

Memorandum of Understanding (MOU)

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. STATEMENT OF INITIATIVE

To establish a Federal-State partnership between the Centers for Medicare & Medicaid Services (CMS) and the State of Washington (the Washington State Health Authority/Washington State Department of Social & Health Services) to implement HealthPathWashington: A Medicare and Medicaid Integration Project, Managed Fee-for-Service Model (Demonstration) to better serve individuals eligible for both Medicare and Medicaid (“Medicare-Medicaid enrollees” or “beneficiaries”). The Federal-State partnership will provide the State with a new opportunity to establish a care management program for Medicare-Medicaid enrollees meeting high-cost/high-risk criteria that will coordinate services across Medicare and Medicaid, and allow the State and the Federal government to benefit from savings resulting from improvements in quality and reductions in costs. CMS plans to begin this Managed Fee-for-Service Financial Alignment Demonstration on April 1, 2013, and continue until December 31, 2016, unless terminated or extended pursuant to the terms and conditions of the Final Demonstration Agreement. The initiative is intended to alleviate fragmentation and improve coordination of services for high-cost, high-risk Medicare-Medicaid enrollees served primarily in fee-for-service systems of care. Improved coordination is intended to improve beneficiary outcomes and reduce overall costs over time for the State and the Federal government. (See Appendix 1 for definitions of terms and acronyms used in this MOU.)

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.

Individuals eligible for this Demonstration are those meeting the following criteria: are eligible for and enrolled in Medicare and receiving full Medicaid benefits under fee-for-service arrangements (excepting the provision of mental health services through Washington's 1915(b) Federal authority); are eligible for Medicaid health home services under the State's Medicaid State Plan; and reside in specified geographic areas. Additional detail is in section III.B below.

Under this Demonstration, the State will be accountable for improving the coordination of care across existing providers and Medicare and Medicaid service delivery systems. In return, the State will be eligible to receive a retrospective performance payment based on its performance on quality and savings criteria, as outlined later in this document at section III.G and in Appendix 6.

Eligible Medicare-Medicaid enrollees will elect to receive health home services from Health Home Care Coordinators, supplemented by multidisciplinary teams that coordinate across disciplines, including primary, acute, prescription drugs, behavioral health, and long-term services and supports (LTSS). Health home services will include: comprehensive care management; care coordination and health promotion; comprehensive transitional care; individual and family supports; referral to community and social support services; and the use of a web-based clinical decision support tool (PRISM) and other health information technology to improve communication and coordination of services.

Individuals in this Demonstration will continue to receive services including primary, acute, pharmacy, mental health, chemical dependency, long-term services and supports and developmental disability services through existing Medicare and Medicaid service delivery systems. The geographic area for this Demonstration is all counties in the State, with the exception of any counties in which Washington receives approval from CMS to implement a capitated Financial Alignment Demonstration (See Appendix 3 for additional information).

Under this Demonstration, beneficiaries decide whether to receive health home services. With

the exception of the addition of Medicaid health home services, this Demonstration does not change Medicare or Medicaid benefits in any way, nor does it affect an individual's choice of Medicare and Medicaid providers. Health home services will not be provided unless and until a beneficiary elects to receive them. The process by which beneficiaries will be identified as eligible for and elect to receive health home services is as follows (See III.B and Appendix 7 for additional information):

1. **Beneficiary Eligibility:** On a monthly basis, the State will identify which beneficiaries meet the eligibility criteria to receive health home services (See III.B for additional detail).
2. **Enrollment:** Effective the first of the following month, the State will enroll those beneficiaries (excepting certain populations as specified in III.B.1) with a qualified Health Home Network. This step requires no action by beneficiaries and does not change their eligibility for other services or choice of Medicare or Medicaid providers in any way.
3. **Assignment:** Following enrollment, the Health Home Lead Entity will assign enrolled beneficiaries to one of their subcontracted Health Home Care Coordination Organizations.
4. **Outreach and Engagement:** The Health Home Care Coordination Organization will perform outreach and engagement activities to those beneficiaries it has been assigned.
5. **Health Action Plan and Health Home Services:** Following outreach and engagement, a beneficiary will have the opportunity to elect whether to receive health home services, through completion of a Health Action Plan (a beneficiary-prioritized plan identifying what the beneficiary plans to do to improve his/her health). If a beneficiary elects to receive health home services, delivery of health home services to the beneficiary will begin, as will provider reimbursement for these services. (See Appendix 1 for definitions of terminology used above.)

CMS will also attribute beneficiaries to this Demonstration for the purposes of analyzing the impact of the Demonstration on quality and costs, and for determining retrospective performance payments. Attribution will have no impact on the services beneficiaries receive or on provider reimbursement. (See III.B and Appendix 7 for additional detail).

CMS will implement this Demonstration under Demonstration authority for Medicare and Demonstration or State Plan or waiver authority for Medicaid as described in section III.A and detailed in Appendices 4 and 5.

Program oversight will focus on performance measurement and continuous quality improvement based on the Demonstration's key objectives. Except as otherwise specified in this MOU, the State will be required to comply with all applicable Medicaid rules and regulations and to promote access to all Medicare covered services. The State must also comply with all terms and conditions specific to this Demonstration and evaluation requirements.

Preceding the signing of this MOU, the State has undergone necessary planning activities consistent with the CMS standards and conditions for participation, as detailed through supporting documentation provided in Appendix 2. These activities included a robust beneficiary- and stakeholder- engagement process. The implementation of this Demonstration in each county (as specified in Appendix 3) is contingent upon the State receiving CMS approval of its health home State Plan Amendment (SPA) in that county. In addition, before execution of the Final Demonstration Agreement, the State must satisfy all readiness requirements. Should the health home SPAs not be approved or the State fail to satisfy any readiness requirements, this Demonstration will not go forward.

II. SPECIFIC PURPOSE OF THIS MEMORANDUM OF UNDERSTANDING (MOU)

This document details the principles under which CMS and the State plan to implement and operate the aforementioned Demonstration. It also outlines the activities CMS and the State plan to conduct in preparation for implementation of the Demonstration, before the parties execute a Final Demonstration Agreement setting forth the terms and conditions of the Demonstration and initiate the Demonstration. Following the signing of this MOU and prior to implementation of the Demonstration, CMS and the State intend to enter into a Final Demonstration Agreement that will include additional operational and technical requirements pertinent to the implementation of the Demonstration.

III. PROGRAM DESIGN / OPERATIONAL PLAN

The following is a summary of the terms and conditions the parties intend to incorporate into the Final Demonstration Agreement as well as those activities the parties intend to conduct prior to entering into the Final Demonstration Agreement and initiating the Demonstration. This section and any appendices referenced herein are not intended to create contractual or other legal rights between the parties.

A. PROGRAM AUTHORITY

1. Demonstration Authority: Under the authority at section 1115A of the Social Security Act (“Act”), the Center for Medicare and Medicaid Innovation is authorized to “...test payment and service delivery models ...to determine the effect of applying such models under [Medicare and Medicaid].” Such models include but are not limited to the models described in section 1115A(b)(2)(B) of the Act. Section 1115A(d)(1) authorizes the Secretary to waive such requirements of titles XI and XVIII of the Act and of Sections 1902(a)(1), 1902(a)(13),

and 1903(m)(2)(A)(iii) of the Act as may be necessary solely for purposes of testing models described in section 1115A(b).

2. Medicare Authority: The Medicare portions of the Demonstration shall operate according to existing Medicare law, regulation, and sub-regulatory guidance, and is subject to existing requirements for financial and program integrity, except to the extent these requirements are waived or modified as provided for in Appendix 4.

3. Medicaid Authority: The Medicaid elements of the Demonstration shall operate according to existing Medicaid law and regulation, sub-regulatory guidance, is subject to existing requirements for financial and program integrity, and Washington's approved State Plan and applicable waiver programs, except to the extent these requirements are waived as provided for in Appendix 5. Washington will submit SPAs for Medicaid health home services; implementation of Washington's Managed Fee-for-Service Demonstration is contingent upon CMS approval of these SPAs.

B. ELIGIBILITY

1. Eligible Populations: Subject to approval of Washington's health home SPA(s), beneficiaries must meet all of the following criteria to be eligible for attribution to this Demonstration:

- Be enrolled in Medicare Parts A and B and eligible for Part D and Medicaid, regardless of age, and have no other comprehensive private or public health insurance;
- Be eligible for Medicaid State Plan health home services under section 1945(h)(2) of the Social Security Act, and any approved health home SPA(s) in the State, due to the presence of at least two chronic conditions, one chronic condition and risk for another, or one serious and persistent mental health condition; and

- Reside in a county where the State is pursuing the Managed Fee-for-Service Demonstration (see Appendix 3 for more detail on the geographic scope of this Demonstration).

Beneficiaries enrolled in a Medicare Advantage plan, the Program of All-inclusive Care for the Elderly (PACE), or receiving hospice services are not eligible for attribution to this Demonstration. Such beneficiaries may participate in and are eligible for attribution to this initiative if they disenroll from their existing programs.

CMS will work with the State to address beneficiary or provider participation in other Medicare shared savings programs or initiatives, such as Accountable Care Organizations (ACOs). If a beneficiary qualifies for attribution to this Demonstration and another model that involves Medicare shared savings and both start on the same date, the beneficiary will be attributed to this Demonstration. Medicare-Medicaid enrollees in Washington that are already attributed to a Medicare initiative involving shared savings as of the beginning of this Demonstration will remain attributed to that model and will not be attributed to this Demonstration until they no longer qualify for attribution to that model. (See Appendix 7 for additional information.)

In addition, the State will assure that health home services and payments will not duplicate any other services or payments provided either through the State Plan or a waiver of the State Plan. The State must address and prevent any potential duplication of care coordination activities that an individual may receive once an individual is in a health home.

2. Health Home Enrollment and Disenrollment Processes: The State will automatically enroll eligible beneficiaries, other than American Indians/Alaska natives, to a qualified Health Home Network. Enrollment will be done in phases to ensure ability to provide sufficient outreach, capacity and readiness on the part of the network to perform screenings and health action planning for those electing to participate. (American Indians/Alaska natives may choose to enroll in health homes at any time but will not be automatically enrolled into a qualified Health Home Network by the State.) The lead entity of the qualified Health Home Network will assign enrolled beneficiaries to one of their subcontracted Health Home Care Coordination Organizations to perform outreach and engagement activities. A beneficiary elects to receive health home services and consent to receive services is confirmed through beneficiary completion of a Health Action Plan (See I and III.C.2 for more detail).

Beneficiaries may change Health Home Care Coordination Organizations within the network or discontinue health home services at any time. Health home services will not be provided or reimbursed unless a beneficiary elects to receive health home services.

If a beneficiary elects to no longer receive health home services there are a number of ways to do so, including: the beneficiary could call and submit a request through the Interactive Voice Recognition System (IVR) or the Medical Assistance Customer Service Center (MACSC, see III.D.6); or the beneficiary could complete a paper request which would be sent to the Medical Assistance Customer Service Center. The health home coordinator or network lead would provide any necessary assistance to the beneficiary to request disenrollment.

Beneficiaries who disenroll from the health home or elect to not receive health home services but meet the eligibility requirements for attribution to the Demonstration (as described in Section III.B.1) would remain part of the Demonstration group and remain attributed to the Demonstration for the purposes of evaluation and determination of performance payments. However, no health home services would be provided to beneficiaries who choose to disenroll from the health home and/or to not receive health home services. Washington's MMIS contains a system edit preventing payment after disenrollment occurs to ensure reimbursement under the health home SPA is not made. A beneficiary is no longer eligible for attribution to this Demonstration when he or she no longer meets the Demonstration eligibility criteria, as specified in III.B.1.

- 3. Attribution Date:** Attribution is the process by which CMS will work with the State to align beneficiaries with this Demonstration to create the Demonstration group for the purposes of evaluation and making performance payment determinations, including ensuring that beneficiaries are appropriately attributed across Medicare shared savings initiatives. Attribution has no impact on the services beneficiaries are eligible to receive or on provider reimbursement and is distinct from the process used by the State to enroll eligible beneficiaries with a qualified Health Home Network. Beneficiaries are attributed to this Demonstration beginning on the date on which the health home SPA is in effect in the geographic area in which the beneficiary resides and the beneficiary meets the Demonstration eligibility criteria; attributed beneficiaries are those eligible for the Demonstration (as specified in III.B.1) , both those that do and do not engage with health home providers. With the exception of beneficiaries who are newly eligible for this Demonstration due to development of chronic conditions and/or risk factors, gaining Medicare-Medicaid enrollee status, or moving into the Demonstration area, beneficiaries must be attributed to this Demonstration within 9 months of the Demonstration start (See Appendix 7 for additional detail.)
- 4. Outreach and Education:** The State will develop outreach and education materials designed to ensure beneficiaries are meaningfully informed about the opportunity to receive

health home services and to notify beneficiaries of the Demonstration. The State will send these materials to eligible beneficiaries prior to auto-enrollment in a qualified Health Home Network. In addition, the State will send a Health Home Information Booklet describing the program in more detail when beneficiaries are auto-enrolled; this would include information on eligibility for attribution to the Demonstration as applicable.

Materials may include, but are not limited to, outreach and education materials and benefit coverage information. Materials must be accessible and understandable to beneficiaries, including individuals with disabilities and those with limited English proficiency, in accordance with Federal guidelines for Medicare and Medicaid. Materials will be translated into languages required under applicable Medicare and Medicaid rules, using the program standard that is more generous to beneficiaries. Washington translates enrollee mailings into Spanish, Vietnamese, Cambodian, Chinese, Russian, Laotian, Somali, and Korean. The State will partner with local organizations serving minority and underserved populations to increase the likelihood of reaching beneficiaries whose first language is not English. In addition, materials will be available in alternative formats, such as large font, if requested by a beneficiary.

Notices for the Demonstration must contain the following information:

- Full Medicare and Medicaid benefits remain unchanged;
- Beneficiaries maintain their choice of providers;
- Description of new benefits and services provided under the Demonstration;
- Resources for the beneficiary to obtain additional information on the Demonstration;
- Date the Demonstration will begin; and
- Beneficiary appeal rights.

Educational notices and the Health Home Information Booklet will be distributed by the State. Individual outreach to enrolled beneficiaries will be performed by qualified health home providers. All outreach and education materials and activities referencing this

Demonstration shall require approval by CMS prior to dissemination, unless otherwise agreed upon by CMS and the State.

CMS and the State will coordinate to provide additional outreach activities, including regional meetings, direct mailings, posters, and the ability for local organizations, providers and hospitals to refer potentially eligible beneficiaries to a qualified Health Home Network. The State will also distribute fact sheets and other informational materials to ensure partner organizations that provide information, assistance, and options counseling are informed regarding health home services.

C. DELIVERY SYSTEMS AND BENEFITS

- 1. Delivery Systems:** Washington will implement a Managed Fee-for-Service model built around Medicaid health homes. Under the Managed Fee-for-Service model and as defined in this MOU, the State is eligible to benefit from savings resulting from this Demonstration if it meets the applicable quality standards. The State will ensure coordination and facilitate access to all necessary services across the Medicare and Medicaid programs.

Under this Demonstration, health homes will be responsible for integration and coordination of primary, acute, prescription drug, behavioral health, and long-term supports and services across Medicare and Medicaid for those eligible Medicare-Medicaid enrollees who opt to receive health home services. The health home will work with existing service delivery systems, authorizing entities, and specialty care/case managers, and will not duplicate functions provided within these systems of care.

The State is accountable for ensuring the provision of person-centered care coordination, which must include robust and meaningful mechanisms to involve the beneficiary in improving health outcomes and in getting the right care at the right time and place. A number of functions are critical to this work, including ensuring smooth care transitions to maximize continuity of care. Examples of strategies to improve care transitions include: a notification system between the health home and hospitals, nursing facilities, and

residential/rehabilitation facilities to provide prompt communication of a beneficiary's admission or discharge; and the active participation of the Health Home Care Coordinator in all phases of care transition, including in-person visits during hospitalizations or nursing home stays, post-hospital/institutional stay home visits, and telephone calls.

To facilitate the delivery of person-centered health home services, health home providers must also work with beneficiaries and their caregivers to create a Health Action Plan. A Health Action Plan is a beneficiary-prioritized plan identifying what the beneficiary plans to do to improve her or his health; at least one beneficiary-prioritized goal; the actions the beneficiary is taking to achieve the goal; and the actions of the Health Home Care Coordinators (including the use of health, social or community resources and services that support the Health Action Plan).

Washington delivers mental health services through a 1915(b) specialty managed care plan administered through the Regional Support Networks (RSNs). RSNs contract with mental health providers to provide services to Medicaid beneficiaries, including Medicare-Medicaid enrollees. Beneficiaries will continue to receive their mental health services under the 1915(b) Federal authority. (See Appendix 7 for additional details.)

- 2. Medicare and Medicaid Benefits:** The State shall demonstrate its ability to assure coordination of all necessary Medicare and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and long-term supports and services. Medicare covered benefits shall be provided in accordance with existing Medicare Fee-for-Service (FFS) rules, Medicare Part D rules, and all other applicable laws and regulations. Medicaid covered benefits shall be provided in accordance with the requirements in the approved Medicaid State plan, any applicable Medicaid waiver programs, and all other applicable laws and regulations. With the exception of the addition of Medicaid health home services, this Demonstration does not change Medicare or Medicaid benefits in any way, nor does it affect an individual's choice of Medicare and Medicaid providers.

Care Model: In addition to the Medicare and Medicaid benefits to which eligible Medicare-

Medicaid enrollees are entitled, health home services will be newly available. The health home services include:

- Comprehensive care management, using team-based strategies;
- Care coordination and health promotion;
- Comprehensive transitional care between care settings;
- Individual and family support;
- Referral to community and social support services; and
- The use of a web-based clinical decision support tool (PRISM) and other health information technology to link services, as feasible and appropriate.

Washington's qualified Health Home Networks must include local community agencies that have committed to working together to improve the integration of services at the local service delivery level. These agencies include those that authorize Medicaid State or federally funded mental health, long-term services and supports, chemical dependency, and medical services. Entities that may be part of a Health Home Network include Regional Support Networks, Community Mental Health Agencies, Area Agencies on Aging, substance use treatment providers, public health districts, primary care clinics including rural health clinics and Federally Qualified Health Centers, hospitals, regional health alliances, and community supports that assist with housing. Entities within a qualified Health Home Network providing health home coordination functions are responsible to actively engage assigned beneficiaries, provide outreach and education, and notify the Health Home Lead Entity if a beneficiary elects to receive health home services or not.

Health home providers must also coordinate across the full continuum of health services; work with direct services providers to facilitate the delivery of evidence-based/evidence-informed services; and arrange for timely post-institutional or facility discharge follow-up, including medication reconciliation and substance use treatment and mental health after care. For beneficiaries who elect to receive health home services, the Health Home Care Coordinator will perform a comprehensive in-person health screening and work with the beneficiary to complete a Health Action Plan within 30 days of the beneficiary expressing

interest in receiving health home services. The screening is conducted to identify physical and behavioral health needs, chronic conditions, gaps in care, functional impairments, need for assistance with activities of daily living, beneficiary activation level, and opportunities to address potentially avoidable use of emergency department, inpatient hospital, and institutional services. The results of the screening are used to make appropriate referrals to all necessary providers and assist the beneficiary in developing Health Action Plan goals. In some instances, a beneficiary may not be able to complete a Health Action Plan within 30 days of expressing interest to participate in health home services. In these instances, the health home coordinator will remain actively engaged with the beneficiary to develop the Health Action Plan.

Consistent with beneficiaries' comprehensive health screenings and Health Action Plans, health home providers will coordinate across the delivery system to ensure Health Action Plans are shared, gaps in care are identified, and communication channels are created between primary, acute, prescription drug, behavioral health, and long-term supports and services for Medicare-Medicaid enrollees through activities including:

- Ongoing screening and health risk assessment;
- Assisting beneficiaries to access needed services and to self-advocate;
- Signed subcontracts/memoranda of agreement (MOAs) across organizations/agencies to ensure referrals and ongoing coordination, addressing issues such as roles and responsibilities of different parties;
- Standardized training and technical assistance to Health Home Network providers to ensure understanding of expectations (See Appendix 7 for additional information);
- Use of PRISM, a web-based clinical decision support tool that integrates information across primary and behavioral health domains, to identify beneficiaries most in need of care coordination based on risk scores and to serve as a care coordination tool for providers; and

- Communication of Health Action Plan goals to service providers as permission from the beneficiary allows.

D. BENEFICIARY PROTECTIONS, PARTICIPATION, AND CUSTOMER SERVICE

- 1. Choice of Providers:** Consistent with requirements for Medicaid health homes, Medicare-Medicaid enrollees will maintain their choice of qualified Health Home Care Coordination Organizations, and may exercise that choice at any time. This includes the right to choose a different health home provider or choose not to receive any health home services. A change in health home provider will take effect the first of the following month in which the request is made. In addition, beneficiaries will maintain their choice of plans and providers, and may exercise that choice at any time. This includes the right to choose to continue to receive care through Medicare Fee-for-Service (FFS) providers and a Prescription Drug Plan, to choose a Medicare Advantage Plan, and to receive Medicaid services consistent with Washington's approved Medicaid State Plan and applicable waiver programs.
- 2. Continuity of Care:** CMS and the State will ensure that individuals continue to have access to all covered items, services, and primary, acute, prescription drugs, behavioral health and long-term service and support providers. With the exception of the addition of Medicaid health home services, this Demonstration does not change Medicare or Medicaid benefits in any way, nor does it change an individual's choice of Medicare and Medicaid providers.
- 3. Person-Centered, Appropriate Care:** CMS, the State, and health home providers shall ensure that health home services are person-centered and can accommodate and encourage consumer-direction, that appropriate covered services are provided to beneficiaries, and that services are delivered in the least restrictive community setting and in accordance with the beneficiary's Health Action Plan. CMS, the State, and health home providers shall promote the coordination of all medically necessary covered benefits to beneficiaries in a manner that is sensitive to the beneficiary's functional and cognitive needs; language and culture; personal preferences and choices; allows for involvement of caregivers; and is in an

appropriate care setting, with a preference for the home and the community when indicated by the beneficiary.

- 4. Americans with Disabilities Act (ADA) and Civil Rights Act of 1964:** CMS and the State believe provider compliance with the ADA and the Civil Rights Act of 1964 is crucial to the success of the HealthPathWashington Demonstration and will support better health outcomes for beneficiaries. In particular, CMS and the State recognize that successful person-centered care requires physical access to buildings, services and equipment, and flexibility in scheduling and processes. The State and CMS will require health home providers to demonstrate their commitment and ability to accommodate the physical access and flexible scheduling needs of their enrollees. The State and CMS also recognize access includes effective communication. The State and CMS will require health home providers to communicate with beneficiaries in a manner that accommodates their individual needs, including requiring interpreters for those who are deaf or hard of hearing and interpreters for those who do not speak English as their primary language. Finally, CMS and the State recognize the importance of staff training on accessibility and accommodation, independent living and recovery, and wellness philosophies. CMS and the State will continue to work with stakeholders, including beneficiaries, to further develop learning opportunities, monitoring mechanisms, and quality measures to ensure health home providers comply with all requirements of the ADA and the Civil Rights Act.

- 5. Beneficiary Participation on Governing and Advisory Boards:** As part of the Demonstration, CMS and the State shall require Health Home Networks to establish mechanisms to ensure meaningful beneficiary input processes and the involvement of beneficiaries in planning and process improvements. This will be addressed in the State's qualification process for Health Home Networks. In addition, the State will provide avenues for ongoing beneficiary input into the Demonstration model, including beneficiary participation in the HealthPathWashington Advisory Team (HAT), which provides regular feedback to the State on the Demonstration. Other mechanisms such as focus groups, surveys, and attendance at community meetings will be used to ensure beneficiaries participating in the Demonstration are encouraged to share their feedback and experience and help inform system improvements. Beneficiary feedback collected by the State will be shared with Health Home Networks and will be part of the State's process improvement efforts.
- 6. Customer Service Representatives:** Consistent with requirements under Medicaid health homes, CMS and the State shall require health homes to offer after-hours access to assist the beneficiary in making decisions regarding urgent beneficiary health care needs. In addition, CMS will equip 1-800-MEDICARE call center representatives with information on the State's Managed Fee-for-Service Demonstration. The State will also train its Medical Assistance Customer Service Center (MACSC) with information on this Demonstration so the MACSC can assist beneficiaries who call and have questions about their enrollment choices, what health home services are, facilitate enrollment and disenrollment from the health home (see III.B.2 for additional information), and provide information on the Demonstration. The MACSC operates Monday through Friday from 7:30 am to 5:00 pm Pacific Time and is responsible for customer service activities including beneficiary assistance, education and information, accessing necessary services, enrollment and disenrollment.

The State ensures access to interpreter services for beneficiaries who call the MACSC and materials in alternative formats can also be requested through this call center. CMS and the

State shall work to assure the language and cultural competency of customer service representatives to adequately meet the needs of the beneficiary population.

- 7. Privacy and Security:** CMS and the State shall require all health home providers to ensure privacy and security of beneficiary health records, and provide access by beneficiaries to such records as required by HIPAA and all other applicable State and Federal laws.
- 8. Appeals and Grievances:** As referenced in Appendix 7, the State and health home providers will assist Medicare-Medicaid enrollees in exercising grievance and appeal rights under Medicare and/or Medicaid, as applicable. Grievance and appeal processes and timeframes will remain the same under the Demonstration as currently exist under the Medicare and Medicaid programs.

E. ADMINISTRATION AND REPORTING

- 1. Readiness Reviews:** Prior to implementation, a readiness review will be conducted to ensure the State has the necessary infrastructure and capacity to implement, monitor, and oversee the proposed model. The readiness review may include, but will not be limited to, a review of provider capacity to meet beneficiary needs under the health home model, provider and beneficiary materials, State training modules, monitoring and oversight processes, and data systems. The readiness review will take place prior to the signing of the Final Demonstration Agreement. If gaps in readiness are identified, the State must address these for implementation to proceed.
- 2. Day-to-Day Monitoring:** The State will be responsible for the day-to-day monitoring of the health home benefit with periodic reporting to CMS in an agreed upon manner and timeline. This responsibility includes the State being accountable for adhering to and updating the health home standards on an initial and ongoing basis, including monitoring the health home program. Ongoing monitoring and oversight activities (including Medicare Part D oversight and provider licensure, survey, and certification activities occurring at the State and Federal level) will continue by the State and CMS respectively, independent of the Demonstration.

3. **Accept and Process Data:** CMS, or its designated agent(s), and the State shall accept and process uniform person-level data, as may be necessary for the purposes of program eligibility, payment, or evaluation. Submission of data to the State and CMS must comply with all relevant Federal and State laws and regulations, including, but not limited to, regulations related to HIPAA and to electronic file submissions of patient identifiable information. Such data will be shared by each party with the other party to the extent allowed by law and regulation. This is discussed in more detail in Appendix 7.

F. QUALITY MANAGEMENT

1. **Quality Management and Monitoring:** As a model conducted under the authority of Section 1115A of the Social Security Act, the Demonstration and independent evaluation will include and assess quality measures designed to ensure beneficiaries are receiving high quality care (see Appendix 7 for additional detail).
2. **Quality Standards:** CMS and the State shall monitor the Demonstration's performance through an array of quality measures. Any performance payment will be contingent upon meeting the established quality standards to assure the Demonstration not only produces savings but also improves quality of care. Performance payments will be tiered relative to quality thresholds (see Appendix 6 for additional information). The State will also implement, in coordination with CMS, a health home quality strategy, including core set and state-specific measures that health home providers will report to the State as a condition of receiving payment for health home services.

G. FINANCING AND PAYMENT

Medicare and Medicaid Payment and Savings: Providers will receive FFS payment from CMS for Medicare services and FFS and capitated payments from the State for Medicaid services. In addition, health home providers will receive a per member per month (PMPM) payment from the State, as specified in the approved SPAs, for individuals eligible for and receiving Medicaid health home services from a qualified health home provider. Under this

Demonstration, the State will be eligible to receive a retrospective performance payment based on quality and savings criteria. Appendix 6 specifies the methodology for savings determinations and the calculation of performance payments.

H. EVALUATION

- 1. Evaluation Data to Be Collected:** CMS and the State have developed processes and protocols for collecting and reporting to CMS the data needed for evaluation, as specified in Appendix 7.

- 2. Monitoring and Evaluation:** CMS will fund an external evaluation. The Demonstration will be evaluated in accordance with Section 1115A(b)(4) of the Social Security Act. As further detailed in Appendix 7, CMS or its contractor will measure, monitor, and evaluate the overall impact of the Demonstration, including the impacts on person-level health outcomes and beneficiary experience of care; changes in patterns of primary, acute, and long-term supports and services use and expenditures; and any shifting of services between medical and non-medical expenses. Rapid-cycle evaluation and feedback will be used to inform the implementation of the Demonstration and to guide midcourse corrections and improvements as needed. Key aspects and administrative features of the Demonstration will also be examined per qualitative and descriptive methods. The evaluation will consider potential interactions with other demonstrations and initiatives, and seek to isolate the effect of this Demonstration as appropriate. The State will collaborate with CMS or its designated agent(s) during all monitoring and evaluation activities. The State will submit all data required for the monitoring and evaluation of this Demonstration. The State will submit both historical data relevant to the evaluation, including MSIS data from the years immediately preceding the Demonstration, and data generated during the Demonstration period.

- 3. Review of Findings:** 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.

4. **Health Home Evaluation(s):** The State will also participate in all evaluations of the health home SPA(s).

I. 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.

J. MODIFICATION OR TERMINATION OF FINAL DEMONSTRATION AGREEMENT

The State agrees to provide notice to CMS of any State Plan or waiver changes that may have an impact on 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' notice due to a material breach of a provision of the Final Demonstration Agreement.
- 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.
- 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.

4. General Provisions

- a. Limitations of MOU - This MOU is not intended to, and does not, create any right or benefit, substantive, contractual or procedural, enforceable at law or in equity, by any party against the United States, its agencies, instrumentalities, or entities, its officers, employees, or agents, or any other person. Nothing in this MOU may be construed to

obligate the parties to any current or future expenditure of resources. This MOU does not obligate any funds by either of the parties. Each party acknowledges that it is entering into this MOU under its own authority.

- b. Modification - Either CMS or the State may seek to modify or amend this MOU 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.
- c. Termination - The parties may terminate this MOU under the following circumstances:
- 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.
 - Termination pursuant to Social Security Act § 1115A(b)(3)(B).
 - Termination for cause - Either party may terminate this MOU upon 30 days' notice due to a material breach of a provision of this MOU or the Final Demonstration Agreement.
 - Termination due to a Change in Law - In addition, CMS or the State may terminate this MOU upon 30 days' notice due to a material change in law, or with less or no notice if required by law.

K. SIGNATURES

This MOU is effective on October 24, 2012.

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:


Marilyn Tavenner
Acting Administrator, Centers for Medicare & Medicaid Services

10/24/12
(Date)

State of Washington:


Robin Arnold-Williams
Secretary, Social and Health Services

10-24-12
(Date)


MaryAnne Lundeblad
Director, Health Care Authority

Oct. 24, 2012
(Date)

APPENDICES

- Appendix 1: Definitions
- Appendix 2: CMS Standards and Conditions Checklist and Supporting State Documentation
- Appendix 3: Details of State Demonstration Area
- Appendix 4: Medicare Authorities and Waivers
- Appendix 5: Medicaid Authorities and Waivers
- Appendix 6: Performance Payments to the State
- Appendix 7: Demonstration Parameters

Appendix 1: Definitions

Behavioral Health Services – Services that address the promotion of emotional health; the prevention of mental illness and substance use disorders; and the treatment of substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders.

Assignment – The process used by a Health Home Lead Entity to determine which Health Home Care Coordination Organization is responsible for education and outreach to eligible enrolled beneficiaries.

Attribution – The process by which CMS will work with the State to align beneficiaries with unique interventions for the purposes of making performance payment determinations. CMS and the State will ensure that beneficiaries are appropriately attributed across Medicare shared savings programs and other non-shared savings programs to ensure that shared savings are not duplicated across programs. An individual is considered eligible for attribution to the Demonstration, for the purposes of evaluation and determination of performance payments, regardless of whether or not they elect to receive health home services. For the purposes of this Demonstration, beneficiary attribution and beneficiary alignment have the same meaning.

Center for Medicare and Medicaid Innovation (CMMI or Innovation Center) – Established by Section 3021 of the Affordable Care Act, CMMI was established to test innovative payment and service delivery models to reduce program expenditures under [Medicare and Medicaid] while preserving or enhancing the quality of care furnished to individuals under such titles.

CMS – Centers for Medicare & Medicaid Services.

Comparison Group – The group used to identify the change in costs and certain quality metrics from one period of time to another. A change in costs for the comparison group will be compared with the change in costs for the Demonstration population. The methodology for defining the Comparison Group is identified in Appendix 7.

Covered Services – The set of services across Medicare and Medicaid to be coordinated as part of this Demonstration, including Medicaid health home services.

Demonstration Group – Individuals eligible for attribution to/eligible to participate in this Demonstration are those beneficiaries enrolled in Medicare Parts A and B and eligible for Medicare Part D and Medicaid; are not enrolled in a Medicare Advantage Plan, in the Program of All-Inclusive Care for the Elderly (PACE), or receiving hospice services; have no other comprehensive private or public health insurance; are eligible for Medicaid health home services; and reside in a county where the State is pursuing the Managed Fee-for-Service Demonstration.

Enrollment – An automated process used to place health home eligible beneficiaries into a qualified Health Home Network.

Evaluation Contractor (Evaluator) – The contractor selected by CMS to measure the impact of the Financial Alignment Demonstration. CMS and the State will collaborate on and coordinate during any evaluation activity.

Final Demonstration Agreement – The agreement developed to implement the terms of the MOU and that further outlines the operational and technical aspects of Demonstration implementation.

Health Action Plan – A Health Action Plan is a beneficiary-prioritized plan identifying what the beneficiary plans to do to improve her or his health and should include at least one beneficiary-prioritized goal, identify what actions the beneficiary is taking to achieve the goal, and include the actions of the Health Home Care Coordinators (including the use of health, social or community resources and services that support the Health Action Plan). The initial Health Action Plan is finalized within 30 days of an assigned beneficiary agreeing to receive health home services and is routinely reviewed and revised to reflect the beneficiary’s health action goals.

The Health Care Authority (HCA) – The Medicaid agency responsible for purchasing Medicaid medical services.

Health Home Care Coordination Organization – Sub-contracted to the Health Home Lead Entity and responsible for the delivery of health home services through the use of a Health Home Care Coordinator.

Health Home Care Coordinator – Registered nurse, licensed practical nurse, physician’s assistant, or a BSW or MSW prepared social worker hired by the Health Home Care Coordination Organization to directly provide health home services.

Health Home Lead Entity – Contracted directly with HCA and responsible for administrative and oversight functions within a qualified health home.

Health Home Network – An entity qualified by the State to provide health home services to eligible beneficiaries. The network is responsible for coordinating and integrating care across the continuum of services needed and used by eligible beneficiaries. The network includes a broad representation of community-based organizations, including primary, acute, mental health, substance abuse disorder, and long-term services and supports providers. Each network has a lead entity and a broad representation of Health Home Care Coordination Organizations to serve the enrolled population (see Appendix 7 for additional requirements).

Health Home Services – Intensive services that coordinate care across several domains, as defined under Section 2703 of the Affordable Care Act. The purpose is to coordinate the full breadth of clinical and social service expertise for high-cost/high-risk beneficiaries with complex chronic conditions, mental health and substance use disorder issues, and/or long term service needs and supports.

HealthPathWashington – Washington’s approach to integrating care for Medicare-Medicaid enrollees, which includes both Managed Fee-for-Service and Capitated Financial Alignment models.

High-Cost/High-Risk Individuals – Beneficiaries identified by the State as in most need of comprehensive care coordination, based on prospective risk scores. The State defines high-cost/high-risk individuals as those with a PRISM risk score of 1.5 or greater (meaning the individual’s future medical expenditures are expected to be 50% greater than other beneficiaries) or having two or more hospitalizations in the previous 15 months.

Intent to Treat – An evaluation approach in which all individuals that meet the criteria to receive the “treatment” are considered part of the “intervention group” for purposes of evaluation, regardless of whether they elect to receive these services or actively participate in the intervention. In this Demonstration, all individuals who are eligible for the Demonstration (as specified in III.B.1) are considered part of the intervention group (Demonstration group), regardless of whether they elect to receive health home services.

Implementation Contractor – The contractor selected by CMS to assist with implementation of the Financial Alignment Demonstration. Under the Managed Fee-for-Service model, the Implementation Contractor will determine whether the State met the quality thresholds, factor State performance on individual quality measures into the performance payment calculation, and finalize the performance payment amount, if any.

Long Term Services and Supports (LTSS) – A wide variety of services and supports that help people with functional impairments meet their daily needs for assistance in qualified settings and attain the highest level of independence possible. Examples include personal care assistance with daily activities such as bathing, dressing and personal hygiene, home-delivered meals, personal emergency response systems, adult day services, environmental modifications and other services designed to divert individuals from nursing facility care. LTSS are provided either in short periods of time when recovering from an injury or acute health episode or over an extended period and may be delivered in in-home, licensed community residential settings, or licensed nursing facilities.

Medical Assistance Customer Service Center (MACSC) – The toll-free customer support and service center operated by the Washington State Health Care Authority. The MACSC can be accessed at 1-800-562-3022 (TTY: 1-800-848-5492) Monday through Friday between the hours of 7:30 am and 5:00 pm Pacific Time.

Medicare-Medicaid Coordination Office – Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

Medicare-Medicaid Enrollees – For the purposes of this Demonstration, individuals who are enrolled in Medicare Part A and B and eligible for and receiving Medicaid and no other comprehensive private or public health coverage.

Medicaid – The program of medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations and Waivers thereof.

Medicaid MSF – The minimum threshold for determining whether any increases in Federal Medicaid costs will be deducted from Medicare savings. For more detail see Appendix 6.

Medicare – The Federal health insurance program authorized under Title XVIII of the Social Security Act.

Minimum Savings Rate (MSR) – The minimum threshold of Medicare savings States will have to achieve in order to benefit from Medicare savings. For more detail see Appendix 6.

Predictive Risk Intelligence System (PRISM) – A web-based tool used for predictive modeling and clinical decision support. PRISM provides prospective medical risk scores that are a measure of expected costs in the next 12 months based on the beneficiary's disease profile and pharmacy utilization. PRISM identifies clients in most need of comprehensive care coordination based on risk scores; integrates information from primary, acute, social services, behavioral health, and long term care payment and assessment data systems; and displays health and demographic information from administrative data sources.

Privacy – Requirements established in the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, as well as relevant Washington privacy laws.

Readiness Review – Prior to implementation, a readiness review will be conducted to ensure the State has the necessary infrastructure and capacity to implement and oversee the proposed model. If gaps in readiness are identified, the State must address these for implementation to proceed.

Regional Support Networks (RSN) – A county authority or group of county authorities or other entity recognized by the Secretary of the Washington State Department of Social and Health Services to administer mental health services in a defined region within Washington State. RSNs are specialty behavioral health plans operating under 1915(b) Medicaid authority.

State – The State of Washington.

The Washington Department of Social and Health Services, Aging and Disability Services Administration (DSHS/ADSA) – The agency which is responsible for purchasing, program and service development for mental health, chemical dependency, long term services and supports, and services to individuals with developmental disabilities.

Appendix 2: CMS Standards and Conditions and Supporting State Documentation

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
Integration of Benefits	Proposed model ensures the provision and coordination of all necessary Medicare and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and long-term supports and services.	pp. 11, 17, Addendum
Care Model	Proposed model offers mechanisms for person-centered coordination of care and includes robust and meaningful mechanisms for improving care transitions (e.g., between providers and/or settings) to maximize continuity of care.	pp. 10, 11, 13, 19, 40, 91
Stakeholder Engagement	State can provide evidence of ongoing and meaningful stakeholder engagement during the planning phase and has incorporated such input into its proposal. This will include dates/descriptions of all meetings, workgroups, advisory committees, focus groups, etc. that were held to discuss proposed model with relevant stakeholders. Stakeholders include, but are not limited to, beneficiaries and their families, consumer organizations, beneficiary advocates, providers, and plans that are relevant to the proposed population and care model.	pp. 3, 22-25, 51-60, cover memo listing changes to proposal
	State has also established a plan for continuing to gather and incorporate stakeholder feedback on an ongoing basis for the duration of the Demonstration (i.e., implementation, monitoring and evaluation), including a process for informing beneficiaries (and their representatives) of the changes related to this initiative.	pp. 26, 51, 61-68

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
Beneficiary Protections	State has identified protections (e.g., enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care, etc.) that would be established, modified, or maintained to ensure beneficiary health and safety and beneficiary access to high quality health and supportive services necessary to meet the beneficiary’s needs. At a minimum, States will be required to:	
	· Establish meaningful beneficiary input processes which may include beneficiary participation in development and oversight of the model	p. 26-51
	· Develop, in conjunction with CMS, enrollee materials that are accessible and understandable to the beneficiaries who will be enrolled in the plans, including those with disabilities, speech, hearing and vision limitations, and limited English proficiency.	pp. 23-25
	· Ensure privacy of enrollee health records and provide for access by enrollees to such records.	p. 104
	· Ensure that all medically necessary benefits are provided, allow for involvement of caregivers, and in an appropriate setting, including in the home and community.	pp. 3-5
	· Ensure access to services in a manner that is sensitive to the beneficiary’s language and culture, including customer service representatives that are able to answer enrollee questions and respond to complaints/concerns appropriately.	pp. 5, 23
	· Ensure an adequate and appropriate provider network, as detailed below.	pp. 2, 11, 24
		· Ensure that beneficiaries are meaningfully informed about their care options.
	· Ensure access to grievance and appeals rights under Medicare and/or Medicaid.	

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
	<ul style="list-style-type: none"> o <i>For Capitated Model</i>, this includes development of a unified set of requirements for Participating Plan complaints and internal appeals processes. o <i>For Managed FFS Model</i>, the State will ensure a mechanism is in place for assisting the participant in choosing whether to pursue grievance and appeal rights under Medicare and/or Medicaid if both are applicable. 	p. 25, Addendum
State Capacity	State demonstrates that it has the necessary infrastructure/capacity to implement and oversee the proposed model or has demonstrated an ability to build the necessary infrastructure prior to implementation. This includes having necessary staffing resources, an appropriate use of contractors, and the capacity to receive and/or analyze Medicare data.	pp. 7-8, 33, 36-37, 42-45
Network Adequacy	The Demonstration will ensure adequate access to medical and supportive service providers that are appropriate for and proficient in addressing the needs of the target population as further described in the MOU template.	pp. 2, 11, 24
Measurement/ Reporting	State demonstrates that it has the necessary systems in place for oversight and monitoring to ensure continuous quality improvement, including an ability to collect and track data on key metrics related to the model's quality and cost outcomes for the target population. These metrics may include, but are not limited to beneficiary experience, access to and quality of all covered services (including behavioral health and long term services and supports), utilization, etc., in order to promote beneficiaries receiving high quality care and for purposes of the evaluation.	pp. 29, 68-70, 105
Data	State has agreed to collect and/or provide data to CMS to inform program management, rate development and evaluation, including but not limited to:	

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
	<ul style="list-style-type: none"> · Beneficiary level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models; 	pp. 105
	<ul style="list-style-type: none"> · Description of any changes to the State Plan that would affect Medicare-Medicaid enrollees during this three year period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.): and 	pp. 105
	<ul style="list-style-type: none"> · State supplemental payments to providers (e.g., DSH, UPL) during the three year period. 	pp. 105
Enrollment	State has identified enrollment targets for proposed Demonstration based on analysis of current target population and has strategies for conducting beneficiary education and outreach. Enrollment is sufficient to support financial alignment model to ensure a stable, viable, and evaluable program.	pp. 3, 11, 17
Expected Savings	Financial modeling demonstrates that the payment model being tested will achieve meaningful savings while maintaining or improving quality.	p. 71-74
Public Notice	State has provided sufficient public notice, including:	
	<ul style="list-style-type: none"> · At least a 30 day public notice process and comment period 	pp. 3, 23
	<ul style="list-style-type: none"> · At least two public meetings prior to submission of a proposal, and 	p. 3
	<ul style="list-style-type: none"> · Appropriate tribal consultation for any new or changes to existing Medicaid waivers, State Plan Amendments, or Demonstration proposals. 	p. 22
Implementation	State has demonstrated that it has the reasonable ability to meet the following planning and implementation milestones prior to implementation:	
	<ul style="list-style-type: none"> · Continued meaningful stakeholder engagement 	pp. 26, 51, 61-68

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
	· Submission and approval of any necessary Medicaid waiver applications and/or State Plan amendments	p. 12
	· Receipt of any necessary State legislative or budget authority	pp. 34, 49
	· Joint procurement process (for capitated models only)	
	· Beneficiary outreach/notification of enrollment processes, etc.	pp. 14, 22-25

Appendix 3: Details of State Demonstration Area

The Demonstration will operate in all counties of the State in which the State has qualified health home providers, with the exception of King, Snohomish, and Whatcom counties (where the State is pursuing the capitated Financial Alignment Demonstration). To the extent CMS and the State agree that the State has the capacity and the authority to establish the Managed Fee-for-Service Model Demonstration in any of the three excepted counties noted and to the extent that the State no longer seeks to implement a capitated model in any of the three counties, Washington may expand this Demonstration to those additional counties beginning by November 1, 2013, at the latest. The State must inform and engage stakeholders before expanding this Demonstration to any of those additional counties.

Appendix 4: Medicare Authorities and Waivers

All statutory and regulatory requirements of Medicare Parts A, B, and D, including the provisions of Title XI of the Social Security Act (the “Act”), shall apply to the Demonstration project, except that the provisions of section 1899 of the Act, and applicable implementing regulations, are waived to the extent such provisions are inconsistent with the provisions of this MOU or the Final Demonstration Agreement. Waivers issued pursuant to section 1899(f) of the Act, as amended or superseded from time to time, do not apply to this Demonstration, nor do waivers issued for any other demonstration or pilot program.

Appendix 5: Medicaid Authorities and Waivers

All requirements of the Medicaid program expressed in law, regulation, and policy statement, including the provisions of Title XI of the Social Security Act, shall apply to the Demonstration project. The implementation of this Demonstration in each county (as specified in Appendix 3) is contingent upon the State receiving CMS approval for its health home SPA in that county. At a minimum, the health home program must comply with all SPA requirements, including the requirement that all categorically needy individuals who meet the State's criteria are eligible to receive health home services (and a State option may include individuals in any medically needy group).

Appendix 6: Performance Payments to the State

I. General

Under this Demonstration, the State will have the opportunity to earn a retrospective performance payment. The retrospective performance payment will be calculated and paid assuming the following principles:

- Qualification for the retrospective performance payment is contingent on performance/quality. No retrospective performance payment will be made if quality requirements, outlined in Appendix 7, are not met.
- Qualification for the retrospective performance payment is contingent on achieving overall Federal savings. Therefore, in determining the retrospective performance payment, any Medicare savings may be offset by any increases in Federal Medicaid expenditures.
- The same Medicare savings cannot be shared more than once. Therefore, CMS will apply attribution (alignment) rules to ensure that the experiences of specific beneficiaries are not simultaneously attributed to this Demonstration and to other Medicare shared savings initiatives. Attribution rules are described further in Appendix 7.
- The State of Washington is primarily responsible for the new investments and operating costs associated with the Demonstration, with costs eligible for Federal matching funds based on applicable Medicaid rules. Therefore, the State assumes some financial risk associated with those new investments. If the Demonstration is failing to meet cost or performance objectives, CMS will pursue corrective action or termination, as described in Section III.J *Modification and Termination of Final Demonstration Agreement* in the body of this MOU.

Demonstration Years: Figure 6-1 below outlines how the Demonstration Years will be defined for the purposes of this effort.

Figure 6-1. Demonstration Year Dates

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

II. Elements of the Medicare Savings Calculation

1. Comparison Groups

- *Independent Evaluator* – CMS has contracted with an independent evaluator (the Evaluation Contractor) to measure, monitor, and evaluate the impact of the Washington Managed Fee-for-Service Demonstration. The Evaluation Contractor will:
 - Employ a pre-post evaluation design with a comparison group using an intent-to-treat framework.
 - Select a comparison group using pre-Demonstration period data and will measure changes in both the Demonstration group (individuals eligible for attribution to the Demonstration, see Appendix 1 for additional detail) and comparison group.
 - Contrast the changes in outcomes and costs for the Demonstration group with the changes in outcomes/costs observed for a comparison group.

- *Comparison Group Selection* – The savings determination will compare actual spending for the Demonstration group to the spending that would have been expected in the absence of the Demonstration. Based on the anticipated implementation schedule and geographic scope of this Demonstration, CMS and its evaluator will establish a comparison group of Medicare-Medicaid enrollees in other states matched to the Demonstration group in Washington.
 - The Evaluation Contractor will draw a comparison group of Medicare-Medicaid enrollees from states or regions of states not pursuing

implementation of financial alignment models (or from geographic areas of financial alignment states where there is no financial alignment demonstration activity).

- The evaluator will use cluster analysis to identify potential comparison States that are most statistically similar to Washington by analyzing data on factors such as Medicare and Medicaid expenditures for Medicare-Medicaid enrollees, long-term care service users by type of provider, managed care penetration rates, and other criteria, among other factors. CMS and the evaluator will also consider factors, such as timeliness of data reporting, in comparison State selection.
- Once the comparison States are selected, all Medicare-Medicaid enrollees in the comparison area or areas who would have met Washington's eligibility criteria to participate in its integrated care Demonstration had the Demonstration been implemented in that area will be identified as potential members of the comparison group. The comparison group will be weighted so that the distribution of beneficiary characteristics prior to the start of the Demonstration matches that of Washington's Demonstration group.

2. Medicare and Medicaid Savings Calculations

- *General* - The savings calculation will be based on the difference in changes over time in both Medicare and Federal Medicaid expenditures found between the Demonstration group and the comparison group.
 - The savings determination will compare actual spending for the Demonstration group to the spending that would have been expected in the absence of the Demonstration.
 - Expected spending will be estimated by trending forward baseline per capita spending for the Demonstration group, using a trend observed in a comparison group.

- *Savings Calculation Details* - The Evaluation Contractor will calculate savings using the methodology as outlined below:
 - Calculate baseline (pre-Demonstration) Medicare and Medicaid per capita spending for the Demonstration group and comparison group. The baseline spending will be based on actual Medicare and Medicaid costs during a two-year period prior to the start of the Demonstration.
 - Calculate a Medicare growth percentage and a Medicaid growth percentage by measuring the actual rate of increase in Medicare and Federal Medicaid per capita spending in the comparison group between the baseline and performance years.
 - Apply the growth percentages to the Demonstration group Medicare and Medicaid baselines to determine per capita expected cost for the Demonstration group.
 - Determine the difference between the expected costs and actual costs.

- *Adjustments in the Calculation* – The evaluator will make necessary adjustments to the data including:
 - Cap all beneficiary expenditures at the 99th percentile of costs; and
 - Monitor and make adjustments for changes in Federal and State policies or related factors that could affect the calculations, as appropriate.

3. ***Medicaid Increase:*** For the purposes of this Demonstration, the Medicare savings as calculated above will be offset by the Federal share of Medicaid costs increases to determine the total amount available for sharing with the State.

- The Federal Medicaid increase will be assessed based on all Federal Medicaid costs (including new health home payments in the Demonstration group).
- The Medicaid increase calculation will follow the comparison group and adjustment approaches described for the Medicare savings calculation above.

III. Calculation of the Retrospective Performance Payment

1. General Parameters

- Implementation Contractor - CMS has contracted with a contractor to calculate retrospective performance payments. The Implementation Contractor will:
 - Determine whether Medicare savings calculated above meet the minimum savings requirements outlined in this section;
 - Calculate the amount available for retrospective performance payments to the State; and
 - Calculate the amount of the retrospective performance payment to the State based on the State's quality performance.
- Retrospective Performance Payment Guidelines - Once Medicare savings are demonstrated according to the calculation above, Washington will have the opportunity to earn a retrospective performance payment.
 - The savings calculated must meet a Medicare Minimum Savings Rate (MSR) before any savings can be shared with the State.
 - In order to receive a retrospective performance payment, the State must meet the quality requirements as outlined in Appendix 7.
 - The State will not be at risk for Medicare cost increases during the Demonstration. However, increased Medicare costs may trigger corrective action or termination.

2. Payment Calculation

- *Medicare Minimum Savings Rate (MSR)* – CMS will develop a Medicare Minimum Savings Rate for the Demonstration. The MSR will be applied to this Demonstration depending on the size of the Demonstration population. The minimum MSR will be 2%. Figure 6-2 shows examples of the MSRs for various levels of potential enrollment in the Demonstration. This figure demonstrates the MSR as applied at various points. An MSR within this range will be applied each year based on actual number of beneficiaries

considered as part of the savings calculation. Beneficiary points not shown below will be extrapolated based on the underlying curve.

Figure 6-2. Medicare MSR Range

Number of Beneficiaries	MSR
5,000	4.50%
10,000	3.20%
20,000	2.45%
50,000+	2.00%

- *Application of the MSR* – Medicare savings, as calculated above, will be compared to the MSR established for this Demonstration. If the Medicare savings calculated are less than the MSR, the State will not qualify for a retrospective performance payment.
- *Medicaid Significance Factor (MSF)* – CMS will develop a Medicaid significance factor for the Demonstration. This factor will be set at the same percentage as the Medicare MSR.
- *Application of the MSF* – Medicaid costs, as calculated above, will be compared to the MSF established for this Demonstration. If increases in Federal Medicaid costs are less than the MSF, CMS will not deduct from the Medicare savings for the purposes of calculating a retrospective performance payment.
- *Deduction of Medicaid increases* – If increases in Medicaid costs exceed the MSF, then the Federal share of the Medicaid increase (including costs below the MSF) will be deducted from the amount of Medicare savings to establish the net Federal savings.
- *Net Federal savings available for sharing with the State* – If Medicare savings calculated exceed the MSR, the State will qualify to earn up to 50% of the net Federal savings (i.e., 50% of the total Medicare savings after deducting the Federal Medicaid increase, if the Federal Medicaid increase exceeds the MSF).

- *Quality Percentage Distribution* – If the State meets the minimum quality requirements as outlined in Appendix 7, it will be eligible to receive 60% of the amount calculated above. The remaining 40% will be dependent upon State performance on individual measures.
- *Maximum Payment* – The performance payment shall be no greater than 6% of total Medicare expenditures for the Demonstration population.

IV. Timing: CMS will calculate retrospective performance payments on an annual basis. Each annual calculation will be independent of the prior year’s findings. The timing of performance payments is dependent on data availability, including the timeliness of submitting Medicaid data to CMS. To account for claims run-out and the time necessary for analysis and review, the earliest Washington would be able to receive a performance payment would be 9 to 11 months after the end of each Demonstration year.

V. Process for Reviewing Findings: CMS will consult with the State on methodological issues and data collection to execute the retrospective performance payment calculations. As described in Section H.3 of the body of this MOU, CMS and the State will meet at least annually to review the analysis and findings from the retrospective performance payment calculations.

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).

Any subsequent review of the retrospective performance payment may require that additional data be provided and reviewed. Parties agree to provide this data timely to resolve the issue. If, in the judgment of CMS, an error occurred in the original payment calculation resulting in an underpayment, CMS will pay the additional amount necessary

to correct the mistake. If an error produced payment to the State exceeding the appropriate amount, the State will refund the difference.

The terms of this MOU are subject to Federal program audit and expenditure requirements. If it is determined as a result of an independent audit or program review that there has been an overpayment made, both parties are responsible for complying with those findings.

Appendix 7: Demonstration Parameters

The purpose of this appendix is to describe the parameters that will govern this Federal-State partnership; the parameters are based upon those articulated by CMS in its July 8, 2011, State Medicaid Directors' Letter. CMS and the State have further established these parameters, as specified below.

***I.* State of Washington Delegation of Administrative Authority and Operational Roles and Responsibilities**

The Washington State Health Care Authority (HCA) is the single state agency for the Medicaid program. Through authority delegated by the HCA, the Department of Social and Health Services (DSHS) is responsible for the provision and oversight of mental health, chemical dependency, developmental disability, and long-term services and supports to individuals eligible for Medicaid. Together, these two agencies directly oversee the staff that will be involved with implementation and monitoring the Demonstration. The Demonstration will benefit from the direct and ongoing involvement of staff and programs across HCA and DSHS as described below.

To fully support the State's integration efforts and to align the work of the two agencies to achieve the goals of integration, the Demonstration is jointly sponsored and oversight of the work of this Demonstration is shared across these agencies. An Integration Executive Leadership Team made up of the State's HCA Medicaid Director, the Secretary of the Department of Social and Health Services, and policy and budget staff from the Governor's office meet on a routine basis to ensure the goals of the Demonstration are reached.

Monitoring and oversight of health home services and the Demonstration are conducted by dedicated program management staff of these two agencies responsible for daily Demonstration management duties. This work is supported by data,

analytics, evaluation, and PRISM development conducted by the DSHS, Research and Data Analysis unit.

II. Grievances and Appeals

The State will provide Demonstration participants with assistance in exercising grievance and appeals rights as applicable under Medicare and/or Medicaid. If a beneficiary requires assistance, the health home will be a first point of contact for information sharing and providing assistance. The State and CMS will leverage existing State and Federal resources to further assist individuals with grievances and appeals. These resources include mental health ombudsman, care managers in long term services and supports and developmental disabilities, the Statewide Health Insurance Benefits Advisor (SHIBA), the Office of the Insurance Commissioner, and 1-800-MEDICARE. These resources will provide responses to beneficiary questions on the Medicare and Medicaid grievances and appeals processes.

III. Administration and Oversight

1. Beneficiary Attribution: CMS will allow beneficiaries to be attributed with only one initiative involving Medicare shared savings, based on the following principles:

- In order to promote continuity of care, Medicare-Medicaid enrollees in Washington that are already attributed to a Medicare initiative involving shared savings as of the beginning of this Demonstration will remain attributed to that model, and will not be attributed to this Demonstration, until they are no longer attributed to that model.
- If a beneficiary is not attributed with a Medicare initiative involving shared savings, CMS will attribute that beneficiary with this Demonstration (HealthPathWashington: A Medicare and Medicaid Integration Project, Managed Fee-for-Service Model) if he or she qualifies for attribution to this Demonstration (See III.B.1 for additional information).

- If the beneficiary qualifies for this Demonstration and could be attributed to another model that involves Medicare shared savings and both start on the same date, the individual would be attributed to this Demonstration.
- Once a health home SPA is in effect, additional beneficiaries residing in the applicable geographic area will be attributed with this Demonstration on a monthly basis as they develop the chronic conditions and/or risk factors making them eligible to receive health home services, become Medicare-Medicaid enrollees, and/or move into the Demonstration area. If the State phases in the provision of health home services in different geographic areas through multiple health home SPAs, beneficiaries would become eligible for attribution to this Demonstration on dates consistent with each SPA's effective date. For individuals that become newly eligible for attribution to the Demonstration during a performance year, Medicare and Medicaid payments on behalf of these beneficiaries will be included in the performance payment calculations if the individuals meet the eligibility criteria for the Demonstration and are not already participating in another Medicare initiative involving shared savings.
- For this Demonstration, once an individual is attributed that beneficiary will continue to be so attributed until he or she loses eligibility for this Demonstration (e.g. moves out of the geographic area, is no longer enrolled in Medicare Parts A and B and eligible for Medicare Parts D and Medicaid).

2. ***Monthly Enrollment File Submissions:*** Beginning December 2012 and continuing monthly once the State begins its Demonstration, Washington must submit an enrollment file to CMS' beneficiary alignment contractor. This data will be updated into CMS' Master Database Management (MDM) system for beneficiary attribution purposes. This will ensure that no beneficiary is

attributed to multiple CMS initiatives or demonstrations involving Medicare shared savings.

3. Quality Metrics and Reporting for Determining the Retrospective Performance Payment:

General Principles: Under this Demonstration, Washington will be eligible to receive a retrospective performance payment based on its performance on quality and savings criteria, as outlined in Appendix 6 and in this section. The quality metrics and requirements outlined in this Section are for purposes of determining the State's retrospective performance payment. A separate evaluation conducted as part of the Demonstration will complement this analysis and more extensively examine beneficiary experiences, outcomes, and service utilization patterns. Additional discussion of the evaluation is provided in Appendix 7, Section 4.

Approach: If the State meets the minimum quality threshold, it will receive 60% of the retrospective performance payment calculated in Appendix 6. Once the minimum quality threshold is met, the State may qualify to receive the remaining 40% of the retrospective performance payment, or some portion thereof, dependent upon State performance on the individual quality measures outlined in this Section.

Measurement Groups: The Demonstration will consider quality for payment purposes in three grouping:

- Model Core Measures
- State-specific Process Measures
- State-specific Demonstration Measures

Quality Threshold: State performance on individual measures will be scored

using a 100 point system with the highest score for an individual measure being 100 points, 0 the lowest. For purposes of determining whether the State meets the minimum quality threshold, measures will be grouped as outlined above, and a weighted average of those measure groupings will be used to calculate the State's quality score. The State's quality score will then be measured against the minimum quality threshold.

If the State's quality score meets or exceeds the minimum quality threshold, it will receive 60% of the retrospective performance payment calculated in Appendix 6. Once the minimum quality threshold is met, the State may receive up to 40% of the retrospective performance payment dependent upon State performance on the individual quality measures outlined in this Section. The portion of the 40% that the State receives will be based on the points earned for each individual measure.

If the State does not meet the minimum quality threshold in a particular Demonstration year, no performance payment will be made for that Demonstration year and the State may be required to undergo a corrective action plan or to terminate the Demonstration.

Benchmarking: Established quality metric benchmarks do not currently exist for the Medicare-Medicaid enrollee target population for this intervention. The establishment of appropriate benchmarks for the target population will require analysis of multiple years of baseline data, both to measure baseline levels of performance and to quantify the degree of inherent variability in the performance metrics over time. CMS will establish benchmarks for each measure based on an analysis of the State's quality performance. Analysis provided by the Implementation Contractor will be used to establish the benchmarks.

Evaluation Contractor: The Evaluation Contractor will develop specifications

for the Model Core measures, calculate the State's performance on each measure, and share the results with the Implementation Contractor. Subject to CMS approval, the State will develop specifications for the State-specific Measures and Process Measures.

Implementation Contractor: The Implementation Contractor will determine whether the State met the quality thresholds, factor State performance on individual quality measures into the performance payment calculation, and finalize the performance payment amount, if any.

The specifications for each measure, minimum quality threshold, and scoring calculations will be established in the Final Demonstration Agreement.

Measures: See following table.

MFFS Measure Table (By Demonstration Year)

Model Core Measures	Year 1	Year 2	Year 3
All Cause Hospital Readmission <i>(30-Day All-Cause Risk Standardized Readmission Rate – CMS)</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: State must select the Health Action Plan and Health Home Network Training Process Measures, and select at least one other process measure	Year 1	Year 2	Year 3
Health Action Plans: Percentage of beneficiaries with Health Action Plans within 60 days of beneficiary being assigned to a Care Coordination Organization (Required)	Reporting	Benchmark	Benchmark
Training: State delivery of training for Health Home Networks on disability and cultural competence and health action planning (Required)	Benchmark	Benchmark	Benchmark
Discharge Follow-up: Percentage of beneficiaries with 30 days between hospital discharge to first follow-up visit	Benchmark	Benchmark	Benchmark
Real Time Hospital Admission Notifications: Percentage of hospital admission notifications occurring within specified timeframe	Reporting	Benchmark	Benchmark
Percentage of health homes with an agreement to receive data from health home beneficiaries' Medicare Part D Plans	Reporting	Benchmark	Benchmark
State-Specific Demonstration Measures- State must select at least 3, but no more than 5	Year 1	Year 2	Year 3
*State-Specific Demonstration measures – Including LTSS and/or community integration measures	Specified in Final Demonstration Agreement	Specified in Final Demonstration Agreement	Specified in Final Demonstration Agreement

**CMS will adapt base measures to incorporate a denominator relative to the Demonstration specific populations at a State level.*

Timing:

For the purposes of quality measurement under the Demonstration:

- Complete reporting means that all parts/elements of the measure must be reported in order for it to be considered “complete.” Even if the answers are ‘no’ a certain action was not done or if clinical values are unfavorable, full credit would be given because all parts of the measure were reported completely.
- Accurate reporting means that all parts of the measure are reported truthfully. All quality measures reported should accurately reflect medical record data, non-medical data and other information contained in the source data systems. Even if reported values are unfavorable, credit is given because the measure was reported accurately.

Year 1 - In the first year of the Demonstration, the State, working with a CMS contractor, will be required to use Medicare data to completely and accurately report core measures.

Demonstration Core Measures (Year 1):

- All cause hospital readmission - (30-Day All-Cause Risk Standardized Readmission Rate – CMS)
- Ambulatory care-sensitive condition hospital admission - (PQI Composite #90)
- Number of emergency department visits for ambulatory sensitive conditions - (Rosenthal)
- Follow-up after hospitalization for mental illness - (NQF #0576)

State-specific Process Measures: Also, beginning in Year 1, State performance on process measures will be tracked for the life of the Demonstration. There will be two mandatory process measures:

- Health Action Plans: Percentage of beneficiaries with Health Action Plans within 60 days of the beneficiary being assigned to a Care Coordination Organization
- Training: State delivery of training for Health Home Networks on disability and cultural competence and health action planning

The State also must select at least one of the following process measures:

- Discharge Follow-up: Percentage of beneficiaries with 30 days between hospital discharge to first follow-up visit
- Real Time Hospital Admission Notifications: Percentage of hospital admission notifications occurring within specified timeframe
- Percentage of health homes with an agreement in place to receive data from a beneficiary's Part D Plan

State-Specific Demonstration Measures: The State will select, and CMS will approve, between three and five State-specific Demonstration measures. These measures must be tailored to the State's target population and overall Demonstration. The State must select at least one measure that will address community integration and/or long-term care rebalancing. The State will determine, subject to CMS approval, the specifications for these measures. CMS will determine the benchmarks for these measures.

Year 2 - In year 2, CMS and the State will transition from reporting to measurement for the year 1 core measures; transition from reporting to measurement for process measures; and add core measures for reporting listed below.

New Demonstration Core Measures: CMS will work with Washington to begin preparations for reporting these measures in year 1 to assure complete and

accurate reporting as these measures require information from sources beyond the claims record:

- Depression screening and follow-up care - (#0418)
- Care transition record transmitted to health care professional - (NQF#648)

Reporting and measurement for the State-specific Process Measures and State-specific Demonstration Measures will continue.

Year 3 - In year 2, CMS and the State will continue the transition from reporting to measurement for the core measures; continue measurement for process measures; and add core measures for reporting listed below.

New Demonstration Core Measures: CMS will work with Washington to begin preparations for reporting these measures in years 1 and 2 to assure complete and accurate reporting as these measures require information from sources beyond the claims record:

- Screening for fall risk - (#0101)
- Initiation and engagement of alcohol and other drug dependent treatment:
(a) initiation, (b) engagement - (NQF #0004)

Reporting and measurement for the State-specific Process Measures and State-specific Demonstration Measures will continue.

Other Related Activities: In addition to the quality measures noted above and the activities noted in Appendix 7, Section 4, CMS and the State will undertake the following activities to collect and evaluate the experience of beneficiaries in this Demonstration:

- **Health Home Reporting:** The State and its health home providers will participate in all required reporting required under any approved health home SPA(s), including the reporting of health home measures for all health home beneficiaries.
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS):** In order to assess beneficiary experience, the State will work with CMS and its contractors to implement beneficiary and caregiver surveys (including the CAHPS survey).
- **Medicaid Statistical Information System (MSIS) Data:** The State will submit both historical MSIS data and continue to submit all ongoing MSIS data in a timely manner.
- **PRISM:** The State will continue to maintain and operate the PRISM system (discussed further below), to support coordinated service delivery through use of Medicare and Medicaid data, among other sources of information.

4. DSHS Predictive Risk Intelligence System (PRISM): PRISM is a web-based clinical decision support tool used to support integrated service delivery by providing predictive modeling to identify Medicare-Medicaid enrollees who have complex care needs and require assistance from multiple systems. Information contained in PRISM is pulled from centralized data warehouses and includes Medicaid and Medicare claims, encounter data and assessment information. The information in PRISM is organized and displayed to create a holistic picture of risk factors, clinical indicators, treating providers, gaps in care and drivers of health care utilization. This tool has been used in Washington State's chronic care management programs since 2009 and development and

maintenance of the tool is done by the Washington Department of Social and Health Services.

The State will continue to maintain and operate the PRISM system for purpose of this Demonstration. CMS will provide Medicare data to the State for use within the PRISM system. Both parties will update and comply with terms of all applicable Data Use Agreements.

5. ***Washington State Health Home Essential Requirements:*** This section describes Washington's health home requirements; to the extent that there is any variance between this section and the State's approved health home SPAs, the SPAs govern. Under Washington State's approach, health homes are the bridge to integrate care within existing care systems. A health home is the central point for coordinating person-centered care and is accountable for reducing preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up; and improving patient outcomes by mobilizing and coordinating primary medical, specialist, behavioral health and long-term care services and supports. Care Coordinators must be embedded in community-based settings to effectively manage the full breadth of beneficiary needs.

Health Home Network: The network must include local community agencies that provide or authorize Medicaid, state or federally funded mental health, long-term services and supports, chemical dependency and medical services.

Examples of potential health home providers are Regional Support Networks (RSNs), Community Mental Health Agencies (CMHAs), Area Agencies on Aging, Substance Use Disorder providers, Hospitals, Public Health Districts, Accountable Care Organizations, Medical Homes, Charities, Network Alliances, and community supports that assist with housing.

HCA and the DSHS have identified specific administrative functions for both lead entities and Health Home Care Coordination Organizations. The State will assure that these functions are accounted for in the health home qualification process and documented in signed contracts and subcontracts. A qualified Health Home Network may base those functions on its organizational structure with some services performed by the lead entity if agreed to by the State.

Health Home Lead Entity Requirements – The Health Home Lead Entity is accountable for administration of the health home. The lead entity:

1. Has experience operating broad-based regional provider networks;
2. Contracts directly with the State as a qualified health home;
3. Ensures person-centered and integrated health action planning including the provision of high-touch care management, such as the beneficiary to care coordinator ratio and documentation of support staff that complement the work of a care coordinator;
4. Provides a toll-free line to answer questions regarding health home enrollment, disenrollment, and how to access services or request a change to another Health Home Care Coordination Organization;
5. Subcontracts with organizations to directly provide the health home care coordination services (contractual relationships between the lead entity and their Care Coordination partners must be developed and in place prior to enrollee assignment);
6. Assigns health home enrollees to Care Coordination Organizations, using an assignment process, whenever possible, that includes:
 - Uses PRISM or other data systems to match the beneficiary to the Care Coordination Organization that provides most of their services; and
 - Optimizes beneficiary choice.
7. Maintains a list of Care Coordination Organizations and their assigned health home population;

8. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home Network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable.
9. Collects and reports encounters;
10. Disburses payment to Care Coordination Organizations based upon encounters;
11. Ensures Care Coordination Organization standards are met; and
12. Collects, analyzes and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting health home and Demonstration goals.

Health Home Care Coordination Organization Requirements – The Health Home Care Coordination Organization must:

1. Subcontract with the Health Home Lead Entity;
2. Assign a Health Home Care Coordinator to provide health home services;
3. Coordinate with primary care providers, specialty care managers and other providers – including home and community-based services waiver case managers – based on beneficiary needs.
4. Provide health home services in a culturally competent manner that addresses health disparities. Examples of cultural competency:
 - Interacting directly with the beneficiary and their families by speaking their preferred language
 - Recognizing and applying cultural norms when creating the Health Action Plan
 - Understanding the dynamics of substance use disorder without judgment

5. Ensure that Health Home Care Coordinators provide in-person beneficiary health screening and health action planning, using HCA and DSHS standardized and approved protocols;
6. Ensure that Health Home Care Coordinators actively engage the beneficiary, his/her family, and caregivers in developing a Health Action Plan;
7. Ensure that Health Home Care Coordinators accompany the beneficiary to critical appointments when necessary to assist in achieving Health Action Plan goals;
8. Ensure that Health Home Care Coordinators coordinate and mobilize treating/authorizing entities as necessary to reinforce and support the beneficiary's Health Action Plan goals;
9. Ensure that Health Home Care Coordinators deliver culturally appropriate interventions, educational and informational materials;
10. Ensure that Health Home Care Coordinators include and leverage direct care workers (paid and unpaid) who have a role in supporting beneficiaries to achieve Health Action Plan goals and access health care services;
11. Ensure that Health Home Care Coordinators address the full array of beneficiary needs, as reflected in the implementation of a person-centered Health Action Plan. This includes administering standardized health screening, identifying the root causes for inappropriate or gaps in health care utilization and making referrals and coordinating communication across systems of care.
12. Document when staff are complementing the work of a Care Coordinator by providing indirect care coordination support;
13. Implement a systematic protocol to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post discharge care;
14. Establish methods to share hallmark events (such as emergency room visits, inpatient hospitalizations, inpatient discharges, missed prescription

refills, institutional placement and/or discharge, and the need for preventive care) with the Health Home Care Coordinator within established time periods;

15. Use a system to track and share beneficiary information and care needs across providers, to monitor processes of care and outcomes, and to initiate recommended changes in care, as necessary, to address achievement of Health Action Plan goals including the beneficiaries preferences and identified needs;
16. Provide 24/7 availability of information and emergency consultation services to the beneficiary (this may be provided by the lead entity);
17. Assure that hospitals have procedures in place for referring health home-eligible beneficiaries who seek or need treatment in a hospital emergency department for health home enrollment;
18. Use informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural, and environmental factors impacting health and health care choices;
19. Ensure that Health Home Care Coordinators (within the Care Coordination Organization) can discuss with the treating/authorizing entities on an as needed basis, changes in beneficiary circumstances, condition or Health Action Plan that may necessitate timely, and in some circumstances, immediate changes in treatment or services
 - A Care Coordination Organization must establish data sharing agreement that conforms to HIPAA requirements must be in place when sharing either hard copy or electronic health information.
 - The health home beneficiary must sign a “Health Home Information Sharing Consent Form” before the Health Home Care Coordinator can share protected health information with other health care professionals and caregivers.

20. Ensure that Health Home Care Coordinators have access to PRISM to view cross-system health and social service utilization to identify care opportunities;
21. Ensure through monitoring activities that Health Home Care Coordinators maintain a caseload that ensures fidelity to provide required health home services, including the interventions required by the State contract to deliver high-touch, in-person care coordination. Community health workers, peer counselors, or other non-clinical staff may be used to facilitate the work of the assigned Care Coordinator.

Training of Qualified Health Homes: Training of qualified health home lead and care coordination entities will be jointly sponsored between the Health Care Authority, the Department of Social and Health Services, and the Department of Health. Training activities will include: regional forums, training events, webinars, routine online training, and case review. Training will ensure partnerships are developed at the local service delivery level to support integrated health home services and that care coordinators understand the essential requirements and key elements of Washington’s approach to health home service delivery, in addition to building core skills. Topics of training will include the administration and interpretation of the Patient Activation Measure tool, beneficiary and family engagement, cultural and disability competence, care coordination strategies, standardized screening and measurement tools, health promotion and disease prevention, Medicare benefits and appeal processes, and health action planning.

Regional Support Network (RSN) Role: As entities that authorize mental health services and manage the contracted mental health provider network, RSNs will be an essential partner within qualified Health Home Networks to ensure the coordination of service delivery and to assist the beneficiary to achieve their identified Health Action Plan goals.

Qualified Health Home Networks and RSNs will be expected to implement procedures to share pertinent information regarding the care of beneficiaries to facilitate care coordination and achievement of Health Action Plan goals, reduce duplication, and ensure protection of beneficiary confidentiality and rights. It is anticipated that RSNs may also provide lead entity functions and/or health home coordination functions in some qualified Health Home Networks.

6. *Evaluation:* CMS has contracted with an independent evaluator (the Evaluation Contractor) to measure, monitor, and evaluate the impact of this Demonstration on beneficiary experience, quality, utilization, and cost. The evaluator will also explore how the Washington initiative operates, how it transforms and evolves over time, and beneficiaries' perspectives and experiences of care. The evaluation will assess beneficiary perspective and experience related to the key Demonstration goals, including the ability to self-direct care, be involved in one's care, and live independently in the community. The key issues targeted by the evaluation will include (but are not limited to):

- Beneficiary health status and outcomes;
- Beneficiary satisfaction and experience;
- Quality of care provided across care settings;
- Beneficiary access to and utilization of care across care settings;
- Administrative and systems changes and efficiencies; and
- Overall costs or savings for Medicare and Medicaid.

The evaluator will design a State-specific evaluation plan for this Demonstration using a mixed methods approach to capture quantitative and qualitative information. Qualitative methods will include site visits, qualitative analysis of program data, and collection and analysis of focus group and key informant interview data. Quantitative analyses will consist of tracking changes in selected

quality, utilization and cost measures over the course of the Demonstration; evaluating the impact of the Demonstration on quality, utilization, and cost measures; and calculating savings attributable to the Demonstration. Specific evaluation strategies include:

- Focus groups conducted with beneficiaries, family members and caregivers;
- Key informant interviews conducted with advocacy organizations and other stakeholders;
- Analysis of beneficiary survey results, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys as well as surveys administered by the State.
- Analysis of Medicare and Medicaid data to examine quality, utilization and cost experience, as well as MDS data, and additional data on State-specific measures to be reported by the State. The evaluation will also assess program data, including complaint, appeal and grievance data

The evaluation will employ a pre-post evaluation design with a comparison group using an intent-to-treat framework. The evaluator will contrast the change in outcomes and savings for the Demonstration group of Medicare-Medicaid enrollees eligible to participate in the Demonstration in Washington with the changes in outcomes/savings observed for a comparison group. The evaluator will use pre-demonstration period data to select the comparison group and measure changes in both the Demonstration and comparison groups.

The evaluator will draw a comparison group of Medicare-Medicaid enrollees from statistically similar States or regions not pursuing a financial alignment model under this CMS Demonstration. The evaluator will use cluster analysis to identify potential comparison States that are most similar to Washington on factors such as Medicare and Medicaid expenditures for Medicare-Medicaid enrollees, long-term care service users by type of provider, and managed care

penetration rates, among other factors.

The comparison group will start with all Medicare-Medicaid enrollees in the comparison area who would have met Washington's eligibility criteria to participate in the Demonstration had the Demonstration been implemented in that area. Within this group, the evaluator will develop the comparison group by using propensity scoring to adjust for differences in key observed characteristics between the Demonstration and comparison group members, and to eliminate certain individuals from the comparison group based on their dissimilarity to the Demonstration group. This reweighting technique adjusts for differences in individual-level characteristics between the Demonstration and comparison group members using data on beneficiary-level (demographics, health and disability status) and county-level (health care market and local economic) characteristics.

The evaluator will develop Washington-specific annual reports that incorporate qualitative and quantitative findings to date, and will submit a final evaluation report at the end of the Demonstration. CMS will share a draft of the final evaluation report with the State for review before finalization; the final evaluation report will be a public document.

Washington is required to cooperate, collaborate, and coordinate with CMS and the independent evaluator in all monitoring and evaluation activities. Washington must submit all required data for the monitoring and evaluation of this Demonstration. Washington will track beneficiaries eligible for the Demonstration, including which beneficiaries choose to enroll or disenroll, enabling the evaluation to identify differences in outcomes for these groups.

Washington will continue to submit all Medicaid Statistical Information System (MSIS) data in a timely manner. As of September 2012, Washington has submitted all 2011 MSIS files to CMS.

7. ***Learning and Diffusion Activities:*** Washington will also participate in learning and diffusion activities regarding this Demonstration. These may include sharing lessons learned with other States, participating in period webinars and/or teleconferences, or other activities