Washington Complex Discharge Task Force and Pilot: Interim Recommendations

INTERIM REPORT PER SB 5187, SEC.135(12)

TO
GOVERNOR JAY INSLEE
SENATE WAYS AND MEANS COMMITTEE
SENATE HEALTH AND LONG-TERM CARE COMMITTEE
SENATE LAW & JUSTICE COMMITTEE
HOUSE APPROPRIATIONS COMMITTEE
HOUSE HEALTH CARE AND WELLNESS COMMITTEE
HOUSE CIVIL RIGHTS & JUDICIARY COMMITTEE

FROM
THE COMPLEX DISCHARGE TASK FORCE

JULY 1, 2024

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Executive Summary

The Challenge

Many individuals remain in acute care hospitals when they are medically ready for discharge but unable to leave due to a range of systemic barriers as well as complex physical, behavioral, or social needs. These individuals are ultimately not receiving appropriate care and specialized supports to address their needs and facilitate transitions to lower levels of care. According to quarterly surveys of Washington hospitals, around 900 patients on any given day across the state are ready for discharge from acute care hospitals, but unable to be placed in appropriate community and post-acute care settings.[1] Approximately one third of these patients are Medicaid beneficiaries.

Broad system change is needed to ensure that individuals who are medically ready for discharge are able to transition into post-acute care or community settings that can address their needs. This change is also important to alleviate strain on hospital capacity and ensure that Washington communities have access to hospital acute care settings when needed.

Complex Discharge Task Force and Pilot

Pursuant to a budget provision approved during the 2023 Washington State legislative session, the Complex Discharge Task Force (Task Force) was established to oversee a pilot program and to make recommendations to the Governor and appropriate committees of the Legislature about how to address systemic, statewide challenges with discharging patients from acute care to post-acute care and community settings.[2] This work builds on a history of legislative and other efforts over the last seven years to address these challenges (See Appendix A).

The Complex Discharge Pilot is testing an Enhanced Care Management (ECM) model of care for Medicaid beneficiaries. ECM is the coordination of patient-specific social, behavioral, and medical services, which begin in the hospital and follow the patient through the continuum of care to step-down levels of care needed. The goal of ECM is to support patients to transition from the hospital into appropriate post-acute care settings, including skilled nursing facilities, assisted living, adult family homes, other community settings, and if possible, back to their homes. This model is intended to facilitate strong cross-system collaboration across multiple partners – including hospitals, post-acute care providers, managed care organizations, HCA, DSHS, families and patients – to engage a range of services and supports needed to support patients to transition into care settings that support their needs.

The five Complex Discharge Pilot sites, Health Care Authority (HCA), and Department of Social and Health Services (DSHS) have been engaged in the design and development of the Complex Discharge Pilot model of care, payment model, and implementation planning. As of June 2024, three of the Pilot sites have successfully launched, and the remaining sites are anticipated to launch in August 2024.

[1] Washington State Hospital Association. (2024). *Quarterly Surveys of Hospitals.*

[2] Senate Bill 5187 (2023), Section 211, Proviso 65. Accessed at: https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20240618210945

Task Force Interim Recommendations & Roadmap of Critical Issues

The Task Force would like to underscore that the Pilot sites are testing a new model of care that has taken significant time and effort to bring cross-system partners together around the design, payment, contracting, and implementation. Initially, the Legislature funded a Pilot launch by November 1, 2023 to allow for a two-year pilot. Given the timeframes to establish Pilot site contracts, the Task Force identified early on the need to delay launch until January 2024. Since January this year, there has been further work by Pilot sites and State Agencies to align on and finalize the pilot design, payment model, common definitions & protocols, and contracts. Each Pilot site has also worked independently to prepare for implementation, including hiring staff, identifying SNF and other post-acute care partners, and setting up internal systems and core infrastructure needed to operate the pilot.

This development work has informed our **Interim Recommendations** for future expansion and sustainability of the Pilot model, as well as the roadmap of critical issues to be addressed in order to remove discharge barriers for patients with complex needs. In this report, we identify Interim Recommendations for legislative action during the 2025 session, contingent on the availability of funding, to support the pilot and work ahead. In addition, in the body of this report, we outline a roadmap of critical issues that will be worked on over the course of the Pilot and addressed in the final report due next year. The roadmap will guide the Task Force and workgroup focus on key issues, outlined in the body of this report, and the development of recommendations for actions needed by the Legislature, state agencies, and system partners to remove discharge barriers for patients with complex needs.

Interim Recommendations

1. **Request for authorization of short-term two-year extension of the Complex Discharge Pilot through June 2027:** This extension will allow time for the Pilot to operate to gain understanding of current system resources and gaps. An extension would also allow the Pilot to align with the timeline for leveraging federal Medicaid funding to support continuous funding of pilot services in the future. Further consideration of additional slots may also be needed based on pilot utilization of existing slots.
2. **Establish a workgroup that is co-chaired by HCA and DSHS to evaluate how Washington's existing and potential Medicaid funding authorities may support the current or an expanded Complex Discharge Pilot, and the steps needed for obtaining approval and funding for a permanent statewide expansion of the Pilot.** The workgroup should report to the Task Force by June 30, 2026. This work may be supported by a contractor identified by HCA.
3. **Continue to take action to address known system barriers.**
   a. **Patient Decision-Making Capacity:** Building the 2024 legislative investments to expand Office of Public Guardian guardianship capacity (SB 5835), the Task Force recommends continued steps to address discharge delay due to decision-making barriers, including consideration of relationship to Tribal governments and jurisdiction in these processes.
   b. **LTSS Services for Noncitizens:** The Task Force continues to recommend expanding state-funded long-term care for non-citizens.
4. **Conduct process improvement exercises that bring together cross-system and cross-agency partners to examine current processes, identify gaps in these existing processes, and collaboratively identify ideas for solutions.** This work will be critical to the development of recommendations in the Final Report that address the roadmap of critical issues to be examined in the coming year. These exercises will involve convening in-person workshops to bring all partners into the room to engage in deep review of existing process and identification of solutions to barriers or gaps. Given the complexity and multitude of issues that contribute to discharge barriers, the Task Force is recommending investment of additional funding for facilitation and agency time needed for this work.

Background

During the 2023 Washington State legislative session, the Legislature approved and funded a budget proviso in SB 5187 to create the Complex Discharge Task Force (Task Force).[3] The objectives of the Task Force are to oversee a pilot program and make recommendations to the Governor and appropriate committees of the Legislature about how to address systemic challenges with discharging patients from acute care to post-acute care and community settings that could be applied on a statewide basis. The Task Force is charged to deliver recommendations on the following topics:

- Pilot program implementation and evaluation of the two-year five-site pilot, and recommendations for statewide implementation (the pilot model of care is to be informed by the Harborview Medical Center's Bed Readiness Program);[4]
- Available funding mechanisms;
- Post-acute care and hospital administrative day rates;
- Managed care contracting; and
- Legal, regulatory, and administrative barriers to discharge.

The Task Force was directed to complete a report with initial recommendations by November 1, 2023, interim recommendations and findings by July 1, 2024, and a final report by July 1, 2025. This report is the second in the series of reports outlined and fulfills the requirements due July 1, 2024.

Task Force and Workgroup Structure

The Task Force consists of seven members appointed by the Governor's Office to develop recommendations.[5] Representatives serving on the Task Force include the following:

1. Governor's Office
2. Department of Social and Health Services
3. Washington State Health Care Authority
4. Washington State Hospital Association
5. Post Acute Care Provider Association
6. Harborview Medical Center
7. Patient and Families Representative

In addition, the Task Force may establish workgroups, composed of stakeholders and partners representing diverse perspectives, to inform the areas of recommendations it must deliver. During the Fall of 2023, the Task Force formed five workgroups: 1) Pilot Implementation, 2) Discharge Barriers, 3) Contracts and Regulatory, 4) Rates, and 5) Funding Mechanisms. These groups met several times between August and October 2023 to inform the Task Force's understanding of the current issues and challenges related to complex discharge in their respective areas of focus. In addition, an All-Workgroup

[3] Senate Bill 5187 (2023), Section 211, Proviso 65. The Task Force is adopting the terminology of "complex discharge" in place of "difficult to discharge" (used in the legislation) throughout its work. Accessed at: https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20240618210945

[4] ESSB 5950– 2024 legislative amendments allow multiple hospitals within a geographic region, per recommendation from the Task Force.

[5] In addition to the six seats named in legislation (SB 5187), the Task Force created an additional seat to represent patients and families with complex discharge needs.

meeting was convened in May 2024 to provide an update on progress to launch the Complex Discharge Pilot and development of Task Force Recommendations. The hospital pilot participants have also met on an approximately monthly basis to engage in launch and implementation planning efforts that have informed the Task Force's recommendations in this report.

Overview: Complex Discharge Pilot

The Complex Discharge Pilot is testing an ECM model of care to support patient transitions from hospital into appropriate post-acute care settings, including skilled nursing facilities, assisted living, adult family homes, other community settings, and if possible, back to their homes. ECM is the coordination of patient-specific social, behavioral, and medical services, which begins in the hospital and follows the patient through the continuum of care to the next step down level of care that is needed.

Key components of the Pilot ECM model of care include:

- **ECM Team:** Pilot sites are responsible for forming an ECM Team to develop a care plan and support patients as they transition into appropriate post-acute care settings. The ECM team are hospital-based and include licensed and non-licensed staff, such as social workers, case managers, and nurses.
- **Skilled Nursing Facilities and other Post-Acute Care Partners**: Hospitals participating in the Pilot are partnering with dedicated SNFs and other Post-Acute Care providers that receive additional resources to build capacity to manage more complex patients.
- **Supportive Services**: Pilot sites have funding for Supportive Services to address patient-level barriers to discharge, facilitating transitions of care and allowing flexibility in addressing barriers to discharge.[6]
- **HCS Assessment Staff**: DSHS has hired dedicated staff to ensure the timeliness of HCS assessments of patient functional and financial eligibility determination for long-term care services.
- **Multi-disciplinary care team:** To implement the care plan, the ECM team will convene weekly multi-disciplinary care team meetings that involve a range of cross-system partners involved in the patient's care. This team includes the patient, their family or representative, the patient's healthcare providers, SNF partners, designated case managers from the HCS team at DSHS, MCOs, social supports, and any other individuals that have a role in the patient's care.

The Pilot will run from May 2024 to July 2025. There are five hospitals participating in the Complex Discharge Pilot located across the state:

- Harborview Medical Center – Seattle
- MultiCare – Spokane and Tacoma
- PeaceHealth – Vancouver
- Providence Swedish – Everett
- Virginia Mason Franciscan Health – Tacoma

[6] Supportive Services funding is only to be used for the following services: Medical transportation; Durable Medical Equipment (DME); 1:1 Sitters; Behavioral health support; Medical supplies; Caregiver support; Home health support. Pilot sites may also submit a written request for an exception to HCA to approval.

Initially the pilot included one hospital in each of the geographic areas outlined above. During the 2024 legislative session, the Legislature provided additional flexibility to allow participating hospitals to expand their geographic footprint.[7] This new flexibility allows a health system to serve more than one region, which facilitates participation by hospitals with fewer patients with complex discharge needs.

Each pilot site has 30 slots for which they can refer patients to ECM. Hospitals will identify individuals eligible for pilot enrollment and refer them to their ECM teams based on:

- ***Patient Criteria:*** Adult patients who are medically ready to be transferred outside of an acute care setting but are unable to due to transition barriers.
- ***Payer Eligibility:*** Individuals who are covered under Medicaid managed care or Medicaid fee-for-service or are dually covered under Medicaid and Medicare.[8]

Patients eligible for ECM will be screened by the hospital ECM team to determine which services are necessary to facilitate their transition of care. Subsequently, the ECM team will develop a care plan, which will include targeted interventions that address the patient's identified needs and barriers to discharge. To implement the care plan, the ECM team will work with the multidisciplinary care team representing a range of partners involved in the patient's care to support cross-system collaboration needed for patient transitions. Pilot sites will submit weekly reports to HCA containing information on the individuals enrolled in the pilot and care plan interventions, as discussed further in the *Pilot Evaluation Framework* section of this report.

Payment model for complex discharge model of care

The Washington State OFM, with support from the state agencies and the Task Force, led the effort to establish three funding streams to sustain the pilot across fiscal years 2024 and 2025. Each of the funding streams was designed with flexibility in mind, not only to provide the pilot sites with options that best suit their operations, but also to test their efficacy in supporting ECM. Allowing the pilot sites flexibility in how they leverage funding can also inform if they could be sustainable options for supporting ECM as a statewide benefit. Pilot sites are required to submit logs to HCA which list the services that were funded by either Administrative Payments or Supportive Services Payments.

Funding Stream	Purpose	Payment Methodology
Administrative Payments	Funding to support services provided by the SNF partnering with hospital pilot participants for patients enrolled in the pilot. This funding is provided on top of existing Medicaid payment rates and is meant to help participating SNFs develop capacity to care for patients with more complex needs.	Pilot hospitals and SNFs have the flexibility to contract with SNF partner using one of three daily payment model options: • $200 per bed, • $280 per patient, or • $50/$200 bed/patient hybrid model ($50 per bed per day, with

[7] Each hospital will continue to have a total of 30 ECM slots, but there is flexibility for hospitals to divide their slots equally between two discrete hospital locations in different regions.

[8] Note: Eligibility of individuals for the Pilot with pending Medicaid coverage will be reviewed on by HCA on a case-by-case basis.

		an additional $200 daily payment for each patient within a bed)
Enhanced Care Management (ECM) Payments	Funding to support the hospital pilot sites in increasing capacity, including hiring staff to support ECM and administering ECM services to pilot patients with a 15:1 caseload ratio.	Each pilot site will be paid a lump sum of $41,500 monthly through the end of Fiscal Year 2024. Beginning Fiscal Year 2025, ECM payments will be paid by HCA based on utilization at $1,500 per patient per month. The maximum amount a pilot site can receive is $45,000 per month, or $1,500 for each of the 30 filled ECM slots.
Supportive Services Payments	Funding to support pilot sites and post-acute partners in addressing patients' barriers to discharge. Funding is only to be used for the following services, unless an exception is approved by HCA: • Medical transportation • Durable medical equipment • 1:1 Sitters • Behavioral health support • Medical supplies • Caregiver support • Home health support	For Fiscal Year 2024, each pilot site will be allocated $250,000. For Fiscal Year 2025, each pilot site will be allocated $1.2 million. Pilot sites have the option to bill HCA for services after they are rendered or receive a lump sum amount. If a pilot site chooses to receive a lump sum, they are expected to return excess funds that are not used to HCA prior to the end of the fiscal year.

Work with State Agency Partners

To guide its work, the Task Force is working closely with HCA and DSHS as the lead state agencies administering the pilot and other services for individuals with complex discharge needs covered by Medicaid. HCA is responsible for administering Medicaid coverage through Medicaid integrated managed care contracts as well as the Fee-for-Service program. This includes coverage of physical and behavioral health services provided in acute care and outpatient settings, as well as rehabilitative and skilled care services provided through home health and SNFs. DSHS is responsible for long-term care services for Medicaid populations eligible for these services, such as care provided in nursing facilities, adult family homes, and assisted living facilities, as well as personal care services in a person's home. The Task Force's work builds on HCA and DSHS expertise regarding past and current programs serving individuals with complex discharge needs.

Pilot Goals and Evaluation Framework

The objective of the pilot is to understand if the ECM model of care is effective in reducing the patient's length of stay and supports quicker, safer care transitions to the most appropriate setting for the patient. To validate that the pilot is successful in accomplishing this objective, the evaluation framework will assess if the following outcomes are met:

- Reducing the length of stay in the hospital for patients who are medically ready for discharge, and supporting efficient and timely transitions to post-acute care and community settings.
- Reducing the total cost of care.
- Increasing patient satisfaction.

As the intent of the pilot is to test a model of care that can be adapted as a statewide benefit, the outcomes will be measured from the perspective of a continuum of care full system solution. Each transition of care, from the hospital, to a SNF or other long-term care post-acute settings, to a stable setting in the community, will be taken into consideration in the evaluation framework (see Figure A). Through this approach, the Task Force and state agency partners can ascertain if ECM is effective in mitigating any bottlenecks or barriers in each of the patient's transitions. **Table A** provides overview of the Pilot evaluation framework, including key outcomes, measures, and data sources. Existing data on the Complex Discharge patient population will be used as a baseline of comparison to those receiving ECM through the Complex Discharge Pilot.

Figure A. Pilot Evaluation of Patient Transitions Across Post-Acute Care and Community Settings

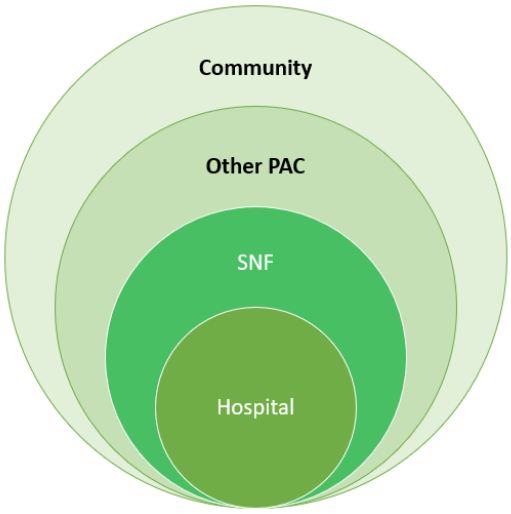

Table A. Complex Discharge Pilot Evaluation Framework: Outcomes, Measures, and Data Sources

High Level Outcome	Specific Outcome	Key Results & Measures
Reduce length of stay for patients who are medically ready for discharge	Reduce length of stay in hospital for patients who are medically ready for discharge	- Total Hospital LOS for Pilot Patients - Average Hospital LOS by Site (1) - Average Hospital LOS by Payor (3) - Average Hospital LOS by Demographics (4) - Average hospital LOS by Barrier(s) to Discharge (5) - Total duration enrolled in ECM - Average LOS between entering ECM and discharging from hospital
	Reduce length of stay in SNF for patients who are medically ready for discharge	- Total SNF LOS for Pilot Patients - Average SNF LOS by Site - Average SNF LOS by Payor - Average SNF LOS by Demographics
Efficient and timely care transitions	Reduce length of care transitions	- Total length of transition between each setting - Average length of transition between each setting by Site - Average length of transition between each setting by Payor - Average length of transition between each setting by Demographics
Reduce total cost of care	Reduce day beyond medical necessity in hospital	- Average hospital LOS after denied continued stay (2) - Average cost to hospital of a patient in bed per day
	Reduce readmissions to hospital	- Readmissions Rate for Pilot Participants (11) - Average Cost Per Readmission
Increasing patient satisfaction	Increase Patient Reported Satisfaction	- ECM staff to administer standard exit survey at each Pilot Site
Create a structure / model that rapidly resolves barriers to care	Demonstrate program utilization	- Percent ECM Slots Enrolled (16) - Volume of pilot participant discharges per week (7) - Discharge Disposition from Hospital by Frequency by Site (8) - Discharge Disposition from SNF or other post-acute care facility by Frequency by Site - Average length of patient enrollment in pilot (12)
	Identify and study barriers to transitions	- Barriers selected by ECM Staff by frequency by site and by demographics (9 & 10)
	Identify and study selected ECM Interventions	- ECM Interventions selected by ECM Staff - Supportive Services by frequency by site (14 & 15)

Qualitative Questions

- What are the gaps in funding to support a sustainable payment model?
- How can additional mechanisms or funding be leveraged to support these services?
- Where should the ECM model of care be centered? (community sites, hospital role)
- Were goals effectively set with patients, and were they met?
- Was cross-system coordination (i.e., multidisciplinary care team model) effective in ensuring patient goals were met?
- Was the patient's engagement in transition planning increased through use of this model?
- What are the challenges and barriers to post-acute care provider participation?
- What types of services and supports are necessary to effectuate appropriate transitions across the care continuum (from hospital to home)?
- What types of specialized facilities and services needed to support the care transitions?
- If a pilot patient is denied by a setting despite having ECM support, what is the cause or reason for the denial?

Data Sources

Pre-Pilot Data (i.e. baseline for comparison)

- WSHA discharge barriers data
- MCO data collected by HCA
- Data kept by DSHS

Post-Pilot Data

Report Title	Frequency	Purpose
Complex Discharge Pilot Site Report	Weekly	Provides an ongoing roster of the patients enrolled in ECM at each of the pilot sites. The report includes data fields to capture demographic information, discharge barriers, ECM interventions, and discharge planning information.
Administrative Payments Log	Monthly	Requires pilot sites to report what services rendered by their Skilled Nursing Facility (SNF) partners were funded using administrative payment dollars for each patient. Can inform state agencies and Task Force on
Supportive Services Log	Monthly	Requires pilot sites to report what services were funded using supportive services dollars to support ECM or transitions of care.

Complex Discharge Task Force Interim Recommendations

Based on the learnings from the Pilot design and launch, the Task Force has identified several **Interim Recommendations** for legislative action in 2025, contingent on the availability of funding. These recommendations provide important support for our work ahead. In addition, in the section to follow these recommendations, we outline a roadmap of critical issues to be addressed by the Task Force and workgroups in the coming year. This work will form the basis of more comprehensive recommendations and actions needed in our final report due July 1, 2025.

Interim Recommendations

1. **Request for authorization of short-term two-year extension of the Complex Discharge Pilot through June 2027.**
   The Task Force is recommending a two-year extension (i.e., and additional biennium beginning July 2025 through June 2027). This extension will allow time for the Pilot to operate to gain understanding of current system resources and gaps. An extension would also allow the Pilot to align with the timeline for leveraging federal Medicaid funding to support continuous funding of pilot services in the future. Further consideration of additional slots may also be needed based on pilot utilization of existing slots.

2. **Establish a workgroup that is co-chaired by HCA and DSHS to evaluate and make recommendations on how Medicaid funding mechanisms could be operationalized to support sustainable funding for the model of care being tested by the Pilot.**
   The Task Force has identified the need for a deeper analysis of Washington's existing and potential federal Medicaid authorities that could provide longer-term sustainable funding for the pilot model of care. This analysis should address how Washington's existing and potential Medicaid funding authorities may support the current or an expanded Complex Discharge Pilot, and the steps needed for obtaining approval and funding for a permanent statewide expansion of the Pilot. The workgroup should report to the Task Force by June 30, 2026. This work may be supported by a contractor identified by HCA.

3. **Continue to take action to address known system barriers.**
   a. **Patient Decision-Making Capacity*:*** Building the 2024 legislative investments to expand Office of Public Guardian guardianship capacity (SB 5835), the Task Force recommends continued steps to address discharge delay due to decision-making barriers, including further expanding OPG guardianship capacity; funding to increase Washington state court capacity to address guardianship cases; expanding supported decision making; and consideration of relationship to Tribal governments and jurisdiction in these processes.
   b. **LTSS Services for Noncitizens:** The Task Force continues to recommend expanding state-funded long-term care for non-citizens.

4. **Conduct process improvement exercises that bring together cross-system and cross-agency partners to examine current processes, identify gaps in these existing processes, and collaboratively identify ideas for solutions.**
   This work will be critical to the development of recommendations in the Final Report that address the roadmap of critical issues to be examined in the coming year. These exercises will involve convening in-person workshops to bring all partners into the room to engage in deep review of existing process and identification of solutions to barriers or gaps. Given the complexity and multitude of issues that contribute to discharge barriers, the Task Force is recommending investment of additional funding for facilitation and agency time needed for this work.

Roadmap of Critical Issues for Work Ahead

This report outlines a "roadmap" of work needed on critical issues to remove barriers for patients with complex discharge needs. The roadmap will guide the work of the Task Force and workgroups in the coming year, and is organized within the five major areas of the Task Force's charge by the Legislature:

1. Pilot Implementation
2. Discharge Barriers
3. Managed Care Contracting
4. Post-acute care and administrative day rates
5. Funding Mechanisms

In this report, the roadmap establishes foundational context of current efforts relevant to the critical issues identified in each of these five areas. In our final report due next year, the Task Force expects to make more comprehensive recommendations to address all issues identified in the roadmap. These recommendations will provide a comprehensive plan for actions needed by the Legislature, state agencies, and system partners to remove discharge barriers for patients with complex needs.

I. Pilot Implementation

The work to design and launch the pilot has required significant time for the state agencies, hospitals, and post-acute care partners to develop a common understanding of the goals of the pilot and appreciation of the barriers different parts of the system face in establishing innovative approaches. Despite the delay in launching, a significant amount of work in aligning processes has been accomplished. Additionally, learning about issues occurring in different communities has been crucial to the development of programs that will work for each pilot site. This development work has informed our Interim Recommendations for future expansion and sustainability of the Pilot model, as well as the roadmap of critical issues to be addressed in the coming year.

1. Identify system investments needed to support a sustainable, multi-system coordinated approach to supporting care transitions.

Strong collaboration and partnership across multiple partners and systems is a foundational component of work to successfully transition patients with complex needs from hospitals into appropriate post-acute care and community settings. The Task Force would like to underscore the importance of this principle. There is no single point of responsibility for addressing the complex issues that may need to be navigated – rather there is shared responsibility and accountability for collaborative problem solving across system partners. Each partner – including hospitals, post-acute care providers, outpatient and other service providers, MCOs, state agencies, and other entities involved in serving patients – brings a specific set of resources and responsibilities to the table for addressing a range of issues that may be impacting the ability of patients to transition out of hospitals.

Although barriers exist across multiple systems, the reality currently is a default reliance on hospitals as the primary point of responsibility for patient discharge planning given patients are residing in hospital settings. The Complex Discharge Pilot model of care is working to build the 'collaborative muscle' across siloed systems to redesign how care is delivered and support a cross-system approach to patient care

transitions. Key features of the pilot intended to support cross-system collaboration include for example:

- A multidisciplinary and cross-system team and dedicated staff located at hospitals. (Hospitals, SNFs, MCOs, HCS, HCA, DSHS/HCS)
- Training and educating system partners on roles, responsibilities, and resources
- Establishing partnerships between hospitals and post-acute care providers
- Workflows to ensure effective communication
- Cross state agency alignment and coordination
- Data collection to track outcomes across systems

Early lessons from the Pilot design and the cross-system implementation planning work to date include:

- As discussed above, building the cross-system infrastructure needed to support appropriate transitions for patients with complex needs requires significant investment of time and resources by all partners. This has included the need for education and clarification of Pilot expectations, as well as significant work by system partners to form the partnerships and system capacities needed to support appropriate patient transitions. State agencies also need resources to provide the backbone support needed for this cross-system collaboration, such as cross-agency planning meetings as well as joint meetings with partners.
- The Pilot model of care is focused on intensive care coordination and post-acute care transitions for a subset of patients with complex needs who face barriers to discharge. To test this model of care, the Pilot is investing in specialized training and resources needed across the continuum of care for addressing discharge barriers experienced by patients with complex needs. Given the specialized skills and capacity needed, and the fact patients with complex discharge needs are only a small subset of the population being discharged from hospitals, further consideration is needed for a statewide approach for this model. With the continued implementation of the Pilot, the Task Force will consider:
    - What are opportunities for centralized resources that could be shared across the state.
    - Whether there should be an approach based on 'centers of excellence' that specialize in navigating issues faced by patients with complex discharge needs, versus having every hospital, SNF and other post-acute care partners develop these specialized skillsets and capacities.
- Continued work for the pilot will include development of resources to define roles and responsibilities, workflows, and shared decision making, as outlined further in the section addressing *Discharge Barriers*. This work is essential before the Task Force can determine gaps in services or other resources that are needed in Washington to address a number of discharge barriers identified.
- Pilot sites have experienced challenges in identifying staff to fill ECM positions, and in a number of cases, are working with contract staff. The Task Force recognizes these challenges as reflective of broader health care workforce shortages. Close attention will be paid to ECM staffing and potential implications for the expansion and sustainability of the model.

2. Implement geographic model as opportunity for regional partners to work together to coordinate community needs and resources.

The Task Force recognizes legislative actions taken during the 2024 session to allow flexibility for participating hospital systems to develop pilot sites in multiple geographic regions. Each hospital will continue to have a total of 30 ECM slots, but there is flexibility for hospitals to divide their slots equally between two discrete hospital locations in different regions. This new flexibility facilitates participation by hospitals with fewer patients with complex discharge needs.

The Task Force is focused first on supporting implementation of the ECM model with hospital-based ECM staff. We note, however, that a future consideration for the expansion of the pilot model statewide in the development of a "community-based" model that enrolls patients from multiple hospitals in a region. This kind of model has the potential to meet the unique needs of rural communities and smaller hospitals with less population density by supporting the sharing of regional resources and infrastructure. The early learnings from the geographic flexibility allowing multiple hospital sites in a region will inform implementation and infrastructure needed to stand up a community-based model in the future.

II. Discharge Barriers

3. Multi-system process improvement exercises in 2024 and 2025 will bring together cross-system and cross-agency partners to examine current processes, identify gaps in these existing processes, and collaboratively identify ideas for solutions.

Given the complexity and multitude of issues that contribute to discharge barriers, process improvement exercises will be a critical tool for engaging cross-system partners in collaborative problem-solving discussions that outline current-system barriers and identify future-state solutions. This work will center on the facilitation of in-person workshops that bring all partners into the room to engage in an in-depth review of existing process and identification of solutions.

Key outcomes of the process improvement workshops will include:

1. Support communication and interface between system partners.
2. Understanding of each other's roles and responsibilities, including which partner is lead for coordinating services for individual patients.
3. Common definitions and standard tools to support collaboration across partners.
4. Examination of processes from the patient's perspective as they move through care settings in order to improve patient experience.
5. Build upon progress and continue to strengthen work to address a range of discharge barriers.
6. Identification of barriers and gaps in systems and processes.
7. Solutions and ideas that can be tested to improve the patient experience.

For each in-person workshop, partners will identify a topic of focus and engage in a facilitated exercise to understand who is doing what and identify where there are gaps, differences in understandings across partners, or frequent errors.[9] With this foundational understanding, the group will focus on identification of solutions that can be tested through the pilot. These solutions may involve improved processes to leverage existing system resources, as well as identification of where there are true system gaps and new resources are needed. The workshops will be a time-intensive exercise that requiring full commitment to this collaborative work and dedicated staff time from all partners.

The process improvement focus areas will include topics outlined in **Table B.** *Summary of Discharge Barriers and Task Force Next Steps* where the Task Force has identified the need for process improvement work to address barriers identified. This Table also incorporates the priority discharge barriers identified in the November 1, 2023 Task Force report, focusing on barriers that are impactable and have the highest volume of patients.[10]

[9] Note: Previous efforts to outline process workflows will be reviewed to establish an understanding of current processes that can serve as the foundation of solution-oriented discussion in the workshops.

[10] In the November 1, 2023 Task Force report, the Task Force identified priority discharge barriers for the Complex Discharge Pilot that focus on issues that are impactable and have the highest volume of patients (Note: Patients eligible for Complex Discharge Pilot services are not required to have these barriers/conditions.) The following five discharge barriers were identified as priorities: 1) Mental Health/Substance Use Disorders, 2. Behaviors/Restraints (includes neurocognitive disorders, such as Traumatic Brain Injury (TBI) and Dementia, 3) DSHS Eligibility and Authorization of Services (includes pending Department assessments, service planning, provider identification, and

4. Build on and strengthen existing efforts to address known system barriers.

Table B outlines current work to address a range of discharge barriers and next steps for the Task Force and workgroups to build on this work.

other processes), 4) High Care Needs (includes bariatric, wound, dialysis, and/or complex treatment regimens), 5) Homelessness.

Table B. Summary of Discharge Barriers and Task Force Next Steps

Barrier	Brief Description	Current Efforts	Next Steps
Patient Decision-Making Capacity	To transition to a LTSS care settings, patients must be able to make decisions to self-direct their care or to identify a decision maker or rely on a previously executed durable power of attorney. According to DSHS interpretation, Medicaid patients surrogate decision makers (RCW 7.70.065) may consent to medical care, but not long-term services and supports. The process to appoint a legal decision maker (such as a guardian) or identify other decision-makers can significantly delay patient transitions out of acute care hospital settings. Patients who cannot make their own decisions and have not authorized a decision maker, may remain in the hospital	**HCS Guardianship Process** Beginning in July 2022, the *HCS Guardianship Pilot* has worked to support collaboration between HCS and acute care hospitals to identify proposed guardians for a subset of clients needing a decision maker in order to transition to LTSS settings.[11] HCS is in the process of transitioning the pilot to a standard program. (Note: The eligibility criteria for the pilot exclude patients with certain diagnoses and patients in certain settings, such as bed readiness programs.) *Successes/Outcomes:* ✓ Of the 60 clients in the Guardianship Pilot, approximately 81.6% of cases have successfully had a guardian appointment as of August 2023. ✓ Development of workflows and processes to support collaboration between hospitals and HCS to identify clients in need of decision-making support and engage in early planning to refer to the Office of Public Guardianship. ✓ Even with the pilot support, there is still significant time required to appoint	➢ See Interim Recommendation (above) for expanded guardianship capacity. ➢ Incorporate Guardianship Pilot learnings into Complex Discharge Pilot process improvement exercise to develop comprehensive policies and processes to navigate key discharge barriers that clients face. ➢ Further explore areas of additional work needed highlighted by the HCS Guardianship Pilot.[13]

[11] Aging and Long-Term Support Administration. (Updated August 20, 2023). *Home and Community Services Guardianship Pilot Project – 1 Year Summary*. Retrieved from https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/Guardianship%20Pilot%20Project/08.20.2023.HCS-Guardianship%20Pilot%20Project%201%20Pager.pdf

[13] Id.

Barrier	Brief Description	Current Efforts	Next Steps
	for four to six months solely because of the lengthy court process.	guardians. From the time of acceptance into the Guardianship Pilot Project, the average time to final guardian or conservator court appointment is approximately 3.2 months. **Office of Public Guardianship Expansion** SB 5825, passed in the 2024 legislative session, expands public guardianship services for hospital patients who are at or below 400% of the federal poverty level, lack decision making capacity, and do not have a family member or friend able to serve as a guardian. SB 5825 creates guardianship capacity that prioritizes hospitalized patients, establishes a guardianship navigator within the OPG and provides for specialized training for guardians on complex patient needs (such as behavioral health, family law and Medicaid). The accompanying funding substantially expands OPG capacity. **1115 Waiver Amendment Pending CMS Approval:** Washington submitted a request for expenditures to provide guardianship and legal decision-making supports to individuals qualifying for LTSS.[12]	

[12] See Centers for Medicare & Medicaid Services. *Washington 1115 Medicaid Transformation Project 2.0 Approval Letter and Special Terms and Conditions* (page 15 - summary of requests not being approved at this time): https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transformation-ca-06302023.pdf

Barrier	Brief Description	Current Efforts	Next Steps
LTSS Services for Noncitizens	People who are not Medicaid eligible due to immigration status face substantial challenges accessing post-acute care. As a result, these patients may wait months or years in inappropriate hospital settings.	The AEM program provides coverage of acute care services of individuals with a qualifying emergency medical condition who are not eligible for Medicaid due to immigration status. ALTSA has a limited amount of state funding (114 slots) available for non-citizens in need of long-term care services in a nursing facility, adult family home, assisted living facility, or in-home care.[14] ALTSA prioritizes availability to hospital patients and then nursing facility residents awaiting a payment source. There are currently 144 people on the waiting list for the state-funded LTSS program.	➢ See Interim Recommendation (above) for expanded LTSS coverage for Noncitizens. ➢ Work in the coming year should evaluate the number of additional slots needed for coverage of non-citizens, including validation of the current waitlist and understanding the demand for the program.
Submission of complete Medicaid financial eligibility applications	Complete Medicaid financial eligibility applications are required for determining eligibility for Medicaid services for patients with complex needs.	DSHS has worked with hospitals to provide education on the need for submission of complete Medicaid financial eligibility applications in order for DSHS to initiate their assessment process.	➢ Incorporate submission of complete Medicaid financial eligibility applications into process improvement exercises.
DSHS Assessment Turnaround Times	Patients have experienced delays in DSHS assessment turnaround times. These assessments are required for Medicaid patient transitions from acute care hospitals into community-based long term care settings (*i.e.,* in-	Over the last few years, HCS has worked with acute care hospitals to improve the process of hospital referrals to HCS and the timeliness of HCS assessments needed to support patient	➢ Incorporate DSHS assessment turnaround times into process improvement exercise, including focus on presumptive eligibility, and consideration of findings available from the DSHS evaluation.

[14] See state-funded long-term care for noncitizens overview at: https://www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/state-funded-long-term-care-noncitizens

Barrier	Brief Description	Current Efforts	Next Steps
	home, and community residential settings such as Adult Family Homes and Assisted Living Facilities). (Note: DSHS assessment is not needed for patient transitions to SNFs.)	transitions from hospitals into appropriate long-term care settings.[15] *Key Successes/Current Efforts* ✓ Between 2020 and 2024 HCS reduced the average length of stay for individuals referred from the hospital from an average of 57 days to 29 days. This includes assessment and transition planning. ✓ Patients referred to HCS for assessment and transition who stay in the hospital 60 days or more after referral have been reduced by 54%. ✓ As part of the Complex Discharge Pilot, the legislature authorized a total of 11 new FTE to support functional and financial HCS eligibility assessments across the Pilot sites. HCS has hired these staff and is assigning to pilot site hospitals based on the expected number of patients in each region. This additional FTE is intended to support the timeliness of HCS assessment turnaround times. The Pilot is required to track the HCS turnaround times as part of the Pilot evaluation. ✓ Beginning December 2023, HCS began implementation of the *LTSS Presumptive*	➢ Development and sharing of best practices.

[15] See program resources outlined on ALTSA Acute Care Hospitals webpage available at: https://www.dshs.wa.gov/altsa/home-and-community-services/acute-care-hospitals . Specifically, the ALTSA Long-Term Care Manual (Chapter 9 – Hospital Assessments) sets forth a detailed description of the criteria and processes for acute care hospitals to refer patients for HCS Assessments.

Barrier	Brief Description	Current Efforts	Next Steps
		Eligibility Program, which will allow clients to access in-home home and community-based services as well as Medicaid medical and behavioral health benefits more quickly while waiting for a full HCS functional and financial assessment.[16] This program is intended to support faster access to long-term care services for individuals transitioning from acute hospital settings, and is supported by legislative direction, as well as federal approval through Washington's 1115 demonstration program. The state is beginning implementation with individuals who are hospitalized and transitioning to all in-home settings. Future phases will include individuals seeking to transition to residential settings.[17] (Note: Clients pending eligibility in an inpatient setting also lack care coordination as they are not yet assigned to an MCO. Many clients needing LTSS in the community will not have their Medicaid 'activated' until discharge. Presumptive eligibility determination may help to address this challenge.)	

[16] Washington LTSS Presumptive Eligibility Program. (December 2023). Retrieved from https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/Acute%20Care%20Hospitals/Presumptive%20Eligibility%20Project%20Flyer%201%203%2024.pdf

[17] Washington State Aging and Long-Term Support Administration. (November 2023). *Long-term Services and Supports Presumptive Eligibility.* Retrieved from https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/Acute%20Care%20Hospitals/2023%20LTSS%20PE%20Fact%20Sheet%20for%20Acute%20Care%20Hospitals%20%28FINAL%29.pdf

Barrier	Brief Description	Current Efforts	Next Steps
		✓ In 2023 the state legislature directed HCS to conduct a study of functional assessments conducted by the department prior to acute care hospital discharge and placement in a post-acute facility. The study includes evaluation of timeliness, impacts on patient, staff, and length of stay, and best practices from other states. The study also includes assessment of potential benefits of, and barriers to, outsourcing some or all of the functional assessment process to hospitals. Study results are due June 30, 2025	
Lack of communication and connection between hospitals and Indian Health Care Providers to provide available services and supports to American Indian and Alaska Native populations discharged from	AI/AN populations comprise a disproportionate percent of individuals facing complex discharge barriers in Washington.[18] More than 52% of American Indian/Alaska Native populations covered by Medicaid FFS rather than through Medicaid MCOs. Indian Health Care Providers (IHCPs) provide care	The Centers for Medicare & Medicaid Services has released guidance regarding the development of Care Coordination Agreements between Indian Health Service/Tribal providers and non-IHS/Tribal providers.[19] These agreements may serve as a tool to ensure coordination between hospitals and IHCPs. There are currently no Care Coordination Agreements in place between hospitals and Tribes/IHCPs in Washington. IHCPs have raised concern regarding hospital discharge of AI/AN patients with complex	➢ Incorporate into process improvement exercise (see above). ➢ Development and sharing of best practices. ➢ Work with Pilot Sites to develop Care Coordination Agreements with Tribes/IHCPs for shared patients served by the ECM pilot, including hospital, emergency department, and other entity coordination and notification to IHCPs.

[18] Washington State Health Care Authority. (2024). Complex Discharge Population Data for AI/AN individuals versus total AI/AN population by Washington County.

[19] Centers for Medicare & Medicaid Services. (February 26, 2016). *Federal Funding for Services 'Received Through' an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives.* Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf

Barrier	Brief Description	Current Efforts	Next Steps
hospitals with complex needs.	management for AI/AN individuals, but are not reimbursed for the level of support provided. If enrolled in Medicaid FFS, these individuals are not receiving the care coordination that is provided through Medicaid MCOs.	needs without communicating with their IHCP provider to provide resources and transition support that are available to these individuals. IHCPs have also highlighted examples of Tribal patients discharged from Emergency Departments without connecting to IHCPs. While ED discharge may not always be related to complex discharge issues, IHCPs have underscored that this is a symptom of a broader systemic problem where discharge planning does not adequately address the needs of AI/AN individuals.	➢ Work with American Indian Health Commission (AIHC) and HCA Office of Tribal Affairs (OTA) to deliver training to pilot sites regarding the Tribal government to government relationship and services for AI/AN individuals.
Acute Care Hospital Use of Seclusion or Restraints	Many hospitals lack sufficient staffing, physical space, or adequate training to minimize use of seclusion or restraints among patients with complex behaviors. These methods do not address the underlying care needs of patients, and patients are not able to be transitioned into post-acute and community settings if they are in seclusion or restraints due to a lack of post-acute care facilities capable of managing these patients.	Some hospitals are addressing complex or challenging behaviors in ways that improve patient outcomes and support transitions into community and post-acute care settings. Examples include use hospital 'strike teams' or applied behavior analysis (ABA) therapists to support the development of patient behavior plans that can be replicated in the community as well as use of 1:1 monitoring.	➢ Incorporate into process improvement exercise (see above). ➢ Development and sharing of best practices. ➢ Consider the need for specialized post-acute care facilities to address patients with complex behaviors.

Barrier	Brief Description	Current Efforts	Next Steps
Substance Use Disorder	When patients are discharged from hospitals, SUD symptoms may not be adequately managed to support transition to post-acute care settings. Post-Acute Care facilities lack expertise and resources for administering maintenance therapies and supporting patients with SUD. Facilities also have challenges distinguishing between patients with active SUD and patients in recovery.	DSHS, HCA, and MCOs are working with hospital and SNF partners to address barriers related to SUD and can inform Pilot strategies and recommendations to address this barrier. There is also ongoing work with the Long-Term Care Skilled Nursing Facility Associations, DSHS Residential Care Services, HCA and Washington Post-Acute and Long-Term Care on SUD barriers and best practices.	➢ Incorporate into process improvement exercise (see above). ➢ Development and sharing of best practices. The Complex Discharge Pilot will inform further understanding and provide education for partners about SUD treatments and management for patients facing barriers to discharge. In addition, the Pilot will inform recommendations for strategies and resources needed to support patients with SUD.

Barrier	Brief Description	Current Efforts	Next Steps
Specialized Settings and Services	Patient needs may require specialized facilities or resources that individual providers do not have capacity or infrastructure needed to address. Common diagnoses include TBI, stroke, dementia, tumors. Patient needs include behavioral issues that create a safety risk for the patient or others in the patient's environment. Hospitals are not able to care for patients with these conditions long term after their acute medical issues have been addressed.	There are currently a number of specialized post-acute care facilities and services that provide care to specific populations or individuals with specialized needs. These include, for example, the Transitional Care Center of Seattle (TCCS), Long Term Civil Commitment, Intensive Behavioral Health Treatment Facilities, Expanded Community Services, Specialized Behavioral Support, Community Stability Supports, Enhanced Services Facilities, and Inpatient Rehabilitation Facilities. Proposals have also been raised for the development of specialized facilities for rehab and LTC facilities for Traumatic Brain Injury (TBI) and neurocognitive disorders. Further consideration is needed regarding individuals who have needs that exceed the capacity of current providers.	➢ The Task Force recognizes that some patients have needs that will not be able to be addressed by the Pilot due to patient complexity exceeding resources available through the pilot. Further consideration and investigation are needed to identify the optimal approach for addressing barriers experienced by these populations, including whether there is a need for specialized facilities to support care for these patients. The Pilot will gather learnings from both patients served by the pilot and patients who are declined from pilot participation due to extreme complexity.
Homelessness	Hospitals face challenges in discharge planning for people experiencing homelessness.	Washington is engaging a number of initiatives to provide support for people to access stable housing. These include, for example, Medicaid 1115 Demonstration services such as Foundational Community Supports (supported housing, short-term rental assistance, housing transition and navigation support), and medical respite (recuperative care and short-term post-hospitalization housing). In addition, HCA and the Department of	Work with homeless service providers to develop and share best practices to understand of needs and support access to housing supports for patients experiencing homelessness.

Barrier	Brief Description	Current Efforts	Next Steps
		Commerce are implementing Apple Health and Homes program, a joint initiative to create new housing options that are aligned with the Medicaid-funded housing supports.	
High Care Needs	Post-Acute Care facilities may lack necessary resources for supporting patients with high care needs (e.g., behavioral health, bariatric wound, dialysis, and/or complex treatment regimens), including available staff with skills and competencies needed.	A number of hospitals have established existing bed readiness programs to support patient transitions into post-acute care facilities. During the pandemic, the Rapid Response Team program was implemented to support long-term care facilities staff beds with 1:1 support. Funding for this program ended in Spring 2024.	➢ Incorporate into process improvement exercise (see above). ➢ Development and sharing of best practices.
PAC Patient Acceptance Requirements	Washington has a highly regulated environment, and facilities are cautious to accept patients given interpretation of these requirements if they lack the available resources, including staff with necessary skills and competencies to care for and support patients with complex needs (*e.g.,* SUD medications, wound care).	PAC providers have underscored concerns around compliance with state and federal rules governing patient admissions and facility capacity to serve.[20]	➢ Incorporate into process improvement exercise (see above). ➢ Development and sharing of best practices. ➢ Further understanding is needed regarding state and federal SNF rule and regulations governing the acceptance of patients with complex discharge needs. This will help to inform future recommendations for support needed in PAC settings to care for these patients while also meeting regulatory requirements.

[20] RCW 74.42.450 (2024). Retrieved from https://app.leg.wa.gov/rcw/default.aspx?cite=74.42.450

Barrier	Brief Description	Current Efforts	Next Steps
PAC Patient Readmission Denials	Patients in PAC settings may be admitted to the hospital for acute care, and subsequently are denied readmission to the PAC setting.	This is an issue that is frequently raised by patients and families through the State Long Term Care Ombuds Program.	➢ Track patient readmission denials in the Complex Discharge Pilot evaluation. Further data is needed to understand the scope of the problem or reasons this may be occurring.
Patient Refusal to Discharge from the Hospital or other Post-Acute Care Setting	Patients and/or family members may refuse discharge options offered.		➢ Incorporate into process improvement exercise (see above). ➢ Development and sharing of best practices.

III. Managed Care Contracting

5. Engage Medicaid MCOs and Dual-Eligible Special Needs Plans (DSNPs) in Complex Discharge Pilot to effectively implement current authorities and resources to support care transitions for individuals with complex discharge needs. Identify existing barriers and make recommendations for contract amendments or longer-term MCO contract re-procurement.

With the implementation of the Complex Discharge Pilot, the Task Force seeks to emphasize the importance of engaging Medicaid MCOs and DSNPs to leverage current HCA contract requirements and covered benefits to maximize available support for individuals with complex discharge needs, particularly with new services recently authorized through Washington's 1115 demonstration or other federal Medicaid authorities.

Medicaid MCO and DSNP roles and responsibilities are set forth through contracts with HCA, as further outlined in this section. With the work of the Pilot, the Task Force seeks to identify best practices and/or gaps that can be incorporated into annual contract amendments or a future full Medicaid MCO or DSNP State Medicaid Agency Contract (SMAC) re-procurement. [21]

In addition, the Task Force understands that, while the Pilot is focused on Medicaid (FFS and Managed Care) and Dual-Eligible beneficiaries, individuals with complex discharge needs may have a range of coverage types, including Medicare, Medicare Advantage, Veterans, and commercial coverage. The Task Force seeks to take lessons from the Pilot to inform future considerations for individuals with these other coverage sources.

Medicaid MCOs

Medicaid managed care plans are responsible for care coordination and authorization, discharge planning, and a range of medical, behavioral, and social services to support Medicaid members in transitions from acute care hospitals into post-acute care and community settings.[22] These responsibilities require MCOs to work with hospitals, HCS, post-acute care and other community partners to implement comprehensive discharge plans that assure access to medically necessary covered services as well as coordination with long-term care services and other community resources. Key examples of MCO responsibilities to support patient transitions from acute care hospitals into community and post-acute care settings include:

- ✓ Care coordination and transitional care services
- ✓ Provision of comprehensive care management and care coordination, including Health Homes
- ✓ Coordination with Hospital staff and other partners to ensure development and implementation of a written discharge plan, including scheduled follow-up appointments
- ✓ Ensure timely access to follow-up care post discharge, including medically necessary covered medical, behavioral, pharmacy, and social services[23]
- ✓ Ensure timely prior authorization review with 24 hours
- ✓ Ensure network adequacy to provide access to care

[21] The State Medicaid Agency Contract (SMAC) is the contract with Dual-Eligible Special Needs Plans (DSNPs).
[22] Washington Apple Health Integrated Managed Care Contract (Updated 1/1/2024). Retrieved from https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf
[23] See Washington Administrative Code (WAC) 182-501-0060 for overview of Washington Apple Health benefit packages covered by MCOs. Retrieved from: https://apps.leg.wa.gov/wac/default.aspx?cite=182-501-0060

- ✓ Assist in finding community or post-acute care transition settings
- ✓ Coverage of SNF stays that meet rehabilitative or skilled level of care determine based on evidence-based clinical guidelines
- ✓ Ensure an in-person assessment by the enrollee's primary care provider or care coordinator for post-discharge support within seven (7) calendar days of hospital discharge for individuals with physical or behavioral health disorders or discharge from a SUD treatment program
- ✓ Telephonic reinforcement of the discharge plan and problem-solving two to three business days following discharge
- ✓ Identify and re-engage enrollees who do not receive post discharge care

In addition to patient transitions out of hospitals, MCOs have responsibilities to provide care management for their members across the continuum of their care needs. As patients transition out of the ECM program, MCOs will have responsibility for longer term care management and are accountable to performance metrics such as hospital readmissions.

Over the last five years, HCA has also worked with Washington's Medicaid MCOs to develop complex discharge strategies to address barriers to discharge experienced by plan enrollees. Through this work, MCOs work with partners such as DDA and HCA to proactively identify enrollees with complex discharge needs based on a common set of criteria and collaborate with hospitals and partners to provide comprehensive care coordination and supports to address a range of client needs. These strategies have focused on supports needed to support enrollee discharge from hospital settings, but do not continue to follow clients through the continuum of post-acute care and community settings.[24] **Table C** provides an overview of MCO strategies in 2023 to address the top discharge barriers that have been identified by plans. Effective July 2024, MCO expectations relating to care coordination and other support for individuals with complex needs are incorporated into Washington's Integrated Managed Care and Integrated Foster Care contracts (see Appendix A).

Table C. 2023 MCO Complex Discharge Strategies by Type of Discharge Barrier

Discharge Barrier	MCO 2023 Complex Discharge Strategies and Supports
SUD	• MCOs ensure SNF referrals include pertinent information, including: last use date, length of sobriety, engagement with SUD treatment provider, willingness to continue treatment services while at a SNF, etc. MCOs collaborate with SUD treatment providers to ensure enrollees continue to receive treatment and support. When appropriate, MCOs work with acute care facilities to transition enrollees from Methadone to Suboxone or Sublocade prior to SNF admission, as Methadone has been identified by SNFs as a barrier to admission due to legal requirements surrounding the dispensing of this drug.
Bariatric	• Developed and implemented "Exceptional Care Request Form" to be completed by SNFs prior to admission to indicate the services and support needed by SNFs to provide appropriate care for bariatric members (including equipment needs, level of assistance, anticipated length of stay, etc.). All MCOs are identifying bariatric

[24] Note: Though the HCA-MCO complex discharge program is limited to the acute care hospital setting, MCOs do provide care coordination support throughout the continuum of care, as noted previously.

Discharge Barrier	MCO 2023 Complex Discharge Strategies and Supports
	enrollees while inpatient and offering single-case agreements, highest reimbursement, along with an extended SNF prior authorization approval (14-28 days) when appropriate. Care coordinator staff to work with SNFs to ensure all needs are in place for SNF admission, and to provide transition support. MCOs to collaborate with DME companies to secure bariatric equipment and to ensure timely delivery of equipment.
Unhoused	• MCOs review EHR to assess cognitive awareness and to determine expected functional status post-SNF; MCOs communicate this information to SNFs. MCOs work with SNFs to transition unhoused members post-SNF and to provide housing resources to enrollees. One plan hired a SDOH liaison, whose primary role is to provide resources including housing vouchers; considering contracting with additional medical respite facilities.
Behaviors	• MCOs reimburse SNFs for one-on-one sitters, through single case agreements or additional funds. MCOs offer highest tier payment with an extended initial SNF prior authorization approval on a case-by-case basis.
Hemodialysis	• The barrier is lack of reliable transportation to and from hemodialysis from SNFs. MCO discussed this with HCA's NEMT team and identified that driver and staffing shortages are the main cause. Transportation brokers are working on filling open positions. • MCOs are referring hemodialysis enrollees to a SNF that is now offering on-site hemodialysis (with 18 hemodialysis chairs total).
Wounds	• The barrier is not wound care, but wound care with co-occurring conditions (ex: behaviors, HD, etc.) MCOs are identifying enrollees needing wound care while IP and offering single-case agreements, highest reimbursement, along with an extended SNF prior authorization approval when appropriate.
Year in review and plan 2024	• MCOs to continue to identify barriers and problem solve to implement targeted solutions addressing barriers to discharge.

Dual-Eligible Special Needs Plans (DSNPs)

Individuals served by the Complex Discharge Pilot will include dual-eligible Medicare-Medicaid beneficiaries. These individuals receive their coverage through managed care plans called Dual-Eligible Special Needs Plans (DSNPs), as well as through Medicaid fee-for-service and Medicare Advantage plans. For behavioral health services, however, most dual-eligible beneficiaries will receive coverage through Medicaid managed care organizations. Similar to Medicaid MCOs, the DSNPs play a critical role in supporting transitions of care into appropriate post-acute care and community settings for individuals who are otherwise experiencing hospital discharge barriers and coordinating with other entities responsible for coverage of care. Specific expectations for DSNPs are laid out in the Apple Health Medicare Connect program through the State Medicaid Agency Contract (SMAC).[25]

[25] Washington Health Care Authority. State Medicaid Agency Contract (effective January 1, 2024). Available at: https://www.hca.wa.gov/assets/billers-and-providers/model-state-medicaid-agency-contract.pdf (Note: new provisions for 2025 outline additional care coordination expectations.)

Medicaid Fee For Service

The Task Force also recognizes Medicaid FFS as a key coverage type of individuals eligible for the Pilot. Washington's Medicaid FFS program does not cover care coordination as a covered benefit, except through the Health Homes program (see **Table E**). This lack of coverage for care coordination through the Medicaid FFS program at the level reimbursed to MCOs may have a particular impact on Tribal populations, with more than 52% of American Indian/Alaska Native populations covered by Medicaid FFS rather than through Medicaid MCOs. Indian Health Care Providers provide care management to their patients, but it is not reimbursed by Medicaid FFS at the same level paid to MCOs. The Complex Discharge Pilot will track potential differences in outcomes and key gaps for populations covered through Medicaid FFS. As a general principal, it will be important to ensure that the ECM model serves MCO and FFS populations equitably.

IV. Post Acute Care and Hospital Administrative Rates

6. Develop learnings from the Complex Discharge Pilot to evaluate whether there are gaps in payment across the care continuum, including hospital administrative rates, post-acute care facility rates, or broader supportive services needed to support successful transitions.

The Complex Discharge Pilot payment model is designed to provide payment for services and supports to successfully transition patients from hospitals into appropriate post-acute care and community settings. Payments begin while the patient is in the hospital and follow the individual throughout their care until they are in a stable environment that is supporting their longer-term needs. ECM services are a time-limited benefit that may be provided for up to 180 days, with the option to extend for up to 30 days at a time upon approval from HCA. The Pilot payment model includes three primary components:

1. *Enhanced Care Management Team Payment:* this is a payment for a multidisciplinary team that engages all of the system partners and provides intensive care coordination for individuals with complex needs. The team begins working with patients in the hospital during the discharge planning process and continues to follow the client until they are ultimately in a stable and appropriate care setting.

2. *SNF Administrative Payment:* this is in a payment to SNF partners in recognition of the additional costs for serving individuals with complex needs.

3. *Supportive Services Payment:* this includes payments for services that can wrap around a patient and supplement potential gaps in services across post-acute care and community settings.

The Complex Discharge Pilot allows the opportunity to test the model of care and evaluate whether there are gaps in payment across the care continuum, including hospital administrative rates, post-acute care facility rates, or broader supportive services needed to support successful transitions.

The Task Force recognizes significant investment that the Legislature has made in post-acute care facility rates over the last several years, including Medicaid rate increases for most long-term care settings, as well as funding for SNF exceptional care rates (Vent/Trach care, Expanded Behavior Supports Plus, Expanded Community Respite).

Figure 1 provides an overview of current facility payments across hospital and post-acute care settings; definitions of each of the payment types identified are listed in **Table D**. Rates paid to facilities vary by region and by the level of care determined necessary for the individual. In addition to these facility rates, patients may receive additional Medicaid covered benefits, including physical health, behavioral health, health-related social needs, and home and community-based services.

The Complex Discharge Pilot will facilitate deeper understanding of how to optimize these different facility rates for individuals with complex discharge needs, as well as identify where there may be gaps in services and supports. This will include work to consider whether rates need to be further adjusted for patient acuity, as well as whether rate increases or exceptions that are authorized through MCOs can be applicable or replicated for FFS. Access to enhanced rates through FFS has particular impact on AI/AN individuals given more than half of AI/AN Medicaid beneficiaries are covered by FFS. Further work in 2024 will consider learnings from the pilot to inform these questions.

Figure 1. Facility Payments Available Across Hospital and Post-Acute Care Settings*>

	Hospital	SNF	Adult Family Home	Assisted Living Facility	Adult Residential Care/ Enhanced ARC	Enhanced Services Facility	Other Specialized Facilities
HCA/ MCOs	• Administrative Day Rate (MCO and FFS)	• Skilled or rehab LOC Payment (MCO) • Community Home Project (FFS)	• Intensive Behavioral Supportive Supervision (IBSS) (MCO) • Community Behavioral Health Support (CBHS) Supportive Supervision* (MCO/FFS)	• Intensive Behavioral Supportive Supervision/IBSS (MCO) • Community Behavioral Health Support (CBHS) Supportive Supervision (MCO/FFS)	• Community Behavioral Health Support (CBHS) Supportive Supervision (MCO/FFS)	• Intensive Behavioral Supportive Supervision/IBSS (MCO) • Community Behavioral Health Support (CBHS) Supportive Supervision (MCO/FFS)	
DSHS		• Medicaid NH Daily Rate (Custodial Care) • Exceptional Care Needs Program • Enhanced Behavior Support • Enhanced Behavior Support Plus • Expanded Community Services Respite • Vent/Trach Care	• Adult Family Home Base Rate • Adult Family Home + Community Integration • Expanded Community Services Add-On for Adult Family Home • Specialized Behavior Supports	• Assisted Living Base Rate • Assisted Living + Capital Add-On • Expanded Community Services Add-On for Assisted Living	• Adult Residential Care Base Rate • Enhanced Adult Residential Care • Expanded Community Services Add-On for EARC • Community Stability Supports for EARC	• Enhanced Service Facility Rate	• Specialized Dementia Care • Specialized Dementia Care Plus

* This figure represents payments available to acute care hospitals and post-acute care facilities. It does not include or represent all services and supports available to support individuals outside of facility payments.
> See Table C for definitions of payments/services.

Table D. Definitions of Facility Payments in Figure 2 (Facility Payments Available Across Hospital and Post-Acute Care Settings)

Eligible Settings	Payment Definitions
Acute Care Hospital	**Hospital Administrative Day Rate (MCO and FFS):** Administrative days are days of an inpatient hospital stay when an acute inpatient or observational level of care is no longer medically necessary and appropriate non-inpatient hospital placement is not available. Administrative days are paid at the administrative day rate. The administrative day rate is the weighted statewide average Medicaid daily nursing facility rate set by DSHS. In addition to the day rate, pharmaceuticals and other medically necessary services provided during the administrative portion of the patient's stay may be reimbursed separately at a ratio of cost to charges.[26] The FFS rate sets a floor that MCOs may exceed.
Skilled Nursing Facility[27]	**Skilled or Rehab Level of Care (MCO):** MCOs pay for medically necessary skilled nursing facility (SNF) stays for rehabilitation or skilled medical care when the MCO determines that nursing facility care is more appropriate than acute hospital care. These services require prior authorization (PA) by the MCO and will be contracted through a network agreement or a Single Case Agreement (SCA) by the MCO. The SNF must have an agreement with the MCO to receive payment. All billing for rehabilitation or skilled nursing services must be submitted to the MCO following the terms of their agreement including appropriate MCO covered days.
Skilled Nursing Facility	**Community Home Project (FFS):** Medicaid NH Rate patient class code 20 daily rate plus additional costs for skilled nursing and skilled therapy and rehabilitation supplies and services. The Community Home Project (CHP) is a limited duration authorization to assist clients in an inpatient hospital setting whose goal is to transition to a community home setting. CHP provides services in a SNF that are not included in a daily rate and not payable through other means. The client needs to be approved for this type of care by HCS before payment will be authorized.
Skilled Nursing Facility	**Daily Medicaid NH Rate (Custodial Care) (DSHS):** Daily Medicaid NH Rate (patient class code 20). Set every semiannual period but can be more frequent. This rate may be paid when the patient no longer meets criteria for the skilled or rehabilitation level of care, and they are assessed by DSHS to meet a nursing facility level of care (NFLOC).
Skilled Nursing Facility	**Exceptional Care Needs Program (DSHS):** The Exceptional Care Needs Program is a limited duration authorization for those clients with exceptional care needs who are leaving hospitals and in need of skilled nursing or extensive skilled therapy in a SNF with the goal of returning to a community setting. Medically complex clients whose needs exceed a typical skilled nursing stay include individuals with longer term daily skilled nursing care needs such as wound care, bariatric, IV therapy, and nutritional interventions such as PEG tube/TPN. Services provided under this program are authorized for a limited duration, typically 60 to 90 days, and are negotiated by the payer on a case-by-case basis.

[26] See Washington Health Care Authority. *Inpatient Hospital Services Billing Guide* (February 1, 2024). Retrieved from https://www.hca.wa.gov/assets/billers-and-providers/Inpatient-hospital-bg-20240201.pdf

[27] *Note:* Definitions in this table for payments to Skilled Nursing Facilities are from Washington State Health Care Authority. *Nursing Facilities Billing Guide (April 1, 2024).* Retrieved from https://www.hca.wa.gov/assets/billers-and-providers/Nursing-facilites-bg-20240401.pdf

Eligible Settings	Payment Definitions
Skilled Nursing Facility	**Enhanced Behavioral Support (EBS) (DSHS):** Medicaid NH patient class code 20 daily rate plus $80. Expanded Behavior Support (EBS) is designed to provide enhanced behavior support services to clients who have either moved into the NH after a stay at a state psychiatric hospital or who are at risk for psychiatric hospitalization due to high behavioral and personal care needs. Medicaid NF needs to get contract approval.
Skilled Nursing Facility	**EBS Plus (DSHS):** Medicaid NH patient class code 20 daily rate plus $175. EBS Plus means: A level of intensive behavior support service provision which includes dedicated staffing on site behavior support consultation and training in a skilled nursing environment. Requires HCS contract approval.
Skilled Nursing Facility	**EBS Plus Specialized Services (DSHS):** Medicaid NH patient class code 20 daily rate plus $235. EBS Plus Specialized Services means: A level of intensive behavior support service provision which includes dedicated staffing on site behavior support consultation and training in a skilled nursing environment for individuals discharging or diverting from state hospitals who need a level of behavior support with coordinated skilled care that exceeds that available through the EBS services. Requires HCS contract approval.
Skilled Nursing Facility	**Expanded Community Support (ECS) Respite (DSHS):** (Behavioral Support Respite) Medicaid NH patient class code 20 daily rate plus $175. The length of stay in the ECS Respite bed will be 20 days or less for any particular episode of service for any particular ECS residential client unless an exception is provided by the HCS Field Services Administrator or his/her designee. ECS Respite means a short-term medically based SNF admission as an intervention for ECS or SBS residential clients experiencing an escalation in behavioral challenges that does not fit the definition for mental health voluntary or involuntary detention but that jeopardizes the ECS client's residential living as determined by HCS.
Skilled Nursing Facility	**Ventilator Care (DSHS):** Medicaid NH patient class code 20 daily rate plus $192. The SNF must have a Medicaid approval for vent/trach client services in this setting.
Skilled Nursing Facility	**Tracheotomy Care (DSHS):** Medicaid NH patient class code 20 daily rate plus $192. The SNF must have a Medicaid approval for vent/trach client services in this setting.
Adult Family Home Assisted Living Facility Enhanced Services Facility	**Intensive Behavioral Supportive Supervision (IBSS) (MCO)**: is a voluntary In Lieu of Service (ILOS) available to Apple Health (Medicaid) clients enrolled with a managed care organizations (MCO) who have complex behaviors and cognitive impairment experiencing high risk of institutionalization and hospitalization and requiring direct staffing supports to prevent harm to self or others. IBSS Services may be provided by Adult Family Homes, Assisted Living Facilities, or Enhanced Services Facilities.[28] IBSS Services require authorization by the MCO and must be requested by the facility receiving the patient (*e.g.,* AFH, ALF, etc.).
Adult Family Home	**Community Behavioral Health Support (CBHS) – Supportive Supervision (MCO/FFS):** new program beginning July 1, 2024. This benefit will help people who have a significant mental health diagnosis and need additional support to live

[28] Washington State Health Care Authority. (2024). *Intensive Behavioral Supportive Supervision.* Retrieved from https://www.hca.wa.gov/assets/billers-and-providers/intensive-behavioral-supportive-supervision.pdf

Eligible Settings	Payment Definitions
Enhanced Services Facility **Assisted Living Facility** **Adult Residential Facility** **Enhanced Adult Residential Care Facility**	in a community setting like an adult family home or an assisted living facility. This new service will replace most of the Behavioral Health Personal Care (BHPC) managed care organization (MCO) wrap-around funding.[29] These services require authorization by the MCO and must be requested by the facility receiving the patient (e.g., an AFH, ALF, etc).
Adult Family Home **Assisted Living Facility** **Enhanced Adult Residential Care Facilities**	**Expanded Community Services (ECS) (DSHS):** All individuals eligible for Residential Support Waiver can receive ECS in residential settings that have an ECS contract. ECS clients in settings with the ECS contract will receive personal care services, medication oversight, and contracted Behavior Support services. Residential providers may offer increased staff or activities to support the client in the residence. Client services and supports are available 24-hours per day by on-site staff for support and response.[30]
Adult Family Home	**Specialized Behavior Supports (SBS) (DSHS):** SBS is the second level of service that may be accessed in an AFH with an SBS contract. Clients receiving this service will get the same support as the ECS level in addition to one-to-one staffing. The SBS contract requires an additional 6-8 hours of daily staffing to provide behavioral support for each SBS client.[31]
Enhanced Adult Residential Care	**Community Stability Supports (CSS) (DSHS):** Clients receiving CSS services in an Enhanced Adult Residential Care (EARC) setting with a CSS contract will receive personal care, medication oversight, and specialized staffing, including on-site nursing 40 hours per week and on-call coverage 24 hours, seven days a week. This service provides additional caregiver staffing and a Behavior Support clinician on-site 40 hours per week. A client-specific Behavior Support Plan is written and implemented by staff. Mental health treatment services are covered and funded by FFS or by the

[29] Washington State Health Care Authority. (2024). *Community Behavioral Health Support.* Retrieved from https://www.hca.wa.gov/billers-providers-partners/program-information-providers/community-behavioral-health-support-cbhs-services

[30] For definition of Expanded Community Services and eligible settings, see *ALTSA Long-Term Care Manual (Chapter 7f: Residential Support Waiver) (October 2023).* Retrieved from https://www.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual

[31] For definition of Specialized Behavior Supports and eligible settings, see *ALTSA Long-Term Care Manual (Chapter 7f: Residential Support Waiver) (October 2023).* Retrieved from https://www.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual

Eligible Settings	Payment Definitions
	Managed Care Organization (MCO) as part of their Medicaid benefit and delivered by a Community Behavioral Health Agency provider.[32]
Enhanced Services Facility	**Enhanced Services Facility (ESF) (DSHS):** ESF is the highest level of RSW services available. Priority is given for individuals coming out of state hospitals or diverting from going into a state hospital. Clients in an ESF will receive personal care services, medication oversight, and the highest level of specialized staffing, with 24-hour on-site nursing and 8 hours per day of Behavior Support provided by on-site mental health professionals. ESF staff implement client-specific Behavior Support Plans and provide support and response. Behavioral and mental health services are provided to the client by the local Managed Care Organization (MCO) through the client's private insurance or Medicaid coverage.[33]
Adult Family Home	**Adult Family Home Base Rate (DSHS):** Adult Family Homes are privately owned or rented by a licensed provider in a community-based neighborhood. AFHs are licensed to care for two to eight residents who are age 18 or older. AFHs provide a room (shared or single), meals, laundry, supervision, medication administration and varying levels of assistance based on individual support needs. They may also provide specialized care for people with intellectual and developmental disabilities, mental health issues, dementia and nursing care needs. The AFH provider will complete a negotiated care plan for each resident based on their CARE assessment to be agreed upon by the resident and or guardian.[34] Rates paid to facilities are available on the Office of Rates Management webpage and vary by region and by the level of care determined necessary for the individual. [35]
Adult Family Home	**Adult Family Home + Community Integration (DSHS):** Community Integration will be added to the daily rate for DSHS funded AFH residents who have an assessed need for support and an interest in participating in community activities. Community Integration is person-centered and individualized based on each resident's interests and is intended to be provided individually. AFH residents will each receive 4 hours per month of Community Integration activities. The 4 hours of AFH staff time per month may include assisting the resident identify, plan, and arrange activities; arranging/assisting the resident to arrange, or providing transportation to/from the activity; accompanying the resident during the activity (if needed); and looking for additional opportunities the resident may want to participate in a community activity. Rates paid to facilities are available on the Office of Rates Management webpage and vary by

[32] For definition of Community Stability Supports and eligible settings, see *ALTSA Long-Term Care Manual (Chapter 7f: Residential Support Waiver) (October 2023).* Retrieved from https://www.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual

[33] For definition of Enhanced Services Facility and eligible settings, see *ALTSA Long-Term Care Manual (Chapter 7f: Residential Support Waiver) (October 2023).* Retrieved from https://www.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual

[34] Washington State Department of Social and Health Services. *Adult Family Homes Fact Sheet* (January 2023). Available at: https://fortress.wa.gov/dshs/adsaapps/about/factsheets/DDA/Adult%20Family%20Home.pdf . See also: RCW 70.128.010, WAC 388-76-10000.

[35] See Provider rates available at: https://www.dshs.wa.gov/altsa/management-services-division/office-rates-management

Eligible Settings	Payment Definitions
	region and by the level of care determined necessary for the individual.[36] AFH providers may also be reimbursed for mileage for Community Integration activities.[37]
Assisted Living Facility	**Assisted Living Facility Base Rate (DSHS):** ALFs offer a package of services that include personal care services, intermittent nursing services, and medication administration services. Assisted living services include housing for the resident in a private apartment-like unit.[38] Rates paid to ALFs are available on the Office of Rates Management webpage and vary by region and by the level of care determined necessary for the individual.[39]
Assisted Living Facility	**Assisted Living + Capital Add-On (DSHS):** Capital Add-On rate is a facility specific rate component used to incentivize providers to serve Medicaid clients in Assisted Living Facilities. The Office of Rates Management sets the Capital Add-On Rate for Assisted Living Facilities each July 1.[40]
Adult Residential Care Facility	**Adult Residential Care (DSHS):** Adult Residential Care is a package of services provided by an Assisted Living Facility. This service package includes helping a resident who is able to take his/her own medication but needs some help (e.g. a reminder to take it or the medication handed to him/her) and personal care (e.g. bathing, dressing, personal hygiene). Residents who need to be monitored for their safety may get limited supervision.[41] Rates paid for ARC are available on the Office of Rates Management webpage and vary by region and by the level of care determined necessary for the individual.[42]
Enhanced Adult Residential Care Facility	**Enhanced Adult Residential Care (DSHS):** This service package includes ARC services as well as medication administration. Some type of nursing care must be provided occasionally. No more than two people will share a room.[43] Rates paid for EARC are available on the Office of Rates Management webpage and vary by region and by the level of care determined necessary for the individual.[44]

[36] See Provider rates available at: https://www.dshs.wa.gov/altsa/management-services-division/office-rates-management

[37] See Washington State Department of Social and Health Services. *Community Integration Frequently Asked Questions.* Available at: https://www.dshs.wa.gov/dda/community-residential-services-adults

[38] Washington Administrative Code 388-110-020 (Definitions). Retrieved from https://app.leg.wa.gov/wac/default.aspx?dispo=true&cite=388-110

[39] See Provider rates available at: https://www.dshs.wa.gov/altsa/management-services-division/office-rates-management

[40] See Capital Add-On Rate for Assisted Lived Facilities (March 2021). Retrieved from https://www.dshs.wa.gov/sites/default/files/ALTSA/msd/documents/CAPITAL%20ADD-ON%20RATE%20FOR%20ALF_051821.pdf

[41] WAC 388-110-020 (Definitions). Retrieved from https://app.leg.wa.gov/wac/default.aspx?dispo=true&cite=388-110 . *See also* Assisted Living Facility Service Packages. Retrieved from https://www.dshs.wa.gov/altsa/home-and-community-services/assisted-living-facility-service-packages

[42] *See* Provider rates available at: https://www.dshs.wa.gov/altsa/management-services-division/office-rates-management

[43] WAC 388-110-020 (Definitions). Retrieved from https://app.leg.wa.gov/wac/default.aspx?dispo=true&cite=388-110 .

[44] *See* Provider rates available at: https://www.dshs.wa.gov/altsa/management-services-division/office-rates-management

Eligible Settings	Payment Definitions
Enhanced Adult Residential Care Facility	**Specialized Dementia Care (DSHS):** This is a service package of enhanced adult residential care – specialized dementia care. Services include specialized dementia care assessment and care planning, personal care services, intermittent nursing services, medication administration services, specialized environmental features and accommodations, and activity programming. Enhanced adult residential care-specialized dementia care services are delivered only within: (1) Contracted assisted living facilities that are dedicated solely to the care of individuals with dementia, including Alzheimer's disease, and that meet the requirements of parts I and III of this chapter; or (2) Designated, separate units located within contracted assisted living facilities that are dedicated solely to the care of individuals with dementia, including Alzheimer's disease, and that meet the requirements of parts I and III of this chapter.[45] Rates paid for Specialized Dementia Care are available on the Office of Rates Management webpage and vary by region and by the level of care determined necessary for the individual.[46]
Enhanced Adult Residential Care Facility	**Specialized Dementia Care Program Plus (SDCP) (pilot):** This program is for an EARC facility with a Specialized Dementia Care Program contract for at least one year. SDCP Plus is for individuals who qualify for the SDCP program under WAC 388-106-0033 but require additional support related to behavioral complexity with or without medical complexity.[47]

[45] WAC 388-110-020 (Definitions). Retrieved from https://app.leg.wa.gov/wac/default.aspx?dispo=true&cite=388-110 . See also: DSHS *Specialized Dementia Care Program.* Retrieved from https://www.dshs.wa.gov/altsa/home-and-community-services/what-specialized-dementia-care-program

[46] See Washington State Department of Social and Health Services. ALTSA Office of Rates Management. Provider rates available at: https://www.dshs.wa.gov/altsa/management-services-division/office-rates-management

[47] ALTSA Home and Community Services. (June 22, 2023). Specialized Behavior Support Services in Residential Settings.

V. Funding Mechanisms

7. Maximize Pilot opportunity to implement and test Washington's current Federal Medicaid Authorities to deliver a broad range of services and supports that are needed to successfully transition individuals with complex needs into post-acute care, home, and community settings. Identify areas where additional federal Medicaid authorities would be beneficial.

Washington has successfully obtained federal Medicaid approval through waivers and state plan amendments to cover a broad range of services and supports that can be leveraged to ensure comprehensive care for individuals with complex discharge needs.[48] With the Complex Discharge Pilot, the Task Force emphasizes the opportunity to develop clear implementation mechanisms and processes to ensure access to these services, as well as to identify barriers and gaps in these existing authorities. This work is foundational to ensure longer-term funding and sustainability of the Complex Discharge Pilot model of care past the Pilot period.

The Complex Discharge Pilot is testing a model of care that provides enhanced care management as well as a broader set of services and supports to address needs of individuals beyond services that are covered under traditional Medicaid benefits. These services may include, for example, housing support, nutrition, and other social supports that may be needed to support individuals with complex needs to transition into post-acute care and community settings.[49] **Table E** provides an overview of Washington current services and authorities that may be leveraged to support the Pilot model of care, including services that are authorized through the following federal authorities:

- ✓ 1115 Demonstration (2023 renewal)
- ✓ 1915I, 1915(k) and 1915(i) Authorities
- ✓ In Lieu of Services
- ✓ State Plan Amendments

The state is now doing the difficult work to implement these various options in a way that is person-centered and understandable to the people that need them and the organizations serving them. The Complex Discharge Pilot offers state partners, providers, patients, and others the chance to test and refine many of these new tools and identify additional gaps and federal authorities that the state may need to seek in the future. The timing of this pilot as a learning lab for these new tools is optimal, given the historical pattern of states using 1115 Medicaid waivers to test and refine ideas that often become new Medicaid benefits, as well as Washington's plans for reprocuring Medicaid managed care contracts in the next few years.

[48] See Centers for Medicare & Medicaid Services. *Washington Medicaid Transformation Project 2.0*, Special Terms and Conditions – Technical Corrections (Effective July 1, 2023 – June 30, 2028). (December 8, 2023). Retrieved from https://www.medicaid.gov/sites/default/files/2023-12/wa-medicaid-transformation-ca-12082023.pdf . See also About MTP 2.0 (August 2023). Retrieved from https://www.hca.wa.gov/assets/program/about-mtp-2.0.pdf

[49] These services are referred to by Medicaid as 'Health Related Social Needs.'

8. Evaluate how Washington's existing and potential Medicaid funding authorities may support the current or an expanded Complex Discharge Pilot, and the steps needed for obtaining approval and funding for a permanent statewide expansion of the Pilot. (See Interim Recommendations above to establish as workgroup that is co-chaired by HCA and DSHS).

The Task Force has identified the need for a deeper analysis of Washington's existing and potential federal Medicaid authorities that could provide longer-term sustainable funding for the pilot model of care. This evaluation should include:

1. **An analysis of the strategies for leveraging federal Medicaid funding to support the pilot model of care, and expand statewide in Washington**
    a. Evaluate the applicability of current mechanisms through the Washington's 1115 waiver and whether there is need for further amendments.
    b. Explore the intersection of the newly authorized role of Community Hubs under the Accountable Communities of Health and the ECM pilot happening in 4 of the 9 Medicaid regions.
    c. Evaluate opportunities and steps needed to obtain authority as an In Lieu of Services (ILOS).
    d. Evaluate expansion and/or revision of Washington's Section 2703 Health Homes program, and other State Plan Amendment (SPA) opportunities.

2. **An analysis of strategies to fund the state share of Medicaid services**
    a. Evaluate range of mechanisms that may be used to identify state funding to support the state match on Medicaid services. These mechanisms may include provider taxes, including but not limited to MCO and hospital taxes, and inter-governmental transfers (IGTs).

As noted previously in the *Pilot Implementation* section, the Task Force is recommending extension of the pilot to align with the timeline for leveraging federal Medicaid funding to support continuous funding of pilot services. Analysis of funding mechanisms should include evaluation of the timeline for approval and steps needed to support seamless transition of pilot services into a program with sustainable funding and ability to be expanded statewide.

This analysis will provide foundational understanding of Washington's options to leverage federal Medicaid dollars as a longer-term funding source for the pilot model of care. Over the next year, implementation of the Complex Discharge Pilot will provide the experience needed to identify specific gaps in services and the associated costs that need to be supported by new sustainable funding mechanisms.

Table E: Overview of Washington Medicaid Authorities that may be Leveraged to Support Individuals with Complex Discharge Needs

Benefit	Delivery System	Federal Authority Source	Population Covered	Current Status in Washington
Foundational Community Supports – Supported Employment	HCA has contracted with Amerigroup/Well point as the third party administrator (TPA) to authorize enrollments, pay claims, and manage the FCS provider network.[50]	1115 Medicaid waiver	Individuals, age 16 or older, who have a qualifying social risk factor and a needs based factor, such as a behavioral health need, SUD, or a long-term care or physical disability care need. These services are available to Medicaid MCO and FFS beneficiaries.	Approved and implemented in 2018 waiver. Being expanded to a broader population in the 2023 waiver renewal. As of April 2024, there is a waitlist.[51]
Foundational Community Supports – Supported Housing		1115 Medicaid waiver		Approved and implemented in 2018 waiver. Being expanded to a broader population in the 2023 waiver renewal. As of April 2024, there is a waitlist.
Foundational Community Supports – Short-term rental assistance		1115 Medicaid waiver		Approved in the 2023 waiver renewal. Implementation planned for Q3 or Q4 of 2024.
Foundational Community Supports – Housing Transition and Navigation Support		1115 Medicaid waiver		Approved in the 2023 waiver renewal. Implementation planned for Q3 or Q4 of 2024.
Recuperative Care & Short-Term Post Hospitalization	*TBD*	1115 Medicaid waiver	These services are available to Medicaid MCO and FFS beneficiaries.	Approved in the 2023 waiver renewal

[50] See Foundational Community Supports Fact Sheet (October 2023). Retrieved from https://www.hca.wa.gov/assets/program/fact-sheet-foundational-community-supports.pdf

[51] See Washington HCA. *Foundational Community Supports FAQ (April 2024)*. Retrieved from https://www.hca.wa.gov/assets/program/fcs-enrollment-pause-waitlist-faq.pdf#page=3

Benefit	Delivery System	Federal Authority Source	Population Covered	Current Status in Washington
Housing (Medical Respite): Provides a safe and stable place for eligible individuals transitioning out of institutions, and who are at risk of incurring other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits.			These services are available to Medicaid MCO and FFS beneficiaries.	
Pre-Release Services for Incarcerated Individuals: Case management, medication assisted treatment for SUD, CHW services, and other benefits) that may begin up to 90 days prior to expected date of release	*TBD*	1115 Medicaid waiver	Incarcerated individuals who would otherwise be eligible for Medicaid or CHIP These services are available to Medicaid MCO and FFS beneficiaries.	Approved in 1115 waiver (Noting this authority is example of current authority that provides targeted case management support to high-risk population to support transitions of care into community.)
Native Hub: statewide network of Indian health care providers, tribal	Native Hubs will be the contracting provider with HCA	1115 Medicaid waiver	American Indian/Alaska Native Individuals who may have multiple health and social needs (i.e., vulnerable individuals)	Approved in the 2023 waiver renewal

Benefit	Delivery System	Federal Authority Source	Population Covered	Current Status in Washington
social service divisions, and Native-led, Native-serving organizations focused on whole-person care coordination.			Medicaid FFS beneficiaries.	
Community Care Coordination Hubs: This program focuses on community-based care coordination, including screening patients, determining patient needs, connecting patients to community organizations.	Community Care Coordination Hubs operated by Accountable Communities of Health will be the contracting provider with HCA.	1115 Medicaid waiver	Individuals who may have multiple health and social needs (i.e., vulnerable individuals). Medicaid FFS beneficiaries.	Approved as part of the 2023 waiver renewal, currently being implemented with Care Coordination Hubs as the first service. After this, any new services will be implemented in tandem with approval through ILOS for the managed care population.
Other Health Related Social Needs • Nutritional Supports • Housing supports • Stabilizing Centers • Home/ Environmental	Apple Health MCOs will administer for MCO enrollees. Community Based Care Coordination Hubs will administer for FFS beneficiaries.	In Lieu of Services (MCOs) 1115 Medicaid waiver (FFS)	Medicaid beneficiaries for whom it is clinically appropriate using clinical and other health related-social needs criteria. These services are available to Medicaid MCO and FFS beneficiaries.	Will be approved for the MCO population under ILOS. Approved for FFS population as part of the 2023 waiver renewal.

Benefit	Delivery System	Federal Authority Source	Population Covered	Current Status in Washington
Accessibility and Remediation Adaptations • Day habilitation programs • Caregiver respite • Post-hospitalization housing and recuperative care (medical respite) • Community transition services				
Apple Health and Homes: This program aligns housing resources (capital financing and rental/ operations assistance) with the Foundational Community Supports program (above) to create new housing	This program is a joint effort led by HCA and the Department of Commerce.	N/A	Creates housing resources for individuals eligible for Foundation Community Supports program (see above)	Implemented in 2023.[52]

[52] *See* Department of Commerce. *Apple Health & Homes Initiative.* Retrieved from https://www.commerce.wa.gov/building-infrastructure/housing/ahah-psh/ahah-program/

Benefit	Delivery System	Federal Authority Source	Population Covered	Current Status in Washington
options for eligible individuals.				
Presumptive Eligibility for Home and Community Based Supports: Allows certain entities to determine individual eligible for HCBS before a CARE assessment and financial eligibility is determined	HCBS	1115 Medicaid waiver	Individuals presumptively determined to be eligible for section 1915(c) COPES, section 1915(k) Community First Choice, or State Plan Medicaid Personal Care.	Implementation launched in December 2023. The state is beginning implementation with individuals who are hospitalized and transitioning to all in-home settings. Future phases will include individuals seeking to transition to residential settings.[53]
Guardianship Expansion: Washington submitted a request for expenditures to provide guardianship and legal decision-making supports to	Proposal pending approval by CMS	1115 Waiver Proposal Pending Approval	Individuals qualifying for LTSS	Washington submitted a request for expenditures to provide guardianship and legal decision-making supports to individuals qualifying for LTSS. This proposal pending approval by CMS.[54]

[53] Washington State Aging and Long-Term Support Administration. (November 2023). *Long-term Services and Supports Presumptive Eligibility.* Retrieved from https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/Acute%20Care%20Hospitals/2023%20LTSS%20PE%20Fact%20Sheet%20for%20Acute%20Care%20Hospitals%20%28FINAL%29.pdf

[54] See Centers for Medicare & Medicaid Services. *Washington 1115 Medicaid Transformation Project 2.0 Approval Letter and Special Terms and Conditions* (page 15 - summary of requests not being approved at this time): https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transformation-ca-06302023.pdf

Benefit	Delivery System	Federal Authority Source	Population Covered	Current Status in Washington
individuals qualifying for LTSS.				
Health Homes Program: • Comprehensive care management • Care coordination • Health promotion • Comprehensive transitional care • Individual and family support • Referral to community and social support services	Provided through Apple Health MCOs for those enrolled in managed care, and through Health Homes coordinating agencies for Medicaid fee for service beneficiaries.	State Plan Amendment Section 2703	All Medicaid beneficiaries with at least one chronic condition and at risk for another, and a PRISM score of 1.5 or more. These services are available to Medicaid MCO and FFS beneficiaries.	Health Homes program is being implemented under an approved Section 2703 State Plan Amendment.[55]
Tribal Health Homes[56] • Comprehensive care management • Care coordination • Health promotion • Comprehensive transitional care	Same as above	State Plan Amendment Section 2703	The 2021 State Legislature provided a remedy for lead agency reimbursement issues that created a barrier for contracting with Tribes. The HCA and DSHS have prepared a Tribal Care Coordination Organization Agreement (CCOA) for use by all Health Home Lead Organizations.	Health Homes program is being implemented under an approved Section 2703 State Plan Amendment.[57]

[55] *See* Washington State Health Care Authority. Health Home webpage at: https://www.hca.wa.gov/billers-providers-partners/program-information-providers/health-home. See also ALTSA Health Home webpage at: https://www.dshs.wa.gov/altsa/washington-health-home-program

[56] See https://www.dshs.wa.gov/altsa/washington-health-home-program

[57] *See* Washington State Health Care Authority. Health Home webpage at: https://www.hca.wa.gov/billers-providers-partners/program-information-providers/health-home. See also ALTSA Health Home webpage at: https://www.dshs.wa.gov/altsa/washington-health-home-program

Benefit	Delivery System	Federal Authority Source	Population Covered	Current Status in Washington
• Individual and family support				
Intensive Behavioral Supportive Supervision:[58] • In person monitoring, redirection, diversion, cueing to prevent high risk behaviors – staffing to support the individual's behavior stabilization in community residential settings. • Person-centered assistance to build skills and resiliency to support stabilized	MCOs	In Lieu of Service (ILOS)	• Individuals who are at risk for hospitalization or institutionalization and where previous institutionalization may have negatively impacted the individual's quality of life due to frequent provider movements and hospitalizations; • Individuals who have exceptional behavioral care needs requiring additional supports in the community due to being unable to remain stable outside of hospital or institutional settings without behavioral supports; • Due to the impaired cognitive functioning paired with risky behaviors, the risk of needing inpatient care for stabilization is high thus all individuals in IMC, IFC, or BHSO managed care programs are eligible.[59]	Implemented (beginning January 2024)

[58] Washington State Health Care Authority. (2024). *Intensive Behavioral Supportive Supervision.* Retrieved from https://www.hca.wa.gov/assets/billers-and-providers/intensive-behavioral-supportive-supervision.pdf

[59] Washington State Health Care Authority. (2023). *Health-Related Social Needs Services (HRSN) & In Lieu of Services (ILOS) Policy Guide.* Retrieved from https://www.hca.wa.gov/assets/billers-and-providers/hrsn-and-ilos-policy-guide-202310.pdf

Benefit	Delivery System	Federal Authority Source	Population Covered	Current Status in Washington
living and integration. • Interventions that are not direct personal care.				
Community Behavioral Health Support (CBHS) – Supportive Supervision[60] [formerly Behavioral Health Personal Care]	MCO and FFS	1915(i) State Plan Amendment	• Eligible for or receiving Home and Community Services (HCS); • Have a qualifying diagnosis; and • Transitioning from an inpatient psychiatric setting or are experiencing challenges living in community settings.	Effective July 1, 2024
Roads to Community Living: Support for individuals to move from institutional settings into the community. Services may start while a person is in an institution to prepare for discharge, and following discharge can be authorized	HCBS	State Money Follows the Person Demonstration	Medicaid beneficiaries in a qualified institution (hospital, nursing home, residential habilitation center) for more than 60 consecutive days; and have received at least one day of Medicaid-paid inpatient services immediately prior to discharge from the institutional setting; and intend to move to a home and community based setting.	Implemented, approved through 2026

[60] Washington State Health Care Authority. (2024). *Community Behavioral Health Support.* Retrieved from https://www.hca.wa.gov/billers-providers-partners/program-information-providers/community-behavioral-health-support-cbhs-services

Benefit	Delivery System	Federal Authority Source	Population Covered	Current Status in Washington
for no more than 365 days. [61]				
Community First Choice: Services to support individuals to live in the community, including personal care, relief care, skills acquisition training, personal emergency response system, and assistive technology.[62]	HCBS	State Plan via 1915k	Individuals who meet the nursing facility level of care (NFLOC) or criteria to reside in an Intermediate Care Facility for the Intellectually Disabled (ICF/ID), and who are functionally and financially eligible	Implemented
Medicaid Personal Care Services: assistance with personal care tasks and health-related tasks (nurse delegation) so that individuals can remain in their own home or move into a community-based setting.[63]	HCBS	State Plan	Individuals who do not meet the Nursing Facility level of care, and who are functionally and financially eligible.	Implemented

[61] WAC 388-106-0250, et. seq.

[62] WAC 388-106-0270 retrieved from https://apps.leg.wa.gov/wac/default.aspx?cite=388-106-0270

[63] See ALTSA Long-Term Care Manual (Chapter 7c – Medicaid Personal Care). Accessed at https://www.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual

Benefit	Delivery System	Federal Authority Source	Population Covered	Current Status in Washington
HCBS Long Term Services and Supports Waivers:[64] **ALTSA** • Community Options Program Entry System (COPES) • New Freedom • Residential Support Waiver (RSW) **DDA** • Basic Plus • Core • Community Protection (CP) • Children with Intensive In-home Behavioral Supports (CIIBS) • Individual and Family Services (IFS)	HCBS	1915c waivers	Individuals who would need a nursing facility level of care if they did not reside in the community. Specific waiver determined by CARE assessment and is intended to wrap around the Community First Choice State Plan Program.	Implemented

[64] See *ALTSA Long-Term Care Manual (Chapter 7).* Accessed at https://www.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual

Appendix A. History of Washington Initiatives Addressing Complex Discharge Challenges

The work of the Task Force builds on significant efforts over the past several years led by Washington policymakers, state agencies, providers, and patient advocates to address a range of system and policy barriers impacting the complex discharge challenge. Examples of this current work include individual hospital programs to address care for patients with complex discharge needs, work to identify the varied issues that create discharge barriers, adjustments to hospital and post-acute care provider payment rates, investments in specialized post-acute care programs, and efforts to expand guardianship capacity. During the COVID-19 pandemic, in particular, there were focused investments in programs to transition individuals who were otherwise medically ready out of hospitals in order to ensure this vital acute care capacity for patients in need. A summary of key legislative actions over the past seven years to address complex discharge challenges is also provided below.

The Task Force also recognizes the work of the Bree Collaborative Complex Discharge Workgroup and the release of the Complex Discharge guidelines in January 2024 to support the appropriate and timely discharge of people from acute care facilities to post-acute settings.[65] These guidelines outline recommended practices by key sectors including hospitals, health plans, Department of Social and Health Services, post-acute care facilities, Adult Family Homes, and Assisted Living Facilities.

History of Washington Actions to Address Complex Discharge Challenges:

2017	➢ Legislative report on skilled nursing facility barriers to hospital transitions[66]
2018	➢ SNF-MCO Pilot Kickoff, focused on improving admissions and reducing barriers ➢ HCS complex discharge pilot implemented (King) ➢ Increased HCA & DSHS coordination on exceptions payments, complex discharge protocols ➢ Washington State Hospitals Association statewide hospital workgroup on complex discharge (ongoing)
2019	➢ Database developed to track acute hospital referrals, barriers, and length of stay
2020	➢ COVID-19 flexibilities implemented (telephonic assessments, incentive payments) ➢ DSHS develops strategic plan measures for Acute Care Hospital Discharge ➢ DSHS FTE increases to meet demand

[65] Bree Collaborative. *Complex Patient Discharge Report and Guidelines* (January 24, 2024). Retrieved from https://www.qualityhealth.org/bree/wp-content/uploads/sites/8/2024/01/Bree-Complex-Discharge-Recommendations-FINAL-0124.pdf

[66] Washington State Health Care Authority. *Skilled Nursing Facility/Acute Care Hospital Work Group*. (December 1, 2017). Retrieved from https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=2017%20HCA%20Report%20-%20Skilled%20Nursing%20Facility_31d8fee5-7ae7-4dd7-8cab-31b8dfca57e2.pdf

	➢ Transitional Care Center Seattle purchased to help serve patients that other LTSS facilities or services are not able to serve
2021	➢ Pilot with the Centers for Medicare and Medicaid Services to allow presumptive eligibility for hospital discharges ➢ Rapid Response Team implemented to support long-term care facilities staff beds with 1:1 support
2022	➢ Rapid Response Team expanded in response to ongoing need (funding ended in May 2024) ➢ Home and Community Services Guardianship Pilot launched
2023	➢ Legislature funds SNF exceptional care rates (Vent/Trach care, Expanded Behavior Supports Plus, Expanded Community Respite) ➢ Legislature approves Medicaid rate increases for most LTSS settings, including SNFs ➢ Legislature established the Complex Discharge Task Force and Pilot ➢ Investment in additional HCS FTE dedicated to assisting with Complex Discharge Pilot acute care hospital transitions ➢ LTSS Presumptive Eligibility Program implemented to support faster transition of eligible patients in acute care hospitals to appropriate long-term care settings.[67]

[67] LTSS Presumptive Eligibility Program. (December 2023). Retrieved from https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/Acute%20Care%20Hospitals/Presumptive%20Eligibility%20Project%20Flyer%201%203%2024.pdf

Appendix B. Medicaid MCO New Contract Sections re Care Coordination and Discharge Planning for Individuals with Complex Discharge Needs

Contract language in New Section 14.18.6 of the Integrated Managed Care contract (also included New Section 14.19.9 of the Integrated Foster Care contract) – Effective July 1, 2024

The Contractor shall use the following criteria and sources to identify Enrollees, –at acute care hospitals, with complex discharge needs who are facing barriers to discharge:

14.18.6.1 Enrollees with denied continued stay due to no longer meeting medical necessity, if:

14.18.6.1.1 Enrollee does not have a discharge plan in place;

14.18.6.1.2 Enrollee is facing barriers to discharge;

14.18.6.1.3 Enrollee receiving administrative days;

14.18.6.1.4 Referrals escalated through HCA for discharge planning and Care Coordination support;

14.18.6.1.5 Enrollee is on observation status greater than 72 hours;

14.18.6.1.6 Enrollee is participating in the complex discharge pilot program; or.

14.18.6.1.7 If an Enrollee does not meet the criteria outlined above, and if the Contractor believes that the Enrollee would benefit from being added to the Complex Discharge report, the Contractor may use their own judgment to add these Enrollees to the report.

14.18.6.2 The Contractor shall provide timely and appropriate Care Coordination and discharge planning support, that meet contractual expectations, for these Enrollees until they are discharged from the acute care hospital setting to a lower level of care. This includes collaboration with hospitals and other care team members to address barriers to discharge.

14.18.6.3 The Contractor shall add these Enrollees to a Complex Discharge report. Enrollees will remain on the report until they are discharged from the acute care setting. The Contractor shall update these reports on a weekly basis and email completed reports to HCA's Complex Discharge mailbox at HCAComplexDischarge@hca.wa.gov by close of business every Tuesday. If HCA has follow-up questions on Enrollees, the Contractor must respond in a timely manner.

Appendix C. Acronyms

Acronym	Term
ABA	Applied Behavior Analysis
AEM	Alien Emergency Medical
AFH	Adult Family Home
AI/AN	American Indian and Alaska Native
ALF	Adult Living Facility
ALTSA	Aging and Long-Term Support Administration
BHPC	Behavioral Health Personal Care
BHSO	Behavioral Health Services Only
CARE	Comprehensive Assessment Reporting Evaluation
CBHS	Community Behavioral Health Support
CCOA	Care Coordination Organization Agreement
CHIP	Children's Health Insurance Program
CHP	Community Home Project
CIIBS	Children with Intensive In-home Behavioral Support
COPES	Community Options Program Entry System
CP	Community Protection
CSS	Community Stability Supports
DDA	Developmental Disabilities Administration
DME	Durable Medical Equipment
DSHS	Department of Social and Health Services
DSNP	Dual Special Needs Plan
EARC	Enhanced Adult Residential Care
EBS	Enhanced Behavioral Support
ECM	Enhanced Care Management
ECS	Expanded Community Services
ED	Emergency Department
EHR	Electronic Health Record
ESF	Enhanced Services Facility
FCS	Foundational Community Supports
FFS	Fee For Service
FTE	Full Time Employee
HCA	Health Care Authority
HCBS	Home and Community Based Services
HCS	Home and Community Services
HD	Huntington's Disease
HRSN	Health Related Social Needs
IBSS	Intensive Behavioral Supportive Supervision
ICF/ID	Intermediate Care Facility for the Intellectually Disabled
IFC	Integrated Foster Care
IFS	Individual and Family Services
IGT	Inter-Governmental Transfer
IHCP	Indian Health Care Provider
IHS	Indian Health Services

Acronym	Term
ILOS	In Lieu of Services
IMC	Integrated Managed Care
IP	Inpatient
IV	Intravenous
LTC	Long Term Care
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
NEMT	Non-Emergency Medical Transportation
NFLOC	Nursing Facility Level of Care
NH	Nursing Home
OFM	Office of Financial Management
OPG	Office of Public Guardianship
PA	Prior Authorization
PAC	Post-Acute Care
PEG	Percutaneous Endoscopic Gastrostomy
PRISM	Predictive Risk Intelligence System
RSW	Residential Support Waiver
SBS	Specialized Behavior Supports
SCA	Single Case Agreement
SDCP	Specialized Dementia Care Program
SDOH	Social Determinants of Health
SMAC	State Medicaid Agency Contract
SNF	Skilled Nursing Facility
SPA	State Plan Amendment
SUD	Substance Use Disorder
TBI	Traumatic Brain Injury
TCCS	Transitional Care Center of Seattle
TPA	Third Party Administrator
TPN	Total Parenteral Nutrition
WAC	Washington Administrative Code

Appendix D. Definitions

Term	Definition	Source
Applied Behavior Analysis	"Applied Behavior Analysis (ABA)" is an approach to improve behavior and skills related to core impairments associated with autism and a number of other developmental disabilities, such as social communication and restrictive behaviors. It uses principles of human behavior, such as reinforcement, to teach social, communication, adaptive, and self-management skills while reducing harmful behaviors.	https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-medical-dental-or-vision-care/applied-behavior-analysis
Alien Emergency Medical	"Alien Emergency Medical (AEM)" is for individuals who have a qualifying medical emergency and do not qualify for any other Apple Health program due to citizenship/immigration requirements under WAC 182-503-0535. This includes qualified aliens who have not met the 5-year and are not exempt from the 5-year bar, nonpregnant nonqualified aliens, and undocumented individuals.	https://www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/apple-health-alien-emergency-medical
Adult Family Home	"Adult Family Homes (AFH)" are residential homes licensed to care for up to six non-related residents. They provide room, board, laundry, necessary supervision, and necessary help with activities of daily living, personal care, and social services.	https://www.dshs.wa.gov/altsa/residential-care-services/about-adult-family-homes
American Indian and Alaska Native	"American Indian/Alaska Native (AI/AN)" means any individual defined at 25 USC § 1603(13), § 1603(28), or § 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual is a member of a Tribe or resides in an urban center and meets one or more of the following criteria: • Is a member of a tribe, band, or other organized group of Indians, including those tribes,	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf

Term	Definition	Source
	bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is descendant, in the first or second degree, of any such member; • Is an Eskimo or Aleut or other Alaska Native; • Is considered by the Secretary of the Interior to be an Indian for any purpose; or • Is determined to be an Indian under regulations issued by the Secretary. The term AI/AN also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.	
Assisted Living Facility	"Assisted Living Facilities (ALF)" are facilities in a community setting where staff assumes responsibility for the safety and well-being of the adult. Housing, meals, laundry, supervision, and varying levels of assistance with care are provided. Some provide nursing care. Some offer specialized care for people with mental health issues, developmental disabilities, or dementia. The home can have seven or more residents and is licensed by the state.	https://www.dshs.wa.gov/altsa/residential-care-services/long-term-care-residential-options
Aging and Long-Term Support Administration	"Aging and Long-Term Support Administration (ALTSA)" is responsible for providing a safe home, community, and nursing facility array of long-term supports for Washington citizens.	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf

Term	Definition	Source
Behavioral Health Services Only	"Behavioral Health Services Only (BHSO)" means those Enrollees who receive only behavioral health benefits through this Contract and the companion non-Medicaid Contract.	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf
Comprehensive Assessment Report and Evaluation	"Comprehensive Assessment Report and Evaluation (CARE)" means a person centered, automated assessment tool used for determining Medicaid functional eligibility, level of care for budget and comprehensive care planning, as defined in chapter 388-106 WAC.	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf
Community Behavioral Health Support	"Community Behavioral Health Support (CBHS)" services is a new program beginning July 1, 2024. This benefit will help people who have a significant mental health diagnosis and need additional support to live in a community setting like an adult family home or an assisted living facility.	https://www.hca.wa.gov/billers-providers-partners/program-information-providers/community-behavioral-health-support-cbhs-services
Children's Health Insurance Program	"Children's Health Insurance Program (CHIP)" means a program to provide access to medical care for children under Title XXI of the Social Security Act, the Children's Health Insurance Program Reauthorization Act of 2009, RCW 74.09.470 and chapter 182-505 WAC.	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf
Community Options Program Entry System	"Community Options Program Entry System (COPES)" is one of the 1915(c) Medicaid waivers operated by ALTSA. This waiver provides the opportunity for individuals who, in the absence of the home and community-based services and supports provided under COPES, would otherwise require the level of care furnished in a nursing facility.	https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%207d.docx
Community Protection	"Community Protection (CP)" is a waiver that offers therapeutic residential supports for individuals assessed to require 24-hour, on-site staff supervision to ensure the safety	https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/22-0637%20CP%20Brochure%2022-1757.pdf

Term	Definition	Source
	of others. Participants voluntarily agree to follow the Community Protection guidelines. Individuals served are age 18 and older.	
Community Stability Supports	"Community Stability Supports (CSS)" is a service to help clients with personal care needs and behavioral challenges remain in community-based settings. CSS contracts are available in facilities with an Assisted Living Facility (ALF) license and the ALF and/or Enhanced Adult Residential Care (EARC) contracts and include personal care, medication oversight, specialized settings, and behavior support.	https://www.dshs.wa.gov/altsa/home-and-community-services/residential-long-term-care-facilities-specialty-contracts#:~:text=Expanded%20Community%20Services%20(ECS)%20%2D,the%20client%20in%20the%20residence
Developmental Disabilities Administration	"Developmental Disabilities Administration (DDA)" is responsible for providing a safe, high-quality array of home, community, and facility-based residential services and employment support for Washington citizens with disabilities.	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf
Durable Medical Equipment	"Durable Medical Equipment (DME)" means equipment which can withstand repeated use and which is used to serve a medical purpose when supplied to individuals with an illness, injury or disability. DME includes, but is not limited to: wheelchairs, walkers, specialty beds, and mattresses.	https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2016.doc
Department of Social and Health Services	"Department of Social and Health Services (DSHS)" means the Washington State agency responsible for providing a broad array of health care and social services.	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf
Dual Special Needs Plan	"Dual Eligible Special Needs Plans (DSNP)" enroll individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.	https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/dual-eligible#:~:text=Dual%20Eligible%20Special%20Needs%20Plans%20(D%2DSNPs)%20enroll%20individuals,state%20and%20the%20individual's%20eligibility

Term	Definition	Source
Enhanced Adult Residential Care	"Enhanced Adult Residential Care (EARC)" is a package of services provided by an assisted living facility that is licensed under Chapter 18.20 RCW and that has a contract with the department to provide personal care services, intermittent nursing services, and medication administration services in accordance with Parts I and III of Chapter 388-110 WAC.	https://www.dshs.wa.gov/faq/what-difference-between-arc-earc-and-al-contracts
Enhanced Care Management	"Enhanced Care Management (ECM)" is the coordination of patient-specific social, behavioral, and medical services, which begins in the hospital and follows the patient through the continuum of care to the next step down level of care that is needed.	See *Overview: Complex Discharge Pilot* section within Task Force Report.
Expanded Community Services	"Expanded Community Services (ECS)" means that clients in settings with this contract will receive personal care services, medication oversight, and contracted behavior support services. Residential providers may offer increased staff or activities to support the client in the residence. Client services and supports are available 24-hours per day by on-site staff who provide supervision and support.	https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/LTC%20Manual%20Chapter%207f.doc
Electronic Health Record	"Electronic Health Record (EHR)" means a real-time patient health record with access to evidence-based decision support tools that can be used to aid clinicians in decision making. The EHR can automate and streamline a clinician's workflow, ensuring that all clinical information is communicated. It can also prevent delays in response that result in gaps in care. The EHR can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public health disease surveillance and reporting.	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf
Enhanced Services Facility	"Enhanced Services Facilities (ESF)" provide personal care services,	https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/docum

Term	Definition	Source
	medication oversight and the highest level of specialized staffing, with 24-hour on-site nursing and 8 hours per day of behavior support provided by on-site mental health professionals. ESF staff implement client-specific behavior support plans and provide supervision and support.	ents/LTCManual/LTC%20Manual%20Chapter%207f.doc
Foundational Community Supports	"Foundational Community Supports (FCS)" is currently one of the original 5 initiatives developed under Washington State's 1115 Medicaid Transformation waiver, or MTP. In 2018, FCS began providing targeted supportive housing (SH) and supported employment (SE) services to Medicaid beneficiaries with behavioral health needs and other risk factors. By focusing on the social determinants of health, the program aims to reduce barriers and promote health equity. These services are designed to strengthen self-sufficiency by helping participants obtain and maintain housing and/or employment.	https://www.hca.wa.gov/assets/program/fact-sheet-foundational-community-supports.pdf
Fee-for-Service	"Fee-for-Service (FFS)" means clients who are not served in managed care receive services through the Medicaid Fee-for-Service program, where HCA pays providers directly for each service they provide.	https://www.hca.wa.gov/sites/default/files/program/managed-care-and-ffs.pdf
Health Care Authority	"Health Care Authority (HCA)" means the Washington State Health Care Authority, any division, section, office, unit or other entity of HCA, or any of the officers or other officials lawfully representing HCA.	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf
Home and Community Based Services	"Community Based Services (HCBS)" are five waivers offered by the Developmental Disabilities Administration (DDA): • Basic Plus • Children's Intensive In-home Behavioral Supports (CIIBS) • Community Protection	https://www.dshs.wa.gov/dda/consumers-and-families/home-and-community-based-waivers-hcbs

Term	Definition	Source
	• Core • Individual and Family Services (IFS). Each of the five waivers provides an array of services tailored to the specific populations they serve. Waiver services provide additional support when Medicaid state plan services and other supports are not sufficient.	
Home and Community Services	"Home and Community Services (HCS)" division promotes, plans, develops and provides long-term care services for persons with disabilities and the elderly who may need state funds (Medicaid) to help pay for them.	https://www.dshs.wa.gov/altsa/home-and-community-services-information-professionals
Health Related Social Needs	"Health Related Social Needs (HRSN)" are an individual's unmet, adverse social conditions (e.g., housing instability, homelessness, nutrition insecurity) that contribute to poor health and are a result of underlying social determinants of health (conditions in which people are born, grow, work, and age).	https://www.hca.wa.gov/assets/billers-and-providers/hrsn-and-ilos-policy-guide-202310.pdf
Intensive Behavioral Supportive Supervision	"Intensive Behavioral Supportive Supervision (IBSS)" is a voluntary In Lieu of Service (ILOS) available to Apple Health (Medicaid) clients enrolled with a managed care organizations (MCO) who have complex behaviors and cognitive impairment experiencing high risk of institutionalization and hospitalization and requiring direct staffing supports to prevent harm to self or others.	https://www.hca.wa.gov/assets/billers-and-providers/intensive-behavioral-supportive-supervision.pdf
Intermediate Care Facility for the Intellectually Disabled	"Intermediate Care Facilities for individuals with Intellectual disability (ICF/ID)" is an optional Medicaid benefit that enables states to provide comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence. Although it is an optional benefit, all states offer it, if only as an alternative to home and community-based	https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/intermediate-care-facilities-individuals-intellectual-disability/index.html

Term	Definition	Source
	services waivers for individuals at the ICF/ID level of care.	
Individual and Family Services	"Individual and Family Services (IFS)" waiver supports individuals who require waiver services to remain in the family home. Individuals must live with a family member. Services are limited by the amount of the annual allocation, which is determined by the DDA assessment ($1,200; $1,800; $2,400; or $3,600).	https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/22-0639%20IFS%20Waiver%20Brochure%2022-1758.pdf
Inter-Governmental Transfer	"Inter-Governmental Transfer (IGT)" is a transfer of public funds between governmental entities, such as from a county or a public hospital to the state. The source of funding for each IGT that is proposed by a governmental entity must be reviewed to ensure that it meets state and federal requirements for permissible transfers.	https://www.betterhealthtogether.org/bold-solutions-content/igt-faq
Indian Health Care Provider	"Indian Health Care Provider (IHCP)" means the Indian Health Service and/or any Tribe, Tribal organization, or Urban Indian Health Program (UIHP) that provides Medicaid-reimbursable services.	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf
Indian Health Services	"Indian Health Service (IHS)" means the federal agency in the Department of Health and Human Services, including contracted Tribal health programs, entrusted with the responsibility to assist eligible AI/ANs with health care services.	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf
In Lieu of Services	"In lieu of service or setting (ILOS)" means a service or setting that is provided to an Enrollee as a substitute for Covered Services or a setting covered under the Medicaid State Plan in accordance with 42 CFR § 438.3(e)(2). An ILOS can be used as an immediate or longer-term substitute for a service or setting that is covered under the State Plan, or when the ILOS can be expected to reduce or prevent	https://www.hca.wa.gov/assets/billers-and-providers/hrsn-and-ilos-policy-guide-202310.pdf

Term	Definition	Source
	the future need to utilize the covered service or setting.	
Integrated Managed Care	"Integrated Managed Care (IMC)" combines each Apple Health (Medicaid) client's physical health and behavioral health services together under a single Managed Care Organization (MCO) responsible for delivery of both sets of benefits.	https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-medical-dental-or-vision-care/apple-health-managed-care
Managed Care Organization	"Managed Care Organization (MCO)" means an organization having a certificate of authority or certificate of registration from the Washington State Office of Insurance Commissioner that contracts with HCA under a comprehensive risk contract to provide prepaid health care services to eligible HCA Enrollees under HCA Managed Care programs.	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf
Nursing Facility Level of Care	"Nursing Facility Level of Care (NFLOC)" means ongoing support services provided in a SNF/Nursing Facility for Enrollees who do not meet the criteria for rehabilitative or skilled nursing services.	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf
Office of Financial Management	The "Office of Financial Management (OFM)" provides vital information, fiscal services and policy support that the governor, Legislature and state agencies need to serve the people of Washington.	https://ofm.wa.gov/about/what-we-do
Office of Public Guardianship	The "Office of the Public Guardian (OPG)" was established within the Administrative Office of the Courts through the passage of Substitute Senate Bill 5320 in 2007. The work of public guardians results in both non-monetary and monetary benefits. Non- monetary benefits include improved functioning and social connections; These result from preventing or stopping incidents of abuse, neglect or exploitation, improving food security or sanitation, and reconnecting incapacitated persons with family and friends.	https://www.courts.wa.gov/guardianportal/index.cfm?fa=guardianportal.opg&content=about

Term	Definition	Source
	Monetary benefits include reducing public costs, through strategic use of benefits, resolving or mitigating legal issues, lowering health care costs, by focusing on preventive care and reducing emergency room visits, recovering of financial assets, and moving to less restrictive (and less costly) residential settings.	
Prior Authorization	"Prior Authorization (PA)" means the requirement that a provider must request, on behalf of an Enrollee and when required by rule or HCA billing instructions, HCA or HCA's designee's approval to provide a health care service before the Enrollee receives the health care service, prescribed drug, device, or drug-related supply. HCA or HCA's designee's approval is based on medical necessity. Receipt of prior authorization does not guarantee payment. Expedited prior authorization and limitation extension are types of prior authorization (WAC 182-500-0085).	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf
Predictive Risk Intelligence System	"Predictive Risk Intelligence System (PRISM)" means a DSHS-secure web-based predictive modeling and clinical decision support tool. It provides a unified view of medical, behavioral health, and long-term care service data that is refreshed on a weekly basis. PRISM provides prospective medical risk scores that are a measure of expected medical costs in the next twelve (12) months based on the patient's disease profile and pharmacy utilization.	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf
Residential Support Waiver	"Residential Support Waiver (RSW)" is a home and community-based program designed to provide personal care, community options, and specialized services for eligible clients with personal care and behavioral support needs. The RSW provides a	https://www.dshs.wa.gov/altsa/home-and-community-services/residential-long-term-care-facilities-specialty-contracts

Term	Definition	Source
	cohesive and comprehensive continuum of specialized services targeted to adults with extremely challenging behavior who meet the eligibility requirements found in WAC 388-106-0338.	
Specialized Behavior Supports	"Specialized Behavior Supports (SBS)" means clients receiving SBS services in adult family homes with an SBS contract will receive the same services as in an ECS setting and additional staffing. The SBS contract requires additional staffing to provide closer supervision, behavioral support, and one-on-one services for SBS clients.	https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/LTC%20Manual%20Chapter%207f.doc
Single Case Agreement	"Single Case Agreement (SCA)" means a written agreement between the Contractor and a non-Participating Provider to deliver services to an Enrollee.	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf
Specialized Dementia Care Program	"Specialized Dementia Care Program (SDCP)" is for a person with dementia who can no longer live at home and needs state-funding (Medicaid) to help pay for long-term care services in a facility. Offered through the Department of Social and Health Services (DSHS), a person with dementia receives a package of specialized dementia care services while living at an Assisted Living Facility.	https://www.dshs.wa.gov/altsa/home-and-community-services/what-specialized-dementia-care-program
Social Determinants of Health	"Social Determinants of Health (SDOH)" are the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.	https://www.hca.wa.gov/assets/billers-and-providers/hrsn-and-ilos-policy-guide-202310.pdf
State Medicaid Agency Contract	"State Medicaid Agency Contract (SMAC)" identifies the requirements and guidelines Medicare Advantage (MA) Health Plans must follow when serving the dual-eligible individuals, allowing care coordination between	https://www.hca.wa.gov/billers-providers-partners/program-information-providers/model-managed-care-contracts

Term	Definition	Source
	Medicare and Apple Health (Medicaid) services.	
State Plan Amendment	The Medicaid State Plan is an agreement between Washington and the Federal government describing how Washington administers its Medicaid programs. When Medicaid program policies or operations change or new information is added, the state sends "State Plan Amendments (SPAs)" to the Centers for Medicare & Medicaid Services (CMS) for review and approval.	https://www.hca.wa.gov/about-hca/programs-and-initiatives/apple-health-medicaid/approved-state-plan-amendments
Substance Use Disorder	"Substance Use Disorder (SUD)" means a problematic pattern of use of substances that causes clinical and functional impairment, such as health problems, disability, and failure to meet major responsibilities at work, school or home. Clinicians use criteria from the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM 5) to diagnose SUD.	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf
Washington Administrative Code	Regulations of executive branch agencies are issued by authority of statutes. The "Washington Administrative Code (WAC)" codifies the regulations and arranges them by subject or agency.	https://leg.wa.gov/LawsAndAgencyRules/Pages/default.aspx#:~:text=Washington%20Administrative%20Code%20(WAC)%20%E2%80%94,primary%20law%20in%20Washington%20State