Healthier Washington Medicaid Transformation Section 1115 Waiver Amendment Request

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Healthier WASHINGTON

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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 2015, more than 700 individuals died from an opioid-related overdose in Washington. 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 as well as treating it.

The state is committed to providing appropriate care for individuals with substance use disorder (SUD) that require inpatient treatment. In Substitute Senate Bill 5883, the Washington State Legislature directed the Health Care Authority (HCA) and Department of Social and Health Services (DSHS) to apply for a waiver from the Centers for Medicare & Medicaid Services (CMS) to allow for the full costs of stays in institutions for mental disease (IMDs).

In its November 1, 2017 letter to State Medicaid Directors (SMD # 17-003), CMS provided new guidance on improving access to SUD services and quality of treatment for Medicaid beneficiaries as part of a department-wide effort to combat the ongoing opioid crisis. CMS offered a more flexible, streamlined approach to accelerate states' abilities to respond to the national opioid crisis, through Section 1115 waivers.

Under the Section 1115 waiver authority, states have flexibility to design initiatives that improve access to high quality, clinically appropriate treatment for opioid use disorder (OUD) and other SUDs, while incorporating quality improvement metrics to measure health outcomes. States will also have an opportunity to receive federal financial participation (FFP) for the continuum of services to treat addiction to opioids or other substances, including services provided to Medicaid enrollees residing in residential treatment facilities.

On January 9, 2017, Washington State received federal approval of its request for a Section 1115 waiver, the Medicaid Transformation Project (MTP). The waiver is approved through December 31, 2021. Given the recent CMS guidance on opioid crisis response, Washington State is requesting flexibility through this amendment to the MTP to include the following:

1. The state is requesting expenditure authority to claim FFP for services provided to Medicaid beneficiaries aged 21-64 who receive inpatient SUD services in an IMD; and
2. The state is requesting corrections to the Special Terms and Conditions to ensure the terms accurately reflect the agreement between the state and CMS.

Substance use disorder amendment request

Background

Approval of this amendment request will allow Washington State to maintain and expand access to inpatient and residential treatment for SUD. In 42 C.F.R. 438.6(e), as amended in July 2016, FFP for IMD stays of over 15 days in a calendar month for Medicaid beneficiaries aged 21-64 is prohibited. Federal

rules also prohibit the use of FFP for capitated payments to managed care entities during any month where the individual has a stay of longer than 15 days in an IMD.

Prior to this rule change, Washington State was able to utilize FFP for services in IMD facilities in lieu of providing those services in non-IMD settings. This authority was included in the state's 1915(b) waiver, and deemed a cost effective alternative to Medicaid State Plan services. Under the 1915(b) in lieu of waiver authority, Washington State was able to demonstrate that using FFP for services in IMD facilities was a cost-effective approach to ensuring network sufficiency for those in need of inpatient and residential services.

Washington State has 1,742 beds across 21 SUD facilities that meet the definition of an IMD. Two of those IMD facilities are tribally affiliated. Of those beds, 264 are in facilities that treat youth, and another 45 are dedicated to pregnant and parenting women. The 2016 Managed Care Final Rule prohibits use of FFP in these facilities when the stay lasts longer than 15 days. As a result, the state and the managed care entities it contracts with must use limited state dollars to pay for treatment.

Use of state dollars to pay for services in IMD settings reduces the ability to focus state funding on other vital services. These changes have led some treatment facilities to reduce their bed capacity to 16 beds. Others have delayed plans to expand their capacity beyond the 16-bed limit. In a time when treatment beds are at a premium, Medicaid beneficiaries need more access to residential and inpatient treatment, not less.

Approval of this amendment request will allow expansion of bed capacity in Washington State, allowing Medicaid beneficiaries timely access to the full range of treatment modalities. If this waiver amendment is approved, it is expected that existing facilities will expand their bed capacity to greater than 16 beds.

Detailed request

Washington State is requesting waiver authority to allow FFP for payment of services to Medicaid beneficiaries aged 21-64 who are receiving treatment in an SUD IMD. The state is also seeking the authority to make capitation payments to state contracted managed care entities to pay for services to Medicaid beneficiaries aged 21-64, regardless of the length of stay in an IMD.

Washington State is requesting that the waiver authorities described in this amendment apply to Medicaid beneficiaries in both the managed care and fee-for-service (FFS) systems. Application of the waiver to both systems would ensure equal access to this benefit for all Medicaid beneficiaries.

Specifically, HCA seeks a waiver of the following requirements:

Policy	Waiver/Expenditure Authority	Statutory and Regulatory Citation
Allow the state to make capitated payments to managed care entities for individuals aged 21-64 in an SUD IMD for more than 15 days in a calendar month regardless of the length of stay. The capitated payments may be used to pay for treatment in IMD	Waivers of all IMD payment restrictions Expenditure authority for IMD payments	42 CFR 438.6(e)

settings and services provided before or after discharge from the facility during the calendar month. Any in lieu of services provided in an IMD would meet the requirements of 42 CFR 438.3(e).		
To allow for FFP in expenditures for services provided to managed care and FFS Medicaid beneficiaries in SUD IMD facilities, including IMD facilities that are public institutions.	Expenditure authority for IMD payments	§1905(a)(29) paragraphs A and B

Proposed milestones

Appendix A includes the state's initial approach to key system reform milestones. These milestones address system reforms described in the State Medicaid Director's Letter which outlines a path toward an IMD exception for SUD services using the 1115 waiver process. Based on initial conversations with CMS, the state will be expected to partner with CMS on further development of its approach to the milestones through the development of an implementation plan. This plan is expected after the amendment request is approved.

Corrections to the 1115 Special Terms and Conditions

Background

As part of the acceptance letter to the terms and conditions for the MTP, and through subsequent discussions with CMS, Washington State requested several technical corrections to the Special Terms and Conditions (STCs). These corrections were intended to ensure the STCs accurately reflect the agreement between the state and CMS. CMS incorporated some of the state's technical changes in an updated version of the STCs provided to the state on November 10, 2017. However, a number of requests were not accepted because they did not fit within the scope of how technical corrections are defined by CMS. Through this 1115 amendment request, Washington State is requesting an update to the STCs with a number of revisions. These revisions are provided in track changes as Appendix B of this amendment.

Detailed request

The state is requesting corrections to the following STCs:

STC	Title	Correction
49	TSOA Benefits Package	Add language to mirror STC 47 regarding the prevention of duplicated services offered under the Tailored Supports for Older Adults (TSOA) benefits package.
54	Quality Measures	Add and edit language to reflect the state's development of a Quality Improvement System (QIS) that includes performance measurement and quarterly/annual reports, in accordance with

		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.
56	Presumptive Eligibility	Remove language in part (e)(i)(3) regarding joint non-excluded income to align this STC with STC 48, mirroring the standards for full and presumptive eligibility for TSOA.
79	Reporting Expenditures Under the Demonstration	Remove the sentence, "Pharmacy rebates are excluded from the determination of budget neutrality." The state has confirmed that pharmacy rebates are included in budget neutrality calculations.
80	Expenditures Subject to the Budget Neutrality Agreement	Add language to reflect expenditures are subject to budget neutrality agreement, including those authorized in the Medicaid Sate Plan through Section 1915(b) and 1915(c).
92	DSHP Claiming Protocol	Add language in part (b) regarding the state's reduction of each reported "County Levy" program costs by 3.6% to reflect the exclusion of coverage of services to undocumented individuals.

Budget neutrality

As required by CMS, this amendment request must include a budget neutrality analysis. Based on CMS guidance, the state completed a detailed budget neutrality analysis. The analysis includes calculations that consider expenditures with and without waiver authority, which address:

1. The waiver's expenditure authority (costs not otherwise matchable) is limited to expenditures for otherwise covered services, furnished to otherwise eligible individuals who are receiving SUD treatment and are short-term residents in facilities that meet the definition of an IMD.
2. The waiver's expenditure authority includes expenditure authority for IMD exclusions related to medical assistance, as well as expenditure authority for additional hypothetical[1] services that can be provided outside the IMD.

The full budget neutrality analysis is provided in Appendix C.

Evaluation

The currently approved MTP seeks to advance the following goals:

- 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

[1] Additional hypothetical services may include optional services that could be included in the State Plan, but are being authorized using expenditure authority.

- Provide new targeted services that address the needs of the state's aging populations and address key determinants of health

This amendment request is consistent with delivery system reform work already underway in Washington State targeted at addressing the opioid epidemic.

Washington's 1115 waiver evaluation design was initially approved by CMS on October 26, 2017, and will be modified to incorporate the IMD exclusion waiver amendment. The evaluation design will be modified to incorporate an assessment of whether authorizing expenditure authority for services in IMDs will increase SUD inpatient and residential bed capacity, increase Medicaid beneficiary access to inpatient and residential SUD treatment services, and increase the likelihood that Medicaid beneficiaries receive SUD treatment in the setting most appropriate for their needs.

Public process

Per the MTP's STCs, the state is required to comply with state notice procedures (set forth in 59 Fed. Reg. 49249, September 27, 1994), and follow the state public notice process (outlined in 42 CFR §431.408). The state requested technical assistance from CMS regarding the public notice process, as 42 CFR §431.408 pertains to waiver applications or extensions, not amendments. As a result, CMS clarified that the state has fulfilled the public process requirements for this amendment request, as this amendment request was the result of a directive from the Washington State Legislature (see Appendix D). Additionally, the state was advised to fulfill the requirements outlined in 59 Fed. Reg. 49249.

Public input

The state is committed to extensive and transparent stakeholder engagement. The state engaged providers by making presentations at the Health Care Authority's Substance User Disorder Providers Meeting, as well as the Behavioral Health Organization Administrator's Meeting.

The state also opened public comment on the waiver amendment request from January 4 through February 5, 2018. The state provided notice about the amendment request by posting an announcement on the Health Care Authority's Medicaid Transformation webpage, and sent multiple emails to the Healthier Washington Feedback Network email distribution list (see Appendix E). No revisions to this amendment request were necessary based on the outcome of the public comment period. Those organizations and individuals who provided feedback during the public comment period were in support of the state's pursuit of the waiver amendment. Many of the comments received referenced the timeliness and critical nature of the amendment request. Formal comments received during the public comment period are provided in Appendix F.

Tribal engagement

Washington State is home to 29 federally recognized tribal governments and two urban Indian health organizations. On November 21, 2017, in accordance with 42 CFR 431.408(b), the state notified tribes, urban Indian health organizations, and other tribal parties of its intent to pursue an amendment to its

Section 1115 waiver, and request for two roundtable sessions and formal tribal consultation. A copy of the notification letter is provided in Appendix G.

On December 6, 2017 and January 8, 2018, state staff met with representatives and staff from tribes and urban Indian health organizations to foster mutual understanding of the amendment request, and determine the implications and potential benefits for tribes and urban Indian health organizations.

The state held formal tribal consultation on January 22, 2018 to further discuss the content and impact of the waiver amendment request. The state incorporated feedback received during tribal consultation, including adding greater detail regarding tribal SUD services in the SUD milestones (Appendix A).The meeting minutes from tribal consultation are provided in Appendix H.

Conclusion

The proposed flexibilities described in this amendment request build on Washington's current efforts to improve care for Medicaid beneficiaries by focusing on building health systems capacity, care delivery redesign, prevention and health promotion, and preparing for a value-based system. These flexibilities will allow us to continue to improve the quality and integration of care delivery, while also addressing critical issues such as the opioid crisis.

We look forward to continuing the discussion with CMS regarding Washington's amendment request to improve health outcomes for our Medicaid beneficiaries. We thank our federal partners at CMS in advance for their consideration of this important request.

State contact

Contact information for the state's point of contact for the MTP amendment request:
Name and Title: Kali Klein, Medicaid Transformation Manager
Telephone Number: (360) 725-1240
Email Address: kali.klein@hca.wa.gov
Mailing address:
Washington Health Care Authority
Mail Stop 45502
628 8th Ave SE
Olympia, WA 98501

Appendices

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Appendix A. Substance Use Disorder Milestones: Description of the Current System

Milestone 1. Coverage of a) outpatient, b) intensive outpatient services, c) medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state), d) intensive levels of care in residential and inpatient settings, and e) medically supervised withdrawal management.

Proposed Timeframe: Within 12 to 24 months of demonstration approval -- subject to negotiation.

Washington State's substance use disorder (SUD) treatment system includes all of the elements described in this milestone. The state ensures sufficient coverage by contractually requiring the nine Behavioral Health Organizations (BHO) and one Managed Care Organization (MCO) responsible for SUD care to assure network adequacy for services. If services are unavailable within the specific region, the BHO or MCO is required to contract for services with providers outside the defined geographical boundaries. Contractually, network adequacy is defined as ability to meet 90% of needs of Medicaid beneficiaries. The contractually required SUD services are described below. American Indian/Alaska Native (AI/AN) individuals may choose to access SUD services through a fee-for-service (FFS) system rather than through the managed care entities described above.

Outpatient treatment: (ASAM Level 1) Consists 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 conduct and 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.

Intensive Outpatient Treatment: (ASAM Level 2): Consists of a minimum of seventy-two hours of treatment services within a maximum of twelve 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, group sessions of at least one hour and attending self-help groups in addition to the seventy-two hours of treatment services.

Residential SUD Treatment: (ASAM Level 3): Inpatient treatment that provides a concentrated program with length of stay dependent on 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 substance use disorder treatment provides services in accordance with American Society of Addiction Medicine (ASAM) level from 3.1 to 3.7 criteria. Programs are licensed to provide Level 3 services not specifically defined within ASAM sub-levels (i.e. Residential 3.1, 3.3, 3.5 3.7), which allows facilities to self-define the level of care they provide. 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.

Withdrawal Management: (aka Detox) services are provided to help people safely withdraw from the physical effects of psychoactive substances. The need for withdrawal management (WM) services is determined by patient assessment using the American Society of Addiction Medicine (ASAM).

There are three levels of detox facilities recognized in Washington. Assessment of severity, medical complications, and specific drug or alcohol withdrawal risk determines placement within each level of service. All programs are licensed under the single ASAM Withdrawal Management requirements. (WAC 388-877B-0100 - WAC 388-877B-0120)

Substance use disorder detoxification services for youth require program-specific certification—Youth detoxification services. (WAC 388-877B-0130)

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 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 physician's on-call 24/7 for consultation. They have "standing orders" and available medications to help with withdrawal symptoms. They are not hospitals but have referral relationships. These facilities are regulated by DOH and are DBHR certified.

Acute Hospital Detox: ASAM 4.0-WM Medically Managed Intensive Inpatient are considered acute hospital detox. They 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 license and are not DBHR certified. This level of care is considered hospital care and not part of the behavioral health benefits provided through BHOs/MCOs. (Fact Sheet: Adult Withdrawal Management (Detox) Services. Authority: RCW 71.24.520 WAC 388-877B-0100 through WAC 388-877B-0130)

Medication Assisted Treatment programs: Washington has two different specific options for Medication Assisted Treatment, Opiate Treatment Programs (OTP) and Office Based Opiate Treatment Programs (OBOT). Traditionally OTP programs have provided methadone, yet currently some providers are also providing Buprenorphine MAT services. There are certified 25 DBHR certified and four Veterans Administration OTP programs.

Milestone 2a. Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines.

Proposed Timeframe: Within 12 to 24 months of demonstration approval -- subject to negotiation

The state requires all SUD providers to assess and provide treatment services using the ASAM criteria. The Division of Behavioral Health and Recovery (DBHR) currently requires all SUD assessments to be

based on as defined in Washington Administrative Code (WAC). Patient Placement Criteria (PPC) means admission, continued service, and discharge criteria found in the patient placement criteria (PPC) for the treatment of substance-related disorders as published by the American Society of Addiction Medicine (ASAM). (WAC 388-877-0200).

Milestone 2b. Implementation of a utilization management approach such that a) beneficiaries have access to SUD services at the appropriate level of care and that b) interventions are appropriate for the diagnosis and level of care, including c) an independent process for reviewing placement in residential treatment settings.

Proposed Timeframe: Within 24 months of demonstration approval -- subject to negotiation.

The state administers services for mental health and substance use disorders through contracts with nine Behavioral Health Organizations (BHOs) and two Managed Care Organizations (MCOs). AI/AN individuals have the additional option of receiving services through a FFS system. Federal requirements mandate that every state Medicaid agency that contracts with managed care organizations provide for an external quality review of healthcare services provided to enrollees, to assess the accessibility, timeliness, and quality of the care they provide. DBHR contracts with Qualis Health as its External Quality Review Organization (EQRO).

Qualis Health reviews results of compliance monitoring, results of Encounter Data Validation (EDV), follow-up of the previous year's corrective action plans, either a full Information Systems Capabilities Assessment (ISCA) or a follow-up of the previous year's ISCA, validation of the BHO's Performance Improvement Projects (PIPs), as well as a Focused Study of the Wraparound with Intensive Services (WISe) Program, which includes EDV results and a review of grievances.

The BHO/MCO authorization process is an independent review of residential authorization treatment. The outpatient and/or residential agency providing the services must obtain independent approval from the BHO or MCO. The FFS system available to AI/AN individuals does not require authorization for services.

Milestone 3a. Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria or other 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.

Proposed Timeframe: Within 12 to 24 months of demonstration approval -- subject to negotiation.

Division of Behavioral Health and Recovery (DBHR) provider licensure requirements define specific levels of care. These requirements apply to facilities providing services under managed care and FFS. There are four program specific certifications which defines care within Residential Treatment services. They are

intensive inpatient services; recovery house treatment services, long-term residential treatment services and youth residential services.

In addition to meeting the agency administrative and personnel requirements in WAC 388-877-0400 through 388-877-0530, an agency providing substance use disorder residential treatment services must ensure all substance use disorder assessment and counseling services are provided by a chemical dependency professional (CDP), or a CDP trainee (CDPT) under the supervision of an approved supervisor (WAC 388-877B-0210).

Intensive inpatient services are substance use disorder residential treatment services that provide a concentrated minimum of twenty hours of treatment services 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. Providers are required to document progress notes, referral and discharge summary within required timeframes. . Additional requirements can be found in (WAC 388-877B-0250).

Recovery house services are substance use disorder residential treatment services that provide a program of care and treatment with social, vocational, and recreational activities to aid in individual adjustment to abstinence and to 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. (WAC 388-877B-0260)

Long-term treatment services are substance use disorder residential treatment services that provide a program for an individual needing consistent structure over a longer period of time to develop and maintain abstinence, develop recovery skills, and to improve overall health. Long-term treatment services require program-specific certification by the department's division of behavioral health and recovery. An agency providing long-term treatment services must: Provide an individual a minimum of two hours each week of individual or group counseling. Provide an individual a minimum of two hours each week of education regarding alcohol, other drugs, and other addictions. Document progress notes in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type occur, or documentation as to why this did not occur. Progress notes should include the date, time, duration, participant names, and a brief summary of the session and the names of the staff member who provided it. Provide an individual, during the course of services, with Education on social and coping skills, Social and recreational activities. Assistance in seeking employment, when appropriate; and Assistance with re-entry living skills to include seeking and obtaining safe housing. The provider is required to conduct and document an individual service plan review at least monthly. (WAC 388-877B-0270)

Youth residential services are substance use disorder residential treatment services provided to an individual seventeen 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; Provide group meetings to promote personal growth, leisure, and other therapy or related activities. – Programs must provide seven or more hours of structured recreation each week that is led or supervised by staff

members. 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.

Clinical records are required to contain consent or release forms signed by the youth and their parent or legal guardian. Documents any problems identified in specific youth assessment, including any referrals to school and community support services, on the individual service plan. Other requirements can be found in WAC 388-877B-0280.

Milestone 3b. Implementation of state process for reviewing residential treatment providers to assure compliance with these standards.

Proposed Timeframe: Within 12 to 24 months of demonstration approval -- subject to negotiation.

DBHR licenses and certifies treatment programs, and regulates treatment agencies providing services for substance use disorders, 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 goals to improve services to vulnerable adults. When people have access to the behavioral health care they need, it benefits everyone in the community.

There are approximately 584 licensed and certified substance use disorder 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. (https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/licensing-and-certification-behavioral-health-agencies)

Current licensing and certification standards are driven by the Revised Code of Washington, 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 Program: 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 substance use disorder treatment services. DBHR integrated requirements and standards of the American Society of Addiction Medicine's (ASAM) Criteria in 1998. Washington administrative rules require licensed agencies to use *The ASAM Criteria* for making admission, continued services, and discharge decisions. Agency 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.

Milestone 3c. Requirement that residential treatment facilities offer MAT on-site or facilitate access off site.

Proposed Timeframe: Within12 to 24 months of demonstration approval -- subject to negotiation.

The state does not currently have a requirement that residential treatment facilities offer MAT on-site or make it available. There has been significant progress in encouraging MAT though training to providers related to offering patient choice. The utilization of the SAMHSA PDOA and STR grants projects have provided additional models in making MAT more broadly available and accepted.

Milestone 4. Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT.

Proposed Timeframe: Within 12 months of demonstration approval -- subject to negotiation.

The state expects to be able to develop the assessment described in this milestone within 12 months of demonstration approval. This assessment will indicate whether facilities accept clients funded through managed care, FFS, or both. 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 provide MAT in addition to routine services however the number is unknown at this time.

Milestone 5a. Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse.

Proposed Timeframe: Over the course of the demonstration.

Opioid prescribing/pain management guidelines

The Washington Agency Medical Directors' Group (AMDG) develops guidelines for medical providers caring for patients of state agency programs in WA 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. 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

The relevant WACs for each profession can be found here. Pain Management Adopted Rules: Washington State Department of Health

Other pain management resources:

- 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.
- 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.

Prescription Monitoring Program (PMP)

The WA State Department of Health Prescription Monitoring Program (sometimes called 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.

The Health Care Authority (HCA) is sending out 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 but are tailored to HCA's Medicaid population where applicable. The best practices recommendations reflect the CDC's guidelines for prescribing opioids.

Milestone 5b. Expanded coverage of and access to naloxone.

Proposed Timeframe: Over the course of the demonstration.

DBHR has been working on issues related to developing capacity for Naloxone distribution since 2015. Using Substance Abuse Block Grant (SABG) funding and working with the University of Washington Alcohol and Drug Abuse Institute (ADAI), to create a comprehensive website to provide education, locations for purchasing and distribution network. This collaboration has influenced changes to state laws including WA State law RCW 69.50.315 allowing 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. WA 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.

RCW 69.41.095 also permits non-medical persons to distribute naloxone under a prescriber's standing order.

As sovereign nations, Tribes are able to create and enforce their own laws and rules. As a result, some of the laws described in this section do not apply to Tribal jurisdictions.

Immunity from liability: Several laws in WA State (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. (Stopoverdose.org)

The Division of Behavioral Health and Recovery (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.

The Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO) is a collaborative five-year grant project between the Washington Department of Social and Health Services' (DSHS) Division of Behavioral Health and Recovery (DBHR) and the University of Washington's Alcohol and Drug Abuse Institute (ADAI) with the purpose of preventing opioid overdose and deaths from opioid overdose, and building local infrastructure to 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. (Washington PDO Grant to Prevent Prescription Drug/Opioid Overdose-Related Deaths)

The 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, across much of Washington State 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.

Milestone 6. Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities.

Timeframe: Within 12 to 24 months of demonstration approval -- subject to negotiation.

The Division of Behavioral Health and Recovery (DBHR) requires all SUD residential providers to maintain Clinical record content and documentation requirements.be based as defined in Washington Administrative Code (WAC 388-877B-0220). This includes an individual is transferring to another service provider, documentation that copies of documents pertinent to the individual's course of treatment were forwarded to the new service provider to include:

The individual's demographic information; and the diagnostic assessment statement and other assessment information to include: Documentation of the HIV/AIDS intervention, Tuberculosis (TB) screen or test result. A record of the individual's detoxification and treatment history. The reason for

the individual's transfer. Court mandated, department of correction supervision status or the agency's recommended follow-up treatment. A discharge summary and continuing care plan. The individual's demographic information; and the diagnostic assessment statement and other assessment information.

For the purposes of discharge planning and coordination of care, Tribal operated facilities meet these requirements in the same manner as non-Tribal facilities.

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, 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 consistent with the approved Special Terms and Conditions (STC).

These waivers are effective beginning January 9, 2017 through December 31, 2021.

Title XIX Waivers

WAIVERS OF TITLE XIX REQUIREMENTS

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.

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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.

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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 56. 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 90.

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

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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, 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. General Financial Requirements
X. Designated State Health Programs (DSHP)
XI. Monitoring Budget Neutrality
XII. Evaluation of the Demonstration
XIII. 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

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Attachment H: Tribal Engagement and Collaboration Protocol
Attachment I: Foundational Community Supports 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 $1.125 billion (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.

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 and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid program and Children's Health Insurance Program (CHIP) for the separate CHIP population, expressed in law, regulation, and policy statement, that are not expressly waived or identified as not applicable in the waiver and expenditure authority documents apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such change and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to provide the state with additional notice of the changes. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing within 30 calendar days of receipt.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**

    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 a 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 subparagraph.

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

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI State Plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP State Plan is affected by a change to the demonstration, a conforming amendment to the appropriate State Plan may be required except as otherwise noted in these STCs. In all such cases, the Medicaid State Plan governs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements specified in these STCs 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 or begin operational changes to these elements without prior approval by CMS of the amendment to the demonstration. 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 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS 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. An explanation of the public process used by the state consistent with the requirements of STC 16 to reach a decision regarding the requested amendment;
   b. A data analysis which identifies the specific "with waiver" (WW) impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable (TC) WW and "without waiver" (WOW) status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the WW expenditure total as a result of the proposed amendment which isolates, by Medicaid Eligibility Group (MEG), the impact of the amendment;
   c. An up-to-date CHIP allotment neutrality worksheet, if necessary;
   d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming title XIX and/or title XXI State Plan amendment, if necessary; and
   e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 12 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 10.

   a. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 16.
   b. The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the current approval period, and separately for the requested period of the extension. The state must provide five years of historical expenditure and enrollment data for Medicaid and demonstration populations that are to be included in the demonstration extension. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included. The state and CMS agree that if a demonstration extension or new demonstration is requested at the expiration of this 5-year demonstration, such future budget neutrality must be developed using updated historical data for the purposes of determining WOW limits, considering possible adjustments for the impact of alternative payment methodologies and other innovations in managed care.
   c. Upon application from the state, CMS reserves the right to temporarily extend the demonstration including making any amendments deemed necessary to effectuate the demonstration extension including but not limited to bringing the demonstration into compliance with changes to federal law, regulation and policy.

9. **Compliance with Transparency Requirements 42 CFR §431.412.** As part of any demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 16, as well as include the following supporting documentation:

   a. <u>Demonstration Summary and Objectives.</u> The state must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met.
   b. <u>Special Terms and Conditions.</u> The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the areas described in (c), (d), or (e) below, they need not be documented a second time.
   c. <u>Quality.</u> The state must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and state quality assurance monitoring and any other documentation of the quality of care provided under the demonstration.

d. Compliance with the Budget Neutrality Cap. The state must provide financial data (as set forth in the current STCs) demonstrating that the state has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension.

e. Interim Evaluation Report. The state must provide an evaluation report reflecting the hypotheses being tested and any results available.

10. Demonstration Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. **Notification of Suspension or Termination:** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.
The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b. **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), and the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c. **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 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 discussed in the October 1, 2010, State Health Official Letter #10-008.

d. **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the state, FFP will be limited to normal closeout costs associated with terminating the demonstration, including services and administrative costs of disenrolling participants.

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11. **Post Award Forum:** Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can either use its Title XIX Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments in the quarterly report as specified in STC 74 associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in STC 76.

12. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration, subject to adequate public notice (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 must promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

13. **Finding of Non-Compliance.** If CMS finds that the state has not complied with any of the terms of the demonstration, the state does not relinquish its rights to administratively and/or judicially challenge CMS' finding that the state materially failed to comply.

14. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw the waivers or expenditure authority for the waiver at any time it determines that continuing the waiver or expenditure authority would no longer be in the public interest or promote the objectives of title XIX. To allow for adequate phase-down, at least six months prior to any such action, CMS will notify the state of its initial determination and the reasons for proposed withdrawal, together with a proposed effective date of termination. After providing the notice, CMS must publish the notice on its website for a 30-day public comment period to seek input on the public interest. In addition, CMS must conduct tribal consultation with Washington tribes and Indian health programs within 30 days of publishing the notice on its website. After the public comment and tribal consultation period has concluded, the state will have an opportunity to request a hearing to challenge CMS' determination, which must be held at least 90 days prior to the effective date of any proposed termination. The hearing procedures will be those outlined in Subpart D of 42 CFR 430, unless the parties mutually agree on alternative procedures. If a waiver or expenditure authority is withdrawn, FFP after that point is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

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

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16. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR. §431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 7 are proposed by the state.

a. *Consultation with Federally Recognized Tribes on New Demonstration Proposals Applications and Renewals of Existing Demonstrations*. In states with Federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

b. *Seeking Advice and Guidance from Indian Health Programs Demonstration Proposals, Renewals, and Amendments*. In states with Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities in accordance with the process in the state's approved Medicaid state plan prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration.

c. *Public Notice*. 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.

17. Indian Health Care Providers.

a. 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.

b. 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.).

18. **AI/AN Managed Care Protections.** The 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 section 438.14.

19. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter, or later date if so identified elsewhere in these STCs or in the lists of waiver or expenditure authorities.

IV. POPULATIONS AFFECTED BY THE DEMONSTRATION

20. **Eligibility Groups Affected By the Demonstration.** All individuals eligible under the Medicaid State Plan are affected by the MTP 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 23, 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 23). 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 21-23 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 21) 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 44 below (see Chart B). 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.

21. 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).

22. **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.

23. **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 24;
    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.

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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.

24. **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 and 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.

25. **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:

a. To provide opportunity to review programs and projects implemented through delivery system reform efforts within this demonstration;
b. 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;
c. 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
d. To support other tribal-specific projects implemented through this demonstration to the extent appropriate.

26. 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.

a. 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.).

b. 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.

c. 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.

27. 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.

a. 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.

b. 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.

28. 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).

29. 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.

30. 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

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

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 required by the state for Medicaid managed care plans (see Table 1 under STC 41 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.

31. 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:

a. *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.

b. *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 30 and specific project area.

c. *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 30 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).

32. 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 30 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.

33. 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 42(a). 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).

34. 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 36, 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.

35. 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:

a. 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.
b. 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;
c. 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.
d. 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.
e. 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 107.
f. 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.
g. 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.

h. Include criteria and methodology for project valuation, including a range of available incentive funding per project.
i. Include pre-project plan milestones for capacity-building incentive payments.

36. 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 30 of this section.
c. Milestones should be organized as described above in STCs 31-32 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.

37. 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.

38. 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).

39. 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

a. 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.
b. 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.
c. 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.

d. 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.
e. 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.
f. 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.
g. 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.

h. 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

40. 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 41.
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.

41. 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.

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

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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)
   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.

42. 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 41. 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

[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).

withholds and DSRIP funding for MCO VBP attainment (see STC 41(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).

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.

43. Federal Financial Participation (FFP) for DSRIP. The state may claim, as authorized expenditures under the demonstration, up to $1.125 billion 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.

a. 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.

b. 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.

c. 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.

d. 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.

e. 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 74. This report must identify the funding sources associated with each type of payment received by each provider.

44. 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	$217,300,000	$190,000,000
Percent At Risk for Performance	0%	0%	5%	10%	20%
Dollar Amount at Risk for Performance	N/A	N/A	$11,795,000	$21,730,000	$38,000,000

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 41, 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.

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

a. ***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 34, 35 and 41 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.

b. ***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.

c. ***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

46. 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.

47. 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 47(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:

a. 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

b. 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

c. 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

d. 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

48. 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.
f. 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.

i. 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:
   1. Transfer of asset penalties do not apply
   2. Excess home equity provisions do not apply

49. 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 ~~in STC 47(a) through (d)~~ 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 47(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

50. 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).

51. 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.

52. **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.

53. **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).

54. **Quality Measures.** The state will develop a Quality Improvement System (QIS)~~Plan should~~ that includes~~ the following~~:

a. ~~Continuance of 1915(c) performance measure collection and reporting (as would be due in a 1915(c) waiver or 1915(i) State Plan Amendment) until the Comprehensive Quality Improvement System (QIS) for the entire 1115 waiver has been approved and implemented.~~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. ~~The Comprehensive QIS~~Performance measures should ~~include~~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

55. 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.

56. Presumptive Eligibility. The state will provide the MAC and TSOA services outlined in STCs 47 and 49 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]

[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.

3. The individual's separate non-excluded income is equal to or less than the Special Income Level (SIL) ~~or one half of a married couple's joint non-excluded income is at or below the SIL based on the individual's self-attested statement of income~~.
4. The individual's separate non-excluded resources are at or below $53,100 or, for a married couple, that joint non-excluded resources are at or below a combination of $53,100 plus the current state Spousal Resource Standard using spousal impoverishment protections, based on the individual's self-attested statement of their household resources.

ii. For MAC:

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.

57. 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.

58. 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

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

exceed the expenditure authority under STC 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

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

60. 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.

61. 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.)

62. 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.

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

64. 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.

65. 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.

66. 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.

67. 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 under STC 9 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.

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VIII. GENERAL REPORTING REQUIREMENTS

68. 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.

69. 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.

70. 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.

71. 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.

72. 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.

73. 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.

74. Quarterly Operational Reports. The state must submit progress reports in the format specified by CMS, no later than 60 calendar days following the end of each quarter along with any other Protocol required deliverables described in these STCs. 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

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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 34 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.

75. 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.

76. 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 74. The state must submit the draft annual report no later than October 1st of each year. Within 60 calendar days of receipt of comments from CMS, a final annual report must be submitted.

77. 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.

IX. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

78. 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.

79. 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 excluded from the determination of budget neutrality.~~ 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 nine 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. **DSRIP:** Expenditures authorized under the demonstration for delivery system transformation
   3. **Non-Expansion Adults:** Expenditures authorized under the demonstration for Medicaid

beneficiaries specified in STC 18.

4. **MAC:** Expenditures authorized under the demonstration for beneficiaries receiving Medicaid Alternative Care (MAC) services.
5. **TSOA:** Expenditures authorized under the demonstration for beneficiaries receiving Tailored Supports for Older Adults (TSOA) services.
6. **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.
7. **Foundational Community Supports 2:** HCBS that could be provided to the individual under a 1915(c) waiver or 1915(i) SPA.
8. **HepC:** Expenditures for prescription drugs ("HepC Rx") related to a diagnosis of Hepatitis C for individuals affected by or eligible under the demonstration.
9. **MAC and TSOA Not Eligible:** Expenditures authorized under the demonstration for beneficiaries receiving presumptive eligibility for TSOA and MAC services and determined ineligible.

80. 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.

81. Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, 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.

82. 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.

83. 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 74, the actual number of eligible member months for the populations affected by this demonstration as defined in STC 20. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

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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.

84. 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.

85. 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.

86. 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.

87. 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 (or under section 1115 authority) payments, 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 as allowable under 42 CFR §433.51 used to satisfy demonstration expenditures. 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. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. 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 claimed expenditure. Moreover, 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.

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

89. 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

90. 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 91. 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 3 beginning January 9, 2017 through December 31, 2021 in accordance with an approved DSHP claiming protocol as described in STC 92.

Table 3: 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)

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91. 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 $928,481,856 million TC for DSHP expenditures incurred through December 31, 2021. The TC DSHP amount for DY1 will not exceed $240 million. Beginning in DY2, the TC DSHP amount will be reduced by ten (10) percent and increase to a twenty-one (21) percent reduction by DY5 (see Table 4 below).

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 4 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.

c. *Funding At Risk for Quality Improvement Goals under DSRIP*. A share of total DSHP funding will be at risk if the state fails to demonstrate progress toward meeting the 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.

Table 4: 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**
DSHP Phase Down Percentage		10%	12%	17%	21%
Maximum Allowable DSHP	$240,000,000	$216,000,000	$190,080,000	$157,766,400	$124,635,456
Percent At Risk for Performance	0%	0%	5%	10%	20%
Amount At Risk for Performance	$0	$0	$9,504,000	$15,776,640	$24,927,091
Maximum Allowable DSRIP	$242,100,000	$240,600,000	$235,900,000	$217,300,000	$190,000,000
Difference DSHP & DSRIP	$2,100,100	$24,600,000	$45,820,000	$59,533,600	$65,364,544

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92. 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

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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.

93. **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.

94. **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

95. **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.

96. **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 78 and 79. 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.

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97. 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.

98. 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 TC basis—by first aggregating the member months of the: (a) Disabled Adults and Children; (b) non-ABD "Classic Adults;" and (c) Aged Medicaid beneficiaries—then multiplying that summed amount by the predetermined per member per month (PMPM) cost (see Table 5 below). The product of the above calculation will provide the state with a single "Total Expenditures" for the demonstration's "Non-Expansion Adults" (NEA) for each DY. The aggregated NEA population's Total Expenditures summed across DYs will represent the budget neutrality limit for the entire 5-year 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 in this section. The federal share will be calculated by multiplying the TC budget neutrality limit by Composite Federal Share, which is defined in STC 101 below. The demonstration expenditures subject to the budget neutrality limit are those reported under STC 79(d).

Table 5: PMPM Expenditure Limits by Demonstration Year

MEG	Trend Rate	DY1 PMPM	DY2 PMPM	DY3 PMPM	DY4 PMPM	DY5 PMPM
Non-Expansion Adults Only	3.3%	$1,012.82	$1,046.24	$1,080.77	$1,116.44	$1,153.28

99. Hypotheticals. Demonstration eligible populations that could have been covered via the Medicaid State Plan, but instead are being implemented using demonstration authority, may be designated "hypotheticals." CMS allows adjustments to the WOW baseline to accommodate costs related to hypotheticals. Separate WOW cost limits are provided for hypothetical costs. Hypothetical costs factor into the overall budget neutrality determination only to the extent that they exceed their separate limits. Hypothetical "savings' may not be used to offset other costs in the overall budget neutrality test. In addition to the expenditures associated with the hypothetical MAC, TSOA and Foundational Community Supports (ACI and ACE) MEGs, the following population/expenditures is also included as hypothetical in the demonstration:

Table 6: Hypothetical Expenditures

a. HepC Rx. Expenditures 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 (pass through) 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 104 below.

b. If expenditures for each hypothetical group exceeds its yearly limits, the excess amounts/"overage" will be subtracted from the overall budget neutrality savings, except in the case of HepC Rx costs.

100. 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.

101. 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

	DY1	DY2	DY3	DY4	DY5
HepC Rx	$131,821,200	$136,171,300	$140,664,952	$145,306,896	$150,102,023
MAC and TSOA[6]	$5,979,600	$19,327,770	$36,832,950	$53,179,830	$57,363,570
Foundational Community Supports 1 & 2	$14,992,000	$33,226,000	$47,238,000	$51,782,000	$53,383,000

pharmacy rebates, by TC demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for extended family planning program must be subtracted from numerator and denominator, respectively, prior to calculation of this ratio. 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.

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

102. Future Adjustments to the Budget Neutrality Expenditure Limit. The budget neutrality expenditure limit may be adjusted by CMS to be consistent with decisions outside of the state Medicaid program's control, including enforcement of impermissible provider payments, state or federal judicial action, health care related taxes, new federal or state statutes, or policy interpretations implemented through letters, memoranda, regulation or other sub-regulatory guidance that impact provision or funding levels for services under this demonstration.

103. 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 104 below). If the state exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified in Table 6 below for any of the demonstration years (DY), the state must submit a corrective action plan to CMS for approval.

Table 6: 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.

104. 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 6 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 99(a), the state will also report expenditures related to HepC Rx.

105. 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 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 available for the state's first Quarterly Progress Report in 2017.

106. 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 101, 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

107. 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.

108. 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.

109. 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?

110. 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.

111. 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.

112. 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.

113. Evaluation Reports.

a. **Interim Evaluation Report.** The state must submit a Draft Interim Evaluation Report 90 calendar days following the completion of DY 4. 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.

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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 34, 35
60 calendar days after approval date	Submit Draft DSHP Claiming Protocol (Attachment B)	STC 92
90 calendar days after approval date	Submit Tribal Engagement and Collaboration Protocol (Attachment H)	STC 24
October 1, 2017 and due on October 1 of each year annually thereafter	Submit Value-Based Roadmap (Original) (Attachment F)	STC 41
120 calendar days after approval date.	Submit Intergovernmental (IGT)Transfer Protocol (Attachment E)	STC 87
60 calendar days after approval date	Submit Financial Executor Role (Attachment G)	STC 27
60 calendar days after approval date	Submit Foundational Community Supports Protocol (Attachment I)	STC 66
Evaluations		
120 calendar days after approval date	Submit Draft Design for Evaluation Report	STC 107
90 calendar days after the completion of DY 4	Submit Draft Interim Evaluation Report	STC 113
60 calendar days after receipt of CMS comments	Submit Final Interim Evaluation Report	STC 113
January 31, 2022	Submit Draft Final Evaluation Report	STC 113
60 calendar days after receipt of CMS comments	Submit Final Evaluation Report	STC 113
Quarterly/Annual/Final Reports		
Quarterly Deliverables due 60 calendar days after end of each quarter, except 4th quarter	Quarterly Progress Reports	STC 74
	Quarterly Expenditure Reports	STC 78

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Annual Deliverables due 120 calendar days after end of each 4th quarter	Annual Reports	STC 76
Annual Budget Neutrality Reports due on or before July 1, 2018 , and on July 1 of each year thereafter	Annual Budget Neutrality Reports	STC 104
Final Report due 120 days after the end of the demonstration	Final Report	STC 77

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1115 Budget Neutrality MEG Blending Development

Historic Data Summary

	SUD IMD User Months			
	CY 2013	CY 2014	CY 2015	CY 2016
Disabled Adults	1,495	1,515	1,223	1,223
Non-Disabled Adults	1,469	1,646	1,515	1,515
Disabled Children	252	145	190	190
Non-Disabled Children	912	1,034	873	873
Newly Eligible		9,908	8,967	8,967
AI/AN FFS	n/a	n/a	n/a	1,952

	Total Medicaid Member Months			
	CY 2013	CY 2014	CY 2015	CY 2016
Disabled Adults	1,524,981	1,486,397	1,472,819	1,472,819
Non-Disabled Adults	2,437,200	2,721,310	2,763,390	2,763,390
Disabled Children	572,053	593,486	604,405	604,405
Non-Disabled Children	8,255,742	8,590,992	9,113,417	9,113,417
Newly Eligible		4,922,334	6,706,708	6,706,708
AI/AN FFS	n/a	n/a	n/a	n/a

	SUD Encounter/FFS PMPMs			SUD Capitation PMPMs
	CY 2013	CY 2014	CY 2015	CY 2016
Disabled Adults	$ 121.52	$ 119.86	$ 118.73	$ 163.43
Non-Disabled Adults	$ 25.03	$ 23.23	$ 24.18	$ 36.41
Disabled Children	$ 68.82	$ 66.19	$ 58.86	$ 101.70
Non-Disabled Children	$ 11.29	$ 10.98	$ 10.50	$ 14.70
Newly Eligible		$ 35.78	$ 32.69	$ 55.57
AI/AN FFS	n/a	n/a	n/a	n/a

	SUD MEG PMPM Blending (Based on SUD IMD User Months Mix)			
	CY 2013	CY 2014	CY 2015	CY 2016
Disabled	$ 113.92	$ 115.18	$ 110.68	$ 155.13
Non-Disabled	$ 19.77	$ 18.50	$ 19.18	$ 28.47
Newly Eligible		$ 35.78	$ 32.69	$ 55.57
AI/AN FFS	n/a	n/a	n/a	n/a

	Acute Care Blended PMPM
Disabled	$ 850.42
Non-Disabled - Child	$ 134.91
Non-Disabled - Adult	$ 301.08
Non-Disabled - Total	$ 240.33
Newly Eligible	$ 360.81

	AI/AN IMD Enrollment / PMPMs	
	IMD User Months	SUD IMD PMPM
CY 2015 (Total IMD Population)	1,262	$ 3,007.80
2H CY 2017 (FFS Opt-Out Only)	1,004	$ 2,623.22
Trend Rate	2.30%	5.40%
CY 2015 Weight for Blending		50.0%
DY 00 (CY 2016) Blended	1,952	$ 2,813.27

1115 Budget Neutrality Historic Data Summary

SUD Historical Spending Data - 5 Years

	Historical Data Period					
Total State Expenditures: Disabled	**CY 2012**	**CY 2013**	**CY 2014**	**CY 2015**	**CY 2016**	**4-YEARS**
TOTAL EXPENDITURES		$ 238,888,126	$ 239,552,358	$ 229,910,427	**$ 322,241,831**	$ 1,030,592,742
ELIGIBLE MEMBER MONTHS		2,097,034	2,079,883	2,077,224	**2,077,224**	8,331,365
PMPM COST		$ 113.92	$ 115.18	$ 110.68	**$ 155.13**	$ 123.70
TREND RATES						
TOTAL EXPENDITURE			0.28%	-4.02%	40.16%	10.50%
ELIGIBLE MEMBER MONTHS			-0.82%	-0.13%	0.00%	-0.30%
PMPM COST			1.10%	-3.90%	40.16%	10.80%

	Historical Data Period					
Total State Expenditures: Non-Disabled	**CY 2012**	**CY 2013**	**CY 2014**	**CY 2015**	**CY 2016**	**4-YEARS**
TOTAL EXPENDITURES		$ 211,399,168	$ 209,321,377	$ 227,784,780	**$ 338,166,141**	$ 986,671,466
ELIGIBLE MEMBER MONTHS		10,692,942	11,312,302	11,876,807	**11,876,807**	45,758,858
PMPM COST		$ 19.77	$ 18.50	$ 19.18	**$ 28.47**	$ 21.56
TREND RATES						
TOTAL EXPENDITURE			-0.98%	8.82%	48.46%	17.00%
ELIGIBLE MEMBER MONTHS			5.79%	4.99%	0.00%	3.60%
PMPM COST			-6.40%	3.65%	48.46%	12.90%

	Historical Data Period					
Total State Expenditures: Newly Eligible	**CY 2012**	**CY 2013**	**CY 2014**	**CY 2015**	**CY 2016**	**3-YEARS**
TOTAL EXPENDITURES			$ 176,135,688	$ 219,233,364	**$ 372,678,291**	$ 768,047,343
ELIGIBLE MEMBER MONTHS			4,922,334	6,706,708	**6,706,708**	18,335,750
PMPM COST			$ 35.78	$ 32.69	**$ 55.57**	$ 41.89
TREND RATES						
TOTAL EXPENDITURE				24.47%	69.99%	45.50%
ELIGIBLE MEMBER MONTHS				36.25%	0.00%	16.70%
PMPM COST				-8.65%	69.99%	24.60%

	Historical Data Period					
Total State Expenditures: AI/AN FFS	**CY 2012**	**CY 2013**	**CY 2014**	**CY 2015**	**CY 2016**	**1-YEAR**
TOTAL EXPENDITURES		n/a	n/a	n/a	**$ 5,490,729**	$ 5,490,729
ELIGIBLE MEMBER MONTHS		n/a	n/a	n/a	**1,952**	1,952
PMPM COST		$ -	$ -	$ -	**$ 2,813.27**	$ 2,813.27
TREND RATES						
TOTAL EXPENDITURE				0.00%	0.00%	n/a
ELIGIBLE MEMBER MONTHS				0.00%	0.00%	n/a
PMPM COST				0.00%	0.00%	n/a

Adjusted CY 2016 Baseline

Medicaid Eligibility Group (MEG)	CY 2016 Estimated Total Expenditures for SUD Medical Assistance Provided in an IMD	Estimated PMPM for All Other non-SUD/IMD Title XIX State Plan Medical Assistance (Acute Care Capitation)	Baseline Eligible Member Months for All Medical Assistance Provided in an IMD	Revised Baseline PMPM Cost
Disabled	$ 322,241,831	$ 850.42	2,077,224	**$ 1,005.55**
Non-Disabled	$ 338,166,141	$ 240.33	11,876,807	**$ 268.80**
Newly Eligible	$ 372,678,291	$ 360.81	6,706,708	**$ 416.38**
AI/AN FFS	$ 5,490,729	$ -	1,952	**$ 2,813.27**
All MEGs	$ 1,038,576,992	$ 340.75	20,662,691	**$ 391.01**

1115 Budget Neutrality Caseload Projections

Projected SUD IMD Member Months/Caseloads

				Caseload Projections by Demonstration Year (DY)				
	Trend Rate	DY 00 SUD IMD User Months	Months of Trend	DY 01	DY 02	DY 03	DY 04	DY 05
Disabled	1.4%	1,432	24		1,472	1,492	1,513	1,534
Non-Disabled	1.3%	2,420	24		2,486	2,519	2,553	2,587
Newly Eligible	2.7%	9,210	24		9,715	9,978	10,248	10,525
AI/AN FFS	2.3%	1,952	24		2,043	2,090	2,138	2,187

1115 Budget Neutrality Projections

Without-Waiver Projections

		BASE YEAR	TREND	DEMONSTRATION YEARS (DY)					TOTAL
		DY 00	RATE	DY 01	DY 02	DY 03	DY 04	DY 05	WOW
Disabled	Eligible Member Months	2,077,224	n.a.		1,472	1,492	1,513	1,534	
Disabled	PMPM Cost	$ 1,005.55	5.1%		$ 1,110.52	$ 1,167.04	$ 1,226.44	$ 1,288.86	
Disabled	Total Expenditure				$ 1,634,685	$ 1,741,224	$ 1,855,604	$ 1,977,111	$ 7,208,624
Non-Disabled	Eligible Member Months	11,876,807	n.a.		2,486	2,519	2,553	2,587	
Non-Disabled	PMPM Cost	$ 268.80	5.0%		$ 296.11	$ 310.79	$ 326.19	$ 342.36	
Non-Disabled	Total Expenditure				$ 736,129	$ 782,880	$ 832,763	$ 885,685	$ 3,237,458
Newly Eligible	Eligible Member Months	6,706,708	n.a.		9,715	9,978	10,248	10,525	
Newly Eligible	PMPM Cost	$ 416.38	5.5%		$ 463.67	$ 489.29	$ 516.33	$ 544.86	
Newly Eligible	Total Expenditure				$ 4,504,554	$ 4,882,136	$ 5,291,350	$ 5,734,652	$ 20,412,691
AI/AN FFS	Eligible Member Months	1,952	n.a.		2,043	2,090	2,138	2,187	
AI/AN FFS	PMPM Cost	$ 2,813.27	5.4%		$ 3,125.30	$ 3,294.07	$ 3,471.95	$ 3,659.44	
AI/AN FFS	Total Expenditure				$ 6,384,988	$ 6,884,606	$ 7,423,029	$ 8,003,195	$ 28,695,819

With-Waiver Projections

		BASE YEAR	TREND	DEMONSTRATION YEARS (DY)					TOTAL
		DY 00	RATE	DY 01	DY 02	DY 03	DY 04	DY 05	WW
Disabled	Eligible Member Months	2,077,224	n.a.		1,472	1,492	1,513	1,534	
Disabled	PMPM Cost	$ 1,005.55	5.1%		$ 1,110.52	$ 1,167.04	$ 1,226.44	$ 1,288.86	
Disabled	Total Expenditure				$ 1,634,685	$ 1,741,224	$ 1,855,604	$ 1,977,111	$ 7,208,624
Non-Disabled	Eligible Member Months	11,876,807	n.a.		2,486	2,519	2,553	2,587	
Non-Disabled	PMPM Cost	$ 268.80	5.0%		$ 296.11	$ 310.79	$ 326.19	$ 342.36	
Non-Disabled	Total Expenditure				$ 736,129	$ 782,880	$ 832,763	$ 885,685	$ 3,237,458
Newly Eligible	Eligible Member Months	6,706,708	n.a.		9,715	9,978	10,248	10,525	
Newly Eligible	PMPM Cost	$ 416.38	5.5%		$ 463.67	$ 489.29	$ 516.33	$ 544.86	
Newly Eligible	Total Expenditure				$ 4,504,554	$ 4,882,136	$ 5,291,350	$ 5,734,652	$ 20,412,691
AI/AN FFS	Eligible Member Months	1,952	n.a.		2,043	2,090	2,138	2,187	
AI/AN FFS	PMPM Cost	$ 2,813.27	5.4%		$ 3,125.30	$ 3,294.07	$ 3,471.95	$ 3,659.44	
AI/AN FFS	Total Expenditure				$ 6,384,988	$ 6,884,606	$ 7,423,029	$ 8,003,195	$ 28,695,819

Appendix D. Substitute Senate Bill 5883

CERTIFICATION OF ENROLLMENT

SUBSTITUTE SENATE BILL 5883

Chapter 1, Laws of 2017

(partial veto)

65th Legislature
2017 3rd Special Session

OPERATING BUDGET

EFFECTIVE DATE: 6/30/2017 -- Except for section 990, which becomes effective June 30, 2019.

Passed by the Senate June 30, 2017
Yeas 39 Nays 10

CYRUS HABIB

President of the Senate

Passed by the House June 30, 2017
Yeas 70 Nays 23

FRANK CHOPP

Speaker of the House of Representatives

Approved June 30, 2017 11:15 PM with the exception of sections 103(4); 136(2); 150(8); 207(12); 213(1)(a), page 108 lines 37-39, through page 109, line 2, beginning with "The administration" and ending with "administrative costs."; 217(1); 217(2); 222(4); 302(2); 610(13); 734; 964(3); and 1213(1), page 455, lines 6-9, which are vetoed.

JAY INSLEE

Governor of the State of Washington

CERTIFICATE

I, Hunter G. Goodman, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **SUBSTITUTE SENATE BILL 5883** as passed by Senate and the House of Representatives on the dates hereon set forth.

HUNTER G. GOODMAN

Secretary

FILED

July 3, 2017

Secretary of State
State of Washington

SUBSTITUTE SENATE BILL 5883

Passed Legislature - 2017 3rd Special Session

State of Washington 65th Legislature 2017 Regular Session

By Senate Ways & Means (originally sponsored by Senator Braun)

READ FIRST TIME 06/30/17.

AN ACT Relating to fiscal matters; amending RCW 19.118.110, 28B.15.210, 28B.15.310, 28B.35.370, 28B.50.360, 28B.95.092, 28B.115.070, 28B.122.050, 28C.04.535, 36.70A.725, 38.52.105, 41.26.450, 41.26.802, 41.60.050, 43.08.190, 43.09.475, 43.41.450, 43.43.839, 43.79.445, 43.79.460, 43.101.220, 43.101.200, 43.330.250, 43.320.110, 50.16.010, 66.08.170, 69.50.540, 70.105D.070, 71.24.580, 74.13.621, 77.12.201, 77.12.203, 79.64.040, 79.64.110, 79.105.150, 79A.80.090, 82.19.040, 82.19.040, 83.100.230, 39.26.200, and 79A.25.210; amending 2013 2nd sp.s. c 15 s 8 (uncodified); amending 2015 c 15 ss 8 and 9 (uncodified); amending 2017 c 313 s 201 (uncodified); amending 2016 sp.s. c 36 ss 112, 113, 114, 117, 119, 118, 120, 121, 124, 125, 127, 128, 130, 131, 132, 134, 135, 136, 137, 139, 141, 143, 147, 148, 149, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 216, 217, 218, 219, 220, 221, 301, 302, 303, 304, 305, 306, 307, 308, 310, 311, 402, 501, 502, 503, 504, 505, 506, 507, 508, 509, 511, 512, 513, 514, 516, 517, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 615, 617, 701, 706, 801, and 804 (uncodified); amending 2015 3rd sp.s. c 4 ss 125, 506, and 703 (uncodified); reenacting and amending RCW 43.155.050 and 43.155.050; adding new sections to 2015 3rd sp.s. c 4 (uncodified); adding a new section to chapter 43.31 RCW; adding a new section to chapter 43.41 RCW; adding a new section to chapter 28B.76 RCW; making

appropriations; providing effective dates; providing an expiration date; and declaring an emergency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** (1) A budget is hereby adopted and, subject to the provisions set forth in the following sections, the several amounts specified in parts I through IX of this act, or so much thereof as shall be sufficient to accomplish the purposes designated, are hereby appropriated and authorized to be incurred for salaries, wages, and other expenses of the agencies and offices of the state and for other specified purposes for the fiscal biennium beginning July 1, 2017, and ending June 30, 2019, except as otherwise provided, out of the several funds of the state hereinafter named.

(2) Unless the context clearly requires otherwise, the definitions in this section apply throughout this act.

(a) "Fiscal year 2018" or "FY 2018" means the fiscal year ending June 30, 2018.

(b) "Fiscal year 2019" or "FY 2019" means the fiscal year ending June 30, 2019.

(c) "FTE" means full time equivalent.

(d) "Lapse" or "revert" means the amount shall return to an unappropriated status.

(e) "Provided solely" means the specified amount may be spent only for the specified purpose. Unless otherwise specifically authorized in this act, any portion of an amount provided solely for a specified purpose which is not expended subject to the specified conditions and limitations to fulfill the specified purpose shall lapse.

PART I
GENERAL GOVERNMENT

NEW SECTION. **Sec. 101. FOR THE HOUSE OF REPRESENTATIVES**

General Fund—State Appropriation (FY 2018). $37,642,000
General Fund—State Appropriation (FY 2019). $39,205,000
Motor Vehicle Account—State Appropriation. $2,011,000
TOTAL APPROPRIATION. $78,858,000

PAGES OMITTED

the governor and the appropriate legislative committees by February 1, 2018, with any recommendations for public policy that increases public safety.

NEW SECTION. **Sec. 204. FOR THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES—MENTAL HEALTH PROGRAM**

(1) COMMUNITY SERVICES/BEHAVIORAL HEALTH ORGANIZATIONS

General Fund—State Appropriation (FY 2018). $391,457,000
General Fund—State Appropriation (FY 2019). $409,108,000
General Fund—Federal Appropriation. $1,021,705,000
General Fund—Private/Local Appropriation. $17,864,000
Dedicated Marijuana Account—State Appropriation
(FY 2018). $3,684,000
Dedicated Marijuana Account—State Appropriation
(FY 2019). $3,684,000
TOTAL APPROPRIATION. $1,847,502,000

The appropriations in this subsection are subject to the following conditions and limitations:

(a) For the purposes of this subsection, amounts provided for behavioral health organizations shall also be available for the health care authority to contract with entities that assume the responsibilities of behavioral health organizations in regions in which the health care authority is purchasing medical and behavioral health services through fully integrated contracts pursuant to RCW 71.24.380.

(b) $6,590,000 of the general fund—state appropriation for fiscal year 2018, $6,590,000 of the general fund—state appropriation for fiscal year 2019, and $7,620,000 of the general fund—federal appropriation are provided solely for the department and behavioral health organizations to continue to contract for implementation of high-intensity programs for assertive community treatment (PACT) teams. In determining the proportion of medicaid and nonmedicaid funding provided to behavioral health organizations with PACT teams, the department shall consider the differences between behavioral health organizations in the percentages of services and other costs associated with the teams that are not reimbursable under medicaid. The department may allow behavioral health organizations which have nonmedicaid reimbursable costs that are higher than the nonmedicaid allocation they receive under this section to supplement these funds

with local dollars or funds received under (g) of this subsection. The department and behavioral health organizations shall maintain consistency with all essential elements of the PACT evidence-based practice model in programs funded under this section.

(c) From the general fund—state appropriations in this subsection, the department shall assure that behavioral health organizations reimburse the department of social and health services aging and long term support administration for the general fund—state cost of medicaid personal care services that enrolled behavioral health organization consumers use because of their psychiatric disability.

(d) $3,520,000 of the general fund—federal appropriation is provided solely for the department to maintain a pilot project to put peer bridging staff into each behavioral health organization as part of the state psychiatric liaison teams to promote continuity of service as individuals return to their communities. The department must collect data and submit a report to the office of financial management and the appropriate committees of the legislature on the impact of peer staff on state hospital discharges and community placements by December 1, 2017.

(e) $6,858,000 of the general fund—state appropriation for fiscal year 2019 and $4,023,000 of the general fund—federal appropriation are provided solely for new crisis triage or stabilization centers. The department must seek proposals from behavioral health organizations for the use of these funds based on regional priorities. Services in these facilities may include crisis stabilization and intervention, individual counseling, peer support, medication management, education, and referral assistance. The department shall monitor each center's effectiveness at lowering the rate of state psychiatric hospital admissions.

(f) $15,862,000 of the general fund—state appropriation for fiscal year 2018 is provided solely to assist behavioral health organizations with the costs of providing services to medicaid clients receiving services in psychiatric facilities classified as institutions of mental diseases. The department must distribute these amounts proportionate to the number of bed days for medicaid clients in institutions for mental diseases that were excluded from behavioral health organization fiscal year 2018 capitation rates because they exceeded the amounts allowed under federal regulations.

The department must also use these amounts to directly pay for costs that are ineligible for medicaid reimbursement in institutions of mental disease facilities for American Indian and Alaska Natives who opt to receive behavioral health services on a fee for service basis. The amounts used for these individuals must be reduced from the allocation of the behavioral health organization where the individual resides. If a behavioral health organization receives more funding through this subsection than is needed to pay for the cost of their medicaid clients in institutions for mental diseases, they must use the remainder of the amounts to provide other services not covered under the medicaid program. The department must apply for a waiver from the center for medicaid and medicare services to allow for the full cost of stays in institutions of mental diseases to be included in fiscal year 2019 behavioral health organization capitation rates. The department must submit a report on the status of the waiver to the office of financial management and the appropriate committees of the legislature by December 1, 2017.

(g) $81,930,000 of the general fund—state appropriation for fiscal year 2018 and $81,930,000 of the general fund—state appropriation for fiscal year 2019 are provided solely for persons and services not covered by the medicaid program. To the extent possible, levels of behavioral health organization spending shall be maintained in the following priority order: Crisis and commitment services; community inpatient services; and residential care services, including personal care and emergency housing assistance. These amounts must be distributed to behavioral health organizations proportionate to the fiscal year 2017 allocation of flexible nonmedicaid funds. The department must include the following language in medicaid contracts with behavioral health organizations unless they are provided formal notification from the center for medicaid and medicare services that the language will result in the loss of federal medicaid participation: "The contractor may voluntarily provide services that are in addition to those covered under the state plan, although the cost of these services cannot be included when determining payment rates unless including these costs are specifically allowed under federal law or an approved waiver."

(h) The department is authorized to continue to contract directly, rather than through contracts with behavioral health organizations for children's long-term inpatient facility services.

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is not enacted by July 31, 2017, the amount provided in this subsection shall lapse.

(4) $81,000 of the general fund—state appropriation for fiscal year 2018, $86,000 of the general fund—state appropriation for fiscal year 2019, and $167,000 of the general fund—federal appropriation are provided solely for the implementation of an agreement reached between the governor and the Washington federation of state employees for the language access providers under the provisions of chapter 41.56 RCW for the 2017-2019 fiscal biennium. Funding is contingent upon the enactment of Senate Bill No. 5969 (transparency in public employee collective bargaining). If the bill is not enacted by July 31, 2017, the amounts provided is this subsection shall lapse.

NEW SECTION. **Sec. 212. FOR THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES—PAYMENTS TO OTHER AGENCIES PROGRAM**

General Fund—State Appropriation (FY 2018). $81,319,000
General Fund—State Appropriation (FY 2019). $43,380,000
General Fund—Federal Appropriation. $57,578,000
TOTAL APPROPRIATION. $182,277,000

The appropriations in this section are subject to the following conditions and limitations:

(1) $39,000 of the general fund—state appropriation for fiscal year 2018 and $11,000 of the general fund—federal appropriation are provided solely for the implementation of Engrossed Second Substitute House Bill No. 1661 (child, youth, families department). If the bill is not enacted by July 31, 2017, the amounts provided in this subsection shall lapse.

(2) $12,000 of the general fund—state appropriation for fiscal year 2018, $12,000 of the general fund—state appropriation for fiscal year 2019, and $24,000 of the general fund—federal appropriation are provided solely for the implementation of chapter 268, Laws of 2017 (2SHB 1402) (incapacitated persons/rights).

*NEW SECTION. **Sec. 213. FOR THE STATE HEALTH CARE AUTHORITY**

During the 2017-2019 fiscal biennium, the health care authority shall provide support and data as required by the office of the state actuary in providing the legislature with health care actuarial analysis, including providing any information in the possession of the health care authority or available to the health care authority

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individuals with treatment providers in the community upon their release.

(rr) $6,487,000 of the general fund—state appropriation for fiscal year 2018 and $1,340,000 of the general fund—state appropriation for fiscal year 2019 are provided solely for the physical health care costs of medicaid clients receiving services in facilities classified as institutions for mental diseases for longer than 15 days in a calendar month. The authority must apply for a waiver from the center for medicare and medicaid services to allow for the full cost of stays in institutions for mental diseases to be included in managed care rates beginning on July 1, 2018. The authority must submit a report on the status of the waiver to the office of financial management and the appropriate committees of the legislature by December 1, 2017.

(ss) The authority shall evaluate adding a tele-pyschiatry consultation benefit for medicaid covered individuals. The authority shall submit a report with the cost associated with adding such a benefit to the governor and appropriate committees of the legislature by October 1, 2017.

(tt) $33,000 of the general fund—state appropriation for fiscal year 2018, $7,000 of the state health care authority administrative account—state appropriation, and $42,000 of the general fund—federal appropriation are provided solely for the bleeding disorder collaborative for care.

(uu) $304,000 of the general fund—state appropriation for fiscal year 2018, $304,000 of the general fund—state appropriation for fiscal year 2019, and $608,000 of the general fund—federal appropriation are provided solely for the authority to contract with the University of Washington tele-pain pain management program and pain management call center to advance primary care provider knowledge of complex pain management issues, including opioid addiction.

(vv) $165,000 of the general fund—state appropriation for fiscal year 2018, $329,000 of the general fund—state appropriation for fiscal year 2019, and $604,000 of the general fund—federal appropriation are provided solely for implementation of chapter 202, Laws of 2017 (Engrossed Second Substitute House Bill No. 1713) (children's mental health).

Appendix E. Notice for public comment

Having trouble viewing this email? View it as a Web page.

On January 9, 2017, Washington State received federal approval of its request for a Section 1115 demonstration waiver, the Medicaid Transformation Project Demonstration.

Washington State is requesting an amendment to the waiver to include the following:

- The state is requesting expenditure authority to claim Federal Financial Participation (FFP) for services provided to Medicaid beneficiaries aged 21-64 who receive inpatient services in a Substance Use Disorder (SUD) Institution for Mental Disease (IMD); and
- The state is requesting corrections to the Special Terms and Conditions to ensure the terms accurately reflect the agreement between the state and CMS.

The Health Care Authority is seeking public comment through February 2, 2018. To submit your feedback, email medicaidtransformation@hca.wa.gov.

For more information about the waiver amendment, visit the Healthier Washington Medicaid transformation page.

About Healthier Washington

Healthier Washington is a multi-sector partnership to transform the health care system. The result: Better health, better care, and lower costs. Our initiatives advance whole-person health, focus on paying for value rather than volume of health care services, and take a community-centered approach to care.

Please do not reply directly to this message. If you have feedback or questions, please visit the Healthier Washington website.

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Washington State Health Care Authority

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Washington State Health Care Authority · 626 8th Avenue SE · Olympia, WA 98501

GOVDELIVERY

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January 29, 2018

Reminder: Section 1115 waiver amendment open for public comment

On January 9, 2017, Washington State received federal approval of its request for a Section 1115 waiver, the Healthier Washington Medicaid Transformation.

Washington State is requesting an amendment to the waiver to include the following:

- The state is requesting expenditure authority to claim federal financial participation for services provided to Medicaid beneficiaries, aged 21-64, who receive inpatient services in a substance use disorder institution for mental disease.
- The state is requesting corrections to the Special Terms and Conditions to ensure the terms accurately reflect the agreement between the state and the Centers for Medicare and Medicaid Services.

Read the Section 1115 waiver amendment draft. The document can also be found on the Medicaid transformation web page, under New Resources.

The public comment period has been extended through Monday, February 5, 2018.

Email your feedback on the waiver amendment: medicaidtransformation@hca.wa.gov.

For more information about Medicaid Transformation and the waiver amendment, visit the Healthier Washington Medicaid Transformation website.

About Healthier Washington

Healthier Washington is a multi-sector partnership to transform the health care system. The result: Better health, better care, and lower costs. Our initiatives advance whole-person health, focus on paying for value rather than volume of health care services, and take a community-centered approach to care.

Please do not reply directly to this message. If you have feedback or questions, please visit the Healthier Washington website.

Disclosure notice

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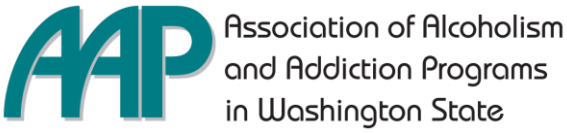


Email transmission to: medicaidtransformation@hca.wa.gov

February 1, 2018

To: Washington Health Care Authority

RE: **Requested amendment to "WA Medicaid Transformation Project Demonstration" Section 1115 Waiver**

The Washington Association of Alcoholism & Addictions Programs fully supports the proposed amendment to the 1115 waiver, which will help increase access to substance use disorder care. In Washington State nearly 80% of public sector patients present with opioid use disorder. 10,000 individuals have died of heroin and opiate prescription overdose in the past decade, and deaths are increasing exponentially in the current opiate crisis.

To save lives this State needs have immediate access to the appropriate levels of treatment. The IMD Exclusion, limiting Medicaid funds to the few small facilities in this state, only exacerbates the crisis. Removal of this IMD Exclusion is an essential health policy and the introduction of many various bills in Congress to remove it indicate the increasing awareness of the urgency of removing this.

This waiver is timely and critical. Because most of the residential capacity in Washington State was developed in facilities with more than 16 beds, the IMD exclusion makes this critical level of care unavailable to most Medicaid recipients. The opioid crisis is killing daily dozens of young people in this state and we must take immediate action to utilize existing residential facilities to address this epidemic.

Waiving this IMD exclusion will save lives, improve capacity, improve quality of care and save dollars. Small facilities are more costly to operate and tend to be limited in their ability to offer specialized services because of the small staffing.

Substance use disorder is treatable--much data exists on the cost savings obtained through treatment. It is good public policy to expand access through removing institutional barriers such as the IMD Exclusion. We commend the Health Care Authority for pursuing this critical SUD waiver amendment and offer any support we can lend.

Sincerely,

ASSOCIATION OF ALCOHOLISM & ADDICTIONS PROGRAMS IN WASHINGTON STATE (AAP)
By:

Jared Sanford,	Christine Lynch	Linda Grant	Scott Munson
Lifeline Connections	Olalla Recovery Centers	Evergreen Recover Centers	Sundown M Ranch
AAP President	AAP Vice President	AAP Secretary	AAP Treasurer

February 2, 2018

To: Washington Health Care Authority

RE: Requested amendment to "WA Medicaid Transformation Project Demonstration" Section 1115 Waiver

As an IMD residential provider, Seattle Drug and Narcotic Center, Inc., "Seadrunar", fully supports the proposed amendment to the 1115 waiver, which will help increase access to substance use disorder care. Access to care in conjunction with access to full continuum of care is a must to provide assistance to the nearly 80% public sector Washington State patients presenting an opioid use disorder. Without access to care, this will increase the opioid deaths and opiate prescription overdoses in the current opiate crisis.

To save lives, this State needs allow individuals to have immediate access to the **appropriate** levels of treatment. Barriers such as the IMD exclusion and limiting Medicaid funds to specialized facilities in this state, only exacerbates the crisis. It is essential to fight this crisis.

This waiver is timely and critical. Because most of the residential capacity in Washington State was developed in facilities with more than 16 beds, like ours, the IMD exclusion makes this critical level of care unavailable to most Medicaid recipients. Why? The State Block Grant can't financially support it. The opioid crisis is killing dozens of young people in this state daily and we must take immediate action to utilize existing residential facilities to address this epidemic.

Waiving this IMD exclusion will save lives, improve capacity, improve quality of care and save dollars. Small facilities are more costly to operate and tend to be limited in their ability to offer specialized services because of the small staffing.

Substance use disorders are treatable. Data exists on the cost savings obtained through treatment. Public policy will benefit to expand access through removing institutional barriers such as the IMD exclusion. We commend the Health Care Authority for pursing this critical SUD waiver amendment and offer any support necessary.

Sincerely,

Sheri Healey

Sheri Healey
Executive Director
Seadrunar
Seattle Drug & Narcotic Center, Inc. (est. 1968)

600 Stewart Street, Suite 202 | Seattle, Washington 98101
P 206 628 4608 | F 206 448 2448 | thewashingtoncouncil.org

WASHINGTON COUNCIL
FOR BEHAVIORAL HEALTH

February 2, 2018

Sue Birch, Director
Washington State Health Care Authority
626 8th Avenue SE
Olympia, WA 98501

Dear Director Birch:

I write today on behalf of the Washington Council for Behavioral Health to offer comments on the Authority's request for a section 1115 waiver amendment allowing the state to claim Federal financial participation (FFP) for substance use disorder services provided to Medicaid beneficiaries in an institution for mental disease (IMD). The Council is the professional association of licensed community behavioral health agencies. Our more than 40 member agencies provide a range of mental health and substance use disorder treatment services across the state.

The state has set forth several proposed milestones to ensure success in the waiver amendment.

- **Milestone 3(a):** This milestone notes that an agency providing substance use disorder (SUD) residential treatment services must ensure all SUD assessment and counseling services are provided by a chemical dependency professional (CDP), or a CDP trainee (CDPT) under the supervision of an approved supervisor. Currently, the Washington State Department of Health is proposing a 31 percent increase in the license application and renewal fees for CDPs. Any remediation of this proposed increase would aid in recruiting and retaining qualified people into this vitally needed profession.

- **Milestone 4:** This milestone requires the completion of an assessment of the availability of providers enrolled in Medicaid and accepting new patients in critical levels of care, including medication assisted treatment (MAT). The Council is supportive of this milestone, however, we would like to reiterate the importance of the definition of "provider" in this context as meaning agencies rather than individual providers working in agencies.

- **Milestone 5a:** This milestone includes the use of the Prescription Monitoring Program (PMP), a tool allowing prescribers to access their patient's prescription history and notifying them of an overdose event. Though individual prescribers may receive this information, facilities without a Department of Health (DOH) license are unable to access this information on an organization-wide level. Many community behavioral health and SUD agencies solely have Department of Social and Health Services licensure. Though there have been recent legislative efforts moving

this licensing responsibility to DOH and thus allowing these agencies full access to the PMP, none have succeeded as yet. We are hopeful that a solution to this issue will be found either legislatively or via executive action from the state. The data obtained from expanded PMP access would result in both improved treatment plans for patients and better data collection abilities for agencies and the state.

The Council is glad to see the state is taking action to address the growing opioid crisis via the Medicaid Transformation Demonstration. We believe that the added ability to claim FFP for SUD treatment for Medicaid beneficiaries in IMDs will not only expand the ability of providers to offer such treatments, it will benefit patients with co-occurring mental health and substance use disorder issues already receiving treatment in IMDs. Please feel free to contact me with any questions.

Sincerely,

Michael F. Hatchett
Policy Analyst

February 5, 2018

Medicaid Transformation Team
Washington State Health Care Authority
626 8th Ave SE
Olympia, WA 98501

RE: Feedback on the 1115 Medicaid Demonstration STC Amendment Request

Dear Medicaid Transformation Team:

Thank you for this opportunity to provide feedback on the 1115 Medicaid Demonstration STC Amendment request. We appreciate ongoing opportunities to engage with the Health Care Authority as it continues implementation of the waiver.

Appendix A. Substance Use Disorder Milestones – Milestone 1
Milestone 1 indicates that the state ensures sufficient coverage by contractually requiring network adequacy for services from the BHO/MCO, defined as meeting 90% of the needs of Medicaid beneficiaries. How is HCA planning to enforce network adequacy requirements? As the state moves towards Fully Integrated Managed Care by 2020, the trend has been reducing the number of plans available in the FIMC regions, which may lead to reduced access to providers for Medicaid Managed Care enrollees in that region. How is HCA going to ensure that Medicaid enrollees continue to have access to necessary services?

Further, Milestone 1 refers to "nine BHOs and one MCO." This is no longer accurate with North Central's implementation of FIMC in January 2018, there are now eight BHOs and four plans with BH responsibility in one or both of the two FIMC regions in the state. Please update to accurately capture the state's current situation.

Thank you very much for your consideration of our comments. Please feel free to contact us with any questions about this document or other issues regarding ACHs and the Medicaid Demonstration.

Sincerely,

/s/
Huma Zarif
Staff Attorney
206-325-6464 ext. 11

Appendix G. Tribal notification letter

STATE OF WASHINGTON

HEALTH CARE AUTHORITY

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

November 21, 2017

Dear Tribal Leader:

SUBJECT: Tribal Roundtables and Consultation on Amendments to the Section 1115 Demonstration Waiver and the Section 1915(b) Behavioral Health Waiver

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

To ensure timely notification with the upcoming holidays, the agency and DSHS have scheduled two Tribal Roundtables followed by a Tribal Consultation on the following dates and times:

Meeting	Date	Time	Location Webinar Registration URL
Roundtable #1	December 6, 2017	10:00–Noon	Apple Conference Room, Cherry Street Plaza 626 - 8th Ave. SE, Olympia, WA (during the second and third hours of the HCA Monthly Tribal Meeting) *https://attendee.gotowebinar.com/register/3709015944847816449*
Roundtable #2	January 8, 2018	1:00–3:00 PM	Sue Crystal Conference Center, Cherry Street Plaza 626 - 8th Ave. SE, Olympia, WA *https://attendee.gotowebinar.com/register/4001657562264399363*
Consultation	January 22, 2018	1:00–3:00 PM	Sue Crystal Conference Center, Cherry Street Plaza 626 - 8th Ave. SE, Olympia, WA *https://attendee.gotowebinar.com/register/5664138934671123971*

For those who cannot attend in person, we are offering webinar access (registration links for each meeting are provided above). Even if you wish to participate by phone (without the webinar), please register for the webinar – you will receive a phone number after registration.

Purpose
The agency and DSHS intend to submit amendments to the Section 1115 demonstration waiver and/or the Section 1915b behavioral health waiver to authorize the state:

1. To use Medicaid funds to pay for services to individuals receiving residential substance use disorder (SUD) treatment in an Institute for Mental Diseases (IMD) for more than 15 days during a month. An IMD is a facility with more than 16 beds that primarily provides behavioral health services.

2. To use Medicaid funds to pay for services to individuals receiving residential mental health treatment in an IMD for more than 15 days during a month.

3. To make clarifying corrections to the Special Terms and Conditions (STCs) of the Section 1115 demonstration waiver that were initially approved by CMS on January 9, 2017.

Waiver amendment(s) related to IMDs
Previously the state was able, through the Section 1915(b) behavioral health waiver, to use Medicaid funds to purchase managed care services in IMD facilities. A federal rule change effective July 1, 2017, now limits the use of Medicaid funds to IMD services that are 15 days or less. Senate Bill 5883, enacted during the 2017 legislative session, directs the agency to apply for a federal waiver that would authorize the state to use Medicaid funds for the full cost of treatment in IMDs, effective July 1, 2018.

For residential SUD treatments in IMDs, the agency and DSHS will request an amendment to the Section 1115 demonstration waiver to authorize the state to use federal funds in both the Medicaid managed care and fee-for-service (FFS) programs. The proposed effective date for this amendment is July 1, 2018.

For mental health treatments in IMDs, the agency and DSHS are exploring with the Centers for Medicare and Medicaid Services (CMS) whether to request an amendment to the Section 1115 demonstration waiver or an amendment to the Section 1915(b) behavioral health waiver. The approach of amending the Section 1915(b) behavioral health waiver would authorize the state to use federal funds only in Medicaid managed care programs, whereas amending the Section 1115 demonstration waiver would authorize the state to use federal funds in both the Medicaid managed care and FFS programs. However, the agency is not likely to meet the budget neutrality requirements for an amendment to the Section 1115 demonstration waiver. The agency and DSHS anticipate making a final decision by the end of November 2017 about which waiver authority to pursue for that request. The proposed effective date for this amendment is July 1, 2018.

Clarifying Corrections to the Section 1115 Demonstration Waiver
The agency requested that CMS issue technical corrections to the STCs of the Section 1115 demonstration waiver. The technical corrections would ensure that the STCs accurately reflect the approval of the demonstration. CMS was unable to accept a number of the technical correction requests because the requests were more comprehensive than is acceptable for a

technical correction. As a result, the agency and DSHS will request an amendment to implement these clarifying corrections. The proposed effective date for this amendment is July 1, 2018.

Anticipated Impact on Indians/Indian Health Programs/Urban Indian Health Organizations

The proposed amendments related to IMDs could have an impact specific to American Indian/Alaska Native (AI/AN) Medicaid beneficiaries. Under current Medicaid authority, the state may use Medicaid funds to pay for up to 15 days in an IMD if the person has Medicaid coverage in the managed care program. In July 2017, the state implemented full-scope behavioral health coverage in the Medicaid FFS program. If the person has Medicaid coverage in the FFS program, no federal funds may be used for treatments in IMDs. The previous exception under the Section 1915b behavioral health waiver did not allow for Medicaid funds to pay for services covered in the FFS program either, because that exception was available only to the managed care program. With these waiver amendment(s), the agency and DSHS are requesting the authority to use Medicaid funds to pay for treatments in IMD facilities for all beneficiaries, whether their coverage is in the Medicaid managed care program or Medicaid FFS program.

The proposed amendment for technical corrections to the STCs of the Section 1115 demonstration waiver is not anticipated to have an impact specific to American Indian/Alaska Native (AI/AN) Medicaid beneficiaries. The corrections are intended to clarify original intent of select terms and conditions. The agency and DSHS are not requesting language changes that will have an impact on implementation of any of the three demonstration initiatives.

Copy Available on Request

The agency and DSHS are in the process of completing the draft waiver amendments. A copy will be distributed to Tribal representatives as soon as it becomes available and no later than during Tribal Roundtable #2.

Comments and Questions

The agency and DSHS would appreciate any input or concerns that Tribal representatives wish to share regarding these waiver amendments. To request a copy of the draft waiver amendments or return any comments:

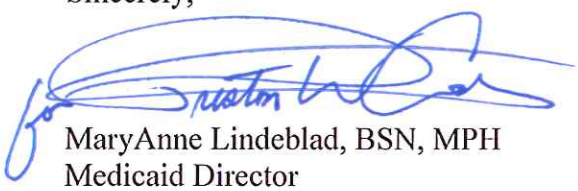
- For the IMD-related waiver amendments, please contact Richard VanCleave, Federal Programs Manager, by telephone at 360-725-3703 or via email at vanclrl@dshs.wa.gov by December 20, 2017.

- For the waiver amendment with the clarifying corrections to the STCs of the Section 1115 demonstration waiver, please contact Kali Klein, Medicaid Transformation Manager, by telephone at 360-725-1240 or via email at kali.klein@hca.wa.gov by December 20, 2017.

Please contact Jessie Dean, Administrator, Tribal Affairs and Analysis, by telephone at 360-725-1649 or via email at jessie.dean@hca.wa.gov if you would like to request formal consultation or have tribal affairs-related questions.

Please forward this information to any interested party.

Sincerely,



MaryAnne Lindeblad, BSN, MPH
Medicaid Director

cc: Chris Imhoff, Director, DBHR, BHA, DSHS
Melena Thompson, Office Chief, Federal Programs, DBHR, BHA, DSHS
Richard VanCleave, Federal Programs Manager, DBHR, BHA, DSHS
Jessie Dean, Administrator, Tribal Affairs and Analysis, EXO, HCA
Kali Klein, Medicaid Transformation Manager, PD, HCA
Ann Myers, State Plan Coordinator, DLS, HCA

Myers, Ann (HCA)

From: Lougheed, Amber (HCA)
Sent: Wednesday, November 22, 2017 8:37 AM
To: Myers, Ann (HCA)
Subject: FW: Tribal Roundtable & Consultation on 1115 & 1915(b) Waiver Amendments Notice
Attachments: TribalRoundtables+ConsultationRe1115+ 1915bWaiverAmendmentsTribalLetter11-21-17.pdf

This notice was distributed to the following: 'jenny@BetterHealthTogether.org'; 'lisarey@olympicch.org'; Erb, Heather (DOHi) <heather@erblawfirm.com>; Gamble, Cynthia (DOHi) <csgamble5@gmail.com>; 'aihc.general.delivery@outlook.com'; 'Olmstead, Jan (DOHi) (janolmstead@gmail.com)'; Schmitz, Lou (DOHi) <lou.schmitz.AIHC@outlook.com>; Charlene Abrahamson <cabrahamson@chehalistribe.org>; 'chairman@chehalistribe.org'; Walker, Denise (DOHi) <dwalker@chehalistribe.org>; 'hhancock@bmc.portland.ihs.gov'; 'trhuby@bmc.portland.ihs.gov'; 'cway@bmc.portland.ihs.gov'; 'jrowland@bmc.portland.ihs.gov'; Desautel, Alexandria (DOHi) <Ali.desautel@colvilletribes.com>; 'nancy.johnson@colvilletribes.com'; 'michael.marchand@colvilletribes.com'; Cawston, Coleen (DOHi) <colleen.cawston@ihs.gov>; Culbertson, Kay (DOHi) <kculbertson@cowlitz.org>; 'wiyall@cowlitz.org'; Kutz, Stephen (DOHi) <skutz.health@cowlitz.org>; Sherrill, James (DOHi) <jsherrill.health@cowlitz.org>; 'rhonda.martinez-mcfarland@cms.hhs.gov'; Lowe, Sheryl (DOH) <sheryl.lowe@doh.wa.gov>; Bobba, Marietta (DSHS/ALTSA) <BobbaM@dshs.wa.gov>; Dahl, Ann <DahlA@dshs.wa.gov>; Mena Tyree, Sandra (DSHS/BHA/MH) <MenaSA@dshs.wa.gov>; 'lucilla.mendoza@dshs.wa.gov'; Bond, Jaime (DSHS/DDA) <BondJL@dshs.wa.gov>; Eliason, Mark R. (DSHS/DDA) <EliasMR@dshs.wa.gov>; Hakim, Saif (DSHS/DDA) <HakimSS@DSHS.WA.GOV>; Manion, Shannon (DSHS/DDA) <ManioSK@dshs.wa.gov>; Pettersen, Mick M (DSHS/DDA) <PetteMM@dshs.wa.gov>; Roberts, Debbie (DSHS/DDA) <roberdx@dshs.wa.gov>; Weedin, Charles (DSHS/DDA) <Weedict@dshs.wa.gov>; Rossnagle, Brady <RossnBX@dshs.wa.gov>; Collins, Tim (DSHS/OIP) <collitj@dshs.wa.gov>; Francis-Thomas, Brenda D (DSHS/OIP) <francbd@dshs.wa.gov>; 'leah.muasau@dshs.wa.gov'; Bill, Craig (GOIA) <cbill@goia.wa.gov>; Hurtado, Mystique (GOIA) <MHurtad@goia.wa.gov>; 'deborah.sosa@wahbexchange.org'; Podszus, Rebecca (HCA) <rebecca.podszus@hca.wa.gov>; 'reyn.leno@grandronde.org'; 'rebeccac@healinglodge.org'; Ashue, Melvinjohn (DOHi) <e.d@hohtribe-nsn.org>; 'marial@hohtribe-nsn.org'; 'David.Battese@ihs.gov'; 'terry.dean@ihs.gov'; 'Peggy.Ollgaard@ihs.gov'; 'Seyler, Dean (DOHi) (dean.seyler@ihs.gov)' <Dean.Seyler@ihs.gov>; 'brad@indigenouspact.com'; 'kurt@indigenouspact.com'; 'julie@indigenouspact.com'; 'bob@indigenouspact.com'; Allen, Ron <rallen@jamestowntribe.org>; 'lgreninger@jamestowntribe.org'; Liz Mueller <lmueller@jamestowntribe.org>; Simcosky, Brent (DOHi) <bsimcosky@jamestowntribe.org>; 'kgeorge@camashealth.com'; Guzman, Lisa (DOHi) <lguzman@camashealth.com>; 'gnenema@kalispeltribe.com'; Poplawski, Ron (DOHi) <rpoplawski@camashealth.com>; 'frances.charles@elwha.nsn.us'; Colby, Lance (DOHi) <lance.colby@elwha.org>; 'timothyb@lummi-nsn.gov'; 'NikkiF@lummi-nsn.gov'; 'nickolausl@lummi-nsn.gov'; 'EvanM@lummi-nsn.gov'; Smith, Veronica (DOHi) <veronicas@lummi-nsn.gov>; Anderson, Patrick (DOHi) <Patrick.anderson@ihs.gov>; 'john.miller@makah.com'; 'nate.tyler@makah.com'; 'Mick.Clarke@Muckleshoot-Health.Com'; 'virginia.cross@muckleshoot.nsn.us'; 'Kat.Goodwin@Muckleshoot-health.com'; 'narajam@aol.com'; 'tlodge@nativeproject.org'; MacPherson, Vinetta (DOHi) <vmacpherson@nativeproject.org>; 'mrosette@nativeproject.org'; 'NPTEC@nezperce.org'; 'jeniferw@nimiipuu.org'; 'tinab@nimiipuu.org'; 'frazier.allen@nisqually-nsn.gov'; 'mccloud.farron@nisqually-nsn.gov'; Phillips, Samantha (DOHi) <samantha.phillips@nisquallyhealth.org>; Wells, Lisa (DOHi) <lisa.wells@nisquallyhealth.org>; Johnson, Lona (DOHi) <ljohnson@nooksack-nsn.gov>; 'bkelly@nooksack-nsn.gov'; Barbara Juarez <barbara@indianhealthboard.org>; Finkbonner, Joe (DOHi) <jfinkbonner@npaihb.org>; 'lplatero@npaihb.org'; Dixon, Karol (DOHi) <karold@pgst.nsn.us>; Powell, Kerstin (DOHi) <kerstin@pgst.nsn.us>; 'jeromys@pgst.nsn.us'; LaPointe, Jennifer (DOHi) <Jenniferl@eptha.com>; 'bill.sterud@puyalluptribe.com'; 'lwhitaker@eptha.com'; 'andrew.shogren@quileutenation.org'; 'chas.woodruff@quileutenation.org'; 'pballer@quinault.org'; Brown, Aliza (DOHi) <abrown@quinault.org>; 'afabini@quinault.org'; 'fsharp@quinault.org'; 'LWatanabe@eptha.com'; 'jliantonio@samishtribe.nsn.us'; Matthews, Dana (DOHi) <dmatthews@samishtribe.nsn.us>;

'tomwooten@samishtribe.nsn.us'; 'njoseph@sauk-suiattle.com'; Metcalf, Rhonda (DOHi) <rmetcalf@sauk-suiattle.com>; 'lizh@sihb.org'; Lucero, Esther (DOHi) <estherl@sihb.org>; Sparcks, Aren (DOHi) <arens@uihi.org>; 'crystalt@sihb.org'; 'cnelson@shoalwaterbay-nsn.gov'; Zillett Harris, Kim (DOHi) <kzillyett@shoalwaterbay-nsn.gov>; 'mblakesley@skokomish.org'; Fox, Ed (DOHi) <efox@skokomish.org>; 'gmiller@skokomish.org'; 'leahn@skokomish.org'; Jack-Lynn Smith <jsmith@skokomish.org>; 'sunny.clear@snoqualmietribe.us'; 'catherine.fackrell@snoqualmietribe.us'; 'julie.reed@snoqualmietribe.us'; 'lynette.thorlakson@snoqualmietribe.us'; Colvin, Tawhnee (DOHi) <tawhneec@spokanetribe.com>; 'carole@spokanetribe.com'; Martinez, Marcus (DOHi) <marcus.martinez@ihs.gov>; 'acooper@squaxin.us'; Sanchez, Bonnie (DOHi) <bsanchez@squaxin.us>; Collins, Kevin (DOHi) <kcollins@stillaguamish.com>; 'syanity@stillaguamish.com'; 'adonovan@suquamish.nsn.us'; 'lforsman@suquamish.nsn.us'; Hoffman, Barbara (DOHi) <bhoffman@suquamish.nsn.us>; 'rjones@suquamish.nsn.us'; 'bcladoosby@swinomish.nsn.us'; Rasar, Cheryl (DOHi) <crasar@swinomish.nsn.us>; Stephens, John (DOHi) <jstephens@swinomish.nsn.us>; 'hfenrich@tulalipmail.com'; Steinruck, Jim (DOHi) <jsteinruck@tulaliptribes-nsn.gov>; 'jenniferwilliams@tulaliptribes-nsn.gov'; 'mzackuse@tulaliptribes-nsn.gov'; 'garyburke@ctuir.org'; 'lindahettinga@yellowhawk.org'; 'sandrasampson@yellowhawk.org'; Phelps, Stacy (DOHi) <stacyp@upperskagit.com>; Scott, Marilyn (DOHi) <marilyns@upperskagit.com>; 'Jenniferw@upperskagit.com'; 'dpvyvyan@outlook.com'; 'jravin@wacmhc.org'; 'austin.greene@wstribes.org'; 'jode@yakama.com'; 'bnason@yakama.com'; 'ksaluskin@yakama.com'; Sampson, Jay (DOHi) <jay.sampson@ihs.gov>; 'rjones@suquamish.nsn.us'; Barcus, Wendy (HCA) <Wendy.Barcus@hca.wa.gov>; Banker, Candy (DSHS) <BankeBR@dshs.wa.gov>; 'bedelld@dshs.wa.gov'; 'ctam300@dshs.wa.gov'; Crewdson, Amy <Amy.Crewdson@ColumbiaLegal.org>; 'daniel@nohla.org'; Geiger, Barbara (DSHS/CA) <GeigeBL@dshs.wa.gov>; Grayum, Jenny E (DSHS) <GrayuJE@dshs.wa.gov>; Knudsen, Kristi (DSHS/ALTSA) <KnudsKL@dshs.wa.gov>; 'kristi.knudsen@dshs.wa.gov'; Koptur, Nancy (DSHS/DCS) <koptun@dshs.wa.gov>; 'bill.moss@dshs.wa.gov'; 'luannem@nwjustice.org'; Thompson, Tami (DOH) <tami.thompson@doh.wa.gov>; 'janet@nohla.org'; 'ann@nohla.org'; Weiher, Heather E. (HCA) <heather.weiher@hca.wa.gov>; Yanagida, Lisa (DSHS/ALTSA) <Yanagln2@dshs.wa.gov>

From: Lougheed, Amber (HCA)
Sent: Wednesday, November 22, 2017 8:23 AM
Cc: Dean, Jessie M. (HCA) <jessie.dean@hca.wa.gov>; Collins, Tim (DSHS/OIP) <collitj@dshs.wa.gov>; VanCleave, Richard L. (DSHS/BHA) <vanclrl@dshs.wa.gov>; Thompson, Melena L. (DSHS/BHA/MH) <thompml2@dshs.wa.gov>; Imhoff, Chris (DSHS/BHA/CD) <ImhofC@dshs.wa.gov>; Myers, Ann (HCA) <ann.myers@hca.wa.gov>; Klein, Kali A (HCA) <kali.klein@hca.wa.gov>
Subject: Tribal Roundtable & Consultation on 1115 & 1915(b) Waiver Amendments Notice

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

To ensure timely notification with the upcoming holidays, the agency and DSHS have scheduled two Tribal Roundtables followed by a Tribal Consultation on the following dates and times:

Meeting	Date	Time	Location Webinar Registration URL
Roundtable #1	December 6, 2017	10:00–Noon	Apple Conference Room, Cherry Street Plaza 626 - 8th Ave. SE, Olympia, WA (during the second and third hours of the HCA Monthly Tribal Meeting) *https://attendee.gotowebinar.com/register/3709015944847816449*
Roundtable #2	January 8, 2018	1:00–3:00 PM	Sue Crystal Conference Center, Cherry Street Plaza 626 - 8th Ave. SE, Olympia, WA *https://attendee.gotowebinar.com/register/4001657562264399363*

Consultation	January 22, 2018	1:00–3:00 PM	Sue Crystal Conference Center, Cherry Street Plaza 626 - 8th Ave. SE, Olympia, WA *https://attendee.gotowebinar.com/register/5664138934671123971*

For those who cannot attend in person, we are offering webinar access (registration links for each meeting are provided above). Even if you wish to participate by phone (without the webinar), please register for the webinar – you will receive a phone number after registration.

Purpose

The agency and DSHS intend to submit amendments to the Section 1115 demonstration waiver and/or the Section 1915b behavioral health waiver to authorize the state:

1. To use Medicaid funds to pay for services to individuals receiving residential substance use disorder (SUD) treatment in an Institute for Mental Diseases (IMD) for more than 15 days during a month. An IMD is a facility with more than 16 beds that primarily provides behavioral health services.
2. To use Medicaid funds to pay for services to individuals receiving residential mental health treatment in an IMD for more than 15 days during a month.
3. To make clarifying corrections to the Special Terms and Conditions (STCs) of the Section 1115 demonstration waiver that were initially approved by CMS on January 9, 2017.

Waiver amendment(s) related to IMDs

Previously the state was able, through the Section 1915(b) behavioral health waiver, to use Medicaid funds to purchase managed care services in IMD facilities. A federal rule change effective July 1, 2017, now limits the use of Medicaid funds to IMD services that are 15 days or less. Senate Bill 5883, enacted during the 2017 legislative session, directs the agency to apply for a federal waiver that would authorize the state to use Medicaid funds for the full cost of treatment in IMDs, effective July 1, 2018.

For residential SUD treatments in IMDs, the agency and DSHS will request an amendment to the Section 1115 demonstration waiver to authorize the state to use federal funds in both the Medicaid managed care and fee-for-service (FFS) programs. The proposed effective date for this amendment is July 1, 2018.

For mental health treatments in IMDs, the agency and DSHS are exploring with the Centers for Medicare and Medicaid Services (CMS) whether to request an amendment to the Section 1115 demonstration waiver or an amendment to the Section 1915(b) behavioral health waiver. The approach of amending the Section 1915(b) behavioral health waiver would authorize the state to use federal funds only in Medicaid managed care programs, whereas amending the Section 1115 demonstration waiver would authorize the state to use federal funds in both the Medicaid managed care and FFS programs. However, the agency is not likely to meet the budget neutrality requirements for an amendment to the Section 1115 demonstration waiver. The agency and DSHS anticipate making a final decision by the end of November 2017 about which waiver authority to pursue for that request. The proposed effective date for this amendment is July 1, 2018.

Clarifying Corrections to the Section 1115 Demonstration Waiver

The agency requested that CMS issue technical corrections to the STCs of the Section 1115 demonstration waiver. The technical corrections would ensure that the STCs accurately reflect the approval of the demonstration. CMS was unable to accept a number of the technical correction requests because the requests were more comprehensive than is acceptable for a technical correction. As a result, the agency and DSHS will request an amendment to implement these clarifying corrections. The proposed effective date for this amendment is July 1, 2018.

Anticipated Impact on Indians/Indian Health Programs/Urban Indian Health Organizations

The proposed amendments related to IMDs could have an impact specific to American Indian/Alaska Native (AI/AN) Medicaid beneficiaries. Under current Medicaid authority, the state may use Medicaid funds to pay for up to 15 days in an IMD if the person has Medicaid

coverage in the managed care program. In July 2017, the state implemented full-scope behavioral health coverage in the Medicaid FFS program. If the person has Medicaid coverage in the FFS program, no federal funds may be used for treatments in IMDs. The previous exception under the Section 1915b behavioral health waiver did not allow for Medicaid funds to pay for services covered in the FFS program either, because that exception was available only to the managed care program. With these waiver amendment(s), the agency and DSHS are requesting the authority to use Medicaid funds to pay for treatments in IMD facilities for all beneficiaries, whether their coverage is in the Medicaid managed care program or Medicaid FFS program.

The proposed amendment for technical corrections to the STCs of the Section 1115 demonstration waiver is not anticipated to have an impact specific to American Indian/Alaska Native (AI/AN) Medicaid beneficiaries. The corrections are intended to clarify original intent of select terms and conditions. The agency and DSHS are not requesting language changes that will have an impact on implementation of any of the three demonstration initiatives.

Copy Available on Request

The agency and DSHS are in the process of completing the draft waiver amendments. A copy will be distributed to Tribal representatives as soon as it becomes available and no later than during Tribal Roundtable #2.

Comments and Questions

The agency and DSHS would appreciate any input or concerns that Tribal representatives wish to share regarding these waiver amendments. To request a copy of the draft waiver amendments or return any comments:

- For the IMD-related waiver amendments, please contact Richard VanCleave, Federal Programs Manager, by telephone at 360-725-3703 or via email at vanclrl@dshs.wa.gov by December 20, 2017.
- For the waiver amendment with the clarifying corrections to the STCs of the Section 1115 demonstration waiver, please contact Kali Klein, Medicaid Transformation Manager, by telephone at 360-725-1240 or via email at kali.klein@hca.wa.gov by December 20, 2017.

Please contact Jessie Dean, Administrator, Tribal Affairs and Analysis, by telephone at 360-725-1649 or via email at jessie.dean@hca.wa.gov if you would like to request formal consultation or have tribal affairs-related questions.

Please forward this information to any interested party.

Thank you.

The Honorable Don Secena
Chehalis Tribal Council
420 Howanut Rd
Oakville, WA 98568

The Honorable Maria Lopez
Hoh Tribe Business Committee
PO Box 2196
Forks, WA 98331

The Honorable Frances Charles
Lower Elwha Tribal Council
2851 Lower Elwha Rd
Port Angeles, WA 98363

The Honorable Virginia Cross
Muckleshoot Tribal Council
39015 172nd Ave SE
Auburn, WA 98092

The Honorable Jeromy Sullivan
Port Gamble S'Klallam Tribal Council
31912 Little Boston Rd NE
Kingston, WA 98346

The Honorable Fawn Sharp
Quinault Tribal Council
PO Box 189
Taholah, WA 98587

The Honorable Charlene Nelson
Shoalwater Bay Tribal Council
PO Box 130
Tokeland, WA 98590

The Honorable Carol Evans
Spokane Tribal Business Council
PO Box 100
Wellpinit, WA 99040

The Honorable Leonard Forsman
Suquamish Tribal Council
PO Box 498
Suquamish, WA 98392

The Honorable Jennifer Washington
Upper Skagit Tribal Council
25944 Community Plaza
Sedro-Wooley, WA 98284

The Honorable Mike Marchand
Colville Business Council
PO Box 150
Nespelem, WA 99155

The Honorable W. Ron Allen
Jamestown S'Klallam Tribe
1033 Old Blyn Hwy
Sequim, WA 98382

The Honorable Timothy Ballew II
Lummi Indian Business Council
2665 Kwina Rd
Bellingham, WA 98226

The Honorable Farron McCloud
Nisqually Tribal Council
4820 She-Nah-Num Dr SE
Olympia, WA 98513

The Honorable Bill Sterud
Puyallup Tribal Council
3009 East Portland Ave
Tacoma, WA 98404

The Honorable Tom Wooten
Samish Tribal Council
PO Box 217
Anacortes, WA 98221

The Honorable Charles "Guy" Miller
Skokomish Tribal Council
North 80 Tribal Center Rd
Skokomish Nation, WA 98584

The Honorable Dave Lopeman
Squaxin Island Tribal Council
10 SE Squaxin Ln
Shelton, WA 98584

The Honorable Brian Cladoosby
Swinomish Indian Senate
11404 Moorage Way
La Conner, WA 98257

The Honorable JoDe L. Goudy
Yakama Nation Tribal Council
PO Box 151
Toppenish, WA 98948

The Honorable William Iyall
Cowlitz Tribal Council
1055 9th Ave Ste B
Longview, WA 98632

The Honorable Glen Nenema
Kalispel Tribe Business Council
PO Box 39
Usk, WA 99180

The Honorable Nathan Tyler
Makah Tribal Council
PO Box 115
Neah Bay, WA 98357

The Honorable Bob Kelly
Nooksack Tribal Council
PO Box 157
Deming, WA 98244

The Honorable Charles Woodruff
Quileute Tribal Council
PO Box 279
La Push, WA 98350

The Honorable Norma Joseph
Sauk-Suiattle Tribal Council
5318 Chief Brown Ln
Darrington, WA 98241

The Honorable Carolyn Lubenau
Snoqualmie Tribe Council
PO Box 969
Snoqualmie, WA 98065

The Honorable Shawn Yanity
Stillaguamish Tribal Council
PO Box 277
Arlington, WA 982230

The Honorable Marie Zackuse
Tulalip Tribes Board of Directors
6406 Marine Dr
Tulalip, WA 98271

Appendix H. Tribal Consultation minutes

Minutes
Tribal Consultation: 1115 Waiver Amendments
Health Care Authority • Cherry Street Plaza and Webinar
June 22, 2018, 1:00 – 3:00 p.m.

In attendance:

Tribe/Tribal Org.	Name	State Agency/Org.	Name
AIHC	Vicki Lowe (Executive Director), Heather Erb	HCA	Lou McDermott (Deputy Director), MaryAnne Lindeblad (Medicaid Director), Jessie Dean, Kaitlyn Donahoe, Kali Klein, Taylor Linke, Michael Longnecker, Lena Nachand, Carol Smith
Colville	Alexandria Desautel (LRCHC Executive Director)	DSHS/BHA	Carla Reyes (Assistant Secretary), Chris Imhoff (DBHR Director), Lucille Mendoza, David Reed, Richard Van Cleave
Cowlitz	Stephen Kutz (Councilman and HHS Director), Kay Culbertson (Health Director)	DSHS/OIP	Tim Collins (Senior Director), Brenda Francis-Thomas, Aimee Gone
Kalispel	Lisa Guzman (Health Care Administrator), Ron Poplawski	DSHS/ALTSA	Marietta Bobba, Ann Dahl
Lower Elwha Klallam	Meriah Gille (Health Director)	CMS	Rhonda Martinez-McFarland
Lummi Nation	Nickolaus Lewis (Councilman)	Better Health Together ACH	Jenny Slagle
Muckleshoot	Bradley Couts (Indigenous Pact), Robert Kershner (Indigenous Pact)	Olympic Community of Health ACH	Lisa Rey Thomas
NPAIHB	Sarah Sullivan		
Port Gamble S'Klallam	Karol Dixon (Health Director)		
Shoalwater Bay	Kim Thompson (Health Director)		
Seattle Indian Health Board	Aren Sparck (Government Relations), Jason Stiener (Government Relations)		
Skokomish	Leah Niccolocci (Behavioral Health Services Manager)		
Spokane	Tawhnee Colvin (HHS Assistant Director)		
Squaxin Island	June O'Brien (NWITC Director)		
Suquamish	Andrew Shogren (Health Director)		
Upper Skagit	Marilyn Scott (Councilwoman)		

1:05 p.m. Welcome, Blessing, and Introductions

Overview and Background	
HCA	Context: 1. Two previous Roundtables a. December 6, 2017 and January 8, 2018 2. 1115 Amendment serving two purposes a. Extend the use of federal funds for substance use disorder (SUD) treatment in institutions for mental diseases (IMDs) for stays lasting more than 15 days/month b. Refine STC technical language
DSHS	Background: • 42 C.F.R. 438.6(e), amended in July 2016, prohibits federal financial participation (FFP) for IMD stays of over 15 days in a calendar month for Medicaid beneficiaries aged 21 – 64. This applies to IMDs with more than 16 beds, treating either SUD or mental health. • Substitute Senate Bill 5883 (2017) directed HCA and DSHS to apply for a waiver to enable the full costs of stays in IMDs to be eligible for Medicaid funding.
Tribe	*Question*: Please clarify the 15 days rule. *DSHS Response*: Medicaid will cover up to 15 days; at the 16th day Medicaid will cover none of the costs or any other medical costs as CMS considers the individual institutionalized at that point.
Tribe	*Question*: What happened to the amendment to the 1915(b) Waiver? *DSHS Response*: HCA and DSHS were pursuing both an 1115 waiver amendment for residential SUD and an amendment to the 1915(b) waiver for in-patient mental health. CMS indicated that, while the 1115 waiver amendment relating to residential SUD treatment could be approved, an amendment to the 1915(b) waiver relating to in-patient mental health stays could not. HCA and DSHS decided not to pursue the 1915(b) waiver amendment.
1115 Waiver Amendment: SUD IMDs	
DSHS	Reviewed key milestone language; no changes since last Tribal Roundtable.
Tribe	*Question*: Does the state have access to data on opioid/prescription-drug related deaths? *HCA and DSHS Response*: • https://www.doh.wa.gov/Portals/1/Documents/Pubs/346-083-SummaryOpioidOverdoseData.pdf • https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/OpioidPrescribing
Tribe	*Question*: Is the state aware of IHS prescribing guidelines to ensure alignment with state prescribing guidelines? *HCA and DSHS Response*: We will work on getting specifics and compare.
Tribe	*Question*: Do the milestones that pertain to state law reflect the limitations of state law on Tribal land? *DSHS Response*: Not currently; the state will edit the language to appropriately reflect Tribal laws.
Tribe	*Question*: Does Milestone #6, which refers to discharge planning and warm hand-offs to community-based services, specifically call out IHCPs? *DSHS Response*: Not currently, the state will edit the language to include this specific provider type.
Tribe	*Question*: If the number of Tribal in-patient SUD providers change, would that require an amendment? *DSHS Response*: No, the intent of giving the number of providers is to show the extent of treatment in Washington State. The state will edit the language to specifically call out the number of Tribal-specific SUD providers as of submission of the amendment.
1115 Waiver Amendment: Technical Corrections	
HCA	Reviewed list of technical corrections to reflect further clarity between the State and CMS; no changes since last Tribal Roundtable.

Issue Raised by Lummi Nation and Upper Skagit Tribe	
Tribes	Nickolaus Lewis (Lummi Nation Councilmember) reviewed briefing document prepared by the Lummi Nation, summarizing concerns with crisis providers not accepting AI/AN clients enrolled in the Medicaid fee-for-service program because managed care (BHO) rates are significantly higher than the fee-for-service rates. Marilyn Scott (Upper Skagit Tribe Councilmember) agreed with the concerns raised and shared additional information.

Adjourned: 3:00 p.m.

Action Items:

- IHS Opioid Guidelines
  - Vicki Lowe (AIHC) will email Tom Weiser to ask for copy of IHS Opioid Guidelines.
  - HCA/DBHR will compare state's guidelines against CDC's guidelines (and IHS guidelines if available) and send the results to tribes/UIHPs.
- 1115 Waiver Milestone 5a
  - DBHR will refer to tribal laws whenever state laws are referenced, and explain how state laws and tribal laws apply.
- 1115 Waiver Milestone 6
  - DBHR will refer to tribal programs whenever referring to transitions and care coordination.
  - DBHR will also include a sentence similar to: "As of ____, we have __ facilities, including ___ tribal facilities."
- BHO-FFS rates differences and providers not accepting FFS rates
  - Tim Collins (DSHS) will review email chain related to July 2016 IPAC discussion.
  - Vicki Lowe (AIHC) will send request to tribes for specific cases/examples where referral for BHO-level service was not completed. The request will be for:
    - Either ProviderOne number OR full name and date of birth
    - Referral information, including the referring provider, the referred-to provider (facility referred to), and the diagnosis and service requested (ideally, there would be a completed referral form)
    - Referred-to provider response (written communication or documentation stating reason for denial).