**DEPARTMENT OF HEALTH & HUMAN SERVICES**
**Centers for Medicare & Medicaid Services**
**7500 Security Boulevard, Mail Stop S2-01-16**
**Baltimore, Maryland 21244-1850**

**CMS**
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

**State Demonstrations Group**

FEB 16 2018

MaryAnne Lindeblad
Medicaid Director
Washington State Health Care Authority
626 8th Avenue SE
P.O. Box 45502
Olympia, Washington 98504-5502

Dear Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) is issuing technical corrections to the Washington State section 1115 Medicaid demonstration, entitled "Medicaid Transformation Project" (Project No. 11-W-00304/0), which was approved on January 5, 2016 under the authority of section 1115(a) of the Social Security Act ("the Act"). The technical corrections ensure that the Special Terms and Conditions (STC) reflect how the state is currently operating its demonstration.

If you have any questions, please do not hesitate to contact your project officer, Mr. Adam Goldman Mr. Goldman can be reached at (410) 786-2242, or at Adam.Goldman@cms.hhs.gov.

We look forward to continuing work with your staff on the administration of Washington's Medicaid Transformation Project demonstration.

Sincerely,

[redacted]

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: David Meacham, Associate Regional Administrator, Seattle Regional Office

**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.

To the extent necessary to enable the state to restrict freedom of choice of provider for individuals receiving who receive foundational community supports benefits under the demonstration.

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

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

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

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

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

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**EXPENDITURE AUTHORITY**

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

**TITLE:** **Washington State Medicaid Transformation Project**

**AWARDEE:** **Washington State Health Care Authority**

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

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

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

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

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

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

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

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

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

7. **Presumptive Eligibility for MAC and TSOA**
   Expenditures for each individual presumptively determined to be eligible for MAC or TSOA services, during the presumptive eligibility period described in STC 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.

**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:

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.

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. Demonstration Summary and Objectives. 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. Special Terms and Conditions. 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. Quality. 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.

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.

**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.

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/

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 ().** 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. 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 Quality Plan should include 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.

1. The Comprehensive QIS should include 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]
      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

[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.

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 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

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

**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.

## 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 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(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.

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) |

**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 |

**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.

**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.

**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**

| | 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 |

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

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

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 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.

**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.

## 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 |

| | | |
|---|---|---|
| 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 |

## ATTACHMENT A:
## QUARTERLY REPORT FORMAT

### Quarterly Report Template

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

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

### NARRATIVE REPORT FORMAT:

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

Title Line Two: Section 1115 Quarterly Report

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

### Introduction

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

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

Discuss the following:

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

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

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

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

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

**Attribution by Residence Counts for Quarter and Year to Date**

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

| Name of ACH | Current Enrollees (year to date) |
|---|---|
| | |
| | |
| | |
| | |
| | |

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

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

## IX. Financial/Budget Neutrality Development/Issues

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

## XI. Consumer Issues

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

## XII. Quality Assurance/Monitoring Activity

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

## XIII. Demonstration Evaluation

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

## XIV. Enclosures/Attachments

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

## XV. State Contact(s)

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

**ATTACHMENT B**
**DSHP Claiming Protocol and County Levy Programs**

## I. Review of DSHPs included in STCs

To support the goals of health system transformation, the state may claim Federal Financial Participation (FFP) for actual expenditures related to Designated State Health Programs (DSHP), subject to a maximum 5-year capped amount of $928,481,856 (total computable; see Section X). As described in these STCs, DSHP expenditures may be claimed for the period beginning January 9, 2017 and ending December 31, 2021. The state's programs that will serve as DSHPs are described in Table A below (see also STC 90, Table 3) and the limits and timelines under which the state may claim matching funds for these expenditures are described in Table B (see also STC 91, Table 4). This protocol describes the methodology and guidelines by which the state may claim FFP for DSHP expenditures.

**Table A. Designated State Health Programs (DSHP) List**

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

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

**Table B. DSHP Limits**

| Demonstration Year (DY) | DSHP Total |
|---|---|
| DY1 (1/9/2017-12/31/2017) | $240,000,000 |
| DY2 (1/1/2018 – 12/31/2018) | $216,000,000 |
| DY3 (1/1/2019 – 12/31/2019) | $190,080,000 |
| DY4 (1/1/2020 – 12/31/2020) | $157,766,400 |
| DY5 (1/1/2021 – 12/31/2021) | $124,635,456 |
| **Total** | **$928,481,856** |

## II. Documentation of Expenditures for General DSHP

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

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

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

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

## III. Unallowable DSHP Expenditures

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

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

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

## IV. Background on Washington's Financing and Accounting Systems

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

### A. Agency Financial Reporting System (AFRS)

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

### B. Sources of Non-Federal Share

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

For purposes of expenditures claimed under this protocol, the state will use certified public expenditures (CPE) as the funding mechanism to claim federal match for the approved state and local DSHPs as identified in STC 87(c). In addition to certifying that expenditures are eligible for FFP under the DSHP provisions of the demonstration project, the contributing Responsible Entities must certify that the sources of the non-federal share comply with the terms of this paragraph, excluding the types of program costs that are not eligible for FFP as defined in STC 92(b).

**Certified Public Expenditure Process**

For each DSHP, the state must perform the following steps to determine the amount of the DSHP expenditures eligible for FFP. The payments and associated claimed expenditures must be commensurate with actual program services delivered and actual allowable program expenditures. DSHPs with claims processed through ProviderOne[7] are based on an approved unit rate.

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

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

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

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

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

- information submitted is true, accurate, and complete
- information submitted is prepared in accordance with governing law and HCA instructions
- acknowledge that all information submitted in the CPE application is subject to audit by HCA or its authorized designee

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

- unallowable expenditures as defined in STC 92(b) are excluded from certified expenditures, only net expenditures are being claimed

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

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

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

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

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

## V. DSHP Program Details

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

**A. Program Title:** Kidney Disease Program (KDP)

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

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

- In-center dialysis
- In-home dialysis
- Medications
- Anti-rejection medication for transplant patients
- Home helper costs
- Equipment and home supplies
- Transportation
- Pre-transplant dental work (with prior authorization)

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

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

Eligible Population:

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

Unallowable State Match Expenditure List for the demonstration:

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

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

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

Brief Description:

Medicaid services for non-Medicaid eligible elderly and disabled populations not meeting functional and/or financial requirements through the traditional Medicaid Long Term Services and Supports (LTSS) system. Services include in-home personal care, residential care, dementia care, behavioral supports, and other in-home services, which may include personal response systems, equipment, and registered nurse delegation.

Clients receive services based on their individual assessment, which measures their level of need with activities of daily living (ADL) in addition to other supports/needs.

Eligible Population:

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

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

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

Washington Roads:

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

- Cohort 1. Individuals eligible for WA Roads while in an institution are:
    - People age 18 and older with a continuous 30-day or longer stay in a hospital or nursing facility; and
    - Medicaid recipients in the institution for at least one day or Fast Track eligible; and
    - Functionally and financially eligible (or Fast Tracked) for waiver/state plan home and community based services (HCBS), which currently include Community First Choice (CFC), Medicaid Personal Care (MPC), Alternative Benefit Plan – Medicaid Personal Care (ABP-MPC), Community Options Program Entry System (COPES), Residential Support Waiver (RSW) and New Freedom.

- Cohort 2. Individuals eligible for WA Roads while living in the community are functionally and financially eligible for waiver/state plan HCBS AND have any one of these characteristics:
    - Unstable residential or in-home settings
    - Frequent institutional contacts (ER visits, SNF stays, hospital admits, etc.)
    - Frequent turnover of caregivers
    - Multiple systems involvement (DOC, psychiatric institutions, etc.)
    - Is interested in obtaining employment through the Steps to Employment (S2E) project and the project is available in the individual's geographical area.
- Cohort 3. Individuals living in subsidized housing that have been coordinated through ALTSA (including NED, Bridge, 811, etc.), regardless of whether they are currently eligible for, or receiving, waiver/state plan HCBS.

    Individuals who are not eligible for WA Roads are:

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

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in the Special Terms & Conditions of the demonstration. Any unallowable expenditures identified for the items listed in STC 92(b)(i) through (xxiii) will be excluded from claiming. Controls exist within ProviderOne and IPOne[8] to identify those expenditures that should be excluded. Expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

**C. Program Title:** State Family Caregiver Support

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

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

Brief Description:

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

Eligible Population:

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

Unallowable State Match Expenditure List for the demonstration:

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

**D. Program Title:** Senior Citizen's Services Act (SCSA)
Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

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

Eligible Population:

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

Unallowable State Match Expenditure List for the demonstration:

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

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

This program is solely funded by general fund state dollars.

Brief Description:

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

Eligible Population:

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

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

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in the Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the

items listed in STC 92(b) i through xxiii. All expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

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

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

Brief Description:

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

Eligible Population:

Individuals who:

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

Unallowable State Match Expenditure List for the demonstration:

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

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

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

Brief Description:

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

Eligible Population:

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

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in the STCs of the demonstration. Any unallowable expenditures identified for the items listed in STC 92(b) i through xxiii will be excluded from

claiming. Controls exist within ProviderOne and IPOne to identify those expenditures that should be excluded. Expenditures on these contracts are related to grants to organizations to provide services to clients. Costs for administering the program, including the program reviews and audits noted above are not included in the DSHP claims. It is noted that services are not provided to undocumented individuals.

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

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

Brief Description:

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

Eligible Population:

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

Unallowable State Match Expenditure List for the demonstration:

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

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

This program is solely funded by general fund state dollars.

Brief Description:

An evidence-based program for people with the most severe and persistent mental illness who experience significant difficulties with activities of daily living, with active

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

Eligible Population:

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

Unallowable State Match Expenditure List for the demonstration:

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

**J. Program Title:** Offender Re-entry Community Safety Program
Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

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

Eligible Population:

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

Unallowable State Match Expenditure List for the demonstration:

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

**K. Program Title:** Spokane Acute Care Diversion
Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

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

Eligible Population:

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

Unallowable State Match Expenditure List for the demonstration:

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

**M. Program Title:** Outpatient and Support Services
Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

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

Eligible Population:

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

Unallowable State Match Expenditure List for the demonstration:

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

**N. Program Title:** Residential Services

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

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

Eligible Population:

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

Unallowable State Match Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of unallowable state match program expenditures included in these Special Terms & Conditions of the demonstration. For this

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

**P. Program Title:** Problem Gambling Services

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

This program funds problem and pathological gambling prevention efforts. Activities include elder awareness, literature distribution, and problem gambling prevention activities targeting young adults. Training specific to problem and pathological gambling is provided for chemical dependency professionals, licensed mental health counselors, psychologists, and agency affiliated counselors. A 24-hour helpline for problem and pathological gambling assists people with referrals to treatment providers and crisis stabilization.

Eligible Population:

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

Unallowable State Match Expenditure List for the demonstration:

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

**Q. Program Title:** Mental Health Transition Services

Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

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

Eligible Population:

Any releasing offender with identified mental health transition assistance needs.

Unallowable State Match Expenditure List for the demonstration:

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

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

This program is solely funded by general fund state dollars.

Brief Description:

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

Eligible Population:

Seriously mentally ill offenders transitioning back into the community.

Unallowable State Match Expenditure List for the demonstration:

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

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

This program is solely funded by general fund state dollars.

Brief Description:

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

Eligible Population:

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

Unallowable State Match Expenditure List for the demonstration:

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

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

This program is solely funded by general fund state dollars.

Brief Description:

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

Eligible Population:

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

Unallowable State Match Expenditure List for the demonstration:

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

**U. Program Title:** Tobacco and Marijuana Prevention and Education
Funding Sources: Dedicated Marijuana Account (State), Tobacco Control Program (Federal)

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

Brief Description:

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

Eligible Population:

The Washington State Tobacco Quitline (1-800-QUIT-NOW) serves all of Washington and triages callers to their health plan. About 40 percent of the calls are transferred to Medicaid or a private insurance plan. DOH covers people who are uninsured and the

underinsured (callers with a health plan with no telephone counseling or nicotine replacement benefit). The Quitline does not collect income information.

Unallowable State Match Expenditure List for the demonstration:

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

**V. Program Title:** Family Planning Non-Title X
Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

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

Eligible Population:

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

Unallowable State Match Expenditure List for the demonstration:

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

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

This program is solely funded by general fund state dollars.

Brief Description:

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

Eligible Population:

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

Unallowable State Match Expenditure List for the demonstration:

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

**X. Program Title:** Health Professional Loan Repayments (WA Student Achievement Council)
Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

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

Eligible Population:

Health professionals serving rural or underserved urban areas.

Unallowable State Match Expenditure List for the demonstration:

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

**Y. Program Title:** Street Youth Service (Department of Commerce)
Funding Sources: General Fund State

This program is solely funded by general fund state dollars.

Brief Description:

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

Eligible Population:

Unaccompanied homeless youth under the age of 18.

Unallowable State Match Expenditure List for the demonstration:

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

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

Brief Description:

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

Eligible Population:

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

Unallowable State Match Expenditure List for the demonstration:

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

**ATTACHMENT C**
**DSRIP Planning Protocol**

## I. Preface

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

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

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

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

## II. ACH Project Plan Requirements

### *a. Introduction*

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

community-specific needs and further the objectives of the demonstration. The plans also will describe the ACH's capacities, composition and governance structure. In order to be eligible to receive DSRIP incentive payments, an ACH must have an approved Project Plan.

There are three steps for ACH Project Plan approval:

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

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

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

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

*b. ACH Certification Criteria*

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

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

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

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

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

3. Community and Stakeholder Engagement to describe concrete actions that have occurred since Phase 1 Certification. Provide details for how the ACH will satisfy public engagement requirements for Project Plan development outlined in STC 23.
4. Budget and funds flow to summarize strategic use of funding and decision making processes regarding incentive funding distribution.
5. Data-informed decision making strategies, including processes for applying available data to project selection and implementation planning.
6. Transformation project planning to describe progress on project selection processes.
7. Other requirements as the state may establish.

*c. ACH Project Plan Requirements*

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

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

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

obligations of the ACH as the lead and other partnering providers in the ACH in order to be eligible to receive DSRIP incentive funding.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. *Regional Assets, Anticipated Challenges and Proposed Solutions*: Description of the assets that the ACH and partnering providers bring to the delivery system transformation efforts, and the challenges or barriers they expect to confront in improving outcomes and lowering costs for the target populations. For identified challenges, the ACH must describe how it expects to mitigate the impact of these challenges and what new capabilities will be required to be successful.

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

## III. Project Toolkit

*a. Overview of Project Categories*

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

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

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

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

*b. Description of project domains*

**i. Health Systems and Community Capacity Building**
This domain addresses the core health system capacities to be developed or enhanced to transition the delivery system according to Washington's

Medicaid Transformation demonstration. Domain 1 does not outline individual projects, but rather three required focus areas to be implemented and expanded across the delivery system, inclusive of all provider types, to benefit the entire Medicaid population. The three areas of focus are: financial sustainability through value-based payment, workforce, and systems for population health management. Each of these areas will need to be addressed progressively throughout the five-year timeline to directly support Domain 2 and Domain 3 transformation project success.

**ii. Care Delivery Redesign**

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

**iii. Prevention and Health Promotion**

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

**Table 1. Menu of Transformation Projects**

| # | Project | Description |
|---|---|---|
| **Health Systems and Community Capacity Building** | | Foundational activities that address the core health system capacities to be developed or enhanced to transition the delivery system in accordance with the demonstration's goals and transformation objectives. |
| **Financial sustainability through value-based payment** | | Paying for value across the continuum of care is necessary to ensure the sustainability of the transformation projects undertaken through this demonstration. A transition away from paying for volume may be challenging to some providers, both financially and administratively. As not all provider organizations are equipped at present to successfully operate in these payment models, providers may need assistance to develop additional capabilities and infrastructure. |

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|---|---|---|
| **Workforce** | | The health services workforce will need to evolve to meet the demands of the redesigned system of care. Workforce transformation will be supported through the provision of training and education services, hiring and deployment processes, and integration of new positions and titles to support transition to team-based, patient-centered care and ensure the equity of care delivery across populations. |
| **Systems for population health management** | | The expansion, evolution, and integration of health information systems and technology will need to be supported to improve the speed, quality, safety, and cost of care. This includes linkages to community-based care models. Health data and analytics capacity will need to be improved to support system transformation efforts, including combining clinical and claims data to advance VBP models and to achieve the triple aim. |
| **Care Delivery Redesign** | | Strategies that focus on innovative models of care to improve the quality, efficiency, and effectiveness of care processes. Person-centered approaches and integrated models are emphasized. |
| 2A | **Bi-directional integration of physical and behavioral health through care transformation** | The Medicaid system aims to support person-centered care that delivers the right services in the right place at the right time. Primary care services are a key gateway to the behavioral health system, and primary care providers need additional support and resources to screen and treat individuals for behavioral health care needs, provide or link with appropriate services, and manage care. Similarly, for persons not engaged in primary care services, behavioral health settings can be equipped to provide essential primary care services. Integrating mental health, substance use disorder, and primary care services has been demonstrated to deliver positive outcomes and is an effective approach to caring for people with multiple health care needs. Through a whole-person approach to care, physical and behavioral health needs will be addressed in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through managed care organizations, for people enrolled in Medicaid. |
| 2B | **Care coordination** | Care coordination is essential for ensuring that children and adults with complex health service needs are connected to the evidence-based interventions and services that will improve their outcomes. Appropriately coordinated care is especially important for high-risk |

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| | | populations, such as those living with chronic conditions, those impacted by the social determinants of health such as unstable housing and/or food insecurity, the aging community, and those dependent on institutionalized settings. Communities are challenged to leverage and coordinate existing services, as well as establish new services to fill gaps. Without a centralized approach to "coordinating the coordinators," a single person might be assigned multiple care coordinators who are unaware of one another, potentially provide redundant services, and risk creating confusion for the individual. |
| 2C | **Transitional care** | Points of transition out of intensive services/settings, such as individuals discharged from acute care, inpatient care or from jail or prison into the community are critical intervention points in the care continuum. Transitional care services provide opportunities to reduce or eliminate avoidable admissions, readmissions and jail use. Individuals discharged from intensive settings may not have a stable environment to return to or may lack access to reliable care. Transitions can be especially difficult on beneficiaries and caregivers when there are substantial changes in medications or routines or an increase in care tasks. This project includes multiple care management and transitional care approaches. |
| 2D | **Diversion interventions** | Diversion strategies provide opportunities to re-direct individuals away from high-cost medical and legal avenues and into community-based health care and social services that can offer comprehensive assessment, care/case planning and management to lead to more positive outcomes. This strategy promotes more appropriate use of emergency care services and also supports person-centered care through increased access to primary care and social services, especially for medically underserved populations. |
| **Prevention and Health Promotion** | | Projects focus on prevention and health promotion to eliminate disparities and achieve health equity across regions and populations. |
| 3A | **Addressing opioid use public health crisis** | The opioid epidemic affects communities, families, and overwhelms law enforcement, health care and social service providers. Opioid use disorder is a devastating and life-threatening chronic medical condition and access to treatments that support recovery and access to lifesaving medications to reverse overdose needs to be improved. This project will support strategies focused on addressing prevention, treatment, overdose prevention and recovery supports aimed at supporting whole-person health |

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| 3B | **Reproductive and maternal/child ealth** | Focusing on the health of women and children is a primary focus for the Medicaid program as Medicaid funds more than half of the births in the state and provides coverage to more than half of Washington's children. This project focuses on ensuring access to ongoing women's health care to improve utilization of effective family planning strategies. It further focuses on providing mothers and their children with home visits that have been demonstrated to improve maternal and child health. Home visitors work with the expectant or new mother in supporting a healthy pregnancy, by recognizing and reducing risk factors, promoting prenatal health care through healthy diet, exercise, stress management, ongoing well-woman care, and by supporting positive parenting practices that facilitate the infant and young child's safe and healthy development. Child health promotion is a state priority to keep children as healthy and safe as possible, which includes parents accessing timely and routine preventative care for children, especially well-child screenings and assessments. |
| 3C | **Access to oral health services** | Oral health impacts overall health and quality life, and most oral disease is preventable. Oral disease has been associated with increased risk for serious adverse health outcomes. Increasing access to oral health services for adults provides an opportunity to prevent or control the progression of oral disease, and to reduce reliance on emergency departments for oral pain and related conditions. This project focuses on providing oral health screening and assessment, intervention, and referral in the primary care setting, or through the deployment of mobile clinics and/or portable equipment. The project seeks to leverage the primary care workforce, and to strengthen relationships between primary care and dental providers, through stronger referral networks, improved communications, and shared incentives. |
| 3D | **Chronic disease prevention and control** | Chronic health conditions are prevalent among Washington's Medicaid beneficiaries, and the number of individuals with or at risk for chronic disease is increasing. Disease prevention and effective management is critical to quality of life and longevity. Many individuals face cultural, linguistic and structural barriers to accessing quality care, navigating the health care system, and understanding how to take steps to improve their health. Improving health care services and health behaviors is only part of the solution. Washington State recognizes the impact that factors outside the health care system have on health and is committed to a |

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| | | "health in all policies" approach to effective health promotion and improved treatment of disease. The Chronic Disease Prevention and Control Project focuses on integrating health system and community approaches to improve chronic disease management and control. |

## IV. Project Stages, Milestones, and Metrics

*a. Overview*

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

To monitor performance, ACHs will be accountable for achieving targeted levels of improvement for project-specific outcome measures. These measures are primarily "pay-for-performance," or "P4P," since ACHs are only rewarded if defined outcome metric targets are achieved. However, a subset of these measures will be rewarded on a P4R basis for reasons that include: to allow ACHs time for project implementation activities; to allow time to establish necessary reporting infrastructure; and to allow for the testing of new, innovative outcome measures for project areas where there is a lack of nationally-vetted, widely used outcome measures. Performance metrics are are consistent with the objectives of the demonstration as outlined in STC 30.

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

**Table 2. Demonstration Milestone/Metric Categories**

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

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

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

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

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

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

*d. Value-based Payment Milestones*

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

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

**Table 3. Value-based Payment Milestone Categories**

| Value-based Payment DSRIP Pool | DY 1 | | DY 2 | | DY 3 | | DY 4 | | DY 5 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | P4R | P4P | P4R | P4P | P4R | P4P | P4R | P4P | P4R | P4P |
| MCO VBP Incentives | 75% | 25% | 50% | 50% | 25% | 75% | 0% | 100% | 0% | 100% |
| ACH VBP Incentives | 100% | 0% | 75% | 25% | 50% | 50% | 25% | 75% | 0% | 100% |

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

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

## V. Process for Project Plan Modification

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

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

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

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

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

**ATTACHMENT D**
**DSRIP Program Funding & Mechanics Protocol**

## I. Accountable Communities of Health

*a. Introduction*

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

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

*b. ACH Service Regions*

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

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

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

*c. ACH Composition and Partnering Provider Guidelines*

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

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

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

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

- Financial
- Clinical
- Community

- Data and Performance Monitoring
- Program management and strategy development

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

## II. Projects, Metrics and Metric Targets

*a. Overview of Projects*

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

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

*b. Project Metrics*

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

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

*c. Outcome Metric Goals and Improvement Target*

ACHs will have a performance goal for each outcome metric. On an annual basis, the state will measure ACH improvement from a baseline toward this goal to

evaluate whether or not the ACH has achieved the metric improvement target. Each ACH will have its own baseline starting point. Both existing and new measures' baselines will be set based on performance during Demonstration Year (DY) 1.

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

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

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

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

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

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

## III. Incentive Funding Formula and Project Design Funds

*a. Demonstration Year 1 (DY1)*

*i. Project Design Funds*

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

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

*ii. Project Funding*

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

*b. Demonstration Years 2 through 5 Funding and Project Valuation*

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

determines maximum incentive payments allotted to each ACH, by project, which will be available for distribution to partnering providers. As described in STC 35, the annual maximum project valuation is determined based on the attributed number of Medicaid beneficiaries residing in the ACH RSA(s) and on the Project Plan application scores.

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

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

*c. Calculating Maximum ACH Project Valuation*

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

Step 1: Assigning Project Weighting

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

Each project has associated metrics that ACHs must achieve to earn funding tied to the project. An ACH's payment for project implementation is based on pay-for-

reporting (P4R) in DY1 and DY2 and based on both P4R and pay-for-performance (P4P) in DY3, DY4 and DY5. The maximum amount of incentive funding that an ACH can earn is determined based on the ACH's project selection, the value of the projects selected, the quality and score of Project Plan applications, and the number of Medicaid beneficiaries attributed to the ACH. Project weights outlined in Table 1 were assigned with consideration of the following factors:

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

**Table 1. Transformation Project Weighting**

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

***Projects listed in order of Project Weighting***

Project 2A (Bi-Directional Integration of Care and Primary Care Transformation) represents the state's primary objective under Initiative 1 of the demonstration. Project 2A requires the highest level of integration of all other projects and, therefore, houses the largest corresponding set of P4P metrics. Furthermore, Project 2A has the potential to yield the greatest achievement of value for Medicaid

members through an evidence-based approach—and is likely to result in significant cost-savings for both the state and federal government. Regions that have implemented fully integrated managed care are be better positioned to scale project 2A and are eligible for an enhanced DY1 valuation based on project plan scoring methodology.

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

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

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

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

Project 3A (Addressing the Opioid Use Public Health Crisis) will affect a subset of the state's substance use disorder (SUD) population of Medicaid beneficiaries, anticipated to be proportionally smaller than most other Domain 3 projects, by aligning with Governor Inslee's Executive Order 16-09.[9] Based on public comments and feedback to the Project Toolkit (Attachment C), Project 3A has now been escalated as a required project for all ACHs.

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

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

Step 2: Calculating Maximum ACH Project Funding

In accordance with STC 28 and STC 35(b), the state developed an allocation methodology for maximum ACH project funding based on project selection, transformation impact of projects, and attribution based on residence. The state will use the defined RSA boundaries to determine beneficiary attribution for the funding methodology using the November 2017 client-by-month file. The relative level of Medicaid attribution determined at that time will determine maximum DSRIP funds per ACH throughout the demonstration, as outlined below. Maximum funding by project is calculated by multiplying the total state ACH project funds available by the respective project weight (see Table 1 for project weighting).

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

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

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

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

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

*d. Earning Incentive Payments*

In DY2 through DY5, ACHs earn incentive payments for successful implementation and reporting of selected projects. Successful implementation is defined for each

project as meeting the associated reporting-based progress measures and performance-based outcome metrics.

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

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

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

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

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

**Table 2. Example Calculation of Achievement Values**

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

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

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

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

*e. Managed Care Integration*

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

Regions that implement fully integrated managed care prior to 2020 are eligible to earn incentive payments above the maximum valuation for project 2A. To earn incentives above the maximum valuation for project 2A, regions must submit binding letters of intent to implement full integration. This will be reported in Project Plan submissions.

The incentive payment is calculated using a base rate of up to $2 million and a per member rate based on total attributed Medicaid beneficiaries, with payments distributed to the ACH in the calendar year of completion.

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

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

**Table 4. Weighting of Integration Progress Measures by Phase**

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

*f. Value-based Payment Incentives*

In accordance with STCs 41 and 42 and the state's Value-based Roadmap (Attachment F), the state will set aside no more than 15 percent of annually available DSRIP funds to reward MCO and ACH partnering providers for provider-level attainment of VBP targets as well as progression from baseline as described in STCs 41 and 42. VBP targets reflect goal levels of adoption of Alternative Payment Models (APM) and Advanced APMs in managed care contracting.

## IV. ACH Reporting Requirements

These activities are detailed below.

*a. Semi-Annual Reporting for ACH Project Achievement*

Two times per year, ACHs seeking payment under the demonstration shall submit reports that include the information and data necessary to evaluate ACH projects using a standardized reporting form developed by the state. ACHs must use the document to report on their progress against the milestones and metrics described in their approved Project Plans. Based on these reports, as well as data generated by the state on performance metrics, the state will calculate aggregate incentive payments in accordance with this protocol. The ACH reports will be reviewed by

state and the Independent Assessor. Upon request, ACHs will provide back-up documentation in support of their progress. These reports will be due as indicated below after the end of each reporting period:

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

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

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

## V. State Oversight Activities

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

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

reporting outlined in this protocol as a condition for qualifying for demonstration funds.

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

*a. Quarterly Operational Reports*

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

*b. Learning Collaboratives*

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

*c. Program Evaluation*

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

## VI. Statewide Performance and Unearned DSRIP Funding

*a. Accountability for State Performance*

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

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

*Statewide Accountability Metrics*

1. Mental Health Treatment Penetration
2. Substance Use Disorder Treatment Penetration

3. Outpatient Emergency Department Visits per 1000 Member Months
4. Plan All-Cause Readmission Rate (30 days)
5. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
6. Antidepressant Medication Management
7. Medication Management for People with Asthma (5 – 64 Years)
8. Controlling High Blood Pressure
9. Comprehensive Diabetes Care - Blood Pressure Control
10. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control

The state will establish a baseline performance for each measure. The state will adapt the Quality Improvement Score (QIS) methodology, originally developed by HCA for measuring MCO performance, to determine statewide performance across the statewide accountability measures for the demonstration. Each measure is assessed for both achievement of quality and improvement on an annual basis beginning DY3. The weighted sum of all the individual measure quality improvement scores will yield the overall QIS. The overall QIS is then used to indicate whether a reduction of funding is warranted, and to calculate the percentage of funding at risk that should be reduced for that demonstration year. Annual improvement will reflect closing of the relative gap between prior performance year and the goal by up to 10 percent each year, as described in

Attachment C, Section III(c). Quality will be assessed based on existing national benchmark standards where possible. For newer, innovative measures that do not have established national estimates, quality will be determined based on available evidence of reasonable expectation for magnitude of change.

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

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

*b. Reinvestment of Unearned DSRIP Funding*

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

## VII. Demonstration Mid-point Assessment

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

ACHs will be required to participate in the mid-point assessment and adopt recommendations that emerge from the review. The state may withhold a percentage

or all future DSRIP incentive funds if the ACH fails to adopt recommended changes, even if all other requirements for DSRIP payment are met.

**RESERVED FOR ATTACHMENT E**
**Value-Based Purchasing Roadmap**
**(Reserved)**

## ATTACHMENT F
## Financial Executor Role

In coordination with HCA and representatives of the state's nine ACHs, the contracted financial executor (FE) shall be responsible for administering a funding distribution plan as described in Attachment D.

ACHs, through their governing bodies, are responsible for managing and coordinating with partnering providers. The ACHs must meet the qualifications set forth in STCs 21 - 23 and must meet the targets enumerated in Attachment C in order to earn incentive payments. In addition, ACHs will certify as to whether or not the partnering providers have met the milestones required for earning incentive payments within their region. The ACH will also certify to the independent assessor whether or not partnering providers have achieved the milestones (see STC 21). The independent assessor (IA) will review the ACH's certification and make recommendations to the state related to distribution of payment. Once the state affirms the recommendations from the IA, it will send the incentive payments to the FE for distribution to the partnering providers.

The contracted FE will perform the work and complete the deliverables outlined below.

1. Establish a system for recording, processing, distributing and reporting on the payment of incentive funds and other financial transactions between HCA, ACHs and partnering providers in accordance with Attachment D.
    1.1. Establish a standardized process and forms to track payments to partnering providers and instruct partnering providers and ACHs in their use.
    1.2. The distribution of funds must comply with all applicable laws and regulations, including, but not limited to, the following federal fraud and abuse authorities: the anti-kickback statute (sections 1128B(b)(1) and (2) of the Social Security Act (the "Act")); the physician self-referral prohibition (section 1903(s) of the Act); the gainsharing civil monetary penalty (CMP) provisions (sections 1128A(b)(1) and (2) of the Act); and the beneficiary inducement CMP (section 1128A(a)(5) of the Act); as well as with HCA and Washington state rules and generally accepted accounting principles.
2. Provide financial accounting and banking management support for all incentive payments.
    2.1. Establish and maintain appropriate accounts as directed by HCA for the tracking of incentive payment receipts and holding of funds and issuance of payments.

2.2. Regularly track and report on all transactions from such accounts, including but not limited to payments, receipts, refunds and reconciliations.

3. Distribute earned funds in a timely manner to partnering providers in accordance with HCA-approved funding distribution plans.

3.1. Upon instruction and approval from the ACH, issue payments to partnering providers within 14 business days.

3.2. Respond to inquiries from ACHs and partnering providers regarding payments made or owed amounts, within 5 business days.

3.3. Identify, record, resolve and report on any under- or over-payments, including issuing requests for refunds if necessary.

3.4. Record and regularly report to ACHs on funds processed and payments made.

4. Submit scheduled reports to HCA and ACHs on the distribution of transformation project payments, fund balances and reconciliations–in accordance with relevant state and federal rules.

5. Develop and distribute budget forms to partnering providers for receipt of incentive funds.

6. As requested, assist HCA in responding to inquiries from CMS regarding financial transactions and any audits that may be required.

**ATTACHMENT G**
**Intergovernmental Transfer (IGT) Protocol**

## I. Preface

As part of this demonstration, the Delivery System Reform Incentive Payment (DSRIP) program is to provide incentives for Medicaid providers to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities by improving care, improving health and reducing costs. The non-federal share of these payments will come from intergovernmental transfers (IGT) from public hospitals, other local government or tribal funds, or funds that the state has earned by claiming federal match on expenditures for Designated State Health Programs (DSHP).

In accordance with STC 87(d), the state may use IGTs to the extent that such funds are derived from state, tribal, or local monies and are transferred by units of government, which can include a governmentally operated provider, within the state. The state provides assurance that the matching non-federal share of funds for the demonstration is state/local/tribal monies and that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Social Security Act, 42 CFR §433.51 and applicable regulations. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid State Plan.

The IGT protocol (this document, Attachment E) describes the methodology and guidelines by which the state may use IGT as a source of funding for the non-federal share of demonstration expenditures.

## II. IGT Process and the Role of the Accountable Communities of Health (ACH)

Under this demonstration, the state will make performance-based funding available to regionally-based ACHs and their partnering providers with the goal of transforming the delivery system for Medicaid beneficiaries. The ACHs will be responsible for coordinating the efforts of partnering providers in their community to create and implement regional project plans to transform the Medicaid delivery system. The project plans will be reviewed by a third-party Independent Assessor, who will make recommendations to the state as to whether the plans should be approved.

Approved project plans that meet the milestones outlined in the project will be eligible for incentive payments under the demonstration. A component of the non-federal share of these payments will come from IGTs. The responsibility of the Financial Executor includes distributing earned incentives in a timely manner to participating providers in accordance with each ACH's budget plan.

DSRIP payments are made twice per year and are always paid using the same process. The incentive payment amounts are determined by two reporting periods per demonstration year, where ACHs report the metrics and milestones achieved by their transformation projects. The state, with support from the Independent Assessor, will review reports to calculate the incentive payments earned by the ACH. Once incentive amounts are calculated, the state will calculate the non-federal share amount to be transferred by an IGT contributor based on ACH budget plans in order to draw the federal funding for incentive payments related to the achievement of milestones and metrics. Within 14 calendar days after notification by the state of the identified non-federal share amount, the IGT contributor will make an intergovernmental transfer of funds. The state will pay an amount equivalent to the non-federal and federal shares of the incentive payment to the ACH and its partnering providers. The state will then draw the federal funding based on those disbursements. If the IGT is made within the appropriate and approximate 14-day timeframe, the incentive payment will be disbursed within approximately 30 calendar days. The total computable incentive payment must remain with the ACH partnering providers and will not be returned to or retained by the state.

## III. IGT Funding Conditions

IGTs from governmentally operated providers must be in an amount not to exceed the non-federal share of title XIX payments. No pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

An agreement will be executed between the Health Care Authority (HCA), Washington's Medicaid agency, and each IGT contributing entity. The agreement will identify the annual estimated commitments by each IGT contributor. Funds will

be transferred from each IGT contributor and will be under the administrative control of HCA. The state will provide copies of the signed IGT agreements between the state and the public entity providing the IGT funds to the CMS regional office.

IGT contributions for purposes of DSRIP are eligible for a 50 percent federal match. The IGT contributor will, by signature, attest that the IGT contribution is not derived from Federal receipts and that they will maintain records to document the source of non-federal share and furnish those records to HCA and CMS as necessary.

Additionally, the IGT contributor must identify the allowable funding source, over the course of a given DSRIP Year, to support the IGT commitment for DSRIP.

IGT funding as described under this demonstration does not have any interaction with existing provider assessment arrangements, with regard to the federal 6% cap. Incentive payments will also not impact upper payment limit (UPL) or state/hospital specific Disproportionate Share Hospital (DSH) caps. Additionally, IGTs will not interact with existing Certified Public Expenditure (CPE) arrangements or any upper payment limit requirements with governmental (public) hospitals as long as the IGTs are not considered an expenditure for the provision of a hospital service for hospitals that CPE. CPEs are expenditures made for the provision of a Medicaid service and certifying providers can receive no service payments above their certified costs. The IGTs are the expense of financing the non-federal share for other Medicaid purposes, and the public hospitals may not claim the transfer of funds to the Medicaid agency as a Medicaid uncompensated hospital service cost under the State Plan or the waiver since their service costs are fully satisfied.

**RESERVED FOR ATTACHMENT H**
**Tribal Engagement and Collaboration Protocol**
**(Reserved)**

**ATTACHMENT I**
**Foundational Community Supports Program**

Per STC's 59-67, the following protocol outlines the services and payment methodologies for the Foundational Community Supports (FCS) Program. Under this program, the state will provide a set of Home and Community Based Services (HCBS), including Community Support Services (CSS), and Supported Employment-Individual Placement and Support (IPS), to populations that meet the needs-based criteria specified below. These services include HCBS that could be provided to the individual under a 1915(i) state plan amendment (SPA).

## Community Support Services (CSS)

### Target Criteria

CSS eligibility is available to Medicaid clients age 18 or older who meet the following needs-based criteria that would otherwise be allowable under a 1915(i) SPA:

### Needs-Based Criteria

Individual meets at least one of the following health needs-based criteria and is expected to benefit from CSS:

1) Individual assessed to have a behavioral health need, which is defined as one or both of the following criteria:
   **a)** Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or
   b) Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment. The ASAM is a multi-dimensional assessment approach for determining an individual's need for SUD treatment.
2) Individual assessed to have a need for assistance, demonstrated by the need for:
   a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388-106-0010, one of which may be body care, and/or
   b) Hands-on assistance with one or more ADLs, one of which may be body care.
3) Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support).

AND

Individual has at least one of the following risk factors:

1) Homelessness, defined as living in a place not meant for human habitation, a safe haven, or an emergency shelter, as these terms are understood or defined in 24 CFR 578.3:
   a) For at least 12 months, or
   b) On at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months.

2) History of frequent and/or lengthy stays in the settings defined in 24 CFR 578.3, or from, a skilled nursing facility as defined in WAC 388-97-0001.
    a) Frequent is defined as more than one contact in the past 12 months.
    b) Lengthy is defined as 90 or more consecutive days within an institutional care facility.
3) History of frequent adult residential care stays, where
    a) Frequent is defined as more than one contact in the past 12 months.
    b) Adult residential care includes
        i) Residential treatment facilities defined in WAC 246-337-005,
        ii) Adult residential care, enhanced adult residential care, or assisted living facilities defined in WAC 388-110-020, and
        iii) Adult family homes defined in WAC 388-76-10000.
4) History of frequent turnover of in-home caregivers, where within the last 12 months the individual utilized 3 or more different in-home caregiver provider agencies and the current placement is not appropriate for the individual.
5) A Predictive Risk Intelligence System (PRISM) Score of 1.5 or above
    a) The PRISM Risk Score uses diagnosis, prescription, age, and gender information from claims and encounter data to create an index of a client's expected future medical expenditures relative to the expected future medical expenditures of a comparison group (disabled Medicaid adults). The algorithm uses risk factor categories developed at University of California, San Diego known as the Chronic Illness and Disability Payment System (CDPS) and MedicaidRx, which were deemed by the Society of Actuaries to be effective methods of risk adjustment. The PRISM risk score is updated on a monthly basis by the Washington State Department of Social and Health Services' Research and Data Analysis division using the past fifteen months of claims, encounter, and demographic data. A risk score of 1.5 means that an individual's expected future medical expenditures will be 50 percent greater than that of the average Medicaid disabled client. The PRISM risk score was approved by CMS for targeting clients for the Health Home Program and Financial Alignment Dual Demonstration.

**Service Definitions for HCBS That Could Be Provided under a 1915(i) SPA**

**Community Support Services (CSS) benefits package.** CSS includes services that would otherwise be allowable under a Section 1915(i) authority, are determined to be necessary for an individual to obtain and reside in an independent community setting, and are tailored to the end goal of maintaining individual recipients' personal health and welfare in a home and community-based setting. CSS may include one or more of the following components:

Pre-tenancy supports:

a. Conducting a functional needs assessment identifying the participant's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual), assistance in budgeting for housing/living expenses, assistance in connecting the individual with social services to assist with filling out applications and submitting appropriate documentation in order to obtain sources of

income necessary for community living and establishing credit, and in understanding and meeting obligations of tenancy.

b. Assisting individuals to connect with social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs. .
c. Developing an individualized community integration plan based upon the functional needs assessment as part of the overall person centered plan. Identifying and establishing short and long-term measurable goal(s), and establishing how goals will be achieved and how concerns will be addressed.
d. Participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
e. Providing supports and interventions per the person-centered plan.

Tenancy sustaining services:

a. Service planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
b. Coordinating and linking the recipient to services including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports.
c. Entitlement assistance including assisting individuals in obtaining documentation, navigating and monitoring application process, and coordinating with the entitlement agency.
d. Assistance in accessing supports to preserve the most independent living such as individual and family counseling, support groups, and natural supports.
e. Providing supports to assist the individual in the development of independent living skills, such as skills coaching, financial counseling, and anger management.
f. Providing supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
g. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
h. Connecting the individual to training and resources that will assist the individual in being a good tenant and lease compliance, including ongoing support with activities related to household management.

The CSS benefit does not include:

a. Payment of rent or other room and board costs;
b. Capital costs related to the development or modification of housing;
c. Expenses for utilities or other regular occurring bills;
d. Goods or services intended for leisure or recreation;
e. Duplicative services from other state or federal programs
f. Services to individuals in a correctional institution or an IMD (other than services that

meet the exception to the IMD exclusion).

**Supported Employment – Individual Placement and Support**

**Target Criteria**

IPS eligibility include Medicaid clients age 16 or older who meet the following criteria that would otherwise be allowable under a 1915(i) SPA:

**Needs-based criteria**

Individual meets at least one of the following health needs-based criteria and is expected to benefit from IPS:

1) Individual assessed to have a behavioral health need, which is defined as one or both of the following:
    a) Mental health needs, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support), resulting from the presence of a mental illness.
    b) Substance use needs, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment. The ASAM is a multi-dimensional assessment approach for determining an individual's need for SUD treatment.
2) Individual assessed to have a need for assistance demonstrated by the need for:
    a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388-106-0010, one of which may be body care, and/or
    b) Hands-on assistance with one or more ADLs, one of which may be body care.
3) There is objective evidence of physical impairments because of which the individual needs assistance with basic work-related activities, including one or more of the following: Sitting, standing, walking, lifting, carrying, handling, manipulative or postural functions (pushing, pulling, reaching handling, stooping or crouching), seeing, hearing, communicating, remembering, understanding and following instructions, responding appropriately to supervisors and co-workers, tolerating the pressures of a work setting, maintaining appropriate behavior, using judgment, and adapting to changes in a routine work setting.

AND

Individual has at least one of the following Risk Factors:

1) Unable to be gainfully employed for at least 90 consecutive days due to a mental or physical impairment.
2) An inability to obtain or maintain employment resulting from age, physical disability, or traumatic brain injury.
3) More than one instance of inpatient substance use treatment in the past two years.
4) At risk of deterioration of mental illness and/or substance use disorder, including one or more of the following:
    a) Persistent or chronic risk factors such as social isolation due to a lack of family or social supports, poverty, criminal justice involvement, or homelessness.

b) Care for mental illness and/or substance use disorder requires multiple provider types, including behavioral health, primary care, long-term services and supports, and/or other supportive services.
c) Past psychiatric history, with no significant functional improvement that can be maintained without treatment and/or supports.
d) Dysfunction in role performance, including one or more of the following:
    i) Behaviors that disrupt employment or schooling, or put employment at risk of termination or schooling suspension.
    ii) A history of multiple terminations from work or suspensions/expulsions from school.
    iii) Cannot succeed in a structured work or school setting without additional support or accommodations.
    iv) Performance significantly below expectation for cognitive/developmental level.

**Service Definitions for HCBS That Could Be Provided under a 1915(i) SPA**

**Supported Employment – Individual Placements and Support (IPS) benefit package:** The IPS benefit package will be offered to eligible clients through a person-centered planning process where eligible services are identified in the plan of care. IPS includes services that would otherwise be allowable under a Section 1915(i) authority, and are determined to be necessary for an individual to obtain and maintain employment in the community. IPS services are individualized and may include any combination of the following services:

Pre-employment services

a. Pre-vocational/job-related discovery or assessment
b. Person-centered employment planning
c. Individualized job development and placement
d. Job carving
    - Job carving is defined as working with client and employer to modify an existing job description— containing one or more, but not all, of the tasks from the original job description when a potential applicant for a job is unable to perform all of the duties identified in the job description.
e. Benefits education and planning
    - Benefits education and planning is defined as counseling to assist the client in fully understanding the range of state and federal benefits they might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the client's options for returning to work.
f. Transportation (only in conjunction with the delivery of an authorized service)

Employment sustaining services

a. Career advancement services
    - Career advancement services are defined as services that expand opportunities for professional growth, assist with enrollment in higher education or credentialing and certificate programs to expand job skills or enhance career development, and assist the individual in monitoring his/her satisfaction with employment, and

determining level of interest and opportunities for advancement with current employer, and/or changing employers for career advancement.

b. Negotiation with employers
    - Negotiation with employers is defined as services where a provider identifies and addresses job accommodations or assistive technology needs with the employer on behalf of the individual. Job accommodations can include the following: adjusting work schedule to reduce exposure to triggering events (i.e., heavy traffic triggering symptoms of agoraphobia); providing a private area for individuals to take breaks if they experience an increase in symptoms; access to telephone to contact support person if needed while at work; adjusting job schedule to accommodate scheduled appointments; and small, frequent breaks as opposed to one long one. Assistive Technology can include the following: bedside alarms, electronic medication reminders while at work or at home, and use of headset/iPod to block out internal or external distractions.
c. Job analysis
    - Job analysis is defined as the gathering, evaluating, and recording of accurate, objective data about the characteristics of a particular job to ensure the specific matching of skills and amelioration of maladaptive behaviors.
d. Job coaching
e. Benefits education and planning
    - Benefits education and planning is defined as counseling to assist the client in fully understanding the range of state and federal benefits they might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the clients' options for returning to work.
f. Transportation (only in conjunction with the delivery of an authorized service)
g. Asset development
    - Asset development is defined as services supporting the client's accrual of assets that have the potential to help clients improve their economic status, expand opportunities for community participation, and positively impact their quality of life experience. Assets as defined as something with value that is owned by an individual, such as money in the bank, property, and retirement accounts.
h. Follow-along supports
    - Follow-along supports are defined as on-going supports necessary to assist an eligible client to sustain competitive work in an integrated setting of their choice. This service is provided for, or on behalf of, a client, and can include communicating with the client's supervisor or manager, whether in the presence of the client or not (if authorized and appropriate). There is regular contact and follow-up with the client and employer to reinforce and stabilize job placement. Follow along support and/or accommodations are negotiated with an employer prior to client starting work or as circumstances arise.

The IPS benefit does not include:

a. Generalized employer contacts that are not connected to a specific enrolled individual or an authorized service
b. Employment support for individuals in sub-minimum wage, or sheltered workshop settings
c. Facility-based habilitation or personal care services

d. Wage or wage enhancements for individuals
e. Duplicative services from other state or federal programs

**HCBS Supported Employment**

IPS services defined in this protocol shall adhere to 42 CFR 440.180(c)(2)(iii), 441.302(i) and 441.303(h).and shall not include habilitation services such as facility-based day habilitation or personal care. Furthermore, services are to be provided in conjunction with a client's existing services and supports, and are therefore separate from special education or related services defined under sections 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16 and 17)) or as services under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. section 730).

**HCBS requirements**

a. **Person-Centered Planning.** The state agrees to use person-centered planning processes to identify eligible clients' Foundational Community Supports needs and the resources available to meet those needs, and to identify clients' additional service and support needs.
b. **Conflict of Interest.** The state agrees that the entity that authorizes the services is external to the agency or agencies that provide FCS services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.
c. **Home and Community-Based Setting Requirements.** The state will assure compliance with the home and community-based settings requirements for those services that could be authorized under section 1915(i).

**Provider Qualifications**
Contracted providers must ensure staff providing FCS services maintain appropriate qualifications in order to effectively serve FCS enrollees. Below are typical provider qualifications, however they may be substituted with appropriate combination of education, experience and skills, as determined by the provider contract.

| Provider | Education (typical) | Experience (typical) | Skills (preferred) | Services |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Community Support Services Providers | Bachelor's degree in a human/social services field; may also be an Associate's degree in a relevant field, with field experience. | 1 year case management experience, or Bachelor's degree in a related field and field experience. | Knowledge of principles, methods, and procedures of services included under community support services (as outlined above), or comparable services meant to support client ability obtain and maintain residence in independent community settings.<br>g. | Pre-tenancy supports; tenancy sustaining services (as outlined above). |
| Supported Employment – IPS Providers<br>h. | Bachelor's degree in a human/social services field; may also be an Associate's degree in a relevant field, with field experience. | 1 year case management experience, or Bachelor's degree in a related field and field experience. | Knowledge of principles, methods and procedures of services included under supported employment – individual placement and support (as outlined above), or comparable services that support client ability to obtain and maintain employment. | Pre-employment services; employment sustaining services (as outlined above). |

**Payment Methodologies**

HCA will reimburse a Third Party Administrator (TPA) for the CSS and IPS services provided at the CSS and IPS rates. The rates shall not exceed the amount expended by the TPA for the direct service costs incurred by the provider. Rates may vary by region and may be developed based on a target cost per CSS and IPS service, along with variables such as geographic location, FCS-related travel costs, intensity of services, and duration of services or contracted provider per unit costs.

The TPA is required to submit quarterly reports and an annual report to HCA. Ongoing quarterly/annual reporting will include, at a minimum: (i) Number of FCS beneficiaries broken out by program (CSS and IPS supported employment); (ii) Number of new CSS and IPS supported employment person-centered service plans; (iii) Percent of clients receiving CSS and/or IPS supported employment services whose needs are re-assessed annually; and (iv) Amount of funds spent on CSS and IPS supported employment services. The purpose of the reports is to demonstrate that the program is conducted in compliance with the requirements set forth in the STCs and post-approval protocols, attachments, any agreement between HCA and the TPA, and policy letters and/or guidance from HCA.

The TPA will invoice HCA for FCS services provided to a specific Medicaid beneficiary. As part of this invoicing process, the TPA must submit documentation to HCA of the Medicaid beneficiary's eligibility status, the dates of service, and the types of service that were provided.

The TPA is required to ensure FCS providers meet minimum documentation standards and cooperate in any evaluation activities by HCA, CMS, or their contractors. The state assures that there is no duplication of federal funding and the state has processes in place to ensure there is no duplication of federal funding.