage to more than half of Washington's children. This project focuses on ensuring access to ongoing women's health care to improve utilization of effective family planning strategies. It further focuses on providing mothers and their children with home visits that have been demonstrated to improve maternal and child health. Home visitors work with the expectant or new mother in supporting a healthy pregnancy, by recognizing and reducing risk factors, promoting prenatal health care through healthy diet, exercise, stress management, ongoing well-woman care, and by supporting positive parenting practices that facilitate the infant and young child's safe and healthy development. Child health promotion is a state priority to keep children as healthy and safe as possible, which includes parents accessing timely and routine preventative care for children, especially well-child screenings and assessments.
3C	**Access to oral health services**	Oral health impacts overall health and quality life, and most oral disease is preventable. Oral disease has been associated with increased risk for serious adverse health outcomes. Increasing access to oral health services for adults provides an opportunity to prevent or control the progression of oral disease, and to reduce reliance on emergency departments for oral pain and related conditions. This project focuses on providing oral health screening and assessment, intervention, and referral in the primary care setting, or through the deployment of mobile clinics and/or portable

		equipment. The project seeks to leverage the primary care workforce, and to strengthen relationships between primary care and dental providers, through stronger referral networks, improved communications, and shared incentives.
3D	**Chronic disease prevention and control**	Chronic health conditions are prevalent among Washington's Medicaid beneficiaries, and the number of individuals with or at risk for chronic disease is increasing. Disease prevention and effective management is critical to quality of life and longevity. Many individuals face cultural, linguistic and structural barriers to accessing quality care, navigating the health care system, and understanding how to take steps to improve their health. Improving health care services and health behaviors is only part of the solution. Washington State recognizes the impact that factors outside the health care system have on health and is committed to a "health in all policies" approach to effective health promotion and improved treatment of disease. The Chronic Disease Prevention and Control Project focuses on integrating health system and community approaches to improve chronic disease management and control.

IV. Project Stages, Milestones, and Metrics

a. Overview

In accordance with STC 35, over the duration of the demonstration, the state will shift accountability from a focus on rewarding achievement of progress milestones in the early years of the demonstration to rewarding improvement on performance metrics in the later years of the demonstration. During Years 2, 3 and 4, ACHs will be required to report against several progress milestones for each project, as described further below and as detailed in the Project and Metrics Specification guide. These progress milestones are, by definition, 'pay-for-reporting' or 'P4R,' since ACHs will be rewarded based on reported progress. Project progress milestones are defined in the Project Toolkit, specific to each project focus, and organized into three core categories: project planning milestones, project implementation progress milestones, and scale and sustain milestones.

To monitor performance, ACHs will be accountable for achieving targeted levels of improvement for project-specific outcome measures. These measures are primarily "pay-for-performance," or "P4P," since ACHs are only rewarded if defined outcome metric targets are achieved. However, a subset of these measures will be rewarded on a P4R basis for reasons that include: to allow ACHs time for project implementation activities; to allow time to establish necessary reporting infrastructure; and to allow for the testing of new, innovative outcome measures

for project areas where there is a lack of nationally-vetted, widely used outcome measures. Performance metrics are are consistent with the objectives of the demonstration as outlined in STC 30.

Table 2 below summarizes the different categories of measures. Each category is described in further detail below.

Table 2. Demonstration Milestone/Metric Categories

Milestone/Metric Type	DY1 (2017)	DY2 (2018)	DY3 (2019)	DY4 (2020)	DY5 (2021)
Project Progress Milestones	NA	P4R	P4R	P4R	NA
Performance Metrics	NA	NA	P4R/P4P	P4R/P4P	P4R/P4P
Value-based Payment Metrics	P4R/P4P	P4R/P4P	P4R/P4P	P4R/P4P	P4P

b. *Progress Milestones (Capacity Building Elements, Progress/Planning Milestones, and Metrics)*

During demonstration Year 1, each ACH will be responsible for the development, submission and approval of a Project Plan application. As part of the Project Plan application, the ACH will provide a timeline for implementation and completion of each project, in alignment with progress milestones specified in the Project Toolkit and accompanying documents. General categories of progress milestones required to be completed for each project include:

- Identify target population and assess partnering providers' capacity to fulfill project requirements. Collectively, partnering providers should serve a significant portion of Medicaid covered lives in the region and represent a broad spectrum of care and related social services that are critical to improving how care is delivered and paid for.
- Engage and obtain formal commitment from partnering providers responsible for carrying out project activities.
- Develop a detailed implementation plan, including timing of activities, financial sustainability, workforce strategies, and population health management.
- Ongoing reporting of standardized process measures, including number of individuals served, number of staff recruited and trained, and impact measures as defined in the evaluation plan.

c. *Performance Metrics* (Statewide and Project-level Outcome Metrics)

See Appendix II for the project metrics that will be used to measure progress against meeting project goals and targeted levels of improvement against outcome-based performance indicators. Section III of the Funding and Mechanics Protocol provides further detail on how identified measures will be used to evaluate ACH performance.

d. Value-based Payment Milestones

Pursuant to STC 40, the state will update its Value-based Roadmap annually, which will address how the state will achieve its goal of converting 90 percent of Medicaid provider payments to reward outcomes by 2021. This Roadmap is a document that describes the payment reforms required for a high-quality and financially sustainable Medicaid delivery system and establishes VBP targets and incentives for the Managed Care Organizations (MCOs) and ACHs. This document also serves to revise and clarify the details surrounding Washington State's VBP incentives and framework.

Achievement of VBP targets will be assessed at both a regional and MCO-specific level. As indicated in Table 3, ACHs and MCOs will be rewarded based on reported progress in the early years of the demonstration. This will shift to rewarding for performance on the VBP targets.

Table 3. Value-based Payment Milestone Categories

Through this demonstration, the DSRIP program and initiatives such as the Health Care Payment Learning Action Network will yield new best practices. Therefore, this Roadmap will be updated annually throughout the demonstration to ensure long-term sustainability of the improvements made possible by the DSRIP investment and that best practices and lessons learned can be incorporated into the state's overall vision of delivery system reform.

Washington will submit quarterly progress updates to CMS, which will include the progress made both in terms of total dollars included in VBP arrangements and quantitative and qualitative lessons learned.

V. Process for Project Plan Modification

No more than twice a year, ACHs may submit proposed modifications to an approved Project Plan for state review and approval/denial. In certain limited cases it may become evident that the methodology used to identify a performance goal and/or improvement target is no longer appropriate, or that unique circumstances/developments outside of an ACH's control require the ACH to modify its original plan. Examples of these circumstances could include a significant regulatory change that requires an ACH to cease a planned project intervention or initiate substantial changes to the way a standard performance metric is measured, requiring an ACH to modify its planned approach.

In order to request a Project Plan modification, an ACH must submit a formal request, with supporting documentation, for review by the state. The state will have 60 calendar days to review and respond to the request. Allowable Project Plan modifications are not anticipated to change the overall ACH project incentive valuation. However, modifications to decrease scope of a project may result in a decrease in the valuation of potential earnable funds. Unearned funds as a result of a decrease in the scope of a project will be directed to the Reinvestment pool and earned in accordance with the DSRIP Funding and Mechanics Protocol (Attachment D). The state will not permit modifications that lower expectations for performance because of greater than expected difficulty in meeting a milestone. Removal of a planned project intervention may result in a forfeiture of funding for that project as determined by the state,

VI. Health Information Technology. (The state will discuss how it plans to meet the Health IT goals/milestones outlined in the STCs.)

In accordance with STC 39, the state will use Health Information Technology ("Health IT") and Health information exchange services to link core providers across the continuum of care to the greatest extent possible. To detail how the state will achieve its stated Health IT goals, the state will provide a Health IT strategy by April 1, 2017. That document provides detailed tactics and initiatives, technical gaps addressed, critical actions, policy levers and key metrics in place or planned for the following key business processes:

1. Addressing data needs and gaps
2. Acquiring Clinical Data
3. Leveraging Data Resources
4. Supporting clinical decisions with integrated patient information
5. Ensuring data integrity
6. Making large sets of clinical data available for program and business decisions

ATTACHMENT D
DSRIP Program Funding & Mechanics Protocol

I. Accountable Communities of Health

a. Introduction

This demonstration aims to transform the health care delivery system through regional, collaborative efforts led by ACHs. ACHs are self-governing organizations with multiple community representatives that are focused on improving health and transforming care delivery for the populations that live within the region. Providers within ACH regions will partner to implement evidence-based programs and emerging innovations, as defined in the DSRIP Planning Protocol (Attachment C), that address the needs of Medicaid beneficiaries. ACHs, through their governing bodies, are responsible for managing and coordinating the projects undertaken with partnering providers as well as state reporting.

This protocol provides detail and criteria that ACHs and their partnering providers must meet in order to receive DSRIP funding and the process that the state will follow to ensure that ACHs will meet these standards.

b. ACH Service Regions

There are nine ACHs that cover the entire state, with the boundaries of each aligned with the state's Medicaid Regional Service Areas (RSA). The RSAs were designated in 2014 through legislation that required the state to continue regionalizing its Medicaid purchasing approach. The RSA geographic boundaries were designated by assessing the degree to which they:

- Support naturally occurring health care delivery system and community service referral patterns across contiguous counties;
- Reflect active collaboration with community planning that prioritizes the health and well-being of residents;
- Include a minimum number of beneficiaries (at least 60,000 covered Medicaid lives) to ensure active and sustainable participation by health insurance companies that serve whole region; and
- Ensure access to adequate provider networks, consider typical utilization and travel patterns, and consider the availability of specialty services and the continuity of care.

ACH Name	Counties in RSA
Better Health Together	Adams, Ferry, Lincoln, Pend Oreille, Spokane Stevens
Greater Columbia ACH	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, Yakima
Southwest Washington ACH	Clark, Klickitat, Skamania
Cascade Pacific Action Alliance	Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, Wahkiakum
Olympic Community of Health	Clallam, Kitsap, Jefferson
King County ACH	King
Pierce County ACH	Pierce
North Sound ACH	Island, San Juan, Skagit, Snohomish Whatcom
North Central ACH	Chelan, Douglas, Grant, Okanogan

c. ACH Composition and Partnering Provider Guidelines

Each ACH consists of partnering providers. The commitment to serving Medicaid beneficiaries, as well as the diversity and expertise of those providers and social service organizations, is important in evaluating Project Plan applications.

d. The ACH serves as the lead for the projects with partnering providers that are participating in Medicaid transformation projects. The ACH must submit a single Project Plan application on behalf of the partnering providers, and serve as the single point of performance accountability in the Independent Assessor's evaluation of projects and metrics. *ACH Governance and Management*

Each ACH must describe its primary decision-making process, process for conflict resolution, and its structure (e.g., a Board or Steering Committee) that is subject to composition and participation guidelines as outlined in STC 23. Each ACH's primary decision-making body will be responsible for approving the selection of transformation projects. Each ACH will comply with STCs 22 and 23 in its decision-making structure, which compliance the state will review and approve as part of ACH certification. .

The overall organizational structure of the ACH must reflect the capability to make decisions and oversee regional efforts in alignment with the following five domains, at a minimum:

- Financial
- Clinical
- Community
- Data and Performance Monitoring

- Program management and strategy development

The ACH's responsibilities include engaging stakeholders region-wide; supporting partnering providers in planning and implementing projects in accordance with requirements of the demonstration; developing budget plans for the distribution of DSRIP funds to partnering providers in accordance with the funding methodology provided in this protocol; collaborating with partnering providers in ACH leadership and oversight; and leading and complying with all state and CMS reporting requirements.

II. Projects, Metrics and Metric Targets

a. Overview of Projects

ACHs must select and implement at least four Transformation projects from the Project Toolkit (described in the DSRIP Planning Protocol [Attachment C]). ACHs must provide project details in the Project Plan application and describe how selected projects are directly responsive to the needs and characteristics of the Medicaid populations served in the region.

Projects described in the DSRIP Planning Protocol (Attachment C) are grouped into three domains: Health Systems and Community Capacity, Care Delivery Redesign, and Prevention and Health Promotion. The ACHs are responsible for demonstrating progress in relation to progress milestones and outcome metrics for each project.

b. Project Metrics

As part of their Project Plans, ACHs must develop timelines for implementation of projects, in alignment with state-specified process milestones included in Attachment C. Metrics that track progress in project planning, implementation, and efforts to scale and sustain project activities will be used to evaluate ACH milestone achievement.

ACHs must report on these metrics in their semi-annual reports (described in Section V). For each reporting period, ACHs are eligible to receive incentive payments for progress milestones and improvement toward performance metric targets. For designated performance metrics, ACHs will be awarded Achievement Values (AV), based on the mechanism described in Section IV of this protocol.

c. Outcome Metric Goals and Improvement Target

ACHs will have a performance goal for each outcome metric. On an annual basis, the state will measure ACH improvement from a baseline toward this goal to evaluate whether or not the ACH has achieved the metric improvement target. Each

ACH will have its own baseline starting point. Both existing and new measures' baselines will be set based on performance during Demonstration Year (DY) 1.

Annual improvement targets for ACH outcome metrics will be established using one of two methodologies:

(1) Gap to Goal Closure: This methodology will be used for metrics that have available state or national Medicaid, or other comparable populations, 90th percentile benchmarks. Outcome targets will be based on these state or national performance benchmarks, whenever available, but adjustments may be made to reflect the socioeconomic and demographic characteristics of the populations serviced by ACHs, where possible.

The "gap" in this methodology is defined as the difference between the baseline (or end of prior DY) performance and the 90th percentile benchmark. Annual improvement targets will be an up to 10 percent closure of the gap year over year.

An example to illustrate the gap to goal methodology: If the baseline data for a measure is 52 percent and the goal is 90 percent, the gap to the goal is 38. The target for the project's first year of performance would be a 3.8 percent increase in the result (target 55.8%). Each subsequent year would continue to be set with a target using the most recent year's data. For example, should an ACH meet or exceed the first year's target of 55.8 percent, the next annual target would be up to 10 percent of the new gap to the goal. This will account for smaller gains in subsequent years as performance improves toward the goal or measurement ceiling.

In cases where ACH performance meets or exceeds the performance goal (i.e., the 90 percent performance in the example above), incentives are earned based on continued performance above the goal. If an ACH has already surpassed the goal in the baseline year, the measure will be dropped and value of the remaining measures rebased.

(2) Improvement-Over-Self: For those metrics without a state or national Medicaid benchmark available, including innovative metrics, the state will set a standard percent improvement relative to each ACH's previous DY performance. This percent improvement target will be determined on a metric-by-metric basis based on available evidence of a reasonable expectation for magnitude of change. Improvement targets for these metrics will be set to be consistent with the magnitude of change required to meet targets in the gap-to-goal methodology measures. The improvement-over-self-target for each metric will be consistent across each ACH.

III. Incentive Funding Formula and Project Design Funds

a. Demonstration Year 1 (DY1)

i. Project Design Funds

In accordance with STCs 35(i) and 45, during DY1, the state will provide project design funds to ACHs for completing the designated certification process. The design funds are a fixed component distributed equally across ACHs for completing the certification process described in Attachment C and can be used to develop specific and comprehensive Project Plans. This funding allows ACHs to begin to develop the technology, tools, and human resources to support the necessary capacity ACHs need to pursue demonstration goals in accordance with community-based priorities.

Design funds payments will total up to 25 percent of allowable expenditures in DY1 with payments distributed in two phases between June and September 2017. As described in the DSRIP Planning Protocol (Attachment C), ACHs are required to complete the two-phase certification process for receipt of design funds. In order to be eligible for incentive payments, beyond design funds, an ACH must submit and receive state approval of a Project Plan.

ii. Project Funding

The state will distribute the remaining DY1 DSRIP funding (excluding state administrative expenses) to certified ACHs upon approval of the Project Plan application. The amount of DSRIP funding available for each ACH will be scaled based on application scoring by the Independent Assessor as outlined in STC 36.

b. Demonstration Years 2 through 5 Funding and Project Valuation

In accordance with STC 35(h), the state has developed criteria and methodology for project valuation by which ACHs will continue to earn incentive payments in DY 2 through 5 by reporting on and achieving progress measures and performance-based outcome metrics. Project valuation is calculated during DY1 once each certified ACH submits a Project Plan application detailing project selection and implementation strategies. Based on this content, the state determines maximum incentive payments allotted to each ACH, by project, which will be available for distribution to partnering providers. As described in STC 35, the annual maximum project valuation is determined based on the

attributed number of Medicaid beneficiaries residing in the ACH RSA(s) and on the Project Plan application scores.

The maximum amount of ACH incentive funding is determined according to the methodology described in (c) below. Once each project is assigned a maximum valuation, the project's corresponding, individual progress measures and outcome metrics are valued according to the methodology described in (d) below.

Maximum ACH and project valuations are subject to monitoring by the state and CMS. In the event that an ACH does not meet the expected targets for each project's reporting-based progress measures and performance-based outcome metrics, the ACH's project valuation may be commensurately reduced from the maximum available project valuation. In addition, ACHs may receive less than their maximum available project valuation if DSRIP funding is reduced based on performance of the statewide measure bundle described in Section VII.

c. Calculating Maximum ACH Project Valuation

Each DY, a maximum statewide amount of DSRIP project funding will be identified. For approved tribal specific projects, a percentage of annual DSRIP funding will be allocated to tribal-specific projects in a manner consistent with this Protocol and the Tribal Protocol, which describes tribal projects and funds flow. Remaining project funds will be available to ACHs based on the methodology outlined below.

Step 1: Assigning Project Weighting

The state has weighed the projects in the Transformation Project Toolkit (Attachment C) relative to one another as a percentage of the total annual DSRIP project funding available, known as the project weight. ACHs must select at least four projects, including Project 2A (Bi-Directional Integration of Physical and Behavioral Health through Care Transformation), Project 3A (Addressing the Opioid Use Public Health Crisis) and least two additional projects, one from Domain 2 and one from Domain 3.

Each project has associated metrics that ACHs must achieve to earn funding tied to the project. An ACH's payment for project implementation is based on pay-for-reporting (P4R) in DY1 and DY2 and based on both P4R and pay-for-performance (P4P) in DY3, DY4 and DY5. The maximum amount of incentive funding that an ACH can earn is determined based on the ACH's project selection, the value of the projects selected, the quality and score of Project Plan

applications, and the number of Medicaid beneficiaries attributed to the ACH. Project weights outlined in Table 1 were assigned with consideration of the following factors:

- Alignment with statewide measures to better incentivize the achievement of statewide objectives.
- Number of Medicaid beneficiaries within scope and capacity of projects to address population need and improve population health.
- Potential cost-savings to ensure that the state's Medicaid per-capita cost is below national trends.
- Existence of evidence-based strategies to ensure a reduction in avoidable use of intensive services.
- Focus on quality of services, rather than quantity, to accelerate transition to value-based payment.

Table 1. Transformation Project Weighting

Project Weighting	
Project	Weight
2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation	32%
2B: Community-Based Care Coordination	22%
2C: Transitional Care	13%
2D: Diversions Interventions	13%
3A: Addressing the Opioid Use Public Health Crisis	4%
3B: Reproductive and Maternal and Child Health	5%
3C: Access to Oral Health Services	3%
3D: Chronic Disease Prevention and Control	8%

Projects listed in order of Project Weighting

Project 2A (Bi-Directional Integration of Care and Primary Care Transformation) represents the state's primary objective under Initiative 1 of the demonstration. Project 2A requires the highest level of integration of all other projects and, therefore, houses the largest corresponding set of P4P metrics. Furthermore, Project 2A has the potential to yield the greatest achievement of value for Medicaid members through an evidence-based approach—and is likely to result in significant cost-savings for both the state and federal government. Regions that have implemented fully integrated managed care are be better positioned to scale project 2A and are eligible for an enhanced DY1 valuation based on project plan scoring methodology.

Project 2B (Community-Based Care Coordination) has the potential to realize significant healthcare spending reductions while providing local services to many of the state's most vulnerable Medicaid beneficiaries. To earn payments for this project, an ACH must transition early in the demonstration to P4P.

The project weights of Project 2C (Transitional Care) and Project 2D (Diversion Interventions) are each 13 percent. Both projects allow ACHs to select one or more evidence-based approaches to result in cost-savings for a smaller population of Medicaid beneficiaries compared to Projects 2A and 2B. In addition, these two projects have a smaller number of measures moving to P4P throughout the demonstration period compared to other Domain 2 projects.

Project 3D (Chronic Disease Prevention and Control) has the greatest project weighting in Domain 3s, at 8 percent. Project 3D has the potential to yield significant results for a large population of Medicaid beneficiaries by including multiple chronic diseases within the project. By affecting a large population through an evidence-based model, Project 3D has the potential to result in significant cost savings.

Project 3B (Reproductive and Maternal and Child Health) impacts a large subpopulation of Medicaid beneficiaries. This project offers several optional evidence-based approaches to drive success and a suitable number of metrics to measure performance.

Project 3A (Addressing the Opioid Use Public Health Crisis) will affect a subset of the state's substance use disorder (SUD) population of Medicaid beneficiaries, anticipated to be proportionally smaller than most other Domain 3 projects, by aligning with Governor Inslee's Executive Order 16-09.[15] Based on public comments and feedback to the Project Toolkit (Attachment C), Project 3A has now been escalated as a required project for all ACHs.

Project 3C (Access to Oral Health Services) is primarily targeted at the adult population, who will benefit from the evidence-based approach selected by the ACH, and there is a defined number of P4R metrics that will be used to measure an ACH's performance.

Step 2: Calculating Maximum ACH Project Funding

In accordance with STC 28 and STC 35(b), the state developed an allocation methodology for maximum ACH project funding based on project selection, transformation impact of projects, and attribution based on residence. The state will use the defined RSA boundaries to determine beneficiary attribution for the funding

[15] Available at http://www.governor.wa.gov/sites/default/files/exe_order/eo_16-09.pdf.

methodology using the November 2017 client-by-month file. The relative level of Medicaid attribution determined at that time will determine maximum DSRIP funds per ACH throughout the demonstration, as outlined below. Maximum funding by project is calculated by multiplying the total state ACH project funds available by the respective project weight (see Table 1 for project weighting).

Maximum Statewide Funding by Project = [Total Annual Statewide ACH Project Funds Available by DY] x [Project Weight]

In order to determine the maximum annual ACH funding by project, the maximum annual statewide funding by project is multiplied by total Medicaid beneficiaries residing in the ACH RSA.

Maximum ACH Funding by Project = [Maximum Annual Statewide Funding by Project] x [Percent of Total Attributed Medicaid Beneficiaries

This formula will be repeated for all selected projects, and the sum of selected project valuations equals the maximum amount of financial incentive payments each ACH can earn for successful project implementation over the course of the demonstration. Each ACH is required to select at least four projects, including Project 2A and Project 3A. If ACHs choose fewer than the total eight projects, project weights will be rebased proportionately for DY2 through DY5. This maximum ACH valuation will be earned upon achieving defined reporting-based progress measures and performance-based outcome metrics and may be reduced based on application of the statewide penalty described in Section VII.

For DY1, the maximum ACH Funding by Project will be adjusted based on Project Plan scores. Each ACH Project Plan will be scored by the Independent Assessor. The scoring criteria will be developed in conjunction with the Project Plan template (see DSRIP Planning Protocol).

d. Earning Incentive Payments

In DY2 through DY5, ACHs earn incentive payments for successful implementation and reporting of selected projects. Successful implementation is defined for each project as meeting the associated reporting-based progress measures and performance-based outcome metrics.

Within each payment period, ACHs are evaluated against these designated metrics and awarded Achievement Values (AV), which are point values assigned to each metric that is payment-driving. The maximum value of an AV is one (1) in the instance in which an ACH meets the designated metric.

The amount of incentive funding paid to an ACH will be based on the amount of progress made toward achieving its improvement target on each outcome metric. An ACH may achieve an AV based on meeting a minimum threshold of 25% of its gap-to-goal target in the year. If this performance threshold is not achieved, and ACH would forfeit the project incentive payment associated with that metric.

Enhanced AV valuation can be achieved if the ACH realizes a higher percentage of the gap-to-goal performance target, beyond the 25% threshold:

- 100 percent achievement of performance goal (achievement value = 1)
- Less than 100 percent achievement of performance goal and at least 75 percent achievement of performance goal (achievement value = .75)
- Less than 75 percent achievement of performance goal and at least 50 percent achievement of performance goal (achievement value = .50)
- Less than 50 percent achievement of performance goal and at least 25 percent achievement of performance goal (achievement value = .25)
- Less than 25 percent threshold achievement (achievement value = 0)

To determine Total Achievement Value (TAV) for each project in a given payment period, the AVs earned within the project are summed according to their relative weighting as illustrated in Table 2. From there, the Percentage Achievement Value (PAV) is calculated by dividing the TAV by the weighted total of possible AVs for the project in that payment period. The purpose of the PAV is to represent the proportion of metrics an ACH has achieved for each project in each payment period and will be used to determine the distribution of dollars earned out of the maximum annual ACH project funding as follows:

Table 2. Example Calculation of Achievement Values

Measure/Metric	Achievement Value
Outcome Metric 1	0
Outcome Metric 2	1
Outcome Metric 3	0.5
TAV	**1.5**
PAV	**50.0%**

To support the expected outcomes from successful project implementation, ACHs are solely responsible for P4R progress measures in DY1 and DY2. The state will transition a robust set of outcome metrics to be P4P, meaning a portion of project funds are dependent on ACH demonstrating improvement toward performance targets in the out years. Table 3 illustrates the timing and distribution of transition to P4P:

Table 3. Transition to Pay-for-Performance, Percentage of Annual DSRIP Incentive Payment Allocation

Metric Type	DY1	DY2	DY3	DY4	DY5
P4R	100%	100%	75%	50%	25%
P4P	0%	0%	25%	50%	75%

e. Managed Care Integration

A primary goal of the demonstration is to support implementation of a fully integrated physical health and behavioral health managed care system. Although there are RSAs that have made progress toward integration, a majority of the state requires significant investments to achieve statewide integration of physical and behavioral health services by January 2020.

Regions that implement fully integrated managed care prior to 2020 are eligible to earn incentive payments above the maximum valuation for project 2A. To earn incentives above the maximum valuation for project 2A, regions must submit binding letters of intent to implement full integration. This will be reported in Project Plan submissions. The incentive payment is calculated using a base rate of up to $2 million and a per member rate based on total attributed Medicaid beneficiaries, with payments distributed to the ACH in the calendar year of completion.

Integration Incentive = [Base Rate] + [Member Adjustment x Total Attributed Medicaid Beneficiaries] x [Phase Weight]

The incentives for fully integrated managed care will be distributed in two phases associated with reporting on progress measures: binding letter(s) of intent, and implementation. These phases represent two key activities towards integration. ACHs and partnering providers are eligible for an incentive payment for reporting on the completion of each phase.

Table 4. Weighting of Integration Progress Measures by Phase

Phase Weights	
Phase 1: Binding Letter(s) of Intent	40%
Phase 2: Implementation	60%

f. Value-based Payment Incentives

In accordance with STCs 41 and 42 and the state's Value-based Roadmap (Attachment F), the state will set aside no more than 15 percent of annually available DSRIP funds to reward MCO and ACH partnering providers for

provider-level attainment of VBP targets as well as progression from baseline as described in STCs 41 and 42. VBP targets reflect goal levels of adoption of Alternative Payment Models (APM) and Advanced APMs in managed care contracting.

IV. ACH Reporting Requirements

These activities are detailed below.

a. Semi-Annual Reporting for ACH Project Achievement

Two times per year, ACHs seeking payment under the demonstration shall submit reports that include the information and data necessary to evaluate ACH projects using a standardized reporting form developed by the state. ACHs must use the document to report on their progress against the milestones and metrics described in their approved Project Plans. Based on these reports, as well as data generated by the state on performance metrics, the state will calculate aggregate incentive payments in accordance with this protocol. The ACH reports will be reviewed by state and the Independent Assessor. Upon request, ACHs will provide back-up documentation in support of their progress. These reports will be due as indicated below after the end of each reporting period:

- For the reporting period encompassing January 1 through June 30 of each year; the semi-annual report and the corresponding request for payment must be submitted by the ACH to the state before July 31.
- For the reporting period encompassing July 1 through December 31 of each year; the semi-annual report and the corresponding request for payment must be submitted by the ACH to the state before January 31.

The state shall have 30 calendar days after these reporting deadlines to review and approve or request additional information regarding the data reported for each milestones/metric and measure. If additional information is requested, the ACH shall respond to the request within 15 calendar days and the state shall have an additional 15 calendar days to review, approve, or deny the request for payment, based on the additional information provided. The state shall schedule the payment transaction for each ACH within 30 calendar days following state approval of the semi-annual report. Approved payments will be transferred to the Financial Executor until the ACH provides direction for payment distribution to partnering providers.

The state must use this documentation in support of claims made on the MBES/CBES 64.9 Waiver form, and this documentation must be made available to CMS upon request.

V. State Oversight Activities

The state will provide oversight to ensure accountability for the demonstration funds being invested in Washington State, as well as to promote learning with the state and across the country from the work being done under the MTP demonstration. Throughout the demonstration, the state and/or its designee will oversee the activities of ACHs and submit regular reports to CMS pursuant to STC 37.

Each ACH must enter into a contract with the Washington State Health Care Authority (HCA) to be eligible to receive project design funds, as well as other incentive funding under the demonstration. This contract sets forth the requirements and obligations of the ACHs as the leads for DSRIP and other partnering providers. The contract addresses reporting requirements, data sharing agreements, performance standards, compliance with the STCs of the demonstration, and the ACH's agreement to participate in state oversight and audit activity to ensure program integrity of the demonstration. In the contract, HCA requires ACHs to participate in semi-annual reporting outlined in this protocol as a condition for qualifying for demonstration funds.

The state will support ACHs by providing guidance and support on the state's expectations and requirements. Additionally, state activities designed to ensure program integrity are detailed below:

a. Quarterly Operational Reports

The state will submit progress reports on a quarterly basis to CMS. The reports will present the state's analysis of the status of implementation; identify challenges and effective strategies for overcoming them; review any available data on progress toward meeting metrics; describe upcoming activities; and include a payment summary by ACH as available. The reports will provide sufficient information for CMS to maintain awareness regarding progress of the demonstration.

b. Learning Collaboratives

Annual learning collaboratives will be sponsored by the state to support an environment of learning and sharing among ACHs. Specifically, the collaboratives will promote the exchange of strategies for effectively implementing projects and addressing operational and administrative challenges. ACHs will be required to participate and contribute to learning collaboratives as specified in STCs 37(c) and 45(a)(v).

c. Program Evaluation

In accordance with STCs 35 and 107, the state will develop an evaluation plan for the DSRIP component of the draft evaluation design. The state will contract with an independent evaluator to evaluate the demonstration. The evaluator will be selected after a formal bidding process that will include consideration of the applicant's qualifications, experience, neutrality, and proposed budget. Evaluation drafts and reports will be submitted in accordance with deadlines in section 7 of the STCs.

VI. Statewide Performance and Unearned DSRIP Funding

a. Accountability for State Performance

The state is accountable for demonstrating progress toward meeting the demonstration's objectives. Funding for ACHs and partnering providers may be reduced in DY3, DY4, and DY5 if the state fails to demonstrate quality and improvement on the statewide measures listed below. STC 44 specifies the amount of annual DSRIP funding at risk based on statewide performance on these measures. The funding reductions will be applied proportionally to all ACHs based on their maximum Project Funding amount.

A statewide performance goal will be established for the statewide metrics. The state will be accountable for achieving these goals by the end of the demonstration period. During DY3 and DY4, annual assessment of quality and improvement from a defined baseline toward these goals will be used to measure and evaluate whether or not the statewide metric improvement target has been achieved.

Statewide Accountability Metrics

1. Mental Health Treatment Penetration
2. Substance Use Disorder Treatment Penetration
3. Outpatient Emergency Department Visits per 1000 Member Months
4. Plan All-Cause Readmission Rate (30 days)
5. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
6. Antidepressant Medication Management
7. Medication Management for People with Asthma (5 – 64 Years)
8. Controlling High Blood Pressure
9. Comprehensive Diabetes Care - Blood Pressure Control

10. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control

The state will establish a baseline performance for each measure. The state will adapt the Quality Improvement Score (QIS) methodology, originally developed by HCA for measuring MCO performance, to determine statewide performance across the statewide accountability measures for the demonstration. Each measure is assessed for both achievement of quality and improvement on an annual basis beginning DY3. The weighted sum of all the individual measure quality improvement scores will yield the overall QIS. The overall QIS is then used to indicate whether a reduction of funding is warranted, and to calculate the percentage of funding at risk that should be reduced for that demonstration year. Annual improvement will reflect closing of the relative gap between prior performance year and the goal by up to 10 percent each year, as described in Attachment C, Section III(c). Quality will be assessed based on existing national benchmark standards where possible. For newer, innovative measures that do not have established national estimates, quality will be determined based on available evidence of reasonable expectation for magnitude of change.

If the state fails to achieve its annual quality improvement score on a given statewide accountability metric, funding will be reduced by the amount tied to the QIS.

The draw of the FFP match for all at-risk funds under statewide accountability metrics, or reporting of payments on the CMS-64 form, will not occur until the QIS have been approved by the state and CMS. The state will submit the QIS and supporting documentation to CMS for review and approval. CMS will have 90 calendar days to review and approve the QIS. Once the at-risk payments are approved, the state will disburse the portion of the withheld at-risk funds that were earned, and the state will report such expenditures on the CMS 64 form and draw down FFP accordingly. The state may not claim FFP for any at-risk expenditures until CMS has issued formal approval.

b. Reinvestment of Unearned DSRIP Funding

DSRIP funding that is unearned because the ACH failed to achieve certain performance metrics for a given reporting period may be directed toward DSRIP High Performance incentives. Unearned project funds directed to high performers will be used to support the scope of the statewide DSRIP program or to reward ACHs whose performance substantively and consistently exceeds their targets as measured according to a modified version of the QIS described above. The state does not plan to withhold any amounts to subsidize this reinvestment pool.

VII. Demonstration Mid-point Assessment

In accordance with STC 21, a mid-point assessment will be conducted by the Independent Assessor in DY3. Based on qualitative and quantitative information, and stakeholder and community input, the mid-point assessment will be used to systematically identify recommendations for improving individual ACHs and implementation of their Project Plans. If the state decides to discontinue specific projects that do not merit continued funding, the project funds may be made available for expanding successful project plans in DY 4 and DY5.

ACHs will be required to participate in the mid-point assessment and adopt recommendations that emerge from the review. The state may withhold a percentage or all future DSRIP incentive funds if the ACH fails to adopt recommended changes, even if all other requirements for DSRIP payment are met.

ATTACHMENT E
Value-Based Roadmap (Original)

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Purpose

The Apple Health Appendix reflects specific initiatives and changes pertaining to the Apple Health (Medicaid) program, in alignment with the Health Care Authority's (HCA) Value-based Roadmap. This document describes how managed care is transforming in alignment with the

Medicaid Transformation Project (demonstration), and establishes targets for Value-based Payment (VBP) attainment and related incentives under the Delivery System Reform Incentive Payment (DSRIP) program for Managed Care Organizations (MCO) and Accountable Communities of Health (ACH).

This document addresses the following topics:

- Identified VBP targets and approach for measuring, categorizing and validating progress towards regional ACH and statewide MCO attainment of said VBP goals.
- Alternative payment models deployed between MCOs and providers to reward performance consistent with DSRIP objectives and measures.
- Use of DSRIP measures and objectives by the state in their contracting strategy approach for managed care plans.
- Measurement of MCOs based on utilization and quality in a manner consistent with DSRIP objectives and measures.
- Inclusion of DSRIP objectives and measures reporting in MCO contract amendments.
- Evolution toward further alignment with the Medicare & CHIP Reauthorization Act (MACRA) and other advanced Alternative Payment Models (APM).
- Approaches that MCOs and the state will use with providers to encourage practices consistent with DSRIP objectives, metrics, and VBP targets.

In accordance with the Special Terms and Conditions (STCs) of the demonstration, the Appendix will be updated annually to ensure best practices and lessons learned are captured and incorporated into HCA's overall vision of delivery system reform. The Appendix will remain a living document throughout the duration of the demonstration; subject to change and adjustment to ensure that Washington State is able to achieve its purchasing goals.

Introduction

Apple Health and VBP Reform

To reach the goals defined in the Value-based Roadmap, including shifting 90% of state-financed health care to VBP by 2021, Apple Health must play a leading role in transforming Washington's health care payment system. On January 9, 2017, Washington State and the Centers for Medicare and Medicaid Services (CMS) reached agreement on a groundbreaking five-year demonstration that allows the state to invest in comprehensive Medicaid delivery and payment reform efforts through a DSRIP program.

As Washington transitions to a new health care purchasing system for Apple Health, HCA recognizes that a comprehensive and successful transformation requires a multilayered approach that can address the needs of MCOs, individual providers, and Medicaid beneficiaries. Initiatives under the demonstration, including community-led delivery system reform strategies, play a major role in assisting the overall system transformation.

HCA strives to align its efforts with the perspectives of MCOs and providers who bear the administrative burden of implementing new purchasing methodologies. Alignment requires that, while HCA assesses the individualized requirements of different stakeholders in the Medicaid

system, it works to ensure that system reforms support and reinforce each other without leading to unnecessary administrative burden. As HCA implements VBP strategies for the Medicaid program, Medicare is making significant strides in implementing similar VBP reforms. Likewise, multiple commercial payers in the state are building VBP into their contracting strategies. Providers must frequently navigate all of these systems, presenting significant opportunities to align value-based methodologies across payer markets.

Alignment and Health Care Payment & Learning Action Network (HCP-LAN)

VBP strategies are built into the fabric of the demonstration by their inclusion as a foundational element of delivery system reform activities. Yet, HCA's commitment to value-based purchasing extends beyond the demonstration. Within Medicaid, HCA has changed MCO contracts in ways that align with the demonstration's goals. These efforts will be discussed throughout this document, along with those required under the demonstration STCs.

A primary mechanism for alignment across payer markets is the use of the HCP-LAN Framework,[16] as discussed in the Roadmap. These categories will form a framework for the implementation of VBP in Washington by defining payment models subject to incentives and penalties, aligned with Healthier Washington's broader delivery system goals. The HCP-LAN Framework recognizes a variety of approaches that can advance value-based purchasing, and thereby provide flexibility to providers to address the circumstances of the services they provide and the communities in which they provide them.

By adopting a national framework, Washington ensures that providers do not face conflicting guidance on how payment models will be classified. This uniformity with national standards is intended to enhance engagement and reduce the administrative burden for providers in learning to operate under VBP methodologies.

Strategies in Support of VBP

The shift from fee for service (FFS) to VBP requires delivery system changes. Time-limited DSRIP funds allow providers to make these changes through initial investment in the health system transformation process, and build provider capability as it relates to VBP. In turn, VBP adoption can reinforce and sustain DSRIP investments. This can occur through the longer-term payer, provider, member, and community partnerships, as well as investments in population health management. The end goal is a transformed system of health and wellness, bolstered by VBP.

DSRIP Project Toolkit and the ACHs

DSRIP provides the opportunity for delivery system reform that will promote improved health outcomes, and provide resources to providers to move along the VBP continuum. Under DSRIP, transformation efforts will be driven by ACHs and coalitions of partnering providers as they select and implement a set of strategies from the Project Toolkit to address regional health needs.

[16] For purposes of alignment, this appendix leverages the version of HCP-LAN framework that was available in January of 2017 when CMS approved the state's Medicaid Transformation demonstration.

To be successful, ACHs must integrate foundational cross-cutting health system and community capacity building elements that address workforce, systems for population health management, and financial sustainability through VBP.

Key milestones associated with project implementation require ACHs to demonstrate how they have considered financial sustainability of project efforts beyond the years of the demonstration. Key milestones during the project planning stage include: identification of strategies to support regional attainment of statewide VBP targets; a defined path toward VBP adoption reflecting current state and implementation of DSRIP projects; as well as a plan for encouraging annual VBP survey participation. A milestone for each DSRIP project requires the identification of strategies that will support financial sustainability of project activities, signaling the importance of ensuring that investments are lasting. In later years of the demonstration, ACHs are expected to identify and document the adoption of payment models that support integrated care approaches and the transition to value based payment for services by partnering providers.

The Project Toolkit specifies metrics that will be assessed for performance. Metrics were prioritized for inclusion in the Toolkit based on the relevancy to project strategies, their link to state and demonstration priority areas, and to ensure consistency and alignment with measures in MCO contracts, cross-system outcome measures for adults enrolled in Medicaid per House Bill 1519, and the State Common Measure Set.

Provider readiness for VBP models and contracts will be critical to meet statewide and regional DSRIP VBP payment arrangement targets, as well as other state VBP goals. Across the project stages, providers partnering with their ACH may be eligible to receive incentive payments by contributing to the completion of project milestones and regional improvement on clinical and population health measures. The incentive funds earned by providers allow them to make the investments necessary to be successful in the project, as well as promote efforts to scale and sustain strategies that prove to have positive health and wellness impacts in their communities. In order to be financially sustainable, however, other sources of funding must be identified to sustain these strategies, which could come through success in VBP contracts.

While VBP arrangements vary in complexity and provider risk, success in any requires providers to be able to effectively measure and influence the quality and/or cost of care provided. The presence and maturity of a number of underlying capabilities influence whether providers will perform well in their VBP contracts. ACHs will undertake efforts to understand the current state of VBP capabilities among their provider partners, and how they can leverage DSRIP funds to support development of capabilities moving forward.

Medicaid Value-based Payment (MVP) Action Team

Role and Purpose

The Medicaid Value-based Payment (MVP) Action Team serves as a learning collaborative to support ACHs, MCOs, and providers to attain VBP targets. It serves as a forum to facilitate provider preparation for value-based contract arrangements and to provide guidance on HCA's

VBP standards. The Action Team promotes provider participation in VBP assessments, including the state's Medicaid VBP survey, and helps facilitate value-based contract arrangements by providing support and making recommendations to ACHs. To date, meetings have focused on topics such as: the role of ACHs in implementing VBP, required capabilities for providers to successfully implement and sustain VBP strategies, and strategies for engaging providers with little to no VBP experience.

The MVP Action Team has also assisted HCA in designing and fielding VBP surveys of MCOs and providers to capture a baseline of VBP levels. Additional assessments will be conducted annually to monitor progress from the baseline.

Moving forward and building from existing work when applicable, the MVP Action Team will:

- Assist HCA in deploying surveys or other assessments of VBP adoption to understand the current types of VBP arrangements across the industry.
- Review and communicate the level of VBP arrangements as a percentage of total payments across the region to determine current VBP baseline.
- Support ACHs as they perform assessments of VBP readiness across regional provider systems, and help ACHs develop strategies for advancing VBP.
- Develop recommendations to improve VBP readiness across the industry.

Implementing value-based purchasing throughout Medicaid requires a dedicated effort from diverse stakeholders, and the MVP Action Team plays a central role in bringing these stakeholder groups together. The MVP Action Team serves as an advisory board and a learning collaborative to both engage with HCA on VBP guidance and decisions, and create an environment where regional approaches can be shared and best practices cataloged. The MVP Action Team identifies enablers and challenges to VBP implementation and develops recommendations to improve the readiness of MCOs, providers, and ACHs.

Membership

The MVP Action Team is comprised of health care leaders from around Washington with significant experience with Medicaid and payment transformation efforts. The MVP Action Team includes state, regional and local level stakeholders, and tribal government partners representing: physical and behavioral healthcare providers, hospitals, clinics, Indian health care providers, community-based organizations, MCOs, public health providers and others. To ensure balanced membership representing varying perspectives, each MCO and ACH nominated a representative to serve on the MVP Action Team.

A Look Ahead

The MVP Action Team will meet on a quarterly basis throughout the demonstration to support ACHs, MCOs, and providers as they strive to implement VBP strategies and sustain them after the demonstration. The MVP Action team will be engaged in the annual updates to this document to ensure it aligns with the current state of VBP in Washington and reflects challenges

faced by Washington providers. The MVP Action Team will continue to weigh in on MCO and provider surveys to communicate a VBP baseline for each ACH and help them to strategize and implement VBP that will best meet the needs and capacity of their region. The MVP Action Team will continue to serve as a source of guidance for ACHs and HCA during the demonstration.

VBP: Targets and Incentives

Beyond promoting the investment in foundational strategies that promote provider readiness for VBP, paying for value across the continuum of care is necessary to ensure the sustainability of the transformation projects undertaken through the demonstration. HCA and CMS agreed upon targets for VBP adoption under the demonstration (see Table A) based on the percentage of payments to providers that fall into categories 2C through 4B of the HCP-LAN APM Framework, starting in Demonstration Year (DY) 1, with progressive targets throughout the demonstration.

Table A: Annual VBP Goals for DSRIP

Annual VBP Goals for MCOs and ACH Regions (STC 41)					
	DY 1	DY 2	DY 3	DY 4	DY 5
HCP LAN 2C – 4B	30%	50%	75%	85%	90%
Subset: HCP LAN 3A – 4B	n/a	10%	20%	30%	50%
Subset: MACRA A-APMs	n/a	n/a	TBD*	TBD	TBD

**To be defined in future updates to this document.*

To encourage MCOs and providers to pursue VBP arrangements, DSRIP funds are available to incentivize MCO and ACH regional progress towards VBP targets as defined by the state in STC 41. These incentives can be earned as follows:

1. Incentives to reward **MCO** reporting, attainment and improvement towards annual VBP goals (in addition to those incentive embedded in the MCO contract, outlined below).

2. Incentives to reward regional **ACH** reporting, attainment and improvement towards annual VBP goals.

Funds will be distributed to MCOs through the Challenge Pool, based on percentage of Medicaid lives. Funds will be distributed evenly across the nine ACHs through the Reinvestment Pool.

Detailed parameters for how VBP incentive funds are earned and distributed to qualifying entities are outlined in subsequent sections of this document. The following parameters apply to both MCO and ACH VBP Incentives:

- MCOs and ACHs will earn VBP Incentives based on pay-for-reporting (P4R) and pay-for-performance (P4P), with the portion associated with P4P increasing year-over-year, per Table B.
- MCOs will report data on the status of VBP contracting levels annually, which will provide the basis for VBP adoption assessment for both the MCOs and ACHs, and thus is the data source for determining P4P VBP Incentives for both ACHs and MCOs. Results will be reviewed by a third party validator; the review methodology is under development.
- VBP Incentives (P4R and P4P) will be calculated and paid once per year.
- Unearned VBP Incentives are redirected to reward MCOs/ACHs based on their performance on quality metrics.
- Total potential VBP Incentive funding is set each year by HCA, taking into account any remaining VBP-designated funds after Integration Incentives have been distributed. Given the anticipated volume of Integration Incentives in DYs 1 and 3, VBP Incentives may be lower in those years.

Table B: VBP Milestone Categories, by Demonstration Year

Annual VBP Incentives: P4R and P4P (Planning Protocol)										
	DY 1		DY 2		DY 3		DY 4		DY 5	
	P4R	P4P	P4R	P4P	P4R	P4P	P4R	P4P	P4R	P4P
MCO VBP Incentives	75%	25%	50%	50%	25%	75%	0%	100%	0%	100%
ACH VBP Incentives	100%	0%	75%	25%	50%	50%	25%	75%	0%	100%

VBP Incentives: MCO Improvement and Attainment of VBP Targets

MCO improvement and attainment of VBP targets are key to the success and sustainability of Washington's DSRIP program. The following describes the MCO eligibility for earning incentives, earnable funds, reporting requirements, and measurement of MCO VBP attainment:

Eligibility: MCOs are eligible for VBP Incentives based on P4R and P4P, with P4P increasing year-over-year, as outlined in Table B [DSRIP Planning Protocol, section IV, Table 3].

Threshold for Years 4 and 5: As indicated in Table C below, no MCO VBP Incentives (P4R or P4P) can be earned if the MCO does not achieve the thresholds of 30% and 50% of provider payments in HCP-LAN categories 3A and above in Years 4 and 5, respectively.

Potential Earnable Funds: For a given demonstration year, the maximum potential VBP Incentives per MCO will be based on the MCO's share of total Apple Health Managed Care member months for that year. The available funds are earned through the DSRIP Challenge Pool. Available funds in each year are split between P4R and P4P, which are separately earned as outlined below.

MCO P4R VBP Requirements: P4R for MCOs is entirely based on timely and complete annual submission of MCO VBP data, by HCP-LAN APM category and region, via the standard VBP survey template. Completion of the required VBP survey template is being integrated as a requirement in MCO contracts. P4R for MCOs has an "all or nothing" standard; if an MCO does not submit the required data in a timely and complete fashion, zero percent of earnable P4R funds are earned that year. MCOs may earn 100% of earnable funds if the required data is submitted in a timely and complete fashion.

Measurement of MCO VBP Attainment (P4P): MCO VBP adoption levels will be measured based on MCO-provided data. MCOs will complete an annual quantitative report on VBP adoption by region and by LAN category.

VBP P4P will be based on a model that incorporates attainment of the target and improvement over prior year performance, with achievement increasing in weight over time (see Table C).

Table C: Weighting of Improvement and Achievement of Annual MCO VBP Targets

	Y1	**Y2**	**Y3**	**Y4**	**Y5**
Improvement Over Self *(from Previous Year)*	60%	60%	50%	45%	40%
Achievement of Annual VBP Target (Overall / Subset Target Attainment)	40%	35% / 5%	45% / 5%	50% / 5%	55% / 5%
Requirement to Meet 3A–4B Attainment Threshold for <u>Any</u> VBP Funds	N	N	N	Y – 30%	Y – 50%

Subset Attainment Target: Each year, up to 5% of MCO P4P VBP Incentive funds will be based on achieving certain additional VBP adoption criteria outlined in STC 41:

- Year 2: At least one VBP contract in category 3B or above
- Year 3: At least one VBP contract as a MACRA A-APM (to be defined)
- Year 4 and Year 5: At least one VBP contract in category 3B or above and including at least one of the following features:
    - More than nominal risk for shared losses
    - Payments tied to provider improvement or attainment on metrics from the statewide common measure set using HCA quality improvement model or similar tool
    - Care transformation requirements including state-level best practices
    - Use of certified EHR technology in support of VBP methods

QIS – Assessing Achievement: Achievement requires VBP adoption at or above the VBP target goal in the STCs, per Table A. Credit is only earned for meeting or exceeding the defined target for the applicable demonstration year.

QIS – Measuring Improvement:
If the MCO <u>did not achieve</u> the VBP goal for the year:

- Improvement will be measured as the percent change in VBP adoption relative to the prior year performance.
- Improvement values are capped at 100%.

If the MCO has achieved the VBP goal for the year:

- Any incremental additional improvement over prior performance will secure a 100% improvement score.

QIS –Final Score and Distribution of Earned Funds: The weighted scores for improvement, overall achievement and subset-achievement are added together to arrive at a final MCO VBP P4P QIS. The final results from the MCO QIS assessment will determine the proportion of maximum potential P4P VBP incentives earned by an MCO in a given year.

Unearned funds from Challenge Pool: Funds that remain unearned from the Challenge Pool are redirected to reward MCO performance on a standard set of clinical quality measures.

VBP Incentives: ACH Regional Improvement and Attainment of VBP Targets

The success and sustainability of the state's DSRIP program is largely dependent on moving along the VBP continuum as a state and at the regional level. The STCs of the demonstration put forward annual VBP targets that the state and the ACHs are accountable for reaching. Furthermore, if VBP benchmarks for statewide VBP attainment are not met, a percentage of statewide DSRIP funding will be at risk beginning DY3.

Eligibility: ACHs can earn VBP Incentives based on P4R and P4P, with P4P increasing year-over-year, as outlined in Table B [DSRIP Planning Protocol, section IV, Table 3].

Threshold for Years 4 and 5: As indicated in Table D below, no ACH VBP Incentives (P4R or P4P) can be earned if the ACH region does not achieve the thresholds of 30% and 50% of provider payments from MCOs in HCP-LAN categories 3A and above in Years 4 and 5, respectively.

Potential Earnable Funds: Statewide ACH VBP Incentives will be evenly split across all ACHs to identify the maximum potential VBP Incentives per ACH in a given year. The available funds are earned through the DSRIP Reinvestment Pool. Available funds in each year are split between P4R and P4P, which are separately earned as outlined below.

ACH VBP P4R Requirements: Requirements for VBP P4R for ACHs will change as the demonstration progresses. ACHs will report on VBP milestones as part of their semi-annual reports. P4R achievement will be based on providing evidence of completion of each milestone per year. Each milestone will receive a value of 0% (not reported, or not completed) or 100% (reported and evidence of completion).

Each year's P4R achievement will be the average of the P4R milestone scores attained, with ACHs earning the proportion of p4R associated VBP incentives equivalent to the total P4R score.

Table D: ACH VBP P4R Milestones

ACH P4R Milestones	
Year 1 (2017)	• Documented outreach to provider partners to support HCA-administered VBP Provider Survey participation.
Year 2 (2018)	• Documented completion of Domain 1 VBP milestones from the Project Toolkit: o Inform providers of VBP readiness tools and resources. o Connect providers to training and TA from HCA and the MVP Action Team. o Support VBP assessments to help the MVP Action Team substantiate reporting accuracy. o Disseminate MVP Action Team and other state / regional VBP implementation efforts' learnings to providers. o Develop a regional VBP transition plan.
Year 3 (2019)/ Year 4 (2020)	• Report on progress on implementing the Regional VBP Transition Plan. • Engagement and contribution to the MVP Action Team.

Measurement of ACH VBP Attainment (P4P): ACH VBP adoption levels will be measured based on MCO-provided data. MCOs will complete an annual quantitative report on VBP adoption by region and by LAN category. The resulting data will be aggregated across all MCOs by region and LAN category, prior to distribution to ACHs.

VBP P4P will be based on a model that incorporates attainment of the target and improvement over prior year performance, with achievement increasing in weight over time (see Table E).

Table E: Weighting of Improvement and Achievement of Annual ACH VBP Targets

	Y1	Y2	Y3	Y4	Y5
Improvement Over Self *(from Previous Year)*	*n/a*	60%	50%	45%	40%
Achievement of Annual VBP Target (Overall / Subset Target Attainment)	*n/a*	35% / 5%	45% / 5%	50% / 5%	55% / 5%
Requirement to Meet 3A–4B Attainment Threshold for <u>Any</u> VBP Funds	*n/a*	N	N	Y – 30%	Y – 50%

Subset Attainment Target: Each year, up to 5% of P4P ACH VBP incentive funds will be based on achieving certain additional VBP adoption criteria outlined in STC 41:

- Year 2: At least one VBP contract in category 3B or above.
- Year 3: At least one VBP contract as a MACRA A-APM (to be defined).
- Year 4 and Year 5: At least one VBP contract in category 3B or above and including at least one of the following features:
    - More than nominal risk for shared losses.

- Payments tied to provider improvement or attainment on statewide common measure set using HCA quality improvement model or similar tool.
- Care transformation requirements including state-level best practices.
- Use of certified EHR technology in support of VBP methods.

QIS – Assessing Achievement: Achievement requires VBP adoption at or above the VBP target goal in the STCs, per Table A. Credit is only earned for meeting or exceeding the defined target for the applicable demonstration year.

QIS – Measuring Improvement:
If the ACH did not achieve the VBP goal for the year:

- Improvement will be measured as the percent change in VBP adoption relative to the prior year.
- Improvement values are capped at 100%.

If the ACH has achieved the VBP goal for the year:

- Any incremental additional improvement will secure a 100% improvement score.

QIS – Final Score and Distribution of Earned Funds: The weighted scores for improvement, overall achievement and subset-achievement are added together to arrive at a final ACH VBP P4P QIS score. The final results from the ACH QIS assessment will determine the proportion of maximum potential VBP Incentives earned by an ACH for a given year.

Unearned funds from Reinvestment Pool: Unearned ACH VBP Incentive funds from the Reinvestment Pool are distributed to reward ACH quality performance. ACHs are eligible to earn incentives by demonstrating high performance on the following measures as determined by a separate QIS for DSRIP high performance:

1. Mental Health Treatment Penetration
2. Substance Use Disorder Treatment Penetration
3. Outpatient Emergency Department Visits per 1000 Member Months
4. Plan All-Cause Readmission Rate (30 days)
5. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
6. Antidepressant Medication Management
7. Medication Management for People with Asthma (5 – 64 Years)

VBP in MCO Contracts

A central component of implementing VBP in Washington is incentivizing MCOs to adopt VBP with network providers through HCA's contract with the MCO. HCA currently contracts with five MCOs, paying them a per member per month (or "capitated") premium to deliver Medicaid services to the majority of the state's Medicaid beneficiaries. By incentivizing VBP in the MCO contracts, along with the other efforts described in this Appendix, HCA expects value-based purchasing to expand and continue well beyond the five years of the demonstration.

To incentivize VBP adoption, HCA has designed and implemented a withhold program, under which a percentage of each MCOs' monthly per member per month premium is withheld pending achievement of certain targets, as shown in the figure below.

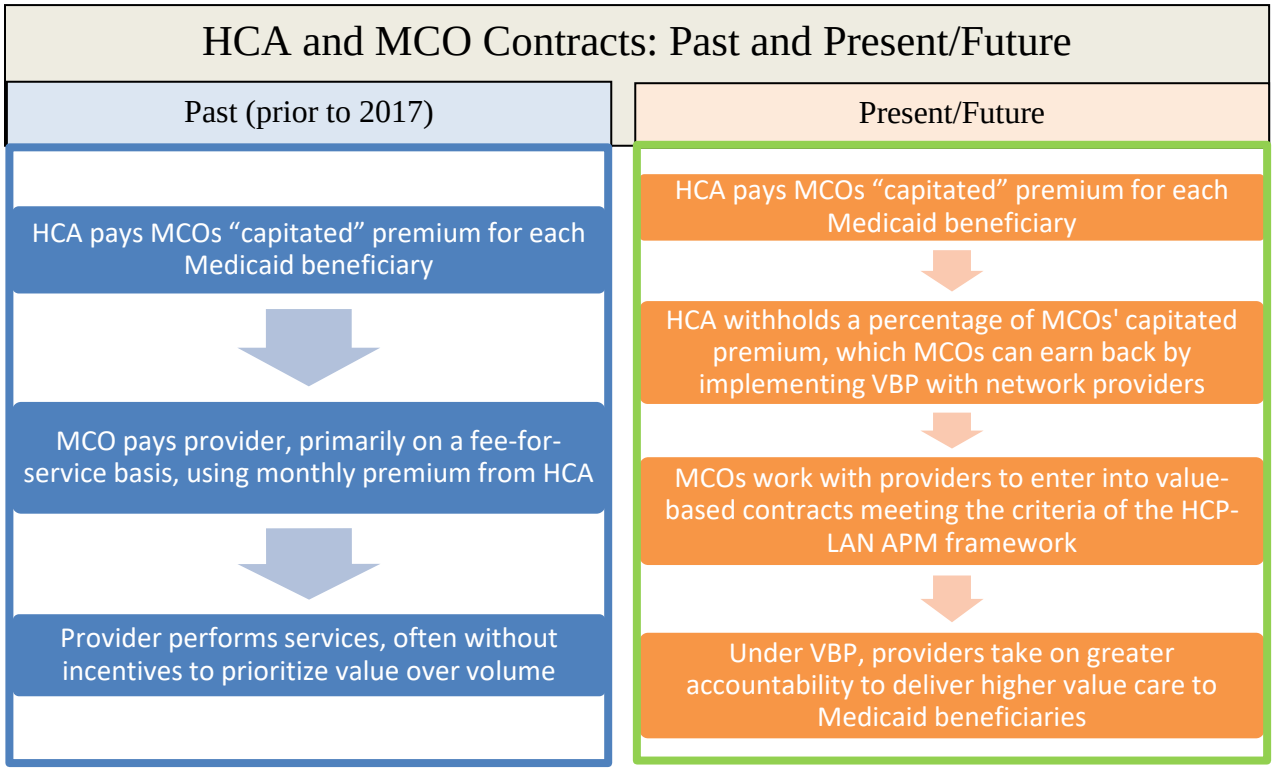


Figure 1: HCA and MCO Contracts: Past and Present/Future

The total percentage withhold is set to increase incrementally (0.5 percent per year) from one percent in 2017 to three percent in 2021. The amount withheld from each MCO's premiums may be earned in three ways, each of which seeks to advance value-based purchasing:

- **VBP Portion (12.5%):** The VBP Portion of the withhold focuses on the percent of an MCO's total purchasing that is within a recognized value based purchasing arrangement. The target for this element will increase from 30% to 90% by 2021. Qualifying VBP arrangements must meet the definition of Category 2C or higher within the HCP-LAN categorization.
- **Provider Incentives Portion (12.5%):** The Provider Incentives Portion of the withhold focuses on the percent of funding, within recognized VBP arrangements, that is directly conditioned on meeting quality metrics. Up to 12.5 percent of the Provider Incentives portion of the withhold may be earned back by making qualifying provider incentive payments tied to quality and financial attainment or losses. The target for this element will increase from .75% to 2.5% by 2021.

- **QIS Portion (75%)**: The QIS Portion of the withhold may be earned back by demonstrating quality improvement and attainment on HEDIS clinical performance measures as calculated under HCA's QIS model. Following receipt of HEDIS scores, on or before July 1 following the performance year, HCA shall determine the percentage of the contract withhold earned back by the Contractor based on the Contractor's achieving Quality Improvement Score (QIS) targets. Up to 75 percent of the withhold may be earned by achieving quality improvement targets. The target for this element will increase from 0.75% to 2.5% by 2021.

These three components of HCA's withhold program, as well as the annual target percentages that must be met in order for MCOs to receive the full withhold amount, are shown in Figure 2 below.

Figure 2: MCO Contract Withhold Components

MCO Contract Withhold Components

Percentage Targets by Year

VBP Share: 12.5%		Provider Incentives Share: 12.5%		QIS Share: 12.5%	
Performance Year	Target	Performance Year	Target	Performance Year	Target
2017	30%	2017	.75%	2017	.75%
2018	50%	2018	1%	2018	1%
2019	80%	2019	1.5%	2019	1.5%
2020	85%	2020	2.0%	2020	2.0%
2021	90%	2021	2.5%	2021	2.5%

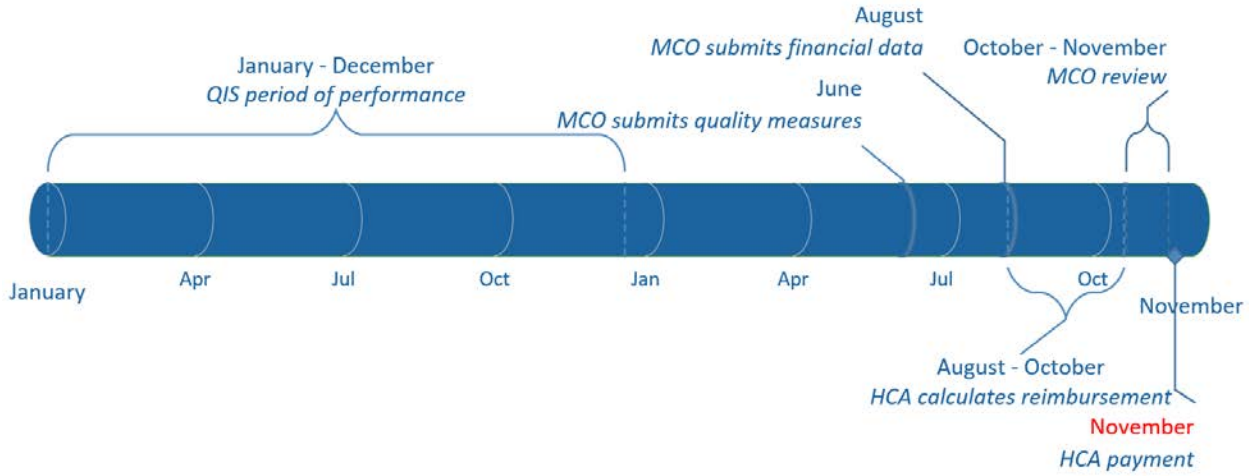
An example of the measures and benchmarks used in the QIS model is shown below (Table F) for the Managed Care contracts. The Integrated Managed Care and Foster Care contracts use the measures below, as well as additional measures particular to the populations covered under those contracts.

Table F: Quality Measures

	Quality Measure	Quality Measures Description	Measure Weight	Target	Mean
Adult Measures	NQF 0059	Comprehensive Diabetes Care - Poor HbA1c Control (>9%)	Equally weighted	NCQA Quality Compass Medicaid HMO 90th percentile values	NCQA Quality Compass Medicaid HMO average values
	NQF 0061	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)			
	NQF 0018	Controlling High Blood Pressure (<140/90)			
	NQF 0105	Antidepressant Medication Management – Effective Acute Phase Treatment			
	NQF 0105	Antidepressant Medication Management - Effective Continuation Phase Treatment (6 Months)			
Pediatric Measures	NQF 0038	Childhood Immunization Status - Combo 10			
	NQF 1516	Well-child visits in the 3rd, 4th, 5th and 6th years of life			
	NQF 1799	Medication Management for people with Asthma: Medication Compliance 75% (Ages 5-11)			
	NQF 1799	Medication Management for people with Asthma: Medication Compliance 75% (Ages 12-18)			

An overview of the timeline for annual performance, data submission, and HCA's review process before issuing payment is shown in Figure 3 below. The two-year performance and review period continues on a rolling basis as shown, so that the subsequent performance year begins while data for the prior performance year is submitted to and reviewed by HCA.

Figure 3: Timeline for annual performance, data submission, and HCA's review process.

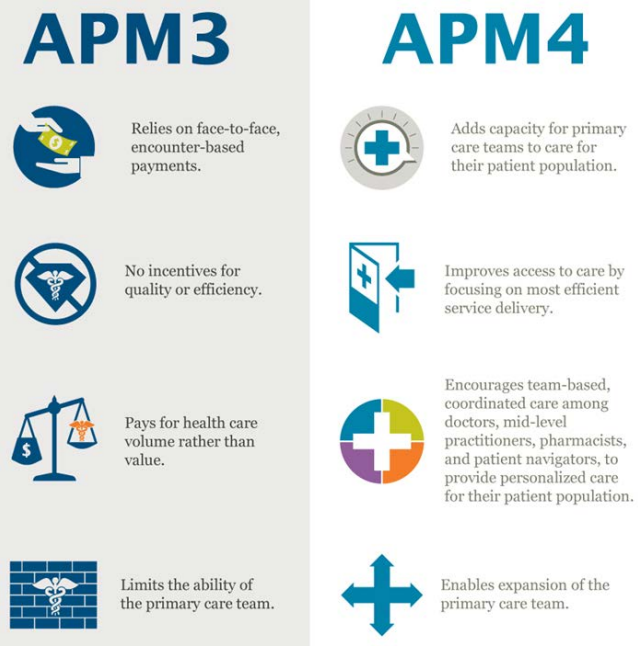


The structure of the MCO withhold program reinforces the links to quality that are emphasized by both CMS and the demonstration. It specifically ties incentive payments to the presence and use of value-based payment strategies, value-based purchasing strategies, and quality improvement.

VBP in Rural Settings

HCA is also turning its focus towards health systems transformation in rural health settings. More than 41% of current Medicaid beneficiaries and 1 in 10 Washingtonians are served in a federally qualified health center (FQHC) or a rural health clinic (RHC) for primary care. Most of rural Washington is served by federally designated critical access hospitals (CAH). These providers offer some of the most innovative and integrated delivery models in the state, yet their reimbursement structure is tied to each encounter with a client, which stifles care delivery innovation. In these settings, payment changes are especially difficult given statutory and regulatory barriers and business models that rely on encounter-driven, cost-based reimbursement.

With strong support from these clinics and hospitals, the state has introduced a value-based alternative payment methodology, or Alternative Payment Methodology 4 (APM4), in Medicaid for FQHCs and RHCs and is pursuing flexibility in delivery and financial incentives for participating CAHs. The model will test how increased financial flexibility can support promising models that expand care delivery.



HCA will determine prospective adjustment percentages annually based on the clinics achieving quality improvement score targets. Clinics that demonstrate quality improvement and attainment against their baseline will continue to receive their full PMPM rate. Clinics that do not demonstrate quality improvement and attainment will be subject to downward adjustment of their PMPM rate. In total dollars, downward adjustment of the PMPM rate will never go below APM3 equivalent payment amounts. After being adjusted downward, clinics that meet quality improvement targets can earn back the full benefit of the baseline PMPM rate (as trended by the MEI) in future years.

Each clinic will be measured by seven quality measures from the Statewide Common Measure Set, consistent with the MCO contracts and PEBB ACP. The goal of APM4 is to allow clinics to improve access to care by focusing on improvement against specific quality measures, and allowing clinicians to work at the top of their license. This payment methodology provides flexibility for primary care providers to have a larger member panel without the burden of increasing the number of face-to-face patient encounters, thus expanding primary care capacity in medically underserved areas. APM4 is also intended to incentivize alternatives to face-to-face visits and allow the clinics to offer more convenient access to primary care services.

Measuring VBP in Washington: VBP Surveys

During the summer of 2017, HCA surveyed MCOs and provider organizations to assess progress towards VBP goals. In order to understand the state's movement toward its demonstration goals, provider surveys will be administered on an annual basis. MCO surveys have transitioned into an annual reporting requirement in MCO contracts.

MCO Survey

In accordance with STCs, the state is required to monitor attainment of HCP-LAN category-specific VBP thresholds at both a statewide and regional level (see STC 40-41). Prior to 2017, the state did not have a data source to measure volume of qualifying provider payments in VBP arrangements by MCO and by region. To measure progress towards VBP by MCOs at the state and regional levels, MCOs were asked to report on levels of VBP adoption with providers. The 2017 MCO report, using calendar year 2016 levels of VBP adoption, will be leveraged to provide a statewide historical baseline from which VBP progress can be measured over the course of the demonstration.

Objective

The purpose surveying MCO data is to collect information on payments that MCOs make to providers through VBP arrangements (as defined by Categories 2C through 4B of the HCP-LAN APM framework) and to understand the MCO perspective on enablers and challenges of VBP adoption. The 2017 MCO report serves multiple objectives:

- To establish a historical measure of VBP attainment for MCOs and the state.
- To inform payments made through the state's withhold arrangement program, described above.
- With the integration of the VBP survey into the MCO contracts, VBP adoption data will be available at state and regional (ACH) levels for 2017 (from 2018 data reporting) and on.

In the future, MCO surveys will be incorporated into MCO contracts as required reporting. Future year MCO reporting will be used to establish annual statewide and regional VBP attainment under the demonstration, in order to assess eligibility for VBP Incentives.

Method

Survey administration. HCA released the VBP survey to all five MCOs in Washington State on June 2, 2017. The survey window was open from June 2, 2017 to July 19, 2017. The survey was administered via email, and on June 9, 2017, HCA published formal answers to questions received by June 7, 2017. MCOs were asked to respond to the survey using a standardized survey response template, provided in Excel. MCOs were instructed to submit one response per organization.

Survey Instrument. To measure the level of VBP attainment, MCOs were instructed to report on total payments[17] made to providers during the calendar year, as well as total Managed Care

[17] Total Payments were defined as the total Medicaid payments made to providers, excluding any case payments, administrative dollars, Washington State Health Insurance Pool (WSHIP), premium tax, Safety Net Assessment Fund (SNAF), Provider Access Payment (PAP) or Trauma funding, from January 1, 2016 through December 31, 2016. Total payments include pharmacy, inpatient, outpatient, physician/professional, and other health services, excluding any pass-through payments.

enrollees by HCP-LAN category. MCOs were asked to report their payments by HCP-LAN APM category (1 through 4B). The framework was included as a reference in the survey template. Regions were defined according to ACH boundaries, outlined in the DSRIP Funding and Mechanics protocol (Section I). To account for providers that have locations or deliver services in multiple regions, the following formula was applied to approximate the regional breakdown:

Dollars attributed to a provider for a region = Total dollars for APM subcategory across all provider locations x [number of billing providers in region / total number of providers contributing to APM subcategory]

HCA understands that individuals may receive care from multiple providers who may be reimbursed under different payment models. In this survey, a member month may be attributed to more than one APM subcategory. This is a limitation of the survey, and may result in double, or multi-counting in some instances. However, HCA sees value in collecting an estimate of covered lives, and understands that this will be inexact.

MCO's were asked to complete the following sections:

- Total Medicaid Payments: the total annual payments made through each type of payment arrangement, by geographic region. This calculation is at the level of the provider group, summing all the corresponding amounts.

- Total Covered Lives: the total number of member months attributed to each type of payment arrangement, by geographic region.

- Provider Incentives: the total amount of Medicaid paid incentives and paid disincentives, as well as a request for examples of most common incentive structures by associated APM subcategory. Reporting for statewide Medicaid paid incentives and disincentives is mandatory. However, further breakdown to the regional level is preferred, but not required. Provider Incentives are defined as follows:

    - *Paid Incentives* means payments paid exclusively to providers in a value-based payment arrangement, as defined by Category 2C or higher of the HCP-LAN APM Framework White Paper, such as bonus payments and shared savings arrangements that offer financial rewards to providers who meet, exceed, or improve their performance on specified quality measure targets.

In addition, MCO's were encouraged to respond to the following sections; however, completion was not mandatory:

- Non-Medicaid Payments: the total annual non-Medicaid payments made through each type of payment arrangement, by type of insurance product (i.e., Medicare or Commercial).

- Non-Medicaid Covered Lives: the total number of member months attributed to each type of payment arrangement, by type of insurance product (i.e., Medicare or Commercial).
- Qualitative Questions: Key domains include:
    - Barriers and Enablers to VBP Adoption.
    - Quality Metrics Applied to Current VBP Contracts: Alignment of Quality Measures Used to Assess Provider Performance in Current VBP Contracts.
    - Traditional MCO Functions: The degree to which MCOs may shift traditionally MCO-based functions onto contracted providers under certain VBP arrangements.

Analysis and Reporting of Results. HCA will perform initial data analysis for MCO survey data. Results will be publicly available in aggregate form on HCA's webpage. Individual MCO responses will not be shared publicly.

Provider Surveys

While assessments and reports have been conducted on the national level and in other contexts, understanding the Washington provider experience with VBP is crucial to inform the progression along the VBP continuum. Additionally, an in depth understanding of the provider landscape is a crucial component of the work undertaken by ACHs. Provider feedback will promote robust project plan design, improved implementation and the foundation for successful plan for project sustainability. For these reasons, HCA developed a provider-facing VBP survey in 2017 to assess adoption levels, barriers and enablers of VBP amongst providers. While provider survey completion is not mandatory, ACHs are requested and incentivized to encourage survey participation, particularly among large provider groups in their regions.

Objective

The goal of the provider survey is to understand the level of VBP attainment, as defined by the percentage of total revenue in key VBP categories, and to identify key barriers and enablers to entering into VBP arrangements among Washington State providers.

Method

Survey administration. HCA released the provider survey to provider organizations in Washington on June 2, 2017. The survey window was open from July 10, 2017 to September 8, 2017. The survey was administered via email, and HCA sent email reminders to potential respondents in advance of the survey submission deadline in coordination with the MVP Action Team and ACH leadership. The survey response template was provided in Excel, in an effort to standardize with concurrent survey efforts in the state. The survey tool required about 30 minutes to complete, based on results of survey pre-testing. Provider organizations were instructed to submit one response per provider organization. Due to the content of the survey, HCA provided the recommendation that the survey be completed by an administrative lead (with consultation by clinical leadership as needed). Results will be publicly available in aggregate form, and will

not be shared at the individual provider organization level. If he provider consents, individual results will be shared with the ACH.

Survey instrument. To provide context for the scope of care the survey response represents, all providers were instructed to identify:

- Type of provider organization they represent.
- Number of full time clinician equivalents (FTEs) employed with the organization.
- Counties served by the organization.

To measure the level of VBP attainment, providers were instructed to report on payments received during the calendar year. Payments were reported by payer type (e.g., Medicaid, Medicare, commercial insurance) and further categorized according to HCP-LAN APM Framework definitions. The detailed survey instrument can be found on the HCA webpage.

To learn about provider experience in transitioning to a value-based system of care, providers were asked the following:

- *If you are receiving VBP from any payer, how has your overall experience with VBP been?*
- *If you are receiving VBP from any payer, what has enabled your participation in VBP?*
- *What are the greatest barriers for engaging in value-based payment arrangements?*
- *Realistically, how do you expect your participation in VPB to change over the next 12 months?*

Categorical response options were provided, with an opportunity to provide a response not captured in the list of enablers and barriers to participation.

Analysis and Reporting of Results. HCA is responsible for performing analysis of data collected from provider survey responses. Results will be publicly available in aggregate form on HCA's webpage. Individual organization responses will not be shared publicly.

Survey Results

Key results from the MCO survey (n=5) include the following:

MCOs reported that in calendar year 2016, 28% of their payments to providers are in VBP arrangements as defined by HCP-LAN Framework Categories 2C through 4B. The top five enablers facilitating the adoption of VBP arrangements were (in order of significance):

- Trusted partnerships and collaboration
- Aligned incentives and/or contract requirements
- Payment model technical assistance

- Interoperable data systems
- Aligned quality measurements and definitions

The top five barriers impeding the adoption of VBP arrangements were (in order of significance):

- Disparate incentives and/or contract requirements
- Lack of interoperable data systems
- Lack of collaboration
- Lack of consumer engagement
- Disparate quality measures and definitions

Key results from the provider survey (n=80) include:

More than 75% of responding providers receive at least some revenue in HCP-LAN Framework Categories 2C-4B. Approximately 65% of responding providers (who reported their experience with VBP) reported having had a positive experience with VBP. The top five enablers impeding the adoption of VBP arrangements were (in order of most-referenced):

- Trusted partnerships and collaboration with payers
- Aligned quality measures and definitions
- Aligned incentives and/or contract requirements
- Ability to understand and analyze payment models
- Access to comprehensive data on patient populations

The top five barriers impeding the adoption of VBP arrangements were (in order of most-referenced):

- Lack of interoperable data systems
- Lack of timely patient population cost data
- Insufficient access to comprehensive data on patient populations
- Inability to adequately understand and analyze payment models
- Misaligned quality measures and definitions

Additional survey results and reporting will be discussed in future updates to this document.

Progress to Date

Annual Update

This document will undergo updates annually. Upcoming editions will include more information on progress made towards achieving state and demonstration VBP targets, as well as the state's evolution in seeking continued alignment with MACRA and other advanced alternative payment model updates.

Next Steps

Beginning in calendar year 2017 the MCO survey will transition to a contractual reporting requirement in MCO contracts. HCA will identify a third-party validator to review MCO-

reported payments by HCP-LAN category. HCA is developing a methodology for validating reported payment data, which will be shared with MCOs and ACHs for public comment. The validation methodology will be incorporated in the next VBP withhold.

Lessons Learned

Additional information will be provided in future updates to this document.

Additional Resources

More information about Washington's demonstration is available at: https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation.

Interested parties can sign up to be notified of demonstration developments, release of new materials, and opportunities for public comment through the Healthier Washington listserv. Instructions are available at: https://public.govdelivery.com/accounts/WAHCA/subscriber/new?topic_id=WAHCA_237%27%3E

ATTACHMENT F
Financial Executor Role

In coordination with HCA and representatives of the state's nine ACHs, the contracted financial executor (FE) shall be responsible for administering a funding distribution plan as described in Attachment D.

ACHs, through their governing bodies, are responsible for managing and coordinating with partnering providers. The ACHs must meet the qualifications set forth in STCs 21 - 23 and must meet the targets enumerated in Attachment C in order to earn incentive payments. In addition, ACHs will certify as to whether or not the partnering providers have met the milestones required for earning incentive payments within their region. The ACH will also certify to the independent assessor whether or not partnering providers have achieved the milestones (see STC 21). The independent assessor (IA) will review the ACH's certification and make recommendations to the state related to distribution of payment. Once the state affirms the recommendations from the IA, it will send the incentive payments to the FE for distribution to the partnering providers.

The contracted FE will perform the work and complete the deliverables outlined below.

1. Establish a system for recording, processing, distributing and reporting on the payment of incentive funds and other financial transactions between HCA, ACHs and partnering providers in accordance with Attachment D.

    1.1. Establish a standardized process and forms to track payments to partnering providers and instruct partnering providers and ACHs in their use.

    1.2. The distribution of funds must comply with all applicable laws and regulations, including, but not limited to, the following federal fraud and abuse authorities: the anti-kickback statute (sections 1128B(b)(1) and (2) of the Social Security Act (the "Act")); the physician self-referral prohibition (section 1903(s) of the Act); the gainsharing civil monetary penalty (CMP) provisions (sections 1128A(b)(1) and (2) of the Act); and the beneficiary inducement CMP (section 1128A(a)(5) of the Act); as well as with HCA and Washington state rules and generally accepted accounting principles.

2. Provide financial accounting and banking management support for all incentive payments.

    2.1. Establish and maintain appropriate accounts as directed by HCA for the tracking of incentive payment receipts and holding of funds and issuance of payments.

    2.2. Regularly track and report on all transactions from such accounts, including but not limited to payments, receipts, refunds and reconciliations.

3. Distribute earned funds in a timely manner to partnering providers in accordance with HCA-approved funding distribution plans.

3.1. Upon instruction and approval from the ACH, issue payments to partnering providers within 14 business days.

3.2. Respond to inquiries from ACHs and partnering providers regarding payments made or owed amounts, within 5 business days.

3.3. Identify, record, resolve and report on any under- or over-payments, including issuing requests for refunds if necessary.

3.4. Record and regularly report to ACHs on funds processed and payments made.

4. Submit scheduled reports to HCA and ACHs on the distribution of transformation project payments, fund balances and reconciliations–in accordance with relevant state and federal rules.

5. Develop and distribute budget forms to partnering providers for receipt of incentive funds.

6. As requested, assist HCA in responding to inquiries from CMS regarding financial transactions and any audits that may be required.

ATTACHMENT G
Intergovernmental Transfer (IGT) Protocol

I. Preface

As part of this demonstration, the Delivery System Reform Incentive Payment (DSRIP) program is to provide incentives for Medicaid providers to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities by improving care, improving health and reducing costs. The non-federal share of these payments will come from intergovernmental transfers (IGT) from public hospitals, other local government or tribal funds, or funds that the state has earned by claiming federal match on expenditures for Designated State Health Programs (DSHP).

In accordance with STC 87(d), the state may use IGTs to the extent that such funds are derived from state, tribal, or local monies and are transferred by units of government, which can include a governmentally operated provider, within the state. The state provides assurance that the matching non-federal share of funds for the demonstration is state/local/tribal monies and that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Social Security Act, 42 CFR §433.51 and applicable regulations. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid State Plan.

The IGT protocol (this document, Attachment E) describes the methodology and guidelines by which the state may use IGT as a source of funding for the non-federal share of demonstration expenditures.

II. IGT Process and the Role of the Accountable Communities of Health (ACH)

Under this demonstration, the state will make performance-based funding available to regionally-based ACHs and their partnering providers with the goal of transforming the delivery system for Medicaid beneficiaries. The ACHs will be responsible for coordinating the efforts of partnering providers in their community to create and implement regional project plans to transform the Medicaid delivery system. The project plans will be reviewed by a third-party Independent Assessor, who will make recommendations to the state as to whether the plans should be approved.

Approved project plans that meet the milestones outlined in the project will be eligible for incentive payments under the demonstration. A component of the non-

federal share of these payments will come from IGTs. The responsibility of the Financial Executor includes distributing earned incentives in a timely manner to participating providers in accordance with each ACH's budget plan.

DSRIP payments are made twice per year and are always paid using the same process. The incentive payment amounts are determined by two reporting periods per demonstration year, where ACHs report the metrics and milestones achieved by their transformation projects. The state, with support from the Independent Assessor, will review reports to calculate the incentive payments earned by the ACH. Once incentive amounts are calculated, the state will calculate the non-federal share amount to be transferred by an IGT contributor based on ACH budget plans in order to draw the federal funding for incentive payments related to the achievement of milestones and metrics. Within 14 calendar days after notification by the state of the identified non-federal share amount, the IGT contributor will make an intergovernmental transfer of funds. The state will pay an amount equivalent to the non-federal and federal shares of the incentive payment to the ACH and its partnering providers. The state will then draw the federal funding based on those disbursements. If the IGT is made within the appropriate and approximate 14-day timeframe, the incentive payment will be disbursed within approximately 30 calendar days. The total computable incentive payment must remain with the ACH partnering providers and will not be returned to or retained by the state.

III. IGT Funding Conditions

IGTs from governmentally operated providers must be in an amount not to exceed the non-federal share of title XIX payments. No pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

An agreement will be executed between the Health Care Authority (HCA), Washington's Medicaid agency, and each IGT contributing entity. The agreement will identify the annual estimated commitments by each IGT contributor. Funds will be transferred from each IGT contributor and will be under the administrative control of HCA. The state will provide copies of the signed IGT agreements between the state and the public entity providing the IGT funds to the CMS regional office.

IGT contributions for purposes of DSRIP are eligible for a 50 percent federal match. The IGT contributor will, by signature, attest that the IGT contribution is not derived from Federal receipts and that they will maintain records to document the source of non-federal share and furnish those records to HCA and CMS as necessary.

Additionally, the IGT contributor must identify the allowable funding source, over the course of a given DSRIP Year, to support the IGT commitment for DSRIP.

IGT funding as described under this demonstration does not have any interaction with existing provider assessment arrangements, with regard to the federal 6% cap. Incentive payments will also not impact upper payment limit (UPL) or state/hospital specific Disproportionate Share Hospital (DSH) caps. Additionally, IGTs will not interact with existing Certified Public Expenditure (CPE) arrangements or any upper payment limit requirements with governmental (public) hospitals as long as the IGTs are not considered an expenditure for the provision of a hospital service for hospitals that CPE. CPEs are expenditures made for the provision of a Medicaid service and certifying providers can receive no service payments above their certified costs. The IGTs are the expense of financing the non-federal share for other Medicaid purposes, and the public hospitals may not claim the transfer of funds to the Medicaid agency as a Medicaid uncompensated hospital service cost under the State Plan or the waiver since their service costs are fully satisfied.

ATTACHMENT H
Indian Health Care Provider (IHCP) Protocol
(Formerly known as the "Tribal Engagement and Collaboration Protocol")

I. RESTATEMENT OF NATIONAL POLICY

In Section 3 of the Indian Health Care Improvement Act (codified at 25 U.S. Code § 1602), Congress declared that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to American Indians:

1. To ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;
2. To raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;
3. To ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;
4. To increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;
5. To require that all actions under this chapter shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this chapter and the national policy of Indian self-determination;
6. To ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and
7. To provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service."

II. DEFINED TERMS

1. **Accountable Community of Health** or **ACH** has the meaning set forth in the Special Terms and Conditions for the Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration.

2. **American Indian/Alaska Native** or **AI/AN** means "Indian" as defined in 25 U.S. Code § 1603(13).

3. **Community Health Aide Program** or **CHAP** refers to that program authorized under 25 U.S. Code § 1616l.

4. **Indian Health Care Provider** or **IHCP** has the meaning set forth in 42 C.F.R. § 438.14(a).

5. **Indian Health Service or IHS** means the agency within the U.S. Department of Health and Human Services responsible for providing federal health services to AI/ANs.

6. **Tribe** means "Indian tribe" as defined in 25 U.S. Code § 1603(14).

7. **Urban Indian Health Program** or **UIHP** means an Urban Indian Organization as defined in 25 U.S. Code § 1603(29) that receives IHS funding to provide health care services to AI/ANs.

III. DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM

1. **Objectives.** With the IHCP specific projects, the state and the tribes and UIHPs seek to achieve the following interests in Medicaid transformation.

    a. ***Collaborative Medicaid Transformation***. Due to treaty obligations and the special trust responsibility, tribes have government-to-government relations with both federal and state governments and IHS facilities and UIHPs have the right to be solicited for advice on Medicaid matters that affect them or their AI/AN patients. In addition, under chapter 43.376 of the Revised Code of Washington, state agencies are required to make reasonable efforts to collaborate with Indian tribes in the development of policies, agreements, and program implementation that directly affect tribes. In recognition of these relationships and requirements, the Medicaid Transformation Demonstration will support the tribes', IHS facilities', and UIHPs' planning efforts by allocating a total of $5,400,000 of Demonstration Year 1 (DY1) incentive payment funds to support the planning and various infrastructure investments related to IHCP-specific projects.

    b. ***IHCP Health Systems and Capacity.*** In recognition of the complexity of IHCP health systems due to the legacy of the IHS Resource and Patient Management System (RPMS) and federal reporting requirements under the Government Performance and Results Act of 1993, the Medicaid Transformation Demonstration will provide incentive payments for achieving milestones that reflect the development of more effective health systems and greater capacity within IHCPs to support and expand the coordination of physical and behavioral health care and social services for Medicid clients and to enable IHCPs to help reduce unnecessary use of intensive services and settings by Medicaid clients without impairing health outcomes. To support financial sustainability, investments in IHCP health systems and capacity will be made in ways that maximize their access and availability to as many tribes, IHS facilities, and UIHPs as possible using information technology protocols and platforms in common use with the state Medicaid program and providers, while respecting individual tribal government needs. Potential investments areas include:

        i. <u>Workforce Capacity and Innovation</u>

            A. *CHAP Board*. Support for the creation of a certification board, similar to the Community Health Aide Certification Board (as

defined in 25 U.S. Code § 1616l) in Alaska, to oversee the training and continuing education for Dental Health Aide Therapists, Behavioral Health Aides, Community Health Aides, and other mid-level providers.

B. *CHAP Education*. Support for the creation of an education program, housed within an established institution of higher education, for various community health aides, including behavioral health aides.

C. *CHAP Provider Implementation*. Support for incorporating new CHAP Board-certified providers into tribal health programs.

ii. Health Systems

A. *Electronic Behavioral Health Records*. Support for the installation of electronic behavioral health records that interface with electronic health records.

B. *Clinical Data Repository*. Support for the creation of the system interfaces for tribal health programs, IHS facilities, and UIHPs to export and import client clinical data into one or more clinical data repositories including state-contracted data repositories (such as Link4Health operated by OneHealthPort and the Emergency Department Information Exchange (EDIE) operated by CollectiveMedical Technologies, Inc.).

C. *Population Health Management*. Support for the creation of a population health management tool for tribal health programs, IHS facilities, and UIHPs to use, drawing data from clinical data repositories and other state-contracted data repositories (such as Link4Health operated by OneHealthPort and the Emergency Department Information Exchange (EDIE) operated by CollectiveMedical Technologies, Inc.).

c. ***Financial Sustainability***. The tribes, IHS facilities, and UIHPs will be given greater flexibility in how they assure the sustainability of the transformation projects undertaken through the Medicaid Transformation Project demonstration in recognition of the special trust responsibility and the following recent CMS guidance, which the state is in the process of implementing:

i. CMS State Health Official Letter #16-002, dated February 26, 2016; and

ii. CMS Frequently Asked Questions (FAQs): Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-

Eligible American Indians and Alaska Natives (SHO #16-002), dated January 18, 2017.

d. ***Statewide Improvement of Behavioral Health for AI/AN Medicaid Clients***. In recognition of the significant health disparities in AI/AN mental health and substance use disorder and intergenerational trauma (collectively, behavioral health), the special trust responsibility, and the significant investments tribes and UIHPs have made in integrating physical and behavioral health despite enduring decades of severe underfunding, the Medicaid Transformation Project demonstration will offer flexibility outside of the approved DSRIP Planning Protocol to support culturally relevant IHCP-specific innovations that seek to improve the behavioral health of Medicaid-enrolled AI/ANs statewide by providing directed support for each IHCP to implement IHCP-specific physical and behavioral health and social service innovations identified in the following resources:

i. The National Tribal Behavioral Health Agenda (https://www.nihb.org/behavioral_health/behavioral_health_agenda.php);

ii. The Urban Indian Health Institute (UIHI) Report: "Supporting Sobriety Among American Indians and Alaska Natives: A Literature Review – February 2014" (http://www.uihi.org/download/supporting-sobriety-among-american-indians-alaska-natives-literature-review-february-2014/?wpdmdl=11604); and

iii. The UIHI Report: "Addressing Depression Among American Indians and Alaska Natives: A Literature Review – August 2012" (http://www.uihi.org/download/addressing-depression-among-american-indians-alaska-natives-literature-review/?wpdmdl=11408).

e. ***Other Tribal- or IHCP-Specific Objectives*** as may be agreed upon by the Centers for Medicare and Medicaid Services, the state, and the proposing tribes and/or IHCPs.

2. **Timeline.**

a. ***IHCP Planning Funds Plan***. No later than December 31, 2017, the tribes and IHCPs will submit to the state a consolidated IHCP Planning Funds Plan. Upon review and acceptance of the IHCP Planning Funds Plan, the state will issue $5,400,000 out of Demonstration Year 1 incentive payment funds in accordance with the instructions received from the tribes and IHCPs. To be accepted by the state, the IHCP Planning Funds Plan must include:

i. Statewide Inventory of Indian Health and Indian Health Care, which includes:

A. An inventory of the health needs, including the behavioral health needs, of the different AI/AN communities in Washington State, both tribal and non-tribal (such as urban), with a particular focus on the barriers to care for Medicaid-covered AI/ANs;

B. An inventory of the physical health care, behavioral health care, dental care, and social service resources available at tribes, IHS facilities, and UIHPs in Washington State;

C. An inventory of the data, health information technology, and population health management systems at tribes, IHS facilities, and UIHPs in Washington State and analogous social service/case management data and information systems at tribes in Washington State;

D. An inventory of the evidence-based and promising practices, including behavioral health-related practices, that have been used by tribes, IHS facilities, and UIHPs to improve health care and health outcomes for their clients; and

E. An inventory of the barriers (federal and state laws and regulations, practical impacts of Medicaid and Medicare programs, etc.) to implementing these evidence-based and promising practices, including behavioral health-related practices.

ii. Plan for Statewide Improvement of AI/AN Behavioral Health, which includes:

A. A framework based on the National Tribal Behavioral Health Agenda;

B. Strategies within the framework that build on the services available at tribes, IHS facilities, and UIHPs, and on the evidence-based and promising practices that have been used by tribes, IHS facilities, and UIHPs to improve AI/AN behavioral health and behavioral health care;

C. Anticipated investments in data, health information technology, and population health management systems at tribes, IHS facilities, and UIHPs and analogous social service/case management data and information systems at tribes to enable tribes, IHS facilities,

and UIHPs to implement the strategies and evidence-based and promising practices; and

D. Explanations of how these strategies and investments will achieve the objectives of the Medicaid Transformation Demonstration.

iii. Instructions for Payment of Earned IHCP Planning Funds, including:

A. *Decision Making*. The tribes and UIHPs have agreed that decisions regarding payment of earned IHCP Planning Funds will be made by majority vote of tribes and UIHPs, with each having one vote to be held by the AIHC delegate from the tribe or UIHP unless the tribe or UIHP directs that vote to be held by someone else. If the IHCP Planning Funds are earned before the tribes and UIHPs agree on how to allocate the funds, the state will not allocate the earned funds until the tribes and UIHPs instruct the state on whom will receive the funds and in what amounts.

B. *Funding Priorities*. The tribes and UIHPs have agreed that the IHCP Planning Funds will be allocated to support the following:

- Work that was done to earn the IHCP Planning Funds, including completion of the Tribal Protocol;
- Work that needs to be done to complete the IHCP Projects Plan, with one portion allocated equally to every tribe and UIHP in the state and the remaining portion allocated based on percentage of a total, such AI/AN Medicaid clients or IHS User Population; and
- Infrastructure investments to increase the ability of all tribes and UIHPs to attain the milestones in the IHCP Projects Plan, such as the CHAP Board and the clinical data repository/population health management.

b. ***IHCP Projects Plan***. No later than October 1, 2018, the tribes and IHCPs will submit to the state a consolidated IHCP Projects Plan, which will include both a statewide default project focused on statewide improvement of behavioral health for AI/AN and any additional projects that the tribes and IHCPs agree upon. Upon acceptance of the IHCP Projects Plan, the state will issue incentive payments upon achievement of the milestones in the IHCP Projects Plan in accordance with the instructions received from the tribes and IHCPs.

3. **Process.** The following provisions supersede the various protocols related to the DSRIP program:

a. ***ACH Certification - Tribal Requirement***. The State will require every ACH to adopt and demonstrate compliance with the Model ACH Tribal Collaboration and Communication Policy, , or a policy agreed upon in writing by the ACH and every IHCP in the ACH region, as part of the ACH certification process.

b. ***Application to IHCPs***. The term "ACH" in the DSRIP Planning Protocol will be interpreted to include IHCPs where appropriate to enable IHCPs to participate in the DSRIP Program in accordance with the terms of this Tribal Protocol.

c. ***No Requirement for Tribal Certification***. The State will not require any IHCP to undergo the ACH certification process in order to participate in the DSRIP Program. HCA will work with IHCPs to maintain compliance with federal requirements applicable to IHCPs participating in the DSRIP Program.

d. ***DSRIP Program Models***. For IHCPs participating in the DSRIP Program, the State will accept evidence-based or promising care models developed for, or tailored to, AI/AN clients that otherwise meet the requirements of the Transformation Project Toolkit (Attachment C to the Special Terms and Conditions for the Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration).

e. ***DSRIP Program Guidance and Technical Assistance for IHCPs***. The State will work with the Tribal Coordinating Entity to provide targeted guidance and technical assistance to help IHCPs implement one or more projects in the IHCP's regional ACH Project Plan or the IHCP Projects Plan or both, including appropriate milestones and outcome measurement goals that qualify for incentive payments.

f. ***Regional Health Needs Inventories (RHNIs) and Regional Health Improvement Plans (RHIPs)***. In respect for the sovereignty and representative governmental processes of tribes and their knowledge of their citizens and their systems, the State will accept tribe-developed alternatives to formal RHNIs or RHIPs as a demonstration of population health needs for participation in the DSRIP Program. In respect for the complex systems of IHCPs and their unique role in helping the U.S. Department of Health and Human Services meet its federal trust responsibility to AI/ANs (including urban Indians and AI/ANs not living near their Indian reservations or villages), the State will accept IHCP-developed alternatives to formal RHNIs or RHIPs as a demonstration of population health needs for participation in the DSRIP Program.

g. ***No Required Projects for IHCPs***. The State will support tribes and IHCPs in their choices of DSRIP Program projects. IHCPs will not be required to implement either of the required projects listed in the Transformation Project Toolkit, nor

will they be required to implement a minimum number of projects as provided for in the Transformation Project Toolkit.

h. ***Statewide Tribal-IHCP Projects***. The State encourages and will support IHCPs in a statewide IHCP effort to implement one or more projects in the IHCP Projects Plan, with incentive payments for collaborative sharing of expertise and individual IHCP efforts.

i. ***Financial Sustainability***. In respect for the sovereignty of Tribes and their responsibility in meeting the health needs of their clients, the State will not require IHCPs to adopt value-based payment methodologies, nor will the State be required to include IHCPs in value-based payment incentive programs, in meeting the financial sustainability requirements of the demonstration. In respect for the complex systems of IHCPs and their unique role in helping the U.S. Department of Health and Human Services meet its federal trust responsibility to AI/ANs (including urban Indians and AI/ANs not living near their Indian reservations or villages), the State will not require IHCPs to adopt value-based payment methodologies in meeting the financial sustainability requirements of the demonstration. For IHCPs, the State will accept alternative financial sustainability models.

j. ***Performance Measurement***. The State will accept Government Performance and Results Act (GPRA), and/or Universal Data System (UDS) measures in lieu of comparable statewide common performance measures when such substitution will reduce duplicative reporting and avoid excessive administrative burden on IHCPs.

4. **Funding and Mechanics.** The following provisions supercede the various protocols related to the DSRIP program:

a. ***Application to IHCPs***. The term "ACH" in the DSRIP Program Funding and Mechanics Protocol will be interpreted to include IHCPs where appropriate to enable IHCPs to participate in the DSRIP Program in accordance with the terms of this Tribal Protocol.

b. ***IHCP Incentive Funds***. Notwithstanding STC 28 and STC 35(b) and in accordance with DSRIP Funding and Mechanics Protocol III(c), the state will use the ratio of AI/AN Medicaid enrollees to total Medicaid enrollees to determine the percentage of the maximum statewide amount of DSRIP project funding to allocate to IHCP-specific projects (also referred to in the DSRIP Funding and Mechanics Protocol as tribal-specific projects).

IV. MEDICAID ALTERNATIVE CARE AND TAILORED SUPPORTS FOR OLDER ADULTS

1. **Eligibility to Provide Health Care Services and Acceptance of Tribal Attestation.** To the extent that services provided under the Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) programs are health care services, the state will accept any IHCP as a provider eligible to receive payment under the MAC and TSOA programs for health care services furnished to an AI/AN on the same basis as any other provider qualified to participate as a provider of health care services under the MAC and TSOA programs in accordance with 25 U.S.C. § 1647a(a)(1). To the extent permitted by federal and state law, the state will accept tribal attestation of compliance with state provider requirements for health care services if a tribe establishes provider entity standards with comparable client protections.

2. **Exemption from Washington State Licensure.** To the extent that services provided under the MAC and TSOA programs are provided by licensed health professionals, the state will accept health professionals employed by the tribe who are licensed in another state and are performing services described in the contract or compact of the Indian health program under Indian Self-Determination and Education Assistance Act in accordance with 25 U.S.C. § 1621t.

3. **Client Presumptive Eligibility Assessments.** To the extent that any IHCP has the capacity and desire to perform presumptive eligibility assessments under the MAC and TSOA programs in accordance with federal and state requirements, the state will pay the standard case management rate for such activity.

4. **Client Services.** To the extent that any IHCP has the capacity and desire to provide client services under the MAC and TSOA programs in accordance with federal and state requirements (including federal conflict of interest rules), the state will pay the Medicaid contracted provider rate for each service.

5. **Coordination with IHCPs.** The state will make available to IHCPs training dates, information, and curriculum pertaining to the MAC and TSOA programs.

V. FOUNDATIONAL COMMUNITY SUPPORTS

1. **Eligibility to Provide Health Care Services and Acceptance of Tribal Attestation.** To the extent that services provided under the Foundational Community Supports program are health care services, the state and its administrative entity will accept any IHCP as a provider eligible to receive payment under the Foundational Community Supports program for health care services furnished to an AI/AN on the same basis as any other provider qualified to participate as a provider of health care services under the Foundational Community Supports program in accordance with 25 U.S.C. § 1647a(a)(1). To the extent permitted by federal and state law, the state will accept tribal attestation of

compliance with state provider requirements for health care services if a tribe establishes provider entity standards with comparable client protections.

2. **Exemption from Washington State Licensure.** To the extent that services provided under the Foundational Community Supports program are provided by licensed health professionals, the state will accept health professionals employed by the tribe who are licensed in another state and are performing services described in the contract or compact of the Indian health program under Indian Self-Determination and Education Assistance Act in accordance with 25 U.S.C. § 1621t.

3. **Client Services.** To the extent that any IHCP has the capacity and desire to provide client services under the Foundational Community Supports program in accordance with federal and state requirements, the state will pay the Medicaid contracted provider rate for each service through the administrative entity.

4. **Coordination with IHCPs.** The state will make available to IHCPs training dates, information, and curriculum pertaining to the Foundational Community Supports program. The state will facilitate one or more meetings between IHCPs and the Foundational Community Supports program administrative entity and providers to increase mutual understanding of capacity and systems related to the Foundational Community Supports program.

ATTACHMENT I
Foundational Community Supports Protocol

Per STC's 59-67, the following protocol outlines the services and payment methodologies for the Foundational Community Supports (FCS) Program. Under this program, the state will provide a set of Home and Community Based Services (HCBS), including Community Support Services (CSS), and Supported Employment-Individual Placement and Support (IPS), to populations that meet the needs-based criteria specified below. These services include HCBS that could be provided to the individual under a 1915(i) state plan amendment (SPA).

Community Support Services (CSS)

Target Criteria

CSS eligibility is available to Medicaid clients age 18 or older who meet the following needs-based criteria that would otherwise be allowable under a 1915(i) SPA:

Needs-Based Criteria

Individual meets at least one of the following health needs-based criteria and is expected to benefit from CSS:

1) Individual assessed to have a behavioral health need, which is defined as one or both of the following criteria:
   - **a)** Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or
   - b) Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment. The ASAM is a multi-dimensional assessment approach for determining an individual's need for SUD treatment.
2) Individual assessed to have a need for assistance, demonstrated by the need for:
   - a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388-106-0010, one of which may be body care, and/or
   - b) Hands-on assistance with one or more ADLs, one of which may be body care.
3) Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support).

AND

Individual has at least one of the following risk factors:

1) Homelessness, defined as living in a place not meant for human habitation, a safe haven, or an emergency shelter, as these terms are understood or defined in 24 CFR 578.3:
   - a) For at least 12 months, or
   - b) On at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months.

2) History of frequent and/or lengthy stays in the settings defined in 24 CFR 578.3, or from, a skilled nursing facility as defined in WAC 388-97-0001.
   a) Frequent is defined as more than one contact in the past 12 months.
   b) Lengthy is defined as 90 or more consecutive days within an institutional care facility.
3) History of frequent adult residential care stays, where
   a) Frequent is defined as more than one contact in the past 12 months.
   b) Adult residential care includes
      i) Residential treatment facilities defined in WAC 246-337-005,
      ii) Adult residential care, enhanced adult residential care, or assisted living facilities defined in WAC 388-110-020, and
      iii) Adult family homes defined in WAC 388-76-10000.
4) History of frequent turnover of in-home caregivers, where within the last 12 months the individual utilized 3 or more different in-home caregiver provider agencies and the current placement is not appropriate for the individual.
5) A Predictive Risk Intelligence System (PRISM) Score of 1.5 or above
   a) The PRISM Risk Score uses diagnosis, prescription, age, and gender information from claims and encounter data to create an index of a client's expected future medical expenditures relative to the expected future medical expenditures of a comparison group (disabled Medicaid adults). The algorithm uses risk factor categories developed at University of California, San Diego known as the Chronic Illness and Disability Payment System (CDPS) and MedicaidRx, which were deemed by the Society of Actuaries to be effective methods of risk adjustment. The PRISM risk score is updated on a monthly basis by the Washington State Department of Social and Health Services' Research and Data Analysis division using the past fifteen months of claims, encounter, and demographic data. A risk score of 1.5 means that an individual's expected future medical expenditures will be 50 percent greater than that of the average Medicaid disabled client. The PRISM risk score was approved by CMS for targeting clients for the Health Home Program and Financial Alignment Dual Demonstration.

Service Definitions for HCBS That Could Be Provided under a 1915(i) SPA

Community Support Services (CSS) benefits package. CSS includes services that would otherwise be allowable under a Section 1915(i) authority, are determined to be necessary for an individual to obtain and reside in an independent community setting, and are tailored to the end goal of maintaining individual recipients' personal health and welfare in a home and community-based setting. CSS may include one or more of the following components:

Pre-tenancy supports:

a. Conducting a functional needs assessment identifying the participant's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual), assistance in budgeting for housing/living expenses, assistance in connecting the individual with social services to assist with filling out applications and submitting appropriate documentation in order to obtain sources of

income necessary for community living and establishing credit, and in understanding and meeting obligations of tenancy.

b. Assisting individuals to connect with social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs. .
c. Developing an individualized community integration plan based upon the functional needs assessment as part of the overall person centered plan. Identifying and establishing short and long-term measurable goal(s), and establishing how goals will be achieved and how concerns will be addressed.
d. Participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
e. Providing supports and interventions per the person-centered plan.

Tenancy sustaining services:

a. Service planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
b. Coordinating and linking the recipient to services including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports.
c. Entitlement assistance including assisting individuals in obtaining documentation, navigating and monitoring application process, and coordinating with the entitlement agency.
d. Assistance in accessing supports to preserve the most independent living such as individual and family counseling, support groups, and natural supports.
e. Providing supports to assist the individual in the development of independent living skills, such as skills coaching, financial counseling, and anger management.
f. Providing supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
g. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
h. Connecting the individual to training and resources that will assist the individual in being a good tenant and lease compliance, including ongoing support with activities related to household management.

The CSS benefit does not include:

a. Payment of rent or other room and board costs;
b. Capital costs related to the development or modification of housing;
c. Expenses for utilities or other regular occurring bills;
d. Goods or services intended for leisure or recreation;
e. Duplicative services from other state or federal programs
f. Services to individuals in a correctional institution or an IMD (other than services that

meet the exception to the IMD exclusion).

Supported Employment – Individual Placement and Support

Target Criteria

IPS eligibility include Medicaid clients age 16 or older who meet the following criteria that would otherwise be allowable under a 1915(i) SPA:

Needs-based criteria

Individual meets at least one of the following health needs-based criteria and is expected to benefit from IPS:

1) Individual assessed to have a behavioral health need, which is defined as one or both of the following:
    a) Mental health needs, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support), resulting from the presence of a mental illness.
    b) Substance use needs, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment. The ASAM is a multi-dimensional assessment approach for determining an individual's need for SUD treatment.
2) Individual assessed to have a need for assistance demonstrated by the need for:
    a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388-106-0010, one of which may be body care, and/or
    b) Hands-on assistance with one or more ADLs, one of which may be body care.
3) There is objective evidence of physical impairments because of which the individual needs assistance with basic work-related activities, including one or more of the following: Sitting, standing, walking, lifting, carrying, handling, manipulative or postural functions (pushing, pulling, reaching handling, stooping or crouching), seeing, hearing, communicating, remembering, understanding and following instructions, responding appropriately to supervisors and co-workers, tolerating the pressures of a work setting, maintaining appropriate behavior, using judgment, and adapting to changes in a routine work setting.

AND

Individual has at least one of the following Risk Factors:

1) Unable to be gainfully employed for at least 90 consecutive days due to a mental or physical impairment.
2) An inability to obtain or maintain employment resulting from age, physical disability, or traumatic brain injury.
3) More than one instance of inpatient substance use treatment in the past two years.
4) At risk of deterioration of mental illness and/or substance use disorder, including one or more of the following:
    a) Persistent or chronic risk factors such as social isolation due to a lack of family or social supports, poverty, criminal justice involvement, or homelessness.

b) Care for mental illness and/or substance use disorder requires multiple provider types, including behavioral health, primary care, long-term services and supports, and/or other supportive services.
c) Past psychiatric history, with no significant functional improvement that can be maintained without treatment and/or supports.
d) Dysfunction in role performance, including one or more of the following:
    i) Behaviors that disrupt employment or schooling, or put employment at risk of termination or schooling suspension.
    ii) A history of multiple terminations from work or suspensions/expulsions from school.
    iii) Cannot succeed in a structured work or school setting without additional support or accommodations.
    iv) Performance significantly below expectation for cognitive/developmental level.

Service Definitions for HCBS That Could Be Provided under a 1915(i) SPA

Supported Employment – Individual Placements and Support (IPS) benefit package: The IPS benefit package will be offered to eligible clients through a person-centered planning process where eligible services are identified in the plan of care. IPS includes services that would otherwise be allowable under a Section 1915(i) authority, and are determined to be necessary for an individual to obtain and maintain employment in the community. IPS services are individualized and may include any combination of the following services:

Pre-employment services

a. Pre-vocational/job-related discovery or assessment
b. Person-centered employment planning
c. Individualized job development and placement
d. Job carving
    - Job carving is defined as working with client and employer to modify an existing job description— containing one or more, but not all, of the tasks from the original job description when a potential applicant for a job is unable to perform all of the duties identified in the job description.
e. Benefits education and planning
    - Benefits education and planning is defined as counseling to assist the client in fully understanding the range of state and federal benefits they might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the client's options for returning to work.
f. Transportation (only in conjunction with the delivery of an authorized service)

Employment sustaining services

a. Career advancement services
    - Career advancement services are defined as services that expand opportunities for professional growth, assist with enrollment in higher education or credentialing and certificate programs to expand job skills or enhance career development, and assist the individual in monitoring his/her satisfaction with employment, and

determining level of interest and opportunities for advancement with current employer, and/or changing employers for career advancement.

b. Negotiation with employers
    - Negotiation with employers is defined as services where a provider identifies and addresses job accommodations or assistive technology needs with the employer on behalf of the individual. Job accommodations can include the following: adjusting work schedule to reduce exposure to triggering events (i.e., heavy traffic triggering symptoms of agoraphobia); providing a private area for individuals to take breaks if they experience an increase in symptoms; access to telephone to contact support person if needed while at work; adjusting job schedule to accommodate scheduled appointments; and small, frequent breaks as opposed to one long one. Assistive Technology can include the following: bedside alarms, electronic medication reminders while at work or at home, and use of headset/iPod to block out internal or external distractions.
c. Job analysis
    - Job analysis is defined as the gathering, evaluating, and recording of accurate, objective data about the characteristics of a particular job to ensure the specific matching of skills and amelioration of maladaptive behaviors.
d. Job coaching
e. Benefits education and planning
    - Benefits education and planning is defined as counseling to assist the client in fully understanding the range of state and federal benefits they might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the clients' options for returning to work.
f. Transportation (only in conjunction with the delivery of an authorized service)
g. Asset development
    - Asset development is defined as services supporting the client's accrual of assets that have the potential to help clients improve their economic status, expand opportunities for community participation, and positively impact their quality of life experience. Assets as defined as something with value that is owned by an individual, such as money in the bank, property, and retirement accounts.
h. Follow-along supports
    - Follow-along supports are defined as on-going supports necessary to assist an eligible client to sustain competitive work in an integrated setting of their choice. This service is provided for, or on behalf of, a client, and can include communicating with the client's supervisor or manager, whether in the presence of the client or not (if authorized and appropriate). There is regular contact and follow-up with the client and employer to reinforce and stabilize job placement. Follow along support and/or accommodations are negotiated with an employer prior to client starting work or as circumstances arise.

The IPS benefit does not include:

a. Generalized employer contacts that are not connected to a specific enrolled individual or an authorized service
b. Employment support for individuals in sub-minimum wage, or sheltered workshop settings
c. Facility-based habilitation or personal care services

d. Wage or wage enhancements for individuals
e. Duplicative services from other state or federal programs

HCBS Supported Employment

IPS services defined in this protocol shall adhere to 42 CFR 440.180(c)(2)(iii), 441.302(i) and 441.303(h).and shall not include habilitation services such as facility-based day habilitation or personal care. Furthermore, services are to be provided in conjunction with a client's existing services and supports, and are therefore separate from special education or related services defined under sections 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16 and 17)) or as services under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. section 730).

HCBS requirements

a. **Person-Centered Planning.** The state agrees to use person-centered planning processes to identify eligible clients' Foundational Community Supports needs and the resources available to meet those needs, and to identify clients' additional service and support needs.
b. **Conflict of Interest.** The state agrees that the entity that authorizes the services is external to the agency or agencies that provide FCS services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.
c. **Home and Community-Based Setting Requirements.** The state will assure compliance with the home and community-based settings requirements for those services that could be authorized under section 1915(i).

Provider Qualifications
Contracted providers must ensure staff providing FCS services maintain appropriate qualifications in order to effectively serve FCS enrollees. Below are typical provider qualifications, however they may be substituted with appropriate combination of education, experience and skills, as determined by the provider contract.

Provider	Education (typical)	Experience (typical)	Skills (preferred)	Services

Community Support Services Providers	Bachelor's degree in a human/social services field; may also be an Associate's degree in a relevant field, with field experience.	1 year case management experience, or Bachelor's degree in a related field and field experience.	Knowledge of principles, methods, and procedures of services included under community support services (as outlined above), or comparable services meant to support client ability obtain and maintain residence in independent community settings.	Pre-tenancy supports; tenancy sustaining services (as outlined above).
Supported Employment – IPS Providers	Bachelor's degree in a human/social services field; may also be an Associate's degree in a relevant field, with field experience.	1 year case management experience, or Bachelor's degree in a related field and field experience.	Knowledge of principles, methods and procedures of services included under supported employment – individual placement and support (as outlined above), or comparable services that support client ability to obtain and maintain employment.	Pre-employment services; employment sustaining services (as outlined above).

Payment Methodologies

HCA will reimburse a Third Party Administrator (TPA) for the CSS and IPS services provided at the CSS and IPS rates. The rates shall not exceed the amount expended by the TPA for the direct service costs incurred by the provider. Rates may vary by region and may be developed based on a target cost per CSS and IPS service, along with variables such as geographic location, FCS-related travel costs, intensity of services, and duration of services or contracted provider per unit costs.

The TPA is required to submit quarterly reports and an annual report to HCA. Ongoing quarterly/annual reporting will include, at a minimum: (i) Number of FCS beneficiaries broken out by program (CSS and IPS supported employment); (ii) Number of new CSS and IPS supported employment person-centered service plans; (iii) Percent of clients receiving CSS and/or IPS supported employment services whose needs are re-assessed annually; and (iv) Amount of funds spent on CSS and IPS supported employment services. The purpose of the reports is to demonstrate that the program is conducted in compliance with the requirements set forth in the STCs and post-approval protocols, attachments, any agreement between HCA and the TPA, and policy letters and/or guidance from HCA.

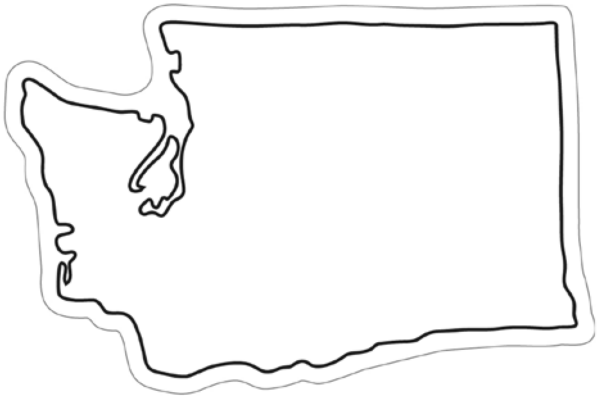
The TPA will invoice HCA for FCS services provided to a specific Medicaid beneficiary. As part of this invoicing process, the TPA must submit documentation to HCA of the Medicaid beneficiary's eligibility status, the dates of service, and the types of service that were provided.

The TPA is required to ensure FCS providers meet minimum documentation standards and cooperate in any evaluation activities by HCA, CMS, or their contractors. The state assures that there is no duplication of federal funding and the state has processes in place to ensure there is no duplication of federal funding.

ATTACHMENT J
Evaluation Design

Medicaid Transformation Project Demonstration Evaluation Design

Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration



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Medicaid Transformation Project Demonstration Evaluation Design

Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration

APPROVED JANUARY 9, 2017

Section 1: Overview of the Medicaid Transformation Project Demonstration

On January 9, 2017, the Centers for Medicare and Medicaid Services (CMS) approved Washington State's request for a Section 1115 Medicaid demonstration entitled Medicaid Transformation Project. The activities under the Demonstration are targeted to transform the health care delivery system to address local health priorities, deliver high-quality, cost-effective care that treats the whole person, and create sustainable linkages between clinical and community-based services. The Demonstration will test changes to payment, care delivery models and targeted services. The Demonstration is approved through December 21, 2021.

Over the next five years, Washington will:

- Integrate physical and behavioral health purchasing and service delivery to better meet whole person needs;
- Convert 90 percent of Medicaid provider payments to reward outcomes instead of volume;
- Support provider capacity to adopt new payment and care models;
- Implement population health strategies that improve health equity; and
- Provide new targeted services that address the needs of the state's aging populations and address key determinants of health.

The state will address the aims of the Demonstration through three programs:

- Delivery System Reform Incentive Payment (DSRIP) Program: Transformation through Accountable Communities of Health
- Long Term Services and Supports (LTSS) - Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)
- Foundational Community Supports (FCS) -Targeted Home and Community-Based Services (HCBS) for eligible individuals.

DSRIP Program: Transformation through Accountable Communities of Health

This initiative aims to transform the health care delivery system through regional, collaborative efforts led by ACHs. ACHs are self-governing organizations comprised of multiple community representatives, and focused on improving health and transforming care delivery for the

populations that live within the region. Providers within ACH regions will partner to implement evidence-based programs and promising practices, as defined in the DSRIP Planning Protocol (Attachment C), that address the needs of Medicaid beneficiaries.

Each ACH, through its partnering providers, is required to implement at least four transformation projects from the Transformation Project Toolkit and participate in statewide capacity building efforts to address the needs of Medicaid beneficiaries. Project performance will be measured based on state-defined milestones and metrics that track project planning, implementation, and sustainability. Transformation projects are spread across three domains:

- ***Domain 1: Health Systems and Community Capacity Building:*** This domain addresses the core health system capacities to be developed or enhanced to support delivery system transformation. Domain 1 outlines three required focus areas to be implemented and expanded across the delivery system, inclusive of all provider types, to benefit the entire Medicaid population.
- ***Domain 2: Care Delivery Redesign:*** Transformation projects within this domain focus on innovative models of care that will improve the quality, efficiency, and effectiveness of care processes. Person-centered approaches and integrated models are emphasized. Domain 2 includes one required and three optional projects. ACHs are required to select at least one of the optional projects for a minimum of two Domain 2 projects in total.
- ***Domain 3: Prevention and Health Promotion:*** Transformation projects within this domain focus on prevention and health promotion to reduce disparities and achieve health equity across regions and populations. Domain 3 includes one required and three optional projects. ACHs are required to select at least one of the optional projects for a minimum of two Domain 3 projects in total.

The domains, and the strategies defined within each domain, are interdependent. Domain 1 is focused on system wide planning and capacity building to reinforce transformation projects. Domain 1 strategies are to be tailored to support efforts in Domain 2 and Domain 3; projects in Domain 2 and Domain 3 integrate and apply Domain 1 strategies to the specified topics and approaches. In addition to the foundational activities in Domain 1, the Transformation Project Toolkit includes eight projects areas.

TABLE 1.
Menu of Transformation Projects

Domain 1	Health and Community Systems Capacity Building	
		Financial Sustainability through Value-based Payment
		Workforce
		Systems for Population Health Management
Domain 2	Care Delivery Redesign	
Project	2A	Bi-directional Integration of Physical and Behavioral Health through Care Transformation *(Required)*
Project	2B	Community-Based Care Coordination
Project	2C	Transitional Care
Project	2D	Diversion Interventions

Domain 3	Prevention and Health Promotion	
Project	3A	Addressing the Opioid Use Public Health Crisis *(Required)*
Project	3B	Reproductive and Maternal/Child Health
Project	3C	Access to Oral Health Services
Project	3D	Chronic Disease Prevention and Control

In support of delivery system reform and alignment with the aims of the overall demonstration, this initiative seeks to achieve the following objectives:

- ***Health Systems and Community Capacity.*** Create appropriate health systems capacity in order to expand effective community based-treatment models; reduce unnecessary use of intensive services and settings; and support prevention.
- ***Financial Sustainability through Participation in Value-based Payment.*** Accelerate the transition to paying for value across the continuum of Medicaid services to assure the sustainability of the transformation activities under DSRIP, and support the success of Alternative Payment Models required by the state for Medicaid managed care plans (see: STC 41, Table 1).
- ***Bi-directional Integration of physical and behavioral health.*** Achieve comprehensive integration of physical and behavioral health services through new care models.
- ***Community-based Whole-person Care.*** Use or enhance existing services in the community to promote care coordination across the continuum of health for beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.
- ***Improve Health Equity and Reduce Health Disparities.*** Implement prevention and health promotion strategies for targeted populations to address health disparities and achieve health equity.

Long Term Services and Supports (LTSS) - Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)

Washington is a national leader in providing long-term services and supports (LTSS) to help people remain in their homes and communities, saving billions of dollars over the past two decades. Our LTSS system has sustained AARP's ranking of second in the nation for its high performance, while at the same time ranking among the lowest (34th) in cost. However, our population is aging, increasing the number of individuals who will be in need of these services. By 2040, the number of people 65 and older will more than double. As we age, we often need assistance with daily tasks such as bathing and medication reminders in order to stay in our own homes and communities rather than in expensive institutional care. While we will continue to provide more intensive services to those who need them, the Demonstration will help Washington State prepare for the "age wave." It will test new services and expand existing services traditionally provided outside of Medicaid that support unpaid family caregivers.

This "next generation" system of care will help protect people's savings and provide more support for family members and other unpaid caregivers who provide approximately 80 percent of care to people in need of long-term services and support. The majority of Washingtonians are uninsured for LTSS, with no affordable options for coverage. Individuals and their families often have no practical way to prepare financially for future LTSS needs, except by impoverishing

themselves so they are eligible for full-scope Medicaid benefits. To highlight the importance of supporting unpaid caregivers, if just one-fifth of these caregivers stopped providing care, it would double the cost of LTSS in Washington State. Providing care for a family member can be among the most rewarding things a person can do, but it also has challenges. A high proportion of caregivers show increases in stress and effects on their own physical and mental health.

The Demonstration will offer additional choices that are intended to:

- Preserve and promote choice in how individuals and families receive services
- Support families in caring for loved ones while increasing the well-being of caregivers
- Delay or avoid the need for more intensive Medicaid-funded LTSS when possible

Medicaid Alternative Care (MAC) will provide support for unpaid family caregivers who support individuals who are eligible for Medicaid but choose to wrap services around their unpaid caregiver as an alternative to other forms of traditional paid services. This benefit package will provide supports enabling unpaid caregivers to continue to provide high-quality care while also focusing on their own health and well-being. It will include needed services such as training, support groups, respite services, and help with housework, errands, supplies, and home-delivered meals.

Tailored Supports for Older Adults (TSOA) will establish a new eligibility category and benefit package for individuals at risk of future Medicaid LTSS use, who currently do not meet Medicaid financial eligibility criteria, but do meet functional criteria for care. It is designed to help individuals and their families avoid or delay impoverishment and the future need for Medicaid LTSS services, while providing support to individuals and unpaid family caregivers. As with MAC, TSOA will include supports such as training, support groups, respite services, and help with housework, errands, supplies, and home-delivered meals. Individuals who do not have unpaid caregivers will receive services such as personal care, adult day services and home delivered meals.

Foundational Community Supports (FCS) -Targeted Home and Community-Based Services (HCBS) for Eligible Individuals

Demonstration HCBS, Community Transition Services (CTS) and Community Support Services (CSS), will help Medicaid beneficiaries reside in stable community settings.[18] The goal is to enhance the availability of services for those who are the most vulnerable and have complex care needs. The CTS and CSS benefits will provide services that link qualifying Medicaid enrollees to appropriate services, and one-time supports necessary for individuals to avoid more intensive care placements and move into stable community settings. The Demonstration -funded CTS and CSS benefits will not supplant existing services currently available to eligible populations. It will be targeted to serve specific high-risk populations and achieve the following outcomes:

- Support those who are unable to reside in stable community settings
- Decrease dependence on costly or restrictive institutional or residential care
- Provide continuity of care by reducing incidents of eviction and provider turnover

[18] Potential changes to the FCS protocol are currently being reviewed with CMS. This document references FCS program descriptions reflected in the originally approved STCs, for purposes of illustrating the proposed evaluation approach. The final evaluation approach will reflect the actual design of the implemented FCS program.

- Support those at highest risk for adverse outcomes

Demonstration-funded supported employment services will help Medicaid enrollees with physical, behavioral, or LTSS service needs gain and maintain stable employment. These services will include individualized job coaching and training, employer relations, and assistance with job placement. Informed by stakeholder engagement and population analysis, four outcomes have been identified and corresponding target populations are proposed. Targeted outcomes include:

- Helping individuals stay engaged in the labor market,
- Preventing the escalation of behavioral health service needs,
- Supporting those with significant long-term services and supports needs, and
- Supporting vulnerable youth and young adults.

In order to be eligible for these services, individuals must receive a needs assessment and meet well-defined housing or employment support need criteria, along with additional risk criteria.

Section 2: Evaluation Goals and Objectives

This section describes the overarching framework for evaluation of Demonstration impacts on delivery systems, clinical care, health outcomes, and costs in Washington State. Evaluation activities will be led by an independent external evaluator and supported by state agency teams with complementary data management and analytic subject matter expertise. Detailed design elements related to qualitative evaluation and quasi-experimental evaluation of ACH projects will be determined in conjunction with the independent external evaluator, and after detailed project design information becomes available from ACH project plans. The evaluation will encompass both an assessment of the impact of the Demonstration on the entire delivery system and evaluation of specific projects implemented under all three initiatives. Evaluation goals will include:

- **Assessment of overall Medicaid system performance under the DSRIP program** in developing community capacity to support health system transformation. This will be based on an assessment of post-demonstration changes in statewide performance levels, relative to pre-demonstration baseline performance levels, across the following measurement domains:[19]
  - Access to primary care, behavioral health care, and other preventive health care services;
  - Quality of care;

[19] At this time we cannot commit to a comparison-group approach to measuring statewide Demonstration impacts, primarily due to uncertainty about the availability of the national T-MSIS data necessary for identifying comparison groups and measuring outcomes for beneficiaries drawn from Medicaid populations in other states. At the time of this writing, we note that the evaluation of the impact of Washington State's Health Home program on Medicaid program costs conducted for CMS by RTI, which takes a comparison-state approach using T-MSIS data, is two years overdue as a result of T-MSIS data limitations. We also note that a within-state contemporaneous comparison group cannot be used to measure overall Demonstration impacts, given the statewide scope of the Demonstration.

- Reduction in use of costly ED, inpatient, or institutional care, including through the reduction of utilization for ambulatory care sensitive conditions and reduction of utilization disparities for persons with behavioral health risk factors;
- Social outcomes including housing stability and employment measured using beneficiary-level administrative data drawn from the State's rich integrated data environment (described further below); and
- Overall Medicaid expenditures on a per beneficiary per month basis.

- **Assessment of progress toward meeting VBP penetration targets.** This assessment is expected to be both qualitative and quantitative in nature, based on data sources such as provider surveys, focus groups, key informant interviews, and document review.[20] The independent external evaluator will assess the extent of use of VBP in contracting, the effectiveness of readiness support provided to providers, and the impact of use of VBP approaches on provider/plan behavior, patient health outcomes, and patient experience. This activity will leverage the assessments of the role of VBP approaches at the project scale, as outlined in the project-level evaluation design detail in Section 5.
- **Assessment of the impact of the Demonstration on the development of the workforce capacity needed to support health system transformation.** This assessment is also expected to be both qualitative and quantitative in nature, based on data sources such as:
  - Provider network adequacy information supplied by MCOs;
  - Performance metrics related to access to services, quality of care, and reduction in use of costly inpatient or institutional care; and
  - Provider surveys, focus groups, and key informant interviews, leveraging assessment of workforce capacity at the project scale as outlined in the project-level evaluation design detail in Section 5.
- **Assessment of the impact of the Demonstration on provider adoption and use of health information technology.** The methodology for assessing impacts in this area will be determined by the independent external evaluator and is expected to leverage provider surveys, focus groups, and/or key informant interviews to assess whether the Demonstration has affected the use of electronic and interoperable health information exchange to promote care coordination, targeted services, and positive outcomes of clinical care. As required by STC 109(b), this assessment will examine the extent to which the Demonstration has enhanced the state's health IT ecosystem to support delivery system and payment reform and the impact on ACH and provider partners' governance, financing, policy/legal issues and business operations. This evaluation activity would include providers who are and are not eligible for the Medicaid EHR Incentive Program, with a focus on use of HIT to improve health outcomes for high-risk populations including persons with co-occurring physical and behavioral health conditions. This activity will leverage the assessments of the role of HIT at the project scale, as outlined in the project-level evaluation design detail in Section 5.
- **Measurement of project-level impacts at the state and ACH level.** Outcomes will be assessed for project-specific target populations at the state and ACH level. Outcome

[20] More detail concerning the types of documents expected to be reviewed is contained in Section 3.

measures will be produced centrally leveraging the state's rich integrated data environment and capacity for performance measure production. Evaluation will not rely on aggregation of performance measures produced separately by ACHs. This allows great flexibility in the creation of valid comparison groups for use in the application of quasi-experimental evaluation techniques, as described below. For projects that are undertaken by multiple ACHs, a comparative analysis will be undertaken to help determine key drivers of outcomes, dependencies and environmental factors that might contribute to positive or negative outcomes for specific projects.[21] As described in the sections that follow, the state will leverage its nation-leading internal analytic capacity and integrated data environment to support the independent external evaluator and provide a data infrastructure able to:

  - Identify beneficiary-level project participation, including potentially overlapping participation across multiple projects and initiatives;
  - Measure project outcomes at the ACH-project scale using statistically valid quasi-experimental evaluation designs; and
  - Assess differences in outcomes across ACHs within project areas based on factors such as differences in target populations (i.e., actual populations served).

- **Rapid-cycle project implementation support (formative evaluation).** Timely implementation reports will especially be useful to inform efforts early in the project implementation process. These reports will be available to CMS if requested. The design and frequency of these reports will be determined in collaboration with the independent external evaluator and ACH partners. An example set of implementation reports would include monthly or quarterly health risk factor profiles of the populations engaged in specific projects/initiatives, compared to target population benchmarks. Such reports would help assess levels of engagement and potential differences across ACHs in the composition of engaged beneficiaries that could inform the early stages of project implementation. Early implementation reports will be mainly used to identify and mitigate risks or take advantage of opportunities to improve project implementation. Later implementation reports will also be used to inform the broader analysis of project impacts and outcomes, in advance of delivery of STC-required evaluation reports in the fourth and fifth years of the Demonstration. These implementation support activities reflect formative evaluation of the development and early implementation of Demonstration-funded initiatives and component projects.

Detailed project-level specification of required evaluation design components is contained in Section 5 and Appendix 1, including project-level descriptions of:

  - Initiative and project goals and objectives
  - Target populations
  - Evaluation questions and testable hypotheses
  - Data strategies, data sources and data collection frequency
  - Outcome metrics

[21] Note that the CMS response to the prior evaluation design draft assumed that ACHs could choose different outcome measures for the same project. However, we anticipate using the same set (or at least a highly overlapping set) of centrally produced measures for all ACH projects within a given project type.

- The statistical framework for measuring project impacts
- Potential subgroup analyses to assess disparities and differences in beneficiary engagement and project impacts.

At the state level, data will be analyzed to determine if the Demonstration has affected the pre-Demonstration trajectory of measures of access to care, quality of care, health and social outcomes, and Medicaid cost measures. This will be based on an assessment of post-demonstration changes in statewide performance levels, relative to pre-demonstration baseline performance levels, across the range of measurement domains described in the previous section.[22] While project-specific evaluations will use quasi-experimental program evaluation techniques focused on targeted project populations, the statewide analysis will include a broader Medicaid population perspective reflecting the potential combined impact of all activities undertaken under the Demonstration. The statewide impact evaluation will also focus on higher-risk beneficiaries who are expected to be significantly positively impacted by Demonstration initiatives, including but not limited to beneficiaries with SMI or co-occurring disorders, with multiple chronic conditions, with functional needs for LTSS services, living in underserved areas, or experiencing baseline disparities in health outcomes. Washington State has significant experience identifying and measuring disparities in access, quality, and health outcomes across these populations.

While the evaluation may not be able to completely isolate the effects of the Demonstration from other policy and program changes and investments under the SIM Grant, differences in timing, specific areas of impact, and target populations will facilitate the measurement of impacts associated with initiatives under the Demonstration. For example, the financial integration of behavioral and physical health services is being instituted under SIM and is expected to be completed by 2020. The financial integration of behavioral and physical health services is seen as a critical support for the effective integration of clinical care. Financial integration is being phased regionally, which will provide the opportunity to compare the effectiveness of Demonstration projects at the ACH scale across regions at the same stage of financial integration. Through the identification of appropriate comparison groups by region, the evaluation should be able to isolate the impact of Demonstration initiatives from financial integration impacts. As discussed further below, propensity score matching methodologies will be used in project-level analyses to ensure the identification of appropriate comparison groups for measuring impacts.

Section 3. Overview of Major Evaluation Components and Activities

This section provides additional detail about the major evaluation activities expected to be undertaken across all three initiatives by the independent external evaluator and state agency evaluation support teams. We start with a description of qualitative methods used to support project implementation and inform quantitative evaluation analyses, and then turn to describing the rigorous quantitative evaluation methods that will leverage the State's advanced integrated analytical environment. Section 5 and Appendix 1 provide detailed project-specific mapping of

[22] Note that the CMS response to the prior evaluation design draft suggested use of an approach in the spirit of a regression-discontinuity design which would include comparative data on the population "just over the eligibility threshold" for the purposes of state-level evaluation. While this approach may be feasible in the context of evaluating specific projects, it would not be feasible for the evaluation of statewide impacts due to the lack of access to health care encounter data for persons not enrolled in Medicaid.

demonstration hypotheses (STC 108), domains of focus (STC 109), research questions, testable hypotheses, outcome measures, and data sources, for both quantitative evaluation components, along with mapping of demonstration hypotheses, domains of focus, research questions, and testable hypotheses for qualitative evaluation components.

Qualitative analysis. Evaluation activities will include qualitative analysis of program implementation and operations to support both formative evaluation deliverables and quantitative analysis of program impacts. Qualitative analysis will address program implementation questions such as:

- How programs are designed;
- The level of readiness for the program among stakeholders;
- The effectiveness of VBP readiness support for providers and the impact of use of VBP approaches on provider/plan behavior and patient health outcomes;
- Provider capacity development, including domains such as HIT acquisition and use, VBP use, workforce availability, and workforce readiness/training;
- How acquisition and use of HIT and health information exchange technologies impact service delivery transformation; and
- Efforts to make the organizational changes necessary to support system transformation.

Qualitative analysis will help inform our understanding of why the Demonstration and its component projects did or did not achieve the expected effects, by exploring:

- Experiences of beneficiaries, providers, and other key stakeholders through focus groups, key informant interviews, and survey methods;
- Contextual changes that might affect outcomes;
- Unintended programmatic side effects; and
- How faithfully projects were implemented.

Qualitative analysis will help make more accessible findings from the quantitative impact analysis, by reinforcing quantitative findings in a non-technical format (e.g., through key-informant quotes, rather than statistics), helping to open the “black box” of program effects.

The design and execution of qualitative methods supporting the evaluation will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Subjects for qualitative data collection and analysis are expected to include beneficiaries, providers, ACH staff/administrators, MCO staff/administrators, and state agency staff. Individual ACH projects are expected to define strata for sampling of subjects for qualitative analyses, to ensure representation from targeted beneficiaries and providers.

Quantitative analyses leveraging integrated administrative data. The evaluation will leverage the integrated administrative data maintained in the Department of Social and Health Services Integrated Client Databases (ICDB) to support quasi-experimental evaluation across all three initiatives, including evaluation at the ACH-project scale. The ICDB was explicitly designed to support quasi-experimental evaluation of health and social service interventions in

Washington State, and has been widely used in evaluation studies published in peer-reviewed journals.[23]

The ICDB contains nearly 20 years of individual-level, massively dimensional data for nearly 6 million persons residing in Washington State over that time span. It contains data from approximately 20 administrative data systems, including the State's ProviderOne MMIS data system and all other data sources necessary to implement the quantitative evaluation design described in this document, except in a few areas discussed below where new data collection may be required.

More specifically, the ICDB contains:

- Service event level utilization data across all Medicaid funded delivery systems (physical, mental health, substance use disorder, long-term services and support, and developmental disability services);
- Expenditure data at the service event and per-member per-month level of aggregation by major service modality, for all Medicaid beneficiaries over the time period relevant to this evaluation (with a few caveats related to issues like the methods for applying pharmacy rebates);
- Risk factors associated with chronic and acute disease conditions, including mental illness and substance use disorders, derived from the CDPS and Medicaid-Rx risk models and related tools;[24]
- Assessment data on functional support needs, cognitive impairment, and behavioral challenges for persons receiving LTSS services;
- Data on "social outcomes" including arrests, employment and earnings, and homelessness and housing stability;
- Client demographics (age, gender, race/ethnicity);
- Medicaid enrollment by detailed coverage category;
- MCO enrollment or fee-for-service Medicaid coverage status;
- Medicare Parts A, B, and D integration for persons dually enrolled in Medicaid and Medicare; and
- Geographic residential location spans which are critical to regional attribution models.
- With regard to CMS reviewer questions pertaining to how frequently data is collected, the ICDB is updated on a quarterly basis. The ICDB analytical data infrastructure is complemented by a suite of HEDIS and related metric measurement algorithms that currently regularly produce most of the quantitative outcome metrics listed in Section 5 and Appendix 1 on at least a semi-annual basis for all Medicaid beneficiaries in Washington State meeting measure specification requirements. Furthermore, the state agency teams maintaining the ICDB have deep expertise in identity management processes that may be necessary to link new ad hoc data sources required for ACH project attribution.

Among the advantages to leveraging the State's nation-leading integrated analytical data environment is the elimination of dependencies on ACHs for data collection and measurement,

[23] For a recent example, see Jingping Xing, Candace Goehring and David Mancuso. Care Coordination Program For Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs Care Coordination Program For Washington State. Health Affairs, 34, no.4 (2015):653-661.

[24] For more information about the CDPS and Medicaid-Rx, visit http://cdps.ucsd.edu/.

which otherwise would likely result in variation across projects in data integrity and measurement quality. We also note that the State's analytical environment can readily absorb new and changing measurement concepts, and apply those concepts retroactively for all relevant history to maintain consistent time series for analysis. For example, the addition of "FUA" and "FUM" metrics first implemented in the HEDIS® 2017 provided the state with useful new tools to assess coordination of physical and behavioral health care for persons with co-occurring conditions, and we retroactively produce those measures for prior time periods. Given the active work underway by NQF and NCQA, driven by CMS support, to improve the breadth of quality and outcome measures related to behavioral health conditions, if new measures are developed and released in 2018 or 2019 we would be able to retroactively engineer those measures into baseline time periods for the entire qualifying Medicaid population. This is one of the factors that support the expectation that the measure sets described in this design document may be modified if better performance measurement tools become available in the evaluation window.

Primary data collection for research questions that cannot be addressed using administrative data. Evaluation activities are expected to include key informant interviews, focus groups, stakeholder surveys, document review, and other activities as necessary to inform the qualitative analysis of initiative and project design and implementation. Qualitative analysis will be particularly important in evaluating the impact of DSRIP activities on progress toward meeting VBP penetration targets, the development of workforce capacity, and provider adoption and use of the state's health IT.

Methods such as key informant interviews, focus groups, and stakeholder surveys are expected to be used to assess the extent to which DSRIP funding has enhanced the state's health IT ecosystem to support delivery system and payment reform, with a focus on governance, financing, resolution of policy and legal barriers, and impacts on business operations. As noted elsewhere, the design and execution of qualitative methods supporting the evaluation will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments.

Subjects for key informant interviews and focus groups will be identified through consultation with State subject matter experts, and are expected to span the range of Demonstration activities and participants. Data will be collected from state agency staff, ACHs, MCOs, provider organizations, local health jurisdictions, tribes, and other key public and private stakeholders as identified.

Documentation will be identified in consultation with subject matter experts within HCA. Documents would include, but not be limited to, annual updates to the VBP roadmap; the annual VBP provider[25] survey; available documentation and data on provider adoption of VBP;

[25] HCA issues an annual value-based payment (VBP) survey to track progress towards the state's paying for value goals, and to identify barriers impeding desired progress. The provider survey will offer valuable insight into the challenges providers face as they consider adopting new payment arrangements and guide state health care purchasing strategies in support of overcoming those challenges. The commercial health plan survey will help HCA track progress towards our paying for value goals, with particular insight into non-state purchased health care programs. The MCO survey will establish a statewide and regional

consumer experience surveys, such as the CAHPS[26] survey, provided to Medicaid clients; the HIT strategic roadmap and updates to the operational plan; ACH project plans and implementation plans; Independent Assessor assessments of plans, semi-annual review of ACH progress against miles stones and metrics included in approved project plans, any documents associated with at risk projects, mid-point assessment, and other documents created by the Independent Assessor related to the challenge pool and the reinvestment pool including annual assessments of MCO and ACH performance; and all quarterly reports submitted by HCA to CMS.

In addition, caregiver and care receiver survey data collection is planned to support evaluation of the MAC and TSOA programs. Survey data will mitigate the impact on the evaluation of the absence of comparable health service utilization data for non-Medicaid clients, and lack of LTSS-related functional assessment data for Medicaid clients not receiving LTSS services. More detail about the design and data collection and analysis processes for these surveys is contained in Section 5.

Statewide beneficiary project attribution model. Given the scale of the initiatives and projects supported by the Demonstration, a statewide project attribution data infrastructure will be necessary to support evaluation – in particular evaluation of the Demonstration at the ACH-project scale. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration -funded projects across all three initiatives. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs described below.

The attribution model will be based on regularly updated claims, encounters, Medicaid eligibility, and residential location data processed through the ICDB, supplemented where necessary with regularly updated ACH project-specific data streams (e.g., monthly participating beneficiary and/or provider rosters) for ACH projects where claims and encounters processed into the ICDB are not sufficient to identify participating beneficiaries. For initiatives 2 and 3, we have determined that data identifying utilization of Demonstration services will be available through information routinely integrated into the ICDB – for example, supportive housing and supported employment encounters submitted by the third-party administrator (Amerigroup) into the ProviderOne (MMIS) system.

Final evaluation design determination. The statewide evaluation will identify whether the Demonstration impacted key metrics from a macro state-level perspective. However, it remains critical from the long-term sustainability perspective to understand which ACH projects positively impacted outcomes for participants, even if they were not implemented at a scale to produce statistically significant changes at the ACH or statewide geographic scale. This is critical information to identify which interventions should be supported or expanded after the demonstration ends.

(designated by Accountable Communities of Health) baseline of VBP attainment for requirements under the new Apple Health contracts and VBP incentives under the Medicaid Transformation Demonstration Project, respectively.

[26] The State uses the Adult CAHPS Survey and the Child and Child with Chronic Conditions Survey for Apple Health Medicaid enrollees, with adult and child surveys rotated every other year.

Finalizing many components of the detailed evaluation design at the project scale will need to be deferred until after ACH project implementation plans are available in the spring of 2018, and will be done in collaboration with the independent external evaluator. This timing is necessary because much of critical information for finalizing the evaluation design is dependent on knowing what types of projects will be implemented by ACHs. Project-level evaluation designs cannot be completed until we know the answers to questions including:

- Which interventions have been selected?
- How program participants will be targeted?
- Which providers will be participating?
- How much capacity will be developed to serve the targeted population?
- What level of engagement in the target population is likely to be achieved?
- Are other ACHs targeting similar populations for their initiatives?

At this point we can provide a discussion of evaluation design options, with recognition that specific design choices are dependent on currently unknown parameters and guidance from the independent external evaluator.

For example, if we knew that a particular ACH project was going to serve a relatively high proportion of a well-defined target population, and we knew that population was not a target for projects in some of the other ACHs, we would likely consider an intent-to-treat difference-of-difference design where we would compare relative changes in the entire target population in both the implementing ACH and the comparison ACHs that did not target this population. The intent-to-treat aspect of the design and the geographic variation in implementation would be instruments available to us to reduce the impact of selection bias on estimated project impacts.

However, if an ACH project were designed to reach only a small proportion of the potential target population in that ACH, an intent-to-treat approach would wash out the effect of the project on "treated" beneficiaries, by including their experience with the vastly larger number of untreated beneficiaries in the target population. From one perspective, the intent-to-treat approach would answer the question of whether the intervention impacted outcomes in the larger ACH target population. With low intervention penetration, the answer would likely be "no." But the question of whether the intervention impacted outcomes for those who engaged in the project is still highly relevant from the perspective of determining which interventions should be supported or expanded after the demonstration ends. And to address the question of impacts on the treated population, we would likely use a propensity score matching approach to identify an untreated comparison group. In the context of low intervention penetration, it might be appropriate to draw comparison group members from within the ACH implementing the intervention being evaluated, particularly if the ACH also implemented broad-based health system delivery redesign and community capacity building initiatives that are unique to the region.

These types of considerations will be worked through with the support of the independent external evaluator, after ACH project designs become available. We expect CMS to provide input and concur in the appropriateness of the final evaluation designs.

Propensity-score methods to estimate project-specific impacts. Propensity score matched comparison group designs will be broadly deployed across all project areas that are amenable to impact analysis using administrative data, including MMIS-derived health service utilization

data, LTSS assessment data, and linked "social determinant" outcome data.[27] Evaluation of Transformation project impacts at the ACH level is necessary to:

- Understand variation in outcomes across ACHs,
- Understand the degree to which improvements can be attributed to the specific activities undertaken under the Demonstration, and
- Inform post-Demonstration resource priorities in the state authorizing environment.

A matched comparison group is expected to be created for each ACH project, based on the characteristics of the target population for the specific intervention. The pre-post boundary for the treatment group will be based on the point at which they engage in the intervention. The pre-post boundary for the comparison group will be defined through the matching process, as described below. The matching process will generally proceed through the following steps:

- **Comparison frames for matching are identified by an initial broad set of criteria that align with the project targeting criteria.** For example, if an ACH intervention is targeting persons discharged from a hospital setting for improved care transitions, the starting point in defining the matching frame will be the identification of other qualifying discharges in the intervention "intake window", potentially both within and outside of the ACH (based on overarching evaluation design considerations discussed above). Similarly, if a care coordination intervention targets a particular set of beneficiaries using well-defined risk criteria, this initial stage of the process will identify all person-months for persons not receiving the intervention where the person meets the targeted risk criteria in the relevant baseline window (e.g., has PRISM risk scores within the eligibility range in the prior 12 month period). This approach to building a "person-month" frame for matching against the "person-months" associated with entry into the intervention by persons comprising the treatment group is illustrated in the evaluation of the precursor to the State's Health Home Program (Health Affairs, April 2015).[28] This approach leverages the richness of the State's integrated data environment and design of its analytical data infrastructure, which supports data management techniques that scan all relevant persons at all relevant points in time (months in this case) where they might be a "best" match to a person who entered the specific intervention under study at the time when they entered the intervention. The RDA project team supporting the independent external evaluator has extensive experience using these techniques for producing the high-volume of rigorous project evaluations required by the Demonstration.
- **Key predictors of engagement within the pooled intervention and comparison matching frame are examined to ensure inclusion of appropriate measurement dimensions in the PS model.** This includes creating an extensive set of "engagement predictors" that are determined, ex ante, to be potentially relevant to the matching process. This set of predictors is generally expected to span a wide range of the measurement domains contained with the State's ICDB, which may include:

[27] Examples of propensity-score impact analyses using the types of linked administrative data available for the Demonstration evaluation can be found here: https://www.dshs.wa.gov/sesa/research-and-data-analysis. For a recently published specific example, see: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-8-33.pdf.

[28] Jingping Xing, Candace Goehring and David Mancuso. Care Coordination Program For Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs Care Coordination Program For Washington State. Health Affairs, 34, no.4 (2015):653-661.

- Service utilization data across all Medicaid funded delivery systems (physical, mental health, substance use disorder, long-term services and support, and developmental disability services);
- Expenditure data at the "major modality" (e.g., IP hospitalization, OP ED visits, etc.) per-member per-month level;
- Risk factors associated with chronic and acute disease conditions, including mental illness and substance use disorders, derived from the CDPS and Medicaid-Rx risk models;
- Data on functional support needs, cognitive impairment, and behavioral challenges for persons receiving LTSS services when applicable;
- Data on arrests, employment and earnings, and homelessness and housing stability when applicable;
- Client demographics (age, gender, race/ethnicity);
- Medicaid enrollment by detailed coverage category; and
- Urban/rural/frontier characteristics of the beneficiary's residential location.

- Application of machine learning techniques (e.g., stepwise logistic or lasso regression) to determine the final propensity score model.
- Propensity score matching using procedures in the R programming language (e.g., the Matchit procedure). For some interventions, exact matching may be required for key variables.

Project-level utilization and cost analyses generally will be conducted using a difference-of-difference design, where the pre-to-post change in experiences for beneficiaries receiving a particular intervention will be compared against the change experienced by the matched comparison group. As described above, for analyses using a difference-of-difference design the pre-post boundary for the treatment group will be based on the point at which they engage in the intervention. The pre-post boundary for the comparison group will be defined through the matching process, which uses a person-month matching frame for matching against the "person-months" associated with entry into the intervention by persons comprising the treatment group. This approach leverages the richness of the State's integrated data environment and design of its analytical data infrastructure, which support data management techniques that scan all relevant persons at all relevant points in time (months in this case) where they might be a "best" match to a person who entered the specific intervention under study. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. Outcome metrics and measurement approaches will be partially aligned with those used for determining ACH performance payments, where feasible.

In response to comments received on the prior draft of this document, we want to emphasize the appropriateness (and critical importance) of matching based on pre-treatment utilization patterns in evaluating many of the interventions supported by the Demonstration. Past utilization is not endogenous because it cannot be impacted by future treatment. The outcome of interest is <u>future</u> (that is, post treatment entry) utilization, not past utilization. Future utilization is never appropriate for inclusion in the matching process, while past utilization patterns can be essential to control for when interventions are targeted specifically based on prior risk or service utilization patterns, as will likely be the case in many care coordination, care transition, and

diversion projects. Controlling for past utilization is one of the key ways to ensure that treatment and comparison groups do not have embedded within them differential expected levels of regression to the mean in utilization and cost metrics.

Data gap identification for each component of evaluation. Evaluation activities will ensure that data will be collected for all Demonstration projects as needed to facilitate the dissemination and comparison of valid quantitative data. Gaps in the extant data sources available to complete proposed evaluation activities will be identified and addressed. Currently known gaps, and the strategies to collect the necessary data, are summarized below:

- Qualitative data necessary for formative evaluation and support of the interpretation of quantitative findings will be collected using methods such as focus groups, key informant interviews, and surveys of beneficiaries and providers.
- New survey data will mitigate the impact on the evaluation of the absence of comparable health service utilization data for non-Medicaid clients, and lack of LTSS-related functional assessment data for Medicaid clients not receiving LTSS services, in the evaluation of the MAC and TSOA programs.
- Qualitative data related to health IT adoption and use by providers, who are and are not eligible for the Medicaid EHR Incentive Program, workforce supports needed to support adoption and use, and barriers to use.
- ACHs may be required to regularly report patient and/or provider rosters associated with specific projects, if that information cannot be obtained through regularly collected claims or encounter data. Reporting of this information may be considered as a potential component of "pay for reporting" criteria of the ACH performance payment formula.

Assessment of data limitations and threats to internal validity and generalizability outside of the Washington State environment. Evaluation products will include an assessment of threats to validity and generalizability. From the perspective of internal validity, a key potential threat is the presence of selection bias in the engagement of beneficiaries in specific projects, in the absence of randomized trial designs for project implementation. Although the propensity matching approach is recognized as a valid evaluation design, frequently accepted in the peer-reviewed program evaluation literature, the approach may not fully mitigate the threat of selection bias. In implementing this design, it will remain critical to understand the process that "selects" clients into projects and to use this knowledge to define a credible "matching frame" for each project.

In particular, we note that the specification of the structure of the matching model can have a large effect on the estimated program impact. For example, if selection into a project is tied to a specific pattern of service delivery (e.g., release from a hospital), or due to extreme baseline utilization, then ensuring that the matched comparison group has a similar "trajectory" of service use into the boundary of the pre/post periods will be critical. The richness of the administrative data available to the evaluation team will help reduce the selection bias threat, by moving more client characteristics from the "unobservable variable" column to the "observable variable" column, including the trajectory of prior health service utilization in the baseline period used for matching.[29] The recent evaluation of the State's "Money Follows the Person" program (Roads to

[29] For a recently published example of an impact analysis using propensity matching and leveraging detailed information on the

Community Living) illustrates the criticality of matching on pre-period utilization trends in the context of interventions that target clients with specific pre-period utilization patterns. In the context of the RCL evaluation, the intervention requires a pattern of prior nursing facility utilization and client interest in community re-integration. The target population would tend to show significant regression to the mean (future reductions) in LTSS expenditures in the absence of any intervention. Comparing the intervention group against the experience of the broader nursing facility population would vastly overstate RCL program treatment effects. The chart on page 5 of the report referenced below illustrates this phenomenon, and the importance of matching on prior service utilization trends leading into the pre/post time boundary.[30]

Another threat to the internal validity of evaluation findings will be the challenge of controlling for all potential confounding interventions and policy changes – in particular the potential for beneficiaries to experience multiple overlapping treatment effects, both from other Demonstration projects and from other initiatives occurring simultaneously to the Demonstration. This risk will be mitigated through the development and maintenance of the statewide beneficiary project attribution model, as described above. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs.

The threats to the generalizability of project impact findings include the following considerations. First, conditions may be different in Washington State than in other states to which Demonstration-supported interventions might be extended. For example, Washington State has a highly rebalanced Medicaid LTSS delivery system, which has already achieved significant rebalancing of care from institutions to home and community settings. Second, variation in local conditions across Washington State may make it more challenging to generalize the effect of ACH-specific initiatives to other regions of the state. Required evaluation deliverables will speak to the potential to generalize findings outside of the Washington State environment.

Section 4. Process to Select an Outside Contractor

Required qualifications. Washington will select an independent external evaluator that has the expertise, experience, and impartiality to conduct a sophisticated program evaluation that meets all requirements specified in the Special Terms and Conditions including specified reporting timeframes. Required qualifications and experience include multi-disciplinary health services research skills and experience; an understanding of and experience with the Medicaid program; familiarity with Washington State Medicaid programs and populations; experience assessing the ability of health IT ecosystems to support delivery system and payment reforms, including issues related to governance, financing, policy/legal issues and business operations; and experience conducting complex, multi-faceted evaluations of large, multi-site health and/or social services programs.

Potential evaluation entities will be assessed on their relevant work experience, staff expertise, data management and analytic capacity, experience working with state agency program and research staff, proposed resource levels and availability of key staff, track record of related

trajectory of prior health service utilization, see: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-8-33.pdf.

[30] See: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-8-33.pdf.

publications in peer-reviewed journals, and the overall quality of their proposal. Proposed deliverables must meet all standards of leading academic institutions and academic journal peer review. In the process of identifying, selecting, and contracting with an independent external evaluator, the State will act appropriately to prevent a conflict of interest with the independent external evaluator. The independent external evaluator will have no affiliation with ACHs or their providers.

Cooperation with potential federal evaluator. Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully, to the greatest extent possible, with CMS or the evaluator selected by CMS. To promote efficiency, consistency, and best practices, the State independent external evaluator and any CMS evaluator will share data sources and methodology. There may be cases where the State and CMS evaluator choose to focus in different areas or pursue different modeling and statistical techniques. This will lead to a fuller and more nuanced understanding of the success and challenges of the Demonstration, as long as, both approaches fully consider the unique systems and experience in Washington State.

Collaboration with state agency program and research staff. The core evaluation, to be completed by the independent external evaluator, will include all elements required in the STCs. The state plans to fully leverage the independent evaluation to inform and support implementation, to develop internal reporting capability, to share lessons learned across projects and geography. To ensure that the evaluation work can be fully leveraged by the State; the independent external evaluator will be expected to consult extensively with State research staff to ensure agreement on scope, approach, and interpretation of the Washington context. Careful consultation will be essential to develop an evaluation that is responsive to the Washington experience, while identifying generalizable results.

The independent external evaluator will lead the evaluation and ultimately be responsible for the validity, reproducibility, and interpretation of the results. The State's role is to provide extensive guidance on unique aspects of the State's health system; health system participants; data availability, content, and interpretation; information flows; history and context of service provision, etc. The State will provide guidance on its needs and use cases for materials and results produced for the evaluation. The State will use its expertise and experience to provide the independent external evaluator with model identification and application within the Washington context. While all aspects of the evaluation plan outlined here will be the responsibility of the independent external evaluator, the State will participate in and conduct its own ongoing analysis and evaluation to support success across the Domains of the Demonstration.

The state plans to provide extensive consultation and data support for the independent external evaluator. The independent external evaluator will receive reports described in the STC under section 37 including bi-annual milestone and metric reports submitted by ACHs, quarterly DSRIP operational report protocols submitted by the state, and additional progress milestones for at risk projects. The independent external evaluator will conduct ongoing analyses of these data to inform both the interim and final evaluation reports.

Budget for the independent external evaluator evaluation activities. The total budget for the independent external evaluator is estimated to be over $4 Million for four years (Jan 1, 2018 through Dec 31, 2021). The estimated budget amount will cover all evaluation expenses, including salary, fringe, administrative costs, other direct costs such as travel for data collection, conference calls, etc., as well as, all costs related to quantitative and qualitative data collection

and analysis, and report development. More detail and justification for proposed costs will be provided through the independent external evaluator selection process.

The state will also budget for sufficient state agency staff, at both HCA and DSHS, to efficiently and effectively support the independent external evaluator. State support will be similar to the level needed to undertake evaluation on its own. That is, state data, analytic, and research staff will have to undertake data gathering, prepping, and submitting in line with the research goals and objectives. State researchers will provide technical assistance, will create intermediate data products, will share their in-depth knowledge of existing state programs; state populations; Medicaid operations; and will leverage existing relationships with partner organizations. They will also provide information on state IT, local and provider information technology systems as well; data structures, collections, definitions; and compliance with state policies such as privacy and security.

The state will select and enter into a contract with an independent entity to conduct the evaluation of the Demonstration to meet the following timeframes and deliverables.

TABLE 2.
Evaluation Deliverables and Timeline

Deliverable	Responsible Party (from to)	Date
Draft Evaluation Design	State	May 9th, 2017
– **Comments from CMS**	CMS	60 days from receipt
– **Final evaluation design**	State	60 days from receipt
DSRIP Deliverables		DY 2, 3, 4, and 5
Quarterly progress reports from independent external evaluator to include quarterly activities, data analysis, reflections and insight on the implementation of projects drawing on key informant interviews, document review, meetings attended, and activity review.	Independent External Evaluator (IE) to State	One month prior to State quarterly and annual reports.
State progress reports will include information on submittals from IE and progress of evaluation.	State to CMS	Include in Quarterly and Annual reports
Semi-annual milestone and metric reports submitted by ACHs, including any additional milestones reported for at-risk projects	ACHs to State/State to IE	Twice a year or according to established schedule
Quarterly DSRIP operational report protocols	State to IE	All available and then quarterly starting with IE contract initiation.

Deliverable	Responsible Party (from to)	Date
Health IT (STC39)	State to CMS	Quarterly
Specification for data required from state including a timeline, data gap analysis, and plan to address data gaps.	IE to State	DY2, Q3
Quarterly, semi-annual, and annual metric updates (depending on metric frequency) for P4P measures	State to IE	Quarterly starting DY 2, Q3
Receipt of annual data submissions from state to support baseline analysis	State to CMS	Annually starting DY 2, Q4
Focus groups and key informant interviews to create baseline information for qualitative analysis	IE to State	90 days after submittal of detailed project plans
Analysis of (2017) baseline state metrics and data	IE	DY 3, Q1
Analysis of VBP materials including existing survey results, data, key informant interviews, and focus groups to create a baseline line assessment of VBP readiness and use in contracting both at the plan and provider level.	IE to State	DY 3, Q1 90 days after receiving focus group data
Review and synthesize documents, data, focus groups, and key informant interviews on baseline workforce capacity	IE to State	DY 3, Q1 90 days after receiving focus group data
Review and synthesize documents, data, focus groups, and key informant interviews on baseline ability and readiness of state HIT/HIE to support health system transformation	IE to State	DY 3, Q1 90 days after receiving focus group data
Qualitative analysis of other aspects of program implementation and operations	IE to State	DY 3, Q1 90 days after receiving focus group data
Identification and baseline analysis of high risk populations expected to be significantly impacted by Demonstration initiatives.	IE to State	DY 3, Q1
Quantitative baseline analysis of overall target populations at the state and ACH levels.	IE to State	DY 3, Q2

Deliverable	Responsible Party (from to)	Date
Quantitative analysis of project target populations both within and across ACHs.	IE to State	DY 3, Q2
Rapid cycle implementation reports	Joint IE/State products	To be included in quarterly reports to start 90 days after implementation. Quarterly starting DY 3, Q1
Evaluation of specific projects implemented under all three initiatives. Both ACH specific results and Statewide implementation.	IE to State	DY 4, Q1 preliminary results DY 5, Q4 final results
Focus groups and key informant interviews to assess impact of Demonstration on all initiatives	IE to State	DY4, Q2
Focus groups and key informant interviews to assess impact of Demonstration on all initiatives	IE to State	DY 5, Q2
Analysis of VBP materials including provider survey results, key informant interviews, and focus groups to assess impact of Demonstration activities on VBP readiness, adoption, and use in contracting both at the plan and provider level.	IE to State	90 days after receiving focus group data (target date DY 5 Q4)
Analyze documents, data, focus groups, and key information interviews to assess Demonstration impact on healthcare workforce capacity	IE to State	90 days after receiving focus group data (target date DY 5 Q4)
Analyze documents, data, focus groups, and key information interviews to assess impact of Demonstration on HIT/HIE investments, use, and impact on health system transformation	IE to State	90 days after receiving focus group data (target date DY 5 Q4)
Qualitative analysis of other aspects of program implementation and operations	IE to State	90 days after receiving focus group data (target date DY 5 Q4)
Draft Interim Evaluation Report	State	April 3rd, 2021
– **CMS comments**	CMS	TBD
– **Final interim evaluation report**	State	60 days from receipt of CMS comments

Deliverable	Responsible Party (from to)	Date
Draft Final Evaluation Report	State	January 30th, 2022
– **CMS comments**	CMS	TBD
– **Final evaluation report**	State	60 days from receipt of CMS comments

The independent external evaluator will provide additional analyses and reporting to enable Washington to fully leverage the work of evaluation to inform and improve the implementation of the initiatives under the Demonstration. For this reason, the evaluation will need to be undertaken in stages, with reports and information being produced for internal stakeholders at each stage. Early work will focus on qualitative data gathered from focus groups, key informant interviews, and surveys. As the implementation progresses, analysis and reports will move towards impact and outcomes. Washington will also be interested in an evaluation of the effectiveness of our measurement process and incentive payments in promoting effective project selection and implementation, and the extent to which measure selection promoted a positive impact on the targeted populations.

Washington is undertaking an ambitious set of Medicaid innovation initiatives to continue and build upon current success in transforming the way health services are provided. Washington seeks an independent external evaluator who has the capacity and vision to pursue publication of results in peer reviewed journals. Washington is committed to the value of sharing both positive and negative experiences with innovation in order to inform the broader health care transformation effort.

Section 5: PROJECT-LEVEL DETAIL

DSRIP Program: Transformation through Accountable Communities of Health

Project 2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation (Required)

Component	Description
Goals and objectives	Through a whole-person approach to care, address physical and behavioral health (BH) needs through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need.
Target populations	All Medicaid beneficiaries (children and adults) particularly those with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD).
Evaluation questions and testable hypotheses	Evaluation questions pertain to understanding whether projects undertaken to better integrate the delivery of physical and behavioral health services: • Increase screening and identification of need for behavioral and physical health care services • Increase access to and engagement in treatment for BH conditions • Improve quality of care for behavioral and physical health conditions • Improve patient behavioral and physical health outcomes • Reduce disparities in health and social outcomes for persons with behavioral health risk factors • Reduce inpatient, psychiatric inpatient, and ED utilization Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and LTSS service utilization data, LTSS assessment data, and linked "social determinant" outcome data. Data are routinely collected through the operation of existing data interfaces, and is generally linked (collected into) into the State's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research

Component	Description
	questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the State's integrated client data environment will include: • Measures of health service utilization and cost, including ED visits, inpatient admissions, LTSS utilization and overall Medicaid expenditures • Access to mental health and substance use disorder treatment • Other health care quality measures (e.g., psychotropic medication adherence, comprehensive diabetes care) Specific examples of potential measures include (but are not limited to): • Outpatient Emergency Department Visits per 1000 Member Months • Inpatient Admissions per 1,000 Member Months • Plan All-Cause 30-Day Readmission Rate • Psychiatric Hospital 30-Day Readmission Rate • Antidepressant Medication Management • Child and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Eye Exam (Retinal) Performed • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Medication Management for People with Asthma (5 to 64 Years) • Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness

Component	Description
	• Mental Health Treatment Penetration (Broad Version) • Substance Use Disorder Treatment Penetration Analyses may also consider impacts on social outcomes including measures of homelessness and housing stability; employment, hours worked, and earnings levels; and criminal justice involvement (arrests). Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care contracts. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Provider capacity to effectively deliver integrated care • Implementation fidelity to adopted models of integration (e.g., Bree Collaborative recommendations, Collaborative Care Model principles) • The adoption of EHRs and other systems that support bi-directional data sharing • The extent of clinical-community linkages

Component	Description
	• Communication flows among care team members • Adoption of care coordination and management processes • Supply of mental health providers, substance use disorder providers, social workers, nurse practitioners, primary care providers • Opportunities for use of telehealth • Workflow changes to support integration of new screening and care processes, care integration, communication • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatments
Subgroup analyses to assess disparities and differences	Analyses will be conducted to assess variation in outcome measures across groups with a history of significant differences and disparities in beneficiary experience. For example, the underlying rationale for prioritizing projects addressing bi-directional integration of physical and behavioral health care includes the observation that there are extreme rates of inpatient and ED utilization for Medicaid beneficiaries with serious mental illness and/or substance use disorders. Adult Medicaid beneficiaries with co-occurring mental illness and SUD experience inpatient hospitalizations and ED utilization at about 3 times the rate observed in the general medical population, and experience similar disparities in rates of arrest and homelessness. Other notable disparities include differences in measures of access and/or quality of care across racial and ethnic groups, between urban and rural/frontier regions of the state, and between persons with significant functional impairments receiving LTSS services and other Medicaid beneficiaries. Based on these considerations, we expect subgroup analyses to assess disparities in access to services and outcomes to include analysis of variation in beneficiary outcomes by: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Behavioral health risk characteristics: severity of mental illness, SUD, co-occurring mental illness and SUD • Presence of physical comorbidities or need for functional supports

Project 2B: Community-Based Care Coordination (optional).

Component	Description
Goals and objectives	Promote care coordination across the continuum of health services for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.
Target populations	Medicaid beneficiaries (adults and children) with one or more chronic disease or condition, or mental illness, or substance use disorder and at least one risk factor (e.g., unstable housing, food insecurity, high EMS utilization).
Evaluation questions and testable hypotheses	General hypothesis—Care coordination is essential for ensuring that children and adults with complex health needs are connected to evidence-based interventions and services that will improve their outcomes. A hub-based (or similar) model provides a platform for communication among multiple care providers, so that each is able to work in a more coordinated fashion. Specific hypotheses - Implementation of a hub-based coordination model is expected to: • Increase access to and engagement in treatment for those with complex and/or co-occurring conditions • Improve quality of care for behavioral and physical health conditions • Improve patient behavioral and physical health outcomes • Reduce disparities in health and social outcomes for persons with behavioral health risk factors and persons needing functional supports • Reduce inpatient, psychiatric inpatient, and ED utilization • Improve access to Home and Community-based LTSS services Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and LTSS service utilization data, LTSS assessment data, and linked "social determinant" outcome data. Data are routinely collected through the operation of existing data interfaces, and is generally linked into the state's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis

Component	Description
	and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the state's integrated client data environment will include: • Measures of health service utilization and cost, including ED visits, inpatient admissions, LTSS utilization and overall Medicaid expenditures • Access to mental health and substance use disorder treatment • Other health care quality measures (e.g., psychotropic medication adherence, comprehensive diabetes care) Specific examples of potential measures include (but are not limited to): • Outpatient Emergency Department Visits per 1000 Member Months • Inpatient Admissions per 1,000 Member Months • Plan All-Cause 30-Day Readmission Rate • Psychiatric Hospital 30-Day Readmission Rate • Antidepressant Medication Management • Child and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Eye Exam (Retinal) Performed • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Medication Management for People with Asthma (5 to 64 Years) • Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Substance Use Disorder Treatment Penetration • Percent Homeless (Narrow Definition) • Percent Employed (Medicaid) • Home and Community-based Long Term Services and Supports Use • Skilled Nursing and Rehabilitation Facility Use

Component	Description
	Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address issues such as: • Implementation fidelity to the adopted evidence-based care coordination approach (e.g., Pathways Community HUB) • Adequacy of procedures used to identify risk factors • Identification of evidence-based and best practice interventions • Capability of EHRs and other technologies used for identifying high-risk populations, linking to services, tracking beneficiaries, and documenting outcomes • Capacity and shortages for workforce to implement the selected care coordination focus areas • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery
Subgroup analyses to assess	Analyses will be conducted to assess variation in outcome measures across groups with a history of significant differences and disparities in

Component	Description
disparities and differences	beneficiary experience. Understanding variation in the ability of care coordination interventions to engage and impact outcomes for different populations is an important consideration in assessing the success and extensibility of ACH interventions. Subgroup analyses to assess disparities in outcomes may include: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Type of risk factors, physical health conditions, behavioral health conditions, need for LTSS supports

Project 2C: Transitional Care (optional).

Component	Description
Goals and objectives	Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.
Target populations	Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care to home or to supportive housing, and beneficiaries with SMI discharged from inpatient care, or clients returning to the community from prison or jail.
Evaluation questions and testable hypotheses	General hypothesis—Points of transition out of intensive services/settings and into the community are critical intervention points in the care continuum. Individuals discharged from intensive settings may not have a stable environment to return to or may lack access to reliable care. More intensive transitional care and care management can improve access to care for these individuals and reduce avoidable hospital utilization. Specific hypotheses—Implementation of enhanced transitional care is expected to: • Increase access to and engagement in community-based treatment for physical and behavioral health conditions • Reduce inpatient admissions, psychiatric inpatient admissions, ED utilization, and institutional stays • Improve access to Home and Community-based Long Term Services and Supports Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy,	**Administrative data.** Impact analyses will use MMIS-derived physical,

sources and collection frequency	behavioral health, and LTSS service utilization data, LTSS assessment data, and linked "social determinant" outcome data. Data are routinely collected through the operation of existing data interfaces, and are generally linked into the state's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the state's integrated client data environment will include: • Measures of health service utilization and cost, including ED visits, inpatient admissions, LTSS utilization and overall Medicaid expenditures • Access to mental health and substance use disorder treatment • Other health care quality measures (e.g., psychotropic medication adherence, comprehensive diabetes care) Specific examples of potential measures include (but are not limited to): • Outpatient Emergency Department Visits per 1000 Member Months • Inpatient Admissions per 1,000 Member Months • Plan All-Cause 30-Day Readmission Rate • Psychiatric Hospital 30-Day Readmission Rate • Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness • Percent Homeless (Narrow Definition) • Home and Community-based Long Term Services and Supports Use Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.

	Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Implementation fidelity to the adopted evidence-based or evidence-informed approaches to transitional care (e.g., INTERACT, TCM, CTI, APIC Model) • Capacity of population health management/HIT systems to effectively deliver care transition services • Workforce capacity and shortages • Workflow changes to support integration of care transition processes and communications • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include, depending on the specific populations targeted by the selected transitional care initiatives: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Delivery system affiliation (e.g., transfers from Acute inpatient care, SNF, inpatient psychiatric care, prison, or jail

- Chronicity of housing instability
- Extent of prior criminal justice involvement

Project 2D: Diversion Interventions (optional).

Component	Description
Goals and objectives	Implement diversion strategies to: (1) promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, and (2) redirect low-level offenders engaged in drug or prostitution activity to community-based services, instead of jail and prosecution.
Target populations	Medicaid beneficiaries presenting at the ED for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergent condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.
Evaluation questions and testable hypotheses	General hypothesis—Diversion strategies provide opportunities to re-direct individuals away from high-cost medical and legal avenues and into community based health care and social services that can offer comprehensive assessment, care/case planning and management to lead to more positive outcomes. Specific hypotheses—Implementation of these diversion strategies is expected to: • Reduce ED utilization • Improve access to primary care • Improve access to behavioral health services • Reduce homeless rates • Reduce arrest rates Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and LTSS service utilization data, LTSS assessment data, and linked "social determinant" outcome data. Data are routinely collected through the operation of existing data interfaces, and is generally linked into the State's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis

Component	Description
	and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the State's integrated client data environment will include: • Measures of health service utilization and cost, including ED visits, inpatient admissions, and overall Medicaid expenditures • Access to mental health and substance use disorder treatment • Social outcomes including homelessness and criminal justice involvement Specific examples of potential measures include (but are not limited to): • Percent Homeless (Narrow Definition) • Percent Arrested • Outpatient Emergency Department Visits per 1000 Member Months • Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence • Adult Access to Preventive/Ambulatory Care • Mental Health Treatment Penetration (Broad Version) • Substance Use Disorder Treatment Penetration Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated

Component	Description
	managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Implementation fidelity to evidence-supported diversion strategies • Willingness and readiness of stakeholders to participate • Potential shortages of community health workers, social workers, mental health providers, substance abuse disorder providers. • Ability to use electronic health records (EHRs) and Health Information Exchange (HIE) systems to facilitate communication between emergency departments, community paramedics and other health care providers • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include, depending on the specific populations targeted by the selected diversion initiatives: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Functional risk factors (presence of behavioral risks, severity of physical comorbidities) • Extent of prior criminal justice involvement • Chronicity of housing instability

Project 3A: Addressing the Opioid Use Public Health Crisis (required).

Component	Description
Goals and objectives	Reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, overdose prevention, and recovery supports.

	Selected specific objectives include: • Reducing opioid use through prevention measures (e.g., adherence to opioid prescribing guidelines, Prescription Drug Monitoring Program promotion) • Increasing opioid use disorder treatment capacity (e.g., numbers of providers certified to prescribe medication-assisted therapies, innovative use of telehealth in rural areas) • Identifying and treating opioid use disorder among pregnant women • Increasing treatment engagement (e.g., promoting projects that offer low barrier access to buprenorphine in emergency departments, correctional facilities, syringe exchange programs, SUD and mental health programs) • Preventing overdoses (e.g. increased availability of naloxone)
Target populations	Medicaid beneficiaries, including youth, who use, misuse, or abuse, prescription opioids and/or heroin.
Evaluation questions and testable hypotheses	Implementation of strategies to reduce opioid-related morbidity and mortality is expected to: • Reduce opioid-related deaths • Reduce non-fatal overdose involving prescription opioids • Increase substance use disorder treatment penetration among opioid users • Reduce the number of patients on high-dose chronic opioid therapy • Increase the numbers receiving Medication Assisted Therapy (MAT) with Buprenorphine and Methadone Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and LTSS service utilization data, LTSS assessment data, and linked "social determinant" outcome data. Data are routinely collected through the operation of existing data interfaces, and is generally linked into the State's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key

	informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the State's integrated client data environment will include: • Opioid Related Deaths (Medicaid Enrollees and Total Population) per 100,000 covered lives • Non-fatal overdose involving prescription opioids per 100,000 covered lives • Substance Use Disorder Treatment Penetration, by type of treatment, for persons with opiate use disorder • Outpatient Emergency Department Visits per 1000 Member Months • Inpatient Admissions per 1,000 Member Months Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the

	quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Enhancements in EHRs and other systems to support clinical decisions in accordance with guidelines • Efforts to increase use of the Prescription Drug Monitoring Program (PDMP) • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery • Results of integrating telehealth approaches • Effectiveness of structural supports (e.g. case management capacity, nurse care managers, integration with substance use disorder providers) to support medical providers to implement and sustain medication assisted treatment
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Nature of opioid use (heroin injection, prescription opioids) • Presence of co-occurring mental illness, physical comorbidities and functional support needs • Extent of homelessness • Extent of prior criminal justice involvement In response to feedback on the initial evaluation design submission, we note that persons with opiate use disorders (and, more generally, persons with substance use disorders) have extremely high rates of homelessness and criminal justice involvement, relative to the general Medicaid population. As such, understanding the impact of opioid-related initiatives on populations with a history of prior homelessness or criminal justice involvement is of particular concern, as these beneficiaries are at high risk of experiencing adverse future outcomes.

Project 3B: Reproductive and Maternal/Child Health (optional).

Component	Description
Goals and objectives	Broad objective—Ensure that women have access to high quality reproductive health care throughout their lives and promote the health and safety of Washington's children. Specific objectives include: • Ensuring that families have intended and healthy pregnancies that lead to healthy children by promoting utilization of effective reproductive health strategies, healthy behaviors and risk reduction,

Component	Description
	effective contraceptive use, safe and quality prenatal and perinatal care, and general preventive care • Promoting healthy pregnancy and parenting through evidence-based home visiting models for pregnant high-risk mothers. • Improving child health through improving regional well-child visit rates and childhood immunization rates.
Target populations	Medicaid beneficiaries who are women of reproductive age, pregnant women, mothers of children ages 0-3, and children ages 0-17.
Evaluation questions and testable hypotheses	Implementation of strategies related to reproductive health and maternal/child health are expected to: • Reduce rates of teen pregnancy • Reduce the number of unintended pregnancies • Reduce the rate of low-birth weight deliveries • Increase substance use disorder treatment penetration among pregnant women • Increase Well-Child Visit rates among infants and young children • Increase rates of Chlamydia Screening • Improve access to effective contraceptive care (including LARC) • Increase childhood immunization rates Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will primarily use MMIS-derived physical and behavioral health data, and vital records (birth certificates from the Department of Health Center for Health Statistics individually linked to Medicaid clients in the First Steps Database, a component of the ICDB). Data are routinely collected through the operation of existing data interfaces, and is generally linked into the State's integrated client data environment on a quarterly basis. Measures related to unintended pregnancy and immunization rates will use Department of Health's the Pregnancy Risk Assessment Monitoring System (PRAMS) survey and immunization registry data, respectively. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This

Component	Description
	responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative and PRAMS survey data sources in the State's integrated client data environment will include: • Rate of Teen Pregnancy (15 – 19) • Rate of Unintended Pregnancies (PRAMS survey) • Rate of Low Birth Weight Births • Prenatal care in the first trimester of pregnancy • Mental Health Treatment Penetration (Broad Version) • Substance Use Disorder Treatment Penetration • Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life • Well-Child Visits in the First 15 Months of Life • Chlamydia Screening in Women Ages 16 to 24 • Contraceptive Care – Most & Moderately Effective Methods • Contraceptive Care – Access to LARC • Contraceptive Care – Postpartum • Childhood Immunization Status Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation

Component	Description
	designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Fidelity to evidence-based models (e.g., Nurse Family Partnership, Bright Futures) • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery • Barriers to increasing immunization rates • Adoption of evidence-based interventions to reduce substance abuse during pregnancy
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include, depending on the specific projects designed in this domain: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Behavioral health risk factors (e.g., maternal depression, other maternal mental illness conditions, substance use during pregnancy)

Project 3C: Access to Oral Health Services (optional).

Component	Description
Goals and objectives	Increase access to oral health services to prevent or control the progression of oral disease and ensure that oral health is recognized as a fundamental component of whole-person care.
Target populations	All Medicaid beneficiaries, especially adults.
Evaluation questions and testable hypotheses	The project focuses on providing oral health screening and assessment, intervention, and referral in the primary care setting, or through the deployment of mobile clinics and/or portable equipment. This is expected to increase access to oral health services for adults, improve prevention

Component	Description
	and control the progression of oral disease, and reduce reliance on emergency departments for oral pain and related conditions. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and dental service data. Data are routinely collected through the operation of existing data interfaces, and are generally linked into the State's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the State's integrated client data environment will include: • Oral health services utilization among Medicaid beneficiaries • Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers • Outpatient Emergency Department Visits per 1000 Member Months • Ongoing Care in Adults with Chronic Periodontitis • Periodontal Evaluation in Adults with Chronic Periodontitis • Caries at Recall (Adults and Children) • Adult Treatment Plan Completed • Sealants - % Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk • Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.

Component	Description
	Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Ability to elicit dental service provider participation • Shortages of dentist, hygienist, and other dental care providers, and primary care providers • Alignment between payment structures and the integration of oral health services • Referral relationships with dentists and other specialists, such as ENTs and periodontists • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include, depending on the specific projects designed in this domain: • Race/ethnicity, age and gender

Component	Description
	• Geography (ACH region, urban/rural/frontier), including an assessment of regional variation in the supply of oral health providers • Factors such as behavioral health conditions and functional support needs that might affect ability to access dental services

Project 3D: Chronic Disease Prevention and Control (optional).

Component	Description
Goals and objectives	Integrate health system and community approaches to improve chronic disease management and control.
Target populations	Medicaid beneficiaries (children and adults) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a focus on those populations experiencing the greatest burden of chronic disease(s) in the region.
Evaluation questions and testable hypotheses	The project focuses on integrating health system and community approaches to improve chronic disease management and control. Implementation of evidence-based guidelines and best practices for chronic disease care and management using the Chronic Care Model is expected to: • Improve the quality of care for chronic conditions • Improve patient outcomes • Reduce utilization of inpatient and emergency department services • Increase patient activation/confidence to self-manage chronic conditions Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Data strategy, sources and collection frequency	**Administrative data.** Impact analyses will use MMIS-derived physical, behavioral health, and LTSS service utilization data, and LTSS assessment data. Data are routinely collected through the operation of existing data interfaces, and are generally linked into the State's integrated client data environment on a quarterly basis. **Primary data collection.** Primary data will be collected for research questions that cannot be addressed using administrative data. Data collection efforts may include key informant interviews, focus groups, and stakeholder surveys. These data will support the qualitative analysis

Component	Description
	and interpretation of quantitative impact findings. The design and execution of qualitative methods and associated primary data collection will be the lead responsibility of the independent external evaluator. This responsibility will include: defining the number of focus groups, key informant interviews, and provider surveys; determining the universes and/or sample frames from which participants will be selected; determining when focus groups, interviews, or surveys will be conducted; aligning data collection instruments to specific research questions and hypotheses; and designing the specific data collection instruments. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1.
Measures	Measures derived from administrative data sources in the State's integrated client data environment may include (depending on region-specific target populations): • Outpatient Emergency Department Visits per 1000 Member Months • Inpatient Admissions per 1000 Medicaid Member Months • Child and Adolescents' Access to Primary Care Practitioners • Adult Access to Preventive/Ambulatory Care • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Medical attention for nephropathy • Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life • Well-Child Visits in the First 15 Months of Life • Medication Management for People with Asthma (5 – 64 Years) • Influenza Immunizations 6 months of age and older • Statin Therapy for Patients with Cardiovascular Disease • Adult Body Mass Index Assessment Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2.
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of

Component	Description
	physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. ACH projects will be separately evaluated, using difference-of-difference designs, where the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. Analyses will draw on qualitative information to help interpret the quantitative assessment of project impacts on beneficiary outcomes. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Fidelity to Chronic Care Model (CCM) guidelines • Ability of Health Information Technology systems to support data sharing, clinical-community linkages, timely communication among care team members, and care coordination and management processes • Shortages of Community Health Workers, Certified Asthma Educators, Certified Diabetes Educators, Home Health care Providers • Required workflow changes to support Registered Nurses and other clinical staff to be working to the top of professional licensure • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery
Subgroup analyses to assess disparities and differences	Subgroup analyses to assess disparities in access to services and outcomes may include, depending on the specific projects designed in this domain: • Race/ethnicity, age and gender • Geography (ACH region, urban/rural/frontier) • Differences in selected target populations and chronic conditions

PROJECT-LEVEL DETAIL
Long Term Services and Supports (LTSS) - Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)

Component	Description
Goals and objectives	Providing limited-scope LTSS to individuals "at risk" for Medicaid – and to Medicaid beneficiaries who are not currently receiving Medicaid-funded LTSS – to 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.
Target populations	**MAC.** Eligible individuals for the MAC program include current Medicaid beneficiaries who are functionally eligible for LTSS, but have chosen to receive limited-scope services supporting an unpaid caregiver rather than traditional Medicaid-funded LTSS. Further eligibility criteria include: • Age 55 or older; • Eligible for Categorically Needy (CN) or Alternative Benefit Plan (ABP) services; and • Meet functional eligibility criteria for Nursing Facility Level of Care (NFLOC) as determined through an eligibility assessment. **TSOA.** The demonstration establishes a new eligibility category for persons "at risk" of becoming eligible for Medicaid in order to access LTSS. This "At Risk" or "Tailored Supports for Older Adults" (TSOA) eligibility group is comprised of individuals who could receive Medicaid State Plan benefits under 42 CFR §435.236 and §435.217.Under the Demonstration, these persons may access a new LTSS benefit package designed to preserve quality of life while delaying increases in support needs (and the financial impoverishment) required for full Medicaid benefits. The individuals must: • Be age 55 or older; • Be a U.S. citizen or in eligible immigration status; • Not be currently eligible for CN or ABP Medicaid; • Meet functional eligibility criteria for NFLOC as determined through an eligibility assessment; • Be cared for by an unpaid caregiver in need of support services, or be an individual without a caregiver; • Have income up to 300% of the SSI Federal Benefit Rate. – To determine eligibility for TSOA services, the state will consider the income of the applicant, not their spouse/dependents, when determining if gross income is at or below the 300% SSI Federal Benefit Rate limit; and – 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

Component	Description
	treatment of income will apply and eligibility will be determined using only the applicant's income. Like the MAC population, Washington will not apply post-eligibility treatment of income to the TSOA populations. • Resource Limits -- Have countable resources below $53,100 for a single applicant and below $53,100 plus the state spousal resource standard for a married couple. – To determine resources, the State will us the Social Security Income (SSI)-related resource rules currently in use for determining eligibility for Medicaid LTSS with the following exceptions: a. Transfer of asset penalties do not apply b. Excess home equity provisions do not apply
Evaluation questions and testable hypotheses	Demonstration hypotheses (STC 108) associated with this initiative pertain to understanding the effects of modifying eligibility criteria and benefit packages for long-term services and supports, and assessing whether providing limited scope LTSS to individuals "at risk" for Medicaid – and to Medicaid beneficiaries who are not currently receiving Medicaid-funded LTSS – 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. The domains of focus and associated research questions specified in STC 109 are: "What are the effects of modifying eligibility criteria and benefit packages for long-term services and supports?" Detailed project-level mapping of Initiative 2 research questions, testable hypotheses, data sources, and outcome metrics are provided in this section, and are not reproduced in Appendix 1. 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

Component	Description
	• 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? Detailed mapping of research questions, outcome metrics, and data sources are provided in the sections below, and are not reproduced in Appendix 1.
Data strategy, sources and collection frequency	**Participant Self-Report Data.** Self-report data from Caregivers (CG) and care receivers (CR) to support evaluation of the MAC and TSOA programs will be collected from participants through two sources: (1) assessments (Tailored Caregiver Assessment and Referral (TCARE®) for caregivers and GetCare for persons without caregivers) and related administrative data and (2) surveys. These two data collection methods are complementary, as some data is best collected in the course of screening, establishing eligibility, service planning and periodic re-screening and re-assessment. Other data elements are best collected through survey methods. Self-report data to be collected are expected to include: • Opportunities and challenges encountered in program implementation (supporting formative evaluation); • Satisfaction with program participation; • Caregiver characteristics, perceived burdens, stressors, relationship with care receiver, quality of life, and physical/mental health issues; • Care receiver living situation, assistance needs, problematic behaviors, cognitive status, quality of life, and physical/mental health; • Values/preferences related to decision-making around these programs; • LTSS placement intentions; and • Qualitative descriptions of caregiver and care receiver experiences, in their own words. Self-report data will mitigate the impact on the evaluation of the absence of comparable health service utilization data for non-Medicaid clients, and lack of LTSS-related functional assessment data for Medicaid clients

Component	Description
	not receiving LTSS services. ***Self-Reported Administrative Assessment Data.*** IT systems used to administer the MAC and TSOA programs (e.g., TCARE and GetCare) are expected to collect information on a number of domains of interest for evaluation. These data are expected to be gathered by the program in the course of application, planning, and initial and ongoing screenings and assessments. Program IT systems will capture information for the universe of persons served, and are likely to be relied upon to support the range of potential subgroup analyses. In some cases, information captured by administrative data systems are collected at a time that best reflects the circumstances of caregivers and care receivers at the time of decision-making. Data will be collected initially at the time of initial application, screening and assessment. For those receiving ongoing services, re-screening will occur every 6 months and reassessment annually, allowing longitudinal analysis. The following measurement domains may be particularly informed by data gathered using program IT systems: • Caregiver characteristics, perceived burdens, relationship with care receiver, issues with caregiving, mental health indicators, and overall health status; • Care receiver living situation, assistance needs, problematic behaviors, cognitive status, and items related to physical/mental health; • LTSS placement intentions ***Survey Data.*** The primary purpose of the surveys will be to describe the experiences, outcomes, and conditions/circumstances of caregivers and care receivers participating in the programs. Survey instruments will be designed to complement the information available in administrative data, and collect additional key data and more in-depth information. Surveys can address questions beyond those involved in screening, establishing eligibility, and assessment. They allow more detailed answers, less opportunity for bias, and precise identification of respondent. The surveys will also collect early feedback on program implementation to support formative evaluation. Survey data are expected to be collected by the survey unit of the DSHS Research and Data Analysis Division (RDA), with the independent external evaluator having primary responsibility for analyzing the collected data. Data to be collected with these surveys are expected to

Component	Description
	include: • Opportunities and challenges encountered in program implementation (supporting formative evaluation); • Satisfaction with program participation; • Care receiver quality of life; • Values/preferences related to decision-making around these programs; • Qualitative descriptions of caregiver and care receiver experiences, in their own words; and • In-depth data regarding issues addressed in self-report data from assessments and related data (e.g., caregiver quality of life and LTSS placement intentions). **Survey 1.** In the winter of 2018 (at least 4 months after program implementation), RDA will conduct a survey to identify emerging issues from the perspective of caregivers and care receivers. This survey will also serve as a pilot test to refine procedures, survey questions, and data collection cost estimates for subsequent survey waves. Because the primary goal of this survey wave is rapid collection of qualitative data to support program implementation through formative evaluation, the sample size will be relatively small. RDA will complete at least 50 telephone interviews with enrolled CGs and 50 with CRs who have completed full intake assessments of each of the two programs (MAC and TSOA), with a planned total of 232 interviews (accounting for pretesting and expected differences in response rates). **Survey 2.** Between April 2018 and December 2018, RDA will survey a random sample of CG-CR dyads soon after they first receive services/benefits through MAC or TSOA. The time required for reliable identification of all beneficiaries is still unknown, but we anticipate contact attempts starting approximately 30 days after first receipt of benefits. Survey 2 will serve as a "baseline" for comparisons of measures representing the domains listed above. **Survey 3**. Between March 2019 and September 2019, RDA will conduct another survey targeting participants interviewed in Survey 2. Contact attempts will begin approximately 12 months after the Survey 2 interview date. Survey 3 will provide a second measurement point that will enable description of how CGs and CRs experience the effects of participation in the MAC and TSOA programs. **Survey design and sampling.** The study population for all three surveys

Component	Description
	will be caregiver/care receiver dyads enrolled in MAC and TSOA, or TSOA individuals who have a completed care plan to receive first-time stage 3 services. All survey samples will utilize random sampling, and will be stratified by program. If indicated by the pilot results and enrollee characteristics, additional stratification factors may be chosen for surveys 2 and 3. A primary purpose of Survey 1 is to obtain early feedback about implementation. For this reason, selection for survey 1 will focus on early enrollees who are new to LTSS. The specific selection criteria will depend on the pace of enrollment, characteristics and geographic dispersion of early enrollees, and availability of the sampling frame. In general, all members of a group with slowest enrollment will be selected sequentially until a target proportional to that population is reached. Other groups will be sampled systematically from a random start point, with every kth dyad selected according to an interval determined by the expected enrollment of each group over the time period required to complete the slowest group. Surveys 2 and 3 are planned as two longitudinal waves in which respondents to survey 2 will be re-interviewed for survey 3. Depending on pilot results, resources, project needs, we expect to augment survey 3 with a cross-sectional random sample. All participants interviewed in Survey 2 will be eligible to complete survey 3, including those who are no longer receiving services. Based on experience conducting surveys of similar populations, we estimate that 70% of CG/CR dyads can be contacted and will consent to take the survey in the first year, but 25% of CRs will be unable to complete an interview due to cognitive or physical limitations. We estimate 1-year attrition of up to 56%, based on a 2014 RDA analysis of TCARE assessment results for the Family Caregiver Support Program (FCSP). The final plan for survey 2 sample selection will be determined after evaluation of survey 1 results and enrollment patterns in Demonstration Year 1. Sample size estimates are based on paired t-test requirements for 90% power to detect differences of 1 SD ($p < .05$) in a population with $M = 0$ and $SD = 1$, plus a contingency adjustment of 1.25 (minimum $n = 30$ pairs for each combination of program (MAC or TSOA) and role (CG or CR). In the event of high attrition, augmenting the survey 3 sample with up to 170 additional participants with similar length of participation (85 CG-CR dyads) will allow equivalent power for cross-sectional (two-

Component	Description
	sample) t-test comparisons. Data will be weighted to reflect selection probabilities and (if needed) adjusted for nonresponse. **Assessment and mitigation of potential biasing factors.** In any longitudinal survey there is potential for bias if nonresponse is correlated with the measurements of interest. The abundance of administrative and program data will allow us to assess this potential in surveys 2 and 3 by analyzing the relationships between survey response and variables from the NFLOC prescreening and TCARE assessments, including but not limited to LTSS placement intentions, caregiver ratings of care receiver health and quality of life, caregiver health status and burdens experienced, and demographic characteristics. If these analyses indicate the potential for nonresponse bias, post-stratification weights will be constructed using the factors that are most strongly related to nonresponse. Weighted survey data will be analyzed using routines that adjust for complex designs using the Taylor series method or resampling methods for variance adjustment, such as SAS PROC SURVEYREG. **LTSS utilization and cost impact estimates.** These estimates will use Medicaid-paid LTSS cost and utilization data derived from ProviderOne and related service payment data, linked to Medicare Part A, B and D data for persons dually eligible for Medicare and Medicaid. As described in detail in Section 3, Medicaid data are routinely collected through the operation of existing payment processes, and is generally linked into the State's ICDB environment on a quarterly basis. Washington State is a national leader in the integration of Medicare data to support analytical and care management uses for dual eligibles. Medicaid-paid LTSS cost and utilization data will be 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 (CPEM) maintained by the OFM Forecasting and Research Division. The CPEM is expected to be updated by the end of CY 2017 with projections through at least 2025, with updates on an approximately annual basis as new American Community Survey data are released.
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,

Component	Description
	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.
Statistical framework for measuring impacts	**Survey and administrative assessment measures.** Due to the lack of data necessary to create a "comparison sampling frame" for persons meeting comparable eligibility criteria who do not engage in MAC or TSOA services, analysis of survey and assessment data will focus on

Component	Description
	levels and changes in measures for the intervention group between the second (baseline) and third survey waves described above. This is essentially a pre-test/post-test design, where we recognize that the pre-test survey wave will occur very early in the "treatment period" (e.g., approximately 30 days after first receipt of benefits). Analysis of administrative data from TCARE assessments and related sources will take a similar approach, with changes in caregiver and care receiver circumstances measured from their initial assessment through subsequent assessments. In the absence of comparison groups of similar caregiver and care receiver dyads not receiving MAC or TSOA services, analysis of administrative assessment data is likely to be used primarily to understand participant experiences and differences in experiences across populations. **Comparisons between MAC clients and recipients of traditional Medicaid LTSS services.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation designs. An assessment of the difference between MAC clients and recipients of traditional Medicaid LTSS services will be conducted using difference-of-difference designs where appropriate, wherein the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. The matching process will leverage the available baseline assessment data for MAC clients and recipients of traditional Medicaid LTSS services. The pre-post boundary for each treatment group (MAC and traditional LTSS) will be based on the point at which they first engage in the intervention, with the imposition of a minimum prior period with no LTSS service receipt. The PS matching process will proceed through the following steps: • Examination of key baseline predictors of treatment entry within the pooled intervention and comparison matching frame to ensure

Component	Description
	inclusion of appropriate measurement dimensions in the PS model. This includes creating an extensive set of predictors that are determined, ex ante, to be potentially relevant to the matching process. This set of predictors is generally expected to span a wide range of the measurement domains contained with the State's ICDB, which may include: – Service utilization data across Medicare and Medicaid funded delivery systems (physical, mental health, substance use disorder, long-term services and support, and developmental disability services); – Expenditure data at the "major modality" (e.g., IP hospitalization, OP ED visits, etc.) per-member per-month level; – Risk factors associated with chronic disease conditions, including mental illness and substance use disorders, derived from the CDPS and Medicaid-Rx risk models; – Data on functional support needs, cognitive impairment, and behavioral challenges from the client's initial LTSS assessment at the point of intake into the MAC or traditional LTSS service; – Client demographics (age, gender, race/ethnicity); – Medicaid enrollment by detailed coverage category; and – Urban/rural/frontier characteristics of the beneficiary's residential location. • Application of machine learning techniques (e.g., stepwise logistic or lasso regression) to determine the final propensity score model. • Propensity score matching using procedures in the R programming language (e.g., the Matchit procedure). Exact matching may be required for key variables (e.g., age and gender). As with all Demonstration initiatives, target populations are expected to partially overlap across projects and programs. The statewide project attribution data infrastructure will be leveraged to identify project participation longitudinally at the beneficiary level. Analyses may be limited to subpopulations of clients with "common support" across baseline matching criteria, and subpopulations not engaged in other Demonstration projects or other initiatives. This restriction has parallels to study enrollment restrictions commonly imposed in the randomized clinical trial context. The baseline period for construction of matching variables will typically be the prior 12 months, but may be of longer duration if information from prior periods is determined to be predictive of engagement in MAC or traditional LTSS services. Outcome periods will typically be periods

Component	Description
	comprised of one or more 12-month segments or intervals, depending on the length of available follow-up time. Impact will generally be estimated in a regression framework using SAS regression procedures and models including controls for baseline characteristics, notably including those characteristics on which exact matching is not imposed. The ICDB will be the data source all measurement within this component of the evaluation. As was discussed in more detail in Section 3, the ICDB is designed to support quasi-experimental evaluation of health and social service interventions in Washington State, has been widely used in evaluation studies published in peer-reviewed journals, and contains data from the administrative data systems, including Medicare Parts A, B, and D data and the State's ProviderOne MMIS data system, necessary to implement this component of the quantitative evaluation design. **Overall LTSS utilization and state and federal cost impact estimates.** Estimates of impacts on Medicaid-paid LTSS utilization and costs will be done using a "synthetic estimation projection" approach. This approach involves: • Measuring baseline SFY 2017 (pre-Demonstration) Medicaid-paid LTSS utilization in Washington State, by detailed demographic cells defined by age, gender, race/ethnicity, and income level as derived from ACS data for Washington State; • Applying these utilization rates to (1) observed changes in per cap (per service user per month)[31] costs by LTSS service modality and (2) the forecast demographic composition of the Washington State population based on a process maintained by the Governor's Office of Financial Management which leverages ACS data for Washington State; and • Comparing the actual levels of Medicaid-paid LTSS utilization and costs under the Demonstration, including the MAC and TSOA program costs, to the levels of utilization and costs projected from the synthetic estimation model derived from baseline utilization, the observed evolution of per cap LTSS costs, and forecast changes to the composition of the Washington State population.
Subgroup analyses to assess disparities and differences	The dimensions to be considered for analysis of disparities and differences in access to services and outcomes, to the extent feasible using available survey and administrative data, may include: • Age and gender

[31] These are per user per month costs by major LTSS service modality (nursing facility, in-home personal care, and community residential care) that are used as key components of the State's LTSS budget forecast, along with monthly caseload data. In other words, we expect to use the observed evolution of these LTSS cost parameters in this analysis.

Component	Description
	• Race/ethnicity • Geography (urban/rural/frontier) • Functional risk factors (presence of cognitive impairment or dementia, behavioral risks, severity of physical comorbidities) • Care receiver relationship to caregiver • For the TSOA program, clients with caregivers relative to clients without caregivers

PROJECT-LEVEL DETAIL
Foundational Community Supports Program

Component	Description
Goals and objectives	Provide targeted community transition services, community support services, and supported employment services to help at-risk clients reside in stable community settings and gain and maintain stable employment, helping to improve beneficiary housing stability, employment outcomes, health outcomes, quality of life, and reduce Medicaid program costs[32].
Target populations	Potential changes to the FCS protocol are currently being reviewed with CMS. This table references FCS program descriptions reflected in the originally approved STCs, for purposes of illustrating the proposed evaluation approach. The final evaluation approach will reflect the actual design of the implemented FCS program. As with all Demonstration initiatives, target populations are expected to partially overlap across projects and programs. The statewide project attribution data infrastructure will be leveraged to identify project participation longitudinally at the beneficiary level. Analyses based on the propensity score matching approach may be limited to subpopulations of FCS clients with "common support" across baseline matching criteria, and subpopulations not engaged in other Demonstration projects or other initiatives. This restriction has parallels to study enrollment restrictions commonly imposed in the randomized clinical trial context. Eligible individuals include those who would be eligible under a section 1915(c) waiver program or a section 1915(i) state plan amendment and

[32] Potential changes to the FCS protocol are currently being reviewed with CMS. This document references FCS program descriptions reflected in the originally approved STCs, for purposes of illustrating the proposed evaluation approach. The final evaluation approach will reflect the actual design of the implemented FCS program.

Component	Description
	are determined to be require FCS services in order to obtain and maintain stable housing and/or employment. FCS is comprised of: • **Community Transition Services (CTS).** One-time supports designed to assist eligible clients transitioning out of institutional settings, or prevent eligible clients from entering institutional settings. Supports cover expenses necessary to enable an eligible client to obtain an independent, community-based living setting. • **Community Support Services (CSS).** Ongoing supportive services designed to support placement in an independent, community-based setting, as established in the eligible client's needs assessment and individualized treatment plan. • **Supported Employment - Individual Placement and Support (IPS).** Ongoing supports to participants who, because of their disabilities, need intensive support to obtain and maintain employment in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. CTS eligibility criteria include Medicaid clients age 18 and older, who meet the following criteria: • But for the provision of such services, the client would require admission into an institutional setting, or, • Is transitioning out of an institutional setting and, but for the provision of such services, would not be able to access and maintain a community-based setting; and • Exhibits one or more of the following characteristics: – Chronically homeless, as defined by the US Department of Housing and Urban Development, – Frequent or lengthy institutional or residential care stays, – Frequent turnover of in-home caregivers, or – Has a Predictive Risk Intelligence System (PRISM) score of 1.5 or above PRISM integrates medical, behavioral health and long-term care data to assess an individual's projected service needs. For the purposes of CTS, institutional settings include settings requiring a nursing facility level of care, inpatient medical hospitals, or inpatient behavioral health facilities. CSS eligibility criteria include Medicaid clients age 18 or older who are in need of Community Support Services, as determined by a functional needs assessment. The assessment must determine that one or more of the

Component	Description
	following characteristics are present: • Chronically homeless as defined by the US Department of Housing and Urban Development, • Frequent or lengthy institutional contacts as defined in the functional needs assessment, • Frequent or lengthy adult residential care stays as defined in the functional needs assessment, • Frequent turnover of in-home caregivers as defined in the functional needs assessment, or • Have a Predictive Risk Intelligence System (PRISM) Risk Score of 1.5 or above. IPS eligibility includes Medicaid clients age 16 or older who are in need of IPS, as determined by a functional needs assessment. The assessment must determine that one or more of the following characteristics are present: • Enrolled in the state Housing and Essential Needs (HEN) or Aged, Blind or Disabled (ABD) program • A diagnosed Serious and Persistent Mental Illness (SPMI) • Multiple instances of inpatient substance use treatment • Co-occurring mental and substance-use disorders • Working age youth, age 16 and older, with a behavioral health diagnosis • Receiving long-term services and supports
Evaluation questions and testable hypotheses	Demonstration hypotheses (STC 108) associated with this initiative pertain to understanding whether the provision of foundational community supports - supportive housing and supported employment - will improve health outcomes and reduce costs for a targeted subset of the Medicaid population. The domains of focus and associated research questions specified in STC 109 include assessing the effectiveness of the providing foundational community supports in terms of health, quality of life, and other benefits to the Medicaid program. Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. The term “targeted subset” used in the STC refers to the targeted eligibility criteria associated with the FCS program, as indicated in the “target population” section immediately above. Again, we note that as with all Demonstration initiatives, target populations are expected to partially overlap across projects and programs. The statewide project attribution data infrastructure will be leveraged to identify project

Component	Description
	participation longitudinally at the beneficiary level. Analyses based on the propensity score matching approach may be limited to subpopulations of FCS clients with "common support" across baseline matching criteria, and subpopulations not engaged in other Demonstration projects or other initiatives. This restriction has parallels to study enrollment restrictions commonly imposed in the randomized clinical trial context. Evaluation questions pertain to understanding whether the provision of foundational community supports will improve health outcomes and reduce costs for a targeted subset of the Medicaid population. Specific testable hypotheses, as described in more detail in Appendix 1, will include: • Do CTS or CSS services reduce homelessness and increase housing stability? • Do IPS services increase employment rates and earnings levels? • Do CTS, CSS or IPS services reduce the risk of criminal justice involvement? • Do CTS, CSS or IPS services reduce health service utilization and costs, including ED visits, inpatient admissions, or institutional LTSS utilization and overall Medicaid expenditures? • Is receipt of CTS, CSS or IPS services associated with increased engagement in other supportive preventative care, mental health or substance use treatment services (with increased engagement in such services considered to be a positive outcome)? • Is receipt of CTS, CSS or IPS services associated with increased measures of health care quality, consistent with positive effects on the beneficiary's ability to manage physical and behavioral health conditions? • Is Health IT used to support service delivery on behalf of persons for whom CTS, CSS, or IPS services are provided. For example, does health technology support the exchange of information between programs (such as criminal justice, Homeless Management Information System, Vocational Rehabilitation, and Medicaid) or providers (such as Emergency medical Response, EDs, acute care hospitals, and MH/SUD providers))? If so, how? If not, why not?
Data strategy, sources and collection frequency	Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Impact analyses will use MMIS-derived physical and behavioral health service utilization data, LTSS assessment data, and linked "social determinant" outcome data. Data is routinely collected through the operation of existing data interfaces, and is generally linked into the

Component	Description
	State's integrated client data environment on a quarterly basis. To address a request for clarification from feedback received on the prior draft, we note that LTSS data is one of multiple sources of health risk factor information (e.g., ICD-10 diagnoses, cognitive performance scale scores, ADL functional need scores) integrated into the State's ICDB. Propensity-score models will generally match treatment group members to comparison group members with comparable baseline levels of LTSS utilization. In this context, use of LTSS assessment data ensures balance on assessment-derived risk factors for subpopulations with comparable balance in their exposure to LTSS assessment processes. This is an example of our use of the vast dimensionality of risk information in the ICDB to reduce (i.e., mitigate) the magnitude of selection bias that could occur if the proposed analytical approaches were undertaken in a less information-rich environment.
Measures	Detailed project-level mapping of evaluation research questions, testable hypotheses, data sources, and outcome metrics is provided in Appendix 1. Specifications for many of the state-developed outcome measures are provided in Appendix 2. Measures derived from administrative data sources in the State's integrated client data environment will include: • Measures of homelessness and housing stability • Measures of employment, hours worked and earnings • Measures of criminal justice involvement • Measures of health service utilization and cost, including ED visits, inpatient admissions, nursing facility utilization and overall Medicaid expenditures • Access to mental health and substance use disorder treatment • Other health care quality measures (e.g., psychotropic medication adherence, comprehensive diabetes care)
Statistical framework for measuring impacts	**Quantitative impact analysis.** A statewide project attribution data infrastructure will support the evaluation. The attribution model will capture the timing of beneficiary and/or provider engagement in Demonstration-funded projects. The model will also identify potentially confounding policy changes and programs, such as participation in Health Homes or regional variation in the timing of implementation of physical and behavioral health integration through fully integrated managed care products. The attribution model will be a foundational data source for implementation of propensity score based quasi-experimental evaluation

Component	Description

	designs. An assessment of the difference between FCS program participants and non-participants with comparable baseline attributes will be conducted using difference-of-difference designs where appropriate, wherein the pre-to-post change in experiences for beneficiaries receiving services will be compared against the change experienced by a matched comparison group. The matching process will leverage the richness of baseline demographic, risk, and utilization data contained in the State's ICDB. The pre-post boundary for each treatment group will be based on the point at which they first engage in the intervention. The PS matching process will proceed through the following steps:
	• Examination of key baseline predictors of treatment entry within the pooled intervention and comparison matching frame to ensure inclusion of appropriate measurement dimensions in the PS model. This includes creating an extensive set of predictors that are determined, ex ante, to be potentially relevant to the matching process. This set of predictors is generally expected to span a wide range of the measurement domains contained with the State's ICDB, which may include:
	  – Service utilization data across Medicaid funded delivery systems (physical, mental health, substance use disorder, long-term services and support, and developmental disability services);
	  – Expenditure data at the "major modality" (e.g., IP hospitalization, OP ED visits, etc.) per-member per-month level;
	  – Risk factors associated with chronic disease conditions, including mental illness and substance use disorders, derived from the CDPS and Medicaid-Rx risk models;
	  – Data on functional (ADL) support needs, cognitive impairment, and behavioral challenges from the client's current LTSS assessment, if applicable;
	  – Prior patterns of housing instability or homelessness;
	  – Prior rates of employment and earnings levels;
	  – Prior arrest experiences;
	  – Client demographics (age, gender, race/ethnicity);
	  – Medicaid enrollment by detailed coverage category; and
	  – Urban/rural/frontier characteristics of the beneficiary's residential location.
	• Application of machine learning techniques (e.g., stepwise logistic or lasso regression) to determine the final propensity score model.

Component	Description
	• Propensity score matching using procedures in the R programming language (e.g., the Matchit procedure). Exact matching may be required for key variables (e.g., age and gender). As with all Demonstration initiatives, target populations are expected to partially overlap across projects and programs. The statewide project attribution data infrastructure will be leveraged to identify project participation longitudinally at the beneficiary level. Analyses may be limited to subpopulations of clients with "common support" across baseline matching criteria, and subpopulations not engaged in other Demonstration projects or other initiatives. This restriction has parallels to study enrollment restrictions commonly imposed in the randomized clinical trial context. The baseline period for construction of matching variables will typically be the prior 12 months, but may be of longer duration if information from prior periods is determined to be predictive of engagement in FCS services. Outcome periods will typically be periods comprised of one or more 12-month segments or intervals, depending on the length of available follow-up time. Impact will generally be estimated in a regression framework using SAS regression procedures and models including controls for baseline characteristics, notably including those baseline characteristics on which exact matching is not imposed. The ICDB will be the data source all measurement within this component of the evaluation. As was discussed in more detail in Section 3, the ICDB is designed to support quasi-experimental evaluation of health and social service interventions in Washington State, has been widely used in evaluation studies published in peer-reviewed journals, and contains data from the administrative data systems, including Medicare Parts A, B, and D data and the State's ProviderOne MMIS data system, necessary to implement this component of the quantitative evaluation design. **Qualitative analysis.** A qualitative analysis of project implementation and operations will be conducted to identify implementation risks, determine opportunities to improve implementation, and inform the quantitative analysis of project impacts. The analysis for this project may address implementation issues such as: • Provider capacity to effectively deliver CTS, CSS and supported employment services • Implementation fidelity to CTS, CSS and supported employment service models

Component	Description
	• Use of HIT to support delivery of CTS, CSS and supported employment services • The extent of linkages between CTS, CSS and supported employment service providers and other health care providers • Effectiveness of payment structures and VBP payment models to incentivize effective service delivery
Subgroup analyses to assess disparities and differences	Among the dimensions that will be considered for analysis of disparities and differences in access to services and outcomes include: • Race/ethnicity, age and gender • Geography (urban/rural/frontier) • Delivery system affiliation (e.g., physical health, mental health, SUD, LTSS and/or Tribal) • Chronicity of housing instability • Extent of prior employment history • Functional risk factors (presence of cognitive impairment or TBI, behavioral health risk factors, severity of physical comorbidities) • Extent of prior criminal justice involvement • Previously institutionalized populations

APPENDIX 1

Alignment of Demonstration and Project-Specific Testable Hypotheses to Evaluation Metrics and Data Sources

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TABLE 1.
Project 2A: Bi-Directional Integration of Care and Primary Care Transformation

H_1	
Demonstration Hypotheses (STC 108)	**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**

Research Questions Identified in Domains of Focus (STC 109)	**Q**	***Were ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*

Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . increase ***screening*** for physical health conditions, with a focus on eliminating disparities for persons with behavioral health risk factors?
		PERFORMANCE METRICS • NCQA HEDIS® Adults' Access to Preventive/Ambulatory Health Services (AAP) • NCQA HEDIS® Child and Adolescents' Access to Primary Care Practitioners • NCQA HEDIS® Breast Cancer Screening (BCS) • NCQA HEDIS® Cervical Cancer Screening (CCS) • NCQA HEDIS® Colorectal Cancer Screening (COL) • NCQA HEDIS® Chlamydia Screening (CHL) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . increase ***access*** to and ***engagement*** in treatment for mental illness and/or substance use disorders?
		PERFORMANCE METRICS • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification)

		• Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • NCQA HEDIS® Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . improve ***quality*** of care for behavioral and physical health conditions?
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Comprehensive Diabetes Care: Eye Exam (Retinal) Performed • NCQA HEDIS® Comprehensive Diabetes Care: Medical Attention for Nephropathy • NCQA HEDIS® Comprehensive Diabetes Care: Hemoglobin A1c Testing • NCQA HEDIS® Medication Management for People with Asthma (MMA) • NCQA HEDIS® Antidepressant Medication Management (AMM) • NCQA HEDIS® Adherence to Antipsychotics for Persons with Schizophrenia (SAA) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . improve ***coordination*** of care for persons with co-occurring behavioral and physical health conditions?
		PERFORMANCE METRICS • NCQA HEDIS® Diabetes Screening for People with Schizophrenia/Bipolar Disorder • NCQA HEDIS® Follow-up after Emergency Department Visit for Alcohol or Drug Dependence within 7/30 Days (FUA)

		• NCQA HEDIS® Follow-up after Emergency Department Visit for Mental Illness within 7/30 Days (FUM) • NCQA HEDIS® Follow-Up After Hospitalization for Mental Illness (FUH) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.5	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . improve beneficiary ***health and social outcomes***?
		PERFORMANCE METRICS • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) • Employment Rate (state-defined, see Appendix 2 for measure specification) • Arrest Rate (state-defined, see Appendix 2 for measure specification) • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.6	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . reduce disparities in health and social outcomes for persons with mental illness and/or substance use disorders, relative to Medicaid beneficiaries without behavioral health service needs?
		PERFORMANCE METRICS Stratification of measures listed above related to physical health care, service utilization, and cost into subpopulations based with mental illness and/or substance use disorders. • Presence of mental illness will be defined using the denominator criteria from the state-defined mental health service penetration rate metric.

		• Presence of substance use disorder will be defined using the denominator criteria from the state-defined Substance Use Disorder Treatment penetration rate metric. • Subpopulations with serious mental illness (SMI) may be defined by use of Chronic Illness and Disability Payment System (CDPS) Psychiatric High, Psychiatric Medium, and Psychiatrics Medium Low risk groups which include persons with schizophrenia, mania/bipolar disorders, major recurrent depression, and conditions of comparable severity. **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2

Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . reduce ED utilization?
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . reduce utilization of nursing facility care for persons requiring long-term services and supports?
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.4	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . reduce per-member per-month health care expenditures?
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H3	
Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 2.
Project 2B: Community-Based Care Coordination

H_1	
Demonstration Hypotheses (STC 108)	**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Community-Based Care Coordination effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*

Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Community-Based Care Coordination increase access to and engagement in treatment for those with complex and/or co-occurring conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® Adults' Access to Preventive/Ambulatory Health Services (AAP) • NCQA HEDIS® Child and Adolescents' Access to Primary Care Practitioners • NCQA HEDIS® Comprehensive Diabetes Care: Eye Exam (Retinal) Performed • NCQA HEDIS® Comprehensive Diabetes Care: Medical Attention for Nephropathy • NCQA HEDIS® Diabetes Screening for People with Schizophrenia/Bipolar Disorder • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification) • Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • NCQA HEDIS® Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Community-Based Care Coordination improve quality of care for behavioral and physical health conditions?***

		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Comprehensive Diabetes Care (CDC) • NCQA HEDIS® Medication Management for People with Asthma (MMA) • NCQA HEDIS® Antidepressant Medication Management (AMM) • NCQA HEDIS® Adherence to Antipsychotics for Persons with Schizophrenia (SAA) • NCQA HEDIS® Follow-Up After Hospitalization for Mental Illness (FUH) • NCQA HEDIS® Follow-up after Emergency Department Visit for Alcohol or Drug Dependence within 7/30 Days (FUA) • NCQA HEDIS® Follow-up after Emergency Department Visit for Mental Illness within 7/30 Days (FUM) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Community-Based Care Coordination improve patient health and social outcomes?***
		PERFORMANCE METRICS • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative • Employment Rate (state-defined, see Appendix 2 for measure specification) • Arrest Rate (state-defined, see Appendix 2 for measure specification) • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Community-Based Care Coordination improve health and social outcomes for persons with behavioral health risk factors and persons needing functional supports (e.g., persons receiving home- and community-based LTSS services)?***

	PERFORMANCE METRICS Stratification of measures listed above related to physical health care, service utilization, and cost into subpopulations with mental illness and/or substance use disorders and use of LTSS services. • Presence of mental illness will be defined using the denominator criteria from the state-defined mental health service penetration rate metric. • Presence of substance use disorder will be defined using the denominator criteria from the state-defined Substance use disorder treatment penetration rate metric. • Subpopulations with serious mental illness (SMI) may be defined by use of Chronic Illness and Disability Payment System (CDPS) Psychiatric High, Psychiatric Medium, and Psychiatrics Medium Low risk groups which include persons with schizophrenia, mania/bipolar disorders, major recurrent depression, and conditions of comparable severity. • LTSS service utilization will be derived from payment data. **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H2

Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Community-Based Care Coordination effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Community-Based Care Coordination reduce inpatient, psychiatric inpatient, and ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES**

		RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing Community-Based Care Coordination reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Community-Based Care Coordination reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	2.4	***Do ACH projects addressing Community-Based Care Coordination reduce utilization of nursing facility care for persons requiring long-term services and supports?***
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	2.5	***Do ACH projects addressing Community-Based Care Coordination reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains

DATA SOURCES
RDA Integrated Client Databases supplemented by project data if required for attribution.

H3	
Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Community-Based Care Coordination support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Community-Based Care Coordination expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care

		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Community-Based Care Coordination expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Community-Based Care Coordination accelerate adoption of value-based payment reform?***
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 3.
Project 2C: Transitional Care

H1	
Demonstration Hypotheses (STC 108)	**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Transitional Care effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*

Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Transitional Care increase access to and engagement in community-based treatment for behavioral health conditions?***
		PERFORMANCE METRICS • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification) • Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • NCQA HEDIS® Follow-Up After Hospitalization for Mental Illness (FUH) • NCQA HEDIS® Follow-up after Emergency Department Visit for Alcohol or Drug Dependence within 7/30 Days (FUA) • NCQA HEDIS® Follow-up after Emergency Department Visit for Mental Illness within 7/30 Days (FUM) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Transitional Care reduce inpatient admissions, psychiatric inpatient admissions, ED utilization, and institutional stays?***
		PERFORMANCE METRICS • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative • NCQA HEDIS® All-Cause 30-Day Readmission (PCR)

		• State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Transitional Care improve access to Home and Community-based Long Term Services and Supports?***
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.
Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Bi-Directional Integration of Care and Primary Care Transformation . . .*** . . . improve beneficiary ***social outcomes***?
		PERFORMANCE METRICS • Employment Rate (state-defined, see Appendix 2 for measure specification) • Arrest Rate (state-defined, see Appendix 2 for measure specification) • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2	
Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions	**Q.**	***Were ACH projects addressing Transitional Care effective in achieving lower health care costs?***

Identified in Domains of Focus (STC 109)		

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Transitional Care reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing Transitional Care reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Transitional Care reduce utilization of nursing facility care for persons requiring long-term services and supports?***
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

	2.4	***Do ACH projects addressing Transitional Care reduce per-member***

Project-Specific Testable Hypotheses		***per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H3	
Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Transitional Care support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific	3.2	***Do ACH projects addressing Transitional Care expand health system capacity?***

Testable Hypotheses		HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Transitional Care expand health system capacity?*** • Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Transitional Care accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS

		• Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 4.
Project 2D: Diversion Interventions

H_1	
Demonstration Hypotheses (STC 108)	**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Diversion Interventions effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*

Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Diversion Interventions reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Diversion Interventions improve access to primary care?***
		PERFORMANCE METRICS • NCQA HEDIS® Adults' Access to Preventive/Ambulatory Health Services (AAP) • NCQA HEDIS® Child and Adolescents' Access to Primary Care Practitioners **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if

		required for attribution.

Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Diversion Interventions improve access to behavioral health services?***
		PERFORMANCE METRICS • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification) • Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • NCQA HEDIS® Follow-up after Emergency Department Visit for Alcohol or Drug Dependence within 7/30 Days (FUA) • NCQA HEDIS® Follow-up after Emergency Department Visit for Mental Illness within 7/30 Days (FUM) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Diversion Interventions reduce homelessness rates?***
		PERFORMANCE METRICS • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.5	***Do ACH projects addressing Diversion Interventions reduce arrest rates?***
		PERFORMANCE METRICS • Arrest Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2	
Demonstration Hypotheses (STC	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth**

108)	**below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Diversion Interventions effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Diversion Interventions reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing Diversion Interventions reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Diversion Interventions reduce utilization of nursing facility care for persons requiring long-term services and supports?***
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES**

		RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.4	***Do ACH projects addressing Diversion Interventions reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H3	
Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Diversion Interventions support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES**

		Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Diversion Interventions expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Diversion Interventions expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific	3.4	***Do ACH projects addressing Diversion Interventions accelerate adoption of value-based payment reform?***

Testable Hypotheses		This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 5.
Project 3A: Addressing the Opioid Use Public Health Crisis

H_1	
Demonstration Hypotheses (STC 108)	**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects "Addressing the Opioid Use Public Health Crisis" effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*

Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce opioid-related deaths?***
		PERFORMANCE METRICS • Opioid Related Deaths (Medicaid Enrollees and Total Population) per 100,000 covered live (CDC standards used to define opioid related deaths) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific	1.2	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce non-fatal overdose involving prescription opioids?***

Testable Hypotheses		**PERFORMANCE METRICS** • Non-fatal overdose involving prescription opioids per 100,000 covered lives **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing the Opioid Use Public Health Crisis increase substance use disorder treatment penetration among opioid users?***
		PERFORMANCE METRICS • Substance Use Disorder Treatment Penetration, for persons with opiate use disorder (variation of state-defined metric restricted to persons with identified opiate use disorder – see Appendix 2 2) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce the number of patients on high-dose chronic opioid therapy?***
		PERFORMANCE METRICS • Bree Collaborative: Patients on high-dose chronic opioid therapy by varying thresholds (specification under development) • Bree Collaborative: Patients with concurrent sedatives prescriptions (specification under development) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.5	***Do ACH projects addressing the Opioid Use Public Health Crisis increase the numbers receiving Medication Assisted Therapy (MAT) with Buprenorphine and Methadone?***
		PERFORMANCE METRICS • Bree Collaborative: Medication Assisted Therapy (MAT) for Opiate Use Disorder Using Buprenorphine or Methadone (specification under development) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if

		required for attribution.

H2	
Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects "Addressing the Opioid Use Public Health Crisis" effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce utilization of nursing facility care for persons requiring long-term services and supports?***
		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.4	***Do ACH projects addressing the Opioid Use Public Health Crisis reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific	3.1	***Do ACH projects addressing the Opioid Use Public Health Crisis support redesigned care delivery?***

Testable Hypotheses		This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing the Opioid Use Public Health Crisis expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing the Opioid Use Public Health Crisis expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes

		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing the Opioid Use Public Health Crisis accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 6.
Project 3B: Reproductive and Maternal Child Health

H_1	
Demonstration Hypotheses (STC 108)	**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Reproductive and Maternal/Child Health effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*

Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce rates of teen pregnancy?***
		PERFORMANCE METRICS • State-defined measure rate of teen pregnancy (specification forthcoming) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce the number of unintended pregnancies?***
		PERFORMANCE METRICS • Washington State Department of Health Rate of Unintended Pregnancies (PRAMS survey) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce the rate of low-birth weight deliveries?***
		PERFORMANCE METRICS • Agency for Healthcare Research and Quality (AHRQ) Rate of Low Birth Weight Births (state-defined, specification forthcoming)

		• NCQA HEDIS® Prenatal care in the first trimester of pregnancy (PPC) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Reproductive and Maternal/Child Health increase engagement in behavioral health treatment penetration among pregnant women?***
		PERFORMANCE METRICS • Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.5	***Do ACH projects addressing Reproductive and Maternal/Child Health increase Well-Child Visit rates among infants and young children?***
		PERFORMANCE METRICS • NCQA HEDIS® Well-Child Visits in the First 15 Months of Life • NCQA HEDIS® Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.6	***Do ACH projects addressing Reproductive and Maternal/Child Health increase rates of Chlamydia screening?***
		PERFORMANCE METRICS • NCQA HEDIS® Chlamydia Screening (CHL) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

	1.7	***Do ACH projects addressing Reproductive and Maternal/Child***

Project-Specific Testable Hypotheses		***Health improve access to effective contraceptive care (including LARC)?***
		PERFORMANCE METRICS • U.S. Office of Population Affairs (OPA) Contraceptive Care – Most & Moderately Effective Methods (specification forthcoming) • U.S. Office of Population Affairs (OPA) Contraceptive Care – Access to LARC (specification forthcoming) • U.S. Office of Population Affairs (OPA) Contraceptive Care – Postpartum (specification forthcoming) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.8	***Do ACH projects addressing Reproductive and Maternal/Child Health increase childhood immunization rates?***
		PERFORMANCE METRICS • NCQA HEDIS® Childhood Immunization Status (CIS) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2	
Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Reproductive and Maternal/Child Health effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***

		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Reproductive and Maternal/Child Health reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the***

Domains of Focus (STC 109)		***intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Reproductive and Maternal/Child Health support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Reproductive and Maternal/Child Health expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Reproductive and Maternal/Child Health expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages

		• Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.
Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Reproductive and Maternal/Child Health accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 7.
Project 3C: Access to Oral Health Services

H_1	
Demonstration Hypotheses (STC 108)	**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**

Research Questions Identified in	**Q.**	***Were ACH projects addressing Access to Oral Health Services effective in achieving the goals of better care for individuals, including:***

Domains of Focus (STC 109)		• *Access to care,* • *Quality of care, and* • *Health outcomes?*

Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Access to Oral Health Services increase access to oral health services for children?***
		PERFORMANCE METRICS • Dental Quality Alliance (DQA) Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers (specification forthcoming) • Dental Quality Alliance (DQA) Caries at Recall (Children) (specification forthcoming) • Dental Quality Alliance (DQA) Sealants - % Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk (specification forthcoming) • Dental Quality Alliance (DQA) Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk (specification forthcoming) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Access to Oral Health Services increase access to oral health services for adults?***
		PERFORMANCE METRICS • State-defined measure of oral health services utilization among Medicaid beneficiaries (specification forthcoming) • National Network for Oral Health Access (NNOHA) Adult Treatment Plan Completed (specification forthcoming) • National Network for Oral Health Access (NNOHA) Caries at Recall (Adult) (specification forthcoming) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.3	***Do ACH projects addressing Access to Oral Health Services improve prevention and control the progression of oral disease?***
		PERFORMANCE METRICS • Dental Quality Alliance (DQA) Ongoing Care in Adults with Chronic Periodontitis (specification forthcoming) • Dental Quality Alliance (DQA) Periodontal Evaluation in Adults with Chronic Periodontitis (specification forthcoming)

		DATA SOURCES RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.4	***Do ACH projects addressing Access to Oral Health Services reduce reliance on emergency departments for oral pain and related conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative, with stratification to identify oral pain and related conditions **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2	
Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Access to Oral Health Services effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Access to Oral Health Services reduce potentially avoidable utilization of inpatient hospital services?***
		PERFORMANCE METRICS • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific	2.2	***Do ACH projects addressing Access to Oral Health Services reduce ED utilization?***

Testable Hypotheses		**PERFORMANCE METRICS** • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Access to Oral Health Services reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H3	
Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Access to Oral Health Services support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care

		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Access to Oral Health Services expand health system capacity?*** HIT/HIE related capacity: • Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Access to Oral Health Services expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator

		DATA SOURCES Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Access to Oral Health Services accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 8.
Project 3D: Chronic Disease Prevention and Control

H_1	
Demonstration Hypotheses (STC 108)	**Do ACH projects improve individual health outcomes, and thereby contribute to improved population health outcomes?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Chronic Disease Prevention and Control effective in achieving the goals of better care for individuals, including:*** • *Access to care,* • *Quality of care, and* • *Health outcomes?*

Project-Specific Testable Hypotheses	1.1	***Do ACH projects addressing Chronic Disease Prevention and Control improve the quality of care for chronic conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® Comprehensive Diabetes Care: Eye Exam (Retinal) Performed • NCQA HEDIS® Comprehensive Diabetes Care: Medical Attention for Nephropathy • NCQA HEDIS® Medication Management for People with Asthma (MMA) • Statin Therapy for Patients with Cardiovascular Disease • Adult Body Mass Index Assessment **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	1.2	***Do ACH projects addressing Chronic Disease Prevention and Control reduce utilization of inpatient and emergency department services?***
		PERFORMANCE METRICS • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H2	
Demonstration Hypotheses (STC 108)	**Do ACH projects reduce use of potentially avoidable intensive services and service settings, contributing to holding spending growth below national trends?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Were ACH projects addressing Chronic Disease Prevention and Control effective in achieving lower health care costs?***

Project-Specific Testable Hypotheses	2.1	***Do ACH projects addressing Chronic Disease Prevention and Control reduce potentially avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.2	***Do ACH projects addressing Chronic Disease Prevention and Control reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Project-Specific Testable Hypotheses	2.3	***Do ACH projects addressing Chronic Disease Prevention and Control reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS

	• State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H3

Demonstration Hypotheses (STC 108)	**Are ACHs able to implement projects that (1) support redesigned care delivery, (2) expand health system capacity, and (3) accelerate adoption of value-based payment reform?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***To what extent are ACH projects in this domain implemented with fidelity to the selected models of care?***
	Q.	***To what extent do ACH projects in this domain achieve the intended care delivery reform?***
	Q.	***To what extent do ACH projects in this domain contribute to advancements in the state's health IT ecosystem?***
	Q.	***To what extent do ACH projects in this domain contribute to adoption of value-based payment reform?***

Project-Specific Testable Hypotheses	3.1	***Do ACH projects addressing Chronic Disease Prevention and Control support redesigned care delivery?*** This includes: • Provider capacity to effectively deliver integrated care • Fidelity to the adopted models of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.2	***Do ACH projects addressing Chronic Disease Prevention and Control expand health system capacity?*** HIT/HIE related capacity:

		• Increased use of HIT/HIE technologies • Adoption of EHRs and other IT systems • Supporting the creation, exchange, and re-use of data • Improved care coordination through use of HIT/HIE technologies • Acquisition and use of interoperable HIT/HIE technologies • Using HIT/HIE to impact quality, continuity and cost of care
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.
Project-Specific Testable Hypotheses	3.3	***Do ACH projects addressing Chronic Disease Prevention and Control expand health system capacity?*** Provider related capacity: • Increase clinical-community linkages • Increase communication flows among care team members • Adoption of integrated care coordination and care management process • Increase supply of behavioral health providers, social workers, nurse practitioners, and primary care providers • Use of telehealth • Changes in workflows to support integration of new screenings and care processes
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Project-Specific Testable Hypotheses	3.4	***Do ACH projects addressing Chronic Disease Prevention and Control accelerate adoption of value-based payment reform?*** This includes: • Adoption of VBP payment models to incentivize effective service delivery • Adoption of evidence-based treatment
		PERFORMANCE METRICS

	• Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

TABLE 9.
Initiative 3: Foundational Community Supports Program

H1	
Demonstration Hypotheses (STC 108)	**Does the provision of foundational community supports - supportive housing and supported employment - improve health outcomes for a targeted subset of the Medicaid population?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***What impact does the provision of foundational community supports have on beneficiary health and quality of life?***

Initiative-Specific Testable Hypotheses	1.1	***Does participation in the Foundational Community Supports Program increase access to and engagement in treatment for mental illness and/or substance use disorders?***
		PERFORMANCE METRICS • Mental Health Service Penetration (state-defined, see Appendix 2 for measure specification) • Substance Used Disorder Treatment Penetration (state-defined, see Appendix 2 for measure specification) • NCQA HEDIS® Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Initiative-Specific Testable Hypotheses	1.2	***Does participation in the Foundational Community Supports Program improve quality of care for behavioral and physical health conditions?***

		PERFORMANCE METRICS • NCQA HEDIS® Comprehensive Diabetes Care (CDC) • NCQA HEDIS® Medication Management for People with Asthma (MMA) • NCQA HEDIS® Antidepressant Medication Management (AMM) • NCQA HEDIS® Adherence to Antipsychotics for Persons with Schizophrenia (SAA) • NCQA HEDIS® Follow-Up After Hospitalization for Mental Illness (FUH) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Initiative-Specific Testable Hypotheses	1.3	***Does participation in the Foundational Community Supports Program reduce avoidable utilization of inpatient hospital services related to physical or behavioral health conditions?***
		PERFORMANCE METRICS • NCQA HEDIS® All-Cause 30-Day Readmission (PCR) • State-defined 30-Day Readmission psychiatric readmission measure analogous to NCQA HEDIS®PCR (see Appendix 2 for measure specification) • NCQA HEDIS® Inpatient Hospital Utilization (IHU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Initiative-Specific Testable Hypotheses	1.4	***Does participation in the Foundational Community Supports Program reduce ED utilization?***
		PERFORMANCE METRICS • NCQA HEDIS® Emergency Department Utilization (EDU) or similar state-defined alternative **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Initiative-Specific Testable Hypotheses	1.5	***Does participation in the Foundational Community Supports Program reduce utilization of nursing facility care for persons requiring LTSS services?***

		PERFORMANCE METRICS • Balance between institutional (nursing facility) and home- and community-based LTSS utilization (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

Initiative-Specific Testable Hypotheses	1.6	***Does participation in the Foundational Community Supports Program improve social outcome metrics (reduce homelessness, increase employment, reduce risk of criminal justice involvement)?***
		PERFORMANCE METRICS • Employment Rate (state-defined, see Appendix 2 for measure specification) • Arrest Rate (state-defined, see Appendix 2 for measure specification) • Homelessness Rate (state-defined, see Appendix 2 for measure specification) **DATA SOURCES** RDA Integrated Client Databases supplemented by project data if required for attribution.

H_2	
Demonstration Hypotheses (STC 108)	**Does the provision of foundational community supports - supportive housing and supported employment - reduce costs for a targeted subset of the Medicaid population?**

Research Questions Identified in Domains of Focus (STC 109)	**Q.**	***Does the provision of foundational community supports provide other benefits to the Medicaid program?***

Initiative-Specific Testable Hypotheses	2.1	***Does participation in the Foundational Community Supports Program reduce per-member per-month health care expenditures?***
		PERFORMANCE METRICS • State-defined measures of per-member per-month health care expenditures across physical health, mental health, substance use disorder, and LTSS service domains

		DATA SOURCES RDA Integrated Client Databases supplemented by project data if required for attribution.

Initiative-Specific Testable Hypotheses	2.2	***Do the components of the Foundational Community Supports Program show fidelity to adopted evidence-based models of care?***
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Initiative-Specific Testable Hypotheses	2.3	***Does the Foundational Community Supports Program use HIT to support eligibility determinations and service delivery?***
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

Initiative-Specific Testable Hypotheses	2.4	***Does the Foundational Community Supports Program use electronic health information exchange (e.g., providers' use (creation and transmission) of employment/housing assessment templates, OneHealthPort (OHP) services (e.g., registration and use of the Clinical Data Repository (CDR))?***
		PERFORMANCE METRICS • Measures, measurement instruments, sample frames, sampling strategy, and data collection strategy to be designed by the independent external evaluator **DATA SOURCES** Data collection strategy to be designed by the independent external evaluator.

APPENDIX 2

State Developed Specification Definitions

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Arrest
Measure Definition (ARREST)

December 27, 2016
Medicaid Version 1.1

Description

The percentage of Medicaid enrollees who were arrested at least once in the measurement year. These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	18 – 64
Minimum Medicaid enrollment	A minimum of 7 months of Medicaid enrollment is required in the measurement year.
Anchor date	December 31 of the measurement year for calendar-year reporting
Identification window for Behavioral Health Service Needs	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months) for calendar-year reporting. For quarterly reporting a comparable 24-month period is used, anchored to the end of quarterly reporting period.
Benefit	Medicaid
Service contracting entity attribution	For Behavioral Health Organization (BHO), Area Agency on Aging (AAA) and Managed Care Organization (MCO) reporting, members must meet the additional attribution criteria defined below: • BHO Mental Health populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator mental health need criteria specified in the Mental Health Service Penetration metric. • BHO Substance Use Disorder (SUD) populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator SUD criteria specified in the SUD Treatment Penetration metric. • AAA populations must reside in the AAA catchment area for at least 7 months in the measurement year, and must receive Home- or Community-Based long-term services and supports in at least 7 months in the measurement year.

	• MCO populations must be enrolled with the MCO in at least 7 months in the measurement year.
Claim status for service contracting entity attribution	Include only final paid claims or accepted encounters for BHO attribution.

Denominator

Include in the measure denominator all individuals in the eligible population for the service contracting entity. In particular, note that persons who are dually eligible for Medicare or with Third-Party Liability (coverage) are included in the measure population.

Numerator

Include all denominator-eligible members with at least one arrest in the measurement year recorded in the Washington State Identification System (WASIS) arrest database maintained by the Washington State Patrol. The database is comprised of arrest charges for offenses resulting in fingerprint identification. The database provides a relatively complete record of felony and gross misdemeanor charges, but excludes some arrest charges for misdemeanor offenses that are not required to be reported.

Employment Rate
Measure Definition (EMP)

December 27, 2016
Medicaid Version 1.2

Description

The percentage of Medicaid enrollees with any earnings reported in Employment Security Department (ESD) employment data in the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	Separate reporting for age groups 18 – 64 and 65+
Minimum Medicaid enrollment	A minimum of 7 months of Medicaid enrollment is required in the measurement year.
Anchor date	December 31 of the measurement year for calendar-year reporting
Identification	January 1 of the year prior to the measurement year through December 31

window for Behavioral Health Service Needs	of the measurement year (24 months) for calendar-year reporting. For quarterly reporting a comparable 24-month period is used, anchored to the end of quarterly reporting period.
Benefit	Medicaid
Service contracting entity attribution	For Behavioral Health Organization (BHO), Area Agency on Aging (AAA) and Managed Care Organization (MCO) reporting, members must meet the additional attribution criteria defined below: • BHO Mental Health populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator mental health need criteria specified in the Mental Health Service Penetration metric. • BHO Substance Use Disorder (SUD) populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator SUD criteria specified in the SUD Treatment Penetration metric. • AAA populations must reside in the AAA catchment area for at least 7 months in the measurement year, and must receive Home- or Community-Based long-term services and supports in at least 7 months in the measurement year. • MCO populations must be enrolled with the MCO in at least 7 months in the measurement year.
Claim status for service contracting entity attribution	Include only final paid claims or accepted encounters for BHO attribution.

Denominator

Include in the measure denominator all individuals in the eligible population for the service contracting entity. In particular, note that persons who are dually eligible for Medicare or with Third-Party Liability (coverage) are included in the measure population.

Numerator

Include all members with at least one quarter in the measurement year with positive earnings recorded in ESD quarterly wage data. Note that ESD reported earnings data do not include self-employment, federal employment, or unreported earnings.

Homelessness Broad and Narrow
Measure Definitions (HOME-N and HOME-B)

December 27, 2016
Medicaid Version 1.2

Description

The percentage of Medicaid enrollees who were homeless in at least one month in the measurement year. These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	Separate reporting for age groups 0-17, 18 – 64 and 65+
Minimum Medicaid enrollment	A minimum of 7 months of Medicaid enrollment is required in the measurement year.
Anchor date	December 31 of the measurement year for calendar-year reporting
Identification window for Behavioral Health Service Needs	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months) for calendar-year reporting. For quarterly reporting a comparable 24-month period is used, anchored to the end of quarterly reporting period.
Benefit	Medicaid
Service contracting entity attribution	For Behavioral Health Organization (BHO), Area Agency on Aging (AAA) and Managed Care Organization (MCO) reporting, members must meet the additional attribution criteria defined below: • BHO Mental Health populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator mental health need criteria specified in the Mental Health Service Penetration metric. • BHO Substance Use Disorder (SUD) populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator SUD criteria specified in the SUD Treatment Penetration metric. • AAA populations must reside in the AAA catchment area for at least 7 months in the measurement year, and must receive Home- or Community-Based long-term services and supports in at least 7 months in the measurement year.

	• MCO populations must be enrolled with the MCO in at least 7 months in the measurement year.
Claim status for service contracting entity attribution	Include only final paid claims or accepted encounters for BHO attribution.
Data source for identifying homelessness	The DSHS Economic Services Administration's Automated Client Eligibility System (ACES); used by caseworkers to record information about client self-reported living arrangements and shelter expenses when determining eligibility for cash, food, and medical assistance.

Denominator

Include in the measure denominator all individuals in the eligible population for the service contracting entity. In particular, note that persons who are dually eligible for Medicare or with Third-Party Liability (coverage) are included in the measure population.

Numerator – Narrow

Include all denominator-eligible members with at least one month with a living arrangement status of "Homeless without Housing", "Emergency Shelter" or "Battered Spouse Shelter" recorded in the ACES eligibility data system.

Numerator – Broad

Include all denominator-eligible members with at least one month with a living arrangement status of "Homeless with Housing", "Homeless without Housing", "Emergency Shelter" or "Battered Spouse Shelter" recorded in the ACES eligibility data system.

Mental Health Service Penetration – Broad
Measure Definition (MH-B)

July 25, 2017
Medicaid Version 1.8

Description

The percentage of members with a mental health service need who received mental health services in the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

NOTE: Measure specification is currently undergoing revision to account for delivery system changes resulting from BHO and FIMC implementation.

Eligible Population

Ages	Separate reporting for age groups 6 – 17, 18 – 64 and 65+
Continuous enrollment	Applied only to the measurement year
Allowable gap	Member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year
Identification window	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months)
Benefit	Medicaid-only and dual eligibles excluding Part C enrollees Exclude persons with third-party liability (coverage)
Data sources	Medicaid MCO encounters and HCA-paid claims RSN/BHO encounter data and DBHR-paid behavioral health services Medicare Parts A and B claims and Medicare Part D encounters
Event/diagnosis	Members meeting the mental health service need criteria defined below
Claim status	Include only final paid claims or accepted encounters in measure calculation

Mental Health Service Need Definition

Mental health service need is identified by the occurrence of any of the following conditions:

1. Receipt of any mental health service meeting the numerator service criteria in the 24-month identification window

2. Any diagnosis of mental illness (not restricted to primary) in any of the categories listed in MH-Dx-value-set.xlsx in the 24-month identification window. These categories include:
    a. Psychotic Diagnosis Set 101
    b. Mania/Bipolar Diagnosis Set 102
    c. Depression Diagnosis Set 103
    d. Anxiety Diagnosis Set 104
    e. ADHD Diagnosis Set 105
    f. Disruptive/Impulse/Conduct Diagnosis Set 106
    g. Adjustment Diagnosis Set 107
3. Receipt of any psychotropic medication listed in MH-Rx-value-set.xlsx in the 24-month identification window. These medications comprise the following drug therapy classes:
    a. Antianxiety Rx
    b. Antidepressants Rx
    c. Antimania Rx
    d. Antipsychotic Rx
    e. ADHD Rx
4. Any claim with a service procedure code in the following set: 90791, 90792, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90825, 90826, 90827, 90828, 90829, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 90889, H0023, H0025, H0027, H0030, H0031, H0032, H0035, H0036, H0037, H0038, H0039, H0040, H0046, H1011, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2021, H2022, H2023, H2027, H2030, H2031, H2033, M0064, Q5008, S9480, S9482, S9484, S9485, T1025, T1026, T2038, T2048, 96101, 96102, 96103, 96110, 96111, 96116, 96118, 96119, 96120
5. Any psychiatric inpatient stay in the following facility types: Community Psychiatric Hospital, Evaluation & Treatment Center, Child Long-Term Inpatient, Child Study Treatment Center, Eastern and Western State Hospital
6. A tribal mental health encounter paid through ProviderOne

Denominator

Include in the denominator all individuals in the eligible population with a mental health service need in the 24-month identification window.

Numerator

Include in the numerator all individuals receiving at least one mental health services meeting at least one of the following criteria in the 12-month measurement year:

TABLE 1.
Numerator Service Criteria

Criterion	Value Sets

Mental health service modality from RSN/BHO encounter data	• Brief intervention treatment • Care coordination services • Child family team meeting • Co-occurring treatment • Crisis services • Day support • Engagement & outreach • Family treatment • Group treatment services • High intensity treatment • Housing and Recovery Through Peer Support (HARPS) • Individual treatment services • Intake evaluation • Medication management • Medication monitoring • Mental health clubhouse • Residential treatment services • Peer support • Psychological assessment • Offender Reentry Community Safety Program (ORCSP) • Rehabilitation case management • Special population evaluation • Stabilization services • Supported employment • Therapeutic psychoeducation • Community transition • Community based wraparound services Note: Classification of outpatient or residential BHO services is based on procedure code and modifier field values defined in the applicable BHO Service Encounter Reporting Instructions (SERI)
Tribal mental health encounter	A tribal mental health encounter paid through ProviderOne
Mental health provider taxonomy	Primary diagnosis code is a valid value in the MH-Dx-value-set.xlsx set AND Servicing provider taxonomy code is in the set: 101Y00000X, 101YM0800X, 101YP2500X, 103G00000X, 103T00000X, 103TB0200X,

	103TC0700X, 103TC1900X, 103TC2200X, 103TF0000X, 103TH0100X, 103TP0016X, 103TP0814X, 103TP2700X, 103TP2701X, 103TR0400X, 104100000X, 1041C0700X, 106H00000X, 163WP0809X, 2080P0006X, 2084A0401X, 2084F0202X, 2084N0400X, 2084N0402X, 2084N0600X, 2084P0015X, 2084P0800X, 2084P0802X, 2084P0804X, 2084P0805X, 2084S0012X, 2084V0102X, 251S00000X, 261QM0801X, 273R00000X, 283Q00000X, 323P00000X, 363LP0808X, 364SP0808X
Mental health procedure code	90791, 90792, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90825, 90826, 90827, 90828, 90829, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 90889, H0004, H0023, H0025, H0027, H0030, H0031, H0032, H0035, H0036, H0037, H0038, H0039, H0040, H0046, H1011, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2021, H2022, H2023, H2035, H2027, H2030, H2031, H2033, M0064, Q5008, S9480, S9482, S9484, S9485, T1025, T1026, T2038, T2048, 96101, 96102, 96103, 96110, 96111, 96116, 96118, 96119, 96120
Mental health condition management in primary care	Primary diagnosis code is a valid value in the MH-Dx-value-set.xlsx set AND Procedure code is in the set: 99201-99215 (Office), 99241-99255 (Consultation), or 99441-99444 (telephonic or online) AND (for Medicaid claims/encounters) Servicing provider taxonomy code is in the set: 101YA0400X, 101YM0800X, 101YP2500X, 103T00000X, 103TC0700X, 103TP0016X, 104100000X, 1041C0700X, 106H00000X, 163W00000X, 163WH0200X, 163WP0807X, 163WP0808X, 163WP0809X, 163WW0101X, 193200000X, 193400000X, 207LA0401X, 207LP2900X, 207P00000X, 207Q00000X, 207QA0000X, 207QA0401X, 207QA0505X, 207QG0300X, 207QH0002X, 207QS1201X, 207R00000X, 207RA0000X, 207RA0401X, 207RC0000X, 207RC0001X, 207RC0200X, 207RE0101X, 207RG0100X, 207RG0300X, 207RH0000X, 207RH0002X, 207RH0003X, 207RI0001X, 207RI0008X, 207RI0011X, 207RI0200X, 207RN0300X, 207RP1001X, 207RR0500X, 207RS0010X, 207RS0012X, 207RT0003X, 207RX0202X, 207V00000X, 207VC0200X, 207VG0400X, 207VM0101X, 207VX0000X, 207VX0201X, 208000000X, 2080A0000X,

	2080H0002X, 2080P0006X, 2080P0008X, 2080P0201X, 2080P0202X, 2080P0204X, 2080P0205X, 2080P0206X, 2080P0207X, 2080P0208X, 2080P0210X, 2080P0214X, 2080P0216X, 2083P0901X, 2084A0401X, 2084F0202X, 2084N0400X, 2084N0402X, 2084P0015X, 2084P0800X, 2084P0802X, 2084P0804X, 2084P0805X, 208800000X, 208D00000X, 208M00000X, 208VP0000X, 208VP0014X, 251S00000X, 261Q00000X, 261QD1600X, 261QF0400X, 261QM0801X, 261QM1300X, 261QP0904X, 261QP0905X, 261QP2300X, 261QR0200X, 261QR0400X, 261QR0405X, 261QR1300X, 261QU0200X, 273R00000X,282N00000X, 282NC0060X, 282NC2000X, 282NR1301X, 283Q00000X, 320800000X, 324500000X, 363LA2100X, 363LA2200X, 363LC1500X, 363LF0000X, 363LG0600X, 363LP0200X, 363LP0808X, 363LP1700X, 363LP2300X, 363LW0102X, 363LX0001X, 363LX0106X, 364S00000X, 364SF0001X, 364SP0808X, 367A00000X For Medicare paid claims, allow any servicing provider taxonomy code under this criterion

Substance Use Disorder Treatment Penetration Measure Definition (AOD)

December 27, 2016
Medicaid Version 1.3

Description

The percentage of members with a substance use disorder treatment need who received substance use disorder treatment in the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

NOTE: Measure specification is currently undergoing revision to account for delivery system changes resulting from BHO and FIMC implementation.

Eligible Population

Ages	Separate reporting for age groups 12 – 17, 18 – 64 and 65+
Continuous enrollment	The measurement year

Allowable gap	Member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year
Identification window	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months)
Benefit	Medicaid-only and dual eligibles excluding Part C enrollees Exclude persons with third-party liability (coverage)
Data sources	Medicaid MCO encounters and HCA-paid claims RSN/BHO encounter data and DBHR-paid behavioral health services CARE assessment diagnoses for identification of SUD treatment need Medicare Parts A and B claims and Medicare Part D encounters
Event/diagnosis	Members meeting the substance use disorder treatment need criteria defined below
Claim status	Include only final paid claims or accepted encounters in measure calculation

Substance Use Disorder Treatment Need

Substance use disorder treatment need is identified by the occurrence of any of the following in the identification window:

1. Diagnosis of a drug or alcohol use disorder in any health service event (SUD-Tx-Pen-Value-Set-1.xlsx)
2. Receipt of a substance use disorder treatment service meeting numerator criteria:
    a. Procedure, DRG, revenue and related codes: SUD-Tx-Pen-Value-Set-2.xls
    b. NDC codes: SUD-Tx-Pen-Value-Set-3.xlsx
3. Receipt of brief intervention (SBIRT) services (SUD-Tx-Pen-Value-Set-4.xlsx)
4. Receipt of medically managed detox services (SUD-Tx-Pen-Value-Set-5.xlsx).

Denominator

Include in the denominator all individuals in the eligible population with a substance use disorder treatment need.

Numerator

Include in the numerator all individuals receiving at least one substance use disorder treatment service meeting at least one of the following criteria in the 12-month measurement year (SUD-Tx-Pen-Value-Set-2.xlsx and SUD-Tx-Pen-Value-Set-3.xlsx):

1. Inpatient or residential substance use disorder treatment services
2. Outpatient substance use disorder treatment services
3. Methadone opiate substitution treatment services
4. Other medication-assisted treatment using medications indicated in SUD-Tx-Pen-Value-Set-3.xlsx

Classification of BHO services is based on procedure code and modifier field values defined in the applicable Service Encounter Reporting Instructions (SERI).

Emergency Department Utilization Measure Definition (ED)

July 25, 2016
Medicaid Version 1.1

Description

Outpatient Emergency Department (ED) Visits per 1,000 Member Months

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	Separate reporting for age groups 10 – 17, 18 – 64 and 65+
Medicaid enrollment	Continuous Medicaid coverage in the 6 months up to and including the denominator-compliant member month
Anchor date	December 31 of the measurement year
Identification window	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months)
Benefit	Full benefit Medicaid-only and dual eligibles excluding Part C enrollees Exclude persons with third-party liability (coverage)
Data sources	Medicaid MCO encounters and HCA-paid claims RSN/BHO encounter data and DBHR-paid behavioral health services

	CARE assessment diagnoses for identification of mental illness and substance use disorder Medicare Parts A and B claims and Medicare Part D encounters Long-term care service data for AAA affiliation
Service contracting entity attribution	For Behavioral Health Organization (BHO), Area Agency on Aging (AAA) and Managed Care Organization (MCO) reporting, members must meet the additional attribution criteria defined below: • Resided in the BHO service area continuously in the 6 months up to and including the qualifying service month AND presented an indication of a mental health treatment need in the 24 months leading up to and including the denominator-compliant member month • Resided in the BHO service area continuously in the 6 months up to and including the qualifying service month AND presented an indication of a substance use disorder treatment need in the 24 months leading up to and including the denominator-compliant member month • Resided in the AAA service area continuously in the 6 months up to and including the qualifying service month AND received ALTSA-funded in-home personal care services continuously in the 6 months up to and including the denominator-compliant member month • Enrolled with the MCO continuously in the 6 months up to and including the denominator-compliant member month
Event	Outpatient ED visits meeting the numerator criteria defined below
Claim status	Include only final paid claims or accepted encounters in measure calculation

Denominator

Medical coverage months in the eligible population in the measurement year.

Numerator

Outpatient ED visits during medical coverage months in the eligible population in the measurement year.

ED visits are defined by the following criteria:

- Claim or encounter is a hospital outpatient claim type AND
- One or more of the following criteria is met:
  - Revenue code in the set ('0450', '0451', '0452', '0456', '0459')
  - Procedure code in the set ('99281' ,'99282' ,'99283' ,'99284' ,'99285', ‘99288’)
  - Place of service code = Emergency Department

Measure is expressed as a rate per 1,000 denominator member months in the measurement year.

Home- and Community-Based Long Term Services and Supports Use Measure Definition (HCBS)

July 25, 2016
Medicaid Version 1.1

Description

Proportion of months receiving long-term services and supports (LTSS) associated with receipt of services in home- and community-based settings during the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	Separate reporting for age groups 18 – 64 and 65+
Medicaid enrollment	Enrolled in Medicaid coverage in the denominator-compliant member month
Anchor date	December 31 of the measurement year
Identification window for Behavioral Health Risk factors	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months)
Benefit	Full benefit Medicaid-only and dual eligibles excluding Part C enrollees Exclude persons with other third-party liability (coverage)
Data sources	Medicaid MCO encounters and HCA-paid claims RSN/BHO encounter data and DBHR-paid behavioral health services CARE assessment diagnoses for identification of mental illness and substance use disorder Medicare Parts A and B claims and Medicare Part D encounters Long-term care service data

Service contracting entity attribution	• For Behavioral Health Organization (BHO), Area Agency on Aging (AAA) and Managed Care Organization (MCO) reporting, members must meet the additional attribution criteria defined below: • Resided in the BHO service area in the qualifying service month AND presented an indication of a mental health treatment need in the 24 months leading up to and including the denominator-compliant member month • Resided in the BHO service area in the qualifying service month AND presented an indication of a substance use disorder treatment need in the 24 months leading up to and including the denominator-compliant member month • Resided in the AAA service area in the denominator-compliant member month • Enrolled with the MCO in the denominator-compliant member month
LTSS service criteria	Receipt of any one or more of the following service modalities in the index month: • Home- and community-based services – In-home personal care services – Adult family home services – Adult residential care services – Assisted living services • Nursing home services
Claim status	Include only final paid claims or accepted encounters in measure calculation

Denominator

Person-months associated with receipt of LTSS services by persons in the eligible population in the measurement year (includes HCBS and nursing home services).

Numerator

Person-months associated with receipt of home- and community-based LTSS by persons in the eligible population in the measurement year (excludes nursing home services).

Measure may be expressed as a rate per 1,000 member months or, equivalently, as a percentage of denominator-compliant member months.

Psychiatric Inpatient Readmissions – Medicaid
Measure Definition (PCR-P)

Description

For members 18 years of age and older, the proportion of acute inpatient psychiatric stays during the measurement year that were followed by an acute psychiatric readmission within 30 days. Data are reported in the following categories:

1. Count of Index Hospital Stays (IHS) (denominator).
2. Count of 30-Day Readmissions (numerator).

NOTE: Measure specification is currently undergoing revision to account for delivery system changes resulting from BHO and FIMC implementation.

Definitions

IHS	Index hospital stay. An acute psychiatric inpatient stay with a discharge on or between January 1 and December 1 of the measurement year. Include stays that meet the inclusion criteria in the denominator section. A client may have multiple qualifying discharges in the measurement period.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute psychiatric inpatient stay with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.
Classification Period	365 days prior to and including an Index Discharge Date.

Eligible Population Administrative Specification

Denominator	The eligible population.
Step 1	Identify all acute inpatient psychiatric stays with a discharge date on or between January 1 and December 1 of the measurement year. Include only acute admissions to behavioral healthcare facilities, as identified in Table 1 below.
Step 2	Acute-to–acute transfers: Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date.
Step 3	Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.
Step 4	Exclude stays with discharges for death from the observation set.
Step 5	Calculate continuous enrollment and determine whether the observation meets continuous enrollment criteria.

Table 1. Eligible Acute Inpatient Psychiatric Events

Event	Source
Community Psychiatric Hospital Admissions	ProviderOne

Evaluation & Treatment Center Admissions	ProviderOne, supplemented by DBHR Consumer Information System
Child Long-Term Inpatient Admissions	DBHR Consumer Information System
Child Study Treatment Center Admissions	DBHR Consumer Information System
Eastern and Western State Hospital Admissions	DBHR Consumer Information System

Numerator

At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date from the facilities identified in Table 1.

ATTACHMENT K
SUD Implementation Plan Protocol

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Introduction

Opioid misuse and addiction is a public health crisis in Washington State and across the country. In communities across the state, this epidemic is devastating families and overwhelming law enforcement and social services. In 2016, there were 694 opioid related deaths in Washington State. Of these deaths, 382 individuals died from a prescription opioid overdose, 278 died from a heroin overdose, and 90 died from a fentanyl overdose. This high mortality is due to the increase in heroin overdose deaths even though prescription opioid overdose deaths have decreased.

The state is committed to providing appropriate care for individuals with substance use disorder (SUD). In October 2016, Governor Jay Inslee issued Executive Order 16-09, marshalling the state's resources to combat this crisis, including preventing opioid use disorder (OUD) as well as treating it. In addition, Washington will respond to the opioid use public health crisis by utilizing its Section 1115 demonstration waiver to pursue the following goals, aligned with the Centers for Medicare and Medicaid Services (CMS):

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increased adherence to and retention in treatment for OUD and other SUDs;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUD; and
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

The following implementation plan outlines Washington's path to provide a full continuum of care for all Medicaid beneficiaries with OUD and other SUDs, and expanding access and improving outcomes in the most cost-effective manner possible. The plan is organized by six key milestones identified by CMS:

1. Access to critical levels of care for OUD and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including Medication Assisted Treatment (MAT);
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

Washington has already made great progress on many of these milestones, and believes it can accomplish all six goals of the SUD waiver by focusing on a cohesive review processes for SUD

residential admission assessments, ensuring sufficient provider capacity and expansion of access to MAT, as well as enhancing care coordination.

Milestone 1: Access to critical levels of care for OUD and other SUDs

Washington State's Medicaid funded programs provide access to all critical levels of care for OUD and other SUD. Prepaid Inpatient Health Plan (PIHP) contracts with the state's Behavioral Health Organizations (BHOs) require BHOs to provide access to the American Society of Addition Medicine (ASAM) levels described below. As regions around the state move toward the Integrated Managed Care (IMC) model, contracts with Managed Care Organizations (MCOs) will retain these requirements.

The outpatient benefits described below are delivered pursuant to the "Chemical dependency treatment" service requirements located at (13)(d)(2)(c) on Page 40 of Attachment 3.1-A of the State Plan, while the "detox" and inpatient services are provided pursuant to the service requirements located at (13)(d)(2)(b) on Page 38 of Attachment 3.1-A of the State Plan.

Inpatient and detoxification (withdrawal management) services must be provided in state certified facilities. SUD counseling in the categories described below must be provided by a state licensed Chemical Dependency Professional (CDP) or trainee (CDP-T).

The Washington Administrative Code (WAC) outlines treatment requirements for the following service categories:

WAC Requirements by Service Category[33]	
Service Category	**WAC**
Outpatient SUD	WAC 388-877-0738 to 0753
Residential SUD	WAC 388-877-1108 to 1116
General Residential Requirements	WAC 388-877-1108
ASAM 3.5 Intensive Inpatient SUD	WAC 388-877-1110
ASAM 3.1 Recovery House	WAC 388-877-1112
ASAM 3.1 Long-Term SUD Residential SUD	WAC 388-877-1114
Specific Rules for Youth Residential SUD	WAC 388-877-1116
Withdrawal Management	WAC 388-877-1100 to 1106
Opioid Treatment Programs	WAC 388-877-1000 to 1025

[33] http://apps.leg.wa.gov/wac/default.aspx?cite=388-877

ASAM Level 1 Outpatient Services
Current State:

Currently, outpatient services consist of less than nine hours of service per week provided in both individual and group treatment services of varying duration and intensity according to a prescribed plan which is developed before treatment begins. Providers document an individual service plan review for each individual once a month for the first three months and quarterly thereafter or sooner if required by other laws.

State Plan Page Number/Section:

- (13)(d)(2)(c) on Page 40.

Future State:

- No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None.

ASAM Level 2.1 Intensive Outpatient Services
Current State:

Intensive outpatient services include a minimum of 72 hours of treatment for a maximum of 12 weeks. The treatment includes the following: at least three sessions are required each week during the first four weeks of treatment, with each session occurring on separate days of the week, and group sessions of at least one hour and attending self-help groups in addition to the 72 hours of treatment services.

State Plan Page Number/Section:

- (13)(d)(2)(c) on Page 40.
-

Future State:

- No changes are expected at this ASAM level of care.
-

Summary of Actions Needed:

- None.

ASAM Level 3 Residential Services
Current State:

Residential services are dependent upon initial and ongoing ASAM assessments. Treatment consists of individual and group counseling, education, and activities for clients who have completed withdrawal management services (formerly referred to as detox). This level of SUD treatment provides services in accordance with ASAM level 3.1 and 3.5. Note: ASAM level 3.7 is included in the withdrawal management section below. Length of stay is not fixed, although some treatment programs are oriented to offer 30 to 60 day programs. Actual length of stay is dependent on progress towards treatment goals and reassessment.

State Plan Page Number/Section:

- (13)(d)(2)(b) on Page 38.

Future State:

- No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None.

Medication Assisted Treatment
Current State:

Washington has two Medication Assisted Treatment (MAT) options: Opiate Treatment Programs (OTP) and Office Based Opiate Treatment Programs (OBOT). Traditionally OTP programs have provided methadone, but some providers are also providing Buprenorphine MAT services. The Department of Social and Health Services' Division of Behavioral Health and Recovery (DBHR) has certified 25 OTP programs in addition to four Veterans Administration OTP programs.

State Plan Page Number/Section:

- (13)(d)(2)(c) on Page 40
-

Future State:

- No changes are expected at this ASAM level of care.
-

Summary of Actions Needed:

- None.

Withdrawal Management
Current State:

Withdrawal management services are provided to assist in safe withdrawal from the physical effects of psychoactive substances. The need for withdrawal management (WM) services is determined by patient assessment using the ASAM guidelines.

There are three levels of detox facilities recognized in Washington. Assessment of severity, medical complications, and specific drug or alcohol withdrawal risk determine placement within each level of service. All programs are licensed under the single ASAM Withdrawal Management requirements.

Sub-acute Detox (ASAM 3.2-WM): Clinically Managed Residential Facilities are considered sub-acute detox. They have limited medical coverage by staff and counselors who monitor patients and generally, any treatment medications are self-administered. These facilities are regulated by the Department of Health (DOH) and are DBHR-certified.

Acute Detox (ASAM 3.7-WM): Medically Monitored Inpatient Programs are considered acute detox. They have medical coverage by nurses with physicians on-call at all times for consultation. They have "standing orders" and available medications to help with withdrawal symptoms. Facilities for these programs are not hospitals, but do have referral relationships. These facilities are regulated by DOH and are DBHR-certified.

Acute Hospital Detox ASAM 4.0-WM): Medically Managed Intensive Inpatient Programs are considered acute hospital detox. The programs have medical coverage by RN and nurses with doctors available 24/7. There is full access to medical acute care including ICU if needed. Doctors, nurses, and counselors work as a part of an interdisciplinary team who medically manage the care of the patient. These facilities are regulated by DOH and hospital licensed, but are not DBHR-certified. This level of care is considered hospital care and not part of the behavioral health benefits provided through BHOs/MCOs.

State Plan Page Number/Section:

- (13)(d)(2)(b) on Page 38.

Future State:

- No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None.

Milestone 2: Widespread use of evidence-based, SUD-specific patient placement criteria

Current State:

The state requires all SUD providers to assess and provide treatment services using the ASAM criteria. The DBHR currently requires SUD assessments as defined in the WAC. The ASAM Patient Placement Criteria (PPC) are used to guide admission, continued service, and discharge planning.

The BHO/MCO authorization process is an independent review of residential authorization treatment. The residential agency providing the services must obtain independent approval from the BHO or MCO. This review process varies by managed care organization but in all cases is required to be based upon medical necessity and ASAM placement criteria.

In the Fee-for-Service (FFS) system there are no managed care or administrative services organizations providing review of admissions to residential SUD facilities. In most cases, an individual in the FFS system is assessed by a licensed outpatient provider not associated with the residential facility. This independent provider determines whether the individual meets the ASAM residential level of care and when appropriate makes a referral to a residential facility.

Current Monitoring Activities

Current state rules (WACs) require providers to use ASAM criteria for admission, continued services, and discharge planning and decisions.

WAC Requirements by Service Category[34]	
Service Category	**WAC**
Outpatient SUD	WAC 388-877-0738 to 0753
Residential SUD	WAC 388-877-1108 to 1116

All agencies providing these services are monitored by the state licensing and certification team. This team provides on-site visits that include a clinical review of charts at least once every three years for outpatient and annually for residential facilities. This review includes monitoring of ASAM treatment standards for types of services, hours of clinical care and staff credentials. These audits include a review of the appropriateness of placement and length of stay.

In addition to the licensing activities, BHOs and MCOs are required to monitor providers for appropriateness of clinical decision making, including the use of ASAM for admission, continued services, and discharge planning.

Evidence Based Admission Criteria

The state believes the current WAC rules requiring providers to use ASAM for admission, continued services, and discharge planning and decisions meets the requirement for evidenced-based SUD placement criteria.

[34] http://apps.leg.wa.gov/wac/default.aspx?cite=388-877

Future State:

Independent Review Process

To avoid barriers and delays for access to care, the state's approach to independent review for the FFS system is to have initial assessments performed independently from the treating facility. Given that most of the individuals affected by this FFS requirement are AI/AN, this approach offers more flexibility and is preferred over requiring that assessments be performed by an entirely different organization. Because of the limited number of Tribal providers, requiring an entirely separate organization would force AI/AN individuals to seek assessments from non-Tribal providers.

Summary of Actions Needed:

Within 12 months, FFS staff within the Federal Programs team at DBHR/HCA will update the SUD FFS Billing Guide to include a requirement that any FFS SUD residential stays must include an assessment for residential ASAM level of care prior to admit to the residential facility, and that the assessment must be completed independently of the SUD residential facility.

Implementation Timeline, Milestone 2	
Date	**Action**
July 1, 2018	Effective date of 1115 SUD/IMD Waiver Amendment.
September 2018	Convene workgroup that includes subject matter experts and staff responsible for the FFS Billing Guide. Include data management staff.
November 2018	• Finalize data reporting content and format. • Assess needs for changes to the data reporting system.
January 2019	Complete billing guide changes. Distribute to providers.
February 2019	Complete any changes to the data reporting system.

Milestone 3: Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities

Provider Qualification and Treatment Standards
Current State:

WAC rules require programs to meet ASAM Criteria and to adhere to ASAM treatment standards for types of services, hours of clinical care and staff credentials. These standards are found in the following WAC sections:

WAC Requirements by Service Category[35]	
Service Category	**WAC**

[35] http://apps.leg.wa.gov/wac/default.aspx?cite=388-877

General Residential Requirements	WAC 388-877-1108
ASAM 3.5 Intensive Inpatient SUD	WAC 388-877-1110
ASAM 3.1 Recovery House	WAC 388-877-1112
ASAM 3.1 Long-Term Residential SUD	WAC 388-877-1114
Specific Rules for Youth Residential SUD	WAC 388-877-1116

In addition to meeting the WAC administrative and personnel requirements, an agency providing substance use disorder residential treatment services must ensure all SUD assessment and counseling services are provided by a CDP or a CDPT under the supervision of an approved supervisor.

All of the Medicaid-covered service components described in the sections below are rehabilitative services of diagnostic evaluation and face-to-face individual or group counseling, pursuant to the state plan.

Intensive inpatient services (ASAM 3.5 Intensive Inpatient SUD WAC 388-877-1110) are SUD residential treatment services that provide a minimum of 20 hours of treatment services, including a program of individual and group counseling, education, and activities. An agency providing intensive inpatient services must:

- Complete the individual service plan within five days of admission.
- Conduct and document at least weekly, one face-to-face individual substance use disorder counseling session with the individual.
- Document progress notes, referrals and discharge summaries within required timeframes.

Recovery house services (ASAM 3.1 Recovery House WAC 388-877-1112) are SUD residential treatment services that provide social, vocational, and recreational activities to assist individuals adjust to abstinence, and to assist aid in job training, employment, or participating in other types of community services. Recovery house services require program-specific certification by the department's division of behavioral health and recovery.

Youth residential services (WAC 388-877-1116) are substance use disorder residential treatment services provided to an individual 17 years of age or younger. The agency is required to ensure at least one adult staff member of each gender is present or on call at all times if co-educational treatment services are provided. All staff members are trained in safe and therapeutic techniques for dealing with a youth's behavior and emotional crisis, including:

- Verbal de-escalation.
- Crisis intervention.
- Anger management.
- Suicide assessment and intervention.
- Conflict management and problem solving skills.

- Group meetings to promote personal growth, leisure, and other therapy or related activities.

These programs must provide seven or more hours of supervised, structured recreation each week. Provide and document each youth one or more hours per day, five days each week, of supervised academic tutoring or instruction by a certified teacher when the youth is unable to attend school for an estimated period of four weeks or more.

Requirements for providers to use evidence based practices (e.g. motivational interview, cognitive-behavioral therapy).

Providers are not required to utilize any specific evidence-based practices. However, WAC 388-877-0410 (3)(c)(ii), does require agencies to develop and maintain a written internal quality management plan and process that continuously improves the quality of care through use of evidence-based and promising practices.

Requirements for availability of a physical exam or consultation with a physician/ARNP.

Residential SUD facilities are required to complete a health assessment or physical exam. The level of detail and type of exam depends on how the facility is licensed with the DOH. To qualify as a residential SUD facility, the facility must be licensed by DOH in one of the following categories:

- Hospital (chapter 246-320 WAC);
- Private psychiatric or alcoholism hospital (chapter 246-322 WAC);
- Private alcohol and substance use disorder hospital (chapter 246-324 WAC); or
- Residential treatment facility (chapter 246-337 WAC).

The physical exam requirements can be found in the WACs listed above under the "patient care services" section of each rule.

Future State:

No changes.

Summary of Actions Needed:

None.

Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards

Current State:

DBHR licenses and certifies treatment programs and regulates treatment agencies providing services for SUD, community mental health (voluntary and involuntary commitment services),

and problem and pathological gambling. The DBHR Certification, Licensing, and Customer Relations Section supports our state's goal to improve services to vulnerable adults.

There are approximately 584 licensed and certified SUD treatment agencies, 202 community mental health agencies offering treatment services at 553 sites, and 21 problem and pathological gambling treatment agencies. Certification and licensing activities reduce health risks for patients and family members by ensuring that treatment agencies are:

- Surveyed within 12 months of initial approval and every three years; and
- In compliance with regulations; and
- Evaluated rapidly when complaints are received.[36]

Current licensing and certification standards are driven by the Revised Code of Washington (RCW), Code of Federal Regulations, and federal block grants. These standards were established to ensure:

- Quality health care services of equal intensity, duration, and scope.
- Quality management.
- Consistent application of clinical standards and practices.
- Consistent implementation of patient health and safety standards.
- Certified and licensed chemical dependency and mental health professionals are operating within the scope of their practice.
- Consistent risk management monitoring of substance use disorder treatment programs and community mental health agencies.
- Rapid response to complaints regarding substance use disorder treatment programs, community mental health agencies, and providers to ensure patient health and safety.

Opioid Treatment Programs

The DBHR licenses and certifies opioid treatment programs (OTPs) in Washington State. DBHR helps ensure that programs comply with federal and state laws and regulations through regular on-site surveys.

DBHR is a federally recognized OTP Accreditation Body by the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. Each OTP must be accredited and can choose DBHR or another approved accreditation body.

DBHR, through its licensing and regulatory program, supports compliance with nationally recognized standards for agencies that provide SUD treatment services. DBHR integrated requirements and standards of the ASAM criteria in 1998. Washington administrative rules require licensed agencies to use the ASAM criteria for making admission, continued services,

[36] https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/licensing-and-certification-behavioral-health-agencies

and discharge decisions. Agencies must use the ASAM criteria while conducting and developing SUD assessments, individual service plans, treatment plan reviews transitioning to levels of care, and coordinating discharge planning.

Current Monitoring Activities

All state agencies providing these services are monitored by the state licensing and certification team. This team provides on-site visits that include a clinical review of charts at least once every three years for outpatient providers and annually for residential facilities. This review includes monitoring of ASAM treatment standards for types of services, hours of clinical care and staff credentials. These audits include a review of the appropriateness of placement and length of stay.

In addition to the licensing activities, BHOs and MCOs are required to monitor providers for appropriateness of clinical decision making, including the level and types of services provided in agreement with ASAM levels of care.

Future State:

No changes. The state believes the current WAC rules requiring providers to use ASAM for admission, continued services, and discharge planning and decisions meets this requirement.

Summary of Actions Needed:

None.

Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off site

Current State:

The state does not require residential treatment facilities to offer MAT on-site. However, the state has promoted the use of MAT in these settings through provider training. Through these trainings, the state has encouraged providers to focus on patient choice when making decisions around the use of MAT. In addition, the state has utilized the Substance Abuse and Mental Health Services Administration's (SAMHSA) Prescription Drug and Opioid Addition (PDOA) and State Targeted Response (STR) grants to develop greater acceptance and availability of MAT.

Tribal and Urban Indian representatives in Washington have expressed objections to the requirement to offer or facilitate access to MAT for AI/AN clients. It is the state's understanding that CMS cannot offer an exemption for Tribal or Urban Indian residential treatment facilities at this time.

Tribal providers that do not provide of facilitate access to MAT as a treatment choice will not be included in the demonstration.

Future State:

The state will implement a requirement that residential treatment facilities offer MAT on-site or facilitate access off-site.

Summary of Actions Needed:

The HCA will work with the DOH to make these WAC changes. As of July 1, 2017 the policy and federal programs functions within DBHR will integrate into HCA. At the same time the DBHR licensing and certification team will become part of the DOH. These requirements will be implemented in two stages:

1. Within 12 months: The state will add to PIHP and MCO contracts a requirement that they require residential treatment providers to offer MAT on-site or facilitate access off-site.
2. Within 24 months: The state will update the WAC to include a requirement that residential treatment providers offer MAT on-site or facilitate access off-site.

Implementation Timeline, Milestone 3	
Contract Changes	
Date	**Action**
July 1, 2018	Effective date of 1115 SUD/IMD Waiver Amendment.
September 2018	• Begin developing new contract language that meets the requirements described above. • Convene group of subject matter experts to advise on development of requirements.
November 2018	Finalize new contract language.
January-March 2019 (or sooner)	Begin contract negotiations with MCOs/BHOs regarding new language.
April-June 2019 (or sooner)	Update MCO and BHO contracts to include the new requirements.
WAC Changes	
Date	**Action**
January 2019	Convene group that includes SUD subject matter experts and DOH/HCA staff responsible for updating WACs.
April 2019	Finalize draft WAC language.

May 2019	Begin public notice and rules hearing process.
September 2019	Finalize rules changes.
January 2020	Effective date of WAC changes.

Milestone 4: Sufficient provider capacity at critical levels of care including for Medication Assisted Treatment

Current State:

The state expects to develop the assessment described in this milestone within 12 months of demonstration approval. An initial assessment of providers enrolled in Medicaid and accepting new patients is described below.

Residential SUD Treatment

- 84 Providers – total licensed residential treatment agencies (includes withdrawal management). It is unknown at this time how many of these residential providers offer MAT services.
- 32 of these residential providers offer withdrawal management services.

Outpatient SUD Treatment

- There are 500 SUD outpatient providers, and 24 of these offer MAT services. The 24 agencies are licensed Opiate Treatment Programs (OTPs). Four new OTPs are planned for early 2018. Other licensed outpatient SUD agencies contract with waivered clinicians to provide MAT services.

Future State:

The state will complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state including those that offer MAT:

- Outpatient services.
- Intensive outpatient services.
- MAT (medications as well as counseling and other services).
- Intensive care in residential and inpatient settings.
- Medically supervised withdrawal management.

The assessment will help the state determine whether it has sufficient provider capacity in the areas listed above. If any area is determined to be below capacity, the report will include the state's plans to increase availability of this service.

Summary of Actions Needed:

This activity will be completed within 12 months. The HCA will work with the state's data analytics team to complete this task.

Implementation Timeline, Milestone 4	
Date	**Action**
July 1, 2018	Effective date of 1115 SUD/IMD Waiver Amendment.
September 2018	• Convene workgroup that includes the state's data analytics team. • Outline the parameters of the data requirements.
November 2018	Finalize data reporting content and format.
January 2019	Complete data analysis.
February 2019	If any area is below capacity, determine next steps to increase availability of this service.
April 2019	Finalize the report and send to CMS.

Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD

Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse

Current State:

The Washington Agency Medical Directors' Group (AMDG) develops guidelines for medical providers caring for patients of state agency programs in Washington State. The AMDG 2015 Interagency Guideline on Prescribing Opioids for Pain recommends best practices for opioid-based and non-opioid pain management to improve care of patients with chronic pain and to reduce their risk of addiction and overdose.[37] These guidelines are published as an educational tool for medical providers caring for patients of state agency programs, and state agencies use the guidelines to evaluate health technologies, including devices, durable medical equipment, procedures, diagnostics, and off-label drug use.

[37] http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

Along with the AMDG Guideline, five prescribing profession boards and commissions have adopted rules on the management of chronic, non-cancer pain:

- Medical Quality Assurance Commission
- Board of Osteopathic Medicine and Surgery
- Nursing Care Quality Assurance Commission
- Dental Quality Assurance Commission
- Podiatric Medical Board

While still in draft form and being reviewed by the respective commissions and boards, each medical specialty will require at least one hour of continuing education for practitioners licensed to prescribe opioids. Prescribers will attest to having met this requirement.

The relevant WACs for each profession can be found in DOH's Pain Management Adopted Rules.[38]

For Washington's Apple Health (Medicaid) program, the Washington State Health Care Authority implemented clinical policies pertaining to opioid prescriptions on November 1, 2017. This policy is intended to be a prevention and patient safety tool and limits the quantity of opioids that can be prescribed to opiate naïve patients for non-cancer pain.[39] This policy takes effect through both managed care organizations and fee-for-service.

Programs administered by the Health Care Authority are also required to implement the recommendations put forth by the Dr. Robert Bree Collaborative. In 2017 the Bree Collaborative issued recommendations for Opioid Prescribing Metrics.[40] The HCA Medicaid program has adopted three of these measures used in annual reports to providers who are the highest prescribers in the areas of: numbers of patients on high dose opioids, number of patients receiving high MEDs of opioids and those receiving opioids concurrently with other sedative hypnotics. These reports are informational and meant for quality improvement.

Additionally, the following pain management resources are available to providers:

- The University of Washington Department of Anesthesiology and Pain Medicine's Pain Medicine Provider Toolkit has a comprehensive list of clinical tools and patient education materials.
- The University of Washington School of Medicine COPE program offers a suite of free CME courses for primary care doctors, nurses, physician assistants, and other health care specialists who treat patients with chronic pain and want to learn how to safely address opioid prescribing.

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[38] https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/OpioidPrescribing/AdoptedRules
[39] https://www.hca.wa.gov/assets/billers-and-providers/opioid-policy.pdf
[40] http://www.breecollaborative.org/wp-content/uploads/Bree-Opioid-Prescribing-Metrics-Final-2017.pdf

- The WA State Department of Health Pain Management Resources website includes pain rules, dosage calculator, clinical tools, and CME training opportunities.
- The American Medical Association also offers CME courses and webinars on safe opioid prescribing.

Future State:

- No changes. Continue current activities.

Summary of Actions Needed:

- None.

Expanded coverage of, and access to, naloxone for overdose reversal

Current State:

DBHR has worked to increase Naloxone since 2015. Using Substance Abuse Block Grant (SABG) funding and working with the University of Washington Alcohol and Drug Abuse Institute (ADAI), DBHR has created a comprehensive website to provide education, locations for purchasing, and information on the distribution network. The collaboration between DBHR and ADAI has influenced changes to state laws including Washington State law RCW 69.50.315, which allows anyone "at risk for having or witnessing a drug overdose" to obtain naloxone and administer it in an overdose. This includes people who use opioids, family members, friends and professionals.

Washington State's 2015 "Naloxone law" RCW 69.41.095 also permits naloxone to be prescribed directly to an "entity" such as a police department, homeless shelter or social service agency for staff to administer if they witness an overdose when performing their professional duties. Additionally, RCW 69.41.095 also permits non-medical persons to distribute naloxone under a prescriber's standing order.

Immunity from liability. Several laws in Washington (commonly called "Good Samaritan" laws) give certain protections to laypersons trying to assist in a medical emergency. RCW 4.24.300 provides immunity from civil liabilities when responding in a medical emergency. RCW 69.50.315 further protects both the overdose victim and the person assisting in an overdose from prosecution for drug possession.

The Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO)[41] is a collaborative five-year grant project between the DBHR and the ADAI with the purpose of preventing opioid overdose and deaths from opioid overdose, and building local infrastructure to

[41] The DBHR currently directs the grant to Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO) (FOA) No. SP-16-005: Catalogue of Federal Domestic Assistance (CFDA) NO.: 93.243.

plan, implement, evaluate and fund overdose prevention efforts in the long-term. WA-PDO will develop a statewide network of opioid overdose experts and interventions, leveraging ADAI's Center for Opioid Safety Education program (COSE) as the central hub and four regional nodes coordinating WA-PDO overdose prevention activities; this will efficiently extend core overdose prevention expertise and centralized resources at COSE to four diverse, high-need areas (HNA) across the state.

WA-PDO will reach adults who use prescription opioids/heroin and professionals and community members who may be first responders at an overdose. Core interventions include stakeholder engagement, overdose prevention/response training, and naloxone distribution. Over the five-year project our activities will reach 2,400 police, fire, and emergency medical services personnel responders; 13,200 lay responders, 1,400 health care providers; 120 pharmacies; and 160 community organizations across four priority regions.

The Washington State Targeted Response (WA-STR) Naloxone project will provide medication to vulnerable and underserved populations in partnership with ADAI. Despite the resources provided by the 2016 Preventing Death from Opioids (PDO) grant, there remains a substantial gap between need and availability of take-home-naloxone provided to those at highest risk for witnessing an overdose. This program will help meet this need by providing additional naloxone to places at both high relative risk (in terms of the local opioid overdose mortality rate) and high absolute risk (in terms of the total number of fatal opioid overdoses and estimated heroin using population).

Currently all Syringe Exchange programs in Washington are distributing Naloxone as a component of the work provided by ADAI utilizing funding provided through DBHR SABG, PDO and WA-STR funding. The website stopoverdose.org continues to be a major source of education and training. ADAI continues to provide outreach and training for professional first-responders requesting training and naloxone.

Future State:

- No changes. Continue current activities.

Summary of Actions Needed:

- None.

Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs

Current State:

The Washington State Department of Health Prescription Monitoring Program (sometimes referred to as Prescription Review) is a centralized online database that holds controlled

substance prescription information for all patients across the state. Prescribers are able to review their patients' prescription history information before they prescribe or dispense drugs. This allows them to look for duplicate prescribing, possible misuse, drug interactions and other potential concerns. More information and factsheets on program rules, registration, use, and reports are available on the Prescription Monitoring Program website.[42]

The HCA sends opioid prescribing reports to physicians as part of the Centers for Disease Control's (CDC) Prescription Drug Overdose grant. These reports are intended to inform providers of their prescribing practices to support quality improvement efforts. The metrics used in this report mirror the Dr. Robert Bree Collaborative Opioid Prescribing Metrics[43] and are tailored to HCA's Medicaid population where applicable. The best practices recommendations reflect the CDC's guidelines for prescribing opioids.[44]

Future State:

- No changes. Continue current activities.

Summary of Actions Needed:

- None.

Milestone 6: Improved care coordination and transitions between levels of care

Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities
Current state:

While the state understands the value of coordination between levels of care and expects providers to provide warm hand-offs during the transition between residential and outpatient treatment, there are not any rules or policies in place requiring this for SUD services. The concept of coordination between the outpatient and inpatient settings has long been a part of the mental health system through discharge planning requirements and dedicated "hospital liaison" positions. However, the state recognizes that the SUD residential and outpatient systems may not yet coordinate to this level.

Additional policies to ensure coordination of care for co-occurring physical and mental health conditions
Washington State is moving toward an integrated managed care system. In this system, each Medicaid individual's behavioral health and physical health care is coordinated by a single entity (an MCO). There is an expectation that having both behavioral health and physical health services managed by one organization will improve coordination among those systems.

[42] http://www.wapmp.org/
[43] http://www.breecollaborative.org/wp-content/uploads/Opioid-Prescribing-Metrics-Specifications-Draft-2017.pdf
[44] https://www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-a.pdf

In addition to these system-wide changes, the state has current contract language requiring coordination with primary care providers (PCP) or, if the client does not have a PCP, that the behavioral health provider refer the individual to a PCP.

Future State:

The state will implement a requirement that MCOs, residential treatment providers, and outpatient providers work to develop policies and practices that enhance care coordination, including transitions between levels of care following residential treatment stays.

Summary of Actions Needed:

HCA will work with the DOH to make these WAC changes. As of July 1, 2017 the policy and federal programs functions within DBHR will integrate into HCA. At the same time the DBHR licensing and certification team will become part of the DOH.

1. Within 12 months: The state will add these requirements to PIHP and MCO contracts.
2. Within 24 months: The state will update the WAC to include these requirements

Implementation Timeline, Milestone 6	
Contract Changes	
Date	**Action**
July 1, 2018	Effective date of 1115 SUD/IMD Waiver Amendment
September 2018	• Begin developing new contract language that meets the requirements described above. • Convene group of subject matter experts to advise on development of requirements.
November 2018	Finalize new contract language.
January-March 2019 (or sooner)	Begin contract negotiations with MCOs/BHOs regarding new language.
April-June 2019 (or sooner)	Update MCO and BHO contracts to include the new requirements.
WAC Changes	
Date	**Action**
January 2019	Convene group that includes SUD subject matter experts and DOH/HCA staff responsible for updating WACs.
April 2019	Finalize draft WAC language.
May 2019	Begin public notice and rules hearing process.
September 2019	Finalize rules changes.
January 2020	Effective date of WAC changes.

Attachment A: SUD Health Information Technology (IT) Plan

The table below identifies Washington's SUD Health Information Technology (IT) Plan, including current and planned future state, and specific actions and timeline, to address needed enhancements over the course of the demonstration.

Section I. State Health IT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
5. Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and OUD, that is: *--Enhance the state's health IT functionality to support its PDMP; and* *--Enhance and/or support clinicians in their usage of the state's PDMP.*	*Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP, and supports to enhance clinicians' use of the state's health IT functionality to achieve the goals of the PDMP.*	*Provide an overview of plans for enhancing the state's PDMP, related enhancements to its health IT functionalities, and related enhancements to support clinicians' use of the health IT functionality to achieve the goals of the PDMP.*	*Specify a list of action items needed to be completed to meet the HIT/PDMP milestones identified in the first column. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item*
Prescription Drug Monitoring Program (PDMP) Functionalities			
Identify funding sources to enhance the functionality of the PDMP and support its use by clinicians			Funding is needed to support the design, development, operation, and/or maintenance of each of the tasks described below in the SUD HIT Plan. Contingent on the availability of funds, the Health Care Authority (HCA), in collaboration with the

			Department of Health (DOH), will: • Explore options for funding (i) PDMP enhancements (as described in the activities below) and (ii) the use of the PDMP by clinicians on behalf of Medicaid and non-Medicaid patients; and • Develop a financial mapping tool that identifies sources of funds (e.g., HITECH, MMIS, grants, private sector funds) that will be used to execute the activities in this SUD HIT Plan on behalf of Medicaid and non-Medicaid patients and their treating providers. For example, the ability to accurately match patient who are prescribed opioids with patients in the PDMP, and match patients in the PDMP with other data sources is

			critically important for most tasks in the SUD HIT Plan. Activities F and I below describe the need to explore options to enable patient matching. The financial mapping tool will identify funding sources that will be used to implement these activities. Timeline: 3 – 6 months
Enhanced interstate data sharing in order to better track patient specific prescription data	The Washington Prescription Monitoring Program[45] (PMP) is intended to improve patient care and stop prescription drug misuse by collecting dispensing records for Schedule II, III, IV and V drugs, and making the information available to medical providers and pharmacists as a tool in patient care. Washington State allows healthcare professionals licensed in and by	The state will continue current enhancement activities, and identify the most appropriate solution for additional state-to-state data sharing. Per the 2016 Washington State Interagency Opioid Working Plan,[46] the state is working to reduce current policy and technical barriers to enable	Contingent on the availability of funds, the Health Care Authority (HCA) and the Department of Health (DOH) will identify facilitators and barriers, as well as options to enhance interstate data sharing to better track of patient specific prescription data. Considerations will include identifying the costs of, and funding mechanisms for,

[45] https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PrescriptionMonitoringProgramPMP
[46] http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

	other states to register for and access the Washington PMP. Washington provides links to three regional PDMP websites (AK, OR, and ID) and a link to the national PDMP training and TA center. Washington also has agreements with Oregon and Idaho allowing PDMP data exchange in emergency departments via the Emergency Department Information Exchange (EDIE).	sharing of PMP data with border states (Goal 4, Strategy 1). Currently under review are PMP InterConnect (per National Association of Boards of Pharmacy) and Rx Check (per Bureau of Justice Assistance). Solution must meet State of Washington data security standards and be HIPPA compliant.	supporting the collaboration and identification of options. HCA and DOH will develop and implement a strategy to identify the costs of and secure funding needed to support additional state-to-state data sharing. Timeline: 12-24 months.
Enhanced "ease of use" for prescribers and other state and federal stakeholders	DOH has offered education and training regarding the PMP, and provided guidance to providers regarding access to PMP and resources. Washington State rules support and require the use of the PMP for the following: (1) Opioid prescribing rules suggest that providers should include review of any available PMP data when evaluating patients for chronic non-cancer pain; (2) The workers' compensation	The state must develop solutions that effectively balance the need for security with ease of use to support provider use of the PMP. A workgroup of subject matter and technical experts from DOH, Washington Technology Solutions (WaTech) and the Office of Cyber Security are gathering feedback and evaluating options in collaboration with providers and professional associations that	Contingent on the availability of funds, HCA and DOH will identify and implement feasible PMP Portal enhancements per workgroup recommendations. Some enhancements may be contingent on availability of funds. If implementation of identified enhancements rely on acquiring funding, the state will work to identify potential funding sources to support the

	program requires prescribers to use the PMP.	meet the state's shared goals of security and patient safety.[47]	implementation of PMP Portal enhancements. HCA in collaboration with DOH will develop and implement a strategy to identify the costs of and secure funding needed to identify and implement PDMP enhancements to facilitate "ease of use" for prescribers and other stakeholders. Timeline: 12-24 months
Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange	The PMP's connection to HIE has been in place since late 2013. EDIE was the first to take advantage of that connection. EDIE is in use across all acute care hospitals in Washington State. PMP data went live on the EDIE system in November 2014. Through 2015 more than 2.2 million PMP queries were completed by EDIE, about 120% more than the number of queries made by all other health	Per the 2016 Washington State Interagency Opioid Working Plan,[49] the state is exploring options to require health care systems to connect to the PMP through the statewide electronic health information exchange (Goal 4, Strategy 1). DOH is also exploring alternative connectivity options	DOH will work to reintroduce legislation (ESHB 2489) during the 2019 legislative session. DOH will then work with partner agencies to prioritize and support adoption of bill. Implementation of enhanced PDMP connections to the statewide HIE is contingent on acquiring funding, including

[47] https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PrescriptionMonitoringProgramPMP/EaseofUseProject
[49] http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

	care providers (HCPs) in all other health care settings over the PMP web portal for the year. The connection between the DOH PMP system vendor, OneHealthPort HIE and Epic EHR system were successfully piloted in the summer of 2015. EPIC developed and released a module to its Washington clients in December of 2015. This new module allows Epic users to transact and transmit PMP data directly to the patient record in the native EMR. At present providers can access the PMP by building a connection to the OneHealthPort HIE and integrating the PMP transaction into their EHR (rather than separately logging into the PMP Portal).	through the use of third party vendors. These vendors would provide application programming interface (API) options for medical entities whose vendor will not create the HIE connection, or for entities without the means to acquire the HIE connection. The state will pursue PDMP database vendor enhancements, use of state developed database architecture, or possible utilization of database architecture developed by another state.	funding for the following activities: • The state will identify additional third party vendors to develop API for HIE connections, and determine costs of per instance use, or single payment and "open source" distribution of state purchased API. • DOH and HCA will work to upgrade the PMP API interface to adopt standards identified by CMS. Per CMS rule-1694-p, the PMP API interface will need to be updated in response to the IPPS requirement to adopt NCPDP 2017071 by 2019 for e-prescribing. The interface currently uses an older widely adopted standard NCPDP 10.6. The state will require technical

	DOH has worked to support legislation (ESHB 2489[48]) that would mandate federally certified electronic health record systems to be utilized in the State of Washington to ensure the system can integrate with the state PMP via the HIE. However, legislation has not passed.		assistance and funding for needed upgrades to the PDMP system, any vendor fees, and additional staff to work on this Design, Development, and Implementation (DDI) work. The state will identify sources of additional funding for a state operated database, and pursue a public RFP per state contracting best practices for non-government entity. HCA and DOH will develop and implement a strategy to identify the costs of and secure funding as needed to upgrade the PDMP and enhance connectivity to the statewide health information exchange, including:

[48] http://apps2.leg.wa.gov/billsummary?BillNumber=2489&Year=2017&BillNumber=2489&Year=2017

			• upgrades to the new NCPDP standard (required by CMS), • any vendor fees, additional staff to work on this DDI work; and • changes to the health information exchange service provided by OneHealthPort, the statewide health information exchange organization, to support these PDMP enhancements. Timeline: 24+ months.
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns[50] (see also "Use of PDMP" #2 below)	The primary goal for using the PMP is patient safety, with additional goals of providing the highest quality of care and reducing harm. The PMP informs the HCP of a patient's controlled substance prescription history. That helps prevent drug-drug interactions that may lead to an adverse outcome, and therapeutic duplication. It alerts the HCP to length of time a patient	The state will explore further enhancements to the PMP functionality, including additional tools or alerts for HCPs.	Contingent on the availability of funds, HCA and DOH, in collaboration with Health Care Providers (HCPs and Managed Care Organizations (MCOs) will (1) identify clinical decision support (CDS) tools or alerts that could be usefully integrated into the PMP; and (2) integrate

[50] Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1.

	has taken prescription opioids, and understanding of undertreated pain. PMP data can alert the HCP of (1) patients receiving opioids, benzodiazepines, and other drugs that can create an adverse outcome at the same time, (2) patients receiving high morphine equivalent dose (MED) opioids, and (3) people who have potential abuse patterns, such as having seen five or more opioid prescribers and dispensers. The PMP also allows prescribers and dispensers to check for possible prescription misuse, multiple prescribers, adverse drug interactions, and undertreated pain.		these CDS into the PMP API. To the extent practical and appropriate, the CDS tools/alerts identified in this activity will support the use cases developed in Activities below. HCA and DOH will develop and implement a strategy to identify the costs of and secure funding as needed to identify and integrate CDS tools/alerts into the PMP API. Timeline: 12-24 months.
Current and Future PDMP Query Capabilities			
Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query)	The PMP database via the OneHealthPort HIE requires a match of the requested patient record. The query via the HIE is a one-to-one return based on provider search criteria (ie. "John Smith" returns only "John Smith").	Per the 2016 Washington State Interagency Opioid Working Plan[51] the state will work to: (1) link PMP data to overdose death and hospitalization data to determine relationships between prescribing, patient risk behavior, and overdoses, and	Contingent on the availability of funds, HCA in collaboration with DOH will: 1. Consider the accuracy of patient matching for patients with data in the PDMP with other data

[51] http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

	The MTP HIT Strategic Roadmap and HIT Operational Plan identify a need for improved patient entity matching, including a focus on and task to identify various Master Person Identifiers (MPIs) used across programs and discuss options and considerations of multiple vs. single MPI.	disseminate results to individual counties, (2) develop and disseminate population-level PMP reports on buprenorphine prescribing practices, (3) develop measures using PMP data to monitor prescribing trends and assess impact of interventions on prescribing practices, and (4) explore options to aggregate and analyze PMP data by health plan/payer. As part of future PDMP database development, RFP/architecture design will require improved clustering and aggregation of patient identifiers.	sources (e.g., data on hospitalizations, overdose deaths) 2. If the accuracy of patient matching needs improvement, then HCA, in collaboration with DOH will: (1) identify facilitators and barriers, and (2) explore options to link Patient Identifiers and Provider Identifiers across different systems to improve the accuracy of matching patients with data in the PDMP with other data sources; and 3. Develop and implement a strategy to improve the accuracy of patient matching with regard to the PDMP. HCA and DOH will develop and implement a strategy to identify consider the actions will include identifying the need for and if needed costs of and funding mechanisms needed to implement the strategy to improve the accuracy of for

			linking Patient Identifiers and Provider matching Identifiers across different systems Timeline: 12-24 months.
Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow	As mentioned above, integration of the PMP, OneHealthPort HIE and Epic has occurred. The Epic EHR has the biggest footprint among Washington State health care providers (compared to other EHR vendors). The PMP has assisted eight medical entities move to data exchange production or testing across the state. This includes EHR systems utilizing Epic, Cerner, AllScripts and NextGen. Once medical entities move into production with a given EHR, PMP staff attempt to identify other healthcare providers/entities utilizing that EHR in order to	Per the 2016 Washington State Interagency Opioid Working Plan[52] the state will work to: (1) Promote the use of the PMP, including use of delegate accounts, among health care providers to help identify opioid use patterns, sedative co-prescribing, and indicators of poorly coordinated care/access. (2) Link PMP data to overdose death and hospitalization data to determine relationships between prescribing, patient risk behavior, and overdoses, and disseminate results to individual counties. (3) Develop and disseminate population-level PMP reports on buprenorphine	Contingent on the availability of funds, HCA in collaboration with DOH will sponsor work to: • identify for 3-5 use cases the clinical workflows/business processes for accessing the PDMP prior to prescribing an opioid or other controlled substance; and • develop change management guidance for implementing the identified clinical workflows/business processes

[52] http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

	possibly connect those medical providers/entities to the HIE via the API already developed. The state is supportive of clinicians accessing the PDMP prior to prescribing an opioid and have developed this interface in conjunction with ONC and the vendor community.	prescribing practices. (4) Enhance medical, nursing, and physician assistant school curricula on pain management, PMP, and treatment of opioid use disorder. (5) Educate law enforcement on the PMP and how it works" (6) Increase PMP reporting frequency from weekly to daily. (7) Provide easy access to the PMP data for providers through electronic medical record systems. (8) Provide MED calculations within the PMP for chronic opioid patients with automated program alerts for providers. (9) Evaluate policy interventions for effectiveness and impact (e.g., pain management rules, mandatory PMP registration). Additionally, regional work is being completed by Accountable Communities of Health (ACH) to support and reinforce the 2016 Washington	HCA and DOH will develop and implement a strategy to identify the costs of and secure funding for the identification of the use cases and associated clinical work flows/business processes, and change management guidance Timeline: 24+ months.

		State Interagency Opioid Working Plan.	
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription	As mentioned above, integration of the PMP, OneHealthPort HIE and Epic has occurred. The Epic EHR has the biggest footprint among Washington State health care providers (compared to other EHR vendors). The state is supportive of clinicians accessing the PDMP prior to prescribing an opioid and have developed this interface in conjunction with ONC and the vendor community.	As described above, the 2016 Washington State Interagency Opioid Working Plan[53] goals and strategies, as well as supportive regional work completed by ACHs, are intended to increase the use of the PMP prior to the issuance of an opioid prescription.	Contingent on the availability of funds: • In addition to pursuing the strategies described in the 2016 Washington State Interagency Opioid Working Plan, HCA and DOH will collaborate to identify facilitators and barriers to develop enhanced supports for clinician review of the PMP. • HCA in collaboration with DOH will develop and implement a strategy to identify the costs of and secure funding for any additional/enhanced

[53] http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

			clinician supports to use the PDMP. Timeline: 24+ months.
Master Patient Index / Identity Management			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	The master patient index, or Master Data Management (MDM), is a component of the Enterprise Architecture. The foundation was created with the Medicaid Eligibility and Enrollment modernization MMIS purchase of the IBM Truven software. The state recognizes limitations in currently supported patient matching in the PDMP, and intends to find ways to link this issue to improve data linkage and identity mapping.	DOH and HCA will explore feasibility and options of developing a shared Master Patient Index and Master Provider Index.	As described above and contingent on the availability of funds: HCA and DOH will explore the need to and options for enhancing patient matching (such as developing a shared Master Patient Index and Master Provider Index; or creating a the ability to crosswalk of patient/provider identifiers between the PDMP and other data sources); and implement a strategy to improve the accuracy of patient matching with regard to the PDMP. HCA, in collaboration with and DOH, will develop and implement a strategy to identify the costs of and secure funding to enhance the patient matching between the PDMP and other

			data sources. Timeline: 12-24 months.

Attestation Requirements

Statement 1*: Indicate whether the state has sufficient health IT infrastructure/" ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration.*

Washington State has Health IT infrastructure in place to support the goals of the SUD demonstration. This SUD HIT plan lists infrastructure enhancements, contingent on securing necessary funding, which support expanding effective and reusable health information technology and exchange capabilities statewide. The state agencies, HCA and DOH, will collaborate over the next 12-24 months to identify and pursue funding opportunities that will support improvements to the state health IT infrastructure.

HCA will lead the development of the financial mapping tool. HCA and DOH will collaborate in the development and implementation of the:

- SUD Monitoring Protocol that will provide the strategies to increase utilization and improve functionality of prescription drug monitoring programs as described above in the SUD Health Information Technology (IT) Plan; and
- Strategy to identify the costs of and secure funding needed for each of the activities identified about in the SUD Health IT Plan.

Statement 2*: Indicate whether the state's SUD Health IT Plan is "aligned with the state's broader State Health IT Plan (SMHP) and if applicable, the state's Behavioral Health (BH) Health IT Plan."*

Washington State's SUD Health IT plan is aligned with the broader State Medicaid Health IT Roadmap and Operational Plan approved by CMS under the Medicaid Transformation Project. Upon approval of the IMD Waiver, the state will review the Health IT Operational Plan and incorporate any additional tasks needed to align with approved SUD HIT Plan. Washington State is updating its State Medicaid Health IT Plan and commits to aligning the SMHP with the approved SUD HIT Plan.

Statement 3: *Indicate that the state will include appropriate standards referenced in the ONC Interoperability Standards Advisory (ISA) https://www.healthit.gov/isa/ and 45 CFR 170 Subpart B in subsequent MCO contract amendments or Medicaid funded MCO/ Health Care Plan re-procurements.*

The Washington State Health Care Authority includes appropriate standards referenced in the ONC Interoperability Standards Advisory (ISA) in its Managed Care contracts.

Section II. Implementation Administration
The state's point of contact for the SUD Health IT Plan is listed below.

Name and Title: Shaun Wilhelm, Deputy State HIT Coordinator
Telephone Number: (360) 725-0777
Email Address: shaun.wilhelm@hca.wa.gov

Attachment L
Reserved for SUD Monitoring Protocol

ATTACHMENT M
Health IT Protocol

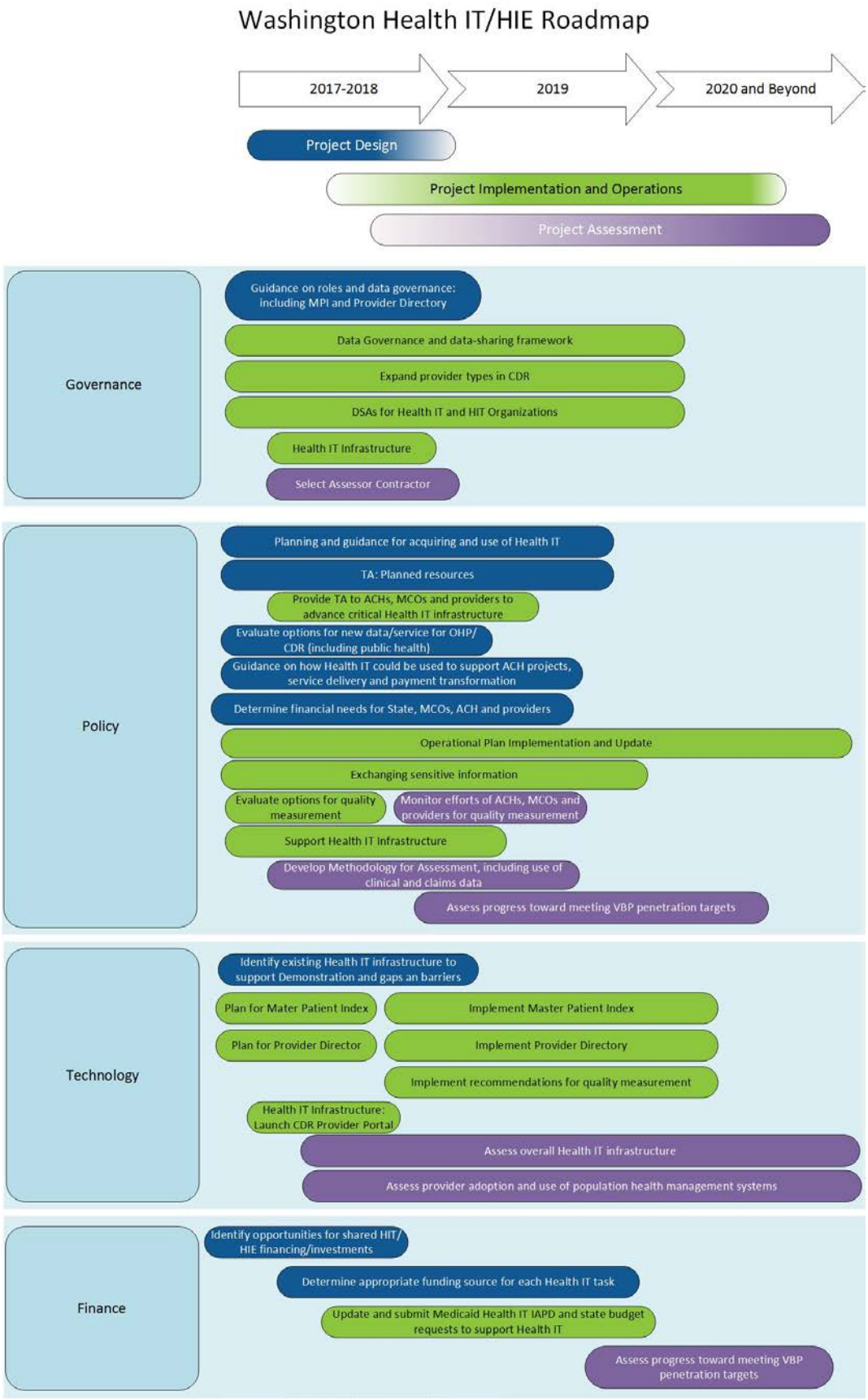
Introduction

The Washington State Medicaid Transformation Demonstration is a five-year agreement between the state and the federal government that provides up to $1.1 billion in federal investment for regional and statewide health system transformation projects that benefit Apple Health (Medicaid) Clients. Achieving health system transformation for Washington State will require the use of interoperable health information technology (Health IT) and health information exchange (HIE). Interoperable Health IT[54] and HIE[55] have the potential to improve the quality, continuity, coordination, and safety of patient care, while at the same time reducing unnecessary and costly services. Furthermore, the use of these technologies will help facilitate the State's broader goals of moving toward value-based purchasing.

This Health IT Strategic Roadmap identifies activities necessary to advance the use of interoperable Health IT and HIE across the care continuum in support of the programmatic objectives of the Demonstration. The Roadmap divides efforts into the three phases of the Demonstration: Project Design, Project Implementation and Operations, and Project Assessment, and articulates the role the State, Medicaid Managed Care Organizations, providers and Accountable Communities of Health (ACH) have in advancing Health IT and HIE. In addition to this Roadmap, the State has created an Operational Plan that details the first 16 months (remainder of 2017 and 2018) of activities that provide actionable steps to advance Health IT and HIE in support of the Demonstration. The Operational Plan is appended to this document and will be revised quarterly to reflect progress and document next steps. The Operational Plan will be updated in 2018 to provide the details for 2019 and annually mid-year for the details of the following year. The following diagram highlights the key elements of the strategic roadmap and operational plan:

[54] Health Information Technology is the range of technologies to store, share, and analyze health information, including clinical and claims related data

[55] Health information exchange is the electronic exchange of health information to facilitate delivery system and payment transformation, care coordination and improved health outcomes


Washington Health IT/HIE Roadmap
2017-2018
2019
2020 and Beyond
Project Design
Project Implementation and Operations
Project Assessment
Governance
Guidance on roles and data governance: including MPI and Provider Directory
Data Governance and data-sharing framework
Expand provider types in CDR
DSAs for Health IT and HIT Organizations
Health IT Infrastructure
Select Assessor Contractor
Policy
Planning and guidance for acquiring and use of Health IT
TA: Planned resources
Provide TA to ACHs, MCOs and providers to advance critical Health IT infrastructure
Evaluate options for new data/service for OHP/ CDR (including public health)
Guidance on how Health IT could be used to support ACH projects, service delivery and payment transformation
Determine financial needs for State, MCOs, ACH and providers
Operational Plan Implementation and Update
Exchanging sensitive information
Evaluate options for quality measurement
Monitor efforts of ACHs, MCOs and providers for quality measurement
Support Health IT Infrastructure
Develop Methodology for Assessment, including use of clinical and claims data
Assess progress toward meeting VBP penetration targets
Technology
Identify existing Health IT infrastructure to support Demonstration and gaps an barriers
Plan for Mater Patient Index
Implement Master Patient Index
Plan for Provider Director
Implement Provider Directory
Implement recommendations for quality measurement
Health IT Infrastructure: Launch CDR Provider Portal
Assess overall Health IT infrastructure
Assess provider adoption and use of population health management systems
Finance
Identify opportunities for shared HIT/ HIE financing/investments
Determine appropriate funding source for each Health IT task
Update and submit Medicaid Health IT IAPD and state budget requests to support Health IT
Assess progress toward meeting VBP penetration targets

Background

Washington State understands the role of and need for interoperable Health IT and HIE to enable the efficient exchange and use of health information, a foundational requirement to achieving the triple aim. In 2009, the Washington State Legislature passed Substitute Senate Bill 5501 to accelerate the secure electronic exchange of high-value health information within the state. This legislation resulted in the designation of OneHealthPort as the lead HIE organization. Subsequently, a clinical data repository (CDR) was created to address some of the challenges with interoperability.

Purpose and Goals

Washington State is undertaking an innovative and ambitious agenda through the Demonstration to advance coordination of care and improve patient outcomes that will be supported, in part, through its use of the CDR and additional activities identified in this Roadmap. The purpose of the Roadmap is to identify the broad goals of how Health IT and HIE will support the Demonstration, recognizing that the more detailed tasks are identified, expanded upon, and tracked in the accompanying operational plan. The Roadmap is built on the following goals:

- Develop policies and procedures to advance the widespread use of interoperable Health IT and HIE across the care continuum;
-
- Coordinate at the regional and statewide level to ensure that interoperable Health IT and HIE efforts are shared and identified best practices are shared throughout the state;
- Improve coordination and integration among behavioral health, physical health, and Home and Community Based Services (HCBS) providers, as well as community-level collaborators;
- Support the acquisition and implementation of interoperable Health IT particularly for providers who are ineligible for the Electronic Health Record (EHR) incentive program;
- Encourage use of clinical and claims data by the State, ACHs, payers, and others to support a variety of health improvement activities as represented by ACH project plans;
- Develop or expand the critical infrastructure needed to facilitate population health management, including prescription drug monitoring, disease registries and electronic lab reporting;
- Support the electronic exchange of interoperable clinical health information, using standards identified in Interoperability Standards Advisory (ISA);
- Support the development and use of a Medicaid enterprise master patient index and comprehensive provider directory strategy to facilitate more efficient information exchange;

- Align with the Washington State Health IT & HIE Strategy; and
- Ensure the roadmap provides guidance & alignment throughout the duration of the Demonstration, as well as beyond the Demonstration's end date.

Demonstration Health IT Framework

The work of the Health IT Strategic Roadmap is intended to align with the Demonstration's three phases of work: design, implementation and operations, and assessment. These phases are cyclical, with project assessment feeding into future project design. Activities described in this document require work by the State and the ACHs to assemble the infrastructure, develop policies and procedures, and implement incentives to advance the use of Health IT and HIE in support of broader Demonstration activities. As described in this document, these phases support, and are consistent with, the three project stages (design, implementation and operations, and assessment) in the State's approved DSRIP Planning Protocol. This framework recognizes the varying levels of interoperability that exist among regions and providers in the state, allowing regional efforts to advance Health IT and HIE in coordination with the broader statewide approach.

Project Design

Initial phase August to December 2017

During the project design phase, the State will engage and collaborate with ACHs, providers, payers, OneHealthPort, and other stakeholders to develop and disseminate the tasks and deliverables (which will inform the Operational Plan) to advance the use of Health IT for population health management.

This phase will identify the gaps and opportunities to advance in the Health IT and HIE infrastructure, policies and procedures, and incentives necessary to facilitate population health management. ACHs will be expected to identify payers (including Medicaid MCO payers) and providers (e.g., physical health, behavioral health, long-term services and supports, and other community-based services/providers) to collaborate with the State and other stakeholders to assist in and inform the development of the Operational Plan.

The State will provide guidance to the ACHs on how Health IT and HIE elements will be required for incorporation in the ACH project plans and what resources will be made available to support project implementation. ACHs will incorporate this guidance into their project plans to be submitted in November.

Task	Additional Description	Proposed Due Date
The State will engage and collaborate with ACHs, providers, payers (including Medicaid MCOs), OneHealthPort, and other stakeholders to develop and disseminate an Operational Plan	The Operational Plan will address the following topics: <u>Governance:</u> • Roles of stakeholders • Data governance • Health IT governance <u>Policy:</u> • Shared policies and technical standards for secure Health IT and HIE systems • Performance measures related to the adoption and use of Health IT and HIE <u>Technology:</u> • Types of and how population health management systems that could be used to support: ACH projects, service delivery and payment transformation, and quality and performance management • Gaps and barriers <u>Finance</u> • Determine financial needs for State, MCOs, ACHs and providers • Determine appropriate funding source, including role of Medicaid Financing (IAPDU-SPA-Waiver)	2017

The State will develop and disseminate guidance for planning, acquisition and use of Health IT and HIE	Policy: • This guidance will include interoperable HIT and HIE to support ACH activities Finance: • Opportunities for shared HIT/HIE financing/investments	2017 -2018
The State will identify technical assistance needs to assist in the acquisition, adoption, implementation, and use of Health IT and HIE. The State will notify ACHs of these planned resources.	Policy: • State will develop and make available to ACHs TA resources for HIT/HIE activities in support of Demonstration activities. TA resources may include assistance related to: o Billing IT and HIT applications; o Vendor evaluation and selection criteria; o Workflow considerations; and o Use of the CDR	*2017 – 2018 (initially and ongoing through 2020)*
The State will determine the need, and if so how and when, to integrate key Medical, clinical, and public health data with the Clinical Data Repository	Policy: This data will potentially include: • Assessment and care plan data; and • Public Health data such as: o Immunizations o Prescription drug monitoring	2017-2018

Project Implementation and Operations

Initial phase January 2018-

The project implementation phase will consist of implementing the Operational Plan, collaboratively addressing the Health IT and HIE gaps, aligning statewide initiatives, and positioning the ACHs and state for success in their programmatic objectives.

The Operational Plan will seek to identify and address gaps in Health IT and HIE, prioritizing the most important elements to support Health IT and HIE and ACH-proposed projects. The State will focus on several elements, including data governance and data sharing frameworks, facilitating HIE across multiple provider types, and developing a master patient index and statewide provider directory.

The State is also committed to ongoing alignment among all Health IT- and HIE-related activities within the state, including State Innovation Model efforts, Medicaid Health IT Plan, and Health IT Implementation Advanced Planning Document (IAPD).

During the project implementation phase, ACHs will assist the State in identifying critical gaps and will collaborate with providers, payers, and other stakeholders to develop and support the use of best practices in leveraging Health IT and HIE to support their transformation efforts.

Task	Additional Description	Proposed Due Date
The State will implement, review, update, and disseminate the Operational Plan	Policy: The State, in collaboration with stakeholders, will: • Annually update the Operational Plan and implement Accordingly • Identify and share emerging best practices • Identify and assist in resolving emerging issues; and • Provide quarterly updates on progress on implementing the Operational Plan to CMS/ONC	2017, 2018, 2019, 2020
State will support and advance critical HIT/HIE infrastructure	The State will support several activities needed to advance the HIT/HIE infrastructure, including: Governance: • The State will develop and disseminate guidance to the ACHs, payers and providers related to exchange of information, including data governance and data sharing framework • The State will develop and disseminate guidance to the ACHs, payers and providers related to onboarding and registration of additional provider types, including expanding the provider types sending and receiving content from the CDR	2018

Task	Additional Description	Proposed Due Date
	• The State will develop and disseminate guidance to the ACHs, payers and providers related to establishing electronic health information sharing agreements with HIT/HIE organizations Policy: This includes developing and disseminating guidance and providing TA to the ACHs, payers, providers, and other stakeholders on the activities, including the following: • Supporting the onboarding of additional providers to the CDR • Use of Consolidated Clinical Document Architecture (C-CDA) in electronic health information exchange activities • The State will develop and disseminate guidance to the ACHs, payers, providers, and other stakeholders related to exchanging sensitive information (e.g. SUD data) Technology: • Launching of the CDR provider portal • Develop and/or purchase other technology as identified and needed	
The State will disseminate information on efforts to streamline Behavioral Health reporting	Policy: State will seek to align reporting requirements to support and align with HIE/HIT standards and support data use	2018

Task	Additional Description	Proposed Due Date
	State will disseminate information on the results of the alignment effort, including requirements	
The State will determine and implement the most appropriate method for the creation and management of the Master Patient Index	Policy: • Document gaps and barriers in existing State infrastructure • Identify work plan for developing a Master Patient Index for use across information systems (e.g. MMIS, OHP) Technology: • Acquire /implement technology solution based on work plan	2018-2019
The State will determine and implement the most appropriate method for the creation and management of the Provider Directory	Policy: • Document gaps and barriers in existing State infrastructure • Identify work plan for developing a Provider Directory for use across information systems (e.g. MMIS, OHP) Technology: • Acquire/implement technology solution based on work plan	2018-2019
The State will evaluate options and draft recommendations for leveraging clinical and claims data to support needed quality measurement/analytic activities of the state,	Policy: • The state with stakeholder input will evaluate options for leveraging clinical and claims data to support needed quality measurement/analytic activities of the state, MCOs, ACHs, providers and payers.	2018

Task	Additional Description	Proposed Due Date
MCOs, ACHs, providers and payers.	• Based on the evaluation of options, the state will draft recommendations for leveraging clinical and claims data to support needed quality measurement/analytic activities of the state, MCOs, ACHs, providers and payers.	
State will implement approved recommendations for leveraging clinical and claims data to support quality measurement/analytic activities of the state and will oversee the efforts of the Medicaid MCOs, ACHs and providers	Technology: • The State will implement approved recommendations for leveraging clinical and claims data to support quality measurement/analytic activities of the state	

The State will use the HIT/HIE Strategic Roadmap and Operational Plan to update and align key documents and activities	Policy:
	
	• Based on the completion of the OP for 2017-2018, the state will update as needed
	  • SIM HIT documents;
	  • State Medicaid HIT plan;
	  • Health IT IAPD; and
	  • Medicaid EHR Incentive Program
	  State initiated MACRA Advanced Alternative Payment models.
	
	• Based on the updated OP for 2019, the state will update as needed the same documents.
		2017 for 2017 and 2018

Task	Additional Description	Proposed Due Date
	• Based on the updated OP for 2020, the state will update as needed the same documents.	2018 for 2019 2019 for 2020
The state will update and submit Medicaid Health IT IAPD and state budget requests to support implementation of Health IT, including interoperable HIE and services	Finance: • Prepare Implementation Advance Planning Document Update • Prepare state budget requests	As required

Project Assessment

Initial phase beginning January 2019

The project assessment phase will focus on assessing the direction of the Health IT and HIE in ACH projects and their utility in achieving the goals of the Demonstration. The assessment for each project will be tailored to the specifics of the project and will be conducted by an independent, external evaluator. Assessments will include a mix of qualitative and quantitative analysis, using a variety of data types including clinical, administration, and survey data.

Information obtained through these assessments will be made available to future project planning efforts to ensure any identified shortcomings are not repeated.

Task	Additional Description	Proposed Due Date
The State will contract with and support an independent external evaluator	This evaluator will perform the following: • Develop a methodology to qualitatively and quantitatively assess the impact of the	2019

	Demonstration on delivery systems, clinical care, health outcomes, and costs; • Assess overall Medicaid system performance under the DSRIP program; • Assess overall Health IT infrastructure; • Assess progress toward meeting VBP penetration targets; • The State will oversee the efforts of the Medicaid MCOs, ACHs and providers; • Assess progress toward meeting VBP penetration targets; and • Assess impact of the Demonstration on provider adoption and use of population health management systems, including the use of interoperable HIT and HIE. • •	

It is understood that the Health IT and HIE needs of the State and the ACHs are evolving, which will require both the Roadmap and the Operational Plan to be updated regularly. HCA will provide annual updates to the Health IT Roadmap to document changes in priorities and highlight progress made during the duration of the Demonstration. HCA will also provide reports and updated Operational Plan quarterly to document the progress towards completing activities identified in the Health IT Strategic Roadmap.

ATTACHMENT N
Budget Neutrality Corrective Action Plan

Washington State Health Care Authority

Medicaid Transformation Project
Corrective Action Plan Request - Updated

I. Background Concerning the Corrective Action Plan Request

Washington State Health Care Authority (HCA) has committed to the federal government that spending for the Medicaid Transformation Project (MTP) will be budget neutral. In setting the baseline for budget neutrality negotiations with the federal government, the state used Medicaid costs from calendar year (CY) 2011-2013. Since then, Long Term Services and Supports (LTSS) costs have grown.

The largest drivers of LTSS costs are not Medicaid policies, but rather include changes to the State's and city minimum wage laws, collective bargaining agreements with individual providers and adult family homes, and the US Department of Labor's home care overtime rule. The historical data used to develop the current budget neutrality caps did not include these large LTSS cost increases. Because of this, the state's current projections show Medicaid Transformation spending will exceed budget neutrality. It is important to acknowledge these cost drivers are not associated with MTP initiatives. HCA does not anticipate the level of increases that are occurring in LTSS Medicaid programs (not associated with the 1115 waiver) to change in future biennia. This is due to the continued increases in our caseload which result in a case mix change in the overall Medicaid program, the continued rise in the state's minimum wage, and the corresponding impact on direct care worker wages and benefits in the LTSS industry.

HCA met with CMS, through a series of meetings over the past year, including an in-person visit in May 2019, to address our projected budget neutrality exceedance. After months of discussion, CMS agreed to a proposal which provides prospective adjustments to help offset the projected two year budget neutrality overage. HCA's corrective action plan request addresses the projected budget neutrality exceedance by requesting a carve out of LTSS costs and a reduction in Transformation programs expenditure limits.

II. Description of the Corrective Action Plan Request

This corrective action includes two primary components: budget neutrality methodology adjustments and reductions to Designated State Health Programs (DSHP), Delivery System Reform Incentive Payments (DSRIP), Medicaid Alternative Care (MAC), Tailored Support for Older Adults (TSOA) and Foundational Community Supports (FCS) expenditure limits. As of February 2020, HCA projects an overage of $394.4M at the end of demonstration year 2 (CY 2018). The adjustments proposed in this request will offset the two year overage and allow HCA to meet budget neutrality over the life of the demonstration.

a. Proposed adjustments to the budget neutrality methodology in Section XI: Monitoring Budget Neutrality for the Demonstration

The proposed methodology includes the following adjustment assumptions:

- The methodology will include the original data baseline as in the previous budget neutrality agreement when calculating the adjusted Without Waiver (WOW) PMPMs for the non-expansion adult population beginning in DY3 (CY 2019);
- The state will use the same baseline data period of CY2011-2013 and carve out LTSS costs in order to calculate the revised DY3-5 WOW PMPMs;
- LTSS costs will only be included in DY1 and DY2 for the non-expansion adult population;
- All LTSS will be carved out from both the WOW and WW side beginning in DY3 (January 1, 2019); and
- The state will use the post-LTSS carve out trend rate of 4.0%.

b. Proposed reductions to annual DSHP, DSRIP, MAC, TSOA and FCS expenditure limits

In addition to the budget neutrality methodology adjustment, the state proposes reductions to DSHP, DSRIP, MAC, TSOA and FCS funding limits to support budget neutrality over the life of the waiver. As a result of the proposed DSHP reduction, the original DSHP phase down approach within the STCs will need to be revisited. The proposed expenditure limits for the programs mentioned above have been pasted in Appendix A (table 11) for reference.

III. Analysis of the Impact of the Proposed Corrective Action Plan

Based on current projections, the proposed adjustments submitted in this request will result in budget neutrality over the life of the demonstration.

The combination of the budget neutrality methodology adjustment and program reductions allows the state to achieve budget neutrality while also adequately supporting critical WA goals related to Value-Based Payment (VBP) attainment, quality improvement, integrated care, Substance Use Disorder (SUD) response efforts, critical services to address social determinants of health, and related cost savings/avoidance expectations.

The updated 1115 waiver budget neutrality template accompanies this corrective action plan request and has been pasted in Appendix A for reference.

Appendix A: Proposed Methodology Adjustments Beginning in DY3

1. Overview of Budget Neutrality Workbook

As described in the waiver application:

Actual populations included in the calculations are limited to only those clients with full scope Title XIX or Title XXI coverage.
Base year enrollment numbers are adjusted to reflect the most up-to-date projections from Washington State's Caseload Forecast Council.
http://www.cfc.wa.gov/default.htm
The Caseload Forecast Council is statutorily authorized by the State to provide the official Medical caseload forecasts used in all Washington State's budgeting estimations.
Base year (CY 2016) per-capita costs for eligibility groups (1-5) are based on historical total costs and enrollment for all Medicaid services provided under Washington's State Plan for the populations described.
A weighted avearge of CY2011-2013 & CY2015-2016 is the base for calculating historical total costs, enrollment and baseline (CY 2016) in this workbook.

Eligibility Groups Included:

1	Disabled Adults and Children= MN Blind/Disabled + HWD/Medicaid Buy-In + CN BCCT + CN Bl/Dis(excludes presumptive SSI)
2	Non-disabled Children=CN Children + SCHIP + CN Family Medical<19
3	Non-ABD 'Classic' Adults=CN family Medical>=19 + CN Pregnant Women
4	ACA Expansion Adults
5	Aged=CN Aged + MN Aged
6	Hypothetical populations=supportive housing, supported employment, Medicaid Alternative Cae (MAC)
7	Expansion population=Tailored Supports for Older Adults

Service Modalities Included:
Medical = includes all medical services excluding Medicare part D Clawback payments
Long-term Support Services = Nursing homes, residential care, In-home care, adult family homes, assisted living, managed care
Mental Health = all Medicaid mental health services paid outside of the medical benefit, excluding state hospital inpatient
Substance use Disorder treatment = Medicaid portion only, as provided by the program budget

Worksheet:	**Contents Description:**
Historic Data	**Caseload and Expenditures from CY2011-2013** Average monthly caseloads were included in the waiver application table 10. See tab "Inputs"
WOW	Projected caseload and expenditures by eligibility group, WITHOUT the waiver. Trends based on data from Office of the Actuary Report - see tab "Trend Projections" Eligible member months - see tab "caseload projections"
WW	Projected caseload and expenditures by eligibility group, WITH the waiver. Trends based on data from Office of the Actuary Report - see tab "Trend Projections" Eligible member months - see tab "caseload projections"
DSH	DSH allotment deferred not applicable to Washington's waiver
Summary	Summary of expenditures by eligibility group, with and without waiver
Inputs	Details of historic caseload and expenditures CY2014-2016
Trend projections	Historic and future projections from Office of the Actuary Report (table 16) https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2014.pdf
Hypos-exp	Monthly caseload and expenditure projections for hypothetical populations With waiver projections include targeting of services
Caseload Projections	Average monthly caseloads by calendar year Enrollment projections for the five year Demonstration period are based upon the most recent Caseload Forecast Council's forecasts for the Demonstration years. The Caseload Forecast Council is statutorily authorized by the State to provide the official Medical caseload forecasts used in all Washington State's budgeting estimations. http://www.cfc.wa.gov/default.htm

2. Proposed Without Waiver PMPMs beginning in DY3 and proposed trend rate of 4.0% (excludes LTSS costs)

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	CY2016 BASE YEAR DY 00	TREND RATE 2	CY2017 DEMONSTRATION YEARS (DY) DY 01	CY2018 DY 02	CY2019 DY 03	CY2020 DY 04	CY2021 DY 05	TOTAL WOW
Non-Expansion Populations										
Pop Type:	**Medicaid**									
Eligible Member Months	n.a.	n.a.	4,608,843	n.a.	4,683,310	4,743,704	4,802,722	4,859,686	4,915,937	
PMPM Cost	4.0%	36	$ 617.30	4.0%	$ 641.99	$ 667.67	$ 694.38	$ 722.16	$ 751.05	
Total Expenditure					$ 3,006,638,428	$ 3,167,228,745	$ 3,334,914,191	$ 3,509,470,956	$ 3,692,114,668	$ 16,710,366,988
Expansion Adults										
Pop Type:	**Medicaid**									
Eligible Member Months	n.a.	n.a.	7,303,402	n.a.	7,466,264	7,497,354	7,525,448	7,546,643	7,569,742	
PMPM Cost	n.a.	n.a.	$426.88	see trend tab	$ 450.55	$ 472.21	$ 495.89	$ 521.22	$ 546.91	
Total Expenditure					$ 3,363,925,072	$ 3,540,325,436	$ 3,731,794,385	$ 3,933,461,229	$ 4,139,967,608	$ 18,709,473,729

3. Proposed With Waiver PMPMs beginning in DY3 (excludes LTSS costs)

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS								
	CY2016		CY2017	CY2018	CY2019	CY2020	CY2021	
			DEMONSTRATION YEARS (DY)					TOTAL WW
ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DY 01	DY 02	DY 03	DY 04	DY 05	
Non-Expansion Populations								
Pop Type:	**Medicaid**							
Eligible Member Months	4,608,843	n.a.	4,683,310	4,743,704	4,802,722	4,859,686	4,915,937	
PMPM Cost	$ 617.30	0.9%	$ 622.86	$ 628.47	$ 634.13	$ 639.84	$ 645.60	
	reduc -->	**3.1%**						
Total Expenditure			$ 2,917,046,701	$ 2,981,275,554	$ 3,045,550,183	$ 3,109,421,591	$ 3,173,729,086	$ 15,227,023,115
Expansion Adults								
Pop Type:	**Medicaid**							
Eligible Member Months	7,303,402	n.a.	7,466,264	7,497,354	7,525,448	7,546,643	7,569,742	
PMPM Cost	$ 426.88	see trend tab	$ 437.32	$ 444.79	$ 453.30	$ 462.41	$ 470.86	
Total Expenditure			$ 3,265,146,404	$ 3,334,747,995	$ 3,411,285,557	$ 3,489,643,158	$ 3,564,288,727	$ 17,065,111,841
Exp Pop 1	**TSOA**							
Pop Type:	**Expansion**							
Eligible Member Months								
PMPM Cost								
Total Expenditure			$2,094,037	$6,226,036	$10,749,449	$13,282,397	$13,919,239	$ 46,271,158

4. Three years of current WA State budget data used for baseline calculation

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

REVISED: MEDICAL & BH ONLY - WITHOUT LTSS COSTS

Non-Expansion Populations	CY 2011	CY 2012	CY 2013	3-YEARS
TOTAL EXPENDITURES	$ 2,223,422,597	$ 2,287,482,943	$ 2,448,662,181	$ 6,959,567,721
ELIGIBLE MEMBER MONTHS	4,381,553	4,422,122	4,462,043	
PMPM COST	$ 507.45	$ 517.28	$ 548.78	
TREND RATES				
	ANNUAL CHANGE			
TOTAL EXPENDITURE	.	2.88%	7.05%	
ELIGIBLE MEMBER MONTHS	.	0.93%	0.90%	
PMPM COST	.	1.94%	6.09%	4.00%

LTSS COSTS ONLY

Non-Expansion Populations	CY 2011	CY 2012	CY 2013	3-YEARS
TOTAL EXPENDITURES	$ 1,427,423,069	$ 1,462,290,033	$ 1,520,174,660	$ 4,409,887,761
ELIGIBLE MEMBER MONTHS	4,381,553	4,422,122	4,462,043	
PMPM COST	$ 325.78	$ 330.68	$ 340.69	
TREND RATES				
	ANNUAL CHANGE			
TOTAL EXPENDITURE	.	2.44%	3.96%	
ELIGIBLE MEMBER MONTHS	.	0.93%	0.90%	
PMPM COST	.	1.50%	3.03%	2.30%

COMBINED MEDICAL, BH, & LTSS - ORIGINAL SUBMISSION

Non-Expansion Populations	CY 2011	CY 2012	CY 2013	3-YEARS
TOTAL EXPENDITURES	$ 3,650,845,666	$ 3,749,772,975	$ 3,968,836,841	$ 11,369,455,482
ELIGIBLE MEMBER MONTHS	4,381,553	4,422,122	4,462,043	
PMPM COST	$ 833.23	$ 847.96	$ 889.47	
TREND RATES				
	ANNUAL CHANGE			
TOTAL EXPENDITURE	.	2.71%	5.84%	
ELIGIBLE MEMBER MONTHS	.	0.93%	0.90%	
PMPM COST	.	1.77%	4.90%	3.30%

5. Budget Neutrality Summary

Without-Waiver Total Expenditures	CY2017	CY2018	CY2019	CY2020	CY2021	
	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Non-Expansion Populations	$ 3,006,638,428	$ 3,167,228,745	$ 3,334,914,191	$ 3,509,470,956	$ 3,692,114,668	$ 16,710,366,988
Hep C Rx Costs	$ 131,821,200	$ 136,171,300	$ 140,664,952	$ 145,306,896	$ 150,102,023	$ 704,066,371
Total Costs	$ 3,138,459,628	$ 3,303,400,045	$ 3,475,579,143	$ 3,654,777,852	$ 3,842,216,691	$ 17,414,433,359
Eligibles	4,683,310	4,743,704	4,802,722	4,859,686	4,915,937	
PMPM	$ 670.14	$ 696.38	$ 723.67	$ 752.06	$ 781.58	
~~Expansion Adults~~	~~$ 3,363,925,072~~	~~$ 3,540,325,436~~	~~$ 3,731,794,385~~	~~$ 3,933,461,229~~	~~$ 4,139,967,608~~	~~$ 18,709,473,729~~
~~Hypothetical~~s						
~~All~~						
TOTAL	$ 3,138,459,628	$ 3,303,400,045	$ 3,475,579,143	$ 3,654,777,852	$ 3,842,216,691	$ 17,414,433,359

With-Waiver Total Expenditures						
	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Non-Expansion Populations	$ 2,917,046,701	$ 2,981,275,554	$ 3,045,550,183	$ 3,109,421,591	$ 3,173,729,086	$ 15,227,023,115
Hep C Rx Costs	$ 131,821,200	$ 136,171,300	$ 140,664,952	$ 145,306,896	$ 150,102,023	$ 704,066,371
Total Costs	$ 3,048,867,901	$ 3,117,446,854	$ 3,186,215,135	$ 3,254,728,487	$ 3,323,831,109	$ 15,931,089,486
Eligibles	4,683,310	4,743,704	4,802,722	4,859,686	4,915,937	
PMPM	$ 651.01	$ 657.18	$ 663.42	$ 669.74	$ 676.13	
~~Expansion Adults~~	~~$ 3,265,146,404~~	~~$ 3,334,747,995~~	~~$ 3,411,285,557~~	~~$ 3,489,643,158~~	~~$ 3,564,288,727~~	~~$ 17,065,111,841~~
Expansion Populations						
~~Exp Population - TSOA~~	~~$ 2,094,037~~	~~$ 6,226,036~~	~~$ 10,749,449~~	~~$ 13,282,397~~	~~$ 13,919,239~~	~~$ 46,271,158~~
~~Hypothetical~~s						
~~All~~						
TOTAL	$ 3,048,867,901	$ 3,117,446,854	$ 3,186,215,135	$ 3,254,728,487	$ 3,323,831,109	$ 15,931,089,486

VARIANCE	$ 89,591,727	$ 185,953,191	$ 289,364,008	$ 400,049,364	$ 518,385,583	$ 1,483,343,873

6. Inputs by Population and Eligibility

Population	2014	2015	2016
ELIGIBLES			
Disabled	1,818,313	1,801,007	1,823,350
Non-Disabled Children	8,892,595	9,456,880	9,956,041
Non-ABD 'Classic' Adults	1,933,680	1,947,281	1,881,541
Expansion Adults	4,858,655	6,668,892	7,303,402
Aged	857,855	880,882	903,951
EXPENDITURES			
Disabled	$1,819,641,959	$1,909,255,215	$2,107,762,734
Non-Disabled Children	$1,426,894,169	$1,477,973,736	$1,656,635,064
Non-ABD 'Classic' Adults	$889,178,108	$849,803,061	$812,168,771
Expansion Adults	$3,067,612,192	$2,807,542,892	$3,117,660,147
Aged	$1,179,301,030	$1,273,545,466	$1,389,908,182

MEDICAL				
COHORT	Children		1	1
YEAR		2014	2015	2016
TOTAL_MED		$1,327,708,126	$1,374,841,255	$1,533,416,760
ELIGIBLES		8,892,595	9,456,880	9,956,041
COHORT	Classic' Adults		2	2
YEAR		2014	2015	2016
TOTAL_MED		$825,042,770	$781,274,798	$749,260,172
ELIGIBLES		1,933,680	1,947,281	1,881,541
COHORT	Disabled		3	3
YEAR		2014	2015	2016
TOTAL_MED		$1,071,234,259	$1,123,672,664	$1,231,609,464
ELIGIBLES		1,818,313	1,801,007	1,823,350
COHORT	Aged		4	4
YEAR		2014	2015	2016
TOTAL_MED		$111,152,393	$122,814,483	$129,617,952
ELIGIBLES		857,855	880,882	903,951
COHORT	Expansion Adul		5	5
YEAR		2014	2015	2016
TOTAL_MED		$2,800,146,114	$2,448,637,189	$2,674,514,579
ELIGIBLES		4,858,655	6,668,892	7,303,402

AOD				
COHORT	Children		1	1
YEAR		2014	2015	2016
TOTAL_AOD		$12,784,926	$11,325,072	$23,296,849
COHORT	Classic' Adults		2	2
YEAR		2014	2015	2016
TOTAL_AOD		$28,663,765	$29,917,501	$22,960,449
COHORT	Disabled		3	3
YEAR		2014	2015	2016
TOTAL_AOD		$20,429,045	$20,150,762	$27,784,170
COHORT	Aged		4	4
YEAR		2014	2015	2016
TOTAL_AOD		$827,525	$946,192	$1,191,521
COHORT	Expansion Adul		5	5
YEAR		2014	2015	2016
TOTAL_AOD		$73,252,548	$87,951,709	$149,905,925

LTSS				
COHORT	Children		1	1
YEAR		2014	2015	2016
TOTAL_LTSS		$684,908	$162,147	$143,664
COHORT	Classic' Adults		2	2
YEAR		2014	2015	2016
TOTAL_LTSS		$3,171,385	$4,688,041	$5,492,384
COHORT	Disabled		3	3
YEAR		2014	2015	2016
TOTAL_LTSS		$522,409,936	$560,567,662	$634,202,035
COHORT	Aged		4	4
YEAR		2014	2015	2016
TOTAL_LTSS		$1,051,068,594	$1,133,059,517	$1,241,289,311
COHORT	Expansion Adul		5	5
YEAR		2014	2015	2016
TOTAL_LTSS		$22,050,885	$29,155,397	$32,566,721

MH				
COHORT	Children		1	1
YEAR		2014	2015	2016
TOTAL_MH		$85,716,209	$91,645,262	$99,777,791
COHORT	Classic' Adults		2	2
YEAR		2014	2015	2016
TOTAL_MH		$32,300,187	$33,922,720	$34,455,766
COHORT	Disabled		3	3
YEAR		2014	2015	2016
TOTAL_MH		$205,568,719	$204,864,126	$214,167,065
COHORT	Aged		4	4
YEAR		2014	2015	2016
TOTAL_MH		$16,252,517	$16,725,274	$17,809,398
COHORT	Expansion Adul		5	5
YEAR		2014	2015	2016
TOTAL_MH		$172,162,645	$241,798,597	$260,672,923
		$512,000,278	$588,955,980	$626,882,943

7. Trends Projections

Projections: From CMS Actuary		2013	2014	2015	2016	2017	2018	2019	2020	2021
1	*Disabled*	$17,352	$17,755	$18,285	$18,927	$19,790	$20,682	$21,609	$22,573	$23,577
2	*Children*	$2,807	$2,844	$2,926	$3,002	$3,144	$3,307	$3,492	$3,685	$3,884
3	*'Classic' Adults*	$4,391	$4,650	$4,817	$4,964	$5,220	$5,504	$5,816	$6,152	$6,509
4	*Exp Adults*	...	$5,517	$4,281	$3,606	$3,806	$3,989	$4,189	$4,403	$4,620
5	*Aged*	$15,483	$15,630	$15,999	$16,626	$17,505	$18,296	$19,098	$19,946	$20,838

		Baseline Years				Demonstration Years				
1	*Disabled*	...	2.32%	2.99%	3.51%	4.56%	4.51%	4.48%	4.46%	4.45%
2	*Children*	...	1.32%	2.88%	2.60%	4.73%	5.18%	5.59%	5.53%	5.40%
3	*'Classic' Adults*	...	5.90%	3.59%	3.05%	5.16%	5.44%	5.67%	5.78%	5.80%
4	*Exp Adults*	...	5.90%	3.59%	3.05%	5.55%	4.81%	5.01%	5.11%	4.93%
5	*Aged*	...	0.95%	2.36%	3.92%	5.29%	4.52%	4.38%	4.44%	4.47%

** - Newly elig use classic adults as proxy for baseline years*

8. Hypothetical – Caseload and Expenditures

	Without Waiver					
	Hypothetical - MAC		Hypothetical - Supported Housing		Hypothetical - Supported Employment	
Month	Caseload	All Funds	Caseload	All Funds	Caseload	All Funds
Jan-17	864	$431,806	948	$547,586	813	$447,123
Feb-17	1,732	$865,914	1,899	$1,096,531	1,629	$895,724
Mar-17	2,605	$1,302,333	2,852	$1,646,839	2,447	$1,345,804
Apr-17	3,482	$1,741,072	3,807	$2,198,512	3,268	$1,797,370
May-17	4,364	$2,182,142	4,765	$2,751,551	4,092	$2,250,423
Jun-17	5,251	$2,625,550	5,725	$3,305,961	4,918	$2,704,967
Jul-17	6,143	$3,071,306	6,687	$3,861,743	5,747	$3,161,007
Aug-17	7,039	$3,519,421	7,652	$4,418,899	6,579	$3,618,546
Sep-17	7,940	$3,969,902	8,619	$4,977,434	7,414	$4,077,588
Oct-17	8,846	$4,422,760	9,588	$5,537,348	8,251	$4,538,136
Nov-17	9,756	$4,878,004	10,560	$6,098,645	9,091	$5,000,194
Dec-17	10,671	$5,335,643	11,535	$6,661,326	9,934	$5,463,766
Jan-18	11,591	$5,882,623	12,512	$7,333,777	10,780	$6,017,789
Feb-18	12,516	$6,352,019	13,491	$7,907,719	11,628	$6,491,399
Mar-18	13,446	$6,823,875	14,472	$8,483,075	12,479	$6,966,557
Apr-18	14,381	$7,298,202	15,456	$9,059,847	13,333	$7,443,267
May-18	15,320	$7,775,009	16,443	$9,638,038	14,190	$7,921,533
Jun-18	16,265	$8,254,306	17,431	$10,217,650	15,049	$8,401,358
Jul-18	17,214	$8,736,103	18,423	$10,798,688	15,912	$8,882,746
Aug-18	18,168	$9,220,410	19,416	$11,381,152	16,777	$9,365,702
Sep-18	19,128	$9,707,237	20,413	$11,965,045	17,645	$9,850,229
Oct-18	20,092	$10,196,593	21,411	$12,550,371	18,516	$10,336,330
Nov-18	21,061	$10,688,489	22,412	$13,137,132	19,389	$10,824,011
Dec-18	22,035	$11,182,935	23,416	$13,725,330	20,266	$11,313,274
Jan-19	23,015	$11,855,141	23,445	$13,948,506	21,145	$11,981,185
Feb-19	23,999	$12,362,210	23,474	$13,965,822	22,027	$12,481,012
Mar-19	24,989	$12,871,899	23,503	$13,983,161	22,912	$12,982,457
Apr-19	25,983	$13,384,217	23,532	$14,000,521	23,800	$13,485,525
May-19	26,983	$13,899,175	23,561	$14,017,902	24,690	$13,990,219

Jun-19	27,988	$14,416,784	23,591	$14,035,305	25,584	$14,496,543
Jul-19	28,998	$14,937,052	23,620	$14,052,730	26,481	$15,004,501
Aug-19	30,013	$15,459,992	23,649	$14,070,176	27,380	$15,514,098
Sep-19	31,033	$15,985,614	23,679	$14,087,644	28,282	$16,025,337
Oct-19	32,059	$16,513,928	23,708	$14,105,134	29,187	$16,538,222
Nov-19	33,090	$17,044,944	23,737	$14,122,645	30,095	$17,052,758
Dec-19	34,126	$17,578,675	23,767	$14,140,178	31,006	$17,568,949
Jan-20	34,217	$17,889,914	23,796	$14,370,099	31,058	$17,861,935
Feb-20	34,308	$17,937,600	23,826	$14,387,939	31,109	$17,891,435
Mar-20	34,400	$17,985,413	23,855	$14,405,802	31,160	$17,920,984
Apr-20	34,491	$18,033,354	23,885	$14,423,687	31,212	$17,950,582
May-20	34,583	$18,081,422	23,915	$14,441,593	31,263	$17,980,229
Jun-20	34,675	$18,129,619	23,944	$14,459,522	31,315	$18,009,925
Jul-20	34,768	$18,177,944	23,974	$14,477,474	31,367	$18,039,670
Aug-20	34,860	$18,226,398	24,004	$14,495,447	31,418	$18,069,464
Sep-20	34,953	$18,274,981	24,034	$14,513,443	31,470	$18,099,307
Oct-20	35,047	$18,323,693	24,064	$14,531,462	31,522	$18,129,199
Nov-20	35,140	$18,372,536	24,093	$14,549,502	31,574	$18,159,141
Dec-20	35,234	$18,421,508	24,123	$14,567,565	31,627	$18,189,133
Jan-21	35,328	$18,747,670	24,153	$14,804,435	31,679	$18,492,461
Feb-21	35,422	$18,797,643	24,183	$14,822,815	31,731	$18,523,003
Mar-21	35,516	$18,847,749	24,213	$14,841,217	31,783	$18,553,595
Apr-21	35,611	$18,897,988	24,243	$14,859,642	31,836	$18,584,238
May-21	35,706	$18,948,361	24,273	$14,878,091	31,889	$18,614,931
Jun-21	35,801	$18,998,868	24,304	$14,896,561	31,941	$18,645,675
Jul-21	35,896	$19,049,510	24,334	$14,915,055	31,994	$18,676,470
Aug-21	35,992	$19,100,287	24,364	$14,933,572	32,047	$18,707,316
Sep-21	36,088	$19,151,200	24,394	$14,952,112	32,100	$18,738,212
Oct-21	36,184	$19,202,248	24,424	$14,970,675	32,153	$18,769,160
Nov-21	36,281	$19,253,432	24,455	$14,989,261	32,206	$18,800,159
Dec-21	36,377	$19,304,753	24,485	$15,007,870	32,259	$18,831,209
CY2017	***68,692***	***$34,345,852***	***74,636***	***$43,102,375***	***64,183***	***$35,300,648***
CY2018	***201,217***	***$102,117,801***	***215,295***	***$126,197,823***	***185,964***	***$103,814,193***
CY2019	***342,274***	***$176,309,632***	***283,265***	***$168,529,725***	***312,590***	***$177,120,807***
CY2020	***416,676***	***$217,854,384***	***287,514***	***$173,623,536***	***376,095***	***$216,301,004***

CY2021	***430,201***	***$228,299,709***	***291,826***	***$178,871,307***	***383,617***	***$223,936,430***

	With Waiver							
	Hypothetical - MAC		Hypothetical - Supported Housing		Hypothetical - Supported Employment		Expansion - TSOA	
Month	**Caseload**	**All Funds**	**Caseload**	**All Funds**	**Caseload**	**All Funds**	**Caseload**	**All Funds**
Jan-17	115	$57,574	156	$90,346	76	$41,821	79	$26,327
Feb-17	231	$115,455	313	$180,917	152	$83,780	159	$52,794
Mar-17	347	$173,644	470	$271,713	229	$125,878	239	$79,402
Apr-17	464	$232,143	628	$362,733	306	$168,114	320	$106,152
May-17	582	$290,952	786	$453,979	383	$210,490	401	$133,043
Jun-17	700	$350,073	945	$545,452	460	$253,005	483	$160,078
Jul-17	819	$409,508	1,103	$637,150	538	$295,660	565	$187,255
Aug-17	939	$469,256	1,262	$729,076	615	$338,455	647	$214,576
Sep-17	1,059	$529,320	1,422	$821,229	693	$381,391	730	$242,042
Oct-17	1,179	$589,701	1,582	$913,609	772	$424,467	813	$269,652
Nov-17	1,301	$650,400	1,742	$1,006,218	850	$467,685	897	$297,408
Dec-17	1,423	$711,419	1,903	$1,099,055	929	$511,045	981	$325,310
Jan-18	1,546	$784,350	2,064	$1,210,003	1,008	$562,864	1,065	$358,659
Feb-18	1,669	$846,936	2,226	$1,304,697	1,088	$607,163	1,150	$387,277
Mar-18	1,793	$909,850	2,388	$1,399,626	1,167	$651,606	1,236	$416,046
Apr-18	1,917	$973,094	2,550	$1,494,787	1,247	$696,194	1,322	$444,965
May-18	2,043	$1,036,668	2,713	$1,590,183	1,327	$740,928	1,408	$474,036
Jun-18	2,169	$1,100,574	2,876	$1,685,814	1,408	$785,808	1,495	$503,258
Jul-18	2,295	$1,164,814	3,040	$1,781,679	1,488	$830,834	1,582	$532,633
Aug-18	2,422	$1,229,388	3,204	$1,877,780	1,569	$876,006	1,670	$562,161
Sep-18	2,550	$1,294,298	3,368	$1,974,117	1,650	$921,326	1,758	$591,842
Oct-18	2,679	$1,359,546	3,533	$2,070,690	1,732	$966,793	1,847	$621,678
Nov-18	2,808	$1,425,132	3,698	$2,167,500	1,814	$1,012,407	1,936	$651,668
Dec-18	2,938	$1,491,058	3,863	$2,264,547	1,896	$1,058,169	2,025	$681,814
Jan-19	3,069	$1,580,685	3,868	$2,301,369	1,978	$1,120,641	2,115	$722,798
Feb-19	3,200	$1,648,295	3,873	$2,304,226	2,060	$1,167,392	2,206	$753,713
Mar-19	3,332	$1,716,253	3,878	$2,307,087	2,143	$1,214,294	2,297	$784,789

Apr-19	3,464	$1,784,562	3,883	$2,309,951	2,226	$1,261,348	2,388	$816,024
May-19	3,598	$1,853,223	3,887	$2,312,819	2,309	$1,308,553	2,480	$847,421
Jun-19	3,732	$1,922,238	3,892	$2,315,690	2,393	$1,355,911	2,572	$878,979
Jul-19	3,866	$1,991,607	3,897	$2,318,565	2,477	$1,403,423	2,665	$910,699
Aug-19	4,002	$2,061,332	3,902	$2,321,444	2,561	$1,451,087	2,759	$942,583
Sep-19	4,138	$2,131,415	3,907	$2,324,326	2,645	$1,498,905	2,852	$974,629
Oct-19	4,275	$2,201,857	3,912	$2,327,211	2,730	$1,546,877	2,947	$1,006,840
Nov-19	4,412	$2,272,659	3,916	$2,330,100	2,815	$1,595,003	3,041	$1,039,216
Dec-19	4,550	$2,343,823	3,921	$2,332,993	2,900	$1,643,284	3,137	$1,071,757
Jan-20	4,562	$2,385,322	3,926	$2,370,928	2,905	$1,670,688	3,145	$1,090,733
Feb-20	4,574	$2,391,680	3,931	$2,373,871	2,910	$1,673,447	3,153	$1,093,640
Mar-20	4,587	$2,398,055	3,936	$2,376,819	2,915	$1,676,211	3,162	$1,096,555
Apr-20	4,599	$2,404,447	3,941	$2,379,769	2,919	$1,678,980	3,170	$1,099,478
May-20	4,611	$2,410,856	3,946	$2,382,724	2,924	$1,681,753	3,179	$1,102,409
Jun-20	4,623	$2,417,283	3,951	$2,385,682	2,929	$1,684,530	3,187	$1,105,347
Jul-20	4,636	$2,423,726	3,955	$2,388,644	2,934	$1,687,312	3,196	$1,108,294
Aug-20	4,648	$2,430,186	3,960	$2,391,609	2,939	$1,690,099	3,204	$1,111,248
Sep-20	4,660	$2,436,664	3,965	$2,394,578	2,944	$1,692,890	3,213	$1,114,210
Oct-20	4,673	$2,443,159	3,970	$2,397,551	2,948	$1,695,686	3,221	$1,117,180
Nov-20	4,685	$2,449,671	3,975	$2,400,528	2,953	$1,698,487	3,230	$1,120,158
Dec-20	4,698	$2,456,201	3,980	$2,403,508	2,958	$1,701,292	3,238	$1,123,144
Jan-21	4,710	$2,499,689	3,985	$2,442,589	2,963	$1,729,663	3,247	$1,143,030
Feb-21	4,723	$2,506,352	3,990	$2,445,622	2,968	$1,732,520	3,256	$1,146,076
Mar-21	4,735	$2,513,033	3,995	$2,448,658	2,973	$1,735,382	3,264	$1,149,131
Apr-21	4,748	$2,519,732	4,000	$2,451,698	2,978	$1,738,248	3,273	$1,152,194
May-21	4,761	$2,526,448	4,005	$2,454,742	2,983	$1,741,119	3,282	$1,155,265
Jun-21	4,773	$2,533,182	4,010	$2,457,789	2,988	$1,743,994	3,291	$1,158,345
Jul-21	4,786	$2,539,935	4,015	$2,460,840	2,993	$1,746,874	3,299	$1,161,432
Aug-21	4,799	$2,546,705	4,020	$2,463,896	2,997	$1,749,760	3,308	$1,164,528
Sep-21	4,812	$2,553,493	4,025	$2,466,954	3,002	$1,752,649	3,317	$1,167,632
Oct-21	4,825	$2,560,300	4,030	$2,470,017	3,007	$1,755,544	3,326	$1,170,745
Nov-21	4,837	$2,567,124	4,035	$2,473,084	3,012	$1,758,444	3,335	$1,173,865
Dec-21	4,850	$2,573,967	4,040	$2,476,154	3,017	$1,761,348	3,344	$1,176,994
CY2017	***9,159***	***$4,579,447***	***12,314***	***$7,111,477***	***6,003***	***$3,301,791***	***6,314***	***$2,094,037***
CY2018	***26,829***	***$13,615,707***	***35,522***	***$20,821,425***	***17,394***	***$9,710,098***	***18,495***	***$6,226,036***

CY2019	***45,637***	***$23,507,951***	***46,736***	***$27,805,781***	***29,238***	***$16,566,718***	***31,460***	***$10,749,449***
CY2020	***55,557***	***$29,047,251***	***47,437***	***$28,646,210***	***35,177***	***$20,231,377***	***38,298***	***$13,282,397***
CY2021	***57,360***	***$30,439,961***	***48,149***	***$29,512,042***	***35,881***	***$20,945,544***	***39,541***	***$13,919,239***

9. Historical Data CY06-16

WASHINGTON STATE HISTORICAL MEDICAID EXPENDITURES & ELIGIBLES - by CALENDAR YEAR & PROGRAM										Report Date =	22-Mar-16	
Program - Population	**CY 2006**	**CY 2007**	**CY 2008**	**CY 2009**	**CY 2010**	**CY 2011**	**CY 2012**	**CY 2013**	**CY 2014**	**CY 2015**	**CY 2016**	
SUD TX - Annual Expenditures												
DISABLED CHILDREN & ADULTS	$7,133,941	$7,748,711	$8,732,091	$9,010,080	$7,754,015	$11,821,459	$13,458,615	$15,415,034	$20,429,045	$20,150,762	$27,784,170	
NON-DISABLED CHILDREN	$6,110,683	$6,097,484	$6,798,332	$6,517,057	$6,154,257	$9,510,107	$10,280,130	$10,693,318	$12,784,926	$11,325,072	$23,296,849	
NON-ABD 'CLASSIC' ADULTS	$9,582,559	$10,533,848	$11,812,878	$11,503,785	$8,788,654	$13,086,530	$17,834,023	$21,009,594	$28,663,765	$29,917,501	$22,960,449	
EXPANSION ADULTS	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	$73,252,548	$87,951,709	$149,905,925	
ELDERS	$210,600	$165,140	$196,330	$196,588	$198,065	$292,502	$328,578	$475,222	$827,525	$946,192	$1,191,521	
LTSS - Annual Expenditures												
DISABLED CHILDREN & ADULTS	$334,506,773	$367,813,257	$417,259,220	$455,440,258	$477,580,687	$481,018,750	$489,613,549	$512,635,809	$522,409,936	$560,567,662	$634,202,035	
NON-DISABLED CHILDREN	$448,754	$636,714	$943,003	$707,086	$746,206	$743,447	$492,624	$596,708	$684,908	$162,147	$143,664	
NON-ABD 'CLASSIC' ADULTS	$2,255,240	$2,498,686	$2,986,489	$2,979,586	$3,051,708	$2,376,118	$2,170,232	$2,336,461	$3,171,385	$4,688,041	$5,492,384	
EXPANSION ADULTS	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	$22,050,885	$29,155,397	$32,566,721	
ELDERS	$801,237,168	$841,653,052	$905,658,694	$933,860,002	$951,621,781	$944,028,201	$970,506,252	$1,005,202,390	$1,051,068,594	$1,133,059,517	$1,241,289,311	
MH - Annual Expenditures												
DISABLED CHILDREN & ADULTS	$163,920,559	$165,170,561	$160,675,091	$165,676,831	$182,643,803	$201,497,477	$201,684,316	$208,442,855	$205,568,719	$204,864,126	$214,167,065	
NON-DISABLED CHILDREN	$68,939,389	$76,149,608	$80,031,703	$84,981,760	$95,429,366	$105,271,147	$105,269,898	$111,828,281	$85,716,209	$91,645,262	$99,777,791	
NON-ABD 'CLASSIC' ADULTS	$15,567,014	$17,851,785	$19,695,755	$23,318,044	$28,803,476	$30,140,880	$29,473,567	$30,377,278	$32,300,187	$33,922,720	$34,455,766	
EXPANSION ADULTS	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	$172,162,645	$241,798,597	$260,672,923	
ELDERS	$12,556,250	$13,105,326	$13,952,692	$13,424,332	$15,311,622	$16,964,275	$18,429,231	$19,137,512	$16,252,517	$16,725,274	$17,809,398	
MEDICAL - Annual Expenditures												
DISABLED CHILDREN & ADULTS	$845,625,646	$954,282,753	$1,096,667,179	$1,174,578,132	$1,163,619,188	$1,094,146,465	$1,164,470,776	$1,299,930,917	$1,071,234,259	$1,123,672,664	$1,231,609,464	
NON-DISABLED CHILDREN	$987,400,718	$1,065,934,992	$1,177,281,127	$1,182,475,824	$1,239,182,553	$1,287,144,759	$1,285,736,614	$1,294,993,069	$1,327,708,126	$1,374,841,255	$1,533,416,760	
NON-ABD 'CLASSIC' ADULTS	$609,753,090	$611,965,075	$655,813,209	$728,125,773	$755,547,619	$753,065,507	$740,602,474	$748,333,883	$825,042,770	$781,274,798	$749,260,172	
EXPANSION ADULTS	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	$2,800,146,114	$2,448,637,189	$2,674,514,579	
ELDERS	$147,982,991	$154,264,494	$161,319,457	$141,777,716	$115,554,633	$102,407,502	$101,201,363	$105,539,886	$111,152,393	$122,814,483	$129,617,952	
TOTAL - Annual Expenditures												
DISABLED CHILDREN & ADULTS	$1,351,186,919	$1,495,015,281	$1,683,333,581	$1,804,705,300	$1,831,597,693	$1,788,484,151	$1,869,227,255	$2,036,424,614	$1,819,641,959	$1,909,255,215	$2,107,762,734	
NON-DISABLED CHILDREN	$1,062,899,545	$1,148,818,798	$1,265,054,164	$1,274,681,727	$1,341,512,382	$1,402,669,459	$1,401,779,265	$1,418,111,376	$1,426,894,169	$1,477,973,736	$1,656,635,064	
NON-ABD 'CLASSIC' ADULTS	$637,157,902	$642,849,394	$690,308,331	$765,927,188	$796,191,456	$798,669,035	$790,080,296	$802,057,216	$889,178,108	$849,803,061	$812,168,771	
EXPANSION ADULTS	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	$3,067,612,192	$2,807,542,892	$3,117,660,147	
ELDERS	$961,987,009	$1,009,188,012	$1,081,127,173	$1,089,258,638	$1,082,686,101	$1,063,692,480	$1,090,465,424	$1,130,355,011	$1,179,301,030	$1,273,545,466	$1,389,908,182	
NON-EXPANSION POPS - Medical & BH Only	$1,812,332,650	$1,935,087,692	$2,128,864,683	$2,267,611,281	$2,278,221,074	**$2,223,422,597**	**$2,287,482,943**	**$2,448,662,181**	$2,311,471,180	$2,334,288,522	$2,428,855,958	
NON-EXPANSION POPS - LTSS Only	$1,137,999,181	$1,211,964,995	$1,325,904,403	$1,392,279,845	$1,432,254,176	**$1,427,423,069**	**$1,462,290,033**	**$1,520,174,660**	$1,576,649,916	$1,698,315,220	$1,880,983,730	
NON-EXPANSION POPS - Medical, BH, & LTSS	$2,950,331,831	$3,147,052,687	$3,454,769,085	$3,659,891,126	$3,710,475,251	**$3,650,845,666**	**$3,749,772,975**	**$3,968,836,841**	$3,888,121,096	$4,032,603,741	$4,309,839,687	
										$2,313,000	$7,103,900	<-- HEP-C Family
										$22,131,000	$53,678,000	<-- HEP-C Disabled
												Other
												Other
									$0	$24,444,000	$60,781,900	Total Additional
NON-EXPANSION POPS - REV	$2,950,331,831	$3,147,052,687	$3,454,769,085	$3,659,891,126	$3,710,475,251	$3,650,845,666	$3,749,772,975	$3,968,836,841	$3,888,121,096	**$4,057,047,741**	**$4,370,621,587**	Revised Overall Total

ELIGIBLES - Annual Member Months											
DISABLED CHILDREN & ADULTS	1,544,576	1,573,852	1,615,872	1,663,538	1,762,214	1,851,898	1,887,003	1,913,440	1,818,313	1,801,007	1,823,350
NON-DISABLED CHILDREN	6,240,874	6,328,901	6,646,291	7,399,057	7,999,905	8,324,806	8,404,510	8,440,614	8,892,595	9,456,880	9,956,041
NON-ABD 'CLASSIC' ADULTS	1,539,435	1,452,108	1,445,986	1,515,725	1,610,959	1,725,990	1,712,637	1,707,833	1,933,680	1,947,281	1,881,541
EXPANSION ADULTS	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	4,858,655	6,668,892	7,303,402
ELDERS	747,013	746,056	750,796	764,743	782,798	803,665	822,482	840,770	857,855	880,882	903,951
NON-EXPANSION POPS	3,831,024	3,772,016	3,812,654	3,944,007	4,155,971	4,381,553	4,422,122	4,462,043	4,609,848	4,629,169	4,608,843
Average PMPM											
DISABLED CHILDREN & ADULTS	$874.79	$949.91	$1,041.75	$1,084.86	$1,039.37	$965.76	$990.58	$1,064.27	$1,000.73	$1,060.10	$1,155.98
NON-DISABLED CHILDREN	$170.31	$181.52	$190.34	$172.28	$167.69	$168.49	$166.79	$168.01	$160.46	$156.29	$166.39
NON-ABD 'CLASSIC' ADULTS	$413.89	$442.70	$477.40	$505.32	$494.23	$462.73	$461.32	$469.63	$459.84	$436.41	$431.65
EXPANSION ADULTS	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	$631.37	$420.99	$426.88
ELDERS	$1,287.78	$1,352.70	$1,439.97	$1,424.35	$1,383.10	$1,323.55	$1,325.82	$1,344.43	$1,374.71	$1,445.76	$1,537.59
NON-EXPANSION POPS	$770.12	$834.32	$906.13	$927.96	$892.81	$833.23	$847.96	$889.47	$843.44	$871.13	$935.12
Average PMPM % Grwth											
DISABLED CHILDREN & ADULTS		*8.6%*	*9.7%*	*4.1%*	*-4.2%*	*-7.1%*	*2.6%*	*7.4%*	*-6.0%*	*5.9%*	*9.0%*
NON-DISABLED CHILDREN		*6.6%*	*4.9%*	*-9.5%*	*-2.7%*	*0.5%*	*-1.0%*	*0.7%*	*-4.5%*	*-2.6%*	*6.5%*
NON-ABD 'CLASSIC' ADULTS		*7.0%*	*7.8%*	*5.8%*	*-2.2%*	*-6.4%*	*-0.3%*	*1.8%*	*-2.1%*	*-5.1%*	*-1.1%*
EXPANSION ADULTS		*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*-33.3%*	*1.4%*
ELDERS		*5.0%*	*6.5%*	*-1.1%*	*-2.9%*	*-4.3%*	*0.2%*	*1.4%*	*2.3%*	*5.2%*	*6.4%*
NON-EXPANSION POPS		*8.3%*	*8.6%*	*2.4%*	*-3.8%*	*-6.7%*	*1.8%*	*4.9%*	*-5.2%*	*3.3%*	*7.3%*

10. Caseload Projections

Average Monthly Caseloads by Calendar Year

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
All Disabled	128,715	131,154	134,656	138,628	146,851	154,325	157,250	159,453	151,526	150,084	151,946	154,170	155,179	155,935	156,611	157,293
Children Non-Disabled	520,073	527,408	553,858	616,588	666,659	693,734	700,376	703,385	741,050	788,073	829,670	846,670	852,390	858,280	864,756	871,972
Adults Non-ABD	128,286	121,009	120,499	126,310	134,247	143,833	142,720	142,319	161,140	162,273	156,795	158,586	159,324	159,975	160,475	161,021
Expansion Adults	0	1	2	3	4	5	6	7	404,888	555,741	608,617	622,189	624,779	627,121	628,887	630,812
Aged	62,251	62,171	62,566	63,729	65,233	66,972	68,540	70,064	71,488	73,407	75,329	77,521	80,806	84,317	87,888	91,348
All Disabled	1,544,576	1,573,852	1,615,872	1,663,538	1,762,214	1,851,898	1,887,003	1,913,440	1,818,313	1,801,007	1,823,350	1,850,034	1,862,143	1,871,216	1,879,335	1,887,516
Children Non-Disabled	6,240,874	6,328,901	6,646,291	7,399,057	7,999,905	8,324,806	8,404,510	8,440,614	8,892,595	9,456,880	9,956,041	10,160,041	10,228,683	10,299,361	10,377,072	10,463,660
Adults Non-ABD	1,539,435	1,452,108	1,445,986	1,515,725	1,610,959	1,725,990	1,712,637	1,707,833	1,933,680	1,947,281	1,881,541	1,903,029	1,911,885	1,919,699	1,925,699	1,932,248
Expansion Adults	0	12	24	36	48	60	72	84	4,858,655	6,668,892	7,303,402	7,466,264	7,497,354	7,525,448	7,546,643	7,569,742
Aged	747,013	746,056	750,796	764,743	782,798	803,665	822,482	840,770	857,855	880,882	903,951	930,247	969,676	1,011,807	1,054,653	1,096,173
Non-Expansion Adults	3,831,024	3,772,016	3,812,654	3,944,007	4,155,971	4,381,553	4,422,122	4,462,043	4,609,848	4,629,169	4,608,843	4,683,310	4,743,704	4,802,722	4,859,686	4,915,937

11. Proposed Medicaid Transformation program limits

DSHP Annual Limits	DEMONSTRATION YEARS (DY)					
	CY2017 DY 01	CY2018 DY 02	CY2019 DY 03	CY2020 DY 04	CY2021 DY 05	TOTAL
Original Maximum Allowable DSHP	$240,000,000	$216,000,000	$190,080,000	$157,766,400	$124,635,456	$928,481,856
Proposed Maximum Allowable DSHP	$240,000,000	$216,000,000	$117,008,060	$76,543,710	$98,879,556	$748,431,326
Proposed Reduction	$0	$0	$73,071,940	$81,222,690	$25,755,900	$180,050,530

DSRIP Annual Limits	DEMONSTRATION YEARS (DY)					
	CY2017 DY 01	CY2018 DY 02	CY2019 DY 03	CY2020 DY 04	CY2021 DY 05	TOTAL
Original Maximum Allowable DSRIP	$242,100,000	$240,600,000	$235,900,000	$217,300,000	$190,000,000	$1,125,900,000
Proposed Maximum Allowable DSRIP	$242,100,000	$240,600,000	$235,900,000	$151,510,022	$124,210,022	$994,320,044
Proposed Reduction	$0	$0	$0	$65,789,978	$65,789,978	$131,579,956

MAC and TSOA Annual Limits	DEMONSTRATION YEARS (DY)					
	CY2017 DY 01	CY2018 DY 02	CY2019 DY 03	CY2020 DY 04	CY2021 DY 05	TOTAL
Original Maximum Allowable MAC and TSOA	$5,979,600	$19,327,770	$36,832,950	$53,179,830	$57,363,570	$172,683,720
Proposed Maximum Allowable MAC and TSOA	$5,979,600	$19,327,770	$23,039,000	$35,493,000	$49,451,000	$133,290,370
Proposed Reduction	$0	$0	$13,793,950	$17,686,830	$7,912,570	$39,393,350

FCS Annual Limits	DEMONSTRATION YEARS (DY)					
	CY2017 DY 01	CY2018 DY 02	CY2019 DY 03	CY2020 DY 04	CY2021 DY 05	TOTAL
Original Maximum Allowable FCS	$14,992,000	$33,226,000	$47,238,000	$51,782,000	$53,383,000	$200,621,000
Proposed Maximum Allowable FCS	$14,992,000	$33,226,000	$27,346,190	$39,155,919	$42,494,053	$157,214,162
Proposed Reduction	$0	$0	$19,891,810	$12,626,081	$10,888,947	$43,406,838

	DEMONSTRATION YEARS (DY)					
	CY2017 DY 01	CY2018 DY 02	CY2019 DY 03	CY2020 DY 04	CY2021 DY 05	TOTAL
Total Proposed Reduction (all programs)	**$0**	**$0**	**$106,757,700**	**$177,325,579**	**$110,347,395**	**$394,430,673**