



Northwest Justice Project *Northwest Health Law Advocates*



October 9, 2015

Victoria Wachino
Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
200 Independence Ave SW
Washington, DC 20201

RE: Comments Regarding Washington’s Application for a Section 1115 Medicaid Waiver Demonstration – The Washington State Medicaid Transformation Waiver

Dear Ms. Wachino:

Northwest Health Law Advocates (NoHLA), Northwest Justice Project (NJP), Solid Ground, and Columbia Legal Services (CLS) offer these comments on the Health Care Authority’s Section 1115 Medicaid Waiver (Global Waiver) 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. Solid Ground works to end poverty and undo racism and other oppressions that are root causes of poverty. Its Family Assistance program offers legal assistance for single adults and families with public benefits issues. CLS advocates for people facing injustice and poverty seeking to achieve social and economic justice for all using policy reform, litigation, and innovative partnerships to reveal and end actions that harm the communities we serve.

Our organizations support the broad goals of the proposals articulated by the State in its application: to reduce avoidable use of high-cost services, improve population health, and pay for good care outcomes. We are encouraged by efforts to break down silos and integrate care so to better serve vulnerable populations and improve health outcomes. Despite our support for these goals, we have identified issues that require further attention. During the draft application process, we provided comments to the State requesting more details on the long-term care proposal and raising concerns about the readiness and expanded role of regionally-based Accountable Communities of Health (ACHs), the sustainability of the program beyond the five-year demonstration period, and the need for transparency as the waiver plan is developed and implementation proceeds. The issues identified below point to



gaps and potential negative impacts that must be addressed prior to the implementation of this proposal. We urge the State and CMS to ensure that these questions and concerns are addressed in a timely manner and that waiver conditions are adopted that safeguard the interests of Medicaid enrollees. We also request further opportunity to review aspects of the proposal as additional details are available.

We want to acknowledge the State's efforts to engage stakeholders in the process and highlight that the organizations submitting these comments have established routine calls with the State to address concerns.

Initiative 2: Long Term Support Services

As a rule, demonstration projects are supposed to help states experiment with ways of improving health care coverage or access through Medicaid. It is unclear from the application what the State proposes to test within this Initiative, specifically with regard to heightening the functional eligibility standard for nursing home care, other than cost-savings. Cost-savings is not an innovative change in the delivery of health coverage, expansion of coverage or experimental approach to Medicaid services. In many respects, this Initiative proposal bears no relationship to the other broad goals of the demonstration calling into question the underlying rationale for including it in the demonstration application.

Increased functional eligibility requirements for nursing home facility level of care

The application says that the State intends to change the functional eligibility standards for nursing home eligibility, but does not say what the new standard will be. We do not think that CMS has the authority to waive standards for nursing home eligibility. Further, we think the State's existing eligibility standards violate federal law because they are already too narrow.

The waiver application does not ask for authority to waive or change Washington's nursing facility standards. Even if the State did ask for this authority, CMS may not waive nursing facility criteria standards. These criteria are not contained in 42 U.S.C. § 1396a. A Section 1115 demonstration may only waive provisions of 42 U.S.C. § 1396a (and other provisions not applicable here.) 42 U.S.C. § 1315(a)(1).

Notwithstanding these observations, CMS should not approve this provision for a number of reasons. Assuming for the sake of discussion that CMS was permitted to waive federal law (and we strongly believe it cannot), CMS should defer its decision on whether to approve a change until after the State explains why it believes CMS has the authority to allow it to narrow the state's nursing home eligibility criteria – assuming that CMS even calls for such an explanation, which it should not due to the non-waivable nature of this provision.

We also note that unlike some other states, few, if any, Washingtonians languish in nursing homes with no home and community-based alternatives.¹ If there are nursing home residents

¹ 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

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. 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. If this proposal gets any traction with CMS (and we think it should not), we are interested in the State's explanation about 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 readily 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. The State 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. Narrowing nursing facility criteria is not going to solve these problems, but exacerbate them.

To our second point, CMS should not approve the State's proposal because our eligibility criteria are already too narrow. Nursing facilities services are a mandatory coverage category. 42 U.S.C. § 1396d(a)(4)(A). The Code of Federal Regulations (CFR) contains two definitions of "nursing facility services." One regulation pertains to services provided at facilities addressed in 42 U.S.C. § 1396r(a)(1)(A), essentially "skilled level care," and the other pertains to nursing facilities services provided at nursing facilities addressed in 42 U.S.C. § 1396r(a)(1)(C). States must allow Medicaid recipients who require either (1)(A) and (1)(C) levels of care to receive needed services in nursing facilities.

42 C.F. R. § 440.40(a)(i) describes skilled nursing services as those that are "[n]eeded on a *daily* basis and required to be provided on an inpatient basis under §§ 409.31 through 409.35 of this chapter." (emphasis added) 42 C.F.R. § 409.31(a)(2)-(3), in turn, defines "skilled services" as those that "[r]equire the skills of technical or professional personnel such as registered nurses [or] licensed practical (vocational) nurses . . . furnished directly by, or under the supervision of, such personnel," on a *daily* basis. 42 C.F.R. § 409.31(b). These regulations address the (1)(A) level of care requirement.

CMS that the law allows CFC to be offered to people who do not meet the intended, future higher nursing facility standard?

42 C.F.R. §440.155 is the second regulation defining “nursing facility services.” It addresses the level of care described in 42 U.S.C. § 1396r(a)(1)(C). 42 C.F.R. § 440.155 provides, in part:

- (a) “Nursing facility services, other than in an institution for mental diseases” means services provided in a facility that–
 - (1) Fully meets the requirements for a State license to provide, on a regular basis, health-related services to individuals who do not require hospital care, but whose mental or physical condition requires services that–
 - (i) Are above the level of room and board; and
 - (ii) Can be made available only through institutional facilities[.]

Washington’s existing rule on eligibility for nursing facility care services is Washington Administrative Code 388-106-0355. It requires, in part, that the client “require care provided by or under the supervision of a registered nurse or licensed practical nurse on a daily basis.” WAC 388-106-0355(1)(a). This requirement imposes a too-restrictive eligibility criteria not allowed under federal law. *See Maryland Dept. of Health and Mental Hygiene v. Brown*. 177 Md. App. 440, 935 A.2d 1128 (Md.App., Nov 27, 2007.)

Plainly, 42 C.F.R. § 440.155 does not require involvement of, or service provided by, skilled or trained medical personnel. Washington should not have been conditioning NFLOC criteria on the need for skilled nursing care provided by a registered or licensed practical nurse or supervision by them as provided in WAC 388-106-0355(1). And, we note, basing HCBS enrollment for the COPEs waiver on NFLOC that was too narrow meant eligibility for the COPEs waiver has been too narrow. And, enrollment on CFC, is likewise been too restrictive because it is also based on the too-narrow NFLOC.

Medicaid Alternative Care Proposal

Many more details are needed regarding the Medicaid Alternative Care (MAC) benefit eligibility criteria. We are understandably concerned about this proposed benefit because if it is approved, the state will have an enormous incentive to deprive HCBS-eligible people of higher cost services in favor of lower cost services. We cannot endorse this proposal unless substantial additional information is made available and CMS imposes safeguards to protect HCBS-eligible clients. CMS should require the State to indicate:

- What will be the default program?
- Once a person is enrolled in MAC, how difficult will it be to exit MAC for HCBS? We are concerned the state will discourage transfer to HCBS in a variety of ways, including reminders about HCBS being subject to estate recovery, failing to recommend HCBS when HCBS is needed, and other tactics intended to discourage transfer to HCBS when more intensive services are needed. What protections will the State implement to ensure enrollees’ choices as to level of service are safeguarded? Will written guaranties spell out MAC participants’ right to move to HCBS, or

nursing home, if eligible? Will case managers obtain informed consent in writing from MAC participants spelling out that the participant understands the right to obtain full HCBS or nursing home care, if eligible, and that participant has opted to choose MAC instead? Will that information be reiterated at every assessment? Will informed consent be obtained at every assessment?

- What will the State do if someone who is HCBS-eligible wants to choose MAC but MAC cannot provide a sufficient level of support necessary with respect to the client's quality of life along with her health and safety? Will the State permit someone to enroll in MAC even when doing so is not in the person's best interest? The waiver application says the State "seeks to provide services and supports to family caregivers" but what if an HCBS-eligible person does not have family caregivers to assist her? How does enrolling that person in MAC carry out the waiver application's stated intent to support family caregivers? In situations where there are no unpaid caregivers to assist an HCBS-eligible person, MAC is just a program to save money.
- Will MAC participants be assessed annually? Will MAC participants be eligible for reassessment if there is a significant change in their circumstances?
- Will nursing home residents be offered MAC enrollment? And if so, how will this be accomplished?

CMS should require the State to flesh out many more details about the proposed MAC benefit before approving a waiver that includes it. We think the best way to safeguard clients' interests is to require the State to work with us to address these concerns as a condition of moving forward with implementation of this new benefit.

We also recommend that if CMS thinks the MAC approach is worth examining, that it also impose the following conditions:

- 1) MAC should be rolled out gradually. This will give the State, clients, and stakeholders the opportunity to evaluate its impact on a limited number of clients at an early stage and make any necessary modifications. The state has a history of deploying new programs or approaches on a rolling basis.
- 2) We are concerned that MAC applicants will not get the information they need to make an informed choice. Below, we discuss post-eligibility monitoring and why we think that monitoring is important. But, MAC applicants need to have truly informed choice before they select MAC. We ask CMS to not only require the monitoring we describe below, but CMS should also require the State to work with us to develop informed choice protocols that fully protect applicants' interests before approving the MAC benefit.
- 3) We believe it is likely that the State will not adequately assess whether MAC is the right program for HCBS-eligible people because of the financial incentives to divert

people to MAC, will not fully explain the differences between MAC and other HCBS programs to potential enrollees, will emphasize the absence of estate recovery in order to induce MAC enrollment, and will allow potential clients to enroll in MAC even though it is not in their best interests. CMS should require the State to enter into a monitoring arrangement with a fully independent entity that can assess whether MAC participants understood their options, why they chose MAC over HCBS, and whether MAC benefits are sufficient to meet their needs. This entity should meet directly with MAC participants and their caregivers to gather information without any representative from the State being present. The monitoring entity should also meet privately with case managers to ask them, under the strictest confidentiality, what they were told about MAC – were they given the authority to deny MAC enrollment when MAC was not an adequate program to meet the client’s needs, were they encouraged or discouraged from doing so, and were they told that MAC is the preferred program? How hard were they told to “sell” the exemption from estate recovery as a desirable feature for MAC? CMS should give us access to this information as well as requiring the State to address problems revealed by the monitoring process. CMS should require the State to work with us on a plan to address issues discovered by the monitoring.

Tailored Supports for Older Adults Proposal

According to the waiver proposal, applicants would be eligible for Tailored Supports for Older Adults (TSOA) only if the applicant’s income is less than 300% of the Federal Benefit Rate which is currently \$2,199. Since the application does not elaborate, we request that the waiver assure that the income criteria and methodology to be used may not be more restrictive than those of other Categorically Needy institutional, HCB waiver and hospice programs.

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* p. 28). (“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 the State proposes that 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. 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. CMS should require that state to more fully flesh out its TSOA cost sharing proposal.

CMS should also require the State to explain:

- What happens when a TSOA participant becomes eligible for some other benefit program? What information will the State provide to TSOA participants about other Medicaid benefit options and to what other resources (e.g., independent options counselors, the long-term care ombuds program, etc.) will the participant be referred?

As discussed above, with respect to the new MAC benefit, we have similar concerns about what will happen if the TSOA participant needs HCBS services or becomes eligible for them? CMS must impose strict requirements on the State to ensure that TSOA participants are transitioned to other services when it is in their best interests.

- Will TSOA enrollees be assessed annually? Will TSOA participants be eligible for or required to reassessment if there is a significant change in their circumstances?

Measuring Outcomes for LTSS proposals: MAC, TSOA, and NFLOC

The 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. (Application, pp. 6; 21-22; Appendix 2). With respect to measuring outcomes within this Initiative, the State has neglected to propose performance measures or any metrics to determine the full range of impacts on the aging population. In the application, proposed performance measures seem restricted to measuring the impact of transformation projects (which could or could not be targeted toward the aging population) and the foundational community supports. However, the success (but not failure) of the LTSS proposal is measured by one hypothesis – that the quality of life of beneficiaries receiving limited scope benefits will improve. (Application, p. 25). The other proposed hypotheses are targeted towards measuring impacts on program costs and enrollment. *Id.* The application asserts that the State seeks, through approval of the waiver, to “provide services and supports to family caregivers who have chosen to take on the responsibility, without compensation, of supporting their loved ones to remain in their own homes. This population currently falls through the cracks of Medicaid LTSS leading to burnout, out of home placements and increased state and federal costs.” (Application, p. 16). The State cites to a state-funded family caregiver support program operated for a year, but the obvious thrust of the proposal is to reduce LTSS costs on the horizon because of the “age wave.”

While testing and measuring increased quality of life for limited-scope benefit recipients is a worthy goal, it will not tell the entire story about the proposed changes impact on beneficiaries. CMS should require the State to 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 application does not sufficiently address the potential negative impacts on clients, specifically:

- Those who enroll in the limited MAC benefit , rather than HCBS for which they are also eligible, or
- Those who cannot obtain HCBS due to tightened institutional standards, or
- Those who no longer qualify for nursing home level of care.

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 caregivers. These metrics would more appropriately measure whether the changes are successful in meeting the clients' 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.

Broad Proposals May Not Have Predictable Outcomes

We are concerned by the vague nature of some of the proposals and responses to public comment contained in the application and attendant appendices. One area includes the remaining lack of detail for ACH's and the regionally-driven approach. This may open the door to many incongruous results across the State. In another case, many of the public comments, including ours, submitted during the draft application highlight the need for greater transparency and explanation of the apportionment of risk among various entities (MCO/BHO/ACH/community-based organizations) to ensure that Medicaid funds are spent to improve the health of enrollees and that there is sufficient oversight built into the system detailing which entity will ultimately be responsible if proposed performance measures – whatever they may eventually be – are not met. At the heart of this concern is that money will not be invested in a way that actually improves health by furnishing medical assistance to Medicaid enrollees and that the money will be spent without effective public oversight. These – and other – vague proposals demand more definition and clarity from the state.

Throughout the development of this demonstration application process, the state has provided numerous opportunities for stakeholders and members of the general public to provide questions and feedback to agency staff, and much information about the contours of this evolving proposal has been disseminated. However, even in response to direct questions from advocates, the state has failed to flesh out many of the fundamental details on which the various interlocking parts of the demonstration proposal turn, instead – indicating in public meetings and the final application that much of the detail of the demonstration will be worked out in terms and condition negotiation with CMS or in a proposed workgroup structure (see discussion below). This approach is troubling, partly because it removes the meat of what was intended by law to be an essentially public process from public view and participation. It also brings into question the extent to which so many existing unresolved critical details about so many parts of the many programmatic changes proposed in the waiver application can be thought through and worked out within the short timeline proposed by the state. With much left to define and develop – hopefully with meaningful stakeholder input – we are concerned with the lack of clarity in numerous areas at this point. As we explain in greater detail throughout these comments, stakeholders need more certainty before we can meaningfully review and provide input into the proposals. We request that CMS require the State to provide greater clarity in the areas of concern we highlight and accept stakeholder input before moving to the next stage of demonstration implementation.

Waiver Related Workgroups

Throughout the waiver application, the state refers to various “workgroups” it either has or will convene to address, discuss, and plan discrete proposals or issues in the demonstration application. Many of these references to workgroups are in response to comments and

questions raised by stakeholders during the draft application comment period. (Application, Appendix 9). While we appreciate the state's commitment to engaging stakeholders in this manner and to establishing a process by which the remaining gaps and concerns can be discussed, we have some concerns about this process. We have asked the state for more details about these workgroups. A promise for more information was made and we continue to monitor the development and opportunity for input in these workgroups.

The lack of information about workgroups is compounded by the fact that the state has deferred responding to questions that commenters raised by stating that it is planning to address these questions via workgroups. The promise to establish workgroups alone without more substantive responses to public input is insufficient. First, we need clearer answers to questions about the proposed demonstration. Second, there must be a clearly defined process for the workgroups which must have a meaningful, accessible, and public impact in the development and implementation of the demonstration. Finally, to the extent that these workgroups are charged with working out the details of the demonstration proposals, for example, establishing the proposed heightened nursing home care criteria (see Appendix 9), the short timeline proposed by the state to settle terms and conditions and being implementation in year 0 is troubling. The timeline and lack of specifics at this stage in the process contribute to the concern that the public will have little opportunity to engage in this process. While we continue to work with the State learn more and engage in this process, we hope CMS can also push for the state to more clearly identify the workgroup structure and process, including how stakeholders will be involved.

Sustainability and Budget Neutrality

The State must emphasize 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 predominately 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.² 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.

Shared Savings Reinvestment Strategy

The state provides limited detail regarding its “shared savings reinvestment strategy” stating that the savings generated from the demonstration project must be shared among the various entities involved, including managed care plans, hospitals, and community-based organizations. (Application, p. 18). Without details we cannot review and provide specific comments on this proposal. However, at least a couple significant questions are raised by the State's application.

² 42 U.S.C. § 1396-1

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. More details about how long shared savings are likely to be redirected to health system participants and how they will be phased out are needed. Savings should be shared not just with providers but with clients by improvements in service access and quality. Similar questions were raised regarding the draft application distributed by the State. However, almost no additional detail was provided in the final application, which indicated that such issues would be addressed by a workgroup and in negotiations with CMS (Application, Appendix 9, pdf p. 140). In those negotiations, CMS should require the State to address these issues and answer questions that remain.

Transparency and Accountability

Section 1115 demonstrations must be “likely to assist in promoting the objectives” of the Medicaid Act.³ 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 have significant impacts on overall health, the State 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. The state is responsible for monitoring, enforcement, and oversight over coordinating entities to which it delegates duties involved in implementing the Medicaid program, including the transformation projects. If an ACH is unable to perform these duties, the state must be prepared to step in and implement the transformation projects for ACH’s region itself either for the duration of the waiver or until a substitute coordinating entity in that region can be found and determined to be qualified for the task.

The state has not clearly explained how funds will flow from the ACHs to the providers and community-based organizations carrying out the transformation project. This concern is compounded by the lack of detail in the application with regard to how the state will ensure that the ACHs are prepared to manage and track funds going to the community providers.

The State should provide concrete assurances that the demonstration funds are used primarily to assist Medicaid enrollees. The state describes a baseline requirement for funneling

³ 42 U.S.C. § 1315(a).

Medicaid dollars through ACH's to providers and community-based organizations responsible for transformation projects. In particular, it indicates that "[t]he State will require that most payments target providers with a Medicaid caseload volume above a threshold (yet to be defined) for the region." (Application, p. 41). The state has yet to define this threshold, though it promised to do so in a forthcoming FAQ (see Appendix 9). But a threshold alone is not sufficient. The state must develop additional criteria that ensure that Medicaid dollars are used to benefit enrollees in the program. For example, as described in the application, a minority of the project payments could target providers who have no Medicaid clients. Or, funding awarded to providers who have an as yet undetermined threshold number of Medicaid clients, might still be directed towards projects that primarily if not exclusively benefit individuals who do not receive Medicaid. This raises concern about ensuring the integrity of Medicaid spending. That said, we do not mean to imply that no funding can be spent on projects that incidentally benefit some individuals who are not on the Medicaid rolls. For example, funding provided to a neighborhood clinic whose patients are 95% Medicaid recipients to upgrade its electronic health information systems or to purchase a mobile clinic to deliver services at patient's homes might benefit all clinic clients, including the few who are not Medicaid recipients. However, without a clearer idea of the threshold or any additional criteria the state envisions as being sufficient to qualify for funding through the demonstrations, we are unable to provide more specific comment. The State must better articulate its proposed policy and permit public review before finalizing it. This explanation should respond to the following questions:

- What is the purpose of the threshold and how will it be developed?
- What other criteria will be used to select transformation projects that benefit Medicaid enrollees?
- How does this proposal ensure access and quality of care for Medicaid enrollees?
- How will the State provide oversight and hold ACHs/community-based organizations accountable for compliance with Medicaid requirements and ensuring demonstration funds benefit Medicaid enrollees?

Value-Based Payments

We recognize the state's interest in reducing costs, but in the process of doing so, it is vital that the quality of care for Medicaid enrollees is preserved and improved. Within the proposed demonstration, there are several unanswered questions about how the State will ensure that access to quality care is not diminished through implementation of this payment scheme. We recommend that CMS work with the state, with stakeholder input, to develop meaningful protections to ensure that access to quality care is not diminished.

Ensuring Access to Small, Culturally Important Providers

We are concerned that providers who serve patients with the most complex health care needs may not always be properly or adequately incentivized. The state acknowledged that this point was an "important" comment made during the draft application period. In response, the

state highlighted that despite the benefits of paying for value, not volume, ensuring that small, particularly culturally-based agencies that have strong capacity in reaching target populations yet may have low amounts of working capital must be able to participate. Despite acknowledging this potential problem, the state does not clearly state how it will address smaller provider groups and individuals and ensure that the payment arrangements do not leave them out. Therefore, the state must ensure all providers whose care contributes to savings are rewarded according to their contribution and that performance measures are established which can adequately measure outcomes from these providers and develop administrative reporting requirements that are not burdensome for these providers.

ACH Role in Building Provider Capacity

Elsewhere in our comments we express our concern with the pivotal reliance on the untested, newly-established ACH entity that are at the core of most of the proposals within this application (and have a central role in the broader Healthier Washington initiatives outside of the Medicaid context). Within the framework of value based payments, the state has proposed 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. In this formulation, the state 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. (Application, p. 37).

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. The state 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.

CMS should require the state to address remaining unanswered questions. For example:

- Which entity –MCO/BHO or ACH – will ultimately be responsible if a provider fails to hold up their end of the contract? Will it be the provider and how will they be held responsible? Will it be the ACH because it was responsible for ensuring providers had the capacity to take on and be successful in VBP arrangements?
- Considering the readiness of the ACHs and the amount of responsibility for demonstration proposals they have, will there be enough time to build the capacity of providers to enter into these arrangements by 2019?

- What scope of authority does the State propose ACHs will have in this area? How will the state facilitate and provide resources to ACHs to enable leverage over local provider groups to prompt them to make the changes needed to make them “ready” for such types of contracting?
- What specific waiver funding will be available to support this ACH role?
- What assistance from the Health Practice Transformation Hub (HPTH) does the State expect to be available to assist providers with making infrastructure and administrative changes needed to adapt to value-based contracts?
- How does the State plan to ensure, smaller provider groups have the ability to engage in value-based purchasing arrangements with Medicaid MCOs and BHOs?
- What mechanism does the State plan to implement to review, monitor, and oversee this process to ensure that the Medicaid providers will 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
- How will the State accommodate smaller providers and other when exceptions should be made to these requirements so that more traditional reimbursement models can be retained or implemented?

Shifting of Risk

The discussion of value-based payments on p. 45 of the final application suggests that payment models that shift much of the risk to providers may be used in combination with other value-based payment systems. 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). CMS must take up the challenge posed to it by the State, which indicated that:

A roadmap to value-based payment would be an essential milestone in Special terms and Conditions for an approved Medicaid Transformation Demonstration. Technical assistance from CMS will be important in building a road-map that recognizes the intersecting paths we are taking.”

(Application, pp. 45-46). We thus urge CMS to require the State to show how it will protect against incentivizing providers to withhold appropriate care to help their bottom line or avoid taking on patients with conditions or other circumstances that are not as sensitive to the providers’ chief strategies for achieving savings as other patients might be. If the new payment methodology results in increased risk for providers, the state must work with stakeholders to develop consumer protections such as requirements to disclose all treatment options, processes for second opinions, and revised due process policies to ensure access to the most appropriate care.

Performance Measures and Incentive-based Payments

Even if the demonstration does not rely predominately on requiring providers to fully assume the financial risk associated with their patients' care, CMS must require that the State offer more information and more attention to the structuring of alternate value-based payment models. For example, additional information is needed 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 significantly despite medical and other foundational support interventions. Similarly, payment models should provide disincentives for treating patients who require (that expenditures be made to furnish them) accommodations or other services to enable them to achieve equal access to the health care system. Many factors unrelated to a provider's or caregiver's competence will impact the types and duration of care they receive and the cost of that care. Examples may be found in considering 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. As the State readily concedes elsewhere in its demonstration application, a myriad of social circumstances and stresses may be the greatly predominate influences on the health of low-income and other individuals' health. This makes it extremely challenging to isolate the effects of clinical treatment, particularly for individuals experiencing negative impacts in the social determinants of health. It is critical to ensure that the incentive-based payment system does not lead providers to avoid treating patients in difficult circumstances. We raised questions about this in our comments on the draft application, but received little response in the final waiver request other than in the State's appeal to CMS to assist them generally in working out these payment systems. We urge CMS to require that the any payment methodology mandated by the waiver's programs and that provide quality bonuses to providers: 1) includes provisions to incentivize the treatment of typically high-cost patients; and 2) avoid creating unintended incentives to avoid treating individuals who are less likely to show savings in their care based on the metrics adopted by the State. Particularly because the spread of such value-based payment models across the large balance of state-funded health care is a fundamental feature of the demonstration, we request that a further public comment period be provided for any draft payment systems that are proposed.

Quality-based Supplemental Payments for High-performing ACHs and Providers

We recommend that CMS prohibit the state from establishing a methodology for determining how to make "quality-based payments" to "high performers," or at least require the state to clarify how this will 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. (Application, p. 46).

Accountable Communities of Health

Accountable Communities of Health were first proposed and their development funded under the State's "SIM" Grant for the Healthier Washington health care innovation program.

However, the waiver application proposes substantial changes to ACHs' funding mechanism, potential responsibilities, required infrastructure and the conditions that would be placed on the projects they could sponsor. This creates challenges for ACHs in allowing them to stay true to their original mandate to identify and seek to address *regional* needs and ameliorate *regional* health care disparities without a requirement to focus on assisting Medicaid clients. The State correctly indicates that it will require ACH-selected project to comply with some uniform state-wide standards, and it has proposed that the projects ACHs select to sponsor with waiver funds will be chosen from a limited menu of state-endorsed project types. Also, as we have stated elsewhere in these comments, it is critical for CMS and the State to build strong assurances into rules governing the regional transformation projects to be administered by ACHs under the waiver that these projects will focus primarily on benefiting Medicaid clients' health and access to health care. These requirements, however, stand in tension to the primary purpose articulated by the state when it originally devised the role of ACHs as regional entities charged with identifying the most significant health needs and disparities in their region and selecting projects that seek to remedy those needs by addressing the social determinants of health, rather than necessarily directly expanding or furnishing better quality health care. More information is required about how ACHs will be given the flexibility to continue to pursue their foundational goals, while ensuring that they adequately enforce Medicaid requirements governing programs that benefit Medicaid clients.

The enhanced role for ACHs envisioned by the waiver application also creates a challenge for the State to ensure that ACHs become adequately adapted to the substantially different, diverse and expanded duties now being proposed for them.

During the application drafting process, we requested that the state provide substantially more information about the larger role outlined for ACHs under the proposed Medicaid waiver program. We also requested that the key criteria and tools around which the enhanced ACH program would operate be developed in consultation with stakeholders, including consumers, and that drafts would be able to be vetted by the public whose feedback would be given meaningful consideration. The State's final waiver application and its response to prior comments provided little detail on these issues, largely deferring them to later discussions to the extent that they were addressed at all. Notably, in its Appendix 9 responses, the State did not commit to providing public drafts for stakeholder review of key documents necessary for the success of the ACH project prior to those documents' adoption. Such documents and criteria include the tool to be used to assess ACHs' readiness to shoulder the substantial responsibilities of being a coordinating entity, the process milestones by which initial ACH operations will be judged, and the menu of possible transformation project topics from which regions will be able to choose in funding local projects.

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

- The application explains that readiness assessment for ACHs will include stakeholder feedback but does not describe the precise process for stakeholders to provide that input. There should be a clear explanation of the stakeholder process. The State should consult with stakeholders, including consumer representatives in creating the

initial draft list and release 1-2 draft ACH readiness assessments for stakeholder feedback prior to the State adopting a final set of criteria.

- The 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. This same process should be used for incentive-based payments that are expected to be used in Year 3.
- The State must ensure that the regional health needs assessment process is meaningful and sufficiently responds to community input. Elsewhere in the application, the state 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 the State 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.

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, and 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. The State is responsible for ensuring compliance with federal Medicaid law and the success of the waiver, and 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 unclear how the State expects that the other seven ACHs will be designated by the end of 2015 and, as the State itself admits, compliance with a different and more rigorous set of criteria will be a condition of ACHs being designated as coordinating entities. It is concerning that the State 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 further developed during the waiver application process and discussions with CMS.

For example, while the application indicates that the State will work with the ACHs to coordinate selection of transformation projects, and that the ACHs, in conjunction with a core set of statewide projects, will identify opportunities for targeted transformation projects based on the needs of the communities in each region, the ACHs are primarily responsible for deciding which transformation projects each region will have. The State will provide a menu of transformation projects and a workgroup to create this menu, but the ACHs will need additional guidance to ensure that the transformation projects promote access to care for all Medicaid beneficiaries. Additionally, ACHs are expected to “[a]lign their members to submit applications for regional transformation project investments.” (Application p. 15). It is, again, left to the ACHs to choose the project and make sure health care services are provided to diverse populations. Given this, there should be clear guidelines, even with a designated menu, for how the ACHs should be choosing projects to ensure that the projects meet the regional and statewide goals, as well as Medicaid requirements.

Opportunities to focus on equity, address health disparities, and engage consumers

We appreciate the State’s assurances that some regional transformation projects “will be centered on increasing health equity” and that they will consider the suggestion having a plan to address health equity be a condition for designation of an ACH as a coordinating entity. Application, Appendix 9, pdf page 139. But, more concrete assurances and requirements are needed to ensure that ACHs’ goals of addressing their regional health disparities and inequities are not lost amid their gearing up to carry out the duties of and comply with the requirements for being coordinating entities. The global waiver application provides the opportunity for this, but does not require it, putting at risk the success of this pillar of the waiver program. Robust consumer voices must be included in all levels of ACH decision-making to ensure that ACHs are accurately assessing local health needs and priorities and selecting projects that seek to remedy continuing inequities, rather than reifying disparities maintained by the current health care system. We urge CMS to require that this be included in the Special Terms and Conditions of the waiver program.

Statewide Consistency vs. Regional Need

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. The State acknowledged this comment and responded that a statewide process for evaluating ACHs is a “starting place” for “operational unanimity” statewide. This response is insufficient to address the concerns we raised. We recommend that CMS require the state to develop a process to centrally plan and organize which types of projects addressing specific regional needs will be chosen and funded throughout the State. This should include:

- More detailed criteria for creating the menu of transformation projects; how the menu will be operationalized and used by ACH’s; what oversight and accountability mechanisms the State will use to ensure that regional need is balanced with equity across the State.

- A clear, public mechanism for permitting consumer stakeholders and community-based organizations that represent stakeholders to participate in developing the menu.
- Establishing top priorities at the State level to help ACHs focus their efforts, allow for additional state supports across communities, and produce better outcomes in the long-run.

Priority of Projects for Complex and Atypical Patients

The application indicates that transformation projects will be prioritized based on evidence- and research-based success. (Application pp. 13-14). We are concerned that prioritizing selection and funding for projects in this way will make it difficult to fund projects focusing on patients whose conditions, whose profile of co-occurring conditions, or whose subpopulations have not been extensively studied. For example, use of the stated process outlined in this application could mean that people who have 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. Or, a proposal to fund a promising care modality for seniors with a particular condition might be rejected, if there is a different evidence-based treatment for condition, even if that treatment was almost exclusively studied with a different sample population (e.g., non-senior adults). The State seems to acknowledge this weakness in exclusively funding practices founded on “research.” Application, p. 14. And, we appreciate its stated wiliness to “consider promising practices...especially where they address health disparities and improve health for minorities or Tribal communities that have not fully benefited from pilots or research to date.” *Id.* Nonetheless, more is required than mere consideration, to ensure that the disparities experienced by some of the hardest to treat individuals and individuals who belong to groups that have been neglected by the health care research establishment are not reinforced by a focus on funding programs asserted to be supported by clinical evidence. CMS should require the State to explain how this prioritization process will avoid these pitfalls. More specifically, the State should be required to clearly define how promising practices and those with potential for success for treating less well-studied conditions and populations will be able to be funded as transformation projects on equal footing with other programs. (Application, p. 14).

Health Systems Capacity Building Domain

The proposal relies on ACH’s to shoulder a heavy burden within this domain. They would be expected to “address regional gaps that would otherwise hinder providers from participating in the Demonstration.” Application, p. 31. Substantially more information is required to demonstrate that the ACH’s are or will be prepared to adequately determine, address, and resolve workforce capacity and infrastructure issues. It is not clear how the State plans to ensure that, based on the level of ACH current readiness across the State, that ACH’s will be able to take on and achieve the goals laid out in the application within the proposed timeline. Furthermore, the State 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. Lastly, it is not clear from the application how the success of projects within the Health Systems Capacity Building domain will be measured. Workforce and

infrastructure development are critical to building a health care system that will support the expanding Medicaid system in years to come. CMS must require the State to better define who these types of projects will be achieved and how ACHs or other entities are expected to support their achievement through the specific tasks the application assigns to them.

Transformation Projects Targeting Formerly Incarcerated Individuals

As noted on page 38, the demonstration project proposal provides a unique opportunity to more directly target improving health outcomes for the formerly incarcerated population. This needs to be more clearly developed. In order to provide timely transitional care to formerly-incarcerated people, the state 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,⁴ 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 most 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 upon release would likely lead to increased access to care and could reduce recidivism.⁵ 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.

ACH sustainability

There should be greater detail about how ACHs and the waiver-funded projects they implement will be able to become financially sustainable at the close of the demonstration period. The State should explicitly state its role 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 the ACH system, but that the ACH system will not be reducing health care need in equivalent amounts.

⁴ 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>.

⁵ 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>.

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. This is important for at least two reasons. Significant savings accrued from local projects may end up being shown in areas other than Medicaid spending. While this is helpful to the regions in which the projects are implemented, it may make it more difficult to sustain funding for them in the absence of the Medicaid funding that sponsored their initial creation. Second, it will be all the more difficult to determine which programs are actually saving Medicaid or the broader social service sector funds and what decreases in programmatic spending are directly attributable to the success of the local transformation projects. 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 State. 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. Since the ACHs will retain a portion of the demonstration funds to cover their own costs and to implement transformation projects, it is incumbent on the State to provide more detailed guidance on how it is expected that after the waiver expires, ACHs will be able to fund their own activities. CMS should also require the State to provide guidance on how the ACHs will be expected to 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 application places on the role of MCOs/BHOs in "identifying community needs, participating in the transformation project selection process, and supporting successful project implementation." Application, p. 40. 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 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. The State should provide more information about cross-sector accountability, and how the MCOs and BHOs will share accountability with the ACHs and to what extent. While transformation projects must meet the goals of the demonstration, it is equally important they provide health care services in accordance with Medicaid requirements.

CMS should require the State to 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? The state may arise between ACHs and MCOs/BHOs serving Medicaid clients.

We recommend that CMS require the state to develop a process to ensure some amount of consistency among the nine ACHs in how the State 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.

Back up Plan if ACH cannot meet the requirements of a coordinating entity

The proposed demonstration project hinges upon the ability of ACH's to competently serve as the coordinating entity. What if this is not possible? A "Plan B" is needed to carry out the waiver when an ACH cannot serve or be certified as the coordinating entity. We previously commented and have had discussions with the State during the draft application phase regarding the need for such a plan. CMS should require the state to create a backup plan that addresses, at a minimum:

- What is the detailed plan when an ACH cannot or chooses not to be a coordinating entity?
- What other entity could serve as the coordinating entity if an ACH could not?

Considering the proposed rapid timeline and the varying level of readiness amongst the ACH's to perform all the tasks proposed by the State, the State must provide detail and provide the public opportunity to review and provide input soon.

Plan to Address Conflict of Interest

The application fails to sufficiently address the potential and existing conflicts of interests within ACH governance structures and backbone organizations. The organizations that make up the ACHs will certainly include entities that will be the primary candidates to contract to carry out transformation projects. The state must address these conflicts of interest and present a plan for public review and input.

Foundational Community Supports

We urge CMS to require the State to more clearly explain the outreach and enrollment process for these proposals. The State acknowledged this input from various stakeholders during the comment period and incorporated more into the application. However, we recommend that CMS require the State to provide a more detailed plan regarding how the agency will ensure eligible individuals are informed about their rights to this benefit in addition to engaging stakeholders in the process development and ensuring that implementation is working in order to make course corrections as the demonstration moves forward. This should include:

- Improving the State's automated auto-renewal system
- Pursuing strategies to increase opportunities for renewal, which should include conducting outreach to health plans, assisters, and DSHS to help people renew who are terminated or at risk of termination.

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

Sincerely,



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