SELLERS DORSEY COVERAGE

CMS 1115 Demonstration Waiver Approvals

Washington 1115 Waiver Renewal

July 2023

EXECUTIVE SUMMARY

On June 30, CMS approved the extension of Washington's 1115 Demonstration Waiver, titled "Medicaid Transformation Project 2.0 (MTP 2.0)." Through this waiver, the state will continue to evaluate the effectiveness of innovative projects, activities, and services to best serve the Medicaid population and advance high-quality care. The renewal preserves and extends several authorities formerly authorized, including Medicaid Alternative Care and Tailored Supports for Older Adults programs, Foundational Community Supports, and substance use disorder and serious mental illness programs. The renewal also introduces new initiatives and investments that focus on continuous enrollment for children, extended coverage for postpartum individuals, presumptive eligibility for those applying for certain home and community-based services, contingency management, and services to address health-related social needs. The State is in continued discussion with CMS on several other proposals that were not approved at this time. The approval is effective July 1, 2023, through June 30, 2028. The State's key goals include:

EXPANDING

coverage and access to care, ensuring that people can get the care they need.

ADVANCING

whole-person primary, preventive, and home and community-based care.

ACCELERATING

care delivery and payment innovation, focused on health-related social needs (HRSNs).

PROGRAM COMPONENTS

Existing Authorities and Programs Maintained and Enhanced

- **Expands its Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)** programs through additional covered services and increased TSOA eligibility standards.
- **Modifies the housing component of the Foundational Community Supports (FCS) program,** which helps people with complex care needs find stable housing and employment, to alter the age limit for supportive housing from individuals 18 or older to instead age 16 and older.
- **Continues Substance Use Disorder (SUD) and Serious Mental Illness (SMI) programs,** including the ability to offer SUD treatment and SMI in institutions for mental diseases (IMD) settings.
- **Facilitates the conclusion of the State's Delivery System Reform Incentive Payments (DSRIP)** initiative, for a one-year period to close out pending payments. The only expenditures permitted are incentive payments for prior periods of performance and administrative activities. This authority expires on June 30, 2024.

New Initiatives and Investments

Presumptive Eligibility

The approval authorizes the State to implement a presumptive eligibility (PE) process **where individuals who need access to home and community-based services (HCBS) services may self-attest** to meeting financial and functional requirements. Once it is determined the individual appears to meet the requirements, they will receive a limited benefit package pending a full eligibility determination and approval.

Children and Postpartum Continuous Coverage

Building on the State's continuous post-partum coverage for individuals 12-month postpartum in its Medicaid state plan, this approval allows the State to provide that **coverage for individuals who apply for Medicaid during their postpartum period – in other words, individuals who were not previously eligible for Medicaid or CHIP prior to delivery.** The approval also authorizes the State to provide continuous eligibility for **children through five years of age**.

Contingency Management

Through this approval, CMS is allowing the State to **implement a contingency management benefit for eligible beneficiaries with a SUD.** This benefit is an evidence-based clinical practice that provides a series of motivational incentives for meeting treatment goals, such as cash equivalents for medication adherence or non-use of substances.

Pre-Release Services for Incarcerated Individuals

Similar to the approval of California's 1115 demonstration amendment, this approval permits the State to deliver a **targeted set of Medicaid services** to all beneficiaries eligible for Medicaid or CHIP coverage who reside in **state prisons, county and city jails, and youth correctional facilities up to 90 days immediately prior to release**. As part of this implementation, the State will design a service level approach that allows facilities to select a service level category. Service-level one provides the minimum required pre-release benefits which includes **case management, medication assisted treatment services for all types of SUD, and 30-day supply of all prescription medications**. Other benefits participating facilities may provide include medications during incarceration, community health worker services, clinical and behavioral health consultations, laboratory and radiology services, and medical equipment and supplies in-hand upon release. The State will define additional levels in its Implementation Plan.

HRSN Services

The approval allows the State to provide or increase coverage of certain services that address HRSN. As seen in other states waiver demonstration approvals – such as Oregon, Massachusetts, and New Jersey – these services include nutritional services **and nutritional education, transitional housing services, case management, outreach, and education among others.** CMS is providing expenditure authority to cover HRSN services, such that the State is approved to spend up to **$1.5 billion over the five-year Demonstration period on services, and up to $270 million on infrastructure-building activities to support HRSN service capacity.**

Community Hubs and Native Hub

The approval authorizes **new Community Hubs and the Native Hub to administer some HRSN services.** These hubs will deliver these services to targeted populations, regardless of tribal membership, race, or

national/ethnic origin. Whereas the Native Hub will provide services statewide, the Community Hubs can limit services to their associated region.

Waiver Request Not Currently Approved

At this time, CMS is not approving:

- Authority for the State to provide postpartum coverage to noncitizens, although the State has committed to providing such coverage through State funds.

Washington and CMS will continue to discuss:

- Re-entry services for individuals leaving IMDs/state hospitals.
- Rental subsidies beyond six months.
- Expenditure authority for local, community-based projects to advance health equity.
- Leveraging Designated State Health Programs (DSHP) funding to support new MPT 2.0 initiatives.
- Funding for an assessment tool, technical assistance and provider incentives for integrated care, and compensation for guardians/decision making supports for individuals qualifying for LTSS.

FINANCIAL COMPONENTS

Consistent with recent approvals in several other states (i.e., Massachusetts, Oregon, Arizona, and New Jersey), Washington's waiver renewal includes the following financial component requirements:

Medicaid-to-Medicare Provider Rate Ratio

- As a condition of approval, Washington is required to increase and (at least) maintain Medicaid fee-for-service provider base rates and Medicaid managed care payment rates in **primary care, behavioral health, and obstetrics care**, if the State's Medicaid to Medicare provider rate ratio is below 80% in any of these service categories.
- At a minimum, a **two-percentage point payment increase** will be applied to each of the services, within the service category, in the Medicaid managed care and fee-for-service delivery systems, **if in that delivery system the ratio is the lowest ratio among the three service categories and below 80% in any service category.**

Evaluation of HRSN Initiatives

- The evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. CMS has also updated its approach to mid-course corrections in this demonstration approval to provide flexibility and stability for the state over the life of this demonstration.

Changes to the Budget Neutrality Approach

- CMS is moving away from its 2018 budget neutrality policy to provide states with flexibility and funding to implement innovative programs with a focus on advancing health equity and addressing disproportionate HRSNs. CMS stated it continues to apply this approach to all similarly situated states going forward.
- CMS is making several changes to give states greater access to funding while maintaining fiscal integrity. These changes include the following:

Area of Focus	2018 SMD Guidance	Changes approved through WA waiver	Anticipated Impact
Without Waiver (WOW) Baseline	Adjusted WOW per-member-per-month (PMPM) cost estimates to reflect only the recent actual PMPM costs.	Uses a weighted average of WA's historical WOW PMPM baseline and its actual PMPM costs.	Expected to result in a slightly higher WOW baseline.
Trend rate for Expected Expenditures	Used the lower of the state's historical trend rate or the President's Budget trend rate.	Projected demonstration expenditures associated with each Medicaid Eligibility Group in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period.	Increases budget room and aligns the demonstration trend rate with federal budgeting principles and assumptions.
Demonstration "Savings" Rollover	CMS explained that it expected to permit states to roll over "savings" to a demonstration extension from only the most recent five years of prior approvals, and that there would be a transitional phase-down of accrued "savings."	The "savings" amount available for the extension approval period has been limited to the lower of: (1) The "savings" available in the current extension approval period plus net savings from up to 10 years of the immediately prior demonstration approval period(s) (2) 15% of the state's projected total Medicaid expenditures in aggregate for the demonstration extension period.	States can access more "savings" from prior approval periods to fund program innovations.
"Hypothetical" Expenditures for HRSN Infrastructure and Services	No explicit categorization of HRSN expenditures as hypothetical expenditures.	CMS is treating certain HRSN expenditures as "hypothetical" expenditures. There is an additional sub-cap to HRSN infrastructure expenditures, referring to these expenditures as "capped hypothetical expenditures" in the Special Terms and Conditions (STCs). Unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year.	States do not have to find demonstration "savings" to offset hypothetical expenditures, thereby freeing up funds/adding flexibility.

EVALUATION

GENERAL

- **Must perform a demonstration cost assessment** that examines administrative costs of demonstration implementation and operation, Medicaid health services expenditures, provider uncompensated care costs, without limitation to look at other areas.
- **Must analyze the cost and cost effectiveness of the HRSN services** and budgetary effects of the HRSN services; the overall medical assistance service expenditures; uncompensated care and associated costs for populations eligible for continuous eligibility, including in comparison to populations not eligible for such policies; and the initiative around pre-release services (described below).
- **Must leverage findings from hypothesis results** to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

HRSN

- **Must focus on areas such as assessing the effectiveness of the HRSN services** in mitigating identified needs of beneficiaries.
- **Must include analysis of how the initiatives affect utilization of preventive and routine care** and beneficiary physical and mental health outcomes.
- **Must coordinate with managed care plans to secure necessary data** to inform the effectiveness of the HRSN services in mitigating identified needs of beneficiaries.
- **Must focus on understanding the impact of HRSN initiatives** on advancing health equity.
    - Must assess the effectiveness of the infrastructure investments to support the development and implementation of the HRSN initiatives.
- **Must include a cost analysis to support developing comprehensive and accurate cost estimates** of delivering these services.
- **Must include a robust assessment of potential improvements in the quality and effectiveness of downstream services** that can be provided under the state plan authority, and associated cost implications.

Pre-Release Services

- **Must examine whether the initiative expands Medicaid coverage** through increased enrollment of eligible individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release.
- **Must focus on the goals for the reentry initiative**, including but not limited to cross-system communication and coordination; connections between carceral and community services; access to and quality of care in carceral and community settings; preventive and routine physical and behavioral health care utilization; nonemergent emergency department visits and inpatient hospitalizations; and all-cause deaths.
- **Must develop a comprehensive analysis of services** defined by type of service over the duration of the 90-day coverage period immediately prior to the expected date of release.
- **Must detail any relationship identified between the provision and timing of particular services** with relevant post-release outcomes (e.g., utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release).
- **Must analyze how providing the coverage timeline allowed for more coordination**, effective reentry planning, enabled pre-release management and stabilization of physical and behavioral health conditions, helped alleviate any potential operational challenges the state might have otherwise encountered had there been a shorter timeline for coverage or pre-release services.
- **Must examine specific care qualifications and standards across carceral providers**, in addition to experiences of carceral and community providers, to understand process and challenges encountered to develop relationships and coordinate transitions.
- **Must include a cost analysis to support developing comprehensive and accurate cost estimates** of implementing the initiative, including delivering these services.

SUD

- **Must assess the objectives of this demonstration initiative** such as initiation and engagement with treatment, utilization of services, and improved care outcomes.

Contingency Management

- **Must align hypotheses with the goals for the SUD program** to advance outcomes across identification, initiation and engagement in treatment, adherence to treatment, reduced overdose deaths, reduced utilization, reduced administration (where medically appropriate), and improved access to care.

SMI/SED

- **Must assess the objectives of this demonstration initiative** such as utilization and length of stay in emergency departments, reductions in preventable readmissions, availability of crisis stabilization services, and care coordination.

Continuous Eligibility

- **Must evaluate the impact of the program** on all relevant populations for the specific time span of eligibility.
- **Must evaluate how the policy affects coverage**, enrollment, population-specific measures of service utilization and health outcomes.
- **Encouraged to conduct a comprehensive qualitative assessment** involving beneficiary focus groups and interviews with relevant stakeholders to evaluate merits of these modified policies.

Postpartum Care

- **Must examine outcomes related to primary and preventative care utilization**, maternal and infant health, and as appropriate, treatment for behavioral health. The evaluation should focus on addressing any demographic disparities.

MAC and TSOA

- **Must assess the impacts and effectiveness** of these program services in mitigating recognized needs of beneficiaries.

Presumptive Eligibility

- **Must examine the degree of access** to care changes for beneficiaries, such as changes in time to first appointments.
- **Encouraged to leverage monitoring data** to assess whether the processes for presuming eligibility are accurate and reliable.