Final Demonstration Agreement

Between

The Centers for Medicare & Medicaid Services (CMS)

And

The State of Washington

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

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

Amended December 23, 2016

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I. SPECIFIC PURPOSE OF THIS FINAL DEMONSTRATION AGREEMENT

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

This Final Demonstration Agreement, effective July 1, 2013, is hereby amended effective January 1, 2017.

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

II. LEGAL PARAMETERS

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

III. READINESS REVIEW

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

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

IV. PROCESS AND OPERATIONAL PROVISIONS

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

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

CMS and the State agree to begin this Managed Fee-for-Service Financial Alignment Demonstration on July 1, 2013, and continue until December 31, 2018, unless extended or terminated pursuant to the terms and conditions in Section V or VI, respectively, of this Agreement.

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

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

1. Program Authority:

a. *Medicare Authority*: Intentionally Left Blank.

b. *Medicaid Authority*: See Section H on Medicaid Authority and Appendix 5 of the MOU.

2. Eligibility:

a. *Eligible Populations:* Beneficiaries with one chronic condition and at risk of developing another are eligible for the State's approved health home SPAs #13-08, #13-17 and 15-0011, as summarized below:

i. *Chronic Conditions:* The applicable chronic conditions for eligibility are: mental health condition, substance use disorder, asthma, diabetes, heart disease, cancer, cerebrovascular disease, coronary artery disease, dementia or Alzheimer's disease, intellectual disability or disease, HIV/AIDS, renal failure, chronic respiratory conditions, neurological disease, gastrointestinal, hematological and musculoskeletal conditions.

ii. *At Risk of Developing Another Chronic Condition:* Risk of a second chronic condition is defined by a minimum predictive risk score of 1.5.

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

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

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

3. Delivery Systems and Benefits:

a. For beneficiaries who elect to receive health home services, the Health Home Care Coordinator will perform a comprehensive in-person health screening and work with the beneficiary to complete a Health Action Plan within 90 days of the date when the Lead Entity was notified of the beneficiary's health home eligibility.

4. Beneficiary Protections, Participation, and Customer Service:

a. **Beneficiary Participation on Governing and Advisory Boards:** As part of the Demonstration, CMS and the State shall require Health Home Networks to establish mechanisms to ensure meaningful beneficiary input processes and the involvement of beneficiaries in planning and process improvements. This will be addressed in the State's qualification process for Health Home Networks. In addition, the State will provide avenues for ongoing beneficiary or beneficiary advocates to provide input into the Demonstration model, including participation in the HealthHome Advisory Team (HAT), which provides regular feedback to the State on the Demonstration. Feedback collected by the State will be shared with Health Home Networks and will be part of the State's process improvement efforts.

5. Administration and Reporting

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

b. *Monitoring:* Intentionally Left Blank.

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

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

8. **Evaluation:** Intentionally Left Blank

***D. DEFINITIONS (APPENDIX 1 of the MOU)*:** The following terms are added:

Region 1: The 37 original counties in which the Demonstration began operating in 2013, specifically: Adams, Asotin, Benton, Chelan, Clallam, Clark, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Island, Jefferson, Kitsap, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Skamania, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, Whitman, and Yakima counties.

Region 2: King and Snohomish counties.

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

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

As of July 1, 2013, in conjunction with the approved Health Home SPA #13-08, the Demonstration began operating in the following 14 counties:

Coverage Area 4: Pierce County

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

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

In addition, starting October 2013, in conjunction with the approved Health Home SPA #13-17,

the Demonstration began operating in the following 23 counties:

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

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

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

For the purposes of this Final Demonstration Agreement, the above 37 counties are referred to as Region 1.

If CMS and the State agree that the State has the capacity and the authority to establish the Managed Fee-for-Service Model Demonstration in King and/or Snohomish counties, Washington may, no earlier than April 1, 2017, add such county or counties to the Demonstration. The State must inform and engage stakeholders before adding either of these additional counties to the Demonstration. Operation of the Demonstration in King and/or Snohomish counties is contingent upon the submission and CMS approval of a Health Home SPA and the presence of qualified health home providers. For the purposes of this Final Demonstration Agreement, King and Snohomish counties are referred to as Region 2.

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

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

On June 28, 2013, CMS approved Health Home SPA #13-08, effective July 1, 2013, to authorize implementation of the health home benefit in 14 counties. On December 11, 2013, CMS approved Health Home SPA#13-17, effective October 1, 2013, to authorize implementation of the health home benefit in 23 additional counties (See Section F). The implementation of this Demonstration in King and/or Snohomish counties (as specified in Section F) is contingent upon the State's receiving CMS approval for its health home SPA for those counties.

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

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

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

Figure 6-1. Updated Demonstration Year Dates

Demonstration Year	Calendar Dates
1	July 1, 2013 – December 31, 2014
2	January 1, 2015 – December 31, 2015
3	January 1, 2016 – December 31, 2016
4	January 1, 2017 – December 31, 2017
5	January 1, 2018 – December 31, 2018

2. **Savings Calculation Detail:** After each year of the Demonstration, the Evaluation Contractor will perform a calculation to determine whether the Demonstration achieved savings, and the amount of any savings. The calculation will determine the difference in

per beneficiary per month (PBPM) spending found between the demonstration group and a target amount determined by trending demonstration group expenditures in a two-year pre-Demonstration base period by the change in costs of the comparison group.

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

a. *Identifying Beneficiaries Eligible for Inclusion:* Both the demonstration and comparison group will be identified using an intent-to-treat approach. The data used to identify demonstration and comparison beneficiaries will reflect eligibility on the Demonstration start date. The demonstration group will be identified retrospectively, after the Demonstration year has ended, to allow for additional data to become available.

    i. Every beneficiary included in the first performance payment calculation must meet all of the following criteria to be included in the savings calculation:

        1. Meet the Demonstration eligibility criteria for at least 3 months and have at least 3 months of baseline claims

    ii. Individuals in an MA or PACE plan will not be included in the base period, and their experience during the Demonstration will also be excluded from the savings calculation.

    iii. Only the member months during which a beneficiary was eligible for the demonstration or comparison group will be included in the calculation.

Terminations in eligibility will result from moving out of area, death, loss of eligibility for Medicare Parts A and B, Medicare becoming a secondary payer, loss of eligibility for full Medicaid benefits, or receipt of Medicare or Medicaid hospice. The same rules for terminating eligibility for inclusion in the savings calculation will be applied to both the demonstration and comparison groups.

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

i. The baseline for beneficiaries who become eligible for the Demonstration after the Demonstration start date will be their experience from their date of Demonstration eligibility to the end of that Demonstration year. Such beneficiaries will then enter the calculation on the first day of the next Demonstration year. The same approach will be used to determine baseline experience for beneficiaries in the comparison group who newly meet Demonstration eligibility criteria after the Demonstration start date.

ii. The actual savings achieved for beneficiaries who become eligible for this Demonstration after the start date will not be included in the savings calculation until the following year (i.e., until the beneficiaries' first full Demonstration year of eligibility).

1. For the Demonstration year in which the beneficiary became eligible for this Demonstration after the start date, the savings percentage calculated for beneficiaries that are included in the savings calculation (i.e. beneficiaries in the demonstration and comparison groups who were eligible on the Demonstration start date, or at the beginning of the previous Demonstration year, as applicable) will be attributed to the beneficiaries who become

eligible for this Demonstration after the start date in the year that they become eligible.

2. Each Demonstration year, a new cohort will be created for beneficiaries who became newly eligible the previous year.

iii. Beneficiaries becoming eligible for the Demonstration during the first year will be incorporated into the savings calculation using the attribution approach described in IV.I.2.b.ii, above. These beneficiaries will be included in a new cohort on the start date of the second Demonstration year.

iv. All beneficiaries that become eligible for the Demonstration during the second Demonstration year will form a cohort that begins in the third Demonstration year. The same approach will be used for all beneficiaries becoming eligible during Demonstration years three and four.

v. Beneficiaries becoming eligible in Demonstration year five will not be included in the calculation of savings percentages, but will have savings applied to their expenditures using the methodology described in IV.I.2.b.ii .

vi. For each new cohort of demonstration beneficiaries, there will be a corresponding new cohort of comparison beneficiaries.

c. *Cell Structure*

i. Beneficiaries in the demonstration group and the comparison group will be grouped into cells according to characteristics that influence expected

costs (e.g., residing in a nursing facility, serious and persistent mental illness, age).

ii. The cells are the following:

1. Three by category of care delivery: facility, HCBS waiver, and community other.

2. Two by mental condition: the presence or absence of serious and persistent mental illness (SPMI).

3. Two by age: age 65 and older, and under age 65.

iii. If a particular cell contains zero or a small number of member months, as determined by CMS and its evaluation contractor, the cell category will be eliminated and any beneficiaries in the eliminated cell will be included in another applicable cell. A cell will also be eliminated if data needed to make the cell placements are not available.

iv. Beneficiaries will be placed into cells according to their characteristics as of the date they enter the savings calculation (i.e. the Demonstration start date or the first date of a new cohort), and will remain in that cell throughout the Demonstration, for the months they remain eligible for the Demonstration.

v. Savings will be measured separately for each cell. Aggregate savings will be determined by weighting each comparison group cell according to the distribution of the demonstration population.

d. *Capping Individual Costs:* The annual costs of individuals included in the savings calculation will be capped at the 99th percentile of annual expenditures. Medicare and Medicaid expenditures will be capped separately.

e. *Savings Calculation:* Savings will be calculated one cell at a time, one year at a time, and one cohort at a time, as follows:

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

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

ii. $M_{X,D}$ = months of eligibility for the beneficiaries in cell (X) in the demonstration group. Each cell in the comparison group will have the same weight as the corresponding cell in the demonstration group.

iii. $TPBPM_{X,P}$ = target per beneficiary per month cost in cell (X) for a particular program

iv. $PBPM_{X,D,P}$ = actual per beneficiary per month cost of the beneficiaries in cell (X) in the demonstration group for a particular program

1. The $PBPM_{X,D,P}$ is equal to the Medicare A/B costs or the Medicaid costs (excluding the costs above the cap) incurred during the period of eligibility for all beneficiaries in cell (X) in the demonstration group, divided by the months of eligibility for all beneficiaries in cell (X) in the demonstration group.

2. Whenever a beneficiary is eligible for part of a month (e.g. for a death that occurs in the middle of a month), then a fraction of the month will be used in determining the total number of months of eligibility.

v. Aggregate savings across all cells will be the sum of the savings for all cells and for both programs: $S\$_A = \sum\sum S\$_X$

vi. The target PBPM ($TPBPM_{X,P}$) is a projection of the baseline PBPM of a cell (X) and the program (P) of the demonstration group based on the rate of increase of the corresponding cell of the comparison group:

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

where:

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

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

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

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

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

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

1. $S\$_{Total} = S\$_{Cohort} + S\%_{Cohort} * E_{NewCohort}$, where: $S\%_{Cohort}$, $S\$_{Cohort}$, M_{Cohort}, and $TPBPM_{Cohort}$ have the meanings described above but summed across all cells and the for the Medicaid and Medicare programs.

2. $E_{NewCohort}$ represents the amount spent on beneficiaries in the cohort of beneficiaries who become eligible for this Demonstration after the start date; the percentage savings calculated for the previous cohort(s) is being attributed to the cohort of beneficiaries who become eligible for this Demonstration after the start date in the equation IV.I.2.e.viii, immediately above.

J. DEMONSTRATION PARAMETERS (APPENDIX 7 of the MOU)

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

2. **Grievances and Appeals:** Intentionally Left Blank

3. **Administration and Oversight**

a. *Monthly Eligibility File Submissions:* Beginning June 2013, Washington must submit a monthly eligibility file to CMS' beneficiary alignment contractor. This data will be updated into CMS' Master Database Management (MDM) system for

beneficiary attribution purposes, and used by the evaluation contractor to identify the eligible population.

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

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

2. Medicare Beneficiary Claim Account Number (HICN)

3. ProviderOne Identification number

4. Social Security Number

5. Gender

6. Person First and Last Name, Birthdate, and Zip Code

7. Eligibility identification flag - Coded 0 if not identified as eligible for the Demonstration, 1 if identified by administrative criteria (e.g. claims), and 2 if by non-administrative criteria (e.g. BMI, smoking)

8. Monthly Demonstration eligibility indicator (Each monthly eligibility flag variable would be coded 1 if eligible, and 0 if not)

9. Monthly Health Home Enrollment indicator (Each monthly enrollment flag variable would be coded 1 if enrolled with a Health Home Lead Entity, and 0 if not)

10. Monthly Health Home Engagement indicator (Each monthly engagement variable would be coded 1 if received a health home service during the month, and 0 if not)

ii. Washington shall also submit summary level data for the State Data Reporting System on a quarterly basis, including monthly data for the following but not limited to:

1. The number of beneficiaries eligible for the Demonstration, appropriately excluding all individual beneficiaries not eligible for the Demonstration.

2. The number of beneficiaries who are no longer eligible for the Demonstration (e.g. through Medicare Advantage enrollment or moving out of the State).

3. The number of Health Home Lead Entities participating in the Demonstration.

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

i. CMS will review and update the Demonstration core measures and measure specifications annually to ensure compliance with current science

on measure development, and consistency with other CMS initiatives when applicable and appropriate.

ii. The State will review and, with CMS approval, update State-specific measures and measure specifications annually to ensure compliance with current science on measure development. Where applicable and appropriate, CMS and the State will adhere to nationally-endorsed specifications and Medicaid modifications for relevant measures.

iii. CMS will establish benchmarks for each core measure based on an analysis of the State's quality performance and national references, as further detailed in Section IV.J.3.b.v.1 below. The State will be allowed to review and comment on the CMS proposed core measure benchmarks. For State-specific process and Demonstration measures, the State will provide CMS with recommended benchmarks and supporting analysis. CMS will approve the final benchmarks for all measures. CMS and the State will consider modification of benchmarks when the specifications for a measure are changed from the previous year.

iv. The Demonstration Measurement Set (including core measures revised from the MOU, State-specific process measures, and State-specific Demonstration measures) are as follows for the 37 original counties (Region 1, Table 1) and for King and Snohomish counties (Region 2, Table 2):

Table 1 – Demonstration Measurement Set – Region 1 (37 Original Counties)						
Measure Number	**Model Core Measures**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
A.1	All Cause Hospital Readmission *(Plan All Cause Readmission #1768)*	Reporting	Benchmark	Benchmark	Benchmark	Benchmark
A.2	Ambulatory Care-Sensitive Condition Hospital Admission *(PQI Composite #90)*	Reporting	Benchmark	Benchmark	Benchmark	Benchmark
A.3	ED Visits for Ambulatory Care-Sensitive Conditions *(Rosenthal)*	Reporting	Benchmark	Benchmark	Benchmark	Benchmark
A.4	Follow-Up after Hospitalization for Mental Illness *(NQF #0576)*	Reporting	Benchmark	Benchmark	Benchmark	Benchmark
A.5	Depression screening and follow-up care[1] *(#0418)*		Reporting	Reporting	Reporting (Transition to Benchmark To Be Determined)	Reporting (Transition to Benchmark To Be Determined)
A.6	Care transition record transmitted to health care professional[2] *(NQF #648)*		Suspended	Suspended	Resumption of Reporting To Be Determined	Resumption of Reporting To Be Determined
A.7	Screening for fall risk *(#0101)*			Reporting	Reporting	Benchmark
A.8	Initiation of alcohol and other drug dependent treatment *(NQF #0004)*			Reporting	Reporting	Benchmark
A.9	Enrollees with an Assessment Completed: Percentage of demonstration-eligible Medicare-Medicaid enrollees who are enrolled with a care coordination entity and had an assessment					Reporting

	completed within 90 days of enrollment with a care coordination entity					
A.10	Enrollees with a Care Plan Completed: Percentage of demonstration-eligible Medicare-Medicaid enrollees who are enrolled with a care coordination entity and had a care plan completed within 90 days of enrollment with a care coordination entity					Reporting
	State-Specific Process Measures	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
B.1	Health Action Plans: Percentage of beneficiaries with Health Action Plans within 90 days of enrollment[3]	Reporting	Reporting	Benchmark	Benchmark	Retired
B.2	Training: Delivery of standardized state training for Health Home Care Coordinators on the Health Action Plan	Reporting	Benchmark	Benchmark	Benchmark	Benchmark
B.3	Discharge Follow-up: Percentage of demonstration-eligible beneficiaries with 30 days between hospital discharge to first follow-up visit	Reporting	Reporting	Benchmark	Benchmark	Benchmark
	State-Specific Demonstration Measures	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
C.1	Average change in Patient Activation Measure (PAM) score for participating Medicare-Medicaid Enrollees who initially were least activated	Reporting	Benchmark	Benchmark	Benchmark	Benchmark
C.2	Percent of high-risk Medicare-Medicaid demonstration-eligible beneficiaries receiving community-based LTCSS	Reporting	Benchmark	Benchmark	Benchmark	Benchmark
C.3	Percent of high-risk Medicare-Medicaid demonstration-eligible beneficiaries receiving institutional long term care services	Reporting	Benchmark	Benchmark	Benchmark	Benchmark

1. CMS and Washington will work to reassess the reporting specifications for this measure in future years and move to benchmark status when data collection is stable and valid representation of performance in this area.
2. CMS has suspended collection of this measure. Washington will provide an update to CMS on at least a bi-annual basis on the State's efforts to implement systems to collect this information statewide. CMS may consider reinstating this measure at a later date.
3. This measure is retired as of Demonstration Year 5 due to reporting and benchmarking of the following two measures under Model Core Measures as of Demonstration Year 5: Enrollees with an Assessment Completed and Enrollees with a Care Plan Completed.

Table 2 – Demonstration Measurement Set – Region 2 (King and Snohomish Counties)						
Measure Number	**Model Core Measures**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
A.1	All Cause Hospital Readmission *(Plan All Cause Readmission #1768)*				Reporting	Benchmark
A.2	Ambulatory Care-Sensitive Condition Hospital Admission *(PQI Composite #90)*				Reporting	Benchmark
A.3	ED Visits for Ambulatory Care-Sensitive Conditions *(Rosenthal)*				Reporting	Benchmark
A.4	Follow-Up after Hospitalization for Mental Illness *(NQF #0576)*				Reporting	Benchmark
A.5	Depression screening and follow-up care[1] *(#0418)*					Reporting
A.6	Care transition record transmitted to health care professional[2] *(NQF #648)*					Reporting To Be Determined
A.7	Screening for fall risk *(#0101)*					
A.8	Initiation of alcohol and other drug dependent treatment: *(NQF #0004)*					
A.9	Enrollees with an Assessment Completed: Percentage of demonstration-eligible Medicare-Medicaid enrollees who are enrolled with a care coordination entity and had an assessment completed within 90 days of enrollment with a care coordination entity					Reporting
A.10	Enrollees with a Care Plan Completed: Percentage of demonstration-eligible Medicare-Medicaid enrollees who are enrolled with a care coordination entity and had a care plan completed within 90 days of enrollment					Reporting

	with a care coordination entity					
	State-Specific Process Measures	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
B.1	Health Action Plans: Percentage of beneficiaries with Health Action Plans within 90 days of enrollment[3]				Reporting	Retired
B.2	Training: Delivery of standardized state training for Health Home Care Coordinators on the Health Action Plan				Reporting	Benchmark
B.3	Discharge Follow-up: Percentage of demonstration-eligible beneficiaries with 30 days between hospital discharge to first follow-up visit				Reporting	Reporting
	State-Specific Demonstration Measures	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
C.1	Average change in Patient Activation Measure (PAM) score for participating Medicare-Medicaid Enrollees who initially were least activated				Reporting	Benchmark
C.2	Percent of high-risk Medicare-Medicaid demonstration-eligible beneficiaries receiving community-based LTCSS				Reporting	Benchmark
C.3	Percent of high-risk Medicare-Medicaid demonstration-eligible beneficiaries receiving institutional long term care services				Reporting	Benchmark

1. CMS and Washington will work to reassess the reporting specifications for this measure in future years and move to benchmark status when data collection is stable and valid representation of performance in this area.
2. CMS has suspended collection of this measure. Washington will provide an update to CMS on at least a bi-annual basis on the State's efforts to implement systems to collect this information statewide. CMS may consider reinstating this measure at a later date.
3. This measure is retired as of Demonstration Year 5 due to reporting and benchmarking of the following two measures under Model Core Measures as of Demonstration Year 5: Enrollees with an Assessment Completed and Enrollees with a Care Plan Completed.

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

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

a. CMS will set benchmark levels for core measures. Once benchmark levels are set, CMS will provide the State with no less than 30 days to review the benchmark levels, the methodological considerations, and the data supporting any baseline calculations.

b. For State-specific process and Demonstration measures, the State will provide CMS with recommended benchmarks and supporting analysis; CMS will approve the final benchmarks for these measures.

c. All benchmarks will consider the population served under the Demonstration, changes in the population, and for measures in which the baseline is set from pre-Demonstration experience, the extent to which pre-Demonstration experience data is reflective of the Demonstration population.

d. Benchmarks will include minimum achievement levels, improvement relative to those levels, or both (i.e., either/or).

e. For claims-based measures, where it is feasible to assess experience prior to the start of the Demonstration, improvement-focused benchmarking will be based on improvement from the pre-Demonstration baseline.

f. For measures for which the baseline cannot be based on pre-Demonstration experience, improvement-focused benchmarking will be based on improvement from the reporting period baseline. For the Patient Activation Measure (PAM), improvement-focused benchmarking will be based on positive average PAM score changes for beneficiaries who were initially least activated.

g. Given that the State already has achieved one of the lowest rates of institutional long term care placement in the country, the two long-term services and supports State-specific demonstration measures will allow credit for maintaining or improving performance over time.

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

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

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

vi. *Scoring Methodology*: The State will receive a "met" or "not met" score for each measure. If the State meets the determined benchmark or improvement goal, it will receive a "met" for that measure. If the State does not meet the benchmark or improvement goal, it will receive a "not met" for that measure.

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

vii. *Retrospective Performance Payment*: The maximum retrospective performance payment available to the State under this model is based on achieving overall federal savings as described in the MOU and in Section IV.I above. The performance payment qualifications will vary by year:

1. Demonstration Year 1: In year one, payment is based on the percentage of measures for which the State has completely and accurately reported data. The State would qualify for the full retrospective performance payment in the first year based on complete and accurate reporting of all measures included in that demonstration year.

    a. Specifically, the State will qualify for the full retrospective performance payment if the following 10 measures are completely and accurately reported: A.1, A.2, A.3, A.4, B.1, B.2, B.3, C.1, C.2, and C.3.

2. Demonstration Year 2: In year two, the retrospective performance payment will be distributed in three components.

    a. The first component (30% of the retrospective performance payment) will be distributed once it is determined that the State has completely and accurately reported all measures included in Demonstration Year 2, except for the measure newly-introduced in year two (A.5).

        i. Specifically, the State will qualify for the first component (30% of the retrospective performance payment) if the following 10 measures are completely and accurately reported: A.1, A.2, A.3, A.4, B.1, B.2, B.3, C.1, C.2, and C.3.

    b. The second component (30% of the retrospective performance payment) will be distributed once it is determined that the State has scored a "met" on at least 50% of the "benchmark" measures included in that demonstration year. If the State does not "meet" at least 50% of these measures, no payment will be made for this component.

        i. Specifically, the State will qualify for the second component (30% of the retrospective performance payment) once it has been determined that the State has met the benchmark for at least 50% (4) of the following 8 measures: A.1, A.2, A.3, A.4, B.2, C.1, C.2, and C.3.

c. The third component (40% of the retrospective performance payment) is only available if the State has met the criteria for the first two components. The third component will be distributed based on the number of percentage points above 50% of measures for which the State has scored a "met," multiplied by (4/3), including all measures included in that demonstration year, with each measure weighted equally. (For example, if the State meets 60% of measures, it will qualify for one-third of this component. If the State meets 70% of measures, it will qualify for two-thirds of this component.) Meeting 80% or more of all measures would qualify the State for the maximum performance payment.

    i. Distribution of the third component is based on the number of measures for which the State has completely and accurately reported (applicable for 3 measures: A.5, B.1, and B.3) and met the benchmark or improvement goal (applicable for 8 measures: A.1, A.2, A.3, A.4, B.2, C.1, C.2, and C.3). Among these total 11 measures considered, the State qualifies for this component as follows:

        1. Meets 9 or more measures – qualifies for the full 40% (100% of this component).

        2. Meets 8 measures – qualifies for 30% (76% of this component).

3. Meets 7 measures – qualifies for 18% (45% of this component).

4. Meets 6 measures – qualifies for 6% (15% of this component).

5. Meets 5 or fewer measures – qualifies for 0% of this component.

3. Demonstration Year 3: In year three the retrospective performance payment will be distributed in two components.

    a. The first component (60% of the retrospective performance payment) will be distributed once it is determined that the State has scored a "met" on at least 50% of the "benchmark/improvement" measures included in that demonstration year. If the State does not "meet" at least 50% of these measures, no payment will be made for this component.

        i. Specifically, the State will qualify for the first component (60% of the retrospective performance payment) once it has been determined that the State has met the benchmark or improvement goal for at least 50% (5) of the following 10 measures: A.1, A.2, A.3, A.4, B.1, B.2, B.3, C.1, C.2 and C.3.

    b. The second component (40% of the retrospective performance payment) is only available if the State has met

the criteria for the first component. The second component will be distributed based on the number of percentage points above 50% of measures for which the State has scored a "met," multiplied by (4/3), including all measures included in that demonstration year, with each measure weighted equally. (For example, if the State meet 60% of measures, it will qualify for one-third of this component. If the State meets 70% of measures, it will qualify for two-thirds of this component.) Meeting 80% or more of all measures would qualify the State for the maximum performance payment.

i. Distribution of the second component is based on the number of measures for which the State has completely and accurately reported (applicable for 3 measures: A.5, A.7, and A.8) and met the benchmark or improvement goal (applicable for 10 measures: A.1, A.2, A.3, A.4, B.1, B.2, B.3, C.1, C.2, and C.3). Among these total 13 measures considered, the State qualifies for this component as follows:

    1. Meets 11 or more measures – qualifies for the full 40% (100% of this component).

    2. Meets 10 measures – qualifies for 36% (90% of this component).

3. Meets 9 measures – qualifies for 26% (64% of this component).

4. Meets 8 measures – qualifies for 15% (38% of this component).

5. Meets 7 measures – qualifies for 5% (13% of this component).

6. Meets 6 or fewer measures – qualifies for 0% of this component.

4. Demonstration Years 4 and 5: In years four and five the retrospective performance payment will be distributed based on separate calculations for Region 1 (the original 37 counties) and Region 2 (King and Snohomish counties). The Demonstration Years 4 and 5 total retrospective performance payment will be allocated separately for Region 1 and Region 2. After the total available retrospective performance payment amount is calculated on a statewide basis, the portion of this total retrospective performance payment associated with Region 1 and Region 2 will be allocated based on the percentage of member months for individuals eligible for alignment with the demonstration in Region 1 versus Region 2 in each Demonstration Year, to generate the Region 1 total retrospective performance payment and the Region 2 total retrospective performance payment.

    a. Region 1: In Demonstration Years 4 and 5, the Region 1 retrospective performance payment will be allocated

consistent with the approach taken in Demonstration Year 3, as follows:

i. The first component (60% of the Region 1 retrospective performance payment) will be distributed once it is determined that the State has scored a "met" on at least 50% of the "benchmark/improvement " measures included in the applicable Demonstration Year for Region 1. If the State does not "meet" at least 50% of these measures, no payment will be made for this component.

1. Specifically, for Demonstration Year 4, the State will qualify for the first component (60% of the retrospective performance payment) for Region 1 once it has been determined that the State has met the benchmark or improvement goal for at least 50% (5) of the following 10 measures: A.1, A.2, A.3, A.4, B.1, B.2, B.3, C.1, C.2 and C.3.

2. Specifically for Demonstration Year 5, the State will qualify for the first component (60% of the retrospective performance payment) for Region 1 once it has been determined that the State has met the benchmark or improvement goal for at least 50% (6) of the following 11 measures: A.1,

A.2, A.3, A.4, A.7, A.8, B.2, B.3, C.1, C.2 and C.3.

ii. The second component (40% of the retrospective performance payment) for Region 1 is only available if the State has met the criteria for the first component. The second component will be distributed based on the number of percentage points above 50% of measures for which the State has scored a "met," multiplied by (4/3), including all measures included in the applicable Demonstration Year for Region 1, with each measure weighted equally. (For example, if the State meets 60% of measures, it will qualify for one-third of this component. If the State meets 70% of measures, it will qualify for two-thirds of this component.) Meeting 80% or more of all measures would qualify the State for the maximum Region 1 performance payment.

1. Specifically, for Demonstration Year 4, distribution of the second component is based on the number of measures for which the state has completely and accurately reported (applicable for 3 measures: A.5, A.7, A.8) and met the benchmark or improvement goal (applicable for 10 measures: A.1, A.2, A.3, A.4, B.1, B.2, B.3, C.1, C.2, C.3). Among these total 13

measures considered, the State qualifies for this component as follows:

a. Meets 11 or more measures – qualifies for the full 40% (100% of this component).

b. Meets 10 measures – qualifies for 36% (90% of this component).

c. Meets 9 measures – qualifies for 26% (64% of this component).

d. Meets 8 measures – qualifies for 15% (38% of this component).

e. Meets 7 measures – qualifies for 5% (13% of this component).

f. Meets 6 or fewer measures – qualifies for 0% of this component.

2. Specifically, for Demonstration Year 5, distribution of the second component is based on the number of measures for which the state has completely and accurately reported (applicable for 3 measures: A.5, A.9, A.10) and met the benchmark or improvement goal (applicable for 11

measures: A.1, A.2, A.3, A.4, A.7, A.8, B.2, B.3, C.1, C.2, and C.3). Among these total 14 measures considered, the State qualifies for this component as follows:

a. Meets 12 or more measures – qualifies for the full 40% (100% of this component).

b. Meets 11 measures – qualifies for 38% (95% of this component).

c. Meets 10 measures – qualifies for 29% (71% of this component).

d. Meets 9 measures – qualifies for 19% (48% of this component).

e. Meets 8 measures – qualifies for 10% (24% of this component).

f. Meets 7 or fewer measures – qualifies for 0% of this component.

b. Region 2:

i. In Demonstration Year 4, The Region 2 retrospective performance payment will be allocated as follows, consistent with the approach

taken in Demonstration Year 1 for Region 1, as follows:

1. Payment for the portion of the Region 2 retrospective performance payment is based on the percentage of measures applicable for Region 2 in Demonstration Year 4 for which the State has completely and accurately reported data. The State would qualify for the full Region 2 retrospective performance payment based on complete and accurate reporting of all measures included in Demonstration Year 4 for Region 2.

    a. Specifically, the State will qualify for the full retrospective performance payment for Region 2 if the following 10 measures are completely and accurately reported: A.1, A.2, A.3, A.4, B.1, B.2, B.3, C.1, C.2, and C.3.

ii. In Demonstration Year 5, The Region 2 retrospective performance payment will be allocated as follows, consistent with the approach taken in Demonstration Year 2 for Region 1, as follows

1. The first component (30% of the Region 2 retrospective performance payment) will be distributed once it is determined that the State has completely and accurately reported all measures included in Demonstration Year 5, except for the measure newly-introduced in Year 5 (A.5).

    a. Specifically, the State will qualify for the first component (30% of the retrospective performance payment) if the following 11 measures are completely and accurately reported: A.1, A.2, A.3, A.4, A.9, A.10, B.2, B.3, C.1., C.2, and C.3.

2. The second component (30% of the Region 2 retrospective performance payment) will be distributed once it is determined that the State has scored a "met" on at least 50% of the "benchmark/improvement" measures included in that demonstration year. If the State does not "meet" at least 50% of these measures, no payment will be made for this component.

    a. Specifically, the State will qualify for the second component (30% of the retrospective performance payment) once it has been

determined that the State has met the benchmark or improvement goal for at least 50% (4) of the following 8 measures: A.1, A.2, A.3, A.4, B.2, C.1, C.2 and C.3.

3. The third component (40% of the Region 2 retrospective performance payment) is only available if the State has met the criteria for the first two components. The third component will be distributed based on the number of percentage points above 50% of measures for which the State has scored a "met," multiplied by (4/3), including all measures included in Demonstration Year 5 for Region 2, with each measure weighted equally. (For example, if the State meets 60% of measures, it will qualify for one-third of this component. If the State meets 70% of measures, it will qualify for two-thirds of this component.) Meeting 80% or more of all measures would qualify the State for the maximum Region 2 performance payment.

    a. Specifically, for Demonstration Year 5, distribution of the second component is based on the number of measures for which the State has completely and accurately reported

(applicable for 4 measures: A.5, A.9, A.10, B.3) and met the benchmark or improvement goal (applicable for 8 measures: A.1, A.2, A.3, A.4, B.2, C.1, C.2, and C.3). Among these total 12 measures considered, the State qualifies for this component as follows:

i. Meets 10 or more measures – qualifies for the full 40% (100% of this component).

ii. Meets 9 measures – qualifies for 33% (83% of this component).

iii. Meets 8 measures – qualifies for 22% (56% of this component).

iv. Meets 7 measures – qualifies for 11% (28% of this component).

v. Meets 6 or fewer measures – qualifies for 0% of this component.

5. Calculation of Retrospective Performance Payment: CMS will consult with the State on methodological issues and data collection to execute the retrospective performance payment calculations.

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

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

6. Interim and Final Performance Payments: For each Demonstration Year, based on availability, CMS may make one or more interim payments prior to the final performance payment, if the State meets the quality and Medicare savings criteria for a retrospective performance payment. CMS anticipates that the timing of any interim performance payment would be no sooner than 12-18 months after the end of the demonstration year. The final performance payment will occur at a later date once all Medicare and Medicaid data required for analysis is complete. The interim performance payment will consider preliminary analysis of Medicare and Medicaid savings, and will require final assessment

of the relevant quality measure performance for the relevant demonstration year. The calculation for the interim performance payment will follow that as described IV.I.2 above, with the exception of a discount factor that will be applied to any interim findings to reflect data incompleteness and run out. To the extent that the interim performance payment exceeds the amount due to the State after final examination of all data as part of the final performance payment calculation, CMS will recoup the difference from the State.

viii. *State Participation in CAHPS Survey*: CMS will administer a standardized experience of care survey. The State, as part of the requirements of the Demonstration, will assist CMS and its designated contractor in administering the survey by helping to identify appropriate beneficiaries and providing necessary data. While the State is required to participate in the CMS-sponsored CAHPS survey as part of the Demonstration, the CAHPS measures will not be scored for purposes of determining the retrospective performance payment.

ix. *Reporting Timeframes*: All quality measures will be reported based on services provided during the demonstration year. If the State fails to report by the requested deadline or does not provide a reasonable explanation for delayed reporting, the State may be subject to corrective action for failing to report quality measures. Inaccurate or incomplete reporting, or failure to make timely corrections following notice to resubmit data may lead to termination from the Demonstration.

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

c. *Washington State Health Home Essential Requirements*

i. *16. Health Home Care Coordination Organization Requirements*: Care Coordinators are available during business hours to assist clients with urgent needs and can help ensure that clients have a functional emergency plan.

ii. *Training:* Training of qualified health home designated/lead providers and Care Coordination Organizations will be sponsored between HCA and DSHS. DSHS nursing staff will develop a set of core curriculum materials, including materials focused on disability and cultural competence, for health homes to support the provision of timely, comprehensive, high-quality health homes services that are whole person focused. DSHS will offer technical assistance training for core skill building on relevant topics throughout the Demonstration. Webinars, community network development meetings and/or learning collaborative will foster shared learning, information sharing and problem solving. Additional detail may be found in Health Home SPAs #13-08, #13-17 and #15-0011.

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

V. EXTENSION OF FINAL DEMONSTRATION AGREEMENT

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

VI. MODIFICATION OR TERMINATION OF FINAL DEMONSTRATION AGREEMENT

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

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

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

a. Termination without cause - Except as otherwise permitted below, a termination by CMS or the State for any reason will require that CMS or the State provides a minimum of 90 days advance notice to the other entity and 60 days advance notice is given to beneficiaries and the general public.

b. Termination pursuant to Social Security Act § 1115A(b)(3)(B).

c. Termination for cause - Either party may terminate upon 30 days' prior written notice due to a material breach of a provision of the Final Demonstration Agreement, including termination of any relevant Health Home State Plan Amendment(s).

d. Termination due to a Change in Law - In addition, CMS or the State may terminate upon 30 days' notice due to a material change in law, or with less or no notice if required by law.

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

a. Notification of Suspension or Termination - The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. The State shall summarize comments received and share such summary with CMS. The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must begin no sooner than 14 days after CMS approval of the phase-out plan.

b. Phase-out Plan Requirements - The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), and any community outreach activities.

c. Phase-out Procedures - The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230.

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

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

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

VII. STANDARD CMS TERMS AND CONDITIONS

A. **Payments** - The State will be entitled to payments under this Demonstration only if all conditions of the MOU (signed by the parties on October 24, 2012) and this Agreement (signed June 28, 2013) and any amendments to this Agreement, have been satisfied, including compliance with any waivers or other authorities upon which the MOU was contingent**.**

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

(a) Waivers or other authorities, including any Health Home State Plan Amendments, referenced in Section IV of this Agreement.

(b) Any amendments to this Agreement.

(c) This Agreement

(d) The MOU.

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

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

VIII. SIGNATURES

This Final Demonstration Agreement is effective on January 1, 2017.

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

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

Lindsay P. Barnette — 12/23/2016 (Date)
Director, Models, Demonstrations, and Analytics Group
Federal Coordinated Health Care Office

State of Washington:

Patricia Lashway — 12/22/2016 (Date)
Acting Secretary, Department of Social and Health Services

MaryAnne Lindeblad — 12-21-16 (Date)
Medicaid Director, Health Care Authority