DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

State Demonstrations Group

AUG 0 8 2017

MaryAnne Lindeblad
Medicaid Director
Washington State Health Care Authority
626 8th Avenue SE
P.O. Box 45502
Olympia, Washington 98504-5502

Dear Ms. Lindeblad:

This letter is to inform you that Washington State's submission of the IGT Protocol and Financial Executor Role have been approved. These protocols have been found to be in accordance with the Special Terms and Conditions (STC) of the state's section 1115 demonstration, entitled "Medicaid Transformation Project" (MTP) (No. 11-W-00304/0). These protocols are approved for the period starting with the date of this approval letter through December 31, 2021—and are hereby incorporated into the STCs as Attachments E and G, respectively.

Additionally, CMS has reviewed the state's proposed evaluation design submitted to CMS on May 9, 2017 and assessed its compliance with the approved STCs dated January 9, 2017. We have enclosed our comments and recommendations in the attached version of the evaluation design and accompanying memorandum.

Your project officer for this demonstration is Mr. Adam Goldman. He is available to answer any questions concerning your section 1115 demonstration. Mr. Goldman's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-2242
E-mail: Adam.Goldman@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Goldman and to Mr. David Meacham, Associate Regional Administrator in our Seattle Regional Office. Mr. Meacham's contact information is as follows:

Centers for Medicare & Medicaid Services
Office of the Regional Administrator
701 Fifth Avenue, Suite 1600
Seattle, WA 98104
Telephone: (206) 615-2356
E-mail: David.Meacham@cms.hhs.gov

We look forward to working closely with the Health Care Authority to monitor progress along the way.

Sincerely,

[redacted]

for Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: David Meacham, Associate Regional Administrator, Seattle Regional Office

ATTACHMENT E

Intergovernmental Transfer (IGT) Protocol

I. Preface

As part of this demonstration, the Delivery System Reform Incentive Payment (DSRIP) program is to provide incentives for Medicaid providers to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities by improving care, improving health and reducing costs. The non-federal share of these payments will come from intergovernmental transfers (IGT) from public hospitals, other local government or tribal funds, or funds that the state has earned by claiming federal match on expenditures for Designated State Health Programs (DSHP).

In accordance with STC 87(d), the state may use IGTs to the extent that such funds are derived from state, tribal, or local monies and are transferred by units of government, which can include a governmentally operated provider, within the state. The state provides assurance that the matching non-federal share of funds for the demonstration is state/local/tribal monies and that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Social Security Act, 42 CFR §433.51 and applicable regulations. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid State Plan.

The IGT protocol (this document, Attachment E) describes the methodology and guidelines by which the state may use IGT as a source of funding for the non-federal share of demonstration expenditures.

II. IGT Process and the Role of the Accountable Communities of Health (ACH)

Under this demonstration, the state will make performance-based funding available to regionally-based ACHs and their partnering providers with the goal of transforming the delivery system for Medicaid beneficiaries. The ACHs will be responsible for coordinating the efforts of partnering providers in their community to create and implement regional project plans to transform the Medicaid delivery system. The project plans will be reviewed by a third-party Independent Assessor, who will make recommendations to the state as to whether the plans should be approved.

Approved project plans that meet the milestones outlined in the project will be eligible for incentive payments under the demonstration. A component of the non-federal share of these payments will come from IGTs. The responsibility of the Financial Executor includes distributing earned incentives in a timely manner to participating providers in accordance with each ACH's budget plan.

DSRIP payments are made twice per year and are always paid using the same process. The incentive payment amounts are determined by two reporting periods per demonstration year,

where ACHs report the metrics and milestones achieved by their transformation projects. The state, with support from the Independent Assessor, will review reports to calculate the incentive payments earned by the ACH. Once incentive amounts are calculated, the state will calculate the non-federal share amount to be transferred by an IGT contributor based on ACH budget plans in order to draw the federal funding for incentive payments related to the achievement of milestones and metrics. Within 14 calendar days after notification by the state of the identified non-federal share amount, the IGT contributor will make an intergovernmental transfer of funds. The state will pay an amount equivalent to the non-federal and federal shares of the incentive payment to the ACH and its partnering providers. The state will then draw the federal funding based on those disbursements. If the IGT is made within the appropriate and approximate 14-day timeframe, the incentive payment will be disbursed within approximately 30 calendar days. The total computable incentive payment must remain with the ACH partnering providers and will not be returned to or retained by the state.

III. IGT Funding Conditions

IGTs from governmentally operated providers must be in an amount not to exceed the non-federal share of title XIX payments. No pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

An agreement will be executed between the Health Care Authority (HCA), Washington's Medicaid agency, and each IGT contributing entity. The agreement will identify the annual estimated commitments by each IGT contributor. Funds will be transferred from each IGT contributor and will be under the administrative control of HCA. The state will provide copies of the signed IGT agreements between the state and the public entity providing the IGT funds to the CMS regional office.

IGT contributions for purposes of DSRIP are eligible for a 50 percent federal match. The IGT contributor will, by signature, attest that the IGT contribution is not derived from Federal receipts and that they will maintain records to document the source of non-federal share and furnish those records to HCA and CMS as necessary.

Additionally, the IGT contributor must identify the allowable funding source, over the course of a given DSRIP Year, to support the IGT commitment for DSRIP.

IGT funding as described under this demonstration does not have any interaction with existing provider assessment arrangements, with regard to the federal 6% cap. Incentive payments will also not impact upper payment limit (UPL) or state/hospital specific Disproportionate Share Hospital (DSH) caps. Additionally, IGTs will not interact with existing Certified Public Expenditure (CPE) arrangements or any upper payment limit requirements with governmental (public) hospitals as long as the IGTs are not considered an

expenditure for the provision of a hospital service for hospitals that CPE. CPEs are expenditures made for the provision of a Medicaid service and certifying providers can receive no service payments above their certified costs. The IGTs are the expense of financing the non-federal share for other Medicaid purposes, and the public hospitals may not claim the transfer of funds to the Medicaid agency as a Medicaid uncompensated hospital service cost under the State Plan or the waiver since their service costs are fully satisfied.

ATTACHMENT G

Financial Executor Role

In coordination with HCA and representatives of the state's nine ACHs, the contracted financial executor (FE) shall be responsible for administering a funding distribution plan as described in Attachment D.

ACHs, through their governing bodies, are responsible for managing and coordinating with partnering providers. The ACHs must meet the qualifications set forth in STCs 21 - 23 and must meet the targets enumerated in Attachment C in order to earn incentive payments. In addition, ACHs will certify as to whether or not the partnering providers have met the milestones required for earning incentive payments within their region. The ACH will also certify to the independent assessor whether or not partnering providers have achieved the milestones (see STC 21). The independent assessor (IA) will review the ACH's certification and make recommendations to the state related to distribution of payment. Once the state affirms the recommendations from the IA, it will send the incentive payments to the FE for distribution to the partnering providers.

The contracted FE will perform the work and complete the deliverables outlined below.

1. Establish a system for recording, processing, distributing and reporting on the payment of incentive funds and other financial transactions between HCA, ACHs and partnering providers in accordance with Attachment D.
    1.1. Establish a standardized process and forms to track payments to partnering providers and instruct partnering providers and ACHs in their use.
    1.2. The distribution of funds must comply with all applicable laws and regulations, including, but not limited to, the following federal fraud and abuse authorities: the anti-kickback statute (sections 1128B(b)(1) and (2) of the Social Security Act (the "Act")); the physician self-referral prohibition (section 1903(s) of the Act); the gainsharing civil monetary penalty (CMP) provisions (sections 1128A(b)(1) and (2) of the Act); and the beneficiary inducement CMP (section 1128A(a)(5) of the Act); as well as with HCA and Washington state rules and generally accepted accounting principles.
2. Provide financial accounting and banking management support for all incentive payments.
    2.1. Establish and maintain appropriate accounts as directed by HCA for the tracking of incentive payment receipts and holding of funds and issuance of payments.
    2.2. Regularly track and report on all transactions from such accounts, including but not limited to payments, receipts, refunds and reconciliations.
3. Distribute earned funds in a timely manner to partnering providers in accordance with HCA-approved funding distribution plans.
    3.1. Upon instruction and approval from the ACH, issue payments to partnering providers within 14 business days.

3.2. Respond to inquiries from ACHs and partnering providers regarding payments made or owed amounts, within 5 business days.

3.3. Identify, record, resolve and report on any under- or over-payments, including issuing requests for refunds if necessary.

3.4. Record and regularly report to ACHs on funds processed and payments made.

4. Submit scheduled reports to HCA and ACHs on the distribution of transformation project payments, fund balances and reconciliations–in accordance with relevant state and federal rules.

5. Develop and distribute budget forms to partnering providers for receipt of incentive funds.

6. As requested, assist HCA in responding to inquiries from CMS regarding financial transactions and any audits that may be required.