

Final Demonstration Agreement

Between

The Centers for Medicare & Medicaid Services (CMS)

And

The State of Washington

Regarding a Federal-State Partnership to Test a Managed Fee-for-Service Financial Alignment Model for Medicare-Medicaid Enrollees

**HealthPathWashington:
A Medicare and Medicaid Integration Project
(Managed Fee-for-Service Model)**

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I. SPECIFIC PURPOSE OF THIS FINAL DEMONSTRATION AGREEMENT

The purpose of this Final Demonstration Agreement (Agreement) is to provide the terms and conditions for the implementation of HealthPathWashington: A Medicare and Medicaid Integration Project, Managed Fee-for-Service Model (Demonstration), first established in the Memorandum of Understanding (MOU) signed on October 24, 2012. All provisions of the MOU are incorporated by reference into this Agreement unless otherwise specified or unless this Agreement includes provisions that are inconsistent with the MOU. Any provision in this Agreement that is inconsistent with or in conflict with a provision of the MOU will supersede such MOU provision.

Beneficiary needs and experiences, including the ability to self-direct care, be involved in one's care, and live independently in the community, are central to this Demonstration. Key objectives of the Demonstration are to improve beneficiary experience in accessing care, promote person-centered health action planning, promote independence in the community, improve quality of care, assist beneficiaries in getting the right care at the right time and place, reduce health disparities, improve transitions among care settings, and achieve cost savings for the State and the Federal government through improvements in health and functional outcomes.

II. LEGAL PARAMETERS

The parties agree to be bound to the terms and conditions of this Agreement.

III. READINESS REVIEW

The purpose of the readiness review is to confirm that the State is prepared to implement the Managed Fee-for-Service (MFFS) Financial Alignment Demonstration in accordance with the model as outlined in the MOU. The goal is to ensure the successful transition of Medicare-Medicaid enrollees into the Demonstration and to ensure the State has the necessary infrastructure and capacity to implement, monitor, and oversee the proposed model.

CMS has conducted a readiness review and determined that the State has reached a level of readiness to implement the Demonstration. CMS and the State will finalize benchmarks for the Demonstration quality metrics for the retrospective performance payment, as described in Section IV.J.3.b.

IV. PROCESS AND OPERATIONAL PROVISIONS

Items are listed in accordance to relevant MOU sections; “Intentionally Left Blank” is noted for those sections for which there are no changes from the MOU. For definitions, please refer to the MOU.

A. STATEMENT OF INITIATIVE (SECTION I of the MOU)

CMS and the State agree to begin this Managed Fee-for-Service Financial Alignment Demonstration on July 1, 2013, and continue until December 31, 2016, unless extended or terminated pursuant to the terms and conditions in Section V or VI, respectively, of this Agreement.

B. SPECIFIC PURPOSE OF THE MEMORANDUM OF UNDERSTANDING (SECTION II of the MOU)

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C. PROGRAM DESIGN/OPERATIONAL PLAN (SECTION III of the MOU)

1. Program Authority:

- a. *Medicare Authority:* Intentionally Left Blank.
- b. *Medicaid Authority:* See Section H on Medicaid Authority and Appendix 5 of the MOU.

2. Eligibility:

- a. *Eligible Populations:* Beneficiaries with one chronic condition and at risk of developing another are eligible for the State's approved health home SPA #13-08, as summarized below:
 - i. *Chronic Conditions:* The applicable chronic conditions for eligibility are: mental health condition, substance use disorder, asthma, diabetes, heart disease, cancer, cerebrovascular disease, coronary artery disease, dementia or Alzheimer's disease, intellectual disability or disease, HIV/AIDS, renal failure, chronic respiratory conditions, neurological disease, gastrointestinal, hematological and musculoskeletal conditions.
 - ii. *At Risk of Developing Another Chronic Condition:* Risk of a second chronic condition is defined by a minimum predictive risk score of 1.5.

The predictive risk score of 1.5 means a beneficiary's expected future medical expenditures is expected to be 50% greater than the base reference group, the Washington SSI disability population. The Washington risk score is based on the Chronic Illness & Disability Payment System and Medicaid-Rx risk groupers developed by Rick Kronick and Todd Gilmer at the University of California, San Diego, with risk weights normalized for the Washington Medicaid population. Diagnoses, prescriptions, age, and gender from the beneficiary's medical claims and eligibility history for the past 15 months (24 months for children) are analyzed, a risk score is calculated and chronic conditions checked across all categorically needy populations, and a clinical indicator (Y=qualifies; N=does not qualify) is loaded into the Washington Medicaid Management Information System (MMIS).

iii. Potentially eligible beneficiaries with insufficient claims history may be referred to the program by contacting the Washington Health Care Authority (HCA). A tool has been developed to manually calculate risk. This tool will be on the health home website and distributed to the designated providers. Once a provider has determined a beneficiary is eligible by manually calculating their risk that information will be sent to HCA for further analysis. If the beneficiary is eligible, he or she will be enrolled into a health home.

b. *Outreach and Education:* The State and CMS will coordinate to provide additional outreach to providers, including regional meetings, webinars, focus groups, informational emails via the HCA listserv, and the ability for local organizations, providers, and hospitals to refer potentially eligible beneficiaries to a qualified Health Home Network.

3. Delivery Systems and Benefits: Intentionally Left Blank

4. Beneficiary Protections, Participation, and Customer Service: Intentionally Left Blank

5. Administration and Reporting

a. *Readiness Review:* See Section III for discussion of Readiness Review.

b. *Monitoring:* Intentionally Left Blank.

6. Quality Management: See Section J for additional detail.

7. Financing and Payment: See Sections I and J for additional detail.

8. Evaluation: Intentionally Left Blank

D. DEFINITIONS (APPENDIX 1 of the MOU)

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E. CMS STANDARDS AND CONDITIONS AND SUPPORTING STATE DOCUMENTATION (APPENDIX 2 of the MOU)

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F. DETAILS OF THE STATE DEMONSTRATION AREA (APPENDIX 3 of the MOU)

As of July 1, 2013, in conjunction with the approved Health Home SPA #13-08, the Demonstration will operate in all of the following counties in which the State has qualified health home providers:

Coverage Area 4: Pierce County

Coverage Area 5: Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum Counties

Coverage Area 7: Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, and Yakima Counties

In addition, starting October 2013, the Demonstration will operate in the remaining counties of the State (except King and Snohomish Counties), pending submission and approval of a Health Home SPA and the presence of qualified health home providers:

Coverage Area 1: Clallam, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, and Thurston Counties

Coverage Area 2: Island, San Juan, Skagit, and Whatcom Counties

Coverage Area 6: Adams, Chelan, Douglas, Grant, Ferry, Lincoln, Okanogan, Pend Oreille, Stevens, Spokane, and Whitman Counties

If CMS and the State agree that the State has the capacity and the authority to establish the Managed Fee-for-Service Model Demonstration in one or both of the two excepted counties

noted above, then so long as the State no longer seeks to implement a capitated model in one or both of the two counties, Washington may, no later than January 1, 2014, expand this Demonstration to such county or counties, as the case may be, in which the capitated model is not being implemented. The State must inform and engage stakeholders before expanding this Demonstration to either of those additional counties.

G. MEDICARE AUTHORITIES AND WAIVERS (APPENDIX 4 of the MOU)

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H. MEDICAID AUTHORITIES AND WAIVERS (APPENDIX 5 of the MOU)

On June 28, 2013, CMS approved Health Home SPA #13-08, effective July 1, 2013, to authorize implementation of the health home benefit in 14 counties (See Section F). The implementation of this Demonstration in additional counties (as specified in Section F) is contingent upon the State's receiving CMS approval for its health home SPA for those counties.

Continued operation and implementation of this Demonstration is contingent on the State's ongoing compliance with the terms of the approved State Plan.

I. PERFORMANCE PAYMENTS TO THE STATE (APPENDIX 6 of the MOU)

- 1. Demonstration Years:** Figure 6-1 below outlines the updated Demonstration Years for the purposes of this Agreement.

Figure 6-1. Updated Demonstration Year Dates

Demonstration Year	Calendar Dates
1	July 1, 2013 – December 31, 2014
2	January 1, 2015 – December 31, 2015
3	January 1, 2016 – December 31, 2016

- 2. Savings Calculation Detail:** After each year of the Demonstration, the Evaluation Contractor will perform a calculation to determine whether the Demonstration achieved savings, and the amount of any savings. The calculation will determine the difference in per beneficiary per month (PBPM) spending found between the demonstration group and a target amount determined by trending demonstration group expenditures in a two-year pre-Demonstration base period by the change in costs of the comparison group.

The savings calculations will use an actuarial methodology to provide CMS with the resulting Medicare and Medicaid savings achieved. The calculation will reflect any increase in Federal Medicaid spending, including fees or enhanced FMAP for health home services, associated with beneficiaries in Washington or the comparison group.

- a. *Identifying Beneficiaries Eligible for Inclusion:* Both the demonstration and comparison group will be identified using an intent-to-treat approach. The data used to identify demonstration and comparison beneficiaries will reflect eligibility on the Demonstration start date. The demonstration group will be identified retrospectively, after the Demonstration year has ended, to allow for additional data to become available.
 - i. Every beneficiary included in the first performance payment calculation must meet all of the following criteria to be included in the savings calculation:

1. Meet the Demonstration eligibility criteria for at least 3 months and have at least 3 months of baseline claims; and
 2. Not be eligible for Medicaid by spend down.
- ii. Individuals in an MA or PACE plan on the Demonstration start date will not be included in the base period. Unless such individuals disenroll from MA or PACE and become eligible for the Demonstration, their experience during the Demonstration will also be excluded from the savings calculation. For beneficiaries who disenroll from MA or PACE and become eligible for the Demonstration, the plan capitation payments will be used as the basis for their baseline Medicare and Medicaid costs if applicable, and their actual experience during the Demonstration will be included in the savings calculation.
 - iii. Only the member months during which a beneficiary was eligible for the demonstration or comparison group will be included in the calculation. Terminations in eligibility will result from moving out of area, death, loss of eligibility for Medicare Parts A and B, Medicare becoming a secondary payer, or loss of eligibility for full Medicaid benefits. The same rules for terminating eligibility for inclusion in the savings calculation will be applied to both the demonstration and comparison groups.

b. *Beneficiaries who Become Eligible for this Demonstration After the Start Date*

- i. The baseline for beneficiaries who become eligible for the Demonstration after the Demonstration start date will be their experience from their date of Demonstration eligibility to the end of that Demonstration year. Such beneficiaries will then enter the calculation on the first day of the next

Demonstration year. The same approach will be used to determine baseline experience for beneficiaries in the comparison group who newly meet Demonstration eligibility criteria after the Demonstration start date.

- ii. The actual savings achieved for beneficiaries who become eligible for this Demonstration after the start date will not be included in the savings calculation until the following year (i.e., until the beneficiaries' first full Demonstration year of eligibility).
 1. For the Demonstration year in which the beneficiary became eligible for this Demonstration after the start date, the savings percentage calculated for beneficiaries that are included in the savings calculation (i.e. beneficiaries in the demonstration and comparison groups who were eligible on the Demonstration start date, or at the beginning of the previous Demonstration year, as applicable) will be attributed to the beneficiaries who become eligible for this Demonstration after the start date in the year that they become eligible.
 2. Each Demonstration year, a new cohort will be created for beneficiaries who became newly eligible the previous year.
- iii. Beneficiaries becoming eligible for the Demonstration during the first year will be incorporated into the savings calculation using the attribution approach described in IV.I.2.b.ii, above. These beneficiaries will be included in a new cohort on the start date of the second Demonstration year.

- iv. All beneficiaries that become eligible for the Demonstration during the second Demonstration year will form a cohort that begins in the third Demonstration year.
- v. Beneficiaries becoming eligible in Demonstration year three will not be included in the calculation of savings percentages, but will have savings applied to their expenditures using the methodology described in IV.I.2.b.ii .
- vi. For each new cohort of demonstration beneficiaries, there will be a corresponding new cohort of comparison beneficiaries.

c. *Cell Structure*

- i. Beneficiaries in the demonstration group and the comparison group will be grouped into cells according to characteristics that influence expected costs (e.g., residing in a nursing facility, serious and persistent mental illness, age).
- ii. The cells are the following:
 - 1. Three by category of care delivery: facility, HCBS waiver, and community other.
 - 2. Two by mental condition: the presence or absence of serious and persistent mental illness (SPMI).
 - 3. Two by age: age 65 and older, and under age 65.

- iii. If a particular cell contains zero or a small number of member months, as determined by CMS and its evaluation contractor, the cell category will be eliminated and any beneficiaries in the eliminated cell will be included in another applicable cell. A cell will also be eliminated if data needed to make the cell placements are not available.
 - iv. Beneficiaries will be placed into cells according to their characteristics as of the date they enter the savings calculation (i.e. the Demonstration start date or the first date of a new cohort), and will remain in that cell throughout the Demonstration, for the months they remain eligible for the Demonstration.
 - v. Savings will be measured separately for each cell. Aggregate savings will be determined by weighting each comparison group cell according to the distribution of the demonstration population.
- d. *Capping Individual Costs:* The annual costs of individuals included in the savings calculation will be capped at the 99th percentile of annual expenditures. Medicare and Medicaid expenditures will be capped separately.
- e. *Savings Calculation:* Savings will be calculated one cell at a time, one year at a time, and one cohort at a time, as follows:

$$S\$_{X,P} = M_{X,D} * (TPBPM_{X,P} - PBPM_{X,D,P}), \text{ where:}$$

- i. $S\$_{X,P}$ = savings in dollars for a particular cell (X) for a particular cohort in a particular Demonstration year for a particular program (Medicare or Medicaid)

- ii. $M_{X,D}$ = months of eligibility for the beneficiaries in cell (X) in the demonstration group. Each cell in the comparison group will have the same weight as the corresponding cell in the demonstration group.
- iii. $TPBPM_{X,P}$ = target per beneficiary per month cost in cell (X) for a particular program
- iv. $PBPM_{X,D,P}$ = actual per beneficiary per month cost of the beneficiaries in cell (X) in the demonstration group for a particular program
 - 1. The $PBPM_{X,D,P}$ is equal to the Medicare A/B costs or the Medicaid costs (excluding the costs above the cap) incurred during the period of eligibility for all beneficiaries in cell (X) in the demonstration group, divided by the months of eligibility for all beneficiaries in cell (X) in the demonstration group.
 - 2. Whenever a beneficiary is eligible for part of a month (e.g. for a death that occurs in the middle of a month), then a fraction of the month will be used in determining the total number of months of eligibility.
- v. Aggregate savings across all cells will be the sum of the savings for all cells and for both programs: $S\$_A = \sum \sum S\$_X$
- vi. The target PBPM ($TPBPM_{X,P}$) is a projection of the baseline PBPM of a cell (X) and the program (P) of the demonstration group based on the rate of increase of the corresponding cell of the comparison group:

$$TPBPM_{X,P} = PBPM_{X,D,P}(BY) * (PBPM_{X,C,P}(DY) / PBPM_{X,C,P}(BY)),$$

where:

1. $PBPM_{X,D,P}(BY)$ = the demonstration group PBPM in the base years in cell (X) and program (P)
2. $PBPM_{X,C,P}(BY)$ = the comparison group PBPM in the base years in cell (X) and program (P)
3. $PBPM_{X,C,P}(DY)$ = the comparison group PBPM in the demonstration year in cell (X) and program (P)

vii. Percentage savings in aggregate across all cells and both Medicare and Medicaid is calculated as follows:

$$S\%_{\text{Cohort}} = S\$_{\text{Cohort}} / (M_{\text{Cohort}} * TPBPM_{\text{Cohort}})$$

viii. Total dollar savings will be the dollar savings from those beneficiaries in the calculation of the percentage savings plus the attributed savings to the cohort of beneficiaries who become eligible for this Demonstration after the start date:

1. $S\$_{\text{Total}} = S\$_{\text{Cohort}} + S\%_{\text{Cohort}} * E_{\text{NewCohort}}$, where: $S\%_{\text{Cohort}}$, $S\$_{\text{Cohort}}$, M_{Cohort} , and $TPBPM_{\text{Cohort}}$ have the meanings described above but summed across all cells and the for the Medicaid and Medicare programs.
2. $E_{\text{NewCohort}}$ represents the amount spent on beneficiaries in the cohort of beneficiaries who become eligible for this Demonstration after the start date; the percentage savings calculated for the

previous cohort(s) is being attributed to the cohort of beneficiaries who become eligible for this Demonstration after the start date in the equation IV.I.2.e.viii, immediately above.

J. DEMONSTRATION PARAMETERS (APPENDIX 7 of the MOU)

1. State of Washington Delegation of Administrative Authority and Operational Roles and Responsibilities: Intentionally Left Blank

2. Grievances and Appeals: Intentionally Left Blank

3. Administration and Oversight

a. *Monthly Eligibility File Submissions:* Beginning June 2013, Washington must submit a monthly eligibility file to CMS' beneficiary alignment contractor. This data will be updated into CMS' Master Database Management (MDM) system for beneficiary attribution purposes, and used by the evaluation contractor to identify the eligible population.

i. Washington will need to provide information including but not limited to the following:

1. Beneficiary-level data identifying beneficiaries eligible for the Demonstration

2. Medicare Beneficiary Claim Account Number (HICN)

3. MSIS number
 4. Social Security Number
 5. Gender
 6. Person First and Last Name, Birthdate, and Zip Code
 7. Eligibility identification flag - Coded 0 if not identified as eligible for the Demonstration, 1 if identified by administrative criteria (e.g. claims), and 2 if by non-administrative criteria (e.g. BMI, smoking)
 8. Monthly Demonstration eligibility indicator (Each monthly eligibility flag variable would be coded 1 if eligible, and 0 if not)
- ii. Washington shall also submit on a quarterly basis to the evaluation contractor both the monthly information under Section IV.J.3.a.i above (i.e., each quarterly submission will contain data for each month of the quarter) and the information below for each month of the quarter:
- i. Facility status (coded 1 if in a nursing facility, 0 if not)
 - ii. HCBS waiver status (coded 1 if enrolled in HCBS waiver, 0 if not)
- iii. Washington shall also submit summary level data for the State Data Reporting System on a quarterly basis, including monthly data for the following but not limited to:

1. The number of beneficiaries eligible for the Demonstration, appropriately excluding all individual beneficiaries not eligible for the Demonstration.
2. The number of beneficiaries who are no longer eligible for the Demonstration (e.g. through Medicare Advantage enrollment or moving out of the State).
3. The number of health homes participating in the Demonstration.

b. *Quality Metrics and Reporting for Determining the Retrospective Performance Payment*

- i. CMS will review and update the Demonstration core measures and measure specifications annually to ensure compliance with current science and measure development.
- ii. The State will review and, with CMS approval, update State-specific measures and measure specifications annually to ensure compliance with current science and measure development. Where applicable, CMS will adhere to nationally-endorsed specifications for relevant measures.
- iii. CMS will establish benchmarks for each measure based on an analysis of the State's quality performance, as further detailed in Section IV.J.3.b.v.1 below.

- iv. The Demonstration Measurement Set (including core measures revised from the MOU, State-specific process measures, and State-specific Demonstration measures) is as follows:

Model Core Measures	Year 1	Year 2	Year 3
All Cause Hospital Readmission <i>(Plan All Cause Readmission #1768)</i>	Reporting	Benchmark	Benchmark
Ambulatory Care-Sensitive Condition Hospital Admission <i>(PQI Composite #90)</i>	Reporting	Benchmark	Benchmark
ED Visits for Ambulatory Care-Sensitive Conditions <i>(Rosenthal)</i>	Reporting	Benchmark	Benchmark
Follow-Up after Hospitalization for Mental Illness <i>(NQF #0576)</i>	Reporting	Benchmark	Benchmark
Depression screening and follow-up care <i>(#0418)</i>		Reporting	Benchmark
Care transition record transmitted to health care professional <i>(NQF #648)</i>		Reporting	Reporting
Screening for fall risk <i>(#0101)</i>			Reporting
Initiation and engagement of alcohol and other drug dependent treatment: (a) initiation, (b) engagement <i>(NQF #0004)</i>			Reporting
State-Specific Process Measures	Year 1	Year 2	Year 3
Health Action Plans: Percentage of beneficiaries with Health Action Plans within 90 days of enrollment	Reporting	Benchmark	Benchmark
Training: Delivery of standardized state training for Health Home Care Coordinators on the Health Action Plan	Reporting	Benchmark	Benchmark
Discharge Follow-up: Percentage of beneficiaries with 30 days between hospital discharge to first follow-up visit	Reporting	Reporting	Benchmark

State-Specific Demonstration Measures	Year 1	Year 2	Year 3
Average change in Patient Activation Measure (PAM) score for participating Medicare-Medicaid Enrollees who initially were least activated	Reporting	Benchmark	Benchmark
Percent of high-risk Medicare-Medicaid Enrollees receiving community-based LTCSS	Reporting	Benchmark	Benchmark
Percent of high-risk Medicare-Medicaid Enrollees receiving institutional long term care services	Reporting	Benchmark	Benchmark

v. *Benchmarking and Scoring State Performance:* Benchmarks for individual measures will be determined through an analysis of State-specific data.

1. CMS will establish benchmarks for the Demonstration based on the following principles:

- a. CMS will set benchmark levels. Once benchmark levels are set, CMS will provide the State with no less than 30 days to review the benchmark levels, the methodological considerations, and the data supporting any baseline calculations.
- b. All benchmarks will consider the population served under the Demonstration, and for measures in which the baseline is set from pre-Demonstration experience, the extent to which pre-Demonstration experience data is reflective of the Demonstration population.

- c. Benchmarks will include minimum achievement levels, improvement relative to those levels, or both (i.e., either/or).
- d. For claims-based measures, where it is feasible to assess experience prior to the start of the Demonstration, improvement-focused benchmarking will be based on improvement from the pre-Demonstration baseline.
- e. For measures for which the baseline cannot be based on pre-Demonstration experience, improvement-focused benchmarking will be based on improvement from the reporting period baseline. For the Patient Activation Measure, improvement-focused benchmarking will be based on positive average PAM score changes for beneficiaries who were initially least activated.
- f. Given that the State already has achieved one of the lowest rates of institutional long term care placement in the country, the two long-term services and supports State-specific demonstration measures will allow credit for maintaining or improving performance over time.

2. The State may earn credit on measures in two ways:

- a. If the State meets the established benchmark on an individual measure; or

- b. If the State meets the established goal for closing the gap between their performance in the 12 months prior to the performance period and the established benchmark by a stipulated percentage.

- vi. *Scoring Methodology*: The State will receive a “pass” or “fail” score for each measure. If the State meets the determined benchmark, it will receive a “pass” for that measure. If the State does not meet the benchmark, it will receive a “fail” for that measure.

For the measures based solely on reporting (as indicated in the table above), a “pass” is based on full and accurate reporting. For each measure, receiving a “pass” is contingent on the State attesting to complete and accurate reporting for that measure and subject to CMS validation of the data being reported.

- vii. *Retrospective Performance Payment*: The maximum retrospective performance payment available to the State under this model is based on achieving overall federal savings as described in the MOU and in Section IV.I above. The performance payment qualifications will vary by year:
 - 1. *Demonstration Year 1*: In year one, payment is based on the percentage of measures for which the State has completely and accurately reported data. The State would qualify for the full retrospective performance payment in the first year based on complete and accurate reporting of all measures included in that demonstration year.

2. Demonstration Year 2: In year two, the retrospective performance payment will be distributed in three components.
 - a. The first component (30% of the retrospective performance payment) will be distributed once it is determined that the State has completely and accurately reported all measures included in that demonstration year, except for the two measures newly-introduced in year two.
 - b. The second component (30% of the retrospective performance payment) will be distributed once it is determined that the State has scored a “pass” on at least 50% of the “benchmark” measures included in that demonstration year. If the State does not “pass” at least 50% of these measures, no payment will be made for this component.
 - c. The third component (40% of the retrospective performance payment) is only available if the State has met the criteria for the first two components. The third component will be distributed based on the number of percentage points above 50% of measures for which the State has scored a “pass,” multiplied by $(4/3)$, including all measures included in that demonstration year, with each measure weighted equally. (For example, if the State passes 60% of measures, it will qualify for one-third of this component. If the State passes 70% of measures, it will qualify for two-thirds of this component.) Passing 80% or more of all measures would qualify the State for the maximum performance payment.

3. **Demonstration Year 3:** In year three, the retrospective performance payment will be distributed in two components.
 - a. The first component (60% of the retrospective performance payment) will be distributed once it is determined that the State has scored a “pass” on at least 50% of the “benchmark” measures included in that demonstration year. If the State does not “pass” at least 50% of these measures, no payment will be made for this component.
 - b. The second component (40% of the retrospective performance payment) is only available if the State has met the criteria for the first component. The second component will be distributed based on the number of percentage points above 50% of measures for which the State has scored a “pass,” multiplied by (4/3), including all measures included in that demonstration year, with each measure weighted equally. (For example, if the State passes 60% of measures, it will qualify for one-third of this component. If the State passes 70% of measures, it will qualify for two-thirds of this component.) Passing 80% or more of all measures would qualify the State for the maximum performance payment.
4. **Calculation of Retrospective Performance Payment:** CMS will consult with the State on methodological issues and data collection to execute the retrospective performance payment calculations.

CMS and the State will meet at least annually to review interim evaluation findings, including for quality of care measures and analysis to review eligibility for the retrospective performance payment. CMS will provide the State with the data and assumptions used in calculating baseline and annual quality metrics, cost estimates and performance payments.

The State of Washington may request, in writing, that CMS reconsider the calculation of the retrospective performance payment or the calculations behind the payment's components (e.g., quality measures). The State must initiate any such requests within 90 days of written notification from CMS on the amount of the performance payment (or lack thereof).

- viii. *State Participation in CAHPS Survey*: CMS will administer a standardized experience of care survey. The State, as part of the requirements of the Demonstration, will assist CMS and its designated contractor in administering the survey by helping to identify appropriate beneficiaries and providing necessary data. While the State is required to participate in the CMS-sponsored CAHPS survey as part of the Demonstration, the CAHPS measures will not be scored for purposes of determining the retrospective performance payment.
- ix. *Reporting Timeframes*: All quality measures will be reported based on services provided during the demonstration year. If the State fails to report by the requested deadline or does not provide a reasonable explanation for delayed reporting, the State may be subject to corrective action for failing to report quality measures. Inaccurate or incomplete reporting, or failure to make timely corrections following notice to resubmit data may lead to termination from the Demonstration.

The State must provide an attestation to the completeness and accuracy of the data reported. The data reported will be validated and is subject to audit.

c. *Washington State Health Home Essential Requirements*

- i. *Training* – Training of qualified health home designated/lead providers and Care Coordination Organizations will be sponsored between HCA and DSHS. DSHS nursing staff will develop a set of core curriculum materials, including materials focused on disability and cultural competence, for health homes to support the provision of timely, comprehensive, high-quality health homes services that are whole person focused. DSHS will offer technical assistance training for core skill building on relevant topics throughout the Demonstration. Webinars, community network development meetings and/or learning collaborative will foster shared learning, information sharing and problem solving. Additional detail may be found in Health Home SPA #13-08.

- d. *Evaluation:* The State will work with the evaluation contractor to determine what care coordination/case management data are available and will share data with evaluator to support analysis of care coordination utilization patterns. Based on discussions with the evaluation contractor, the State may be asked to provide additional data, such as HICNs, on beneficiaries receiving care coordination during any given month.

V. EXTENSION OF FINAL DEMONSTRATION AGREEMENT

The State may request an extension of this Demonstration, which will be evaluated consistent with terms specified under Section 1115A(b)(3) of the Social Security Act, and based on whether the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality and care and reducing spending. Any extension request may be granted at CMS's sole discretion.

VI. MODIFICATION OR TERMINATION OF FINAL DEMONSTRATION AGREEMENT

The State agrees to provide advance written notice to CMS of any State Plan, waiver, or policy changes that may have an impact on the Demonstration. This includes any changes to underlying Medicaid provisions that impact rates to providers or policy changes that may impact provisions under the Demonstration.

- 1. Modification:** Either CMS or the State may seek to modify or amend the Final Demonstration Agreement per a written request and subject to requirements set forth in Section 1115A(b)(3) of the Social Security Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality and care and reducing spending. Any material modification shall require written agreement by both parties and a stakeholder engagement process that is consistent with the process required under this Demonstration.

2. Termination: The parties intend to allow termination of the Final Demonstration Agreement under the following circumstances:

- a. Termination without cause - Except as otherwise permitted below, a termination by CMS or the State for any reason will require that CMS or the State provides a minimum of 90 days advance notice to the other entity and 60 days advance notice is given to beneficiaries and the general public.
- b. Termination pursuant to Social Security Act § 1115A(b)(3)(B).
- c. Termination for cause - Either party may terminate upon 30 days' prior written notice due to a material breach of a provision of the Final Demonstration Agreement, including termination of any relevant Health Home State Plan Amendment(s).
- d. Termination due to a Change in Law - In addition, CMS or the State may terminate upon 30 days' notice due to a material change in law, or with less or no notice if required by law.

3. Demonstration phase-out: Any planned termination during or at the end of the Demonstration must follow the following procedures:

- 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 5 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. The State shall summarize comments received and share such summary with CMS. 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 begin 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 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.

- d. Federal Financial Participation (FFP) - If the Demonstration is terminated, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participating enrollees from health home services to the extent health home services are terminated.

- e. Health Home SPAs - If as part of the termination of this Demonstration the State is also making changes to or terminating its health home SPAs, the State must follow the requirements of the health home SPAs. If the State terminates its health home SPAs, this Demonstration will also terminate on the same date, and the State shall follow the notification requirements under Section VI.2.c.

- f. Close Out of Performance Payment - If the Demonstration is terminated for cause due to a material breach of a provision of this MOU or the Final Demonstration Agreement, the State will not be eligible to receive any outstanding performance payments. If the Demonstration is terminated without cause by the State, the State will only be eligible to receive performance payment(s) for performance in Demonstration year(s) that have concluded prior to termination. If the Demonstration is terminated without cause by CMS, the State will be eligible to receive a prorated performance payment for the time period up until the termination of the Demonstration.

VII. STANDARD CMS TERMS AND CONDITIONS

- A. **Payments** - The State will be entitled to payments under this Demonstration only if all conditions of the MOU (signed by the parties on October 24, 2012) and this Agreement have been satisfied, including compliance with any waivers or other authorities upon which the MOU was contingent.

- B. **Order of Precedence** - Any inconsistency in the documents referenced in this Agreement shall be resolved by giving precedence in the following order:

(a) Waivers or other authorities referenced in Section IV of this Agreement.

(b) This Agreement.

(c) The MOU.

(d) The State's proposal and application documents.

C. **Changes** - Changes in the terms and conditions of this Agreement may be made only by written agreement of the parties.

VIII. SIGNATURES

This Final Demonstration Agreement is effective on July 1, 2013.

In Witness Whereof, CMS and the State of Washington have caused this Agreement to be executed by their respective authorized officers:

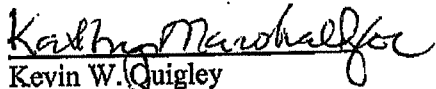
United States Department of Health and Human Services, Centers for Medicare & Medicaid Services:



Tim Engelhardt
Director, Models, Demonstrations, and Analytics Group
Federal Coordinated Health Care Office

6-28-13
(Date)

State of Washington:



Kevin W. Quigley
Secretary, Department of Social and Health Services

6-28-13
(Date)



MaryAnn Lindeblad
Medicaid Director, Health Care Authority

June 28, 2013
(Date)