



Northwest Justice Project



Northwest Health Law Advocates

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Dear Director Lindeblad:

Northwest Health Law Advocates (NoHLA) and Northwest Justice Project (NJP) offer these comments on the Health Care Authority's Section 1115 Medicaid Waiver (Global Waiver) draft application. NoHLA's mission is to advocate for improved access to health care, particularly for low-income and vulnerable Washington State residents. NJP provides free civil legal services to low-income people throughout Washington State through its toll-free intake line and field offices, and has represented many individuals in cases involving authorization of and access to Medicaid-covered services.

We appreciate the state's intent to strengthen the system of care for low-income individuals. We support the goals of eliminating gaps and silos in care delivery and of developing and strengthening linkages between health care and other support services. We agree with the need to focus on outcomes for individuals rather than simply providing services. However, in these comments we emphasize that in its efforts to transform the system, HCA must recognize that every individual Medicaid enrollee has unique needs. There is no "one size fits all" solution that works for everyone. This acknowledgment will be important in designing and implementing this demonstration in a sensitive manner, to ensure that no person loses access to needed care as a result of the proposed changes.

Similarly, the waiver request should consider the specific needs of subpopulations within the Medicaid enrollee group who could benefit from a broader and more comprehensive approach to care delivery. Some have been mentioned in the draft application, such as those needing long-term supports, and American Indians and Alaska Natives. Below, we propose that HCA call-out a more specific focus on formerly incarcerated populations who would



benefit from targeted supportive services. The waiver application should further emphasize and provide avenues to target supports for the unique needs of populations experiencing health disparities and immigrants. This approach is consistent with the overall premise of the waiver application - that it will reduce clients' use of acute care hospitals and other facilities, thereby improving health outcomes and reducing costs.

It is unclear how the changes proposed will affect individuals. While the waiver envisions a broadly transformed health care system to meet the stated goals, there is not yet sufficient definition of the component projects, how they will be administered and evaluated, availability of appropriate service providers, structures for accountability, or safeguards to ensure that coordinating entities and the waiver-funded regionally-based projects are effective and on a sustainable path. If a project or program turns out to be ineffective or unsustainable, it is important to have a plan for altering the course.

It is similarly critical that mechanisms for robust stakeholder involvement in the development and oversight of the waiver program be described explicitly in the waiver application itself. We appreciate that the current application anticipates the use of stakeholder feedback in shaping the final waiver program through the State's negotiations with CMS. In our comments, we suggest ways in which the waiver application should make an across-the-board and detailed commitment to meaningful stakeholder involvement in these processes, including responsible and supported participation by the diverse, low-income health care consumers who will be primarily impacted by the waiver's programs.

The LTSS proposals, which we gather are the work of the Department of Social and Health Services' Aging and Long Term Services Administration, do not seem to have much in common with the transformative efforts described in what we assume are the HCA sections of the application. The LTSS proposals raise concerns that will be discussed below.

As the waiver application moves forward, we urge a strong focus on implementing safeguards and accountability measures to ensure that this extraordinarily large investment of Medicaid dollars is targeted to improvements in serving the needs of clients within its mandate. The investments described will apparently be spent on restructuring systems rather than increasing the amount of care. Washington must balance the need for sustainability of the system with the central purpose of the Medicaid program – to enable states to provide medical assistance to vulnerable individuals whose income and resources are insufficient to meet the costs of necessary health care services and the supports these individuals need to live independently.¹ It is critical that the quality of care clients receive is not degraded through this process.

We look forward to partnering with HCA to help shape and refine various aspects of the proposals. Our comments below track the outline of the draft waiver application. They are organized according to the draft application headings and corresponding subparts.

¹ 42 U.S.C. § 1396-1

I. PROGRAM DESCRIPTION

Sustainability of the System

While federal approval of the waiver will provide important investments to transform health care delivery, the state must ensure that the funds provided to regionally-based projects are safeguarded so that they are sustainable long term. For consumers who will come to rely on the new system built up by this demonstration, any beneficial improvements must be able to be continued beyond the waiver term. We understand the state's rationale that long-term sustainability means paying for health services differently, but we must not undermine the existing infrastructure that already provides necessary care to so many individuals. Below we describe specific concerns and recommendations for ensuring sustainability beyond the five-year demonstration period:

- Ensure that measures for sustainability emphasize the effectiveness of the change, rather than simply the reduced cost. For example, if more people are served than previously, there could be an increase in cost (e.g., persons with mental illness who would have better access than in past; growth of LTSS population).
- When determining the successful performance of regionally-based transformation projects, the state must ensure that benefits in other areas are recognized in the calculation (e.g., savings accrued in the criminal justice system).
- Incentivizing value is a good objective, but we are concerned that providers who serve patients with the most complex health care needs may not always be properly or adequately incentivized. Question 10 (p. 38) identifies the Statewide Common Core Set, though it is unclear from the application whether these will be the only measures used. If so, this is a very limited set of measures that may not adequately measure the outcomes for this population. (See further discussion in Hypothesis/Performance Measure section below.)

However, even if more or different measures are used, we would need much more information to understand how an incentive payment formula would adequately reflect the challenges involved in treating patients who may not be capable of stabilizing or improving despite medical and other foundational support interventions and treatment. The state must consider how extraneous factors unrelated to the provider's or caregiver's competence (e.g., an infant born with a terminal illness, a patient with a particular chronic condition who experiences the loss of a loved one, a primary care patient who is injured and requires extensive specialty care, someone with a rare disease for which there is not yet a clear treatment path, or a patient speaking a rare language for which few interpreters are unavailable) will be accounted for in the proposed payment methodology. It is hard to imagine an incentive model and performance measures that are so precisely tuned to the varied situations and lives of Medicaid enrollees that they can track every situation fairly and equitably and translate it into appropriate payment incentives. But without this level of precision, there is a danger that such providers will be discouraged from

continuing to treat these patients. We recognize that in a large patient population, these risks may be mitigated by the size of the group; however this mitigating factor may not apply to a smaller provider group specializing in treating certain individuals for whom the chosen performance measures are less relevant.

- We recognize the state's interest in reducing costs, but we think this is secondary to providing quality care. The response to Question 9 (*see* pp. 37-38) suggests that payment models that shift much of the risk to providers may be used in combination with other models. Our concern is that this assumes that "paying for value" necessarily means "shifting accountability for risk" onto providers, when it can be done instead by rewarding for high quality care regardless of cost (though cost savings will almost certainly flow as a result). We want to ensure that providers are in no way incentivized to stint on appropriate care to help their bottom line. If providers have increased risk, we would like to work with HCA to develop consumer protections such as requirements to disclose all treatment options, processes for second opinions, and revised due process policies.
- HCA has made assurances that there would be many checks and balances within the MCO and BHO contracts to ensure sustainability. We are concerned that despite these assurances and without sufficient detail about the actual contract terms it will be challenging to develop contracts that consider length of time to achieve savings that may go beyond contract period.
- Smaller providers may encounter significant barriers to demonstrating sustainability under the parameters and strategies proposed by this application. This could lead to inadvertent prioritization of large providers which could not be the providers in the best interests of all patients. HCA should clarify how it will ensure that smaller provider practices are not burdened too much by administrative reporting requirements and show how smaller practices can minimize risk if the "experiment" does not prove sustainable.
- It is not clear how dual eligibles and others who are in non-capitated coverage would be affected by this waiver.
- Section 1115 waivers are temporary and DSRIP-funded projects are intended to be short-term infrastructure-type investments. To ensure sustainability beyond the five-year demonstration period the sustainability plan must be something more than reliance on perpetual renewals of the 1115 waiver. HCA must create a workable mechanism to ensure that future funding that will be needed is equitably distributed both across the state and within various regions. Private money infused into the system through regionally based sustainability plans or otherwise must not influence which promising projects go forward.
- There will be a need for frequent auditing by HCA to ensure compliance with requirements, standards, and expectations. Federal regulations require states to conduct periodic reviews of implementation. This review process must involve public

participation. More development of an audit structure is needed to comply with federal rules and to ensure the process is on track to make course corrections in real time to the extent possible.² The audit team should have the power to impose corrective action plans if an ACH does not comply with requirements or is not meeting performance measures.

Hypotheses

Clarity on Intended Outcomes & Performance Measures

The intended outcomes of this demonstration need to be clarified. While the application references two state data sets and a few measures that will be included, it does not specify the complete list of measures and the timeframe in which they will be used. HCA should also clarify which entity (the state, ACH, MCO, BHO) is accountable for which outcomes. It would also be helpful if HCA considered the various performance measures and identified specific subpopulations experiencing the measured health needs (e.g., formerly-incarcerated individuals experience high rates of chemical dependency and mental health needs, both of which are performance measures in MCO and HBO contracts). HCA should produce a crosswalk outlining the common set of measures across ACHs, MCOs and BHOs as well as any additional measures that apply to only some of these entities. If the measures change or shift over time, HCA should detail how this crosswalk may change over time. Please also reference measures that may be aligned with regional needs assessments.

In the final application, as well as subsequent documents, HCA should provide greater detail regarding the performance measures to be used to evaluate the hypotheses found on pages 13-14 of the draft application. HCA should also clarify how the measures listed in the chart align with the measures the state proposes to include in the MCO and BHO contracts. Draft Application pp. 13-14; 30. We understand that this is an iterative process, developing over time. However, we encourage HCA to clearly identify the measures as well as alignment/overlap between responsible entities (state, MCO/BHO, ACH, and transformation project providers) as soon as possible. Finally, we recommend that for each demonstration hypothesis, HCA list the specific performance measure and source thereof that will be used to test it; which entities (MCO, BHO, ACH or state) will be responsible for monitoring, collecting, and reporting results; which of these entities will be accountable for underperforming results; and the consequences of underperformance. If any of these measures will be part of contracts or agreements between the state and other entities (MCO, BHO, ACH), the contracts or agreements must be provided to the public for review and comment. HCA should seek public input when identifying which measures to use when reviewing the outcomes.

Health Disparities

Health disparities are not mentioned in the context of the hypotheses or elsewhere with regard to performance measurement. The absence of a hypothesis and correlated performance measures related to addressing health disparities is troubling. HCA should require entities and agencies involved in administering LTSS and targeted foundational support benefits to

² 42 C.F.R § 431.420(b). Within six months of the date the waiver is approved, and annually thereafter, the state must hold public forums to solicit feedback.

focus on increasing equity, not just on improving the health of its overall population. This responsibility should extend to each ACH and regionally-based transformation project as well as the state agencies (and any regionally-based partnerships related to administering those benefits). We recommend that HCA use performance measures that capture not only improvements in the health of the overall population, but also in the health of sub-populations. All measures should be stratified with sufficient granularity to evaluate outcomes for these subpopulations.

Importance of Measuring Clients' Access to Services

HCA should build into the evaluation strategy patient-reported measures that reflect actual improvements in clients' ability to access Medicaid services promptly even when not measurable in other ways. Measuring access should be a two-pronged approach. First, it should include periodic surveys of the clients themselves regarding met and unmet needs. Second, quality measures should be coupled with collection, analysis, and reporting of data on utilization, complaints, appeals, stratified by subpopulations. These are absolutely critical performance measures that should be incorporated into the mechanisms HCA proposes to determine success and ensure accountability.

Hypotheses related to Initiative 1: Transformation through Accountable Communities of Health

Individuals with multiple chronic conditions will have higher quality of care after transformation projects are implemented

It is unclear why this metric is restricted to "individuals with multiple chronic conditions." This limitation is not present elsewhere in the application. In fact, while we support improvement in quality of care for these individuals, this restriction seems incongruent with the overall approach of regionalism and flexibility. We understand that HCA may have limited this measurement in such a way because this population is least well-served in the current system. It is also possible that this resulted from a conflation of the hypotheses to be tested by the ACH-administered transformation projects, which are not elsewhere defined as focusing on individuals with chronic conditions, with the hypotheses to be tested by the statewide targeted foundational supports, supported housing and supported employment, which the waiver proposed to make available only to individuals with chronic conditions. If this is correct, it would be helpful to tease these hypotheses into two evaluation questions – one to address ACHs/community collaborations, and one to address the statewide foundational supports specifically targeted to individuals with chronic conditions. We are concerned that with regard to measuring impact within Initiative 1, this may be too narrowly crafted to capture the results HCA proposes to measure in other places throughout the draft application and properly demonstrate the effectiveness of regional transformation projects to have an impact on "individual population health outcomes" that result in a reduction in need for more intensive services; a reduction in spending growth below national trends; and accelerate value-based payment reform. Draft Application p.11.

It is also unclear the extent to which the "menu of evidence-and research-based transformation projects" that the State intends to create will specifically target populations with multiple chronic conditions. Draft Application p. 5. This metric may not be broad

enough to capture the potential successful transformation projects which will target populations other than those with multiple chronic diseases. Since these projects are intended to be based on regional needs assessments (Draft Application p. 5) and specifically crafted to address the needs identified by the community, it would be appropriate to develop a hypothesis related to this initiative that would seek to impact and measure the quality of care for all the populations served by the regionally-based transformation projects.

Furthermore, the application should more clearly explain which “targeted” metrics within the HEDIS and state-defined health care quality and outcome measures HCA intends to track and measure. There are multiple metrics within HEDIS to be tracked and the application does not explicitly say which measures will be targeted to track the outcomes of this hypothesis. Also, it is unclear which set of performance measures HCA is referring to as the “state-defined health care quality and outcome measures.” Presumably, HCA is referring to the [Statewide Common Core Set of Measures approved by the Performance Measure Coordinating Committee in December 2014](#) (PMCC). This should be made clear in the application. Similarly, HCA should make clear which “state-defined health care quality and outcome measures using Washington State’s Integrated Client Database” it will track to monitor the outcomes of this initiative. It is not clear which of the fifty-two metrics from the PMCC, as listed on the Healthier Washington website, are intended to track and measure improved quality of care. If HCA is referring to another set of metrics to measure improved quality of care, it should explicitly state which set of metrics and of those the “targeted” subset within that larger set.

Total cost of care for individuals with multiple chronic conditions will be lower

As with the hypothesis related to increasing quality of care, this hypothesis targets individuals with chronic health conditions only. It is unclear why HCA has limited this metric to populations with multiple chronic conditions when this limiting factor is not present in other areas of the draft application nor does it seem to reflect the overall theme of the global waiver which is to have community based transformation projects reflect and relate back to regional needs assessments. Presuming that all communities will not implement transformation projects targeted at only individuals with multiple chronic health conditions, HCA should consider expanding this hypothesis to capture the potential positive impacts on lower cost of care for all individuals served by transformation projects.

We recognize that monitoring the cost of care is important to the budget neutrality and sustainability aspects of the demonstration. However, we emphasize again that cost measurement should not crowd out attention to what is paramount: improving health care quality and access for Medicaid clients. While attention to costs is valid, the value of this demonstration should lie in maintaining and improving health care to individuals, and costs to meet unmet need may be inevitable in some situations, especially to properly care for those with multiple chronic conditions.

Hypotheses related to Initiative 2: Targeted Long Term Services and Supports

The draft application emphasizes the impending “age wave” in Washington State and the expected impact it will have on the sustainability of the state’s health care system. Draft

Application pp. 3, 9. (Please see our concerns related to Initiative 2 in the Demonstration Eligibility and the Demonstration Benefits and Cost Sharing sections below.) With respect to measuring outcomes within this Initiative, the state has neglected to propose a hypothesis or any metrics to determine the impact on the aging population. HCA must place equal weight and consideration on measuring the impacts that the proposals in this Initiative may have on (1) access to medically necessary services in the appropriate care setting, and (2) improvements in health and well-being. The draft hypotheses do not sufficiently address the potential negative impacts on these populations, specifically for those who will no longer qualify for nursing home level of care or those who enroll in the limited MAC benefit, rather than HCBS for which they are also eligible or individuals who cannot obtain HCBS due to tightened institutional standards. For example, the state could measure the impact of implementing the MAC benefit alternative by creating a metric around informed choice or other confidential metrics measuring issues with family caregiver or pressure to use family caregiver. These metrics would more appropriately measure whether the changes are successful in meeting the patients' needs, rather than just measuring rates of enrollment or utilization. The measure of success or failure of the demonstration cannot be simply that costs are lower—a decrease in recipients receiving full HCBS benefits or treatment in nursing home settings does not necessarily mean a decrease in need.

Hypothesis related to Initiative 3: Provision of foundational community supports - supportive housing and employment

This hypothesis is broadly worded to simply see if there will be “better outcomes” for individuals who receive supportive housing or supportive employment than those who do not. Draft Application p. 14. The state should more specifically seek to improve health outcomes for populations receiving these supports rather than only targeting measures of social services costs, homelessness, and employment rates. These are certainly worthy goals in a system of care, and we understand how improvements in these social determinants of health are expected to have correlating benefits to the target population's health. However, Medicaid funded projects should most directly impact and be measured on their success in improving access to health care and health outcomes. In a Medicaid program where there are so many gaps and with so many existing recipients struggling to access needed care, it is incumbent on the state to measure the impact of these non-traditional Medicaid services on health outcomes. In addition, we should ensure that the provision of these services does not result in reductions in access to medically necessary health services; this should be evaluated also. Here too, it is important to survey clients about their perceptions of the impacts of these interventions on their health.

II. DEMONSTRATION ELIGIBILITY

Medicaid Alternative Care eligibility criteria

Many more details are needed regarding the Medicaid Alternative Care (MAC) benefit eligibility criteria. Our questions and concerns about this proposal include:

- Please confirm that MAC will not be applied to individuals enrolled HCBS/nursing home at the time of implementation.
- Will current HCBS participants or nursing home residents be offered MAC enrollment?
- What will be the default program?
- Will someone enrolled in MAC be able to transfer to MPC, CFC, or nursing home status if eligible?
- We are concerned about the posture of “choice” within the context of enrolling in MAC or full HCBS both when an individual is a new enrollee and when circumstances change. This choice must be functionalized to not be passive – i.e., an individual remains on MAC unless she indicates she wants HCBS.
- What protections will HCA be implementing to ensure the enrollee’s choice is safeguarded? Will written guaranties spell out MAC participants’ right to move to other programs? Will case managers obtain informed consent in writing from MAC participants spelling out that the participant understand the right to obtain full HCBS or nursing home care and choose MAC instead?
- How often and how does someone in MAC get reviewed for HCBS eligibility? We recommend regular review of eligibility and upon review if an individual is determined eligible, default into HCBS.

At this time, there are simply too many unknowns about MAC that must be revealed, discussed, and fleshed out before CMS approves a waiver that includes this proposed benefit.

Tailored Supports for Older Adults eligibility criteria

According to the waiver proposal, Tailored Supports for Older Adults (TSOA) eligibility would be determined only by the applicant’s income. Applicants may have up to 300% of the Federal Benefit Rate which is currently \$2,199. An applicant with income of \$2,200 will not be eligible even if the applicant’s spouse has little or no income. A married couple who apply together could both be eligible so long as each spouse’s income was \$2,199 per month or less.³

Similar to the MAC benefit, we have many questions and concerns about how this new category will be implemented and functionalized:

- What happens when a TSOA enrollee becomes eligible for some other benefit program?

³ The same potential inequities for married couples are present in the proposed MAC benefit as well, i.e., eligibility for a lower-income spouse, but not a higher income spouse.

- How often will TSOA enrollees be reviewed? If there is a choice between receiving TSOA and another scope of benefits, HCA should default the individual out of TSOA and into the more robust coverage.
- Does HCA propose that TSOA will be a choice for enrollees in the same manner as MAC/HCBS? If so, we oppose this proposal. However, if there will be a choice, there must be protections in place to ensure that individuals enroll in less robust coverage options only when there is fully informed decision making.

As with MAC, we recommend HCA more clearly explain how this program will be implemented in relation to the existing LTSS and other Medicaid program eligibility processes.

Inequitable treatment of married couples

The state should explain why these possible inequities with respect to married couples in the two programs are acceptable, or more preferably, devise a system where eligibility for MAC or TSOA services is not determined by the randomness of the needy spouse's income. Eligibility for tax-payer funded services should never be driven by the luck-of-the draw.

The application suggests that a MAC or TSOA beneficiary will *not* have to contribute toward the cost of the services provided by MAC or TSOA, i.e., there will be no participation for MAC and TSOA beneficiaries. *See* pp. 18-19. (“Because the cost of these benefit packages is relatively low and the eligibility threshold are high, the assigned amount of participation may exceed the actual benefits value. If this were the case there would be no incentive to use the program and beneficiaries would resort to more intensive and costly services.”) But, TSOA participants will pay for some services on a sliding scale, so there will be “participation” for personal care services as well as respite and household chores.⁴ Receiving services for free will also incentivize applicants and/or their families for MAC. But, given the inequity described immediately above, it is possible that some married couples with a needy spouse will not be able to access MAC and TSOA while other married couples with much higher combined incomes with *two* needy spouses will be able to do so.⁵

Increased functional eligibility requirements for nursing home level care

First, the draft application says that HCA intends to change the functional eligibility standards for nursing home eligibility, but does not say what the new standard will be. The dearth of information makes this proposal impossible to evaluate and determine the impact on clients. The proposal is not supported by any explanation or data justifying a change in the standard. The state must go through a formal, public, stakeholder process about whether the standard *should* be changed, explaining in detail *why* the state thinks the standard should be

⁴ Because the proposal is so short on details, it is not possible to know if the cost sharing for some services offered in the TSOA package runs afoul of 42 U.S.C. § 1396o(f) which sets out under what circumstances CMS may allow cost sharing in an 1115 waiver.

⁵ Like MAC, the application does not say what happens when someone on TSOA becomes eligible for MPC or CFC. How often will TSOA participants be reviewed? Once a TSOA participant becomes eligible for full scope HCBS services, transfer should be automatic unless the choice to remain is well-documented and includes full disclosure about what the TSOA participant is foregoing by *not* transitioning.

changed, what the new standard will be, and consider input from stakeholders and the public.⁶

Second, which clients does HCA wish to exclude from nursing home services? Unlike some other states, few, if any, Washingtonians languish in nursing homes with no home and community-based alternatives. If there are nursing home residents who are Medicaid-eligible who are able to live in the community *and want to do so*, the state works very hard to enable that. There may be some places in Washington where a nursing home resident who wants to live in the community cannot do so because of lack of housing, lack of culturally-competent or language-competent in-home care services, or because the resident needs more supports than can be provided under the home and community-based care system. A revision of nursing home services criteria will very likely exacerbate that problem for some Washingtonians who cannot remain safely at home, but who may not meet the (undisclosed) new criteria. Since the state already facilitates home and community-based care for nursing home residents who want to live in the community *and are able to do so* while likewise trying very hard, in the first place, to prevent nursing home placement with proactive efforts, we are interested in HCA's response regarding how a revision of nursing home services criteria will have anything but adverse effects on some Washingtonians who will need nursing home placement in the future.

On the other hand, individuals living in HCBS settings may lack access to care that is more easily available in nursing homes. For example, physical, occupational and speech therapy is more readily available in the nursing home setting. Barriers to receiving care in home exist. For example, is often difficult to get providers to make home visits as they are paid little and not reimbursed for travel time (a problem especially in rural areas), and it is hard to arrange for a homebound individual to attend a therapy appointment outside the home. Lack of access is a barrier for individuals who are ready to leave a nursing home or rehab facility, where on-site therapy services are routinely available. HCA should consider a more comprehensive approach to improving this access in HCBS settings, which could enable people to leave facilities sooner or avoid them altogether.

Supportive Housing and Supportive Employment

Use of PRISM score

The waiver application states that eligibility for supportive housing and employment services would be conditioned on a having a score of 1.5 calculated using the PRISM system. To better understand why this has been chosen as a requirement for receipt of these services and the implications of restricting services in this manner, it would be helpful to provide more information about this. In particular, the application should broadly describe how the PRISM score is calculated, state specifically what is being measured by the PRISM algorithm,

⁶ Will changing the nursing facility standard result in people being ineligible for CFC services when they qualify only under the current standard and not the proposed higher standard for nursing facility care? This is what it appears to say in the regulations. 42 C.F.R. § 441.510(c). Does the state have some assurance from CMS that the law allows CFC to be offered to people who do not meet the intended, future higher nursing facility standard?

discuss the evidentiary and/or scientific basis for the PRISM algorithm's use to measure this, and explain the significance of the 1.5 score cut-off as a condition of eligibility for these services as well as why other potential cut-off scores were rejected.

If this is the same PRISM tool and risk score calculation as is used as a condition of eligibility for health home services, there is a significant concern about the potential fit between this eligibility criterion and the need for the services for which it is being established as a precondition. As we understand it, the PRISM tool used in health homes eligibility determinations calculates a client's risk of accruing health care costs over the following year, with a higher score being associated with a likelihood of higher health care costs. It is not clear that having a likelihood of high health costs is closely associated with benefiting from supporting housing or supportive employment. For example, it could be true that clients with very high risk scores will benefit less from supportive employment services because a higher average acuity of their conditions will make it difficult for them to fulfill job responsibilities or maintain employment. And, some expensive to treat conditions may not be rendered significantly cheaper to treat with the assistance of supported housing or employment. More information would be helpful to explain why the PRISM score in question was used as an eligibility criterion, whether other possible criteria have been used for similar services elsewhere, the extent to which other such criteria were considered and, if they were considered, why they were rejected. In particular, it would be helpful to explain whether PRISM is effective in measuring utilization, risks and costs for behavioral health in the same way that it does for physical health, as well as whether a high PRISM score is more closely associated with high utilization/costs than other possible metrics are.

Finally, we want to ensure that if a 1.5 PRISM score is used only to determine initial eligibility, as it is with health homes. It seems that if the individual obtains stable supportive housing, their PRISM score could decrease. If this happens, we want to ensure that the individual would remain eligible for services. Please clarify when the PRISM score would be use (i.e., for initial eligibility determinations and renewals). If PRISM will not be used for renewal of eligibility for the benefit, please clarify what renewal eligibility criteria will be.

Use of HUD's Chronically Homeless Definition

We are concerned that the HUD definition of "chronically homeless" may be too restrictive which would unnecessarily exclude individuals who should be eligible for these types of foundational supports from receiving benefits that would improve their health outcomes and contribute to HCA's goal of reducing Medicaid costs. Specifically, we are concerned that the HUD definition includes a requirement that individuals document their chronic homelessness. For a large segment of the chronically homeless population, including the formerly-incarcerated, their medical and behavioral health impairments and the nature of their status as homeless are barriers to retaining and providing documentation to prove chronic homelessness. HCA should implement a maximum requirement of self-attestation to show that one is chronically homeless. Also, some individuals who would qualify for the supportive housing benefit, except for the requirement under the HUD definition that excludes individuals who reside in transitional housing from the definition of homeless. Finally, the HUD definition seems to exclude those with severe behavioral health issues, and high utilization rates that may not meet this specific definition.

III. DEMONSTRATION BENEFITS AND COST SHARING REQUIREMENTS

TSOA Cost-Sharing Requirement

Though studies show that even low copays negatively impact access to necessary care for low income individuals, the Medicaid Act provides States substantial flexibility to customize cost sharing structures to fit their needs.⁷ Washington Medicaid policy currently prohibits cost-sharing. HCA now proposes to impose cost-sharing on TSOA enrollees. Draft Application p. 25. The state vaguely describes the cost-sharing structure as “sliding scale - to be determined based on income.” We are concerned by the lack of detail with respect to the cost-sharing requirement proposed for this population. Without understanding more regarding the proposed cost-sharing it is not clear that creating TSOA with cost-sharing will increase access to care. If the state’s goal is to reduce future LTSS costs by “catching people early,” it does not make sense to create an incentive for people to not use the early care. Please clarify the details of the cost-sharing amounts and the methodology used to determine said amounts.

Person-Center Services/Financial Management Services

Since the application indicates that the Demonstration will provide personal care and/or long term services and supports, HCA should provide information about the person-centered services and any financial management services that will be part of personal care and/or LTSS. HCA should clearly explain about how the new benefits in these areas will be provided. If TSOA and MAC beneficiaries will be given a limited budget from which to pay for services of their choice from a menu of options, it would be important to list at least the proposed budget and, to the extent possible, the likely prices of services from which beneficiaries will be able to choose.

IV. DELIVERY SYSTEM AND PAYMENT RATES FOR SERVICES

Initiative 1: Transformation through Accountable Communities of Health (ACHs).

Conceptually, the idea that transformation projects reflect the specific needs of the diverse regions across Washington is promising. However, the draft application positions ACHs at the central component to health system transformation creating a more robust role for ACHs than previously laid out in other Healthier Washington initiatives and descriptions. While ACHs could provide a valuable forum for planning to address community needs and social determinants of health, their development varies considerably across the state. As a result of the variability, critical information about regional efforts is lacking. To ensure full collaboration and address these concerns, we believe the final application must include a clear process for transparency and stakeholder engagement to support plans for design and implementation of statewide and regional initiatives. The important role that ACHs play in this demonstration require that the ACH structure must be transparent, support involvement

⁷ David Machleht and Jane Perkins, *Medicaid Premiums and Cost Sharing*, National Health Law Program (March 2014), available at <http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing#.VctxCPIVhBe>

of key stakeholders, including consumers, and assure preparedness for the significant role ACH's would play under the waiver.

We recommend stronger requirements for ACHs to ensure transparency, readiness, and accountability. For example:

- The draft application explains that readiness assessment for ACHs will include stakeholder feedback but does not describe the precise process for stakeholders to provide that input. We recommend clearly explaining the stakeholder process in the application submitted to CMS. That process should include that 1-2 draft ACH readiness assessments be released for stakeholder feedback prior to HCA engaging in the process.
- The draft application indicates that process milestones will be used to distribute ACH funds in Years 1-2. Stakeholders should have opportunity to offer feedback on these process milestones. We recommend requiring that 1-2 drafts of a process milestones list be released for stakeholder feedback prior to finalization.
- HCA must ensure that the regional health needs assessment process is meaningful and responsive to community input. Elsewhere in the draft application, HCA proposes that MCOs, who are members of ACHs and by design have a substantial role, will help craft the selection and funding of regionally-based transformation projects. There is an inherent tension in these two proposals that HCA must unwind. Deference and priority must be given to the community feedback and a clearer process must be identified. The state should require each ACH to meaningfully review each option according to state-created decision-making criteria. Also, the state should require ACHs to provide opportunity for public review and comment on the needs assessment process.

Defining the projects providers will undertake to enable transformation.

Statewide Consistency vs. Regional Need

Inherent in the proposal to base transformation projects on regional needs is the potential for inequalities to arise across the state. Since ACHs across the state are at varying operability levels and could end up addressing vastly different regional needs, there will inevitably be differences in how the ACHs coordinate, select, and deploy transformation projects. We recommend that HCA develop a process to centrally plan and organize which types of projects addressing specific regional needs will be chosen and funded throughout the state. HCA has proposed to create a “menu” of transformation projects – hopefully with consumer input – however, more detail is needed with regard to the creation of this menu, how ACHs will use the menu to select and fund project, and what oversight and accountability mechanisms the state will use to ensure that regional need is balanced with equity across the state. The regional work conducted through transformation projects will likely be more successful if there is state-level coordination among the nine ACHs. Setting top priorities at the state level will help the ACHs focus their efforts, allow for additional state supports across communities, and may produce better outcomes in the long-run.

Stakeholder Input Developing “Menu” of Transformation Projects

We recommend that as the state is developing its “menu” of transportation projects. HCA should develop an explicit mechanism for stakeholders input. The process of shaping this list should include soliciting feedback by releasing a draft, collecting and incorporating feedback, and then releasing an updated second draft before finalizing and discussing with CMS.

Create a ACH Centralized Website

HCA should support a webpage for ACH information that includes key links to ACH website and/or charter and meeting documents. At this time, the public information about existing ACHs, both design and pilots, is patchwork and inconsistent. The variability of available public information is significant from some ACHs, like King County that have websites dedicated to the ACH information to the Olympic ACH that has no publicly available information online.

Priority of Projects for Complex and Atypical Patients

The draft application indicates that transformation projects will be prioritized based on evidence- and research-based success. Draft Application p. 27. We are concerned that prioritizing selection and funding for projects in this way will eliminate care for complex or atypical patients whose conditions could not be easily studied, or have not been. For example, people with a combination of physical and behavioral health conditions that are not amenable to the studied practices, might be de-prioritized or remain unserved by transformation projects by the stated process outlined in this application. This application should not leave out groups of patients by design who are not easily defined, especially in light of the fact that one of the goals is to improve healthcare for all Medicaid beneficiaries. The application does indicate that the promising practices and those with potential for success may be considered; especially where it relates to minorities and Tribal communities, but these will not be prioritized. Draft Application p 27. We are concerned that the process explained in the application could have the effect of excluding entire populations.

Health Systems Capacity Building Domain

It is not clear from the application how the projects within the Health Systems Capacity Building domain will be measured for success. Nor is it clear whether specific locations within each region (e.g., specific cities) will be considered when choosing projects to make sure that all people within a county or city (who are Medicaid eligible) have access to projects. HCA should support projects that serve all populations of Medicaid-eligible individuals. There will likely be differences in how the project goals affect different parts of a city or county. HCA should develop guidance for ACHs regarding how to ensure that the needs of all individuals are met and how to account for these types of differences in needs. To this end, regional gaps, as discussed in the draft application, might not be entirely regional. For example, the use of telemedicine might be a good choice for some situations, but not the optimal choice in all situations. The availability of telemedicine in a rural area should not deprive a person who lives there from the opportunity to be examined in person, and HCA should support equal care to people in all parts of the state.

HCA requires much from ACHs within this domain and relies heavily on needs assessments to “address regional gaps that would otherwise hinder providers from participating in the Demonstration.” Draft Application p. 27. We are concerned by the proposed role the ACHs will fill in determining, addressing, and resolving workforce capacity and infrastructure issues. How can HCA be so sure that, based on the level of ACH current readiness across the state that ACHs will be able to take on and achieve the goals laid out in the application within the proposed timeline? Furthermore, HCA has not proposed a back-up plan for when and if a regional needs assessment does not reveal community-driven needs necessarily tied to addressing workforce or infrastructure gaps. HCA must be cautious and develop strict oversight when developing the multitude of tasks and deliverables for ACHs.

Population Health Improvement Domain

The draft application indicates that certain populations of Medicaid beneficiaries will be targeted. Draft Application p. 29. If this is the intent, HCA should provide guidance to the ACHs for choosing among these populations, and policies and contractual requirements to ensure that all those eligible are able to access care.

Transformation Projects Targeting Formerly Incarcerated Individuals

The demonstration project proposal provides a unique opportunity to more directly target improving health outcomes for the formerly incarcerated population, something HCA identified in the global waiver concept paper but has not mentioned in the waiver application. Projects to connect these individuals to health care should be explicitly mentioned in the waiver application. In order to provide timely transitional care to formerly-incarcerated people, HCA and the ACHs will need to work closely with the Washington Department of Corrections (DOC) and county and city jails. A majority of formerly-incarcerated individuals were not eligible for health coverage before the Affordable Care Act’s implementation,⁸ which makes it unlikely that they have received adequate health care in the recent past. Further, the inadequacy of prison health care and the demonstrated frequency of serious health issues among incarcerated people point to a critical need for prompt health care upon release. Now that coverage is available to releasing individuals through the expansion of Washington Apple Health, access to health care could positively affect identified health needs. Yet, connecting formerly-incarcerated individuals to care is challenging. This connection requires support to ensure that individuals access care. Focusing on transitional care for this population would likely lead to increased access to care and could reduce recidivism.⁹ It is important to consider strategies for case management pre- and post-release. Currently, DOC is only enrolling single individuals who are not returning to spouses or children in the community in Apple Health. An increased focus on this population would require coordination between DOC and the regional ACHs, making this an ideal type of transformation project.

⁸ COUNCIL OF STATE JUSTICE GOV’T. JUSTICE CTR., *Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System* (Dec. 2013), available at <http://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf>.

⁹ Nathan James, *Offender Reentry: Correctional Statistics, Reintegration into the Community, and Recidivism*, CONG. RES. SERV. (January 12, 2015), available at <https://fas.org/sgp/crs/misc/RL34287.pdf>.

Role of the ACHs

ACHs will be central to the success and sustainability of facilitating programs through this demonstration. These developing entities are envisioned to play the arbiter that determines which programs are selected for DSRIP financing and subsequently funded; the builder of infrastructure to create, sustain, and maintain regionally-based transformation projects; and the drafter of performance agreements with providers. All of these functions will affect Medicaid clients; the state is delegating much authority for their care and payment for that care to the ACHs. This expanded role requires that the state be very thoughtful and deliberate about how the existing entities on which the state intends to rely will be expected to operate. HCA is responsible for ensuring compliance with federal Medicaid law and the success of the waiver, so it must oversee ACH regulatory compliance, governance structure, funding ranges, financial risk borne by the ACHs, impact on existing value-based programs, DSRIP financing requirements and standards, projected savings measures, performances measures and outcomes, and ACH capacity. These concepts are mentioned throughout the application, and the ACHs will need specific guidelines and support for each. At this point, only two ACHs have been designated, and even those are still developing. It is concerning that HCA envisions relying so heavily on the ACHs to carry out the demonstration without providing more detailed information about how this should take place. This should be outlined in the application and further developed during the waiver application process.

For example, the ACHs will be expected to “[d]etermine which of the transformation projects identified by the State will be funded in their region,” but it is left up to the ACHs to choose the specific projects. Additionally, ACHs are expected to “[a]lign their members to submit applications for regional transformation projects that represent diverse sectors. It is, again, left to the ACHs to choose the projects and make sure health care services are provided to diverse populations. Given this, there should be clear guidelines for how the ACHs should be choosing projects to ensure that the projects chosen by each ACH meet the regional and statewide goals, as well as Medicaid requirements.

The ACHs will “[r]eceive funds from the State and distribute performance-based payments to project participants,” and will be expected to “[e]stablish performance agreements with providers chosen to be funded for project implementation.” While the application does include information about the use of these funds, it is concerning that the focus seems to be on performance and outcome measures for specific projects. It needs to clear to the ACHs that the transformation projects must support the goals of the Healthier Washington initiative and must comply with Medicaid requirements.

HCA expects that ACHs will play a significant role in assisting Medicaid service providers, and small providers in particular, with switching their practices to value-based contracting with MCOs and BHOs. *See* Waiver application pp. 6; 30. To this end, HCA correctly recognizes that smaller provider groups will be less able to take on the financial risk associated with at least some types of value-based purchasing due to their comparative lack of resources and infrastructure.

Yet the way ACHs are expected to address this need is to “draw on the expertise of their hospital and health system members, as well as MCOs, BHOs, and others, to

ensure readiness across the network of Medicaid providers in the region.” Id. at 30. This is likely to be a tall order. We are concerned about the scope of authority HCA proposed ACHs to have in this area. It is not clear that ACHs will have significant leverage over local provider groups to prompt them to make the changes needed to make them “ready” for such types of contracting.

We understand that there may be waiver funding and assistance from the Health Practice Transformation Hub (HPTH) available to assist providers with making infrastructure and administrative changes needed to adapt to value-based contracts. Nonetheless, almost no information is provided in the application about how ACHs will be able to assist, much less ensure, smaller provider groups’ ability to engage in value-based purchasing arrangements with Medicaid MCOs and BHOs, or specifically how the waiver grants or the HPTH will assist them with this formidable task. Moreover, while waiver funding and technical assistance may help providers build infrastructure needed to implement value-based contracts, it is less obvious how small providers will be made to have the financial status to enter into the more robust forms of value-based reimbursement, such as risk-based contracts. Much care and expertise will be required in shaping such agreements to ensure that they do not create incentives for providers to eschew retaining or taking on clients with expensive to treat conditions or generally more complex medical profiles. In any event, this is a significantly bigger role than previously expected of ACHs. Moreover, the scope of this task (in addition to the many other tasks assigned to ACHs through this demonstration) is likely to vary significantly between regions, depending on the size and dominance of different provider groups that furnish key services to Medicaid enrollees in the particular area. HCA should not propose giving this responsibility to the ACHs without providing clear and explicit guidance about what it expects ACHs to do to ensure providers’ ability to enter into value-based contracts, what kind of provider payment contracts will qualify as such, and what support and guidance it will make available to the ACHs on how this should be accomplished, including a process for identifying these Medicaid providers and working with them to prepare them for taking on these risks.

HCA will need to review, monitor, and oversee this process to ensure that the Medicaid providers will, in fact, be able to take on the risks associated with value-based purchasing without forcing them to merge with or be acquired by large provider groups, as well as whether and when exceptions should be made to these requirements so that more traditional reimbursement models can be retained or implemented. For Medicaid clients, access to providers can be a challenge, and continuity of care can be critical. It is imperative that these relationships not be disrupted, or access problems exacerbated, purely because of administrative or risk-related considerations.

ACH sustainability

Please provide greater detail about how ACHs and the waiver-funded projects they approve will be able to become financially sustainable at the close of the demonstration period. What role HCA will play in supporting that sustainability? Unlike the foundational supports (e.g., supported housing and employment) that will be created and funded initially by the waiver on a statewide basis, it is not readily apparent that most regional waiver-funded projects will be as easily and quickly suited to scaling to allow them to be adopted as MCO or BHO

benefits that can be paid for as part of the overall managed care rates. Over the long term we are concerned that money could be diverted from the current Medicaid budget to sustain ACH system, but that the ACH system will not be reducing health care need in equivalent amounts.¹⁰

The waiver application correctly acknowledges that one part of the financial sustainability of waiver-funded projects will come from devising ways of identifying savings accrued from the implementation of those projects and sharing those savings with the stakeholders that have lost revenue as a result of these programmatic successes. This is likely to be a tough job on a statewide scale. However, at least the State has the ability to seek shifts in funding between its Departments and their subdivisions and has a relatively low number of Medicaid managed care carriers and BHOs with whom to negotiate these matters. On a regional scale, it seems likely to be at least as difficult (if not more so) to identify when a certain program's investments in one area yield reduced spending in an entirely different area. Also, it is not apparent that ACHs will have the financial or legal leverage needed to extract agreements from multiple public and private stakeholders to take part of local programs' savings to pay for its continued operation and/or subsidize the losses of other ACH partners past the waiver period.

Moreover, the expanded role that the waiver envisions for ACHs will carry with it an equally expanded need for financing for ACHs to carry out their duties, making planning for the sustainability of such funding in the waiver's absence more challenging as well. Of course, financial sustainability has been a challenge with no clear roadmap provided to ACHs from the first. But, the significantly larger portfolio of activities to be conferred on ACHs, and the larger amount of funding ACHs will have to fund projects, as a result of the waiver's implementation, makes sustainability an even more pressing issue for ACHs now. It is incumbent on HCA to provide in the waiver application more detailed guidance on how it is expected that after the waiver expires, ACHs will be able to fund their own activities, as well as identify and implement shared savings across a multitude of stakeholders to continue to fund waiver-created regional projects, or what alternate means the State may be able to employ to assist ACHs and their programs become financially sustainable.

The role of the MCO/BHO.

We are concerned by the strong emphasis the draft application places on the role of MCOs/BHOs in "identifying community needs, participating in the transformation project selection process, and supporting successful project implementation." Draft Application p. 31. First, there is a dearth of commitment to involving actual health care consumers in this application and in the current models of ACH governing bodies. Where, as here, the plan is for ACHs to transform Medicaid at a local level, it is important for these bodies to include Medicaid clients, and include the perspectives of immigrants, older adults, persons with disabilities and others experiencing health disparities. It is inappropriate to herald the "essential" role that MCOs – most of which are for-profit entities who are beholden to shareholders with a financial interest in the outcome of ACH decisions – will have in directing the formation, selection, and financing of waiver-funded projects. Rather, input

¹⁰ For example, if an ACH reduces the need for dialysis by 100 patients, but the state diverts 150 patients' care worth of money to sustain the ACH, the state will have a net loss in health care provided.

from the community itself must be essential. The MCOs and BHOs operate statewide and should not have a central role in determining what regional projects the ACH will choose. Second, this proposal seems to clash with the overall theme of regionally-driven approaches to addressing community needs. Measures must be put into place to ensure that community input is not only sought by ACHs but is given substantial weight in determining how projects are selected and funded. Finally, it is unclear who is ultimately accountable for the success of the transformation projects. Please provide more information about how the MCOs and BHOs will share accountability with the ACHs and to what extent. HCA must ensure that the transformation projects not only meet the goals of the demonstration, but also provide health care services in accordance with Medicaid requirements.

HCA should clarify how it envisions that the relationship between the MCOs/BHOs and ACHs will progress over the period of the demonstration. For example:

- Will the ACHs be expected to develop contracts with the MCOs and BHOs?
- How will disputes between MCOs/BHO's and ACHs be resolved? HCA should establish a dispute resolution process to address any conflicts that may arise between ACHs and MCOs/BHOs serving Medicaid clients.

We recommend HCA develop a process to ensure some amount of consistency among the nine ACHs in how the authority will monitor how individual ACHs interact, partner, and develop with the MCOs and BHOs. For example, if each ACH chooses different transformation projects that address different regional needs, this could impact the MCOs' and BHOs' overall ability to provide Medicaid coverage to individuals across the state.

HCA needs to ensure that there is not a conflict between meeting regional health care (and other social) needs and meeting health care needs across the state.

Ensuring that Demonstration funds are used effectively

Section 1115 demonstrations must be “likely to assist in promoting the objectives” of the Medicaid Act.¹¹ The objective of Medicaid is to furnish health care to certain low-income individuals. While we support, in concept, the idea that addressing the “social determinants” of health in order to breakdown silos and treat the whole person can and certainly does have impacts on overall health, HCA must ensure that the central purpose of Medicaid is preserved and promoted by this demonstration. With respect to using Medicaid funds to pay for non-healthcare related activities, the state must ensure statewide accountability for regionally based transformation projects' compliance with Medicaid and other legal requirements. The state must be a strong actor when it comes to monitoring, enforcement and oversight over coordinating entities (i.e., ACHs).

HCA intends to use the contracting process for fiscal accountability, and we expect that contracts will incorporate Medicaid law and other legal requirements in an enforceable manner. The state has mentioned throughout the stakeholder engagement process that regions

¹¹ 42 U.S.C. § 1315(a).

will be responsible for “moving the needle” to enable individuals to get access to needed services and HCA envisions this as an “an iterative process.” With respect to funding, HCA has proposed that some funding to the regions will be used to invest in infrastructure and other funding will either be grant based or will be predicated based on progress.

In addition to being unclear, these funding mechanisms seem intentionally unstructured. On the one hand, we agree that it is necessary to allow time for the structure to emerge. However, on the other hand, HCA should make assurances that the savings achieved through the waiver should flow back to the health care system. Medicaid funds invested in social determinants should result in lower Medicaid spending on health care due to decreased need; this should not be a budget-driven decrease. The social determinant work that is funded must have a clear nexus or relationship to health care.

We would like clarification with regard to the proposal that the state “will require that most payments target providers with a Medicaid volume above a State-defined threshold for the region.” Draft Application p. 31. What is the purpose of this threshold and how will it be developed? What is the process for HCA to determine the “state-defined threshold”? We are concerned that whatever factors underlie this proposal, they could undermine access and quality of care.

Initiative 2: Provide targeted long-term services and supports to individuals at risk of utilizing more intensive services.

Creation of New Limited Benefit Package and New Eligibility Category

The expansion of services to older individuals is a worthy endeavor and we support the methods described within this waiver proposal to provide access to additional supports to aging individuals so that they can remain in their home if they wish, to support family caregivers, and if successful, to improve their health and quality of life. However, we have significant concerns, particularly about how the Medicaid Alternative Care (MAC) benefit will be administered and the Targeted Supports for Older Adults (TSOA) eligibility category. Our specific objections are as follows (please also see concerns expressed infra in Demonstration Eligibility):

- Both MAC and TSOA benefits will not be subject to estate recovery or post-eligibility treatment of income.¹² We anticipate the state will use this as a selling point with prospective clients and/or their families to entice enrollment. But, MAC and TSOA, as the waiver application notes, are “*limited* benefit packages.” We cannot support MAC or TSOA unless the state is required, as a condition of waiver approval, to provide neutral, easy-to-understand information about the pros and cons of MAC and TSOA in reference to other programs for which a prospective client may be eligible. This information must be written by a neutral, third party such as the Washington State Bar Association Elder Law Section or legal services advocates, with input from DSHS as to accuracy only. Legal services advocates are experts in the field whose publications for long-term care clients are already in use and

¹² We assume that resource limits for single and married beneficiaries would still apply.

respected. Each person or family considering MAC or TSOA must be given the neutral information.

- Please clarify whether this new package of benefits would be considered minimum essential coverage (MEC) for the purposes of qualifying for premium tax credits when purchasing qualified health plans (QHP) on the state-based exchange, Washington Healthplanfinder and for imposition of the individual mandate tax penalties for failure to maintain MEC throughout the year. If it is not MEC, it would be possible for individuals to receive both this package and (if otherwise eligible) tax credits to purchase a Qualified Health Plan through Washington Healthplanfinder. However, if it is MEC, that would preclude tax credit eligibility. While we recognize that Medicare clients do not qualify for tax credits, not all in the TSOA/MAC population are eligible for Medicare.
- With regard to TSOA, it is unclear who would be providing personal care, respite, and housework and errand services under this new eligibility category. We recommend that HCA ensure that provider qualifications are the same for these programs as for the Medicaid Personal Care program.

Increase in Nursing Home Level of Care Functional Eligibility Criteria

Grandfathering existing enrollees

We are concerned about individuals served in nursing facilities at the time of waiver approval. The application states that they will continue to be eligible for nursing home level of care under the functional eligibility criteria in place upon their admission to the facility. Draft Application p, 17. However, the application does not address what criteria will be used when an individual is transferred or when there is a temporary absence from a nursing facility. Individuals in nursing facilities who are transferred to hospitals, geriatric psych facilities, and other such institutional/residential treatment milieus already face barriers to being readmitted to a nursing facility. HCA should clarify that people who leave a nursing facility in the aforementioned scenarios are still considered grandfathered (i.e., they will be able to return to a nursing facility under the currently existing admission criteria) and not treated essentially as new applicants for nursing home level care subject to the new, more restrictive criteria. We strongly urge you to adopt this approach. Otherwise, residents will have an incentive to remain in nursing facilities and neither seeks appropriate care outside the facilities nor try out more independent placements for fear of losing their ability to return to a nursing facility.

Initiative 3: Provision of targeted foundational community supports.

While we are pleased that HCA recognizes the importance of addressing social determinants of health as a comprehensive approach to improving health outcomes, especially for those with the most complex health care needs, we want to reiterate that HCA must ensure tight controls and accountability measures for the use of Medicaid funds to support non-health care related activities and to ensure providers of services funded by waiver funds adhere to Medicaid and other legal requirements. Below are some specific concerns with respect to the

supportive housing and supportive housing benefits. We recommend that stakeholders (including a cross-section of physical health care and behavioral health providers, housing providers, social service providers, corrections officials, and consumer health advocates) be invited to participate in any planning and negotiations regarding the specific details of these two benefits. We also have concerns about the sustainability of these projects after the five year demonstration period ends.

Supportive Housing

Beneficiary Notification and Enrollment

The chronically homeless population is especially vulnerable and can be difficult to reach using conventional methods. Often these individuals do not have a consistent mailing address and even when they do, they cannot or do not access their mail on a regular basis. In light of these communication barriers, merely mailing a notification of eligibility will be inadequate in many instances. To ensure people are informed of their right to this benefit package, which impacts take up rates, contributing to HCA's overall goal of reducing spending and being able to reinvest ROI, In order to ensure that all individuals who are eligible for this benefit are properly informed of the opportunity to enroll, outreach will be crucial. We recommend HCA conduct outreach to this population by outreach to navigator and assisters, mental and physical health providers, social service providers, and corrections officials. To facilitate outreach, HCA must share data about eligible enrollees with the providers that will be conducting outreach.

It is unclear which entity (HCA, MCO/BHO, social service provider, housing provider) will be making the eligibility determination for the supportive housing benefit. We believe that HCA, as the single state Medicaid agency, should make the eligibility determinations for this entitlement and ensure that full due process rights are attached to the eligibility determination. All applicants for the supportive housing benefit should be subject to the rights set out in WAC 182-503-0100, including timing of application processing, written notice requirements, equal access services, and the right to an appeal. In the event of a denial, HCA must notify individuals of their appeal rights in a written denial letter that includes Administrative Hearing Rights.

Please clarify that any individual who seeks supportive housing can apply directly to HCA and be assured the rights afforded all Medicaid applicants under WAC 182-503-0110. We are especially concerned about individuals leaving county jail and Department of Corrections' facilities as they are not specifically identified in the matrix listed on p. 21 of the draft application.

The draft application says that based on preliminary modeling, an estimated 7,500 individuals would be eligible for this benefit. Draft Application p. 18. Please clarify whether HCA intends to impose a cap on the number of individuals that will be eligible for supportive housing services. If a cap is possible, please explain how the number will be determined and under what circumstances this number would change. Would a waiting list be established in the event that the cap is exceeded?

Pursuing Strategies to Ensure Coverage Retention

Due to the complex nature and severity of physical and behavioral health issues faced by this population, it is critical that individuals remain on Medicaid to ensure that they can access services. The current auto-renewal system for MAGI-based Medicaid clients relies on information in various databases that may not be current and fails to include Washington's own public assistance database. Non-MAGI clients do not yet have access to auto-renewal. As a result of both these limitations, some DSHS clients who should be renewed may fall through the cracks. We recommend that HCA improve its automated auto-renewal system and also pursue strategies to increase opportunities for renewal, which should include conducting outreach to plans, assisters, and DSHS to help people renew who are terminated or at risk of termination.

Funding Sustainability - Cost Savings and Reinvestment

CMS has indicated that non-Medicaid funding can be used to support housing related activities and can be used in the cost/cost savings calculations.¹³ We are concerned that this emphasis on using non-Medicaid funding could lead to inequitable implementation of services and sustainable services in different regions. We are concerned that not all regions of the state have the same access to non-Medicaid funding and other local housing and community resources.

Supportive Employment

Please clarify that the Ticket to Work Program and Milestone payments are not in conflict with payment for Medicaid services, as both are made for outcomes, not service delivery.¹⁴

It is not clear how individuals will be notified that they are eligible for these services and whether they will be able to apply through HCA. Please clarify how HCA (or other responsible entities) will be required to notify eligible individuals and provide detailed plans for targeted outreach. Assuming that other entities outside HCA are responsible for administering the benefit (i.e., determining eligibility, providing notices to individuals who apply, handling appeals), we recommend that HCA either retain significant oversight or not abdicate its role as the single state Medicaid agency. Individuals should be permitted to apply for the supportive employment benefits in the same manner as other Medicaid benefits (see WAC 182-503-0010). The rights conferred upon Medicaid applicants should be similarly conferred upon those applying for supportive employment benefit (see WAC 182-503-0110). This includes notifying individuals of their appeal rights in a written denial letter that includes Administrative Hearing Rights.

¹³ CMCS Informational Bulletin (June 26, 2015), available at <http://medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf>.

¹⁴ CMCS Informational Bulletin (September 16, 2011), available at <http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CIB-9-16-11.pdf>.

Questions 3-10

Question 9

Value-based Payment

The waiver application places a great emphasis on converting the State's health care system to a value-based reimbursement system both as a vehicle for recouping the savings required to render the waiver budget neutral and as a feature of the Healthier Washington plan, which anticipates changing Medicaid and PEBB programs to procure 80% of their health care through value-based arrangements by 2019. See Draft Application p. 37. Consequently, it is critical that the waiver application be clear about what sorts of changes are expected to be encompassed within this system-wide conversion, and how they will be made. For example, Figure 3 appears to count as a value-based payment system "Traditional FFS 'Plus'" arrangements, in which reimbursement is mostly made on a FFS basis, with limited incentive payments for hitting quality or other targets. Such payment arrangements seem likely to be easier to implement and be adopted by a wider variety of provider groups and types than what the figure describes as "Accountability for Full Risk" by provider groups. The waiver application also anticipates that "ACHs will maximize the value-based purchasing effect by bringing to bear the impact of community service linkages on measurable health system outcomes." This statement would benefit from clarification. If HCA expects ACHs to play a significant role in facilitating the adoption of value-based payment arrangements between carriers and provider groups, and that the ACHs' efforts in this area will yield a substantial part of the anticipated switch to "80%" value-based purchasing in public medical programs, it is important to spell out clearly how ACHs may facilitate these changes, what types of value-based purchasing arrangements will qualify, and what level of change to such purchasing agreements ACHs are expected to bring about.

Shared Savings

The waiver correctly identifies the need to provide some sort of "shared savings" or similar incentive payments to MCOs, BHOs and other entities that would otherwise be financial "losers" due to the loss of business resulting from the shifting and ultimately cutting health care costs of the waiver's transformation programs, should the waiver programs prove successful. This, however, raises two significant issues that would benefit from greater elucidation in the waiver application. First, it will often be difficult to properly identify and measure "savings" in one area that result from waiver expenditures in another area. Even when such savings are properly recognized, getting independent organizations to share the financial benefits they have accrued from waiver activities is likely to pose significant challenges. Given the size and both substantive and geographic variation of the numerous waiver programs, this project will be rendered much more complex. The waiver application should, at the very least, outline the ways in which it is anticipated that waiver-derived savings will be measured and recouped from the various organizations playing a role in the waiver's various programs.

Second, while it is entirely appropriate to subsidize various stakeholders' financial losses that result from the success of the waivers' programs, this must be done only a temporary basis, to ease those stakeholders' transition to the transformed health care environment. The waiver

application should provide more detail about how long shared savings are likely to be redirected to health system participants and how they will be phased out. Savings should be shared not just with providers but with clients by improvements in service access and quality.

Question 10

We suggest that the waiver application eliminate the proposal to develop “quality-based supplemental payments for **high-performing ACHs...**” (emphasis added) or at least clarify how this might be done without providing incentives for ACHs to focus primarily on projects that serve well-researched populations and that seem more certain to yield benefits, if only relatively moderate ones. ACHs have a responsibility to address the significant health needs in their particular regions. They are given the rare opportunity to focus on addressing problems experienced by populations in their areas with the highest level of health and health care disparities. These include minority populations, including persons of color, immigrants, and seniors, on which available research is often less rich. If performance payments are awarded to ACHs based on the “success” of the waiver-funded projects they approve in accruing savings, the ACHs will have an incentive to pursue well-understood projects of more generic applicability that are known to save money, even of the needs of their communities would best be served by directing funding in a different direction and/or actually testing out promising practices in the absence of strong research on interventions to address those needs. If any performance-based payments are to be made to the ACHs, they should be based on operational performance measures rather than on health or financial outcomes.

V. IMPLEMENTATION OF DEMONSTRATION

Initiative 1:

Year 0 - Scope and Timing

The waiver application sets out an incredibly ambitious agenda for the first six months after the federal approval. It is difficult to understand how the State, ACHs, and regional providers can realistically expect to create the “menu” of potential transformation projects, develop the readiness criteria and assessments for ACHs to demonstrate their ability to carry out the duties of a coordination entity, providing the ACHs sufficient time to review all of these requirements and develop the capacity to exercise them, develop a waiver-funded project grant application, have local providers submit proposals for waiver-funded projects, have ACHs choose among potential waiver-funded projects and apply to HCA for funding for them, have HCA select among applications and distribute funding for them through the ACHs within this time period, all presumably with significant stakeholder participation at both the State and ACH levels. At least a year should be devoted to this. Tentative timeline dates should be laid out for each of these steps, along with deadlines for formation of and actions taken by stakeholder oversight and advisory entities to assist HCA with these tasks.

Stakeholder/Consumer Participation

It is critical for the success and accountability of the regionally-based transformation projects that stakeholders, including low-income health care consumers and their representatives, play a responsible role in the development of the various tools and plans and decisions to be made during this period. In the application, HCA should make a specific commitment to creating a

statewide multi-sector stakeholder oversight and advisory body that will participate and provide feedback to the Authority on these activities. A minimum of 30% of its membership should be low-income health consumers, with a strong effort made to include persons of color, LGBTQ individuals, seniors and persons with disabilities. HCA should also make a specific commitment to having health equity serve as an explicit focus of the oversight/advisory body's activities to ensure that the waiver helps to remedy rather than reify existing health disparities and disparities in access to health care experienced by low-income individuals and minority populations.

Alternate Waiver-funded Coordinating Entities

If an ACH is determined by HCA to be unable to or does not wish to qualify as a waiver-funded coordinating entity, plans must be in place to solicit, assess, and select alternate entities to administer waiver-funded transformation projects in a region in which the ACH will not serve in that role. The application should provide more detail about how and when that will be done.

Initiative 2

Stakeholder/Consumer Participation

The above-suggested stakeholder oversight/advisory body should be given a clear mandate to address all areas of waiver-related activities, and not just those related to developing and approving those activities in which ACHs are expected to play a major role. For example, the stakeholder education plan and trainings related to the waiver's LTSS programs should be developed in concert with our suggested stakeholder oversight body. Also, changes to eligibility and IT systems should be made with consumer and in consultation with stakeholder oversight.

Initiative 2

Outreach plan

A truly effective outreach plan can only be developed and implemented using the resources and expertise of providers, consumers, and other stakeholders who already provide similar LTSS services and who best understand their own and their families' needs for LTSS services. The application should state explicitly that the outreach plan will be developed in concert with stakeholders.

The application should state more explicitly how MAC will be provided, including provisions for independent counseling organizations to be funded/utilized for this purpose.

Initiative 3

Outreach Plan

The application should state explicitly that HCA will develop an outreach plan to publicize the roll-out of the targeted community supports benefits and educate potential beneficiaries, their families and their providers about those benefits and how to apply for them. This outreach plan should be developed in concert with stakeholders.

VI. DEMONSTRATION FINANCING AND BUDGET NEUTRALITY

The budget neutrality calculation is necessary to the implementation of this waiver and must be clear and transparent. We believe more clarity is needed up front. For example, going forward, the proposal projects 2% savings per capita “with waiver” as compared to “without waiver,” although it appears to say that budget neutrality does not put the state at risk for these savings (*see* Draft Application pp. 43-44). Please clarify that this is correct.

Clarity would help to ensure that the calculation does not compromise the state, and thus Medicaid enrollees, in the future. The state would be at risk if the budget neutrality methodology, which anticipates future trends, calculates a limit that is later found to underestimate actual trends: “If total computable per-capita costs were above “without waiver” estimates, the excess would be borne by the State.” This is a gamble; it does not appear to allow for later adjustments of the “without waiver” estimates. For example, if inflation is higher than anticipated, or Washington adopts a minimum wage that results in unanticipated pay increases to health care workers, the state could be at risk for the excess over the previously-projected trend. The waiver should provide for retrospective adjustment or some type of “risk-corridor”-like arrangement if there are unforeseen changes that affect the budget neutrality calculation the root of cause of which lies in factors outside of the waiver’s implementation.

This is of particular concern because a new group is being added to the waiver - the hypothetical “Initiative 2” group who would be newly eligible for Long-Term Support Services. Developing and then relying on a new budget neutrality calculation for this group with no data will be challenging and is inherently risky to rely on. The waiver should allow for retrospective adjustment of this calculation after there is experience with the Initiative 2 group with respect to both size and cost of the population.

If savings result in a decrease in the need for funding for a particular program or service, we are concerned that these waiver-related savings may be assumed and redirected before it is clearly established that they are durable, i.e., that the level of spending is sufficient for future years. In addition, there may be a greater need for the program or service, suggesting that the “savings” should be kept in that area. For example, as the need for Long Term Support Services is expected to climb, the initial findings that savings result may not extend into the future. Higher levels of funding may be required to maintain needed services or to restore, enhance or implement other useful LTSS programs.

VII. CONCLUSION

The draft application describes a large, ambitious goal with many interconnected parts and proposals and despite our close review, the comments contained herein do not represent all of our potential concerns. We appreciate that the HCA Director and waiver team have been open to discussing our questions and concerns about this document, and we hope to see written clarification of many of these issues in the final application and, as appropriate, in further development of the waiver request. Over the next several months and throughout the implementation and measurement phases of the demonstration, we look forward to working

together to identify and address concerns about how these proposals impact access and quality of care for Medicaid clients.

Thank you very much for your consideration of our comments. If you have questions, please feel free to contact us.

Sincerely,

A handwritten signature in black ink that reads "Janet Varon". The signature is written in a cursive, flowing style.

Janet Varon
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A handwritten signature in blue ink that reads "Meagan Mackenzie". The signature is written in a cursive, flowing style.

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