Washington Complex Discharge Task Force and Pilot: Final Recommendations

TASK FORCE REPORT PER SB 5187, SEC.135(12)

TO
GOVERNOR BOB FERGUSON
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, 2025

Prepared by Health Management Associates

Dear Governor Ferguson and Members of the Legislature,

On any given day across the State of Washington, nearly 850 patients are ready for discharge from acute care hospitals, but unable to transition into post-acute care or community settings due to a range of system barriers. The human costs of this problem are enormous. Some individuals remain in hospitals for weeks, months, or even years longer than necessary. Access to acute care in hospitals is also strained, and system costs reach millions of dollars annually for hospitals and other providers. These challenges bring into laser focus what is essentially a broken system.

In 2023, the legislature created the Complex Discharge Task Force to move the state toward a comprehensive approach to addressing discharge barriers. Your support for this work has been instrumental in driving collaborative solutions to these challenges, and we are grateful for your continued support for the Task Force in the coming biennium.

Over the past two years, the Task Force has engaged with more than 150 stakeholders from across the health care system to develop a comprehensive understanding of issues and concrete recommendations for improvement. We launched five pilot sites, serving more than 500 patients, and testing an innovative model of care that brings together partners across the system to support successful, patient-centered care transitions. With the completion of the pilot on June 30th, we are continuing to evaluate data, but there are positive signs that the model of care helped reduce length of stay in hospitals and nursing homes, and providers, case workers and patients all expressed high satisfaction with the program.

Discharging patients with multiple physical, behavioral, social, and long-term care needs from hospitals is complex and challenging for many reasons. The attached report, *Recommendations for Complex Discharge*, offers practical investments and streamlined strategies to make existing programs work better for patients—**with a clear path forward for the Task Force, state agencies, and the legislature**. We recognize that the current state budget outlook and uncertainty regarding federal Medicaid program may limit the scope of our efforts in the short term, but we can take meaningful steps now to realize significant savings and to move Washingtonians toward a better future.

Key Findings

The Task Force identified **three key drivers of the challenges in effective care transitions and system performance for individuals with multiple medical, behavioral, social and long-term care needs.**

- **System complexity** results in covered services being underutilized due to the difficulty of navigating system rules and processes. Streamlining these resources is the single most important action item for improving outcomes.
- **System gaps** impede transitions for some patients. Examples include coverage gaps, such as limited availability of one-on-one support, as well as underinvestment in system resources such as case management staff to follow patients across settings and navigate services across multiple systems.
- **Care siloes** lead to fragmented accountability and duplicative, uncoordinated activity at every level, signaling the need for targeted, innovative approaches. At present, no single provider, agency or payer is responsible for the full process. The pilot clearly demonstrated that success relies on a more coordinated, streamlined, and accountable response at every level.

The Path Forward

With the recommendations outlined in this report, the Task Force recognizes the need for strategic actions by the Task Force, state agencies, and the legislature. We also recognize that funding will be needed to support necessary agency staff and resources to carry out these recommendations, along with agency efforts to identify administrative improvements.

- **Sustainable funding and system capacity.** The Task Force, leveraging its state agency participants, will provide the legislature with a plan to secure sustainable funding for the complex discharge model of care. This plan will outline a path for using existing authorities, such as the Health Homes model, and will leverage federal Medicaid funding opportunities to expand the pilot's benefits statewide. The legislature's continued investment in the Task Force will enable this important work to happen.

  The Task Force also will continue to further assess and incorporate learnings from the Pilot to make recommendations on payment models, services for patients with complex needs across programs and settings, and system capacity gaps.

- **Streamlining cross-agency collaboration and system alignment.** At the direction of the governor, the Health Care Authority and the Department of Social and Health Services should establish a leadership structure that oversees and directs agency cross-system initiatives related to transitions of care, building on the issues and suggestions outlined in this report. This is likely to be a multi-year process and will require future requests to the legislature for resources to develop and implement new structures and methods of oversight. Changes in agency leadership provide an opportunity to evaluate current structures, streamline system complexity, and better align efforts across the continuum of care.

- **Contracting and payment for individuals with complex needs.** The Health Care Authority already has the authority to implement many of the recommendations related to contracting included in this report, but additional staff resources may be required for implementation and oversight. The Task Force recommends that the Health Care Authority assess the recommendations and create a plan for adoption, leveraging significant upcoming events including a Medicaid re-procurement.

- **System barriers relating to guardianship.** We call on the legislature for action on a range of policy options identified in this report to address delays in care transitions resulting from guardianship and conservatorship processes. We emphasize the need for upstream solutions to prevent situations in which are guardians are needed, as well as urgent action on policy options that could reduce the significant delays—three to six months or more—that individuals and families experience in hospitals waiting for guardianship or conservatorship appointments. Though the legislature has made important investments over the past several years in the expansion of the Office of Public Guardianship, these investments alone will not impact the delays in care transitions resulting from guardianship processes.

We look forward to working with you to advance this important work. The attached report provides additional detail and recommendations to support these next steps.

Sincerely,

Complex Discharge Task Force Members

Caitlin Safford, Governor's Office
Dr. Brian Waiblinger, Department of Social and Health Services
Elena Madrid, Washington Health Care Association
Glory Dole, Health Care Authority
Madeline Grant, University of Washington
Patricia Hunter, State Long Term Care Ombuds
Zosia Stanley, Washington State Hospital Association

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Complex Discharge Task Force and Pilot

According to quarterly surveys of Washington hospitals, nearly 850 patients on any given day across the State of Washington are ready for discharge from acute care hospitals, but a range of system barriers block their transition into post-acute care or community settings.[1] The human costs of this problem are enormous. Some individuals remain in hospitals weeks, months, or even years longer than necessary. Access for individuals who need acute care is also strained, and system costs for hospitals and other providers are in the millions of dollars annually.

This problem affects individuals with all types of insurance. Approximately 39 percent of individuals facing barriers to discharge are Medicaid beneficiaries or dually eligible for both Medicaid and Medicare, 46 percent are Medicare-only beneficiaries, 8 percent are commercially insured, and the remaining individuals are uninsured or covered by other state or federal programs.[2]

Individuals facing barriers to discharge are often experiencing multiple significant health and social challenges—homelessness, housing insecurity, cancer, stroke, serious mental illness, substance use disorder, dementia, and other conditions requiring specialized care and supports. As they seek to transition out of hospitals, they must navigate a complex system of payers, programs, eligibility determinations, referral processes, provider availability, and other challenges. Ultimately, they face barriers in securing services and settings to meet their needs and allow for a timely discharge.

In 2023, the Washington legislature created the Complex Discharge Task Force to oversee a pilot program to test a model of care that would support care transitions for Medicaid enrollees with multiple complex needs and to develop a comprehensive understanding of the issues and recommendations that address barriers to discharge.

Complex Discharge Pilot Patient Care Transition Example

An individual with substance use disorder (SUD), experiencing homelessness, and requiring kidney dialysis and support for other health concerns had been in the hospital for more than six months due to inability to find a provider to support the individual with multiple complex needs. Through the Complex Discharge pilot, the Enhanced Care Management staff, Home and Community Services case managers, and MCO partners were able to work together with the individual to find an Adult Family Home (AFH) and set up transportation to regular dialysis appointments and SUD treatment. The team was able to work with the AFH to support the individual outside of the walls of the hospital, build trust with the individual and across system partners, and ensure a stable care transition and access to needed services.

Task Force Recommendations

In this report, the Task Force provides concrete recommendations that would improve hospital discharge and post-hospital care for individuals with complex needs, including expanding the pilot model of care statewide, ensuring sustainable funding, and addressing underlying systemic barriers to care transitions. This report outlines actions needed by the legislature and state agencies to advance these priorities, as well as topics for future work by the Task Force. To carry out these recommendations, it will be critical to provide funding for necessary agency staff and resources, along with agency efforts to identify administrative improvements.

[1] Washington State Hospital Association. *Complex Discharge Survey Results,* Q1-2025. Not publicly available.
[2] *Ibid*

Domain	Recommendations	Action
Domain I: Complex Discharge Model of Care and Permanent Funding	**1.** *Develop a plan to leverage Washington's existing Medicaid authorities to expand the Complex Discharge Model of Care (enhanced care management [ECM], supportive services, payments to skilled nursing facilities, and dedicated Department of Social and Health Service [DSHS] and Health Care Authority [HCA] staff) statewide and provide permanent funding. This work should include collaboration with Tribal partners to develop a model of care to ensure care transitions for American Indian and Alaska Native (AI/AN) populations and members of Tribal communities.*	
Domain II: Cross-Agency Collaboration and System Alignment	**2.** *Create a cross-agency leadership structure to lead and direct agency cross-system initiatives relating to transitions of care for Medicaid enrollees with complex needs.*	
	3. *Promote the upstream use of decision-making legal tools and expand guardianship and decision-making options to address care transition delays related to a person's inability to consent.*	
Domain III: Contracting and Payment for Individuals with Complex Needs	**4.** *Leverage MCO and dual special needs plan (D-SNP) contracts to emphasize and reward accountability for care transitions for Medicaid individuals with complex needs.*	
	5. *Develop resources to support provider understanding and ability to navigate Medicaid eligibility and payment of covered services.*	
	6. *Identify options for adjusting Medicaid rates to serve individuals with multiple complex needs and expand coverage to address gaps in the system.*	
Domain IV: System Capacity to Provide Care to Individuals with Complex Needs	**7.** *Establish and strengthen provider-level partnerships to support transitions of care for individuals with complex needs.*	
	8. *Assess system capacity to serve individuals with complex needs and determine specific gaps and recommendations.*	

Action Owner Key

Legislature	Agency	Task Force	Providers
			

Background

During the 2023 legislative session, Washington lawmakers 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 focused on people with Medicaid 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. The Task Force is charged to deliver recommendations on the following topics:

- Pilot program implementation and evaluation of the 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.

This is the third in a series of Task Force reports. The Task Force delivered its first report, with initial recommendations, on November 1, 2023, and the second, with interim recommendations, on July 1, 2024. These reports were issued before the Task Force and its workgroups had completed significant work on their recommendations. Therefore, these reports focused on consensus policies that could address discrete issues in the near term.

This third report provides a comprehensive approach for systematically addressing complex discharge barriers, while also laying out strategic actions that the Task Force, state agencies, and the legislature should take to advance the recommendations identified. This report also provides preliminary pilot outcomes at Harborview Medical Center. A full analysis of the pilot data is forthcoming pending completion of the pilot on June 30, 2025.

During the 2025 legislative session, the Legislature provided additional funding to continue the Task Force into the next biennium. In addition to providing a path forward for policy change, this report lays out areas for further assessment and development of deliverables by the Task Force.[5]

Task Force and Workgroup Structure

The Task Force consists of seven members appointed by the governor to develop recommendations.[6] Members of the Task Force include one representative from each of the following:

1. Governor's Office
2. Department of Social and Health Services

[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. Available 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] SB 5167 (2025), Section 606(54). Available at: https://lawfilesext.leg.wa.gov/biennium/2025-26/Pdf/Bills/Session%20Laws/Senate/5167-S.SL.pdf?q=20250530020748

[6] 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.

3. Washington State Health Care Authority
4. Washington State Hospital Association
5. Post Acute Care Provider Association
6. University of Washington, Harborview Medical Center
7. Patient and Families Representative

The Task Force established five workgroups, composed of system partners representing diverse perspectives, to inform the major areas of recommendations. Partners participating in these groups included representatives from state agencies, Tribal partners and Tribal system experts, hospitals, post-acute care providers, home and community service settings, MCOs, patient organizations, and others.

Complex Discharge Five Workgroups

1) Pilot Implementation
2) Funding Mechanisms
3) Discharge Barriers
4) Managed Care and Fee-for-Service
5) Provider Rates

In 2025, the Task Force convened these groups over several meetings to inform the Task Force's understanding of the current issues and potential solutions to complex discharge challenges in their respective areas of focus. In addition, the Task Force convened the Pilot Implementation Workgroup on a monthly basis beginning in 2023. This group included hospital and pilot partner representatives from each pilot site and focused on the model of care design and ongoing implementation efforts. This process and the diverse perspectives shared through the Complex Discharge Workgroups have substantially informed the Task Force's recommendations in this report.

In carrying out its work, the Task Force engaged Tribal input through workgroups as well as through work with the Tribal Centric Behavioral Health Advisory Board (TCBHAB). In addition, in January 2025, the American Indian Health Commission engaged with pilot sites to provide training on Tribal Sovereignty, the Tribal Health System, and history and cultural considerations in providing care to members of Tribal communities. *Appendix D* provides a summary of Tribal-specific recommendations that are integrated throughout the body of this report.

Work with State Agency Partners

The Task Force worked closely with teams from the Health Care Authority (HCA) and Department of Social and Health Service (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 managed care contracts as well as the fee-for-service (FFS) 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 skilled nursing facilities (SNFs). DSHS is responsible for long-term care services and supports for Medicaid populations eligible for these services, such as care provided in nursing facilities, adult family homes, assisted living facilities, personal care services in a person's home, and supported living and residential habilitation services for individuals with intellectual and developmental disabilities. Both HCA and DSHS teams brought important expertise regarding past and current programs serving individuals with complex discharge needs to inform the Task Force's recommendations.

History of Washington Efforts to Address Complex Discharge Barriers

The work of the Task Force builds on significant efforts over nearly the past decade led by Washington policymakers, state agencies, providers, and patient advocates to address a range of system and policy barriers impacting transitions of care for individuals with complex needs. These efforts include:

- **DSHS Acute Care Hospital and Cross-System Care Coordination** initiatives providing trainings, workflows, weekly meetings, and other resources to support care transitions from hospitals into long term care services and supports.
- **HCA-MCO Complex Discharge program** supporting managed care plans efforts to engage with hospitals and other system partners to proactively identify plan enrollees with complex discharge needs and develop strategies to address barriers to discharge.
- Washington State Hospital Association (WSHA) **statewide Hospital Complex Discharge Workgroup** and ongoing survey and review of trends for hospital complex discharge patients and key barriers.
- **Hospital programs to pay SNFs for post-acute care beds** to support care transitions for patients with complex discharge needs (commonly referred to as 'Bed Readiness' or 'Bridge Bed' programs).
- Release of the **Bree Collaborative Complex Discharge guidelines** in January 2024.[7] These guidelines outline recommended practices by key sectors—including hospitals, health plans, DSHS, post-acute care facilities, Adult Family Homes, and Assisted Living Facilities—to support appropriate and timely discharge of people from acute care facilities to post-acute settings.
- State investments in **specialized post-acute care programs**, such as the purchase of Transitional Care Center Seattle to help serve LTSS patients with multiple complex needs.
- **Expansion of public guardian capacities** to support individuals transitioning from acute care hospitals into long term care. This includes establishment of the HCS Guardianship and Conservator Assistance Program (GCAP) in 2025, as well as the expansion of the Office of Public Guardian program and support for navigators in 2024.
- **COVID-19 pandemic flexibilities** and investments in programs to transition individuals who were otherwise medically ready out of hospitals to ensure this vital acute care capacity for patients in need. This includes implementation of rapid response teams to support long-term care facilities with 1:1 support for patients with complex needs.
- The **2017 Skilled Nursing Facility/Acute Care Hospital Workgroup** legislative report identifying a range of complex discharge barriers and potential solutions. This work led to the development of workflows and resources to support cross-system coordination.[8]

The Task Force recognizes the important contributions of each of these efforts and seeks to strengthen this work through recommendations that provide a comprehensive approach to addressing underlying systemic barriers that will continue to impede transitions of care if not addressed. (See *Appendix A* for further summary of history of efforts.)

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

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

Complex Discharge Pilot

Over the last two years, the Complex Discharge Pilot has designed and tested a complex discharge model of care to support Medicaid patient transitions from hospitals into post-acute care and home and community-based settings, including SNFs, assisted living facilities, adult family homes, other community settings, or patient homes. The model focused on a patient-centered approach to coordination of social, behavioral, medical, and long-term care services, beginning in the hospital and following the patient to the next level of care needed. Key components of the model of care are described below, with further detail regarding patient eligibility and payment included in *Appendix B*.

Complex Discharge Model of Care

Key components of the Complex Discharge model of care tested by the pilot include:

- **ECM Team:** Two hospital-based ECM staff each with a capped caseload (1:15 ECM staff-patient ratio), developed patient care plans, and navigated access across settings.

- **Partnerships with Post-Discharge Providers:** Hospitals participating in the Pilot worked with community providers and contracted with dedicated SNFs to provide payments and other resources to support individuals with complex needs.

- **Supportive Services**: Pilot sites had access to funding for supportive services to address patient-level barriers to discharge, allowing flexibility in addressing barriers to discharge.[9] These funds were used for non-Medicaid covered services or for covered services that could not be accessed timely.

- **DSHS Staffing:** A DSHS case manager was dedicated to each pilot site with a capped caseload (1:30 case manager-client ratio) to support completion of HCS assessments, person-centered care planning, and navigation to access to long-term care services and supports. In addition, DSHS public benefit specialists were dedicated to pilot to support financial eligibility determinations.

- **Multidisciplinary Care Team:** To implement the care plan, a multidisciplinary care team involving cross-system partners convened weekly to coordinate care. This team included ECM staff, DSHS staff, MCOs, SNF partners, and others involved in the patient's care, such as durable medical equipment (DME) specialists or contracted behavioral support and chemical dependency counselors.

[9] 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.

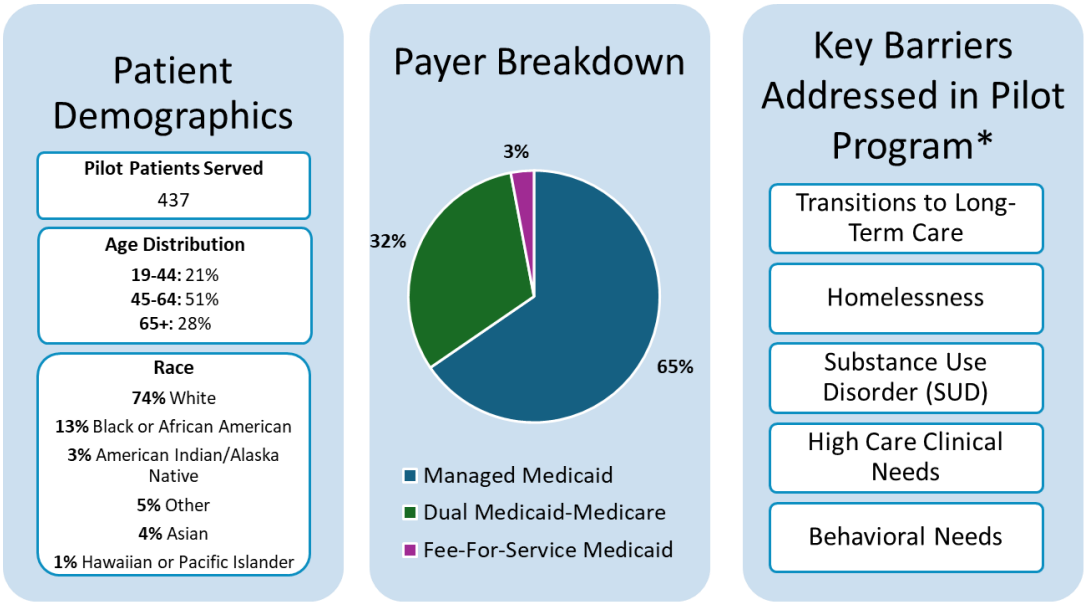
Complex Discharge Pilot Sites & Launch Dates

The pilot included five sites across Washington, with the first site launching in April 2024 and fifth site beginning in January 2025 (see below). While originally envisioned as a two-year pilot, the work to design and launch the pilot required significantly more time and work by partners than anticipated. This included development of a common understanding the pilot goals and expectations, system capacities needed to support care transitions, and greater appreciation of the barriers different parts of the system face in establishing innovative approaches. This work, along with pilot implementation experience in the last year, has informed the recommendations in this report.

Pilot Hospital Site	Region	Skilled Nursing Facility Partner(s)	Pilot Launch Date
Harborview Medical Center	Seattle	Queen Anne Healthcare	April 2024
PeaceHealth	Vancouver	Lacamas Creek Post Acute Bridge Crest Post Acute	May 2024
Virginia Mason Franciscan Health	Seattle Tacoma	Avamere at Pacific Ridge Orchard Park Care Center	June 2024
MultiCare	Spokane Tacoma	Avalon Northpointe Avalon Tacoma	August 2024
Providence Regional Medical Center	Everett	Everett Transitional Care Services	January 2025

Complex Discharge Patients and Key Barriers

Each pilot site had 30 slots for which they could refer patients to the pilot services. Patients eligible for the pilot included Medicaid adults who were medically ready to be transferred outside of an acute care setting but were unable due to transition barriers. Multiple barriers were identified for each individual participating in the pilot. Patient figures below are presented as of April 2025 and will be updated upon completion of the pilot on June 30, 2025.



Complex Discharge Pilot Program: Preliminary Results

Throughout the course of pilot implementation, the pilot sites have reported robust data regarding barriers experienced by pilot patient participants, key interventions and services provided, and overall impacts of the pilot on hospital and skilled nursing facility length of stay and other key factors regarding implementation. After the completion of the pilot on June 30, 2025, the Task Force will update this report with the analysis of data and outcomes across all pilot sites. Please see *Appendix C* for a summary of pilot evaluation methods and data reporting.

As a preliminary indicator of pilot impacts, the data below reflects Harborview's internal analysis of pilot patients as compared to all complex discharge patients at Harborview as well as a comparison to Harborview's Bed Readiness Program.[10] Both the Harborview Bed Readiness and Complex Discharge Pilot included the provision of administrative payments to SNFs. However, the Pilot Program model additionally provided ECM staff, dedicated DSHS staff, and funding for Supportive Services. The Task Force looks forward to providing an update on the full set of pilot data and outcomes.

Preliminary Results from Harborview Pilot Site

- **Harborview complex discharge pilot patients had a 22 percent lower median hospital length of stay (LOS) compared to all complex discharge patients at Harborview (Calendar Year 2024).**

- **Comparison between Harborview's existing Bed Readiness Program and Complex Discharge Pilot Program.**

Metric	Complex Discharge Patients Enrolled in Harborview's Bed Readiness Program	Complex Discharge Pilot Patients enrolled at the Harborview Pilot Site	Result
Average SNF Length of Stay *(Calendar Year 2024)*	114 days	72 days	↓ **42 days** **37% reduction**
Average SNF Length of Stay *(January-April 2025)*	185 days	60 days	↓ **125 days** **68% reduction**
Hospital Readmissions *(Calendar Year 2024)*	6.6%	5.4%	**20% reduction**

- **Hospital Setting Cost Savings:** Harborview estimates **a $1,603.83 decrease in cost per day** for each day reduction in length of stay.

Pilot Patient Satisfaction Across All 5 Pilot Sites

- **79 percent** of patients participating in the pilot who responded to a survey reported their care experience was ***Good*** to ***Excellent*** across all pilot sites.

- **70 percent** of patients participating in the pilot who responded to a survey ***Agreed*** or ***Strongly Agreed*** that the program helped improve their health and well-being across all pilot sites.

[10] Harborview's Bed Readiness Program served as a foundational model for the design of the Complex Discharge Pilot model of care.

Complex Discharge Pilot: Drivers of Success and Key Learnings

The Complex Discharge Pilot has developed and tested a model of care for Medicaid enrollees with complex medical, behavioral, social, and long-term care needs to successfully transition from hospitals into post-acute and community settings. This model focuses on patient-centered care and is built on cross-system collaboration to facilitate access to needed care and supports. Each partner—including hospitals, post-acute and community providers, outpatient and other service providers, MCOs, DSHS and HCA—brings a specific set of resources and responsibilities and has worked collaboratively through the Pilot to support patients to transition into settings that best meet their needs.

Health Management Associates conducted interviews with key pilot participants involved in the implementation of the Complex Discharge Pilot Program. The goals of these interviews were to provide an opportunity to solicit thoughts on the benefits and challenges of the pilot, inform learnings from the pilot, and support Task Force recommendations for a future permanent program.

Pilot Partners Interviewed

- Hospital Pilot Sites (each pilot site was interviewed individually)
- HCS Staff
- HCS Leadership
- MCOs
- SNF partners
- Additional Post-Acute Care and Community Partners

In the section below, we summarize key themes identified through the interviews in the following areas:

- Key features of the model driving success
- Opportunities to refine the model of care
- Continued system gaps/barriers that the model of care is not able to address

These themes inform Task Force recommendations for expansion of statewide program as well as actions needed to address underlying system barriers.

Key features of the model driving success

- ✓ ***Strong relationships among system partners through the Multidisciplinary Care Team.***
  - Allowed for more oversight, follow through, and accountability.
  - Supported information sharing and collective advocacy for the patient.
  - Helped with understanding of what each partner is doing for the patient.

- ✓ ***Longitudinal ECM care management support for patients across range of settings.***
  - Two ECM care managers provided continuity of care across hospital, post-acute and community settings and improves patient engagement in care.
  - Supported acceptance of patients into SNFs and other settings who would not have been accepted previously.

"I have liaisons within the care team, social worker, nurses, therapy, my housing case manager. Everyone works together to make sure I have what I need, medical appointments, equipment, you call me and come to see me here and when I'm in the hospital."

- Complex Discharge Pilot Patient

- Helped connect patients with a range of physical, behavioral, social, and long-term care services in a variety of settings.
- Smaller caseloads (1:15 ECM staff-patient ratio) supported ability to better serve patient needs.

✓ ***Dedicated HCS case managers and financial eligibility staff for each pilot site expedited the process for eligibility determination, care planning, and finding a willing provider for care transitions.***

- Participation in multidisciplinary team, support to navigate potential long-term care programs, and smaller caseloads (1:30 case manager-client ratio, compared to the standard 1:75 ratio for acute care hospital discharge) allowed for expedited service eligibility determinations and transitions to community-based settings.[11]

> *"HCS ratio for ECM is unprecedented; only having 30 patient caseload has been helpful in addressing patient needs."*
>
> **- Complex Discharge Pilot Provider**

✓ ***Access to supportive services funds to overcome barriers to care transitions.***

- Expedited access to care to support care transitions that may otherwise be delayed through prior authorization or other processes to access service
- Provided ability to fund services not covered by Medicaid (*e.g.,* 1:1 care in SNF settings)
- Funded services where there was a lack of provider capacity for Medicaid-covered services (*e.g.* payment for private nursing care when unable to secure home health services)

> *"You called me when I went home to make sure I made it there safely and let me know what was coming like my power wheelchair and other equipment and let me know about my appointments and working with my housing case manager. This was when I left here [SNF]."*
>
> **- Complex Discharge Pilot Patient**

✓ ***Additional SNF reimbursement supported the facility's ability to accept patients with complex needs.***

- Provided financial support for SNFs to provide additional services to Complex Discharge patients while maintaining staff levels needed to support their existing residents.

Opportunities to Refine the Model of Care

❖ **Strengthening Cross-System Collaborative Muscle**

- Ensure organizational leadership support and break down silos across system partners
- Promote engagement of providers across the spectrum of care and throughout care transitions, including establishing relationship with the patient's primary care provider.

❖ **Supportive Services**

- Create understanding about services that are covered and ensure streamlined access

[11] *Note:* HCS case manager caseloads for acute care hospital discharge are expected to increase above the 1:75 case manager-client ratio following the 2025 legislative session.

❖ **Program Enrollment and Reporting**
- Smooth enrollment in Medicaid and in other support programs, including processes related to pending Medicaid eligibility
- Recognition of administrative resources needed to support reporting

❖ **Continued Care Management After Graduation from the Complex Discharge Program**
- Develop plans for transitions to care management programs to provide continued care management support once a person graduates from the program model of care to support the patient's care transition.

❖ **Community-Based or Regional Model**
- Explore modifications needed to share ECM within a region, particularly for rural areas or hospital with few patients with complex discharge needs.

Success of the Complex Discharge model depends on the services provided as well as structures to support cross-system collaboration for streamlined access to and delivery of a range of services to meet the person's care needs. In addition to the model of care, pilot partners emphasized the imperative to address broader system barriers to support care system care transitions that were not impactable through the model of care alone (see examples below). These learnings from pilot partners inform Task Force recommendations in this report.

Pilot Examples of Continued System Gaps/Barriers that the Model of Care is Not Able to Address

- ☐ Lack of system capacity to accept patients with certain high care needs (e.*g.* traumatic brain injury, dialysis).
- ☐ Lack of availability of services even with funding available, *e.g.* behavioral health services, home health services.
- ☐ Skilled nursing facility capacity and regulatory considerations in accepting patients with complex needs.
- ☐ Skilled nursing facility challenges in receiving payments for add-on services.
- ☐ Gaps in facilities accepting and managing patients with challenging behaviors and/or SUD.
- ☐ Processes to secure guardianship appointments for individuals requiring care transition into community-based long-term care.
- ☐ Transitions into long-term care, such as identifying provider settings for patients to transition.
- ☐ Gaps in long-term care coverage for non-citizens.

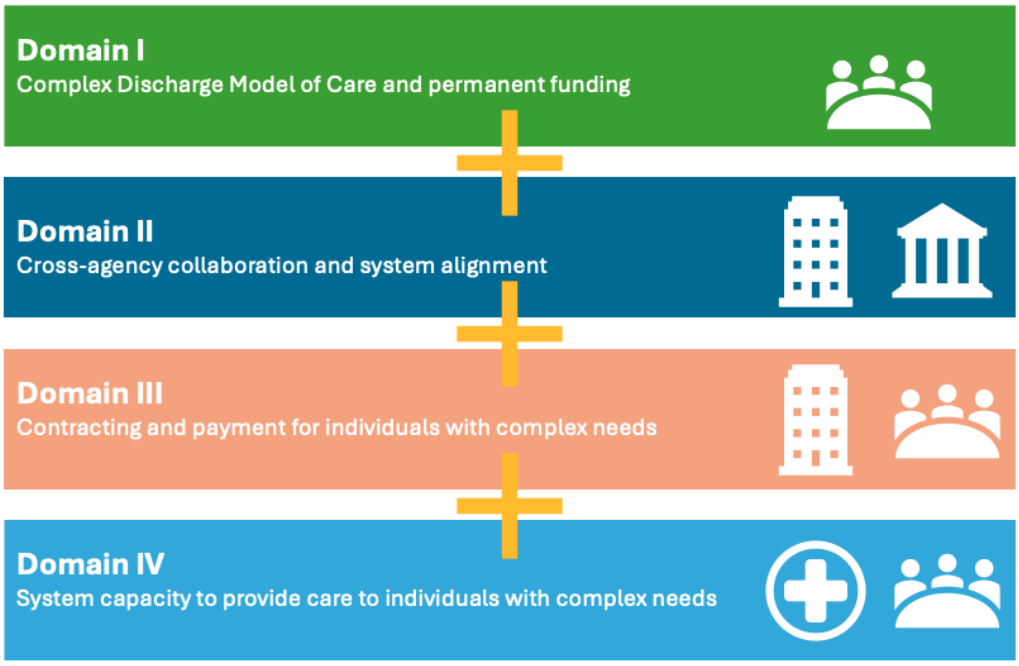
Recommendations

In this report, the Task Force sets forth **eight recommendations** designed to move the state toward the goal of a fully functioning system that supports discharge, care management and transitions across settings for individuals with multiple physical, behavioral, social, and long-term care needs.

With these recommendations, the Task Force calls for statewide expansion of the Complex Discharge Model of Care and actions to address underlying systemic barriers to timely care transitions.

To support this expansion of the model of care to health systems and communities across the state, the Task Force recommendations address underlying systemic barriers that are critical for ensuring alignment and coordination at the agency and payer levels. The Task Force outlines a **path forward and strategic actions needed by the legislature, state agencies, providers, and areas for deeper focus by the Task Force** across four critical domains.

The Task Force recognizes that the recommendations will require funding and diligence by a range of system partners across the care continuum. While the current state budget outlook and uncertainty of federal Medicaid investments may limit the scope of our efforts in the near term, there are meaningful steps we can take to advance our broader system goals. To carry out these recommendations, it will be critical to provide funding to ensure the necessary agency staff and resources, along with agency efforts to identify administrative improvements.



Action Owner Key

Recommendations Snapshot

Domain I

Complex Discharge Model of Care and permanent funding

1. Develop a plan to leverage Washington's existing Medicaid authorities to expand the Complex Discharge Model of Care statewide and provide permanent funding.

After analyzing options for sustainable funding for a statewide program, the Task Force recommends that Washington adapt and expand existing Medicaid authorities to support the Complex Discharge Model of Care in core service areas (ECM, supportive services, and enhanced payments to SNFs and other post-discharge settings). In addition to these core service areas, the Task Force emphasizes the importance of sufficient funding for DSHS and HCA staff for the Complex Discharge Model of Care to work successfully. State agency staff, such as HCS case managers and financial eligibility workers to support transitions to long-term care, are part of the essential features of the model of care.

- ***Path Forward – Task Force:*** The Task Force will engage system partners in the Summer/Fall 2025 to recommend a plan for redesigning the Health Homes program in a manner that encompasses and aligns with ECM and care transitions for individuals with complex needs. This work will include relevant partners from the agencies, Tribes, providers, payers, and patient representatives. The Task Force will keep legislative staff informed of the approach for the redesign work.
- ***Path Forward – Task Force:*** In concert with the work on Health Homes and the ECM component of the model of care, the Task Force will identify financing and programmatic mechanisms to streamline access to Supportive Services (see also *Recommendation 5*), support adequate payments for complex care to SNFs and other post-discharge settings (see also *Recommendation 6*), and address funding for HCS case managers and benefit specialists.
- ***Path Forward – Task Force:*** The Task Force will engage agencies and Tribal partners to develop a model of care to support care transitions for AI/AN populations and members of Tribal communities. This work will include support for development of Tribal Care Coordination Agreements between hospitals and Tribes as well as workflows to support connections with Tribes.

Domain II

Cross-agency collaboration and system alignment

2. Create a cross-agency leadership structure to oversee and direct agency cross-system initiatives relating to transitions of care for Medicaid enrollees with complex needs.

To sustain and strengthen the cross-system collaboration demonstrated in the Complex Discharge Pilot, the Task Force recommends establishing a formal cross-agency leadership structure that is accountable to the governor and charged with providing unified direction and a set of goals and system metrics that move the entire system toward a patient-centered and holistic approach to transitions of care for individuals with complex needs.

- ***Path Forward – State Agencies:*** Agency leadership should work together to establish common goals and outcome measures to drive cross-system coordination to support transitions of care for

individuals with complex needs. Tribal partners should also be engaged to inform this work. Areas of focus include:

a. Identifying a short list of shared metrics that are made publicly available and providing accountability for successful transitions of care that reflect all aspects of a person's care needs including physical, behavioral, social, and long-term care.
b. Establishing an integrated care planning process that is person-centered and allows providers shared access to patient assessment data and outcomes. This could include establishing a platform to share assessment data, exploring opportunities to streamline and coordinate assessment processes, or other mechanisms to support integrated care planning that inform patient service needs and ensure that payments reflect patient complexity (see also *Recommendation 6*)
c. Creating tools to streamline provider access to available program resources across the system and promoting provider ability to navigate available services, including program eligibility, payment rules, claims processes, and availability of beds/services (see also *Recommendations 5* and *8*).
d. Developing provider trainings and best practices for navigating services for patients with a range of medical, behavioral, social, and long-term care needs.

3. Promote the upstream use of decision-making legal tools and expand guardianship and decision-making options to address care transition delays due to a person's inability to consent.

The Task Forces emphasizes the need for upstream solutions, such as promoting use of durable powers of attorney, to prevent situations in which guardians or conservators are needed to make patient care and financial decisions. Alongside these preventive strategies, urgent legislative action is needed on policy options that could reduce the significant delays—three to six months or more—that individuals and families experience in hospitals waiting for guardianship or conservatorship appointments. The Task Force recognizes the important legislative investments to date to expand Office of Public Guardianship (OPG) capacity, but these investments alone will not impact the delays in care transitions resulting from guardianship processes. Further legislative review and action on policy options is critical to address these delays.

- ***Path Forward – State Agencies:*** Agencies and MCOS should include information about health care and financial durable powers of attorney in regular communications with Medicaid enrollees.
- ***Path Forward – Legislature:*** The legislature should evaluate policy options to 1) support the use of upstream strategies to promote use of durable powers of attorney to prevent situations requiring guardianship or conservatorship, and 2) streamline and expedite guardianship and conservatorship processes while maintaining individual's due process protections. The need to re-examine Washington's interpretation of federal Medicaid policy and state surrogate decision maker law relating to patient consent to long-term care, which is a significant driver in guardianship cases for Medicaid patients, should be a main focus. Through this work, the Task Force further underscores the need to engage in proactive efforts to coordinate with Tribes and Tribal courts in guardianship processes.

Domain III

Contracting and payment for individuals with complex needs

4. *Leverage MCO and DSNP contracts to emphasize and reward accountability for care transitions for Medicaid enrollees with complex needs.*

Medicaid MCO and DSNPs are key partners in the Complex Discharge Model of Care. As such, and it is critical that they understand their responsibilities for care transitions for individuals with complex needs. Agencies must hold them accountable for a broader continuum of care. The Task Force recommends a review of current MCO and DSNP contracts to identify ways to promote and incentivize adherence to the Complex Discharge Model of Care and engagement with providers to support care transition. This work should also address agency accountability to serve the Medicaid FFS program in a similar manner for care transition needs.

- ***Path Forward – State Agencies:*** HCA, in coordination with DSHS, should develop specific contract requirements and encourage provider engagement to implement the model of care. Areas of focus include network adequacy requirements, expectations for care management, quality measures, public reporting of payer performance related to transition timelines, reimbursement, and value-based contracting. This review should also include opportunities to strengthen MCO expectations and accountability through the contract re-procurement process.
- ***Path Forward – State Agencies:*** In consultation with DSHS, HCA should develop MCO oversight mechanisms that ensure that contract elements are being properly deployed, and care improvements are being achieved, including specific metrics on this population. The Task Force recognizes the importance of adequate resources to support this work, along with agency efforts to support administrative improvements.

5. *Develop resources to support provider understanding and ability to navigate Medicaid eligibility and payment of covered services.*

The Task Force recognizes the challenge of navigating services for populations whose needs cross multiple domains of physical, behavioral, long-term care, transportation, housing, social supports services, and more. The Task Force recommends that agencies work to develop resources that support provider understanding and ability to navigate this range of program resources.

- ***Path Forward – State Agencies:*** HCA and DSHS should collaborate to develop and regularly update a resource to provide guidance and technical assistance to promote provider understanding and ability to navigate the available services, eligibility criteria, and payment for services across systems. Agencies should engage MCOs in this effort and ensure that these resources align with MCO guidance. The agencies should also work together to streamline access to SNFs and rehab levels or care for individuals who rely on Medicaid FFS, recognizing this as a key Tribal priority.

6. *Identify options for adjusting Medicaid rates to serve individuals with multiple complex needs and expand coverage to address gaps in the system.*

Providers have emphasized concerns that current payment rates are not sufficiently sensitive to the level of care, staffing and facility resources required by individuals with complex needs. Pilot payments to SNFs as well as the pilot supportive services funds increased the ability for post-acute and community partners to accept patients with more complex care needs. As the pilot funding ends, the Task Force will

continue to dedicate attention to rate and reimbursement methods for caring for patients with multiple physical, behavioral, social and long-term care needs.

- ***Path Forward – Task Force:*** The Task Force will use the learnings from the pilot to further develop recommendations to ensure that Medicaid coverage and reimbursement for post-acute and community settings sufficiently address and adjust for the level of care required for individuals with multiple complex needs. The Task Force will also examine coverage gaps, such as 1:1 care in SNF settings, patients requiring single rooms, and coverage of non-citizens in need of long-term care. The Task Force will also work with Tribal communities specifically to understand reimbursement model impacts to the current payment structure for Tribal health system partners.

Domain IV

System capacity to provide care to individuals with complex needs

7. Establish and strengthen provider-level partnerships to support transitions of care for individuals with complex needs.

Strong collaboration and partnership across multiple partners and systems – including hospitals, post-acute, community settings, Tribes, outpatient and other services, and other entities involved in serving patients – is a foundational component of the Complex Discharge Model of Care. Throughout the Pilot, we have seen both the importance of, and the energy required to, realize these provider-level partnerships and develop the collaborative muscle needed to support successful care transitions.

- ***Path Forward – Providers:*** The Task Force would like to underscore the importance of hospitals and other providers in the care continuum continuing to cultivate and expand these relationships. By continuing to support current relationships and programs (like Bed Readiness), health systems will be more ready for adoption and success in the statewide Complex Discharge Model of Care. The Task Force recognizes that these efforts will require resources and should be rewarded. Payers and others should provide resources and tools for this kind of engagement and planning work, such as the development of a platform to share best practices.

8. Assess system capacity to serve individuals with complex needs and determine specific gaps and recommendations.

The Task Force recognizes the need for further assessment of the system's true capacities for serving individuals with complex needs and determination of specific gaps and recommendations. These gaps include specialized services and supports (*e.g.,* dialysis, traumatic brain injury, SUD, bariatric care, neuro-cognitive supports) as well as overall service gaps (*e.g.,* behavioral health services, home health services) to support care transitions. The Task Force also recognizes that system capacity issues are complex and interwoven with other issues, such as variation of capacity based on payer source as well as provider payment levels to serve individuals with multiple complex needs.

- ***Path Forward – Task Force:*** In 2025 and 2026, the Task Force will further explore an understanding of system capacity gaps and develop a framework for evaluating and identifying recommendations to address. The Task Force will also engage Tribal Partners to inform this work.

Recommendations and Rationale

In the section below, we outline in further detail the Task Force's **eight recommendations** and the rationale supporting each recommendation. These recommendations address key drivers of the challenges in effective care transitions for individuals with multiple medical, behavioral, social and long-term care needs, including:

- **System complexity** resulting in covered services being underutilized due to the difficulty of navigating system rules and processes.
- **System gaps in services and provider capacity** that impede transitions for some patients.
- **Care siloes** leading to fragmented accountability and duplicative, uncoordinated activity at every level, signaling the need for collaborative solutions.

The Task Force also notes that while many of these recommendations focus on care transitions for individuals covered through Medicaid, the recommendations will support broader system change for individuals covered through Medicare, commercial and other payers.

Domain I
Complex Discharge Model of Care and permanent funding

Recommendation 1:
Develop plan for leveraging Washington's existing Medicaid authorities to expand the Complex Discharge Model of Care statewide and provide permanent funding.

The Task Force recommends that Washington adapt existing Medicaid authorities to provide permanent funding for the Complex Discharge model of care. The Task Force will take immediate action to frame out this approach and develop a plan for leveraging and adapting the state's existing Medicaid authorities. This plan should support sustained financing for the four core elements of the model of care: 1) ECM, 2) Supportive Services, 3) SNF/community setting payments, and 4) DSHS staff support.

- **Enhanced Care Management:** In the summer/fall of 2025, the Task Force will engage system partners to help redesign the Health Homes program to align the ECM component of the Complex Discharge care model. This work will include representatives of HCA, DSHS, providers, Tribal partners, and MCOs. Relying upon lessons learned from the Complex Discharge Pilot and current Health Homes model, the group will develop a proposed plan for the legislature to consider the redesign of the program and sequence of actions needed to execute. The Task Force will regularly update the Legislature and Governor on progress and approach for this work.

- **Supportive Services:** Individuals with medical, behavioral, social, and/or long-term care needs generally require numerous services to support care transitions. This can include services covered under a range of current Medicaid waivers and state plan authorities. Under *Recommendation 5*, we discuss the need to ensure provider and patient understanding of available services across settings and reduce complexity in accessing services. With experience under the Pilot, the Task Force recognizes the importance of flexible dollars to help providers

navigate expenses that are not covered or act quickly when the timeliness of authorization could result in transition barriers or delays. Some supportive services available through the pilot were able to fund care that is not currently covered by Medicaid, such as 1:1 supportive supervision in SNF settings. As we advance the work outlined in *Recommendation 6* to evaluate options for adjusting rates to reflect patient complexity, the Task Force will identify these unfunded supportive services, and authorities and mechanisms for financing them when needed. The Task Force work under *Recommendation 8* to assess system capacity gaps will also inform understanding of gaps in supportive services as a critical aspect of system capacity when providing care to individuals with complex needs.

- **SNF/Community Settings Payments:** Administrative payments to SNFs to support their ability to accept and ensure necessary care for more complex patients was frequently cited as an invaluable element of the pilot. The Task Force believes that additional administrative support funds are needed for SNFs and other post-acute and community providers to optimize complex care. As outlined in *Recommendation 6*, the Task Force will identify options for adjusting reimbursement rates for SNF and other community settings to better reflect patient complexity and expand the availability of providers to serve individuals with complex needs.

- **DSHS Staffing:** Pilot sites expressed support for, and significant benefit of, dedicated HCS case managers and public benefit specialists with reduced caseloads to support care transitions for individuals with complex needs. Early outcomes from Harborview show reduced hospital and SNF length of stay in the pilot compared to their existing Bed Readiness Program, which suggests a benefit from the additional investment in DSHS staff. Task Force work to build out a sustainable funding plan will include options for sustainable funding of DSHS staff an essential aspect of the model of care. As an interim step, hospitals could be permitted to fund DSHS positions in the next fiscal year.

As part of the plan for sustainable funding, it will be important to consider flexibilities needed to adapt the model of care to share resources and infrastructure. For example, in rural communities, a community-based model could allow for the sharing of regional resources and infrastructure. In addition, the Task Force will engage agencies and Tribal partners to develop a model of care to support care transitions for AI/AN populations and members of Tribal communities. This work will include support for development of Tribal Care Coordination Agreements between hospitals and Tribes as well as workflows to support connections with Tribes.

Key Findings and Rationale

The Complex Discharge Task Force and Sustainable Funding Workgroup evaluated a range of options for permanent Medicaid funding for the pilot model of care. This analysis included Washington's current authorities, potential new authorities, and an evaluation of pros and cons of various approaches. The Task Force and Workgroup considered the extent to which each authority could cover the full scope of the model of care (ECM, supportive services, and SNF administrative payments), coverage of both managed care and FFS enrollees, and the level of effort to secure and maintain federal approval. See *Appendix G* an overview of all federal authority options explored, and *Appendix H* for a review of the pros and cons of the options most aligned with the Complex Discharge Model of Care.

Leveraging Washington's existing Medicaid authorities was determined the best path forward for several reasons (See *Appendix I* for an overview of this option and other authorities considered). The services available under the Health Homes authority are closely aligned with the ECM component of the pilot model of care and other states have successfully utilized this authority to implement ECM. The Health Homes authority includes population eligibility criteria that would encompass individuals with complex discharge needs, covers both managed care and FFS enrollees, and allows ECM providers to follow individuals throughout their transition of care from acute-care hospitals into a range of post-acute and home and community-based settings.

Washington also has multiple existing authorities through its 1115 demonstration, eight 1915(c) waivers, and state plan amendments that offer a range of services across settings. However, pilot sites and other providers have underscored the complexity of understanding and accessing these resources. In considering the opportunity to leverage Washington's existing Medicaid authorities to support the Complex Discharge Model of Care, the Task Force emphasizes the importance of operational streamlining and simplifying access to current services available. The payment structures of Health Homes and other Medicaid services can also contribute to simplification, and the Task Force's further work in *Domain III* addressing payments for individuals with complex needs will incorporate this principle.

The Task Force also recognizes a priority to work with Tribal partners in the development of a Complex Discharge Model of Care for AI/AN individuals and members of Tribal communities. This work will include support for development of Tribal Care Coordination Agreements between hospitals and Tribes to facilitate care transitions for Tribal members. These agreements can outline hospital and Tribal partner contacts and identify the key services that Tribal health systems can offer to support care transitions. In addition, the following specific actions were identified as opportunities to support connections with Tribal partners:

- Use of best practices for asking if a person is AI/AN or a member of a Tribal community.
- Development of training and workflows to support coordination. As part of these workflows, there is opportunity to leverage the Native Resource Hub to obtain contacts for each Tribe as well as access to Tribal Service Profiles.
- Opportunities to share information that allows Tribes to identify if their members are in the hospital.
- Opportunities to coordinate with Tribes operating long-term services and supports (LTSS) program or Area Agencies on Aging (AAAs), as well as processes for communication with Tribes around HCS assessments and impacts on benefits.
- Opportunities to further collaboration with the Native Hub (separate from the Native Resource Hub) which will serve as a care coordination resource for Tribal members.
- Training to support understanding of Tribal health systems and Tribal Sovereignty. This training may build on the training provided by the American Indian Health Commission to the Complex Discharge Pilot sites in January 2025.

Tribes are also actively engaging with the Health Homes model as a primary mechanism for providing care coordination and obtaining reimbursement through the Medicaid FFS program. Some Tribes, for example, have established Tribal Health Homes, which has provided opportunity for greater recognition and connections with other system providers. As the Task Force explores opportunities to adapt the Health Home program, it will be important to engage with Tribal partners and ensure Tribal perspectives in this effort.

As the Task Force moves forward with recommending permanent funding structures, these considerations will be addressed. The Task Force will regularly update the legislature and the governor on financing recommendations, highlighting the ways different options connect to the goals stated in this report and the barriers identified by stakeholders.

Domain II
Cross-agency collaboration and system alignment

Recommendation 2:
Create cross-agency leadership structure to oversee and direct cross-system initiatives relating to transitions of care for Medicaid enrollees with complex needs.

To sustain and strengthen the cross-system collaboration demonstrated in the Complex Discharge Pilot, the Task Force recommends establishing a formal cross-agency leadership structure that is accountable to the governor and charged with providing unifying direction and a set of goals and system metrics that move the entire system toward a person-centered and holistic approach to transitions of care for individuals with complex needs. Tribal partners should also be engaged to inform this work. This cross-agency leadership and alignment should take the form of:

a. Identifying a short list of shared metrics that provide accountability for successful transitions of care that reflect all aspects of a person's care needs including physical, behavioral, social and long-term care.
b. Establishing an integrated care planning process that is person-centered and allows providers shared access to patient assessment data and outcomes. This could include establishing a platform to share assessment data, exploring opportunities for coordinated and streamlined assessment processes, or other mechanisms to support integrated care planning that inform patient service needs and ensure that payments reflect patient complexity (see also *Recommendation 6*).
c. Creating tools to streamline provider access to available program resources across the system and promoting provider ability to navigate available services, including program eligibility, payment rules, claims processes, and availability of beds/services (See also *Recommendation 5* and *Recommendation 8*).
d. Developing provider trainings and best practices for providers to navigate services for patients with a range of medical, behavioral, social, and long-term care needs.

To be successful in these important initiatives, the Task Force recognizes and calls out the importance of sufficient funding for DSHS and HCA staff to effectively conduct and manage these cross-system initiatives.

Key Findings and Rationale

In their 2024 report, the Task Force identified the need for development of cross-system collaborative muscle to support care transitions. Through the experience with the Complex Discharge Pilot, the Task Force recognizes that provider-level collaboration must be supported by robust state agency collaboration with shared accountability for the population. The agencies jointly engaged with pilot sites to support implementation of the programs, developed quality measures, evaluated data, and identified opportunities for improvement, education, and needed resources.

The Task Force recognizes that the Complex Discharge Pilot builds on existing agency efforts to support cross-system collaboration. This includes DSHS' history of administering LTSS and social needs in the community complemented by the physical, behavioral, transportation and interpretation benefits that are administered by HCA and its contracted MCOs or providers in FFS. Recognizing the need for strong care coordination at the provider level, DSHS has developed significant resources to support acute care hospitals to coordinate care transitions into long-term care. This work has included, for example, regular care coordination meetings with hospital and MCO partners, trainings, workflows, and other resources. The Task Force recommendations in this report seek to strengthen these current efforts by deepening cross-agency leadership, oversight, and accountability for ensuring cross-system coordination to support successful care transitions.

Shared Metrics and Accountability

To sustain and further strengthen the level of collaboration experienced through the pilot, agency alignment driven by shared system goals and metrics is imperative. These shared metrics can be used to monitor performance to ensure cross-agency accountability for the complex discharge population. Identifying shared metrics that support alignment requires clarity of goals and expectations for the complex discharge population. These shared metrics can then carry through and drive each agency's contracting incentives and accountability processes, establish an integrated care planning process and shared assessment data, develop provider resources that minimize the administrative burden providers experience and develop shared training efforts to support navigation of the system to address a person's holistic needs.

Shared Assessment and Integrated Care Planning Processes

Assessments are the gateway to accessing services and informed care planning and rates paid to providers. As such, assessment of a person's care needs cannot be fragmented across agencies and partners. Each assessment focuses on a subset of the patient's needs, which results in assessments and data gathering by multiple partners that is not shared or optimized in a manner that results in a holistic care plan reflective of a person's needs. Without tools to support integrated care planning and shared assessment data, providers serving the complex discharge population will continue to experience significant administrative burdens in navigating available services and payments. Moreover, without these tools, patients can at times be left trying to understand and arrange the different services and providers and partners involved in their care.

Notably, the Rates Workgroup emphasized how these complexities impact reimbursement for care and the adequacy of rates to serve individuals with multiple complex needs. The Task Force recognizes opportunities to create operational efficiencies, such as integrated care planning, streamlining and sharing assessment data, improving Medicaid eligibility processes (e.g., pending Medicaid, presumptive eligibility), developing standardized prior authorization policies, and ultimately developing a shared care plan that all agencies and partners can utilize.

Streamlined Access to Program Resources and Operational Efficiencies

Individuals facing barriers to discharge often require a wide range of services, and the source and amount of coverage for these services differs depending on provider type/setting, patient characteristics, and the source of the coverage (Medicaid MCOs, Medicaid FFS, DSNPs, waivers, Medicare, etc.). Through discussions with the Rates Workgroup, the complexity of the system creates provider confusion and uncertainty in payments available to provide care for individuals with complex needs. As outlined further in *Domain III*, it is critical to support providers with streamlined access to information about program resources, services, eligibility, claims, documentation requirements, and payment processes. These resources and information must be developed through cross-agency collaboration and available to all partners and providers with whom they contract to provide an array of services to individuals with complex needs.

Training and Best Practices

As noted throughout this report, the services provided to the complex discharge population often include an array of services administered by DSHS and HCA that are then provided by several different partners. To promote person-centered care that is holistic and comprehensive, trainings must be co-developed by DSHS and HCA to promote provider skill development for navigating services and care transitions for individuals with a range of medical, behavioral health, social, and long-term care needs. Importantly, these trainings can help to ensure provider understanding of available services and willingness for serving individuals with complex needs.

Recommendation 3:
Promote the upstream use of decision-making legal tools and expand guardianship and decision-making options to address care transition delays due to the inability of a person to consent to care.

The Task Forces emphasizes the need for upstream solutions, such as promoting use of durable power of attorney, to prevent situations in which guardians or conservators are needed to make patient care and financial decisions. Alongside these preventive strategies, urgent legislative action is needed on policy options that could reduce the significant delays—three to six months or more—that individuals and families experience in hospitals waiting for guardianship or conservatorship appointments.

While the need for guardians or conservators is not a common occurrence, delays while waiting for these appointments have an outsized impact. These delays are among the top barriers to transitions of care identified by hospitals and can create significant burden for patients and families. In addition, these processes have major financial impacts for hospitals who bear responsibility for the cost of guardianship legal processes as well as other uncompensated costs of care. Hospitals, for example, estimate an average cost of approximately $6,686 per patient relating to processes to seek guardianship appointment.

Over the last several years, the legislature has made important investments to expand OPG guardianship capacities focused on care transitions for individuals from acute care hospitals into home and community settings (SB 5825, 2024). These have been significant and needed investments to address the challenges in identifying guardians with sufficient expertise and willingness to support individuals with complex needs. Expansion of OPG capacity alone however is not enough to address the delays in care transitions related to guardianship.

As an immediate step, the Task Force recommends that state agencies and MCOs take action to include information about health care and financial durable powers of attorney in regular communications with Medicaid enrollees.

Patient Example of Timeframes for Guardianship Process

1/23:	Patient with multiple previous admissions admitted to the hospital with dementia and worsening memory issues. No acute needs but is unhoused and in need of support with activities of daily living. Unsafe to discharge back to streets. Hospital determined long-term care needed, and initiated search for CPG.
2/14:	CPG identified and court petition for guardianship filed. Court hearing date set for April 21.
2/28:	Court Visitor assigned to conduct guardianship investigation**.** Initiated request for special CV consent powers. This allows CV to consent for HCS services, assist with Medicaid application, and for transfer to the SNF. (CV may not consent on financial matters require for LTC eligibility determination)
4/14:	Discharge to SNF enabled through request for CV special consent powers.
4/21:	Court hearing date established upon petition filing.
5/5:	Court hearing date moved due to limited availability of Court Visitor to complete guardianship investigation.
	Guardian appointment

Further, the Task Force recommends the legislature review the policy options outlined below —some of which have been included in previous legislative proposals — and determine what action is needed: [12]

- ***Strategies to support upstream decision-making planning and alternatives to guardianship and conservatorship appointments****, including but not limited to:*
  - Promote upstream completion of financial and healthcare power of attorney documents to reduce reliance on guardianship.
  - Require managed care plans to utilize the contractually required initial health screen and/or health risk assessment process to determine whether an enrollee has a health care and financial power of attorney and to provide education on the benefits and process for designating one.
  - Re-examine Washington's interpretation of federal Medicaid policy regarding patient consent requirements for long-term care services and state surrogate decision maker law, which is a significant driver in guardianship cases for Medicaid patients. Other states do not interpret Medicaid policy to prohibit legal next of kin to consent to transitions out of hospitals into home and community-based settings.
  - Develop a centralized repository and other tools to promote creation and sharing of information relating to financial and healthcare power of attorney documents.
  - Increase understanding and availability of decision-making alternatives to guardianship, such as supported decision-making.

Patient example where legal next of kin is not able to consent for transition into long term care setting:

A 65-year-old man after a stroke is in a minimally conscious state. He has Medicaid and son who was his primary caregiver at home prior to admission involved and willing to consent to transition into long-term care. However, legal next of kin is not recognized as an authorized decision maker based on Washington interpretation of federal Medicaid rules.

- ***Strategies to streamline guardianship and conservatorship court processes,*** *including but not limited to:*
  - Reduce administrative burden & costs, such as filing requirements in a patient's county of residence.
  - Create expedited guardianship processes for individuals in hospitals who are medically ready for discharge and lack a decision maker.
  - Expand options to allow patients waiting in hospitals during the guardianship process to transition to a range of long-term care settings that can better meet their needs.
  - Continue expansion of Certified Public Guardian (CPG) capacity and recruitment strategies for serving individuals with complex needs.
  - Increase Washington State court capacity for guardianship cases.
  - Establish processes to ensure recognition of relationship and proactive engagement with Tribal governments and jurisdiction in guardianship processes.

The Task Force recognizes there are differing perspectives on each of these policy options and the need to balance important considerations with respect to protecting the rights of individuals while also ensuring the system is providing care in manner that can best meet their needs. It is critical to apply continued attention to policy options that can help individuals transition into care settings that meet

[12] House Bill 2083 (2022), accessed at: https://app.leg.wa.gov/BillSummary/?BillNumber=2083&Year=2021&Initiative=false

their needs, while preserving the important due process protections at stake in guardianship proceedings.

Key Findings and Rationale

Individuals transitioning into long-term care settings must be able to make decisions to self-direct their care, identify alternative decision-making supports such as supported decision-making, or rely on a previously executed healthcare and financial durable power of attorney. If unable to make decisions through these options, the individual must engage in the legal process to appoint a guardian or conservator.[13]

Guardianship is a system barrier that will continue to delay care transitions and therefore requires system-level solutions beyond the Complex Discharge Model of Care. While the Task Force recognizes that individuals are able to transition from a hospital to a SNF while guardianship is pending, this does not fix the underlying barriers. SNFs are often hesitant to accept a patient with pending guardianships because of the uncertainty it creates within the facility and the fact that it does not solve the barrier preventing individuals from transitioning into home and community settings that better meet their needs.

The Task Force recognizes that delays due to guardianship or conservatorship processes could be avoided with more emphasis on proactive strategies and investments to support individuals to complete durable powers of attorney for health care and finance. This could prevent the number of situations in which people must rely on the extreme actions of guardianship and conservatorship which transfer an individual's decision-making authority from the individual to a court-appointed person. There is significant opportunity for state agencies, MCOs, and providers to promote the use of durable powers of attorney, particularly when individuals lack these important advance-planning documents.

In our 2024 report, the Task Force recognized legislative investments to increase guardianship capacities and outlined several initial recommendations for continued legislative actions needed. These included continued expansion of guardianship capacity and supported decision-making, increasing Washington State court capacity for guardianship cases, and ensuring recognition of the relationship to Tribal governments and jurisdictions in guardianship processes.

In 2025, the Task Force and the Discharge Barriers Workgroup further identified and discussed policy options to address delays in care transitions due to guardianship processes. The options included both strategies to prevent the need for guardianship processes in the first place, as well as options to expedite these processes for individuals who are medically ready and otherwise unable to be discharged from hospitals. Workgroup members raised the significant implications of guardianship on the legal rights of individuals, as well as the well as underscored the significant pain and anguish families are enduring while loved ones are unable to transition out of hospitals into their homes or community settings that can better meet their needs.

The Task Force recognizes the need to carefully balance these considerations in policy decisions, and underscore this as a high priority for legislative review and action on the policy options to reduce barriers to care transitions due to guardianship-related issues.

[13] A "conservator" is a person appointed by the court to make decisions with respect to the property or financial affairs of an individual. A "guardian" is a person appointment by the court to make decisions with respect to the personal affairs, support, care, health, and welfare of an individual.

Domain III
Contracting and payment for individuals with complex needs

Recommendation 4:
Leverage MCO and DSNP contracts to emphasize and reward accountability for care transitions for Medicaid individuals with complex needs

The Task Force recommends that HCA and DSHS review current MCO and DSNP contracts to promote and incentivize adherence to the Complex Discharge Model of Care and support for care transitions. This review should also include opportunities to strengthen MCO expectations and accountability through the contract re-procurement process.

MCO and DSNP contracts expectations should be explicit and drive coordination across the whole system. Agency review should identify:

- Quality/performance measures to incentivize and hold plans accountable to care transitions
- Public reporting of payer performance related to transition timelines
- Specific contract requirements that demonstrate and further the model of care
- Network adequacy and other provisions to ensure the availability of post-acute providers with specialized skills and capacities
- Payments and operational streamlining to support provider reimbursement for serving individuals with complex needs
- Oversight strategies

To support this work, the Task Force and MCO & FFS Workgroup identified policy options that should be included in this review, as outlined in *Appendices E and F*. This work should also address agency accountability to serve the Medicaid FFS program in a similar manner for care transition needs. Furthermore, as the financing models are articulated under *Recommendation 1*, as well as under any re-procurement for MCOs, agencies should consider mechanisms for articulating requirements and managing performance to adhere to these elements. The Task Force also recognizes that this work requires sufficient investment in agency staff and resources to execute effectively, as well as agency efforts to identify administrative improvements.

Findings and Rationale

Holding payers accountable for the model of care and care transitions is key to successful statewide expansion and implementation of the model. Provider contracts through MCOs/DSNPs are a critical area to emphasize and incentivize accountability for care transitions for individuals with complex needs. To support this effort, the Complex Discharge Task Force and MCO & FFS Workgroup considered current pain points in care transitions for individuals with complex needs, analysis of Washington's current contract requirements, and potential contracting strategies to increase accountability for transitions into post-acute and community settings (see *Appendices E and F*).

Key pain points included:

1. There are neither penalties nor incentives tied to effectively transitioning enrollees out of hospital once they are medically ready.
2. There is variation in MCO payment levels received by providers for skilled and rehab care. Providers have reported uncertainty about payments they will receive and that payments are not sufficient to serve individuals with complex needs.
3. There are challenges in the MCO service authorization process, including hospitals reporting difficulties in securing timely and appropriate authorizations to facilitate discharge planning. Additionally, SNFs report reductions in previously authorized lengths of stay. MCOs report provider confusion regarding documentation requirements and misinterpreting requests for documentation as authorization denials.
4. Lack of understanding of services that are covered across payers/systems and of MCO roles and scope of responsibilities in care management for members with complex needs.
5. Challenges in finding post-hospitalization placements for patients specialized needs (*e.g.,* respiratory support, challenging behaviors) or who are more complex than some SNFs can accommodate both legally and practically.
6. MCOs may lack a sufficient network of post-acute care facilities for this patient population.

To effectively expand the Complex Discharge Model of Care statewide, agency action to drive MCO and DSNP accountability and oversight will be imperative. The Task Force will incorporate this into program and sustainable funding plan.

Recommendation 5:
Develop resources to support provider understanding and ability to navigate Medicaid eligibility and payment of covered services.

The Task Force recommends that agencies work to develop resources that support provider understanding and ability to navigate payment for services for individuals with complex needs. These patient service needs span across a range of Washington's current programs, payers and delivery systems and are currently part of a complex array of benefits that providers are challenged to access.

To maximize use of these resources, HCA and DSHS should work collaboratively to:

- Develop and regularly update resources and provide guidance to promote provider understanding and ability to access the range of available services, eligibility criteria, and payment for services across Medicaid payers and delivery systems. MCOs should also be engaged in this effort to ensure alignment with MCO guidance.
- Streamline access to SNFs and rehab levels or care for individuals who rely on Medicaid FFS, recognizing this as a key Tribal priority.

Key Findings and Rationale

The Task Force recognizes the challenge of navigating services for populations whose complexities cross multiple domains of physical, behavioral, long-term care, transportation, and other needs. Often post-acute care and community providers may have capacity to meet one specific need, but not all. For example, in the case of an individual with obesity and SUD who also needs dialysis and wound care, they would require treatment at a facility with capacity to serve them (bariatric bed), on-site/contracted staff to provide wound care, and access and transportation to dialysis and SUD providers not available on-site.

> *"From the SNF side, it's not just about a payment rate issue. It's about administrative complexity in billing, in getting paid, in taking risks associated with take backs."*
>
> **- Rates Workgroup member**

Through discussion with the Complex Discharge Rates Workgroup, members underscored that payment issues are not just about payment levels, but also about the complexity of the system and getting paid. As an initial step in addressing provider payment issues, therefore, the Task Force recognizes the need for cross-system resources to support provider ability to understand and navigate access to existing services.

Cross-Agency Resources to Streamline Access

As noted throughout the report, there are several entities involved in funding, authorizing and administering the programs that serve individuals considered complex to discharge. Each of the entities has their own criteria and processes for determining who is eligible, the level of care they require, and the rate to be paid for that care. To minimize administrative burden on post-acute care providers, resources are needed to support the ability of providers to understand and navigate access to the range of services that are available to support patient needs. In the current system, knowledge of and access to the providers and facilities that may be able to meet individuals with these multiple layers of needs is done on a case-by-case basis across the state. Developing specific pathways for patients with these characteristics is another way to minimize the administrative burden on post-acute care providers.

Medicaid FFS Skilled and Rehab Payments

Under the Medicaid FFS program, skilled and rehabilitative care in SNFs is paid through the Community Home Project program. DSHS pays for the SNF daily rate, and HCA pays for the therapies. Providers, however, have indicated that there is a lack of understanding of the availability of this coverage, and confusion over billing processes for these services. This results in situations where individuals covered by Medicaid FFS are denied access to a SNF.

This issue has particular impact on care and services for Tribal communities, as many Tribal members are covered under Medicaid FFS rather than through MCOs. In some cases, Medicaid FFS members may elect to enroll in a managed care plan to obtain SNF or rehab coverage for expediency, because they are ready to leave the hospital, and they are unable to identify a placement in a SNF due to misperception that that the Medicaid FFS program will

Challenges for Tribal members in the Medicaid FFS program to access SNF skilled and rehab levels of care

Complex Discharge pilot sites identified challenges in identifying placement in SNFs for Tribal members covered by Medicaid FFS. This reflects a concern that Tribes have raised previously regarding the lack of clear Medicaid FFS billing processes for SNFs to provide therapies beyond the custodial rate. This leads to the misperception among providers that these services are not covered under Medicaid FFS, and results in situations where individuals are denied access to a SNF.

not cover care above the custodial rate. This can be especially problematic for Tribal members where SNFs that are part of MCO networks are often not close in proximity to the Tribal member's community and care is not delivered in keeping with Tribal practices. In addition, the first time that Tribes are often notified of a member in a facility is when they receive a bill for services; this underscores the need to establish relationships between hospitals and Tribes to support proactive care planning for Tribal members transitioning out of hospitals, as further discussed in *Recommendation 1*.

Recommendation 6: Identify options for adjusting Medicaid rates to serve individuals with multiple complex needs and expand coverage to address gaps in the system.

Providers have emphasized concerns that current post-acute and community provider payment rates are not sufficiently sensitive to provide the level of care, staffing and facility resources required by individuals with complex needs. According to quarterly surveys of hospitals by WSHA, for example, almost half of hospitals responding to the survey (47%) reported that they have separate arrangements with post-acute care providers where the hospital covers the cost of a patient's post-acute care in order to facilitate care transitions for patients with more complex needs.[14]

Pilot payments to SNFs as well as the pilot supportive services funds increased the ability for post-acute and community partners to accept patients with more complex care needs. As the pilot funding ends, the Task Force will continue to dedicate attention to post-acute care and community provider rate and reimbursement methods that address the administrative resources and services required to support individuals with multiple complex needs. This review will also consider how patient assessment data informs rate adjustments. As noted in *Recommendation 5* above, clarity about reimbursement methods and covered services is essential to support providers to maximize existing coverage. Work under *Recommendation 6* builds upon this foundation and further evaluates options to adjust payment levels for facilities and other settings to ensure support for care needed by patients with complex needs.

Coverage gaps identified to date through the pilot, for example, include 1:1 care in SNF settings and patients requiring single rooms. These services are particularly valuable in serving individuals with care needs that manifest in behaviors that are considered dangerous to themselves or others. Providing this level of support for individuals in the SNF settings often created more stability for patients that would allow them to eventually transition to lower levels of care. Coverage of non-citizens in need of long-term care is another key gap area of coverage that the Task Force has identified previously. The Task Force therefore continues to recognize the need for expanding state-funded long-term care for non-citizens.

With continued work in 2025 and 2026, the Task Force will use the learnings from the Pilot efforts to identify options for rate and reimbursement methods for a range of post-acute and community settings that reflect the needs of individuals with multiple complex needs. The Task Force will also work with Tribal communities specifically to understand reimbursement model impacts to the current payment structure for Indian Health Care Providers and Urban Indian Health Organizations.

[14] Washington State Hospital Association, Complex Discharge Quarterly Survey Results (Q1-2025)

Domain IV
System capacity to provide care to individuals with complex needs

Recommendation 7:
Establish and strengthen provider-level partnerships to support transitions of care for individuals with complex needs.

Strong collaboration and partnership across multiple partners and systems – including hospitals, post-acute, community settings, Tribes, outpatient and other services, and other entities involved in serving patients – is a foundational component of the Complex Discharge Model of Care. Throughout the Pilot, we have seen both the importance of, and the energy required to, realize these provider partnerships and develop the collaborative muscle needed to support successful care transitions.

The Task Force would like to underscore the importance of hospitals and other providers in the care continuum continuing to cultivate and expand these relationships. By continuing to support current relationships and programs (like Bed Readiness) now, health systems will be more ready for adoption and success in the statewide Complex Discharge Model of Care described in this report. The Task Force recognizes that these efforts will require resources and should be rewarded. Payers and others should provide resources and tools for this kind of engagement and planning work, such as the development of a platform to share best practices.

Key Findings and Rationale

A key finding of the pilot effort was the importance of sound relationships and trust among the providers involved in the model of care. Therefore, the Task Force recommends and encourages providers across the state to engage with each other to build the collaborative muscle that will support deployment of the model of care statewide. This effort should include support for Tribal Care Coordination Agreements between hospitals and Tribes to facilitate care transitions for Tribal members.

In the work to develop and launch the pilot, the Task Force notes the considerable time and effort required to bring partners together around the design, payment, contracting, and implementation. This work took longer than anticipated but resulted in important learnings around the level of effort and attention needed to develop these relationships. Throughout pilot implementation, there has been continued recognition of the trust being built across partners and a driving sense of working toward the same outcomes. We also saw the importance and impact of these relationships in increasing the likelihood that providers will accept individuals with complex needs.

Previously in this report, the Task Force recommended a number of agency actions that would support cross-agency collaboration and provider understanding and ability to navigate this range of program resources. In Recommendation 7, the Task Force is underscoring the importance of building collaborative muscle at all levels of the system to support the expansion of the model of care statewide. With recommendations for the future sustainable funding for the model of care, the Task Force recognizes the resources needed to support the provider-level cross-system collaboration that is essential for implementing the model of care statewide.

Recommendation 8:
Assess system capacity to serve individuals with complex needs and determine specific gaps and recommendations.

The Task Force recognizes the need for further assessment of the system's capacity for serving individuals with complex needs and determination of specific gaps and recommendations. Pilot and system partners overall have emphasized the need for further understanding and development of solutions to address system capacity gaps. These gaps include specialized services and supports, as well as overall service gaps to support care transitions. For example:

- Lack of system capacity for certain specialized care needs (e.*g.* dialysis, traumatic brain injury, SUD, bariatric care, neuro-cognitive supports).
- Lack of availability of services (*e.g.* behavioral health services, home health services).
- Lack of availability of providers accepting Medicaid clients.
- Lack of facilities accepting and able to manage needs of individuals with challenging behaviors.
- Lack of overall provider capacity (*e.g.*, number of SNF beds).

Pilot Patient Example of Capacity Gaps through Limited Provider Availability to Serve Medicaid Clients

A 73 year-old male with history of schizophrenia, cognitive impairment, and experiencing homelessness, was admitted to the hospital due to failure to thrive. An adult family home was identified to support the client's transition back into the community. However, despite intensive searching, ECM care coordinators were not able to identify a Home Health agency to provide ongoing wound care at the AFH. Through pilot funds for supportive services, the hospital was able to hire private pay nursing to visit this patient at his adult family home and complete the bi-weekly wound care until the wound healed.

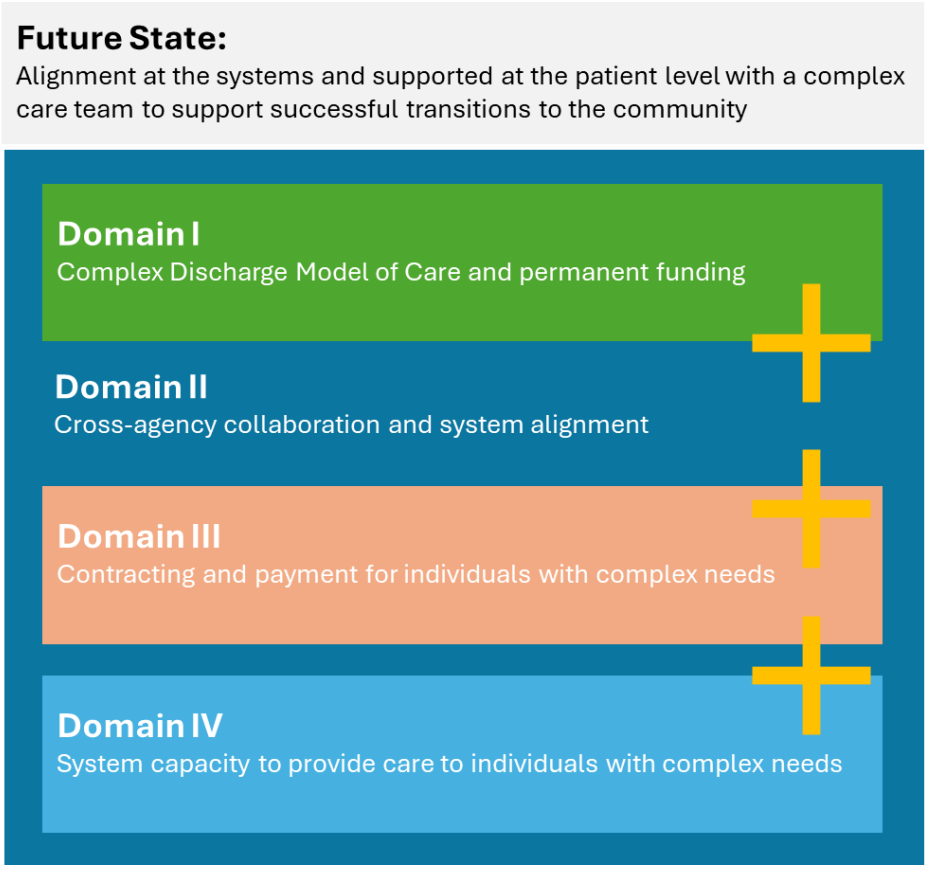
With its continued focus on these issues in 2025 and 2026, the Task Force will further explore an understanding of these system capacity gaps and develop a framework for evaluating and identifying recommendations to address. The Task Force also recognizes that in some cases the issue may be a lack of providers to serve Medicaid clients and the variation in system capacity by payer source. The Task Force will also engage Tribal Partners to inform this work. The Task Force recognizes that system capacity issues are complex and interwoven with other issues addressed by Task Force recommendations, such as provider payments that reflect care for patients with multiple complex needs. With further focus on these issues, the Task Force will identify a range of potential approaches for understanding and developing solutions to address the capacity gaps identified.

Conclusion

With the recommendations outlined in this report, the Task Force recognizes three key drivers to the challenges in effective care transitions and system performance for individuals with multiple medical, behavioral, social, and long-term care needs.

- **System complexity** results in covered services being underutilized due to the difficulty of navigating system rules and processes. Streamlining these resources is the single most important thing that can be done to improve outcomes.
- **System gaps** impede transitions for some patients. Examples include coverage gaps, such as limited availability of one-on-one support, as well as underinvestment in existing resources such as case management staff.
- **Care siloes** lead to fragmented accountability and duplicative, uncoordinated activity at every level, signaling the need for targeted, innovative new approaches. Currently, no single provider, agency or payer is responsible for the full process. The pilot clearly demonstrated that success relies on a more coordinated, streamlined and accountable response at every level.

The Task Force recommendations therefore seek to offer a comprehensive approach and collaborative solutions for addressing discharge barriers for individuals with multiple physical, behavioral, social, and long-term care needs. The recommendations in this report offer a path forward for the legislature, state agencies, providers, and the Task Force to achieve a Future State to expand the Complex Discharge Model of Care statewide and ensure systems alignment and support for care transitions for individuals with needs that span multiple systems.



Appendix A. History of Washington Initiatives Addressing Complex Discharge Challenges

The work of the Task Force builds on significant efforts over the past almost decade led by Washington policymakers, state agencies, providers, and patient advocates to address a range of system and policy barriers impacting the complex discharge challenge. A summary of key actions is provided below.

History of Washington Actions to Address Complex Discharge Challenges:

2017	➢ Legislative report of the Skilled Nursing Facility/Acute Care Hospital Workgroup[15]
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 ➢ WSHA statewide hospital workgroup on complex discharge (ongoing) ➢ HCA/MCO Complex Discharge Workgroup focused on strategies to address complex discharge barriers for plan enrollees
2019	➢ HCA 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 ➢ 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

[15] 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

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.[16]
2024	➢ The Bree Collaborative Complex Discharge Workgroup and the release of the Complex Discharge guidelines in January 2024.[17] 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. ➢ Legislative expansion of public guardian capacities to support individuals transitioning from acute care hospitals into long term care, including establishment of the HCS Guardianship and Conservator Assistance Program (GCAP), and expansion of the Office of Public Guardian program and support for navigators.

[16] 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] 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

Appendix B: Complex Discharge Pilot Overview

Between July 2023 and June 2025, the Complex Discharge Pilot designed and tested a complex discharge model of care to support Medicaid patient transitions from hospitals into post-acute care and home and community-based settings, including skilled nursing facilities, assisted living, adult family homes, other community settings, or back to patient homes. The model focused on a patient-centered approach to coordination of social, behavioral, medical, and long-term care services, beginning in the hospital and following the patient to the next level of care needed. Below is an overview of the pilot partners, patient eligibility, model of care, and the payment model.

Complex Discharge Pilot Hospitals and Partners

The pilot included five sites across Washington, with the first site launching in April 2024 and fifth site beginning in January 2025.

Pilot Hospital Site	Region	Skilled Nursing Facility Partner(s)	Pilot Launch Date
Harborview Medical Center	Seattle	Queen Anne Healthcare	April 2024
PeaceHealth	Vancouver	Lacamas Creek Post Acute Bridge Crest Post Acute	May 2024
Virginia Mason Franciscan Health	Seattle Tacoma	Avamere at Pacific Ridge Orchard Park Care Center	June 2024
MultiCare	Spokane Tacoma	Avalon Northpointe Avalon Tacoma	August 2024
Providence Regional Medical Center	Everett	Everett Transitional Care Services	January 2025

Complex Discharge Model of Care

Key components of the Complex Discharge model of care include:

- **ECM Team:** Two hospital-based Enhanced Care Management (ECM) staff each with a capped caseload (1:15 ECM staff-patient ratio) supported patients to develop care plans and navigate access to care across settings.
- **Partnerships with Post-Discharge Providers:** Hospitals participating in the Pilot contracted with dedicated SNFs and other community partners to provide payments and other resources to support individuals with complex needs.
- **Supportive Services**: Pilot sites had access to funding for Supportive Services to address patient-level barriers to discharge, allowing flexibility in addressing barriers to discharge.[18]
- **DSHS staff:** A DSHS case manager was dedicated to each pilot site with a capped caseload (1:30 case manager-client ratio) to support completion of HCS assessments, person-centered care planning and navigation to access to long-term care services and supports.
- **Multi-disciplinary care team:** To implement the care plan, a multi-disciplinary care team involving cross-system partners convened weekly to coordinate care. This team included ECM staff, DSHS staff, MCOs, SNF partners, and others involved in the patient's care, such as DME specialists or contracted behavioral support and chemical dependency counselors.

[18] 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.

Pilot Patient Eligibility

Each pilot site had 30 slots for which they can refer patients to the pilot services. In addition, hospitals were given flexibility to divide their slots equally between two discrete hospital locations in different regions to accommodate for hospitals with a lower volume of patients with complex needs.

Eligibility criteria for the pilot included:

- ***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. (Note: Eligibility of individuals for the Pilot with pending Medicaid coverage were reviewed on by HCA on a case-by-case basis.)
- ***Payer Eligibility:*** Individuals who are covered under Medicaid managed care or Medicaid fee-for-service or are dually covered under Medicaid and Medicare.

Pilot Payment Model

The Washington State Office of Financial Management, 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.

Funding Stream	Purpose	Payment Methodology
Administrative Payments	Funding to support services provided by the contracted pilot SNF partners. 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 had the flexibility to contract 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 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 was paid a lump sum of $41,500 monthly through the end of Fiscal Year 2024. Beginning Fiscal Year 2025, ECM payments were 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.

Funding Stream	Purpose	Payment Methodology
Supportive Services Payments	Funding to support pilot sites and post-acute partners in addressing patients' barriers to discharge. Funding was limited to use for the following services, unless an exception was 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 was allocated $250,000. For Fiscal Year 2025, each pilot site was allocated $1.2 million. Pilot sites had the option to bill HCA for services after they are rendered or receive a lump sum amount. If a pilot site chose to receive a lump sum, they were expected to return excess funds that are not used to HCA prior to the end of the fiscal year.

Pilot Reporting

Pilot sites submitted weekly reports to HCA containing information on the individuals enrolled in the pilot and care plan interventions, Pilot sites also submitted logs to HCA which list the services that were funded by either Administrative Payments or Supportive Services Payments. Further detail regarding pilot reporting and evaluation is provided in *Appendix C*.

Appendix C. Complex Discharge Pilot Evaluation Methods

Pilot Reporting and Data

To support oversight and monitoring of the pilot program, HCA developed reporting tools to track patients enrolled in the pilot program, each SNF's use of administrative payments, and which services were paid for using supportive services funds. Each hospital site and SNF partner was required to submit reports to HCA. The reports were fed into a data dashboard created by HCA to track and trend metrics such as patient demographics, hospital length of stay, top barriers to discharge, common interventions, use of supportive service dollars, among others. The table below describes each report.

Report Title	Submission Cadence	Summary of Data Fields
Complex Discharge Report	Weekly	• Patient Demographics • Hospital Admission Information • ECM Enrollment and ECM Discharge Information • Discharge Plan and Disposition • Barriers to Discharge • ECM Interventions
Administrative Payments Log	Monthly	• Patient Demographics • Allocation of Administrative Payments • Description of Services Provided • Barriers to Billing Services to Medicaid, if Service is Medicaid Billable • Discharge Plan Post-SNF
Supportive Services Log	Monthly	• Patient Demographics • Description of Services Provided • Barriers to Billing Services to Medicaid, if Service is Medicaid Billable

Pilot Partner Interviews

Health Management Associates conducted hour long interviews with key pilot participants and stakeholders involved in the implementation and administration of the Complex Discharge Pilot Program. The goals of these interviews were to provide an opportunity to solicit thoughts on the benefits and challenges of the pilot, inform learnings from the pilot, and support Task Force recommendations for a future permanent program. Interview questions were structured around the following domains:

- Pilot Program Model of Care
- Pilot Patient Care
- Cross System Collaboration
- Pilot Program Payments & Funding
- General Feedback

Pilot Partners Interviewed

- Hospital Pilot Sites (each pilot site was interviewed individually)
- HCS Staff
- HCS Leadership
- MCOs
- SNF partners
- Additional Post-Acute Care and Community Partners

Pilot Patient Experience Surveys

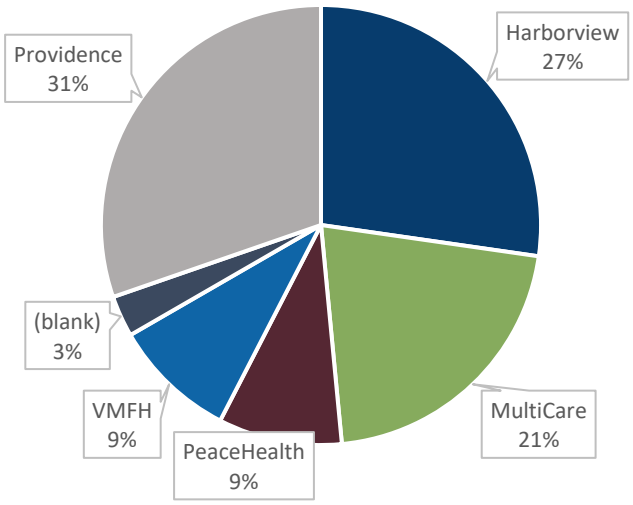
To ensure the voice of the patient is captured in the overall assessment of the pilot program, Health Management Associates developed a pilot patient experience survey for hospital ECM staff to complete with the pilot patients and their family members. The focus of the survey questions was to gather patient perspectives on their care experience and obtain feedback on how the Complex Discharge model of care supported their care goals.

The patient surveys included the following parameters:

- Pilot were requested to survey at least 10 patients that are part of the hospital system's current pilot caseload, and enrolled in the pilot program for more than 2 weeks. (If a Hospital Pilot Site did not have 10 patients who have been enrolled for 2 weeks, they were permitted to interview patients who recently graduated from the pilot.)
- Survey responses were kept anonymous and gathered via Qualtrics or Word document.
- Survey responses were collected through a Likert scale or free text response.

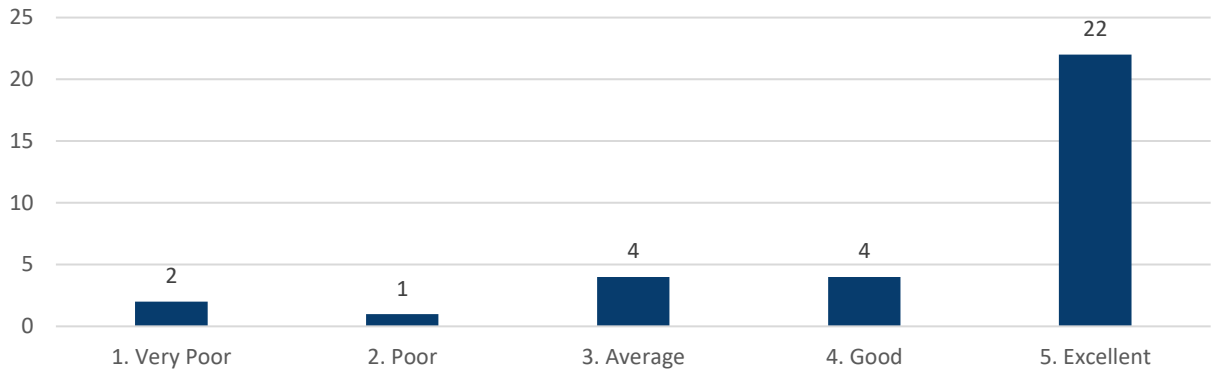
Summary of Survey Results

Question 1: Please indicate the Pilot Site Hospital Name.

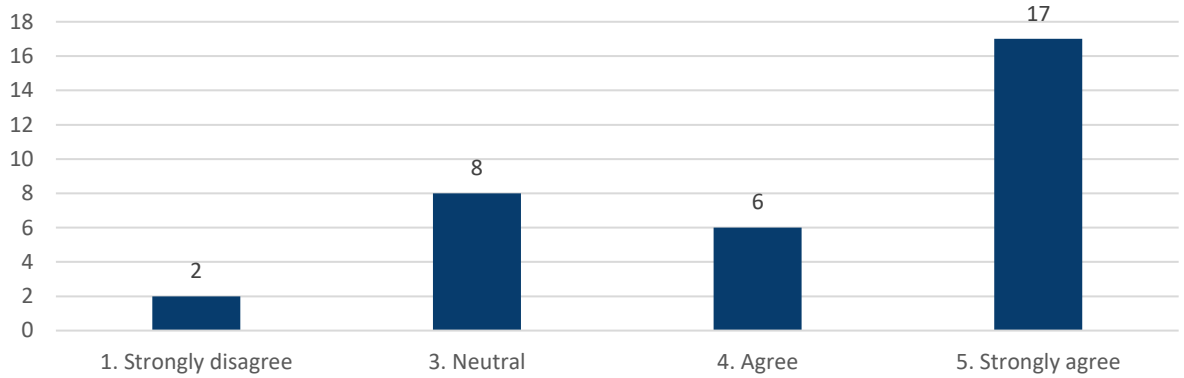


Please indicate the Pilot Site Hospital Name:	Count
Harborview	9
MultiCare	7
PeaceHealth	3
VMFH	3
Providence	10
(blank)	1
Responses Grand Total	**33**

Question 2: On a scale of 1 to 5, how was your care experience with the support of the ECM program?



Question 3: On a scale of 1 to 5, did the support of the ECM program help you to improve your health and wellbeing?



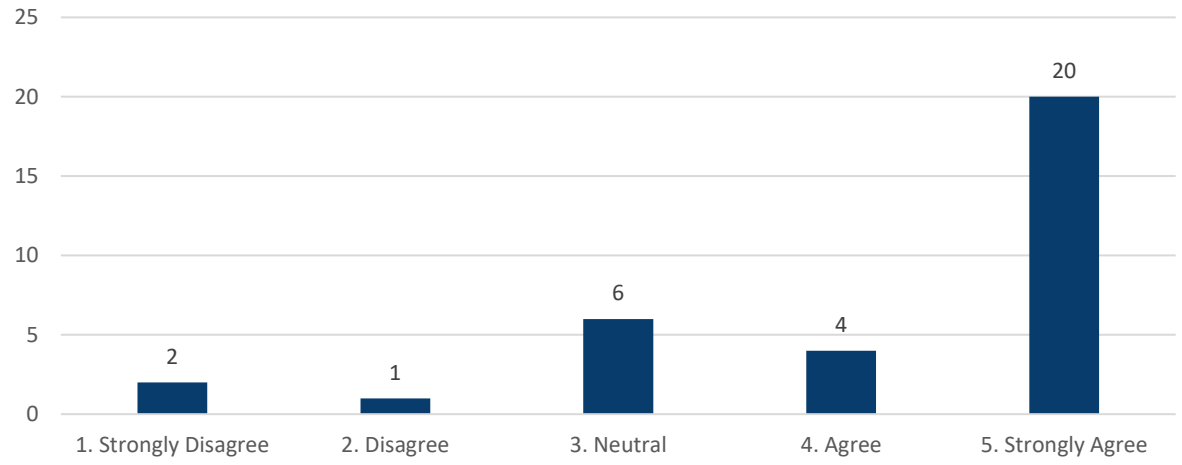
Question 4: Did the support of the ECM program help you to achieve your care goals? Please explain why they did or did not. [Free Text Response]

Common words and phrased are identified in the word cloud below:

Question 5: What important supports were offered by the ECM program? [Free Text Response]

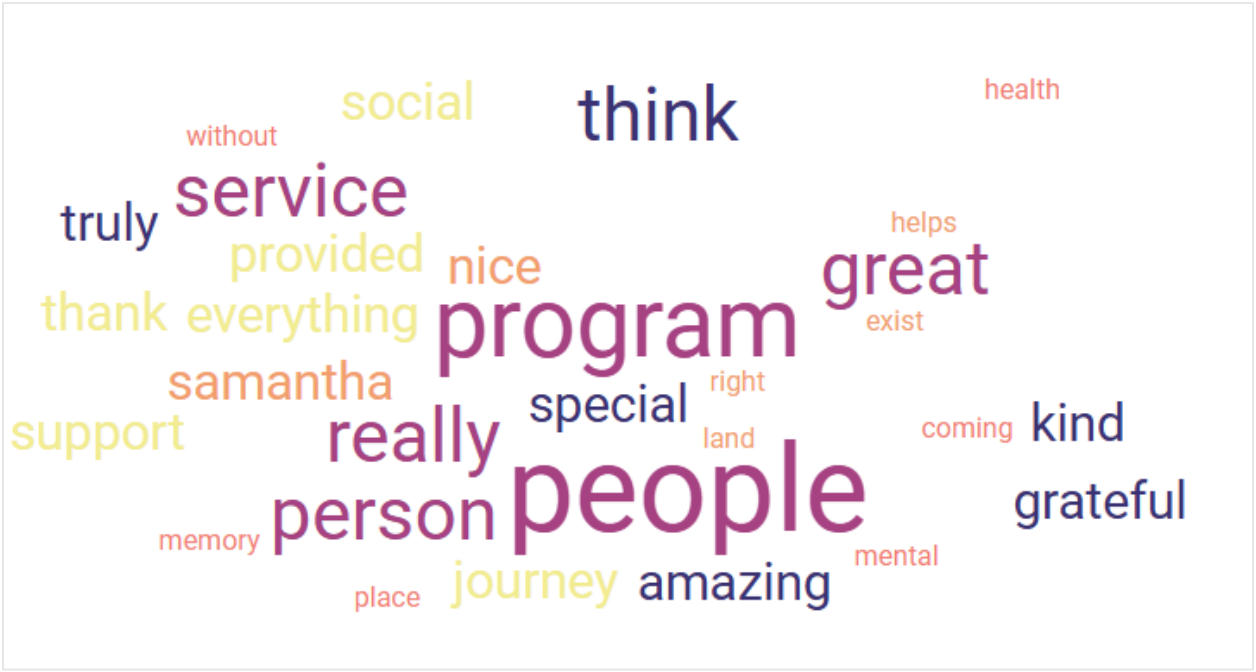
Common words and phrased are identified in the word cloud below:

Question 6: Have you been able to access and receive services as a result of the support of the ECM program?



Question 7: What other feedback about your care experience would you like to share with us? [Free Text Response]

Common words and phrases are identified in the word cloud below:



Appendix D: Summary of Tribal Priorities

In carrying out its work, the Task Force engaged Tribal input through Workgroups as well as through work with the Tribal Centric Behavioral Health Advisory Board (TCBHAB). In addition, in January 2025, the American Indian Health Commission engaged with Pilot Sites to provide training on Tribal Sovereignty, the Tribal Health System, and history and cultural considerations in providing care to members of Tribal communities. This *Appendix D* provides a summary of Tribal recommendations that are integrated throughout the body of the draft Task Force Final Report. The table below excerpts language highlighting Tribal priorities (highlighted in green text) that are embedded throughout the Task Force Recommendations.

Summary of Tribal Priorities Integrated Throughout the Task Force Recommendations (July 1, 2025)	Page #
Executive Summary	
Recommendations *Recommendation #1: Develop a plan to leverage Washington's existing Medicaid authorities to expand the Complex Discharge Model of Care (enhanced care management [ECM], supportive services, payments to skilled nursing facilities, and dedicated Department of Social and Health Service [DSHS] and Health Care Authority [HCA] staff) statewide and provide permanent funding.* *This work should include collaboration with Tribal partners to develop a model of care to ensure care transitions for American Indian and Alaska Native (AI/AN) populations and members of Tribal communities.*	Page 6
Background	
In carrying out its work, the Task Force engaged Tribal input through workgroups as well as through work with the Tribal Centric Behavioral Health Advisory Board (TCBHAB). In addition, in January 2025, the American Indian Health Commission engaged with pilot sites to provide training on Tribal Sovereignty, the Tribal Health System, and history and cultural considerations in providing care to members of Tribal communities. *Appendix D* provides a summary of Tribal-specific recommendations that are integrated throughout the body of this report.	Page 8
Complex Discharge Pilot Program: At A Glance	
Patient Demographics 3% American Indian/Alaska Native	Page 11
Recommendations Snapshot	
Recommendation 1: Develop a Plan to Leverage Washington's existing Medicaid authorities to expand the Complex Discharge model of care statewide and provide permanent funding.	Page 17

Summary of Tribal Priorities Integrated Throughout the Task Force Recommendations (July 1, 2025)	Page #
➢ ***Path Forward – Task Force:*** The Task Force will engage a workgroup in the Summer/Fall 2025 to redesign the Health Homes program in a manner that aligns with ECM and care transitions for individuals with complex needs. This workgroup will include relevant partners from the Agencies, **Tribes**, providers, payers and patient representatives. The Task Force will keep legislative staff informed of how the workgroup is approaching the redesign work. ➢ ***Path Forward – Task Force:*** The Task Force will engage Agencies and Tribal partners to develop a model of care to support care transitions for AI/AN populations and members of Tribal communities. This work will include support for development of Tribal Care Coordination Agreements between hospitals and Tribes as well as workflows to support connections with Tribes.	
Recommendation 2: Create Cross-Agency Leadership Structure to oversee and direct agency cross-system initiatives relating to transitions of care for individuals with complex needs. Tribal partners should also be engaged to inform this work.	Page 18
Recommendation 3: Promote the upstream use of decision-making legal tools and expand guardianship and decision-making options to address care transition delays due to a person's inability to consent. Through this work, the Task Force further underscores the need to engage in proactive efforts to coordinate with Tribes and Tribal courts in guardianship processes.	Page 18
Recommendation 4: Leverage MCO and DSNP contracts to emphasize and reward accountability for care transitions for individuals with complex needs. This work should also address agency accountability to serve the Medicaid FFS program in a similar manner for care transition needs.	Page 19
Recommendation 5: Develop resources to support provider understanding and ability to navigate eligibility and payment of covered services. The agencies should also work together to streamline access to SNFs and rehab levels or care for individuals who rely on Medicaid FFS, recognizing this as a key Tribal priority.	Page 19
Recommendation 6: Identify options for adjusting rates to serve individuals with multiple complex needs and expand coverage to address gaps in the system. The Task Force will also work with Tribal communities specifically to understand reimbursement model impacts to the current payment structure for Tribal health system partners.	Page 20
Recommendation 7: Establish and strengthen provider-level partnerships to support transitions of care for individuals with complex needs. Strong collaboration and partnership across multiple partners and systems – including hospitals, post-acute, community settings, Tribes, outpatient and other services, and other entities involved in serving patients – is a foundational component of the Complex Discharge Model of Care.	Page 20

Summary of Tribal Priorities Integrated Throughout the Task Force Recommendations (July 1, 2025)	Page #
Recommendation 8: Assess system capacity to serve individuals with complex needs and determine specific gaps and recommendations (e.g., Dialysis, TBI, SUD, Bariatric, Neuro-cognitive, Intellectual/Developmental Disability (I/DD), Home Health). The Task Force will also engage Tribal Partners to inform this work.	Page 20
Recommendations and Rationale	
Recommendation 1: Leverage Washington's existing Medicaid authorities to expand the Complex Discharge model of care statewide and provide permanent funding. • **Enhanced Care Management:** In the summer/fall of 2025, the Task Force will engage system partners to help redesign the Health Homes program to align the ECM component of the Complex Discharge care model. This work will include representatives of HCA, DSHS, providers, Tribal partners, and MCOs. Relying upon lessons learned from the Complex Discharge Pilot and current Health Homes model, the group will develop a proposed plan for the legislature to consider the redesign of the program and sequence of actions needed to execute. The Task Force will regularly update the Legislature and Governor on progress and approach for this work. • The Task Force will engage Agencies and Tribal partners to develop a model of care to support care transitions for AI/AN populations and members of Tribal communities. This work will include support for development of Tribal Care Coordination Agreements between hospitals and Tribes as well as workflows to support connections with Tribes. ***Key Findings and Rationale*** The Task Force also recognizes a priority to work with Tribal partners in the development of a Complex Discharge model of care for AI/AN individuals and members of Tribal communities. This work will include support for development of Tribal Care Coordination Agreements between hospitals and Tribes to facilitate care transitions for Tribal members. These agreements can outline hospital and Tribal partner contacts and identify the key services that Tribal health systems can offer to support care transitions. In addition, the following specific actions were identified as opportunities to support connections with Tribal partners: • Use of best practices for asking if a person is AI/AN or a member of a Tribal community. • Development of training and workflows to support coordination. As part of these workflows, there is opportunity to leverage the Native Resource Hub to obtain contacts for each Tribe as well as access to Tribal Service Profiles. • Opportunities to share information that allows Tribes to identify if their members are in the hospital.	Page 22-23

Summary of Tribal Priorities Integrated Throughout the Task Force Recommendations (July 1, 2025)	**Page #**
• Opportunities to coordinate with Tribes operating Long Term Services and Supports (LTSS) program or Area Agencies on Aging (AAAs), as well as processes for communication with Tribes around HCS assessments and impacts on benefits. • Opportunities to further collaboration with the Native Hub (separate from the Native Resource Hub) which will serve as a care coordination resource for Tribal members. • Training to support understanding of Tribal health systems and Tribal Sovereignty. This training may build on the training provided by the American Indian Health Commission to the Complex Discharge pilot sites in January 2025. Tribes are also actively engaging with the Health Homes model as a primary mechanism for providing care coordination and obtaining reimbursement through the Medicaid FFS program. Some Tribes, for example, have established Tribal Health Homes, which has provided opportunity for greater recognition and connections with other system providers. As the Task Force explores opportunities to adapt the Health Home program, it will be important to engage with Tribal Partners and ensure Tribal perspectives in this effort.	
Recommendation 2: Create Cross-Agency Leadership Structure to oversee and direct cross-system initiatives relating to transitions of care. Tribal partners should also be engaged to inform this work.	Page 24
Recommendation 3: Promote the upstream use of decision-making legal tools and expand guardianship and decision-making options to address care transition delays due to a person's inability to consent. ➢ *Strategies to streamline guardianship court processes, including but not limited to:* • Establishing processes to ensure recognition of relationship with Tribal governments and jurisdiction in guardianship processes. In our 2024 report, the Task Force recognized legislative investments to increase guardianship capacities and outlined several initial recommendations for continued legislative actions needed. These included continued expansion of guardianship capacity and supported decision-making, increasing Washington state court capacity for guardianship cases, and ensuring recognition of the relationship to Tribal governments and jurisdictions in guardianship processes.	Page 28-29
Recommendation 4: Leverage MCO and DSNP contracts to emphasize and reward accountability for care transitions for individuals with complex needs. This work should also address agency accountability to serve the Medicaid FFS program in a similar manner for care transition needs.	Page 25
Recommendation 5: Develop resources to support provider understanding and ability to navigate eligibility and payment of covered services. • Streamline access to skilled nursing facilities and rehab levels or care for individuals who rely on Medicaid FFS, recognizing this as a key Tribal priority.	Page 32

Summary of Tribal Priorities Integrated Throughout the Task Force Recommendations (July 1, 2025)	**Page #**
Medicaid FFS Skilled & Rehab Payments This issue has particular impact on care and services for Tribal communities, as many Tribal members are covered under Medicaid FFS rather than through MCOs. In some cases, Medicaid FFS members may elect to enroll in a managed care plan to obtain SNF or rehab coverage for expediency, because they are ready to leave the hospital, and they are unable to identify a placement in a SNF due to misperception that that the Medicaid FFS program will not cover care above the custodial rate. This can be especially problematic for Tribal members where SNFs that are part of MCO networks are often not close in proximity to the Tribal member's community and care is not delivered in keeping with Tribal practices. In addition, the first time that Tribes are often notified of a member in a facility is when they receive a bill for services; this underscores the need to establish relationships between hospitals and Tribes to support proactive care planning for Tribal members transitioning out of hospitals, as further discussed in *Recommendation 1*. ***Challenges for Tribal members in the Medicaid FFS program to access SNF skilled and rehab levels of care*** *Complex Discharge pilot sites identified challenges in identifying placement in SNFs for Tribal members covered by Medicaid FFS. This reflects a concern that Tribes have raised previously regarding the lack of clear Medicaid FFS billing processes for SNFs to provide therapies beyond the custodial rate. This leads to the misperception among providers that these services are not covered under Medicaid FFS, and results in situations where individuals are denied access to a SNF.*	
Recommendation 6: Identify options for adjusting rates to serve individuals with multiple complex needs and expand coverage to address gaps in the system. The Task Force will work with Tribal communities specifically to understand reimbursement model impacts to the current payment structure for Indian Health Care Providers and Urban Indian Health Organizations.	Page 33
Recommendation 7: Establish and strengthen provider-level partnerships to support transitions of care for individuals with complex needs. This effort should include support for Tribal Care Coordination Agreements between hospitals and Tribes to facilitate care transitions for Tribal members.	Page 34
Recommendation 8: Assess system capacity to serve individuals with complex needs and determine specific gaps and recommendations. The Task Force will also engage Tribal Partners to inform this work.	Page 36
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Appendix D. Summary of Tribal Priorities	Page 41
Appendix J. Acronyms ○ **AI/AN American Indian or Alaska Native people**	Page 67

Appendix E: Summary of MCO and DSNP Contract Policy Options & Workgroup Comments

Below is a high-level summary of "pain points" and care transitions for individual with Complex Discharge needs, MCO contract policy options reviewed, and MCO & FFS Workgroup comments. A detailed summary of the pain points, analysis of Washington's current contract requirements, and review of potential policy options and other state examples is provided in Appendix F.

Care Transition Pain Points	MCO Policy Options	MCO & FFS Workgroup Comments
1. There are not penalties or incentives tied to transitioning enrollees out of hospital administrative days.	a. Payment incentives to reduce admin days combined with expectations around quality metrics b. Risk sharing for admin days beyond a certain threshold c. Increased reimbursement for admin days	• General support for policy options reviewed. • Liked the idea of incentives for reductions in admin days combined with metrics for readmission rates; would need to consider appropriate baseline rate. • Suggestion for increasing admin rates to reflect cost of care. • Comment to consider aligning with Medicare policy requiring patient financial responsibility if not meeting in-patient medical necessity and refuses safe discharge.
2. There is variation in MCO payment levels received by providers for Skilled and Rehab Care. Providers have reported uncertainty about payments they will receive and that payments are not sufficient to serve individuals with complex needs.	a. Minimum reimbursement requirements to facilities aligned with FFS payments for exceptional care needs in SNFs b. State directed payments (e.g., VBP in addition to the FFS floor for exceptional care needs in SNFs) c. Define a minimum length of stay to allow time for completion of the HCBS assessment and transition to HCBS services. d. Provider communication and education to clarify reimbursement rates/methodology and alignment across MCOs	• General support for policy options reviewed. • Emphasis that it's not just a payment rate issue, but also an issue of administrative complexity for providers in accessing reimbursement. • Emphasis on the importance of provider education around covered services and reimbursement. • Liked the idea of requiring a minimum length of stay to allow time for completion of the assessment and transition to HCBS services. Suggested that 21 days would be an appropriate amount of time to complete assessments and support discharge planning.

Care Transition Pain Points	MCO Policy Options	MCO & FFS Workgroup Comments
		• Noted the need to recognize that MCO determinations of the Skilled and Rehab length of stay are based on medical necessity which would need to be considered in a minimum length of stay approach.
3. There are challenges in the MCO service authorization process, including hospitals reporting difficulties in securing timely and appropriate authorizations to facilitate discharge planning. Additionally, SNFs report reductions in previously authorized lengths of stay. MCOs report provider confusion regarding documentation requirements and misinterpreting requests for documentation as authorization denials.	Implement any combination of the following options: a. Exempt certain services or supplies from PA b. Align PA policies with FFS or require state approval of MCO policies and services w/ PA c. Gold card program that waives PA for providers with a strong track record d. Limit denials of payment after a service has been provided e. Provider communication re documentation requirements, and align across MCOs & FFS f. State to provide required language for notices requiring additional documentation g. Oversight practices (any combination) i. Audit of PA denials ii. Data on denials overturned at state fair hearing level iii. Publicly post PA statistics iv. Review MCO notices of action to identify opportunities to clarify	• Discussion and support for increased oversight and transparency. • Support for communications to clarify requests for additional documentation and mitigate confusion around assumed denials. • Noted rulemaking in process that would require MCOs to post PA statistics by July 1, 2026. • Concern that Gold Carding can lead to inequities in the system. • MCO noted policies that have exempted PA for SNFs within the first 7 days of admission into a facility in order to ease the transition. However, some facilities are hesitant to admit patients without a prior authorization due to concerns of not being reimbursed.

Care Transition Pain Points	MCO Policy Options	MCO & FFS Workgroup Comments
4. Lack of understanding of services that are covered across payers/systems and of MCO roles and scope of responsibilities in care management for members with complex needs.	a. Include review of complex discharge population in state oversight and audits of MCOs b. Identify quality metrics for the complex discharge population tied to MCO incentives/penalties	• General support for establishing quality metrics around complex discharge population. • Noted need for accountability on both the provider and MCOs sides to understand covered services. • Emphasis on the importance of provider education around covered services and reimbursement. • Noted particular challenges of AFHs as small, family-run businesses, in navigating the complexity of the payment system. • Noted success of the Complex Discharge pilot in bringing agencies together to coordinate and align communications with providers. This is a key aspect of clarifying provider understanding of covered services.
5. There are challenges in finding post-hospitalization placements for patients with greater than skilled nursing or specialized needs (e.g., respiratory support, challenging behaviors). The few facilities that exist are not under contract with the MCOs.	Implement any combination of the following options: a. Require MCO contracts with specific specialty facilities/providers. b. Identify specific clinical conditions for which MCOs must ensure access to appropriate facilities/providers. c. Establish minimum reimbursement requirements to these facilities. d. Create publicly available resource that identifies all facilities and scope of available services. Require MCOs to assist in advertising this resource to their network providers.	• Providers are not able to accept clients if they don't feel able to care for them. • Emphasis on the complexity of reimbursement with rate add-ons, and impact of budget cuts on services and staffing needed for individuals with complex needs. • Current challenge in knowing which facilities can support patients with specific needs (ex. which facilities can take patients who are on ventilators). Stakeholders can work together to share information on which facilities can support certain patients and emphasize the need to keep this information up to date and publicly available. This information does not currently exist publicly.

Care Transition Pain Points	MCO Policy Options	MCO & FFS Workgroup Comments
		• Noted that populations may have challenging behaviors or other characteristics that facilities are not traditionally set up to serve. Need for developing a pathway for addressing patient clinical and/or social needs and identifying settings that are able to meet these needs.
6. The MCOs do not have a sufficient network of post-acute care facilities.	Implement any combination of the following options: a. Establish network adequacy standards. b. Impose contract non-compliance remedies for failure to meet established standards. c. Establish any willing provider provisions. d. Couple any willing provider provisions with ability for MCOs to reimburse below FFS rates to facilities who opt not to contract (as an incentive to facilitate MCO contracting).	• Comments emphasizing importance of stronger network adequacy requirements. The effectiveness of these requirements would depend on HCA's enforcement. • Highlighted need to have an honest conversation around the lack of an adequate network to meet the needs of particular populations. MCOs may have contracts with facilities, but unable to accept patients with complex or specialized needs.
7. The process to appoint a legal decision maker (e.g., guardian) can delay transitions out of acute care hospital settings.	Implement any combination of the following options: a. Utilize the contractually required initial health screen and/or health assessment process to determine whether an enrollee has both a healthcare and financial power of attorney and to provide education on the benefits and process for designating. Consider associated reporting and/or incentives. b. Develop platform to store and share documentation regarding healthcare and financial power of attorney;	• Support for policy option to require MCOs to utilize the contractually required initial health screen and/or health assessment process to determine whether an enrollee has both a healthcare and financial power of attorney and to provide education on the benefits and process for designating one. • Support for the idea of developing a central repository for storing and shared healthcare and financial power of attorney and requiring MCO to access and outreach to members.

Care Transition Pain Points	MCO Policy Options	MCO & FFS Workgroup Comments
	once in place, could require MCOs to review against their enrolled membership to identify individuals without one in place and require targeted outreach and education.	
Opportunity to Strengthen DSNP Contacts to Support Care Transitions	Implement any combination of the following options: a. Opportunity to examine the SMAC to ensure all transitions of care language transfers from MCO contract to DSNP contracts. b. Prior authorization – stricter Medicaid standards would apply. c. DSNP contracts include SNF network adequacy standards, but they require only that contracts are in place and do not guarantee beds are available. d. Opportunity to improve Stars/Accreditation and explore VBP programs with Stars and HEDIS Measures relating to transitions of care. e. State audits could focus on care transitions for individuals with complex needs. f. Consider FIDE plans – carve in the LTSS benefit. Could pilot with one or more plans and require participation in the complex discharge program. g. Health Care and Financial Power of Attorney – determine whether member has during initial health screen and require targeted outreach (same a Medicaid MCO policy options)	

Appendix F: Detailed Analysis of MCO Contract Policy Options and Other State Examples

The Complex Discharge Task Force and MCO & FFS Workgroup considered current "pain points" in care transitions for Complex Discharge patients, analysis of Washington's current contract requirements, and review of potential MCO and DSNP policy options and other state examples to strengthen care transitions. This information is summarized in the table below.

Complex Discharge: Policy Options to Strengthen MCO Contracts for Supporting Care Transitions				
Current Pain Point	**Potential Short-Term Option(s)**	**Current Washington MCO and DSNP Requirement/Practice**	**Other State Examples**	**Assessment of Short-Term Option**
A. There are not penalties or incentives tied to transitioning enrollees out of hospital administrative days.	1. Implement incentives for reductions in administrative days combined with expectations for maintaining or reducing readmission rates and/or other quality metrics (to prevent perverse incentives created for discharge to inappropriate or inadequate placement). 2. Implement risk sharing or disincentives for administrative days beyond an established threshold. 3. Require reimbursement to the hospital at the greater of the SNF or administrative day reimbursement rate when the enrollee no longer meets an acute level of care.	MCOs are required to reimburse hospitals for administrative days at rates no less than those published by HCA for its FFS program, including the Administrative Day rate, which is applicable through the date of discharge, regardless of the level of service being provided. Administrative days are defined as "days of an inpatient hospital stay when an acute inpatient or observational level of care is no longer medically necessary and one of the following is true: 1) Outpatient level of care is not applicable; or 2) Appropriate non-hospital placement is not readily available.	<u>Option 1: Incentives for Reductions in Administrative Days</u> State examples specific to administrative days were not located; however, it is common for states to establish incentive arrangements based on state priority areas. <u>Option 2: Non-Compliance Remedies for Admin Days</u> State examples specific to administrative stays were not located; however, it is common for states to establish penalties for non-compliance (e.g., warnings and official notices of contract term violations, requests for corrective action plans to remediate, payment withholds, enrollment suspensions, financial penalties).	Potential opportunity to create MCO incentives for reductions in administrative days and discharge to the most appropriate setting. Likely requires coupling with other options to increase the availability of appropriate discharge placements.

Complex Discharge: Policy Options to Strengthen MCO Contracts for Supporting Care Transitions				
Current Pain Point	**Potential Short-Term Option(s)**	**Current Washington MCO and DSNP Requirement/Practice**	**Other State Examples**	**Assessment of Short-Term Option**
		HCA may perform retrospective utilization reviews on inpatient hospital admissions to determine appropriate use of administrative days.[19] **DSNPs:** Hospital Administrative payments are defined by the facility contract with the D-SNP. If the hospital is paid on an Inpatient Prospective Payment System, the admin days are considered part of the acute episode and included in the IPPS payment (which includes calculations for payment of outlier days) and the member must have days available in their benefit period. If the hospital is not paid via the IPPS but is paid on an FFS basis, the payment for administrative days can be negotiated in the contract between the facility and the D-SNP.	Option 3: Reimbursement at SNF Rate for Administrative Days *Nevada* The MCO must coordinate with discharge planners to transition members to appropriate post-hospital destination. Failure to transfer the enrollee to the appropriate care setting in a timely manner, defined as within two calendar days after the member no longer meets an acute level of care, will result in the MCO reimbursing the acute care facility at the SNF rate or the administrative day reimbursement rate, whichever is greater.	
B. There is variation in MCO payment levels received by providers for	1. Implement minimum reimbursement requirements to these facilities aligned with fee-for-service (FFS) payments	MCOs pay for medically necessary NF stays for rehabilitation or skilled medical care when the MCO determines that NF care is more appropriate than acute hospital care.	Option 1: Reimbursement Floor *Indiana* Continued on next page.	Potential opportunity to increase SNF willingness to serve Medicaid enrollees

[19] *Sources:* Inpatient Hospital Services Billing Guide; Apple Health Expansion Contract Section 5.18

Complex Discharge: Policy Options to Strengthen MCO Contracts for Supporting Care Transitions				
Current Pain Point	**Potential Short-Term Option(s)**	**Current Washington MCO and DSNP Requirement/Practice**	**Other State Examples**	**Assessment of Short-Term Option**
Skilled and Rehab Care. Providers have reported uncertainty about payments they will receive and that payments are not sufficient to serve individuals with complex needs.	for exceptional care needs in SNFs. 2. State directed payments (e.g., value-based payments in addition to FFS rate floor for exceptional care needs in SNFs). 3. Define a minimum length of stay for skilled and rehabilitation stays for which the MCOs are responsible. This strategy could address provider concerns that current MCO prior authorizations provide insufficient and unpredictable lengths of stay and do not allow time for completion of the HCBS assessment process. However, this would need to be balanced with the need to ensure all authorized stays are medically necessary. 4. Develop provider communication materials to clarify reimbursement rates/methodology and alignment across MCOs.	If the enrollee remains in the NF after they no longer meet medical necessity criteria for skilled or rehabilitative care and are eligible for custodial NF care, ALTSA is responsible for payment of NF room and board beginning on the date it is determined the enrollee no longer meets criteria for the rehabilitative or skilled benefit. The MCO continues to be responsible for all medically necessary services, prescriptions, and equipment not included in the ALTSA NF rate. Section 5.24 of the MCO contract addresses non-hospital reimbursement and establishes a reimbursement floor at the FFS rate for several services. However, NF reimbursement is not called out in this section. **DSNPs** As a Medicare Advantage plan, D-SNPs must cover 100 days for SNF and 90 days for inpatient rehab per benefit period (a new benefit period begins when a person has been out of the facility for 60 days). Payment amounts are negotiated in contracts between the D-SNPs and the facilities.	Requirement to reimburse SNFs at no less than FFS rates for the first five years following implementation of the new PathWays for Aging managed care program. *Nevada* MCOs must pay all providers, no less than FFS rates. Additionally, MCOs must pay all nursing facilities a value-based payment based on performance on quality metrics. *Delaware* & *California* MCOs must use the state's FFS rates to pay NFs. In California, this is required in certain counties named in the contract and in all other counties the FFS rate serves as the reimbursement floor. *New Jersey* MCOs must pay the higher of the rate set by the state or the negotiated rate with the facility. This does not preclude volume-based rate negotiations or using different reimbursement amounts for different specialties or for different practitioners in the same specialty.	through consistent and transparent reimbursement. Consultation with actuaries regarding potential capitation rate implications required.

Complex Discharge: Policy Options to Strengthen MCO Contracts for Supporting Care Transitions				
Current Pain Point	**Potential Short-Term Option(s)**	**Current Washington MCO and DSNP Requirement/Practice**	**Other State Examples**	**Assessment of Short-Term Option**
			Option 2: State Directed Payments (SDPs) In 2024, CMS had approved 27 SDP arrangements targeted at nursing facilities. This included the use of uniform rate increases (19 SDPs), and value-based payment arrangements (8 SDPs).[20]	
C. There are challenges in the MCO service authorization process, including hospitals reporting difficulties in securing timely and appropriate authorizations to facilitate discharge planning. Additionally, SNFs report reductions in previously authorized lengths of stay.	Implement any combination of the following options: 1. Exempt certain services or supplies from PA requirements. 2. Align PA policies with FFS or nationally recognized criteria (e.g., InterQual or MCG) OR require state approval of MCO policies and list of services which require PA. 3. Gold card program that waives PA requirements for providers with a strong track record of PA approvals.	MCOs must participate in the statewide Prior Authorization Simplification Workgroup and abide by best practices agreed to by the Workgroup. The contract also prohibits the MCOs from having authorization policies that inhibit enrollees from obtaining medically necessary contracted services and requiring authorization for services and supplies needed on an ongoing basis more frequently than every six months. MCOs must comply with WAC 284-43-2000(6)(b), chapters 182-538 and 182-550 WAC, WAC 182-5010160 and -0169. The MCO must also comply with WAC 284-43-2060;	Option 1: Exempt Certain Services/Supplies from PA *Nevada* The contract indicates the state may require MCOs to remove PA requirements for various services to align requirements across contractors or if determined necessary for the proper administration of the managed care program. In making such a determination, the state may conduct data analysis on current or historical authorization trends, consult national standards, or consider quality initiatives under the program.	Adding these contractual requirements may provide a foundation for improving PA processes. Conducting an audit of PA denials would provide an opportunity to identify any specific problem areas and potential opportunities for process improvements and/or targeted areas for potential policy reform.

[20] *Source:* MACPAC Issue Brief: Directed Payments in Medicaid Managed Care (October 2024)

Complex Discharge: Policy Options to Strengthen MCO Contracts for Supporting Care Transitions				
Current Pain Point	**Potential Short-Term Option(s)**	**Current Washington MCO and DSNP Requirement/Practice**	**Other State Examples**	**Assessment of Short-Term Option**
MCOs report provider confusion regarding documentation requirements and misinterpreting requests for documentation as authorization denials.	4. Limit denials of payments after a service has been provided, except under limited circumstances. 5. Develop provider communication materials regarding required documentation to be submitted with PA requests and/or align documentation requirements across MCOs and with FFS. 6. State to provide required language to be used in notices of action that require additional documentation to assist in clarity and alignment across MCOs.	when extenuating circumstances are identified and the provider is not able to request a PA prior to treating the enrollee or notify the MCO of an admission, the MCO must allow claims to process as if the standard procedures had been followed. Standard service authorization decisions and notice must be processed within the following timeframes[21]: • Electronic: Three days • Non-electronic: Five days If additional information is required from the provider, the MCO must process within four days of receiving the information. Expedited service authorizations must be processed within the following timeframes[22]: • Electronic: One day • Non-electronic: Two days	Option 2: Align PA Policies with FFS or National Criteria *Indiana* & *Kentucky* MCOs are required to adopt InterQual or MCG. Additionally, Indiana specifies this is required "for the following utilization management reviews: acute inpatient, skilled nursing facility, acute inpatient rehab, long-term acute care facility and behavioral health inpatient. Skilled nursing care is a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse)." *Pennsylvania* MCOs may require PA for services that require PA in the FFS program and must obtain advanced written approval of written policies and procedures and the list and scope of services requiring PA.	The ability to impact PA processes for dual eligibles is limited given Medicaid's role as secondary payor. Additionally, consultation with actuaries regarding potential capitation rate implications required if changes are made to SNF coverage in alignment with Medicare policies.

[21] MCOs are required to issue PA decisions sooner than federally established requirements.

[22] In accordance with 42 CFR 438.210(d)(2), an expedited decision is required for cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

Complex Discharge: Policy Options to Strengthen MCO Contracts for Supporting Care Transitions				
Current Pain Point	**Potential Short-Term Option(s)**	**Current Washington MCO and DSNP Requirement/Practice**	**Other State Examples**	**Assessment of Short-Term Option**
	Consider any combination of the following monitoring and oversight practices: 1. Conduct an audit of MCO PA denials to identify any potential areas which require additional guidance or corrective action. For example, to confirm decisions are being made in accordance with clinical practice guidelines and requirements surrounding provider notification and communications have been followed. 2. If not already required in MCO PA reports, require submission of data on denials ultimately overturned at the state fair hearing level.	If additional information is required from the provider, the MCO must process within two days of receiving the information. **DSNPs:** Stricter Medicaid standards would apply. For DSNPs, standard authorization timeline is 14 days (dropping to 7 days in 2026) and for expedited requests the timeline is 72 hours. Extensions are allowed when documentation is missing. *Washington PA oversight practices*: Concurrent reviews[23] (applicable to requests for enrollees that are currently inpatient) must be conducted within one business day of receipt and notification within one business day of the MCO's decision. The MCOs must also establish protocols to perform concurrent review which identify and actively refer enrollees needing discharge planning who require assistance in transitioning from inpatient care, or	The state may "subject prior authorization denials issued under unapproved prior authorization policies to retrospective review and reversal and may impose sanctions and require corrective action plans in the event that the CHC-MCO improperly implements a prior authorization policy or procedure or implements such policy or procedure without Department approval." *Nevada* The Contractor shall coordinate PA and clinical edit patterns, based on evidence-based and peer-reviewed clinical criteria, with those used in the FFS program to ensure that its authorization requirements are not more restrictive than FFS. Option 3: Gold Card Program *Arkansas, Colorado, Texas, West Virginia & Wyoming*	

[23] Concurrent review is defined in the MCO contract as "the Contractor's review of care and services at the time the event being reviewed is occurring. Concurrent review includes an assessment of the Enrollee's progress toward recovery and readiness for discharge while the Enrollee is hospitalized or in a nursing facility; and may involve an assessment of the medical necessity of tests or procedures while the Enrollee is hospitalized or in a nursing facility."

Complex Discharge: Policy Options to Strengthen MCO Contracts for Supporting Care Transitions				
Current Pain Point	**Potential Short-Term Option(s)**	**Current Washington MCO and DSNP Requirement/Practice**	**Other State Examples**	**Assessment of Short-Term Option**
	3. Publicly post PA statistics for each MCO. (*Note:* 42 CFR 438.210(f), effective in 2026 will require annual MCO reporting regarding: (i) a list of all items and services that require PA; (ii) the percentage of PA requests (standard and expedited) approved, denied, approved after appeal, and approved after the time frame for review was extended; and (iii) the average and median time for processing. The MCOs must post this on their websites, but the state could consider posting as well, comparing performance among MCOs, and requiring service-specific versus aggregate data reporting). 4. Review MCO notices of action to identify if modifications would facilitate enhanced clarity around requests for documentation.	administrative days to the next lower level of care. Protocols must address response to discharge planning requests for enrollee care in which UM review is not applicable, such as observation level of care or non-skilled nursing facility care. MCOs are contractually required to submit quarterly reports to HCA regarding authorization decision timeliness compliance. If compliance is < 90%, the MCO must provide a narrative description of efforts before and after notification to HCA to address the problem.	Option 4: Limit Retrospective Denials *Alaska* PA for medically necessary care cannot be retroactively denied unless the approval was based on incomplete or inaccurate information. *Arkansas* Cannot rescind, limit, condition, or restrict an authorization based on medical necessity unless the provider is notified three business days before scheduled date of admission, service, procedure, or extension of stay. Contract Examples to Facilitate State Monitoring & Oversight *Indiana* & *Iowa* The contract defines the information that must be tracked in the MCO's information systems, including the following for all PA denials: (i) name of requester; (ii) title of requester; (iii) date and time of request; (iv) clinical synopsis, which shall include timeframe of illness or condition,	

Complex Discharge: Policy Options to Strengthen MCO Contracts for Supporting Care Transitions				
Current Pain Point	**Potential Short-Term Option(s)**	**Current Washington MCO and DSNP Requirement/Practice**	**Other State Examples**	**Assessment of Short-Term Option**
			diagnosis and treatment plan; (v) clinical guideline(s) or other rational supporting the denial (e.g., insufficient documentation); (vi) denial notification letter for both members and providers; (vii) date and time of denial notification as well as the name of the individual notified of denial; and (viii) evidence that the treating practitioner was notified of appeal rights including a peer to peer review when appropriate. Iowa's contract also indicates the information shall be provided to the state "on demand."	
D. Lack of understanding of services that are covered across payers/systems and of MCO roles and scope of responsibilities in care management for members with complex needs.	1. Include review of complex discharge population in state oversight and audits of MCOs. 2. Identify quality metrics for the complex discharge population tied to MCO incentives/penalties.	Section 14.18 requires MCOs to provide Transitional Care services to enrollees who are transferring from one care setting to another or one level of care to another. Section 14.18.7 requires MCOs to identify individuals at acute care hospitals with complex discharge needs who are facing barriers to discharge, and to provide Care Coordination and discharge planning support.	State examples specific to a complex discharge population were not located; however, it is common for states to establish incentive arrangements and implement targeted oversight practices based on state priority areas.	Potential opportunity to provide additional accountability for care provided to the complex discharge population.

Complex Discharge: Policy Options to Strengthen MCO Contracts for Supporting Care Transitions				
Current Pain Point	**Potential Short-Term Option(s)**	**Current Washington MCO and DSNP Requirement/Practice**	**Other State Examples**	**Assessment of Short-Term Option**
		MCOs add these enrollees to a Complex Discharge report and submit to HCA weekly. Section 14.19 requires MCOs to provide care coordination and transitional care services for individuals to or from the hospital to SNF or long-term care settings. This includes coordination with hospitals, SNFs, and DSHS/ALTSA. MCOs shall ensure coverage of all medically necessary services, prescriptions, and equipment not included in the negotiated SNF daily rate. Additionally, MCOs are required to have an Allied System Coordination Plan that describes how the Contractor will coordinate and collaborate with healthcare and other allied systems that serve Contractor Enrollees. The Contractor shall collaborate with ACH representatives and representatives of the entities listed in Subsection 14.12 to develop and update this plan as needed.		

Complex Discharge: Policy Options to Strengthen MCO Contracts for Supporting Care Transitions				
Current Pain Point	**Potential Short-Term Option(s)**	**Current Washington MCO and DSNP Requirement/Practice**	**Other State Examples**	**Assessment of Short-Term Option**
		The MCO contracts outline the current metrics associated with the performance withhold program in Exhibit B: Value-Based Purchasing (Table 5); measures for which MCOs may earn back withheld payments are primarily tied to HEDIS measures. **DSNPs:** *Care Coordination* DSNPs are required to have an Individualized Care Plan for every member and to utilize an Interdisciplinary Care Team for creating the ICP. This team must include facility providers if members are in a facility. *Quality Measures:* DSNP contracts include DSNP Stars and HEDIS measures relating to transitions of care.[24]		

[24] **Stars Measures**: I. Transition of Care measure (4 measure roll-up): 1) Notice of Inpatient Admission, 2) Receipt of Discharge Information, 3) Medication Reconciliation post-discharge, and 4) Patient Engagement After Inpatient Discharge. II. Plan All-Cause Readmissions measure introduced in 2024. Separate rate reported for Medicare members discharged to SNF; **SNP Stars Measures:** 1) Medication Review, 2) Functional Status Assessment, 3. Special Needs Plan Care Management; **Other HEDIS measures for NCQA Accreditation:** 1) Follow-Up After Hospitalization for Mental Illness, 2) Hospitalization Following Discharge From a Skilled Nursing Facility, 3) Hospitalization for Potentially Preventable Complications.

Complex Discharge: Policy Options to Strengthen MCO Contracts for Supporting Care Transitions				
Current Pain Point	**Potential Short-Term Option(s)**	**Current Washington MCO and DSNP Requirement/Practice**	**Other State Examples**	**Assessment of Short-Term Option**
E. There are challenges in finding post-hospitalization placements for patients with greater than skilled nursing or specialized (e.g., respiratory support, challenging behaviors). The few facilities that exist are not under contract with the MCOs.	Implement any combination of the following options: 1. Name specific specialty facilities/providers within the contract to which MCOs must extend contract offers. 2. Identify specific clinical conditions for which MCOs must ensure access to appropriate facilities/providers. 3. Implement minimum reimbursement requirements to these facilities. 4. Develop publicly available resource that is regularly updated and identifies all facilities and scope of available services. Require MCOs to assist in advertising this resource to their network providers.	The MCO and DSNP contracts are silent on these facility types.	Option 2: Identify Conditions Network Must Address *Arizona* The contract specifies MCOs must ensure access to SNFs and assisted living facilities that are able to meet the needs of individuals with dementia or related disorders, traumatic brain injuries, substance use disorders, and persistent aggressive behaviors. Option 3: Reimbursement Floors See examples from B (Option 1) above.	Adding these contractual requirements provides a foundation for improving the availability of post-acute care settings and services. However, the degree of effectiveness likely hinges on the oversight and enforcement actions taken by the Washington State Health Care Authority (HCA) for MCOs that fail to comply or meet requirements. Potential monitoring options include requiring MCOs to report on contracting status with required post-acute care settings;
F. The MCOs do not have a sufficient network of post-acute care facilities.	Implement any combination of the following options: 1. Establish network adequacy standards.	The MCO contracts do not specify network adequacy standards specific to skilled nursing facilities. Proposed legislation during the 2025 session (Senate Bill 5124) included requirements for establishment of	Option 1: Network Adequacy Standards *Indiana* Establishes a minimum provider-to-enrollee ratio for SNFs of 1:400	

Complex Discharge: Policy Options to Strengthen MCO Contracts for Supporting Care Transitions				
Current Pain Point	**Potential Short-Term Option(s)**	**Current Washington MCO and DSNP Requirement/Practice**	**Other State Examples**	**Assessment of Short-Term Option**
	2. Impose contract non-compliance remedies for failure to meet established standards. 3. Establish any willing provider provisions (i.e., extend contract offer to all Medicaid-enrolled SNFs and inpatient rehabilitation facilities and enroll all willing to contract). 4. Couple any willing provider provisions with ability for MCOs to reimburse below FFS rates to facilities who opt not to contract (as an incentive to facilitate MCO contracting).	network adequacy standards for post-acute care services, including skilled nursing facilities and inpatient rehabilitation facilities. The contracts establish minimum reimbursement standards for certain provider types; however, SNFs and inpatient rehabilitation facilities are not included in this requirement. State law (RCW 74.09.522) requires an MCO to pay a nonparticipating provider "no more than the lowest amount paid for that service under the managed care organization's contracts with similar providers in the state if the managed care organization has made good faith efforts to contract with the nonparticipating provider." **DSNPs** DSNP contracts include the following standards for Skilled Nursing Facilities (note standards relate to contracts in place and do not account for whether providers are accepting members): ▪ Large metro – 90% within 20 minutes, 10 miles ▪ Metro – 90% within 45 minutes, 30 miles	and at least one facility located in each county, unless there is no facility located in a county. *Ohio* Contract identifies each county in the state and minimum number of nursing facility providers required in the county. *California* Establishes county-specific timeframe (ranging from 5-14 business days) in which enrollees must have access to LTC providers from date of request. *Arizona, Iowa, and Delaware* All three states establish time and distance standards for nursing facilities. *North Carolina* MCO must have at least one nursing facility accepting new patients in every county. Option 2: Contract Non-Compliance Remedies *Indiana* Remedies for failure to meet network access requirements	auditing MCO records for administrative days; and implementing contract non-compliance remedies pending findings. Additionally, some states mandate reports to the legislature on MCO outcomes (e.g., Louisiana, Iowa).

Complex Discharge: Policy Options to Strengthen MCO Contracts for Supporting Care Transitions				
Current Pain Point	**Potential Short-Term Option(s)**	**Current Washington MCO and DSNP Requirement/Practice**	**Other State Examples**	**Assessment of Short-Term Option**
		▪ Micro urban – 85% within 80 minutes, 60 miles ▪ Rural – 85% within 75 minutes, 60 miles	include submission of corrective action plan (CAP); liquidated damages; more frequent reporting; and auto assignment suspension if non-compliance continues for three consecutive months. <u>Option 3: Any Willing Provider Provisions</u> *Indiana* The MCO must contract with any willing nursing facility provider who meets the criteria of licensure and enrollment as a Medicaid provider who is willing to accept the provisions of the MCO's contract. *Iowa* & *New Jersey* For the first two years of the managed care program the MCO must offer network inclusion to all licensed and Medicaid-enrolled NFs. Following this minimum period, the MCO can evaluate each facilities' continued network enrollment based on assessment of quality and performance outcomes (Iowa) or enrollee utilization and access needs (New Jersey).	

Complex Discharge: Policy Options to Strengthen MCO Contracts for Supporting Care Transitions				
Current Pain Point	**Potential Short-Term Option(s)**	**Current Washington MCO and DSNP Requirement/Practice**	**Other State Examples**	**Assessment of Short-Term Option**
			Illinois MCOs must contract with any willing and qualified NF provider so long as the NF agrees to the MCO's rates and adheres to the MCO's quality assurance requirements. The MCO may establish quality standards in addition to state and federal requirements, with state approval of the standards. Contract termination for failure to meet these standards can only occur if the standards have been in effect for a year and the provider was informed of the standard when it went into effect. *California* & *Texas* MCO must contract with any willing NF provider that is licensed, certified, and meets credentialing and quality standards. Option 4: Out-of-Network Reimbursement Below FFS: Historically, Indiana required MCOs to reimburse at 98 percent of the FFS rate once network adequacy standards were met to	

Complex Discharge: Policy Options to Strengthen MCO Contracts for Supporting Care Transitions				
Current Pain Point	**Potential Short-Term Option(s)**	**Current Washington MCO and DSNP Requirement/Practice**	**Other State Examples**	**Assessment of Short-Term Option**
			any providers who opted not to join the MCO contract. This requirement is no longer contained in the contracts; the reason for the change is unknown.	
G. The process to appoint a legal decision maker (e.g., guardian) can delay transitions out of acute care hospital settings.	1. Utilize the contractually required initial health screen and/or health assessment process to determine whether an enrollee has both a healthcare and financial power of attorney and to provide education on the benefits and process for designating one. Consider associated reporting and/or incentives. 2. Develop a platform to store and share documentation regarding healthcare and financial power of attorney; once in place, require MCO to review against their enrolled membership to identify individuals without one in place to and require targeted outreach and education.	MCOs must meet advance directive requirements of WAC 182-501-0125, which includes distributing to enrollees' policies and procedures regarding advance directives. They must also implement policies and procedures to ensure the completion of advance directives.	Option 1: Use Health Screen to Identify Power of Attorney *Indiana* The assessment process must include "an assessment of the member's understanding of their rights, the member's preferences for executing advance directives and whether the member has a guardian, protective order, durable power of attorney or activated power of attorney for health care."	Provides potential opportunity to increase the number of enrollees with a legal decision maker. This may aid in reducing delays in transitions out of acute care hospital settings.

Appendix G. Overview and Analysis of Federal Medicaid Authorities

The Complex Discharge Task Force and Sustainable Funding Workgroup evaluated a range of options for permanent Medicaid funding for the Pilot model of care. This analysis included Washington's current authorities, potential new authorities, the extent to which each authority could cover the full scope of the model of care (ECM, Supportive Services, and SNF Administrative Payments), coverage of both managed care and fee-for-service enrollees, and the level of effort to secure and maintain federal approval. Below is a summary of this analysis.

SUMMARY COMPARISON OF AVAILABLE AUTHORITIES TO SUPPORT PILOT MODEL OF CARE

Federal Authority	Effort to Secure Approval	Program Sustainability	Other Considerations	Potential Applicability to Post-Hospital Discharge Setting			Potential Scope of Coverage				
				NF: Skilled/ Rehab*	NF: Long Term Care	Own Home/ HCBS Setting	SNF Admin	ECM	Support Service	FFS	MCO
1915(c) Waiver	High	Renewal every five years & extensive ongoing reporting	Several waivers already exist that provide potential discharge supports. A new 1915(c) waiver is unlikely to create benefits.	✓		✓		✓	✓	✓	✓
1115 Demo.	High	Renewal every five years & extensive ongoing reporting	Provides flexibility but is susceptible to change in federal policy priorities tied to political changes at the national level.	✓	✓	✓	✓	✓	✓	✓	✓
TCM	Low	Unlimited federal approval with no ongoing reporting	Lack of flexibility in service definition.	✓		✓		✓		✓	✓
1915(i)	Medium	Renewal every five years & moderate ongoing reporting	Would likely require modifying current hospital pilot roles (e.g., unclear if permitted to provide ECM).	✓		✓		✓	✓	✓	✓
Health Homes	Medium	Unlimited federal approval with moderate ongoing reporting	Current Health Homes program may sufficiently target the pilot population. Opportunities may exist for hospitals to participate in model as a CCO. Modifications to the program would require any individual who meets the chronic condition criteria to be eligible.	✓	✓	✓		✓		✓	✓
Admin. Case Man.	Medium	Ongoing federal approval in accordance with cost allocation plan and lowest federal match	Narrow definition of allowable case management. May be perceived by CMS as duplicative of conditions of participation for hospitals (e.g., discharge planning at 42 CFR 482.43).	✓	✓	✓		✓		✓	✓
ILOS	Low	Ongoing approval in alignment with managed care contract and moderate ongoing reporting if costs exceed 1.5%	Available only for managed care enrollees.	✓		✓			✓		✓
PAC Facility Rates (varied)	Low	State plan rates: unlimited federal approval Waiver service rates: renewal every five years	Mechanisms to adjust PAC facility rates depends on the federal authorities used for the service/setting for which a rate increase is sought.	✓	✓	✓	✓			✓	✓

*Assumes short-term stay with transition to community-based setting.

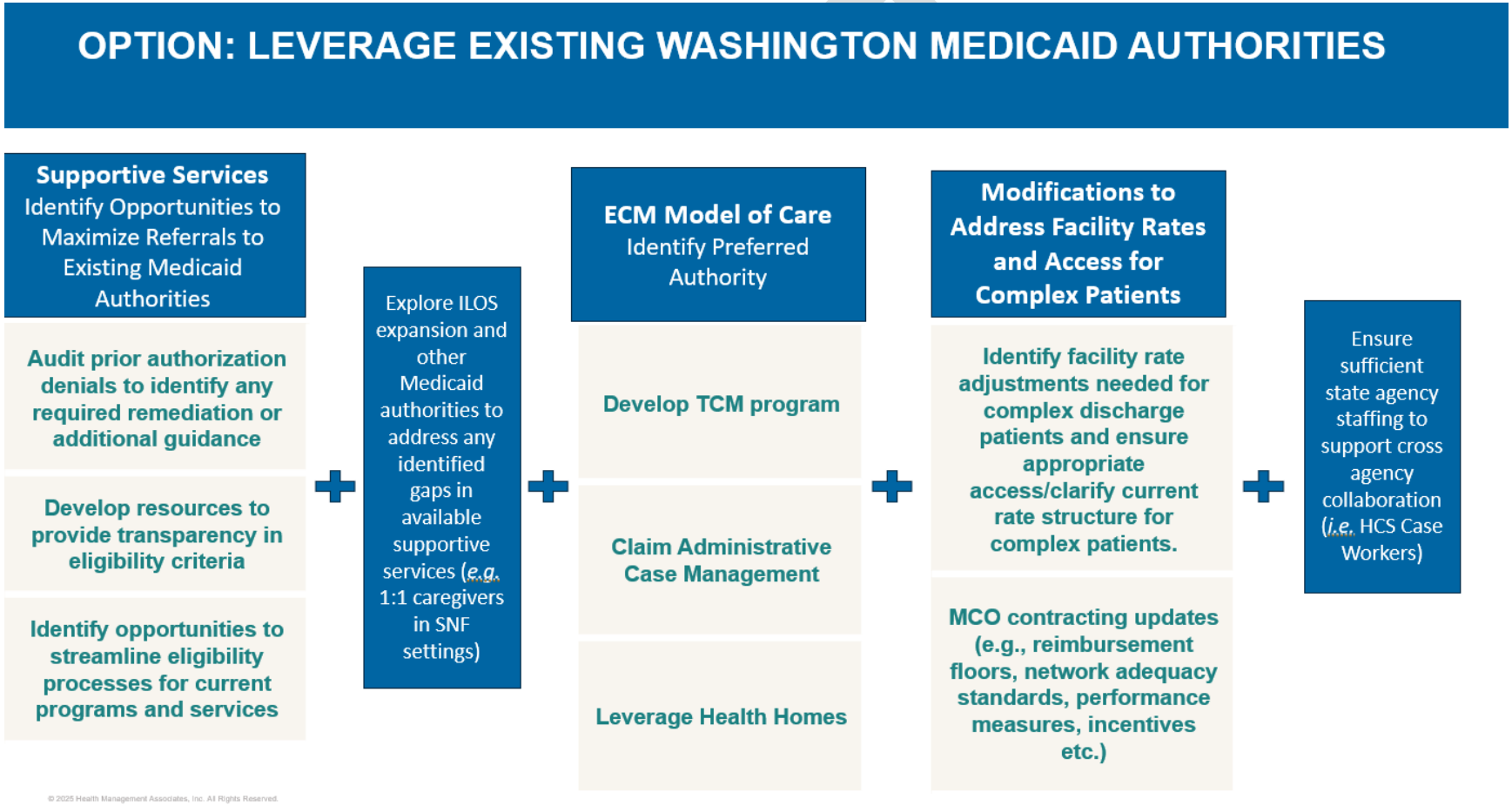
Appendix H. Federal Medicaid Authorities Key Options – Pros and Cons

The Complex Discharge Task Force and Sustainable Funding Workgroup considered the pros & cons Federal Medicaid Authority options most aligned with the Complex Discharge Model of Care, as summarized in the table below.

Federal Authority	Pros	Cons
Leverage Existing Washington Authorities (See visual with further detail in Appendix I visual)	• Amended federal authority required only for ECM. • Each ECM authority option has less extensive federal application and approval process than 1115 demonstration or 1915(i) state plan and does not have a time-limited approval • Allows ECM coverage for both managed care and FFS enrollees	• Process to implement operational modifications requires cross-agency collaboration and investment of resources to streamline access to programs • If ILOS is used to fill identified gaps in supportive services, this would not be available for FFS enrollees
1115	• Flexibility in defining covered services and target population • Likely ability to address the variety of settings to which patients discharge • Potential opportunity to continue providing additional SNF payments (though potential modifications to methodology may be required) • Allows coverage for both managed care and FFS enrollees	• Lengthy federal application and approval process • Susceptible to change in federal policy priorities tied to political changes at the national level • Burdensome evaluation and reporting requirements
1915(i)	• Flexibility in defining covered services and target population • Provides services beyond case management to address discharge barriers and ongoing services required to maintain residence in a community-based setting • Less extensive federal application and approval process than 1115 demonstration • Allows coverage for both managed care and FFS enrollees	• Would not address portion of pilot population that transitions to long-term NF (i.e., custodial care) • Does not provide option to continue coverage of SNF payment methodology utilized in pilot • Modifications to pilot model would be necessary to conform with regulatory requirements surrounding HCBS settings and conflict-free requirements for evaluations, assessment, and service planning processes

Appendix I. Options to Leverage Existing Washington Medicaid Authorities

Among the various state plan and waiver authorities reviewed, leveraging Washington's existing Medicaid authorities was determined the best path forward. Below is a summary of the components of the Complex Discharge Model of Care and approach for leveraging Washington's existing Medicaid authorities. For the ECM portion, the Health Homes authority was identified as the preferred option, recognizing further work needed to ensure alignment and support for care transitions for individuals with complex discharge needs.



Appendix J. Acronyms

Acronym	Term
AAA	Area Agencies on Aging
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
CCO	Care Coordination Organization
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
CPG	Certified Professional Guardian
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
I/DD	Intellectual/Developmental Disability
IFC	Integrated Foster Care
IFS	Individual and Family Services
IGT	Inter-Governmental Transfer
IHCP	Indian Health Care Provider
IHS	Indian Health Services
ILOS	In Lieu of Services
IMC	Integrated Managed Care
IP	Inpatient
IV	Intravenous
JLEC	Joint Legislative Executive Committee
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 Guardian
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 K. Definitions

Term	Definition	Source
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, 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.	HCA Integrated Managed Care Contract https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf

Term	Definition	Source
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
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
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

Term	Definition	Source
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 of others. Participants voluntarily agree to follow the Community Protection guidelines. Individuals served are age 18 and older.	https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/22-0637%20CP%20Brochure%2022-1757.pdf
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, 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.	https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/LTC%20Manual%20Chapter%207f.doc

Term	Definition	Source
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 • 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.	https://www.dshs.wa.gov/dda/consumers-and-families/home-and-community-based-waivers-hcbs
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

Term	Definition	Source
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 services waivers for individuals at the ICF/ID level of care.	https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/intermediate-care-facilities-individuals-intellectual-disability/index.html
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

Term	Definition	Source
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 the future need to utilize the covered service or setting.	https://www.hca.wa.gov/assets/billers-and-providers/hrsn-and-ilos-policy-guide-202310.pdf
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

Term	Definition	Source
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. 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.	https://www.courts.wa.gov/guardianportal/index.cfm?fa=guardianportal.opg&content=about
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
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 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.	https://www.dshs.wa.gov/altsa/home-and-community-services/residential-long-term-care-facilities-specialty-contracts

Term	Definition	Source
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 Medicare and Apple Health (Medicaid) services.	https://www.hca.wa.gov/billers-providers-partners/program-information-providers/model-managed-care-contracts
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

Term	Definition	Source
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