Healthier WASHINGTON

Medicaid Transformation Waiver

Frequently Asked Questions (FAQs)

April 2016

www.hca.wa.gov/hw

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About this Document

This FAQ is a result of the thoughtful questions and issues that have been raised by our partners and stakeholders. We will continue to add to this document in the coming months and post updates in the Medicaid Transformation section of the Healthier Washington website (www.hca.wa.gov/hw).

We invite you to continue to send your questions and comments to medicaidtransformation@hca.wa.gov.

For the most current information on the 1115 waiver, please visit the Medicaid Transformation page on the Healthier Washington website (www.hca.wa.gov/hw) and sign up for updates through the Feedback Network. Send questions and comments to medicaidtransformation@hca.wa.gov.

Background

1. What is the Medicaid Transformation waiver?

The Medicaid Transformation waiver, authorized by Section 1115 of the Social Security Act, is an agreement with the federal government that would allow the state to modify certain federal requirements for the Medicaid program to test new approaches to providing health coverage and care. The waiver's three initiatives bring the Healthier Washington vision—better health, better care, and lower costs—to the 25 percent of the state served by Medicaid. It will help us transform the system from one that rewards providers for offering more procedures and services to one that rewards providers based on the quality of care people receive and its effect on their health—paying for value instead of volume.

Washington's Medicaid program must fundamentally shift its health care delivery system. This means moving from being programmatically "siloed" and focused on disease treatment to being fully integrated, family and community-driven, and focused on health improvement and recovery. Our Medicaid clients need a delivery system that makes their health the highest priority and provides supports for those with chronic illness to improve their health outcomes.

The Medicaid transformation waiver will enable us to make investments in: (1) effective service delivery through community and health system partnerships, (2) improving how we serve those with long-term care needs, and (3) providing our most vulnerable populations with the foundational community supports they need to achieve and maintain good health.

2. Is the Medicaid Transformation waiver part of Healthier Washington?

The waiver is a critical component of the vision for Healthier Washington. It extends the work the State and its partners are doing through the State Innovation Models (SIM) grant, improving how we pay for services, ensuring that health focuses on the whole person, and building healthier communities through a collaborative regional approach. It does this by moving the Medicaid system toward more effective models of care and service delivery.

Like other Healthier Washington initiatives, the Medicaid Transformation waiver is focused on the three Healthier Washington goals: healthier communities, whole-person care, and improvement in how we pay for services. But the Medicaid Transformation waiver is, by definition, focused on Medicaid.

3. What is a Section 1115 waiver?

In this case, the term "waiver" has a particular meaning: The federal government grants a waiver to allow states to do something under Medicaid that they couldn't ordinarily do under Medicaid rules. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects under the Medicaid and CHIP programs that test and evaluate potential program changes that improve care, increase efficiency, and reduce costs. A Section 1115 waiver is often called a Medicaid demonstration waiver.

4. What populations will the waiver cover?

The Medicaid Transformation waiver covers all Medicaid clients. Additionally, Washington will establish new eligibility criteria and a limited benefit package for individuals who are "at risk" for future Medicaid use because they need some long-term services and supports (LTSS) but do not currently meet Medicaid financial eligibility criteria.

5. What will happen to people's existing benefits? Will anyone's benefits be cut?

Medicaid clients' existing benefits will remain in place. No one's benefits will be cut as a result of the Medicaid Transformation demonstration.

As part of the demonstration project, Washington intends to better tailor its long-term services and supports benefits to meet the varying needs of its aging population by offering two additional limited benefit packages—the benefit described in the previous question, and a benefit that will provide supports to unpaid family caregivers.

6. Is the waiver aimed at populations that use the most resources?

While individuals with one or more serious health conditions tend to generate the highest costs, the proposed demonstration is designed to serve the needs of the entire Medicaid population—children as well as adults—and is aimed at improving the system for better health outcomes for **all** Medicaid beneficiaries.

7. Will there be any special focus on the needs of children and youth, who still make up a large portion of those covered by Medicaid?

The demonstration is intended to serve all Medicaid clients in the state of Washington and—at 46% of all of the state's Medicaid beneficiaries—children are a big part of the population. Many of the population health areas aimed at prevention and health promotion will support children's health needs, most specifically pediatric obesity and oral health. And the delivery system reform efforts are intended to benefit all Medicaid recipients, including children. In addition, target populations for the supported employment benefit in Initiative 3 include youth in transition with a behavioral health diagnosis; the benefit applies to working-age youth (age 16 and up). Furthermore, target populations for the supportive housing benefit will include young people with frequent or lengthy contacts with institutions like child welfare, juvenile justice, and other youth and young adult focused systems.

8. Will waiver activities intersect with the Practice Transformation Hub?

We expect that Healthier Washington State Innovation Model (SIM) initiatives such as the Practice Transformation Hub (Hub) will operate in partnership with this demonstration to maximize its effect. The Hub will support local quality improvement efforts by connecting providers with tools, training, and hands-on technical assistance. Accountable Communities of Health (ACHs), in partnership with Regional Health Connectors, will assist health care, mental health, and substance use disorder providers in accessing this clearinghouse of resources for developing the capacity (administrative, financial, and legal) to adopt more integrated and accountable models of care and payment.

9. How does the state envision the role of primary care in Medicaid Transformation?

Primary care providers are critical partners for Medicaid clients across the continuum of care. With the emphasis on whole-person care and improved care coordination, primary care providers will remain central to most individuals' care.

By design, the demonstration aims to support and make investments that enable providers to better address local health priorities and deliver cost-effective quality care that treats the whole person. It will also support provider organizations in moving toward sustainable delivery system reform through increased use of value-based payment models. This transition away from paying for volume may be challenging to providers, both financially and administratively. The Medicaid transformation waiver offers resources and assistance providers may need to develop additional capabilities.

Timeline and Development Process

1. What is the timeline for the Medicaid Transformation waiver?

Unlike most waivers or grant programs—which require the project description, guidelines, and details to be thoroughly outlined in the initial proposal—many of the details of Section 1115 waivers are developed through negotiations between states and CMS. We are currently in the middle of these negotiations.

Throughout the negotiation period, the initiatives and strategies outlined in the application will continue to be developed. These development efforts will be informed by our negotiations with CMS as well as input from our partners and stakeholders. During this period, CMS will be developing the demonstration's Special Terms and Conditions (STCs). Once these are finalized and approved, CMS will release them for public comment.

Once approved, each initiative will have its own development timeline. Previous discussions had specified that a "Year 0" would be available for initiative development. CMS has since made it clear that any planning, development and ramp-up needed must be done within the five-year demonstration period. This means that the development timelines for all three initiatives will occur within Year 1 of the demonstration.

Once an agreement is reached with CMS, a detailed development schedule will be created. Since ramp-up time is still required for all three initiatives, new programs, projects, and benefits will not be available at the outset of Year 1.

2. How will the State keep stakeholders and partners informed?

Throughout the negotiation and development process, we will report out to our partners and stakeholders through regular updates to the Medicaid Transformation website, webinars, and Healthier Washington Feedback Network. Whenever possible, we will update this Frequently Asked Questions document and share other materials as they are developed.

3. How will the State involve partners and stakeholders in planning and development?

We believe that input from our stakeholders and partners, across the state and across sectors, is critical to accomplishing Medicaid transformation. Since many individuals and organizations have expressed an interest in contributing, we are looking at new and expanded ways to efficiently inform and involve stakeholders and partners. We will continue to provide opportunities for stakeholders to comment on and contribute to waiver developments, materials, and proposals throughout the negotiation process. This information will be distributed through our website and webinars, with opportunities to respond and provide feedback through online surveys, the Medicaid Transformation mailbox, and webinars.

In some cases, the State is relying on existing workgroups for input. We encourage stakeholders and other interested parties to continue to send questions, comments, and suggestions to medicaidtransformation@hca.wa.gov.

4. What are Special Terms and Conditions?

Special Terms and Conditions (STCs) refer to the specific authorities and expectations that enable the state to operate an approved 1115 demonstration waiver. The STCs will comprise the final contract between the state and the federal government. The waiver demonstration period begins with the signing of approved STCs.

5. How will the State ensure that there is sufficient planning time before waiver programs and systems "go live"?

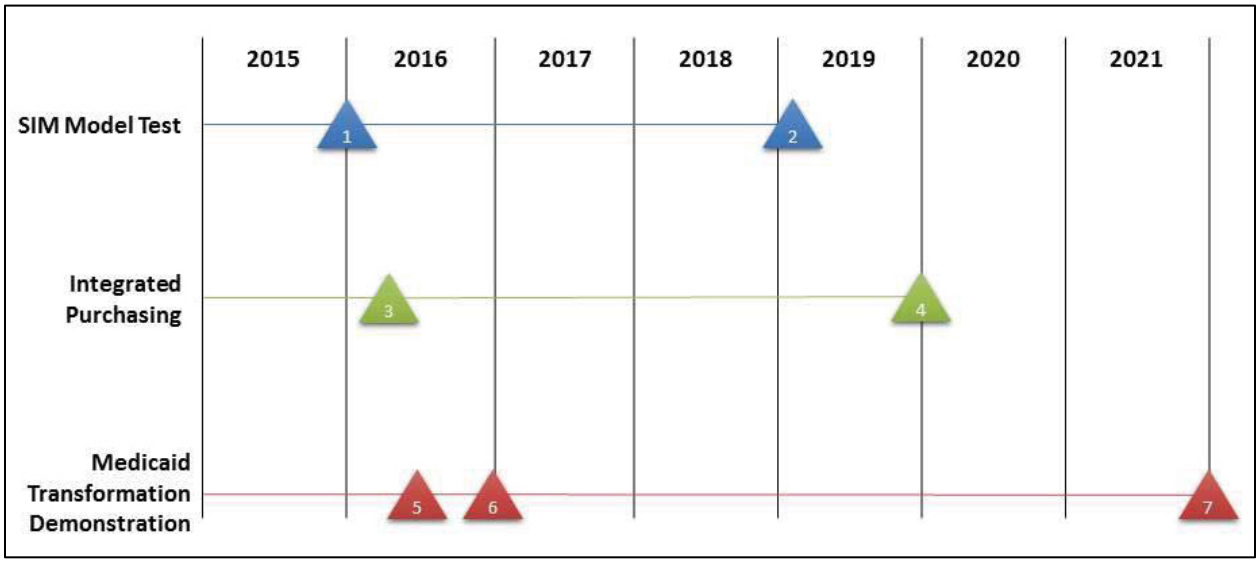
As noted above, CMS has already informed us that there will be no "Year 0" period and the demonstration will begin as soon as Special Terms and Conditions are finalized. However, there will still be a period of planning, development and ramp-up of waiver activities. These include:

- building State infrastructure and technical assistance capacity,
- providing planning dollars and resources for Accountable Communities of Health (ACHs),
- formalizing the toolkit of transformation projects,
- developing a readiness assessment for ACHs,
- developing project plan guidance for ACHs, and
- reviewing and approving project plans submitted by ACHs.

6. How does the 1115 waiver timeline align with other Healthier Washington priorities?

Among other priorities, the waiver is intended to complement and accelerate Healthier Washington priorities. The waiver, like other Healthier Washington priorities, is a tool that supports the Healthier Washington vision. We know there are challenges involved in undertaking such a far-reaching effort. We also know that the benefits of this effort—for Medicaid clients, providers, local communities, and the State—will be just as far-reaching. Tools under Healthier Washington may have differing timelines, but they all have complementary goals. For instance, transformation projects under Initiative 1 that foster the integration of physical and behavioral health services will directly support the ongoing movement to Fully Integrated Managed Care (FIMC). We will be working closely with our partners in ACHs and local communities to make the transition as smooth as possible.

The chart below gives an overview of the general timeline for development and implementation for these Healthier Washington elements.



1 ACHs designated
2 State Innovation Model (SIM) evaluation complete
3 Fully integrated managed care in SW WA; BHOs in other regions
4 Fully integrated managed care health systems statewide
5 Proposed waiver approval; Medicaid transformation demonstration start-up
6 Medicaid transformation investments begin
7 Medicaid transformation evaluation demonstration complete

Prevention and Health Promotion

1. **How does this proposal promote population health and prevention and management of chronic conditions?**

   The Medicaid Transformation waiver will align with and leverage other Healthier Washington efforts to improve the health outcomes and health equity of populations exhibiting the greatest need.

   Prevention and health promotion is one of the three targeted investment domains for transformation projects. Waiver efforts under this domain will target Medicaid populations with specific needs—with a focus on chronic disease prevention and management, and maternal and child health. Ultimately, these investments will promote population health and prevention and management of chronic conditions.

   For additional details about how transformation projects will be developed, see the Transformation Projects section.

2. **How will the waiver address health disparities?**

   Based on the *Institute of Medicines "Unequal Treatment Report* " we know health and health care disparities in the United States are persistent and well documented. We know that communities of color often times fare far worse than their white counterparts across a multitude of health indicators; Life expectancy, infant mortality, prevalence of chronic diseases, self-rated health status, and insurance coverage, to name a few. In Washington State we are not immune to these statistics. The Transformation projects under the Prevention and Health Promotion domain will intentionally focus on eliminating health disparities and increasing health equity.

Accountable Communities of Health

1. **What are Accountable Communities of Health?**

   An Accountable Community of Health (ACH) is a group of people and organizations from a variety of sectors in a given region with a common interest in improving health. Among those represented are health and long-term care providers, health insurance companies, public health agencies, school districts, criminal justice agencies, non-profit social service agencies, local governments, tribes, and philanthropic groups. With support from the state, they are voluntarily organizing to make community-based decisions on health needs and priorities. Their role is to leverage innovation and collaborate without duplicating services. ACHs are at the center of Healthier Washington.

   The Healthier Washington website has additional information, including a map of ACH boundaries and contact information for each ACH.

2. What is the role of ACHs in Medicaid transformation?

With their diverse representation, ACHs are uniquely qualified for the new dimension that Medicaid transformation will bring to their work: coordinating regional investments that address local health priorities and developing systems to deliver cost-effective, quality, whole-person care. We expect that the transformation projects each ACH pursues will be informed by statewide priorities, the project toolkit, and community needs identified through each ACH's Regional Health Needs Inventory (RHNI). The ACH will coordinate these projects, direct investment dollars to providers and other investment partners who are meeting transformation project goals and outcomes, and report on progress.

3. In addition to the ACH designation criteria, will there be criteria released to approve ACHs prior to fulfilling a role in Medicaid Transformation?

While the State believes that ACHs are strategically the most viable entities to serve as the decision-making body for Medicaid transformation projects, the current ACH readiness framework and designation process do not, by themselves, qualify an ACH for this role. It is clear that ACHs will need to have functional and administrative capacities to successfully coordinate and oversee transformation activities. HCA enlisted consultants to provide recommendations for the essential decision-making roles of ACHs. These recommendations will inform ongoing discussions with CMS.

Ultimately, ACH qualifications and functions under the 1115 waiver will be determined by CMS guidance.

4. How will the State support ACHs in building the capacity in this role?

Initial state funding and current SIM investments provide a solid foundation for ACH design, but we recognize the additional capacity needed for Medicaid transformation activities. Other states with approved waivers have invested in broad technical assistance to support organizations that take on this role as they prepare to carry out project objectives. ACHs or the state may choose to contract with a third party to provide some waiver-related support or administrative functions to ACHs. However, core decision-making functions must remain with the ACH.

Under an approved waiver we expect that ACHs will be able to obtain additional resources for capacity development. These resources will be provided to ACHs in the form of significant planning dollars and technical assistance. Planning grants might include hiring of staff, Information Technology (IT) development, project management, contract management, funds flow development, and other areas of infrastructure development. The State and ACHs will discuss what types of technical assistance would be most useful.

While demonstration investments must ultimately be performance-based, payments during the initial years will focus on achievement of operational milestones, such as expanded RHNI's and submission of transformation project plan applications.

5. Why should ACHs have a role in Medicaid transformation?

The ACHs bring a local perspective to health systems transformation, bringing together diverse voices to determine needs and priorities. They are the critical link between clinical and community sectors that is needed to drive change for the Medicaid program and larger Healthier Washington vision. Each region,

through its ACH, will be able to pursue Medicaid transformation projects that will contribute to delivery system transformation by changing the way we serve Medicaid beneficiaries. ACHs will coordinate the projects and be responsible for engaging with and ensuring the success of the network of partners undertaking the implementation of projects.

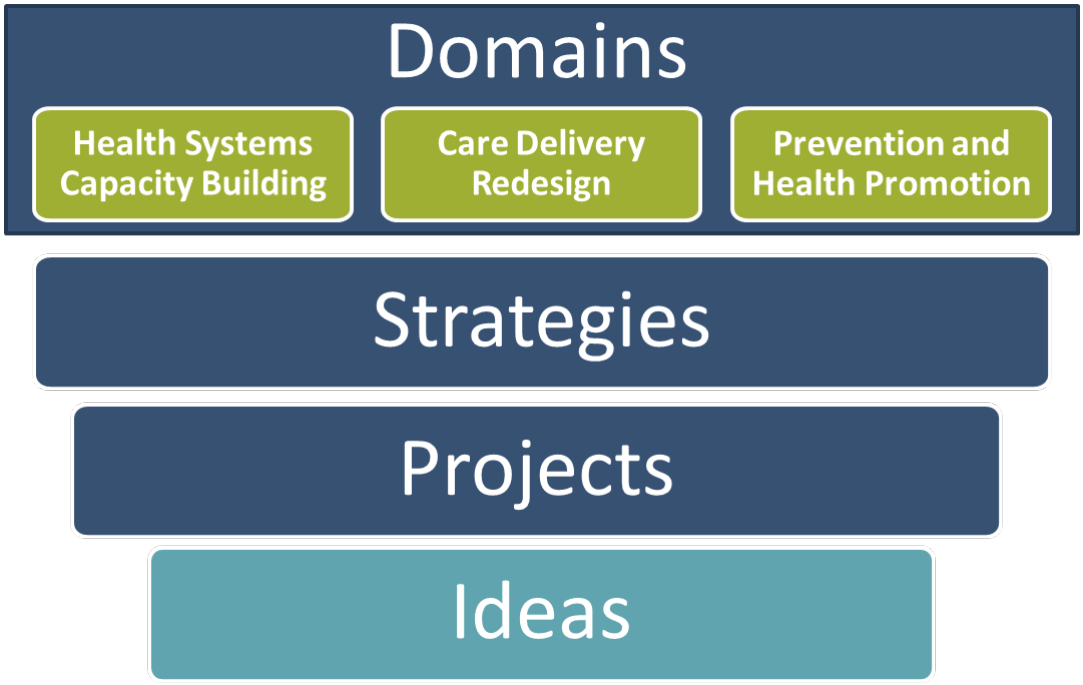
ACHs will apply for projects based on the state's project toolkit and, in turn, will direct incentive funds to partners that meet both process and outcome measures. Projects will not be independent activities; instead, they will work together and include core components of systems transformation that align with the state's priorities and are directly linked to measureable outcomes that support the four primary goals of Medicaid transformation. Nevertheless, projects will be implemented in the manner that best fits local needs and which will ultimately improve overall community health.

Medicaid transformation projects offer ACHs a chance to strengthen their role as a multi-sector coordinating body to improve health care delivery, support a regional system for whole-person care, build clinical-community linkages, and address the social determinants of health. Medicaid transformation represents a significant opportunity as the ACHs continue moving toward whole-population health improvement.

Transformation Projects

1. What is the transformation project toolkit?

To achieve the goals of Medicaid Transformation, the State proposed a transformation toolkit for regional transformation projects that will support changes in care delivery to maximize health care value and strengthen the ability of provider organizations to successfully perform under value-based payment models. Transformation projects are organized into three domains.



Project details are being identified and designed through a thoughtful and iterative process and will ultimately require CMS approval. It is anticipated that each project description within the toolkit will include:

- Rationale for the proposed project (evidence base and reasoning behind the project idea).
- Goals and objectives of the project (the project-specific goals and expected project outcomes).
- Core components, or key activities, that will guide project development and implementation.
- Metrics required for the project to assess performance.

Each project will have a set of core components and metrics that tie incentive payments to performance. This will ensure that all participating providers are working toward generally accepted best practices and common goals in terms of results.

2. How will transformation projects be funded?

Through the waiver, federal investments will support implementation of the transformation projects. Funding for projects under the waiver is time-limited; transformation is expected to be sustainable, without continued federal investment, after the five-year demonstration period ends. This also means expected savings and performance outcome milestones must be achieved within the demonstration period.

3. What happened to all the project ideas submitted during the public process?

We were thrilled to receive such a strong response from the community to our request for project ideas; over 180 ideas were submitted. The draft project framework that is the foundation for the eventual project toolkit draws heavily from the ideas that were submitted, though no project idea is included in the same form as it was submitted.

Other details in idea submissions will not be reflected in the final toolkit. Some of these project ideas contained elements that would not be eligible for incentive payments under the Medicaid Transformation waiver because they included:

- Duplicate services already funded under the Medicaid state plan.
- Activities that overlap with the Medicaid Alternative Care (MAC) and Targeted Supports for Older Adults (TSOA) benefits under Initiative 2 of the waiver proposal.
- Activities that overlap with the targeted supportive housing and supported employment benefits under Initiative 3.
- Activities that do not support predominantly Medicaid eligible populations.

These suggestions and ideas represent valuable opportunities to improve health. Because ACHs play a significant role in transforming health care both within the 1115 waiver and outside of it, we encourage community partners to continue to engage their ACHs in pursuing these ideas through other avenues**.**

4. **Will there be investments in infrastructure to support patient care, including: building systems that share information across hospitals and with other local partners, workforce training and development, and telemedicine?**

   Health systems capacity is one of three investment domains that transformation projects will address. To ensure funds for transformation projects are effectively leveraged, all projects in Domain 1 must demonstrate a direct connection to projects pursued under Domain 2 (Care Delivery Redesign) and/or Domain 3 (Prevention and Health Promotion), or must support providers in developing the capabilities necessary to operate in value-based payment models.

5. **Who will approve the final toolkit?**

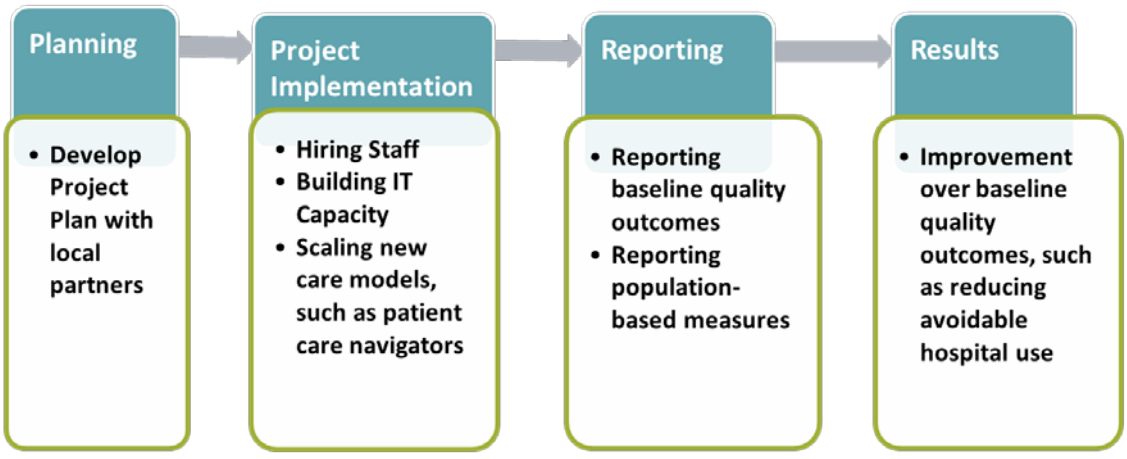
   Ultimately, the eventual transformation toolkit will be approved by CMS.

7. **Will there be projects that ACHs are required to implement?**

   Certain projects will be critical to advancing state-wide transformation goals and will be required efforts for every ACH. While these activities will be required, each ACH will be able tailor core components that best fit their community needs. The State is currently exploring whether certain, or all, projects will be required. Required projects will likely be identified in the Special Terms and Conditions.

8. **How will participating providers receive transformation project funds?**

   Providers and other partners who are participants in regional transformation projects will be eligible to receive transformation funds only after achieving milestones specified within each project. Early on, many of the milestones will focus on planning, policies, and processes; later milestones will be tied to specific outcomes. The graphic below provides some example milestones.



9. What role will Tribes play in the selection and implementation of transformation projects?

The State takes seriously its government-to-government relationship with Tribes and its responsibility to seek advice from Indian Health Service, Tribally operated facilities, and Urban Indian Health Organizations (I/T/Us) on its waivers. While the Accountable Communities of Health (ACHs) are intended to lead the State's efforts with respect to Medicaid Transformation, the State has contracted with the American Indian Health Commission for Washington State (the Commission) to help determine whether and how the Tribes and I/T/Us in Washington State wish to engage with the ACHs and if the Tribes and I/T/Us would like a separate Tribal entity or entities with which to work on Medicaid Transformation. In connection with these efforts, the State and the Commission will gather information on what projects and activities are needed to encourage quality and efficiency and promote more cost-effective care.

Managed Care Organizations

1. What role will managed care organizations (MCOs) play in waiver activities?

Managed care plans play a central role in the delivery of Medicaid services and are key to this demonstration's success. MCOs, like providers, will be partners in many regionally based transformation projects. Priorities for transformation projects will be consistent with MCO and BHO contracted expectations. We anticipate that Performance Improvement Projects (PIPs) in Medicaid MCO contracts will complement regional transformation projects, and that MCOs will be able to use participation in these projects to meet their PIP requirements. In addition, process and performance measures for transformation projects will align with relevant performance measures that are included in MCO contracts.

MCOs (as well as BHOs) will maintain their risk-bearing role for Medicaid services and support transformation activities through aligned efforts to improve quality and efficiency of healthcare delivery. As members of ACHs, managed care health systems will collaborate on the identification and implementation of regional projects and plans for sustaining transformation post-demonstration.

A key goal of our Medicaid Transformation effort is to accelerate the transition to value-based payment. The state's legislature has mandated regional Medicaid purchasing beginning in April 2016 as the first step in a move to fully integrated physical and behavioral health purchasing through managed care health systems by 2020. We further expect that, by 2021, 90% of payments to Medicaid providers will be value based (VBP) and fully incorporated into the business models of our managed care health systems and their provider networks. By leveraging financial incentives, MCOs and ACHs will partner to achieve sustainable quality and value-based payment performance targets over the course of the waiver demonstration.

2. What is the role of MCOs in relation to ACHs?

MCOs play a unique and critical role in ACHs under the 1115 waiver. Each ACH governing board includes at least one MCO representative, providing a voice that is critical in ensuring balanced decision-making. In addition, MCOs are to be key partners with ACHs, helping ensure that regional Medicaid transformation efforts result in improvements to the delivery of health care.

Long-Term Services and Supports (Initiative 2)

1. Washington is already a national leader in the delivery of home and community based services. Why is this waiver needed?

Our population is aging, increasing the number of individuals who will be in need of Long-Term Services & Supports (LTSS):

- Since 2001, expenditures have risen from $2.1 to $3.8 billion—an 81% increase. The majority of this growth is related to increases in caseload.
- By 2040, the 65 and older population in Washington is projected to reach 1.8 million—an increase of over a million individuals since 2010.
- As we age, we often need more assistance. In Washington State 1 in 5 individuals over age 65 report difficulties with self-care and cognition.

The state believes the waiver investment will save public funding by delaying or diverting care receivers from utilizing more expensive and lesser preferred options. An evaluation of the Family Caregiver Support Program (FCSP—which MAC and TSOA are modeled after—showed an estimated savings of $1.67M in the first year, with greater savings expected over time[1]. Later analysis of the data and the continued history of the participants showed greater savings as time progressed.

More information can be found on the Initiative 2 LTSS Executive Summary on our website.

2. Is the model of supporting caregivers evidence-based? Has it been successful elsewhere?

Yes, the model has been used in Washington's state funded Family Caregiver Support Program (FCSP) since 2003. The Tailored Caregiver Assessment and Referral® (TCARE®) System has been proven, through randomized and longitudinal studies, to reduce caregiver stress and clinical depression and increase the positive feelings caregivers have about caregiving. Longitudinal studies have also linked TCARE® with delay of out-of-home placement of the care recipients. These benefits can also translate into shorter hospitals stays and lower health care costs, as TCARE® enables caregivers to continue as primary providers of daily care for persons with chronic conditions.

TCARE® has been implemented in 17 states by over 275 state and local social service organizations and 10 military installations. Based on 2014 research by the DSHS, Research and Data Analysis Division on the FCSP we know that care recipients are 20% less likely to enroll in Medicaid Long-Term Care the year after their caregiver receives a screening.

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[1] Miller, M. (2012). *Did expanding eligibility for family caregiver support program pay for itself by reducing the use of Medicaid-paid long-term care?* (Document No. 12-11-3901). Olympia: Washington State Institute for Public Policy.

3. **Who are the individuals that will be served under this waiver? How many individuals will be served between the two benefits?**

   For either program, care recipients must be 55 years or older. Individuals who are functionally and financially eligible for Medicaid may choose to receive Medicaid Alternative Care (MAC) services instead of other Medicaid Home and Community Based Service options. For Tailored Supports for Older Adults (TSOA), individuals will need to meet the functional eligibility for Medicaid funded LTSS, and will have a financial assessment to determine if they are at risk of spending down their savings to meet Medicaid eligibility. We expect to ramp up the number of people we serve by about 2,500 per year over a period of three years, building to a regular caseload of about 7,500 across both programs. Medicare beneficiaries will not be excluded from either benefit package offered under the 1115 waiver.

4. **Can individuals served under this waiver receive the same benefits in the traditional Medicaid LTSS delivery system?**

   No. The benefits offered under the waiver are new services that are not offered in our traditional Medicaid LTSS delivery system.

5. **Will there be any changes to the existing LTSS system?**

   No. The new benefit packages do not replace existing services an individual may be eligible for; they are another choice in the way services are delivered. The state is committed to developing outreach and enrollment materials, with the help of advocates and stakeholders, to ensure individuals are given a choice of available benefits.

6. **Is the state still pursuing raising the Nursing Facility Level of Care (NFLOC) through the 1115 waiver?**

   No, we are no longer pursuing a change in the NFLOC through this waiver. Since submitting our application we learned through discussions with CMS that delinking nursing home and community eligibility can be done under existing home and community-based federal authorities.

   We will continue to pursue a change in NFLOC eligibility under existing authorities in the future. However, our priority right now is working with CMS to gain approval of this waiver so we can offer new program choices to individuals who need assistance to remain in their own homes.

7. **Will existing provider types be used or will new provider types be created?**

   The state will use the fee-for-service rates and the provider types identified in the state plan for personal care (which will also include respite, housework and errands).

8. How will clients be informed of their benefit options?

Washington follows a person-centered process for service planning. During the initial intake and at every assessment and service planning meeting, case managers provide individuals and family members with information about all services and supports available through the Aging and Long Term Support Administration (ALTSA). Information will also be available in print and web-based formats.

In addition, the state is committed to developing outreach and enrollment materials, with the help of advocates and stakeholders, to ensure individuals are given a choice of available benefits. The new MAC benefit will be offered as part of person-centered planning; individuals may choose which benefit best meets their current needs and those of their family. Individuals may also change to another program as their needs or preferences change.

9. How will the state ensure someone can seamlessly move between benefits?

The state has a robust system to ensure that individuals can easily move between programs if their needs or circumstances change. Individuals who have selected the MAC program also meet the financial and functional eligibility criteria for our traditional Medicaid LTSS programs. Individuals can transition to those programs instead of the MAC program with an updated assessment and service plan.

Individuals who have selected the TSOA program are functionally eligible for the traditional LTSS programs. The State has a Fast Track program using state-only dollars that allows immediate access to our programs while the financial eligibility review is being conducted. The State can use the Fast Track program for TSOA recipients when it is likely the individual has become financially eligible for Medicaid and chooses to move to another program.

Case managers become aware of individuals' changing needs and circumstances through ongoing service planning activities and contacts. They are trained to identify and anticipate these changes and to proactively engage in service planning with individuals. The caregiver assessments in the MAC and TSOA programs are updated every six months and provide opportunities for individuals to reconsider all available program options during updated
service planning.

10. How is financial eligibility established for MAC and TSOA?

Individuals need to be eligible for coverage under an existing Medicaid Categorically Needy (CN) or Alternative Benefits Plan (ABP) medical coverage group to qualify for MAC.

Individuals will submit an application for TSOA to determine whether they qualify. They will be able to file applications online through the Washington Connection web portal or by submitting a paper application.

11. What benefits are available under MAC?

Benefits are centered on supporting unpaid family caregivers so they can continue in their role and better address the needs of their loved one in need of care. The following supportive services will be included:

A. Training and education, for example, dementia consultation on how to address difficult behaviors or training by a physical therapist on how to safely transfer a loved one in and out of the bathtub. Evidence-based programs such as Powerful Tools for Caregivers, which offers peer support and guidance on how to cope with the challenges that caregiving brings, may also be included.

B. Health maintenance and therapy supports, for example, mental health counseling to adapt to changing roles and dynamics in the home or massage therapy to provide relief from stress and depression.

C. Specialized medical equipment and supplies, for example, a bath bench or incontinence supplies not covered by another funding source.

D. Caregiver assistance services, for example, respite care that allows an unpaid caregiver to take time for a counseling session or grocery shopping. This may also include meals delivered to the home.

12. What benefits are available under TSOA?

Benefits are the same as MAC, listed above, with one addition. TSOA also supports people in need of care who do not have an unpaid family caregiver. This population is eligible to receive limited personal care assistance.

13. Are MAC & TSOA budget-based programs?

No. Eligibility for specific services under MAC and TSOA are based both on the level of screening or assessment completed and an evidence-based assessment of needs and preferences.

14. If an individual chooses MAC or TSOA; how is the caregiver determined eligible for services under these new benefits?

Eligibility for these programs is based on the status of the person receiving care. He or she must meet financial and functional criteria and choose to use his/her benefit to support his/her unpaid family caregiver, if there is one. In addition, the unpaid caregiver must be willing to continue in his/her role as a caregiver and be open to receiving support offered through these programs.

Specific benefits are determined through person-centered conversations with the caregiver and care receiver. An evidence-based intervention tool is utilized with the caregiver called TCARE® (Tailored Caregiver Assessment and Referral) which involves a screening, assessment, consultation, and care planning process. TCARE® addresses caregiver identity discrepancy (which looks at how congruent the caregiver feels about their current role), depression, three types of caregiver burden, and uplifts (what's working well); it recommends strategies to help determine the right service at the right time for the particular caregiver. Through this assessment process caregivers not only evaluate what assistance might benefit them; they also have an opportunity to consider whether they should adjust or reduce their related responsibilities and/or transition out of their caregiving role in the best interest of both the care receiver and themselves.

Supportive Housing and Supported Employment (Initiative 3)

1. What services and supports are included in supportive housing?

Service categories listed in the waiver application (Appendix 5) are consistent with categories described in CMS' June 26, 2015 Informational bulletin on Coverage of Housing-Related Activities:

- Services that support an individual's ability to prepare for and transition to housing.
- Services to support individuals to maintain tenancy once housing is secured.
- Activities that support collaborative efforts across public agencies and the private sector to assist the state in identifying and securing housing resources.

These housing-related services ***do not*** include payment for room and board. Instead, we are proposing to use the waiver to pay for ***services*** that will assist Medicaid clients in maintaining stable housing and access to health care and avoiding constant recycling through institutional facilities. For example, supportive housing services may be linked to housing vouchers provided by public housing authorities or housing that has been subsidized with funding from other sources (e.g., HUD's Continuum of Care program, state and local funding, and private philanthropic support for affordable housing development and operations). The proposed waiver services will provide assistance for Medicaid clients to access these housing opportunities and to maintain housing stability in community settings, with the goal of improving health outcomes, reducing avoidable costs, facilitating access to and continuity of care, and reducing churn in Medicaid enrollment.

2. What services are included in supported employment?

Service categories listed in the waiver application (Appendix 6) are consistent with services described in CMS' September 16, 2011 informational bulletin on guidance regarding employment and employment related services.

Services under the proposed supported employment benefit are based on the Individual Placement and Support (IPS) model. IPS aims to provide ongoing intensive support for eligible individuals to obtain and maintain an individual job in competitive or customized employment, or self-employment. Services in support of this include vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, prospective employer negotiation, and job coaching activities. The supported employment benefit will not cover or supplement a beneficiary's wages.

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

3. Will providers receive grants to provide Initiative 3 benefits?

No, funding under Initiative 3 is not structured like a grant. Funding under Initiative 3 is dedicated to the provision of services defined under supportive housing and supported employment. As with other Medicaid benefits, funds will flow through Managed Care Organizations, Behavioral Health Organizations and the Aging and Long-Term Supports Administration and will go to contracted organizations in exchange for providing services.

4. How is eligibility determined for Initiative 3 benefits?

The supportive housing and supported employment services under Initiative 3 are targeted benefits, meaning they aren't entitlements for all enrollees. The target populations for ***supportive housing*** include those who experience:

- Chronic homelessness (as defined by the US Department of Housing and Urban Development)
- Frequent or lengthy institutional contacts
- Frequent or lengthy adult residential care stays
- Frequent turnover of in-home care givers
- PRISM Risk score of 1.5 or above

For ***supported employment***, the target populations include:

- Those enrolled in the Aged, Blind or Disabled program, with potential to be enrolled in the Housing and Essential Needs program
- Individuals with Severe and Persistent Mental Illness (SPMI), Substance Use Disorder (SUD), or co-occurring conditions
- Those with Traumatic Brain Injury (TBI) or physical disabilities
- Youth in transition with a behavioral health diagnosis.

In addition to the target population criteria, providers must establish an individual's need for the services. The specific criteria will be dependent on where these individuals receive services. Those accessing the benefit via Behavioral Health Organizations (BHOs) will need to meet existing access to care standards; those in the Long-Term Services and Supports system will establish need via the Comprehensive Assessment Reporting Evaluation (CARE) assessment; and those accessing the benefit under Managed Care Organizations must meet medical necessity criteria.

5. What role will ACHs play in delivering Initiative 3 services?

Service dollars will not flow through the ACHs. Service dollars will flow through MCOs, BHOs, and DSHS' Aging and Long-Term Support Administration. It may be possible that incentive payments from ACHs would go to supportive housing and supported employment providers participating in transformation projects; however, these are payments driven by achieving process and outcome milestones, not reimbursements for specific services.

Finance Strategy and Sustainability

1. Does the ACH role for transformation projects make them a "risk-bearing" entity?

It is important not to confuse the concept of "risk" or "accountability" envisioned for ACHs with the financial or insurance "risk" borne by MCOs as a fundamental basis of their business model. ACHs are not intended to displace the role of managed care plans as risk-bearing entities. The plans receive capitated payments under contract with the State, primarily for the delivery of physical and behavioral services. In providing coverage for Medicaid clients, they are at financial "risk" should the cost and utilization of services exceed the capitated payments made for *clients*. This type of financial risk is an established principle of insurance and is quite different from the concept of performance accountability envisioned for ACHs.

Accountability for ACHs is focused on planning, and monitoring investments in regional projects that would be financed through the waiver.

2. What is a Delivery System Reform Incentive Payment (DSRIP)?

The Delivery System Reform Incentive Payment (DSRIP) program is a way to provide a targeted source of funds for transforming Medicaid under federal waiver authority. Washington is proposing that DSRIP be used as the mechanism to fund Medicaid transformation projects. DSRIP programs are performance-based payments, not grants. Over the course of the five-year demonstration period, projects funded through DSRIP must show measurable improvements in client outcomes and must demonstrate how these improvements can be sustained once DSRIP funding ends.

3. How will sustainability post-demonstration be achieved?

Assurance that Medicaid transformation projects funded through the waiver will be sustained beyond the waiver—through non-federal funds—is key to CMS' approval of Washington's proposal. A specific plan for sustainability will therefore be an expected milestone in the Special Terms and Conditions. Furthermore, ACHs will be expected to incorporate sustainability into their transformation project plans. The underlying premise of sustainability is that both state and community investment will pave the road for continued transformation support beyond the five-year waiver period. The State will need to work with CMS, ACHs, managed care plans, behavioral health organizations (BHOs), and other health delivery partners during the course of the demonstration project to develop and implement a sustainability plan.

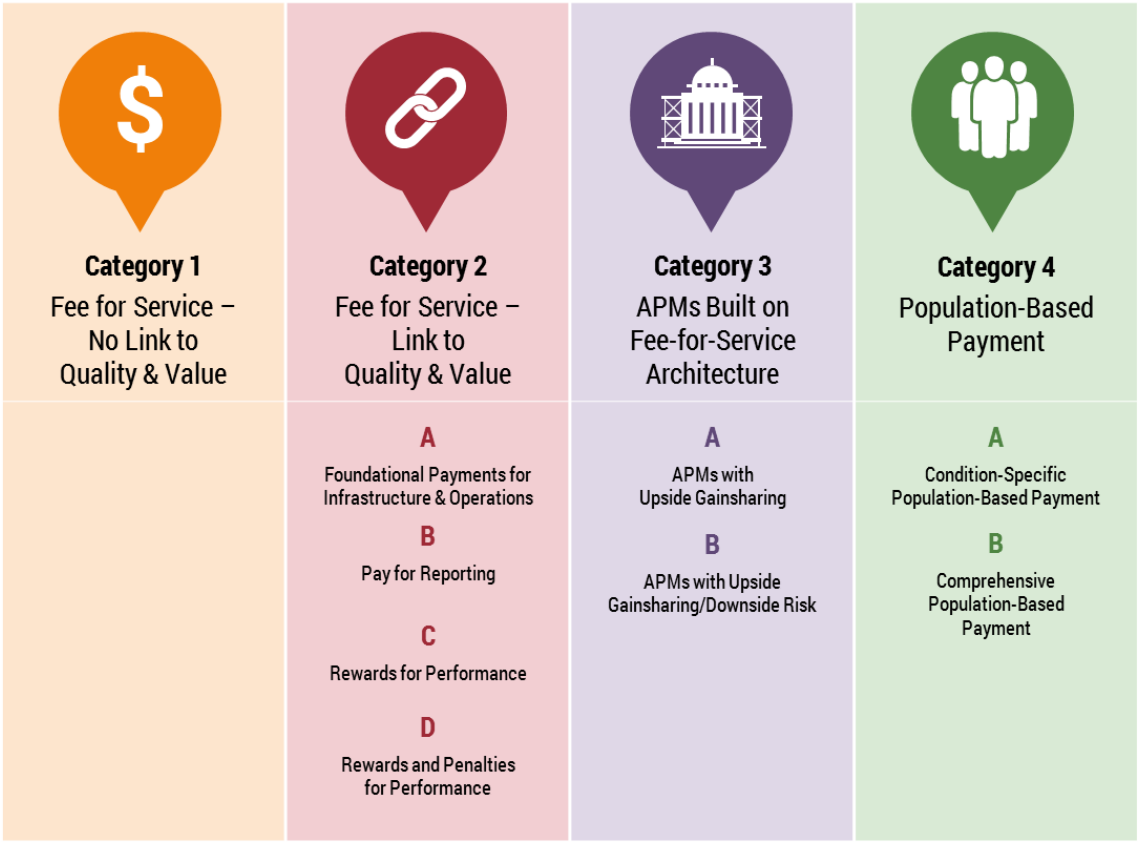
In addition, the success of Medicaid transformation will be supported by (a) infrastructure development currently financed through Healthier Washington initiatives, (b) transitions in Medicaid purchasing toward integrated delivery of physical and behavioral health care through managed health care systems, and (c) the movement toward value-based payments, as supported by transformation projects. Further details on these initiatives are available on the HCA website in the Healthier Washington section: www.hca.wa.gov/hw/

Based on similar waivers in other states we expect that, in Washington:

- Sustainability of Medicaid delivery system transformation funded through demonstration project investments will be achieved through the evolution of performance-based contracts between the

State and managed care plans/BHOS; and through agreements between the State and ACHs, and between ACHs and their members.

- Transformation projects will drive movement from traditional fee-for-service-based provider payments toward value-based payment systems.
  - During Washington's 2013 State Health Care Innovation planning, the blueprint for transformation, we asked Apple Health managed care plans about their payment arrangements with providers serving the physical health care needs of clients. 24 percent of care was provided within a specific "budget" in which payment was not directly triggered by delivery of a specific service, but rather by responsibility for the care of a beneficiary (regardless of the volume of services). Through current transformation initiatives and with the assumption of waiver and SIM investments, by 2019, 80 percent of State-financed health care—Apple Health and the Public Employees Benefits Board (PEBB) Program—will be purchased through managed care systems that adopt value-based payment arrangements.
  - Our classification of value-based purchasing arrangements (below) reflects an array of payment models, most of which are employed to some degree in the current marketplace.



Source: Health Care Payment Learning & Action Network

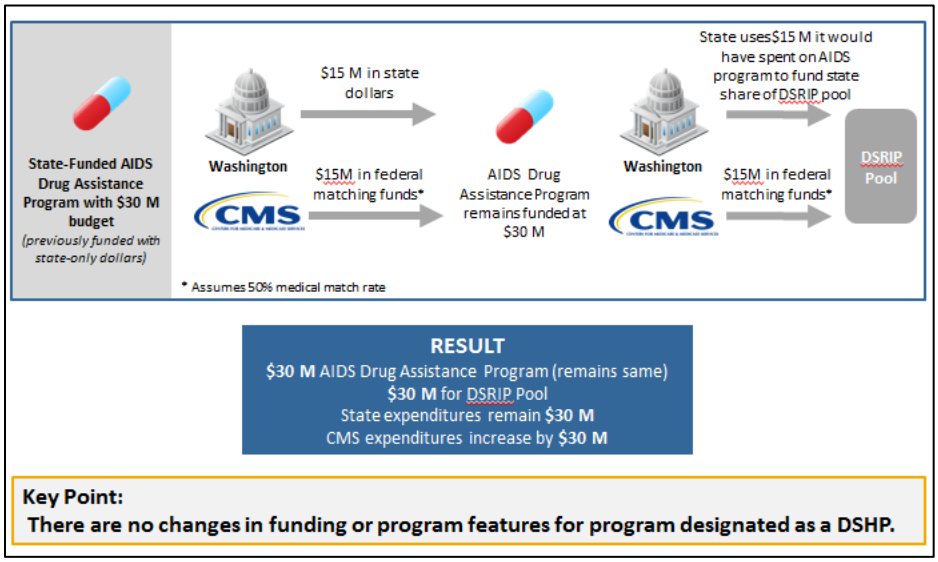
4. What is a Designated State Health Program (DSHP)?

A designated state health program (DSHP) is an existing publicly-funded health program that supports low-income/uninsured individuals and for which CMS may provide federal matching payments the program would not be eligible for otherwise. DSHP programs must be funded completely with State dollars without in-kind contributions.

With respect to the waiver, *after* making payments for DSHP programs, the State would be able to draw down federal matching funds to support transformation investments. There are no changes in funding or additional strings attached to programs designated as a DSHP. These programs, *once approved by CMS*, simply provide an opportunity for the State to generate federal matching dollars for Medicaid transformation projects.

An example of a DSHP program and its potential to leverage federal matching funds is shown in Figure 1. The funds generated by DSHP programs build a pool of dollars, labeled "DSRIP" in the figure, which are then available for transformation investments that are not restricted in any way to the originating DSHP program. For example, the dollars generated by the DSHP program identified in Figure 1 could be available for a transformation investment related to integrating physical and behavioral health care.

Example of DSHP Program Financing (for illustration purposes only)



5. To what extent are intergovernmental transfers (IGTs) from local government and/or hospital systems being considered as a source of non-federal share?

To finance the waiver, Washington must provide a share of investment financing equivalent to the federal investment. We expect to use a combination of intergovernmental transfers (IGT) and designated state health programs (DSHP). The state will follow CMS guidelines to identify the potential sources for funding the non-federal share. Currently, we anticipate the bulk of this financing will come from DSHP programs as described above.

Value-Based Payment

1. **How will the 1115 waiver reinforce the movement towards value-based payment (VBP)?**

   The movement toward value-based payment is critical to the success and sustainability of this waiver demonstration. To ensure the changes in the care delivery system funded through the waiver are sustained well beyond the 5-year demonstration period, we must change the way we pay for services. It will be an expectation that transformation projects reinforce the shift to paying for value over volume. To that end, projects will be expected to support provider and plan capacity in achieving systemic change in how services are reimbursed.

2. **How will the 1115 waiver support provider capacity to implement VBP?**

   Paying for value across the continuum of Medicaid services is necessary to assure the sustainability of the transformation projects undertaken through the Medicaid Transformation waiver. A transition away from paying for volume may be challenging to some providers, both financially and administratively.

   Because not all provider organizations are equipped at present to successfully operate in these payment models, providers may need assistance to develop additional capabilities and infrastructure. To that end, significant financial incentives will be established for attainment of VBP targets over the 5-year demonstration at the regional ACH and managed care plan level. Incentives will support provider and plan capacity in achieving systemic change to how services are reimbursed.

   In addition, there will be opportunities to explore the relationship of each of the project domains to value-based payment.

Performance Measures and Evaluation

1. **Please provide additional details about the process for developing and selecting the statewide performance metrics for the Medicaid Transformation waiver demonstration.**

   In applying for the 1115 waiver, the State has four primary goals:

   - Reduce avoidable use of intensive services, such as hospitals (acute care and psychiatric), nursing homes, traditional long-term services and supports, and jails.
   - Improve population health.
   - Accelerate the transition to value-based payment, using payment methods that pay for quality rather than quantity.
   - Ensure that Washington's Medicaid per-capita cost is below national trends.

   The State will need to negotiate overall performance metrics with CMS to monitor implementation and determine the degree to which these goals are met. Organizations receiving waiver investments will need to report on operational milestones initially, moving to outcome-based metrics over time. These metrics will

assess readiness to carry out transformation projects and, once underway, project performance to support continued funding.

Medicaid Transformation projects will use or build on the performance measure sets already in place in Washington. To guarantee that the state is facilitating mutual accountability across organizations, measures will be consistent with Apple Health managed care contracts. Measures specific to the waiver demonstration will be identified during the negotiation and development processes.

2. Will the state be adopting the Starter Set of measures that the statewide Performance Measures Coordinating Committee (PMCC) developed to measure the success of waiver activities?

We are committed to leveraging the Washington State Common Measure Set for Health Care Quality and Cost in addition to the Medicaid measures framework developed under Engrossed House Bill 1519 (EHB 1519) and Second Substitute Senate Bill 5732 (2SSB 5732). You can read more about the development of a Statewide Common Measures Set on the Healthier Washington website.

Previous work completed to establish standard Medicaid measures across delivery systems is summarized here.

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

Appendix 2: Archive of Out-of-Date Questions

General Questions

Will I have an opportunity to comment on the draft application?

There will be many opportunities to comment on the application. For up-to-date information about the meetings listed below, go to www.hca.wa.gov/hw.

Legislative Committees	
Joint Select Committee on Health Care Oversight John L. O'Brien Building, Room B State Capitol Campus Olympia, WA	Wednesday, July 22, 2015 9 – 11 a.m.

Medicaid Advisory Committee	
Title XIX Medicaid Advisory Committee Courtyard Marriott Seattle/Southcenter Tukwila, WA Call-in option; limited seating. To attend in person, RSVP to medicaidtransformation@hca.wa.gov.	Friday, July 31, 2015 8:40 – 9:40 a.m.

Public Forums If you plan to attend a forum in person please let us know by sending an e-mail to medicaidtransformation@hca.wa.gov. We will send additional information about these meetings, including directions and call-in capacity, later this month.	
Pierce County Pierce College-Ft. Steilacoom Lakewood, WA	Monday, August 3, 2015 8 – 10 a.m.
Snohomish County Everett Community College Everett, WA	Monday, August 3, 2015 1 – 3 p.m.
Yakima County Yakima Valley Community College Yakima, WA	Tuesday, August 4, 2015 8 – 10 a.m.
Franklin County Columbia Basin College Pasco, WA	Tuesday, August 4, 2015 2 – 4 p.m.
Spokane County Spokane Regional Health District Spokane, WA	Wednesday, August 5, 2015 10 – 12 p.m.

Tribal Meetings These meetings are limited to tribal members and their representatives.	
Tribal Roundtable Health Care Authority	Wednesday, July 22, 2015 9 – 11 a.m.
Tribal Public Forum NATIVE Project, Spokane, WA	Wednesday, Aug. 5 2 – 4 p.m.

Tribal Consultation Health Care Authority	Wednesday, Aug. 12 10:30 a.m. – 3 p.m.

For those who are unable to attend these forums, we will also have an August webinar. You can e-mail comments to medicaidtransformation@hca.wa.gov or mail comments to: Washington State Health Care Authority, Attn: Medicaid Transformation, PO Box 42710, Olympia, WA, 98504.

Transformation Projects:

How and when will stakeholders be engaged in the development of the transformation activity toolkit?

The toolkit will be developed during the negotiation process with CMS; it will not be finalized until the demonstration project itself has been approved by CMS and implementation steps have begun.
We recognize that stakeholders have significant experience and perspectives to contribute to shape the menu of projects, and we want to leverage that feedback as we build the transformation toolkit. We know that many of you are interested in participating in the development of the transformation project menu and, given the tight schedule and the number of people interested in contributing, we will not be able to include all interested parties in face-to-face workgroup meetings. To that end, we are developing methods for sharing information—including draft versions of the project toolkit—and gathering public input through our website and other communications. Currently we are working on a process for stakeholders to submit proposals for transformation projects, sharing existing evidence-based practices with us that fall into one or more of the three investment domains and proposing these types of projects for inclusion in the menu of transformation projects. We expect to share this process with our stakeholders through our website and a webinar in early December.