Washington State Department of Health

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 11:22 am, Nov 25, 2020

CN21-28

FOR DEPARTMENT USE ONLY

Date Stamp Here

Fee Received _____

Check #: _____

Initials _____

WASHINGTON STATE CERTIFICATE OF NEED PROGRAM
RCW 70.38 AND WAC 246-310

APPLICATION FOR CERTIFICATE OF NEED HOME HEALTH CARE PROJECTS
(Excludes amendments)

Certificate of Need applications must be submitted with a fee in accordance with the instructions on page 2 of this form. Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310 adopted by the Washington State Department of Health. **I** hereby certify that the statements made in this application are correct to the best of my knowledge and belief.

Signature and Title of Responsible Officer: Mike Miller, Vice President & CFO, Date 11/**25**/20	**Person To Whom Questions Regarding This Application Should Be Directed:** Jamie Brown, Vice President of Home Services Eden Health / EmpRes Home Services Telephone Number: 360-798-8298 4601 NE 77th Avenue #300 Vancouver WA 98662
Legal Name of Applicant: Eden Home Health of King County, LLC **Address of Applicant:** EmpRes Healthcare Management 4601 NE 77th Avenue #300 Vancouver WA 98662 **Telephone Number: 360-514-9358**	**Type of Project (check all that apply):** [ ] New Agency **[X]** Existing Medicare Certified/Medicaid Eligible Agency Expanding into Different County [ ] Existing Licensed-Only Home Health Agency to Become Medicare Certified/Medicaid **Eligible.**
Project Summary: Expand the Medicare Certified/Medicaid Eligible Eden Home Health Agency of King County into Pierce County Estimated capital expenditure: $1,473	

1. Mail an original and one copy of the completed application, with narrative portion to:

Department of Health
Certificate of Need Program
2725 Harrison Avenue, Suite 500
P 0 Box 47852
Olympia, Washington 98504-7852

The application must be accompanied by a check, payable to: ***Department of Health.*** This check is for the review fee as identified on the **enclosed fee schedule.**

2. COMPLETE THE FOLLOWING PRIOR TO SUBMISSION

FOR REVIEW: TOTAL AMOUNT OF FEE ACCOMPANYING

THIS APPLICATION:

PROCESSING FEE: $24,666

APPLICANT NAME: Eden Home Health of King County, LLC (Add Pierce County)

SUBMISSION: 11/25/20 CHECK NUMBER 0440037555

APPLICATION INFORMATION INSTRUCTIONS:

These application information requirements are to be used in preparing a Certificate of Need application. The information will be used to evaluate the conformance of the project with all applicable review criteria contained in RCW 70.38.115 and WAC 246-310-210, 220, 230, and 240.

- The application is to be submitted together with a completed, signed Certificate of Need application face sheet and the appropriate review and processing fee. Please send an original and one copy to:

Department of Health
Certificate of Need Program
111 Israel Rd. S.E.
Tumwater, WA 98501
P O Box 47852
Olympia, Washington 98504Y7852

EDEN HOME HEALTH of KING COUNTY, LLC

CERTIFICATE OF NEED APPLICATION PROPOSING TO SERVE
MEDICARE/MEDICAID PATIENTS IN PIERCE CONTY

TABLE OF CONTENTS

PLEASE NOTE, THE PAGE NUMBERS BELOW CORRESPOND TO THE BOTTOM RIGHT OF EACH PAGE

SECTION 1 - APPLICANT DESCRIPTION……PAGE 9

SECTION 2 - PROJECT DESCRIPTION…….PAGE 12

SECTION 3 - PROJECT RATIONALE……PAGE 16

A. NEED

SECTION 4 - PROJECT RATIONALE……PAGE 51

B. FINANCIAL FEASIBILITY

SECTION 5 - PROJECT RATIONALE……PAGE 59

C. STRUCTURE and PROCESS (QUALITY of CARE)

SECTION 6 - PROJECT RATIONALE……PAGE 67

D. COST CONTAINMENT

ALTERNATIVE 1. POSTPONE SERVICE DEVELOPMENT…….PAGE 67

ALTERNATIVE 2. PURCHASING EXISTING PIERCE AGENCY…….PAGE 69

ALTERNATIVE 3. ADDING THE PIERCE COUNTY SERVICE AREA TO THE EDEN HOME HEALTH OF KING COUNTY, LLC AGENCY……...PAGE 70

LIST OF ATTACHMENTS……...PAGE 74

PLEASE NOTE, THE PAGE NUMBERS BELOW CORRESPOND TO THE BOTTOM RIGHT OF EACH PAGE

Eden Home Health of King County, LLC CoN Application Proposing to Serve Medicare/Medicaid Patients in Pierce County

Table Index

Table 1 – Page 11

Eden Home Health of King County, LLC Existing Utilization

Table 2 – Page 18

2013 - 2015 Lifetime Self-Reported Prevalence of Chronic Disease Age 18+ Comparative Percentage

Table 3 – Page 19

Per Cent Seniors 65 and Older with Self-Reported Health Risks: 2013 – 2015

Table 4 – Page 20

Premature Mortality per 100,000 Persons by Age Group: 2013 - 2015

Table 5 – Page 21

Comparative Mortality Age Adjusted Rates Pierce County, King County and Washington State

Table 6 – Page 22

Per Cent Cause of Death 2013 - 2015

Table 7 – Page 24

Home Health Agency Adjustment Factor for Higher Chronic Illness Burden Due to Health Disparity

Table 8 – Page 25

Pierce County Change in Population by Age Cohort: 2020 through 2024 With Percentage Changes Each Year

Table 9 – Page 25

2020 Medicare-Medicaid CoN Approved Agencies in Pierce County

Table 10 – Page 26

Pierce County Home Health Agency Need 2021 through 2024

Table 11 – Page 27

Net Home Health Agency Need Adjusted for Chronic Illness Burden

Table 12 – Page 28

2020 Medicare-Medicaid CoN Approved Agencies in Pierce County

Table 13 – Page 29

2023 and 2024 Pierce County Home Health Visit Need

Table 14 – Page 30

Revised 2020 Medicare-Medicaid CoN Approved Agencies in Pierce County

Table 15 – Page 30

2023 and 2024 Pierce County Home Health Visit Need

Table 16 – Page 34

Pierce County Home Health Agency Percentage of Patients Admitted to Home Health Within 2 days (reported and Actual)

Table 17 – Page 35

Pierce County Home Health Agency Unplanned Hospital Care (CMS Compare 2018 Data)

Table 18 – Page 40

Patient Register

Table 19 – Page 41

Zip Code Analysis from Patient Register (January – August 2020)

Table 20 – Page 44

Unduplicated Admissions and Visits by Discipline – Pierce County

Table 21 – Page 51

Project Capital Expenditure Estimates

Table 22 – Page 53

Pierce County Project Net Revenue, Costs and Earnings

Table 23 – Page 55

Pierce County Eden Home Health Payer Mix%

Table 24 – Page 56

Calculated Costs and Charges per Discipline During Initial 7-month Start-Up Period and the first 6-months (Covid-19) 2020 Period

Table 25 – Page 57

Anticipated Direct Personnel Costs and Calculated Total Charges per Visit 2021-2023 – Pierce County

Table 26-A – Page 57

Pierce County based Eden Home Health of King County, LLC wages and salaries and the number of FTEs by each discipline under the Pierce CoN

Table 27-A – Page 59

Provides the projected FTEs for 2021 through 2024 (the third full year of agency operation) for Pierce County

Table 27-B – Page 60

Eden Home Health of King County, LLC Projected Number of Employees for King County

Table 27-C – Page 60

Eden Home Health of King County, LLC Projected Number of Employees for King County and Pierce County

Table 28-A – Page 61

Unadjusted Visits per FTE by Classification

Table 28-B – Page 61

Unadjusted Visits per FTE Classification

Eden Home Health of King County, LLC

Certificate of Need Application Proposing to Serve Medicare/Medicaid Patients in Pierce County

2020

Section 1
Applicant Description

A. Provide the legal name(s) of applicant(s).

The applicant is Eden Home Health of King County, LLC. The applicant is 100% owned by Eden Home Health of King County, LLC. Both are part of the family of companies owned by EmpRes Healthcare Group, Inc. Please see Attachment B for an organization chart that depicts the relationships.

B. For each licensed applicant, please provide the professional license number and specialty represented. If the license was not issued by Washington State, please identify the state it was issued.

The Eden Home Health of King County, LLC National Provider Identifier is **1003356403**.

C. For existing facilities, provide the name and address of the facility.

Eden Home Health of King County, LLC is currently Medicare and Medicaid certified to provide home Medicare and Medicaid services within King County. The current name and address is the following:

Eden Home Health of King County, LLC
733 7th Ave, Suite 110
Kirkland, WA 98033

D. Identify the type of ownership (public, private, corporation, non-profit, etc.).

Eden Home Health of King County, LLC is a for profit, limited liability corporation. It is registered as a domestic company with the Washington Secretary of State to do business in Washington.

E. Provide the name and address of owning entity at completion of project (unless same as applicant).

Eden Home Health of King County, LLC is a for profit Washington LLC.

F. Provide the name and address of operating entity at completion of project (unless same as applicant).

Empres Healthcare Group, Inc. (on behalf of Eden Home Health of King County LLC)
4601 NE 77th Avenue, Suite 300,
Vancouver, WA 98662

G. Identify the corporate structure and related parties. Attach a chart showing organizational relationship to related parties.

Please see Attachment B for a chart showing corporate structure and related parties.

H. Provide a general description and address of each facility and other related business(es) owned and/or operated by applicant (include out-of-state facilities, if any).

Please see Attachment C for a list of facilities owned by EmpRes Healthcare Group.

I. For existing facilities, identify the geographic primary service area.

Eden Home Health of King County, LLC is an existing home health agency serving King County. This CoN application is to receive approval to extend the primary service area to provide Medicare and Medicaid home health services to Pierce County residents.

J. Identify the facility licensure/accreditation status.

Eden Home Health of King County, LLC is licensed and accredited.

K. Is the applicant reimbursed for services under Titles XVIII, and XIX of Social Security Act?

Eden Home Health of King County, LLC is reimbursed under Titles XVIII and XIX of the Social Security Act.

L. If applicable, identify the medical director and provide his/her professional licenses number, and specialty represented.

The Medical Director for Eden Home Health of King County, LLC is Gilson R. Girotto, DO, license #OP00002078, NPI 1083690333.

A copy of the Medical Director contract is included in Attachment D.

M. If applicable, please identify whether the medical director is employed directly by or has contracted with the applicant. If services are contracted, please provide a copy of the contract.

Attachment D provides a copy of the Medical Director Agreement.

N. For existing facilities, please provide the following information broken down by discipline (i.e., RN/LPN, OT, PT, home health aide, social worker, etc.) for each county currently serving:

1. Total number of home health *visits* per year for the last three years; and

2. Total number of unduplicated home health *patients* served per year for the last three years.

Table 1 provides home health visits per year and the total number of unduplicated patients per year. Visits for the two partial years were calculated on an assumed 20.2 visits per unduplicated admission. Patients receiving each type of visit were calculated by taking the pro forma (historical experience of Eden) expected visits proportions and adjusting those proportions to take into account the experience of virtually no home health aid visits during the two partial years. Eden has experienced 2 "start-up" periods by opening in 2019 for a 7-month period and then experiencing a 6-month "Covid-19" readjustment that all healthcare providers have experienced during the initial months of the Pandemic.

Table 1

Eden Home Health of King County, LLC - King Existing Utilization					
	Annual Visits by Discipline'			Patients Receiving Each Type of Visit (Calculated)	
	2019 7-months Partial	2020 6-months Partial		2019 Partial	2020 Partial
Unduplicated Admits	143	122			
Calculated Visits	2,889	2,464	Total Patients	155	133
RN/LPN	1099	940	RN	140	120
PT	1075	920	PT	137	117
OT	562	481	OT	72	61
Speech	111	95	Speech	14	12
MSW	41	35	MSW	5	5
HHA	N.A.	N.A.	HHA	N.A.	N.A.

Section 2
Project Description

A. Provide the name and address of the proposed facility.

The office address of the proposed home health agency is:

Eden Home Health of King County, LLC
733 7th Ave, Suite 110
Kirkland, WA 98033

B. Describe the project for which Certificate of Need approval is sought.

This Certificate of Need (CN) request seeks approval to expand the service area of the Eden Home Health of King County, LLC agency to serve Pierce County. Approval is sought in connection with the home health division of EmpRes Healthcare Group, Inc., a 100% employee-owned organization that operates 59 rehabilitation facilities in 7 states as well as operating home health and hospice agencies. In 2014, EmpRes Healthcare established its home health care division through the acquisition of an Ammon, Idaho home health agency called Amedisys Home Health. The EmpRes home health division operates under the brand Eden Home Health.

In 2014, the Eden Home Health division acquired Option Care Enterprises, the Medicare-certified home health agency formerly operated by Walgreen's Infusion Services in Whatcom, Skagit, Island, and Snohomish Counties. Upon acquisition of Option Care, Eden Home Health began instituting its management and clinical improvement protocols in Whatcom County where 70% of the acquired agency's patients resided at that time.

Eden Home Health agencies provide skilled nursing, rehabilitation therapies, medical social services and certified home health aide services to homebound patients throughout the Whatcom, Skagit, Snohomish, Island county, King County and Spokane County and has been approved to establish a home health agency in Clark County. This CN application seeks approval to expand the Eden Home Health division's service offerings to Pierce to provide in-home skilled nursing, rehabilitation therapies, medical social services and certified home health aide services.

Eden Home Health's in-home services will include the full range of care defined by the Medicare home health Conditions of Participation. Eden Home Health also incorporates tele-health and the Coleman Model of Care Transitions services in the monitoring and care for its patients.

C. List new services or changes in services represented by this project. In the following table, please indicate (by marking an 'X' in the appropriate column) which services would be provided directly by the agency and which services would be contracted.

Services to be provided in Pierce County include:

	Direct	Contracted
Skilled Nursing	X	
Physical Therapy	X	
Occupational Therapy	X	
Speech Therapy	X	
Medical Social Work	X	
Home Health Aide	X	
Medical Director		X
Respite Care		
IV Therapy		
Other: Telemedicine	X	

D. General description of the types of patients to be served by the project.

Eden Home Health of King County, LLC will serve homebound Pierce County residents who require intermittent skilled nursing, rehabilitation therapy, medical social work, or certified home health aide services as a result of illness or injury. The average age of patients will be about 77 years old. Eden does not, at this time, plan to provide "mother/baby" care; the typical patient will be over age 18.

E. List the equipment proposed for the project:

1. **Description of equipment proposed; and**

2. **Description of equipment to be replaced, including cost of equipment, disposal or use of the equipment to be replaced.**

The agency will incrementally add some minor moveable equipment such as telephone/hand-held units and lap top computers. The annual cost of these items is identified as an expense line item in the three-year proforma operating statement at Attachment L.

No equipment is being replaced as part of this project.

F. Provide drawings of proposed project:

1. **Single line drawings, *approximately to scale,* of <u>current</u> locations which identify current department and services; and**

2. **Single line drawings, *approximately to scale,* of <u>proposed</u> locations which identify proposed services and departments; and**

3. **Total net and gross square feet of project.**

a) This is space in the existing building – no additional space is required to serve patients in Pierce County.

b) Please see Attachment F for a single-line drawing of the existing agency.

c) Net square feet for the existing agency is 1,576 square feet.

As a tenant, and included in the lease price, Eden-HHS will be able to schedule the intermittent use of conference rooms available at the leased premises.

G. Identify the anticipated dates of both commencement and completion of project.

Eden Home Health will commence serving Pierce County patients upon receipt of final CN approval. The agency is already Medicare/Medicaid certified and accredited by the Accreditation Commission for Health Care (ACHC). The anticipated date of commencement in Pierce County will be April 1, 2020.

The applicant recognizes that DOH defines "completion" of the project as "Initiation of services."

H. Describe the relationship of this project to the applicant's long-range business plan and long-range financial plan (if any).

The EmpRes Healthcare family of companies is organized as an Employee Stock Ownership Plan and as such is a 100% employee-owned organization. The company operates 59 facilities in 7 states. The Eden Home Health division was established to provide clinical integration and continuity of care for residents and patients as they progress through the post-acute care process. The Eden Home Health division now includes 10 home health agencies (one, approved for Clark County but not opened yet) in 4 states including EmpRes Home Health of Bellingham, LLC, d/b/a Eden Home Health located in Bellingham Washington which serves Whatcom, Skagit, Snohomish and Island counties.[1] Eden Home Health of Spokane, LLC is also operational.

The Patient Protection and Affordable Care Act also requires the Center of Medicare and Medicaid Services (CMS) to develop triple aim or value-based care approaches to improve quality of care, customer satisfaction at a lower overall cost. EmpRes believes that our ability to provide home health services as part of the continuum of care we provide will allow us to improve quality of care outcomes through improved care coordination systems focused on the triple aim of providing better quality outcomes and customers service at an overall lower cost for both Medicare and Medicaid patients.

EmpRes currently offers skilled nursing within Pierce County and King County. Service area expansion to include Pierce County is an important objective identified in the Eden's community assessment and resulting business plan:

[1] An employee stock ownership plan (ESOP) is a qualified defined-contribution employee benefit (ERISA) plan.

- The Affordable Care Act imposes financial sanctions for hospitals whose patients are re-admitted within 30 days of discharge. The downstream effect of these sanctions results in increasing demand for post-acute facilities and the rehabilitation services offered there.

- EmpRes Healthcare's Pierce County SNF and 3 SNFs serving Southern King County face substantial difficulty finding home health agencies that can respond timely to referrals of EmpRes discharged patients to their homes.

- The EmpRes Healthcare/Eden Home Health 2020 business plan, therefore, calls for developing home health capacity to provide improved coordination and more rapid transfer of Pierce County patients ready to go home.

- Specific to this project, EmpRes Healthcare is seeking approval to expand the Eden Home Health of King County service area to serve Medicare and Medicaid patients as well as patients in all payer categories in Pierce County.

I. Provide documentation that the applicant has sufficient interest in the site or facility proposed. "Sufficient interest" shall mean any of the following:

1. Clear legal title to the proposed site; or

2. A lease for at least one year with options to renew for not less than a total of three years; or

3. **A legally enforceable agreement (i.e., draft detailed sales or lease agreement, executed sales or lease agreement with contingencies clause) to give such title or such lease if a Certificate of Need is issued for the proposed project.**

The Eden Home Health of King County office space will support administrative functions not provided centrally by EmpRes Healthcare in Vancouver Washington. Please see Attachment G for a copy of the signed lease and extension.

Section 3
Project Rationale

A. Need

1. Identify the proposed geographic service area.

Eden Home Health of King County, LLC proposes to serve the entire geographic area of Pierce County Washington in addition to its current CN approved service area of King County.

2. If the proposed service area is designated as a Medically Underserved Area (MUA) as defined by HCFA or a Health Professional Shortage Area (HPSA), please provide documentation verifying the designation.

Pierce County has 5 health professional shortage areas (HPSAs): 3 primary care, 1 mental health and 1 oral health. All HPSAs are on Key Peninsula.[2] Attachment H provides a map of all Medical Underserved Areas and Health Professional Shortage areas in Washington State. In addition, a Map of the Key Peninsula is also included.

3. Identify and analyze the unmet home health service needs and/or other problems toward which this project is directed.

a. Identify the unmet home health needs of the patient population in the proposed service area(s). *Note that the unmet patient need should not include physical plant deficiencies and/or increase facility operating efficiencies.*

Overview

This project is directed toward providing additional resources, consistent with federal and state priorities and initiatives to improve health status, health care and managing increasing costs. This project is vitally needed to address six key service needs and problems facing patients referred now and in the future for home health services by their caregivers in Pierce County:

1) Need for additional providers to address the increasing demand for and growth in volumes in home health care.
2) Need to improve rapid admission to home health via timely access to home health services in the face of burgeoning demand.

[2] Tacoma-Pierce County Health Department *et al; C*ommunity Health Assessment Pierce County 2019. Page 46

3) Need to support recovered Covid-19 patients as they safely move to residential settings for patient safety and to maintain maximum hospital capacity.
4) Need for the additional providers to address growing health disparity that limits life span and increases the chronic disease burden of residents of Pierce County and adjacent counties.
5) Need for financially accessible home health services for Pierce County residents.
6) Need to provide the additional in-home services through expanded home health resources to continue to support Washington State initiatives such as the Medicare-Medicaid Financial Alignment Initiative, Medicare-Medicaid Managed Fee-for-Service (MFFS) demonstration now in its second extension through 2020; and the Department of Social and Health Services Long-Term Services and Supports (LTSS) Rebalancing that has yield substantial, estimated Medicaid Savings of $4.4 billion from all funding sources from SFY 2000 to SFY 2018.

The following discussion details each of these unmet needs. It addresses not only the need criteria related to absolute capacity of providers in Pierce County but also the criteria concerned with "availability and accessibility." Pierce County's need, availability and accessibility challenges are significantly greater than the 1987 home health agency need methodology projects. This review provides the basis for the determination that establishment of Eden Home Health of King County LLC is vitally needed and will not be an "unnecessary duplication" of services.

1) <u>Need for additional providers in Pierce County to meet growing demand.</u>

To identify unmet Medicare home health care needs in a planning area, the Department of Health uses a numeric need method and standards published in the 1987 Washington State Health Plan (SHP). (See Attachment J for a copy of the method and standards for an agency to be counted in existing supply.) The Certificate of Need Program has applied that methodology, with some revisions, in its review of all recent applications to establish new home health agencies in and all other counties statewide.

The method combines projected planning area population by age cohort with expected home health use rates for each of those age cohorts. The target year number of projected/needed home health visits is divided by 10,000 to determine the total number of home health agencies required to meet the needs of the population of the planning area in that target year. Where there are fewer existing agencies than the number required, the Certificate of Need Program has consistently found that one or more additional agencies are needed. This application has adopted the Certificate of Need Program's method to document the need it expects to meet in County.

The 1987 model was well conceived to address the principal driver for home health services which is the age of the population in most circumstances. This approach readily accounts for changes in existing and forecast age cohorts over the projection period.

Applicants are also expected to assess the general health of the service area population to

see if modifications to the general formula are warranted. EmpRes undertook such an assessment relying primarily on the excellent health data provided in the Washington State Department of Health Chronic Disease Profile for Pierce County in Washington (Attachment Q). The Chronic Disease Profile for King County is included in Attachment R. The data available within that report covers different periods from 2011 through 2016. This is supplemented by vital statistics data covering death rates through 2016. In this comparative analysis Pierce County was compared with King County and the State in terms of the chronic disease burden that results in higher demand for home health services.[3]

The King County profile is included along with the Pierce County profile because the Pierce County service area addition is an additional driver for the overall performance of the Eden Home Health of King County agency. Still, Pierce County and King County are in separate general health service areas as well as home health service areas. Each service area has unique characteristics and they are understood by Eden because Eden currently operates a skilled nursing facility in Pierce County as well as nursing homes and a home health agency in King County.

Table 2 shows that the Chronic Disease Burden for Pierce County is higher than both King County and the State as a whole indicating that more individuals than average will need home health at a greater volume than other areas in the State.

Table 2

2013 - 2015 Lifetime Self-Reported Prevalence of Chronic Disease Age 18+ Comparative Percentages			
	Pierce	**King**	**State**
Chronic Disease			
Cancer	11%	10%	12%
Arthritis	26%	19%	25%
Heart Disease	6%	4%	6%
Diabetes	10%	7%	9%
Asthma	11%	8%	10%
Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.			

Table 3 shows that generally Pierce County seniors 65 and older self-report living chronic illness and specific disabilities that require home health services at higher rates than respondents in King County or the State as a whole.

[3] See Attachment Q and Attachment R. DOH Pierce County and King County Profiles. May 2017 Page 12 in each

Table 3

Per Cent Seniors 65 and Older with Self-Reported Health Risks: 2013 - 2015			
	Pierce	**King**	**State**
Living with Chronic Disease	80%	73%	77%
Difficulty with 1 or More Activities of Daily Living	31%	29%	31%
Cognitive Difficulties	9%	7%	9%
Difficulty Walking	23%	22%	24%
Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.			

Figure 1 shows the most striking finding of the health profile analysis**. The life span for County residents has grown to a 1.3 -years shorter life span than the State as a whole.** King County has an average life span of 81.7 years at Birth for 2018 while Pierce has a life expectancy of 78.9 years and 80.5 years for the State.[4], Figure 1 provides comparative life expectancy for Pierce County and Washington State. The devinition of this metric is:

- Life expectancy—the average number of years a person at birth can expect to live, given current death rates— is a widely used measure of the overall health of a population.
- Life expectancy in Pierce County is significantly lower than in Washington with growing disparity from 2016 to 2018. Within Pierce County, females have a higher life expectancy than males. Black, American Indian or Alaska Native and Native Hawaiian or Pacific Islander life expectancies are lower than Asian, Hispanic and white life expectancies.

Figure 1: Life Expectancy by Demographics, Pierce County, 2012-2016[5]



Source: Washington State Department of Health Center for Health Statistics (CHS), Death Certificate Data,

[4] Washington State Department of Health. 2018 Data and Statistical Reports Health Data Visualization Mortality Dashboards ACHA Deaths Dashboards. 1990-2016, Community Health Assessment Tool (CHAT), October 2017.
[5] Attachment U: Tacoma-Pierce County Community Needs Assessment. Page 40

Drawing the connection between relatively small differences in income and education status that lead to unhealthy lifestyles is a complex process. The Department of Social and Health Services conducted a variety of analyses included in Attachment S under the overall direction of David Mancuso, PhD, Director, DSHS Research and Data Analysis Division summarized by Nancy Archibald, Kathy Moses, and Lauren Rava, The Center for Health Care Strategies.[6] His seminal analyses for DSHS Long-Term Services and Support for the aging population led to initiatives and demonstration projects within DSHS aimed at managing burgeoning healthcare costs for at-risk populations by dramatically increasing outreach, in home and residential services that has dramatically increased Washington residents' ability to live independently while significantly reducing skilled nursing admissions and long-term skilled nursing care.

The conclusion from the DSHS LTSS efforts and the CMS – Washington State Medicare-Medicaid Financial Alignment Initiative current 4-year, ongoing demonstration project is that the health home model treats the chronic illness burden with lower cost treatment options that reduce hospital and skilled nursing length of stay, readmissions and additional chronic illness burdens such as falls after stroke or nutritional illnesses (See Attachment T). While this means aggressive community outreach and care coordination, it also requires expanded home health resources, particularly in Pierce County. Nearly all patients with chronic illness hospitalization should receive home health services as part of their continuum of care whether it starts with inpatient rehabilitation services or skilled nursing services or is the primary supportive discharge service. Given the chronic illness burden in Pierce County, adding home health resources above the statewide average is absolutely called for.

Table 4 shows that the general health of the Pierce County population results in significantly higher, age-adjusted premature death rates than King County or the State as a whole. In fact, the Health District identified that the life span, 78.2 years for residents of County, is 1.3 years shorter than the State as a whole. The Health District carried out a special analysis that shows that these higher death rates are due to disparity in income and education. This is an indicator that new providers need to provide greater access to individuals of lower income.

Table 4

Premature Mortality per 100,000 Persons by Age Group: 2013 - 2015			
	Pierce	**King**	**State**
Premature death less than Age 50	110	81	97
Premature death less than Age 65	247	181	221
Data Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data, 2013-2015.			

[6] Nancy Archibald, Kathy Moses, and Lauren Rava. Using Health Homes to Integrate Care for Dually Eligible Individuals: Washington State's Experiences. Integrated Care Resource Center. Feb. 2019

Table 5 demonstrates that age-adjusted death rates for Pierce County when compared with King County and the State as a whole, are considerably higher. This is another marker of systemic problems in the health care status of residents requiring a greater concentration of services such as home health services to reduce these age-adjusted death rates. The principal driver here is probably premature deaths for the adult population as described in Table 3; and as previously noted, the Tacoma – Pierce Health Department has described health disparity as a significant issue.

Table 5
Comparative Mortality Age Adjusted Rates
Pierce County, King County and Washington State

Mortality Table C7. Diseases of the Heart, Ischemic Heart Diseases, and Cerebrovascular Diseases by County of Residence, 2015

	Diseases of the Heart (I00-I09,I11,I13,I20-I51)			Ischemic Heart Disease (I20-I25)			Cerebrovascular Disease (I60-I69)		
County	Number	Crude Rate[1]	Age-Adj Rate[2]	Number	Crude Rate[1]	Age-Adj Rate[2]	Number	Crude Rate[1]	Age-Adj Rate[2]
State Total	**10,987**	**155.6**	**138.3**	**6,338**	**89.8**	**79.5**	**2,693**	**38.1**	**34.4**
King	2,533	123.4	122.3	1,474	71.8	71.0	620	30.2	30.3
Pierce	1,322	159.3	156.0	789	95.0	93.2	282	34.0	34.5

Mortality Table C6. Diabetes, Alzheimer's Disease, and Major Cardiovascular Disease by County of Residence, 2015

	Diabetes (E10-E14)			Alzheimer's Disease (G30)			Major Cardiovascular Disease (I00-I78)		
County	Number	Crude Rate[1]	Age-Adj Rate[2]	Number	Crude Rate[1]	Age-Adj Rate[2]	Number	Crude Rate[1]	Age-Adj Rate[2]
State Total	**1,805**	**25.6**	**22.5**	**3,489**	**49.4**	**44.9**	**14,858**	**210.4**	**187.6**
King	375	18.3	17.9	903	44.0	44.3	3,471	169.1	168.2
Pierce	201	24.2	22.9	345	41.6	43.5	1,729	208.3	205.8

Mortality Table C8. Influenza & Pneumonia, Chronic Lower Respiratory Disease, and Chronic Liver Disease & Cirrhosis by County of Residence, 2015

	Pneumonia and Influenza (J10-J18)			Chronic Lower Resp. Dis. (J40-J47)			Chronic Liver Disease & Cirrhosis (K70,K73-K74)		
County	Number	Crude Rate[1]	Age-Adj Rate[2]	Number	Crude Rate[1]	Age-Adj Rate[2]	Number	Crude Rate[1]	Age-Adj Rate[2]
State Total	**851**	**12.1**	**10.7**	**3,151**	**44.6**	**39.9**	**1,021**	**14.5**	**12.4**
King	190	9.3	9.2	564	27.5	28.5	230	11.2	10.1
Pierce	114	13.7	13.4	386	46.5	46.5	126	15.2	13.6

[1] Rate per 100,000 population.

[2] Rate per 100,000 age-adjusted to U.S. 2000 population. Does not include deaths where age is unknown.

[*] Rate not calculated because number of deaths was less than 5.

Note: Codes for International Classification of Diseases, Tenth Revision (ICD-10) are in parentheses after each group heading.

Rates based on fewer than 20 deaths are likely to be unstable and imprecise.

Source: Center for Health Statistics, Washington State Department of Health, 07/2016.

Table 6 presents the relative percentages of death by cause and in this case, Pierce County and King County have similar percentages of deaths in many chronic disease as a percentage of total deaths even though Pierce County has significantly higher age-adjusted rates when compared to King County and the state as a whole, while King County generally has lower age-adjusted death for nearly all causes than the State as a whole. [7]

Table 6

Per Cent Cause of Death 2013 - 2015			
	Pierce	**King**	**State**
Cancer	21%	21%	24%
Heart Disease	12%	11%	13%
Diabetes	4%	4%	5%
Stroke	3%	3%	3%
Alzheimer's	5%	4%	6%
COPD or Asthma	5%	6%	6%
Other	50%	51%	43%
Data Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data, 2013-2015.			

The five key findings of this need assessment are the following:

1. The chronic disease burden for the Pierce County population is higher than both the State and King County based on the self-reported prevalence of chronic disease, the age-adjusted, measured premature death rates for the population under age 50 and under age 65 and the overall, age-adjusted, condition-specific death rates for the population.

2. The chronic disease burden and the age-adjusted premature death rates described above lead to higher utilization of hospital discharges to inpatient rehabilitation, skilled nursing homes and home health as shown in Table 6.

3. While Pierce County death rates are substantially higher, the actual mix of chronic conditions and associated death rates that drive home health referrals such as heart disease, stroke, COPD/asthma and Alzheimer's conditions proportionately are very similar. This means that while the need and number of home health agency visits is higher than King County or the State as a whole, the therapy mix (e.g., home health visits, physical therapy visits etc.) should be similar to the mix of services provided by home health agencies throughout Western Washington and the Puget Sound area; and Eden Home Health can rely on its estimates of service mix in its existing operations in Western Washington as well as benchmark data to serve as the template for this application.

[7] *Op cit.* Attachment Q and Attachment R, Page 14 in each Profile

4. **The most important conclusion is that greater home health resources are required in Pierce County to respond to this health disparity life span crisis in Pierce County – initiative 1 in improving health of the population that is part of the federal and state Triple Aim commitment. This increase in home health resources will also support the ongoing initiatives and demonstration projects that can mitigate the significantly higher costs related to the higher disease burden in County. Use of home health maintains individuals in the community and reduces overall healthcare costs for more expensive modalities including acute care, inpatient rehabilitation hospital and skilled nursing facilities. Any access barrier to home health in County will directly lead to much higher healthcare costs than would be experienced on a statewide basis.**

5. **Of near equal importance is that additional home health services will be required to support the DSHS LTSS aging program efforts and the CMS – Washington State Medicare-Medicaid Financial Alignment Initiative in Pierce County so that on a statewide basis these initiatives and demonstration projects will continue to serve Washington residents.**

This higher home health resource requirement particularly comes into play in the second phase of determining home health agency need – determining the impact of a new home health agency provider on the existing system. Clearly, with the reservoir of unmet need, there is a substantial need for additional home health agency capacity that is well beyond the *expected* need generated by the 1987 SHP methodology. The SHP is not promulgated as a rule for determining need but is instead a suggested estimating approach as is the rules-based examination of service area general health need. To quantify this need, EmpRes conducted a disparity analysis to measure the difference in age-adjusted death rates from chronic illness between Pierce County, King County and Washington State that results in an overall 1.3-year shorter life span for Pierce County residents when compared with all Washington State residents.

Table 7 presents the comparative death rates for these illnesses and uses the median difference in age-adjusted death rates between Pierce County residents and Washington State residents. The results are that County median adjusted death rates for listed conditions are 27% greater than Washington State death rates. This factor will be used as an adjustment factor after carrying out the 1987 SHP methodology.

Table 7

Home Health Agency Adjustment Factor for Higher Chronic Illness Burden Due to Health Disparity					
Cause of Death	**Pierce County Age Adj. Death Rate**	**King County Age Adj. Death Rate**	**State Age Adj. Death Rate**	**Pierce County Age Adj. Death Rate as % of King County**	**Pierce County Age Adj. Death Rate as % of State**
Diseases of Heart	156.0	122.3	138.3	128%	113%
Ischemic Heart Disease	93.2	71.0	79.5	131%	117%
Cerebrovascular Disease	34.5	30.2	34.4	114%	100%
Diabetes	22.9	17.9	22.5	128%	102%
Alzheimer's Disease	43.5	44.3	44.9	98%	97%
Maj. Cardiovascular Disease	205.8	168.2	187.6	122%	110%
Pneumonia/Influenza	13.4	9.2	10.7	146%	125%
Chronic Lower Respiratory Disease	46.5	28.5	39.9	163%	117%
Chronic Liver Disease and Cirrhosis	13.6	10.1	12.4	135%	110%
Median Rate Comparison				**128%**	**110%**
Home Health Adjustment Factor				**128%**	**110%**
Source: Center for Health Statistics, Washington State Department of Health, 07/2016.					

The Home Health Agency numeric need approach used by the Department of Health is contained in the 1987 Washington SHP. It is a population-based formula utilized for nearly 30 years. The Department of Health ("Department") has used this same methodology to project home health agency need in each county. This methodology projects need for at least six additional agencies in County before the health disparity adjustment is applied.

WAC 246-310-010(30) defines a home health agency as:
"*...an entity which is, or has declared its intent to become, certified as a provider of home health services in the Medicaid or Medicare program.*"

The methodology determines the projected number of home health visits in each planning area (e.g., County) using the following factors:

- Identifying projected population of the County, broken down by age groups (0 -64; 65-70; & 80 and older);
- Applying estimated home health use for each age group;
- Applying an estimate of number of visits per age group; and
- Dividing the number of projected visits by an assumed average of 10,000 visits per agency.

Table 8 provides the population projections by age group that is used in the methodology to project home health visits. In order to determine the 'net need' for a new home health provider, EmpRes calculated "'supply", based on a list of CoN agencies and State licensed agencies that could qualify as home health agencies and that reported data in the home health survey.

Table 8
Pierce County Change in Population by Age Cohort: 2020 through 2024 With Percentage Changes Each Year

Age	2020	% of Total Pop.	2021	% Change from prior year	2022	% Change from prior year	2023	% Change from prior year	2024	% Change from prior year	% of Total Pop.
0 - 64	765,139	84.90%	769,918	0.60%	774,696	0.60%	779,475	0.60%	784,253	0.60%	82.90%
65 - 79	107,644	11.90%	112,477	4.50%	117,310	4.30%	122,143	4.10%	126,976	4.00%	13.40%
80+	28,470	3.20%	29,945	5.20%	31,419	4.90%	32,894	4.70%	34,368	4.50%	3.60%
Total	901,253	100.00%	912,339	1.20%	923,425	1.20%	934,512	1.20%	945,598	1.20%	100.00%

Source: OFM "2017 County Age and Sex Projections, five-year intervals and age groups"

Table 9 provides the Medicare- Medicaid agencies that are certificate of need approved in Pierce County.

Table 9

2020 Medicare-Medicaid CoN Approved Agencies in Pierce County			
Agency Name	**M/M Pierce County**	**Location**	**Counted Agency**
Assured Home Health	Yes	Federal Way	Yes
Careage Home Health	Yes	DuPont	Yes
CHI Franciscan at Home	Yes	University Place	Yes
Envision HH of Wash	Yes	Burien	Yes
Kaiser HH and Hospice	Yes	Seattle	Yes
Harvard Partners	No	Kirkland	No
Kindred at Home	Yes	Tacoma	Yes
MultiCare Home Health	Yes	Tacoma	Yes
Providence Sound Homecare	Yes	Olympia	Yes
Puget Sound Home Health (Symbol)	Yes	Tacoma	Yes
Wesley Home Community Health	Yes	Des Moines	Yes
Signature Home Health	Yes	Federal Way	Yes
Total Medicare Medicaid Agencies	12		**11**

Table 10 projects the net home health agency need (rounded down) through 2024.

Table 10
Pierce County Home Health Agency Need 2021 through 2024

2021	Age Cohort	County Population	SHP Formula	Number of Visits	=	Projected Visits
	0-64	769,918	0.005	10		38,496
	65-79	112,477	0.044	14		69,286
	80+	29,945	0.183	21		115,077
		912,339			**TOTAL:**	**222,859**
				Number of Expected Visits per Agency		*10,000*
				Projected Agency Need		**22.29**
				Existing CoN Agencies		**11.00**
				Net Need		**11.29**
				Round Need Down		**11**

2022	Age Cohort	County Population	SHP Formula	Number of Visits	=	Projected Visits
	0-64	774,696	0.005	10		38,735
	65-79	117,310	0.044	14		72,263
	80+	31,419	0.183	21		120,744
		923,425			**TOTAL:**	**231,742**
				Number of Expected Visits per Agency		*10,000*
				Projected Agency Need		**23.17**
				Existing CoN Agencies		**11.00**
				Net Need		**12.17**
				Round Need Down		**12**

2023	Age Cohort	County Population	SHP Formula	Number of Visits	=	Projected Visits
	0-64	779,475	0.005	10		38,974
	65-79	122,143	0.044	14		75,240
	80+	32,894	0.183	21		126,411
		934,512			**TOTAL:**	**240,625**
				Number of Expected Visits per Agency		*10,000*
				Projected Agency Need		**24.06**
				Existing CoN Agencies		**11.00**
				Net Need		**13.06**
				Round Need Down		**13**

2024	Age Cohort	County Population	SHP Formula	Number of Visits	=	Projected Number of Visits
	0-64	784,253	0.005	10		39,213
	65-79	126,976	0.044	14		78,217
	80+	34,368	0.183	21		132,078
		945,598			**TOTAL:**	**249,508**
				Number of Expected Visits per Agency		*10,000*
				Projected Agency Need		**24.95**
				Existing CoN Agencies		**11.00**
				Net Need		**13.95**
				Round Need Down		**13**

Table 11 shows that there is substantial home health agency need based on the approved number of home health agencies for a near one million population service area. Table 11 provides the projected number of home health agencies needed from 2020 through 2024 based on projected visits per age group, adjusted to account for the higher Home Health agency need based on illness volume.

Table 11
Net Home Health Agency Need Adjusted for Chronic Illness Burden

	2020	2021	2022	2023
Total HHA Need	21.40	22.29	23.17	24.06
Adjusted HHA Need (10%) for Higher Chronic Illness Burden (Pierce to State from Table 6)	2.14	2.23	2.32	2.41
Less Existing Agencies	11	11	11	11
Net HHA Need	12.56	13.52	14.49	15.47
NET HHA Need Rounded Down	12	13	14	15

Table 12 examines the volume of home health visits for home health agencies that provided information through surveys for 2018 and 2019 covering utilization periods of 2017 and 2018. The methodology and most recent interpretation of agencies to be included in this analysis are agencies that provide responses to the most recent 2019 survey. In this case, two exceptions have been made. Symbol Puget Sound Home Health reported erroneous volume information for 2018 utilization, so 2017 survey utilization is provided. Kaiser Permanente did not respond to the survey. However, the 2017 decision for Envision (CN #18-03) applied a 5,000 visits estimate for Kaiser Permanente, which is provided in Table 12.

Table 12 presents the 2018 reported visits in the last survey based on agencies that reported information.

Table 12

2020 Medicare-Medicaid CoN Approved Agencies in Pierce County			
Agency Name	**M/M Pierce County**	**Location**	**2018 Survey Volume (DOH-CRS, 2019)**
Assured Home Health	Yes	Federal Way	14,224
Careage Home Health	Yes	DuPont	0
CHI Franciscan at Home	Yes	University Place	0
Envision HH of Wash	Yes	Burien	2,951
Kaiser HH and Hospice	Yes	Seattle	0
Harvard Partners	No	Kirkland	0
Kindred at Home**	Yes	Tacoma	77,085
MultiCare Home Health	Yes	Tacoma	42,871
Providence Sound Homecare	Yes	Olympia	2,892
Puget Sound Home Health (Symbol) *	Yes	Tacoma	49,934
Wesley Home Community Health	Yes	Des Moines	4,957
Signature Home Health	Yes	Federal Way	0
Total Medicare Medicaid Agencies			**194,914**
* 2018 DOH-CRS survey reported data because data in the 2019 survey was invalid and unreliable, ** Data is unreliable and corrected with cost report data in Table 14.			

Table 13 indicates that in 2023 there is a need for agencies to provide an additional 45,711 visits while in 2024 there is net need for agencies to provide an additional 54,594 visits using the State projection methodology.

Table 13

2023 and 2024 Pierce County Home Health Visit Need	
2023 Projected Visits	240,625
2018 Survey-Reported Visits	194,914
Projected 2023 Unmet Visit Need	**45,711**
2024 Projected Visit Need	249,508
2018 Survey Reported Visits	194,914
Projected 2024 Unmet Visit Need	**54,594**

Revised Need Based on the Number of Reported Scans Using "Best" Data

Table 14 presents the volume of home health agencies that provided survey response data in 2019. Both Kindred at Home and Symbol Puget Sound Home Health agency reported visit data that was significantly different from historical survey responses and Medicare Cost Reports data. Table 14 provides the most accurate and reliable visit data available to determine agency need.

Table 15 presents the projected unmet 2023 and 2024 need based on unfulfilled visits. Table 15 shows that the actual need based on corrected home health visits exceeds 7 home health agencies (based on 10,000 visits per agency) in 2023 and 8 home health agencies @10,000 visits per agency in 2024.

Table 14

Revised 2020 Medicare-Medicaid CoN Approved Agencies in Pierce County			
Agency Name	**M/M Pierce County**	**Location**	**2018 Survey Volume (DOH-CRS, 2019)**
Assured Home Health	Yes	Federal Way	14,224
Careage Home Health	Yes	DuPont	0
CHI Franciscan at Home	Yes	University Place	0
Envision HH of Wash	Yes	Burien	2,951
Kaiser HH and Hospice	Yes	Seattle	0
Harvard Partners	No	Kirkland	0
Kindred at Home*	Yes	Tacoma	50,366
MultiCare Home Health	Yes	Tacoma	42,871
Providence Sound Homecare	Yes	Olympia	2,892
Puget Sound Home Health (Symbol) *	Yes	Tacoma	50,100
Wesley Home Community Health	Yes	Des Moines	4,957
Signature Home Health	Yes	Federal Way	0
Total Medicare Medicaid Agencies			**168,361**
* DOH-CRS survey reported data was invalid and unreliable. CMS Cost Report visits are reported for 2018			

Table 15

2023 and 2024 Pierce County Home Health Visit Need	
2023 Projected Visits	240,625
2018 Survey-Reported Visits	168,361
Projected 2023 Unmet Visit Need	**72,264**
2024 Projected Visit Need	249,508
2018 Survey Reported Visits	168,361
Projected 2024 Unmet Visit Need	**81,147**

b. Identify the negative impact and consequences of unmet home health needs and deficiencies.

Overview

For over 30 years the Department of Health (Department) has used the same methodology to project home health agency need in each County as described in the previous section. This methodology projects need for at least 13 additional agencies in Pierce County by **2023 or 2024 regardless of which year is selected as the third full year of operation**. If the methodology is adjusted for chronic illness burden, the 2023 home health agency need increases to 15 agencies. In addition to collecting the required information to carry out the methodology used by the Department, EmpRes evaluated each step of the methodology to obtain a better understanding of home health agency need as it applies to the Pierce County population and the various adjustments that should be applied to the need estimate. The steps that EmpRes used to understand need and to address unmet need and assess its consequences are based on the following elements:

- EmpRes fully evaluated the health statistics compiled by the Tacoma – Pierce County Health Department, the Washington Department of Health Death Statistics and reviewed the information with the Tacoma – Pierce County Health Department.

- EmpRes, per recommendations from Department staff, is contacting by phone skilled nursing homes within Pierce County and EmpRes SNFs in King County to identify unmet need and the potential for referrals. To date, the four facilities reporting note difficulty in placing Medicaid patients. Surveys are continuing.

- EmpRes reviewed the HRSA HPSA data base included in Attachment H and the HPSA and MUA data finding for Pierce County analyzed by the Tacoma-Pierce County Health Department that notes that there are 3 general and 2 specialty (e.g., dental, mental health) HPSA sites located on the Key Peninsula.

- EmpRes reviewed an Avalere Health proprietary market report, which provides a proprietary analysis of the Medicare fee-for-service patient referrals from all facilities and individual physicians located within Pierce County to home health agencies.

- EmpRes also applied its experience and referral data gleaned from operating skilled nursing facilities in Pierce County as well as South King County as well as operating home health agencies in King County (new) and an agency serving Snohomish, Skagit, Whatcom, Island and San Juan counties

The overall conclusion from this review of available data and interviews with skilled nursing facility managers is that health disparity caused by income and educational

disparity[8] contributes to a significant burden of chronic illness in Pierce County that requires additional agency resources such as home health agencies that specialize in supporting individuals with chronic illness and provide services to lower income populations such as the Medicaid population. Additional home health resources in Pierce County will substantially improve the ability of individuals to remain at home while reducing overall healthcare costs to payers, families and patients.

1) Need for additional providers in Pierce County to meet growing demand

This key need is the focus of the prior section's as summarized in Tables 10 through 15. The summary need ranges from 13 to 15 agencies under Method 1 (State Methodology population based projected net need based on each agency providing 10,000 visits); and under Method 2 with need ranging from 7 to 8 agencies (Self-Reported visit utilization data for agencies within Pierce Count subtracted from projected visits under Method 1).

Findings: Need Methodology Estimate of Capacity

In mid-2016, the Department of Health revised its method of counting available home health service capacity in the county for which an applicant files a letter of intent. Starting with 2012 HHA evaluations, DOH began including "licensed-only" agencies in existing capacity and it began providing a list to applicants that combined the CON-approved and "licensed-only" agencies for use in the applicant's calculation of the 1987 SHP Home Health Need Estimation Method.[9]

In the December 2017 Evaluation of the Envision Certificate of Need Application #18-03, the Department refined its approach to rely on Certificate of Need approved agencies and state-only agencies that provided utilization data in the annual survey. Given the heightened chronic illness burden in Pierce County, reducing capacity by counting State-only agencies might have been a problem but our analysis is that this approach has not had any adverse impact (e.g., reducing potential supply) within Pierce County.

The greater concern is the accuracy of the data reported by agencies in the 2019 survey covering calendar year 2018 (Kindred and Puget Sound home health agencies). Fortunately, this information could be checked against CMS cost report data for 2018 to address the obviously erroneous data. The result is that there is the need findings for Method 1 (Table 10) and Method 2 (Table 15) that shows significant home health agency need **before adjustments of approximately 10% for the added health disparity in Pierce County (Table 11).**

2) Need for rapid admission to home health via timely access to home health services

[8] Source: *Ibid.* Pp. 28, 30-31

[9] This change in methodology has a minimal effect on counties surrounded by rural areas such as County.

The second key need addressed by this application is the need for patients referred to home health to receive rapid admission for care. A discussion of the negative impact and consequences of delayed admission in Pierce County is discussed next.

Evidence of the problem and Medicare data on "timeliness" of the start of care in Pierce County is provided at Question 9 (b). below discussing availability and accessibility.

Findings: Need for Rapid Admission

Our review of Medicare quality of care data and our interviews with nursing home providers indicates that home health agencies are currently achieving appropriate results in meeting the current need for rapid admission. However, the pressure on hospitals and other providers to rapidly transfer patients to lower levels of care as a result of reimbursement factors and currently the Covid-19 pandemic exposes the documented, fragile chronically ill Pierce County population to even greater need for home health services.

The latest CMS Compare pre-Covid-19 statewide average percentage of patients referred to home health agencies within 2 days from the time of physicians' order was 93.3% and for all home health agencies nationwide was 95.5%. However, in home health shortage situations such as Pierce County, the actual time from hospital discharge to admission to hospice services in the more important variable.

The actual 2-day time from hospital discharge to admission to home health services on a nationwide basis is slightly less that 80%. In Pierce County the actual 2-day time to admission to home health is much lower as shown in Table 16 with a median time from hospital discharge to admission to home health of 30%

Table 16

Pierce County Home Health Agency Percentage of Patients Admitted to Home Health Within 2 days (reported and Actual)		
Agency Name	**CMS Compare MD Order**	**CMS 2019 Claims Time from Hospital Discharge**
Assured Home Health	99.1	57.6
Careage Home Health	NR	NR
CHI Franciscan at Home	98.4	30.2
Envision HH of Wash	95.8	29.6
Kaiser HH and Hospice	95.6	N.A.
Harvard Partners	NA	N.A.
Kindred at Home*	98.7	51.7
MultiCare Home Health	93.5	29.7
Providence Sound Homecare	83.5	NR
Puget Sound Home Health (Symbol) *	99.8	21.8
Wesley Home Community Health	99.3	NR
Signature Home Health	98.7	50.0
All WA Agencies	93.3	NA
All Nationwide Agencies	95.5	78.0
* DOH-CRS survey reported data was invalid and unreliable. CMS Compare 2018, CMS Claims 2019		

The variance between time from physicians' order to home health admission and time from hospital discharge is an important quality concern. The quality concern is that increases in length of time when the patient is not under home health agency oversite can lead to the need for unscheduled hospital services – either hospital readmission or emergency room or other hospital services. CMS has sufficient concern in this area to place financial disincentives on hospitals regarding unplanned hospital care.

Table 17 shows that in Pierce County home health agencies generally have hospital readmission rates that are favorable when compared to the national and statewide average. The opposite is the case for rates of hospital

emergency outpatient/emergency room visits. In each case for these variables there is significant negative variance between home health agencies' performance. In examining the data, hospital readmits and unscheduled hospital emergency room and outpatient visits could be reduced with greater home health agency compacity. For example, there are several home health agencies that are well below the statewide and national averages for these metrics and in the case of unscheduled outpatient and emergency room visits, Washington State can do considerably better and Pierce County can do better if the shortage of home health agency capacity is addressed.

Table 17

Pierce County Home Health Agency Unplanned Hospital Care (CMS Compare 2018 Data)		
Agency Name	**CMS Compare % Hospital Readmit**	**CMS Compare % Outpt./ER Visits**
Assured Home Health	14.2	15.9
Careage Home Health	NR	NR
CHI Franciscan at Home	12.1	14.5
Envision HH of Wash	12.8	15.2
Kaiser HH and Hospice	7.9	7.0
Harvard Partners	NR	NR
Kindred at Home*	15.4	13.9
MultiCare Home Health	15.5	14.7
Providence Sound Homecare	16	15.5
Puget Sound Home Health (Symbol)	15.1	11.4
Wesley Home Community Health	19.2	15.0
Signature Home Health	13.3	14.6
Total: WA State Agencies	**14.7**	**15.6**
Total: National Agencies	**15.6**	**12.8**

Survey results indicate that 4 of 12 responding nursing homes indicated difficulties in appropriate placements. These findings foreshadow access problems that will have adverse effects on health status as well as healthcare costs. If additional capacity is not provided at this time, the gap caused by health disparity in health status within Pierce **County as measured by life span could increase if higher hospital readmissions or emergency room or outpatient hospital visits occur due to delays in home health placement.**

3) Need for the additional providers to address growing health disparity that limits life span and increases the chronic disease burden of residents of Pierce County and adjacent counties.

As previously noted in Figure 1, health disparity reduces life span for Pierce County residents by 1.3 years on a countywide basis. Tables 2 through 5 provide further detailed comparisons of health disparity comparing Pierce County to King County and Washington State as a whole.

The Eden approach has adopted the Coleman model of care to address home health referrals from all patients and payer categories to address direct patient care and continuity of care among community providers. The Coleman Model's Care Transitions Program provides education and coaching support for patients transitioning from one care setting to another, such as from skilled nursing to home. As conditions and personal needs change, the Care Transitions Program allows patients to self-manage their care in the home environment, thus helping patients achieve greater long-term independence.

The Transitions Program model of care is fully congruent with the highly successful health home model of care operated by the Washington State Medicaid program. The demonstration project is designed to provide more integrated, coordinated care for Washington residents who are dually eligible for Medicare and Medicaid. The overall objectives are: (1) comprehensive care management; (2) care coordination; (3) health promotion; (4) comprehensive transitional care and follow-up.[10] The program is targeted toward enrollees with greater than average patient care acuity (1.5 on the PRISM scale). Evaluation details of this Medicaid demonstration project are included because they clearly document the effectiveness of the Eden approach as well as the need to expand home health capacity to address healthcare disparity in Pierce County.[11]

The 2-year preliminary study results were that the study group had fewer hospital inpatient hospital stays (5.36 percent), emergency department visits (-4.11 percent),

[10] Using Health Homes to Integrate Care for Dually Eligible Individuals: Washington State's Experiences, Nancy Archibald, Kathy Moses, and Lauren Rava, Center for Health Care Strategies. Integrated Care Resource Center. February 2019

[11] *Ibid.* Page 9

and skilled nursing facility admissions (-18.63 percent) and a lower probability of long-stay nursing facility (-24.21 percent) than the comparison group. The 30-day all-cause, risk-adjusted hospital readmission rate was higher for the demonstration group.

Financial savings to payers as well as reduced barriers to access to healthcare are described in the next subsection and again use Washington State's own, independently verified costs savings.

4) Need for financially accessible home health services.

This problem of access affects patients referred to home health services, particularly the dual option Medicare-Medicaid patients where "affordable care" is not limited just to the direct patient service but in the patient's ability to maintain independent living.

Table 18 shows that the Medicaid population makes up a substantial portion of all patients currently receiving home health services. There is wide disparity in the percentage of Medicaid patients served as a percentage of total patients with the percent Medicaid ranging from 0% to nearly 28%. Eden estimates that initially approximately 1% of its patient population will be Medicaid patients. Eden also estimates that approximately 2.5% of gross revenue will by charity care and 2% of gross revenue will end up as bad debt.

As detailed in the discussion of "health disparity" the cost of home health services and health services at home compared to the incomes of many who need these services are barriers for living a healthy lifestyle. Without additional intervention by home health and other lower cost health care providers, lower income patients' health will be further exacerbated. Additional home health agencies that are Medicare and Medicaid certified can help these patients address their chronic illness so that they live a longer and higher quality life.

Part of the solution is simply greater resource capacity for home health services which is addressed by this project. Without this capacity, the 20-year efforts of the Department of Social and Health Services Long-Term Services and Supports (LTSS) Rebalancing and the Washington State Medicare-Medicaid Financial Alignment Initiative ,Medicare-Medicaid Managed Fee-for-Service (MFFS) may not achieve maximum effectiveness in addressing the chronic illness burden in Pierce County, affordability for patients and managing increases in healthcare costs.[12] The MFFS project

[12] REPORT FOR WASHINGTON MANAGED FEE-FOR-SERVICE (MFFS) FINAL DEMONSTRATION YEAR 3 REPORT FOR WASHINGTON MANAGED FEE-FOR-SERVICE (MFFS). Actuarial Research Corporation: Michael Sandler, ASA, MAAA, Lan Zhao, PhD, Anthony Simms, ASA, MAAA, Todd Trapnell,

demonstrated that if real-world results are not achieved programs will be cutback. Evaluations through the first four years of operation of the demonstration project yielded the following substantial results:

- Total Demonstration Year 1 Medicare savings were calculated as $34.9 million
- Total Demonstration Year 2 savings were calculated as $30.2 million
- Total Medicare savings in Demonstration Year 3 were calculated as $38.8 million or 10.9 percent. An additional $7.7 million in attributed savings (savings attributed to eligible months prior to the start of the most recent cohort) sums to a grand total final calculated Demonstration Year 3 Medicare savings amount of $46.6 million
- Preliminary Total Medicare savings in Demonstration Year 4 were calculated as $46.5 million or 9.7 percent. Including preliminary attributed Medicare savings estimates of $5.5 million results in a grand total preliminary Demonstration Year 4 Medicare savings estimate of $55.2 million
- The current estimate of grand total Demonstration Medicare savings for all cohorts through Demonstration Year 4 to $166.8 million

In reviewing the metrics in Table 16 and Table 17, the data show that additional home health capacity from agencies committed to continuity of care and engagement of patients in the care process can address patient and payer affordability barriers which will directly address health disparity.

Findings: Need for affordable home health services to address the unique health disparity conditions that reduce life span in Pierce County.

Reforms in the delivery and payment for healthcare are driving increased use of in-home services. The use of in-home care post discharge supports the cost-effective care of post-acute patients after injury, surgery, hospitalization or skilled nursing/nursing home care. Based on requirements of the Affordable Care Act, Medicare set standards and has begun monitoring the re-admission of inpatients who require greater attention to rehabilitation and healing at home.

Hospitals with high re-admission rates are penalized financially by Medicare until the institution's performance reaches a required federal standard for re-admissions. Likewise, patients of post-acute skilled nursing facilities also require follow-up care and therapies upon discharge. Many require immediate post-discharge admission to and treatment by home health service providers.

MPP, Alicia Nussbaum and RTI International: Melissa Morley, PhD, Giuseppina Chiri, MA, Project Director: Edith G. Walsh, PhD. August 2019. Pp. ES 1 – ES 2

These changes and the financial incentives supporting them, emphasize the need for keeping patients clinically stable immediately after discharge. The practice requires rapid admission to home health care of patients determined by their physicians to require such care. Not only must the patient be admitted to the agency, but the patient must receive the appropriate level and frequency of care prescribed by the physician. Patients who cannot access or do not receive timely and adequate home health services may experience many health-related issues and a few of these include:

- Longer lengths of stay for inpatients
- Poor management of required post hospital medications; patient non-compliance or errors
- Unnecessary falls due to inadequate attention to safety issues in the home
- Lack of progress in rehabilitation, e.g., required therapies for joint replacement
- Inadequate monitoring for post-acute complications and worsening of conditions leading to increased morbidity and mortality
- Poor adherence to post-acute dietary instructions, e.g. low salt diet for CHF
- Unnecessary morbidity and earlier mortality at the system level due to an inadequate supply of home health services means:
  - Overall longer lengths of inpatient stays in the highest cost settings
  - Higher capital and operating costs to develop and maintain greater inpatient capacity than would otherwise be needed
  - Additional demand for nursing and other staffing across the system
  - Poor hospital through-put and patient warehousing

4. **<u>Define the types of patients that are expected to be served by the project.</u>**
   The types of patients expected to be served can be defined according to specific needs and circumstances of patients (i.e., culturally diverse, limited English speaking, etc.) or by the number of persons who prefer to receive the services of a recognized school or theory of medical care.

Eden Home Health of King County, LLC will serve homebound Pierce County residents without regard to race, religion, national origin, sex, sexual orientation and handicap who require intermittent skilled nursing, rehabilitation therapy, medical social work, and/or certified home health aide services as a result of illness or injury ordered by their primary physician. Further, Eden Home Health of King County, LLC will have at its disposal appropriate resources and personnel available to serve deaf/hard-of-hearing and patients who have limited English speaking ability.

The types of patients Eden Home Health of King County, LLC will serve in Pierce County will be consistent with the experience in other markets with a similar demographic profile One special population will be Veterans who either migrate or continue to live in Pierce County to be close to Joint Base Lewis- McChord. Eden Home Health of King County, LLC will serve minority populations in Pierce County consistent with their representation within the age stratification detailed below. The average age of the patients served is estimated to be 77, which is like national peer group averages. Ages 18 to 64 will make up approximately 21% of the patients served while the age group from 65 – 79 will be approximately 76% of the total. Those over the age of 80 will be less than 4%.

Table 18 lists the current range of patients treated within King County which will be like the patient mix in Pierce County.

Table 18
Patient Register

PRINCIPAL DIAGNOSIS CLASSIFICATION	ENTRIES	PERCENTAGE OF ENTRIES
Cancer	22	3.5%
Diabetes	60	9.4%
Chronic Obstructive Pulmonary Disease & Respiratory Failure	32	5.0%
Joint Replacement Care / Other Orthopedic	30	4.7%
Fracture Care	87	13.7%
Cardiovascular	67	10.5%
Alzheimer's Disease and Other Dementia	44	6.9%
Cardiovascular	67	8.9%
Stroke	57	10.5%
Wound Care and Pressure Ulcer Care	52	8.9%
Other	117	18.4%
TOTAL	637	100.47%

Expected referral sources:

- Acute Care Hospitals
- Skilled Nursing Facilities/Rehabilitation Centers
- Adult Living Facilities
- Physician Practices
- Clinics (CHF/COPD, Diabetes, Wound Care)
- Senior Clinics
- Community (Retirement communities, Elder Care Attorneys)
- Family members/ Caregivers

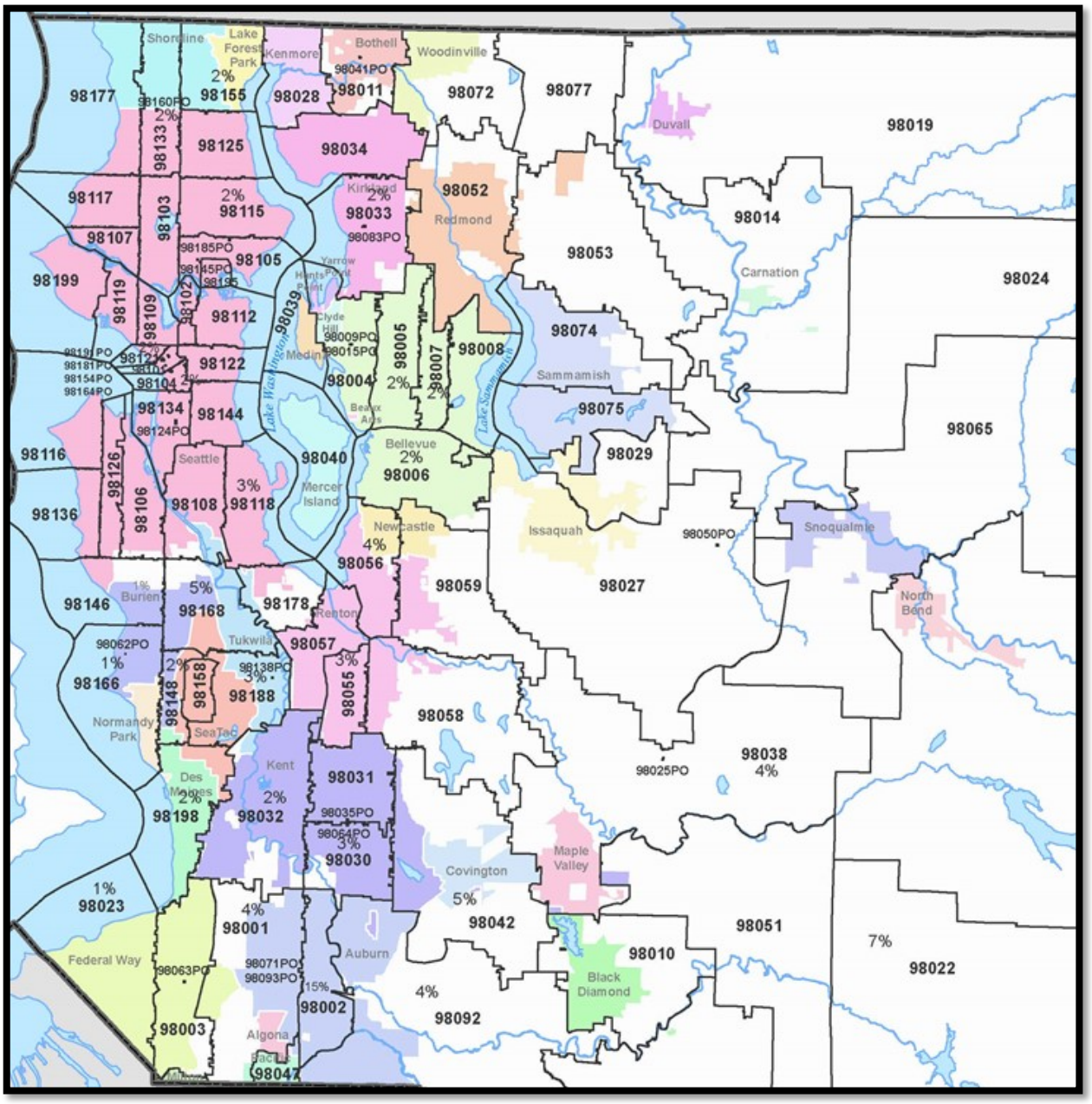
5. **For existing facilities, include a patient origin analysis for at least the most recent three-month period, if such data is maintained, or provide patient origin data from the last statewide patient origin study. Patient origin is to be indicated by**

zip code. Zip codes are to be grouped by city and county and include a zip code map illustrating the service area.

Table 19
Zip Code Analysis from Patient Register (January – August 2020)

ZIP CODE	CITY	ENTRIES	% TOTAL
98002	Auburn	95	15%
98022	Enumclaw	42	7%
98168	Seattle	34	5%
98042	Kent	29	5%
98038	Maple Valley	28	4%
98092	Auburn	26	4%
98056	Renton	25	4%
98001	Auburn	23	4%
98188	Tukwila	18	3%
98118	Seattle	18	3%
98030	Seattle	18	3%
98055	Renton	18	3%
98105	Seattle	16	2%
98106	Seattle	14	2%
98198	Seattle	13	2%
98033	Kirkland	13	2%
98032	Kent	13	2%
98133	Seattle	12	2%
98121	Seattle	12	2%
98104	Seattle	12	2%
98148	Seattle	10	2%
98115	Seattle	10	2%
98007	Bellevue	10	2%
98155	Seattle	10	2%
98146	Burien	9	1%
98166	Burien	8	1%
98023	Federal Way	8	1%
Subtotal		544	85%
Zip codes with less than 1% of Total Record Entries		97	15%
TOTAL ENTRIES		641	

EDEN HOME HEALTH OF KING COUNTY, LLC PATIENT ORIGIN BY ZIP CODE
JANUARY 1, 2020 THROUGH AUGUST 31, 2020



6. **For existing facilities, please identify the number of patients currently receiving skilled services, broken down by type(s) of services (i.e., skilled nursing), by county served.**

The number of Eden Home Health of King County, LLC patients receiving home health services by type of services is included in Table 1, which is also included in response to this question.

7. Please provide utilization forecasts for the following, broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) for each county proposing to serve:

A. Total number of home health *visits* per year for the first three years; and

B. Total number of unduplicated home health *patients* served per year for the first three years.

Table 1 (copied herein) provides the total number of visits for the first two partial years and the first three complete years of operation as well as unduplicated home health patients.

Table 1 (Copied)

Eden Home Health of King County, LLC - King Existing Utilization					
	Annual Visits by Discipline'			Patients Receiving Each Type of Visit (Calculated)	
	2019 7-months Partial	2020 6-months Partial		2019 Partial	2020 Partial
Unduplicated Admits	**143**	**122**			
Calculated Visits	**2,889**	**2,464**	**Total Patients**	**155**	**133**
RN/LPN	1099	940	RN	140	120
PT	1075	920	PT	137	117
OT	562	481	OT	72	61
Speech	111	95	Speech	14	12
MSW	41	35	MSW	5	5
HHA	N.A.	N.A.	HHA	N.A.	N.A.

Table 20			
Unduplicated Admissions and Visits by Discipline			
Pierce County			
	2021	**2022**	**2023**
Unduplicated Admissions	165	315	510
Visits			
Skilled Nursing	1,315	2,511	4,066
Physical Therapy	1,286	2,456	3,976
Occupational Therapy	673	1,285	2,080
Speech Pathology	132	252	409
Medical Social Service	49	94	152
Home Health Aide	211	403	652
Total	**3,667**	**7,001**	**11,335**
King County			
	2021	**2022**	**2023**
Unduplicated Admissions	738	882	1,026
Visits			
Skilled Nursing	5,883	7,031	8,179
Physical Therapy	5,754	6,876	7,999
Occupational Therapy	3,010	3,597	4,184
Speech Pathology	591	707	822
Medical Social Service	221	264	307
Home Health Aide	943	1,127	1,311
Total	**16,402**	**19,603**	**22,803**
Total			
	2021	**2022**	**2023**
Unduplicated Admissions	903	1,197	1,536
Skilled Nursing	7,199	8,897	10,021
Physical Therapy	7,040	23,200	26,988
Occupational Therapy	3,683	707	822
Speech Pathology	724	264	307
Medical Social Service	270	1,127	1,311
Home Health Aide	1,154	21,625	24,826
Total	**20,069**	**26,604**	**34,138**

8. Provide the complete step-by-step quantitative methodology used to construct each utilization forecast. All assumptions related to use rate, market share, intensity of service, and others must be provided.

Planning area growth in demand

Table 8, prepared in response to the 1987 SHP Need Estimate methodology shows, that the Pierce County target population for home health services is expanding

rapidly. Table 10 SHP Need Estimate shows a growth in need between 2021 and 2023 of 17,776 home health visits. In the SHP methodology, this additional demand for care is driven by a combination of an overall Pierce County population growth and by the aging of both the 65 -79-year age cohort and the cohort over age 79. From 2021 through 2023, the population under age 65 will grow by 1.2% while the population in the two older cohorts will each grow over 8.6% and 9.8% respectively fueling a large increase in home health visits of nearly 8% for the time period.

This analysis shows that, in 2023 through 2024 population growth would support 13 home health agencies @10,000 visits per agency under SHP Methodology 1 and a need for 4 – 5 home health agencies @ 10,000 visits per agency as identified in Table 13.

Market Share

Taking only the Medicare-certified agencies as the relevant competitors, Eden Home Health of King County, LLC reviewed the potential market share impact of its 2022 volume estimate. Spreading Eden Home Health of King County, LLC's Pierce County volume of 7,001 visits in 2022, the Pierce County market share of 2022 projected need (Table 10) will be 3%. If volume is adjusted to take into account the impact of health disparity, overall need would be at least 10 % higher which would result in an overall market share of less than 3%. In short, the project will no significant adverse impact on other existing home health provider.

Projected referral sources and assumptions:

1) Skilled Nursing

As part of its volume estimates, Eden Home Health of King County, LLC contacted each of the Eden skilled nursing homes in Pierce County and the 3 EmpRes SNFs serving Pierce County but located in King County. Per the Department's suggestion, Eden is surveying Pierce County-based SNFs that are not affiliated with EmpRes. The responding Discharge Planners and Social Workers on staff at those facilities are responsible for coordinating the discharge of each patient referral to home or another facility. EmpRes owns a 164-bed skilled nursing home in Pierce County. Currently, this facility refers 30 patients per month to home health agencies. However, SNFs will be only one source of referrals; and Eden has experience in the home health referral requirements of SNFs.

Assumption: The Eden overall estimate for the first 3 years of operation in Pierce County is 165 unduplicated admissions in Year 1 increasing to 510 admissions in Year 3. Hospitals and physicians will make up over 80% of expected volume. SNF referrals will represent approximately 20% of referral volume.

Coleman Model: Care Transitions Program (Applies to 1) SNFs and 2) Hospitals)

In alignment with the company-wide continuum of care strategy, Eden Home Health of

King County, LLC will provide the Coleman Model of Care Transitions to the EmpRes skilled nursing facilities and seek partnership from other skilled nursing facilities and hospitals in the area. The Coleman Model's Care Transitions Program provides education and coaching support for patients transitioning from one care setting to another, such as from skilled nursing to home. As conditions and personal needs change, the Care Transitions Program allows patients to self-manage their care in the home environment, thus helping patients achieve greater long-term independence.

The Transitions Program model of care is fully congruent with the highly successful health home model of care operated by the Washington Health Care Authority through that has an extended demonstration project through 2020 for CMS.

Assumption: By year three, patient referrals through the EmpRes Care Transitions Program to Eden Home Health of Pierce County LLC will reach 90% of all such referrals and the source of those referrals will be hospitals (70% of total) and SNFs. (20% of total).

2) Hospitals

Hospitals will account for approximately 60% of referrals using the **Coleman Model: Care Transitions Program** described above.

Assumption: The Eden overall estimate for the first 3 years of operation in Pierce County is 165 unduplicated admissions in Year 1 increasing to 510 admissions in Year 3. Hospitals will make up about 60% of expected volume.

3) Physicians and other Referral Sources

To estimate potential referrals from physicians to Pierce County, Eden Home Health of King County, LLC drew on its home health agency experience in other local markets. In particular, it reviewed the growth in volumes experienced by its affiliate, EmpRes Home Health of Bellingham, LLC since it acquired the Option Care Enterprises home health agency serving Whatcom, Skagit, Snohomish and Island Counties. Based on the combination of the following:

- Care Transitions program,
- Tele-health initiatives, and
- Availability to see newly referred patients from its first day of operation.

In addition to experience in other markets, Eden uses Avalere Health, which produces a proprietary market report, which provides an analysis of the Medicare fee-for-service patient referrals from all facilities and individual physicians located within Pierce County to home health agencies. This helps in prioritizing outreach activities .

As discussed throughout the application, Eden understands and will fully participate in CMS and LTSS quality initiatives that will improve continuity of care and reduce overall healthcare costs which will stimulate demand for home health services.

The volume of referrals in the EmpRes Home Health of Bellingham, LLC service area has grown substantially - from a 200-patient census to 500 patient census in a recent two years period. The Eden overall estimate for the first 3 years of operation in Pierce County is 165 unduplicated admissions in Year 1 increasing to 510 admissions in Year 3. Hospitals and physicians will make up over 80% of expected volume.

Assumption:

In addition to referrals from the EmpRes Care Transitions Program, another portion of referrals will come from a broader referral base of physician practices and as discussed earlier, special outreach to dual eligible (Medicare-Medicaid), Veterans and other special programs. These outreach efforts are expected to provide about 20% of the volume estimates for the Pierce County service area.

.

Eden Home Health Environmental Assessment of Home Health Need

Eden Home Health reviewed four separate assessment approaches to verify that there is a current need for an additional home health agency and a need for

1) **Review of the Pierce County Community Assessment**

Eden Home Health also examined three determinants of need and demand for home health agency visits; population growth, changes in age mix of the population and changes in the affordability of health care. Figure 1. Population Total and Percent Change, Pierce County: 2000 to 2014 from the assessment document shows that Pierce County has experienced population growth of approximately 0.9% per year versus the State population average annual increase of 1.2%. This indicates need and demand increasing over time.

These increases in insurance coverage would be expected to increase the need and demand for new home health agencies.

2) **Access to Care**

The Patient Protection and Affordable Care Act was signed into law in 2011. As of 2014, the new law increased the mandatory minimum income eligibility level for Medicaid to 133% of the federal poverty level. There is also a standard 5% income disregard for most individuals, thereby allowing eligibility to individuals with 138% of the poverty level and below.

The Affordable Care Act also made it mandatory for all U.S. citizens to have health insurance. Those who choose not to sign up for insurance will have to pay a penalty.

However, not all residents are eligible for insurance, including undocumented immigrants and some people who may be exempt from the requirement to have insurance.

Another key provision was that the Affordable Care Act created a new marketplace for each state to offer health benefits to individuals, families and small businesses. The Washington Health Benefit Exchange (created in 2011) is responsible for the creation of Washington Health plan finder, a website on which Washingtonians can find, compare and enroll in qualified health insurance plans. An in-person assistance network was also developed to make support widely available for those who need additional assistance enrolling via Health plan finder.

3) Health Professional Shortage Areas (HPSA) and Medically Underserved Areas (MUA) Analysis

Eden Home Health reviewed the HPSA and MUA shortage area data for Pierce County to determine if there were key shortage areas that could result in increased or decreased need or demand for home health agencies. There are 5 HPSA shortage areas on the Key Peninsula Attachment H provides HPSA and MUA information for Pierce County which indicates only small geographic areas of shortage. We then verified that there were no large designated shortage areas that would affect the home health agency need analysis for Pierce County with the staff of Washington Community Health Systems.

4) Review of the Impact on Home Health Demand as result of CMS New Emerging Reimbursement Model as Included in

The U.S. Department of Health and Human Services CMS – Washington State Medicare-Medicaid Financial Alignment Initiative is in its third phase in addressing fee-for-service for the dual eligible Medicare-Medicaid population. In addition, in Washington State all Medicare fee-for-service home health services are provided under risk-based contracts.

These CMS initiatives along with Medicare Advantage and commercial insurance plans are looking at the post-acute care as an area for significant savings while improving the quality of care outcomes for patients. Based on national literature, consultants as well as in depth discussions with numerous active ACOs and Model 2 BPCI groups, all of these groups share a common strategy surrounding skilled nursing facilities: 1) shift hospital discharges from SNFs to home health and 2) for those patients that still must go to a SNF reduce the average length of stay at those SNFs.

The results of these earlier efforts have created a unique situation in Washington State where the Health Home Program Medicare waiver calls for enhanced funding through 2020 with savings sharing from CMS to Washington State for implementing programs that reduce healthcare costs primarily costs associated with hospitalization and skilled nursing.

EmpRes knows that these new models will increase demand for home health services

and is currently assessing whether the 27% higher home health agency need adjustment factor is sufficient to provide adequate capacity to address the unique disease burden in County and support federal and state initiatives.

9. Provide detailed information on the availability and accessibility of similar existing services to the defined population expected to be served. This section should concentrate on other facilities and services which "compete" with the applicant.

a. Identify all existing providers of services (licensed only and certified) similar to those proposed and provide utilization experience of those providers that demonstrates that existing services are not available to meet all or some portion of the forecasted utilization.

The Department of Health surveyed all home health agencies in late 2018 with an annual survey to measure utilization in the prior year. Table 12 and Table 14 summarize responses. Several certificate of need approved agencies did not respond to the survey and several state-licensed agencies that had responded in the past did not respond. In addition, responding agencies provided inaccurate information in several instances.

b. If existing services are available and accessible, justify why the proposed project does not constitute an unnecessary duplication of services.

Existing services are not available and accessible for the following reasons:

- Need – there is a current need for 13 home health agencies in 2023 and 2024 per the SHP analysis (Methodology 1) provided in Table 10 and assuming no additional agencies are added from the state-licensed list analyzed in Table 11. Adjusting the data for the higher chronic health burden in Pierce County, the agency need grows to 15 agencies by 2023 as shown in Table 11.

- Eden surveyed skilled nursing facilities by telephone in Pierce County and King County. 4 nursing homes indicated access delay issues particularly for placement of Medicaid patients.

- Eden will fully participate in CMS and LTSS quality initiatives that will improve continuity of care and reduce overall healthcare costs which will stimulate demand for home health services.

In addition, with Medicaid expansion under the Affordable Care Act (ACA), the Pierce County residents without health declined from 15% of the population to 5% of the population from 2013 – 2015 and most of those patients are Medicaid patients.[13] Medicaid will only pay for home health services in CMS certified home health agencies although it is studying new approaches under legislative direction.

10. Document the manner in which low-income persons, racial and ethnic

[13] 2015 Demographics and Social Characteristics: Pierce County 2017; Pierce County-Tacoma Health Department. January 2018 . Page 9

minorities, women, people with disabilities, and other under-served groups will have access to the services proposed.

Eden Home Health of King County, LLC is an existing agency. Our admissions and charity care policy and commitment to obtaining a Medicaid contract document that we will accept all patients in need who we are qualified to treat, regardless of race, religion, disability, sex, or income. We have submitted draft admission and charity care and non-discrimination policies that will be reviewed and approved by the Department. Copies of these draft polices are included in Attachment K Admission Information and Charity Care Policy.

11. Please provide copies (draft is acceptable) of the following documents:

a. Admissions policy; and
b. Charity care policy; and
c. **Patient referral policy, if not addressed in admissions policy.**

As noted in response to the previous question, a copy of Eden Home Health of King County, LLC draft polices are included in Attachment K.

12. As applicable, substantiate the following special needs and circumstances that the proposed project is to serve.

a. The special needs and circumstances of entities such as medical and other health professions' schools, multi-disciplinary clinics, and specialty centers that provide a substantial portion of their services, resources or both, to individuals not residing in the health services areas in which the entities are located or in adjacent health services areas.

b. The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

c. The special needs and circumstances of osteopathic hospital and non-allopathic services which the proposed facility/service would be affiliated.

This question is not applicable.

Section 4
Project Rationale

B. Financial Feasibility

1. If applicable provide the proposed capital expenditure for the project.

The proposed capital expenditure is limited to minor equipment and is detailed as follows:

Table 21
Project Capital Expenditure Estimates

Eden Home Health of King County, LLC -- Pierce County Project Costs	
a. Construction costs (Remodeling)	None
b. Moveable Equipment (handheld/laptops)	$1,473
c. Fixed Equipment	None
d. Architect and Engineering, Permits and Fees	None
e. Sales Tax (@9.5%)	Included in (b)
f. Other (Certificate of Need Review Fee)	Not Included
Total Cost	$1,473

2. Explain in detail the methods and sources used for calculating estimated capital expenditures.

This capital expenditure for this project is limited to small equipment purchases and minor remodeling expense for existing space. These costs were based upon Eden Home Health experience in establishing a home health agency in King County and Bellingham agency that covers 5 counties in Northwest Washington.

3. Document the project impact on: (a) Capital costs (b) Operating costs and charges for health services.

The capital costs for the project are minimal and limited to equipment and minor remodeling. In terms of operating costs, home health is a cost-effective adjunct for implementing the Affordable Care Act (ACA). The ACA is focused on improving quality while lowering costs. To do this, there is increasing emphasis on providing services that 1) reduce hospital readmissions and emergency department use and 2) provide coordinated care delivery. The expansion of home health services in County is expected to support the ACA by reducing re-hospitalizations and coordinating care as well as providing additional patient choice in care providers.

CMS has Implemented the Home Health Quality Initiative in Home Health Services

Home health is a covered service under the Part a Medicare benefit. It consists of part-time, medically necessary skilled care (nursing, physical therapy, occupational therapy, and speech-language therapy) that is ordered by a physician. In 2010, there were over 10,800 Medicare certified home health agencies throughout the United States. In 2010, 3,446,057 beneficiaries were served, and 122,578,603 visits made.

Home Health Quality Goals

Quality health care for people with Medicare is a high priority for the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services (CMS).

CMS has adopted the mission of The Institute of Medicine (IOM) which has defined quality as having the following properties or domains:

- **Effectiveness** Relates to providing care processes and achieving outcomes as supported by scientific evidence.
- **Efficiency** Relates to maximizing the quality of a comparable unit of health care delivered or unit of health benefit achieved for a given unit of health care resources used.
- **Equity** Relates to providing health care of equal quality to those who may differ in personal characteristics other than their clinical condition or preferences for care.
- **Patient Centeredness** Relates to meeting patients' needs and preferences and providing education and support.
- **Safety** Relates to actual or potential bodily harm.
- **Timeliness** Relates to obtaining needed care while minimizing delays.

CMS has now implemented a multi-phased innovation initiative, the Bundled Payments for Care Improvement (BCPI). BPCI affords the opportunity to devote resources to integrating our post-acute network to provide episodic value-based care to achieve triple-aim goals – better satisfaction, better outcomes. All Washington State home health agencies participate in this risk-based model that is designed to improve care relative to triple-aim goals (e.g., better satisfaction, better outcomes, lower cost). Eden Home Health, LLC will participate in this initiative.

4. Provide the total estimated operating revenue and expenses for the first three years of operation (please show each year separately) for the items on the following page, as applicable.

Table 22 identifies the operating revenues and expenses for 2021 and the first three complete years through 2023 (the 3rd full year of operation). Detailed operating revenue and expenses are included in Attachment L.

Table 22
Pierce County Project Net Revenue, Costs and Earnings

	2021	2022	2023
REVENUE			
Total Net Revenue	**617,381**	**1,305,535**	**2,113,723**
PATIENT CARE COSTS			
Total Patient Care Costs	**540,235**	**958,853**	**1,503,057**
ADMINISTRATIVE COSTS			
Total Administrative Costs	**206,263**	**254,218**	**310,023**
TOTAL COSTS	**746,498**	**1,213,072**	**1,813,080**
EBITDA	**$ (129,117)**	**$ 92,463**	**$ 300,643**
Depreciation	491	491	491
Amortization	-	-	-
EBIT	**(129,608)**	**91,972**	**300,152**
Interest Expense	-	-	-
EARNINGS BEFORE TAXES	**(129,608)**	**91,972**	**300,152**

5. Please note: according to revised HCFA regulations, home health agencies must have enough reserve funds (determined by an authorized fiscal intermediary) to operate for three months after becoming Medicare/Medicaid certified. Please provide the following information in relation to this requirement:

a. Provide the name and address of the fiscal intermediary you will be using to determine capitalization;

The fiscal intermediary has not been appointed but we expect that the intermediary will be National Government Services. The address is:

National Government Services
P.O. Box 100142
Colombia, South Carolina 29202-3142

b. Provide a copy of the forms you are providing to the fiscal intermediary.

Eden Home Health's fiscal intermediary requires the Form 855 filing to be finalized

within 60 days after initial filing.

6. **Identify the source(s) of financing (loan, grant, gift, etc.) for the proposed project. Provide all financing costs, including reserve account, interest expense, and other financing costs. If acquisition of the asset is to be by lease, copies of any lease agreements, and/or maintenance repair contracts should be provided. For debt amortization, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.**

The members of Eden Home Health of King County, LLC will continue to fund the working capital account of Eden Home Health of King County, LLC at a level sufficient to support the start-up cash flow requirements of the expansion into County. Please see Attachment M for a letter of commitment from the CFO.

The historical cash flow issues of new or expanding home health services agencies have been considerably resolved due to Medicare's policy of providing 60% of each patient episode charge at the beginning of service.

7. **Provide documentation that the funding is, or will be, available and the level of commitment for this project.**

Please see Attachment M for a letter of commitment from Michael Miller, Vice President and Chief Financial Officer.

8. **Provide a cost comparison analysis of the following alternative financing methods: purchase, lease, board-designated reserves, and inter fund loan or bank loan. Provide the rationale for choosing the financing method selected.**

Since financing involves unnecessary interest expense, Eden Home Health of King County, LLC has elected to fund the establishment of the agency with available cash.

9. **Provide a pro forma (projected) balance sheet and expense and revenue statements for the first three years of operation.**

Please see Attachment L for pro forma balance sheet expense and revenue statements for 2021-2023.

10. **Provide a capital expenditure budget through the projected completion and for three years following completion of the project.**

Please see Attachment L for the project's 2021-2023 capital expenditure budget.

11. **Identify the expected sources of revenue for the applicant's total operations (e.g., Medicare, Medicare Managed Care, Medicaid, Health Options, Blue Cross, Labor and Industries, etc.) for the first three years of operation, with anticipated percentage of revenue from each source. Estimate the**

percentage of change per year for each payer source.

The table below, "Eden Home Health of King County, LLC Payer Mix, Percent" indicates the estimated percentage payer mix for the proposed project. The percentages are not expected to change over time.

Table 23
Pierce County Eden Home Health Payer Mix%

Payer	Percent
Medicare	42%
Medicaid	1%
Commercial (Tricare, Managed Medicaid, HMOs etc.	54%
Charity	2%

12. If applicant is an existing provider of health care services, provide expense and revenue statements for the last three full years.

Eden Home Health of King County, LLC is not an existing provider of health services.

13. If the applicant is an existing provider of health care services, provide cash flow statements for the last three full years.

Eden Home Health of King County, LLC is not an existing provider of health services.

14. If applicant is an existing provider of health care services, provide balance sheets detailing the assets, liabilities, and net worth of facility for the last three full fiscal years.

Eden Home Health of King County, LLC is an existing provider of health services.

15. For existing providers, provide actual costs and charges per visit broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) and by payer source for each county proposing to serve.

Eden Home Health of King County, LLC is an existing provider of health services having been in extended start up mode due to opening in mid-2019 and then adjusting the historic and once in 100-year Covid-19 epidemic that has affected home health referrals in its early stages as hospitals restricted all elective admissions and then the workforce constraints of recruitment and maintaining staff under these unusual circumstances. These costs per treatment are fluctuating and do not represent normal operations for the reasons cited above. Washington State is now experiencing a second wave in the Fall and Winter months of 2020. In the first and second quarter of 2021, vaccines with

high effectiveness rates are expected to be introduced than will bring a "new normal" that should be close to the pre-Pandemic health care system, which will allow for normal staff recruitment and retention as well as hospital referrals for home health services related to elective surgical procedures..

Table 24 provides calculated costs and charges for the 7-month start-up period of 2019 and the first 6-month Covid-19 period of 2020. The assumptions that are presented in this table are based on the following:

1. Costs and charges are based on visits estimated at 20.2 visits per unduplicated admission.
2. Charges are calculated on gross revenue from the operating statements.
3. Payer mix fluctuated during the two start-up periods and is not expected to be representative once the agency operations fully mature – in 2019, Medicare represented 34% in 2019 and 38% in 2020 while Medicaid represented 14% in 2019 and 0% in 2020. Commercial Insurance represented 49% in 2019 and 62% in the 2020 period. These percentages are based on total revenue.
4. Direct costs per discipline are based on salary costs for each discipline excluding applied costs such as administration and benefits.
5. A final adjustment is made for home health aid costs which were minimal costs in 2019 and non-existent in the first 6-months of 2020.

Table 24

Claclulated Costs and Charges per Discipline During the Initial 7-month Start-Up Period and the first 6-months (Covid-19) 2020 Period						
		2019			**2020**	
		Direct Costs	**Calculated Charges**		**Direct Costs**	**Calculated Charges**
Skilled Nursing		**85**	**162**		**91**	**270**
Physical Therapy		**62**	**162**		**73**	**270**
Speech Therapy		**140**	**162**		**76**	**270**
Occupational Therapy		**72**	**162**		**68**	**270**
Social Work		**38**	**162**		**209**	**270**
Home Health Aide		**N.A.**	**N.A.**		**N.A.**	**N.A.**
Excludes 25% Fringe Benefit Costs						

Table 24 does not provide relevant information given that it includes essentially two start-up periods and relies heavily on assumptions from the general ledger regarding the total number of treatments which cannot be clarified until total treatments are calculated for cost report purposes.

16. Provide anticipated costs and charges per visit broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) and by payer source for each county proposing to serve.

Anticipated direct personnel costs per discipline are summarized in Table 25 below. Overall charges per visit by therapy are provided below and are based on the overall Medicare charges for the following:

Table 25
Anticipated Direct Personnel Costs and Calculated Total Charges per Visit 2021-2023 – Pierce County

	2021		2022		2023	
	Direct Costs	Calculated Charges	Direct Costs	Calculated Charges	Direct Costs	Calculated Charges
Skilled Nursing	104	226	104	226	104	226
Physical Therapy	94	226	94	226	94	226
Speech Therapy	83	226	83	226	83	226
Occupational Therapy	83	226	83	226	83	226
Social Work	105	226	105	226	105	226
Home Health Aide	46	226	46	226	46	226
Excludes 25% Fringe Benefit Costs						

17. Indicate the addition or reduction of FTEs with the salaries, wages, and employee benefits for each FTE affected, for the first three years of operation. Please list each discipline separately.

Table 26-A below provides Pierce County based Eden Home Health of King County, LLC wages and salaries and the number of FTEs by each discipline under the Pierce CoN. The asterisked positions are shared position with the Eden King County operation and represent a reduction **by allocation** from King County FTEs. The employee benefits are estimated at 25% of wages and salaries for each discipline.

Table 26-A

STAFFING INPUT - BY FTE'S		2021	2022	2023
OPERATIONS				
Physician (Medical Director)	contracted			
Director of Professional Services*	$ 120,000	0.30	0.30	0.30
Clinical Supervisor*	$ 85,000	0.30	0.30	0.30
RN	$ 104,000	1.32	2.51	4.07
PT	$ 93,600	1.29	2.46	3.98
OT	$ 83,200	0.67	1.28	2.08
ST	$ 83,200	0.13	0.25	0.41
MSW	$ 79,040	0.07	0.13	0.20
HHaide	$ 45,760	0.21	0.40	0.65
TOTAL		4.28	7.63	11.99
ADMINISTRATIVE*				
Administrator*	$ 150,000	0.30	0.30	0.30
Office Manager*	$ 54,080	0.30	0.30	0.30
Team Assistant*	$ 54,080	0.30	0.30	0.30
Community Outreach*	$ 80,000	0.30	0.30	0.30
TOTAL		1.20	1.20	1.20
TOTAL FTE'S		5.48	8.83	13.19
* Shared with King County				

18. Please describe how the project will cover the costs of operation until Medicare reimbursement is received. Provide documentation of sufficient reserves.

A majority of Eden Home Health of King County, LLC's patients will be Medicare enrollees. For home health services, Medicare pays 60% of the established rate at the beginning of service to each patient. For this reason, managing cash flow and covering costs of operation while waiting for Medicare reimbursement is not a substantial issue. See also the CFO letter of commitment at Attachment M.

Section 5
Project Rationale

C. Structure and Process (Quality) of Care

1. Please provide the current and projected number of employees for the proposed project, using the following:

Eden Home Health of King County, LLC is not an existing provider of health services. Table 27-A provides the projected FTEs for 2021 through 2024 (the third full year of agency operation) for Pierce County, the Certificate of Need project. Apart from the Medical Director, all positions are presented as employee FTEs.

Table 27-A
Eden Home Health of King County, LLC Projected Number of Employees for Pierce County

STAFFING INPUT - BY FTE'S		2021	2022	2023
OPERATIONS				
Physician (Medical Director)	contracted			
Director of Professional Services*	$ 120,000	0.30	0.30	0.30
Clinical Supervisor*	$ 85,000	0.30	0.30	0.30
RN	$ 104,000	1.32	2.51	4.07
PT	$ 93,600	1.29	2.46	3.98
OT	$ 83,200	0.67	1.28	2.08
ST	$ 83,200	0.13	0.25	0.41
MSW	$ 79,040	0.07	0.13	0.20
HHaide	$ 45,760	0.21	0.40	0.65
SUBTOTAL		**4.28**	**7.63**	**11.99**
ADMINISTRATIVE				
Administrator*	150,000	0.30	0.30	0.30
Office Manager*	54,080	0.30	0.30	0.30
Team Assistant*	54,080	0.30	0.30	0.30
Community Outreach*	80,000	0.30	0.30	0.30
SUBTOTAL		**1.20**	**1.20**	**1.20**
TOTAL FTE'S		**5.48**	**8.83**	**13.19**
* Shared Between King (70%) and Pierce County (30%)				

Table 18-B provides the projected FTEs for 2019 through 2022 (the third full year of agency operation) for King County. Apart from the Medical Director, all positions are presented as employee FTEs.

Table 27-B
Eden Home Health of King County, LLC Projected Number of Employees for King County

STAFFING INPUT - BY FTE'S		2021	2022	2023
OPERATIONS				
Physician (Medical Director)	contracted			
Director of Professional Services*	$120,000	0.70	0.70	0.50
Clinical Supervisor*	$ 85,000	0.70	0.70	0.50
RN	$104,000	5.88	7.03	8.18
PT	$ 93,600	5.75	6.88	8.00
OT	$ 83,200	3.01	3.60	4.18
ST	$ 83,200	0.59	0.71	0.82
MSW	$ 79,040	0.29	0.35	0.41
HHaide	$ 45,760	0.94	1.13	1.31
SUBTOTAL		17.88	21.09	23.91
ADMINISTRATIVE				
Administrator*	150,000	0.70	0.70	0.70
Office Manager*	54,080	0.70	0.70	0.70
Team Assistant*	54,080	0.70	0.70	0.70
Community Outreach*	80,000	0.70	0.70	0.70
SUB TOTAL		2.80	2.80	2.80
TOTAL FTE'S		**20.68**	**23.89**	**26.71**
* Shared Between King and Pierce				

Table 27-C provides the projected FTEs for 2021 through 2024 (the third full year of agency operation) for the full agency. Apart from the Medical Director, all positions are presented as employee FTEs.

Table 27-C
Eden Home Health of King County, LLC Projected Number of Employees for King County and Pierce County

STAFFING INPUT - BY FTE'S		2021	2022	2023
OPERATIONS				
Physician (Medical Director)	contracted			
Director of Professional Services*	$120,000	1.00	1.00	0.80
Clinical Supervisor*	$ 85,000	1.00	1.00	0.80
RN	$104,000	7.20	9.54	12.25
PT	$ 93,600	7.04	9.33	11.98
OT	$ 83,200	3.68	4.88	6.26
ST	$ 83,200	0.72	0.96	1.23
MSW	$ 79,040	0.36	0.48	0.61
HHaide	$ 45,760	1.15	1.53	1.96
SUBTOTAL		22.16	28.72	35.89
ADMINISTRATIVE				
Administrator*	150,000	1.00	1.00	1.00
Office Manager*	54,080	1.00	1.00	1.00
Team Assistant*	54,080	1.00	1.00	1.00
Community Outreach*	80,000	1.00	1.00	1.00
SUB TOTAL		4.00	4.00	**4.00**
TOTAL FTE'S		**26.16**	**32.72**	**39.89**
* Shared Between King and Pierce				

2. Please provide your staff to visit ratio.

The staff -to-visit ratios for Pierce County are detailed in Table 28-A and are consistent with ratios for King County in Table 19-B.

Table 28-A

Unadjusted Visits per FTE by Classification			
	2021	2022	2023
Pierce FTEs			
Skilled Nursing	1.32	2.51	4.07
Physical Therapy	1.29	2.46	3.98
Occupational Therapy	0.67	1.28	2.08
Speech Pathology	0.13	0.25	0.41
Medical Social Service	0.07	0.13	0.20
Home Health Aide	0.21	0.40	0.65
Pierce Projected Unadjusted Visit Volume			
Skilled Nursing	1,315	2,511	4,066
Physical Therapy	1,286	2,456	3,976
Occupational Therapy	673	1,285	2,080
Speech Pathology	132	252	409
Medical Social Service	49	94	152
Home Health Aide	211	403	652
Unadjusted Visits per FTE by Classification			
Skilled Nursing	1,000.00	1,000.00	1,000.00
Physical Therapy	1,000.00	1,000.00	1,000.00
Occupational Therapy	1,000.00	1,000.00	1,000.00
Speech Pathology	1,000.00	1,000.00	1,000.00
Medical Social Service	750.00	750.00	750.00
Home Health Aide	1,000.00	1,000.00	1,000.00

Table 28-B

Unadjusted Visits per FTE by Classification			
	2021	2022	2023
King FTEs			
Skilled Nursing	5.88	7.03	8.18
Physical Therapy	5.75	6.88	8.00
Occupational Therapy	3.01	3.60	4.18
Speech Pathology	0.59	0.71	0.82
Medical Social Service	0.29	0.35	0.41
Home Health Aide	0.94	1.13	1.31
King Projected Unadjusted Visit Volume			
Skilled Nursing	5,883	7,031	8,179
Physical Therapy	5,754	6,876	7,999
Occupational Therapy	3,010	3,597	4,184
Speech Pathology	591	707	822
Medical Social Service	221	264	307
Home Health Aide	943	1,127	1,311
Unadjusted Visits per FTE by Classification			
Skilled Nursing	1,000.00	1,000.00	1,000.00
Physical Therapy	1,000.00	1,000.00	1,000.00
Occupational Therapy	1,000.00	1,000.00	1,000.00
Speech Pathology	1,000.00	1,000.00	1,000.00
Medical Social Service	750.00	750.00	750.00
Home Health Aide	1,000.00	1,000.00	1,000.00

3. Explain how this ratio compares with other national or state standards of care and existing providers for similar services in the proposed service area.

Eden Home Health of King County, LLC used its existing home health agency experience in Washington State and benchmarks its staffing ratios with other home health agencies on a regional and national basis using the Strategic Healthcare Partners, LLC analytics consulting firm.

4. Identify and document the availability of sufficient numbers of qualified health manpower and management personnel. If the staff availability is a problem, describe the manner in which the problem will be addressed.

As a large multi-state organization, EmpRes and Eden have employees and visibility and contacts across numerous job markets. Specific to Pierce County, EmpRes operates a skilled nursing homes in Pierce County as well as skilled nursing homes in King County that draw on patients from Pierce County. Even with all of this experience, Covid-19 represents unique recruitment challenges for all healthcare providers in terms of recruiting a core licensed staff as well as short term replacement staff for employees who become infected or exposed and require quarantine. Fortunately, Eden King has been able to retain its core administrative staff during this epidemic. Experienced management personnel are difficult to recruit at any time.

Eden has aligned the growth of its Eden King County home health agency with its ability to recruit patient care staff. As a result, growth has been less than initially projected as the labor pool was reduced due to Covid-19. Initially in King County, voluntary surgical procedures were eliminated by hospitals but are now taking place. This reduced home health agency demand on a short-term basis for certain patients as well as being an obstacle for recruitment. Elective hospital services have now returned and recruitment of qualified health personnel in the third quarter improved but we are now entering into a second wave that may generate new challenges in staff recruitment.

Regarding this application, the approval for Eden to provide home health services in Pierce County will reduce the recruitment challenges for Eden without adversely affecting other home health agencies. Table 26-A lists 6 positions involving special and general administrative services that will require no additional staffing over the first three years of operation. These positions will be allocated to the different counties on a Pierce, 30% level and King 70% level. In terms of immediate recruitment challenges for direct care staff, the approval of this project will be in 2021. A vaccine may begin to be available for essential workers. In any case, more will be known about Covid-19 and with decreased uncertainty, essential workers should re-enter the work force.

Eden elected to only moderately delay adding additional home health resources with this project until we became assured that this project will free up hospital beds and the staffing associated with those beds in both Pierce County and King County by reducing unscheduled outpatient admissions from home health to hospitals, readmissions to the hospital and days delay in the time when discharged hospital patients wait to receive home health services. Building a resource base will improve the resilience of our Puget

Sound health care system

Staff mobility between markets supports recruitment and retention efforts.

- As an employee-owned organization, EmpRes and Eden experience lower turn-over rates than many other health care providers.

- The EmpRes commitment to Employees/Residents reflected in the company name is also reflected in management efforts to prioritize employees and residents as core to any success.

5. Please identify and provide copies of (if applicable) the in-service training plan for staff. (Components of the training plan should include continue education, home health aide training to meet Medicare criteria, etc.).

Please see Attachment N.

6. Describe your methods for assessing customer satisfaction and quality improvement.

Eden Home Health of King County, LLC will contract with Pinnacle Quality Insight to provide Home Health CAHPS (Consumer Assessment of Healthcare Providers and Systems) for formal customer satisfaction surveys. Pinnacle Quality Insight is a CMS-approved vendor for formal customer satisfaction surveys. These satisfaction surveys follow the standard CMS guidelines and will provide benchmarking regarding Eden Home Health of King County, LLC′s results as well as recommendations and areas on which to focus performance improvement projects.

Strategic Health Care, LLC is the vendor that Eden Home Health of King County, LLC will for outcome-based quality improvement. SHP Strategic Health Partners analysis identifies detailed and overall trending with benchmark comparison. From this analysis, Eden Home Health of King County, LLC will be able to select target outcomes, review process of care, formulate action plans, identify best practices, and evaluates resulting changes for effectiveness.

Please see Attachment N for the Eden Home Health Organization Performance Improvement Plan.

7. Identify your intended hours of operations. In addition, please explain how patients will have access to services outside the intended hours of operation.

Eden Home Health of County′s office hours will be 8:30 a.m. to 5:00 p.m., Monday thru Friday (excluding major holidays).

Eden Home Health of County′s on-call service will take calls after hours. An on-call

nurse will be available to respond to any calls after hours.

8. **Identify and document the relationship of ancillary and support services to proposed services, and the capability of ancillary and support services to meet the service demands of the proposed project.**

EmpRes operates a 164-bed skilled nursing home in Pierce County as well as four SNFs in King County with 3 serving Pierce County. Eden Home Health of King County, LLC will build upon these existing relationships to meet the demands for ancillary and support services for the new agency.

9. **Explain the specific means by which the proposed project will promote continuity in the provision of health care to the defined population and avoid unwarranted fragmentation of services. This section should include the identification of existing and proposed formal working relationships with hospitals, nursing homes, and other health service resources serving your primary service area. This description should include recent, current, and pending cooperative planning activities, shared services agreements, and transfer agreements. Copies of relevant agreements and other documents should be included.**

When entering a new market, Eden local team focuses on relationships with institutions that refer large numbers of their current patients to home health agencies. Especially with skilled nursing facilities under the same ownership, Eden staff is key to implementing the Transitions program that is an evidence-based, 30-day program offered to patients who meet certain criteria and is provided at no cost to the patient.

Participating patients are tracked for re-hospitalization for 60 days from the day of discharge. The goals of the Care Transitions program are to improve patient outcomes, reduce avoidable readmissions as well as reduce health care costs by training or "coaching" as well as encouraging patients to be more involved in their health care.

Eden Home Health partners with LG technologies for its tele-health/virtual care technology platform. With this technology, Eden can obtain vitals for blood pressure, body weight and oxygen saturation are measured daily and monitored at the Eden Home Health office on working business days. Vitals that are outside physician specified parameters are reviewed by a nurse and a subsequent intervention such as a nursing visit and MD notification occurs. In other markets, Eden Home Health has been able to partner with local physicians for video visits to be completed in the patient's home.

Attachment P provides a vendor list of ancillary and support services utilized by Eden Home Health of King County, LLC.

10. **Fully describe any history of the applicant entity and principles in Washington with respect to criminal convictions, denial or revocation of license to operate a health care facility, revocation of license to practice a health profession, or decertification as a provider of services in the Medicare or Medicaid program. If there is such history, provide clear, cogent, and convincing evidence that the**

proposed project will be operated in a manner that ensures safe and adequate care to the public to be served and in conformance with applicable federal and state requirements.

a. Have any of the applicants (see definition of applicant on page 4 of this application) been adjudged insolvent or bankrupt in any state or federal court?

No

b. **Have any of the applicants been involved in a court proceeding to make judgment of insolvency or bankruptcy with respect to the applicant).**

No

11. List the licenses and/or credentials held by the applicant(s) and principals in Washington, as well as other states, if applicable. Include any applicable license numbers.

Please see Attachment C for a list of all facilities, and provider numbers. Attachment E includes the regulatory agency contact list.

12. Provide the background experience and qualifications of the applicant(s).

The Eden Health family of agencies offers a combination of seven home health, hospice and personal care agencies in four states. Each Eden Health agency employs competent and qualified staff, paired with organized and responsive management. Additionally, senior level leadership is provided by the agency's management company, EmpRes Healthcare Management, LLC, located in Vancouver Washington.

Each Eden home health agency has developed an excellent reputation within their respective communities and has built strong relationships with their referral sources and healthcare partners. Eden Home Health of King County, LLC d/b/a Eden Home Health ("Eden Home Health") will establish its agency office at its existing skilled nursing home facility location. Pierce County is home to a skilled nursing facility as has additional SNFs in King County. These entities are affiliates under common ownership with Eden Home Health and which are also managed by EmpRes Healthcare Management, LLC.

The Eden Health family of agencies expanded its provision of home health services into several new locations in the last three years: Idaho Falls, Idaho in 2014 and Elk Grove, California in 2016 and has established home health agencies in King County and Spokane County. Currently Eden is establishing a home health agency in Clark County and has been approved to establish a hospice agency in Whatcom County. Surveys for hospice and home health agencies operated by Eden are included in Attachment V.

13. For existing agencies, provide copies of the last three licensure surveys as appropriate evidence that services will be provided (a) in a manner that ensures safe and adequate care, and (b) in accordance with applicable federal and state laws, rules, and regulations.

Eden Home Health of King County is an existing provider of health services established in 2020. It has not yet received a State licensing survey but has completed a certification survey. Eden is providing the most recent license surveys for all home health and hospice agencies operated by Eden in Attachment V.

Section 6
Project Rationale

D. Cost Containment

1. Identify the exploration of alternatives to the project you have chosen to pursue, including postponing action, shared service arrangements, joint ventures, subcontracting, merger, contract services, and different methods of service provision, including different spatial configurations you have evaluated and rejected. Each alternative should be analyzed by the following:

a. Decision making criteria *(cost limits, availability, quality of care, legal restrictions, etc.);*
b. Advantages and disadvantages, and whether the sum of either the advantages or disadvantages outweighs each other by application of the decision-making criteria;
c. Capital costs;
d. Staffing impact.

The alternatives to the proposed project that Eden Home Health of County considered include:

1. Postponing action
2. Purchasing an existing Pierce County agency
3. Establishing a new agency in a different county

Eden Home Health of Eden Home Health of King County LLC's decision-making criteria for expanding into Pierce County:

- Response to community need including synergy with Transitions program.
- Availability of Home Health Services on a Timely Basis
- Quality of care
- Impact on existing healthcare providers
- Staffing impact
- Capital costs

Alternative 1. Postpone Service Development:

Need: The two need methodologies based on home health agency availability, State Health Plan Calculated Need (Methodology 1) of 13 agencies (no adjustment for higher acuity) and Home Health Survey Reported Utilization by CoN approved and State-only agencies (Methodology 2) show a respective agency availability need of 4 agencies in 2023 and 5 agencies in 2024. Table 10 and Table 13 provide the metrics. Postponing adding the Pierce County service area to Eden Home Health of King County would not address need.

Availability: Eden Home Health has relied on existing healthcare providers for skilled nursing home patients needing home health services as well as Pierce County residents requiring home health services. This alternative is no longer in the best interests of our patients and Pierce County residents. While our surveys of other skilled nursing home facilities did not uncover systemic delays in placing patients our experience indicates that home health agency availability is becoming an issue. Our analysis of home health agency time to admit after hospital discharge shows that Pierce County capacity needs to expand.

Table 16 shows that while CMS Compare 2018 reported time from referral by a physician to home health within two days is generally comparable to state and national averages, actual time from hospital discharge to admission to home health is very low in Pierce with a median rate among 7 reporting home health agencies of 30% achieving referral within 2 days of discharge compared to 70% for home health agencies on a national basis.

Postponing the project would not improve availability wherein only 30% of Pierce County home health agency patients (7 reporting agencies) are admitted to home health within 2 days.

Quality: While Pierce County home health agencies quality metrics from 2018 CMS Compare (See Table 17) are similar to state and national averages for per cent hospital readmissions, nearly all home health agencies have a higher percentage of unscheduled hospital outpatient/ER visits. In short, adding additional agency capacity should improve performance and response times within Pierce County.

Our research also indicated that home health agencies need to play a more dominant role in addressing healthcare disparity that is unique to Pierce County where the average lifespan of residents is 1.3 years lower than the Washington State average. The data indicates that this reduced life span needs providers who can address the chronic health needs of residents that are higher than other counties.

Finally, our review of the ongoing requirements of the DSHS LTSS aging initiative and the CMS – Washington State Medicare-Medicaid Financial Alignment Initiative demonstration project requires substantial increases in in-home resources including home health. Our home health agency solution is efficient in that capital costs and operating costs are minimized by being able to use a portion of our existing skilled nursing home as a separate home health agency office.

Postponing the Pierce project would not address the higher percentage of unscheduled hospital outpatient/ER visits when compared to the statewide and national home health metric for this variable.

Impact on Existing Providers: The Home Health Agency Methodology 1 and Methodology 2 both point to a need for additional home health agencies; and this is before adjusting for higher patient acuity. Only 36% of home health agency patients are admitted to a home health agency in Pierce County within two days of hospital discharge, which

reduces overall home health utilization. Finally, Eden reviewed the income statement and balance sheet of Envision the most recently approved certificate of need for a King County agency approved to serve Pierce County. It had a 2018 net income exceeding $200,000 and a fund balance of over $191,000.

Postponing the Pierce County project would have no significant impact on existing home health agency profitability or fund balance.

Staffing Impact: Staffing impact on existing home health agencies should be minimal. Table 26-A shows that in the first full year of operation less than 4 patient care FTEs will be added and there will be no addition clinical or administrative management or management support staff positions added, while patient service capacity will increase.

Postponing the Pierce County project would have no significant impact on existing home health agency staff recruitment.

Capital Cost Impact: Additional capital costs for supporting the Pierce County expansion are minimal, estimated at less than $1,500 for minor equipment.

Postponing the Pierce County project has no significant impact on capital costs for health care services within Pierce County.

Summary: Overall, waiting and thereby postponing action was rejected as a reasonable alternative. Eden Home Health of King County sees an immediate need to improve timeliness of response to institution referral requests and meeting patient clinical requirements for Pierce County residents and there is no adverse impact on existing providers.

Eden Home Health therefore rejected the Alternative 1 – postponing service development.

Alternative 2: Purchasing an existing Pierce County agency:

Need: Purchasing an existing agency would allow Eden Home Health of Pierce County to more rapidly address identified community need. However, the general approach in Pierce County has been for King County-based agencies to add Pierce County as an additional service area.

Adding Pierce County as a service area would not address the current need for additional home health agency capacity.

Availability: Adding Pierce County as a service area would not address the current need for additional home health agency capacity. Therefore, time to admission to home health would not change.

Quality: Since the same number of agencies, would be providing services, changes in quality of care metrics would not change.

Impact on Existing Providers: Since the same number of agencies would be providing services there would be no impact on existing agencies.

Staffing Impact: Since the same number of agencies would be providing services, staffing would be reduced by only 3 or 4 direct care FTEs at most.

Capital Costs: Acquiring an existing agency would have dramatically higher capital costs since the agencies that would most likely be available are located in counties outside of Pierce County and Eden already has the key clinical and administrative management and management support services available in King County, which would then be duplicated with a new agency.

Summary: Acquiring an existing agency would not improve availability or improved quality of care on the metrics established for this comparison. There could be a minor reduction in direct care staff which would be offset by the duplicative administrative and clinical management staff. Capital costs would be substantially higher than just adding a county service area to the existing Eden of King County home health agency.

Eden therefore rejected this alternative.

Alternative 3: Adding the Pierce County service area to the Eden Home Health of King County, LLC agency

Need: The two need methodologies based on home health agency availability, State Health Plan Calculated Need (Methodology 1) of 13 agencies (no adjustment for higher acuity) and Home Health Survey Reported Utilization by CoN approved and State-only agencies (Methodology 2) show a respective agency availability need of 4 agencies in 2023 and 5 agencies in 2024. Table 10 and Table 13 provide the metrics. Postponing adding the Pierce County service area to Eden Home Health of King County would not address need.

Availability: Eden Home Health has relied on existing healthcare providers for skilled nursing home patients needing home health services as well as Pierce County residents requiring home health services. This alternative is no longer in the best interests of our patients and Pierce County residents. While our surveys of other skilled nursing home facilities did not uncover systemic delays in placing patients our experience indicates that home health agency availability is becoming an issue. Our analysis of home health agency time to admit after hospital discharge shows that Pierce County capacity needs to expand.

Table 16 shows that while CMS Compare 2018 reported time from referral by a physician to home health within two days is generally comparable to state and national averages,

actual time from hospital discharge to admission to home health is very low in Pierce with a median rate among 7 reporting home health agencies of 30% achieving referral within 2 days of discharge compared to 70% for home health agencies on a national basis.

Quality: While Pierce County home health agencies quality metrics from 2018 CMS Compare (See Table 17) are similar to state and national averages for per cent hospital readmissions, nearly all home health agencies have a higher percentage of unscheduled hospital outpatient/ER visits. In short, adding additional agency capacity should improve performance and response times within Pierce County.

Our research also indicated that home health agencies need to play a more dominant role in addressing healthcare disparity that is unique to Pierce County where the average lifespan of residents is 1.3 years lower than the Washington State average. The data indicates that this reduced life span needs providers who can address the chronic health needs of residents that are higher than other counties.

Finally, our review of the ongoing requirements of the DSHS LTSS aging initiative and the CMS – Washington State Medicare-Medicaid Financial Alignment Initiative demonstration project requires substantial increases in in-home resources including home health. Our home health agency solution is efficient in that capital costs and operating costs are minimized by being able to use a portion of our existing skilled nursing home as a separate home health agency office.

Impact on Existing Providers: The Home Health Agency Methodology 1 and Methodology 2 both point to a need for additional home health agencies; and this is before adjusting for higher patient acuity. Only 36% of home health agency patients are admitted to a home health agency in Pierce County within two days of hospital discharge, which reduces overall home health utilization. Finally, Eden reviewed the income statement and balance sheet of Envision the most recently approved certificate of need for a King County agency approved to serve Pierce County. It had a 2018 net income exceeding $200,000 and a fund balance of over $191,000.

Staffing Impact: Staffing impact on existing home health agencies should be minimal. Table 26-A shows that in the first full year of operation less than 4 patient care FTEs will be added and there will be no addition clinical or administrative management or management support staff positions added, while patient service capacity will increase.

Capital Cost Impact: Additional capital costs for supporting the Pierce County expansion are minimal, estimated at less than $1,500 for minor equipment.

Summary: Eden has experience in operating a multi-county home health agency with its EmpRes Home Health at Bellingham 5-county home health agency. Eden Home Health of King County sees an immediate need to improve timeliness of response to institution referral requests and meeting patient clinical requirements for Pierce County residents and there is no adverse impact on existing providers. Adding a new home health agency would

provide further choices and would allow Eden's innovative approaches to tele-health and Care Transitions to be tested in the service area to help reduce the current health disparity within Pierce County.

Eden Home Health of King County, LLC selected this alternative.

2. Describe how the proposal will comply with the Medicare conditions of participation, without exceeding the costs caps.

Eden Home Health of King County does not expect to become subject to Medicare home health services cost caps. These are more typically a concern in hospice. For home health, Eden Home Health has consistently reported cap related values substantially below the national trigger for such cost caps.

3. Describe the specific ways in which the project will promote staff or system efficiency or productivity.

Support systems from corporate offices in Vancouver WA

Eden has developed strong central support systems for administrative and clinical functions. Among those are infrastructure and systems located in Vancouver that do not have to be re-created in each local agency office. Eden's company-wide use of tele-health adds improved patient monitoring and tailoring of home health visits to each patient's current clinical needs.

Supporting timely access to care

The proposed development of a Medicare-certified home health agency in Pierce County will increase the availability of Medicare home health services in the planning area. Home health services are a critical component of cost savings strategies for Pierce County's acute and post-acute hospital and skilled nursing providers. When in-home services are not sufficiently available, inpatient providers have difficulty discharging patients on a timely basis. When a patient's condition allows discharge, it is not only wasteful of money but also of staff time to maintain the patient in the inpatient setting. To address the health disparity issues leading to higher chronic illness burden in Pierce County and a 1.3-year reduced life span will require a significant increase in home health and other rehabilitation strategies to be successful.

Reducing re-hospitalization and ER visits

Furthermore, when a patient recovering from an illness or injury that requires acute care is discharged to the home setting, there is an increased risk of re-injury as the patient adjusts back to the home environment with compromised function. Sufficient in-home services and support can prevent this re-injury and reduce the risk of unnecessary re-admission to the acute setting and the resulting waste of medical care dollars. In addition, if a patient is

discharged without adequate home health support in place, there is an increased risk of unnecessary emergency room visits and the additional morbidity and waste of financial resources that result.

Supporting the DSHS LTSS Aging Services Initiatives and the CMS – Washington State Medicare-Medicaid Financial Alignment Initiative Demonstration project

This application has documented a significant shortage of home health resources to support the 20-year effort of DSHS LTSS aging initiatives to improve the health of aging senior citizens while managing rising healthcare costs. More importantly, Pierce County represents a priority county for addressing the high-risk Medicare-Medicaid target population that is being served through the CMS – Washington State Medicare-Medicaid Financial Alignment Initiative.

Adding a home health agency to the EmpRes post-acute network to support the Pierce SNF and South King SNFs operated by EmpRes will give EmpRes and the community another strategy to improve on the triple aim goals. As a result, Eden Home Health, LLC fully expects that our project will promote continuity in care delivery, support independent living and support the needs of home health patients and their families who currently have difficulties in obtaining successful referrals for home health services. In addition, health care reform initiatives, adding home health to our services will help to ensure timely discharge to home health for hospital patients. This is likely to result in reduced hospital readmissions and hospital length of stay, a key focus of health care reform initiatives.

4. **If applicable, in the case of construction, renovation, or expansion, capital cost reductions achieved by architectural planning and engineering methods and methods of building design and construction. Include an inventory of net and gross square feet for each service and estimated capital cost for each proposed service. Reference appropriate recognized space planning guidelines you have employed in your space allocation activities.**

There are no capital costs related to construction, renovation, or expansion.

5. **If applicable, in the case of construction, renovation or expansion, an analysis of the capital and operation costs of alternative methods of energy consumption, including the rationale for choosing any method other than the least costly. For energy-related projects, document any efforts to obtain a grant under the National Energy Conservation Act.**

This question is not applicable.

List of Attachments

Attachment A: Letter of Intent

Attachment B: Organizational Structure of EmpRes Healthcare Group

Attachment C: List of Facilities

Attachment D: Medical Director Contract

Attachment E: List of Regulatory Agency Contacts

Attachment F: Single Line Drawing

Attachment G: Documentation of Site Control by Eden Home Health of King County, LLC

Attachment H: MUA and HPSA Designations for Pierce County

Attachment I: List of Pierce County Home Health Providers, June 2018

Attachment J: 1987 State Health Plan Methodology and Standards

Attachment K: Draft Admissions Policy Documents & Charity Care Policy

Attachment L: Staffing, Capital Expenditure and Pro Forma

Attachment M: Letter of Financial Commitment

Attachment N: Training and Education Policies

Attachment O: Intentionally Left Blank

Attachment P: Vendor List

Attachment Q: Demographics and Social Characteristics: Pierce County 2017

Attachment R: Demographics and Social Characteristics: King County 2017

Attachment S: Using Health Homes to Integrate Care for Dually Eligible Individuals

Attachment T: Long-Term Services and Supports (LTSS)

Attachment U: Tacoma-Pierce County Community Health

Attachment V: Community Surveys

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT A

LETTER OF INTENT

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 2:09 pm, May 28, 2020

LOI20-05EHHP
ex: NOV 28, 2020

May 27, 2020

Eric Hernandez, Program Manager
Health Facilities and Certificate of Need
Washington State Department of Health
111 Israel Rd., SE
Tumwater, WA 98501

By E-Mail

Re: Eden Home Health of King County, LLC Letter of Intent to Provide Medicare and Medicaid Home Health Services within Pierce County

Dear Mr. Hernandez:

This letter of intent is issued on behalf of Eden Home Health of King County, LLC, a subsidiary of EmpRes Healthcare Group, Inc. Eden Home Health of King County, LLC in accordance with WAC 246-310-080, intends to submit a certificate of need application (CN) to provide Medicare and Medicaid home health services to residents of Pierce County.

1. Description of proposed service
EmpRes Healthcare Group, Inc., through Eden Home Health of King County, LLC requests CN approval to extend its service area to provide Medicare and Medicaid home health services to residents of Pierce County.

2. Estimated cost of the project
Capital costs are estimated to be less than $1,000.

3. Identification of the service area
Eden Home Health of King County, LLC will extend its service area to provide Medicare and Medicaid home health services to residents of Pierce County.

Please address all correspondence to:
Jamie Brown, Vice President of Home Services
EmpRes Healthcare / Eden Health
4601 NE 77th Ave., Ste. 300,
Vancouver, WA 98662

Thank you for your attention.

Sincerely,

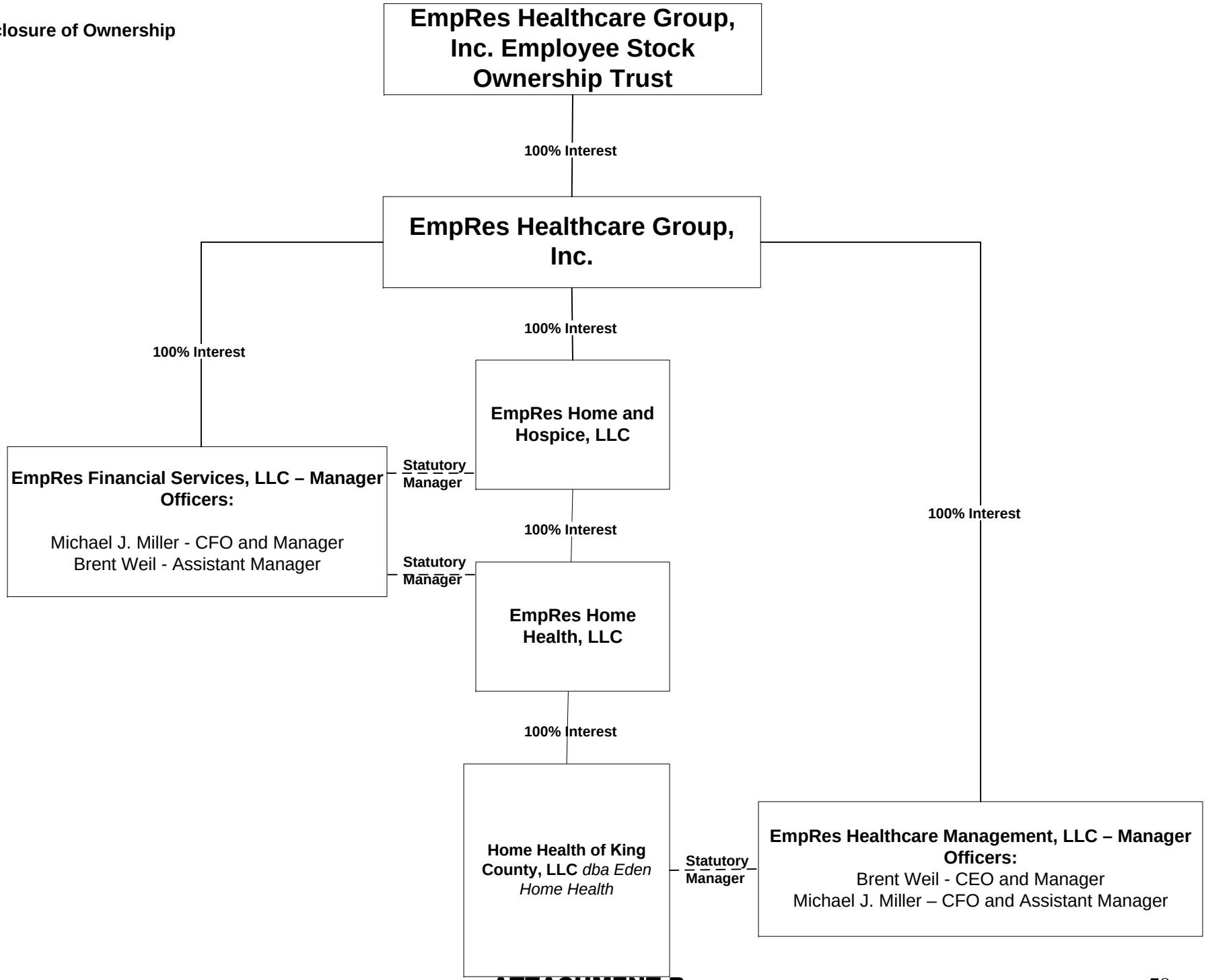
Jamie Brown, Vice President of Home Services
EmpRes Healthcare / Eden Health

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

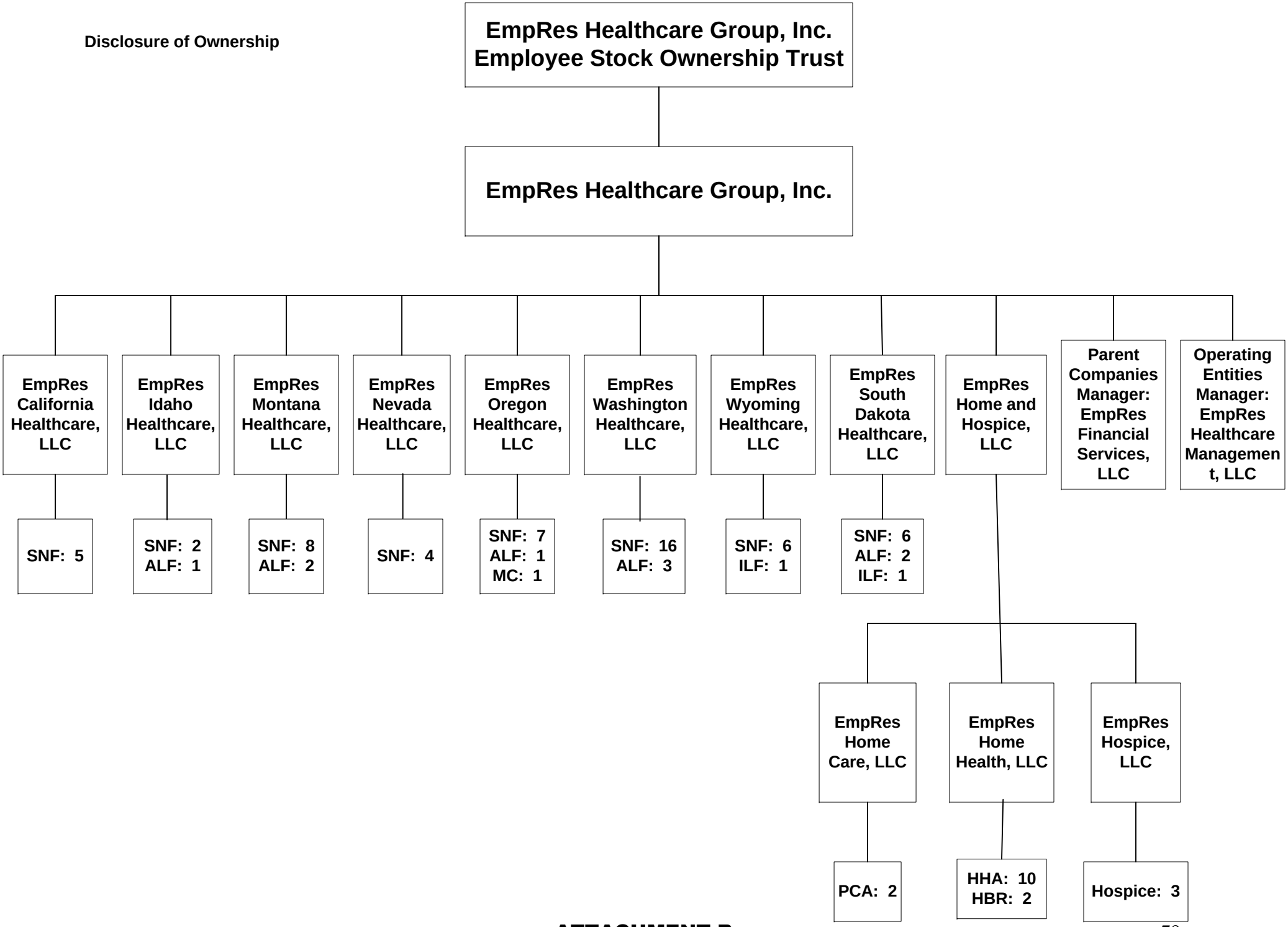
ATTACHMENT B

ORGANIZATIONAL CHART

Disclosure of Ownership



Disclosure of Ownership



ATTACHMENT B

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT C

UPDATED FACILITY LIST

Legal Name	DBA
OPERATING ENTITIES	
ARIZONA	
Eden Hospice at Sierra Vista, LLC	Eden Hospice
Eden Home Health of Sierra Vista, LLC	Eden Home Health
Eden Home Health of Safford, LLC	Eden Home Health of Safford
Eden Hospice at Cochise County, LLC	Eden Hospice in Chochise
CALIFORNIA	
Evergreen at Petaluma, L.L.C.	EmpRes Post Acute Rehabilitation
Evergreen at Salinas, L.L.C.	Katherine Healthcare
Evergreen at Tracy, L.L.C.	New Hope Post Acute Care
Evergreen at Heartwood Avenue, L.L.C.	Heartwood Avenue Healthcare
Evergreen at Springs Road, L.L.C.	Springs Road Healthcare
Eden Home Health of Elk Grove, LLC	Eden Home Health
IDAHO	
EmpRes at Idaho Falls, LLC	Teton Post Acute Care and Rehabilitation
Lewiston Royal Plaza Care, LLC	Royal Plaza Health and Rehabilitation
Lewiston Royal Plaza Retirement, LLC	Royal Plaza Retirement Center
Eden Home Health of Idaho Falls, LLC	Eden Home Health
Eden Home Health of Sandpoint, LLC	Eden Home Health
MONTANA	
Evergreen at Polson, L.L.C.	Polson Health and Rehabilitation Center

Legal Name	DBA
Evergreen at Hot Springs, L.L.C.	Hot Springs Health and Rehabilitation Center
Evergreen at Missoula, L.L.C.	Missoula Health and Rehabilitation Center
Evergreen at Laurel, L.L.C.	Laurel Health and Rehabilitation Center
Evergreen at Livingston, L.L.C.	Livingston Health and Rehabilitation Center
EmpRes at Lewistown, LLC	Central Montana Nursing & Rehabilitation Center
EmpRes at Shelby, LLC	Marias Care Center
EmpRes at Billings, LLC	Aspen Meadows Health and Rehabilitation Center
Aspen Meadows Assisted Living, LLC	Aspen Meadows Assisted Living
NEVADA	
Evergreen at Pahrump, L.L.C.	Pahrump Health and Rehabilitation Center
Evergreen at Carson City, L.L.C.	Ormsby Post Acute Rehab
Evergreen at Mountain View, L.L.C.	Mountain View Health and Rehabilitation Center
Evergreen at Gardnerville, L.L.C.	Gardnerville Health and Rehabilitation Center
EmpRes Personal Care Nevada, LLC	Eden Home Care
Quality Health Care Corporation	Eden Home Health
Eden Hospice at Carson City, LLC	Eden Hospice
OREGON	
Evergreen Oregon Healthcare Mountain Vista, L.L.C.	LaGrande Post Acute Rehab
Evergreen Oregon Healthcare Independence, L.L.C.	Independence Health and Rehabilitation Center
Evergreen Oregon Healthcare Tualatin, L.L.C.	EmpRes Hillsboro Health and Rehabilitation Center

Legal Name	DBA
Evergreen Oregon Healthcare Orchards Rehabilitation, L.L.C.	Milton Freewater Health and Rehabilitation Center
Evergreen Oregon Healthcare Orchards Retirement, L.L.C.	Cascade Valley Assisted Living and Memory Care Cascade Valley Assisted Living Cascade Valley Memory Care
Evergreen Oregon Healthcare Valley Vista, L.L.C.	The Dalles Health and Rehabilitation Center
Evergreen Oregon Healthcare Portland, L.L.C.	Portland Health and Rehabilitation Center
Evergreen Oregon Healthcare Salem, L.L.C.	Windsor Health and Rehabilitation Center
SOUTH DAKOTA	
EmpRes at Mitchell, LLC	Firesteel Healthcare Center
EmpRes at Rapid City, LLC	Fountain Springs Healthcare Center
Rapid City Assisted Living, LLC	Fountain Springs Assisted Living
Sturgis Assisted Living, LLC	Aspen Grove Assisted Living
EmpRes at Garretson, LLC	Palisade Healthcare Center
EmpRes at Woonsocket, LLC	Prairie View Healthcare Center
EmpRes at Flandreau, LLC	Riverview Healthcare Center
Flandreau Independent Living, LLC	Riverview Care Center
EmpRes at Britton, LLC	Wheatcrest Hills Healthcare Center
WASHINGTON	
Evergreen Washington Healthcare Frontier, L.L.C.	Frontier Rehabilitation and Extended Care
Evergreen Washington Healthcare Americana, L.L.C.	Americana Health and Rehabilitation Center
Evergreen Washington Healthcare Whitman, L.L.C.	Whitman Health and Rehabilitation Center
Evergreen Washington Healthcare Seattle, L.L.C.	Seattle Medical Post Acute Care
Evergreen Washington Healthcare Enumclaw, L.L.C.	Enumclaw Health and Rehabilitation Center
Evergreen Washington Healthcare Auburn, L.L.C.	Canterbury House
Eden Hospice at Whatcom L.L.C.	Eden Hospice at Whatcom

Legal Name	DBA
Evergreen at Shelton, L.L.C.	Shelton Health and Rehabilitation Center
Evergreen at Bellingham, L.L.C.	North Cascades Health and Rehabilitation Center
Evergreen at Tacoma, L.L.C.	Alaska Gardens Health and Rehabilitation Center
EmpRes at Alderwood, LLC	Alderwood Park Health and Rehabilitation
EmpRes Highland Care, LLC	Highland Health and Rehabilitation
EmpRes at Snohomish, LLC	Snohomish Health and Rehabilitation
Spokane Royal Park Care, LLC	Royal Park Health and Rehabilitation
Spokane Royal Park Retirement, LLC	Royal Park Retirement Center
EmpRes at Colville, LLC	Buena Vista Healthcare
Fort Vancouver Post Acute, LLC	Fort Vancouver Healthcare Fort Vancouver Post Acute
Fort Vancouver Assisted Living, LLC	Fort Vancouver Assisted Living
EmpRes at Auburn, LLC	Advanced Post Acute
EmpRes Home Health of Bellingham, LLC	Eden Home Health
EmpRes Home Care of Bellingham, LLC	Eden Home Care
Eden Home Health of King County, LLC	Eden Home Health
Eden Home Health of Clark County, LLC	Eden Home Health
Eden Home Health of Spokane County, LLC	Eden Home Health

Legal Name	DBA
WYOMING	
EmpRes at Rock Springs, LLC	Sage View Care Center
EmpRes at Cheyenne, LLC	Granite Rehabilitation and Wellness
EmpRes at Rawlins, LLC	Rawlins Rehabilitation and Wellness
EmpRes at Riverton, LLC	Wind River Rehabilitation and Wellness
EmpRes at Thermopolis, LLC	Thermopolis Rehabilitation and Wellness
EmpRes at Casper, LLC	Shepherd of the Valley Rehabilitation and Wellness
Casper Independent Living, LLC	Maurice Griffith Manor Care

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT D

MEDICAL DIRECTOR AGREEMENT

DIRECTORSHIP INDEPENDENT CONTRACTOR AGREEMENT

THIS DIRECTORSHIP INDEPENDENT CONTRACTOR AGREEMENT ("Agreement"), entered into effective as of the day of 20 ("Effective Date"), is by and between Eden Home Health of King County, LLC ("Agency"), and Dr. Gilson R. Girotto, DO ("Physician").

RECITALS:

A. Agency provides medical care and treatment to patients including the provision of home care services; and

B. Agency has determined that the retention of a physician to provide professional medical direction relating to home care services as the Medical Director of Agency is in the best interest of patients, the community, and Agency; and

C. Physician is duly licensed to practice medicine in the state where Agency operates and has expertise in the provision of home care services; and

D. Agency and Physician mutually desire to enter into this Agreement, which will facilitate the delivery of home care services in Agency through the provision of Physician's medical director services.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is acknowledged by the parties, the parties agree as provided above and as follows:

1. DEFINITIONS: For purposes of this Agreement, the following terms shall have the meanings ascribed thereto unless clearly required by the context in which such term is used.

1.1. Agency Policies. The term "Agency Policies" shall mean the established policies, practices, and procedures of the Agency, all adopted, approved, or amended by the Agency pursuant to normal procedure.

1.2. Medical Director Services. The term "Medical Director Services" shall mean those certain services listed in Section 2.3 herein.

1.3. Patients. The term "Patients" shall mean the patients of Agency.

1.4. Term. The term "Term" shall mean the contract period provided for under the Agreement.

2. COVENANTS OF PHYSICIAN

2.1. Appointment of Physician. Agency hereby appoints Physician as Medical Director of Agency,

ATTACHMENT D

and Physician accepts such appointment, to provide administrative services for Agency in accordance with the terms of this Agreement and in accordance with 45 C.F.R. § 484.14(d).

2.2. Qualifications of Physician. Physician must at all times during the Term of this Agreement (i) hold a valid and unrestricted license to practice medicine in the state in which the Agency is located, and (ii) be fully capable and qualified, in accordance with good medical practice, to provide Medical Director Services as required by this Agreement.

2.3. Duties of Physician. Physician shall be available for consultation relating to the delivery of home care services ("Program") at the Agency and shall provide the following Medical Director

Services:

2.3.1. Quality Improvement. Physician will participate in the quality improvement/utilization review process, review and update protocols periodically and make recommendations to improve quality of Program services.

2.3.2. Education/Program Development. Physician agrees to be utilized to teach assessment skills to the Program clinical staff, develop new patient care protocols and assist/review development of staff and patient education materials.

2.3.3. Executive/Administrative Consultant. Physician will serve on the Program's Advisory Council in order to provide a medical perspective to administrative decision making and help articulate the mission, goals and policies of the Program. The functions of the Advisory Council are to establish and annually review the Program's policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications and Program evaluation.

2.3.4. Community Liaison: The physician agrees to intervene in case of physician/Program problems and will advocate for home care to the physician community. Community Liaison duties do not include marketing Program to other physicians or referral sources.

2.3.5. Health Policy/Regulation. Physician agrees to provide medical input or interpretation of social, political, regulatory or economic factors that impact patient care or the Program and act as a physician spokesperson and resource in representing the Program position in dealing with regulatory or accrediting organizations.

2.3.6. Ethical Issues Consultant. Physician agrees to participate in the development of ethical policies and decisions and provide medical input on patient care issues of an ethical nature.

2.3.7. Planning. Participate in the planning and development activities for the Program.

2.3.8. Medical Records. Monitor the maintenance, retention and required confidentiality of records and information associated with patient care in the Program.

2.4. Miscellaneous Actives. In addition, Physician shall perform such other administrative duties as may from time to time be agreed to between Physician and the Agency. Physician shall perform the duties described in this Section in accordance with Agency Policies.

2.5. Financial Obligation. Physician shall not have the right or authority to, and hereby expressly covenants to, enter into a contract in the name of Agency, or otherwise bind Agency in any way to any financial obligation, without the express written consent of Agency. Physician shall hold Agency harmless from any loss attributable to a violation of this covenant.

2.6. Reports and Records. Physician shall prepare such reports relating to the provision of Medical Director Services as are reasonably requested by Agency. The ownership and right of control of all reports, and supporting documents submitted to or by Physician shall rest exclusively with Agency.

2.7. Confidentiality of Information. Physician agrees to keep confidential and not to use or to disclose to others either during the Term or during any other period of association with Agency extending beyond the Term and for a period of six (6) years thereafter, except as expressly consented to in writing by Agency, any secrets or proprietary information, patient lists,

Page 2 of 13

marketing programs, or trade secrets of Agency (which shall be deemed to include all provisions of this Agreement), or any matter or thing ascertained by Physician through Physician's association with Agency, the use or disclosure of which matter or thing might reasonably be constructed to be contrary to the best interest of Agency. Physician further agrees that should this Agreement be terminated, Physician will neither take nor retain, without prior written authorization from Agency, any papers, policies, forms, patient lists, fee documentation, patient records, quality improvement materials, files or other documents or copies thereof or other confidential information of any kind belonging to Agency pertaining to patients or to Agency's business, sales, financial condition, or products. Physician will comply with all applicable privacy and security regulations as specified in Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent rules. Physician agrees to abide by all state and federal law relevant to the confidentiality of patient identifiable health information including but not limited to the HIPAA. Physician is not to share the protected information with any third party unless there is a stated need to share the information with an identified third party. Any such protected information is to be destroyed or returned to Agency according to Agency policy. Without limiting other possible remedies to Agency for the breach of this covenant, Physician agrees that injunctive or other equitable relief shall be available to enforce this covenant, such relief to be without the necessity of posting a bond, cash or otherwise. Physician further agrees that if any restriction contained in this Section is held by any court of competent jurisdiction to be unenforceable or unreasonable, a lesser restriction shall be enforced in its place and remaining restrictions contained herein shall be enforced independently of each other.

2.8. Exclusivity and Protection of Proprietary Information. Physician shall not provide similar Medical Director Services for any other Agency without the prior written consent of Agency. Further, Physician acknowledges that the manner of operating the Program is proprietary information of Agency, and Physician shall not disclose any such information without the prior written consent of Agency. Nothing herein shall prohibit Physician from engaging in the regular practice of medicine (inclusive of care plan oversight) and/or Physician's participation in clinical consultation services for non-competing business or industries, nor shall it obligate Physician to

ATTACHMENT D

direct referrals of medical business to a particular provider.

2.9. Time Records. Physician shall record promptly and maintain all information that, in the judgment of Agency, is necessary or desirable in order for Agency to have time records documenting the Medical Director Services furnished by Physician hereunder. The form of such time records shall be determined, and may be from time to time amended, by Agency, and Physician agrees to consult with Agency from time to time regarding the form and content of such records. Physician agrees to submit such time records no later than the fifth (5th) day of the month following the month in which the Medical Director Services are furnished.

3. COVENANTS OF AGENCY

3.1. Amount of Compensation. In consideration of the Medical Director Services rendered each month by Physician pursuant to this Agreement, Agency shall pay to Physician the amount of $200.00 per hour, rounded up to the nearest quarter hour. Medical Director Services will not exceed 4 hours per month without the prior authorization of the Agency's Executive Director. Physician agrees that such amount shall be Physician's sole compensation for Medical Director Services furnished pursuant to this Agreement. Physician's provision of professional medical services to patients, regardless of whether patient is also a patient of agency, and the compensation therefore, shall not be governed by this Agreement.

3.2. Payment of Compensation. Upon receipt, review and approval of the physician's invoice, Agency shall remit to Physician compensation amount set forth in Section 3.1 hereof in

accordance with Agency's accounts payable cycle.

4. TERM AND TERMINATION OF AGREEMENT

4.1. Term. This Agreement shall be effective as of the Effective Date for a term of one (1) year therefrom; subject however, to Sections 4.2 through 4.5 hereof. This Agreement will be automatically renewed annually by the parties for additional one-year terms unless terminated pursuant to this Article 4. This Agreement will be reviewed annually by the Agency.

4.2. Immediate Termination for Cause by Agency. Agency may, as its option, terminate this Agreement immediately by written notice to Physician upon the occurrence of any of the following events: (i) Physician's failure to meet any of the qualifications set forth in Section 2.2; (ii) failure of the Physician to fulfill the duties set forth in Section 2.3, (iii) the death or disability of Physician; or (iv) failure of Physician to attend scheduled Professional Advisory Council meetings without at least a 2 hour notice.

4.3. Termination. At any time during the Term of this Agreement, either party may terminate this Agreement without cause upon the giving of thirty (30) days advance written notice to the other party.

4.4. Termination or Notice for Default. In the event that either party shall give written notice to the other that such other party has breached a material provision of this Agreement (other than those specified in Section 4.2 above), and such breach remains uncorrected for a period of ten (10) days after receipt of such written notice, the party giving such notice may, at its option,

after the expiration of the aforesaid ten (10) day period, terminate this Agreement immediately.

4.5. Termination Due to Legislative or Administrative Changes. This Agreement is intended to comply with all relevant state and federal statutes and regulations relating to the delivery of Program services and to reimbursement of Program services under the Medicare, Medicaid, or other third-party payor programs and the federal statutes and regulations governing entities exempt from federal taxation. In the event that there shall be: (i) a change in the statutes, regulations, or instructions relating to the Medicare, Medicaid or other third-party payor programs, or the exemption of entities from federal taxation, including a change in the interpretation or enforcement thereof by government agencies; (ii) the adoption of any new legislation or regulations applicable to this Agreement; or (iii) the initiation of an enforcement action by a governmental entity with respect to legislation, regulations, or instructions applicable to this Agreement any of which affects the continuing viability or legality of this Agreement, then both parties agree to negotiate in good faith to amend the Agreement to conform with the existing laws or regulations. If agreement cannot be reached with respect to such amendments within thirty (30) days after the effective date of such change, adoption, enforcement, or notice (or such earlier time as may be required by such legislation or regulations), then either party may terminate this Agreement by written notice to the other party. Physician agrees to reimburse Agency for any payment that is determined by a court or government agency to be illegal.

5. MISCELLANEOUS

5.1. Status of Physician. It is expressly acknowledged by the parties hereto that Physician, in performing Physician's duties and obligations under this Agreement, is an "independent contractor" and nothing in this Agreement is intended nor shall be construed to create an employer/employee relationship, a joint venture relationship, or to allow Agency to exercise control or direction over the manner or method by which Physician performs the services which are the subject matter of this Agreement; provided, always, that the services to be furnished hereunder by Physician shall be provided in a manner consistent with Program Policies, the

Page 4 of 13

standard governing such services, and the provisions of this Agreement. Physician understands and agrees that, unless otherwise required under applicable federal income tax laws or the term of any agreement between Agency and the Internal Revenue Service, (i) Physician will not be treated as an employee for federal tax purposes; (ii) Agency will not withhold on behalf of Physician pursuant to this Agreement any sums for income tax, unemployment insurance, social security, retirement benefits, or any other withholding pursuant to any law or requirement of any governmental body relating to Physician, or make available to Physician any of the benefits afforded to employees of Agency; (iii) all of such payments, withholdings, and benefits, if any, are the sole responsibility of Physician; and (iv) Physician will indemnify and hold harmless Agency from any and all loss or liability arising with respect to such payments, withholding, or benefits, if any.

5.2. Applicable Standards. Physician shall, as a condition precedent to Agency's obligations under this Agreement and the provision of services by Physician hereunder, provide the Medical Director Services in such a manner as may be required by any standard, ruling, or regulation of the State, the U.S. Department of Health and Human Services or any other applicable federal, state, or local governmental agency, corporate entity, or such other entity exercising authority with respect to Agency. Physician shall perform the Medical Director Services in conformance

with all requirements of the state and federal constitutions and all applicable state and federal statutes and regulations.

5.3. Access to Records. If this Agreement has a value or cost to Agency of $10,000 or more over any twelve-month period, Physician shall perform the obligations as may be from time to time specified for subcontractors in Social Security Act 1861(v)(1)(I) and the regulations promulgated in implementation thereof (currently codified at 42 C.F.R. 420.300.304), including, but not limited to, retention and delivery of records related to this Agreement. In the event any request for this Agreement, or Physician's books, documents, and records is made pursuant to Social Security Act 1861(v)(1)(I) and associated regulations, Physician shall promptly give notice of such request to Agency and provide Agency with a copy of such request and thereafter, consult and cooperate with Agency concerning the proper response to such request. Additionally, Physician shall provide Agency with a copy of each book, document, and record made available to one or more persons and agencies pursuant to Social Security Act 1861(v)(1)(I) or shall identify each such book, document, and record to Agency and shall grant Agency access thereto for review and copying.

5.4. Representations and Warranties Regarding Compensation. Each party represents and warrants on behalf of itself, that all decisions regarding the medical care of patients shall be based solely upon the professional medical judgement of the patients' attending physicians and shall be made in the best interests of patients, that the aggregate benefit given or received under this Agreement, whether in cash or in kind, has been determined in advance through a process of arms-length negotiations that were intended to achieve an exchange of goods and/or services consistent with fair market value in the circumstances, and that any benefit given or received under this Agreement is not intended to induce, does not require, and is not contingent upon, the admission, recommendation or referral of any patient, directly or indirectly, to Agency or Physician. Further, Physician and Agency understand and agree that, while Physician may also serve as an attending physician to patients of the Agency, Physician's roles and functions as a Medical Director under this Agreement are separate from Physician's roles and functions as an attending physician, which involves primary responsibility for the medical care of individual patients.

5.5. Notices. All notices, requests, demands, or other communications hereunder shall be in writing and shall be deemed to have been given or delivered if either personally delivered or mailed by registered mail, return receipt requested, postage prepaid

Page 5 of 13

5.6. Assignment. Physician may not assign or transfer any of Physician's rights, duties, or obligations under this Agreement, in whole or in part, without the prior written consent of Agency.

5.7. No Waiver. The failure of either party to insist at any time upon the strict observance or performance of any provision of this Agreement or to exercise any right or remedy as provided in this Agreement shall not impair any right or remedy of such party or be construed as a waiver or relinquishment thereof with respect to subsequent defaults or breaches. Every right and remedy given by this Agreement to the parties hereto may be exercised from time to time and as often as may be deemed expedient by the appropriate party.

5.8. Additional Assurances. The provisions of this Agreement shall be self-operative and shall not

require further agreement by the parties, except as may be herein specifically provided to the contrary; provided, however, Physician and Agency each shall promptly and duly execute and deliver to the other such additional documents and assurances and take any and all other actions as either party may reasonably request in order to carry out the intent and purpose of this Agreement during the Term hereof.

5.9. Governing Law. This Agreement has been executed and delivered in, and shall be interpreted, construed, and enforced pursuant to and in accordance with the laws of the State of Washington. If any suit or action is filed by any party to enforce or interpret this Agreement, venue shall be in the federal or state courts of Multnomah County, Oregon or Clark County, Washington.

5.10. Master List. Pursuant to 42 CFR 411.357(d)(1)(ii) a master list of contracts which reflects all arrangements and/or agreements between Agency and Physician or Physician's immediate family members, to the extent any such arrangements or agreements exists, is provided by Physician to Agency and maintained by Agency.

5.11. Compliance Certification. Physician acknowledges Agency's Corporate Compliance Program and receipt of AGENCY's Code of Conduct. Physician represents and warrants that each of its employees who provide patient care to Federal health care program beneficiaries at Agency shall read and review Agency's Code of Conduct prior to commencement of services under this Agreement. Physician agrees to obtain and retain a signed certification from its employees providing services under this Agreement that they have received, read and understand Agency's Code of Conduct and agree to abide by the requirements of Agency's Corporate Compliance Program. Such certification shall be obtained prior to commencement of services under this Agreement, shall be maintained by Physician and shall be made available for review by Agency or Agency's agents upon reasonable request.

5.12. Enforcement. In the event Agency resorts to legal action to enforce the terms and provisions of this Agreement, Agency shall be entitled to recover the costs of such action so incurred, including without limitation, reasonable attorney's fees.

5.13. Warranty of Authority. Agency represents and warrants to Physician that it has the full power and authority to enter into this Agreement, that all required corporate action has been duly taken in connection herewith, and that upon execution of this Agreement by Agency, this Agreement shall become a binding obligation of Agency, enforceable against Agency in accordance with its terms and applicable law. Physician represents and warrants to Agency that Physician has the full power and authority to enter into this Agreement, that Physician has no other contract or agreement that conflicts with this Agreement and that this Agreement shall become a binding obligation of Physician, enforceable against Physician in accordance with its terms and applicable law.

Page 6 of 13

5.14. Severability. If any term, covenant, or condition of this Agreement, or the application thereof to any person or circumstance, shall be invalid or unenforceable, the remainder of this Agreement, and the application of any term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and all other terms shall be valid and enforceable to the fullest extent permitted by the law.

5.15. Entire Agreement; Amendments. This Agreement sets forth all of the representations, promises, agreements, conditions, and understandings between the parties relating to the subject matter of this Agreement, and supersedes any prior or contemporaneous representations, promises, agreements, conditions, and understandings between the parties in any manner relating to the subject matter hereof. This Agreement may be amended but only by a written agreement signed by both parties, such amendment(s) to become effective on the date stipulated in such amendment(s).

5.16. Counterparts. This Agreement may be executed in counterparts, and via facsimile or electronically transmitted signature (i.e. emailed scanned true and correct copy of the signed Agreement), each of which will be considered an original and all of which together will constitute one and the same agreement. At the request of a party, the other party will confirm facsimile or electronically transmitted signature page by delivering an original signature page to the requesting party.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date above first written.

[SIGNATURE PAGE FOLLOWS ON NEXT PAGE]

Page 7 of 13

ATTACHMENT D

AGENCY

by its Manager, EmpRes Healthcare Management, LLC.

By: _____

Name: Michael Miller

Title: CFO

Date: 8/8/18

PROVIDER

By: _____

Name: Gilson R. Girotto, DO

Title: Physician

Date: 7/18/2018

UPIN #: H40154

REQUIRED DOCUMENTS FOR CONTRACT COMPLETION
Copy of Liability/Malpractice Insurance - $1M / $3M Liability Limits
Office Address and Phone Number
Copy of Current State of Practice License; Business Card
Copy of applicable Business Licenses
PROVIDER-signed Business Associate Agreement

Business Associate Agreement

This **BUSINESS ASSOCIATE AGREEMENT** ("Agreement") between Eden Home Health of King County, LLC ("Covered Entity") and Dr. Gilson R. Girotto, DO ("Business Associate") is effective upon signature and retroactive to the date that Business Associate first provided services.

For purposes of complying with the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder (collectively, "HIPAA") and the requirements of Subtitle D of the Health Information Technology for Economic and Clinical Health Act and the regulations promulgated thereunder (collectively "HITECH"), if and only to the extent that Business Associate is acting as a business associate (as defined by HIPAA) of Covered Entity, the parties agree as follows:

Recitals

A. Covered Entity(further defined below) wish to disclose certain information to Business Associate (further defined below) pursuant an agreement for the provision of products and/or services.

B. It is the intention of the Covered Entity and Business Associate herein to protect the privacy and provide for the security of PHI disclosed to the BUSINESS ASSOCIATE in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information and Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act").

C. As part of the HIPAA Regulations, the Privacy Rule and Security Rule (defined below) an Agreement containing specific requirements relating to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 164.14(a), 164.502(e), and 164.504(e) of the Code of Federal Regulations ("CFR") is contained in this Agreement.

Definitions.

1. Capitalized terms used, but not otherwise defined in this Agreement, shall have the same meaning as those terms in the HIPAA regulations and HITECH, and the following capitalized terms shall be given the following meanings:

1.1 "**Breach**" means the acquisition, access, use, or disclosure of protected health information in a manner not permitted under the Privacy Rule, which compromises the security or privacy of the protected information.

1.2 "**Business Associate**" shall have the meaning given to such term under the Privacy Rule, the Security Rule, and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17938 and 45 C.F.R. Section 160.103.

1.3 "**Compliance Date**" means, in each case, the date by which compliance is required under the referenced provision of HITECH.

1.4 "**Covered Entity**" shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Section 160.103.

1.5 "**Designated Record Set**" shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Section 160.103.

1.6 "**Disclose**" and "**Disclosure**" mean, with respect to Protected Health Information, the release, transfer, provision of access to, or divulging in any other manner of Protected Health

Information outside Business Associate's internal operations or to Individuals other than its employees as well as to disclosures of Protected Health Information outside of Business Associate's operations to third parties which are required by applicable law (e.g. law enforcement, Health and Human Services, subcontractors, etc.).

1.7 **"Electronic Protected Health Information"** means Protected Health Information that is maintained in or transmitted by electronic media.

1.8 **"Electronic Health Record"** shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C. Section 17921.

1.9 **"Health Care Operations"** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

1.10 **"HITECH"** means the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, Pub. Law No. 111-5, and any regulations promulgated thereunder. References in this Agreement to a section or subsection of title 42 of the United States Code are references to provisions of HITECH. Any reference to provisions of HITECH in this Agreement shall be deemed a reference to that provision and its existing and future implementing regulations, when and as each is effective.

1.12 **"Minimum Necessary Standard"** means to engage reasonable efforts to limit the use of PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request and shall otherwise have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Sections 164.502(b) and 164.514(d).

1.13 **"Privacy Rule"** means the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164, Subparts A and E.

1.14 **"Protected Health Information"** or "PHI" means any information, whether oral or recorded in any form or medium, that (a) relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual; (b) that identifies the individual (or for which there is reasonable basis for believing that the information can be used to identify the individual); and (c) is received by Business Associate from or on behalf of Covered Entity, or is created by Business Associate for Covered Entity, or is made accessible to Business Associate by Covered Entity, and shall have the meaning given to the term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501. Protected Health Information includes Electronic Protected Health Information [45 C.F.R. Sections 160.103, 164.501].

1.15 **"Protected Information"** shall mean PHI provided by the COVERED ENTITY to BUSINESS ASSOCIATE or created or received by BUSINESS ASSOCIATE on behalf of any COVERED ENTITY.

1.16 **"Security Rule"** means the Security Standards for the Protection of Electronic Protected Health Information that is codified at 45 C.F.R. Parts 160 and 164, subparts A and C.

1.17 **"Unsecured Protected Health Information"** or **"Unsecured PHI"** means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued pursuant to the HITECH ACT including, but not limited to, 42 U.S.C. Section 17932(h).

1.18 **"Use"** or **"Uses"** mean, with respect to Protected Health Information, the sharing, employment, application, utilization, examination or analysis of such Protected Health Information within Business Associate's internal operations.

2. **Confidentiality Obligation.** Business Associate will not Use or Disclose PHI other than as permitted by this Agreement or as otherwise Authorized by Law.

3. **Permitted Uses and Disclosures of PHI.** Business Associate shall Use or Disclose PHI only as necessary to perform services under the Agreement or as otherwise Required by Law, including but not limited to such Use or Disclosure as is necessitated by the services provided to Covered Entity. Such Use or Disclosure may occur only under circumstances that would not: (i) violate the Privacy Rule, Security Rule, other applicable provisions of HIPAA or HITECH if done by Covered Entity; or (ii) violate the minimum necessary standard.

4. **Safeguards.** Business Associate shall protect PHI from any improper oral, written, or electronic disclosure by enacting and enforcing safeguards to maintain the security of and to prevent any Use or Disclosure of PHI other than is permitted by law. Such safeguards shall include administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any electronic PHI that it creates, receives, maintains, or transmits on behalf of Covered Entity. Business Associate shall comply with the Security rule requirements set forth at 45 C.F.R. Section 164.308, 164.310, 164.312, and 164.316, as well as additional requirements established by HITECH that relate to security and are applicable to Covered Entity. Business Associate shall also comply with the requirements of Subtitle D of HITECH that relate to privacy and are applicable to Business Associates in performing services on behalf of Covered Entity.

5. **Access and Amendment.** Upon the request of Covered Entity, Business Associate shall: (1) make the PHI specified by Covered Entity available to Covered Entity or to the Individual(s) identified by Covered Entity as being entitled to access in order to meet the requirements under 45 C.F.R. Section 164.524; and (b) make PHI available to Covered Entity for the purpose of amendment and incorporate changes or amendments to PHI when notified to do so by Covered Entity.

6. **Accounting.** Upon Covered Entity's request, Business Associate shall provide to Covered Entity or, when directed in writing by Covered Entity, directly to an Individual in a time and manner specified by Covered Entity, an accounting of each Disclosure of PHI made by Business Associate or its employees, agents, representatives or subcontractors as would be necessary to permit Covered Entity to respond to a request by an Individual for an accounting of Disclosures of PHI in accordance with 45 C.F.R. Section 164.528. Any accounting provided by Business Associate under this subsection shall include: (a) the date of the Disclosure: (b) the name, and address if known, of the entity or person who received the PHI; (c) a brief description of PHI disclosed; and (d) a brief statement of the purpose of the Disclosure. For each Disclosure that could require an accounting under this subsection, Business Associate shall document the information specified in (a) through (d), above, and shall securely retain this documentation for six (6) years from the date of the Disclosure.

7. **Access to Books and Records.** Business Associate shall make its internal practices, books and records relating to the Use and Disclosure of PHI pursuant to this Agreement available to the Secretary of the Department of Health and Human Services for purposes of determining Covered Entity's compliance with HIPAA. Covered Entity shall have the right to access and examine ("Audit") the books, records, and other information of Business Associate related to this Agreement. Such Audit rights shall be in addition to and notwithstanding any audit provisions set forth in the Agreement. Business Associate shall cooperate fully with any such Audit(s) and shall provide all books, records, data and other documentation reasonably requested by Covered Entity. Covered Entity may make copies of such documentation. To the extent possible, Covered Entity will provide Business Associate reasonable notice of the need for an Audit and will conduct the Audit at a reasonable time and place.

Notwithstanding the foregoing, Covered Entity will not have access to any books, records, data and/or documentation related to any of the Business Associate's other clients.

8. **Agents and Subcontractors**. Business Associate shall require all subcontractors and agents to which it provides PHI received from, or created or received on behalf of Covered Entity, to agree to all of the same restrictions and conditions concerning such PHI to which Business Associate is bound in this Agreement.

9. **Reporting of Violations**. Business Associate shall report to Covered Entity any Use or Disclosure of PHI not authorized by this Agreement immediately upon becoming aware of it. This reporting obligation includes, without limitation, the obligation to report any Security Incident, as that term is defined in 45 C.F.R. Section 164.304.

9.1 **Breach Notification**. Business Associate also shall notify Covered Entity of any Breach of Unsecured PHI. Such notification shall occur without unreasonable delay and in no case later than fifteen (15) calendar days after Business Associate discovers the Breach in accordance with 45 C.F.R. Section 164.410. The notification shall comply with the Breach notification requirements set forth at 42 U.S.C. Section 17832 and its implementing regulations at 45 C.F.R. Section 164.410 and shall include: (a) to the extent possible, the identification of each person whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or Disclosed during such Breach; and (b) any other available information about the Breach, including: (i) a description of what happened, including the dates of the Breach and discovery of the Breach, if known; (ii) a description of the types of Unsecured PHI involved in the Breach; (iii) any steps affected persons should take to protect themselves from potential harm resulting from the Breach; and (iv) the steps Business Associate is taking to investigate the Breach, mitigate harm to individuals, and to protect against any further Breaches. Business Associate shall provide Covered Entity with such additional information about the Breach either at the time of its initial notification to Covered Entity or as promptly thereafter as the information becomes available to Business Associate.

10. **Term and Termination.**

10.1 This Agreement remains in effect during the performance of services by Business Associate for or on behalf of the Covered Entity and to the extent that Business Associate maintains PHI in any form unless otherwise terminated.

10.2 In addition to and notwithstanding the termination provisions set forth herein, the Agreement may be terminated by Covered Entity in the event that Covered Entity determines Business Associate has violated a material term of this Agreement and such violation has not been remedied within fifteen (15) days following written notice to Business Associate.

10.3. Except as provided below, upon termination of this Agreement, Business Associate shall either return or destroy all PHI in the possession or control of Business Associate or its agents and subcontractors and shall retain no copies of such PHI. However, if Covered Entity determines that neither return nor destructions of PHI is feasible, Business Associate may retain PHI provided that it extends the protections of this Agreement to the PHI and limits further Uses and Disclosures to those purposes that make the return or destruction of the PHI infeasible, for so long as Business Associate maintains such PHI.

11. **Inconsistent Terms; Interpretation**. If any portion of this Agreement is inconsistent with the terms of the Agreement, the terms of this Agreement shall prevail. Except as set forth above, the remaining provisions of the Agreement are ratified in their entirety. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule, Security Rule, other applicable provisions of HIPAA, and HITECH and any regulations promulgated thereunder.

12. **Regulatory References**. A reference in this Agreement to a section in the Privacy Rule, Security Rule, other applicable provisions of HIPAA or HITECH or any regulations promulgated thereunder means the section as in effect or as amended.

13. **Amendment**. Covered Entity and Business Associate agree to take such action as is necessary to amend this Agreement from time to time as it necessary for the parties to comply with the requirements of the Privacy Rule, Security Rule, other applicable provisions of HIPAA, or HITECH and any regulations promulgated thereunder. Notwithstanding the foregoing, Covered Entity may unilaterally amend this Agreement as is necessary to comply with the applicable law and regulations and the requirements of applicable state and federal regulatory authorities. Covered Entity will provide written notice to Business Associate of such amendment and its effective date. Unless such laws, regulations or regulatory authorities require otherwise, the signature of Business Associate will not be required in order for the amendment to take effect.

14. **Indemnification**. Each Party to this Agreement shall indemnify, defend, and hold harmless the other Party from any and all claims, losses, damages, suits, fees, judgments, costs and expenses, including reasonably incurred attorneys fees, that the Indemnitees may suffer or incur arising out of any acts or omissions of the Indemnifying Party in the performance of this Agreement.

15. **Survival**. The respective rights and obligations of the Parties under section 7, subsection 10.3 and section 14 of this Agreement shall survive the termination of this Agreement.

16. **Entire Agreement**. This Agreement, together with the exhibits attached hereto, constitutes the entire agreement between the parties with respect to the services and all other subject matter hereof and merges all prior and contemporaneous communications and agreements with respect to such subject matter. It will not be modified except by a signed writing dated subsequent to the date of this Agreement and signed on behalf of the parties by their respective duly authorized representatives. No waiver consent, modification, or change of any term of this Agreement will bind either party unless the same is in writing and signed by both parties and all necessary state approvals have been obtained. Such express waiver, consent, modification, or change, if made, will be effective only in the specific instance and the specific purpose set forth in such signed writing.

16. **Counterparts**. This Agreement may be executed in counterparts, and via facsimile or electronically transmitted signature (i.e. emailed scanned true and correct copy of the signed Agreement), each of which will be considered an original and all of which together will constitute one and the same agreement. At the request of a party, the other party will confirm facsimile or electronically transmitted signature page by delivering an original signature page to the requesting party.

IN WITNESS WHEREOF, the Parties hereto have caused their authorized representatives to execute this Business Associate Agreement effective and retroactive as above written.

COVERED ENTITY:

By: _____
by EmpRes Healthcare Management, LLC,
Manager
by Michael Miller, CFO

Date: 8/8/18

BUSINESS ASSOCIATE:

By: _____

Name: Gilson J2 - Girotto, DO

Title: Medical director/Physician

Date: 7/19/2018

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT E

REGULATORY CONTACTS

California – Arvin, Bakersfield, Twin Oaks, Lakeport, Petaluma, Katherine, New Hope, Heartwood, Springs Road and Elk Grove

State of California
Department of Public Health
Licensing and Certification Program
Santa Rosa/Redwood Coast District Office
2170 Northpoint Parkway
Santa Rosa, CA 95407
Telephone: (707) 576-6775
Attn: Dana Forney, District Manager
Arnold Garza, Health Facilities Evaluator Supervisor

State of California
Department of Public Health
Licensing and Certification Program
Bakersfield District Office
4540 California Avenue, Suite 200
Bakersfield, CA 93309-7042
Telephone: (661) 336-0543
Attn: Jean Chiang, District Manager II
Janet Collins, Health Facilities Evaluator Supervisor

State of California
Department of Public Health
Licensing and Certification Program
126 Mission Ranch Blvd.
Chico, CA 95926
Telephone: (530) 895-6711
Attn: Joanne Gilchrist, District Manager II
Susan McBride, Health Facilities Evaluator Supervisor

State of California
Department of Public Health
Licensing and Certification Program
San Jose District Office
100 Paseo de San Antonio, Suite 235
San Jose, CA 95113
Telephone: (408) 277-1784
Attn: Maria Escudero, District Manager
Myrna Mangalindan, Unit Supervisor

State of California
Department of Public Health
Licensing and Certification Program
Sacramento District Office
3901 Lennane Drive, Suite 201
Sacramento, CA 95834-2956
Telephone: (916) 263-5800
Attn: Jacqueline Phillips, District Manager
Charlotte Rice, Health Facilities Evaluator Supervisor

Idaho – Sandpoint ALF, Teton, Lewiston SNF and Lewiston ALF

State of Idaho
Department of Health and Welfare
Division of Licensing and Certification
Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
Telephone: (208) 334-6626, Option 2
Attn: David Scott, Long Term Care Supervisor
Nina Sanderson, Long Term Care Supervisor
Telephone: (208) 364-1962
Attn: Jamie Simpson, ALF Program Supervisor
Lisa Bennett, ALF Health Facility Surveyor

Eden Home Health of Idaho Falls, Eden Hospice at Idaho Falls and Eden Hospice at Carson City

Accreditation Commission for Health Care, Inc.
139 Weston Oaks Court
Cary, NC 27513
Telephone: (919) 785-1214, ext. 301
Attn: Cathie O'Connor, Account Advisor

Montana – Polson, Hot Springs, Missoula, Laurel, Livingston, Central Montana, Marias, Aspen Meadows SNF and Aspen Meadows ALF

State of Montana
Department of Public Health and Human Services
Quality Assurance Division
Certification Bureau
2401 Colonial Drive, 2nd Floor
P.O. Box 202953
Helena, MT 59620
Telephone: (406) 444-2099
Attn: Todd Boucher, Certification Bureau Chief

Nevada – Pahrump, Ormsby, Mountain View, Gardnerville and Eden Home Health

State of Nevada
Department of Health and Human Services
Division of Public and Behavioral Health
Bureau of Health Care Quality and Compliance
4220 South Maryland Parkway, Suite 810, Building D
Las Vegas, NV 89119
Telephone: (702) 486-6515
Attn: Ellen Clark, Health Facilities Inspector III
Jennifer Dunaway, Health Facilities Inspector III
Paul Shubert, Bureau Chief

Oregon – La Grande, Independence, Hillsboro, Milton-Freewater, Cascade Valley, The Dalles, Portland and Windsor

State of Oregon
Department of Human Services
Aging and People with Disabilities
Safety, Oversight and Quality Unit
Office of Licensing and Regulatory Oversight
3406 Cherry Avenue, NE
Salem, OR 97303
Telephone: (503) 373-2227
Attn: Joanne Birney (503) 373-1964
Dave Allm, Nursing Facility Licensing Manager
Cory Oace, Survey Manager
Keith Ramey, Nursing Facility Survey Unit Manager

P.O. Box 14530
Salem, OR 97309
Telephone: (503) 373-0222
(503) 373-0200
(503) 373-0231
Attn: Cynthia Vargo, Nursing Facility Survey Unit Manager
Sheryl Luper (503) 602-5162

Washington – Frontier, Americana, Whitman, Seattle Medical, Enumclaw, Canterbury, North Seattle, Talbot, Shelton, Park Royal, North Cascades, Alaska Gardens, Alderwood, Highland, Snohomish, Royal Park SNF, Royal Park ALF, Buena Vista, Fort Vancouver SNF, Fort Vancouver ALF, Auburn and Eden Home Health

State of Washington
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
P.O. Box 45600
Olympia, WA 98504
Telephone: (360) 664-8422
Attn: Sonya Conway, Acting Field Manager

State of Washington
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
20425 72nd Avenue South, Suite 400
Kent, WA 98032-2388
Telephone: (253) 234-6044
Attn: Loretta Maestas, Region 2 Field Manager

State of Washington
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
P.O. Box 98907
Lakewood, WA 98496
Telephone: (253) 983-3837
Attn: Ruth Futch, Region 3 Acting Field Manager

State of Washington
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
3906 172nd Street NE, Suite 100
Arlington, WA 98223
Telephone: (360) 651-6864
Attn: Kathy Gold, Region 2 Field Manager

State of Washington
Department of Social and Health Services
Aging and Long-Term Support Administration
Division of Residential Care Services
316 West Boone Avenue, Suite 170
Spokane, WA 99201
Attn: Cindy CoVille, Region 1 Field Manager (509) 323-7316
Susan Bergeron, Region 1 Field Manager (509) 323-7324

State of Washington
Department of Social and Health Services
Aging and Long-Term Support Administration
Division of Residential Care Services
800 NE 136th Avenue, Suite 220
Vancouver, WA 98684
Telephone: (360) 397-9549
Attn: Karyl Ramsey, Region 3 Field Manager

Wyoming – Sage View, Granite, Rawlins, Wind River and Thermopolis

State of Wyoming
Aging Division
Healthcare Licensing and Surveys
6101 Yellowstone Road, Suite 186C
Cheyenne, WY 82002
Telephone: (307) 777-7123
Attn: Laura Hudspeth, State Survey Agency Director

Legal Name	DBA	Address	Phone	Fax	Quality of Care Survey State
OPERATING ENTITIES					
CALIFORNIA					
Evergreen at Arvin, L.L.C.	Evergreen Arvin Healthcare	323 Campus Drive, Arvin, CA 93203	661-854-4475	661-854-4950	CA
Evergreen at Bakersfield, L.L.C.	Evergreen Bakersfield Post Acute Care	6212 Tudor Way, Bakersfield, CA 93306	661-871-3133	661-871-1388	CA
Evergreen at Chico, L.L.C.	Twin Oaks Post Acute Rehab	1200 Springfield Drive, Chico, CA 95928	530-342-4885	530-342-2847	CA
Evergreen at Heartwood Avenue, L.L.C.	Heartwood Avenue Healthcare	1044 Heartwood Avenue. Vallejo, CA 94591	707-643-2267	707-643-5209	CA
Evergreen at Lakeport, L.L.C.	Evergreen Lakeport Healthcare	1291 Craig Avenue, Lakeport, CA 95453	707-263-6382	707-263-7213	CA
Evergreen at Petaluma, L.L.C.	EmpRes Post Acute Rehabilitation	300 Douglas Street, Petaluma, CA 94952	707-763-6887	707-763-0314	CA
Evergreen at Salinas, L.L.C.	Katherine Healthcare	315 Alameda Avenue, Salinas, CA 93901	831-424-1878	831-424-3149	CA
Evergreen at Springs Road, L.L.C.	Springs Road Healthcare	1527 Springs Road, Vallejo, CA 94591	707-643-2793	707-554-2876	CA
Evergreen at Tracy, L.L.C.	New Hope Post Acute Care	2586 Buthman Avenue, Tracy, CA 95376	209-832-2273	209-832-0743	CA
Eden Home Health of Elk Grove, LLC	Eden Home Health	Suite 10 Elk Grove, CA 95624	916-681-4949	916-681-4888	CA
IDAHO					
Evergreen Idaho Healthcare Sandpoint, L.L.C.	Evergreen Sandpoint Assisted Living Facility	624 South Division Street, Sandpoint, ID 83864	208-265-2354	208-263-8787	ID
EmpRes at Idaho Falls, LLC	Teton Post Acute Care and Rehabilitation	3111 Channing Way, Idaho Falls, ID 83404-7534	208-529-0067	208-529-4013	ID
Eden Home Health of Idaho Falls, LLC	Eden Home Health	1480 Midway Avenue, Unit 7, Ammon, ID 83406-4587	208-523-1980	208-523-4024	ACHC
Lewiston Royal Plaza Care, LLC	Royal Plaza Health and Rehabilitation	2870 Juniper Drive, Lewiston, ID 83501	208-746-2855	208-746-4994	ID
Lewiston Royal Plaza Retirement, LLC	Royal Plaza Retirement Center	2870 Juniper Drive, Lewiston, ID 83501	208-746-2800	208-746-0164	ID
Eden Hospice at Idaho Falls, LLC	Eden Hospice	1480 Midway Avenue, Unit 7, Ammon, ID 83406-4587	208-523-1980	208-529-4013	ID
MONTANA					
Evergreen at Hot Springs, L.L.C.	Hot Springs Health and Rehabilitation Center	600 First Avenue North, Hot Springs, MT 59845	406-741-2992	406-741-2994	MT
Evergreen at Laurel, L.L.C.	Laurel Health and Rehabilitation Center	820 3rd Avenue, Laurel, MT 59044	406-628-8251	406-628-8253	MT
Evergreen at Livingston, L.L.C.	Livingston Health and Rehabilitation Center	510 South 14th Street, Livingston, MT 59047	406-222-0672	406-222-1406	MT
EmpRes at Lewistown, LLC	Central Montana Nursing & Rehabilitation Center	410 Wendell Avenue, Lewistown, MT 59457	406-535-6225	406-535-6325	MT
Evergreen at Missoula, L.L.C.	Missoula Health and Rehabilitation Center	3018 Rattlesnake Drive, Missoula, MT 59802	406-549-0988	406-549-0111	MT
Evergreen at Polson, L.L.C.	Polson Health and Rehabilitation Center	Nine 14th Avenue West, Polson, MT 59860	406-883-4378	406-883-0039	MT
EmpRes at Shelby, LLC	Marias Care Center	630 Park Drive, PO Box 346, Shelby, MT 59474	406-434-3260	404-343-3274	MT
EmpRes at Billings, LLC	Aspen Meadows Health and Rehabilitation Center	3155 Avenue C, Billings, MT 59102	406-656-8818	406-656-9552	MT
Aspen Meadows Assisted Living, LLC	Aspen Meadows Assisted Living	3155 Avenue C, Billings, MT 59102	406-656-8818	406-656-9552	MT
NEVADA					
Evergreen at Carson City, L.L.C.	Ormsby Post Acute Rehab	3050 North Ormsby Blvd., Carson City, NV 89703	775-841-4646	775-841-4650	NV
Evergreen at Gardnerville, L.L.C.	Gardnerville Health and Rehabilitation Center	1573 Muller Parkway, Gardnerville, NV 89410	775-782-6620	775-782-6945	NV
Evergreen at Mountain View, L.L.C.	Mountain View Health and Rehabilitation Center	201 Koontz Lane, Carson City, NV 89701	775-883-3622	775-883-3744	NV
Evergreen at Pahrump, L.L.C.	Pahrump Health and Rehabilitation Center	4501 N Blagg Road, Pahrump, NV 89060	775-751-6600	775-751-6644	NV
EmpRes Personal Care Nevada, LLC	Eden Home Care	911 Mountain Street, Carson City, NV 89703	775-392-2000		NV

Legal Name	DBA	Address	Phone	Fax	Quality of Care Survey State
Eden Hospice at Carson City, LLC	Eden Hospice	907 Mountain Street, Carson City, NV 89703	775-687-1530	775-687-1535	ACHC
Quality Health Care Corporation	Eden Home Health	Home Office: 1201 Corporate Blvd, Suite 130, Reno, NV 89502-7162 Branch Office: 907 Mountain Street, Carson City, NV 89703	775-828-1000	775-828-1029	NV
OREGON					
Evergreen Oregon Healthcare Independence, L.L.C.	Independence Health and Rehabilitation Center	1525 Monmouth Avenue, Independence, OR 97351	503-838-0001	503-838-7826	OR
Evergreen Oregon Healthcare Mountain Vista, L.L.C.	LaGrande Post Acute Rehab	91 Aries Lane, La Grande, OR 97850	541-963-8678	541-963-5024	OR
Evergreen Oregon Healthcare Orchards Rehabilitation, L.L.C.	Milton Freewater Health and Rehabilitation Center	120 Elzora Street, Milton Freewater, OR 97862	541-938-3318	541-938-4657	OR
Evergreen Oregon Healthcare Orchards Retirement, L.L.C.	Cascade Valley Assisted Living and Memory Care Cascade Valley Assisted Living Cascade Valley Memory Care	1010 NE Third, Milton Freewater, OR 97862	541-938-5693	541-938-4490	OR
Evergreen Oregon Healthcare Portland, L.L.C.	Portland Health and Rehabilitation Center	12441 SE Stark Street, Portland, OR 97233	503-255-7040	503-255-0555	OR
Evergreen Oregon Healthcare Salem, L.L.C.	Windsor Health and Rehabilitation Center	820 Cottage Street NE, Salem, OR 97301	503-399-1135	503-399-7273	OR
Evergreen Oregon Healthcare Tualatin, L.L.C.	EmpRes Hillsboro Health and Rehabilitation Center	1778 NE Cornell Road, Hillsboro, OR 97124	503-648-6621	503-648-4443	OR
Evergreen Oregon Healthcare Valley Vista, L.L.C.	The Dalles Health and Rehabilitation Center	1023 West 25th, The Dalles, OR 97058	541-298-5158	541-298-3864	OR
WASHINGTON					
EmpRes at Alderwood, LLC	Alderwood Park Health and Rehabilitation	2726 Alderwood Avenue, Bellingham, WA 98225	360-733-2322	360-733-0229	WA
Evergreen Washington Healthcare Americana, L.L.C.	Americana Health and Rehabilitation Center	917 7th Avenue, Longview, WA 98632	360-425-5910	360-425-0318	WA
Evergreen Washington Healthcare Auburn, L.L.C.	Canterbury House	502 29th Street, SE, Auburn, WA 98002	253-939-0090	253-939-0095	WA
Evergreen at Bellingham, L.L.C.	North Cascades Health and Rehabilitation Center	4680 Cordata Parkway, Bellingham, WA 98226	360-398-1966	360-398-9346	WA
EmpRes Home Health of Bellingham, LLC	Eden Home Health	Home Office: 316 E. McLeod Rd, Suite 101, Bellingham, WA 98226-6491 Branch Office: 230 South 15th Street, Mount Vernon, WA 98274	360-734-5410	360-734-5435	WA
EmpRes at Colville, LLC	Buena Vista Healthcare	151 Buena Vista Drive, Colville, WA 99114	509-684-4539	509-685-0582	WA
Evergreen Washington Healthcare Enumclaw, L.L.C.	Enumclaw Health and Rehabilitation Center	2323 Jensen Street, Enumclaw, WA 98022	360-825-2541	360-825-4351	WA
Evergreen Washington Healthcare Frontier, L.L.C.	Frontier Rehabilitation and Extended Care	1500 3rd Avenue, Longview, WA 98632	360-423-8800	360-636-3421	WA
Evergreen Washington Healthcare Greenwood, L.L.C.	Health and Rehabilitation of North Seattle	13333 Greenwood Avenue North, Seattle, WA 98133	206-362-0303	206-364-7208	WA
EmpRes Highland Care, LLC	Highland Health and Rehabilitation	2400 Samish Way, Bellingham, WA 98229	360-734-4800	360-734-1013	WA
Evergreen at Park Royal II, L.L.C.	Park Royal Health and Rehabilitation Center	910 16th Avenue, Longview, WA 98632	360-423-2890	360-577-9012	WA
Evergreen Washington Healthcare Seattle, L.L.C.	Seattle Medical Post Acute Care	555 16th Avenue, Seattle, WA 98122	206-324-8200	206-324-4345 206-709-8457	WA
Evergreen at Shelton, L.L.C.	Shelton Health and Rehabilitation Center	153 Johns Court, Shelton, WA 98584	360-427-2575	360-427-2563	WA
EmpRes at Snohomish, LLC	Snohomish Health and Rehabilitation	800 Tenth Street, Snohomish, WA 98290	360-568-3161	360-568-4455	WA
Spokane Royal Park Care, LLC	Royal Park Health and Rehabilitation	7411 North Nevada Street, Spokane, WA 99208	509-489-2273	509-483-3041	WA
Spokane Royal Park Retirement, LLC	Royal Park Retirement Center	302 E. Wedgewood Avenue, Spokane, WA	509-483-7136	509-483-5161	WA
Evergreen at Tacoma, L.L.C.	Alaska Gardens Health and Rehabilitation Center	6220 South Alaska Street, Tacoma, WA 98408	253-476-5300	253-476-5365	WA
Evergreen at Talbot Road, L.L.C.	Talbot Center for Rehabilitation and Healthcare	4430 Talbot Road South, Renton, WA 98055	425-226-7500	425-226-4195	WA

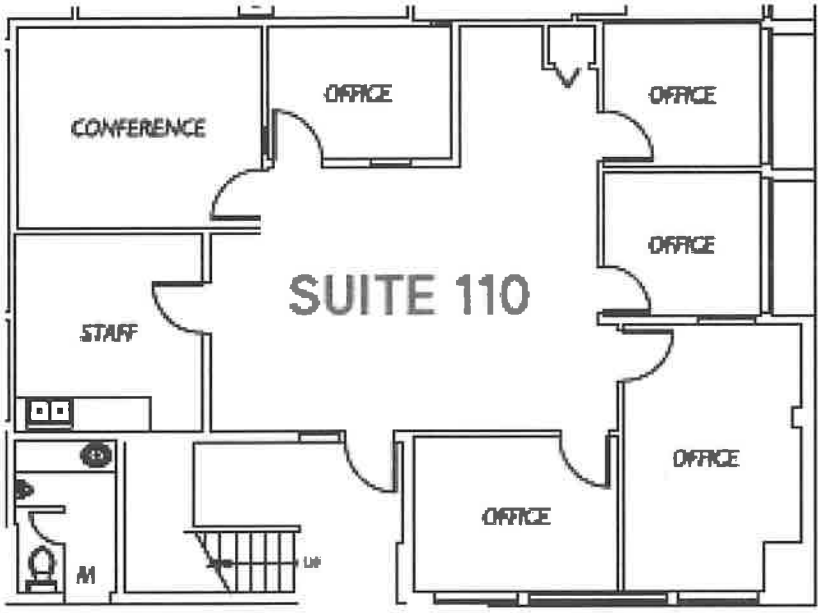
Legal Name	DBA	Address	Phone	Fax	Quality of Care Survey State
Evergreen Washington Healthcare Whitman, L.L.C.	Whitman Health and Rehabilitation Center	1150 W. Fairview Street, Colfax, WA 99111	509-397-4603	509-397-9214	WA
Fort Vancouver Post Acute, LLC	Fort Vancouver Healthcare Fort Vancouver Post Acute	8507 NE 8th Way, Vancouver, WA 98664	360-254-5335	360-892-2086	WA
Fort Vancouver Assisted Living, LLC	Fort Vancouver Assisted Living	8422 NE 8th Way, Vancouver, WA 98664	360-256-2980	360-256-1909	WA
EmpRes Home Care of Bellingham, LLC	Eden Home Care	316 E. McLeod Rd, Suite 101, Bellingham, WA 98226-6491	360-734-5410	360-734-5435	WA
EmpRes at Auburn, LLC	Advanced Post Acute	414 17th Street SE, Auburn, WA 98002	253-833-1740	253-833-2050	WA
Eden Home Health of King County, LLC	Eden Home Health	800 Fifth Avenue, Suite 4100, Floor 41 & 42, Seattle, WA 98104	206-236-8747	206-470-1150	WA
WYOMING					
EmpRes at Rock Springs, LLC	Sage View Care Center	1325 Sage Street, Rock Springs, WY 82901	307-362-3780	307-363-9671	WY
EmpRes at Cheyenne, LLC	Granite Rehabilitation and Wellness	3128 Boxelder Drive, Cheyenne, WY 82001	307-634-7901	307-634-7910	WY
EmpRes at Rawlins, LLC	Rawlins Rehabilitaton and Wellness	542 16th Street, Rawlins, WY 82301	307-324-2759	307-324-7579	WY
EmpRes at Riverton, LLC	Wind River Rehablitation and Wellness	1002 Forest Drive, Riverton WY 82501	307-856-9471	307-856-1749	WY
EmpRes at Thermopolis, LLC	Thermopolis Rehablitation and Wellness	1210 Canyon Hills Road, Thermopolis, WY 82443	307-864-5591	307-864-2847	WY

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT F

SINGLE LINE DRAWING

EXHIBIT A
[Floor Plan/Outline of the Premises]



Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT G

LEASE AGREEMENT

LEASE AGREEMENT
(Multi-Tenant Gross Lease)

THIS LEASE AGREEMENT (the "Lease") is entered into and effective as of this **26th** day of **December, 2018** between **GJR REIH II, LLC, a Washington Limited Liability Company** ("Landlord"), and **Eden Home Health of King County, LLC, a Washington Limited Liability Company** (Tenant"). Landlord and Tenant agree as follows:

1. LEASE SUMMARY.

a. **Leased Premises**. The leased commercial real estate i) consists of an agreed area of **1,576** rentable square feet and is outlined on the floor plan attached as Exhibit A (the "Premises"); ii) is located on the land legally described on attached Exhibit B; and iii) is commonly known **as Parkade Plaza Suite 110 located at 733 7th Ave, Kirkland, WA 98033** (suite number and address). The Premises do not include, and Landlord reserves, the exterior walls and roof of the building in which the Premises are located (the "Building"), the land beneath the Building, the pipes and ducts, conduits, wires, fixtures, and equipment above the suspended ceiling; and the structural elements of the Building. The Building, the land upon which it is situated, all other improvements located on such land, and all common areas appurtenant to the Building are referred to as the "Property." The Building and all other buildings on the Property as of the date of this Lease consist of an agreed area of **25,026** rentable square feet.

b. **Lease Commencement Date**. The term of this Lease shall be for a period of **thirty seven (37) months** and shall commence on **February 1, 2019** or such earlier or later date as provided in Section 3 (the "Commencement Date").

c. **Lease Termination Date**. The term of this Lease shall terminate at midnight on **February 28, 2022** or such earlier or later date as provided in Section 3 (the "Termination Date").

d. **Base Rent**. The base monthly rent shall be (check one): ☐$_____, or ☒according to the Rent Rider attached hereto ("Base Rent"). Rent shall be payable at Landlord's address shown in Section 1(h) below, or such other place designated in writing by Landlord.

e. **Prepaid Rent.** Upon execution of this Lease, Tenant shall deliver to Landlord the sum of **$4,005.67** as prepaid rent, to be applied to the Base Rent and Operating Costs due for month two (__) of the Lease.

f. **Security Deposit**. Upon execution of this Lease, Tenant shall deliver to Landlord the sum of **$4,400.00** to be held as a security deposit pursuant to Section 5 below. The security deposit shall be in the form of (check one): ☒cash, or ☐letter of credit according to the Letter of Credit Rider (CBA Form LCR) attached hereto.

g. **Permitted Use**. The Premises shall be used only for **general office use** and for no other purpose without the prior written consent of Landlord (the "Permitted Use").

h. **Notice and Payment Addresses.**

Landlord: **GJR REIH II, LLC**
C/O KidderMathews
500 - 108th Avenue NE #2400, Bellevue, WA 98004
Attn: Kristin Fabey
Email: **kfabey@kiddermathews.com**
425-283-5787

Tenant: **EmpRes Healthcare Management, LLC, a Washington Limited Liability Company,**

4601 NE 77th Avenue, Suite 300
Vancouver, WA 98662
Attn: Legal/Contracts

2. PREMISES.

a. **Lease of Premises**. Landlord leases to Tenant, and Tenant leases from Landlord, the Premises upon the terms specified in this Lease.

b. **Acceptance of Premises**. Except as specified elsewhere in this Lease, Landlord makes no representations or warranties to Tenant regarding the Premises, including the structural condition of the Premises or the condition of all mechanical, electrical, and other systems on the Premises. Except for any tenant improvements to be completed by Landlord as described on attached Exhibit C (the "Landlord's Work"), Tenant shall be responsible for performing any work necessary to bring the Premises into a condition satisfactory to Tenant. By signing this Lease, Tenant acknowledges that it has had an adequate opportunity to investigate the Premises; acknowledges responsibility for making any corrections, alterations and repairs to the Premises (other than the Landlord's Work); and acknowledges that the time needed to complete any such items shall not delay the Commencement Date.

c. **Furniture**. Tenant acknowledges and agrees all "Built-In" furniture in the Premises, which is not directly owned by Tenant, may be removed from the Premises in the event a sheriff's sale occurs.

d. **Tenant Improvements**. Attached Exhibit C sets forth all Landlord's Work, if any, and all tenant improvements to be completed by Tenant (the "Tenant's Work"), if any, that will be performed on the Premises. Responsibility for design, payment and performance of all such work shall be as set forth on attached Exhibit C. If Tenant fails to notify Landlord of any defects in the Landlord's Work within thirty (30) days of delivery of possession to Tenant, Tenant shall be deemed to have accepted the Premises in their then condition. If Tenant discovers any major defects in the Landlord's Work during this 30-day period that would prevent Tenant from using the Premises for the Permitted Use, Tenant shall notify Landlord and the Commencement Date shall be delayed until after Landlord has notified Tenant that Landlord has corrected the major defects and Tenant has had five (5) days to inspect and approve the Premises. The Commencement Date shall not be delayed if Tenant's inspection reveals minor defects in the Landlord's Work that will not prevent Tenant from using the Premises for the Permitted Use. Tenant shall prepare a punch list of all minor defects in Landlord's Work and provide the punch list to Landlord, which Landlord shall promptly correct.

3. TERM. The term of this Lease shall commence on the Commencement Date specified in Section 1, or on such earlier or later date as may be specified by notice delivered by Landlord to Tenant advising Tenant that the Premises are ready for possession and specifying the Commencement Date, which shall not be less than _____ days (thirty (30) days if not filled in) following the date of such notice.

a. **Early Possession.** If Landlord permits Tenant to possess and occupy the Premises two (2) weeks prior to the Commencement Date specified in Section 1, then such early occupancy shall not advance the Commencement Date or the Termination Date set forth in Section 1, but otherwise all terms and conditions of this Lease shall nevertheless apply during the period of early occupancy before the Commencement Date. Tenant must not interfere with Landlord's Improvement Work outlined in Exhibit C during Early Possession.

b. **Delayed Possession.** Landlord shall act diligently to make the Premises available to Tenant; provided, however, neither Landlord nor any agent or employee of Landlord shall be liable for any damage or loss due to Landlord's inability or failure to deliver possession of the Premises to Tenant as provided in this Lease. If possession is delayed, the Commencement Date set forth in Section 1 shall also be delayed. In addition, the Termination Date set forth in Section 1 shall be modified so that the length of the Lease term remains the same. If Landlord does not deliver possession of

the Premises to Tenant within _____ thirty (30) days if not filled in) after the Commencement Date specified in Section 1, Tenant may elect to cancel this Lease by giving written notice to Landlord within ten (10) days after such time period ends. If Tenant gives such notice of cancellation, the Lease shall be cancelled, all prepaid rent and security deposits shall be refunded to Tenant, and neither Landlord nor Tenant shall have any further obligations to the other. The first "Lease year" shall commence on the Commencement Date and shall end on the date which is twelve (12) months from the end of the month in which the Commencement Date occurs. Each successive Lease year during the initial term and any extension terms shall be twelve (12) months, commencing on the first day following the end of the preceding Lease year. To the extent that the tenant improvements are not completed in time for the Tenant to occupy or take possession of the Premises on the Commencement Date due to the failure of Tenant to fulfill any of its obligations under this Lease, the Lease shall nevertheless commence on the Commencement Date set forth in Section 1.

4. RENT.

a. **Payment of Rent.** Tenant shall pay Landlord without notice, demand, deduction or offset, in lawful money of the United States, the monthly Base Rent stated in Section 1 in advance on or before the first day of each month during the Lease term beginning on (check one): ☒the Commencement Date, or ☐_____ (if no date specified, then on the Commencement Date), and shall also pay any other additional payments due to Landlord ("Additional Rent"), including Operating Costs (collectively the "Rent") when required under this Lease. Payments for any partial month at the beginning or end of the Lease shall be prorated. All payments due to Landlord under this Lease, including late fees and interest, shall also constitute Additional Rent, and upon failure of Tenant to pay any such costs, charges or expenses, Landlord shall have the same rights and remedies as otherwise provided in this Lease for the failure of Tenant to pay rent.

b. **Late Charges; Default Interest**. If any sums payable by Tenant to Landlord under this Lease are not received within seven (7) business days after their due date, Tenant shall pay Landlord an amount equal to the greater of $100 or five percent (5%) of the delinquent amount for the cost of collecting and handling such late payment in addition to the amount due and as Additional Rent. All delinquent sums payable by Tenant to Landlord and not paid within seven (7) business days after their due date shall, at Landlord's option, bear interest at the rate of fifteen percent (15%) per annum, or the highest rate of interest allowable by law, whichever is less (the "Default Rate"). Interest on all delinquent amounts shall be calculated from the original due date to the date of payment.

c. **Less Than Full Payment.** Landlord's acceptance of less than the full amount of any payment due from Tenant shall not be deemed an accord and satisfaction or compromise of such payment unless Landlord specifically consents in writing to payment of such lesser sum as an accord and satisfaction or compromise of the amount which Landlord claims. Any portion that remains to be paid by Tenant shall be subject to the late charges and default interest provisions of this Section.

d. **Base Year.** The Base Rent paid by Tenant under this Lease includes Tenant's Pro Rata Share of Operating Costs for 2019 (the "Base Year"). As additional Rent, Tenant shall pay to Landlord on the first day of each month commencing on the first day of 2019, with Tenant's payment of Base Rent, one-twelfth of the amount, if any, by which Tenant's Pro Rata Share of Operating Costs exceeds Tenant's annualized Pro Rata Share of Operating Costs for the Base Year of this Section. Tenant's percentage share of Operating Costs is computed by dividing the square footage of Tenant's leased Premises by the total rentable square footage of the Building. Tenant's pro-rata share is: 6.3%.

e. **Operating Costs.** As used herein, "Operating Costs" shall mean all costs of operating, maintaining and repairing the Premises, the Building, and the Property, determined in accordance with generally accepted accounting principles, and including without limitation the following: real estate taxes and assessments; electricity, water, sewer, garbage and all other utility charges; all other

usual and necessary costs of operation, management, janitorial, maintenance, and repair, excluding depreciation, loan payments, replacement of major structural elements, and any items which are the direct responsibility of Tenant under this Lease.

5. SECURITY DEPOSIT. Upon execution of this Lease, Tenant shall deliver to Landlord the security deposit specified in Section 1 above. Landlord's obligations with respect to the security deposit are those of a debtor and not of a trustee, and Landlord may commingle the security deposit with its other funds. If Tenant breaches any covenant or condition of this Lease, including but not limited to the payment of Rent, Landlord may apply all or any part of the security deposit to the payment of any sum in default and any damage suffered by Landlord as a result of Tenant's breach. Tenant acknowledges, however, that the security deposit shall not be considered as a measure of Tenant's damages in case of default by Tenant, and any payment to Landlord from the security deposit shall not be construed as a payment of liquidated damages for Tenant's default. If Landlord applies the security deposit as contemplated by this Section, Tenant shall, within five (5) days after written demand therefore by Landlord, deposit with Landlord the amount so applied. If Tenant complies with all of the covenants and conditions of this Lease throughout the Lease term, the security deposit shall be repaid to Tenant without interest within thirty (30) days after the surrender of the Premises by Tenant in the condition required hereunder by Section 12 of this Lease.

6. USES. The Premises shall be used only for the Permitted Use specified in Section 1 above, and for no other business or purpose without the prior written consent of Landlord. No act shall be done on or around the Premises that is unlawful or that will increase the existing rate of insurance on the Premises, the Building, or the Property, or cause the cancellation of any insurance on the Premises, the Building, or the Property. Tenant shall not commit or allow to be committed any waste upon the Premises, or any public or private nuisance. Tenant shall not do or permit anything to be done on the Premises, the Building, or the Property which will obstruct or interfere with the rights of other tenants or occupants of the Property, or their employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees or to injure or annoy such persons.

7. COMPLIANCE WITH LAWS. Tenant shall not cause or permit the Premises to be used in any way which violates any law, ordinance, or governmental regulation or order. Landlord represents to Tenant that, as of the Commencement Date, to Landlord's knowledge, but without duty of investigation, and with the exception of any Tenant's Work, the Premises comply with all applicable laws, rules, regulations, or orders, including without limitation, the Americans With Disabilities Act, if applicable, and Landlord shall be responsible to promptly cure at its sole cost any noncompliance which existed on the Commencement Date. Tenant shall be responsible for complying with all laws applicable to the Premises as a result of the Permitted Use, and Tenant shall be responsible for making any changes or alterations as may be required by law, rule, regulation, or order for Tenant's Permitted Use at its sole cost and expense. Otherwise, if changes or alterations are required by law, rule, regulation, or order unrelated to the Permitted Use, Landlord shall make changes and alterations at its expense.

8. UTILITIES AND SERVICES. Landlord shall provide the Premises the following services, the cost of which shall be included in the Operating Costs, to the extent not separately metered to the Premises: water and electricity for the Premises seven (7) days per week, twenty-four (24) hours per day, and HVAC from **7:00** a.m. to **6:00** p.m. Monday through Friday. Landlord shall provide janitorial service to the Premises and Building five (5) nights each week, exclusive of holidays, the cost of which shall also be included in Operating Costs. HVAC services will also be provided by Landlord to the Premises during additional hours on reasonable notice to Landlord, at Tenant's sole cost and expense, at an hourly rate reasonably established by Landlord from time to time and payable by Tenant, as and when billed, as Additional Rent. Notwithstanding the foregoing, if Tenant's use of the Premises incurs utility service charges which are above those usual and customary for the Permitted Use, Landlord reserves the right to require Tenant to pay a reasonable additional charge for such usage. Landlord shall not be liable for any loss, injury or damage to person or property caused by or resulting from any variation, interruption, or failure of utilities due to any cause whatsoever, and Rent shall not abate as a result thereof.

Tenant shall furnish all other utilities (including, but not limited to, telephone, Internet, and cable service if available) and other services which Tenant requires with respect to the Premises, and shall pay, at Tenant's sole expense, the cost of all utilities separately metered to the Premises, and of all other utilities and other

services which Tenant requires with respect to the Premises, except those to be provided by Landlord and included in Operating Expenses as described above. Landlord shall not be liable for any loss, injury or damage to person or property caused by or resulting from any variation, interruption, or failure of utilities due to any cause whatsoever, and Rent shall not abate as a result thereof.

9. TAXES. Tenant shall pay all taxes, assessments, liens and license fees ("Taxes") levied, assessed or imposed by any authority having the direct or indirect power to tax or assess any such liens, related to or required by Tenant's use of the Premises as well as all Taxes on Tenant's personal property located on the Premises. Landlord shall pay all taxes and assessments with respect to the Property, including any taxes resulting from a reassessment of the Building or the Property due to a change of ownership or otherwise.

10. COMMON AREAS.

a. **Definition**. The term "Common Areas" means all areas, facilities and building systems that are provided and designated from time to time by Landlord for the general non-exclusive use and convenience of Tenant with other tenants and which are not leased or held for the exclusive use of a particular tenant. To the extent that such areas and facilities exist within the Property, Common Areas include hallways, entryways, stairs, elevators, driveways, walkways, terraces, docks, loading areas, restrooms, trash facilities, parking areas and garages, roadways, pedestrian sidewalks, landscaped areas, security areas, lobby or mall areas, common heating, ventilating and air conditioning systems, common electrical service, equipment and facilities, and common mechanical systems, equipment and facilities. Tenant shall comply with reasonable rules and regulations concerning the use of the Common Areas adopted by Landlord from time to time. Without advance notice to Tenant and without any liability to Tenant, Landlord may change the size, use, or nature of any Common Areas, erect improvements on the Common Areas or convert any portion of the Common Areas to the exclusive use of Landlord or selected tenants, so long as Tenant is not thereby deprived of the substantial benefit of the Premises. Landlord reserves the use of exterior walls and the roof, and the right to install, maintain, use, repair and replace pipes, ducts, conduits, and wires leading through the Premises in areas which will not materially interfere with Tenant's use thereof.

b. **Use of the Common Areas**. Tenant shall have the non-exclusive right, in common with such other tenants to whom Landlord has granted or may grant such rights, to use the Common Areas. Tenant shall abide by rules and regulations adopted by Landlord from time to time and shall use its best efforts to cause its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees to comply with those rules and regulations, and not interfere with the use of Common Areas by others.

c. **Maintenance of Common Areas**. Landlord shall maintain the Common Areas in good order, condition and repair. This maintenance cost shall be an Operating Cost chargeable to Tenant pursuant to Section 8. In performing such maintenance, Landlord shall use reasonable efforts to minimize interference with Tenant's use and enjoyment of the Premises.

11. ALTERATIONS. Tenant may make alterations, additions or improvements to the Premises, including any Tenant Work identified on attached Exhibit C (the "Alterations"), only with the prior written consent of Landlord, which, with respect to Alterations not affecting the structural components of the Premises or utility systems therein, shall not be unreasonably withheld, conditioned, or delayed. Landlord shall have thirty (30) days in which to respond to Tenant's request for any Alterations so long as such request includes the name of Tenant's contractors and reasonably detailed plans and specifications therefor. The term "Alterations" shall not include the installation of shelves, movable partitions, Tenant's equipment, and trade fixtures that may be performed without damaging existing improvements or the structural integrity of the Premises, the Building, or the Property, and Landlord's consent shall not be required for Tenant's installation or removal of those items. Tenant shall perform all work at Tenant's expense and in compliance with all applicable laws and shall complete all Alterations in accordance with plans and specifications approved by Landlord, using contractors approved by Landlord, and in a manner so as not to unreasonably interfere with other tenants. Tenant shall pay, when due, or furnish a bond for payment (as set forth in

Section 20) all claims for labor or materials furnished to or for Tenant at or for use in the Premises, which claims are or may be secured by any mechanics' or materialmens' liens against the Premises or the Property or any interest therein. Tenant shall remove all Alterations at the end of the Lease term unless Landlord conditioned its consent upon Tenant leaving a specified Alteration at the Premises, in which case Tenant shall not remove such Alteration, and it shall become Landlord's property. Tenant shall immediately repair any damage to the Premises caused by removal of Alterations.

12. REPAIRS AND MAINTENANCE; SURRENDER. Tenant shall, at its sole expense, maintain the entire Premises in good condition and promptly make all non-structural repairs and replacements necessary to keep the Premises safe and in good condition, including all HVAC components and other utilities and systems to the extent exclusively serving the Premises. Landlord shall maintain and repair the Building structure, foundation, subfloor, exterior walls, roof structure and surface, and HVAC components and other utilities and systems serving more than just the Premises, and the Common Areas, the costs of which shall be included as an Operating Cost. Tenant shall not damage any demising wall or disturb the structural integrity of the Premises, the Building, or the Property and shall promptly repair any damage or injury done to any such demising walls or structural elements caused by Tenant or its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees. Notwithstanding anything in this Section to the contrary, Tenant shall not be responsible for any repairs to the Premises made necessary by the negligence or willful misconduct of Landlord or its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees therein. If Tenant fails to perform Tenant's obligations under this Section, Landlord may at Landlord's option enter upon the Premises after ten (10) days' prior notice to Tenant and put the same in good order, condition and repair and the cost thereof together with interest thereon at the default rate set forth in Section 4 shall be due and payable as additional rent to Landlord together with Tenant's next installment of Base Rent. Upon expiration of the Lease term, whether by lapse of time or otherwise, Tenant shall promptly and peacefully surrender the Premises, together with all keys, to Landlord in as good condition as when received by Tenant from Landlord or as thereafter improved, reasonable wear and tear and insured casualty excepted.

13. ACCESS AND RIGHT OF ENTRY. After twenty-four (24) hours' notice from Landlord and during normal working hours (except in cases of emergency, when no notice shall be required), Tenant shall permit Landlord and its agents, employees and contractors to enter the Premises at all reasonable times to make repairs, inspections, alterations or improvements, provided that Landlord shall use reasonable efforts to minimize interference with Tenant's use and enjoyment of the Premises. This Section shall not impose any repair or other obligation upon Landlord not expressly stated elsewhere in this Lease. After reasonable notice to Tenant, Landlord shall have the right to enter the Premises for the purpose of (a) showing the Premises to prospective purchasers or lenders at any time, and to prospective tenants within one hundred eighty (180) days prior to the expiration or sooner termination of the Lease term; and (b) posting "for lease" signs within one hundred eighty (180) days prior to the expiration or sooner termination of the Lease term.

14. SIGNAGE. Tenant shall obtain Landlord's written consent as to size, location, materials, method of attachment, and appearance, before installing any signs within the Premises. Tenant shall install any approved signage at Tenant's sole expense and in compliance with all applicable laws. Tenant shall not damage or deface the Premises in installing or removing signage and shall repair any injury or damage to the Premises caused by such installation or removal. Landlord will be responsible for all directory and suite signage.

15. DESTRUCTION OR CONDEMNATION.

a. **Damage and Repair**. If the Premises or the portion of the Building or the Property necessary for Tenant's occupancy are partially damaged but not rendered untenantable, by fire or other insured casualty, then Landlord shall diligently restore the Premises and the portion of the Property necessary for Tenant's occupancy to the extent required below and this Lease shall not terminate. Tenant may, however, terminate the Lease if Landlord is unable to restore the Premises within six (6) months of the casualty event by giving twenty (20) days written notice of termination.

   The Premises or the portion of the Building or the Property necessary for Tenant's occupancy shall not be deemed untenantable if twenty-five percent (25%) or less of each of those areas are

damaged. If insurance proceeds are not available or are not sufficient to pay the entire cost of restoring the Premises, or if Landlord's lender does not permit all or any part of the insurance proceeds to be applied toward restoration, then Landlord may elect to terminate this Lease and keep the insurance proceeds, by notifying Tenant within sixty (60) days of the date of such casualty.

If the Premises, the portion of the Building or the Property necessary for Tenant's occupancy, or fifty percent (50%) or more of the rentable area of the Property are entirely destroyed, or partially damaged and rendered untenantable, by fire or other casualty, Landlord may, at its option: (a) terminate this Lease as provided herein, or (b) restore the Premises and the portion of the Property necessary for Tenant's occupancy to their previous condition to the extent required below; provided, however, if such casualty event occurs during the last six (6) months of the Lease term (after considering any option to extend the term timely exercised by Tenant) then either Tenant or Landlord may elect to terminate the Lease. If, within sixty (60) days after receipt by Landlord from Tenant of written notice that Tenant deems the Premises or the portion of the Property necessary for Tenant's occupancy untenantable, Landlord fails to notify Tenant of its election to restore those areas, or if Landlord is unable to restore those areas within six (6) months of the date of the casualty event, then Tenant may elect to terminate the Lease upon twenty (20) days' notice to Landlord unless Landlord, within such twenty (20) day period, notifies Tenant that it will in fact restore the Premises or actually completes such restoration work to the extent required below, as applicable.

If Landlord restores the Premises or the Property under this Section, Landlord shall proceed with reasonable diligence to complete the work, and the Rent shall be abated in the same proportion as the untenantable portion of the Premises bears to the whole Premises, provided that there shall be a Rent abatement only if the damage or destruction of the Premises or the Property did not result from, or was not contributed to directly or indirectly by the act, fault or neglect of Tenant, or Tenant's employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees. No damages, compensation or claim shall be payable by Landlord for inconvenience, loss of business or annoyance directly, incidentally or consequentially arising from any repair or restoration of any portion of the Premises or the Property. Landlord shall have no obligation to carry insurance of any kind for the protection of Tenant; any alterations or improvements paid for by Tenant; any Tenant's Work identified in Exhibit C (regardless of who may have completed them); Tenant's furniture; or on any fixtures, equipment, improvements or appurtenances of Tenant under this Lease, and Landlord's restoration obligations hereunder shall not include any obligation to repair any damage thereto or replace the same.

b. **Condemnation**. If the Premises, the portion of the Building or the Property necessary for Tenant's occupancy, or 50% or more of the rentable area of the Property are made untenantable by eminent domain, or conveyed under a threat of condemnation, this Lease shall terminate at the option of either Landlord or Tenant as of the earlier of the date title vests in the condemning authority or the condemning authority first has possession of the Premises or the portion of the Property taken by the condemning authority. All Rents and other payments shall be paid to that date.

If the condemning authority takes a portion of the Premises or of the Building or the Property necessary for Tenant's occupancy that does not render them untenantable, then this Lease shall continue in full force and effect and the Rent shall be equitably reduced based on the proportion by which the floor area of any structures is reduced. The reduction in Rent shall be effective on the earlier of the date the condemning authority first has possession of such portion or title vests in the condemning authority. The Premises or the portion of the Building or the Property necessary for Tenant's occupancy shall not be deemed untenantable if twenty-five percent (25%) or less of each of those areas are condemned. Landlord shall be entitled to the entire award from the condemning authority attributable to the value of the Premises or the Building or the Property and Tenant shall make no claim for the value of its leasehold. Tenant shall be permitted to make a separate claim against the condemning authority for moving expenses if Tenant may terminate the Lease under this Section, provided that in no event shall Tenant's claim reduce Landlord's award.

16. INSURANCE.

a. **Tenant's Liability Insurance.** During the Lease term, Tenant shall pay for and maintain commercial general liability insurance with broad form property damage and contractual liability endorsements. This policy shall name Landlord, its property manager (if any), and other parties designated by Landlord as additional insureds using an endorsement form acceptable to Landlord, and shall insure Tenant's activities and those of Tenant's employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees with respect to the Premises against loss, damage or liability for personal injury or bodily injury (including death) or loss or damage to property with a combined single limit of not less than $1,000,000, and a deductible of not more than $10,000. Tenant's insurance will be primary and noncontributory with any liability insurance carried by Landlord. Landlord may also require Tenant to obtain and maintain business income coverage for at least six (6) months, business auto liability coverage, and, if applicable to Tenant's Permitted Use, liquor liability insurance and/or warehouseman's coverage.

b. **Tenant's Property Insurance.** During the Lease term, Tenant shall pay for and maintain special form clauses of loss coverage property insurance (with coverage for earthquake if required by Landlord's lender and, if the Premises are situated in a flood plain, flood damage).for all of Tenant's personal property, fixtures and equipment in the amount of their full replacement value, with a deductible of not more than $10,000.

c. **Miscellaneous**. Tenant's insurance required under this Section shall be with companies rated A-/VII or better in Best's Insurance Guide, and which are admitted in the State in which the Premises are located. No insurance policy shall be cancelled or reduced in coverage and each such policy shall provide that it is not subject to cancellation or a reduction in coverage except after thirty (30) days prior written notice to Landlord. Tenant shall deliver to Landlord upon commencement of the Lease and from time to time thereafter, copies of the insurance policies or evidence of insurance and copies of endorsements required by this Section. In no event shall the limits of such policies be considered as limiting the liability of Tenant under this Lease. If Tenant fails to acquire or maintain any insurance or provide any policy or evidence of insurance required by this Section, and such failure continues for three (3) days after notice from Landlord, Landlord may, but shall not be required to, obtain such insurance for Landlord's benefit and Tenant shall reimburse Landlord for the costs of such insurance upon demand. Such amounts shall be Additional Rent payable by Tenant hereunder and in the event of non-payment thereof, Landlord shall have the same rights and remedies with respect to such non-payment as it has with respect to any other non-payment of Rent hereunder.

d. **Landlord's Insurance.** Landlord shall carry special form clauses of loss coverage property insurance of the Building shell and core in the amount of their full replacement value, liability insurance with respect to the Common Areas, and such other insurance of such types and amounts as Landlord, in its discretion, shall deem reasonably appropriate.

e. **Waiver of Subrogation**. Landlord and Tenant hereby release each other and any other tenant, their agents or employees, from responsibility for, and waive their entire claim of recovery for any loss or damage arising from any cause covered by property insurance required to be carried or otherwise carried by each of them. Each party shall provide notice to the property insurance carrier or carriers of this mutual waiver of subrogation, and shall cause its respective property insurance carriers to waive all rights of subrogation against the other. This waiver shall not apply to the extent of the deductible amounts to any such property policies or to the extent of liabilities exceeding the limits of such policies.

17. INDEMNIFICATION.

a. **Indemnification by Tenant**. Tenant shall defend, indemnify, and hold Landlord and its property manager (if any) harmless against all liabilities, damages, costs, and expenses, including attorneys' fees, for personal injury, bodily injury (including death) or property damage arising from any negligent or wrongful act or omission of Tenant or Tenant's employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees on or around the

Premises or the Property, or arising from any breach of this Lease by Tenant. Tenant shall use legal counsel reasonably acceptable to Landlord in defense of any action within Tenant's defense obligation.

b. **Indemnification by Landlord**. Landlord shall defend, indemnify and hold Tenant harmless against all liabilities, damages, costs, and expenses, including attorneys' fees, for personal injury, bodily injury (including death) or property damage arising from any negligent or wrongful act or omission of Landlord or Landlord's employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees on or around the Premises or the Property, or arising from any breach of this Lease by Landlord. Landlord shall use legal counsel reasonably acceptable to Tenant in defense of any action within Landlord's defense obligation.

c. **Waiver of Immunity**. Landlord and Tenant each specifically and expressly waive any immunity that each may be granted under the Washington State Industrial Insurance Act, Title 51 RCW. Neither party's indemnity obligations under this Lease shall be limited by any limitation on the amount or type of damages, compensation, or benefits payable to or for any third party under the Worker Compensation Acts, Disability Benefit Acts or other employee benefit acts.

d. **Exemption of Landlord from Liability**. Except to the extent of claims arising out of Landlord's gross negligence or intentional misconduct, Landlord shall not be liable to Tenant for injury to Tenant's business or assets or any loss of income therefrom or for damage to any property of Tenant or of its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees, or any other person in or about the Premises or the Property.

e. **Survival**. The provisions of this Section shall survive expiration or termination of this Lease.

18. ASSIGNMENT AND SUBLETTING. Tenant shall not assign, sublet, mortgage, encumber or otherwise transfer any interest in this Lease (collectively referred to as a "Transfer") or any part of the Premises, without first obtaining Landlord's written consent, which shall not be unreasonably withheld, conditioned, or delayed. No Transfer shall relieve Tenant of any liability under this Lease notwithstanding Landlord's consent to such Transfer. Consent to any Transfer shall not operate as a waiver of the necessity for Landlord's consent to any subsequent Transfer. In connection with each request for consent to a Transfer, Tenant shall pay the reasonable cost of processing same, including attorneys' fees, upon demand of Landlord, up to a maximum of $1,250.

If Tenant is a partnership, limited liability company, corporation, or other entity, any transfer of this Lease by merger, consolidation, redemption or liquidation, or any change in the ownership of, or power to vote, which singularly or collectively represents a majority of the beneficial interest in Tenant, shall constitute a Transfer under this Section.

As a condition to Landlord's approval, if given, any potential assignee or sublessee otherwise approved by Landlord shall assume all obligations of Tenant under this Lease and shall be jointly and severally liable with Tenant and any guarantor, if required, for the payment of Rent and performance of all terms of this Lease. In connection with any Transfer, Tenant shall provide Landlord with copies of all assignments, subleases and assumption agreement or documents.

19. LIENS. Tenant shall not subject the Landlord's assets to any liens or claims of lien. Tenant shall keep the Premises free from any liens created by or through Tenant. Tenant shall indemnify and hold Landlord harmless from liability for any such liens including, without limitation, liens arising from any Alterations. If a lien is filed against the Premises by any person claiming by, through or under Tenant, Tenant shall, within ten (10) days after Landlord's demand, at Tenant's expense, either remove the lien or furnish to Landlord a bond in form and amount and issued by a surety satisfactory to Landlord, indemnifying Landlord and the Premises against all liabilities, costs and expenses, including attorneys' fees, which Landlord could reasonably incur as a result of such lien.

20. DEFAULT. The following occurrences shall each constitute a default by Tenant (an "Event of Default"):

a. **Failure To Pay**. Failure by Tenant to pay any sum, including Rent, due under this Lease following seven (7) days' notice from Landlord of the failure to pay.

b. **Vacation/Abandonment**. Vacation by Tenant of the Premises (defined as an absence for at least fifteen (15) consecutive days without prior notice to Landlord), or abandonment by Tenant of the Premises (defined as an absence of five (5) days or more while Tenant is in breach of some other term of this Lease). Tenant's vacation or abandonment of the Premises shall not be subject to any notice or right to cure.

c. **Insolvency**. Tenant's insolvency or bankruptcy (whether voluntary or involuntary); or appointment of a receiver, assignee or other liquidating officer for Tenant's business; provided, however, that in the event of any involuntary bankruptcy or other insolvency proceeding, the existence of such proceeding shall constitute an Event of Default only if such proceeding is not dismissed or vacated within sixty (60) days after its institution or commencement.

d. **Levy or Execution**. The taking of Tenant's interest in this Lease or the Premises, or any part thereof, by execution or other process of law directed against Tenant, or attachment of Tenant's interest in this Lease by any creditor of Tenant, if such attachment is not discharged within fifteen (15) days after being levied.

e. **Other Non-Monetary Defaults**. The breach by Tenant of any agreement, term or covenant of this Lease other than one requiring the payment of money and not otherwise enumerated in this Section or elsewhere in this Lease, which breach continues for a period of thirty (30) days after notice by Landlord to Tenant of the breach.

f. **Failure to Take Possession**. Failure by Tenant to take possession of the Premises on the Commencement Date or failure by Tenant to commence any Tenant Improvement in a timely fashion.

21. REMEDIES. Landlord shall have the following remedies upon an Event of Default. Landlord's rights and remedies under this Lease shall be cumulative, and none shall exclude any other right or remedy allowed by law.

a. **Termination of Lease**. Landlord may terminate Tenant's interest under the Lease, but no act by Landlord other than notice of termination from Landlord to Tenant shall terminate this Lease. The Lease shall terminate on the date specified in the notice of termination. Upon termination of this Lease, Tenant will remain liable to Landlord for damages in an amount equal to the Rent and other sums that would have been owing by Tenant under this Lease for the balance of the Lease term, less the net proceeds, if any, of any reletting of the Premises by Landlord subsequent to the termination, after deducting all of Landlord's Reletting Expenses (as defined below). Landlord shall be entitled to either collect damages from Tenant monthly on the days on which rent or other amounts would have been payable under the Lease, or alternatively, Landlord may accelerate Tenant's obligations under the Lease and recover from Tenant: (i) unpaid rent which had been earned at the time of termination; (ii) the amount by which the unpaid rent which would have been earned after termination until the time of award exceeds the amount of rent loss that Tenant proves could reasonably have been avoided; (iii) the amount by which the unpaid rent for the balance of the term of the Lease after the time of award exceeds the amount of rent loss that Tenant proves could reasonably be avoided (discounting such amount by the discount rate of the Federal Reserve Bank of San Francisco at the time of the award, plus 1%); and (iv) any other amount necessary to compensate Landlord for all the detriment proximately caused by Tenant's failure to perform its obligations under the Lease, or which in the ordinary course would be likely to result from the Event of Default, including without limitation Reletting Expenses described below.

b. **Re-Entry and Reletting**. Landlord may continue this Lease in full force and effect, and without demand or notice, re-enter and take possession of the Premises or any part thereof, expel the

Tenant from the Premises and anyone claiming through or under the Tenant, and remove the personal property of either. Landlord may relet the Premises, or any part of them, in Landlord's or Tenant's name for the account of Tenant, for such period of time and at such other terms and conditions as Landlord, in its discretion, may determine. Landlord may collect and receive the rents for the Premises. To the fullest extent permitted by law, the proceeds of any reletting shall be applied: first, to pay Landlord all Reletting Expenses (defined below); second, to pay any indebtedness of Tenant to Landlord other than rent; third, to the rent due and unpaid hereunder; and fourth, the residue, if any, shall be held by Landlord and applied in payment of other or future obligations of Tenant to Landlord as the same may become due and payable, and Tenant shall not be entitled to receive any portion of such revenue. Re-entry or taking possession of the Premises by Landlord under this Section shall not be construed as an election on Landlord's part to terminate this Lease, unless a notice of termination is given to Tenant. Landlord reserves the right following any re-entry or reletting, or both, under this Section to exercise its right to terminate the Lease. Tenant will pay Landlord the Rent and other sums which would be payable under this Lease if repossession had not occurred, less the net proceeds, if any, after reletting the Premises and after deducting Landlord's Reletting Expenses. "Reletting Expenses" is defined to include all expenses incurred by Landlord in connection with reletting the Premises, including without limitation, all repossession costs, brokerage commissions and costs for securing new tenants, attorneys' fees, remodeling and repair costs, costs for removing persons or property, costs for storing Tenant's property and equipment, and costs of tenant improvements and rent concessions granted by Landlord to any new Tenant, prorated over the life of the new lease.

c. **Waiver of Redemption Rights**. Tenant, for itself, and on behalf of any and all persons claiming through or under Tenant, including creditors of all kinds, hereby waives and surrenders all rights and privileges which they may have under any present or future law, to redeem the Premises or to have a continuance of this Lease for the Lease term, or any extension thereof.

d. **Nonpayment of Additional Rent.** All costs which Tenant is obligated to pay to Landlord pursuant to this Lease shall in the event of nonpayment be treated as if they were payments of Rent, and Landlord shall have the same rights it has with respect to nonpayment of Rent.

e. **Failure to Remove Property**. If Tenant fails to remove any of its property from the Premises at Landlord's request following an uncured Event of Default, Landlord may, at its option, remove and store the property at Tenant's expense and risk. If Tenant does not pay the storage cost within five (5) days of Landlord's request, Landlord may, at its option, have any or all of such property sold at public or private sale (and Landlord may become a purchaser at such sale), in such manner as Landlord deems proper, without notice to Tenant. Landlord shall apply the proceeds of such sale: (i) to the expense of such sale, including reasonable attorneys' fees actually incurred; (ii) to the payment of the costs or charges for storing such property; (iii) to the payment of any other sums of money which may then be or thereafter become due Landlord from Tenant under any of the terms hereof; and (iv) the balance, if any, to Tenant. Nothing in this Section shall limit Landlord's right to sell Tenant's personal property as permitted by law or to foreclose Landlord's lien for unpaid rent.

22. MORTGAGE SUBORDINATION AND ATTORNMENT. This Lease shall automatically be subordinate to any mortgage or deed of trust created by Landlord which is now existing or hereafter placed upon the Premises including any advances, interest, modifications, renewals, replacements or extensions ("Landlord's Mortgage"). Tenant shall attorn to the holder of any Landlord's Mortgage or any party acquiring the Premises at any sale or other proceeding under any Landlord's Mortgage provided the acquiring party assumes the obligations of Landlord under this Lease. Tenant shall promptly and in no event later than fifteen (15) days after request execute, acknowledge and deliver documents which the holder of any Landlord's Mortgage may reasonably require as further evidence of this subordination and attornment. Notwithstanding the foregoing, Tenant's obligations under this Section to subordinate in the future are conditioned on the holder of each Landlord's Mortgage and each party acquiring the Premises at any sale or other proceeding under any such Landlord's Mortgage not disturbing Tenant's occupancy and other rights under this Lease, so long as no uncured Event of Default by Tenant exists.

23. NON-WAIVER. Landlord's waiver of any breach of any provision contained in this Lease shall not be deemed to be a waiver of the same provision for subsequent acts of Tenant. The acceptance by Landlord of Rent or other amounts due by Tenant hereunder shall not be deemed to be a waiver of any previous breach by Tenant.

24. HOLDOVER. If Tenant shall, without the written consent of Landlord, remain in possession of the Premises and fail to return them to Landlord after the expiration or termination of this Lease, the tenancy shall be a holdover tenancy and shall be on a month-to-month basis, which may be terminated according to Washington law. During such tenancy, Tenant agrees to pay to Landlord 150% of the rate of rental last payable under this Lease, unless a different rate is agreed upon by Landlord. All other terms of the Lease shall remain in effect. Tenant acknowledges and agrees that this Section does not grant any right to Tenant to holdover, and that Tenant may also be liable to Landlord for any and all damages or expenses which Landlord may have to incur as a result of Tenant's holdover.

25. NOTICES. All notices under this Lease shall be in writing and effective (i) when delivered in person or via overnight courier to the other party, (ii) three (3) days after being sent by registered or certified mail to the other party at the address set forth in Section 1; or (iii) upon confirmed transmission by facsimile to the other party at the facsimile numbers set forth in Section 1. The addresses for notices and payment of rent set forth in Section 1 may be modified by either party only by written notice delivered in conformance with this Section.

26. COSTS AND ATTORNEYS' FEES. If Tenant or Landlord engage the services of an attorney to collect monies due or to bring any action for any relief against the other, declaratory or otherwise, arising out of this Lease, including any suit by Landlord for the recovery of Rent or other payments, or possession of the Premises, the losing party shall pay the prevailing party a reasonable sum for attorneys' fees in such action, whether in mediation or arbitration, at trial, on appeal, or in any bankruptcy proceeding.

27. ESTOPPEL CERTIFICATES. Tenant shall, from time to time, upon written request of Landlord, execute, acknowledge and deliver to Landlord or its designee a written statement specifying the following, subject to any modifications necessary to make such statements true and complete: (i) the total rentable square footage of the Premises; (ii) the date the Lease term commenced and the date it expires; (iii) the amount of minimum monthly Rent and the date to which such Rent has been paid; (iv) that this Lease is in full force and effect and has not been assigned, modified, supplemented or amended in any way; (v) that this Lease represents the entire agreement between the parties; (vi) that all obligations under this Lease to be performed by either party have been satisfied; (vii) that there are no existing claims, defenses or offsets which the Tenant has against the enforcement of this Lease by Landlord; (viii) the amount of Rent, if any, that Tenant paid in advance; (ix) the amount of security that Tenant deposited with Landlord; (x) if Tenant has sublet all or a portion of the Premises or assigned its interest in the Lease and to whom; (xi) if Tenant has any option to extend the Lease or option to purchase the Premises; and (xii) such other factual matters concerning the Lease or the Premises as Landlord may reasonably request. Tenant acknowledges and agrees that any statement delivered pursuant to this Section may be relied upon by a prospective purchaser of Landlord's interest or assignee of any mortgage or new mortgagee of Landlord's interest in the Premises. If Tenant shall fail to respond within ten (10) days to Landlord's request for the statement required by this Section, Landlord may provide the statement and Tenant shall be deemed to have admitted the accuracy of the information provided by Landlord.

28. TRANSFER OF LANDLORD'S INTEREST. This Lease shall be assignable by Landlord without the consent of Tenant. In the event of any transfer or transfers of Landlord's interest in the Premises, other than a transfer for collateral purposes only, upon the assumption of this Lease by the transferee, Landlord shall be automatically relieved of obligations and liabilities accruing from and after the date of such transfer, including any liability for any retained security deposit or prepaid rent, for which the transferee shall be liable, and Tenant shall attorn to the transferee.

29. LANDLORD'S LIABILITY. Anything in this Lease to the contrary notwithstanding, covenants, undertakings and agreements herein made on the part of Landlord are made and intended not as personal covenants, undertakings and agreements for the purpose of binding Landlord personally or the assets of Landlord but are made and intended for the purpose of binding only the Landlord's interest in the Premises,

as the same may from time to time be encumbered. In no event shall Landlord or its partners, shareholders, or members, as the case may be, ever be personally liable hereunder.

30. RIGHT TO PERFORM. If Tenant shall fail to timely pay any sum or perform any other act on its part to be performed hereunder, Landlord may make any such payment or perform any such other act on Tenant's behalf. Tenant shall, within ten (10) days of demand, reimburse Landlord for its expenses incurred in making such payment or performance. Landlord shall (in addition to any other right or remedy of Landlord provided by law) have the same rights and remedies in the event of the nonpayment of sums due under this Section as in the case of default by Tenant in the payment of Rent.

31. HAZARDOUS MATERIAL. As used herein, the term "Hazardous Material" means any hazardous, dangerous, toxic or harmful substance, material or waste including biomedical waste which is or becomes regulated by any local governmental authority, the State of Washington or the United States Government, due to its potential harm to the health, safety or welfare of humans or the environment. Landlord represents and warrants to Tenant that, to Landlord's knowledge without duty of investigation, there is no Hazardous Material on, in, or under the Premises as of the Commencement Date except as may otherwise have been disclosed to Tenant in writing before the execution of this Lease. If there is any Hazardous Material on, in, or under the Premises as of the Commencement Date which has been or thereafter becomes unlawfully released through no fault of Tenant, then Landlord shall indemnify, defend and hold Tenant harmless from any and all claims, judgments, damages, penalties, fines, costs, liabilities or losses including without limitation sums paid in settlement of claims, attorneys' fees, consultant fees and expert fees, incurred or suffered by Tenant either during or after the Lease term as the result of such contamination.

Tenant shall not cause or permit any Hazardous Material to be brought upon, kept, or used in or about, or disposed of on the Premises or the Property by Tenant, its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees, except with Landlord's prior consent and then only upon strict compliance with all applicable federal, state and local laws, regulations, codes and ordinances. If Tenant breaches the obligations stated in the preceding sentence, then Tenant shall indemnify, defend and hold Landlord harmless from any and all claims, judgments, damages, penalties, fines, costs, liabilities or losses including, without limitation, diminution in the value of the Premises or the Property; damages for the loss or restriction on use of rentable or usable space or of any amenity of the Premises or the Property, or elsewhere; damages arising from any adverse impact on marketing of space at the Premises or the Property; and sums paid in settlement of claims, attorneys' fees, consultant fees and expert fees incurred or suffered by Landlord either during or after the Lease term. These indemnifications by Landlord and Tenant include, without limitation, costs incurred in connection with any investigation of site conditions or any clean-up, remedial, removal or restoration work, whether or not required by any federal, state or local governmental agency or political subdivision, because of Hazardous Material present in the Premises, or in soil or ground water on or under the Premises. Tenant shall immediately notify Landlord of any inquiry, investigation or notice that Tenant may receive from any third party regarding the actual or suspected presence of Hazardous Material on the Premises.

Without limiting the foregoing, if the presence of any Hazardous Material brought upon, kept or used in or about the Premises or the Property by Tenant, its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees, results in any unlawful release of any Hazardous Materials on the Premises or the Property, Tenant shall promptly take all actions, at its sole expense, as are necessary to return the Premises or the Property to the condition existing prior to the release of any such Hazardous Material; provided that Landlord's approval of such actions shall first be obtained, which approval may be withheld at Landlord's sole discretion. The provisions of this Section shall survive expiration or termination of this Lease.

32. QUIET ENJOYMENT. So long as Tenant pays the Rent and performs all of its obligations in this Lease, Tenant's possession of the Premises will not be disturbed by Landlord or anyone claiming by, through or under Landlord.

33. MERGER. The voluntary or other surrender of this Lease by Tenant, or a mutual cancellation thereof, shall not work a merger and shall, at the option of Landlord, terminate all or any existing subtenancies or may, at the option of Landlord, operate as an assignment to Landlord of any or all of such subtenancies.

34. GENERAL.

a. **Heirs and Assigns**. This Lease shall apply to and be binding upon Landlord and Tenant and their respective heirs, executors, administrators, successors and assigns.

b. **Brokers' Fees**. Tenant represents and warrants to Landlord that except for Tenant's Broker, if any, described and disclosed in Section 37 of this Lease, it has not engaged any broker, finder or other person who would be entitled to any commission or fees for the negotiation, execution or delivery of this Lease and shall indemnify and hold harmless Landlord against any loss, cost, liability or expense incurred by Landlord as a result of any claim asserted by any such broker, finder or other person on the basis of any arrangements or agreements made or alleged to have been made by or on behalf of Tenant. Landlord represents and warrants to Tenant that except for Landlord's Broker, if any, described and disclosed in Section 37 of this Lease, it has not engaged any broker, finder or other person who would be entitled to any commission or fees for the negotiation, execution or delivery of this Lease and shall indemnify and hold harmless Tenant against any loss, cost, liability or expense incurred by Tenant as a result of any claim asserted by any such broker, finder or other person on the basis of any arrangements or agreements made or alleged to have been made by or on behalf of Landlord.

c. **Entire Agreement.** This Lease contains all of the covenants and agreements between Landlord and Tenant relating to the Premises. No prior or contemporaneous agreements or understandings pertaining to the Lease shall be valid or of any force or effect and the covenants and agreements of this Lease shall not be altered, modified or amended except in writing, signed by Landlord and Tenant.

d. **Severability**. Any provision of this Lease which shall prove to be invalid, void or illegal shall in no way affect, impair or invalidate any other provision of this Lease.

e. **Force Majeure**. Time periods for either party's performance under any provisions of this Lease (excluding payment of Rent) shall be extended for periods of time during which the party's performance is prevented due to circumstances beyond such party's control, including without limitation, fires, floods, earthquakes, lockouts, strikes, embargoes, governmental regulations, acts of God, public enemy, war or other strife.

f. **Governing Law**. This Lease shall be governed by and construed in accordance with the laws of the State of Washington.

g. **Memorandum of Lease**. Neither this Lease nor any memorandum or "short form" thereof shall be recorded without Landlord's prior consent.

h. **Submission of Lease Form Not an Offer**. One party's submission of this Lease to the other for review shall not constitute an offer to lease the Premises. This Lease shall not become effective and binding upon Landlord and Tenant until it has been fully signed by both of them.

i. **No Light, Air or View Easement.** Tenant has not been granted an easement or other right for light, air or view to or from the Premises. Any diminution or shutting off of light, air or view by any structure which may be erected on or adjacent to the Building shall in no way effect this Lease or the obligations of Tenant hereunder or impose any liability on Landlord.

j. **Authority of Parties.** Each party signing this Lease represents and warrants to the other that it has the authority to enter into this Lease, that the execution and delivery of this Lease has been duly authorized, and that upon such execution and delivery, this Lease shall be binding upon and enforceable against the party on signing.

k. **Time**. "Day" as used herein means a calendar day and "business day" means any day on which commercial banks are generally open for business in the state where the Premises are situated. Any period of time which would otherwise end on a non-business day shall be extended to the next following business day. Time is of the essence of this Lease.

35. EXHIBITS AND RIDERS. The following exhibits and riders are made a part of this Lease, and the terms thereof shall control over any inconsistent provision in the sections of this Lease:

Exhibit A Floor Plan/Outline of the Premises
Exhibit B Legal Description of the Property
Exhibit C Tenant Work Letter
Exhibit D Commencement Date Memorandum
Exhibit E Rules and Regulations

CHECK THE BOX FOR ANY OF THE FOLLOWING THAT WILL APPLY. CAPITALIZED TERMS USED IN THE RIDERS SHALL HAVE THE MEANING GIVEN TO THEM IN THE LEASE.
☒Rent Rider
☐Arbitration Rider
☐Letter of Credit Rider
☒Parking Rider
☒Option to Extend Rider
☐Guaranty of Tenant's Lease Obligations Rider

36. AGENCY DISCLOSURE. At the signing of this Lease, Landlord is represented by **Derek Heed of Colliers International** (the "Landlord's Broker"), and Tenant is represented by **Jordan Siek of Kidder Mathews** (the "Tenant's Broker").

This Agency Disclosure creates an agency relationship between Landlord, Landlord's Broker (if any such person is disclosed), and any managing brokers who supervise Landlord's Broker's performance (collectively the "Supervising Brokers"). In addition, this Agency Disclosure creates an agency relationship between Tenant, Tenant's Broker (if any such person is disclosed), and any managing brokers who supervise Tenant's Broker's performance (also collectively the "Supervising Brokers"). If Tenant's Broker and Landlord's Broker are different real estate licensees affiliated with the same Firm, then both Tenant and Landlord confirm their consent to that Firm and both Tenant's and Landlord's Supervising Brokers acting as dual agents. If Tenant's Broker and Landlord's Broker are the same real estate licensee who represents both parties, then both Landlord and Tenant acknowledge that the Broker, his or her Supervising Brokers, and his or her Firm are acting as dual agents and hereby consent to such dual agency. If Tenants' Broker, Landlord's Broker, their Supervising Brokers, or their Firm are dual agents, Landlord and Tenant consent to Tenant's Broker, Landlord's Broker and their Firm being compensated based on a percentage of the rent or as otherwise disclosed on the attached addendum. Neither Tenant's Broker, Landlord's Broker nor either of their Firms are receiving compensation from more than one party to this transaction unless otherwise disclosed on an attached addendum, in which case Landlord and Tenant consent to such compensation. Landlord and Tenant confirm receipt of the pamphlet entitled "The Law of Real Estate Agency."

37. COMMISSION AGREEMENT. If Landlord has not entered into a listing agreement (or other compensation agreement with Landlord's Broker), Landlord agrees to pay a commission to Landlord's Broker (as identified in the Agency Disclosure paragraph above) as follows:

☐ $
☐ _____% of the gross rent payable pursuant to the Lease
☒ Other **$1.00/SF/Yr to Tenant's Broker; $0.50/SF/Yr to Landlord's Broker less any free rent**

Landlord's Broker ☐shall ☐shall not (shall not if not filled in) be entitled to a commission upon the extension by Tenant of the Lease term pursuant to any right reserved to Tenant under the Lease calculated ☐as provided above or ☐as follows _____ (if no box is checked,

as provided above). Landlord's Broker ☐shall ☐shall not (shall not if not filled in) be entitled to a commission upon any expansion of the Premises pursuant to any right reserved to Tenant under the Lease, calculated as provided above or as follows _____ (if no box is checked, as provided above).

Any commission shall be earned upon execution of this Lease, and paid one-half upon execution of the Lease and one-half upon occupancy of the Premises by Tenant. Landlord's Broker shall pay to Tenant's Broker (as identified in the Agency Disclosure paragraph above) the amount stated in a separate agreement between them or, if there is no agreement, $**0.00** or _____% (complete only one) of any commission paid to Landlord's Broker, within five (5) days after receipt by Landlord's Broker.

If any other lease or sale is entered into between Landlord and Tenant pursuant to a right reserved to Tenant under the Lease, Landlord ☐shall ☐shall not (shall not if not filled in) pay an additional commission according to any commission agreement or, in the absence of one, according to the commission schedule of Landlord's Broker in effect as of the execution of this Lease. Landlord's successor shall be obligated to pay any unpaid commissions upon any transfer of this Lease and any such transfer shall not release the transferor from liability to pay such commissions.

38. BROKER PROVISIONS.

LANDLORD'S BROKER, TENANT'S BROKER AND THEIR FIRMS HAVE MADE NO REPRESENTATIONS OR WARRANTIES CONCERNING THE PREMISES; THE MEANING OF THE TERMS AND CONDITIONS OF THIS LEASE; LANDLORD'S OR TENANT'S FINANCIAL STANDING; ZONING OR COMPLIANCE OF THE PREMISES WITH APPLICABLE LAWS; SERVICE OR CAPACITY OF UTILITIES; OPERATING COSTS; OR HAZARDOUS MATERIALS. LANDLORD AND TENANT ARE EACH ADVISED TO SEEK INDEPENDENT LEGAL ADVICE ON THESE AND OTHER MATTERS ARISING UNDER THIS LEASE.

IN WITNESS WHEREOF, this Lease has been executed the date and year first above written.

GJR REIH II, LLC, a Washington Limited Liability Company Washington	Eden Home Health of King County, LLC, a Limited Liability Company by its Manager, EmpRes Healthcare Management, LLC
LANDLORD	**TENANT**
LANDLORD (Signature)	**TENANT (Signature)**
Gary Rubens **BY**	Brent Weil **BY**
Manager **ITS**	CEO **ITS**

State of Washington)
) ss.
County of King)

On this 22nd day of January, 2019 before me personally appeared before me Gary Rubens, to me known to be the Manager of GJR REIH II, the L.L.C. that executed the within and foregoing instrument and acknowledged that he signed the same as his free and voluntary act and deed, for the uses and purposes therein mentioned an on oath stating that he is authorized to execute said instrument.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed by official seal the day and year first written above.

Kendra Mills
(Signature of Notary)

Kendra MILLS
(Legibly Print or Stamp Name of Notary)

Notary public in and for the state of Washington
Residing at Issaquah
My appointment expires 10-2-19.

KENDRA MILLS NOTARY PUBLIC STATE OF WASHINGTON COMMISSION EXPIRES 10-02-19

State of Utah)
) ss.
County of King)

On this 17 day of January, 2019 before me personally appeared before me Brent Weil, to me known to be the CEO of EmpRes Healthcare Management, LLC, a Washington Limited Liability Company Manager of Eden Home Health of King County, LLC, a Washington Limited Liability Company that executed the within and foregoing instrument and acknowledged that he signed the same as his free and voluntary act and deed, for the uses and purposes therein mentioned an on oath stating that he is authorized to execute said instrument.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed by official seal the day and year first written above.

Brooke Nicole Barraza
(Signature of Notary)

Brooke Nicole Barraza
(Legibly Print or Stamp Name of Notary)

Notary public in and for the state of Utah
Residing at Ogden
My appointment expires 10/19/21.

NOTARY PUBLIC
BROOKE NICOLE BARRAZA
697693
COMMISSION EXPIRES
OCTOBER 19, 2021
STATE OF UTAH

EXHIBIT A
[Floor Plan/Outline of the Premises]

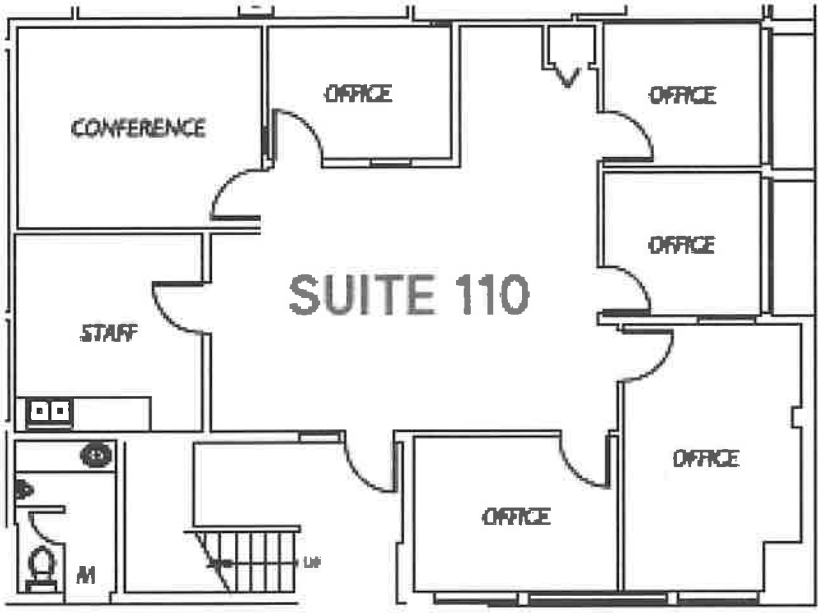


EXHIBIT B
[Legal Description of the Property]

LEGAL DESCRIPTION

PARKADE PLAZA, KIRKLAND, WASHINGTON

PARCEL A:

Lots 8 through 15 inclusive. Block 225. Supplementary Plat to Kirkland, according to the plat thereof recorded in Volume 8 of Plats, Page 5, records of King County, Washington.

PARCEL B:

Lots 1 and 2,. Block 186, Town of Kirkland, according to the plat thereof recorded in Volume 6 of Plats, Page 53, records of King County, Washington.

Together with that portion of Lot 3 and Lot 21, Block 186, of said plat described as follows:

Beginning at the northeasterly corner of said Lot 3:
thence westerly along the northerly line of said Lot 3, a distance of 24.00 feet;
thence south parallel to the easterly line of said Lot 3 a distance of 124.75 feet to the northerly margin of Central Way as conveyed 80 feet in width;
thence northeasterly along said northerly margin to the southeasterly corner of said Lot 3;
thence north along the easterly line of said Lot 3 to the true point of beginning;

(Being known as Lots A and B of City of Kirkland Short Plat No. 78-6-22. recorded under Recording No. 7806270925, records of King County, Washington).

Both situate in the County of King, State of Washington.

EXHIBIT C
[Tenant Work Letter]

Landlord will provide the following initial tenant improvements, at Landlord's sole cost (i) new paint (Tenant to select color); (ii) repair and patch wall prior to painting; (iii) professionally clean carpet and kitchen: and (iv) replace ceiling tiles. Tenant accepts the Premises in its current, "as is" condition, subject to Landlord's construction of the initial tenant improvements. It shall be Tenant's obligation to determine whether the Premises comply with the applicable governmental regulations with regard to Tenant's intended use. Tenant acknowledges that (i) neither Landlord nor any of its employees or agents has made any representations regarding the Premises or the suitability of the Premises for any particular use or the condition thereof; and (ii) except for the Improvements, Landlord has no obligation to perform any work, supply any materials, incur any expense, or make any alterations or improvements to prepare the Premises for Tenant's occupancy.

EXHIBIT D
[Commencement Date Memorandum Form]

This Letter is an amendment to the Lease for space in Parkade Plaza in Kirkland, Washington, executed on the _____ day of _____, 20__ between **GJR REIH II, LLC, a Washington Limited Liability Company**, as Landlord, and **EmpRes Healthcare Management, LLC, a Washington Limited Liability Company, dba Eden Home Health of King County, LLC, a Washington Limited Liability Company,** as Tenant.

Landlord and Tenant agree that:

1. The Premises consists of 1,576 square feet of net rentable area.

2. Except for those items shown on the attached "punch list", if any, which Landlord will remedy within ____ days hereof, Landlord has fully completed the construction work required under the terms of the Lease.

3. The Premises are tenantable, the Landlord has no further obligation for construction (except as specified above), and Tenant acknowledges that both the Building and the Premises are satisfactory in all respects.

4. The Commencement Date of the Lease is agreed to be the _____ day of _____, 20__.

5. The Expiration Date of the Lease is agreed to be the _____ day of _____, 20__.

All other terms and conditions of the Lease are ratified and acknowledged to be unchanged.

Agreed and executed this _____ day of _____, 20___.

ACKNOWLEDGED AND AGREED:	**ACKNOWLEDGED AND AGREED:**
LANDLORD: GJR REIH II, LLC, a Washington Limited Liability Company Washington	**TENANT: Eden Home Health of King County, LLC, a Limited Liability Company, by its Manager EmpRes Healthcare Management, LLC**
By_____	By_____
Name_____	Name Brent Weil
Its_____	Its CEO
Dated: _____	Dated: 1/17/2019

EXHIBIT E
[Rules and Regulations]

1. No sign, placard, picture, advertisement, name or notice shall be installed or displayed on any part of the outside or inside of the Building or Land without the prior written consent of the Landlord. Landlord shall have the right to remove, at Tenant's expense and without notice, any sign installed or displayed in violation of this rule. All approved signs or lettering on doors and walls shall be printed, painted, affixed or inscribed at the expense of Tenant by a person with the appropriate experience performing such work.

2. If Landlord objects in writing to any curtains, blinds, shades, screens or hanging plants or other similar objects attached to or used in connection with any window or door of the Premises, Tenant shall immediately discontinue such use. No awning shall be permitted on any part of the Premises. Tenant shall not place anything against or near glass partitions or doors or windows which may appear unsightly from outside the Premises.

3. Tenant shall not obstruct any sidewalk, halls, passages, exits, entrances, elevators, escalators, or stairways of the Building. The halls, passages, exits, entrances, elevators, escalators and stairways are not open to the general public. Landlord shall in all cases retain the right to control and prevent access to such areas of all persons whose presence in the judgment of Landlord would be prejudicial to the safety, character, reputation and interest of the Land, Building and the Building's tenants; provided that, nothing in this Lease contained shall be construed to prevent such access to persons with whom any Tenant normally deals in the ordinary course of its business, unless such persons are engaged in illegal activities. Tenant shall not go upon the roof of the Building.

4. The directory of the Building will be provided exclusively for the display of the name and location of tenants only, and Landlord reserves the right to exclude any other names there from.

5. Landlord will furnish Tenant, free of charge, two (2) keys to each door lock in the Premises. Landlord may make a reasonable charge for any additional keys. Tenant shall not make or have made additional keys, and Tenant shall not alter any lock or install a new additional lock or bolt on any door of its Premises. Tenant, upon the termination of its tenancy, shall deliver to Landlord the keys of all doors which have been furnished to Tenant, and in the event of loss of any keys so furnished, shall pay Landlord therefor.

6. HVAC service shall be provided to the Premises Monday through Friday from 7:00 a.m. to 6:00 p.m. After-hours HVAC usage will be charged to Tenant.

7. If Tenant requires Telecommunication Services, computer circuits, burglar alarm or similar services or other utility services, it shall first obtain Landlord's approval of the construction or installation of such services. Application for such services shall be made in accordance with the procedure prescribed by Landlord in the Lease.

8. Tenant shall not place a load upon any floor of the Premises which exceeds the load per square foot which such floor was designed to carry and which is allowed by Government Requirements. Landlord shall have the right to, within reason, prescribe the weight, size and position of all equipment, materials, furniture or other property brought into the Building. Heavy objects shall, if considered necessary by Landlord, stand on such platforms as determined by Landlord to be necessary to properly distribute the weight. Business machines and mechanical equipment belonging to Tenant, which cause noise or vibration that may be transmitted to the structure of the Building or to any space in the Building or to any other tenant in the Building, shall be placed and maintained by Tenant, at Tenant's expense, on vibration eliminators or other devices sufficient to eliminate noise or vibration. The persons employed to move such equipment in or out of the Building must be acceptable to Landlord. Landlord will not be responsible for loss of, or damage to, any such equipment or other property from any cause, and all damage done to the Building by maintaining or moving such equipment or other property shall be repaired at the expense of Tenant.

9. Tenant shall not use or keep in the Premises any kerosene, gasoline or inflammable or combustible fluid or material other than those limited quantities permitted by the Lease. Tenant shall not use or permit to be used in the Premises any foul or noxious gas or substance, or permit or allow the Premises to be occupied or used in a manner offensive or objectionable to Landlord or other occupants of the Building by reason of noise, odors or vibrations nor shall Tenant bring into or keep in or about the Premises any birds or animals.

10. Tenant shall not use any method of heating or air conditioning other than that supplied by Landlord.

11. Tenant shall not waste any utility provided by Landlord and agrees to cooperate fully with Landlord to assure the most effective operation of the Building's heating and air conditioning and to comply with any governmental energy-saving rules, laws or regulations of which Tenant has actual notice.

12. Landlord reserves the right, exercisable without notice and without liability to Tenant, to change the name and street address of the Building.

13. Landlord reserves the right to exclude from the Building between the hours of 6 p.m. and 7 a.m. the following day, or such other hours as may be established from time to time by Landlord, and on Sundays and legal holidays, any person other than Tenant's employees. Tenant shall be responsible for all persons for whom it requests passes and shall be liable to Landlord for all acts of such persons. Landlord shall not be liable for damages for any error with regard to the admission to or exclusion from the Building of any person. Landlord reserves the right to prevent access to the Building in case of invasion, mob, riot, public excitement or other commotion by closing the doors or by other appropriate action.

14. Tenant shall close and lock the doors of its Premises and entirely shut off all water faucets or other water apparatus, and electricity, gas or air outlets before Tenant and its employees leave the Premises. Tenant shall be responsible for any damage or injuries sustained by other tenants or occupants of the Building or by Landlord for noncompliance with this rule.

15. The toilet rooms, toilets, urinals, wash bowls and other apparatus shall not be used for any purpose other than that for which they were constructed. The expenses of any breakage, stoppage or damage resulting from the violation or this rule shall be borne by Tenant if it or its employees or invitees shall have caused it.

16. Tenant shall not sell, or permit the sale at retail, of newspapers, magazines, periodicals, theater tickets or any other goods or merchandise to the general public in or on the Premises other than the products that the Tenant markets. Tenant shall not make any room-to-room solicitation of business from other tenants in the Building. Tenant shall not use the Premises for any business or activity other than that specifically provided for in the Lease.

17. Tenant shall not install any radio or television antenna, loudspeaker or other device on the roof or exterior walls of the Building. Tenant shall not interfere with radio or television broadcasting or reception from or in the Building or elsewhere. Other than the usual and customary cellular telephones, Tenant shall not install or utilize any wireless Telecommunication Facilities, including antenna and satellite receiver dishes within the Premises or on, in, or about the Building without first obtaining Landlord's prior written consent and Landlord at its option may require the entry of a supplemental agreement with respect to such construction or installation. Tenant shall comply with all instructions for installation and shall pay or shall cause to be paid the entire cost of such installations. Application for such facilities shall be made in the same manner and shall be subject to the same requirements as specified for Telecommunication Services and Telecommunication Facilities in the paragraph of the Lease entitled "Utilities". Supplemental rules and regulations may be promulgated by Landlord specifying the form of and information to be included with the application and establishing procedures, regulations, and controls with respect to the installation and use of such wireless Telecommunication Facilities.

18. Tenant shall not mark, drive nails, screws or drill into the partitions, woodwork or plaster or in any way deface the Premises unless hanging customary fixtures such as pictures, signs and other commercially reasonable items. Landlord reserves the right to direct electricians as to where and how telephone and telegraph wires are to be introduced to the Premises. Tenant shall not cut or bore holes for wires. Tenant shall not affix any floor covering to the floor of the Premises in any manner except as approved by Landlord. Tenant shall repair any damage resulting from noncompliance with this rule.

19. Tenant shall not install, maintain or operate upon the Premises any vending machine without the written consent of Landlord.

20. Canvassing, soliciting and distribution of handbills or any other written material, and peddling in the Building or Land are prohibited, and Tenant shall cooperate to prevent the same.

21. Landlord reserves the right to exclude or expel from the Building and Land any person who, in Landlord's judgment, is intoxicated, under the influence of liquor or drugs or in violation of any of these Rules and Regulations.

22. Tenant shall store all of its trash and garbage within the Premises. Tenant shall not place in any trash box or receptacle any material which cannot be disposed of in the ordinary and customary manner of trash and garbage disposal. All garbage and refuse disposal shall be made in accordance with directions issued from time to time by Landlord.

23. The Premises shall not be used for lodging or any improper or immoral or objectionable purpose. No cooking shall be done or permitted by Tenant, except that use by Tenant of Underwriters' Laboratory approved equipment for brewing coffee, tea, hot chocolate and similar beverages shall be permitted and the use of a microwave oven; provided that, such equipment and its use is in accordance with all Governmental Requirements.

24. Tenant shall not use in the Premises or in the public halls of the Building any hand truck except those equipped with rubber tires and side guards or such other material-handling equipment as Landlord may approve. Tenant shall not bring any other vehicles of any kind into the Building.

25. Without the prior written consent of Landlord, Tenant shall not use the name of the Building in connection with or in promoting or advertising the business of Tenant except as Tenant's address.

26. Tenant shall comply with all safety, fire protection and evacuation procedures and regulations established by Landlord or any governmental agency.

27. Tenant assumes any and all responsibility for protecting the Premises from theft, robbery and pilferage, which includes keeping doors locked and other means of entry to the Premises closed.

28. The requirements of Tenant will be attended to only upon appropriate application to the Manager of the Building by an authorized individual. Employees of Landlord are not required to perform any work or do anything outside of their regular duties unless under special instructions from Landlord, and no employee of Landlord is required to admit Tenant to any space other than the Premises without specific instructions from Landlord.

29. Tenant shall not park its vehicles in any parking areas designated by Landlord as areas for parking by visitors to the Building or Land. Tenant shall not leave vehicles in the parking areas overnight nor park any vehicles in the Building parking areas other than automobiles, motorcycles, motor driven or non-motor driven bicycles or four-wheeled trucks.

30. Landlord may waive any one or more of these Rules and Regulations for the benefit of Tenant or any other tenant, but no such waiver by Landlord shall be construed as a waiver of such Rules

and Regulations in favor of any other person, nor prevent Landlord from thereafter revoking such waiver and enforcing any such Rules and Regulations against any or all of the tenants of the Building.

31. These Rules and Regulations are in addition to, and shall not be construed to in any way modify or amend, in whole or in part, the covenants and conditions of any lease of premises in the Building. If any provision of these Rules and Regulations conflicts with any provision of the Lease, the terms of the Lease shall prevail.

32. Landlord reserves the right to make such other and reasonable Rules and Regulations as, in its judgment, may from time to time be needed for safety and security, the care and cleanliness of the Building and Land, the preservation of good order in the Building and the maintenance or enhancement of the value of the Building as a rental property. Tenant agrees to abide by all the Rules and Regulations stated in this exhibit and any additional rules and regulations which are so made by Landlord.

33. Tenant shall be responsible for the observance of all of the foregoing rules by Tenant and Tenant's Agents.

RENT RIDER

This Rent Rider ("Rider") is made part of the Lease Agreement dated **December 26, 2018** (the "Lease"), between **GJR REIH II, LLC, a Washington Limited Liability Company** ("Landlord"), and **EmpRes Healthcare Management, LLC, a Washington Limited Liability Company, dba Eden Home Health of King County, LLC, a Washington Limited Liability Company** ("Tenant") concerning the space commonly known as **733 7th Avenue, Suite 110, Kirkland, WA 98033** (the "Premises"), located at the property commonly known as **Parkade Plaza** (the "Property").

☒ **1. BASE MONTHLY RENT SCHEDULE.** Tenant shall pay Landlord base monthly rent during the Lease Term according to the following schedule:

Lease Term	Base Monthly Rent Amount
February 1, 2019– February 28, 2019	$0.00 per month
March 1, 2019 – January 31, 2020	$4,005.67 per month
February 1 2020 – January 31, 2021	$4,137.00 per month
February 1, 2021 – January 31, 2022	$4,268.33 per month
February 1, 2022 – February 28, 2022	$4,399.67 per month

PARKING RIDER

This Parking Rider (the "Rider") is made part of the Lease Agreement dated **December 26, 2018** (the "Lease"), between **GJR REIH II, LLC, a Washington Limited Liability Company** ("Landlord"), and **EmpRes Healthcare Management, LLC, a Washington Limited Liability Company, dba Eden Home Health of King County, LLC, a Washington Limited Liability Company** ("Tenant") concerning the space commonly known as **733 7th Avenue, Suite 110, Kirkland, WA 98033** (the "Premises"), located at the property commonly known as **Parkade Plaza** (the "Property").

1. Tenant's Parking Rights. Tenant's right to park on the Property shall be as follows (check one):

☐ Tenant shall be entitled to use parking stalls on the Property or other designated parking area on a (check one) reserved unreserved (unreserved, if neither box checked) basis at the prevailing monthly rate established by Landlord from time to time. Tenant shall comply with the reasonable rules and regulations which Landlord or its parking operator may adopt from time to time for the safe and orderly operation of the parking areas.

☒ **Free Parking.** Tenant shall be entitled to share parking with Landlord's other tenants in the designated parking areas at no charge at a ratio of 2.8 parking stalls for every 1,000 square feet leased. Tenant shall be responsible for ensuring compliance with the terms of the Lease, this Rider, and any reasonable rules and regulations adopted by Landlord from time to time for the safe and orderly sharing of parking.

☐ **No Parking.** The Lease does not include parking on the Property, and Tenant shall park off the Property at Tenant's own expense.

2. Tenant. For purpose of this Rider only, the term "Tenant" shall include Tenant and Tenant's employees, officers, contractors, licensees, agents, and invitees, except as follows:

_____
_____
_____

OPTION TO EXTEND RIDER

This Option to Extend Rider (the "Rider") is made part of the Lease Agreement dated **December 10, 2018** (the "Lease"), between **GJR REIH II, LLC, a Washington Limited Liability Company** ("Landlord"), and **EmpRes Healthcare Management, LLC, a Washington Limited Liability Company, dba Eden Home Health of King County, LLC, a Washington Limited Liability Company** ("Tenant") concerning the space commonly known as **733 7th Avenue, Suite 110, Kirkland, WA 98033** (the "Premises"), located at the property commonly known as **Parkade Plaza** (the "Property").

1. **Extension of Lease.** Provided Tenant is not in default of any provision of the Lease at the time that Tenant exercises the right to extend the Lease or at the time the new term begins, Tenant shall have one (1) (zero if not completed) successive option to extend the term of the Lease for three (3) years. The term of the Lease shall be extended on the same terms, conditions and covenants set forth in the Lease, except that (i) the amount of the Base Rent stated in the Lease shall be adjusted as set forth below (provided, however, that Base Rent shall not be decreased); (ii) there shall be no free or abated rent periods, tenant improvement allowances or other concessions that may have been granted to Tenant at the beginning of the initial term hereof; and (iii) after exercise of Tenant's final extension term option, there shall be no further extension or renewal term options.

2. **Notice**. To extend the Lease, Tenant must deliver written notice to Landlord not less than one hundred eighty (180) days prior to the expiration of the then-current Lease term. Time is of the essence of this Rider.

3. **Monthly Rent.** Landlord and Tenant shall make a good faith effort to determine and agree on the fair market value of rent for the Premises for the next term of the Lease.

   a. Failure to Agree on Rent. If Landlord and Tenant are unable to agree on the fair market rental value for the Premises within thirty (30) days after Tenant gives notice to extend, they shall then have ten (10) days to select or, appoint one real estate appraiser to determine the fair market value of rent for the Premises. All appraisers selected or appointed pursuant to this Rider shall be a Member of the American Institute of Real Estate Appraisers ("M.A.I.") with at least ten (10) years' experience appraising commercial properties in the commercial leasing market in which the Premises are located, or equivalent. The appraiser appointed shall determine the fair market rental value for the Premises within twenty (20) days of appointment, which determination shall be final, conclusive, and binding upon both Landlord and Tenant, and Base Rent shall be adjusted accordingly for the new term. The appraiser's fees and expenses shall be shared equally between the parties.

   b. Failure to Appoint One Appraiser. If Landlord and Tenant cannot mutually agree upon an appraiser, then either party may give the other party written notice that it has selected and appointed an M.A.I. appraiser, complete with the name, address, and other identifying information about the appraiser. The party receiving such notice shall then have ten (10) days to select and appoint its own M.A.I. appraiser and respond by giving written notice to the other party, complete with the name, address, and other identifying information about the appraiser. If, however, the responding party fails to select and appoint an appraiser and give notice to the other party within ten (10) days, the determination of the appraiser first appointed shall be final, conclusive and binding upon both parties, and the Base Rent shall be adjusted accordingly for the new term. The appraiser's fees and expenses shall be shared equally between the parties.

c. Method of Determining Rent. The appraisers appointed shall proceed to determine fair market rental value within twenty (20) days following their appointment. The conclusion shall be final, conclusive and binding upon both Landlord and Tenant. If the appraisers should fail to agree, but the difference in their conclusions as to fair market rental value is ten percent (10%) or less of the lower of the two

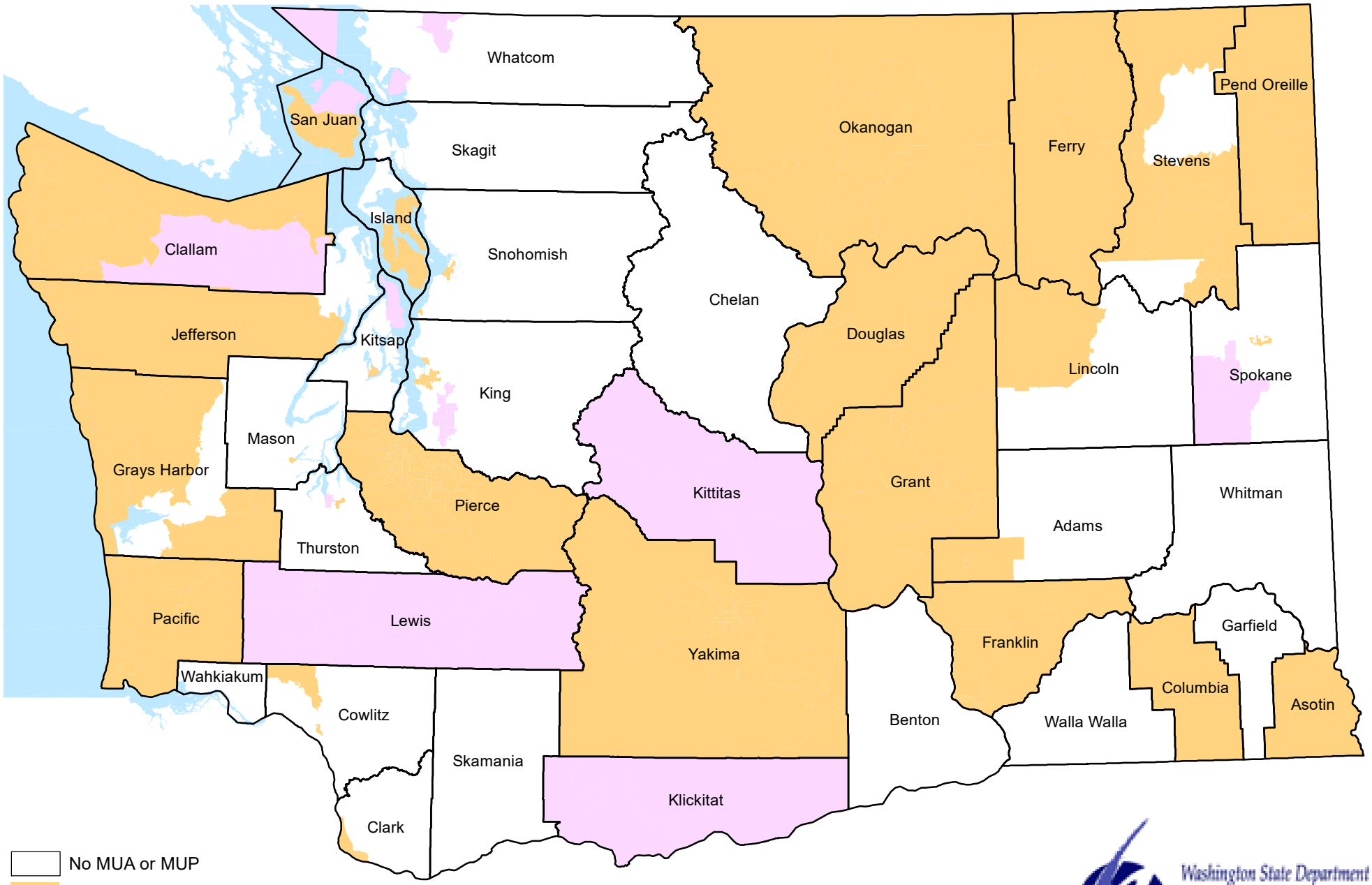
appraisals, then the fair market rental value shall be deemed to be the average of the two, and Base Rent shall be adjusted accordingly for the new term. If the two appraisers should fail to agree on the fair market rental value, and the difference between the two appraisals exceeds ten percent (10%) of the lower of the two appraisals, then the two appraisers shall appoint a third M.A.I.-qualified appraiser. If they fail to agree on a third appraiser within ten (10) days after their individual determination of the fair market rental value, either party may apply to the courts for the county in which the Premises are located, requesting the appointment of a the third M.A.I.-qualified appraiser. The third appraiser shall promptly determine the fair market rental value of the Premises. The parties shall then take the average of the two appraisals that are closest in value, which shall then constitute the fair market value; shall be final, conclusive and binding upon both parties; and Base Rent shall be adjusted accordingly for the new term. Each party shall pay the fees and expenses for its own appraiser. In the event a third appraiser must be appointed, his or her fees and expenses shall be borne equally by the parties.

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT H

COMMUNITY OF FOCUS

Medically Underserved Area & Medically Underserved
December 11, 2018



Designation data from the Office of Community Health Systems.
Designation status changes frequently.
For current information contact Laura Olexa (360) 236-2811.

Washington State Department of Health

ATTACHMENT H (1)
WA MUA 2018

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
Primary Care	1534515068	ICE - Tacoma Northwest Detention Center	Correctional Facility	Washington	Pierce County, WA	2.98	12	Designated	Non-Rural	08/24/2004	12/31/2018

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
ICE - Tacoma Northwest Detention Center	1623 E J St Apt Su	Tacoma	WA	98421-1602	Pierce	Non-Rural

Dental Health	6538611563	ICE - Tacoma Northwest Detention Center	Correctional Facility	Washington	Pierce County, WA	2.82	6	Designated	Non-Rural	09/15/2010	12/31/2018

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
ICE - Tacoma Northwest Detention Center	1623 E J St Ste	Tacoma	WA	98421-1602	Pierce	Non-Rural

Mental Health	7531779917	ICE - Tacoma Northwest Detention Center	Correctional Facility	Washington	Pierce County, WA	0.57	3	Designated	Non-Rural	08/24/2004	12/31/2018

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
ICE - Tacoma Northwest Detention Center	1623 E J St Apt Su	Tacoma	WA	98421-1602	Pierce	Non-Rural

Primary Care	153999531T	Community Health Care	Federally Qualified Health Center	Washington	Pierce County, WA		20	Designated	Non-Rural	12/02/2003	08/18/2019

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
Mental Health	7539995328	Community Health Care	Federally Qualified Health Center	Washington	Pierce County, WA		19	Designated	Non-Rural	12/02/2003	08/18/2019

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
Administrative Offices	1148 Broadway Ste 100	Tacoma	WA	98402-3518	Pierce	Non-Rural
Bethel Learning Center	21818 38th Ave E	Spanaway	WA	98387-6928	Pierce	Non-Rural
Hilltop Regional Health Center	1202 Martin Luther King Jr Way	Tacoma	WA	98405-3926	Pierce	Non-Rural
Information Technology & Training	1102 S I St	Tacoma	WA	98405-4559	Pierce	Non-Rural
Kimi & George Tanbara, MD Health Center	1708 E 44th St	Tacoma	WA	98404-4611	Pierce	Non-Rural
LAKEWOOD CLINIC	10510 Gravelly Lake Dr SW	Lakewood	WA	98499-5036	Pierce	Non-Rural
PARKLAND CLINIC	11225 Pacific Ave S	Tacoma	WA	98444-5525	Pierce	Non-Rural
SBHC at Bethel Middle School	22001 38th Ave E Rm 111	Spanaway	WA	98387-6875	Pierce	Non-Rural
SPANAWAY CLINIC	134 188th St S	Spanaway	WA	98387-4618	Pierce	Non-Rural
Temporary Site - Mobile Site - Stability Clinic	1148 Broadway Ste 100	Tacoma	WA	98402-3518	Pierce	Non-Rural
Wound Care Clinic	3629 S D St	Tacoma	WA	98418-6813	Pierce	Non-Rural

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
Administrative Offices	1148 Broadway Ste 100	Tacoma	WA	98402-3518	Pierce	Non-Rural
Bethel Learning Center	21818 38th Ave E	Spanaway	WA	98387-6928	Pierce	Non-Rural
Hilltop Regional Health Center	1202 Martin Luther King Jr Way	Tacoma	WA	98405-3926	Pierce	Non-Rural
Information Technology & Training	1102 S I St	Tacoma	WA	98405-4559	Pierce	Non-Rural
Kimi & George Tanbara, MD Health Center	1708 E 44th St	Tacoma	WA	98404-4611	Pierce	Non-Rural
LAKEWOOD CLINIC	10510 Gravelly Lake Dr SW	Lakewood	WA	98499-5036	Pierce	Non-Rural
PARKLAND CLINIC	11225 Pacific Ave S	Tacoma	WA	98444-5525	Pierce	Non-Rural
SBHC at Bethel Middle School	22001 38th Ave E Rm 111	Spanaway	WA	98387-6875	Pierce	Non-Rural
SPANAWAY CLINIC	134 188th St S	Spanaway	WA	98387-4618	Pierce	Non-Rural
Temporary Site - Mobile Site - Stability Clinic	1148 Broadway Ste 100	Tacoma	WA	98402-3518	Pierce	Non-Rural
Wound Care Clinic	3629 S D St	Tacoma	WA	98418-6813	Pierce	Non-Rural

Dental Health	6539995359	Community Health Care	Federally Qualified Health Center	Washington	Pierce County, WA		25	Designated	Non-Rural	12/02/2003	08/18/2019

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
Administrative Offices	1148 Broadway Ste 100	Tacoma	WA	98402-3518	Pierce	Non-Rural
Bethel Learning Center	21818 38th Ave E	Spanaway	WA	98387-6928	Pierce	Non-Rural
Hilltop Regional Health Center	1202 Martin Luther King Jr Way	Tacoma	WA	98405-3926	Pierce	Non-Rural
Information Technology & Training	1102 S I St	Tacoma	WA	98405-4559	Pierce	Non-Rural
Kimi & George Tanbara, MD Health Center	1708 E 44th St	Tacoma	WA	98404-4611	Pierce	Non-Rural
LAKEWOOD CLINIC	10510 Gravelly Lake Dr SW	Lakewood	WA	98499-5036	Pierce	Non-Rural
PARKLAND CLINIC	11225 Pacific Ave S	Tacoma	WA	98444-5525	Pierce	Non-Rural
SBHC at Bethel Middle School	22001 38th Ave E Rm 111	Spanaway	WA	98387-6875	Pierce	Non-Rural
SPANAWAY CLINIC	134 188th St S	Spanaway	WA	98387-4618	Pierce	Non-Rural
Temporary Site - Mobile Site - Stability Clinic	1148 Broadway Ste 100	Tacoma	WA	98402-3518	Pierce	Non-Rural
Wound Care Clinic	3629 S D St	Tacoma	WA	98418-6813	Pierce	Non-Rural

Primary Care	153999531Y	Sea-Mar Community Health Center	Federally Qualified Health Center	Washington	King County, WA		20	Designated	Non-Rural	12/02/2003	08/18/2019

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
Sea Mar CHC - Aberdeen Sumner Ave.	1813 Sumner Ave	Aberdeen	WA	98520-4600	Grays Harbor	Rural
Sea Mar CHC - Administration	1040 S Henderson St	Seattle	WA	98108-4720	King	Non-Rural
Sea Mar CHC - Anacortes M Avenue	1004 M Ave Ste 107	Anacortes	WA	98221-1954	Skagit	Rural
Sea Mar CHC - Auburn 12th St. SE	735 12th St SE Fl 1	Auburn	WA	98002-6709	King	Non-Rural
Sea Mar CHC - Battle Ground	118 S Parkway Ave	Battle Ground	WA	98604-9215	Clark	Non-Rural
Sea Mar CHC - Battle Ground NE 189th St.	11117 NE 189th St	Battle Ground	WA	98604-6244	Clark	Non-Rural
Sea Mar CHC - Bellevue 116th Ave. NE	2000 116th Ave NE	Bellevue	WA	98004-3047	King	Non-Rural
Sea Mar CHC - Bellevue 150th Ave. SE	3801 150th Ave SE	Bellevue	WA	98006-1668	King	Non-Rural
Sea Mar CHC - Bellevue 156th Ave. NE	1811 156th Ave NE Ste 2	Bellevue	WA	98007-4344	King	Non-Rural
Sea Mar CHC - Bellevue Bell-Red Rd.	12835 NE Bel Red Rd Ste 100	Bellevue	WA	98005-2625	King	Non-Rural
Sea Mar CHC - Bellingham Behavioral Health	3350 Airport Dr	Bellingham	WA	98226-8048	Whatcom	Non-Rural
Sea Mar CHC - Bellingham Cordata Parkway	4455 Cordata Pkwy	Bellingham	WA	98226-8037	Whatcom	Non-Rural
Sea Mar CHC - Burien 8th Ave. S.	18010 8th Ave S Ste 416	Seatac	WA	98148-1908	King	Non-Rural

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Burien Ambaum Blvd. SW	14434 Ambaum Blvd SW	Burien	WA	98166-1438			King	Non-Rural		
	Sea Mar CHC - Concrete	7438 S D Ave	Concrete	WA	98237-9642			Skagit	Rural		
	Sea Mar CHC - Des Moines S. 242nd St.	2781 S 242nd St	Des Moines	WA	98198-5166			King	Non-Rural		
	Sea Mar CHC - Elma W. Main St.	515 W Main St	Elma	WA	98541-9285			Grays Harbor	Rural		
	Sea Mar CHC - Everett 100th St. SE	1920 100th St SE	Everett	WA	98208-3832			Snohomish	Non-Rural		
	Sea Mar CHC - Everett Claremont Way	5007 Claremont Way	Everett	WA	98203-3321			Snohomish	Non-Rural		
	Sea Mar CHC - Everson Hannegan Rd.	6884 Hannegan Rd	Everson	WA	98247-9637			Whatcom	Non-Rural		
	Sea Mar CHC - Federal Way 18th Ave S	31405 18th Ave S	Federal Way	WA	98003-5433			King	Non-Rural		
	Sea Mar CHC - Gig Harbor 50th St Ct NW	3208 50th Street Ct Ste 202-203	Gig Harbor	WA	98335-8590			Pierce	Non-Rural		
	Sea Mar CHC - Kelso Allen St.	1710 Allen St	Kelso	WA	98626-4907			Cowlitz	Non-Rural		
	Sea Mar CHC - Kent 104th Ave SE	25028 104th Ave SE	Kent	WA	98030-9310			King	Non-Rural		
	Sea Mar CHC - Kent 233 2nd Ave. S.	233 2nd Ave S	Kent	WA	98032-5852			King	Non-Rural		
	Sea Mar CHC - Lacey Woodland Square Loop	669 Woodland Square Loop SE	Lacey	WA	98503-1038			Thurston	Non-Rural		
	Sea Mar CHC - Lakewood Bridgeport Way W	7424 Bridgeport Way W	Lakewood	WA	98499-8120			Pierce	Non-Rural		
	Sea Mar CHC - Lynnwood Alderwood Mall Blvd.	4111 Alderwood Mall Blvd	Lynnwood	WA	98036-6765			Snohomish	Non-Rural		

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Marysville Grove St. NE	4922 Grove St	Marysville	WA		98270-4427		Snohomish	Non-Rural		
	Sea Mar CHC - Marysville State Ave.	9710 State Ave	Marysville	WA		98270-2232		Snohomish	Non-Rural		
	Sea Mar CHC - Mercy Housing Bellingham	512 Sterling Dr	Bellingham	WA		98226-5503		Whatcom	Non-Rural		
	Sea Mar CHC - Monroe Fryelands Blvd. SE	14090 Fryelands Blvd SE	Monroe	WA		98272-2693		Snohomish	Non-Rural		
	Sea Mar CHC - Monroe W. Main St.	17707 W Main St	Monroe	WA		98272-1967		Snohomish	Non-Rural		
	Sea Mar CHC - Mt. Vernon E. College Way	1010 E College Way	Mount Vernon	WA		98273-5624		Skagit	Non-Rural		
	Sea Mar CHC - Mt. Vernon N. LaVenture Rd.	1400 N Laventure Rd	Mount Vernon	WA		98273-2766		Skagit	Non-Rural		
	Sea Mar CHC - Mt. Vernon Old Hwy 99	2203 Old Highway 99 S Rd	Mount Vernon	WA		98273-9009		Skagit	Non-Rural		
	Sea Mar CHC - Oak Harbor 31775 SR 20	31775 WA-20, Ste A3	Oak Harbor	WA		98277-5104		Island	Rural		
	Sea Mar CHC - Oak Harbor BH	31640 State Route 20	Oak Harbor	WA		98277-3128		Island	Rural		
	Sea Mar CHC - Ocean Shores Point Brown Ave.	597 Point Brown Ave NW	Ocean Shores	WA		98569-9632		Grays Harbor	Rural		
	Sea Mar CHC - Olympia 3030 Limited Lane NW	3030 Limited Ln NW	Olympia	WA		98502-2704		Thurston	Non-Rural		
	Sea Mar CHC - Olympia Ensign Rd NE	3622 Ensign Rd NE	Olympia	WA		98506-5081		Thurston	Non-Rural		
	Sea Mar CHC - Port Angeles W. 1st St.	228 W 1st St, Ste L	Port Angeles	WA		98362-2639		Clallam	Rural		
	Sea Mar CHC - Puyallup 101st Avenue Ct. E.	12812 101st Avenue Ct E	Puyallup	WA		98373-9101		Pierce	Non-Rural		

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Puyallup 125th Street Ct. E.	10217 125th Street Ct E	Puyallup	WA	98374-2761			Pierce	Non-Rural		
	Sea Mar CHC - Seattle 17th Place S.	10001 17th Pl S Lowr Levl	Seattle	WA	98168-1615			King	Non-Rural		
	Sea Mar CHC - Seattle 8720 14th Ave. S.	8720 14th Ave S	Seattle	WA	98108-4807			King	Non-Rural		
	Sea Mar CHC - Seattle 8801 14th Ave S	8801 14th Ave S	Seattle	WA	98108-4809			King	Non-Rural		
	Sea Mar CHC - Seattle 8915 14th Ave. S.	8915 14th Ave S	Seattle	WA	98108-4813			King	Non-Rural		
	Sea Mar CHC - Seattle Des Moines Memorial Drive S	9635 Des Moines Memorial Dr	Seattle	WA	98108-5061			King	Non-Rural		
	Sea Mar CHC - Skagit Valley Women's Health Center	125 N 18th St Ste A	Mount Vernon	WA	98273-3902			Skagit	Non-Rural		
	Sea Mar CHC - Tacoma 1215 S. 11th St.	1215 S 11th St	Tacoma	WA	98405-4020			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma 1307 S. 11th St.	1307 S 11th St	Tacoma	WA	98405-3644			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma 6th Ave	1112 6th Ave Ste 301	Tacoma	WA	98405-4048			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma S 14th St	702 S 14th St	Tacoma	WA	98405-4407			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma S. 11th St.	1516 S 11th St	Tacoma	WA	98405-3332			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma S. 19th St.	2121 S 19th St	Tacoma	WA	98405-2922			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma S. Cedar St.	3712 S Cedar St	Tacoma	WA	98409-5715			Pierce	Non-Rural		

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Tacoma S. Cushman Ave.	1112 S Cushman Ave	Tacoma	WA	98405-3631			Pierce	Non-Rural		
	Sea Mar CHC - Tillicum Community Center	14916 Washington Ave SW	Lakewood	WA	98498-2271			Pierce	Non-Rural		
	Sea Mar CHC - Tumwater 6334 Littlerock Rd. SW	6334 Littlerock Rd SW	Tumwater	WA	98512-7332			Thurston	Non-Rural		
	Sea Mar CHC - Tumwater 6336 Littlerock Rd. SW	6336 Littlerock Rd SW	Tumwater	WA	98512-7332			Thurston	Non-Rural		
	Sea Mar CHC - Tumwater Capitol Blvd SE	6004 Capitol Blvd SE	Tumwater	WA	98501-8520			Thurston	Non-Rural		
	Sea Mar CHC - Vancouver 1601 E Fourth Plain Blvd	1601 E Fourth Plain Blvd Bldg 17	Vancouver	WA	98661-3717			Clark	Non-Rural		
	Sea Mar CHC - Vancouver 317 E 39th St	317 E 39th St	Vancouver	WA	98663-2233			Clark	Non-Rural		
	Sea Mar CHC - Vancouver 34th St.	19005 SE 34th St	Vancouver	WA	98683-1450			Clark	Non-Rural		
	Sea Mar CHC - Vancouver 5411 E. Mill Plain Blvd.	5411 E Mill Plain Blvd	Vancouver	WA	98661-7057			Clark	Non-Rural		
	Sea Mar CHC - Vancouver 7803 NE Fourth Plain Rd.	7803 NE Fourth Plain Blvd	Vancouver	WA	98662-7294			Clark	Non-Rural		
	Sea Mar CHC - Vancouver Behavioral Health	5501 NE 109th Ct	Vancouver	WA	98662-6177			Clark	Non-Rural		
	Sea Mar CHC - Vancouver Delaware Lane	7410 Delaware Ln	Vancouver	WA	98664-1408			Clark	Non-Rural		
	Sea Mar CHC - Vancouver Evergreen High School	14300 NE 18th St Rm 213	Vancouver	WA	98684-7807			Clark	Non-Rural		
	Sea Mar CHC - Vancouver Fourth Plain	6100 NE Fourth Plain Blvd	Vancouver	WA	98661-6830			Clark	Non-Rural		
	Sea Mar CHC - Vancouver NE 20th Ave.	14508 NE 20th Ave	Vancouver	WA	98686-6424			Clark	Non-Rural		

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Vancouver NE 65th St.	11801 NE 65th St	Vancouver	WA	98662-5527			Clark	Non-Rural		
	Sea Mar CHC - Vancouver NE 88th St.	1412 NE 88th St	Vancouver	WA	98665-9620			Clark	Non-Rural		
	Sea Mar CHC - Vashon Island	10030 SW 210th St	Vashon	WA	98070-6584			King	Non-Rural		
	Sea Mar CHC - White Center 15th Ave. SW	9650 15th Ave SW Ste 100	Seattle	WA	98106-2576			King	Non-Rural		
	Sea Mar CHC - Yelm Cullens St. NW	202 Cullens St NW	Yelm	WA	98597-9417			Thurston	Non-Rural		
	Sea Mar CHC – Everett W Mukilteo Blvd	215 W Mukilteo Blvd	Everett	WA	98203-2057			Snohomish	Non-Rural		
Mental Health	7539995334	Sea-Mar Community Health Center	Federally Qualified Health Center	Washington	King County, WA		19	Designated	Non-Rural	12/02/2003	08/18/2019

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
Sea Mar CHC - Aberdeen Sumner Ave.	1813 Sumner Ave	Aberdeen	WA	98520-4600	Grays Harbor	Rural
Sea Mar CHC - Administration	1040 S Henderson St	Seattle	WA	98108-4720	King	Non-Rural
Sea Mar CHC - Anacortes M Avenue	1004 M Ave Ste 107	Anacortes	WA	98221-1954	Skagit	Rural
Sea Mar CHC - Auburn 12th St. SE	735 12th St SE Fl 1	Auburn	WA	98002-6709	King	Non-Rural
Sea Mar CHC - Battle Ground	118 S Parkway Ave	Battle Ground	WA	98604-9215	Clark	Non-Rural
Sea Mar CHC - Battle Ground NE 189th St.	11117 NE 189th St	Battle Ground	WA	98604-6244	Clark	Non-Rural
Sea Mar CHC - Bellevue 116th Ave. NE	2000 116th Ave NE	Bellevue	WA	98004-3047	King	Non-Rural
Sea Mar CHC - Bellevue 150th Ave. SE	3801 150th Ave SE	Bellevue	WA	98006-1668	King	Non-Rural
Sea Mar CHC - Bellevue 156th Ave. NE	1811 156th Ave NE Ste 2	Bellevue	WA	98007-4344	King	Non-Rural
Sea Mar CHC - Bellevue Bell-Red Rd.	12835 NE Bel Red Rd Ste 100	Bellevue	WA	98005-2625	King	Non-Rural
Sea Mar CHC - Bellingham Behavioral Health	3350 Airport Dr	Bellingham	WA	98226-8048	Whatcom	Non-Rural
Sea Mar CHC - Bellingham Cordata Parkway	4455 Cordata Pkwy	Bellingham	WA	98226-8037	Whatcom	Non-Rural
Sea Mar CHC - Burien 8th Ave. S.	18010 8th Ave S Ste 416	Seatac	WA	98148-1908	King	Non-Rural

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Burien Ambaum Blvd. SW	14434 Ambaum Blvd SW	Burien	WA	98166-1438			King	Non-Rural		
	Sea Mar CHC - Concrete	7438 S D Ave	Concrete	WA	98237-9642			Skagit	Rural		
	Sea Mar CHC - Des Moines S. 242nd St.	2781 S 242nd St	Des Moines	WA	98198-5166			King	Non-Rural		
	Sea Mar CHC - Elma W. Main St.	515 W Main St	Elma	WA	98541-9285			Grays Harbor	Rural		
	Sea Mar CHC - Everett 100th St. SE	1920 100th St SE	Everett	WA	98208-3832			Snohomish	Non-Rural		
	Sea Mar CHC - Everett Claremont Way	5007 Claremont Way	Everett	WA	98203-3321			Snohomish	Non-Rural		
	Sea Mar CHC - Everson Hannegan Rd.	6884 Hannegan Rd	Everson	WA	98247-9637			Whatcom	Non-Rural		
	Sea Mar CHC - Federal Way 18th Ave S	31405 18th Ave S	Federal Way	WA	98003-5433			King	Non-Rural		
	Sea Mar CHC - Gig Harbor 50th St Ct NW	3208 50th Street Ct Ste 202-203	Gig Harbor	WA	98335-8590			Pierce	Non-Rural		
	Sea Mar CHC - Kelso Allen St.	1710 Allen St	Kelso	WA	98626-4907			Cowlitz	Non-Rural		
	Sea Mar CHC - Kent 104th Ave SE	25028 104th Ave SE	Kent	WA	98030-9310			King	Non-Rural		
	Sea Mar CHC - Kent 233 2nd Ave. S.	233 2nd Ave S	Kent	WA	98032-5852			King	Non-Rural		
	Sea Mar CHC - Lacey Woodland Square Loop	669 Woodland Square Loop SE	Lacey	WA	98503-1038			Thurston	Non-Rural		
	Sea Mar CHC - Lakewood Bridgeport Way W	7424 Bridgeport Way W	Lakewood	WA	98499-8120			Pierce	Non-Rural		
	Sea Mar CHC - Lynnwood Alderwood Mall Blvd.	4111 Alderwood Mall Blvd	Lynnwood	WA	98036-6765			Snohomish	Non-Rural		

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Marysville Grove St. NE	4922 Grove St	Marysville	WA		98270-4427		Snohomish	Non-Rural		
	Sea Mar CHC - Marysville State Ave.	9710 State Ave	Marysville	WA		98270-2232		Snohomish	Non-Rural		
	Sea Mar CHC - Mercy Housing Bellingham	512 Sterling Dr	Bellingham	WA		98226-5503		Whatcom	Non-Rural		
	Sea Mar CHC - Monroe Fryelands Blvd. SE	14090 Fryelands Blvd SE	Monroe	WA		98272-2693		Snohomish	Non-Rural		
	Sea Mar CHC - Monroe W. Main St.	17707 W Main St	Monroe	WA		98272-1967		Snohomish	Non-Rural		
	Sea Mar CHC - Mt. Vernon E. College Way	1010 E College Way	Mount Vernon	WA		98273-5624		Skagit	Non-Rural		
	Sea Mar CHC - Mt. Vernon N. LaVenture Rd.	1400 N Laventure Rd	Mount Vernon	WA		98273-2766		Skagit	Non-Rural		
	Sea Mar CHC - Mt. Vernon Old Hwy 99	2203 Old Highway 99 S Rd	Mount Vernon	WA		98273-9009		Skagit	Non-Rural		
	Sea Mar CHC - Oak Harbor 31775 SR 20	31775 WA-20, Ste A3	Oak Harbor	WA		98277-5104		Island	Rural		
	Sea Mar CHC - Oak Harbor BH	31640 State Route 20	Oak Harbor	WA		98277-3128		Island	Rural		
	Sea Mar CHC - Ocean Shores Point Brown Ave.	597 Point Brown Ave NW	Ocean Shores	WA		98569-9632		Grays Harbor	Rural		
	Sea Mar CHC - Olympia 3030 Limited Lane NW	3030 Limited Ln NW	Olympia	WA		98502-2704		Thurston	Non-Rural		
	Sea Mar CHC - Olympia Ensign Rd NE	3622 Ensign Rd NE	Olympia	WA		98506-5081		Thurston	Non-Rural		
	Sea Mar CHC - Port Angeles W. 1st St.	228 W 1st St, Ste L	Port Angeles	WA		98362-2639		Clallam	Rural		
	Sea Mar CHC - Puyallup 101st Avenue Ct. E.	12812 101st Avenue Ct E	Puyallup	WA		98373-9101		Pierce	Non-Rural		

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Puyallup 125th Street Ct. E.	10217 125th Street Ct E	Puyallup	WA	98374-2761			Pierce	Non-Rural		
	Sea Mar CHC - Seattle 17th Place S.	10001 17th Pl S Lowr Levl	Seattle	WA	98168-1615			King	Non-Rural		
	Sea Mar CHC - Seattle 8720 14th Ave. S.	8720 14th Ave S	Seattle	WA	98108-4807			King	Non-Rural		
	Sea Mar CHC - Seattle 8801 14th Ave S	8801 14th Ave S	Seattle	WA	98108-4809			King	Non-Rural		
	Sea Mar CHC - Seattle 8915 14th Ave. S.	8915 14th Ave S	Seattle	WA	98108-4813			King	Non-Rural		
	Sea Mar CHC - Seattle Des Moines Memorial Drive S	9635 Des Moines Memorial Dr	Seattle	WA	98108-5061			King	Non-Rural		
	Sea Mar CHC - Skagit Valley Women's Health Center	125 N 18th St Ste A	Mount Vernon	WA	98273-3902			Skagit	Non-Rural		
	Sea Mar CHC - Tacoma 1215 S. 11th St.	1215 S 11th St	Tacoma	WA	98405-4020			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma 1307 S. 11th St.	1307 S 11th St	Tacoma	WA	98405-3644			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma 6th Ave	1112 6th Ave Ste 301	Tacoma	WA	98405-4048			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma S 14th St	702 S 14th St	Tacoma	WA	98405-4407			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma S. 11th St.	1516 S 11th St	Tacoma	WA	98405-3332			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma S. 19th St.	2121 S 19th St	Tacoma	WA	98405-2922			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma S. Cedar St.	3712 S Cedar St	Tacoma	WA	98409-5715			Pierce	Non-Rural		

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Tacoma S. Cushman Ave.	1112 S Cushman Ave	Tacoma	WA	98405-3631			Pierce	Non-Rural		
	Sea Mar CHC - Tillicum Community Center	14916 Washington Ave SW	Lakewood	WA	98498-2271			Pierce	Non-Rural		
	Sea Mar CHC - Tumwater 6334 Littlerock Rd. SW	6334 Littlerock Rd SW	Tumwater	WA	98512-7332			Thurston	Non-Rural		
	Sea Mar CHC - Tumwater 6336 Littlerock Rd. SW	6336 Littlerock Rd SW	Tumwater	WA	98512-7332			Thurston	Non-Rural		
	Sea Mar CHC - Tumwater Capitol Blvd SE	6004 Capitol Blvd SE	Tumwater	WA	98501-8520			Thurston	Non-Rural		
	Sea Mar CHC - Vancouver 1601 E Fourth Plain Blvd	1601 E Fourth Plain Blvd Bldg 17	Vancouver	WA	98661-3717			Clark	Non-Rural		
	Sea Mar CHC - Vancouver 317 E 39th St	317 E 39th St	Vancouver	WA	98663-2233			Clark	Non-Rural		
	Sea Mar CHC - Vancouver 34th St.	19005 SE 34th St	Vancouver	WA	98683-1450			Clark	Non-Rural		
	Sea Mar CHC - Vancouver 5411 E. Mill Plain Blvd.	5411 E Mill Plain Blvd	Vancouver	WA	98661-7057			Clark	Non-Rural		
	Sea Mar CHC - Vancouver 7803 NE Fourth Plain Rd.	7803 NE Fourth Plain Blvd	Vancouver	WA	98662-7294			Clark	Non-Rural		
	Sea Mar CHC - Vancouver Behavioral Health	5501 NE 109th Ct	Vancouver	WA	98662-6177			Clark	Non-Rural		
	Sea Mar CHC - Vancouver Delaware Lane	7410 Delaware Ln	Vancouver	WA	98664-1408			Clark	Non-Rural		
	Sea Mar CHC - Vancouver Evergreen High School	14300 NE 18th St Rm 213	Vancouver	WA	98684-7807			Clark	Non-Rural		
	Sea Mar CHC - Vancouver Fourth Plain	6100 NE Fourth Plain Blvd	Vancouver	WA	98661-6830			Clark	Non-Rural		
	Sea Mar CHC - Vancouver NE 20th Ave.	14508 NE 20th Ave	Vancouver	WA	98686-6424			Clark	Non-Rural		

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Vancouver NE 65th St.	11801 NE 65th St	Vancouver	WA	98662-5527			Clark	Non-Rural		
	Sea Mar CHC - Vancouver NE 88th St.	1412 NE 88th St	Vancouver	WA	98665-9620			Clark	Non-Rural		
	Sea Mar CHC - Vashon Island	10030 SW 210th St	Vashon	WA	98070-6584			King	Non-Rural		
	Sea Mar CHC - White Center 15th Ave. SW	9650 15th Ave SW Ste 100	Seattle	WA	98106-2576			King	Non-Rural		
	Sea Mar CHC - Yelm Cullens St. NW	202 Cullens St NW	Yelm	WA	98597-9417			Thurston	Non-Rural		
	Sea Mar CHC – Everett W Mukilteo Blvd	215 W Mukilteo Blvd	Everett	WA	98203-2057			Snohomish	Non-Rural		
Dental Health	6539995360	Sea-Mar Community Health Center	Federally Qualified Health Center	Washington	King County, WA		25	Designated	Non-Rural	07/15/2003	08/18/2019

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
Sea Mar CHC - Aberdeen Sumner Ave.	1813 Sumner Ave	Aberdeen	WA	98520-4600	Grays Harbor	Rural
Sea Mar CHC - Administration	1040 S Henderson St	Seattle	WA	98108-4720	King	Non-Rural
Sea Mar CHC - Anacortes M Avenue	1004 M Ave Ste 107	Anacortes	WA	98221-1954	Skagit	Rural
Sea Mar CHC - Auburn 12th St. SE	735 12th St SE Fl 1	Auburn	WA	98002-6709	King	Non-Rural
Sea Mar CHC - Battle Ground	118 S Parkway Ave	Battle Ground	WA	98604-9215	Clark	Non-Rural
Sea Mar CHC - Battle Ground NE 189th St.	11117 NE 189th St	Battle Ground	WA	98604-6244	Clark	Non-Rural
Sea Mar CHC - Bellevue 116th Ave. NE	2000 116th Ave NE	Bellevue	WA	98004-3047	King	Non-Rural
Sea Mar CHC - Bellevue 150th Ave. SE	3801 150th Ave SE	Bellevue	WA	98006-1668	King	Non-Rural
Sea Mar CHC - Bellevue 156th Ave. NE	1811 156th Ave NE Ste 2	Bellevue	WA	98007-4344	King	Non-Rural
Sea Mar CHC - Bellevue Bell-Red Rd.	12835 NE Bel Red Rd Ste 100	Bellevue	WA	98005-2625	King	Non-Rural
Sea Mar CHC - Bellingham Behavioral Health	3350 Airport Dr	Bellingham	WA	98226-8048	Whatcom	Non-Rural
Sea Mar CHC - Bellingham Cordata Parkway	4455 Cordata Pkwy	Bellingham	WA	98226-8037	Whatcom	Non-Rural
Sea Mar CHC - Burien 8th Ave. S.	18010 8th Ave S Ste 416	Seatac	WA	98148-1908	King	Non-Rural

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Burien Ambaum Blvd. SW	14434 Ambaum Blvd SW	Burien	WA	98166-1438			King	Non-Rural		
	Sea Mar CHC - Concrete	7438 S D Ave	Concrete	WA	98237-9642			Skagit	Rural		
	Sea Mar CHC - Des Moines S. 242nd St.	2781 S 242nd St	Des Moines	WA	98198-5166			King	Non-Rural		
	Sea Mar CHC - Elma W. Main St.	515 W Main St	Elma	WA	98541-9285			Grays Harbor	Rural		
	Sea Mar CHC - Everett 100th St. SE	1920 100th St SE	Everett	WA	98208-3832			Snohomish	Non-Rural		
	Sea Mar CHC - Everett Claremont Way	5007 Claremont Way	Everett	WA	98203-3321			Snohomish	Non-Rural		
	Sea Mar CHC - Everson Hannegan Rd.	6884 Hannegan Rd	Everson	WA	98247-9637			Whatcom	Non-Rural		
	Sea Mar CHC - Federal Way 18th Ave S	31405 18th Ave S	Federal Way	WA	98003-5433			King	Non-Rural		
	Sea Mar CHC - Gig Harbor 50th St Ct NW	3208 50th Street Ct Ste 202-203	Gig Harbor	WA	98335-8590			Pierce	Non-Rural		
	Sea Mar CHC - Kelso Allen St.	1710 Allen St	Kelso	WA	98626-4907			Cowlitz	Non-Rural		
	Sea Mar CHC - Kent 104th Ave SE	25028 104th Ave SE	Kent	WA	98030-9310			King	Non-Rural		
	Sea Mar CHC - Kent 233 2nd Ave. S.	233 2nd Ave S	Kent	WA	98032-5852			King	Non-Rural		
	Sea Mar CHC - Lacey Woodland Square Loop	669 Woodland Square Loop SE	Lacey	WA	98503-1038			Thurston	Non-Rural		
	Sea Mar CHC - Lakewood Bridgeport Way W	7424 Bridgeport Way W	Lakewood	WA	98499-8120			Pierce	Non-Rural		
	Sea Mar CHC - Lynnwood Alderwood Mall Blvd.	4111 Alderwood Mall Blvd	Lynnwood	WA	98036-6765			Snohomish	Non-Rural		

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Marysville Grove St. NE	4922 Grove St	Marysville	WA	98270-4427			Snohomish	Non-Rural		
	Sea Mar CHC - Marysville State Ave.	9710 State Ave	Marysville	WA	98270-2232			Snohomish	Non-Rural		
	Sea Mar CHC - Mercy Housing Bellingham	512 Sterling Dr	Bellingham	WA	98226-5503			Whatcom	Non-Rural		
	Sea Mar CHC - Monroe Fryelands Blvd. SE	14090 Fryelands Blvd SE	Monroe	WA	98272-2693			Snohomish	Non-Rural		
	Sea Mar CHC - Monroe W. Main St.	17707 W Main St	Monroe	WA	98272-1967			Snohomish	Non-Rural		
	Sea Mar CHC - Mt. Vernon E. College Way	1010 E College Way	Mount Vernon	WA	98273-5624			Skagit	Non-Rural		
	Sea Mar CHC - Mt. Vernon N. LaVenture Rd.	1400 N Laventure Rd	Mount Vernon	WA	98273-2766			Skagit	Non-Rural		
	Sea Mar CHC - Mt. Vernon Old Hwy 99	2203 Old Highway 99 S Rd	Mount Vernon	WA	98273-9009			Skagit	Non-Rural		
	Sea Mar CHC - Oak Harbor 31775 SR 20	31775 WA-20, Ste A3	Oak Harbor	WA	98277-5104			Island	Rural		
	Sea Mar CHC - Oak Harbor BH	31640 State Route 20	Oak Harbor	WA	98277-3128			Island	Rural		
	Sea Mar CHC - Ocean Shores Point Brown Ave.	597 Point Brown Ave NW	Ocean Shores	WA	98569-9632			Grays Harbor	Rural		
	Sea Mar CHC - Olympia 3030 Limited Lane NW	3030 Limited Ln NW	Olympia	WA	98502-2704			Thurston	Non-Rural		
	Sea Mar CHC - Olympia Ensign Rd NE	3622 Ensign Rd NE	Olympia	WA	98506-5081			Thurston	Non-Rural		
	Sea Mar CHC - Port Angeles W. 1st St.	228 W 1st St, Ste L	Port Angeles	WA	98362-2639			Clallam	Rural		
	Sea Mar CHC - Puyallup 101st Avenue Ct. E.	12812 101st Avenue Ct E	Puyallup	WA	98373-9101			Pierce	Non-Rural		

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Puyallup 125th Street Ct. E.	10217 125th Street Ct E	Puyallup	WA	98374-2761			Pierce	Non-Rural		
	Sea Mar CHC - Seattle 17th Place S.	10001 17th Pl S Lowr Levl	Seattle	WA	98168-1615			King	Non-Rural		
	Sea Mar CHC - Seattle 8720 14th Ave. S.	8720 14th Ave S	Seattle	WA	98108-4807			King	Non-Rural		
	Sea Mar CHC - Seattle 8801 14th Ave S	8801 14th Ave S	Seattle	WA	98108-4809			King	Non-Rural		
	Sea Mar CHC - Seattle 8915 14th Ave. S.	8915 14th Ave S	Seattle	WA	98108-4813			King	Non-Rural		
	Sea Mar CHC - Seattle Des Moines Memorial Drive S	9635 Des Moines Memorial Dr	Seattle	WA	98108-5061			King	Non-Rural		
	Sea Mar CHC - Skagit Valley Women's Health Center	125 N 18th St Ste A	Mount Vernon	WA	98273-3902			Skagit	Non-Rural		
	Sea Mar CHC - Tacoma 1215 S. 11th St.	1215 S 11th St	Tacoma	WA	98405-4020			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma 1307 S. 11th St.	1307 S 11th St	Tacoma	WA	98405-3644			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma 6th Ave	1112 6th Ave Ste 301	Tacoma	WA	98405-4048			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma S 14th St	702 S 14th St	Tacoma	WA	98405-4407			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma S. 11th St.	1516 S 11th St	Tacoma	WA	98405-3332			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma S. 19th St.	2121 S 19th St	Tacoma	WA	98405-2922			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma S. Cedar St.	3712 S Cedar St	Tacoma	WA	98409-5715			Pierce	Non-Rural		

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Tacoma S. Cushman Ave.	1112 S Cushman Ave	Tacoma	WA	98405-3631			Pierce	Non-Rural		
	Sea Mar CHC - Tillicum Community Center	14916 Washington Ave SW	Lakewood	WA	98498-2271			Pierce	Non-Rural		
	Sea Mar CHC - Tumwater 6334 Littlerock Rd. SW	6334 Littlerock Rd SW	Tumwater	WA	98512-7332			Thurston	Non-Rural		
	Sea Mar CHC - Tumwater 6336 Littlerock Rd. SW	6336 Littlerock Rd SW	Tumwater	WA	98512-7332			Thurston	Non-Rural		
	Sea Mar CHC - Tumwater Capitol Blvd SE	6004 Capitol Blvd SE	Tumwater	WA	98501-8520			Thurston	Non-Rural		
	Sea Mar CHC - Vancouver 1601 E Fourth Plain Blvd	1601 E Fourth Plain Blvd Bldg 17	Vancouver	WA	98661-3717			Clark	Non-Rural		
	Sea Mar CHC - Vancouver 317 E 39th St	317 E 39th St	Vancouver	WA	98663-2233			Clark	Non-Rural		
	Sea Mar CHC - Vancouver 34th St.	19005 SE 34th St	Vancouver	WA	98683-1450			Clark	Non-Rural		
	Sea Mar CHC - Vancouver 5411 E. Mill Plain Blvd.	5411 E Mill Plain Blvd	Vancouver	WA	98661-7057			Clark	Non-Rural		
	Sea Mar CHC - Vancouver 7803 NE Fourth Plain Rd.	7803 NE Fourth Plain Blvd	Vancouver	WA	98662-7294			Clark	Non-Rural		
	Sea Mar CHC - Vancouver Behavioral Health	5501 NE 109th Ct	Vancouver	WA	98662-6177			Clark	Non-Rural		
	Sea Mar CHC - Vancouver Delaware Lane	7410 Delaware Ln	Vancouver	WA	98664-1408			Clark	Non-Rural		
	Sea Mar CHC - Vancouver Evergreen High School	14300 NE 18th St Rm 213	Vancouver	WA	98684-7807			Clark	Non-Rural		
	Sea Mar CHC - Vancouver Fourth Plain	6100 NE Fourth Plain Blvd	Vancouver	WA	98661-6830			Clark	Non-Rural		
	Sea Mar CHC - Vancouver NE 20th Ave.	14508 NE 20th Ave	Vancouver	WA	98686-6424			Clark	Non-Rural		

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Vancouver NE 65th St.	11801 NE 65th St	Vancouver	WA	98662-5527			Clark	Non-Rural		
	Sea Mar CHC - Vancouver NE 88th St.	1412 NE 88th St	Vancouver	WA	98665-9620			Clark	Non-Rural		
	Sea Mar CHC - Vashon Island	10030 SW 210th St	Vashon	WA	98070-6584			King	Non-Rural		
	Sea Mar CHC - White Center 15th Ave. SW	9650 15th Ave SW Ste 100	Seattle	WA	98106-2576			King	Non-Rural		
	Sea Mar CHC - Yelm Cullens St. NW	202 Cullens St NW	Yelm	WA	98597-9417			Thurston	Non-Rural		
	Sea Mar CHC – Everett W Mukilteo Blvd	215 W Mukilteo Blvd	Everett	WA	98203-2057			Snohomish	Non-Rural		
Primary Care	1533072002	Puyallup Tribal Integrative Medicine	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Washington	Pierce County, WA		17	Designated	Non-Rural	08/18/2019	09/09/2019
	Site Name	**Site Address**	**Site City**	**Site State**	**Site ZIP Code**			**County**	**Rural Status**		
	Puyallup Tribal Integrative Medicine	3700 Pacific Hwy E	Fife	WA	98424-1148			Pierce	Non-Rural		
Mental Health	7532043108	Puyallup Tribal Integrative Medicine	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Washington	Pierce County, WA		18	Designated	Non-Rural	08/18/2019	09/09/2019
	Site Name	**Site Address**	**Site City**	**Site State**	**Site ZIP Code**			**County**	**Rural Status**		
	Puyallup Tribal Integrative Medicine	3700 Pacific Hwy E	Fife	WA	98424-1148			Pierce	Non-Rural		
Dental Health	6536816767	Puyallup Tribal Integrative Medicine	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Washington	Pierce County, WA		20	Designated	Non-Rural	08/18/2019	09/09/2019
	Site Name	**Site Address**	**Site City**	**Site State**	**Site ZIP Code**			**County**	**Rural Status**		
	Puyallup Tribal Integrative Medicine	3700 Pacific Hwy E	Fife	WA	98424-1148			Pierce	Non-Rural		

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
Primary Care	15399953L2	Takopid Indian Health Center	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Washington	Pierce County, WA		17	Designated	Non-Rural	10/26/2002	09/09/2019

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
Takopid Indian Health Center	2209 E 32nd St	Tacoma	WA	98404-4922	Pierce	Non-Rural

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
Mental Health	7539995386	Takopid Indian Health Center	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Washington	Pierce County, WA		18	Designated	Non-Rural	10/26/2002	09/09/2019

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
Takopid Indian Health Center	2209 E 32nd St	Tacoma	WA	98404-4922	Pierce	Non-Rural

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
Dental Health	65399953C8	Takopid Indian Health Center	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Washington	Pierce County, WA		20	Designated	Non-Rural	10/26/2002	09/09/2019

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
Takopid Indian Health Center	2209 E 32nd St	Tacoma	WA	98404-4922	Pierce	Non-Rural

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
Primary Care	1535268448	LI-West Tacoma-Lakewood Area	Low Income Population HPSA	Washington	Pierce County, WA	23.33	15	Designated	Non-Rural	07/28/2020	07/28/2020

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date

Component State Name	Component County Name	Component Name	Component Type	Component GEOID	Component Rural Status
Washington	Pierce	Census Tract 603, Pierce County, Washington	Census Tract	53053060300	Non-Rural
Washington	Pierce	Census Tract 604, Pierce County, Washington	Census Tract	53053060400	Non-Rural
Washington	Pierce	Census Tract 605, Pierce County, Washington	Census Tract	53053060500	Non-Rural
Washington	Pierce	Census Tract 606, Pierce County, Washington	Census Tract	53053060600	Non-Rural
Washington	Pierce	Census Tract 607, Pierce County, Washington	Census Tract	53053060700	Non-Rural
Washington	Pierce	Census Tract 608, Pierce County, Washington	Census Tract	53053060800	Non-Rural
Washington	Pierce	Census Tract 609.03, Pierce County, Washington	Census Tract	53053060903	Non-Rural
Washington	Pierce	Census Tract 609.04, Pierce County, Washington	Census Tract	53053060904	Non-Rural
Washington	Pierce	Census Tract 609.05, Pierce County, Washington	Census Tract	53053060905	Non-Rural
Washington	Pierce	Census Tract 609.06, Pierce County, Washington	Census Tract	53053060906	Non-Rural
Washington	Pierce	Census Tract 610.01, Pierce County, Washington	Census Tract	53053061001	Non-Rural
Washington	Pierce	Census Tract 610.02, Pierce County, Washington	Census Tract	53053061002	Non-Rural
Washington	Pierce	Census Tract 611, Pierce County, Washington	Census Tract	53053061100	Non-Rural
Washington	Pierce	Census Tract 612, Pierce County, Washington	Census Tract	53053061200	Non-Rural

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Washington	Pierce	Census Tract 613, Pierce County, Washington	Census Tract			53053061300		Non-Rural		
	Washington	Pierce	Census Tract 614, Pierce County, Washington	Census Tract			53053061400		Non-Rural		
	Washington	Pierce	Census Tract 615, Pierce County, Washington	Census Tract			53053061500		Non-Rural		
	Washington	Pierce	Census Tract 616.01, Pierce County, Washington	Census Tract			53053061601		Non-Rural		
	Washington	Pierce	Census Tract 616.02, Pierce County, Washington	Census Tract			53053061602		Non-Rural		
	Washington	Pierce	Census Tract 617, Pierce County, Washington	Census Tract			53053061700		Non-Rural		
	Washington	Pierce	Census Tract 626, Pierce County, Washington	Census Tract			53053062600		Non-Rural		
	Washington	Pierce	Census Tract 628.01, Pierce County, Washington	Census Tract			53053062801		Non-Rural		
	Washington	Pierce	Census Tract 628.02, Pierce County, Washington	Census Tract			53053062802		Non-Rural		
	Washington	Pierce	Census Tract 629, Pierce County, Washington	Census Tract			53053062900		Non-Rural		
	Washington	Pierce	Census Tract 630, Pierce County, Washington	Census Tract			53053063000		Non-Rural		
	Washington	Pierce	Census Tract 718.03, Pierce County, Washington	Census Tract			53053071803		Non-Rural		
	Washington	Pierce	Census Tract 718.05, Pierce County, Washington	Census Tract			53053071805		Non-Rural		
	Washington	Pierce	Census Tract 718.06, Pierce County, Washington	Census Tract			53053071806		Non-Rural		
	Washington	Pierce	Census Tract 718.07, Pierce County, Washington	Census Tract			53053071807		Non-Rural		

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Washington	Pierce	Census Tract 718.08, Pierce County, Washington	Census Tract			53053071808		Non-Rural		
	Washington	Pierce	Census Tract 719.01, Pierce County, Washington	Census Tract			53053071901		Non-Rural		
	Washington	Pierce	Census Tract 719.02, Pierce County, Washington	Census Tract			53053071902		Non-Rural		
	Washington	Pierce	Census Tract 720, Pierce County, Washington	Census Tract			53053072000		Non-Rural		
	Washington	Pierce	Census Tract 721.05, Pierce County, Washington	Census Tract			53053072105		Non-Rural		
	Washington	Pierce	Census Tract 721.06, Pierce County, Washington	Census Tract			53053072106		Non-Rural		
	Washington	Pierce	Census Tract 721.07, Pierce County, Washington	Census Tract			53053072107		Non-Rural		
	Washington	Pierce	Census Tract 721.08, Pierce County, Washington	Census Tract			53053072108		Non-Rural		
	Washington	Pierce	Census Tract 721.09, Pierce County, Washington	Census Tract			53053072109		Non-Rural		
	Washington	Pierce	Census Tract 721.11, Pierce County, Washington	Census Tract			53053072111		Non-Rural		
	Washington	Pierce	Census Tract 721.12, Pierce County, Washington	Census Tract			53053072112		Non-Rural		
	Washington	Pierce	Census Tract 723.05, Pierce County, Washington	Census Tract			53053072305		Non-Rural		
	Washington	Pierce	Census Tract 723.07, Pierce County, Washington	Census Tract			53053072307		Non-Rural		
	Washington	Pierce	Census Tract 723.08, Pierce County, Washington	Census Tract			53053072308		Non-Rural		
	Washington	Pierce	Census Tract 723.09, Pierce County, Washington	Census Tract			53053072309		Non-Rural		

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Washington	Pierce	Census Tract 723.10, Pierce County, Washington	Census Tract	53053072310				Non-Rural		
	Washington	Pierce	Census Tract 723.11, Pierce County, Washington	Census Tract	53053072311				Non-Rural		
	Washington	Pierce	Census Tract 723.12, Pierce County, Washington	Census Tract	53053072312				Non-Rural		
	Washington	Pierce	Census Tract 723.13, Pierce County, Washington	Census Tract	53053072313				Non-Rural		
	Washington	Pierce	Census Tract 724.07, Pierce County, Washington	Census Tract	53053072407				Non-Rural		
	Washington	Pierce	Census Tract 725.07, Pierce County, Washington	Census Tract	53053072507				Non-Rural		
Primary Care	1531131429	LI-East Tacoma Service Area	Low Income Population HPSA	Washington	Pierce County, WA	19.35	15	Designated	Non-Rural	07/28/2020	07/28/2020

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date

Component State Name	Component County Name	Component Name	Component Type	Component GEOID	Component Rural Status
Washington	Pierce	Census Tract 602, Pierce County, Washington	Census Tract	53053060200	Non-Rural
Washington	Pierce	Census Tract 618, Pierce County, Washington	Census Tract	53053061800	Non-Rural
Washington	Pierce	Census Tract 619, Pierce County, Washington	Census Tract	53053061900	Non-Rural
Washington	Pierce	Census Tract 620, Pierce County, Washington	Census Tract	53053062000	Non-Rural
Washington	Pierce	Census Tract 623, Pierce County, Washington	Census Tract	53053062300	Non-Rural
Washington	Pierce	Census Tract 624, Pierce County, Washington	Census Tract	53053062400	Non-Rural
Washington	Pierce	Census Tract 625, Pierce County, Washington	Census Tract	53053062500	Non-Rural
Washington	Pierce	Census Tract 631, Pierce County, Washington	Census Tract	53053063100	Non-Rural
Washington	Pierce	Census Tract 632, Pierce County, Washington	Census Tract	53053063200	Non-Rural
Washington	Pierce	Census Tract 633, Pierce County, Washington	Census Tract	53053063300	Non-Rural
Washington	Pierce	Census Tract 634, Pierce County, Washington	Census Tract	53053063400	Non-Rural
Washington	Pierce	Census Tract 635.01, Pierce County, Washington	Census Tract	53053063501	Non-Rural
Washington	Pierce	Census Tract 635.02, Pierce County, Washington	Census Tract	53053063502	Non-Rural
Washington	Pierce	Census Tract 707.03, Pierce County, Washington	Census Tract	53053070703	Non-Rural

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Washington	Pierce	Census Tract 711, Pierce County, Washington	Census Tract			53053071100		Non-Rural		
	Washington	Pierce	Census Tract 712.05, Pierce County, Washington	Census Tract			53053071205		Non-Rural		
	Washington	Pierce	Census Tract 712.06, Pierce County, Washington	Census Tract			53053071206		Non-Rural		
	Washington	Pierce	Census Tract 712.07, Pierce County, Washington	Census Tract			53053071207		Non-Rural		
	Washington	Pierce	Census Tract 712.09, Pierce County, Washington	Census Tract			53053071209		Non-Rural		
	Washington	Pierce	Census Tract 712.10, Pierce County, Washington	Census Tract			53053071210		Non-Rural		
	Washington	Pierce	Census Tract 716.01, Pierce County, Washington	Census Tract			53053071601		Non-Rural		
	Washington	Pierce	Census Tract 717.03, Pierce County, Washington	Census Tract			53053071703		Non-Rural		
	Washington	Pierce	Census Tract 734.04, Pierce County, Washington	Census Tract			53053073404		Non-Rural		
	Washington	Pierce	Census Tract 734.05, Pierce County, Washington	Census Tract			53053073405		Non-Rural		
	Washington	Pierce	Census Tract 734.06, Pierce County, Washington	Census Tract			53053073406		Non-Rural		
	Washington	Pierce	Census Tract 734.07, Pierce County, Washington	Census Tract			53053073407		Non-Rural		
	Washington	Pierce	Census Tract 734.08, Pierce County, Washington	Census Tract			53053073408		Non-Rural		
	Washington	Pierce	Census Tract 735, Pierce County, Washington	Census Tract			53053073500		Non-Rural		
	Washington	Pierce	Census Tract 9400.01, Pierce County, Washington	Census Tract			53053940001		Non-Rural		

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Washington	Pierce	Census Tract 9400.02, Pierce County, Washington	Census Tract	53053940002				Non-Rural		
	Washington	Pierce	Census Tract 9400.03, Pierce County, Washington	Census Tract	53053940003				Non-Rural		
	Washington	Pierce	Census Tract 9400.04, Pierce County, Washington	Census Tract	53053940004				Non-Rural		
	Washington	Pierce	Census Tract 9400.05, Pierce County, Washington	Census Tract	53053940005				Non-Rural		
	Washington	Pierce	Census Tract 9400.06, Pierce County, Washington	Census Tract	53053940006				Non-Rural		
	Washington	Pierce	Census Tract 9400.07, Pierce County, Washington	Census Tract	53053940007				Non-Rural		
	Washington	Pierce	Census Tract 9400.08, Pierce County, Washington	Census Tract	53053940008				Non-Rural		
	Washington	Pierce	Census Tract 9400.09, Pierce County, Washington	Census Tract	53053940009				Non-Rural		
	Washington	Pierce	Census Tract 9400.10, Pierce County, Washington	Census Tract	53053940010				Non-Rural		
	Washington	Pierce	Census Tract 9400.11, Pierce County, Washington	Census Tract	53053940011				Non-Rural		
Primary Care	1537498972	Buckley Service Area	Geographic HPSA	Washington	Pierce County, WA	16.23	13	Designated	Partially Rural	10/16/2017	10/16/2017

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
Primary Care	1533817143	Eatonville/Roy	Geographic HPSA	Washington	Pierce County, WA	6.72	15	Designated	Non-Rural	10/16/2017	10/16/2017

Component State Name	Component County Name	Component Name	Component Type	Component GEOID	Component Rural Status
Washington	Pierce	701	Census Tract	53053070100	Rural
Washington	Pierce	702.03	Census Tract	53053070203	Non-Rural
Washington	Pierce	702.04	Census Tract	53053070204	Non-Rural
Washington	Pierce	702.05	Census Tract	53053070205	Non-Rural
Washington	Pierce	702.06	Census Tract	53053070206	Non-Rural
Washington	Pierce	702.07	Census Tract	53053070207	Non-Rural
Washington	Pierce	703.07	Census Tract	53053070307	Non-Rural
Washington	Pierce	703.08	Census Tract	53053070308	Non-Rural
Washington	Pierce	703.09	Census Tract	53053070309	Non-Rural
Washington	Pierce	703.10	Census Tract	53053070310	Non-Rural
Washington	Pierce	703.11	Census Tract	53053070311	Non-Rural
Washington	Pierce	703.12	Census Tract	53053070312	Non-Rural
Washington	Pierce	703.13	Census Tract	53053070313	Non-Rural
Washington	Pierce	703.14	Census Tract	53053070314	Non-Rural
Washington	Pierce	703.15	Census Tract	53053070315	Non-Rural
Washington	Pierce	703.16	Census Tract	53053070316	Non-Rural
Washington	Pierce	704.01	Census Tract	53053070401	Non-Rural
Washington	Pierce	704.03	Census Tract	53053070403	Non-Rural
Washington	Pierce	704.04	Census Tract	53053070404	Non-Rural
Washington	Pierce	733.01	Census Tract	53053073301	Non-Rural
Washington	Pierce	733.02	Census Tract	53053073302	Non-Rural

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date

Component State Name	Component County Name	Component Name	Component Type	Component GEOID	Component Rural Status
Washington	Pierce	730.01	Census Tract	53053073001	Non-Rural
Washington	Pierce	730.05	Census Tract	53053073005	Non-Rural
Washington	Pierce	730.06	Census Tract	53053073006	Non-Rural
Washington	Pierce	731.17	Census Tract	53053073117	Non-Rural
Washington	Pierce	731.19	Census Tract	53053073119	Non-Rural
Washington	Pierce	732	Census Tract	53053073200	Non-Rural

Primary Care	1536626191	Longbranch	Geographic HPSA	Washington	Pierce County, WA	8.42	15	Designated	Non-Rural	10/20/2017	10/20/2017

Component State Name	Component County Name	Component Name	Component Type	Component GEOID	Component Rural Status
Washington	Pierce	725.03	Census Tract	53053072503	Non-Rural
Washington	Pierce	725.04	Census Tract	53053072504	Non-Rural
Washington	Pierce	725.05	Census Tract	53053072505	Non-Rural
Washington	Pierce	725.06	Census Tract	53053072506	Non-Rural
Washington	Pierce	726.01	Census Tract	53053072601	Non-Rural
Washington	Pierce	726.02	Census Tract	53053072602	Non-Rural
Washington	Pierce	726.03	Census Tract	53053072603	Non-Rural

Mental Health	7533858603	Longbranch	Geographic HPSA	Washington	Pierce County, WA	1.65	17	Designated	Non-Rural	10/20/2017	10/20/2017

Component State Name	Component County Name	Component Name	Component Type	Component GEOID	Component Rural Status
Washington	Pierce	725.03	Census Tract	53053072503	Non-Rural
Washington	Pierce	725.04	Census Tract	53053072504	Non-Rural
Washington	Pierce	725.05	Census Tract	53053072505	Non-Rural
Washington	Pierce	725.06	Census Tract	53053072506	Non-Rural
Washington	Pierce	726.01	Census Tract	53053072601	Non-Rural
Washington	Pierce	726.02	Census Tract	53053072602	Non-Rural
Washington	Pierce	726.03	Census Tract	53053072603	Non-Rural

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
Dental Health	6533654623	Longbranch	Geographic HPSA	Washington	Pierce County, WA	5.49	16	Designated	Non-Rural	10/20/2017	10/20/2017

Component State Name	Component County Name	Component Name	Component Type	Component GEOID	Component Rural Status
Washington	Pierce	725.03	Census Tract	53053072503	Non-Rural
Washington	Pierce	725.04	Census Tract	53053072504	Non-Rural
Washington	Pierce	725.05	Census Tract	53053072505	Non-Rural
Washington	Pierce	725.06	Census Tract	53053072506	Non-Rural
Washington	Pierce	726.01	Census Tract	53053072601	Non-Rural
Washington	Pierce	726.02	Census Tract	53053072602	Non-Rural
Washington	Pierce	726.03	Census Tract	53053072603	Non-Rural

Mental Health	7532561491	CF-Washington Corrections Center for Women	Correctional Facility	Washington	Pierce County, WA	0.28	12	Designated	Non-Rural	08/10/2007	11/29/2017

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
CF-Washington Corrections Center for Women	9601 Bujacich Rd NW	Gig Harbor	WA	98332-8300	Pierce	Non-Rural

Mental Health	7538520012	Special Committment Center	State Mental Hospital	Washington	Pierce County, WA	0.86	20	Designated	Non-Rural	08/14/2013	11/27/2017

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
Special Committment Center	1715 Lafayette St	Steilacoom	WA	98388-1327	Pierce	Non-Rural

ATTACHMENT H (2)
PSA DSIGNATION HISTORY PIERCE AND WASHINGTON STATE

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT I

DOH License Number	State	CMS Certification Number (CCN)	Provider Name (ACCORDING TO CMS)	City	Zip	Type of Ownership	County 1	County 2	County 3	County 4	CON Notes
IHS.FS.60497952	WA	507099	ASSURED HOME HEALTH	FEDERAL WAY	98003	Local	King	Pierce	Snohomish		grandfathered in as Nurse Finders; purchased by Assured (LHC Group)
IHS.FS.60506466	WA	507124	CHI FRANCISCAN HEALTH AT HOME	UNIVERSITY PLACE	98466	Official Health Agency	Pierce				CN #1510
IHS.FS.00000305	WA	507007	GROUP HEALTH HOME HEALTH & HOSPICE	SEATTLE	98112	Visiting Nurse Association	King	Kitsap	Pierce	Snohomish	grandfathered in
IHS.FS.00000298	WA	507031	KINDRED AT HOME	TACOMA	98409	Visiting Nurse Association	Pierce				grandfathered in as Olsten Health Services; purchased by Gentiva; purchased by Kindred
IHS.FS.60081744	WA	507046	MULTICARE GOOD SAMARITAN HOME HEALTH	TACOMA	98409	Hospital Based Program	King	Pierce			grandfathered in. Absorbed Good Samaritan Home Health in 2008
IHS.FS.00000420	WA	507004	PROVIDENCE SOUND HOMECARE&HOSPICE	OLYMPIA	98506	Local	Lewis	Mason	Pierce	Thurston	grandfathered in for Sound Home Health Services for Thurston. Purchased by Providence. CN #892 for Lewis County. Purchased St Joseph Home Health, with CN #905 for Pierce and Mason
IHS.FS.00000382	WA	507110	SIGNATURE HOME HEATLH	FEDERAL WAY	98003	Local	King	Kitsap	Pierce		grandfathered in as "New Care Concepts;" purchased by Signature
IHS.FS.00000028	WA	507092	WESLEY HOMES AT HOME, LLC	DES MOINES	98198	Local	King	Pierce			grandfathered in
IHS.FS.60521160	WA	507125	ENVISION HOME HEALTH	BURIEN	98166		King	Pierce			CN #1527, CN#1626
IHS.FS.60007888	WA	507102	CAREAGE HOME HEALTH	DuPont	98327	Local	King	Pierce			CN #1102 for Bessie Burton Sullivan; purchased by Careage, CN #1607

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT J

STATE HEALTH PLAN

(5) Any Type A or Type B CCRC proposing a nursing home project may, at its discretion, designate it as an application against the special statewide pool of CCRC nursing home beds established under the Nursing Home Bed Need Projection Method (General Provision (f) ii and Step 2). No single project shall be considered simultaneously under both the CCRC statewide bed pool and the bed allocation of the Nursing Home Planning Area in which the project is located.

d. Home Health Agencies (HH)

Home health agency means an entity coordinating or providing the organized delivery of home health services.

Home health services means the provision of nursing services along with at least one other therapeutic service or with a supervised home health aide service to ill or disabled persons in their residences on a part-time or intermittent basis, as approved by a physician.

(1) The performance standards policies presented below are interim. The health planning system shall evaluate these standards and revise them as necessary, when data on the costs and use of home health services in the state are available.

(2) The following home health planning areas in each health planning region shall be used to determine population requirements for home health services:

Health Planning Region I

(a) Clallam/West Jefferson
(b) Whatcom
(c) Skagit
(d) San Juan
(e) Island (minus Camano Island)
(f) East Jefferson
(g) Snohomish/Camano Island
(h) King
(i) Pierce
(j) Kitsap

Health Planning Region II

(a) Grays Harbor/Pacific
(b) Thurston/Mason
(c) Lewis
(d) Cowlitz/Wahkiakum
(e) Clark/Skamania/Klickitat

Health Planning Region III

(a) Okanogan
(b) Chelan/Douglas
(c) Kittitas/Yakima
(d) Grant
(e) Benton/Franklin

Health Planning Region IV

(a) Ferry/Stevens/Pend Oreille
(b) Lincoln/Adams
(c) Spokane
(d) Walla Walla/Columbia
(e) Garfield/Asotin/Whitman

(3) The total annual number of home health visits needed in a home health planning area in the next year shall be estimated using the Interim Home Health Agency Need

Estimation Method described below. As utilization data become available, estimates used in this method shall be evaluated and adjusted.

(People under 65 x .005) x 10 visits
+ (People 65-79 x .044) x 14 visits
+ (People 80+ x .183) x 21 visits

= TOTAL VISITS

(4) The appropriate number of home health agencies in each home health planning area shall be determined based on the following policies:

(a) For planning purposes ten thousand (10,000) home health agency visits shall be considered to be the target minimum operating volume for a home health agency.

(b) Two home health agencies may be permitted in each home health planning area to allow competition and consumer choice. Where the projected aggregate need is less than 10,000 visits per year, the burden of proof shall be on a proposed new home health agency to demonstrate that competing agencies will result in greater levels of efficiency, effectiveness and equity in such an environment. In this regard, they shall address at least the considerations in Policies (5)(a)-(g) below.

(c) The maximum number of home health agencies permitted in a home health planning area shall not exceed the number of agencies derived by dividing the visits estimated under Step 3 above by the number 10,000.*

(d) For the purpose of determining the need for additional home health agencies in a home health planning area, existing home health agencies in the planning area are those agencies which can serve the area without further state approval and which provide service use and cost data requested by the health planning system.

(5) Considerations for which preference may be given in reviewing competing proposals to meet a limited need in a planning area are presented below. Preference shall be given to the project that meets the greatest number of the following criteria for preference:

---

*Note: Fractional numbers derived under this calculation would be rounded down to the nearest whole number.

(a) The proposed agency will meet state certification requirements.

(b) The proposed agency will serve either directly or through formal agreements with other providers the entire planning area in which it is proposed to be located.

(c) The proposed agency has a written policy and budget to serve clients without regard to their source of payment.

(d) The agency has a lower charge per visit compared to similarly-organized agencies providing comparable services in the home health planning area. "Organization" refers to whether the agency is freestanding or hospital-based.

(e) The agency assures continuity of care by having documented formal linkages to other levels of care.

(f) The agency has arrangements to provide charity care to clients who are unable to pay for services.

(g) The agency demonstrates a mechanism for measuring and responding to community concerns.

e. Hospice Services (HS)

Hospice means a private or public agency or part thereof that administers or provides hospice care.

Hospice care means care supervised by the attending physician and provided by the hospice to the terminally ill. Hospice care is primarily palliative or medically necessary care provided by a hospice multidisciplinary team with care available 24 hours per day 7 days a week.

Hospice multidisciplinary teams means a team of individuals that provides or supervises care and services offered by the hospice and that is composed of at least a physician (consultant), registered nurse, social worker, and a pastoral, spiritual or other counselor.

Hospice services are provided in a coordinated program of care organized for the purpose of providing palliative and supportive care which is designed to meet the psychosocial, psychological, and spiritual needs of patients and their families (which includes those persons related by blood, marriage, or other significant relationship as designated by the patient). Bereavement services are an essential part of hospice care.

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT K

ADMISSION INFORMATION, and CHARITY CARE POLICY

Reference #:	1021
Effective:	03/16/18
Last Revised:	03/16/18

ADMISSIONS POLICY

PURPOSE:

- The agency develops and maintains written policies and processes governing admissions.

PROCEDURE:

1. The admission policies establish uniform guidelines for personnel to follow when admitting patients to the agency.

2. The admission policies apply to all patients admitted to the Agency without regard to race, color, creed, national origin, age, sex, religion, handicap, ancestry, marital, veteran status, sexual orientation and/or payment source.

3. The objectives of the Agency's admission policies are to:

- **a.** Provide uniform guidelines in the admission of patients to the Agency.
- **b.** Admit patients who can be adequately cared for by the Agency.
- **c.** Reduce patient and family fears and anxieties during the admission process.
- **d.** Review the Agency's policies and processes relating to patient rights, patient care, financial obligations, etc. with the patient and/or the patient's responsible party.
- **e.** Receive appropriate medical and financial records relating to the patient prior to or at admission.

4. The Executive Director (ED) or designee validates that the Agency and the patient follow established admission policies as applicable.

5. The Executive Director adopted the policies outlined within this section as those that best reflect the needs and operational requirements in the admission of patients to the Agency.

6. Admission policies and processes are reviewed for revisions and updates as necessary, but at least annually.

Reference#	1003
Effective:	04/17/14
Last Revised:	03/08/18

INTAKE POLICY

PURPOSE:

- To accept patients for care, treatment, and/or services that are in compliance with the organization's mission, philosophy, scope of services, and with applicable laws and regulations.
- To accept only those patients for care, treatment, and/or services who's identified needs can be reasonably met in the patient's place of residence.

POLICY:

1. Eden Home Health provides care, treatment, and/or services to adult patients, in other words, patients who are over the age of 18.
2. Eden Home Health accepts most private healthcare insurance (please refer to the Agency brochure for further details), Medicare, and Medicaid.
3. A home health patient referral is accepted in accordance with Eden Home Health policies and State Professional Practice Guidelines.
4. Patients are accepted for treatment on the reasonable expectation that Eden Home Health can meet or facilitate the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence.
5. Patients are admitted for service based upon the following criteria:
    a. The patient's needs are compatible with Eden Home Health scope of care, mission, and philosophy.
    b. The patient resides within the geographic area serviced by Eden Home Health.
    c. If the patient is covered by Medicare, he/she is considered to be homebound, as outlined by Federal regulations.
    d. Eden Home Health is able to meet the needs of the patient.
    e. The patient or caregivers are able to assist in the care of the patient.
    f. There is a reasonable expectation that the patient's medical, nursing, and social needs are able to be met adequately in the home environment.
    g. There is a preferred physician taking medical responsibility for the patient's care that performs the face-to-face encounter and establishes and periodically reviews the plan of care.

PROCEDURE:

1. Referrals are accepted telephonically, by fax, e-fax.
2. Referrals are accepted from doctors of medicine, osteopathy, and podiatry, discharge planners, case managers, insurance companies, patients, and families/caregivers.
3. Patient insurance is verified and authorization is received, as appropriate.
    a. Ongoing authorization is obtained, as appropriate.

CHARITY CARE POLICY

POLICY:

1. Patients may be eligible for charity care at the time of admission to Eden Home Health or during the period when they receive home health services, consistent with the Income Guidelines set out below.

2. Admitted Patients can appeal charity care determinations according to the Patient Concerns and Grievances policy.

3. Eligibility for charity care under this policy is at all times contingent upon the patient's cooperation with the application process, including the timely submission of all information that Eden Home Health deems necessary or appropriate to enable it to make a charity care determination.

4. Patients' eligibility for free or discounted care is based on household income and family size as identified in Exhibit 1, which is updated annually, and is based on eligible services.

Income Level of 200% or less — 100% discount level
Income Level of 201% to 300% — 75% discount level
Income Level of 301% to 400% — 50% discount level

EXHIBIT 1

National Federal Poverty Guidelines 2020

Household Size	100% - 199%	200%	300%	400%
1	$12,760	25,520	38,280	51,040
2	$17,240	34,480	51,720	68,960
3	$21,720	43,440	65,160	86,880
4	$26,200	52,400	78,600	104,800
5	$30,680	61,360	92,040	122,720
6	$35,160	70,320	105,480	140,640
7	$39,640	79,280	118,920	158,560
8	$44,120	88,240	132,360	176,480
9	$48,600	97,200	145,800	194,400
10	$53,080	106,160	159,240	212,320

TRANSFER AND DISCHARGE POLICY

PURPOSE:

- To define the circumstances when a patient is transferred or discharged.
- To standardize the process for transferring/discharging patients from Eden Home Health.
- To uphold the patient's right to receive information about his/her care, treatment, and services and to be involved in the decision-making process when appropriate.
- To maintain the continuity of care, treatment, and/or services to meet the patient's needs.
- To exchange appropriate information related to the care, treatment, and/or services with other staff and the receiving healthcare provider when patients are transferred/discharged from Eden Home Health.

POLICY:

1. Eden Home Health is professionally and ethically responsible to provide care, treatment, and services within its financial and service capabilities, mission, and applicable laws and regulations, once a patient has been admitted to the Agency.

2. Eden Home Health retains responsibility and continues to provide care, treatment, and/or services until an appropriate transfer/discharge can be completed.

3. Transfer/discharge of patients occurs in an appropriate manner, guaranteeing that relevant information is communicated to appropriate parties and in such a way as to prevent harm to the patient.

4. The referring and primary care physician is notified of the patient transfer/discharge.

5. The patient and family, as appropriate, is an active participant, when possible, in planning the transfer/discharge.

6. Eden Home Health provides the transfer and discharge policies to the patient and the patient's legal representative (if any) as required.

7. Eden Home Health may transfer or discharge a patient based on the Transfer/Discharge Criteria. The Transfer/Discharge Criteria includes:

a. The transfer or discharge is necessary for the patient's welfare because Eden Home Health and the physician who is responsible for the home health plan of care agree that Eden Home Health can no longer meet the patient's needs, based on the patient's acuity. Eden Home Health must arrange a

safe and appropriate transfer to other care entities when the needs of the patient exceed Eden Home Health's capabilities.

b. The patient or payer will no longer pay for the services provided.

c. The physician who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care have been achieved, and the HHA and the physician who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services.

d. The patient refuses services, or elects to be transferred or discharged.

e. The HHA determines, under The *Discharge For Cause* Policy, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the HHA to operate effectively is seriously impaired.

f. The patient dies.

g. Eden Home Health is closing out a particular service or all of its services.

TRANSFER PROCEDURE:

1. The appropriate time point OASIS data set items are collected in accordance with Federal regulatory requirements and AGENCY's OASIS policies.

2. A transfer summary (Episode Summary Report) is completed and provided to receiving service entity as specified:

a. For a *planned* transfer: within 2 business days, if the patient's care will be immediately continued in a health care facility.

b. For an *unplanned* transfer: within 2 business days of becoming aware of the transfer, if the patient is still receiving care in a health care facility at the time when the agency becomes aware of the transfer.

i. Patient is identified as "on hold" status in Electronic Medical Record.

3. Transfer Summary includes but is not limited to:

a. Date of transfer.

b. Patient identifying information.

c. Emergency Contact.

d. Destination of patient transferred.

e. Date and name of person receiving report.

f. Patient's physician and phone number.

g. Diagnosis related to the transfer.

h. Significant health history.

i. Transfer orders and instructions.

j. Brief description of services provided and ongoing needs that cannot be met.

k. Status of patient at the time of transfer as appropriate.

If the transfer results in the patient no longer receiving services from Eden Home Health, then a discharge/transfer OASIS is completed to the next healthcare provider per the procedure below:

1. Transfers Per Physician Order:
- **a.** The patient and/or family are informed of the transfer by Eden Home Health staff and are active participants in planning the patient's transfer whenever possible.
- **b.** The Clinical Supervisor/Case Manager coordinates the transfer with the receiving organization and provides the organization with relevant and pertinent information.

2. Patient Requires Services Not Provided by Eden Home Health:
- **a.** The Clinical Supervisor/Case Manager notifies the patient/family/ representative and referring physician that the required care, treatment, and/or services is not provided by Eden Home Health and encourages the patient/family to be an active participant in the referral/transfer process whenever possible and appropriate.
- **b.** The physician approves the referral/transfer.
- **c.** The patient is referred/transferred to other organizations or providers for the required care, treatment, and/or services.
- **d.** The transfer/referral is coordinated with the receiving organization/provider with active participation from the patient/family when possible and appropriate.
- **e.** The physician is notified of the referral/transfer verbally and in writing.
- **f.** Instructions/communications are documented in the medical record.

3. Patient's needs can no longer be met by the HHA according to the HHA and the physician who is responsible for the home health plan of care.
- **a.** The HHA must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the HHA's capabilities.
- **b.** The Clinical Supervisor/Case Manager notifies the patient/family/ representative and physicians involved in plan of care of transfer or discharge as appropriate.
- **c.** The transfer/referral is coordinated with the receiving organization/provider with active participation from the patient/family when possible and appropriate.
- **d.** Instructions/communications are documented in the medical record.

4. Patient elects to be transferred or discharged:
- **a.** All attempts are made to resolve grievances per the *Patient Concerns and Grievances Policy.*
- **b.** The HHA will assist with transfer as appropriate.
- **c.** The Clinical Supervisor/Case Manager notifies physician involved in plan of care that the patient has requested transfer or discharge.

d. The patient is referred/transferred to other care entities for the required care, treatment, and/or services.
e. The transfer/referral is coordinated with the receiving organization/provider with active participation from the patient/family when possible and appropriate.
f. Instructions/communications are documented in the medical record.

DISCHARGE PROCEDURE:

1. Updated comprehensive assessments are required:
   a. Within 48 hours of, or knowledge of, discharge to the community or death at home (discharge OASIS assessment with OASIS data items integrated).

2. A discharge summary is completed and OASIS data is collected and documented in medical record.
   a. The Discharge Summary is sent to the patient's primary care practitioner within five (5) business days of discharge.

3. Discharge Summary includes but is not limited to:
   a. Date of transfer/discharge.
   b. Patient identifying information.
   c. Patient's physician and phone number.
   d. Diagnosis.
   e. Reason for Discharge.
   f. Brief description of services provided.
   g. Status of patient at the time of discharge as appropriate.
   h. Instructions given to the patient or responsible party.

4. Medicare and Medicare HMO patients are issued a Notice of Medicare Non-Coverage (NOMNC) at least 48 hours prior to termination of services as appropriate.

REFERENCES:

Centers for Medicare and Medicaid Services (CMS), Home Health Quality Initiatives, OASIS-C, Version 12.2, 2009

Reference #:	7006
Effective:	01/04/18
Last Revised:	01/04/18

DISCHARGE COLLABORATION FOR UNEXPECTED OR UNPLANNED DISCHARGE POLICY

PURPOSE:

- To identify the process for communication for an unexpected or unplanned discharged.

- To provide guidance on the completion of the discharge assessment when an unexpected or unplanned discharge is to take place.

POLICY:

1. When an unplanned or unexpected discharge must take place, the last qualifying clinician who saw the patient completes the discharge comprehensive assessment based on information from his/her last visit.

2. The assessing clinician may supplement the discharge assessment with information documented from patient visits from the agency prior to the unexpected discharge.

3. If the patient had visits within the last 5 days that the patient received care from the agency, those visits can be used to supplement information. The 5 days are defined as the date of the last patient visits, plus the four preceding days.

Reference #:	7002
Effective:	12/22/17
Last Revised:	10/05/18

DISCHARGE FOR CAUSE POLICY

PURPOSE:

- To define the circumstances when a patient may be discharged for cause.
- To uphold the patient's right to receive information about his/her care, treatment, and services, and to be involved in the decision-making process when appropriate.
- To maintain the continuity of care, treatment, and/or services meet the patient's needs.
- To standardize the process for discharging patients for cause from Eden Home Health.
- To exchange appropriate information related to the care, treatment, and/or services with other staff and the receiving healthcare provider when patients are discharged for cause from Eden Home Health.

POLICY:

1. Eden Home Health is professionally and ethically responsible to provide care, treatment, and services within its financial and service capabilities, mission, and applicable laws and regulations, once a patient has been admitted to the Agency.

2. The patient and family, as appropriate, is an active participant, when possible, in planning the discharge.

3. Eden Home Health provides the transfer and discharge policies in the patient or legal representative's primary language.

4. Discharge for Cause Criteria includes:
   - **a.** The patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the HHA to operate effectively is seriously impaired.

5. Discharge of patients occurs in an appropriate manner, guaranteeing that relevant information is communicated to appropriate parties and in such a way as to prevent harm to the patient.
   - **a.** Patients are provided verbal or written notice of discharge 48 hours prior to discharge. Notice of discharge is not required if worker safety, signification patient noncompliance or patient's failure to pay for services rendered.
     - **i.** Documentation of discharge notification and patients understanding documented in patients' medical record.

PROCEDURE:

1. Prior to discharging a patient for cause, Eden Home Health:

- **a.** Advises the patient/representative for the home health plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) that a discharge for cause is being considered.
- **b.** Makes efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other persons in the patient's home, or situation.
- **c.** Provides the patient and representative (if any), with contact information for other agencies or Providers who may be able to provide care.
- **d.** If there is a concern about patient's' ongoing care and safety, submits a report to appropriate state agencies.
- **e.** Documents the problem(s) and efforts made to resolve the problem(s) and enters this documentation into the clinical records.

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT L

ATTACHMENT L -1 PIERCE CON PRO FORMA				

Proforma Operating Statement - Eden HHA - Pierce County				
	2021	**2022**	**2023**	
	165	*315*	*510*	Admissions
REVENUE		*91%*	*62%*	
Medicare	298,032	568,969	921,188	
Medicaid	9,168	17,502	28,337	
Commercial/Other	513,405	980,137	1,586,888	
Charity Care	7,451	14,224	23,030	2.5% of Medicare
Total Gross Revenue	**828,055**	**1,580,833**	**2,559,443**	
Deductions from Revenue				
Contractual Allowances	186,662	229,457	371,502	
Bad Debt	16,561	31,617	51,189	
Adj. For Charity Care	7,451	14,224	23,030	
Total Net Revenue	**617,381**	**1,305,535**	**2,113,723**	
PATIENT CARE COSTS				
Salaries and Benefits:				
Director of Professional Services	36,000	36,000	36,000	70%, King, 30% Pierce
Clinical Manager	25,500	25,500	25,500	70%, King, 30% Pierce
RN	136,802	261,167	422,841	
PT	120,407	229,868	372,167	
OT	55,988	106,886	173,053	
ST	11,001	21,001	34,002	
MSW	5,199	9,926	16,070	
HHaide	9,651	18,424	29,829	
Benefits	100,137	177,193	277,366	
Total Salaries and Benefits	**500,683**	**885,964**	**1,386,828**	
Contract Labor:				
Physician (Medical Director)	2,880	2,880	2,880	70%, King, 30% Pierce
PT	0	0	0	
OT	0	0	0	
Speech	-	-	-	
MSW	-	-	-	
HHA	-	-	-	
Other	-	-	-	
Total Contract Labor	**2,880**	**2,880**	**2,880**	
Medical Supplies	14,669	28,004	45,340	$4 per visit
Mileage & Medical transportation	22,003	42,006	68,009	$6 per visit
Total Patient Care Costs	**540,235**	**958,853**	**1,503,057**	
Gross Patient Margin	**77,146**	**346,681**	**610,666**	
ADMINISTRATIVE COSTS				
Advertising	-	-	-	
Allocated Costs	30,869	65,277	105,686	5% of Revenue
B & O Taxes	11,730	24,805	40,161	1.9% of Revenue
Dues & Subscriptions	15,000	15,000	15,000	
Employee Benefits	25,362	25,362	25,362	25% of Salaries
Information Tech/Computers/R&M	984	984	984	
Insurance	743	743	743	
Legal & Professional	-	-	-	
Licenses & Fees	600	600	600	
Lease Agreement	15,327	15,799	15,839	70%, King, 30% Pierce, no lease escalator after Feb 28, 2022
Administrative S & W non variable	101,448	101,448	101,448	70%, King, 30% Pierce
Supplies and Expensed Equipment	1,200	1,200	1,200	
Mileage - admin/sales	3,000	3,000	3,000	50% of total
Misc Operating Expenses	-	-	-	
Total Administrative Costs	**206,263**	**254,218**	**310,023**	
Total Costs	**746,498**	**1,213,072**	**1,813,080**	
EBITDA	**$ (129,117)**	**$ 92,463**	**$ 300,643**	
Depreciation	491	491	491	No new fixed equipment needed
Amortization	-	-	-	No new fixed equipment needed
EBIT	**(129,608)**	**91,972**	**300,152**	
Interest Expense	-	-	-	
Earnings before Taxes	**(129,608)**	**91,972**	**300,152**	
	-15.65%	5.82%	11.73%	

Pierce County			
Proforma Balance Sheet			
2021-2023			
	2021	**2022**	**2023**
ASSETS			
Current Assets			
Cash & Cash Equivalents	9,308	27,253	39,678
Accounts Receivable (Net)	51,448	108,795	176,144
Prepaid Expenses			
Total Current Assets	**60,757**	**136,048**	**215,822**
Property and Equipment			
Fixed Assets	1,473	1,473	1,473
Accumulated Depreciation	491	982	1,473
Total Property and Equipment	982	491	-
Other Assets			
Intangibles			
Loan Fees			
Accumulated Amortization	-	-	-
Total Other Assets	-	-	-
Total Assets	61,739	136,539	215,822
LIABILITIES AND CAPITAL			
Current Liabilities			
Accounts Payable & Accrued Expenses	20,485	27,259	35,521
Accrued Payroll & Related Payables	20,862	36,915	57,785
Notes Payable			-
Current Portion LT Debt			
Total Current Liabilities	41,346	64,174	93,305
Long-Term Liabilities			
Long Term Note Payable	-	-	-
Less: Current Portion of LTD			
Total Long-Term Liabilities	-	-	-
Total Liabilities	41,346	64,174	93,305
Total Equity	20,392	72,364	122,516
Total Liabilities & Capital	61,739	136,539	215,822
Diff. between Assets & Liab+Equity	-	-	-

Pierce County			
Proforma Cash Flow			
	2021	2022	2023
Cash Flows from operating activities			
Net Income	(129,608)	91,972	300,152
Adjustments to reconcile net income to cash provided by Operations			
Accumulated Depreciation & Amortization	491	491	491
Accounts Receivable	(51,448)	(57,346)	(67,349)
Prepaid Expenses	-	-	-
Accounts Payable	20,485	6,774	8,262
Payroll Related Expenses	20,862	16,053	20,869
Current Portion L.T. Debt			
Line of Credit & Short Term Debt			
Total Adjustments	(9,611)	(34,027)	(37,727)
Net Cash provided by Operations	(139,219)	57,945	262,425
Cash Flows from investing activities Used For:			
Capital equipment and furniture	(1,473)	-	-
Sale of Fixed Assets			
Intangibles & other assets			
Net cash used in investing	(1,473)	-	-
Cash Flows from financing activities			
Proceeds From:			
Note Payable Increase			
Capital Contributions	150,000	(40,000)	(250,000)
Used For:			
Note Payable Repayment	-	-	-
Note Payable Shareholder			
Less: Current Portion of LTD			
Dividends	-	-	-
Net cash used in financing	150,000	(40,000)	(250,000)
Net increase <decrease> in cash	9,308	17,945	12,425
Summary			
Cash Balance at End of Period	9,308	27,253	39,678
Cash Balance at Beg of Period	-	9,308	27,253
Net Increase <Decrease> in Cash	9,308	17,945	12,425

ATTACHMENT L1
PROFORMA CASH FLOW - PIERCE

Proposed Capital Expense			
Eden Home Health of King County, LLC -- Pierce			
Item	Estimated Expense		
Network, telemedicine equip	$ -		
Phone Switch	$ -		
Hand-helds/laptops	$ 1,473.00		
Total	**$ 1,473.00**		
Depreciation Schedule			
	Items	Years	Annual '21-'23
Network, telemedicine equip	$ -	7	$ -
Phone Switch	$ -	7	$ -
Hand-helds/laptops	$ 1,473.00	3	$ 491
Total:	**$ 1,473.00**		**$ 491**

ATTACHMENT L1
PROPOSED CAPITAL EXPENSE - PIERCE

ATTACHMENT L - 2 KING HISTORICAL

Proforma Operating Statement - Eden HHA - King County					
		Jun - Dec 2020*	2020*		
	2018	2019 (Jun - Dec 2019)	2020		
		143	*422*		
REVENUE					
Medicare		173,763	749,523		
Medicaid		65,927	247,748		
Commercial/Other		227,035	1,308,216		
Charity Care		-	62,485		
Total Gross Revenue		**466,725**	**2,305,486**		
		37%			
Deductions from Revenue		14%			
Contractual Allowances		13,401	606,946		
Bad Debt		14,311	39,819		
Adj. For Charity Care		-	12,485		
Total Net Revenue		**439,013**	**1,646,236**		
PATIENT CARE COSTS					
Salaries and Benefits:					
Director of Professional Services		116,203	129,774		
Clinical Manager		84,248	149,585		
RN		93,052	372,946		
PT		66,997	200,099		
OT		78,942	265,769		
ST		7,942	32,881		
MSW		1,570	20,737		
HHaide		2,477	17,382		
Benefits		109,340	296,624		
Total Salaries and Benefits		**560,771**	**1,485,798**		
Contract Labor:					
Physician (Medical Director)		600	600		
PT		-	-		
OT		-	-		
Speech		-	-		
MSW		-	-		
HHA		-	-		
Other		-	-		
Total Contract Labor		**600**	**600**		
Medical Supplies		2,172	112,927		
Mileage & Medical transportation		17,717	58,641		
Total Patient Care Costs		**581,260**	**1,657,966**		
Gross Patient Margin		**(142,247)**	**(11,730)**		
ADMINISTRATIVE COSTS					
Advertising		21,715	21,140		
Allocated Costs		22,666	82,665		
B & O Taxes		8,605	31,415		
Dues & Subscriptions		9,943	15,000		
Employee Benefits			42,429		
Information Tech/Computers/R&M		27,990	22,106		
Insurance		3,333	3,908		
Legal & Professional		393	-		
Licenses & Fees		4,155	5,433		
Lease Agreement		42,208	49,382		
Administrative S & W non variable		158,092	339,432		
Supplies and Expensed Equipment		17,779	10,618		
Mileage - admin/sales		1,776	1,500		
Misc Operating Expenses		-	894		
Total Administrative Costs		**318,655**	**625,922**		
Total Costs		**899,915**	**2,283,888**		
EBITDA		**$ (460,902)**	**$ (637,652)**		
Depreciation		836	5,262		
Amortization		-			
EBIT		**(461,738)**	**(642,914)**		
Internal Interest Expense		14,016	48,312		
Earnings before Taxes		**(475,754)**	**(691,226)**		
* Medicare certification was not obtained until May 29, 2019, 2020 July through December Projected					
2020 performance is based on being hit extremely hard in Seattle area by COVID-19, things are picking back up again					

ATTACHMENT L2
PROFORMA OPERATING STATEMENT - KING

King County		
Proforma Balance Sheet		
2019-2020		
	2019	2020*
ASSETS		
Current Assets		
Cash & Cash Equivalents	155,813	103,959
Accounts Receivable (Net)	73,169	137,186
Prepaid Expenses		
Total Current Assets	**228,982**	**241,146**
Property and Equipment		
Fixed Assets	30,521	29,685
Accumulated Depreciation	836	6,098
Total Property and Equipment	29,685	23,587
Other Assets		
Intangibles		
Loan Fees		
Accumulated Amortization	-	-
Total Other Assets	-	-
Total Assets	258,667	264,733
LIABILITIES AND CAPITAL		
Current Liabilities		
Accounts Payable & Accrued Expenses	56,424	66,457
Accrued Payroll & Related Payables	46,781	61,933
Notes Payable internal line of credit	(14,016)	(48,312)
Current Portion LT Debt		
Total Current Liabilities	89,189	80,079
Long-Term Liabilities		
Long Term Note Payable	-	-
Less: Current Portion of LTD		
Total Long-Term Liabilities	-	-
Total Liabilities	89,189	80,079
Total Capital (Equity)	169,478	184,654
Total Liabilities & Capital	258,667	264,733
Diff. between Assets & Liab+Equity	-	-
* 2020 July thru December Projected		

ATTACHMENT L2
PROFORMA BALANCE SHEET 2019-2020 - KING

King County					
Proforma Cash Flow					
	2019	2020			
Cash Flows from operating activities					
Net Income	(475,754)	(691,226)			
Adjustments to reconcile net income to cash provided by Operations					
Accumulated Depreciation & Amortization	836	5,892			
Accounts Receivable	(73,169)	(64,017)	One month of net receivables		
Prepaid Expenses	-	-			
Accounts Payable	56,424	10,033	One month of accrued payables		
Payroll Related Expenses	46,781	15,152	One-half month of payroll related expenses		
Current Portion L.T. Debt					
Line of Credit & Short Term Debt	14,016	48,312	Interest on the P&L is a non-cash entry		
Total Adjustments	44,888	15,372			
Net Cash provided by Operations	(430,866)	(675,854)			
Cash Flows from investing activities Used For:					
Capital equipment and furniture	(30,521)	-			
Sale of Fixed Assets					
Intangibles & other assets					
Net cash used in investing	(30,521)	-			
Cash Flows from financing activities					
Proceeds From:					
Note Payable Increase					
Capital Contributions	617,200	624,000			
Used For:					
Note Payable Repayment	-	-			
Note Payable Shareholder	-	-			
Less: Current Portion of LTD	-	-			
Dividends	-	-			
Net cash used in financing	617,200	624,000			
Net increase <decrease> in cash	155,813	(51,854)			
Summary					
Cash Balance at End of Period	155,813	103,959			
Cash Balance at Beg of Period	-	155,813			
Net Increase <Decrease> in Cash	155,813	(51,854)			

ATTACHMENT L2
PROFORMA CASH FLOW - KING

ATTACHMENT L - 3 KING CON PRO FORMA

Proforma Operating Statement - Eden HHA - King County					
	2021	**2022**	**2023**		
	738	*882*	*1026*	Admissions	
REVENUE		*20%*	*16%*	% Increase	
Medicare	1,333,014	1,593,114	1,853,214		
Medicaid	41,006	49,007	57,008		
Commercial/Other	2,296,320	2,744,383	3,192,445		
Charity Care	33,325	39,828	46,330	2.5% of Medicare	
Total Gross Revenue	**3,703,665**	**4,426,331**	**5,148,998**		
Deductions from Revenue					
Contractual Allowances	820,914	642,480	747,374		
Bad Debt	74,073	88,527	102,980		
Adj. For Charity Care	33,325	39,828	46,330		
Total Net Revenue	**2,775,353**	**3,655,497**	**4,252,313**		
PATIENT CARE COSTS					
Salaries and Benefits:					
Director of Professional Services	84,000	84,000	84,000	70%, King, 30% Pierce	
Clinical Manager	59,500	59,500	59,500	70%, King, 30% Pierce	
RN	611,876	731,267	850,657		
PT	538,548	643,630	748,713		
OT	250,418	299,280	348,142		
ST	49,202	58,803	68,403		
MSW	23,255	27,792	32,330		
HHaide	43,165	51,587	60,009		
Benefits	414,991	488,965	562,938		
Total Salaries and Benefits	**2,074,954**	**2,444,823**	**2,814,692**		
Contract Labor:					
Physician (Medical Director)	6,720	6,720	6,720	70% shared w/ Pierce County	
PT	0	0	0		
OT	0	0	0		
Speech	-	-	-		
MSW	-	-	-		
HHA	-	-	-		
Other	-	-	-		
Total Contract Labor	**6,720**	**6,720**	**6,720**		
Medical Supplies	65,609	78,411	91,213	$4 per visit	
Mileage & Medical transportation	98,414	117,616	136,819	$6 per visit	
Total Patient Care Costs	**2,245,697**	**2,647,571**	**3,049,444**		
Gross Patient Margin	**529,656**	**1,007,927**	**1,202,869**		
ADMINISTRATIVE COSTS					
Advertising	-	-	-		
Allocated Costs	138,768	182,775	212,616	5% of Revenue	
B & O Taxes	52,732	69,454	80,794	1.9% of Revenue	
Dues & Subscriptions	15,000	15,000	15,000		
Employee Benefits	59,178	59,178	59,178	25% of Salaries	
Information Tech/Computers/R&M	984	984	984		
Insurance	743	743	743		
Legal & Professional	-	-	-		
Licenses & Fees	600	600	600		
Lease Agreement	35,762	36,865	36,957	70%, King, 30% Pierce, no lease escalator after Feb 28, 2022	
Administrative S & W non variable	236,712	236,712	236,712	70%, King, 30% Pierce	
Supplies and Expensed Equipment	1,200	1,200	1,200		
Mileage - admin/sales	3,000	3,000	3,000	50% of total	
Misc Operating Expenses	-	-	-		
Total Administrative Costs	**544,678**	**606,512**	**647,784**		
Total Costs	**2,790,375**	**3,254,082**	**3,697,228**		
EBITDA	**$ (15,023)**	**$ 401,415**	**$ 555,085**		
Depreciation	5,892	5,892	5,892		
Amortization	-	-	-		
EBIT	**(20,915)**	**395,523**	**549,193**		
Internal Interest Expense	65,472	65,472	65,472		
Earnings before Taxes	**(86,387)**	**330,051**	**483,721**		
	-2.33%	7.46%	9.39%		

King County			
Proforma Balance Sheet			
2021-2023			
	2021	**2022**	**2023**
ASSETS			
Current Assets			
Cash & Cash Equivalents	92,284	43,493	20,353
Accounts Receivable (Net)	231,279	304,625	354,359
Prepaid Expenses			
Total Current Assets	**323,563**	**348,117**	**374,712**
Property and Equipment			
Fixed Assets	30,521	30,521	30,521
Accumulated Depreciation	12,826	18,718	24,610
Total Property and Equipment	17,695	11,803	5,911
Other Assets			
Intangibles			
Loan Fees			
Accumulated Amortization	-	-	-
Total Other Assets	-	-	-
Total Assets	341,258	359,920	380,623
LIABILITIES AND CAPITAL			
Current Liabilities			
Accounts Payable & Accrued Expenses	59,058	66,786	72,885
Accrued Payroll & Related Payables	86,736	102,148	117,559
Notes Payable Internal Line of Credit	(65,472)	(65,472)	(65,472)
Current Portion LT Debt			
Total Current Liabilities	80,323	103,462	124,972
Long-Term Liabilities			
Long Term Note Payable	-	-	-
Less: Current Portion of LTD			
Total Long-Term Liabilities	-	-	-
Total Liabilities	80,323	103,462	124,972
Total Capital (Equity)	260,935	256,458	255,652
Total Liabilities & Equity	341,258	359,920	380,623
Diff. between Assets & Liab+Equity	-	-	-

ATTACHMENT L3
PROFORMA BALANCE SHEET 2021-2023 - KING

King County				
Proforma Cash Flow				
	2021	2022	2023	
Cash Flows from operating activities				
Net Income	(86,387)	330,051	483,721	
Adjustments to reconcile net income to cash provided by Operations				
Accumulated Depreciation & Amortization	5,892	5,892	5,892	
Accounts Receivable	(167,262)	(73,345)	(49,735)	One month of net receivables
Prepaid Expenses	-	-	-	
Accounts Payable	49,025	7,728	6,099	One month of accrued payables
Payroll Related Expenses	71,584	15,411	15,411	One-half month of payroll related expenses
Current Portion L.T. Debt				
Line of Credit & Short Term Debt	65,472	65,472	65,472	Interest on the P&L is a non-cash entry
Total Adjustments	24,711	21,158	43,139	
Net Cash provided by Operations	(61,676)	351,209	526,860	
Cash Flows from investing activities Used For:				
Capital equipment and furniture	-	-	-	
Sale of Fixed Assets				
Intangibles & other assets				
Net cash used in investing	-	-	-	
Cash Flows from financing activities				
Proceeds From:				
Note Payable Increase				
Capital Contributions	50,000	(400,000)	(550,000)	
Used For:				
Note Payable Repayment	-	-	-	
Note Payable Shareholder				
Less: Current Portion of LTD				
Dividends	-	-	-	
Net cash used in financing	50,000	(400,000)	(550,000)	
Net increase <decrease> in cash	(11,676)	(48,791)	(23,140)	
Summary				
Cash Balance at End of Period	92,284	43,493	20,353	
Cash Balance at Beg of Period	103,959	92,284	43,493	
Net Increase <Decrease> in Cash	(11,676)	(48,791)	(23,140)	

Proposed Capital Expense			
Eden Home Health of King County, LLC- King			
Item	Estimated Expense		
Network, telemedicine equip	$ 12,900.00		
Phone Switch	$ 7,000.00		
Hand-helds/laptops	$ 9,148.00		
Total	**$ 29,048.00**		
Depreciation Schedule			
	Items	Years	Annual '21-23
Network, telemedicine equip	$ 12,900.00	7	$ 1,843
Phone Switch	$ 7,000.00	7	$ 1,000
Hand-helds/laptops	$ 9,148.00	3	$ 3,049
Total:	**$ 29,048.00**		**$ 5,892**

ATTACHMENT L3
PROPOSED CAPITAL EXPENSE - KING

ATTACHMENT L - 4 KING & PIERCE COMBINED

Proforma Operating Statement - Eden HHA - Combined				
	2021	**2022**	**2023**	
	903	*1197*	*1536*	Admissions
REVENUE				
Medicare	1,631,045	2,162,083	2,774,403	
Medicaid	50,174	66,509	85,345	
Commercial/Other	2,809,725	3,724,519	4,779,333	
Charity Care	40,776	54,052	69,360	2.5% of Medicare
Total Gross Revenue	**4,531,720**	**6,007,164**	**7,708,441**	
Deductions from Revenue				
Contractual Allowances	1,007,575	871,937	1,118,876	
Bad Debt	90,634	120,143	154,169	
Adj. For Charity Care	40,776	54,052	69,360	
Total Net Revenue	**3,392,734**	**4,961,032**	**6,366,036**	
PATIENT CARE COSTS				
Salaries and Benefits:				
Director of Professional Services	120,000	120,000	120,000	.70 King County, .30 Pierce
Clinical Manager	85,000	85,000	85,000	.70 King County, .30 Pierce
RN	748,678	992,433	1,273,498	
PT	658,955	873,498	1,120,880	
OT	306,406	406,166	521,195	
ST	60,203	79,804	102,405	
MSW	28,454	37,718	48,400	
HHaide	52,815	70,011	89,838	
Benefits	515,128	666,157	840,304	
Total Salaries and Benefits	**2,575,638**	**3,330,787**	**4,201,520**	
Contract Labor:				
Physician (Medical Director)	9,600	9,600	9,600	.70 King County, .30 Pierce
PT	0	0	0	
OT	0	0	0	
Speech	-	-	-	
MSW	-	-	-	
HHA	-	-	-	
Other	-	-	-	
Total Contract Labor	**9,600**	**9,600**	**9,600**	
Medical Supplies	80,278	106,415	136,552	$4 per visit
Mileage & Medical transportation	120,417	159,622	204,829	$6 per visit
Total Patient Care Costs	**2,785,932**	**3,606,424**	**4,552,501**	
Gross Patient Margin	**606,802**	**1,354,608**	**1,813,535**	
ADMINISTRATIVE COSTS				
Advertising	-	-	-	
Allocated Costs	169,637	248,052	318,302	5% of Revenue
B & O Taxes	64,462	94,260	120,955	1.9% of Revenue
Dues & Subscriptions	30,000	30,000	30,000	
Employee Benefits	84,540	84,540	84,540	25% of Salaries
Information Tech/Computers/R&M	1,968	1,968	1,968	
Insurance	1,486	1,486	1,486	
Legal & Professional	-	-	-	
Licenses & Fees	1,200	1,200	1,200	
Lease Agreement	51,089	52,665	52,796	.70 King County, .30 Pierce
Administrative S & W non variable	338,160	338,160	338,160	.70 King County, .30 Pierce
Supplies and Expensed Equipment	2,400	2,400	2,400	
Mileage - admin/sales	6,000	6,000	6,000	.50 King County, .50 Pierce
Misc Operating Expenses	-	-	-	
Total Administrative Costs	**750,941**	**860,730**	**957,807**	
Total Costs	**3,536,873**	**4,467,154**	**5,510,308**	
EBITDA	**$ (144,139)**	**$ 493,878**	**$ 855,728**	
Depreciation	6,383	6,383	6,383	No new fixed equipment needed
Amortization	-	-	-	No new fixed equipment needed
EBIT	**(150,522)**	**487,495**	**849,345**	
Interest Expense	65,472	65,472	65,472	Internal reported rate
Earnings before Taxes	**(215,994)**	**422,023**	**783,873**	
	-4.77%	7.03%	10.17%	

ATTACHMENT L4
PROFORMA OPERATING STATEMENT - COMBINED

Combined Proforma Balance Sheet 2021-2023			
	2021	**2022**	**2023**
ASSETS			
Current Assets			
Cash & Cash Equivalents	101,592	70,746	60,031
Accounts Receivable (Net)	282,728	413,419	530,503
Prepaid Expenses			
Total Current Assets	**384,320**	**484,165**	**590,534**
Property and Equipment			
Fixed Assets	30,521	30,521	30,521
Accumulated Depreciation	13,317	19,700	26,083
Total Property and Equipment	17,204	10,821	4,438
Other Assets			
Intangibles			
Loan Fees			
Accumulated Amortization	-	-	-
Total Other Assets	-	-	-
Total Assets	401,524	494,986	594,972
LIABILITIES AND CAPITAL			
Current Liabilities			
Accounts Payable & Accrued Expenses	80,103	93,897	108,266
Accrued Payroll & Related Payables	107,318	138,783	175,063
Notes Payable Internal Line of Credit	(65,472)	(65,472)	(65,472)
Current Portion LT Debt			
Total Current Liabilities	121,949	167,208	217,857
Long-Term Liabilities			
Long Term Note Payable	-	-	-
Less: Current Portion of LTD			
Total Long-Term Liabilities	-	-	-
Total Liabilities	121,949	167,208	217,857
Capital (Equity)	279,575	327,778	377,115
Liabilities and Capital	401,524	494,986	594,972
Diff. between Assets & Liab+Equity	-	-	-

Combined						
Proforma Cash Flow						
	2021	2022	2023			
Cash Flows from operating activities						
Net Income	(215,994)	422,023	783,873			
Adjustments to reconcile net income to cash provided by Operations						
Accumulated Depreciation & Amortization	6,383	6,383	6,383			
Accounts Receivable	(218,710)	(130,691)	(117,084)	One month of net receivables		
Prepaid Expenses	-	-	-			
Accounts Payable	69,510	14,502	14,361	One month of accrued payables		
Payroll Related Expenses	92,446	31,465	36,281	One-half month of payroll related expenses		
Current Portion L.T. Debt						
Line of Credit & Short Term Debt	65,472	65,472	65,472	Interest on the P&L is a non-cash entry		
Total Adjustments	15,100	(12,870)	5,413			
Net Cash provided by Operations	(200,894)	409,153	789,286			
Cash Flows from investing activities Used For:						
Capital equipment and furniture	(1,473)	-	-			
Sale of Fixed Assets						
Intangibles & other assets						
Net cash used in investing	(1,473)	-	-			
Cash Flows from financing activities						
Proceeds From:						
Note Payable Increase						
Capital Contributions	200,000	(440,000)	(800,000)			
Used For:						
Note Payable Repayment	-	-	-			
Note Payable Shareholder						
Less: Current Portion of LTD						
Dividends	-	-	-			
Net cash used in financing	200,000	(440,000)	(800,000)			
Net increase <decrease> in cash	(2,367)	(30,847)	(10,714)			
Summary						
Cash Balance at End of Period	101,592	70,746	60,031			
Cash Balance at Beg of Period	103,959	101,592	70,746			
Net Increase <Decrease> in Cash	(2,367)	(30,847)	(10,714)			

Proposed Capital Expense			
Eden Home Health of King County, LLC- Total			
Item	Estimated Expense		
Network, telemedicine equip	$ 12,900.00		
Phone Switch	$ 7,000.00		
Hand-helds/laptops	$ 10,621.00		
Total	**$ 30,521.00**		
Depreciation Schedule			
	Items	Years	Annual '21-23
Network, telemedicine equip	$ 12,900.00	7	$ 1,843
Phone Switch	$ 7,000.00	7	$ 1,000
Hand-helds/laptops	$ 10,621.00	3	$ 3,540
Total:	**$ 30,521.00**		**$ 6,383**

ATTACHMENT L4
PROPOSED CAPITAL EXPENSE - TOTAL

ATTACHMENT L - 5 KING PRO FORMA W/O PIERCE

Proforma Operating Statement - Eden HHA - King County Without Pierce						
	2021	**2022**	**2023**			
	738	*882*	*1026*	Admissions		
REVENUE						
Medicare	1,333,014	1,593,114	1,853,214			
Medicaid	41,006	49,007	57,008			
Commercial/Other	2,296,320	2,744,383	3,192,445			
Charity Care	33,325	39,828	46,330	2.5% of Medicare		
Total Gross Revenue	**3,703,665**	**4,426,331**	**5,148,998**			
Deductions from Revenue						
Contractual Allowances	820,914	642,480	747,374			
Bad Debt	74,073	88,527	102,980			
Adj. For Charity Care	33,325	39,828	46,330			
Total Net Revenue	**2,775,353**	**3,655,497**	**4,252,313**			
PATIENT CARE COSTS						
Salaries and Benefits:						
Director of Professional Services	120,000	120,000	120,000	100% King		
Clinical Manager	85,000	85,000	85,000	100% King		
RN	611,876	731,267	850,657			
PT	538,548	643,630	748,713			
OT	250,418	299,280	348,142			
ST	49,202	58,803	68,403			
MSW	23,255	27,792	32,330			
HHaide	43,165	51,587	60,009			
Benefits	414,991	488,965	562,938			
Total Salaries and Benefits	**2,136,454**	**2,506,323**	**2,876,192**			
Contract Labor:						
Physician (Medical Director)	9,600	9,600	9,600	100% King		
PT	0	0	0			
OT	0	0	0			
Speech	-	-	-			
MSW	-	-	-			
HHA	-	-	-			
Other	-	-	-			
Total Contract Labor	**9,600**	**9,600**	**9,600**			
Medical Supplies	65,609	78,411	91,213	$4 per visit		
Mileage & Medical transportation	98,414	117,616	136,819	$6 per visit		
Total Patient Care Costs	**2,245,697**	**2,647,571**	**3,049,444**			
Gross Patient Margin	**529,656**	**1,007,927**	**1,202,869**			
ADMINISTRATIVE COSTS						
Advertising	-	-	-			
Allocated Costs	138,768	182,775	212,616	5% of Revenue		
B & O Taxes	52,732	69,454	80,794	1.9% of Revenue		
Dues & Subscriptions	15,000	15,000	15,000			
Employee Benefits	59,178	59,178	59,178	25% of Salaries		
Information Tech/Computers/R&M	984	984	984			
Insurance	743	743	743			
Legal & Professional	-	-	-			
Licenses & Fees	600	600	600			
Lease Agreement	51,089	52,665	52,796	100%, King, no lease escalator after Feb 28, 2022		
Administrative S & W non variable	236,712	236,712	236,712	100% King		
Supplies and Expensed Equipment	1,200	1,200	1,200			
Mileage - admin/sales	3,000	3,000	3,000	Total		
Misc Operating Expenses	-	-	-			
Total Administrative Costs	**560,005**	**622,311**	**663,623**			
Total Costs	**2,805,702**	**3,269,882**	**3,713,067**			
EBITDA	**$ (30,349)**	**$ 385,616**	**$ 539,246**			
Depreciation	5,892	5,892	5,892			
Amortization	-	-	-			
EBIT	**(36,241)**	**379,724**	**533,354**			
Internal Interest Expense	65,472	65,472	65,472			
Earnings before Taxes	**(101,713)**	**314,252**	**467,882**			
	-2.75%	7.10%	9.09%			

ATTACHMENT L5
PROFORMA OPERATING STATEMENT KING-NO PIERCE

King County (Without Pierce)			
Proforma Balance Sheet			
2021-2023			
	2021	**2022**	**2023**
ASSETS			
Current Assets			
Cash & Cash Equivalents	92,284	43,493	20,353
Accounts Receivable (Net)	231,279	304,625	354,359
Prepaid Expenses			
Total Current Assets	**323,563**	**348,117**	**374,712**
Property and Equipment			
Fixed Assets	30,521	30,521	30,521
Accumulated Depreciation	11,990	17,882	23,774
Total Property and Equipment	18,531	12,639	6,747
Other Assets			
Intangibles			
Loan Fees			
Accumulated Amortization	-	-	-
Total Other Assets	-	-	-
Total Assets	342,094	360,756	381,459
LIABILITIES AND CAPITAL			
Current Liabilities			
Accounts Payable & Accrued Expenses	60,336	68,195	74,305
Accrued Payroll & Related Payables	89,419	102,148	117,559
Notes Payable			-
Current Portion LT Debt			
Total Current Liabilities	149,755	170,342	191,863
Long-Term Liabilities			
Long Term Note Payable	-	-	-
Less: Current Portion of LTD			
Total Long-Term Liabilities	-	-	-
Total Liabilities	149,755	170,342	191,863
Capital (Equity)	192,340	190,414	189,596
Total Liabilities & Equity	342,094	360,756	381,459
Diff. between Assets & Liab+Equity	-	-	-

ATTACHMENT L5
PROFORMANCE BALANCE SHEETS KING-WITHOUT PIERCE

King County Without Pierce Proforma Cash Flow				
	2021	**2022**	**2023**	
Cash Flows from operating activities				
Net Income	(101,713)	314,252	467,882	
Adjustments to reconcile net income to cash provided by Operations				
Accumulated Depreciation & Amortization	5,892	5,892	5,892	
Accounts Receivable	(167,262)	(73,345)	(49,735)	One month of net receivables
Prepaid Expenses	-	-	-	
Accounts Payable	(6,122)	7,859	6,110	One month of accrued payables
Payroll Related Expenses	27,486	12,729	15,411	One-half month of payroll related expenses
Current Portion L.T. Debt				
Line of Credit & Short Term Debt	65,472	65,472	65,472	Interest on the P&L is a non-cash entry
Total Adjustments	(74,534)	18,607	43,150	
Net Cash provided by Operations	(176,247)	332,858	511,033	
Cash Flows from investing activities Used For:				
Capital equipment and furniture	-	-	-	
Sale of Fixed Assets				
Intangibles & other assets				
Net cash used in investing	-	-	-	
Cash Flows from financing activities				
Proceeds From:				
Note Payable Increase				
Capital Contributions	100,000	(300,000)	(550,000)	
Used For:				
Note Payable Repayment	-	-	-	
Note Payable Shareholder				
Less: Current Portion of LTD				
Dividends	-	-	-	
Net cash used in financing	100,000	(300,000)	(550,000)	
Net increase <decrease> in cash	(76,247)	32,858	(38,967)	
Summary				
Cash Balance at End of Period	27,712	60,570	21,603	
Cash Balance at Beg of Period	103,959	27,712	60,570	
Net Increase <Decrease> in Cash	(76,247)	32,858	(38,967)	

Proposed Capital Expense Without Pierce			
Eden Home Health of King County, LLC- King			
Item	Estimated Expense		
Network, telemedicine equip	$ 12,900.00		
Phone Switch	$ 7,000.00		
Hand-helds/laptops	$ 9,148.00		
Total	**$ 29,048.00**		
Depreciation Schedule			
	Items	Years	Annual '21-23
Network, telemedicine equip	$ 12,900.00	7	$ 1,843
Phone Switch	$ 7,000.00	7	$ 1,000
Hand-helds/laptops	$ 9,148.00	3	$ 3,049
Total:	**$ 29,048.00**		**$ 5,892**

ATTACHMENT L - 6 2021 - 2023 Assumptions

Proforma Operating Statement Assumptions for Pierce, King, Combined and King W/O Pierce pro formas	
Admissions	Unduplicated Admissions multiplied by 1.3 to calculate episodes, 8% of episodes are LUPA
REVENUE	
Medicare	Medicare Revenue at $189 per visit;, see Table 23 for % of Revenue
Medicaid	Medicaid Revenue at $250 per visit; see Table 23 for % of Revenue
Commercial/Other	Commercial Revenue at $250 per visit; see Table 23 for % of Revenue
Charity Care	2.5% of Medicare Revenue
Total Gross Revenue	
Deductions from Revenue	
Contractual Allowances	23% contractual allowance for Commercial and Medicaid
Bad Debt	2% of Gross Revenue
Adj. For Charity Care	2.5% of Medicare Revenue Adjustment
Total Net Revenue	
PATIENT CARE COSTS	
Salaries and Benefits:	
Director of Professional Services	70%, King, 30% Pierce, See Table 26-A for salary level, and FTE allocations
Clinical Manager	70%, King, 30% Pierce, See Table 26-A for salary level, and FTE allocations
RN	See Table 26-A for salaries: FTEs calculated by expected visits per Unadjusted & LUPA total episodes; productivity @4 visits pr shift
PT	See Table 26-A for salaries: FTEs calculated by expected visits per Unadjusted & LUPA total episodes; productivity @4 visits pr shift
OT	See Table 26-A for salaries: FTEs calculated by expected visits per Unadjusted & LUPA total episodes; productivity @4 visits pr shift
ST	See Table 26-A for salaries: FTEs calculated by expected visits per Unadjusted & LUPA total episodes; productivity @4 visits pr shift
MSW	See Table 26-A for salaries: FTEs calculated by expected visits per Unadjusted & LUPA total episodes; productivity @3 visits pr shift
HHaide	See Table 26-A for salaries: FTEs calculated by expected visits per Unadjusted & LUPA total episodes; productivity @4 visits pr shift
Benefits	25% of Salaries
Total Salaries and Benefits	
Contract Labor:	
Physician (Medical Director)	70%, King, 30% Pierce of Maximum Medical Director expense of 4 hours per month @$200 per hour generally runs much less
PT	
OT	
Speech	
MSW	
HHA	
Other	
Total Contract Labor	
Medical Supplies	$4 per visit
Mileage & Medical transportation	$6 per visit
Total Patient Care Costs	
Gross Patient Margin	
ADMINISTRATIVE COSTS	
Advertising	
Allocated Costs	5% of Revenue
B & O Taxes	1.9% of Revenue
Dues & Subscriptions	Represents 50% of Total .50 King County, .50 Pierce
Employee Benefits	25% of Administrative S & W non variable
Information Tech/Computers/R&M	Represents 50% of Total .50 King County, .50 Pierce
Insurance	Represents 50% of Total .50 King County, .50 Pierce
Legal & Professional	Generally part of allocated costs
Licenses & Fees	Represents 50% of Total .50 King County, .50 Pierce
Lease Agreement	70%, King, 30% Pierce, no lease escalator after Feb 28, 2022
Administrative S & W non variable	70%, King, 30% Pierce
Supplies and Expensed Equipment	Estimate based on experience
Mileage - admin/sales	50% of total
Misc. Operating Expenses	Non-recurring, non-budgeted -- reconciled by adjusting other budget categories if occurring
Total Administrative Costs	
Total Costs	
EBITDA	
Depreciation	No new fixed equipment needed
Amortization	No new fixed equipment needed
EBIT	
Interest Expense	All the interest expense on the P&L for Eden Home Health of King County is interest that is associated with the AR collateralized working capital revolving line of credit that EmpRes Group maintains with MidCap Financial. We make daily draws on said Line of Credit to meet our working capital needs, and every month our GL group allocates the interest that is accrued on that Line of Credit out to our individual operating entities.
Earnings before Taxes	

ATTACHMENT L6 - PROFORMA OPERATING STATEMENT ASSUMPTIONS FOR PIERCE, KING, COMBINED & KING W/O PIERCE

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT M

LETTER OF FINANCIAL COMMITMENT

November 18, 2020

Eric Hernandez, Program Manager
Certificate of Need Program
Washington State Department of Health
111 Israel Road SE Tumwater, WA 98501

RE: Eden Home Health of King County, LLC Addition of Pierce County to Service Area

Dear Ms. Hernandez:

The Certificate of Need program's application for a Medicare-certified home health agency asks for a financial letter of commitment.

The Members of Eden Home Health of King County, LLC have committed the necessary working capital to finance the expansion of the home health service to Pierce County.

On receipt of the Washington Certificate of Need, the members of Eden Home Health of King County, LLC will contribute sufficient funds, currently estimated at approximately $150,000, to the working capital account of Eden Home Health of King County, LLC.

Sincerely,

Michael J. Miller
Chief Financial Office
EmpRes Healthcare Management, LLC

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT N

CONTINUING EDUCATION POLICY
QAPI POLICY
AIDE ORIENTATION POLICY

CONTINUING EDUCATION PROGRAMS POLICY

PURPOSE:

- To provide planned ongoing educational activities for Eden Home Health staff that:
  - Develop and enhance staff skills.
  - Broaden and increase staff knowledge base.
  - Maintain and improve staff competency.

POLICY:

1. This Agency provides educational programs appropriate to the staff's patient care, treatment, and services responsibilities specific to the needs of the patient population served, and as required by applicable laws, regulations, and standards.

2. Educational programs are provided to those staff members whose responsibilities have changed.

3. An annual educational program is planned and implemented based on identified staff needs.

4. Home Health Aides receive a minimum of 12 hours of inservice training every 12 months. Inservice training may occur when an aide is furnishing care to a patient under the supervision of an RN.

5. Staff are evaluated annually and as needed to identify educational needs.

6. Patient care, treatment, and services staff are required to attend or produce evidence of having attended the appropriate number of continuing education programs required by law and regulation to maintain currency of licensure and/or certification.

7. Staff are required to attend, or provide proof of having participated in, mandatory inservice programs. These mandatory inservice training programs include:

- **a.** OSHA/Bloodborne Pathogens
- **b.** Infection Prevention and Control
- **c.** Domestic Violence
- **d.** Workplace Violence Prevention
- **e.** Personal Safety
- **f.** CPR
- **g.** Fire Safety
- **h.** Emergency Management
- **i.** Pain Management
- **j.** Death and Dying
- **k.** Adverse Event Reporting

8. Eden Home Health administration retains the right to designate other inservice programs as mandatory programs.

INSERVICE RESPONSIBILITIES:

1. The Clinical Manager or designee is responsible for providing current and factual information to his/her staff regarding performance of their job duties. New procedures or policies governing such duties are conveyed to the staff in a manner that is understandable and reasonable to those involved. Records of such programs are retained as described in this policy.

2. The administration provides up-to-date and factual information to staff regarding policies, procedures, and benefits. In most cases, policies and procedures are conveyed to department managers, who convey such information to their staff.

PROCEDURE - INSERVICE ATTENDANCE:

1. *Mandatory Inservice Meetings:* Those meetings which have been determined necessary for staff within a particular department or group of common interest are considered to be mandatory. Mandatory attendance is at the discretion of the Clinical Manager or designee with approval of the Executive Director/Administrator or Director of Clinical services.

- **a.** Mandatory meetings are generally those that provide vital and necessary information to staff involved, and attendance is requested with prior notice to those required to attend. Staff receive their regular rate of pay for attendance at mandatory meetings, unless their attendance is not specifically requested. If attendance at a mandatory meeting involves overtime for staff during that work week, specific approval from the department manager is required if an alternate attendance time cannot be arranged.

2. *Voluntary Inservice Meetings:* Those meetings for which attendance is not deemed necessary and vital to a particular department or group of common interest are considered to be voluntary. Attendance at voluntary meetings is at the discretion of the staff member, based on his/her interest in the subject being presented.

3. Credit for Attendance at Inservice Programs:

- **a.** In order to receive proper credit for attendance, the staff member signs his/her name on the sign-in sheet provided at each meeting.
- **b.** The staff member attends the entire program in order to receive credit for attendance.

4. Continuing Education Credits:

- **a.** Programs for which continuing education credits are offered are advertised as such.
- **b.** The number of credit hours is listed with the program information.

c. In order to receive appropriate continuing education credits and a certificate, participants:
    i. Attend the entire program.
    ii. Sign the attendance sheet.

5. Internal Scheduling of Inservice Programs:
a. *Equipment and Supplies:* Audiovisual and other inservice equipment is maintained by the Business Office Manager. Those who desire use of this equipment submit a written request as early in advance as possible.
    i. Supplies necessary for inservice programs are the responsibility of the individual conducting the program. Prior administrative approval is required for expenditures made for inservice program supplies.
b. *Meeting Room Availability:* Meeting rooms are reserved in advance as early as possible through administration.

6. Record Keeping for Education Programs:
a. Records of education programs are maintained in the employee's personnel file or electronically. Proper record keeping contains the following information:
    i. Names and signatures of staff who attended the program.
    ii. Title of the program, name of the individual conducting the program, dates, and times the program was conducted, and the location of the program.
    iii. A description of the content of the program, its relation to the department, and/or staff and voluntary/mandatory status of the program.
b. Results of education program evaluation are compiled and summarized by the Clinical Manager.
c. Summary reports of educational activities and the results of program evaluations are submitted to the Performance Improvement Committee quarterly.

QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) POLICY

PURPOSE:

1. The Agency's Quality Assurance Performance Improvement (QAPI) plan is designed to:

- **a.** Delineate expectations and plan and manage processes to measure, assess, and improve Eden Home Health's Agency's governance, management, clinical, and support activities.
- **b.** Promote positive patient outcomes through the application of optimal patient care, treatment, and services based on clinically sound principles and current knowledge.
- **c.** Identify, on an ongoing basis and in a coordinated and collaborative manner, areas for improvement in the quality of care, treatment, and services.
- **d.** Evaluate, monitor, improve, and resolve areas of concern.

2. The Quality Assurance Performance Improvement (QAPI) plan, established by the senior management of the organization in collaboration with staff members and the Performance Improvement Committee, with the support and approval of the Governing Body, is comprehensive in scope and provides a vehicle to monitor patient care, treatment, and services with the goal of identifying and resolving processes, functions, and services that may adversely impact patient care, treatment, and services, while striving to continuously facilitate positive patient outcomes.

POLICY:

1. The Home Health Agency develops implements and maintains an ongoing, effective, data driven Quality Assurance Performance Improvement (QAPI) program.

2. The Governing Body guarantees the following;

- **a.** The program reflects the complexity of its organization and services.
- **b.** Involves all Home Health agency services (including those under contract or arrangement).
- **c.** Focuses on indicators related to improved outcomes including;
  - **i.** Use of emergency care services.
  - **ii.** Hospital admissions and readmissions.
  - **iii.** Takes actions that address the performance across the spectrum of care.
  - **iv.** Prevention and re-education of medical errors.

Eden Home Health's Quality Assurance Performance Improvement (QAPI) plan is evaluated at least annually and revised as necessary.

3. The Quality Assurance Performance Improvement (QAPI) activities are planned in a collaborative, interdisciplinary manner throughout the organization.

4. In keeping with the organization's mission of providing quality, cost-effective patient care, treatment, and services, the Quality Assurance Performance Improvement (QAPI) plan allows for a systematic, coordinated, and continuous approach to improving performance, focusing upon the process and functions that address these principles.

GOALS:

1. The primary goals of the organizational Quality Assurance Performance Improvement (QAPI) Plan are to continually and systematically plan, design, measure, assess, and improve performance of organization wide key functions and processes relative to patient care, treatment, and services.

2. To achieve this goal, the plan strives to:
    - **a.** Incorporate quality planning throughout the organization.
    - **b.** Collect data to monitor performance.
    - **c.** Provide a systematic mechanism for the organization's appropriate individuals, departments, and professions to function collaboratively in their Quality Assurance Performance Improvement (QAPI) efforts providing feedback and learning throughout the Agency.
    - **d.** Provide for an organization-wide program that assures the Agency designs processes (with special emphasis on design of new or revisions in established services) well and systematically measures, assesses, and improves its performance to achieve optimal patient health outcomes in a collaborative, cross-departmental, interdisciplinary approach. These processes include mechanisms to assess the needs and expectations of patients and their families, staff, and others. Process design contains the following focus elements:
        - **i.** Consistency with the organization's mission, vision, values, goals, and objectives and plans.
        - **ii.** Meets the needs of individuals served, staff, and others.
        - **iii.** Fosters the safety of patients and the quality of care, treatment, and services.
        - **iv.** Supports a culture of safety and quality.
        - **v.** Use of clinically sound and current data sources (e.g. use of practice/clinical guidelines, information from relevant literature and clinical standards).
        - **vi.** Is based upon best practices as evidenced by accrediting bodies.
        - **vii.** Incorporates available information from internal sources and other organizations about the occurrence of medical errors and sentinel events to reduce the risk of similar events in this organization.
        - **viii.** Utilizes reports generated from OASIS data, including the following OASIS reports:
            - Outcome-Based Quality Monitoring (OBQM) Potentially Avoidable Events Report and Patient Listing.
            - Outcome-Based Quality Improvement (OBQI) Outcome Report.

- Error Summary Report.

ix. Utilizes the results of Quality Assurance Performance Improvement (QAPI), patient safety, and risk reduction activities.

x. Management of change and Quality Assurance Performance Improvement (QAPI) supports both safety and quality through the Agency.

e. The organization incorporates information related to these elements, when available and relevant, in the design or redesign of processes, functions, or services.

f. Assure that the improvement process is organization wide, monitoring, assessing, and evaluating the quality and appropriateness of patient care, treatment, and services, patient safety practices, and clinical performance to resolve identified problems and improve performance.

g. Appropriate reporting of information to the Governing Body to provide the leaders with the information they need in fulfilling their responsibility for the quality of patient care, treatment, and services, and safety is a required mandate of this plan.

3. Necessary information is communicated among departments/services when opportunities to improve patient care, treatment, and/or services and patient/staff safety practices impact more than one department/service.

4. The status of identified problems is monitored to assure improvement or resolution.

5. Information from departments/services and the findings of discrete Quality Assurance Performance Improvement (QAPI) activities are analyzed to detect trends, patterns of performance, or potential problems that may impact more than one department/service.

6. The objectives, scope, organization, and mechanisms for overseeing the effectiveness of monitoring, assessing, evaluation, and problem-solving activities in the Quality Assurance Performance Improvement (QAPI) program are evaluated at least annually and revised as necessary.

7. Important key aspects of care to the health and safety of patients are identified. Included are those that occur frequently or affect large numbers of patients; place patients at risk of serious consequences of deprivation of substantial benefit if care is not provided correctly or not provided when indicated; or care provided is not indicated, or those tending to produce problems for patients, their families, or staff.

8. Internal structures can adapt to changes in the environment.

SCOPE OF ACTIVITIES:

1. Eden Home Health measures, analyzes, and tracks quality indicators to enable the agency to assess processes of care, services, and operations.

2. The scope of the organizational Quality Assurance Performance Improvement (QAPI) program includes an overall assessment of the efficacy of Quality Assurance Performance Improvement (QAPI) activities with a focus on continually improving care, treatment, and services, and patient and staff safety practices.

3. The Home Health agency's performance improvement activities must;
   a. Focus on high risk, high volume, or problem-prone areas.
   b. Consider incidence, prevalence, and severity of problems in those areas.
   c. Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients.

4. Performance activities must track adverse patient events, analyze their causes, and implement preventative actions.

5. Assessment of the performance of the following patient care and organizational functions may include but not limited to:
   a. Environment of Care.
   b. Emergency Management, including:
   c. Review of the annual emergency management planning reviews.
   d. Review of emergency response exercises.
   e. Review of response to actual emergencies.
   f. Human Resources.
   g. Infection Prevention and Control.
   h. Information Management.
   i. Leadership.
   j. Medication Management.
   k. Provision of Care, Treatment, and Services.
   l. Performance Improvement.
   m. Record of Care, Treatment, and Services.
   n. Rights and Responsibilities of the Individual.
   o. Waived Testing.

PERFORMANCE IMPROVEMENT PROJECTS:

1. Home Health Agencies must conduct performance improvement projects.

2. The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the Home Health Agencies services and operations.

3. The Home Health Agency must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measureable progress achieved on these projects.

ORGANIZATION:

1. To achieve fulfillment of the objectives, goals, and scope of the organizational Quality Assurance Performance Improvement (QAPI) plan, the organizational structure of the program is designed to facilitate an effective system of monitoring, assessment, and evaluation of the care, treatment, and services provided within the Agency.
    - **a.** The Governing Body is ultimately responsible for the quality of patient care, treatment, and services provided.
        - **i.** The Governing Body requires staff, through the Performance Improvement Committee and Administration, to implement and report on the activities and the mechanisms for monitoring, assessing, and evaluating patient safety practices and the quality of patient care, treatment, and services, for identifying and resolving problems and for identifying opportunities to improve patient care, treatment, and services or performance throughout the organization. This process addresses those departments/disciplines that have a direct or indirect effect on patient care, treatment, and services, including management and administrative functions.
        - **ii.** The Governing Body, through the VP of Home Health and Hospice, Director of Clinical Service, and the Agency Administrator/Executive Director, provide for resources and support systems for the Quality Assurance Performance Improvement (QAPI) functions and risk management functions related to patient care, treatment, and services and safety.
    - **b.** The governing body is responsible for guaranteeing;
        - **i.** The ongoing program for quality improvement and patient safety is defined, implemented, and maintained.
        - **ii.** The Home Health Agency wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improved actions are evaluated for effectiveness.
        - **iii.** That clear expectations for patient safety are established, implemented, and maintained.
        - **iv.** That any findings of fraud or waste are appropriately addressed.

ANNUAL EVALUATION AND APPROVAL:

1. The organizational Quality Assurance Performance Improvement (QAPI) program is evaluated for effectiveness at least annually and revised as necessary to assure appropriateness of the approach to planning processes of improvement: setting priorities for improvement; assessing performance systematically; using statistically valid methods; implementing improvement activities on the basis of assessment; and sustaining achieved improvements.

CONFIDENTIALITY:

1. Information related to Quality Assurance Performance Improvement (QAPI) activities in accordance with this plan is confidential.
    a. Confidential information may include, but is not limited to, staff committee meetings, Quality Assurance Performance Improvement (QAPI) Executive Report, electronic data gathering and reporting, medical record reviews, and untoward incident reporting.
    b. Some information may be disseminated on a "need to know basis" as required by agencies such as federal review agencies, regulatory bodies, or another organization with a proven "need to know basis" as approved by the Agency's Administration and/or the Governing Body.

AIDE ORIENTATION POLICY

PURPOSE:

- To provide a consistent and formalized orientation program for Certified Home Health Aides.

POLICY:

1. Certified Home Health Aides hired by Eden Health participate in an orientation program before receiving patient care assignments.

2. Orientation of new Certified Home Health Aides is the joint responsibility of the Clinical Manager or designee.

PROCEDURE:

1. The Clinical Supervisor or designee is responsible for orienting newly hired Certified Home Health Aides to Eden Health's general Orientation as well as specific Home Health Aide orientation.

2. The Clinical Supervisor or designee is responsible for verifying that newly hired Certified Home Health Aides can demonstrate knowledge of and/or are competent in the following:

- **a.** Basic verbal and written English communication skills.
- **b.** Observation, reporting, and documentation of patient status and the care or service furnished.
- **c.** Reading and recording temperature, pulse, and respiration.
- **d.** Basic infection control procedures.
- **e.** Basic elements of body functioning and changes in body function that are reported to an aide's supervisor.
- **f.** Maintenance of a clean, safe, and healthy environment.
- **g.** Recognizing emergencies and knowledge of emergency procedures.
- **h.** The physical, emotional, and developmental needs of and ways to work with the populations served by the HHA, including the need for respect for the patient, his or her privacy, and his or her property.
- **i.** Appropriate and safe techniques in personal hygiene and grooming that include:
  - **i.** Bed bath.
  - **ii.** Sponge, tub, or shower bath.
  - **iii.** Shampoo, sink, tub, or bed.
  - **iv.** Nail and skin care.
  - **v.** Oral hygiene.
  - **vi.** Toileting and elimination.
  - **vii.** Safe transfer techniques and ambulation.
  - **viii.** Normal range of motion and positioning.
  - **ix.** Adequate nutrition and fluid intake.

x. Another task that the HHA may choose to have the home health aide performs.

j. The following competencies are evaluated while the aide is performing the tasks with a patient (tasks may be performed on a pseudo-patient such as another aide or volunteer in a laboratory setting):

i. Reading and recording temperature, pulse, and respiration.

ii. Safe transfer techniques and ambulation.

iii. Normal range of motion and positioning.

iv. Appropriate and safe techniques in personal hygiene and grooming that include:

- Bed bath.
- Sponge, tub, or shower bath.
- Shampoo, sink, tub, or bed.
- Nail and skin care.
- Oral hygiene.
- Toileting and elimination.
- The other subject areas in this section may be evaluated through written examination, oral examination, or after observation of a Home Health Aide with a patient.

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT P

VENDOR LIST

C: Structure and Process of Care
#8
Appendix P:
Eden Home Health Vendor Listing

1. Medical Supplies – Medline
2. Quality and Outcomes Vendor – Strategic Healthcare Partners (SHP)
3. HHCAHPS – Strategic Healthcare Partners (SHP)
4. Electronic Health Record – Homecare Homebase
5. Clearing House – Zirmed
6. Telephone/Internet Services – Verizon Wireless and Comcast
7. Shredding – Iron Mountain
8. Answering Service (after-hours) – TeleMed
9. Virtual Care Technology/Telehealth – Healthcare Recovery Services (HRS)
10. Coding – Coding Department
11. Learning Management System – Relias
12. Online Patient Education – Krames
13. Shipping/Postage – FedEx
14. Payroll and HR System – Kronos
15. Hazardous Waste Disposal – Stericycle
16. Interpretation – Language Line Services
17. Recruiting – Indeed, Social Media Platforms (Facebook, LinkedIn, etc.)
18. Applicant Tracking System – Newton
19. Background Checks – Assure Hire
20. OIG Searches – Certiphino Screening
21. Office Supplies/Promotional Products – Office Depot

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT Q

Demographics and Social Characteristics Pierce County
2017

Pierce County

Chronic Disease Profile

Introduction

This report summarizes key health statistics related to chronic disease burden and risk for local populations in Washington State. The Department of Health uses established population and health surveillance systems to describe the current prevalence[i] of important health indicators within specific populations, and also to provide comparisons of the prevalence within specific populations to the state overall.

These data can be used to plan interventions or describe the importance and need for health interventions. Interventions may be directed to specific health conditions, or to factors that impact many aspects of health, such as income, education and housing. Therefore, this report may be useful for community members, leaders or other stakeholders who are working to improve the health status of the community.

Life Course Approach[ii]

Health and quality of life at all stages in life depend on the cumulative effects of behaviors and exposures earlier in life, and on social, genetic, and epigenetic effects[iii] that span generations. A mother's experiences even prior to conception can alter the development of the fetus and child. Choices made by adolescents grow out of the experiences of childhood, and can shape behavior later in adulthood. A lifetime of risky behavior or exposure to toxic or stressful conditions can lead to chronic disease, poor quality of life and early death.

This report is organized based on a life course approach. We begin with data on the demographic, social and economic context. Next we show data related to birth and early childhood. We follow these in turn by data for youth (grade 10), adults (age 18+) and seniors (age 65+). Lastly, we provide patterns of mortality.

Health Risk Indicators

Many pieces of health data can be presented in either a positive or negative manner. For example, we could either talk about reducing obesity, or achieving healthy weight. For other data, only the negative presentation makes sense. For example, it would be awkward to discuss increasing the prevalence of people without diabetes. For consistency and ease of comparison, this document presents all data in terms of risk.

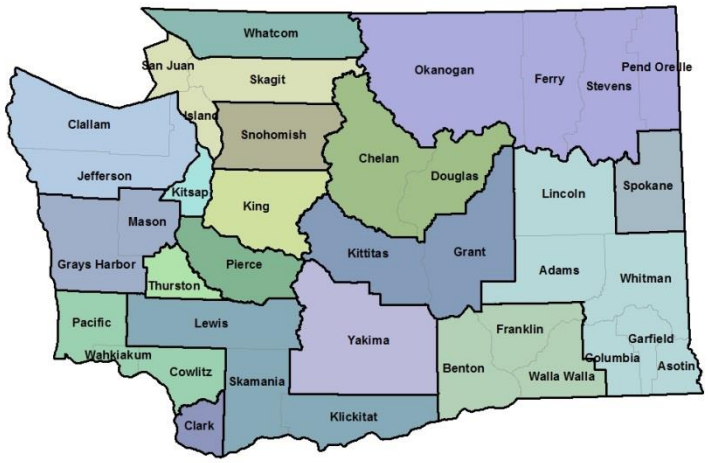
Health data are estimated with some degree of statistical uncertainty. We present the degree of uncertainty by surrounding each estimate in graphs with error bars that represent the 95% confidence interval. See appendix for further detail.

Data sources, explanatory notes, and a glossary of terms are provided in the appendix.

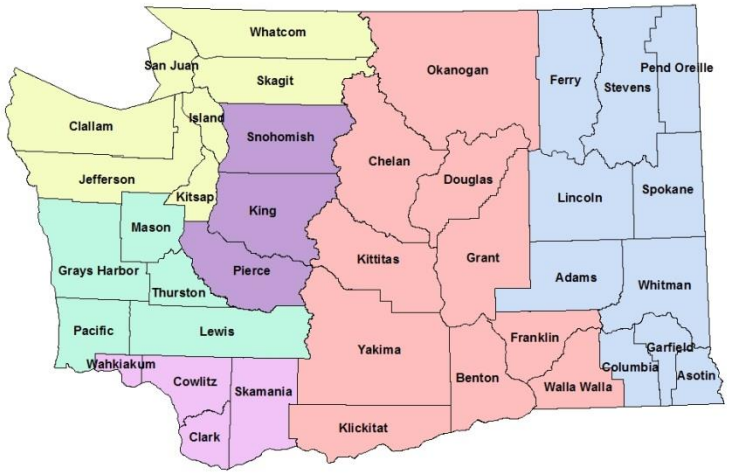
Geography and Sample Size

Whenever possible, we report local data at the county level. Due to small sample sizes in health surveys, this is not always possible. Estimates based on a sample of less than 50 people, or where less than 10 reported the condition of interest, or where the relative standard error[iv] is > 30% are not considered to be reliable. In these cases, we present local data for a multi-county region containing the county of interest, and place an asterix (*) in the chart. Geographic regions used in this report are shown in the maps below.

Map 1. Multi-county regions are based on US Census Bureau Public Use Microdata Areas (PUMA). We use PUMA-County regions when necessary for most data in this report.



Map 2. We use larger multi-county regions when necessary for Pregnancy Risk Assessment Monitoring System (PRAMS) data.



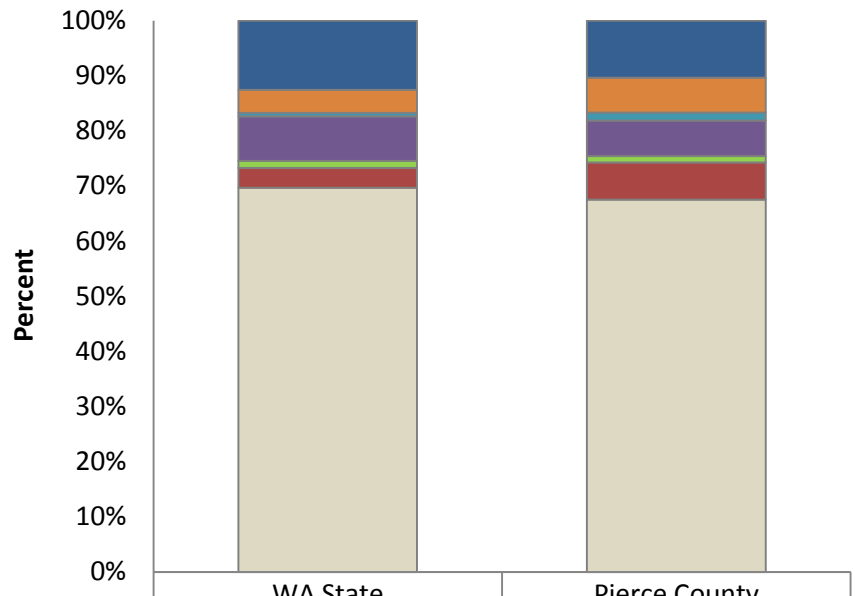
Population

Pierce County Population: 844,492 = 12% of state

Age Distribution

- Washington State: 15% are age 65+; 23% are age < 18
- Pierce County: 14% are age 65+; 24% are age < 18

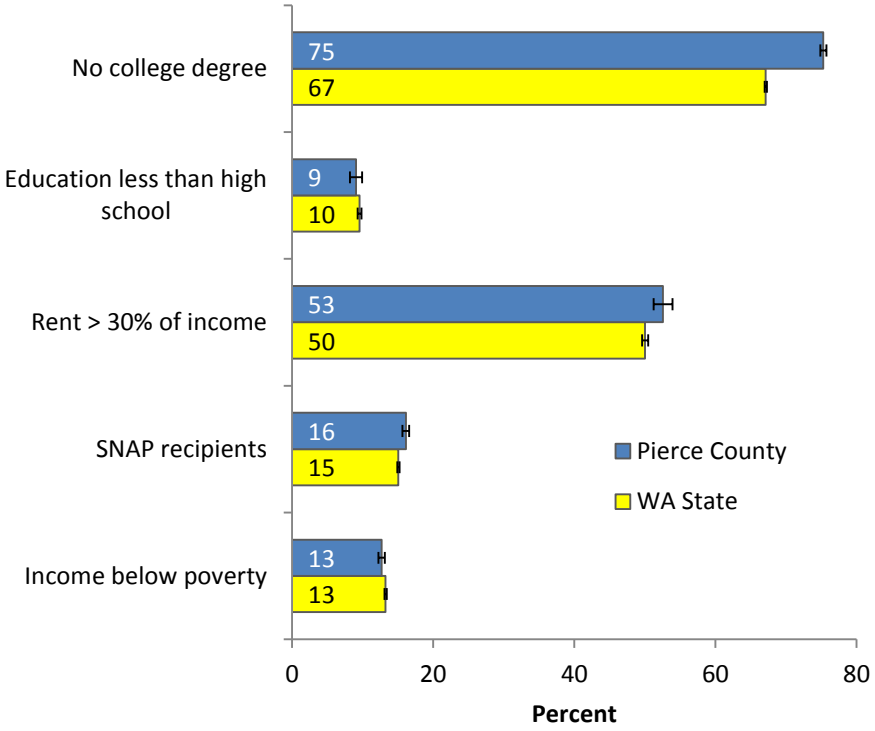
Population by Race / Ethnicity



	WA State	Pierce County
Hispanic	12.6%	10.4%
Non-Hispanic Multiracial	4.1%	6.3%
Non-Hispanic Native Hawaiian / Pacific Islander	0.7%	1.5%
Non-Hispanic Asian	8.0%	6.4%
Non-Hispanic American Indian / Alaska Native	1.3%	1.1%
Non-Hispanic Black	3.6%	6.7%
Non-Hispanic White	69.7%	67.6%

Data Source: Washington State Office of Financial Management, Forecasting Division, single year intercensal estimates, 2016

Social and Economic Risk Factors



Income Disparity

- Washington State: Gini index of income disparity = 0.45.
- Pierce County: Gini index of income disparity =0.42.

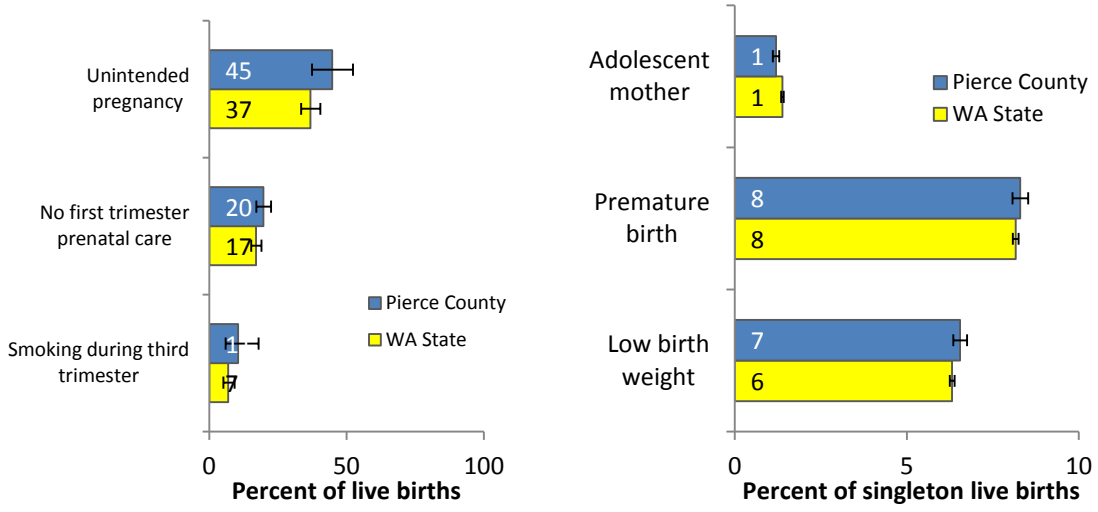
Gini index measures inequality in income. Values range from zero (perfect equality) to one (total inequality).

Indicator Notes

1. Federal Poverty Level (FPL) is determined based on household income and household size. In 2015, the federal poverty level household income for a family of four was $24,250.
2. Highest educational attainment is among adults 25 and older.

Data Source: US Census Bureau, American Community Survey (ACS), 2011-2015

Prenatal and Birth Health Risk Factors



Pregnancy Rate

- Washington State: 64 pregnancy per 1000 reproductive age women (age 15-44)
- Pierce County: 69 pregnancy per 1000 reproductive age women (age 15-44)

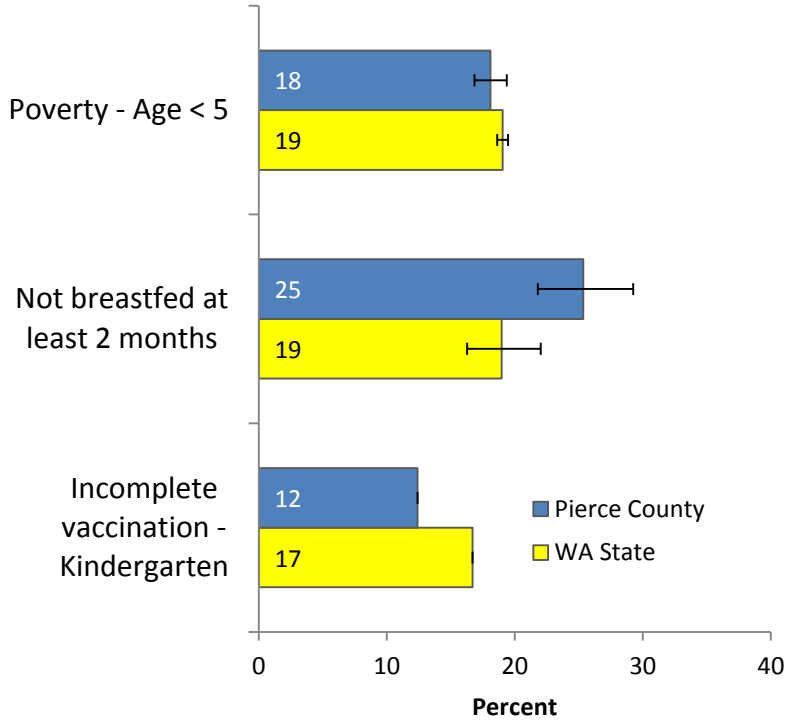
Indicator Notes

1. Third trimester smoking: Smoked one or more cigarettes on an average day during the last three months of pregnancy.
2. Prenatal care includes visits to a doctor, nurse, or other healthcare worker before the baby was born to get checkups and advice about pregnancy.
3. Unintended pregnancy: When asked “Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant?” responded “I wanted to become pregnant later” or “I didn’t want to be pregnant then, or in the future.”
4. Low birth weight is defined as a birth under 2,500g but no lighter than 227g. Infants born less than 227g are considered pre-viable.
5. Premature delivery is defined as gestation < 37 weeks.
6. Adolescent mother is defined as age 15-17.

Data Sources:

- Prenatal: Washington State Department of Health, Pregnancy Risk Assessment Monitoring System (PRAMS), 2012-2014.
- Birth outcomes: Washington State Department of Health, Center for Health Statistics (CHS), Birth Certificate Data, 2011-2015.
- Pregnancy rate: Washington State Department of Health, Center for Health Statistics (CHS), Birth Certificate Data, fetal deaths, and induced abortions, 2013-2015.

Early Childhood Health Risk Factors



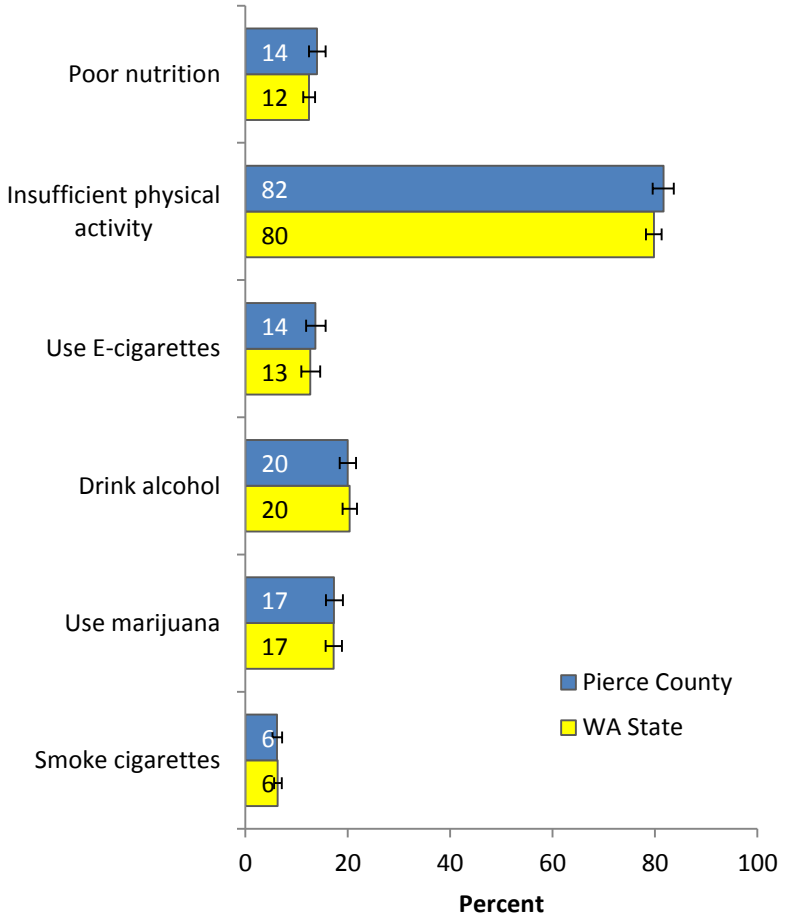
Indicator Notes

1. Incomplete vaccination: Student does not meet all the school-entry requirements for age and grade.
2. Breastfeeding: did not breastfeed baby, or breastfed for less than 8 weeks.
3. Child poverty: Age 0-4, living in a household with income less than FPL.

Data Sources:

- Child poverty: American Community Survey 2011-2015
- Breastfeeding: Pregnancy Risk Assessment Monitoring System 2012-2014
- Vaccination: Washington State Department of Health, Office of Immunization and Child Profile.2015-2016

Youth (10th grade) Health Risk Behaviors

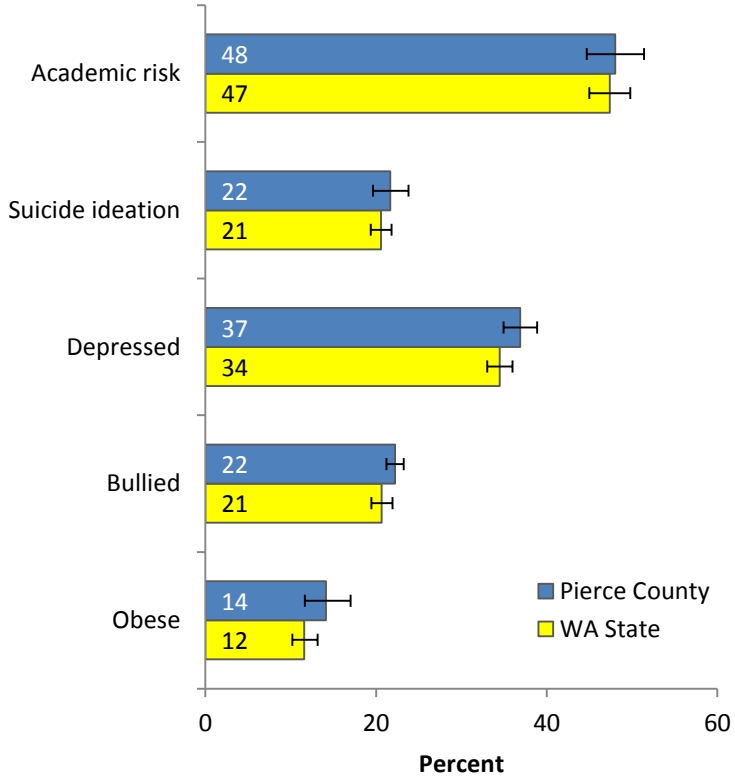


Indicator Notes

1. Youth smoking, marijuana, alcohol, e-cigarettes: Students are asked "during the past 30 days, how many times did you… Smoke cigarettes; Use marijuana or hashish (grass, hash, pot); Drink a glass, can, or bottle of alcohol (beer, wine, wine coolers, hard liquor); use electronic cigarettes or e-cigs?"
2. Soda consumption: Students were asked "How many sodas or pops did you drink yesterday (do not count diet soda)?"
3. The Centers for Disease Control and Prevention (CDC) recommends 60 minutes moderate or vigorous physical activity every day for youths.
4. Poor nutrition is indicated by eating fruits and vegetables less than once a day.

Data Source: Washington State Healthy Youth Survey 2016.

Youth (10th grade) Health Risk Conditions

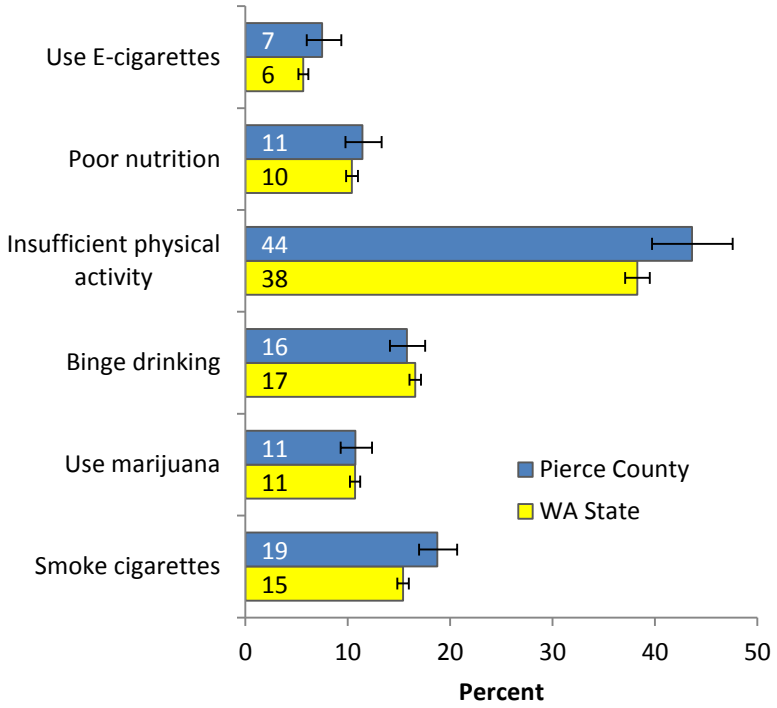


Indicator Notes

1. Youth obesity: Youth are classified as obese if they are in the 95th percentile for body mass index by age and sex based on growth charts developed by the CDC (2000).
2. Bullied: Students are asked "A student is being bullied when another student, or group of students, say or do nasty or unpleasant things to him or her. It is also bullying when a student is teased repeatedly in a way he or she doesn't like. It is NOT bullying when two students of about the same strength argue or fight. In the last 30 days, how often have you been bullied?"
3. Depression: Students were asked "During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?"
4. Suicide ideation: Students were asked "During the past 12 months, did you ever seriously consider attempting suicide?
5. Academic risk: Risk of academic failure including usually getting low grades and grades worse than others, and low commitment to school including school not meaningful or important for future, and cut school.

Data Source: Washington State Healthy Youth Survey 2016.

Adult (Age 18+) Health Risk Behaviors

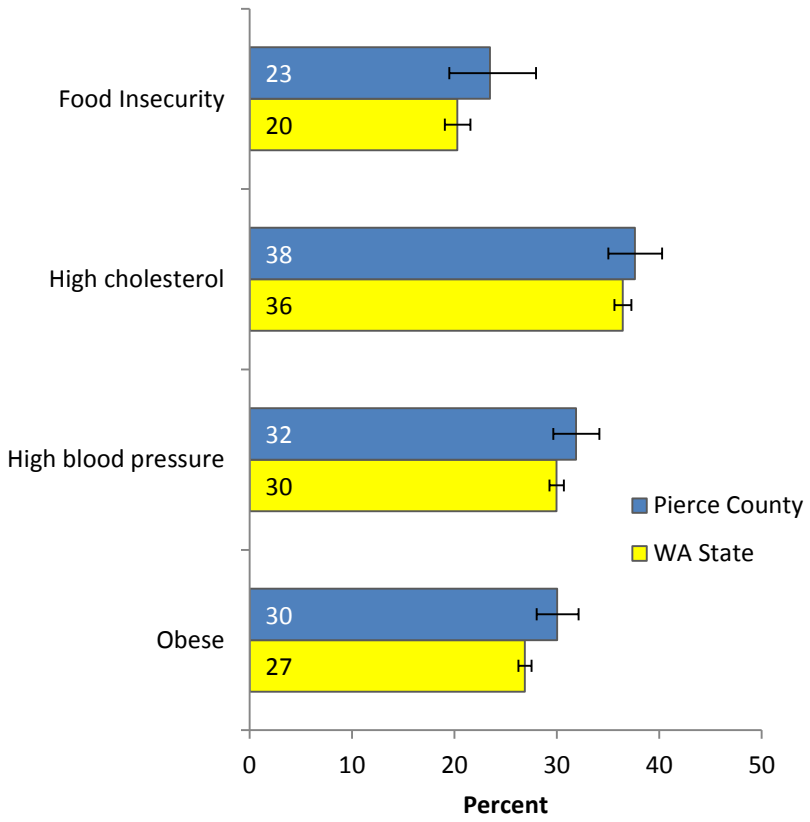


Indicator Notes

1. Adult smoking: Respondents are asked “Have you smoked at least 100 cigarettes in your lifetime?” and “Do you still smoke?”
2. Adult marijuana: Respondents were asked “During the past 30 days, on how many days did you use marijuana or hashish?”
3. Binge drinking: Past 30 days, adult men having five or more drinks or adult women having four or more drinks on one occasion.
4. CDC recommends 150 minutes of moderate aerobic physical activity or 75 minutes of vigorous aerobic physical activity a week, combined with some form of muscle strengthening activity three times a week. People whose work involves mostly walking meet the aerobic recommendation. People whose work involves heavy labor meet both the strength and aerobic recommendations.
5. Nutrition: Respondents are asked a series of questions about fruits and vegetables eaten in the past month. CDC recommends three servings of vegetables and two servings of fruit a day. Very poor nutrition is defined here as eating fruits and vegetables less than once a day.
6. E-Cigarettes: Respondent is asked “During the past 30 days, on how many days did you use electronic cigarettes, also called E-cigarettes or vape pens?”

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Adult (Age 18+) Health Risk Conditions

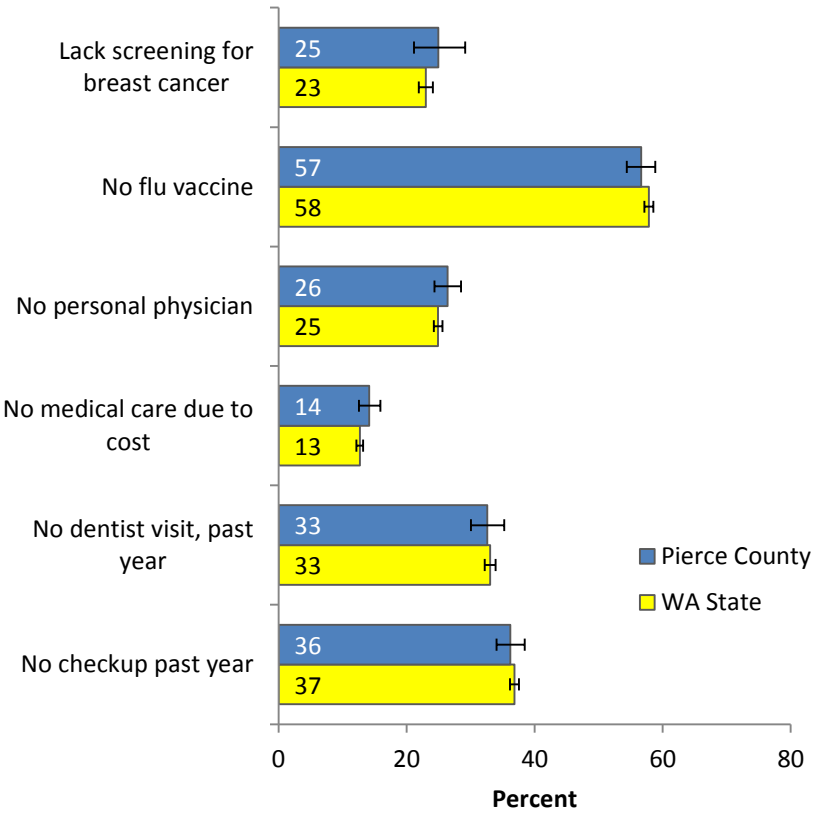


Indicator Notes

1. Obesity in adults is defined as body mass index ≥ 30 kg /m^2 based on self reported height and weight.
2. Self reported lifetime prevalence – Survey respondent answered "yes" to "have you ever been told by a healthcare professional that you have high blood pressure / high cholesterol?"
3. Food Insecurity: Respondents were asked "How often in the past 12 months would you say you were worried or stressed about having enough money to buy nutritious meals?" Responses of "sometimes", "usually", or "always" were considered to be food insecure.

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Adult (Age 18+) Preventive Care

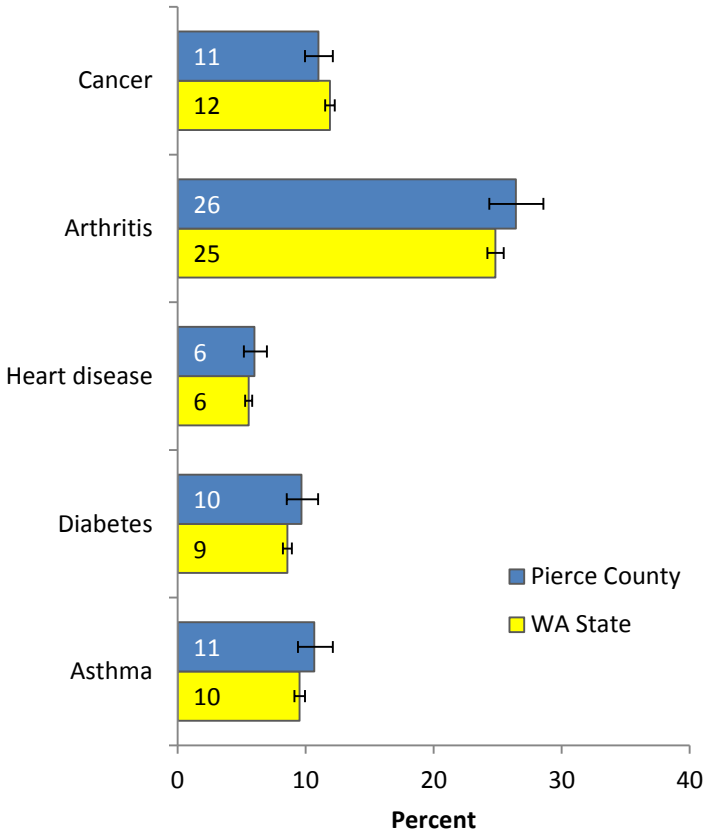


Indicator notes

1. The Department of Health recommends women age 50 or older should have a mammogram every two years.
2. Flu vaccine: Respondent has not had a flu vaccine in the past year.
3. Personal physician: Respondent is asked: “Do you have one person you think of as your personal doctor or health care provider?”
4. Respondent reports needing to see a doctor, but could not due to cost in the past year.
5. No dental visit: Respondent reports it has been more than a year since they visited a dentist for any reason.
6. No checkup: Respondent reports it has been more than a year since they had a routine medical checkup.

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Adult (Age 18+) Chronic Disease

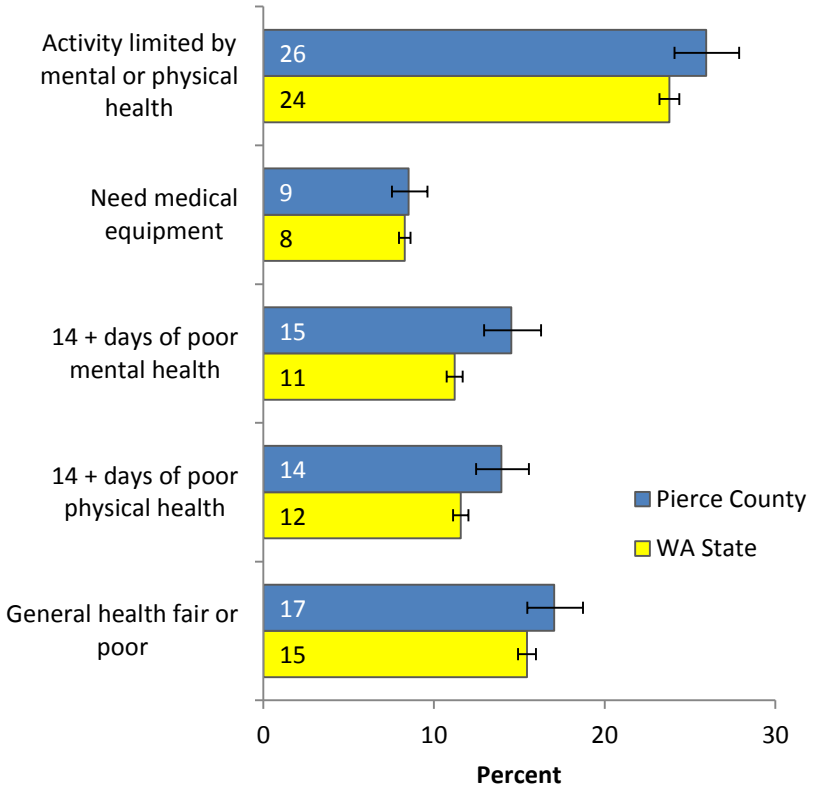


Indicator Notes

1. Self reported lifetime prevalence – Survey respondent answered “yes” to “have you ever been told by a healthcare professional that you have asthma / diabetes / heart attack, coronary heart disease, or angina / arthritis / cancer?”

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Adult (Age 18+) Quality of Life

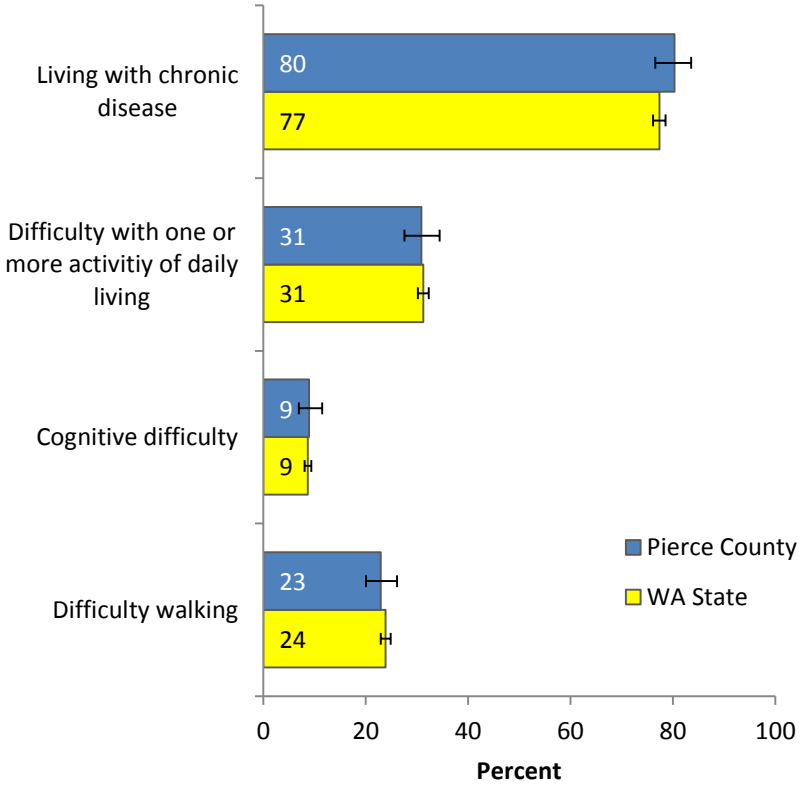


Indicator Notes

1. General health: respondent reports, in general, health is fair or poor.
2. Poor physical health: Respondent reports that on 14 or more of the past 30 days, their physical health was not good.
3. Poor mental health: Respondent reports that on 14 or more of the past 30 days, their mental health was not good.
4. Need medical equipment: Respondents are asked “Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?”
5. Activity limitation: Respondent is asked “Are you limited in any way in any activities because of physical, mental, or emotional problems?”

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Senior (Age 65+) Health Risks

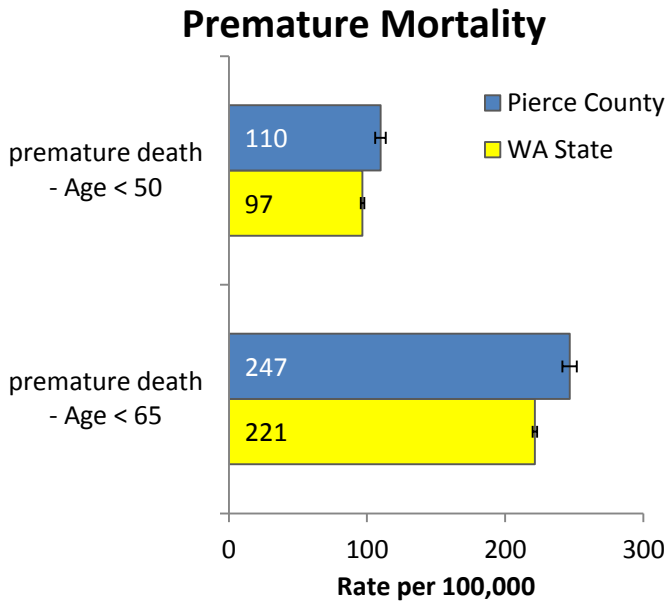


Indicator Notes

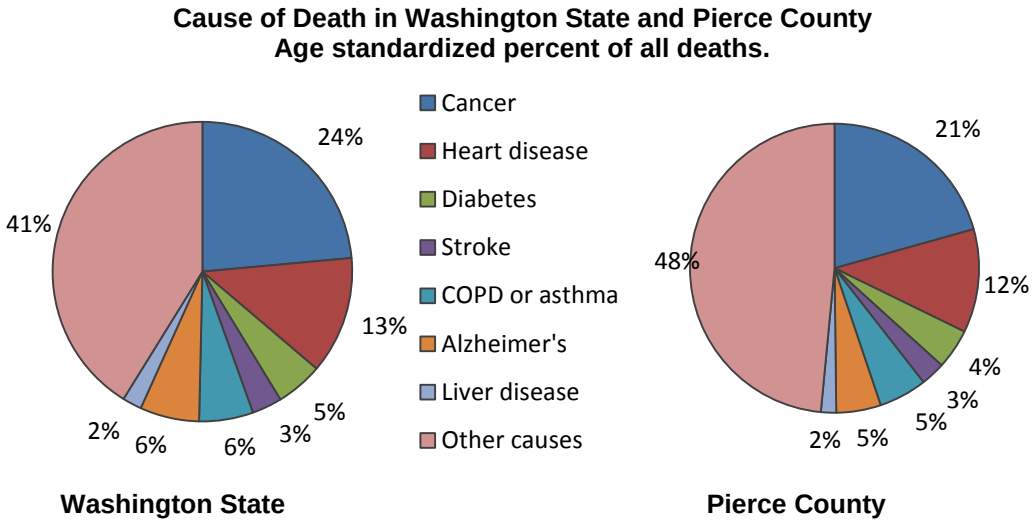
1. Living with chronic disease: Respondent is asked have you ever been told by a doctor or health care professional that you have … arthritis / asthma / COPD / cancer / diabetes, heart disease / stroke / kidney disease.
2. Activities of daily living: Respondent is asked if they have serious difficulty …seeing even with glasses / concentrating remembering or making decisions / walking or climbing stairs / dressing or bathing / doing errands alone such as visiting a doctor or shopping

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Mortality



.



Data Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data, 2013-2015.

Appendix: Data Sources & Definitions

The following provides references for more information on each data system and definitions of technical terms used in this report. Analyses for this report were completed using Stata/IC 13.0. Some estimates were obtained from previously published reports.

DATA SYSTEMS:

Office of Financial Management (OFM) Population Estimates

- For more information on OFM intercensal population estimates, go to: http://www.ofm.wa.gov/pop/default.asp

American Community Survey (ACS) and Public Use Microdata Sample (PUMS)

- For more information on the American Community Survey, go to: http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
- For more information on Public Use Microdata Sample go to: http://www.census.gov/acs/www/data_documentation/public_use_microdata_sample/

Pregnancy Risk Assessment Monitoring Survey (PRAMS)

- For more information on PRAMS, go to: http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/PregnancyRiskAssessmentMonitoringSystem.aspx

Washington Birth Certificate Data

- For more information on birth data, go to: http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/BirthData.aspx

Washington State Department of Health, Office of Immunization and Child Profile

- For more information on immunization data, go to: http://www.doh.wa.gov/DataandStatisticalReports/SchoolImmunization.aspx

Washington State Healthy Youth Survey (HYS)

- For more information on the HYS, go to: http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/HealthyYouthSurvey.aspx or http://www.askhys.net/

- For technical notes on the HYS, go to: http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/HealthyYouthSurvey/TechnicalNotes.aspx

Behavioral Risk Factor Surveillance System (BRFSS)

- For more information on Washington State BRFSS, go to: http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/BehavioralRiskFactorSurveillanceSystemBRFSS.aspx
- For more information on national BRFSS, go to: http://www.cdc.gov/brfss.

Washington State Death Certificate Data

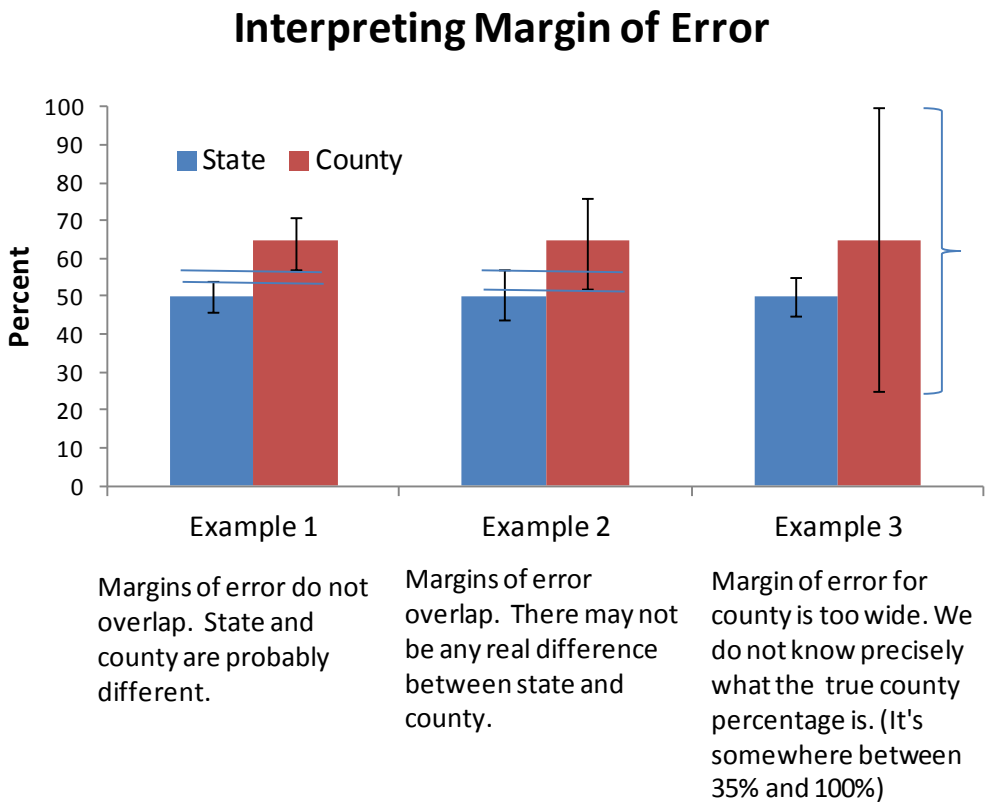
- For more information on death records, go to: http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathData.aspx

Washington State Cancer Registry (WSCR)

- For more information on WSCR, go to: https://fortress.wa.gov/doh/wscr/WSCR/

CONFIDENCE INTERVALS:

Most of the estimates provided in this report come with some intrinsic level of uncertainty due to the random nature of the data. Statistical uncertainty can be summarized by a 95% confidence interval, also called the margin of error. 95% confidence means that, if the survey were repeated in exactly the same way with a different random sample of people, the new estimate would fall within the confidence interval 95% of the time. Confidence intervals are represented on graphs by whisker bars above and below the estimate.



UNRELIABLE DATA:

Estimates based on too few respondents are considered to be unreliable, and may constitute a breach of confidentiality in some circumstances. In this report data with a numerator < 10, or a denominator < 50, or a relative standard error > 30% are not reported. In these cases, local data is presented for multi-county regions for which reliable estimates can be made.

GLOSSARY:

[i] Prevalence: The fraction of the population with a condition at a particular point in time, typically expressed as a percent.
[ii] Life course approach: A philosophy of public health that recognizes the importance of promoting health at all life stages.
[iii] Epigenetic: Conditions in the mother prior to conception can affect how certain genes are expressed in the child.
[iv] Relative standard error (RSE): Standard Error (SE) is a measure of the degree of statistical uncertainty or noise in the data, typically about half the MOE. Relative standard error (RSE) is SE expressed as a percent of the estimate.

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT R

CHRONIC DISEASE PROFILE - KING

King County

Chronic Disease Profile

Introduction

This report summarizes key health statistics related to chronic disease burden and risk for local populations in Washington State. The Department of Health uses established population and health surveillance systems to describe the current prevalence[i] of important health indicators within specific populations, and also to provide comparisons of the prevalence within specific populations to the state overall.

These data can be used to plan interventions or describe the importance and need for health interventions. Interventions may be directed to specific health conditions, or to factors that impact many aspects of health, such as income, education and housing. Therefore, this report may be useful for community members, leaders or other stakeholders who are working to improve the health status of the community.

Life Course Approach[ii]

Health and quality of life at all stages in life depend on the cumulative effects of behaviors and exposures earlier in life, and on social, genetic, and epigenetic effects[iii] that span generations. A mother's experiences even prior to conception can alter the development of the fetus and child. Choices made by adolescents grow out of the experiences of childhood, and can shape behavior later in adulthood. A lifetime of risky behavior or exposure to toxic or stressful conditions can lead to chronic disease, poor quality of life and early death.

This report is organized based on a life course approach. We begin with data on the demographic, social and economic context. Next we show data related to birth and early childhood. We follow these in turn by data for youth (grade 10), adults (age 18+) and seniors (age 65+). Lastly, we provide patterns of mortality.

Health Risk Indicators

Many pieces of health data can be presented in either a positive or negative manner. For example, we could either talk about reducing obesity, or achieving healthy weight. For other data, only the negative presentation makes sense. For example, it would be awkward to discuss increasing the prevalence of people without diabetes. For consistency and ease of comparison, this document presents all data in terms of risk.

Health data are estimated with some degree of statistical uncertainty. We present the degree of uncertainty by surrounding each estimate in graphs with error bars that represent the 95% confidence interval. See appendix for further detail.

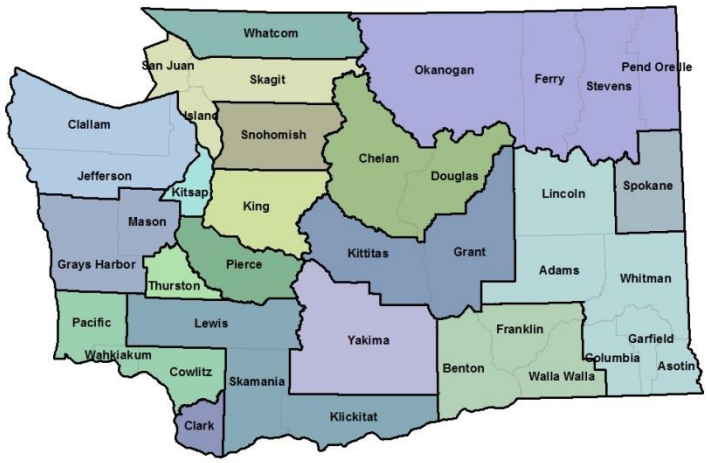
Data sources, explanatory notes, and a glossary of terms are provided in the appendix.

For people with disabilities, this document is available on request in other formats.
To submit a request, please call 1-800-525-0127 (TDD/TTY call 711).

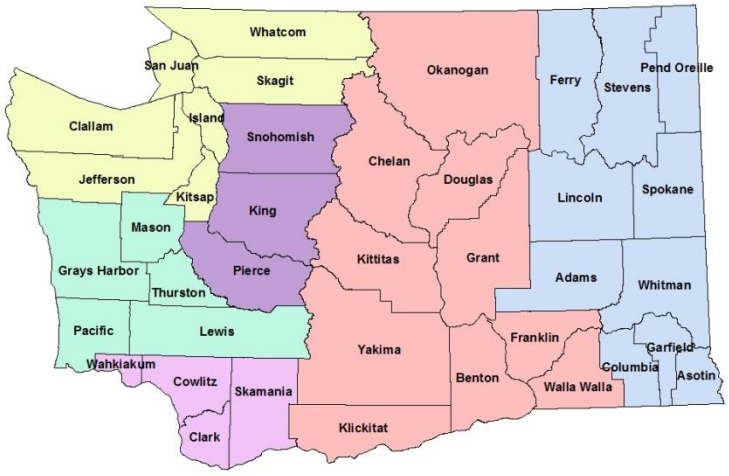
Geography and Sample Size

Whenever possible, we report local data at the county level. Due to small sample sizes in health surveys, this is not always possible. Estimates based on a sample of less than 50 people, or where less than 10 reported the condition of interest, or where the relative standard error[iv] is > 30% are not considered to be reliable. In these cases, we present local data for a multi-county region containing the county of interest, and place an asterix (*) in the chart. Geographic regions used in this report are shown in the maps below.

Map 1. Multi-county regions are based on US Census Bureau Public Use Microdata Areas (PUMA). We use PUMA-County regions when necessary for most data in this report.



Map 2. We use larger multi-county regions when necessary for Pregnancy Risk Assessment Monitoring System (PRAMS) data.



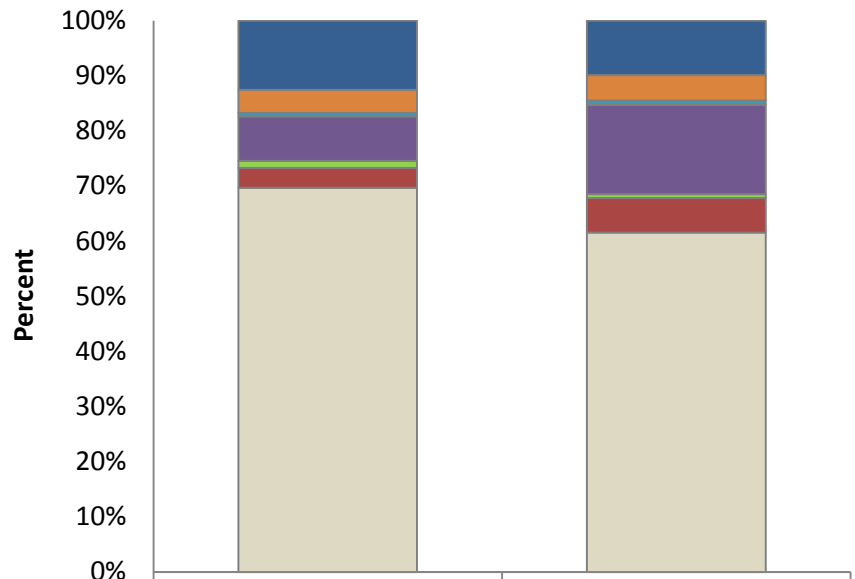
Population

King County Population: 2,105,100 = 29% of state

Age Distribution

- Washington State: 15% are age 65+; 23% are age < 18
- King County: 12% are age 65+; 21% are age < 18

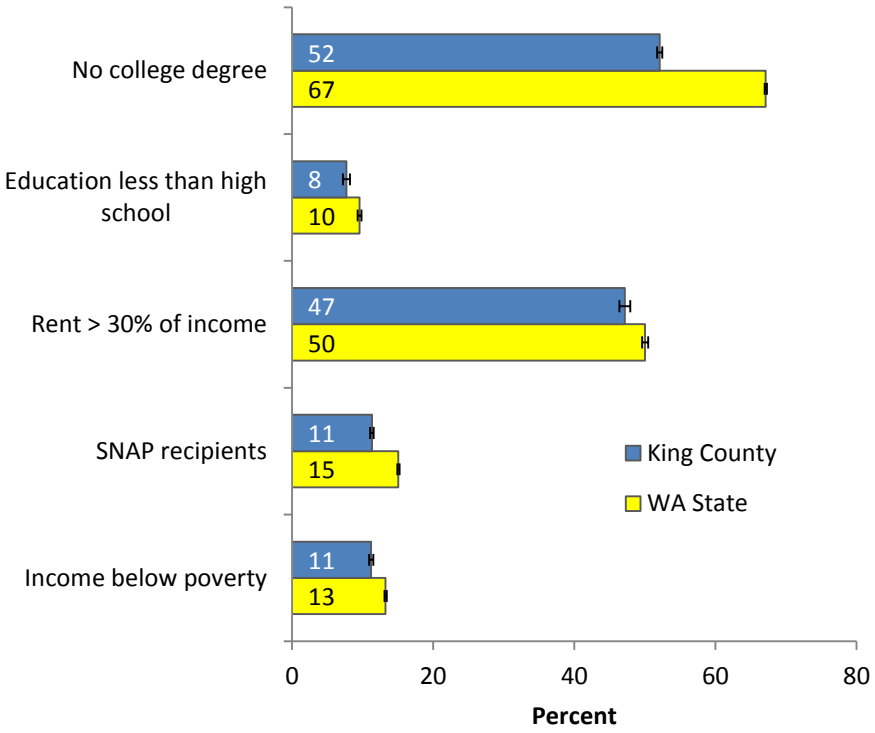
Population by Race / Ethnicity



	WA State	King County
Hispanic	12.6%	9.9%
Non-Hispanic Multiracial	4.1%	4.6%
Non-Hispanic Native Hawaiian / Pacific Islander	0.7%	0.8%
Non-Hispanic Asian	8.0%	16.2%
Non-Hispanic American Indian / Alaska Native	1.3%	0.6%
Non-Hispanic Black	3.6%	6.3%
Non-Hispanic White	69.7%	61.5%

Data Source: Washington State Office of Financial Management, Forecasting Division, single year intercensal estimates, 2016

Social and Economic Risk Factors



Income Disparity

- Washington State: Gini index of income disparity = 0.45.
- King County: Gini index of income disparity =0.47.

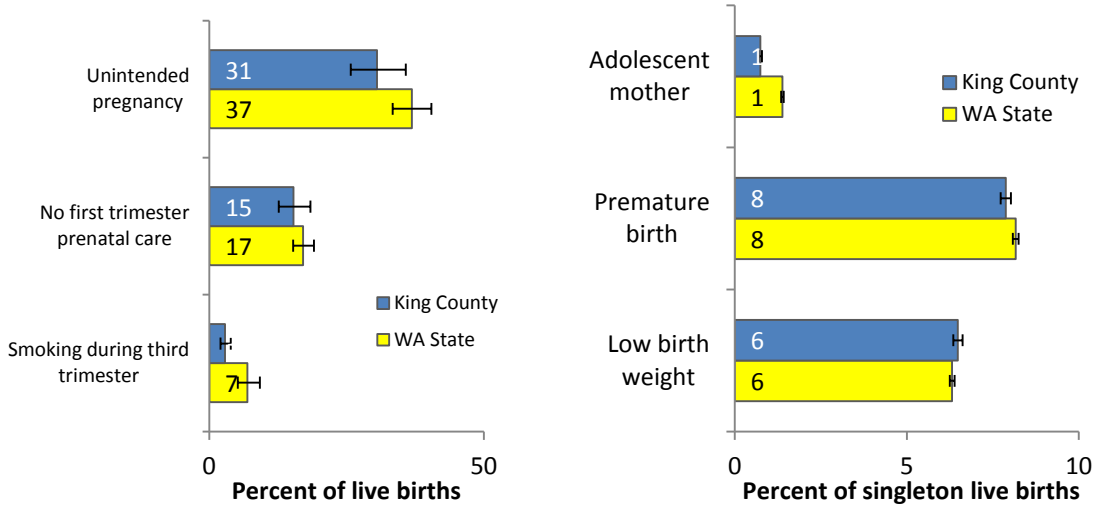
Gini index measures inequality in income. Values range from zero (perfect equality) to one (total inequality).

Indicator Notes

1. Federal Poverty Level (FPL) is determined based on household income and household size. In 2015, the federal poverty level household income for a family of four was $24,250.
2. Highest educational attainment is among adults 25 and older.

Data Source: US Census Bureau, American Community Survey (ACS), 2011-2015

Prenatal and Birth Health Risk Factors



Pregnancy Rate

- Washington State: 64 pregnancies per 1000 reproductive age women (age 15-44)
- King County: 59 pregnancies per 1000 reproductive age women (age 15-44)

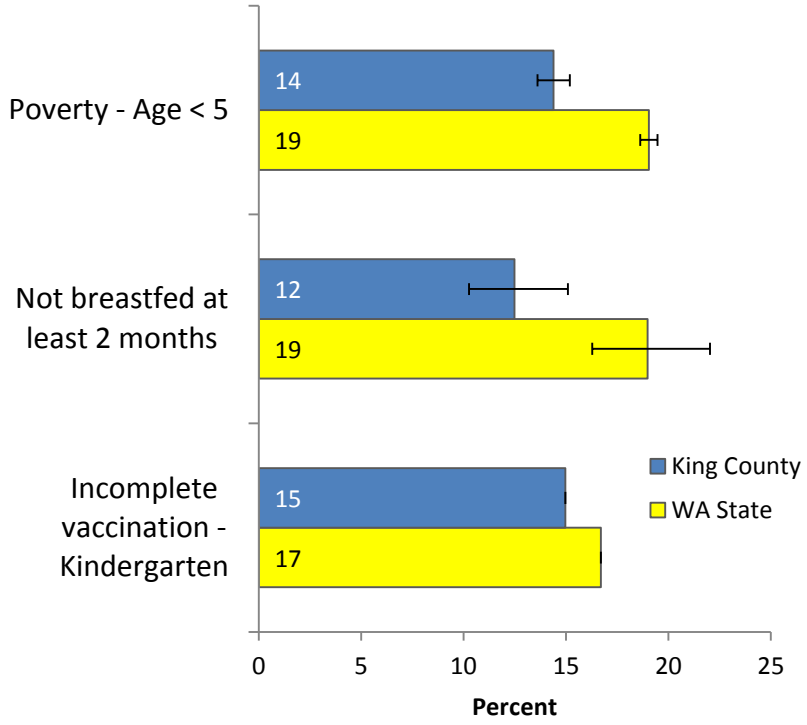
Indicator Notes

1. Third trimester smoking: Smoked one or more cigarettes on an average day during the last three months of pregnancy.
2. Prenatal care includes visits to a doctor, nurse, or other healthcare worker before the baby was born to get checkups and advice about pregnancy.
3. Unintended pregnancy: When asked “Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant?” responded “I wanted to become pregnant later” or “I didn’t want to be pregnant then, or in the future.”
4. Low birth weight is defined as a birth under 2,500g but no lighter than 227g. Infants born less than 227g are considered pre-viable.
5. Premature delivery is defined as gestation < 37 weeks.
6. Adolescent mother is defined as age 15-17.

Data Sources:

- Prenatal: Washington State Department of Health, Pregnancy Risk Assessment Monitoring System (PRAMS), 2012-2014.
- Birth outcomes: Washington State Department of Health, Center for Health Statistics (CHS), Birth Certificate Data, 2011-2015.
- Pregnancy rate: Washington State Department of Health, Center for Health Statistics (CHS), Birth Certificate Data, fetal deaths, and induced abortions, 2013-2015.

Early Childhood Health Risk Factors



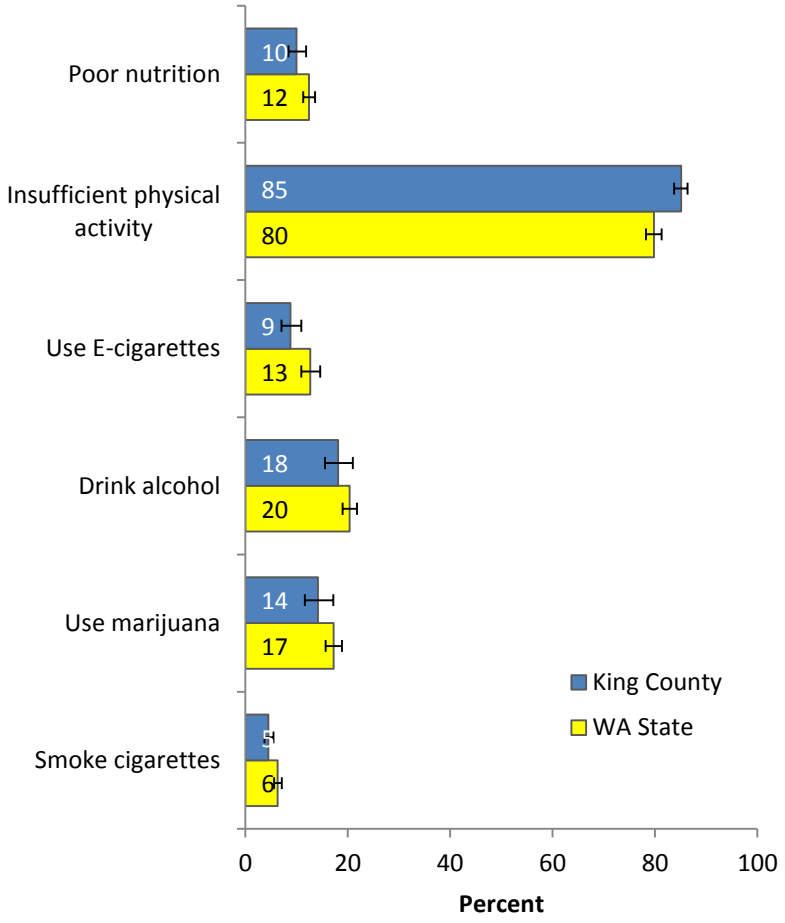
Indicator Notes

1. Incomplete vaccination: Student does not meet all the school-entry requirements for age and grade.
2. Breastfeeding: did not breastfeed baby, or breastfed for less than 8 weeks.
3. Child poverty: Age 0-4, living in a household with income less than FPL.

Data Sources:

- Child poverty: American Community Survey 2011-2015
- Breastfeeding: Pregnancy Risk Assessment Monitoring System 2012-2014
- Vaccination: Washington State Department of Health, Office of Immunization and Child Profile.2015-2016

Youth (10th grade) Health Risk Behaviors

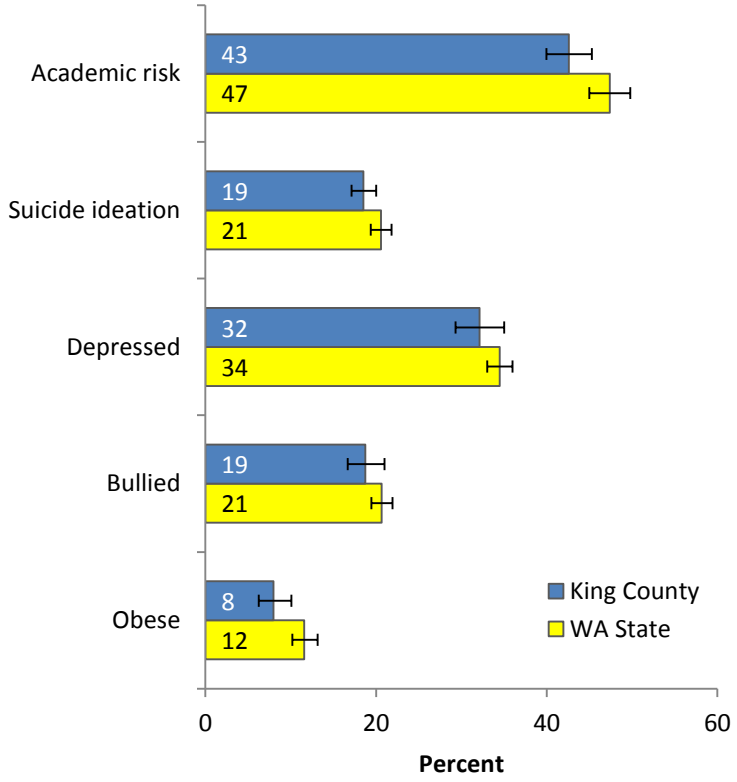


Indicator Notes

1. Youth smoking, marijuana, alcohol, e-cigarettes: Students are asked "during the past 30 days, how many times did you… Smoke cigarettes; Use marijuana or hashish (grass, hash, pot); Drink a glass, can, or bottle of alcohol (beer, wine, wine coolers, hard liquor); use electronic cigarettes or e-cigs?"
2. The Centers for Disease Control and Prevention (CDC) recommends 60 minutes moderate or vigorous physical activity every day for youths.
3. Poor nutrition is indicated by eating fruits and vegetables less than once a day.

Data Source: Washington State Healthy Youth Survey 2016.

Youth (10th grade) Health Risk Conditions

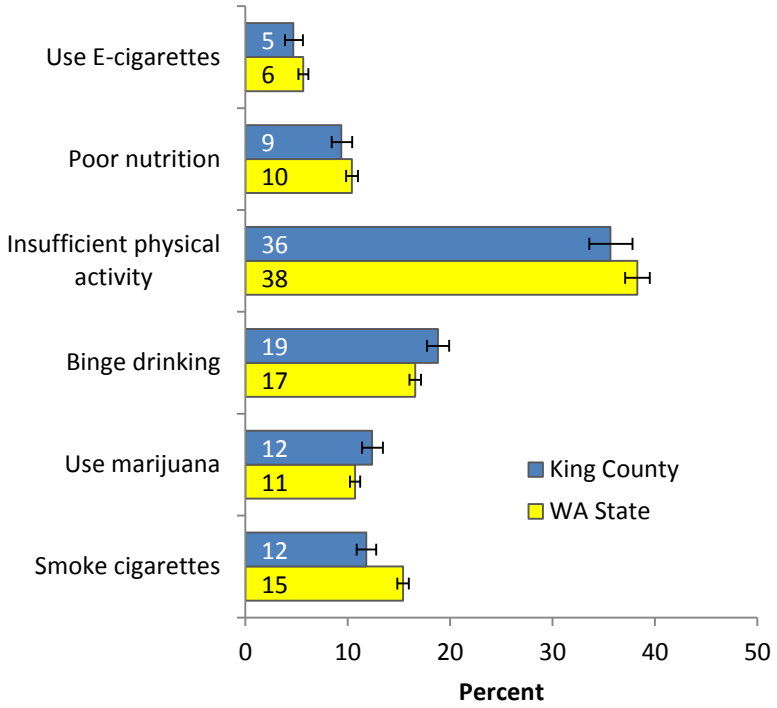


Indicator Notes

1. Youth obesity: Youth are classified as obese if they are in the 95th percentile for body mass index by age and sex based on growth charts developed by the CDC (2000).
2. Bullied: Students are asked "A student is being bullied when another student, or group of students, say or do nasty or unpleasant things to him or her. It is also bullying when a student is teased repeatedly in a way he or she doesn't like. It is NOT bullying when two students of about the same strength argue or fight. In the last 30 days, how often have you been bullied?"
3. Depression: Students were asked "During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?"
4. Suicide ideation: Students were asked "During the past 12 months, did you ever seriously consider attempting suicide?
5. Academic risk: Risk of academic failure including usually getting low grades and grades worse than others, and low commitment to school including school not meaningful or important for future, and cut school.

Data Source: Washington State Healthy Youth Survey 2016.

Adult (Age 18+) Health Risk Behaviors

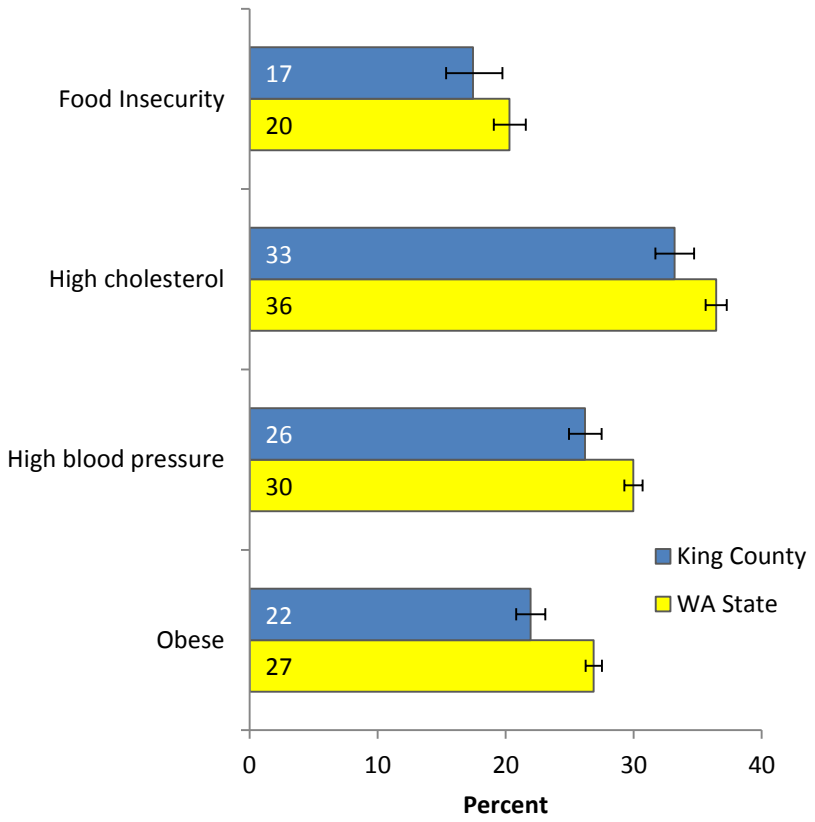


Indicator Notes

1. Adult smoking: Respondents are asked “Have you smoked at least 100 cigarettes in your lifetime?” and “Do you still smoke?”
2. Adult marijuana: Respondents were asked “During the past 30 days, on how many days did you use marijuana or hashish?”
3. Binge drinking: Past 30 days, adult men having five or more drinks or adult women having four or more drinks on one occasion.
4. CDC recommends 150 minutes of moderate aerobic physical activity or 75 minutes of vigorous aerobic physical activity a week, combined with some form of muscle strengthening activity three times a week. People whose work involves mostly walking meet the aerobic recommendation. People whose work involves heavy labor meet both the strength and aerobic recommendations.
5. Nutrition: Respondents are asked a series of questions about fruits and vegetables eaten in the past month. CDC recommends three servings of vegetables and two servings of fruit a day. Very poor nutrition is defined here as eating fruits and vegetables less than once a day.
6. E-Cigarettes: Respondent is asked “During the past 30 days, on how many days did you use electronic cigarettes, also called E-cigarettes or vape pens?”

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Adult (Age 18+) Health Risk Conditions

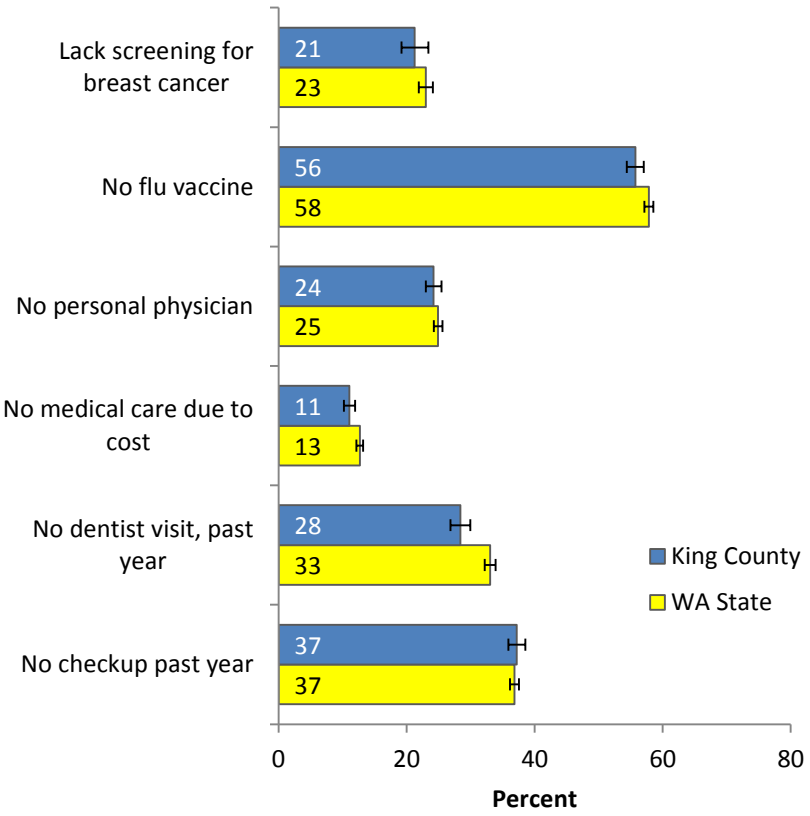


Indicator Notes

1. Obesity in adults is defined as body mass index ≥ 30 kg /m^2 based on self reported height and weight.
2. Self reported lifetime prevalence – Survey respondent answered "yes" to "have you ever been told by a healthcare professional that you have high blood pressure / high cholesterol?"
3. Food Insecurity: Respondents were asked "How often in the past 12 months would you say you were worried or stressed about having enough money to buy nutritious meals?" Responses of "sometimes", "usually", or "always" were considered to be food insecure.

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Adult (Age 18+) Preventive Care

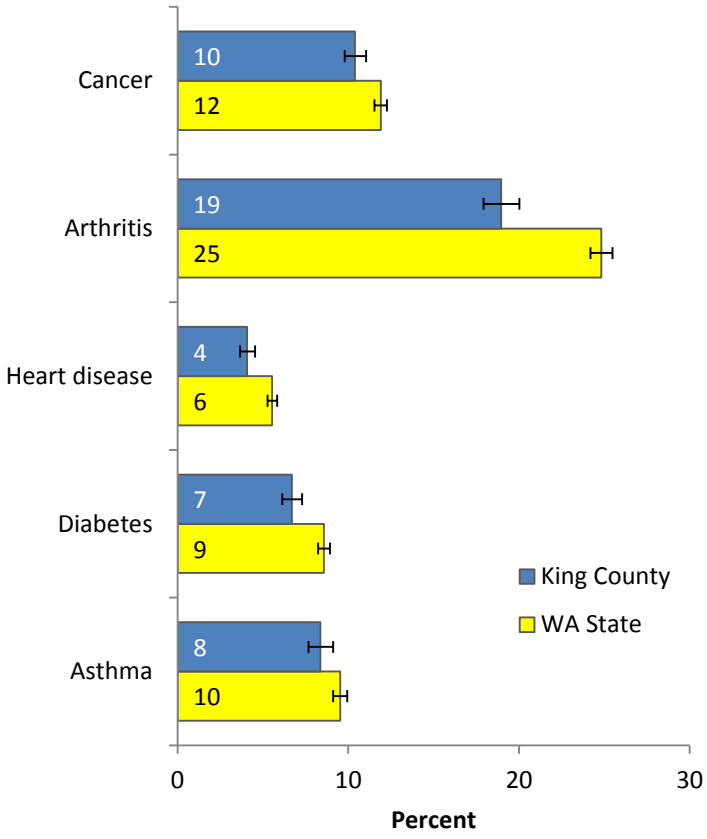


Indicator notes

1. The Department of Health recommends women age 50 or older should have a mammogram every two years.
2. Flu vaccine: Respondent has not had a flu vaccine in the past year.
3. Personal physician: Respondent is asked: “Do you have one person you think of as your personal doctor or health care provider?”
4. Respondent reports needing to see a doctor, but could not due to cost in the past year.
5. No dental visit: Respondent reports it has been more than a year since they visited a dentist for any reason.
6. No checkup: Respondent reports it has been more than a year since they had a routine medical checkup.

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Adult (Age 18+) Chronic Disease

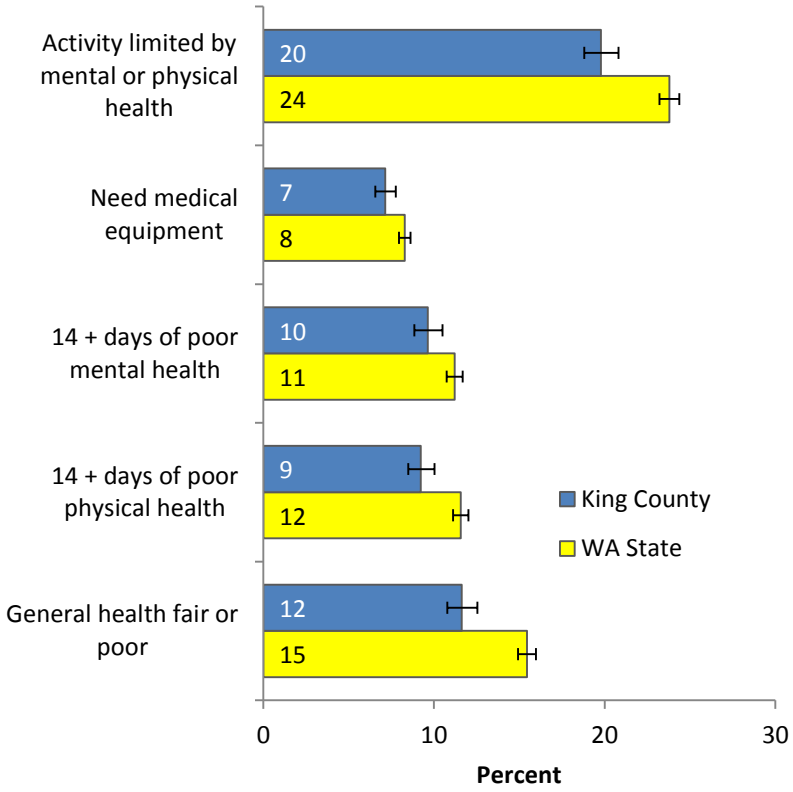


Indicator Notes

1. Self reported lifetime prevalence – Survey respondent answered “yes” to “have you ever been told by a healthcare professional that you have asthma / diabetes / heart attack, coronary heart disease, or angina / arthritis / cancer?”

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Adult (Age 18+) Quality of Life

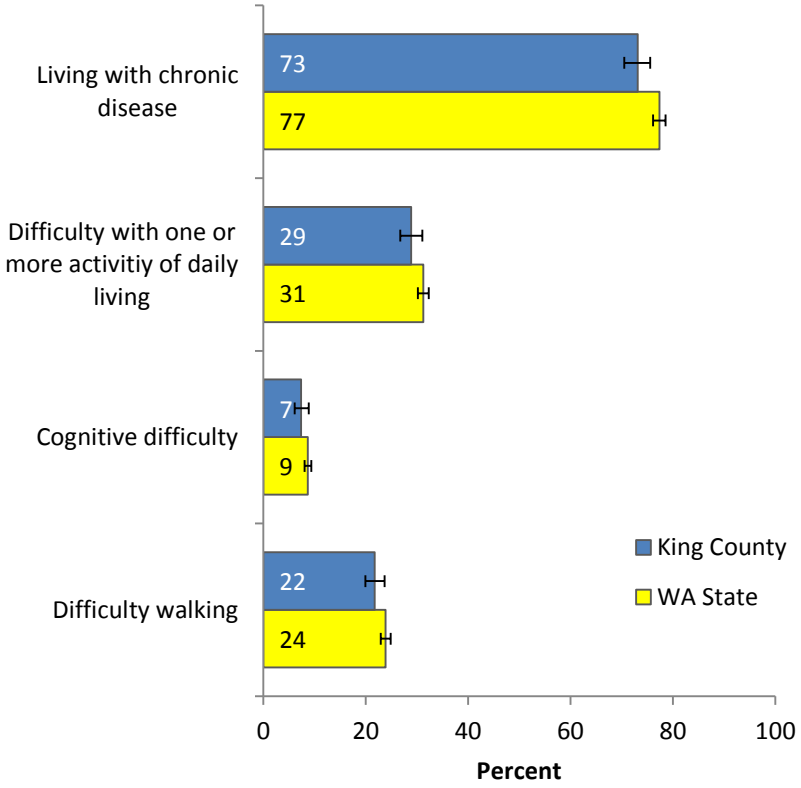


Indicator Notes

1. General health: respondent reports, in general, health is fair or poor.
2. Poor physical health: Respondent reports that on 14 or more of the past 30 days, their physical health was not good.
3. Poor mental health: Respondent reports that on 14 or more of the past 30 days, their mental health was not good.
4. Need medical equipment: Respondents are asked “Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?”
5. Activity limitation: Respondent is asked “Are you limited in any way in any activities because of physical, mental, or emotional problems?”

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Senior (Age 65+) Health Risks

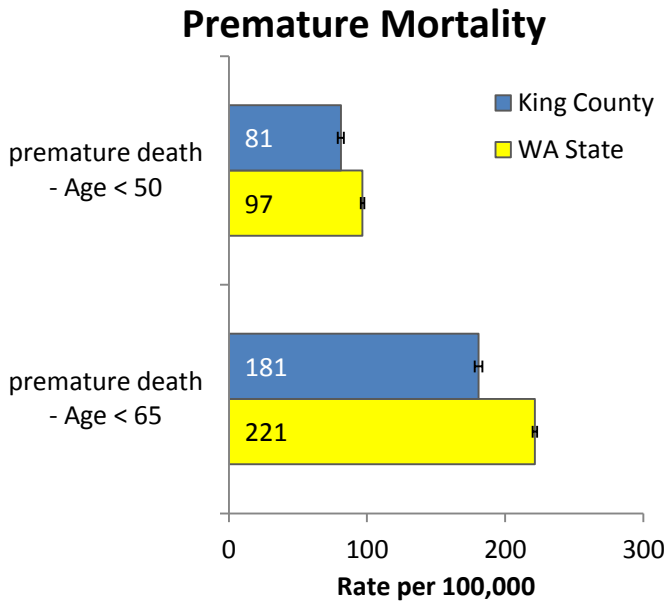


Indicator Notes

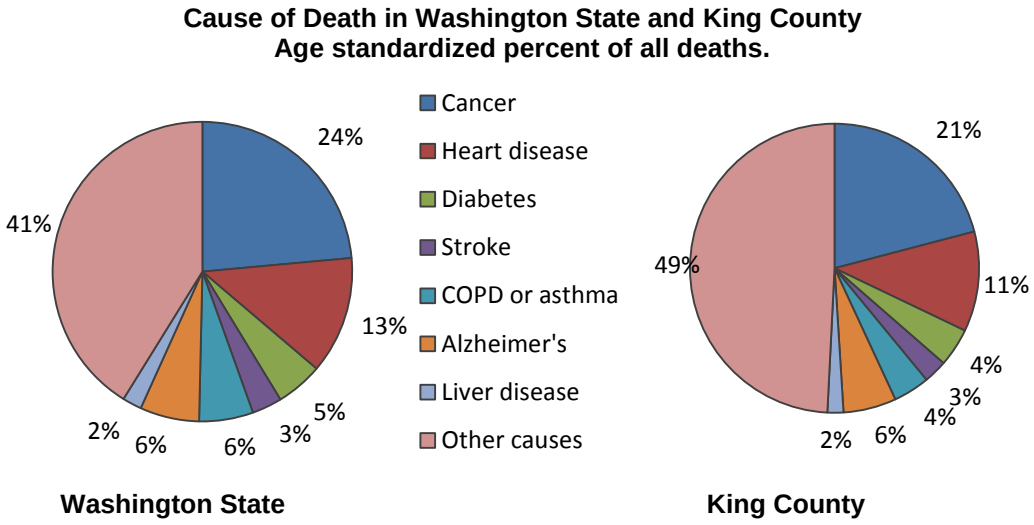
1. Living with chronic disease: Respondent is asked have you ever been told by a doctor or health care professional that you have … arthritis / asthma / COPD / cancer / diabetes, heart disease / stroke / kidney disease.
2. Activities of daily living: Respondent is asked if they have serious difficulty …seeing even with glasses / concentrating remembering or making decisions / walking or climbing stairs / dressing or bathing / doing errands alone such as visiting a doctor or shopping

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Mortality



.



Data Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data, 2013-2015.

Appendix: Data Sources & Definitions

The following provides references for more information on each data system and definitions of technical terms used in this report. Analyses for this report were completed using Stata/IC 13.0. Some estimates were obtained from previously published reports.

DATA SYSTEMS:

Office of Financial Management (OFM) Population Estimates

- For more information on OFM intercensal population estimates, go to: http://www.ofm.wa.gov/pop/default.asp

American Community Survey (ACS) and Public Use Microdata Sample (PUMS)

- For more information on the American Community Survey, go to: http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
- For more information on Public Use Microdata Sample go to: http://www.census.gov/acs/www/data_documentation/public_use_microdata_sample/

Pregnancy Risk Assessment Monitoring Survey (PRAMS)

- For more information on PRAMS, go to: http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/PregnancyRiskAssessmentMonitoringSystem.aspx

Washington Birth Certificate Data

- For more information on birth data, go to: http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/BirthData.aspx

Washington State Department of Health, Office of Immunization and Child Profile

- For more information on immunization data, go to: http://www.doh.wa.gov/DataandStatisticalReports/SchoolImmunization.aspx

Washington State Healthy Youth Survey (HYS)

- For more information on the HYS, go to: http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/HealthyYouthSurvey.aspx or http://www.askhys.net/

- For technical notes on the HYS, go to: http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/HealthyYouthSurvey/TechnicalNotes.aspx

Behavioral Risk Factor Surveillance System (BRFSS)

- For more information on Washington State BRFSS, go to: http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/BehavioralRiskFactorSurveillanceSystemBRFSS.aspx
- For more information on national BRFSS, go to: http://www.cdc.gov/brfss.

Washington State Death Certificate Data

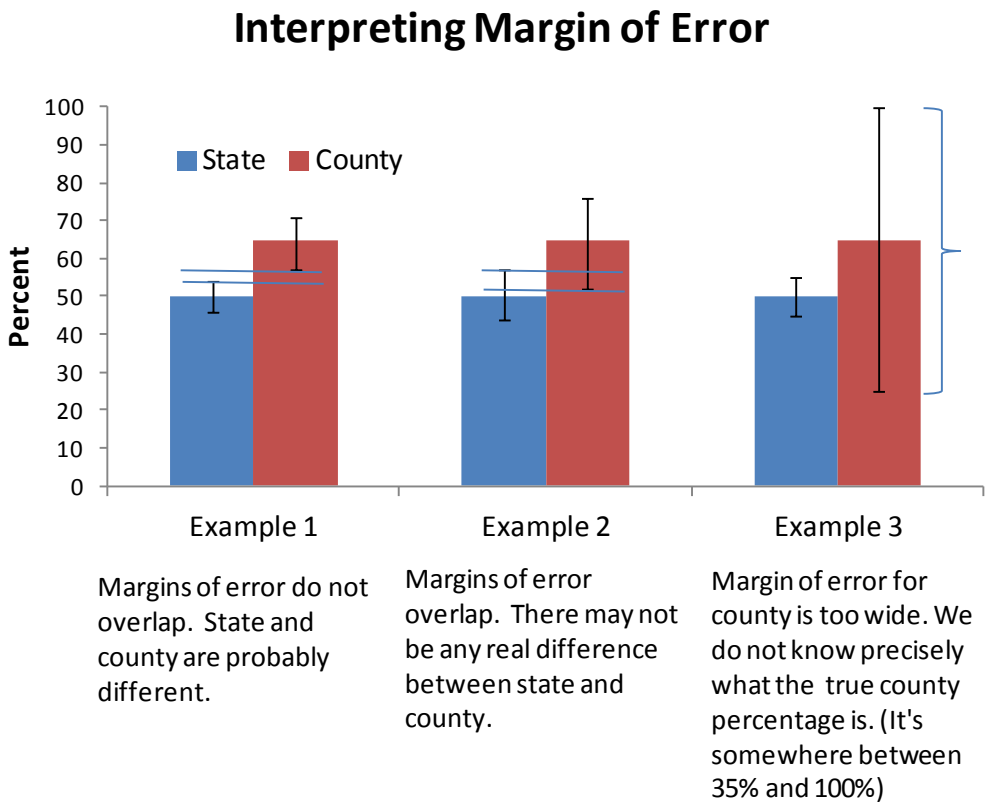
- For more information on death records, go to: http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathData.aspx

Washington State Cancer Registry (WSCR)

- For more information on WSCR, go to: https://fortress.wa.gov/doh/wscr/WSCR/

CONFIDENCE INTERVALS:

Most of the estimates provided in this report come with some intrinsic level of uncertainty due to the random nature of the data. Statistical uncertainty can be summarized by a 95% confidence interval, also called the margin of error. 95% confidence means that, if the survey were repeated in exactly the same way with a different random sample of people, the new estimate would fall within the confidence interval 95% of the time. Confidence intervals are represented on graphs by whisker bars above and below the estimate.



UNRELIABLE DATA:

Estimates based on too few respondents are considered to be unreliable, and may constitute a breach of confidentiality in some circumstances. In this report data with a numerator < 10, or a denominator < 50, or a relative standard error > 30% are not reported. In these cases, local data is presented for multi-county regions for which reliable estimates can be made.

GLOSSARY:

[i] Prevalence: The fraction of the population with a condition at a particular point in time, typically expressed as a percent.
[ii] Life course approach: A philosophy of public health that recognizes the importance of promoting health at all life stages.
[iii] Epigenetic: Conditions in the mother prior to conception can affect how certain genes are expressed in the child.
[iv] Relative standard error (RSE): Standard Error (SE) is a measure of the degree of statistical uncertainty or noise in the data, typically about half the MOE. Relative standard error (RSE) is SE expressed as a percent of the estimate.

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT S

CASE STUDY

Using Health Homes to Integrate Care for Dually Eligible Individuals: Washington State's Experiences

Using Health Homes to Integrate Care for Dually Eligible Individuals: Washington State's Experiences

By Nancy Archibald, Kathy Moses, and Lauren Rava, Center for Health Care Strategies

EXECUTIVE SUMMARY

To provide more integrated, coordinated care for its residents who are dually eligible for Medicare and Medicaid, Washington State is operating a demonstration under the Financial Alignment Initiative offered by the Centers for Medicare & Medicaid Services. This case study describes: (1) the demonstration's structure; (2) results achieved to date; and (3) insights on the demonstration's implementation from the state and other stakeholders.

- **Demonstration Structure:** The demonstration, which was launched in July 2013, uses a managed fee-for-service model based on Medicaid Health Homes. It does not change how enrollees' medical and behavioral health care or long-term services and supports are delivered, but instead uses health homes to better integrate care across these settings. Washington State contracts with Health Home Lead Entities that, in turn, contract with networks of Care Coordination Organizations (CCO), and together they provide the six required core health home services, including comprehensive care management and care coordination. The demonstration targets dually eligible beneficiaries having at least one chronic health condition and who are at risk for developing another condition and incurring significant medical costs.
- **Results to Date:** An external evaluation is documenting the demonstration's implementation and determining its impacts on outcomes. A recent report covering the time period July 1, 2013 through December 31, 2015 found that enrollees are satisfied with their health homes and care coordinators and feel they are achieving their goals.[1] In addition, the demonstration significantly reduced expensive institutional care (e.g., hospital inpatient and skilled nursing facility admissions and the probability of any long-stay nursing facility use); however, it increased rates of hospital readmission. Separate from the programmatic evaluation, CMS determined that Washington was eligible for retrospective performance payments based on Medicare savings and quality benchmarks. The Washington demonstration achieved an estimated $34.9 million in Medicare savings its first 18 months, $30.2 million in the next 12 months, and $42.0 million in the 12-month period after that;[2] however, due to lags in Medicaid data availability, these figures do not include Medicaid savings or costs and will be updated when these data are available. As of November 2018, CMS has made three interim performance payments of $11.6 million, $10.7 million, and $14.2 million to Washington State.[3]
- **Insights on Demonstration Design and Implementation:** Staff from Washington's Department of Social and Health Services and Health Care Authority, as well as Health Home Lead Entities and CCOs, shared insights on the demonstration's design and implementation including:

- **Engaging stakeholders is important to building support for integration activities.** A Health Home Advisory Team -- comprised of representatives from various stakeholder groups -- offered regular input to program design and lobbied for the demonstration when it was in jeopardy.
- **Targeting higher-risk groups offers greater potential to demonstrate results.** Based on the success of its prior chronic care management demonstrations, the state used its advanced data analytics systems to identify and target enrollment to dually eligible beneficiaries with the highest risk and highest costs.
- **Locating and engaging beneficiaries in care management is resource intensive.** Engaging enrollees was more difficult than many had anticipated and required CCOs to adjust their staffing models by hiring staff with expanded skill sets and creating dedicated outreach specialist positions.
- **Encouraging enrollee engagement may improve outcomes.** Health Action Plans (HAPs) promote person-centered planning and improve self-management skills by focusing on an enrollee's goals for his or her own health as well as the action steps needed to achieve those goals.
- **Structuring the health home payment can incent enrollee engagement and in-person care coordination.** Washington's one-time payment for initial enrollee outreach provides an incentive for CCOs to locate enrollees and engage them in their care, while tiered per member per month payments encourage intensive, in-person care coordination.
- **Securing financial support for long-term sustainability is a continuing effort.** Initial financial support for the demonstration came from the 90 percent enhanced federal Medicaid match rate for health home services, but that match ended after eight quarters, and the state has since earned federal Medicare performance payments under the demonstration that provide ongoing financial support.

The health home-based, managed fee-for-service Financial Alignment Initiative demonstration in Washington State carefully targets dually eligible beneficiaries with multiple chronic conditions and high costs. By engaging individuals in their care and focusing on the goals that matter most to them, health home care coordinators help enrollees to make meaningful behavior changes that improve health outcomes and reduce costs. While early evaluation results point to the effectiveness of this model, its long-term sustainability depends on the state's ability to continue to access Medicare performance payments.

Introduction

The nearly 12 million people dually eligible for Medicare and Medicaid are among the highest need enrollees in either program.[4,5] However, a lack of coordination between Medicare and Medicaid makes it difficult for dually eligible beneficiaries to receive the care they need and increases program costs.
In 2011, the Centers for Medicare & Medicaid Services (CMS) announced the Financial Alignment Initiative, which provided states with the opportunity to test new payment and service delivery approaches that fully integrate care for dually eligible individuals.[6,7] Through this Initiative, CMS and Washington State are testing a managed fee-for-service (MFFS) model based on the Medicaid health home state plan option that overlays strategies to improve care management, improve quality and access, increase accountability, and contain costs on top of the existing fee-for-service delivery system.[8] The state sees this model as a pathway to achieving its vision of better outcomes for beneficiaries, system efficiencies, and cost containment.

Various approaches have been tried to foster Medicare-Medicaid integration—the blending of the programs' disparate care management and administrative processes and policies into unified program elements. However, without blended financing, if a state made an investment (e.g., Medicaid-funded care coordination) that reduced expenditures for its dually eligible beneficiaries (e.g., Medicare covered in-patient days), it did not receive any financial benefit from resulting Medicare savings. As such, it has been difficult to align incentives to improve care coordination and reduce unnecessary service use. Under the MFFS model, CMS will make a retrospective performance payment to the state based on reductions in Medicare spending among dually eligible beneficiaries, contingent on achieving required quality thresholds and taking into account any increases in Medicaid spending. While this approach does not blend financing at the payment level, from the state's standpoint it does support the long-term sustainability of the Medicare-Medicaid integration effort in a way that would not otherwise be possible.

This case study provides an overview of the MFFS demonstration in Washington State. It summarizes the demonstration's results to date, and provides stakeholder insights on lessons and promising practices from the demonstration's design and implementation. State Medicaid agencies, particularly those looking to integrate care for dually eligible beneficiaries in non-capitated delivery systems, may find this information useful.

Medicaid Health Home Basics[9]

The Medicaid health home state plan option became available to states in 2011 as a way to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions. Health homes integrate physical and behavioral health (both mental health and substance abuse) and long-term services and supports for high-need, high-cost Medicaid populations. By better coordinating whole-person care (e.g., physical and behavioral health services, long-term services and supports) and linking people to needed services, health homes are designed to improve health care quality and reduce costs. Health homes are specifically designed for Medicaid beneficiaries with chronic conditions—to be eligible, an individual must be a Medicaid beneficiary diagnosed with two chronic conditions, one chronic condition and at risk for a second, or a serious mental illness. As a Medicaid state plan population, dually eligible beneficiaries cannot be excluded from Medicaid health homes.

Health homes must provide six core services: (1) comprehensive care management; (2) care coordination; (3) health promotion; (4) comprehensive transitional care and follow-up; (5) individual and family support; and (6) referral to community and social services. The team providing health home services may include physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, or any professionals that the state deems appropriate for its model. These professionals may be based in primary care or behavioral health providers' offices, coordinated virtually, or located in other settings that suit beneficiaries' needs. States must report specific health home quality measures.

As of January 2019, 22 states and the District of Columbia have a total of 37 approved Medicaid health home models, which have enrolled over 1 million beneficiaries.[10]

Background and Overview of the Demonstration

Demonstrations developed under the Financial Alignment Initiative were required to fully integrate all Medicare Parts A and B and Medicaid-covered services, but states had the flexibility to choose a capitated or MFFS model of care. Washington's demonstration design was based on several prior state efforts to coordinate care for complex populations, including the successful Chronic Care Management pilot program, which operated from 2007 to 2013.[11] The Chronic Care Management program used Washington's Predictive Risk Intelligence SysteM (PRISM), a data-driven clinical support tool, to identify high-risk Medicaid beneficiaries and provide them with care management, education, and support. The current Medicaid health home-based MFFS demonstration also uses PRISM to target high-risk, high-cost full benefit dually eligible individuals. In addition, the demonstration fosters patient activation and engagement, which the state found to be a key component of the Chronic Care Management program.

Early in the demonstration's planning phase, the state held a series of stakeholder listening sessions.[12] Stakeholders had positive experiences with the Chronic Care Management program and were supportive of the state's plan for a demonstration. There was less consensus on whether the demonstration should use a MFFS or capitated model. Initially, the state proposed a capitated model demonstration in the two largest counties – King and Snohomish – and a MFFS demonstration for all the other counties. While the capitated demonstration never came to fruition due in large part to Medicare rate setting issues, the MFFS demonstration launched on July 1, 2013.[13] On April 1, 2017, King and Snohomish counties were added to the MFFS demonstration, making it statewide.[14]

The demonstration is part of a larger state effort to improve care coordination for Medicaid beneficiaries with complex needs and is jointly overseen by Washington State's Health Care Authority and Department of Social and Health Services. Washington State received CMS approval for two Medicaid State Plan Amendments (SPAs) to create health homes for Medicaid beneficiaries with chronic conditions.[15] The state's Medicaid health home program launched the same day as the demonstration (July 1, 2013), and it has a similar structure (i.e., targeting criteria, enrollment process, benefits, care coordination model, payment rates, use of Lead Entities and Care Coordination Organizations (CCOs)) to the demonstration for dually eligible beneficiaries, except that Medicaid-only beneficiaries are more often served by Health Homes Lead Entities based within managed care organizations.[16]

Demonstration Structure

This section describes the overall structure of the demonstration in Washington State, including targeting and eligibility criteria, as well as enrollment processes. It also describes the health home infrastructure that Washington created, benefits covered by the demonstration, and the demonstration's approach to care coordination.[17] The section concludes with a discussion of how health homes are paid.

Target Population and Eligibility

To be eligible for the demonstration, an individual must be enrolled in Medicare Parts A and B and be eligible for Medicare Part D and Medicaid. There are no age restrictions, but individuals cannot have other comprehensive health insurance, be enrolled in a Medicare Advantage plan or the Program of All-Inclusive Care for the Elderly (PACE), or be receiving hospice services.

Individuals eligible for the demonstration must have at least one chronic health condition and be at risk for developing another. Washington targets people who are at the highest risk—those who have a minimum predictive risk score of 1.5 as calculated by PRISM. The state chose the 1.5 score because it identifies the top 20 percent most costly Medicaid beneficiaries, which includes about 40 percent of the dually eligible population.[18] The algorithm uses actuarial methods and an individual's age, gender, and Medicare and Medicaid claims diagnosis and prescription medication data to predict future medical expenditures. As of September 2018, Washington State estimates that of the 34,070 dually eligible individuals who are part of the demonstration population, 20,213 (59 percent) were enrolled in a heath home, 7,756 (23 percent) were not yet enrolled, and 6,101 (18 percent) chose not to participate.[19]

Health Home Lead Entities and Care Coordination Organizations

Washington State contracts with Health Home Lead Entities that are responsible for developing a service delivery model and administering the health home. Lead Entities have experience developing networks of CCOs. Lead Entities must have the capacity to serve 1,000 to 2,000 enrollees and are responsible for: (1) collecting and submitting claims and encounter data to the state; (2) disbursing payments to CCOs based on services rendered; (3) monitoring quality; and (4) collecting, analyzing and reporting financial, health status and performance and outcome measures. As of September 2018, there were nine Health Home Lead Entities taking part in the Washington demonstration across seven geographic regions.[20]

CCOs can be managed care organizations, hospitals, Federally Qualified Health Centers (FQHCs), behavioral health organizations, Area Agencies on Aging, community mental health agencies, substance use disorder treatment providers, home health agencies, primary or specialty providers such as AIDS or ESRD clinics, or other community based service providers. CCOs hire care coordinators and are responsible for direct delivery of health home services. CCOs may be affiliated with multiple Lead Entities. In addition, Lead Entities may also be CCOs. Approximately 82 CCOs have been part of health home affiliated networks since the start of the demonstration.[21]

Health Home Lead Entities and CCOs serve both dually eligible beneficiaries in the demonstration and Medicaid-only health home enrollees who are not in the demonstration.

Enrollment Process

After identifying individuals eligible for the demonstration, the state enrolls them in a Health Home Lead Entity based on the individual's zip code and the entity's capacity.[22] The state sends individuals a letter 30 days before their effective enrollment date to notify them of their enrollment and describe their options. Participation in the health home program is voluntary and individuals can disenroll completely or disenroll from their assigned health home and enroll in a different health home at any time. For individuals who remain enrolled, the Health Home Lead Entity then assigns them to one of its network of affiliated CCOs with which the individual may have an existing relationship. This is done using a "smart" assignment process based on information from PRISM, including the individual's providers and service use history. If no prior enrollee-CCO relationship exists, the Health Home Lead Entity matches the enrollee with the CCO that is most experienced in addressing his or her individual needs as identified by PRISM.

Benefits Provided

The demonstration does not change the way in which enrollees' primary and acute care, behavioral health care, or long-term services and supports (LTSS) are delivered. Instead, the demonstration uses health homes as a bridge to better integrate care across these settings. Health homes must provide six core services: (1) comprehensive care management; (2) care coordination; (3) health promotion; (4) comprehensive transitional care and follow-up; (5) individual and family support; and (6) referral to community and social services.

These six services are provided by the CCO-employed care coordinators who can be clinical or non-clinical professionals (e.g., registered nurses, nurse practitioners or psychiatric nurse practitioners, social workers, mental health social workers, chemical dependency professionals, or counselors). Health home care coordinators do not replace or duplicate the work of case managers for Medicaid home- and community-based services or behavioral health services. CCOs may employ allied health care staff, such as community health workers, peer counselors, or other non-clinical staff to support the care coordinators. To date, CCOs have employed over 700 care coordinators.[23]

Care Coordination

After individuals are enrolled, care coordinators reach out to offer an in-home visit during which they assess the enrollee's functional status and screen for depression and other conditions as indicated by the data stored in the PRISM system. They also use the Patient Activation Measure® (PAM®) to assess enrollees' knowledge, skill, and confidence in managing their health conditions and services.

Care coordinators help beneficiaries to articulate their health goals,[24] and work with them to develop a person-centered Health Action Plan (HAP). The HAP is one of the foundational tools in Washington's health home model and serves to engage individuals in setting their own goals and increase the skills they need to achieve those goals. The HAP documents items including: gaps in the enrollee's care; the PAM® score; opportunities to prevent emergency department visits, hospitalizations, or nursing facility stays; and the enrollee's goals for improved health, strategies to achieve those goals, and ways in which the care coordinator can help the enrollee to achieve those goals. The state reports statistically significant increases in PAM® scores for individuals who were initially the least activated.[25]

With the permission of the enrollee, the care coordinator shares the HAP with the enrollee's providers. The HAP is updated every four months to document the enrollee's progress in reaching his or her goals, as well as any changes in health, functional status, or in the PAM®, which is also performed every four months. CCOs cannot begin billing for health home services until an enrollee's HAP has been finalized and submitted to the state.

Once the initial HAPs are completed, health home services can begin. Care coordination is the most frequently used health home service, but it is not needed on a regular basis by all enrollees; some enrollees manage their care themselves or with the help of family and instead may benefit from other health home core services. Data from PRISM, including weekly updates of Medicare and Medicaid claims data, help care coordinators flag current or potential health concerns. Care coordinators work together with enrollees' providers to give them updated HAPs, communicate changes in enrollees' health status, and

offer more intensive support for highly complex beneficiaries by convening monthly case conferences. (See call out box ***Independence Realized*** for one health home enrollee's story.)

If an enrollee does not currently receive LTSS or behavioral health care, but accessing that service would help to fulfill HAP goals, the care coordinators will work with service-specific case managers (i.e., care managers employed by the state for home- and community-based services waiver programs or by behavioral health providers) to fill in those gaps. As described previously, these service-specific case managers focus narrowly on one service and do not address fragmentation of care across all of an enrollee's providers—meaning that there should be no duplication of effort with the health home care coordinators.

Care coordinators also work with enrollees to create transition plans that support an enrollee's move from one care setting to another (e.g., hospital to home). If enrollees are admitted to a hospital or nursing facility, care coordinators are required to make timely visits to the facility and ensure follow-up care is scheduled. In addition, hospitals submit data to an information system that provides real-time notifications to Health Home Lead Entities when their enrollees are seen in an emergency department or admitted as an inpatient.

Payment for Health Home Services

Washington pays Health Home Lead Entities using a tiered approach. Health Homes Lead Entities receive a one-time payment for each enrollee ($281.28 as of August 2018) for activities related to: initial enrollee engagement; screening and assessment; and development of the HAP.[26] After the HAP has been submitted, the Health Home Lead Entity can begin to bill the state for health home services. In the Washington health home model, the state pays Lead Entities on a per member, per month (PMPM) basis only for months in which the Lead Entity submits data indicating that a CCO has provided at least one of the six health home services.

Health Home Lead Entities may bill the state for rendering either intensive care coordination ($208.36 PMPM) or low-level care coordination ($83.34 PMPM). The Health Home Lead Entities have the flexibility to define "intensive level" and "low level" care coordination based on documented services provided during the month within broader definitions set by the Health Care Authority.

To incent health homes to engage enrollees, in January 2017, the state started making a 20 percent monthly performance payment to Health Home Lead Entities – on top of the amount they were paid for enrollee engagement and intensive/low-level coordination in that month – if they maintained an engagement rate of 20 percent or higher in that month. The Health Home Lead Entities shared this performance payment with their CCOs, but it did not seem to help engagement rates. With the support of the health homes, the state approved a 20 percent rate increase in July 2018, reflected in the rates stated above, and reduced the performance payment to 5 percent for Health Home Lead Entities maintaining an engagement rate of 25 percent or higher. The State Plan Amendment effectuating this change was approved by CMS as of December 2018 (with an effective date of August 1, 2018).[27] State staff report they are beginning to see higher rates of enrollee engagement after the payment increase.

Health Home Enrollee Story: Independence Realized

Mrs. M. had struggled to manage her diabetes and chronic pain. Fluctuating blood sugar levels and other complications of her condition resulted in a skilled nursing facility admission. After she enrolled in a health home, Mrs. M. worked with her care coordinator to set health goals—the most ambitious of which was to transition from the nursing facility to living independently in her own home.

Although her family was supportive and the PAM® showed her to be eager to work toward her goal, Mrs. M. needed to learn more about her diabetes and improve her blood sugar management. Mrs. M.'s care coordinator began by: (1) reviewing basic diabetes education materials with her; (2) providing information about how she could apply for Social Security Disability Income; and (3) sharing information about local housing resources. With the assistance of her care coordinator, Mrs. M. began seeing her primary care provider more regularly and was prescribed a new, more effective medication for her chronic pain.

After five months of working with her care coordinator, Mrs. M. attends a community-based diabetes education class, reports a lower pain score, and, most importantly, now lives independently.

Results to Date

CMS contracted with an external evaluator, RTI International, to evaluate the impacts of the demonstrations under the Financial Alignment Initiative.[28] The evaluations include information about the demonstrations' implementation and both qualitative and quantitative analyses to determine demonstration impacts on: (1) beneficiary experience of and access to care; (2) quality of care; (3) use of primary and acute care, behavioral health services, and LTSS; and (4) cost of care. Sources informing the evaluation include: demonstration-related documents; focus group interviews with beneficiaries; in-person and virtual site visits to the states including interviews with state staff, Health Home Lead Entities, and CCOs (for the Washington demonstration), and other stakeholders; interviews with CMS staff; beneficiary surveys (e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS)); appeals and complaints data; other state-reported information; Medicare and Medicaid data on service use and costs; and data from the Minimum Data Set for individuals with a nursing facility stay.

Preliminary Demonstration Impacts

RTI has published two evaluation reports with qualitative and quantitative analyses of the Washington demonstration from its initiation on July 1, 2013 through December 31, 2015.[29] Key findings include: [30]

- **Beneficiary Experience and Access to Care.** Focus groups conducted by RTI and the CMS-sponsored CAHPS survey both provide insight into beneficiaries' satisfaction with the health home program. Most focus group participants reported satisfaction with their health home and improvement in quality of life, access to services, and overall health. Focus group participants had some difficulty differentiating between their health home care coordinators and case managers in the home- and community-based services and behavioral health systems, but reported very positive relationships with their care coordinators overall. In addition, they said that care coordinators helped them to better manage their chronic conditions and become more engaged in their communities, which, in turn, helped them to achieve other goals. Interestingly, they felt that

they achieved their goals by changing behaviors (with the support of care coordinators) rather than by accessing more services. Some focus group participants reported that care coordinators did connect them to new services, including medical equipment, assistive technology, home modifications, and health education.

- **Service Use.** RTI's quantitative analysis found evidence of demonstration effects on service use during in the period from July 2013 to December 2015.[31,32] The demonstration group had fewer hospital inpatient hospital stays (5.36 percent), emergency department visits (-4.11 percent), and skilled nursing facility admissions (-18.63 percent) and a lower probability of long-stay nursing facility (-24.21 percent) than the comparison group. The 30-day all-cause, risk-adjusted hospital readmission rate was higher for the demonstration group.

Performance Payment

In addition to the regression-based cost calculations conducted as part of the demonstration evaluation, CMS has used an actuarial calculation to determine whether the MFFS model demonstration in Washington is eligible for retrospective performance payments based on cost savings and quality benchmarks.[33,34] To date, the Washington demonstration has achieved gross Medicare savings of $34.9 million in its first 18 months, $30.2 million in the next 12 months, and an estimated $40.2 million in the 12-month period after that.[35] Due to lags in Medicaid data availability, these figures do not include estimated Medicaid expenditures and will be updated when data are available. As of November 2018, CMS has made three interim performance payments of $11.6 million, $10.7 million, and $14.2 million to Washington State.

Insights on Demonstration Design and Implementation

The health home-based MFFS model demonstration in Washington State holds promise as a way to integrate care for dually eligible beneficiaries. To gain further insight into the demonstration, ICRC interviewed staff from: (1) Washington's Department of Social and Health Services and the Health Care Authority; (2) a CCO – the Area Agency on Aging and Disabilities of Southwest Washington (AAADWS); and (3) an organization that is both a Health Home Lead Entity and a CCO – Full Life Care. Following are insights from those conversations:

Engaging stakeholders is important to building support for integration activities.

Stakeholders were familiar with Washington's earlier Chronic Care Management program and supported the state's plan for the demonstration; nevertheless, state staff still saw value in conducting both broad-based stakeholder engagement activities and tailored outreach to specific interest groups.[36]

The state created a Health Home Advisory Team (HAT) – comprised of representatives from consumer advocacy organizations, provider associations, state and county agencies, beneficiaries, and the union representing most home care workers – to offer regular input to program design. The HAT continued to meet through the demonstration's implementation phase. State staff felt that the HAT's input was particularly helpful in late 2015, a point where the preliminary savings analysis was not yet available and the state legislature planned to end the demonstration. The HAT developed a plan to communicate to enrollees about what would happen when the demonstration ended. This activity prompted stakeholders

to lobby the legislature in support of the program which, along with new information about the Medicare performance payment, resulted in the legislature reversing its decision and the demonstration continuing.

The state continues to value stakeholder engagement, and in 2017 it formed a Service Experience Team (SET) that replaced the HAT. SET membership includes nine beneficiaries, six of whom are health home eligible, as well as community advocates. The SET meets three times a year to provide input on ways to promote choice, quality of life, heath, independence, safety, and active engagement in program operations. States designing integrated care programs, including Medicaid health homes, can find value in investing in stakeholder engagement activities.

Targeting higher-risk groups offers greater potential to demonstrate results.

Previous state and federal care coordination and disease management demonstrations for Medicare beneficiaries were not effective in reducing hospital admissions or reducing Medicare costs[37] unless they limited enrollment to individuals with high-cost, chronic conditions who were at high risk of hospitalization.[38] Washington's Chronic Care Management program (2007-2013) enrolled Medicaid beneficiaries with functional limitations who received in-home personal care and whose Medicaid costs were in the top 20 percent of all Washington State's Medicaid beneficiaries. An analysis of the Chronic Care Management program found that it reduced in-patient admission costs by $318 per member per month, although when the cost of the intervention was factored in, the overall reduction of $248 per member per month in total medical costs was not statistically significant.[39]

The state's experiences with the Chronic Care Management program informed the design of the current MFFS demonstration. Washington uses an algorithm called the PRISM risk score to identify high-risk, high-cost full benefit dually eligible beneficiaries (i.e., individuals with a minimum predictive risk score of 1.5, meaning that their predicted medical costs are 50 percent higher than those of Washington State residents receiving Supplemental Security Income benefits). States considering development of an integrated care program may want to consider how they could use data analytics to target program enrollment. Investment in information technology may be needed to access the data for program design and monitoring.

Locating and engaging beneficiaries in care management is resource intensive.

Although the Health Home Lead Entities attempt to assign enrollees to CCOs based on pre-existing service relationships, the two organizations interviewed said that actually only about 10 percent of their enrollees are individuals already known to them. For the other individuals, the process of engagement in health homes begins with an outreach call from the CCO. The CCOs explain what a health home is, who they are, and what the program offers. Although all dually eligible beneficiaries assigned to a health home are sent a letter by the state with health home contact information, they may not receive these letters or understand them, and the CCOs often must make a considerable effort to engage enrollees in health home services. Health Home Lead Entities cannot bill for beneficiary engagement until: (1) the individual has been located and agrees to meet with the care coordinator; and (2) the HAP has been completed and accepted. Health Home Lead Entities reported that they had lost money as a result of difficulty locating certain enrollees that had been assigned to them. Washington convened a work group of state and health home staff to outline the process for care coordinators to use in locating enrollees, including a policy describing what constituted due diligence in attempting to reach an enrollee. Now CCOs must attempt to contact each new

enrollee at least once a month for three consecutive months. Further, Washington submitted a new State Plan Amendment adjusting its payment methodology to give health homes a performance payment for attaining specific engagement rate targets that has resulted in increased engagement.

Both AAADSW and Full Life Care have adjusted their staffing models to increase their rate of enrollee engagement. For its CCO, Full Life Care began with care coordinators both doing enrollee outreach and engagement and carrying a care coordination caseload. It found that by the time its first care coordinator's caseload was half full, she no longer had the time to do outreach. The organization then restructured, hiring bachelor's-prepared, entry-level social workers exclusively dedicated to outreach. Similarly, AAADSW hired an engagement specialist who is trained as a care coordinator, but is very good at engagement. The engagement specialist makes initial contact with the enrollee then transitions care management responsibilities to a care coordinator.

AAADSW staff described how their care coordinators are trained to use PRISM data to engage enrollees. Knowing that enrollees may be motivated to avoid repeating recent negative events (e.g., a hospitalization or emergency department visit), care coordinators try to identify these events in PRISM and use that information to begin a dialogue. For example, they might first ask a person about a recent hospitalization and then about how that experience went or how the person is feeling now. This often is the entree that care coordinators need to get enrollees to talk about circumstances or behaviors that they might be open to changing.

Encouraging enrollee engagement may improve outcomes.

Washington's MFFS demonstration focuses on developing and implementing HAPs to promote person-centered planning and improve self-management skills. A HAP includes the priorities that an enrollee identifies for improving his or her own health as well as the action steps the enrollee will take and other interventions and supports that will help an enrollee achieve his or her goals. A HAP has information about chronic conditions, gaps in care, ways to prevent hospital and institutional care, and the enrollee's ability to manage his or her health. All care coordination is based on the information and action steps outlined in the HAPs.

To develop the HAP, the care coordinator conducts a home visit, during which they explain the HAP, get enrollee agreement to move forward with developing the HAP, and screen for functional limitations and health conditions. The care coordinators also use the PAM® to assess enrollees' knowledge, skill, and confidence in managing their health and establish an enrollee activation level. Care coordinators use this information to start a discussion with the enrollee, who sets priorities about health action goals, and then work with the enrollee to develop a HAP.

Washington provided Health Home Lead Entities with motivational interviewing training to improve care coordinator-enrollee relationships and strengthen skills of care coordinators to promote enrollee self-action. Health home enrollees have reached various health goals through the use of HAPs, including improved blood sugar levels, weight loss, more social connections, better relationships with providers, and fewer emergency department and hospital visits.

While further data analyses are necessary to determine the effect of the Washington demonstration on enrollee outcomes, the use of person-centered planning and enrollee-driven action plans may help enrollees to make behavior changes that lead to improved health. States developing integrated care programs may consider models that emphasize this type of enrollee engagement.

Structuring the health home payment can incent enrollee engagement and in-person care coordination.

Washington uses a tiered system to pay health homes. There is a one-time payment for initial enrollee engagement, screening and assessment, and development of the HAP. As described previously, CCOs often have to put a lot of effort into locating enrollees and convincing them to meet with a care coordinator. By structuring payments such that a CCO can only receive payment after the HAP has been completed, it creates a strong incentive for the CCOs to engage enrollees.

Similarly, tiered payments for care coordination ($208.36 PMPM for intensive care coordination and $83.34 PMPM for low-level care coordination) create an incentive for health homes to provide more intensive care coordination. Both AAADWS and Full Life Care indicated that their care coordination is done almost entirely in-person (rather than telephonically) and that their care coordinator-to-enrollee ratios are approximately 1:50, which they consider appropriate given the risk profile of their enrollees.

States developing health home programs for dually eligible or Medicaid-only beneficiaries could consider how they can structure rates to promote program goals such as prompt beneficiary engagement and in-person care coordination.

Securing support for long-term sustainability is a continuing effort.

A 2012 bill passed by Washington's legislature approving the demonstration did not permit any new state funds to be used for its design or implementation.[40] The 90 percent enhanced federal Medicaid match rate for health home services (see call out box ***Health Home Basics*** for a description of this authority) for the first eight quarters of health home program operation provided a source of funding and led the state to pursue the Medicaid health home state plan option as a vehicle for the demonstration.[41,42] At the end of eight quarters, the state would again receive its regular Federal Medical Assistance Percentage, but it would need to identify another source of funding. The assumption was that the demonstration program would either: (1) realize Medicare savings and become self-sustaining; or (2) not achieve savings and be shut down by the legislature.

In spring 2015, when the federal match for health home services was expiring and Medicare savings calculations had not yet been completed, Washington's legislature moved to end the demonstration. As the Health Care Authority and the Department of Social and Health Services began to make plans to wind-down operations, the state received word that the demonstration had achieved $21.6 million in Medicare savings during the first 18 months of operation.[43] As a result, the legislature allowed the health home program – and the demonstration – to continue.

Now the demonstration will operate at least through its scheduled end date of December 31, 2020, but state staff are looking ahead to plan for the longer term. They believe that the demonstration program, with its focus on high-risk beneficiaries, is helping them to learn which beneficiaries could most benefit

from care coordination and what kinds of services are the most helpful to beneficiaries with different needs. The state plans to develop an 1115 Delivery System Reform Incentive Payment (DSRIP) waiver that will allow it to provide care coordination to a broader population.

Care Coordination Organization Profile: Area Agency on Aging and Disabilities of Southwest Washington

The Area Agency on Aging and Disabilities of Southwest Washington (AAADSW) is a public agency providing assistance to older adults and people with disabilities in five counties—Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum. In 2013, AAADSW became a Care Coordination Organization (CCO) in Washington State's health home program.

Like other CCOs, AAADSW contracts with multiple Health Home Lead Entities, specifically Community Health Plan of Washington, Molina, and OptumHealth.[44] It has developed HAPs for approximately 1,125 demonstration enrollees and has 40 care coordinators dedicated to the health home program.[45] In addition, AAADSW employs four managers who train and supervise the care coordinators, but who do not provide care coordination directly to health home enrollees.

AAADSW reports that its enrollee engagement rate is higher than most CCOs in the health home program, which it attributes to the skills of its care coordination staff who all have a social work background, but also have sales or other life experiences that demonstrate they can make "cold calls" to potential enrollees, begin conversations, and develop a trusting relationship with people who are hard-to-reach.

The organization's leadership also credits its overall success to a combination of the health home program's emphasis on developing person-centered health action plans and AAADSW's care management model. As one staff member described it, "People who enroll in the health home and agree to meet with the care coordinator have a desire to make some change in their lives. Even if it's only a teensy bit – a scrap of a desire – we can take that and grow it and work with them over time to improve how they receive care, change their health behaviors, and improve the way they use the health care system." They believe that monthly in-person visits by the care coordinators to the enrollees' homes – or other locations where enrollees feel comfortable—are their "secret sauce." AAADSW reports that the vast majority of its health home services are for the "intensive care coordination" level of service (described in the ***Payment*** section on page 7).

A 2017 Oregon Health Sciences University study identified AAADSW as having 11 organizational best practices.[46] AAADSW's leadership said that one of the most challenging aspects of their experiences to date was the difficulty of launching the CCO without access to start-up funding. They began with just a few care coordinators, maximizing their caseloads until they generated enough revenue to hire more. Even so, they incurred significant debt. Washington's recent adjustments to the health home payment rates may improve the financial situation for CCOs.

Health Home Lead Entity Profile: Full Life Care[47]

Full Life Care is a community-based, non-profit organization serving low-income older adults and people with disabilities in King and Snohomish counties.[48] Established the 1970s, it provides in-home care, adult day programs, outpatient mental health care, housing supports, and other services to help people remain as independent as possible. In April 2017, Full Life Care became a Health Home Lead Entity, and as of July 2018, it had a demonstration enrollment of 1,491.

Organization leaders said that they greatly benefitted from the experience of another Health Home Lead Entity, the Northwest Regional Council (NWRC) – northwest Washington's Area Agency on Aging – in planning for the launch of their program.[49] Important lessons imparted include how to:

- **Implement a "smart assignment" process** to identify which CCO would be the best fit for an enrollee's needs while simultaneously being responsive to CCOs' referral requests based on staffing capacity. NWRC helped Full Life Care to use the PRISM system to identify enrollees' diagnoses and providers and assign them to the most appropriate CCO.
- **Choose metrics** to monitor the performance of care coordinators, contracted CCOs, and the health home's own internal management. This has helped Full Life Care to better understand when it should ask the state for more enrollees and when it should hire more staff. Establishing measurable operational metrics has been a critical feedback tool for Full Life Care to support contracted CCOs in developing their own health home-related infrastructure, especially given the lack of available start-up funding.
- **Leverage available information technology** to improve performance. NWRC, Full Life Care, and Southeast Washington Aging and Long-Term Care (another Area Agency on Aging) have formed a consortium and share the same care management information system. They work together in an ongoing collaborative to improve the functionality of this system for care coordinators and for administrative operation of their health home programs.

Full Life Care and the other Health Home Lead Entities are responsible for training the CCOs' care coordinators. Health Home Lead Entities take turns to lead two-day training programs that use a curriculum developed by the state.[50] Topics covered include: health home fundamentals; outreach and engagement; PRISM; use of the Patient Activation Measures; motivation and coaching for activation; development of the HAP; care transitions; and documentation and quality assurance. Health Home Lead Entities also provide training to CCO care coordinators on their own care management information systems and ad hoc training on special topics.

Summary

The Washington State MFFS Financial Alignment Initiative demonstration is structured around Medicaid health homes and incorporates many of the elements of earlier care coordination efforts in the state, particularly the Chronic Care Management program. A key element of the demonstration is its use of the state-developed PRISM algorithm and the PRISM secure, web-based information system, to identify and manage individuals at high risk of having future high-cost events. As of September 2018, approximately 34,000 dually eligible individuals were part of the demonstration.

The state assigns enrollees to one of nine Health Home Lead Entities, which, in turn, use a smart assignment process to match enrollees to CCOs based on their diagnoses and providers. CCOs are responsible for engaging the enrollee, developing a person-centered HAP, and providing on-going health home services. The process by which enrollees receive their primary and acute care, behavioral health care, and LTSS remains unchanged: health home services help to integrate and coordinate this care. The

state pays health homes using a tiered approach, including a one-time payment for enrollee engagement and completion of the HAP and per-member per-month payment for either intensive or low-level care coordination if at least one health home service was provided in the month.

A national evaluation of the demonstration has shown good enrollee-reported satisfaction with the program and improvements in quality of life, health, and access to services. Analyses of service use and cost of care have found limited impacts that may be due to enrollees' limited exposure to interventions early in the demonstration. That said, a separate actuarial analysis of Medicare savings found the demonstration saved Medicare a gross total of $107 million over its first three and a half years of operation while maintaining the quality of care provided to enrollees as assessed by CMS' quality measures.[51]

State staff and leadership of a Health Home Lead Entity and CCO provided insights on the demonstration's design and implementation, including:

- Engaging stakeholders is important to build support for integration activities.
- Targeting higher-risk groups offers greater potential to demonstrate results.
- Locating and engaging beneficiaries in care coordination is resource intensive.
- Encouraging enrollee engagement may improve outcomes.
- Structuring the health home payment can incent enrollee engagement and in-person care coordination.
- Securing support for long-term sustainability is a continuing effort.

The information in this case study may be helpful to state Medicaid agencies, particularly those looking to integrate care for dually eligible beneficiaries in non-capitated delivery systems. Twenty-two states currently operate health home programs, which cannot exclude dually eligible beneficiaries. Washington State's health home-based Financial Alignment Initiative demonstration provides an example of how health homes can provide needed care coordination for dually eligible populations with chronic conditions. This model holds promise, especially if states can overcome challenges related to accessing Medicare savings.

ACKNOWLEDGEMENTS

The authors thank the following individuals for their time and expertise: Alice Lind and Agnes Ericson, Washington Health Care Authority; Beverly Court and Karen Fitzharris, Washington Department of Social and Health Services; Jessica Herzer, Tim Morley, and Rena Ferretti, Full Life Care; and David Kelly and Samantha Waldbauer, Area Agency on Aging and Disabilities of Southwest Washington.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the *Integrated Care Resource Center* are coordinated by **Mathematica Policy Research** and the **Center for Health Care Strategies**. For more information, visit **www.integratedcareresourcecenter.com**.

ENDNOTES

[1] D. Justice, et al. "Financial Alignment Initiative Washington Health Homes MFFS Demonstration: Second Annual Evaluation Report." RTI International. November 2018. Available at: https://innovation.cms.gov/Files/reports/fai-wa-secondevalrpt.pdf

[2] Sandler, M., Zhao, L., Trapnell, T., et al. "Report for Washington Health Home Managed Fee-for-Service (MFFS) Final Demonstration Year 2 and Preliminary Demonstration Year 3 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative." CMS, November 2018. Available at: https://innovation.cms.gov/Files/reports/fai-wa-finalyr2preyr3.pdf

[3] Ibid.

[4] Centers for Medicare & Medicaid Services. Medicare-Medicaid Coordination Office. "Medicare-Medicaid Coordination Office Fiscal Year 2017 Report to the Congress." 2018. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/RTC_MMCO_FY2017_06072018.pdf

[5] MedPAC and MACPAC. "Beneficiaries Dually Eligible for Medicare and Medicaid: Data Book." January 2018. Available at: https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/

[6] Ten states (California, Illinois, Massachusetts, Michigan, New York, Ohio, Texas, Rhode Island, South Carolina, and Virginia) used the capitated model in which the state and CMS enter into three-way contracts with health plans to cover all Medicare and Medicaid services in return for a blended prospective payment. New York State has two capitated demonstrations: Fully Integrated Duals Advantage (FIDA); and FIDA I/DD, which enrolls dually eligible beneficiaries with intellectual and developmental disabilities. Virginia ended its demonstration as of December 31, 2017. For more information on the demonstrations, see: Centers for Medicare & Medicaid Services. "Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees." SMDL 11-008. July 2011. Available at: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf

[7] A demonstration in Minnesota is testing an alternative integration model that is separate from the capitated or MFFS models being tested in the other Financial Alignment Initiative demonstrations.

[8] Colorado also tested a MFFS model, based on accountable care organizations, and that demonstration ended as of December 31, 2017.

[9] Health Home Information Resource Center. "Medicaid Health Homes: An Overview." April 2018. Available at: https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf

[10] Health Home Information Resource Center. "Medicaid Health Homes: An Overview." September 2018. Available at: https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf

[11] Jingping Xing, J., Goehring, C., and Mancuso, D. "Care Coordination Program for Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs." Health Affairs, 34(4); April 2015. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0655

[12] See http://www.chcs.org/media/Stateholder_Engagement_without_PPT.pdf and http://www.chcs.org/media/DSHS-HCA_Presentation.pdf for examples of meeting slides, an agenda, and other materials.

[13] Washington's original health home SPA, WA-13-008 (https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-13-08-Ltr.pdf), included 13 counties. A second SPA, WA-13-17 (https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-13-17-HHSPA.pdf), added 23 more counties.

[14] For more information, see Washington's SPA WA-16-0026. Available at: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-16-0026.pdf

[15] Washington's initial two health home State Plan Amendments were: WA-13-008 that covered 14 counties (see: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-13-08-Ltr.pdf); and WA-13-17 that covered 23 additional counties (see: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-13-17-HHSPA.pdf).

[16] WA-13-008: Creates a chronic medical conditions health home model in 14 counties (Phase I) (approved 6/28/13, effective 7/1/13) WA-13-17: Creates a chronic medical conditions health home model in 23 additional counties (Phase II) (approved 12/11/13, effective 10/1/13)

[17] For additional information on the demonstration's design, implementation, and oversight, see the Memorandum of Understanding available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAMFFSMOU.pdf and the final demonstration agreement available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAMFFSFDA_Amendment.pdf

[18] Individuals with a PRISM score of 1.5 are predicted to have medical costs that are 50 percent higher than those of a reference group (Washington residents receiving Supplemental Security Income benefits, average risk score 1.0) over the ensuing 12 months.

[19] Washington State Health Care Authority. "Washington State's Fee-For-Service Dual Eligible Demonstration Monthly Report." October 5, 2018. Available at: https://www.hca.wa.gov/assets/billers-and-providers/HH-duals-demonstration-summary.pdf

[20] Washington State Health Care Authority. "Washington State's Fee-For-Service Dual Eligible Demonstration Monthly Report." October 5, 2018. Available at: https://www.hca.wa.gov/assets/billers-and-providers/HH-duals-demonstration-summary.pdf

[21] Interview with Alice Lind, Washington Health Care Authority and Beverly Court, Washington Department of Social and Health Services. July 5, 2018.

[22] Health Home Lead Entities must have an individual's content to enroll them in the Health Home. The consent form must be maintained in the individual's health record.

[23] Interview with Alice Lind, Washington Health Care Authority and Beverly Court, Washington Department of Social and Health Services. July 5, 2018.

[24] For more information on PAM, see: Hibbard, J., Stockard, J., Mahoney, E., and Tusler, M. "Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers." *Health Services Research*. 2004 Aug; 39(4 Pt 1): 1005–1026. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361049/

[25] Beverly Court. Washington Department of Social and Health Services. Personal communication, November 13, 2018.

[26] Washington Health Care Authority. "Contract: Qualified Managed Fee-for-Service Health Home." Available at: https://www.hca.wa.gov/assets/billers-and-providers/FFScontract.pdf

[27] See: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-18-0028.pdf

[28] E. Walsh, et al. "Measurement, Monitoring, and Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals: Aggregate Evaluation Plan." RTI International. December 2013. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf

[29] D. Justice, et al. "Financial Alignment Initiative Annual Report: Washington Health Homes MFFS Demonstration." RTI International. July 13, 2016 (Updated July 18, 2017). Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAFirstAnnualEvalReport.pdf and D. Justice, et al. "Financial Alignment Initiative Washington Health Homes MFFS Demonstration: Second Annual Evaluation Report." RTI International. November 2018. Available at: https://innovation.cms.gov/Files/reports/fai-wa-secondevalrpt.pdf

[30] D. Justice, et al. "Financial Alignment Initiative Washington Health Homes MFFS Demonstration: Second Annual Evaluation Report." RTI International. November 2018. Available at: https://innovation.cms.gov/Files/reports/fai-wa-secondevalrpt.pdf

[31] Ibid.

[32] The demonstration uses demonstration years (DYs) for the purposes of reporting on quality and savings. For demonstrations not beginning on January 1 of a calendar year, DY 1 was extended until the end of the following calendar year. The Washington demonstration was implemented on July 1, 2013, making DY1 July 1, 2013 through December 31, 2014 for the purposes of evaluation.

[33] The MFFS demonstrations are eligible for performance payments from CMS if they achieve statistically significant Medicare savings, net of any increased federal Medicaid spending, as determined by annual actuarial calculations. In the capitated model

demonstrations, states and CMS establish savings percentages (approximately 1 percent in the Demonstration Year 1, increasing to about 5 percent by year 5) that are deducted up front from the blended Medicaid and Medicare Part A/B payments made to plans. For more information see: Medicaid and CHIP Payment and Access Commission. "Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare." January 2018. Available at: https://www.macpac.gov/wp-content/uploads/2015/09/Financial-Alignment-Initiative-for-Beneficiaries-Dually-Eligible-for-Medicaid-and-Medicare-1.pdf

[34] Note that the actuarial analysis used for the cost savings calculation is different from that used in the qualitative analysis of differences in utilization and costs between the demonstration and comparison groups. For more information on the actuarial method see: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalResults.pdf

[35] Sandler, M., Zhao, L., Trapnell, T., et al. "Report for Washington Health Home Managed Fee-for-Service (MFFS) Final Demonstration Year 2 and Preliminary Demonstration Year 3 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative." CMS, November 2018. Available at: https://innovation.cms.gov/Files/reports/fai-wa-finalyr2preyr3.pdf

[36] Washington State Health Care Authority. "Duals Engagement Framework." July 26, 2011.

[37] L. Nelson. "Lessons from Medicare's Demonstration Projects on Disease Management and Care Coordination." Congressional Budget Office, January 2012. Available at: https://www.cbo.gov/publication/42924

[38] Peikes, D., Chen, A., Schore, J., and Brown, R. "Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures among Medicare Beneficiaries: 15 Randomized Trials." *Journal of the American Medical Association*. 2009;301(6): 603–18.

[39] Jingping Xing, J., op cit.

[40] Washington State Department of Health and Social Services and Washington State Health Care Authority. "State Demonstrations to Integrate Care for Dual Eligibles. Demonstration Proposal: Washington." April 2012. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WashingtonProposal.pdf and "Third Engrossed Substitute House Bill 2127. Chapter 7, Laws of 2012. Effective May, 2, 2012. http://leap.leg.wa.gov/leap/budget/lbns/2012Omni2127-S.SL.pdf

[41] The match is only available for health home services, not other Medicaid-covered services that may be provided to demonstration enrollees as a result of the development or implementation of a HAP (e.g., personal care services, non-emergency medical transportation, substance use disorder treatment, etc.). For more information, see: Centers for Medicare & Medicaid Services. "Health Homes for Enrollees with Chronic Conditions." SMDL: 10-024. November 2010. Available at: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

[42] The Washington demonstration expanded statewide in waves. The program started in 14 counties (Pierce, Clark, Cowlitz, Klickitat, Skamania, Wahkiakum, Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, and Yakima) on July 1, 2013. The enhanced match period for this wave expired on 6/30/15. On 10/1/13, health homes were expanded to 23 additional counties (Clallam, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, Thurston, Island, San Juan, Skagit, Whatcom, Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, and Whitman). The enhanced match period for this wave expired on 9/30/15. The final two counties, King and Snohomish, were added effective on 4/1/17, and the enhanced match will end on 3/31/19.

[43] This number was subsequently revised upward to $34.9 million with another preliminary estimate of $32.1 million in Medicare savings during the next 12 months of operation (Demonstration Period 2). For more information see: Wilkin, J. "Report for Washington Managed Fee-for-Service (MFFS) Final Demonstration Year 1 and Preliminary Demonstration Year 2 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative." RTI International. July 2017. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalMedicareCostYr1FinalYr2Preliminary072817.pdf

[44] AAADSW had a contract with the other Health Home Lead Entity in its service area, but chose not to continue that because of the low rate of enrollee referrals it was receiving.

[45] D. Kelly. "Working As a CBO to Impact Health Outcomes: The Magic Sauce of At-Home In-Person Community Based Case Management." Presentation. Aging and Disability Business Institute. July 17, 2018.

[46] P. Wilkens, R. Pittman, J. Heilman, T. Charleston, and M. Meyers. "Best Practices for Care Coordination: The AAADSW Model." Available at: http://www.helpingelders.org/download/7719/

[47] Full Life Care also operates a CCO, which provides health home services to its own enrollees as well as contracting to provide care coordination services to other Health Home Lead Entities in King and Snohomish counties that are operated by managed care organizations.

[48] For more information, see: https://www.fulllifecare.org/

[49] For more information, see: https://www.nwrcwa.org/

[50] Washington State Department of Social and Health Services. Aging and Long-Term Support Administration. "Health Home Care Coordinator Core Training Materials." Available at: https://www.dshs.wa.gov/altsa/stakeholders/washington-health-home-program-core-training

[51] Sandler, M., et al., op cit.

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT T

REPORT FOR WASHINGTON MANAGED FEE-FOR-SERVICE

August 2019

Report for Washington Managed Fee-for-Service (MFFS)

Final Demonstration Year 3 and Preliminary Demonstration Year 4 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative

Prepared for

Sai Ma
Nancy Chiles Shaffer
Thomas Shaffer
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation
Mail Stop WB-06-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted by

Edith Walsh, PhD
RTI International
1440 Main Street, Suite 310
Waltham, MA 02451-1623

RTI Project Number 0212790.003.002.007/008

REPORT FOR WASHINGTON MANAGED FEE-FOR-SERVICE (MFFS) FINAL DEMONSTRATION YEAR 3 AND PRELIMINARY DEMONSTRATION YEAR 4 MEDICARE SAVINGS ESTIMATES: MEDICARE-MEDICAID FINANCIAL ALIGNMENT INITIATIVE

by

Actuarial Research Corporation
Michael Sandler, ASA, MAAA
Lan Zhao, PhD
Anthony Simms, ASA, MAAA
Todd Trapnell, MPP
Alicia Nussbaum

RTI International
Melissa Morley, PhD
Giuseppina Chiri, MA

Project Director: Edith G. Walsh, PhD

Federal Project Officer: Sai Ma, Nancy Chiles Shaffer, and Thomas Shaffer

RTI International

CMS Contract No. HHSM-500-2014-00037i TO#7

August, 2019

This project was funded by the Centers for Medicare & Medicaid Services under contract no. HHSM-500-2014-00037i TO#7. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. RTI assumes responsibility for the accuracy and completeness of the information contained in this report. The information in this report is intended for the internal use of CMS and is not intended to benefit any third party. Michael Sandler is responsible for the estimates in this memorandum. He is a member of the American Academy of Actuaries and an Associate of the Society of Actuaries and is qualified to perform this analysis.

RTI International is a registered trademark and a trade name of Research Triangle Institute.

Contents

Section **Page**

Executive Summary 1

1. Introduction 1

2. Data Sources for PMPM Cost Analysis 5
   - 2.1 Eligibility Data 5
   - 2.2 Claims Data 5

3. Basic Approach 7
   - 3.1 Categories of Beneficiaries 7
   - 3.2 Cohorts 8
   - 3.3 Determining Member Months 11
   - 3.4 Calculation of PMPM 12
   - 3.5 AGA and Outlier Adjustments 13

4. Analysis of Cohorts 15

5. Results of PMPM Cost Analysis 21
   - 5.1 Medicare Savings before Adjustments 21
   - 5.2 Medicare AGA Adjustments 61
   - 5.3 Outlier Adjustment 90
   - 5.4 Attributed Medicare Savings 98
   - 5.5 Summary of Total Gross Medicare Savings 99
   - 5.6 Additional Analysis 100

List of Tables

Number		Page
1	Cohort Composition	15
1.A	Reasons for ineligibility for Cohort 1	17
1.B	Reasons for ineligibility for Cohort 2	18
1.C	Reasons for ineligibility for Cohort 3	18
1.D	Reasons for ineligibility for Cohort 4	19
1.E	Reasons for ineligibility for Cohort 5A	19
1.F	Reasons for ineligibility for Cohort 5B	20
2.A.1	MEDICARE Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 1	23
2.A.2	MEDICARE Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 1	24
2.B.1	MEDICARE Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 2	25
2.B.2	MEDICARE Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 2	26
2.C.1	MEDICARE Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 3	27
2.C.2	MEDICARE Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 3	28
2.D.1	MEDICARE Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 4	29
2.D.2	MEDICARE Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 4	30
2.E	MEDICARE Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 5A	31
2.F	MEDICARE Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 5B	32
2.G	Comparison group summary (all cohorts)	33
3.A.1	MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 1A	36

3.A.2 MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 1A 37
3.B.1 MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 1B 38
3.B.2 MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 1B 39
3.C.1 MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 1C 40
3.C.2 MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 1C 41
3.D.1 MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 1D 42
3.D.2 MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 1D 43
3.E.1 MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 1E 44
3.E.2 MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 1E 45
3.F.1 MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 1F 46
3.F.2 MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 1F 47
3.G.1 —MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 1 Total 48
3.G.2 —MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 1 Total 49
3.H.1 MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 2 50
3.H.2 MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 2 51

3.I.1 MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 3 52
3.I.2 MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 3 53
3.J.1 MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 4 54
3.J.2 MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 4 55
3.K MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 5A 56
3.L MEDICARE Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 5B 57
4.A Summary by cohort of per member per month (PMPM), baseline versus Demonstration Year 3 58
4.B Summary by cohort of per member per month (PMPM), baseline versus Demonstration Year 4 59
5.A Average AGA factor by group for baseline period and Demonstration Year 3 61
5.B Average AGA factor by group for baseline period and Demonstration Year 4 62
6.A.1 MEDICARE Demonstration Year 3 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1A 64
6.A.2 MEDICARE Demonstration Year 4 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1A 65
6.B.1 MEDICARE Demonstration Year 3 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1B 66
6.B.2 MEDICARE Demonstration Year 4 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1B 67
6.C.1 MEDICARE Demonstration Year 3 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1C 68
6.C.2 MEDICARE Demonstration Year 4 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1C 69
6.D.1 MEDICARE Demonstration Year 3 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1D 70
6.D.2 MEDICARE Demonstration Year 4 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1D 71
6.E.1 MEDICARE Demonstration Year 3 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1E 72
6.E.2 MEDICARE Demonstration Year 4 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1E 73
6.F.1 MEDICARE Demonstration Year 3 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1F 74

6.F.2 MEDICARE Demonstration Year 4 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1F 75
6.G.1 MEDICARE Demonstration Year 3 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1 total..... 76
6.G.2 MEDICARE Demonstration Year 4 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1 total..... 77
6.H.1 MEDICARE Demonstration Year 3 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 2..... 78
6.H.2 MEDICARE Demonstration Year 4 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 2..... 79
6.I.1 MEDICARE Demonstration Year 3 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 3..... 80
6.I.2 MEDICARE Demonstration Year 4 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 3..... 81
6.J.1 MEDICARE Demonstration Year 3 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 4..... 82
6.J.2 MEDICARE Demonstration Year 4 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 4..... 83
6.K MEDICARE Demonstration Year 4 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 5A..... 84
6.L MEDICARE Demonstration Year 4 Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 5B..... 85
7.A MEDICARE Summary of Demonstration Years 1, 2, 3 and 4 savings by cohort not including attributed savings and outlier adjustment 87
7.B MEDICARE Summary of Demonstration Year 3 savings by cohort not including attributed savings and outlier adjustment 88
7.C MEDICARE Summary of Demonstration Year 4 savings by cohort not including attributed savings and outlier adjustment 89
8 MEDICARE Outlier adjustment data 91
9 MEDICARE Summary of Demonstration Years 3 and 4 savings by cohort, including the outlier adjustment but excluding attributed savings 93
10 MEDICARE Summary of Demonstration Years 3 and 4 savings by cohort, After all adjustments including the outlier adjustment and attributed savings 95
11.A MEDICARE PMPM costs for intervention and comparison groups, by month: Cohort 1 101
11.B MEDICARE PMPM costs for intervention and comparison groups, by month: Cohort 2 102
11.C MEDICARE PMPM costs for intervention and comparison groups, by month: Cohort 3 103
11.D MEDICARE PMPM costs for intervention and comparison groups, by month: Cohort 4 104
11.E MEDICARE PMPM costs for intervention and comparison groups, by month: Cohort 5A..... 105
11.F MEDICARE PMPM costs for intervention and comparison groups, by month: Cohort 5B..... 105

12.A MEDICARE PMPM costs for Demonstration Year 3 based on incurred Medicare claims for Cohorts 1, 2, 3 and 4 106
12.B MEDICARE PMPM costs for Demonstration Year 4 based on incurred Medicare claims for Cohorts 1, 2, 3, 4 and 5A/B 107
13.A PMPM costs by category of beneficiary for Demonstration Year 3 based on incurred Medicare claims for Cohorts 1, 2, 3 and 4..... 108
13B PMPM costs by category of beneficiary for Demonstration Year 4 based on incurred Medicare claims for Cohorts 1, 2, 3, 4 and 5A/B..... 109

Executive Summary

The Washington Health Homes MFFS demonstration leverages Medicaid health homes to integrate care for full-benefit Medicare-Medicaid beneficiaries by targeting high-cost, high-risk dual eligible enrollees. The State's existing delivery systems for primary, acute, behavioral and LTSS remain unchanged and health homes serve as the bridge for integrating care across these existing delivery systems. The demonstration service area originally included all but two counties (King and Snohomish) in the state and began enrollment on July 1, 2013. As of April 1, 2017, the demonstration was extended statewide and Demonstration Year 4 (DY4) includes beneficiaries from all counties.

This report includes an analysis of Medicare savings during the 24-month period from January 1, 2016 through December 31, 2017: final Medicare savings estimates for DY3 (January 1, 2016 through December 31, 2016) and preliminary Medicare savings estimates for DY4 (January 1, 2017 through December 31, 2017). Final Medicare savings estimates for DY1 and DY2 and preliminary Medicare savings estimates for DY3 appeared in previously released Washington Medicare savings reports. Future reports will include Medicaid data for Demonstration Years 1, 2, 3 and 4, if available.

The method used to perform the Medicare saving calculations in this report is referred to as the "actuarial method," to distinguish it from the multivariate regression-based method that has been used to estimate the impact of the demonstration on quality and cost outcomes in the annual demonstration evaluation reports. The actuarial method relies on assigning beneficiaries in both the intervention and comparison groups to cohorts and then constructing an eligibility timeline for each beneficiary to determine whether claims occurred during a period of demonstration eligibility. Medicare per member per month (PMPM) expenditures for eligible beneficiaries are tabulated from claims.

The basic approach to the savings calculation is to compare the trend of PMPM Medicare expenditures of those beneficiaries in the intervention group with the trend of the PMPM of those beneficiaries in the comparison group. This is achieved by comparing the actual PMPM of the intervention group beneficiaries with a target PMPM, which represents the baseline intervention group PMPM projected forward by the trend of the actual experience observed in the comparison group going from the baseline period to the Demonstration Year.

Results of the savings calculations are summarized below and include results for multiple cohorts as applicable.

- Total Medicare savings in Demonstration Year 3 were calculated as $38.8 million or 10.9 percent. An additional $7.7 million in attributed savings (savings attributed to eligible months prior to the start of the most recent cohort) sums to a grand total final calculated Demonstration Year 3 Medicare savings amount of $46.6 million.

- Preliminary total Medicare savings in Demonstration Year 4 were calculated as $46.5 million or 9.7 percent. Including preliminary attributed Medicare savings estimates of $5.5 million results in a grand total preliminary Demonstration Year 4 Medicare savings estimate of $55.2 million.

- Per the previous Washington Medicare Savings reports, total Demonstration Year 1 Medicare savings were calculated as $34.9 million and total Demonstration Year 2 savings were calculated as $30.2 million.

- The current estimate of grand total Demonstration Medicare savings for all cohorts through Demonstration Year 4 to $166.8 million.

1. Introduction

The Washington Health Homes MFFS demonstration leverages Medicaid health homes, established under Section 2703 of the Affordable Care Act, to integrate care for full-benefit Medicare-Medicaid beneficiaries. Washington has targeted the demonstration to high-cost, high-risk Medicare-Medicaid enrollees based on the principle that focusing intensive care coordination on those with the greatest need provides the greatest potential for improved health outcomes and cost savings. The demonstration is organized around the principles of patient activation and engagement, and support for enrollees to take steps to improve their own health. In the course of integrating care for enrollees across primary care, long-term services and supports (LTSS), and behavioral health delivery systems, health home care coordinators are charged with conducting assessments, and engaging enrollees to develop Health Action Plans (HAPs) and increase their self-management skills to achieve optimal physical and cognitive health.

The State's existing delivery systems for primary, acute, behavioral, and LTSS remain unchanged. Health homes serve as the bridge for integrating care across these existing delivery systems. Even though the Washington State MFFS demonstration provides services through the traditional fee-for-service Medicare and Medicaid programs and does not affect beneficiaries' choice of providers or limit availability of services, beneficiaries have the option to opt out of receiving health home services. Beneficiaries are auto-assigned to a health home to coordinate their services, and they may choose not to use or engage with that health home. Their Medicare and Medicaid services are not disrupted if they decide not to engage with the health home.

Washington used a competitive Request for Application process to select qualified health homes. Applicants were required to demonstrate a wide range of administrative capabilities, have experience in conducting care coordination, offer multiple vehicles for beneficiary access to supports, and present a network of diverse organizations that can serve enrollees with a range of needs. The organizations selected were Community Choice (a provider consortium); Northwest Regional Council (an Area Agency on Aging); Optum (a Mental Health Regional Support Network); and Southeast Washington Aging and Long Term Care (an Area Agency on Aging). Two managed care plans were also selected to be health homes, Community Health Plan of Washington and United Health Care Community Plan. The State prioritized beneficiary enrollment into the non-managed care health homes and as a result, as of July 2015, less than 5 percent, 4.7 percent, of all enrollees were in new managed care health homes.

During the 2015 Washington legislative session, State funding for the health home program was terminated, effective December 31, 2015. According to a joint statement released by the Washington Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) (DSHS and HCA, 2015), the legislature's decision to terminate funding was based on a lack of supporting information about whether the demonstration would meet its projected savings target amid a challenging budget climate. During the several months following the close of the legislative session in June 2015, the State suspended auto enrollment into the demonstration and began planning for termination.

In late October 2015, new information became available about projected savings for the demonstration. As a result, the State changed course and decided to continue health home services through June 2016, to give the legislature time to review savings projections. During the 2016 legislative session funding for health homes was reinstated. Effective April 1, 2017, the demonstration began to serve King and Snohomish counties, extending the demonstration service area statewide.

This report provides a final Medicare Parts A & B savings analysis of the Washington managed fee-for-service (MFFS) demonstration for Demonstration Year 3 and a preliminary analysis of Medicare data for Demonstration Year 4 under the Medicare-Medicaid Financial Alignment Initiative. During the first three Demonstration Years, Washington had enrolled beneficiaries in the demonstration in all but two counties (King and Snohomish) in the State. Washington began enrollment on July 1, 2013. As of April 1, 2017, the demonstration was extended statewide and Demonstration Year 4 includes beneficiaries from all counties.

This report includes an analysis of Medicare savings during the 24-month period from January 1, 2016 through December 31, 2017 separated into Demonstration Year 3 for the Washington demonstration (January 1, 2016 through December 31, 2016) and Demonstration Year 4 (January 1, 2017 through December 31, 2017). CMS previously released two Medicare savings reports by RTI entitled (1) Final Demonstration Year 1 and Preliminary Demonstration Year 2 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative and (2) Final Demonstration Year 2 and Preliminary Demonstration Year 3 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative. These reports provided final estimates of Medicare savings for Demonstration Years 1 and 2 and preliminary estimates of Medicare savings for Demonstration Years 2 and 3, respectively, for Washington. Demonstration Years 1, 2 and 3 experience and Medicare savings calculations are considered complete.[1] This report provides final Medicare savings estimates for Demonstration Year 3 and preliminary Medicare savings estimates for Demonstration Year 4, the additional 12-month period spanning from January 1, 2017 through December 31, 2017. In addition to developing a savings report for subsequent Demonstration Years, future reports will include Medicaid data for Demonstration Years 1, 2, 3 and 4, if available. Currently, we do not have sufficient Medicaid data for the periods covered in this report to perform any analyses.

The method used to perform the Medicare savings calculations in this report will be referred to as the "actuarial method," to distinguish it from the multivariate regression-based method that will be used to estimate the impact of the demonstration on quality and cost outcomes in the annual evaluation reports for the Washington demonstration. Because the actuarial method constructs cohorts of beneficiaries from the comparison group (as will be explained later), the actuarial savings calculation uses a subset of the comparison group that was constructed for the other descriptive and regression-based analyses that RTI will perform as part of the evaluation. The Centers for Medicare & Medicaid Services (CMS) will use the results of the actuarial method to determine whether Washington is eligible for a performance payment

[1] Any reference to Demonstration Years 1 and 2 experience and savings included in this report is pulled directly from the previous report and does not incorporate any new information or calculations.

under the MFFS Financial Alignment Model. The Medicare and Medicaid savings calculation results will be a factor in that determination.

The Medicare results presented in this report should be viewed as final for Demonstration Year 3, but preliminary for Demonstration Year 4. The Demonstration Year 4 Medicare Parts A and B expenditure data includes 10 months of claims runout (i.e., through October 2018). Note that final the evaluation report will include an analysis of Medicare Part D data, however under the MFFS financial alignment model, Part D spending does not inform the amount of any performance payment to the State and is not included in this report. The preliminary Demonstration Period 3 results included in the previous report included 12 months of claims run-out. This final Medicare savings report for Demonstration Year 3 has been updated to include any retroactive adjustments to eligibility data and additional claims runout for beneficiaries in both the intervention and comparison groups.

Compared to earlier reports, there was one important methodological change made to the Demonstration Year 3 final Medicare savings estimate. This change is detailed in section 3.2 below. In brief, the comparison group for Demonstration Year 3 was updated to reflect a lack of reliable eligibility information reported for dual enrollees in Arkansas beginning in Demonstration Year 3.

[This page intentionally left blank.]

2. Data Sources for PMPM Cost Analysis

2.1 Eligibility Data

As a part of performing cost calculations on a per member per month (PMPM) basis, it was necessary to construct an eligibility timeline for each beneficiary to determine whether claims occurred during periods of eligibility for the demonstration. ARC used beneficiary eligibility information extracted from the appropriate tables on the Integrated Data Repository (IDR) in December 2018, to construct an analytic file that contains eligibility occurrences for Part A coverage, Part B coverage, and primary payer status; eligibility occurrences for State/county codes of residence and, as applicable, the date of death; Group Health Organization (GHO) enrollment (e.g., Medicare Advantage [MA] or the Program of All-Inclusive Care for the Elderly [PACE]); and periods of hospice coverage. Specific eligibility criteria are described in Section 3.2. All of this information was used to construct a historical eligibility record for each beneficiary in all cohorts and Demonstration Years. Thus, these new data were used to produce the final estimate of Medicare savings for demonstration year 3 and preliminary Medicare savings estimates for demonstration year 4.

After creating the historical eligibility file, ARC determined the days on which a beneficiary was eligible for the demonstration. Claims were used to calculate the Medicare PMPM payments only if the beneficiary was eligible to participate in the demonstration on the admission date (for institutional claims) or service date (for all other types of service) on the claim. For future reports, retroactive changes will be applied so that the daily eligibility file for Demonstration Year 4 will include updated values for all months in Demonstration Year 4.

2.2 Claims Data

The source of Medicare Parts A and B claims data for this report was CMS's Chronic Condition Warehouse (CCW). For each of the beneficiary cohorts included in this report, the claims data employed in the analysis were extracted from the CCW and represent claims incurred from the start date of each cohort through December 31, 2017 and processed by CMS through October 2018. The paid claim amounts tabulated for this report do not include estimates of incurred-but-not-reported (IBNR) claims for medical services performed during all 24 months but not yet paid by the end of October 2018. We have assumed the claims runout is effectively 100 percent complete for Demonstration Year 3.

Medicare payments were separated into seven claim categories:

1. Inpatient
2. Skilled Nursing Facility (SNF)
3. Hospice
4. Outpatient
5. Home Health

6. Professional
7. Durable Medical Equipment (DME)

3. Basic Approach

The basic approach to the savings calculation is to compare the trend (as opposed to the level) of per member per month (PMPM) Medicare expenditures of those beneficiaries in the intervention group (i.e., the demonstration group) with the trend of the PMPM of those beneficiaries in the comparison group. This is done by comparing the actual PMPM of the individuals in the intervention group with a target PMPM, which is determined by projecting forward the PMPM of the intervention group in the baseline period to the Demonstration Year. The trend used for the projection is based on the actual experience observed in the comparison group during the baseline period and the Demonstration Year.

For Medicare, the PMPM amounts are calculated by dividing total Medicare Parts A and B expenditures by the number of member months of eligibility. Medicare-paid amounts do not include the amounts for deductibles, coinsurance, or balance billing. For hospital claims, the paid amount is reduced for Medicare Disproportionate Share (DSH) payments and Indirect Medical Education (IME) payments, because these payments are not directly related to the cost of care provided to individual beneficiaries.

3.1 Categories of Beneficiaries

The basic approach is refined by disaggregating the beneficiaries in the intervention and comparison groups by characteristics that affect their level of care and costs. The disaggregation is performed using three characteristics that result in 12 categories, or cells, of beneficiaries:

1. Basis of Medicare eligibility:
   i) Age (65+) or
   ii) Disability (<65)

2. Level of Long-Term Services and Supports (LTSS):
   i) Institution,
   ii) Home and Community-Based Services (HCBS), or
   iii) Community

3. Presence of Severe and Persistent Mental Illness (SPMI):
   i) Yes or
   ii) No

It is important to note that beneficiaries are placed into categories according to their characteristics at the time that they are first assigned to a cohort, even if these characteristics subsequently change. This is done to ensure that the PMPMs in each category change only from the effects of the demonstration and not from the effects of changing the mix of individuals in the category. This will also capture the effect of the demonstration to potentially slow the progression of the use of LTSS. For example, during the demonstration, some of the beneficiaries originally placed in the community category may begin using HCBS or institutional services, which usually result in increased costs of care. If the transition rate of beneficiaries in the community category who move to categories requiring more intensive services during the

demonstration is higher for the comparison group than for the intervention group, then the PMPM of the comparison group would increase faster and the savings model would show demonstration savings.

3.2 Cohorts

The beneficiaries are also disaggregated according to when they become eligible for the demonstration. Beneficiaries are placed into cohorts based on when they first meet the eligibility requirements of the demonstration. Those who met the requirements for eligibility on July 1, 2013 are in Cohort 1. In order to (1) not include the experience of beneficiaries before they become eligible for the demonstration and (2) create closed groups, intervention group Cohort 1 beneficiaries were subdivided into six subgroups; those who first became eligible for the demonstration in each of the 6 months July through December 2013. These subgroups are designated as Cohort 1A through Cohort 1F, respectively. All subsequent cohorts are assigned as follows:

- Cohort 2: Those who met the requirements for eligibility on January 1, 2014 (and who are not in Cohort 1)
- Cohort 3: Those who met the requirements for eligibility on January 1, 2015 (and are not in Cohort 1 or Cohort 2)
- Cohort 4: Those who met the requirements for eligibility on January 1, 2016 (and are not in Cohorts 1, 2 or 3)
- Cohort 5A: Those who met the requirements for eligibility on January 1, 2017 (and are not in Cohorts 1, 2, 3 or 4)
- Cohort 5B: Those residing in King and Snohomish counties who met the requirements for eligibility on April 1, 2017.

Note that the beneficiaries in Cohort 1 and Cohort 2 have experience after the start date of the cohort during Demonstration Year 1 (which spans July 2013 through December 2014), but that Cohort 3 does not. Cohorts 1, 2 and 3 have experience after the start date of the cohort in Demonstration Year 2 (which spans January 2015 through December 2015), but Cohort 4 does not. Cohorts 1, 2, 3 and 4 have experience in Demonstration Year 3. The demonstration extended to include King and Snohomish counties effective April 1, 2017, and as such Cohort 5A has experience for the entirety of Demonstration Year 4 (which spans January 2017 through December 2017) but Cohort 5B only has 9 months of experience in Demonstration Year 4 (April 2017 through December 2017.) In subsequent Demonstration Years, beneficiaries in King and Snohomish counties will continue to be kept in separate sub-cohorts because there was a separate comparison group constructed for these individuals. However, the time periods of experience will be identical.

Washington provided CMS with a file that flags the beneficiaries who have been determined to be eligible for the demonstration, including those having a score of 1.5 or greater

on the Predictive Risk Intelligence System (PRISM)[2]. This eligibility flag is provided for months starting in July 2013, but not for the months in the baseline period. We performed some basic eligibility checks on the beneficiaries and excluded them from the savings calculation if, on the date that we place them in cohorts, they failed to meet any of the following criteria. We also excluded from the baseline period any month for which an eligible beneficiary does not meet these basic eligibility requirements

1. Are eligible for Medicaid
2. Reside in a demonstration county
3. Have not elected hospice care
4. Have both Part A and Part B coverage
5. Are not enrolled in a Group Health Organization
6. Do not have Medicare as a secondary payer
7. Have at least 90 days of experience during the baseline period
8. Are not in another CMS Medicare shared savings initiative.

For beneficiaries in the comparison group, we applied the same checks, except that residence was checked for the appropriate counties in the comparison states.

Each MSA consists of a group of counties. For each state, a non-MSA area was constructed from the counties that do not belong to an MSA. In addition, RTI simulated the PRISM score of each comparison group beneficiary for each quarter of the Demonstration Years. We checked that the comparison group beneficiaries had an RTI-generated simulated PRISM score of at least 1.5 in the first quarter of the demonstration for Cohort 1, in the third quarter of the demonstration for Cohort 2, in the seventh quarter of the demonstration for Cohort 3, in the eleventh quarter of the demonstration for Cohort 4 and in the fifteenth quarter of the demonstration for Cohorts 5A and 5B.

Special Note 1: RTI constructed the comparison group for the original demonstration area from selected Metropolitan Statistical Areas (MSAs) in three States—Georgia, Arkansas, and West Virginia—based on similarities between the demonstration and comparison areas. For the demonstration extension to King and Snohomish counties, RTI constructed the comparison group from selected MSAs in four states—Michigan, North Carolina, Virginia and West Virginia.[3] The use of a separate comparison group for these two counties reflects how they are notably different in composition from other regions of Washington.

[2] The PRISM score is based on a proprietary algorithm developed by the state of Washington.

[3] A description of the comparison group selection methodology will be included in the Washington annual report.

Special Note 2: During the early stages of the Demonstration Year 4 Medicare savings analysis, information was provided to CMS and the evaluation contractor that critically undermined the validity of the eligibility information reported for Arkansas, one of the comparison states, beginning in Demonstration Year 3. Upon further investigation, it became clear that including beneficiaries from Arkansas in the comparison group for purposes of the actuarial savings analysis for Demonstration Years 3 and 4 was not a credible option and they were dropped after consultation with CMS. The paragraph below describes the relative distribution of the intervention and comparison group beneficiaries after the updates.

The intervention group and the comparison group had roughly the same distribution by basis of eligibility. Both groups had roughly 44 percent of individuals aged 65 or older. The distribution by prevalence of SPMI and facility status showed more variation. In the intervention group, there was 35 percent prevalence of SPMI compared with 42 percent in the comparison group. In the intervention group, 41 percent of members used HCBS and 11 percent used facility-based LTSS, whereas the prevalence in the comparison group was 17 percent HCBS and 28 percent facility-based services. Because the savings were calculated for each facility status category separately and weighted according to the intervention group distribution, the savings calculation appropriately takes into account these distributions.

For each cohort after the first, some or all of the baseline experience includes months that are also Demonstration Year months for which the beneficiary could have also been eligible for the demonstration. These are the first few months of eligibility before the start of the cohort, which occurs on January 1. According to the Final Demonstration Agreement, it was agreed to attribute the savings experience of the prior cohort to these months. Thus, for Demonstration Year 1, the savings percentage experienced by Cohort 1 was attributed to these few months of Cohort 2, and for Demonstration Years 2, 3 and 4, the savings percentage experienced by Cohorts 2, 3 and 4 were attributed to these few months for Cohorts 3, 4 and 5A, respectively. Cohorts 6A and 6B will consist of those who were eligible for the demonstration in January 2018 in the original demonstration area and who were not in Cohorts 1, 2, 3, 4 or 5A and those who were eligible for the demonstration in January 2018 in King and Snohomish counties who were not in Cohort 5B. For this report, we have tabulated the eligible member months in Demonstration Year 4 (January 2017 through December 2017 for the original demonstration area and April 2017 through December 2017 for King and Snohomish counties) of preliminary Cohorts 6A and 6B and attribute the PMPM savings achieved for Cohorts 5A and 5B, respectively, to these first few months of eligibility of Cohorts 6A and 6B. As noted in section 5.4 below, these preliminary attributions of savings can change significantly once additional data becomes available.

The reason for employing cohorts for the analysis is to create closed groups of beneficiaries (similarly in the intervention group and the comparison group) whose monthly expenditures (PMPM) can be tracked to determine the effects of the demonstration. If new entrants were allowed into these groups over time, the new entrants would change the PMPM of the groups for reasons unrelated to the effects of the demonstration, but instead related only to the change in the mix of the groups. If the mix of the groups were changing every month in terms of characteristics affecting costs such as age, gender, risk score, and area of residence, then adjustment factors would need to be introduced to take these monthly changes into account. The

use of closed groups means that these characteristics are not changing significantly between the intervention and comparison groups and monthly adjustment factors are not needed.

When the idea of the cohorts was first conceived before the drafting of the preliminary report for demonstration year 1, Cohort 1 was to consist of all of those beneficiaries first identified as eligible for the demonstration in or before July 2013 without any sub-cohorts. However, from those beneficiaries who were dually eligible in July 2013, Washington determined their first month of eligibility for the demonstration in stages over the first 6 months of operations as the demonstration was being rolled out in different areas. That is, a beneficiary was not considered to be eligible for the demonstration for savings calculation purposes until the demonstration had been implemented in the beneficiary's geographic area. It is not possible to re-create this process of rolling entry for the comparison group. Thus, Cohort 1 for the comparison group consists of those beneficiaries who were both dually eligible in July 2013 and deemed eligible for the demonstration in July 2013 by RTI, which simulated the Washington PRISM criteria.

The baseline period for all cohorts is shown below:

- Cohort 1: July 1, 2011 through June 30, 2013.
- Cohort 2: January through December 2013.
- Cohort 3: January through December 2014.
- Cohort 4: January through December 2015.
- Cohort 5A: January through December 2016.
- Cohort 5B: April 2016 through March 2017.

The same beneficiaries are in the baseline and the Demonstration Years and an individual beneficiary must have 3 months of baseline experience before being included in a cohort for the savings calculation. This means that the beneficiary must have met the basic eligibility requirements for at least 3 months during the applicable baseline period. Because the savings calculation methodology relies on determining the trend in PMPM expenditures between the baseline period and the Demonstration Year, it is essential that each beneficiary have relevant experience in both of these periods.

3.3 Determining Member Months

Savings are determined by comparing intervention and comparison group PMPM Medicare expenditures. The first step in determining PMPM amounts is determining the number of member months that are used in the calculation for each beneficiary. For Cohort 1, member months are calculated for each beneficiary starting on July 1, 2013 (or the first day of demonstration eligibility for sub-cohorts) and accruing until one of the following dates or the end of the analytic period (i.e., the first day that is not included as a member month):

1. January 1, 2018.
2. The day after death.
3. The day after moving outside of the intervention area or comparison area.
4. The day of joining a Group Health Organization (GHO).
5. The day that Medicare is no longer the primary payer.
6. The day of loss of coverage for either Medicare Part A or Part B.
7. The day of loss of Medicaid eligibility.
8. For intervention beneficiaries, the day that Washington determines that the beneficiary is no longer eligible for the demonstration.
9. For Cohorts 1 and 2, January 1, 2015 if the beneficiary was a part of a Medicare shared savings program in 2015 but had not been a part of a shared savings program prior to 2015.
10. For Cohorts 1, 2 and 3, January 1, 2016 if the beneficiary was part of a Medicare shared savings program in 2016, but had not been part of a shared savings program prior to 2016.
11. For Cohorts 1, 2, 3 and 4, January 1, 2017 if the beneficiary was part of a Medicare shared savings program in 2017, but had not been part of a shared savings program prior to 2017.

When one of the above occurs during a month, a prorated number of member months are calculated, so that the number of member months contains fractions of whole months. For Cohorts 2, 3, 4, 5A and 5B, the member months are calculated beginning on January 1, 2014 - 2017, and April 1, 2017, respectively, and accrue until one of the above termination events or the end of the analytic period. Also, if a beneficiary meets the demonstration eligibility criteria after being terminated previously, his or her experience would once again be included. Note that a beneficiary is not dropped from the analysis if his or her PRISM score falls below 1.5 or if the beneficiary elects hospice care. Thus, although having a PRISM score below 1.5 or being in hospice care prevents a beneficiary from becoming eligible for the demonstration, these events do not cause a beneficiary who is previously eligible from losing eligibility.

3.4 Calculation of PMPM

For Medicare, the PMPM expenditures for both the baseline period and the Demonstration Years are calculated separately for the intervention and comparison groups, each of the 12 categories of beneficiaries, each cohort, each type of service, and for each month of the Demonstration Year. For the intervention group, when aggregating across months, cells, types of service, or cohorts, expenditures and member months are simply tabulated and divided to obtain the aggregate PMPMs. For the comparison group, however, when aggregating across months,

cells, type of service, or cohorts, expenditures are obtained by multiplying the PMPM of the corresponding comparison group by the member months (MM) of the intervention group, which represents the expenditures that the comparison group would have experienced if it had the same enrollment structure and distribution as the intervention group. Totals obtained in this way are referred to as "reweighted" in subsequent tables.

For each cohort, cell, type of service, and demonstration month, a "target" PMPM is obtained by multiplying the corresponding PMPM of the intervention group in the baseline period (all 24 months combined for Cohort 1 and all 12 months combined for subsequent cohorts) times the ratio of (1) the comparison group PMPM in the demonstration month and (2) the comparison group PMPM in the baseline period. The target represents the PMPM in the baseline period of the intervention group projected forward by the trend in the comparison group. The difference between this target PMPM and the actual PMPM in the intervention group in a Demonstration Year reflects the impact of the demonstration.

3.5 AGA and Outlier Adjustments

Adjustments to the target PMPMs are needed to reflect Federal and State policies and market forces that affect the costs in the comparison States differently from those in the demonstration States and to ensure that calculated savings result only from the demonstration and not from these differences in other factors. For Medicare expenditures, the only necessary adjustment is applying an Average Geographic Adjustment (AGA) factor.[4] The AGA factor reflects varying FFS cost trends in each county over time compared with the costs of the entire nation. The AGA changes at different rates for each geographic area. The target PMPMs are adjusted so that the comparison group trend is what it would be if the AGA factors in the comparison States had changed by the same percentage as the change in the demonstration State between the baseline period and the Demonstration Year.

Another adjustment is calculated for both the intervention and the comparison PMPMs to account for outliers. Average health care expenditures (as represented by the PMPMs) for a group of beneficiaries can be significantly affected by a few very high-cost beneficiaries. Although it is possible to save by managing the care of such high-cost beneficiaries in the intervention group, this savings cannot be measured unless there are corresponding and similar high-cost beneficiaries in the comparison group. The outlier adjustment process begins by combining the intervention and comparison group beneficiaries and ranking them by their annual Medicare expenditures. A threshold amount is set at the 99th percentile of these annual beneficiary-level costs. The expenditures for any individual that exceed this threshold amount are winsorized to the threshold amount. The costs above the threshold are subtracted from the total costs, and the PMPMs are recalculated by excluding the amounts above the threshold.

[4] Other adjustments will have to be made to the Medicaid expenditures.

[This page intentionally left blank.]

4. Analysis of Cohorts

As described above, the purpose of closed cohorts is to ensure that the trend in per member per month (PMPM) results from changes in spending on beneficiaries initially placed in each category, not from new higher or lower cost beneficiaries joining the cohort over time. Although no new entrants are allowed into each cohort after it is created, there will be some terminations, and these will affect the mix of beneficiaries slightly. We have calculated the number and rates of termination for each cohort to determine whether these rates are sufficiently small and similar between the intervention and comparison groups so as to not materially affect the analysis.

Cohort 1 consists of 13,979 Medicare-Medicaid enrollees in the intervention group and 23,233 Medicare-Medicaid enrollees in the comparison group. After 54 months of operations, there were 6,160 eligible intervention group members and 7,405 eligible comparison group members as of December 31, 2017. The monthly attrition rates for the intervention and comparison groups were 1.60 percent and 2.15 percent, respectively. The most common reason for attrition was death and the monthly death rate for the intervention group was 0.77 percent, which was lower than the monthly death rate of 1.07 percent for the comparison group. The intervention group also experienced a lower rate of attrition due to a beneficiary moving out of area or participating in a shared savings program (SSP). However, the intervention group experienced higher monthly rates of attrition from (1) loss of dual eligibility (i.e., loss of Medicare or Medicaid eligibility) or (2) when Washington indicated that the beneficiary was no longer eligible for the demonstration (0.46 percent vs. 0.19 percent[5]).

Cohort 1 for the intervention group was divided into six subgroups denoted by 1A through 1F. The six subgroups consist of those beneficiaries that Washington first identified as being eligible for the demonstration at the start of each of the 6 months from July 2013 through December 2013. The following table of overall monthly attrition rates shows the number of beneficiaries in each subgroup, the monthly death rate, and the total monthly attrition rate for each subgroup.

Table 1. —
Cohort Composition

Subgroup	Number of beneficiaries	Monthly death rate	Total monthly attrition rate
1A	2,216	0.99%	1.67%
1B	3,844	0.61%	1.45%
1C	390	0.77%	1.80%
1D	6,017	0.81%	1.66%
1E	724	0.68%	1.65%
1F	788	0.64%	1.58%

[5] Note that eligibility for the intervention group is determined using Washington provided eligibility criteria including PRISM score. Eligibility for the comparison group is based on the application of Washington eligibility criteria to a comparison group which includes an RTI simulated PRISM score.

Cohort 2 consists of 690 Medicare-Medicaid enrollees in the intervention group and 4,331 Medicare-Medicaid enrollees in the comparison group. After 48 months, there were 265 eligible intervention group members and 1,521 eligible comparison group members. The monthly attrition rates for the intervention and comparison groups were 2.14 percent and 2.29 percent, respectively.

Cohort 3 consists of 5,645 Medicare-Medicaid enrollees in the intervention group and 6,444 Medicare-Medicaid enrollees in the comparison group. After 36 months of operations, there were 2,751 eligible intervention group members and 2,740 eligible comparison group members. The monthly attrition rates for the intervention and comparison groups were 2.00 percent and 2.45 percent, respectively.

Cohort 4 consists of 5,823 Medicare-Medicaid enrollees in the intervention group and 7,219 Medicare-Medicaid enrollees in the comparison group. After 24 months of operations, there were 3,329 eligible intervention group members and 4,061 eligible comparison group members. The monthly attrition rates for the intervention and comparison groups were 2.34 percent and 2.42 percent, respectively.

Cohort 5A consists of 6,165 Medicare-Medicaid enrollees in the intervention group and 5,469 Medicare-Medicaid enrollees in the comparison group. After 12 months of operations, there were 4,574 eligible intervention group members and 4,151 eligible comparison group members. The monthly attrition rates for the intervention and comparison groups were 2.51 percent and 2.32 percent, respectively.

Cohort 5B consists of 5,930 Medicare-Medicaid enrollees in the intervention group and 20,441 Medicare-Medicaid enrollees in the comparison group. After 9 months of operations, there were 4,802 eligible intervention group members and 16,946 eligible comparison group members. The monthly attrition rates for the intervention and comparison groups were 2.34 percent and 2.08 percent, respectively.

Table 1.A summarizes the reasons for ineligibility for members of Cohort 1 who became ineligible during the first 54 months of demonstration operations. ***Table 1.B*** summarizes the reasons for ineligibility for members of Cohort 2 who became ineligible during their 48 months of demonstration operations. ***Tables 1.C–F*** summarize the reasons for ineligibility for members of Cohorts 3, 4, 5A and 5B who became ineligible during their 36, 24, 12 and 9 months of demonstration operations, respectively.

Table 1.A — Reasons for ineligibility for Cohort 1

Final ineligibility reason	Intervention group		Comparison group	
	Number of events	Monthly attrition rate	Number of events	Monthly attrition rate
Death	3,747	0.77%	7,903	1.07%
Loss of Part A or B	47	0.01%	71	0.01%
GHO enrollment	1,072	0.22%	2,036	0.28%
Medicare secondary payer	221	0.05%	341	0.05%
Moved out of service area	352	0.07%	884	0.12%
Participation in SSP	153	0.03%	3,163	0.43%
Loss of eligibility	2,227	0.46%	1,430	0.19%
All ineligibles [1]	7,819	1.60%	15,828	2.15%
Beneficiaries as of 1st day of 1st month of eligibility	13,979		23,233	
Beneficiaries as of 12/31/2017	6,160		7,405	
Total member months	488,824		735,431	

GHO = Group Health Organization.

[1] For Cohorts 1, 2 and 3 we included attrition experience from Demonstration Years 1 and 2 in the count of events, the total member months of exposure and the calculation of the monthly attrition rate in order to show a full picture of the demonstration attrition to date. Because the Demonstration Years 1 and 2 experience was finalized, it was not re-run, but the total beneficiary counts for first day eligible and eligible as of 12/31/2017 reflect most recent run. This can lead to small discrepancies whereby beneficiaries remaining do not equal starting total beneficiaries minus all ineligibles due to retroactive eligibility changes.

Table 1.B —
Reasons for ineligibility for Cohort 2

Final ineligibility reason	Intervention group		Comparison group	
	Number of events	Monthly attrition rate	Number of events	Monthly attrition rate
Death	143	0.72%	1,179	0.96%
Loss of Part A or B	5	0.03%	14	0.01%
GHO enrollment	62	0.31%	349	0.28%
Medicare secondary payer	17	0.09%	56	0.05%
Moved out of service area	29	0.15%	206	0.17%
Participation in SSP	11	0.06%	620	0.51%
Loss of eligibility	158	0.80%	386	0.31%
All ineligibles	425	2.14%	2,810	2.29%
Beneficiaries as of 1/1/2014	690		4,331	
Beneficiaries as of 12/31/2017	265		1,521	
Total member months	19,859		122,673	

Table 1.C —
Reasons for ineligibility for Cohort 3

Final ineligibility reason	Intervention group		Comparison group	
	Number of events	Monthly attrition rate	Number of events	Monthly attrition rate
Death	968	0.67%	1,562	1.03%
Loss of Part A or B	11	0.01%	24	0.02%
GHO enrollment	429	0.30%	385	0.25%
Medicare secondary payer	95	0.07%	72	0.05%
Moved out of service area	149	0.10%	253	0.17%
Participation in SSP	52	0.04%	908	0.60%
Loss of eligibility	1,190	0.82%	500	0.33%
All ineligibles	2,894	2.00%	3,704	2.45%
Beneficiaries as of 1/1/2015	5,645		6,444	
Beneficiaries as of 12/31/2017	2,751		2,740	
Total member months	144,347		150,997	

Table 1.D —
Reasons for ineligibility for Cohort 4

Final ineligibility reason	Intervention group		Comparison group	
	Number of events	Monthly attrition rate	Number of events	Monthly attrition rate
Death	758	0.71%	1,357	1.04%
Loss of Part A or B	17	0.02%	14	0.01%
GHO enrollment	422	0.40%	385	0.30%
Medicare secondary payer	69	0.06%	67	0.05%
Moved out of service area	154	0.14%	234	0.18%
Participation in SSP	30	0.03%	600	0.46%
Loss of eligibility	1,044	0.98%	501	0.38%
All ineligibles	2,494	2.34%	3,158	2.42%
Beneficiaries as of 1/1/2016	5,823		7,219	
Beneficiaries as of 12/31/2017	3,329		4,061	
Total member months	106,497		130,359	

Table 1.E —
Reasons for ineligibility for Cohort 5A

Final ineligibility reason	Intervention group		Comparison group	
	Number of events	Monthly attrition rate	Number of events	Monthly attrition rate
Death	419	0.66%	641	1.13%
Loss of Part A or B	9	0.01%	8	0.01%
GHO enrollment	235	0.37%	231	0.41%
Medicare secondary payer	43	0.07%	42	0.07%
Moved out of service area	84	0.13%	70	0.12%
Loss of eligibility	801	1.26%	326	0.57%
All ineligibles	1,591	2.51%	1,318	2.32%
Beneficiaries as of 1/1/2017	6,165		5,469	
Beneficiaries as of 12/31/2017	4,574		4,151	
Total member months	63,414		56,699	

Table 1.F —
Reasons for ineligibility for Cohort 5B

Final ineligibility reason	Intervention group		Comparison group	
	Number of events	Monthly attrition rate	Number of events	Monthly attrition rate
Death	334	0.69%	1,549	0.92%
Loss of Part A or B	8	0.02%	34	0.02%
GHO enrollment	266	0.55%	600	0.36%
Medicare secondary payer	41	0.09%	153	0.09%
Moved out of service area	397	0.82%	336	0.20%
Loss of eligibility	82	0.17%	823	0.49%
All ineligibles	1,128	2.34%	3,495	2.08%
Beneficiaries as of 4/1/2017	5,930		20,441	
Beneficiaries as of 12/31/2017	4,802		16,946	
Total member months	48,134		167,717	

5. Results of PMPM Cost Analysis

5.1 Medicare Savings before Adjustments

The savings are determined by comparing the rate of growth in expenditures between the intervention group (WA) and the comparison group (the comparison states) as measured by the average monthly costs per beneficiary, the per member per month (PMPM) costs. We begin this calculation by tabulating the PMPM costs for the comparison group in both the baseline period and the Demonstration Years as shown in ***Tables 2A–F***. These tables show the incurred claims, member months, and per member per month (PMPM) costs for Cohort 1 (***Table 2.A***), Cohort 2 (***Table 2.B***), Cohort 3 (***Table 2.C***), Cohort 4 (***Table 2.D***), Cohort 5A (***Table 2.E***) and Cohort 5B (***Table 2.F***) for the baseline period and for Demonstration Years 3 and 4 by category of beneficiary.

The overall results are summarized in ***Table 2G***.

- For comparison group Cohort 1, the PMPM increases by 7.9 percent from $1,600 during the baseline period to $1,727 during Demonstration Year 3 and increases by 10.8 percent to $1,773 during Demonstration Year 4.

- For comparison group Cohort 2, the PMPM decreases by 15.8 percent from $1,607 to $1,353 during Demonstration Year 3 and decreases by 9.2 percent to $1,460 during Demonstration Year 4.

- For comparison group Cohort 3, the PMPM decreases by 21.6 percent from $1,674 to $1,312 during Demonstration Year 3 and decreases by 18.5 percent to $1,364 during Demonstration Year 4.

- For comparison group Cohort 4, the PMPM decreases by 8.7 percent from $1,738 to $1,587 during Demonstration Year 3 and decreases by 14.4 percent to $1,488 during Demonstration Year 4.

- For comparison group Cohort 5A, the PMPM decreases by 7.3 percent from $1,817 to $1,684 during Demonstration Year 4.

- For comparison group cohort 5B, the PMPM increases by 4.1 percent from $1,581 to $1,646 during Demonstration Year 4.

Cohorts 5A and 5B have no experience during Demonstration Year 3.

One significant difference between Cohorts 1 and 5B as compared to Cohorts 2, 3, 4 and 5A is that Cohorts 1 and 5B represent a cross-section of demonstration-eligible beneficiaries, whereas Cohorts 2, 3, 4 and 5A represent newly demonstration-eligible beneficiaries. In other words, Cohorts 1 and 5B beneficiaries could have first met the requirements for demonstration eligibility at any time during the past (perhaps years ago), whereas Cohorts 2, 3, 4 and 5A beneficiaries first met the requirements for demonstration eligibility more recently (otherwise they would have been included in Cohort 1).

Prior to comparison with the intervention group, as will be shown in subsequent tables, the PMPMs in each cell (i.e., the specific category of beneficiary and month) are reweighted by the number of member months in the intervention group. The resulting totals represent the costs that would have occurred in the comparison group if it had the same number and distribution of beneficiaries as the intervention group.

The re-weighted PMPM costs are then further adjusted for two reasons before savings are calculated: (1) to reflect the difference in the trend in the Average Geographic Adjustment factor between Washington and the comparison States, and (2) to include an adjustment for the trimming of outlier costs above the 99th percentile of annual costs of total paid claims.

Table 2.A.1 — MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 1

	Baseline period			Demonstration Year 3			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Total	**495,181.0**	**$792,439,622**	**$1,600.30**	**125,982.4**	**$217,509,711**	**$1,726.51**	**1.07886**
Facility, age 65+, with SPMI	32,115.2	$66,311,502	$2,064.80	6,478.9	$11,037,036	$1,703.54	0.82504
Facility, age 65+, no SPMI	80,858.8	$139,945,392	$1,730.74	13,384.4	$22,137,586	$1,653.99	0.95565
HCBS, age 65+, with SPMI	10,838.8	$20,539,243	$1,894.97	2,808.0	$6,420,223	$2,286.41	1.20657
HCBS, age 65+, no SPMI	51,925.0	$84,282,667	$1,623.16	11,226.5	$25,133,273	$2,238.74	1.37925
Community, age 65+, with SPMI	12,587.9	$16,488,055	$1,309.84	3,811.3	$6,628,937	$1,739.29	1.32787
Community, age 65+, no SPMI	92,332.0	$108,551,869	$1,175.67	24,172.9	$38,552,059	$1,594.85	1.35654
Facility, age <65, with SPMI	10,531.3	$26,564,713	$2,522.45	3,125.2	$6,095,464	$1,950.43	0.77323
Facility, age <65, no SPMI	12,082.5	$28,804,414	$2,383.97	3,240.1	$5,746,960	$1,773.69	0.74401
HCBS, age <65, with SPMI	18,074.4	$30,515,893	$1,688.35	5,390.8	$8,751,191	$1,623.34	0.96150
HCBS, age <65, no SPMI	28,593.8	$55,535,580	$1,942.22	8,398.6	$20,014,187	$2,383.04	1.22697
Community, age <65, with SPMI	58,269.0	$76,748,751	$1,317.15	18,355.8	$23,787,670	$1,295.92	0.98389
Community, age <65, no SPMI	86,972.3	$138,151,543	$1,588.45	25,589.9	$43,205,125	$1,688.37	1.06290

Table 2.A.2 — MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 1

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Total	**495,181.0**	**$792,439,622**	**$1,600.30**	**97,449.8**	**$172,819,600**	**$1,773.42**	**1.10818**
Facility, age 65+, with SPMI	32,115.2	$66,311,502	$2,064.80	4,790.4	$8,117,651	$1,694.55	0.82069
Facility, age 65+, no SPMI	80,858.8	$139,945,392	$1,730.74	8,663.2	$13,801,555	$1,593.12	0.92049
HCBS, age 65+, with SPMI	10,838.8	$20,539,243	$1,894.97	2,141.7	$5,151,617	$2,405.41	1.26936
HCBS, age 65+, no SPMI	51,925.0	$84,282,667	$1,623.16	7,979.6	$19,102,744	$2,393.93	1.47486
Community, age 65+, with SPMI	12,587.9	$16,488,055	$1,309.84	3,113.9	$5,668,192	$1,820.31	1.38972
Community, age 65+, no SPMI	92,332.0	$108,551,869	$1,175.67	18,567.8	$32,642,278	$1,758.00	1.49532
Facility, age <65, with SPMI	10,531.3	$26,564,713	$2,522.45	2,546.6	$5,033,598	$1,976.56	0.78359
Facility, age <65, no SPMI	12,082.5	$28,804,414	$2,383.97	2,467.8	$4,659,232	$1,888.02	0.79197
HCBS, age <65, with SPMI	18,074.4	$30,515,893	$1,688.35	4,171.4	$6,195,328	$1,485.21	0.87968
HCBS, age <65, no SPMI	28,593.8	$55,535,580	$1,942.22	6,689.3	$15,091,472	$2,256.05	1.16158
Community, age <65, with SPMI	58,269.0	$76,748,751	$1,317.15	15,016.5	$19,075,847	$1,270.32	0.96445
Community, age <65, no SPMI	86,972.3	$138,151,543	$1,588.45	21,301.5	$38,280,085	$1,797.06	1.13133

Table 2.B.1 — MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 2

	Baseline period			Demonstration Year 3			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Total	**42,008.3**	**$67,515,192**	**$1,607.19**	**25,382.6**	**$34,342,597**	**$1,353.00**	**0.84184**
Facility, age 65+, with SPMI	2,059.8	$5,419,492	$2,631.14	1,031.5	$2,104,890	$2,040.68	0.77559
Facility, age 65+, no SPMI	6,716.7	$14,724,625	$2,192.23	3,268.4	$4,105,157	$1,256.03	0.57295
HCBS, age 65+, with SPMI	613.4	$1,053,551	$1,717.67	451.5	$819,233	$1,814.60	1.05643
HCBS, age 65+, no SPMI	3,544.0	$5,267,521	$1,486.32	2,011.1	$3,653,367	$1,816.62	1.22222
Community, age 65+, with SPMI	1,074.8	$1,446,270	$1,345.67	757.9	$1,275,799	$1,683.37	1.25095
Community, age 65+, no SPMI	9,976.7	$13,004,722	$1,303.52	6,088.1	$8,259,460	$1,356.67	1.04077
Facility, age <65, with SPMI	668.8	$2,180,795	$3,260.87	448.3	$958,474	$2,138.16	0.65570
Facility, age <65, no SPMI	794.5	$2,553,958	$3,214.35	563.6	$1,128,734	$2,002.86	0.62310
HCBS, age <65, with SPMI	1,076.6	$1,473,625	$1,368.80	591.4	$544,289	$920.30	0.67234
HCBS, age <65, no SPMI	1,902.1	$2,801,867	$1,473.05	1,359.9	$2,009,565	$1,477.78	1.00321
Community, age <65, with SPMI	5,313.9	$6,380,978	$1,200.82	3,637.0	$3,202,716	$880.58	0.73332
Community, age <65, no SPMI	8,267.2	$11,207,788	$1,355.69	5,174.1	$6,280,913	$1,213.92	0.89543

Table 2.B.2 — MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 2

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Total	**42,008.3**	**$67,515,192**	**$1,607.19**	**19,817.2**	**$28,929,588**	**$1,459.82**	**0.90831**
Facility, age 65+, with SPMI	2,059.8	$5,419,492	$2,631.14	687.1	$955,684	$1,390.98	0.52866
Facility, age 65+, no SPMI	6,716.7	$14,724,625	$2,192.23	2,330.4	$3,434,943	$1,473.99	0.67237
HCBS, age 65+, with SPMI	613.4	$1,053,551	$1,717.67	361.7	$786,879	$2,175.70	1.26665
HCBS, age 65+, no SPMI	3,544.0	$5,267,521	$1,486.32	1,490.7	$2,601,758	$1,745.29	1.17423
Community, age 65+, with SPMI	1,074.8	$1,446,270	$1,345.67	555.4	$944,672	$1,700.94	1.26400
Community, age 65+, no SPMI	9,976.7	$13,004,722	$1,303.52	4,691.6	$7,788,394	$1,660.08	1.27354
Facility, age <65, with SPMI	668.8	$2,180,795	$3,260.87	339.4	$422,828	$1,245.97	0.38210
Facility, age <65, no SPMI	794.5	$2,553,958	$3,214.35	425.8	$678,649	$1,593.68	0.49580
HCBS, age <65, with SPMI	1,076.6	$1,473,625	$1,368.80	541.3	$626,540	$1,157.46	0.84560
HCBS, age <65, no SPMI	1,902.1	$2,801,867	$1,473.05	1,123.1	$1,752,241	$1,560.24	1.05918
Community, age <65, with SPMI	5,313.9	$6,380,978	$1,200.82	2,996.5	$3,484,578	$1,162.89	0.96841
Community, age <65, no SPMI	8,267.2	$11,207,788	$1,355.69	4,274.3	$5,452,421	$1,275.62	0.94094

Table 2.C.1 — MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 3

	Baseline period			Demonstration Year 3			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Total	**65,614.5**	**$109,816,298**	**$1,673.66**	**48,033.3**	**$63,024,948**	**$1,312.11**	**0.78398**
Facility, age 65+, with SPMI	4,878.2	$11,042,653	$2,263.65	3,546.3	$5,709,401	$1,609.94	0.71121
Facility, age 65+, no SPMI	12,137.4	$26,728,998	$2,202.20	7,433.4	$10,976,491	$1,476.64	0.67053
HCBS, age 65+, with SPMI	1,111.6	$1,593,577	$1,433.58	841.9	$1,427,482	$1,695.57	1.18275
HCBS, age 65+, no SPMI	4,599.1	$7,305,283	$1,588.42	3,657.7	$5,803,834	$1,586.73	0.99893
Community, age 65+, with SPMI	2,510.0	$3,725,198	$1,484.15	1,842.2	$2,127,567	$1,154.92	0.77817
Community, age 65+, no SPMI	12,485.8	$16,640,967	$1,332.79	9,178.2	$12,360,981	$1,346.77	1.01049
Facility, age <65, with SPMI	1,125.0	$3,949,081	$3,510.30	777.2	$1,608,422	$2,069.57	0.58957
Facility, age <65, no SPMI	1,435.9	$4,985,720	$3,472.12	943.6	$1,827,140	$1,936.39	0.55770
HCBS, age <65, with SPMI	2,068.1	$2,424,892	$1,172.54	1,715.6	$1,426,750	$831.65	0.70928
HCBS, age <65, no SPMI	2,938.7	$3,982,170	$1,355.08	2,536.5	$2,921,454	$1,151.74	0.84995
Community, age <65, with SPMI	10,202.2	$11,555,501	$1,132.64	7,989.3	$6,918,357	$865.96	0.76454
Community, age <65, no SPMI	10,122.4	$15,882,259	$1,569.02	7,571.4	$9,917,068	$1,309.81	0.83480

Table 2.C.2 — MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 3

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Total	**65,614.5**	**$109,816,298**	**$1,673.66**	**35,741.0**	**$48,752,067**	**$1,364.04**	**0.81500**
Facility, age 65+, with SPMI	4,878.2	$11,042,653	$2,263.65	2,410.3	$3,459,712	$1,435.36	0.63409
Facility, age 65+, no SPMI	12,137.4	$26,728,998	$2,202.20	5,125.0	$8,030,688	$1,566.97	0.71155
HCBS, age 65+, with SPMI	1,111.6	$1,593,577	$1,433.58	605.2	$993,281	$1,641.12	1.14477
HCBS, age 65+, no SPMI	4,599.1	$7,305,283	$1,588.42	2,481.8	$4,680,502	$1,885.96	1.18732
Community, age 65+, with SPMI	2,510.0	$3,725,198	$1,484.15	1,438.7	$1,597,600	$1,110.42	0.74818
Community, age 65+, no SPMI	12,485.8	$16,640,967	$1,332.79	6,789.0	$9,265,529	$1,364.79	1.02401
Facility, age <65, with SPMI	1,125.0	$3,949,081	$3,510.30	526.2	$595,272	$1,131.34	0.32229
Facility, age <65, no SPMI	1,435.9	$4,985,720	$3,472.12	663.2	$1,046,474	$1,577.99	0.45448
HCBS, age <65, with SPMI	2,068.1	$2,424,892	$1,172.54	1,422.5	$1,267,900	$891.34	0.76018
HCBS, age <65, no SPMI	2,938.7	$3,982,170	$1,355.08	2,090.2	$2,764,806	$1,322.76	0.97615
Community, age <65, with SPMI	10,202.2	$11,555,501	$1,132.64	6,312.8	$6,068,366	$961.29	0.84871
Community, age <65, no SPMI	10,122.4	$15,882,259	$1,569.02	5,876.2	$8,981,936	$1,528.53	0.97420

Table 2.D.1 — MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 4

	Baseline period			Demonstration Year 3			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Total	**74,886.5**	**$130,154,124**	**$1,738.02**	**76,497.7**	**$121,404,786**	**$1,587.04**	**0.91313**
Facility, age 65+, with SPMI	8,799.9	$23,177,043	$2,633.77	9,280.7	$18,930,494	$2,039.76	0.77446
Facility, age 65+, no SPMI	10,464.5	$21,506,946	$2,055.23	10,738.3	$17,435,867	$1,623.71	0.79004
HCBS, age 65+, with SPMI	2,013.0	$3,798,610	$1,887.04	2,023.0	$4,147,191	$2,050.01	1.08636
HCBS, age 65+, no SPMI	4,656.9	$6,769,043	$1,453.55	4,780.3	$8,495,985	$1,777.28	1.22272
Community, age 65+, with SPMI	3,872.4	$6,423,922	$1,658.90	3,895.8	$5,826,666	$1,495.62	0.90157
Community, age 65+, no SPMI	13,747.0	$17,606,796	$1,280.78	13,928.8	$17,043,224	$1,223.60	0.95536
Facility, age <65, with SPMI	2,039.5	$7,820,424	$3,834.53	2,159.4	$6,170,804	$2,857.61	0.74523
Facility, age <65, no SPMI	1,184.9	$4,054,838	$3,422.18	1,196.4	$2,740,358	$2,290.54	0.66932
HCBS, age <65, with SPMI	2,214.7	$2,946,358	$1,330.34	2,322.2	$3,587,370	$1,544.80	1.16121
HCBS, age <65, no SPMI	2,526.6	$3,932,951	$1,556.63	2,569.5	$4,388,774	$1,708.02	1.09725
Community, age <65, with SPMI	11,399.1	$13,242,226	$1,161.69	11,586.0	$13,455,602	$1,161.37	0.99973
Community, age <65, no SPMI	11,968.0	$18,874,966	$1,577.12	12,017.3	$19,182,452	$1,596.24	1.01213

Table 2.D.2 — MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 4

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Total	**74,886.5**	**$130,154,124**	**$1,738.02**	**53,861.9**	**$80,137,715**	**$1,487.84**	**0.85605**
Facility, age 65+, with SPMI	8,799.9	$23,177,043	$2,633.77	5,776.4	$10,817,550	$1,872.73	0.71104
Facility, age 65+, no SPMI	10,464.5	$21,506,946	$2,055.23	6,740.7	$9,327,758	$1,383.79	0.67330
HCBS, age 65+, with SPMI	2,013.0	$3,798,610	$1,887.04	1,483.9	$2,606,212	$1,756.32	0.93073
HCBS, age 65+, no SPMI	4,656.9	$6,769,043	$1,453.55	3,216.2	$5,806,264	$1,805.32	1.24201
Community, age 65+, with SPMI	3,872.4	$6,423,922	$1,658.90	2,915.4	$3,620,115	$1,241.72	0.74852
Community, age 65+, no SPMI	13,747.0	$17,606,796	$1,280.78	10,330.8	$14,287,571	$1,383.00	1.07981
Facility, age <65, with SPMI	2,039.5	$7,820,424	$3,834.53	1,418.5	$3,432,258	$2,419.68	0.63102
Facility, age <65, no SPMI	1,184.9	$4,054,838	$3,422.18	929.5	$1,987,707	$2,138.49	0.62489
HCBS, age <65, with SPMI	2,214.7	$2,946,358	$1,330.34	1,711.8	$2,282,412	$1,333.35	1.00226
HCBS, age <65, no SPMI	2,526.6	$3,932,951	$1,556.63	2,018.1	$3,493,824	$1,731.27	1.11219
Community, age <65, with SPMI	11,399.1	$13,242,226	$1,161.69	8,585.2	$9,027,868	$1,051.56	0.90520
Community, age <65, no SPMI	11,968.0	$18,874,966	$1,577.12	8,735.4	$13,448,178	$1,539.51	0.97615

Table 2.E — MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 5A

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Total	**55,245.6**	**$100,386,597**	**$1,817.10**	**56,700.0**	**$95,477,026**	**$1,683.90**	**0.92670**
Facility, age 65+, with SPMI	9,703.9	$22,148,153	$2,282.40	9,967.8	$19,360,963	$1,942.35	0.85101
Facility, age 65+, no SPMI	5,789.6	$12,097,397	$2,089.51	6,122.6	$10,854,167	$1,772.81	0.84843
HCBS, age 65+, with SPMI	1,794.4	$3,717,937	$2,071.96	2,130.5	$4,606,960	$2,162.41	1.04365
HCBS, age 65+, no SPMI	2,458.4	$3,967,559	$1,613.91	2,727.6	$5,343,467	$1,959.06	1.21386
Community, age 65+, with SPMI	4,496.5	$7,345,713	$1,633.66	4,655.9	$6,483,245	$1,392.47	0.85237
Community, age 65+, no SPMI	8,094.0	$9,203,556	$1,137.09	7,962.5	$9,585,408	$1,203.82	1.05869
Facility, age <65, with SPMI	2,106.1	$7,470,590	$3,547.09	2,175.4	$7,206,841	$3,312.91	0.93398
Facility, age <65, no SPMI	972.5	$3,486,591	$3,585.31	1,035.1	$2,544,917	$2,458.57	0.68574
HCBS, age <65, with SPMI	2,203.2	$3,920,524	$1,779.45	2,348.5	$5,178,800	$2,205.15	1.23923
HCBS, age <65, no SPMI	1,620.6	$2,444,637	$1,508.51	1,658.9	$2,578,811	$1,554.51	1.03049
Community, age <65, with SPMI	9,311.4	$12,553,567	$1,348.20	9,153.8	$10,827,719	$1,182.87	0.87737
Community, age <65, no SPMI	6,695.2	$12,030,375	$1,796.87	6,761.4	$10,905,728	$1,612.93	0.89763

Table 2.F — MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 5B

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Total	**210,107.5**	**$332,154,386**	**$1,580.88**	**167,717.5**	**$276,001,718**	**$1,645.63**	**1.04096**
Facility, age 65+, with SPMI	24,571.5	$46,542,358	$1,894.16	19,101.3	$33,626,392	$1,760.43	0.92940
Facility, age 65+, no SPMI	10,376.3	$17,633,644	$1,699.41	8,119.7	$12,831,219	$1,580.25	0.92988
HCBS, age 65+, with SPMI	5,802.8	$12,491,351	$2,152.65	5,197.4	$12,011,080	$2,311.00	1.07356
HCBS, age 65+, no SPMI	6,660.5	$11,356,541	$1,705.06	6,192.3	$12,699,805	$2,050.89	1.20283
Community, age 65+, with SPMI	26,044.3	$42,330,576	$1,625.33	20,388.4	$34,989,347	$1,716.14	1.05587
Community, age 65+, no SPMI	34,773.4	$41,557,876	$1,195.11	27,236.1	$39,092,312	$1,435.31	1.20099
Facility, age <65, with SPMI	5,908.3	$15,364,134	$2,600.42	4,803.9	$10,248,687	$2,133.40	0.82040
Facility, age <65, no SPMI	2,785.0	$4,054,836	$1,455.96	2,140.9	$3,904,147	$1,823.64	1.25254
HCBS, age <65, with SPMI	7,262.9	$12,549,958	$1,727.95	6,076.9	$11,385,953	$1,873.63	1.08431
HCBS, age <65, no SPMI	4,331.2	$7,234,071	$1,670.21	3,713.5	$7,027,168	$1,892.33	1.13299
Community, age <65, with SPMI	57,180.0	$81,575,744	$1,426.65	45,360.2	$65,356,057	$1,440.82	1.00993
Community, age <65, no SPMI	24,411.3	$39,463,298	$1,616.60	19,386.9	$32,829,551	$1,693.39	1.04750

Table 2.G —
Comparison group summary (all cohorts)

Cohort	Baseline period			Demonstration Period 3			Cost trend (Demonstration Period 3/ baseline Period)	Demonstration Period 4			Cost trend (Demonstration Period 4/ baseline Period)
	Number of eligible months	Medicaid incurred claims	PMPM	Number of eligible months	Medicaid incurred claims	PMPM		Number of eligible months	Medicaid incurred claims	PMPM	
Cohort 1	495,181.0	$792,439,622	$1,600.30	125,982.4	$217,509,711	$1,726.51	1.07886	97,449.8	$172,819,600	$1,773.42	1.10818
Cohort 2	42,008.3	$67,515,192	$1,607.19	25,382.6	$34,342,597	$1,353.00	0.84184	35,741.0	$48,752,067	$1,364.04	0.81500
Cohort 3	65,614.5	$109,816,298	$1,673.66	48,033.3	$63,024,948	$1,312.11	0.78398	13,384.4	$22,137,586	$1,653.99	0.95565
Cohort 4	74,886.5	$130,154,124	$1,738.02	76,497.7	$121,404,786	$1,587.04	0.91313	53,861.9	$80,137,715	$1,487.84	0.85605
Cohort 5A	55,245.6	$100,386,597	$1,817.10	0.0	$0	$0.00	0.00000	56,700.0	$95,477,026	$1,683.90	0.92670
Cohort 5B	210,107.5	$332,154,386	$1,580.88	0.0	$0	$0.00	0.00000	167,717.5	$276,001,718	$1,645.63	1.04096

Tables 3.A–3.L show the development of the trend rates from the baseline period to the Demonstration Year for the re-weighted comparison group and the intervention group by category of beneficiary. The re-weighting was done by category of beneficiary month by month. Thus, the comparison group PMPMs in ***Tables 3.A–3.L*** do not match exactly the PMPMs in ***Table 2*** by category, because the PMPMs in ***Table 2*** are weighted by the member months in the comparison group while the PMPMs in ***Table 3*** are weighted by the member months in the intervention group. For example, in ***Table 2***, the Cohort 1 baseline PMPM for the category "Facility, Age 65+, with SPMI" is $2,064.80. But in ***Table 3.G*** it is $2,057.93. This is because in ***Tables 3.A–3.L***, the weighted average PMPM across all months in the baseline period is based on the eligible months of the particular cohort of the intervention group beneficiaries and not that of the comparison group beneficiaries, even though the PMPM in any specific month is the same.

Tables 3.G show the results for the entire Cohort 1 for Demonstration Years 3 and 4 separately. ***Table 3.G.1*** shows that, for Demonstration Year 3, the PMPM for the comparison group increased by 16.4 percent from the baseline period, whereas that of the intervention group increased by only 2.7 percent, a difference of 13.7 percentage points. Similarly, ***Table 3.G.2*** shows that, for Demonstration Year 4, the PMPM for the comparison group increased by 19 percent from the baseline period, whereas that of the intervention group increased by only 11 percent, a difference of 8.0 percentage points.

Tables 3.H show the results for Cohort 2. From the baseline period to Demonstration Year 3, the PMPM for the comparison group decreased by 20.2 percent whereas the PMPM for the intervention group decreased by 20.1 percent, a difference of 0.1 percentage points. From the baseline period to Demonstration Year 4, the PMPM for the comparison group decreased by 14.3 percent whereas the PMPM for the intervention group decreased by 14.8 percent, a difference of 0.5 percent.

Tables 3.I show the results for Cohort 3. From the baseline period to Demonstration Year 3, the PMPM for the comparison group decreased by 14.1 percent, and the PMPM for the intervention group also decreased by 14.1 percent. From the baseline period to Demonstration Year 4, the PMPM for the comparison group decreased by 7.3 percent and the PMPM for the intervention group decreased by 13.8 percent, a difference of 6.5 percentage points.

Table 3.J shows the results for Cohort 4. From the baseline period to Demonstration Year 3, the PMPM for the comparison group increased by 0.6 percent, while the PMPM for the intervention group decreased by 13.5 percent, a difference of 14.1 percentage points. From the baseline period to Demonstration Year 4, the PMPM for the comparison group decreased by 2.8 percent, while the intervention group decreased by 14.4 percent, a difference of 11.6 percentage points.

Table 3.K shows the results for Cohort 5A. From the baseline period to Demonstration Year 4, the PMPM for the comparison group increased by 0.8 percent, while the PMPM for the intervention group decreased by 10.6 percent, a difference of 11.4 percentage points. ***Table 3.L*** shows the results for Cohort 5B. From the baseline period to Demonstration Year 4, the PMPM for the comparison group increased by 8.6 percent, while the PMPM for the intervention group decreased by 3.1 percent, a difference of 11.7 percentage points.

Tables 4.A and ***4.B*** summarize the results of ***Tables 3.A–3.L*** by cohort and demonstration year. For Cohort 1, sub-cohorts 1A (the first cohort) and 1D (the largest cohort) show the greatest difference in trends in the direction of Medicare savings. Cohorts 1C, 1E, and 1F all show negative Medicare savings. Cohort 2 shows slight Medicare savings, but the small size of the cohort means the savings is less significant. Cohort 3 shows moderate Medicare savings, in between the savings rates of Cohorts 1 and 2, and Cohorts 4, 5A and 5B all show more significant Medicare savings. The wide variation in the trends by cohort highlights the variability of health care costs. The aggregate experience of all cohorts combined should be considered more reliable than that of the individual cohorts or sub-cohorts.

Table 3.A.1 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 1A

	Baseline period			Demonstration Year 3			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**48,488.0**	**$78,754,198**	**$1,624.20**	**14,540.4**	**$27,919,868**	**$1,920.16**	**1.182**
Facility, age 65+, with SPMI	1,352.5	$2,783,905	$2,058.35	231.9	$394,587	$1,701.52	0.827
Facility, age 65+, no SPMI	2,903.2	$4,986,268	$1,717.53	356.4	$589,399	$1,653.76	0.963
HCBS, age 65+, with SPMI	2,269.5	$4,300,359	$1,894.85	613.5	$1,404,651	$2,289.39	1.208
HCBS, age 65+, no SPMI	10,415.6	$16,922,467	$1,624.72	2,687.8	$6,018,304	$2,239.14	1.378
Community, age 65+, with SPMI	1,044.6	$1,366,976	$1,308.56	329.9	$573,066	$1,736.95	1.327
Community, age 65+, no SPMI	8,618.5	$10,152,870	$1,178.03	2,577.6	$4,114,509	$1,596.25	1.355
Facility, age <65, with SPMI	479.0	$1,208,097	$2,521.97	84.1	$167,796	$1,994.03	0.791
Facility, age <65, no SPMI	596.9	$1,420,117	$2,379.14	215.0	$380,923	$1,771.73	0.745
HCBS, age <65, with SPMI	3,601.9	$6,081,141	$1,688.33	1,254.4	$2,036,226	$1,623.25	0.961
HCBS, age <65, no SPMI	8,245.1	$16,023,110	$1,943.35	3,118.2	$7,427,549	$2,382.00	1.226
Community, age <65, with SPMI	2,682.4	$3,530,797	$1,316.26	951.2	$1,233,464	$1,296.72	0.985
Community, age <65, no SPMI	6,278.7	$9,978,092	$1,589.20	2,120.2	$3,579,393	$1,688.21	1.062
Intervention group	**48,488.0**	**$128,622,626**	**$2,652.67**	**14,540.4**	**$36,051,308**	**$2,479.39**	**0.935**
Facility, age 65+, with SPMI	1,352.5	$4,491,706	$3,321.06	231.9	$386,747	$1,667.71	0.502
Facility, age 65+, no SPMI	2,903.2	$7,189,174	$2,476.33	356.4	$672,103	$1,885.82	0.762
HCBS, age 65+, with SPMI	2,269.5	$6,589,879	$2,903.67	613.5	$1,654,554	$2,696.69	0.929
HCBS, age 65+, no SPMI	10,415.6	$24,885,794	$2,389.27	2,687.8	$6,985,561	$2,599.01	1.088
Community, age 65+, with SPMI	1,044.6	$2,160,270	$2,067.95	329.9	$464,168	$1,406.88	0.680
Community, age 65+, no SPMI	8,618.5	$18,306,257	$2,124.06	2,577.6	$5,594,642	$2,170.47	1.022
Facility, age <65, with SPMI	479.0	$2,542,110	$5,306.80	84.1	$150,780	$1,791.81	0.338
Facility, age <65, no SPMI	596.9	$2,844,227	$4,764.97	215.0	$649,654	$3,021.65	0.634
HCBS, age <65, with SPMI	3,601.9	$10,014,768	$2,780.44	1,254.4	$2,787,476	$2,222.14	0.799
HCBS, age <65, no SPMI	8,245.1	$22,193,360	$2,691.70	3,118.2	$8,660,343	$2,777.36	1.032
Community, age <65, with SPMI	2,682.4	$6,561,637	$2,446.14	951.2	$2,541,466	$2,671.80	1.092
Community, age <65, no SPMI	6,278.7	$20,843,442	$3,319.71	2,120.2	$5,503,814	$2,595.86	0.782

Table 3.A.2 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 1A

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**48,488.0**	**$78,754,198**	**$1,624.20**	**12,196.5**	**$23,833,789**	**$1,954.14**	**1.203**
Facility, age 65+, with SPMI	1,352.5	$2,783,905	$2,058.35	174.0	$295,541	$1,698.86	0.825
Facility, age 65+, no SPMI	2,903.2	$4,986,268	$1,717.53	246.6	$393,078	$1,594.12	0.928
HCBS, age 65+, with SPMI	2,269.5	$4,300,359	$1,894.85	442.2	$1,062,177	$2,402.06	1.268
HCBS, age 65+, no SPMI	10,415.6	$16,922,467	$1,624.72	2,174.8	$5,208,049	$2,394.69	1.474
Community, age 65+, with SPMI	1,044.6	$1,366,976	$1,308.56	278.3	$506,905	$1,821.21	1.392
Community, age 65+, no SPMI	8,618.5	$10,152,870	$1,178.03	2,015.5	$3,545,324	$1,759.04	1.493
Facility, age <65, with SPMI	479.0	$1,208,097	$2,521.97	69.0	$136,978	$1,985.19	0.787
Facility, age <65, no SPMI	596.9	$1,420,117	$2,379.14	174.8	$329,168	$1,883.64	0.792
HCBS, age <65, with SPMI	3,601.9	$6,081,141	$1,688.33	1,144.6	$1,701,982	$1,486.98	0.881
HCBS, age <65, no SPMI	8,245.1	$16,023,110	$1,943.35	2,726.6	$6,153,270	$2,256.75	1.161
Community, age <65, with SPMI	2,682.4	$3,530,797	$1,316.26	835.2	$1,060,227	$1,269.36	0.964
Community, age <65, no SPMI	6,278.7	$9,978,092	$1,589.20	1,915.0	$3,441,091	$1,796.95	1.131
Intervention group	**48,488.0**	**$128,622,626**	**$2,652.67**	**12,196.5**	**$31,144,889**	**$2,553.58**	**0.963**
Facility, age 65+, with SPMI	1,352.5	$4,491,706	$3,321.06	174.0	$401,859	$2,310.01	0.696
Facility, age 65+, no SPMI	2,903.2	$7,189,174	$2,476.33	246.6	$348,234	$1,412.25	0.570
HCBS, age 65+, with SPMI	2,269.5	$6,589,879	$2,903.67	442.2	$1,164,770	$2,634.07	0.907
HCBS, age 65+, no SPMI	10,415.6	$24,885,794	$2,389.27	2,174.8	$5,637,970	$2,592.37	1.085
Community, age 65+, with SPMI	1,044.6	$2,160,270	$2,067.95	278.3	$455,002	$1,634.74	0.791
Community, age 65+, no SPMI	8,618.5	$18,306,257	$2,124.06	2,015.5	$5,377,365	$2,668.02	1.256
Facility, age <65, with SPMI	479.0	$2,542,110	$5,306.80	69.0	$49,920	$723.48	0.136
Facility, age <65, no SPMI	596.9	$2,844,227	$4,764.97	174.8	$464,823	$2,659.92	0.558
HCBS, age <65, with SPMI	3,601.9	$10,014,768	$2,780.44	1,144.6	$2,107,406	$1,841.19	0.662
HCBS, age <65, no SPMI	8,245.1	$22,193,360	$2,691.70	2,726.6	$7,021,681	$2,575.24	0.957
Community, age <65, with SPMI	2,682.4	$6,561,637	$2,446.14	835.2	$2,806,137	$3,359.66	1.373
Community, age <65, no SPMI	6,278.7	$20,843,442	$3,319.71	1,915.0	$5,309,721	$2,772.75	0.835

Table 3.B.1 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 1B

	Baseline period			Demonstration Year 3			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**83,567.1**	**$131,605,106**	**$1,574.84**	**28,211.3**	**$51,776,952**	**$1,835.33**	**1.165**
Facility, age 65+, with SPMI	2,625.5	$5,399,392	$2,056.49	595.9	$1,011,453	$1,697.44	0.825
Facility, age 65+, no SPMI	5,728.2	$9,863,362	$1,721.89	963.4	$1,593,590	$1,654.07	0.961
HCBS, age 65+, with SPMI	3,563.5	$6,749,830	$1,894.18	1,180.7	$2,699,523	$2,286.45	1.207
HCBS, age 65+, no SPMI	15,666.1	$25,409,746	$1,621.96	4,851.2	$10,861,075	$2,238.83	1.380
Community, age 65+, with SPMI	2,079.3	$2,725,280	$1,310.68	722.6	$1,256,876	$1,739.27	1.327
Community, age 65+, no SPMI	16,756.0	$19,691,126	$1,175.17	5,795.9	$9,245,783	$1,595.23	1.357
Facility, age <65, with SPMI	707.2	$1,783,893	$2,522.57	278.0	$543,094	$1,953.58	0.774
Facility, age <65, no SPMI	436.0	$1,056,112	$2,422.27	152.7	$270,938	$1,773.83	0.732
HCBS, age <65, with SPMI	6,710.7	$11,329,713	$1,688.31	2,672.0	$4,337,987	$1,623.48	0.962
HCBS, age <65, no SPMI	9,528.3	$18,510,143	$1,942.64	3,788.8	$9,028,288	$2,382.87	1.227
Community, age <65, with SPMI	8,555.1	$11,262,998	$1,316.53	3,177.1	$4,118,319	$1,296.24	0.985
Community, age <65, no SPMI	11,211.2	$17,823,513	$1,589.79	4,032.8	$6,810,026	$1,688.65	1.062
Intervention group	**83,567.1**	**$108,476,913**	**$1,298.08**	**28,211.3**	**$40,016,796**	**$1,418.47**	**1.093**
Facility, age 65+, with SPMI	2,625.5	$4,153,377	$1,581.91	595.9	$768,793	$1,290.20	0.816
Facility, age 65+, no SPMI	5,728.2	$9,679,939	$1,689.87	963.4	$1,019,788	$1,058.49	0.626
HCBS, age 65+, with SPMI	3,563.5	$5,032,372	$1,412.22	1,180.7	$2,092,736	$1,772.51	1.255
HCBS, age 65+, no SPMI	15,666.1	$18,456,030	$1,178.09	4,851.2	$7,648,845	$1,576.68	1.338
Community, age 65+, with SPMI	2,079.3	$2,370,627	$1,140.11	722.6	$889,628	$1,231.07	1.080
Community, age 65+, no SPMI	16,756.0	$16,271,631	$971.09	5,795.9	$7,529,655	$1,299.14	1.338
Facility, age <65, with SPMI	707.2	$2,294,483	$3,244.58	278.0	$383,941	$1,381.08	0.426
Facility, age <65, no SPMI	436.0	$1,627,921	$3,733.76	152.7	$117,265	$767.74	0.206
HCBS, age <65, with SPMI	6,710.7	$9,300,631	$1,385.95	2,672.0	$3,546,625	$1,327.32	0.958
HCBS, age <65, no SPMI	9,528.3	$14,182,694	$1,488.47	3,788.8	$5,539,712	$1,462.12	0.982
Community, age <65, with SPMI	8,555.1	$9,515,214	$1,112.23	3,177.1	$3,921,940	$1,234.43	1.110
Community, age <65, no SPMI	11,211.2	$15,591,994	$1,390.75	4,032.8	$6,557,867	$1,626.13	1.169

Table 3.B.2 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 1B

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**83,567.1**	**$131,605,106**	**$1,574.84**	**23,641.9**	**$44,485,413**	**$1,881.63**	**1.195**
Facility, age 65+, with SPMI	2,625.5	$5,399,392	$2,056.49	424.0	$718,375	$1,694.45	0.824
Facility, age 65+, no SPMI	5,728.2	$9,863,362	$1,721.89	651.8	$1,039,508	$1,594.88	0.926
HCBS, age 65+, with SPMI	3,563.5	$6,749,830	$1,894.18	963.6	$2,310,835	$2,398.18	1.266
HCBS, age 65+, no SPMI	15,666.1	$25,409,746	$1,621.96	3,912.7	$9,367,960	$2,394.24	1.476
Community, age 65+, with SPMI	2,079.3	$2,725,280	$1,310.68	595.9	$1,086,085	$1,822.59	1.391
Community, age 65+, no SPMI	16,756.0	$19,691,126	$1,175.17	4,628.2	$8,138,129	$1,758.36	1.496
Facility, age <65, with SPMI	707.2	$1,783,893	$2,522.57	241.6	$478,461	$1,980.62	0.785
Facility, age <65, no SPMI	436.0	$1,056,112	$2,422.27	130.4	$246,361	$1,888.79	0.780
HCBS, age <65, with SPMI	6,710.7	$11,329,713	$1,688.31	2,473.5	$3,676,702	$1,486.41	0.880
HCBS, age <65, no SPMI	9,528.3	$18,510,143	$1,942.64	3,391.1	$7,649,443	$2,255.73	1.161
Community, age <65, with SPMI	8,555.1	$11,262,998	$1,316.53	2,709.9	$3,447,777	$1,272.30	0.966
Community, age <65, no SPMI	11,211.2	$17,823,513	$1,589.79	3,519.2	$6,325,777	$1,797.49	1.131
Intervention group	**83,567.1**	**$108,476,913**	**$1,298.08**	**23,641.9**	**$37,666,761**	**$1,593.22**	**1.227**
Facility, age 65+, with SPMI	2,625.5	$4,153,377	$1,581.91	424.0	$574,946	$1,356.14	0.857
Facility, age 65+, no SPMI	5,728.2	$9,679,939	$1,689.87	651.8	$866,896	$1,330.05	0.787
HCBS, age 65+, with SPMI	3,563.5	$5,032,372	$1,412.22	963.6	$1,295,456	$1,344.42	0.952
HCBS, age 65+, no SPMI	15,666.1	$18,456,030	$1,178.09	3,912.7	$6,711,145	$1,715.22	1.456
Community, age 65+, with SPMI	2,079.3	$2,370,627	$1,140.11	595.9	$1,024,962	$1,720.01	1.509
Community, age 65+, no SPMI	16,756.0	$16,271,631	$971.09	4,628.2	$7,429,699	$1,605.29	1.653
Facility, age <65, with SPMI	707.2	$2,294,483	$3,244.58	241.6	$314,022	$1,299.91	0.401
Facility, age <65, no SPMI	436.0	$1,627,921	$3,733.76	130.4	$165,595	$1,269.57	0.340
HCBS, age <65, with SPMI	6,710.7	$9,300,631	$1,385.95	2,473.5	$3,054,622	$1,234.91	0.891
HCBS, age <65, no SPMI	9,528.3	$14,182,694	$1,488.47	3,391.1	$5,743,890	$1,693.80	1.138
Community, age <65, with SPMI	8,555.1	$9,515,214	$1,112.23	2,709.9	$3,977,081	$1,467.63	1.320
Community, age <65, no SPMI	11,211.2	$15,591,994	$1,390.75	3,519.2	$6,508,446	$1,849.40	1.330

Table 3.C.1 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 1C

	Baseline period			Demonstration Year 3			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**7,946.8**	**$12,115,020**	**$1,524.51**	**2,723.6**	**$4,987,358**	**$1,831.17**	**1.201**
Facility, age 65+, with SPMI	78.0	$162,290	$2,080.64	24.0	$41,078	$1,711.59	0.823
Facility, age 65+, no SPMI	509.6	$883,213	$1,733.25	96.4	$159,860	$1,658.08	0.957
HCBS, age 65+, with SPMI	415.4	$787,714	$1,896.19	165.1	$377,180	$2,284.09	1.205
HCBS, age 65+, no SPMI	1,567.7	$2,541,768	$1,621.34	469.8	$1,053,779	$2,242.95	1.383
Community, age 65+, with SPMI	286.6	$380,569	$1,327.67	145.0	$252,196	$1,739.28	1.310
Community, age 65+, no SPMI	2,225.3	$2,627,533	$1,180.74	677.4	$1,081,768	$1,596.90	1.352
Facility, age <65, with SPMI	55.0	$139,181	$2,530.57	6.0	$12,813	$2,147.09	0.848
Facility, age <65, no SPMI	21.0	$55,877	$2,660.81	24.0	$42,509	$1,771.22	0.666
HCBS, age <65, with SPMI	422.7	$715,949	$1,693.58	227.0	$368,196	$1,622.01	0.958
HCBS, age <65, no SPMI	710.1	$1,381,750	$1,945.94	295.0	$702,100	$2,379.74	1.223
Community, age <65, with SPMI	731.4	$963,007	$1,316.70	271.8	$352,204	$1,295.78	0.984
Community, age <65, no SPMI	924.0	$1,476,169	$1,597.59	322.0	$543,675	$1,688.43	1.057
Intervention group	**7,946.8**	**$7,898,710**	**$993.94**	**2,723.6**	**$3,410,228**	**$1,252.11**	**1.260**
Facility, age 65+, with SPMI	78.0	$190,149	$2,437.80	24.0	$1,576	$65.66	0.027
Facility, age 65+, no SPMI	509.6	$823,008	$1,615.10	96.4	$98,916	$1,025.97	0.635
HCBS, age 65+, with SPMI	415.4	$406,330	$978.12	165.1	$195,951	$1,186.63	1.213
HCBS, age 65+, no SPMI	1,567.7	$1,419,597	$905.53	469.8	$693,435	$1,475.96	1.630
Community, age 65+, with SPMI	286.6	$432,595	$1,509.16	145.0	$265,949	$1,834.13	1.215
Community, age 65+, no SPMI	2,225.3	$1,691,547	$760.14	677.4	$691,060	$1,020.14	1.342
Facility, age <65, with SPMI	55.0	$241,153	$4,384.61	6.0	$46,930	$7,863.92	1.794
Facility, age <65, no SPMI	21.0	$210,854	$10,040.68	24.0	$132,484	$5,520.18	0.550
HCBS, age <65, with SPMI	422.7	$312,759	$739.84	227.0	$142,682	$628.56	0.850
HCBS, age <65, no SPMI	710.1	$625,225	$880.51	295.0	$288,382	$977.46	1.110
Community, age <65, with SPMI	731.4	$608,832	$832.44	271.8	$361,224	$1,328.97	1.596
Community, age <65, no SPMI	924.0	$936,659	$1,013.70	322.0	$491,638	$1,526.83	1.506

Table 3.C.2 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 1C

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**7,946.8**	**$12,115,020**	**$1,524.51**	**2,117.5**	**$4,000,204**	**$1,889.13**	**1.239**
Facility, age 65+, with SPMI	78.0	$162,290	$2,080.64	17.0	$29,351	$1,726.54	0.830
Facility, age 65+, no SPMI	509.6	$883,213	$1,733.25	41.8	$66,768	$1,596.29	0.921
HCBS, age 65+, with SPMI	415.4	$787,714	$1,896.19	125.3	$300,586	$2,398.17	1.265
HCBS, age 65+, no SPMI	1,567.7	$2,541,768	$1,621.34	356.9	$854,504	$2,394.04	1.477
Community, age 65+, with SPMI	286.6	$380,569	$1,327.67	121.5	$222,173	$1,827.86	1.377
Community, age 65+, no SPMI	2,225.3	$2,627,533	$1,180.74	467.6	$823,142	$1,760.34	1.491
Facility, age <65, with SPMI	55.0	$139,181	$2,530.57	12.0	$23,780	$1,981.66	0.783
Facility, age <65, no SPMI	21.0	$55,877	$2,660.81	24.0	$45,255	$1,885.63	0.709
HCBS, age <65, with SPMI	422.7	$715,949	$1,693.58	207.4	$307,842	$1,484.05	0.876
HCBS, age <65, no SPMI	710.1	$1,381,750	$1,945.94	249.2	$562,600	$2,258.01	1.160
Community, age <65, with SPMI	731.4	$963,007	$1,316.70	239.3	$304,322	$1,271.60	0.966
Community, age <65, no SPMI	924.0	$1,476,169	$1,597.59	255.3	$459,879	$1,801.17	1.127
Intervention group	**7,946.8**	**$7,898,710**	**$993.94**	**2,117.5**	**$2,702,837**	**$1,276.44**	**1.284**
Facility, age 65+, with SPMI	78.0	$190,149	$2,437.80	17.0	$15,141	$890.67	0.365
Facility, age 65+, no SPMI	509.6	$823,008	$1,615.10	41.8	$26,212	$626.66	0.388
HCBS, age 65+, with SPMI	415.4	$406,330	$978.12	125.3	$268,703	$2,143.80	2.192
HCBS, age 65+, no SPMI	1,567.7	$1,419,597	$905.53	356.9	$440,578	$1,234.36	1.363
Community, age 65+, with SPMI	286.6	$432,595	$1,509.16	121.5	$97,274	$800.29	0.530
Community, age 65+, no SPMI	2,225.3	$1,691,547	$760.14	467.6	$755,196	$1,615.03	2.125
Facility, age <65, with SPMI	55.0	$241,153	$4,384.61	12.0	$86,666	$7,222.17	1.647
Facility, age <65, no SPMI	21.0	$210,854	$10,040.68	24.0	$6,502	$270.92	0.027
HCBS, age <65, with SPMI	422.7	$312,759	$739.84	207.4	$130,593	$629.56	0.851
HCBS, age <65, no SPMI	710.1	$625,225	$880.51	249.2	$321,271	$1,289.43	1.464
Community, age <65, with SPMI	731.4	$608,832	$832.44	239.3	$265,243	$1,108.31	1.331
Community, age <65, no SPMI	924.0	$936,659	$1,013.70	255.3	$289,457	$1,133.69	1.118

Table 3.D.1 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 1D

	Baseline period			Demonstration Year 3			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**129,399.2**	**$207,882,769**	**$1,606.52**	**42,529.9**	**$78,947,138**	**$1,856.28**	**1.155**
Facility, age 65+, with SPMI	3,449.1	$7,099,156	$2,058.27	700.2	$1,192,696	$1,703.31	0.828
Facility, age 65+, no SPMI	9,573.0	$16,530,797	$1,726.81	1,809.9	$2,994,053	$1,654.25	0.958
HCBS, age 65+, with SPMI	5,666.9	$10,738,746	$1,895.01	1,682.5	$3,847,227	$2,286.60	1.207
HCBS, age 65+, no SPMI	24,215.1	$39,358,354	$1,625.36	7,170.9	$16,052,261	$2,238.54	1.377
Community, age 65+, with SPMI	2,995.7	$3,929,249	$1,311.61	989.1	$1,720,446	$1,739.48	1.326
Community, age 65+, no SPMI	19,735.0	$23,217,237	$1,176.45	6,412.1	$10,227,759	$1,595.08	1.356
Facility, age <65, with SPMI	850.9	$2,145,788	$2,521.68	233.8	$460,148	$1,968.12	0.780
Facility, age <65, no SPMI	1,455.9	$3,482,455	$2,391.90	487.0	$864,505	$1,775.16	0.742
HCBS, age <65, with SPMI	8,850.4	$14,942,652	$1,688.37	3,394.5	$5,508,616	$1,622.80	0.961
HCBS, age <65, no SPMI	18,671.7	$36,297,579	$1,943.99	7,052.0	$16,797,056	$2,381.89	1.225
Community, age <65, with SPMI	13,939.8	$18,378,011	$1,318.39	5,070.6	$6,570,995	$1,295.91	0.983
Community, age <65, no SPMI	19,995.6	$31,762,746	$1,588.48	7,527.4	$12,711,375	$1,688.69	1.063
Intervention group	**129,399.2**	**$219,493,469**	**$1,696.25**	**42,529.9**	**$73,252,412**	**$1,722.38**	**1.015**
Facility, age 65+, with SPMI	3,449.1	$8,089,951	$2,345.53	700.2	$951,290	$1,358.55	0.579
Facility, age 65+, no SPMI	9,573.0	$19,529,844	$2,040.09	1,809.9	$2,487,997	$1,374.65	0.674
HCBS, age 65+, with SPMI	5,666.9	$11,401,735	$2,012.00	1,682.5	$3,238,058	$1,924.54	0.957
HCBS, age 65+, no SPMI	24,215.1	$41,155,717	$1,699.59	7,170.9	$14,153,705	$1,973.78	1.161
Community, age 65+, with SPMI	2,995.7	$4,345,812	$1,450.66	989.1	$1,590,082	$1,607.67	1.108
Community, age 65+, no SPMI	19,735.0	$26,698,339	$1,352.84	6,412.1	$9,803,955	$1,528.99	1.130
Facility, age <65, with SPMI	850.9	$2,783,711	$3,271.35	233.8	$497,014	$2,125.80	0.650
Facility, age <65, no SPMI	1,455.9	$6,939,015	$4,766.02	487.0	$1,349,282	$2,770.60	0.581
HCBS, age <65, with SPMI	8,850.4	$14,556,363	$1,644.72	3,394.5	$5,789,510	$1,705.55	1.037
HCBS, age <65, no SPMI	18,671.7	$33,932,964	$1,817.35	7,052.0	$13,414,345	$1,902.21	1.047
Community, age <65, with SPMI	13,939.8	$18,504,005	$1,327.43	5,070.6	$6,200,227	$1,222.79	0.921
Community, age <65, no SPMI	19,995.6	$31,556,013	$1,578.14	7,527.4	$13,776,947	$1,830.24	1.160

Table 3.D.2 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 1D

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**129,399.2**	**$207,882,769**	**$1,606.52**	**35,278.5**	**$66,759,737**	**$1,892.37**	**1.178**
Facility, age 65+, with SPMI	3,449.1	$7,099,156	$2,058.27	479.9	$814,970	$1,698.15	0.825
Facility, age 65+, no SPMI	9,573.0	$16,530,797	$1,726.81	1,197.6	$1,904,059	$1,589.89	0.921
HCBS, age 65+, with SPMI	5,666.9	$10,738,746	$1,895.01	1,341.4	$3,220,033	$2,400.49	1.267
HCBS, age 65+, no SPMI	24,215.1	$39,358,354	$1,625.36	5,705.5	$13,663,871	$2,394.85	1.473
Community, age 65+, with SPMI	2,995.7	$3,929,249	$1,311.61	772.4	$1,406,829	$1,821.35	1.389
Community, age 65+, no SPMI	19,735.0	$23,217,237	$1,176.45	5,229.4	$9,194,252	$1,758.19	1.494
Facility, age <65, with SPMI	850.9	$2,145,788	$2,521.68	179.3	$353,428	$1,971.61	0.782
Facility, age <65, no SPMI	1,455.9	$3,482,455	$2,391.90	330.1	$627,524	$1,901.00	0.795
HCBS, age <65, with SPMI	8,850.4	$14,942,652	$1,688.37	3,123.1	$4,641,245	$1,486.11	0.880
HCBS, age <65, no SPMI	18,671.7	$36,297,579	$1,943.99	6,132.5	$13,842,139	$2,257.19	1.161
Community, age <65, with SPMI	13,939.8	$18,378,011	$1,318.39	4,374.3	$5,558,659	$1,270.75	0.964
Community, age <65, no SPMI	19,995.6	$31,762,746	$1,588.48	6,413.0	$11,532,727	$1,798.33	1.132
Intervention group	**129,399.2**	**$219,493,469**	**$1,696.25**	**35,278.5**	**$65,128,621**	**$1,846.13**	**1.088**
Facility, age 65+, with SPMI	3,449.1	$8,089,951	$2,345.53	479.9	$852,375	$1,776.09	0.757
Facility, age 65+, no SPMI	9,573.0	$19,529,844	$2,040.09	1,197.6	$1,606,716	$1,341.61	0.658
HCBS, age 65+, with SPMI	5,666.9	$11,401,735	$2,012.00	1,341.4	$2,894,483	$2,157.80	1.072
HCBS, age 65+, no SPMI	24,215.1	$41,155,717	$1,699.59	5,705.5	$12,211,127	$2,140.23	1.259
Community, age 65+, with SPMI	2,995.7	$4,345,812	$1,450.66	772.4	$1,064,695	$1,378.41	0.950
Community, age 65+, no SPMI	19,735.0	$26,698,339	$1,352.84	5,229.4	$9,490,402	$1,814.82	1.341
Facility, age <65, with SPMI	850.9	$2,783,711	$3,271.35	179.3	$260,914	$1,455.52	0.445
Facility, age <65, no SPMI	1,455.9	$6,939,015	$4,766.02	330.1	$798,040	$2,417.55	0.507
HCBS, age <65, with SPMI	8,850.4	$14,556,363	$1,644.72	3,123.1	$4,964,974	$1,589.77	0.967
HCBS, age <65, no SPMI	18,671.7	$33,932,964	$1,817.35	6,132.5	$12,197,441	$1,989.00	1.094
Community, age <65, with SPMI	13,939.8	$18,504,005	$1,327.43	4,374.3	$6,431,194	$1,470.22	1.108
Community, age <65, no SPMI	19,995.6	$31,556,013	$1,578.14	6,413.0	$12,356,259	$1,926.75	1.221

Table 3.E.1 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 1E

	Baseline period			Demonstration Year 3			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**15,153.3**	**$23,465,894**	**$1,548.56**	**5,500.6**	**$9,906,663**	**$1,801.01**	**1.163**
Facility, age 65+, with SPMI	279.0	$573,525	$2,055.64	48.0	$82,156	$1,711.59	0.833
Facility, age 65+, no SPMI	1,143.7	$1,980,257	$1,731.43	283.9	$470,558	$1,657.27	0.957
HCBS, age 65+, with SPMI	297.0	$563,184	$1,896.24	69.4	$157,655	$2,272.66	1.199
HCBS, age 65+, no SPMI	3,090.8	$5,031,005	$1,627.75	923.0	$2,069,085	$2,241.61	1.377
Community, age 65+, with SPMI	352.0	$462,917	$1,315.11	109.1	$189,287	$1,735.50	1.320
Community, age 65+, no SPMI	3,588.7	$4,220,750	$1,176.13	1,318.2	$2,102,015	$1,594.59	1.356
Facility, age <65, with SPMI	137.2	$347,384	$2,531.06	53.0	$104,356	$1,968.98	0.778
Facility, age <65, no SPMI	211.0	$502,282	$2,380.48	79.6	$141,194	$1,774.23	0.745
HCBS, age <65, with SPMI	755.0	$1,273,188	$1,686.34	324.4	$526,317	$1,622.26	0.962
HCBS, age <65, no SPMI	1,481.9	$2,878,416	$1,942.35	685.5	$1,632,446	$2,381.49	1.226
Community, age <65, with SPMI	1,654.5	$2,183,008	$1,319.43	714.9	$926,153	$1,295.44	0.982
Community, age <65, no SPMI	2,162.5	$3,449,978	$1,595.37	891.6	$1,505,438	$1,688.53	1.058
Intervention group	**15,153.3**	**$10,288,068**	**$678.93**	**5,500.6**	**$5,855,780**	**$1,064.57**	**1.568**
Facility, age 65+, with SPMI	279.0	$340,940	$1,222.01	48.0	$4,530	$94.38	0.077
Facility, age 65+, no SPMI	1,143.7	$983,611	$860.02	283.9	$164,415	$579.06	0.673
HCBS, age 65+, with SPMI	297.0	$202,815	$682.88	69.4	$208,980	$3,012.54	4.412
HCBS, age 65+, no SPMI	3,090.8	$2,497,709	$808.12	923.0	$1,243,563	$1,347.25	1.667
Community, age 65+, with SPMI	352.0	$271,496	$771.30	109.1	$119,496	$1,095.62	1.420
Community, age 65+, no SPMI	3,588.7	$1,918,612	$534.63	1,318.2	$1,092,192	$828.54	1.550
Facility, age <65, with SPMI	137.2	$57,996	$422.56	53.0	$139,659	$2,635.08	6.236
Facility, age <65, no SPMI	211.0	$260,623	$1,235.18	79.6	$126,247	$1,586.41	1.284
HCBS, age <65, with SPMI	755.0	$439,693	$582.37	324.4	$375,166	$1,156.36	1.986
HCBS, age <65, no SPMI	1,481.9	$849,446	$573.21	685.5	$916,786	$1,337.45	2.333
Community, age <65, with SPMI	1,654.5	$1,149,973	$695.05	714.9	$593,871	$830.67	1.195
Community, age <65, no SPMI	2,162.5	$1,315,153	$608.17	891.6	$870,873	$976.79	1.606

Table 3.E.2 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 1E

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**15,153.3**	**$23,465,894**	**$1,548.56**	**4,418.6**	**$8,164,561**	**$1,847.76**	**1.193**
Facility, age 65+, with SPMI	279.0	$573,525	$2,055.64	39.4	$66,691	$1,692.67	0.823
Facility, age 65+, no SPMI	1,143.7	$1,980,257	$1,731.43	156.4	$248,501	$1,588.79	0.918
HCBS, age 65+, with SPMI	297.0	$563,184	$1,896.24	50.6	$120,769	$2,387.65	1.259
HCBS, age 65+, no SPMI	3,090.8	$5,031,005	$1,627.75	678.9	$1,625,623	$2,394.58	1.471
Community, age 65+, with SPMI	352.0	$462,917	$1,315.11	83.2	$151,574	$1,822.53	1.386
Community, age 65+, no SPMI	3,588.7	$4,220,750	$1,176.13	999.1	$1,755,955	$1,757.58	1.494
Facility, age <65, with SPMI	137.2	$347,384	$2,531.06	48.0	$95,120	$1,981.66	0.783
Facility, age <65, no SPMI	211.0	$502,282	$2,380.48	63.0	$117,995	$1,872.94	0.787
HCBS, age <65, with SPMI	755.0	$1,273,188	$1,686.34	317.8	$472,227	$1,485.75	0.881
HCBS, age <65, no SPMI	1,481.9	$2,878,416	$1,942.35	589.8	$1,332,212	$2,258.85	1.163
Community, age <65, with SPMI	1,654.5	$2,183,008	$1,319.43	626.1	$798,270	$1,274.93	0.966
Community, age <65, no SPMI	2,162.5	$3,449,978	$1,595.37	766.4	$1,379,624	$1,800.19	1.128
Intervention group	**15,153.3**	**$10,288,068**	**$678.93**	**4,418.6**	**$5,380,302**	**$1,217.64**	**1.793**
Facility, age 65+, with SPMI	279.0	$340,940	$1,222.01	39.4	$24,732	$627.72	0.514
Facility, age 65+, no SPMI	1,143.7	$983,611	$860.02	156.4	$294,146	$1,880.63	2.187
HCBS, age 65+, with SPMI	297.0	$202,815	$682.88	50.6	$67,024	$1,325.09	1.940
HCBS, age 65+, no SPMI	3,090.8	$2,497,709	$808.12	678.9	$1,136,933	$1,674.73	2.072
Community, age 65+, with SPMI	352.0	$271,496	$771.30	83.2	$111,057	$1,335.36	1.731
Community, age 65+, no SPMI	3,588.7	$1,918,612	$534.63	999.1	$1,050,107	$1,051.08	1.966
Facility, age <65, with SPMI	137.2	$57,996	$422.56	48.0	$93,879	$1,955.82	4.628
Facility, age <65, no SPMI	211.0	$260,623	$1,235.18	63.0	$62,204	$987.36	0.799
HCBS, age <65, with SPMI	755.0	$439,693	$582.37	317.8	$328,096	$1,032.27	1.773
HCBS, age <65, no SPMI	1,481.9	$849,446	$573.21	589.8	$712,030	$1,207.29	2.106
Community, age <65, with SPMI	1,654.5	$1,149,973	$695.05	626.1	$553,915	$884.67	1.273
Community, age <65, no SPMI	2,162.5	$1,315,153	$608.17	766.4	$946,180	$1,234.61	2.030

Table 3.F.1 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 1F

	Baseline period			Demonstration Year 3			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**15,986.6**	**$24,688,247**	**$1,544.31**	**5,968.2**	**$10,882,090**	**$1,823.35**	**1.181**
Facility, age 65+, with SPMI	250.4	$516,275	$2,061.64	53.5	$90,101	$1,684.49	0.817
Facility, age 65+, no SPMI	838.0	$1,446,285	$1,725.88	199.2	$329,290	$1,652.70	0.958
HCBS, age 65+, with SPMI	480.2	$915,481	$1,906.48	218.0	$497,419	$2,281.74	1.197
HCBS, age 65+, no SPMI	2,635.0	$4,300,912	$1,632.22	750.3	$1,680,247	$2,239.29	1.372
Community, age 65+, with SPMI	438.1	$577,833	$1,318.94	141.0	$245,381	$1,740.29	1.319
Community, age 65+, no SPMI	3,854.1	$4,551,826	$1,181.02	1,474.7	$2,352,326	$1,595.08	1.351
Facility, age <65, with SPMI	99.2	$249,940	$2,519.72	60.0	$116,296	$1,938.26	0.769
Facility, age <65, no SPMI	99.0	$234,480	$2,368.48	47.7	$84,563	$1,771.25	0.748
HCBS, age <65, with SPMI	682.0	$1,153,956	$1,691.97	306.5	$498,306	$1,625.88	0.961
HCBS, age <65, no SPMI	1,969.2	$3,824,528	$1,942.14	883.4	$2,107,151	$2,385.38	1.228
Community, age <65, with SPMI	1,722.2	$2,271,910	$1,319.22	550.0	$713,744	$1,297.67	0.984
Community, age <65, no SPMI	2,919.1	$4,644,822	$1,591.19	1,283.8	$2,167,266	$1,688.22	1.061
Intervention group	**15,986.6**	**$9,731,043**	**$608.70**	**5,968.2**	**$6,178,596**	**$1,035.26**	**1.701**
Facility, age 65+, with SPMI	250.4	$310,844	$1,241.30	53.5	$18,934	$353.98	0.285
Facility, age 65+, no SPMI	838.0	$940,063	$1,121.79	199.2	$183,947	$923.23	0.823
HCBS, age 65+, with SPMI	480.2	$385,684	$803.19	218.0	$412,801	$1,893.58	2.358
HCBS, age 65+, no SPMI	2,635.0	$1,820,644	$690.94	750.3	$852,278	$1,135.84	1.644
Community, age 65+, with SPMI	438.1	$315,186	$719.43	141.0	$130,506	$925.57	1.287
Community, age 65+, no SPMI	3,854.1	$1,841,018	$477.67	1,474.7	$2,073,991	$1,406.35	2.944
Facility, age <65, with SPMI	99.2	$54,697	$551.42	60.0	$104,748	$1,745.80	3.166
Facility, age <65, no SPMI	99.0	$43,706	$441.48	47.7	$75,107	$1,573.18	3.563
HCBS, age <65, with SPMI	682.0	$494,966	$725.74	306.5	$245,771	$801.90	1.105
HCBS, age <65, no SPMI	1,969.2	$751,558	$381.65	883.4	$618,455	$700.12	1.834
Community, age <65, with SPMI	1,722.2	$1,343,004	$779.84	550.0	$422,700	$768.52	0.985
Community, age <65, no SPMI	2,919.1	$1,429,671	$489.77	1,283.8	$1,039,358	$809.62	1.653

Table 3.F.2 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 1F

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**15,986.6**	**$24,688,247**	**$1,544.31**	**4,911.2**	**$9,222,691**	**$1,877.89**	**1.216**
Facility, age 65+, with SPMI	250.4	$516,275	$2,061.64	36.0	$60,860	$1,690.56	0.820
Facility, age 65+, no SPMI	838.0	$1,446,285	$1,725.88	148.4	$235,420	$1,586.18	0.919
HCBS, age 65+, with SPMI	480.2	$915,481	$1,906.48	182.6	$437,804	$2,397.02	1.257
HCBS, age 65+, no SPMI	2,635.0	$4,300,912	$1,632.22	561.6	$1,343,886	$2,392.98	1.466
Community, age 65+, with SPMI	438.1	$577,833	$1,318.94	130.0	$236,952	$1,822.71	1.382
Community, age 65+, no SPMI	3,854.1	$4,551,826	$1,181.02	1,151.3	$2,024,305	$1,758.35	1.489
Facility, age <65, with SPMI	99.2	$249,940	$2,519.72	47.0	$91,829	$1,953.80	0.775
Facility, age <65, no SPMI	99.0	$234,480	$2,368.48	36.0	$67,883	$1,885.63	0.796
HCBS, age <65, with SPMI	682.0	$1,153,956	$1,691.97	263.2	$391,146	$1,485.97	0.878
HCBS, age <65, no SPMI	1,969.2	$3,824,528	$1,942.14	770.6	$1,738,815	$2,256.45	1.162
Community, age <65, with SPMI	1,722.2	$2,271,910	$1,319.22	483.0	$613,674	$1,270.55	0.963
Community, age <65, no SPMI	2,919.1	$4,644,822	$1,591.19	1,101.5	$1,980,118	$1,797.72	1.130
Intervention group	**15,986.6**	**$9,731,043**	**$608.70**	**4,911.2**	**$5,766,735**	**$1,174.20**	**1.929**
Facility, age 65+, with SPMI	250.4	$310,844	$1,241.30	36.0	$15,418	$428.27	0.345
Facility, age 65+, no SPMI	838.0	$940,063	$1,121.79	148.4	$173,292	$1,167.58	1.041
HCBS, age 65+, with SPMI	480.2	$385,684	$803.19	182.6	$436,772	$2,391.37	2.977
HCBS, age 65+, no SPMI	2,635.0	$1,820,644	$690.94	561.6	$657,899	$1,171.48	1.695
Community, age 65+, with SPMI	438.1	$315,186	$719.43	130.0	$88,348	$679.60	0.945
Community, age 65+, no SPMI	3,854.1	$1,841,018	$477.67	1,151.3	$1,664,875	$1,446.14	3.027
Facility, age <65, with SPMI	99.2	$54,697	$551.42	47.0	$80,939	$1,722.11	3.123
Facility, age <65, no SPMI	99.0	$43,706	$441.48	36.0	$8,142	$226.17	0.512
HCBS, age <65, with SPMI	682.0	$494,966	$725.74	263.2	$113,847	$432.51	0.596
HCBS, age <65, no SPMI	1,969.2	$751,558	$381.65	770.6	$643,342	$834.86	2.188
Community, age <65, with SPMI	1,722.2	$1,343,004	$779.84	483.0	$632,515	$1,309.56	1.679
Community, age <65, no SPMI	2,919.1	$1,429,671	$489.77	1,101.5	$1,251,348	$1,136.08	2.320

Table 3.G.1 —MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 1 Total

	Baseline period			Demonstration Year 3			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	300,541.1	$478,511,235	$1,592.17	99,473.9	$184,420,069	$1,853.95	1.164
Facility, age 65+, with SPMI	8,034.5	$16,534,542	$2,057.93	1,653.5	$2,812,071	$1,700.69	0.826
Facility, age 65+, no SPMI	20,695.7	$35,690,181	$1,724.52	3,709.3	$6,136,750	$1,654.40	0.959
HCBS, age 65+, with SPMI	12,692.4	$24,055,314	$1,895.25	3,929.2	$8,983,655	$2,286.37	1.206
HCBS, age 65+, no SPMI	57,590.4	$93,564,252	$1,624.65	16,853.1	$37,734,751	$2,239.04	1.378
Community, age 65+, with SPMI	7,196.4	$9,442,825	$1,312.15	2,436.7	$4,237,253	$1,738.93	1.325
Community, age 65+, no SPMI	54,777.7	$64,461,342	$1,176.78	18,255.9	$29,124,160	$1,595.33	1.356
Facility, age <65, with SPMI	2,328.6	$5,874,283	$2,522.69	714.9	$1,404,504	$1,964.57	0.779
Facility, age <65, no SPMI	2,819.8	$6,751,321	$2,394.22	1,006.1	$1,784,632	$1,773.87	0.741
HCBS, age <65, with SPMI	21,022.7	$35,496,599	$1,688.49	8,178.9	$13,275,649	$1,623.17	0.961
HCBS, age <65, no SPMI	40,606.4	$78,915,525	$1,943.43	15,822.9	$37,694,591	$2,382.29	1.226
Community, age <65, with SPMI	29,285.3	$38,589,730	$1,317.72	10,735.7	$13,914,879	$1,296.14	0.984
Community, age <65, no SPMI	43,491.1	$69,135,320	$1,589.64	16,177.8	$27,317,174	$1,688.56	1.062
Intervention group	300,541.1	$484,510,829	$1,612.13	99,473.9	$164,765,120	$1,656.37	1.027
Facility, age 65+, with SPMI	8,034.5	$17,576,967	$2,187.68	1,653.5	$2,131,869	$1,289.32	0.589
Facility, age 65+, no SPMI	20,695.7	$39,145,639	$1,891.49	3,709.3	$4,627,167	$1,247.43	0.659
HCBS, age 65+, with SPMI	12,692.4	$24,018,817	$1,892.37	3,929.2	$7,803,081	$1,985.91	1.049
HCBS, age 65+, no SPMI	57,590.4	$90,235,491	$1,566.85	16,853.1	$31,577,387	$1,873.69	1.196
Community, age 65+, with SPMI	7,196.4	$9,895,987	$1,375.13	2,436.7	$3,459,830	$1,419.89	1.033
Community, age 65+, no SPMI	54,777.7	$66,727,404	$1,218.15	18,255.9	$26,785,494	$1,467.22	1.204
Facility, age <65, with SPMI	2,328.6	$7,974,151	$3,424.47	714.9	$1,323,071	$1,850.66	0.540
Facility, age <65, no SPMI	2,819.8	$11,926,346	$4,229.44	1,006.1	$2,450,040	$2,435.27	0.576
HCBS, age <65, with SPMI	21,022.7	$35,119,181	$1,670.54	8,178.9	$12,887,230	$1,575.67	0.943
HCBS, age <65, no SPMI	40,606.4	$72,535,248	$1,786.30	15,822.9	$29,438,022	$1,860.47	1.042
Community, age <65, with SPMI	29,285.3	$37,682,667	$1,286.74	10,735.7	$14,041,429	$1,307.92	1.016
Community, age <65, no SPMI	43,491.1	$71,672,932	$1,647.99	16,177.8	$28,240,498	$1,745.64	1.059

Table 3.G.2 —MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 1 Total

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**300,541.1**	**$478,511,235**	**$1,592.17**	**82,564.3**	**$156,466,395**	**$1,895.09**	**1.190**
Facility, age 65+, with SPMI	8,034.5	$16,534,542	$2,057.93	1,170.2	$1,985,788	$1,696.91	0.825
Facility, age 65+, no SPMI	20,695.7	$35,690,181	$1,724.52	2,442.6	$3,887,333	$1,591.46	0.923
HCBS, age 65+, with SPMI	12,692.4	$24,055,314	$1,895.25	3,105.7	$7,452,204	$2,399.49	1.266
HCBS, age 65+, no SPMI	57,590.4	$93,564,252	$1,624.65	13,390.5	$32,063,893	$2,394.53	1.474
Community, age 65+, with SPMI	7,196.4	$9,442,825	$1,312.15	1,981.4	$3,610,517	$1,822.24	1.389
Community, age 65+, no SPMI	54,777.7	$64,461,342	$1,176.78	14,491.1	$25,481,108	$1,758.40	1.494
Facility, age <65, with SPMI	2,328.6	$5,874,283	$2,522.69	596.8	$1,179,595	$1,976.44	0.783
Facility, age <65, no SPMI	2,819.8	$6,751,321	$2,394.22	758.3	$1,434,186	$1,891.35	0.790
HCBS, age <65, with SPMI	21,022.7	$35,496,599	$1,688.49	7,529.7	$11,191,145	$1,486.26	0.880
HCBS, age <65, no SPMI	40,606.4	$78,915,525	$1,943.43	13,859.7	$31,278,480	$2,256.79	1.161
Community, age <65, with SPMI	29,285.3	$38,589,730	$1,317.72	9,267.9	$11,782,929	$1,271.37	0.965
Community, age <65, no SPMI	43,491.1	$69,135,320	$1,589.64	13,970.4	$25,119,216	$1,798.04	1.131
Intervention group	**300,541.1**	**$484,510,829**	**$1,612.13**	**82,564.3**	**$147,790,144**	**$1,790.00**	**1.110**
Facility, age 65+, with SPMI	8,034.5	$17,576,967	$2,187.68	1,170.2	$1,884,472	$1,610.33	0.736
Facility, age 65+, no SPMI	20,695.7	$39,145,639	$1,891.49	2,442.6	$3,315,496	$1,357.35	0.718
HCBS, age 65+, with SPMI	12,692.4	$24,018,817	$1,892.37	3,105.7	$6,127,209	$1,972.86	1.043
HCBS, age 65+, no SPMI	57,590.4	$90,235,491	$1,566.85	13,390.5	$26,795,651	$2,001.10	1.277
Community, age 65+, with SPMI	7,196.4	$9,895,987	$1,375.13	1,981.4	$2,841,339	$1,434.03	1.043
Community, age 65+, no SPMI	54,777.7	$66,727,404	$1,218.15	14,491.1	$25,767,643	$1,778.18	1.460
Facility, age <65, with SPMI	2,328.6	$7,974,151	$3,424.47	596.8	$886,341	$1,485.08	0.434
Facility, age <65, no SPMI	2,819.8	$11,926,346	$4,229.44	758.3	$1,505,305	$1,985.14	0.469
HCBS, age <65, with SPMI	21,022.7	$35,119,181	$1,670.54	7,529.7	$10,699,538	$1,420.98	0.851
HCBS, age <65, no SPMI	40,606.4	$72,535,248	$1,786.30	13,859.7	$26,639,656	$1,922.09	1.076
Community, age <65, with SPMI	29,285.3	$37,682,667	$1,286.74	9,267.9	$14,666,085	$1,582.46	1.230
Community, age <65, no SPMI	43,491.1	$71,672,932	$1,647.99	13,970.4	$26,661,411	$1,908.43	1.158

Table 3.H.1 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 2

	Baseline period			Demonstration Year 3			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**4,220.4**	**$7,342,975**	**$1,739.88**	**4,312.1**	**$5,986,553**	**$1,388.33**	**0.798**
Facility, age 65+, with SPMI	69.3	$194,922	$2,811.37	32.0	$66,093	$2,065.40	0.735
Facility, age 65+, no SPMI	224.1	$559,070	$2,494.36	139.5	$175,187	$1,255.67	0.503
HCBS, age 65+, with SPMI	143.3	$268,777	$1,875.10	143.4	$254,238	$1,773.09	0.946
HCBS, age 65+, no SPMI	667.3	$1,128,010	$1,690.47	633.3	$1,151,931	$1,818.96	1.076
Community, age 65+, with SPMI	112.9	$181,213	$1,605.69	137.9	$231,638	$1,680.10	1.046
Community, age 65+, no SPMI	715.1	$1,136,725	$1,589.61	781.1	$1,058,696	$1,355.41	0.853
Facility, age <65, with SPMI	48.6	$188,821	$3,883.32	53.0	$112,836	$2,128.98	0.548
Facility, age <65, no SPMI	49.0	$186,028	$3,796.49	30.0	$61,270	$2,042.34	0.538
HCBS, age <65, with SPMI	258.8	$412,435	$1,593.54	276.8	$255,895	$924.45	0.580
HCBS, age <65, no SPMI	572.9	$962,097	$1,679.28	718.1	$1,061,562	$1,478.32	0.880
Community, age <65, with SPMI	329.2	$441,888	$1,342.48	315.5	$277,659	$880.02	0.656
Community, age <65, no SPMI	1,029.8	$1,682,991	$1,634.24	1,051.5	$1,279,550	$1,216.87	0.745
Intervention group	**4,220.4**	**$9,945,769**	**$2,356.60**	**4,312.1**	**$8,119,493**	**$1,882.97**	**0.799**
Facility, age 65+, with SPMI	69.3	$438,707	$6,327.51	32.0	$24,903	$778.23	0.123
Facility, age 65+, no SPMI	224.1	$1,196,636	$5,338.95	139.5	$72,639	$520.65	0.098
HCBS, age 65+, with SPMI	143.3	$256,776	$1,791.38	143.4	$299,487	$2,088.66	1.166
HCBS, age 65+, no SPMI	667.3	$1,545,012	$2,315.40	633.3	$1,203,715	$1,900.73	0.821
Community, age 65+, with SPMI	112.9	$289,402	$2,564.32	137.9	$316,294	$2,294.13	0.895
Community, age 65+, no SPMI	715.1	$1,450,968	$2,029.05	781.1	$877,701	$1,123.69	0.554
Facility, age <65, with SPMI	48.6	$110,141	$2,265.17	53.0	$49,055	$925.56	0.409
Facility, age <65, no SPMI	49.0	$450,522	$9,194.32	30.0	$77,679	$2,589.28	0.282
HCBS, age <65, with SPMI	258.8	$748,549	$2,892.19	276.8	$579,929	$2,095.07	0.724
HCBS, age <65, no SPMI	572.9	$1,300,020	$2,269.10	718.1	$1,504,022	$2,094.48	0.923
Community, age <65, with SPMI	329.2	$674,242	$2,048.38	315.5	$315,386	$999.59	0.488
Community, age <65, no SPMI	1,029.8	$1,484,795	$1,441.79	1,051.5	$2,798,684	$2,661.59	1.846

Table 3.H.2 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 2

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**4,220.4**	**$7,342,975**	**$1,739.88**	**3,476.8**	**$5,184,236**	**$1,491.08**	**0.857**
Facility, age 65+, with SPMI	69.3	$194,922	$2,811.37	36.0	$49,073	$1,363.14	0.485
Facility, age 65+, no SPMI	224.1	$559,070	$2,494.36	125.4	$191,397	$1,526.84	0.612
HCBS, age 65+, with SPMI	143.3	$268,777	$1,875.10	105.0	$228,606	$2,177.20	1.161
HCBS, age 65+, no SPMI	667.3	$1,128,010	$1,690.47	492.2	$860,941	$1,749.01	1.035
Community, age 65+, with SPMI	112.9	$181,213	$1,605.69	98.5	$170,652	$1,732.51	1.079
Community, age 65+, no SPMI	715.1	$1,136,725	$1,589.61	620.5	$1,032,481	$1,664.08	1.047
Facility, age <65, with SPMI	48.6	$188,821	$3,883.32	50.0	$63,100	$1,262.89	0.325
Facility, age <65, no SPMI	49.0	$186,028	$3,796.49	23.9	$38,146	$1,593.71	0.420
HCBS, age <65, with SPMI	258.8	$412,435	$1,593.54	261.0	$302,468	$1,158.88	0.727
HCBS, age <65, no SPMI	572.9	$962,097	$1,679.28	571.3	$889,667	$1,557.13	0.927
Community, age <65, with SPMI	329.2	$441,888	$1,342.48	268.3	$311,823	$1,162.35	0.866
Community, age <65, no SPMI	1,029.8	$1,682,991	$1,634.24	824.8	$1,045,882	$1,268.11	0.776
Intervention group	**4,220.4**	**$9,945,769**	**$2,356.60**	**3,476.8**	**$6,979,455**	**$2,007.42**	**0.852**
Facility, age 65+, with SPMI	69.3	$438,707	$6,327.51	36.0	$42,134	$1,170.39	0.185
Facility, age 65+, no SPMI	224.1	$1,196,636	$5,338.95	125.4	$83,847	$668.88	0.125
HCBS, age 65+, with SPMI	143.3	$256,776	$1,791.38	105.0	$139,091	$1,324.68	0.739
HCBS, age 65+, no SPMI	667.3	$1,545,012	$2,315.40	492.2	$1,442,298	$2,930.04	1.265
Community, age 65+, with SPMI	112.9	$289,402	$2,564.32	98.5	$255,473	$2,593.63	1.011
Community, age 65+, no SPMI	715.1	$1,450,968	$2,029.05	620.5	$897,635	$1,446.74	0.713
Facility, age <65, with SPMI	48.6	$110,141	$2,265.17	50.0	$30,282	$606.08	0.268
Facility, age <65, no SPMI	49.0	$450,522	$9,194.32	23.9	$179,740	$7,509.35	0.817
HCBS, age <65, with SPMI	258.8	$748,549	$2,892.19	261.0	$541,586	$2,075.04	0.717
HCBS, age <65, no SPMI	572.9	$1,300,020	$2,269.10	571.3	$941,808	$1,648.39	0.726
Community, age <65, with SPMI	329.2	$674,242	$2,048.38	268.3	$257,075	$958.27	0.468
Community, age <65, no SPMI	1,029.8	$1,484,795	$1,441.79	824.8	$2,168,486	$2,629.25	1.824

Table 3.I.1 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 3

	Baseline period			Demonstration Year 3			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**61,200.6**	**$93,045,998**	**$1,520.35**	**47,319.8**	**$61,824,588**	**$1,306.53**	**0.859**
Facility, age 65+, with SPMI	1,249.3	$2,839,727	$2,273.12	769.1	$1,237,882	$1,609.54	0.708
Facility, age 65+, no SPMI	4,252.8	$9,447,994	$2,221.61	2,098.4	$3,108,400	$1,481.33	0.667
HCBS, age 65+, with SPMI	2,628.5	$3,772,984	$1,435.39	2,019.5	$3,404,997	$1,686.04	1.175
HCBS, age 65+, no SPMI	11,866.5	$18,638,532	$1,570.68	8,656.1	$13,711,736	$1,584.05	1.009
Community, age 65+, with SPMI	1,951.3	$2,888,862	$1,480.46	1,654.6	$1,906,147	$1,152.05	0.778
Community, age 65+, no SPMI	11,506.7	$15,358,114	$1,334.72	9,526.2	$12,826,002	$1,346.40	1.009
Facility, age <65, with SPMI	423.5	$1,488,014	$3,513.99	334.5	$687,071	$2,054.29	0.585
Facility, age <65, no SPMI	696.3	$2,415,969	$3,469.81	555.5	$1,068,686	$1,923.66	0.554
HCBS, age <65, with SPMI	3,460.0	$4,039,095	$1,167.38	3,041.2	$2,522,556	$829.47	0.711
HCBS, age <65, no SPMI	6,699.9	$9,106,677	$1,359.22	5,895.0	$6,800,515	$1,153.60	0.849
Community, age <65, with SPMI	6,565.4	$7,436,908	$1,132.75	4,904.2	$4,248,138	$866.23	0.765
Community, age <65, no SPMI	9,900.5	$15,613,122	$1,577.00	7,865.6	$10,302,457	$1,309.81	0.831
Intervention group	**61,200.6**	**$103,440,434**	**$1,690.19**	**47,319.8**	**$68,725,816**	**$1,452.37**	**0.859**
Facility, age 65+, with SPMI	1,249.3	$3,181,407	$2,546.62	769.1	$1,005,089	$1,306.85	0.513
Facility, age 65+, no SPMI	4,252.8	$9,034,621	$2,124.41	2,098.4	$2,052,054	$977.92	0.460
HCBS, age 65+, with SPMI	2,628.5	$5,191,095	$1,974.89	2,019.5	$3,857,146	$1,909.93	0.967
HCBS, age 65+, no SPMI	11,866.5	$21,031,541	$1,772.34	8,656.1	$15,064,741	$1,740.36	0.982
Community, age 65+, with SPMI	1,951.3	$2,712,797	$1,390.23	1,654.6	$1,984,768	$1,199.57	0.863
Community, age 65+, no SPMI	11,506.7	$14,881,472	$1,293.29	9,526.2	$12,541,219	$1,316.50	1.018
Facility, age <65, with SPMI	423.5	$1,956,037	$4,619.24	334.5	$871,260	$2,605.01	0.564
Facility, age <65, no SPMI	696.3	$3,042,252	$4,369.28	555.5	$1,041,861	$1,875.37	0.429
HCBS, age <65, with SPMI	3,460.0	$6,775,101	$1,958.15	3,041.2	$4,430,152	$1,456.73	0.744
HCBS, age <65, no SPMI	6,699.9	$12,516,956	$1,868.23	5,895.0	$10,057,665	$1,706.13	0.913
Community, age <65, with SPMI	6,565.4	$8,598,440	$1,309.66	4,904.2	$5,452,573	$1,111.82	0.849
Community, age <65, no SPMI	9,900.5	$14,518,716	$1,466.46	7,865.6	$10,367,288	$1,318.05	0.899

Table 3.I.2 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 3

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**61,200.6**	**$93,045,998**	**$1,520.35**	**37,725.3**	**$53,144,243**	**$1,408.72**	**0.927**
Facility, age 65+, with SPMI	1,249.3	$2,839,727	$2,273.12	585.9	$841,469	$1,436.21	0.632
Facility, age 65+, no SPMI	4,252.8	$9,447,994	$2,221.61	1,329.2	$2,076,735	$1,562.39	0.703
HCBS, age 65+, with SPMI	2,628.5	$3,772,984	$1,435.39	1,648.4	$2,721,466	$1,651.02	1.150
HCBS, age 65+, no SPMI	11,866.5	$18,638,532	$1,570.68	6,588.3	$12,411,524	$1,883.87	1.199
Community, age 65+, with SPMI	1,951.3	$2,888,862	$1,480.46	1,336.1	$1,489,594	$1,114.87	0.753
Community, age 65+, no SPMI	11,506.7	$15,358,114	$1,334.72	7,504.0	$10,204,228	$1,359.84	1.019
Facility, age <65, with SPMI	423.5	$1,488,014	$3,513.99	288.2	$320,758	$1,113.11	0.317
Facility, age <65, no SPMI	696.3	$2,415,969	$3,469.81	474.7	$747,822	$1,575.43	0.454
HCBS, age <65, with SPMI	3,460.0	$4,039,095	$1,167.38	2,710.2	$2,405,292	$887.51	0.760
HCBS, age <65, no SPMI	6,699.9	$9,106,677	$1,359.22	5,102.9	$6,717,250	$1,316.36	0.968
Community, age <65, with SPMI	6,565.4	$7,436,908	$1,132.75	4,017.9	$3,858,490	$960.33	0.848
Community, age <65, no SPMI	9,900.5	$15,613,122	$1,577.00	6,139.7	$9,349,618	$1,522.82	0.966
Intervention group	**61,200.6**	**$103,440,434**	**$1,690.19**	**37,725.3**	**$54,956,672**	**$1,456.76**	**0.862**
Facility, age 65+, with SPMI	1,249.3	$3,181,407	$2,546.62	585.9	$883,903	$1,508.63	0.592
Facility, age 65+, no SPMI	4,252.8	$9,034,621	$2,124.41	1,329.2	$1,651,746	$1,242.65	0.585
HCBS, age 65+, with SPMI	2,628.5	$5,191,095	$1,974.89	1,648.4	$2,858,367	$1,734.07	0.878
HCBS, age 65+, no SPMI	11,866.5	$21,031,541	$1,772.34	6,588.3	$10,951,964	$1,662.33	0.938
Community, age 65+, with SPMI	1,951.3	$2,712,797	$1,390.23	1,336.1	$1,504,659	$1,126.15	0.810
Community, age 65+, no SPMI	11,506.7	$14,881,472	$1,293.29	7,504.0	$9,224,262	$1,229.25	0.950
Facility, age <65, with SPMI	423.5	$1,956,037	$4,619.24	288.2	$689,993	$2,394.44	0.518
Facility, age <65, no SPMI	696.3	$3,042,252	$4,369.28	474.7	$1,123,363	$2,366.58	0.542
HCBS, age <65, with SPMI	3,460.0	$6,775,101	$1,958.15	2,710.2	$3,958,714	$1,460.70	0.746
HCBS, age <65, no SPMI	6,699.9	$12,516,956	$1,868.23	5,102.9	$8,611,456	$1,687.57	0.903
Community, age <65, with SPMI	6,565.4	$8,598,440	$1,309.66	4,017.9	$5,037,682	$1,253.81	0.957
Community, age <65, no SPMI	9,900.5	$14,518,716	$1,466.46	6,139.7	$8,460,563	$1,378.02	0.940

Table 3.J.1 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 3, by category of beneficiary: Cohort 4

	Baseline period			Demonstration Year 3			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**62,395.6**	**$96,865,182**	**$1,552.44**	**60,468.5**	**$94,451,494**	**$1,562.00**	**1.006**
Facility, age 65+, with SPMI	2,453.0	$6,453,449	$2,630.84	2,161.3	$4,410,378	$2,040.63	0.776
Facility, age 65+, no SPMI	2,527.9	$5,282,819	$2,089.78	2,128.4	$3,462,225	$1,626.66	0.778
HCBS, age 65+, with SPMI	4,306.6	$8,037,334	$1,866.30	4,115.4	$8,459,190	$2,055.50	1.101
HCBS, age 65+, no SPMI	9,921.7	$14,424,152	$1,453.79	9,486.1	$16,864,793	$1,777.84	1.223
Community, age 65+, with SPMI	2,937.0	$4,882,376	$1,662.39	2,898.9	$4,332,792	$1,494.66	0.899
Community, age 65+, no SPMI	13,051.3	$16,756,974	$1,283.93	12,887.2	$15,758,182	$1,222.77	0.952
Facility, age <65, with SPMI	701.0	$2,687,764	$3,834.18	614.6	$1,768,431	$2,877.39	0.750
Facility, age <65, no SPMI	435.0	$1,496,911	$3,441.17	339.6	$789,423	$2,324.68	0.676
HCBS, age <65, with SPMI	4,420.2	$5,880,332	$1,330.34	4,454.0	$6,887,082	$1,546.25	1.162
HCBS, age <65, no SPMI	5,763.7	$9,009,151	$1,563.09	6,053.6	$10,341,352	$1,708.30	1.093
Community, age <65, with SPMI	7,698.0	$8,968,160	$1,165.00	7,159.5	$8,338,063	$1,164.62	1.000
Community, age <65, no SPMI	8,180.2	$12,985,760	$1,587.47	8,169.9	$13,039,584	$1,596.05	1.005
Intervention group	**62,395.6**	**$108,719,430**	**$1,742.42**	**60,468.5**	**$91,095,889**	**$1,506.50**	**0.865**
Facility, age 65+, with SPMI	2,453.0	$8,183,909	$3,336.29	2,161.3	$4,023,074	$1,861.43	0.558
Facility, age 65+, no SPMI	2,527.9	$5,640,529	$2,231.28	2,128.4	$2,397,601	$1,126.46	0.505
HCBS, age 65+, with SPMI	4,306.6	$10,380,911	$2,410.48	4,115.4	$8,430,791	$2,048.60	0.850
HCBS, age 65+, no SPMI	9,921.7	$16,659,970	$1,679.14	9,486.1	$15,388,228	$1,622.19	0.966
Community, age 65+, with SPMI	2,937.0	$5,604,559	$1,908.28	2,898.9	$4,275,037	$1,474.73	0.773
Community, age 65+, no SPMI	13,051.3	$15,923,824	$1,220.09	12,887.2	$15,276,285	$1,185.38	0.972
Facility, age <65, with SPMI	701.0	$3,135,378	$4,472.72	614.6	$1,914,254	$3,114.66	0.696
Facility, age <65, no SPMI	435.0	$1,415,092	$3,253.09	339.6	$1,143,840	$3,368.37	1.035
HCBS, age <65, with SPMI	4,420.2	$7,918,350	$1,791.41	4,454.0	$7,709,467	$1,730.89	0.966
HCBS, age <65, no SPMI	5,763.7	$10,787,145	$1,871.58	6,053.6	$9,614,920	$1,588.30	0.849
Community, age <65, with SPMI	7,698.0	$11,310,650	$1,469.29	7,159.5	$8,787,583	$1,227.40	0.835
Community, age <65, no SPMI	8,180.2	$11,759,112	$1,437.51	8,169.9	$12,134,807	$1,485.30	1.033

Table 3.J.2 — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 4

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**62,395.6**	**$96,865,182**	**$1,552.44**	**46,028.7**	**$69,458,738**	**$1,509.03**	**0.972**
Facility, age 65+, with SPMI	2,453.0	$6,453,449	$2,630.84	1,450.9	$2,715,289	$1,871.42	0.711
Facility, age 65+, no SPMI	2,527.9	$5,282,819	$2,089.78	1,411.5	$1,952,252	$1,383.12	0.662
HCBS, age 65+, with SPMI	4,306.6	$8,037,334	$1,866.30	3,182.4	$5,594,516	$1,757.96	0.942
HCBS, age 65+, no SPMI	9,921.7	$14,424,152	$1,453.79	6,946.6	$12,526,852	$1,803.31	1.240
Community, age 65+, with SPMI	2,937.0	$4,882,376	$1,662.39	2,257.1	$2,796,114	$1,238.81	0.745
Community, age 65+, no SPMI	13,051.3	$16,756,974	$1,283.93	9,837.2	$13,560,312	$1,378.47	1.074
Facility, age <65, with SPMI	701.0	$2,687,764	$3,834.18	417.2	$1,011,444	$2,424.36	0.632
Facility, age <65, no SPMI	435.0	$1,496,911	$3,441.17	252.1	$539,750	$2,141.32	0.622
HCBS, age <65, with SPMI	4,420.2	$5,880,332	$1,330.34	3,765.4	$5,020,882	$1,333.43	1.002
HCBS, age <65, no SPMI	5,763.7	$9,009,151	$1,563.09	5,013.5	$8,677,925	$1,730.92	1.107
Community, age <65, with SPMI	7,698.0	$8,968,160	$1,165.00	5,408.1	$5,686,645	$1,051.50	0.903
Community, age <65, no SPMI	8,180.2	$12,985,760	$1,587.47	6,086.7	$9,376,757	$1,540.53	0.970
Intervention group	**62,395.6**	**$108,719,430**	**$1,742.42**	**46,028.7**	**$68,678,275**	**$1,492.08**	**0.856**
Facility, age 65+, with SPMI	2,453.0	$8,183,909	$3,336.29	1,450.9	$1,901,152	$1,310.30	0.393
Facility, age 65+, no SPMI	2,527.9	$5,640,529	$2,231.28	1,411.5	$1,408,242	$997.70	0.447
HCBS, age 65+, with SPMI	4,306.6	$10,380,911	$2,410.48	3,182.4	$5,993,420	$1,883.30	0.781
HCBS, age 65+, no SPMI	9,921.7	$16,659,970	$1,679.14	6,946.6	$11,933,812	$1,717.94	1.023
Community, age 65+, with SPMI	2,937.0	$5,604,559	$1,908.28	2,257.1	$3,518,455	$1,558.84	0.817
Community, age 65+, no SPMI	13,051.3	$15,923,824	$1,220.09	9,837.2	$12,188,645	$1,239.03	1.016
Facility, age <65, with SPMI	701.0	$3,135,378	$4,472.72	417.2	$1,039,231	$2,490.96	0.557
Facility, age <65, no SPMI	435.0	$1,415,092	$3,253.09	252.1	$410,563	$1,628.80	0.501
HCBS, age <65, with SPMI	4,420.2	$7,918,350	$1,791.41	3,765.4	$6,434,587	$1,708.87	0.954
HCBS, age <65, no SPMI	5,763.7	$10,787,145	$1,871.58	5,013.5	$8,204,195	$1,636.43	0.874
Community, age <65, with SPMI	7,698.0	$11,310,650	$1,469.29	5,408.1	$6,275,064	$1,160.30	0.790
Community, age <65, no SPMI	8,180.2	$11,759,112	$1,437.51	6,086.7	$9,370,909	$1,539.57	1.071

Table 3.K — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 5A

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**65,787.6**	**$107,754,944**	**$1,637.92**	**63,414.2**	**$104,696,611**	**$1,651.00**	**1.008**
Facility, age 65+, with SPMI	2,842.0	$6,504,251	$2,288.59	2,529.2	$4,910,713	$1,941.59	0.848
Facility, age 65+, no SPMI	2,190.1	$4,599,048	$2,099.96	1,872.9	$3,332,718	$1,779.46	0.847
HCBS, age 65+, with SPMI	6,618.4	$13,664,764	$2,064.67	6,299.1	$13,604,701	$2,159.80	1.046
HCBS, age 65+, no SPMI	8,388.5	$13,376,717	$1,594.65	8,231.0	$16,109,741	$1,957.21	1.227
Community, age 65+, with SPMI	5,124.6	$8,366,445	$1,632.59	4,813.2	$6,709,006	$1,393.87	0.854
Community, age 65+, no SPMI	11,804.2	$13,429,548	$1,137.69	11,384.8	$13,707,607	$1,204.02	1.058
Facility, age <65, with SPMI	776.5	$2,753,515	$3,545.99	767.7	$2,542,236	$3,311.59	0.934
Facility, age <65, no SPMI	321.0	$1,141,345	$3,555.59	328.5	$807,272	$2,457.16	0.691
HCBS, age <65, with SPMI	5,822.6	$10,322,639	$1,772.87	5,901.4	$12,996,456	$2,202.26	1.242
HCBS, age <65, no SPMI	4,131.8	$6,238,202	$1,509.81	4,410.6	$6,850,614	$1,553.23	1.029
Community, age <65, with SPMI	10,170.8	$13,698,967	$1,346.89	9,590.5	$11,350,683	$1,183.54	0.879
Community, age <65, no SPMI	7,597.1	$13,659,502	$1,797.99	7,285.4	$11,774,864	$1,616.23	0.899
Intervention group	**65,787.6**	**$110,905,078**	**$1,685.80**	**63,414.2**	**$95,623,575**	**$1,507.92**	**0.894**
Facility, age 65+, with SPMI	2,842.0	$9,014,995	$3,172.02	2,529.2	$4,368,153	$1,727.07	0.544
Facility, age 65+, no SPMI	2,190.1	$4,385,773	$2,002.58	1,872.9	$2,074,467	$1,107.63	0.553
HCBS, age 65+, with SPMI	6,618.4	$15,158,222	$2,290.32	6,299.1	$13,387,733	$2,125.35	0.928
HCBS, age 65+, no SPMI	8,388.5	$14,806,798	$1,765.13	8,231.0	$13,943,734	$1,694.06	0.960
Community, age 65+, with SPMI	5,124.6	$8,827,429	$1,722.55	4,813.2	$7,265,616	$1,509.51	0.876
Community, age 65+, no SPMI	11,804.2	$12,550,282	$1,063.21	11,384.8	$13,996,984	$1,229.44	1.156
Facility, age <65, with SPMI	776.5	$4,038,014	$5,200.17	767.7	$2,007,396	$2,614.89	0.503
Facility, age <65, no SPMI	321.0	$1,146,659	$3,572.15	328.5	$669,670	$2,038.33	0.571
HCBS, age <65, with SPMI	5,822.6	$12,311,204	$2,114.39	5,901.4	$10,578,587	$1,792.55	0.848
HCBS, age <65, no SPMI	4,131.8	$5,743,258	$1,390.02	4,410.6	$6,778,299	$1,536.83	1.106
Community, age <65, with SPMI	10,170.8	$13,754,663	$1,352.37	9,590.5	$11,482,105	$1,197.24	0.885
Community, age <65, no SPMI	7,597.1	$9,167,779	$1,206.74	7,285.4	$9,070,833	$1,245.07	1.032

Table 3.L — MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 4, by category of beneficiary: Cohort 5B

	Baseline period			Demonstration Year 4			Trend
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	(D/B)
Re-weighted comparison group	**65,411.2**	**$106,963,285**	**$1,635.24**	**48,134.7**	**$85,443,230**	**$1,775.09**	**1.086**
Facility, age 65+, with SPMI	4,124.0	$7,793,211	$1,889.72	3,032.1	$5,339,132	$1,760.85	0.932
Facility, age 65+, no SPMI	2,334.6	$3,957,640	$1,695.24	1,729.1	$2,733,152	$1,580.66	0.932
HCBS, age 65+, with SPMI	8,071.3	$17,484,339	$2,166.25	5,905.3	$13,629,100	$2,307.95	1.065
HCBS, age 65+, no SPMI	9,031.3	$15,448,534	$1,710.55	6,539.3	$13,390,918	$2,047.76	1.197
Community, age 65+, with SPMI	6,083.6	$9,867,185	$1,621.94	4,393.1	$7,539,482	$1,716.20	1.058
Community, age 65+, no SPMI	14,579.5	$17,407,750	$1,193.99	10,565.1	$15,171,302	$1,435.98	1.203
Facility, age <65, with SPMI	1,284.5	$3,345,575	$2,604.48	973.6	$2,076,941	$2,133.19	0.819
Facility, age <65, no SPMI	579.0	$843,478	$1,456.78	455.5	$833,321	$1,829.37	1.256
HCBS, age <65, with SPMI	5,469.1	$9,451,656	$1,728.19	4,197.3	$7,861,520	$1,872.98	1.084
HCBS, age <65, no SPMI	3,758.0	$6,270,810	$1,668.64	2,831.0	$5,355,229	$1,891.64	1.134
Community, age <65, with SPMI	6,450.3	$9,197,331	$1,425.88	4,799.9	$6,918,940	$1,441.49	1.011
Community, age <65, no SPMI	3,646.1	$5,895,776	$1,617.02	2,713.2	$4,594,192	$1,693.27	1.047
Intervention group	**65,411.2**	**$113,102,577**	**$1,729.10**	**48,134.7**	**$80,642,197**	**$1,675.35**	**0.969**
Facility, age 65+, with SPMI	4,124.0	$11,220,281	$2,720.73	3,032.1	$6,007,581	$1,981.30	0.728
Facility, age 65+, no SPMI	2,334.6	$4,975,511	$2,131.24	1,729.1	$2,804,964	$1,622.19	0.761
HCBS, age 65+, with SPMI	8,071.3	$15,592,008	$1,931.80	5,905.3	$10,925,349	$1,850.10	0.958
HCBS, age 65+, no SPMI	9,031.3	$12,021,615	$1,331.10	6,539.3	$9,617,436	$1,470.71	1.105
Community, age 65+, with SPMI	6,083.6	$10,289,715	$1,691.40	4,393.1	$6,865,789	$1,562.85	0.924
Community, age 65+, no SPMI	14,579.5	$17,589,282	$1,206.44	10,565.1	$13,135,609	$1,243.30	1.031
Facility, age <65, with SPMI	1,284.5	$5,382,129	$4,189.90	973.6	$2,747,144	$2,821.54	0.673
Facility, age <65, no SPMI	579.0	$1,328,071	$2,293.73	455.5	$840,500	$1,845.13	0.804
HCBS, age <65, with SPMI	5,469.1	$11,128,966	$2,034.88	4,197.3	$8,856,950	$2,110.14	1.037
HCBS, age <65, no SPMI	3,758.0	$5,231,307	$1,392.03	2,831.0	$4,907,720	$1,733.56	1.245
Community, age <65, with SPMI	6,450.3	$11,304,842	$1,752.61	4,799.9	$8,385,035	$1,746.94	0.997
Community, age <65, no SPMI	3,646.1	$7,038,850	$1,930.53	2,713.2	$5,548,120	$2,044.86	1.059

Table 4.A —
Summary by cohort of per member per month (PMPM), baseline versus Demonstration Year 3

		Baseline period			Demonstration Year 3			
Cohort	Group (comparison/ intervention)	Number of eligible months (intervention group)	Medicare incurred claims	PMPM	Number of eligible months (intervention group)	Medicare incurred claims	PMPM	Cost trend (Demonstration Year/baseline period)
1A	C	48,488.0	$78,754,198	$1,624.20	14,540.4	$27,919,868	$1,920.16	1.182
	I	48,488.0	$128,622,626	$2,652.67	14,540.4	$36,051,308	$2,479.39	0.935
1B	C	83,567.1	$131,605,106	$1,574.84	28,211.3	$51,776,952	$1,835.33	1.165
	I	83,567.1	$108,476,913	$1,298.08	28,211.3	$40,016,796	$1,418.47	1.093
1C	C	7,946.8	$12,115,020	$1,524.51	2,723.6	$4,987,358	$1,831.17	1.201
	I	7,946.8	$7,898,710	$993.94	2,723.6	$3,410,228	$1,252.11	1.260
1D	C	129,399.2	$207,882,769	$1,606.52	42,529.9	$78,947,138	$1,856.28	1.155
	I	129,399.2	$219,493,469	$1,696.25	42,529.9	$73,252,412	$1,722.38	1.015
1E	C	15,153.3	$23,465,894	$1,548.56	5,500.6	$9,906,663	$1,801.01	1.163
	I	15,153.3	$10,288,068	$678.93	5,500.6	$5,855,780	$1,064.57	1.568
1F	C	15,986.6	$24,688,247	$1,544.31	5,968.2	$10,882,090	$1,823.35	1.181
	I	15,986.6	$9,731,043	$608.70	5,968.2	$6,178,596	$1,035.26	1.701
1 total	C	300,541.1	$478,511,235	$1,592.17	99,473.9	$184,420,069	$1,853.95	1.164
	I	300,541.1	$484,510,829	$1,612.13	99,473.9	$164,765,120	$1,656.37	1.027
2	C	4,220.4	$7,342,975	$1,739.88	4,312.1	$5,986,553	$1,388.33	0.798
	I	4,220.4	$9,945,769	$2,356.60	4,312.1	$8,119,493	$1,882.97	0.799
3	C	61,200.6	$93,045,998	$1,520.35	47,319.8	$61,824,588	$1,306.53	0.859
	I	61,200.6	$103,440,434	$1,690.19	47,319.8	$68,725,816	$1,452.37	0.859
4	C	62,395.6	$96,865,182	$1,552.44	60,468.5	$94,451,494	$1,562.00	1.006
	I	62,395.6	$108,719,430	$1,742.42	60,468.5	$91,095,889	$1,506.50	0.865

Table 4.B —
Summary by cohort of per member per month (PMPM), baseline versus Demonstration Year 4

		Baseline period			Demonstration Year 4			
Cohort	Group	Number of eligible months (intervention group)	Medicare incurred claims	PMPM	Number of eligible months (intervention group)	Medicare incurred claims	PMPM	Cost trend (Demonstration Year/baseline period)
1A	C	48,488.0	$78,754,198	$1,624.20	12,196.5	$23,833,789	$1,954.14	1.203
	I	48,488.0	$128,622,626	$2,652.67	12,196.5	$31,144,889	$2,553.58	0.963
1B	C	83,567.1	$131,605,106	$1,574.84	23,641.9	$44,485,413	$1,881.63	1.195
	I	83,567.1	$108,476,913	$1,298.08	23,641.9	$37,666,761	$1,593.22	1.227
1C	C	7,946.8	$12,115,020	$1,524.51	2,117.5	$4,000,204	$1,889.13	1.239
	I	7,946.8	$7,898,710	$993.94	2,117.5	$2,702,837	$1,276.44	1.284
1D	C	129,399.2	$207,882,769	$1,606.52	35,278.5	$66,759,737	$1,892.37	1.178
	I	129,399.2	$219,493,469	$1,696.25	35,278.5	$65,128,621	$1,846.13	1.088
1E	C	15,153.3	$23,465,894	$1,548.56	4,418.6	$8,164,561	$1,847.76	1.193
	I	15,153.3	$10,288,068	$678.93	4,418.6	$5,380,302	$1,217.64	1.793
1F	C	15,986.6	$24,688,247	$1,544.31	4,911.2	$9,222,691	$1,877.89	1.216
	I	15,986.6	$9,731,043	$608.70	4,911.2	$5,766,735	$1,174.20	1.929
1 total	C	300,541.1	$478,511,235	$1,592.17	82,564.3	$156,466,395	$1,895.09	1.190
	I	300,541.1	$484,510,829	$1,612.13	82,564.3	$147,790,144	$1,790.00	1.110
2	C	4,220.4	$7,342,975	$1,739.88	3,476.8	$5,184,236	$1,491.08	0.857
	I	4,220.4	$9,945,769	$2,356.60	3,476.8	$6,979,455	$2,007.42	0.852
3	C	61,200.6	$93,045,998	$1,520.35	37,725.3	$53,144,243	$1,408.72	0.927
	I	61,200.6	$103,440,434	$1,690.19	37,725.3	$54,956,672	$1,456.76	0.862
4	C	62,395.6	$96,865,182	$1,552.44	46,028.7	$69,458,738	$1,509.03	0.972
	I	62,395.6	$108,719,430	$1,742.42	46,028.7	$68,678,275	$1,492.08	0.856

(continued)

Table 4.B — (continued)
Summary by cohort of per member per month (PMPM), baseline versus Demonstration Year 4

		Baseline period			Demonstration Year 4			
Cohort	Group	Number of eligible months (intervention group)	Medicare incurred claims	PMPM	Number of eligible months (intervention group)	Medicare incurred claims	PMPM	Cost trend (Demonstration Year/baseline period)
5A	C	65,787.6	$107,754,944	$1,637.92	63,414.2	$104,696,611	$1,651.00	1.008
	I	65,787.6	$110,905,078	$1,685.80	63,414.2	$95,623,575	$1,507.92	0.894
5B	C	65,411.2	$106,963,285	$1,635.24	48,134.7	$85,443,230	$1,775.09	1.086
	I	65,411.2	$113,102,577	$1,729.10	48,134.7	$80,642,197	$1,675.35	0.969

5.2 Medicare AGA Adjustments

The trend in health care costs is not uniform across the United States; it varies by geographic area. The purpose of this adjustment is to control for geographic variation in secular cost trends. CMS measures these variations for each calendar year by county with the calculation of the Average Geographic Adjustment (AGA) factors. The factors measure the difference in average Medicare costs in each county from the national average. The factors are used to vary payment rates to Medicare Advantage plans by county. Hospice expenditures are excluded in the calculation of the AGA factors. We calculated the average AGA factor across all beneficiaries in the intervention group and the comparison group for the baseline period and the Demonstration Year separately. To determine the average AGA factor, the non-hospice expenditures for each beneficiary were grouped by calendar year and county of residence, and the weighted average AGA factor was calculated for each cohort and for each period (baseline period vs. Demonstration Year).[6] ***Tables 5.A*** and ***5.B*** show the results of the calculations for Demonstration Years 3 and 4, respectively.

For each cohort and Demonstration Year, the AGA adjustment factor was determined by comparing the trend from the baseline period to the Demonstration Year for the intervention group versus that of the comparison group. For Cohort 1, from the baseline period to Demonstration Year 3, the AGA factor decreased by 0.63 percent (a factor of 0.9937) for the comparison group and increased by 4.52 percent (a factor of 1.0452) for the intervention group. If the AGA had increased by the same 4.52 percent in the comparison area as it did in the intervention area, instead of decreasing by 0.63 percent, then the trend of the comparison group would have increased by an additional 5.18 percent (1.0452/0.9937 = 1.0518), which is the AGA adjustment factor that we apply to the comparison group trend. For Cohort 2, the corresponding AGA adjustment factor is 1.0453, for Cohort 3 it is 1.0181 and for Cohort 4 it is 1.0100.

Table 5.A —
Average AGA factor by group for baseline period and Demonstration Year 3

Cohort	Group Comparison Intervention	Baseline period	Demonstration Year 3	Trend in AGA factor	Adjustment to comparison group trend
1 total	C	0.89646	0.89083	0.99372	1.05182
	I	0.88374	0.92369	1.04521	
2	C	0.89647	0.89460	0.99792	1.04533
	I	0.89107	0.92953	1.04316	
3	C	0.88723	0.88898	1.00197	1.01812
	I	0.90748	0.92574	1.02012	
4	C	0.88806	0.89131	1.00366	1.01004
	I	0.90803	0.92051	1.01374	

[6] The non-hospice expenditures of each beneficiary were divided by the AGA factor for their county and year and the sum of the results of this division was divided into the total non-hospice expenditures of the cohort.

For Demonstration Year 4, the corresponding calculations produced AGA adjustment factors of 1.05067 for Cohort 1, 1.04521 for Cohort 2, 1.01431 for Cohort 3, 1.00787 for Cohort 4, 0.99335 for Cohort 5A and 0.99658 for Cohort 5B.

Table 5.B —
Average AGA factor by group for baseline period and Demonstration Year 4

Cohort	Group Comparison Intervention	Baseline period	Demonstration Year 4	Trend in AGA factor	Adjustment to comparison group trend
1 total	C	0.89646	0.89972	1.00364	1.05067
	I	0.88374	0.93190	1.05450	
2	C	0.89647	0.90186	1.00602	1.04521
	I	0.89107	0.93696	1.05150	
3	C	0.88723	0.89849	1.01268	1.01431
	I	0.90748	0.93214	1.02717	
4	C	0.88806	0.89823	1.01145	1.00787
	I	0.90803	0.92566	1.01941	
5A	C	0.89198	0.90302	1.01237	0.99335
	I	0.92372	0.92894	1.00564	
5B	C	0.90560	0.90589	1.00032	0.99658
	I	0.89980	0.89701	0.99690	

Tables 6.A–6.L show the Medicare savings calculations for each cohort and Demonstration Year, taking into account the AGA adjustment factors (but still excluding the outlier adjustment). Column (a) displays the number of member months during the Demonstration Year for the intervention group for each category of beneficiary. Column (b) displays the PMPM during the baseline period for the intervention group beneficiaries. This is the starting PMPM to which the trend factor will be applied to determine the target PMPM. Column (c) is the trend factor obtained by multiplying the PMPM trend from the comparison group by the AGA adjustment factor. Column (d) is the target PMPM, which is the baseline PMPM in column (b) times the trends factor in column (c). Column (e) is the actual PMPM for the intervention group in the Demonstration Year. Column (f) shows the PMPM savings, which is the difference between the actual PMPM in column (e) and the target PMPM in column (d). Multiplying the number of eligible months in column (a) by the PMPM savings gives the total dollar savings of column (g). Finally, column (h) shows the corresponding percentage savings, which is the PMPM savings divided by the target PMPM.

Table 6.G displays the Medicare savings calculation for Cohort 1 in total. The baseline PMPM was $1,612.13. For Demonstration Year 3, the AGA adjusted trend from the comparison group was 1.185, resulting in a target PMPM of $1,910.14. The actual PMPM for the intervention group was $1,656.37, an increase of 2.74 percent over the $1,612.13 baseline PMPM. Because the intervention group PMPM costs increased at a slower rate than the comparison group costs, we estimate a PMPM Medicare savings of $253.78, a savings rate of

13.3 percent. The total calculated Medicare savings dollar amount was $25,244,175. For Demonstration Year 4, we estimate a PMPM Medicare savings of $163.92, or 8.4 percent, with total calculated dollar savings of $13,533,660.

For Demonstration Year 3, the same calculations for Cohort 2 (as shown in ***Table 6.H.1***) result in a PMPM negative Medicare savings of $10.69, or −0.6 percent, and a negative savings dollar amount of $46,097. For Demonstration Year 4 (as shown in ***Table 6.H.2***), the savings is $29.98 on a PMPM basis, 1.5 percent, and $104,218 total dollars.

For Cohort 3, Demonstration Year 3 savings (as shown in ***Table 6.I.1***) is $30.99 PMPM, or 2.1 percent, and $1,466,241 in total dollars. Demonstration Year 4 savings (as shown in ***Table 6.I.2***) is $147.66 PMPM, or 9.2 percent, and $5,570,452 in total dollars.

For Cohort 4, Demonstration Year 3 savings (as shown in ***Table 6.J.1***) is $269.85 PMPM, or 15.2 percent, and $16,317,609 in total dollars. Demonstration Year 4 savings (as shown in ***Table 6.J.2***) is $209.52 PMPM, or 12.3 percent, and $9,643,731 in total dollars.

For Cohort 5A, Demonstration Year 4 savings (as shown in ***Table 6.K***) is $189.60 PMPM, or 11.2 percent, and $12,023,413 in total dollars. For Cohort 5B, Demonstration Year 4 savings (as shown in ***Table 6.L***) is $150.95 PMPM, or 8.3 percent, and $7,266,147 in total dollars.

Table 6.A.1 — MEDICARE Demonstration Year 3
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1A

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**14,540.4**	**$2,652.67**	**1.235**	**$3,275.81**	**$2,479.39**	**$796.42**	**$11,580,231**	**24.3**
Facility, age 65+, with SPMI	231.9	$3,321.06	0.867	$2,879.18	$1,667.71	$1,211.47	$280,944	42.1
Facility, age 65+, no SPMI	356.4	$2,476.33	1.007	$2,494.37	$1,885.82	$608.55	$216,886	24.4
HCBS, age 65+, with SPMI	613.5	$2,903.67	1.268	$3,683.20	$2,696.69	$986.51	$605,273	26.8
HCBS, age 65+, no SPMI	2,687.8	$2,389.27	1.446	$3,454.82	$2,599.01	$855.80	$2,300,201	24.8
Community, age 65+, with SPMI	329.9	$2,067.95	1.394	$2,883.40	$1,406.88	$1,476.52	$487,144	51.2
Community, age 65+, no SPMI	2,577.6	$2,124.06	1.424	$3,023.72	$2,170.47	$853.25	$2,199,352	28.2
Facility, age <65, with SPMI	84.1	$5,306.80	0.830	$4,406.54	$1,791.81	$2,614.73	$220,028	59.3
Facility, age <65, no SPMI	215.0	$4,764.97	0.783	$3,729.49	$3,021.65	$707.84	$152,186	19.0
HCBS, age <65, with SPMI	1,254.4	$2,780.44	1.010	$2,809.25	$2,222.14	$587.11	$736,475	20.9
HCBS, age <65, no SPMI	3,118.2	$2,691.70	1.288	$3,468.22	$2,777.36	$690.86	$2,154,249	19.9
Community, age <65, with SPMI	951.2	$2,446.14	1.036	$2,533.98	$2,671.80	−$137.82	−$131,097	−5.4
Community, age <65, no SPMI	2,120.2	$3,319.71	1.117	$3,708.28	$2,595.86	$1,112.42	$2,358,590	30.0

Table 6.A.2 — MEDICARE Demonstration Year 4
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1A

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**12,196.5**	**$2,652.67**	**1.263**	**$3,351.18**	**$2,553.58**	**$797.59**	**$9,727,900**	**23.8**
Facility, age 65+, with SPMI	174.0	$3,321.06	0.863	$2,867.00	$2,310.01	$556.99	$96,897	19.4
Facility, age 65+, no SPMI	246.6	$2,476.33	0.969	$2,399.89	$1,412.25	$987.63	$243,532	41.2
HCBS, age 65+, with SPMI	442.2	$2,903.67	1.330	$3,860.87	$2,634.07	$1,226.80	$542,482	31.8
HCBS, age 65+, no SPMI	2,174.8	$2,389.27	1.545	$3,690.81	$2,592.37	$1,098.43	$2,388,897	29.8
Community, age 65+, with SPMI	278.3	$2,067.95	1.460	$3,018.75	$1,634.74	$1,384.01	$385,217	45.8
Community, age 65+, no SPMI	2,015.5	$2,124.06	1.567	$3,328.07	$2,668.02	$660.06	$1,330,341	19.8
Facility, age <65, with SPMI	69.0	$5,306.80	0.825	$4,378.56	$723.48	$3,655.08	$252,201	83.5
Facility, age <65, no SPMI	174.8	$4,764.97	0.831	$3,960.45	$2,659.92	$1,300.53	$227,268	32.8
HCBS, age <65, with SPMI	1,144.6	$2,780.44	0.925	$2,570.97	$1,841.19	$729.78	$835,300	28.4
HCBS, age <65, no SPMI	2,726.6	$2,691.70	1.219	$3,280.59	$2,575.24	$705.34	$1,923,198	21.5
Community, age <65, with SPMI	835.2	$2,446.14	1.013	$2,477.68	$3,359.66	−$881.98	−$736,671	−35.6
Community, age <65, no SPMI	1,915.0	$3,319.71	1.187	$3,942.09	$2,772.75	$1,169.34	$2,239,241	29.7

Table 6.B.1 — MEDICARE Demonstration Year 3
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1B

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**28,211.3**	**$1,298.08**	**1.205**	**$1,564.15**	**$1,418.47**	**$145.68**	**$4,109,802**	**9.3**
Facility, age 65+, with SPMI	595.9	$1,581.91	0.866	$1,369.38	$1,290.20	$79.18	$47,182	5.8
Facility, age 65+, no SPMI	963.4	$1,689.87	1.005	$1,698.18	$1,058.49	$639.69	$616,301	37.7
HCBS, age 65+, with SPMI	1,180.7	$1,412.22	1.267	$1,789.72	$1,772.51	$17.21	$20,314	1.0
HCBS, age 65+, no SPMI	4,851.2	$1,178.09	1.448	$1,706.14	$1,576.68	$129.46	$628,039	7.6
Community, age 65+, with SPMI	722.6	$1,140.11	1.394	$1,589.23	$1,231.07	$358.16	$258,821	22.5
Community, age 65+, no SPMI	5,795.9	$971.09	1.426	$1,384.89	$1,299.14	$85.75	$497,025	6.2
Facility, age <65, with SPMI	278.0	$3,244.58	0.813	$2,638.76	$1,381.08	$1,257.67	$349,633	47.7
Facility, age <65, no SPMI	152.7	$3,733.76	0.770	$2,873.73	$767.74	$2,105.99	$321,674	73.3
HCBS, age <65, with SPMI	2,672.0	$1,385.95	1.011	$1,400.52	$1,327.32	$73.20	$195,603	5.2
HCBS, age <65, no SPMI	3,788.8	$1,488.47	1.289	$1,919.28	$1,462.12	$457.16	$1,732,104	23.8
Community, age <65, with SPMI	3,177.1	$1,112.23	1.035	$1,151.51	$1,234.43	−$82.92	−$263,448	−7.2
Community, age <65, no SPMI	4,032.8	$1,390.75	1.117	$1,553.36	$1,626.13	−$72.76	−$293,447	−4.7

Table 6.B.2 — MEDICARE Demonstration Year 4
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1B

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**23,641.9**	**$1,298.08**	**1.234**	**$1,601.55**	**$1,593.22**	**$8.33**	**$196,932**	**0.5**
Facility, age 65+, with SPMI	424.0	$1,581.91	0.862	$1,363.28	$1,356.14	$7.14	$3,029	0.5
Facility, age 65+, no SPMI	651.8	$1,689.87	0.967	$1,634.34	$1,330.05	$304.29	$198,327	18.6
HCBS, age 65+, with SPMI	963.6	$1,412.22	1.328	$1,875.39	$1,344.42	$530.96	$511,623	28.3
HCBS, age 65+, no SPMI	3,912.7	$1,178.09	1.547	$1,822.59	$1,715.22	$107.38	$420,136	5.9
Community, age 65+, with SPMI	595.9	$1,140.11	1.459	$1,662.86	$1,720.01	−$57.15	−$34,057	−3.4
Community, age 65+, no SPMI	4,628.2	$971.09	1.570	$1,524.67	$1,605.29	−$80.62	−$373,135	−5.3
Facility, age <65, with SPMI	241.6	$3,244.58	0.823	$2,670.25	$1,299.91	$1,370.33	$331,034	51.3
Facility, age <65, no SPMI	130.4	$3,733.76	0.819	$3,056.42	$1,269.57	$1,786.84	$233,064	58.5
HCBS, age <65, with SPMI	2,473.5	$1,385.95	0.924	$1,281.05	$1,234.91	$46.14	$114,128	3.6
HCBS, age <65, no SPMI	3,391.1	$1,488.47	1.219	$1,813.96	$1,693.80	$120.15	$407,458	6.6
Community, age <65, with SPMI	2,709.9	$1,112.23	1.015	$1,128.95	$1,467.63	−$338.68	−$917,765	−30.0
Community, age <65, no SPMI	3,519.2	$1,390.75	1.187	$1,651.37	$1,849.40	−$198.03	−$696,909	−12.0

Table 6.C.1 — MEDICARE Demonstration Year 3
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1C

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**2,723.6**	**$993.94**	**1.238**	**$1,230.97**	**$1,252.11**	**−$21.14**	**−$57,574**	**−1.7**
Facility, age 65+, with SPMI	24.0	$2,437.80	0.863	$2,103.24	$65.66	$2,037.58	$48,902	96.9
Facility, age 65+, no SPMI	96.4	$1,615.10	1.001	$1,616.41	$1,025.97	$590.44	$56,926	36.5
HCBS, age 65+, with SPMI	165.1	$978.12	1.265	$1,237.01	$1,186.63	$50.39	$8,320	4.1
HCBS, age 65+, no SPMI	469.8	$905.53	1.451	$1,314.33	$1,475.96	−$161.63	−$75,939	−12.3
Community, age 65+, with SPMI	145.0	$1,509.16	1.376	$2,076.74	$1,834.13	$242.61	$35,178	11.7
Community, age 65+, no SPMI	677.4	$760.14	1.421	$1,080.06	$1,020.14	$59.92	$40,588	5.5
Facility, age <65, with SPMI	6.0	$4,384.61	0.891	$3,906.99	$7,863.92	−$3,956.93	−$23,614	−101.3
Facility, age <65, no SPMI	24.0	$10,040.68	0.700	$7,024.77	$5,520.18	$1,504.59	$36,110	21.4
HCBS, age <65, with SPMI	227.0	$739.84	1.006	$744.61	$628.56	$116.06	$26,345	15.6
HCBS, age <65, no SPMI	295.0	$880.51	1.286	$1,131.94	$977.46	$154.48	$45,578	13.6
Community, age <65, with SPMI	271.8	$832.44	1.035	$861.42	$1,328.97	−$467.54	−$127,082	−54.3
Community, age <65, no SPMI	322.0	$1,013.70	1.111	$1,126.56	$1,526.83	−$400.27	−$128,888	−35.5

Table 6.C.2 — MEDICARE Demonstration Year 4
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1C

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**2,117.5**	**$993.94**	**1.294**	**$1,286.45**	**$1,276.44**	**$10.02**	**$21,208**	**0.8**
Facility, age 65+, with SPMI	17.0	$2,437.80	0.868	$2,116.19	$890.67	$1,225.52	$20,834	57.9
Facility, age 65+, no SPMI	41.8	$1,615.10	0.962	$1,553.17	$626.66	$926.50	$38,753	59.7
HCBS, age 65+, with SPMI	125.3	$978.12	1.327	$1,297.52	$2,143.80	−$846.28	−$106,072	−65.2
HCBS, age 65+, no SPMI	356.9	$905.53	1.548	$1,401.33	$1,234.36	$166.97	$59,598	11.9
Community, age 65+, with SPMI	121.5	$1,509.16	1.444	$2,179.24	$800.29	$1,378.95	$167,609	63.3
Community, age 65+, no SPMI	467.6	$760.14	1.564	$1,189.17	$1,615.03	−$425.86	−$199,135	−35.8
Facility, age <65, with SPMI	12.0	$4,384.61	0.821	$3,598.95	$7,222.17	−$3,623.23	−$43,479	−100.7
Facility, age <65, no SPMI	24.0	$10,040.68	0.744	$7,469.77	$270.92	$7,198.86	$172,773	96.4
HCBS, age <65, with SPMI	207.4	$739.84	0.920	$680.64	$629.56	$51.07	$10,594	7.5
HCBS, age <65, no SPMI	249.2	$880.51	1.218	$1,072.32	$1,289.43	−$217.11	−$54,094	−20.2
Community, age <65, with SPMI	239.3	$832.44	1.014	$844.38	$1,108.31	−$263.93	−$63,164	−31.3
Community, age <65, no SPMI	255.3	$1,013.70	1.184	$1,200.24	$1,133.69	$66.55	$16,992	5.5

Table 6.D.1 — MEDICARE Demonstration Year 3
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1D

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**42,529.9**	**$1,696.25**	**1.195**	**$2,026.82**	**$1,722.38**	**$304.44**	**$12,947,823**	**15.0**
Facility, age 65+, with SPMI	700.2	$2,345.53	0.868	$2,035.70	$1,358.55	$677.15	$474,158	33.3
Facility, age 65+, no SPMI	1,809.9	$2,040.09	1.002	$2,044.52	$1,374.65	$669.88	$1,212,420	32.8
HCBS, age 65+, with SPMI	1,682.5	$2,012.00	1.267	$2,548.86	$1,924.54	$624.33	$1,050,437	24.5
HCBS, age 65+, no SPMI	7,170.9	$1,699.59	1.445	$2,455.92	$1,973.78	$482.14	$3,457,338	19.6
Community, age 65+, with SPMI	989.1	$1,450.66	1.393	$2,020.93	$1,607.67	$413.25	$408,729	20.4
Community, age 65+, no SPMI	6,412.1	$1,352.84	1.424	$1,927.03	$1,528.99	$398.04	$2,552,271	20.7
Facility, age <65, with SPMI	233.8	$3,271.35	0.820	$2,681.34	$2,125.80	$555.54	$129,887	20.7
Facility, age <65, no SPMI	487.0	$4,766.02	0.780	$3,717.53	$2,770.60	$946.93	$461,154	25.5
HCBS, age <65, with SPMI	3,394.5	$1,644.72	1.010	$1,661.27	$1,705.55	−$44.29	−$150,326	−2.7
HCBS, age <65, no SPMI	7,052.0	$1,817.35	1.288	$2,340.75	$1,902.21	$438.54	$3,092,564	18.7
Community, age <65, with SPMI	5,070.6	$1,327.43	1.034	$1,372.02	$1,222.79	$149.23	$756,677	10.9
Community, age <65, no SPMI	7,527.4	$1,578.14	1.118	$1,764.15	$1,830.24	−$66.09	−$497,486	−3.7

Table 6.D.2 — MEDICARE Demonstration Year 4
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1D

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**35,278.5**	**$1,696.25**	**1.214**	**$2,059.03**	**$1,846.13**	**$212.90**	**$7,510,627**	**10.3**
Facility, age 65+, with SPMI	479.9	$2,345.53	0.863	$2,024.16	$1,776.09	$248.07	$119,053	12.3
Facility, age 65+, no SPMI	1,197.6	$2,040.09	0.961	$1,961.24	$1,341.61	$619.63	$742,069	31.6
HCBS, age 65+, with SPMI	1,341.4	$2,012.00	1.329	$2,673.31	$2,157.80	$515.52	$691,518	19.3
HCBS, age 65+, no SPMI	5,705.5	$1,699.59	1.544	$2,624.55	$2,140.23	$484.32	$2,763,317	18.5
Community, age 65+, with SPMI	772.4	$1,450.66	1.456	$2,112.86	$1,378.41	$734.46	$567,301	34.8
Community, age 65+, no SPMI	5,229.4	$1,352.84	1.568	$2,121.53	$1,814.82	$306.70	$1,603,865	14.5
Facility, age <65, with SPMI	179.3	$3,271.35	0.819	$2,680.82	$1,455.52	$1,225.30	$219,645	45.7
Facility, age <65, no SPMI	330.1	$4,766.02	0.834	$3,976.47	$2,417.55	$1,558.92	$514,605	39.2
HCBS, age <65, with SPMI	3,123.1	$1,644.72	0.924	$1,519.89	$1,589.77	−$69.87	−$218,223	−4.6
HCBS, age <65, no SPMI	6,132.5	$1,817.35	1.219	$2,214.65	$1,989.00	$225.65	$1,383,809	10.2
Community, age <65, with SPMI	4,374.3	$1,327.43	1.012	$1,343.84	$1,470.22	−$126.38	−$552,821	−9.4
Community, age <65, no SPMI	6,413.0	$1,578.14	1.189	$1,876.30	$1,926.75	−$50.45	−$323,511	−2.7

Table 6.E.1 — MEDICARE Demonstration Year 3
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1E

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**5,500.6**	**$678.93**	**1.195**	**$811.32**	**$1,064.57**	**−$253.25**	**−$1,393,018**	**−31.2**
Facility, age 65+, with SPMI	48.0	$1,222.01	0.873	$1,067.14	$94.38	$972.76	$46,692	91.2
Facility, age 65+, no SPMI	283.9	$860.02	1.001	$861.18	$579.06	$282.12	$80,104	32.8
HCBS, age 65+, with SPMI	69.4	$682.88	1.258	$859.27	$3,012.54	−$2,153.27	−$149,372	−250.6
HCBS, age 65+, no SPMI	923.0	$808.12	1.445	$1,167.62	$1,347.25	−$179.63	−$165,806	−15.4
Community, age 65+, with SPMI	109.1	$771.30	1.386	$1,069.19	$1,095.62	−$26.43	−$2,882	−2.5
Community, age 65+, no SPMI	1,318.2	$534.63	1.424	$761.51	$828.54	−$67.02	−$88,351	−8.8
Facility, age <65, with SPMI	53.0	$422.56	0.817	$345.21	$2,635.08	−$2,289.87	−$121,363	−663.3
Facility, age <65, no SPMI	79.6	$1,235.18	0.783	$967.57	$1,586.41	−$618.84	−$49,247	−64.0
HCBS, age <65, with SPMI	324.4	$582.37	1.011	$588.74	$1,156.36	−$567.62	−$184,156	−96.4
HCBS, age <65, no SPMI	685.5	$573.21	1.289	$738.79	$1,337.45	−$598.66	−$410,367	−81.0
Community, age <65, with SPMI	714.9	$695.05	1.032	$717.58	$830.67	−$113.09	−$80,853	−15.8
Community, age <65, no SPMI	891.6	$608.17	1.113	$676.85	$976.79	−$299.94	−$267,415	−44.3

Table 6.E.2 — MEDICARE Demonstration Year 4
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1E

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**4,418.6**	**$678.93**	**1.217**	**$826.36**	**$1,217.64**	**−$391.28**	**−$1,728,929**	**−47.4**
Facility, age 65+, with SPMI	39.4	$1,222.01	0.861	$1,052.49	$627.72	$424.77	$16,736	40.4
Facility, age 65+, no SPMI	156.4	$860.02	0.958	$824.01	$1,880.63	−$1,056.61	−$165,263	−128.2
HCBS, age 65+, with SPMI	50.6	$682.88	1.321	$901.87	$1,325.09	−$423.22	−$21,407	−46.9
HCBS, age 65+, no SPMI	678.9	$808.12	1.542	$1,245.94	$1,674.73	−$428.79	−$291,095	−34.4
Community, age 65+, with SPMI	83.2	$771.30	1.454	$1,121.15	$1,335.36	−$214.21	−$17,815	−19.1
Community, age 65+, no SPMI	999.1	$534.63	1.568	$838.35	$1,051.08	−$212.73	−$212,532	−25.4
Facility, age <65, with SPMI	48.0	$422.56	0.821	$346.78	$1,955.82	−$1,609.04	−$77,234	−464.0
Facility, age <65, no SPMI	63.0	$1,235.18	0.826	$1,020.25	$987.36	$32.89	$2,072	3.2
HCBS, age <65, with SPMI	317.8	$582.37	0.925	$538.69	$1,032.27	−$493.58	−$156,880	−91.6
HCBS, age <65, no SPMI	589.8	$573.21	1.221	$699.62	$1,207.29	−$507.67	−$299,412	−72.6
Community, age <65, with SPMI	626.1	$695.05	1.015	$705.41	$884.67	−$179.26	−$112,239	−25.4
Community, age <65, no SPMI	766.4	$608.17	1.185	$720.69	$1,234.61	−$513.93	−$393,861	−71.3

Table 6.F.1 — MEDICARE Demonstration Year 3
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1F

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**5,968.2**	**$608.70**	**1.166**	**$709.68**	**$1,035.26**	**−$325.57**	**−$1,943,089**	**−45.9**
Facility, age 65+, with SPMI	53.5	$1,241.30	0.857	$1,063.60	$353.98	$709.62	$37,957	66.7
Facility, age 65+, no SPMI	199.2	$1,121.79	1.002	$1,123.75	$923.23	$200.52	$39,952	17.8
HCBS, age 65+, with SPMI	218.0	$803.19	1.257	$1,009.25	$1,893.58	−$884.34	−$192,785	−87.6
HCBS, age 65+, no SPMI	750.3	$690.94	1.439	$994.56	$1,135.84	−$141.29	−$106,014	−14.2
Community, age 65+, with SPMI	141.0	$719.43	1.386	$997.14	$925.57	$71.57	$10,091	7.2
Community, age 65+, no SPMI	1,474.7	$477.67	1.419	$677.78	$1,406.35	−$728.57	−$1,074,450	−107.5
Facility, age <65, with SPMI	60.0	$551.42	0.808	$445.44	$1,745.80	−$1,300.36	−$78,022	−291.9
Facility, age <65, no SPMI	47.7	$441.48	0.786	$347.00	$1,573.18	−$1,226.19	−$58,540	−353.4
HCBS, age <65, with SPMI	306.5	$725.74	1.010	$732.86	$801.90	−$69.04	−$21,161	−9.4
HCBS, age <65, no SPMI	883.4	$381.65	1.291	$492.76	$700.12	−$207.36	−$183,174	−42.1
Community, age <65, with SPMI	550.0	$779.84	1.034	$806.62	$768.52	$38.10	$20,955	4.7
Community, age <65, no SPMI	1,283.8	$489.77	1.116	$546.41	$809.62	−$263.21	−$337,898	−48.2

Table 6.F.2 — MEDICARE Demonstration Year 4
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1F

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**4,911.2**	**$608.70**	**1.195**	**$727.45**	**$1,174.20**	**−$446.75**	**−$2,194,077**	**−61.4**
Facility, age 65+, with SPMI	36.0	$1,241.30	0.858	$1,064.58	$428.27	$636.31	$22,907	59.8
Facility, age 65+, no SPMI	148.4	$1,121.79	0.960	$1,076.48	$1,167.58	−$91.11	−$13,522	−8.5
HCBS, age 65+, with SPMI	182.6	$803.19	1.319	$1,059.21	$2,391.37	−$1,332.16	−$243,312	−125.8
HCBS, age 65+, no SPMI	561.6	$690.94	1.537	$1,061.66	$1,171.48	−$109.82	−$61,677	−10.3
Community, age 65+, with SPMI	130.0	$719.43	1.449	$1,042.81	$679.60	$363.22	$47,218	34.8
Community, age 65+, no SPMI	1,151.3	$477.67	1.562	$746.25	$1,446.14	−$699.89	−$805,748	−93.8
Facility, age <65, with SPMI	47.0	$551.42	0.813	$448.13	$1,722.11	−$1,273.98	−$59,877	−284.3
Facility, age <65, no SPMI	36.0	$441.48	0.836	$368.97	$226.17	$142.80	$5,141	38.7
HCBS, age <65, with SPMI	263.2	$725.74	0.922	$669.17	$432.51	$236.66	$62,295	35.4
HCBS, age <65, no SPMI	770.6	$381.65	1.219	$465.37	$834.86	−$369.48	−$284,725	−79.4
Community, age <65, with SPMI	483.0	$779.84	1.012	$788.85	$1,309.56	−$520.70	−$251,499	−66.0
Community, age <65, no SPMI	1,101.5	$489.77	1.187	$581.11	$1,136.08	−$554.97	−$611,278	−95.5

Table 6.G.1 — MEDICARE Demonstration Year 3
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1 total

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**99,473.9**	**$1,612.13**	**1.185**	**$1,910.14**	**$1,656.37**	**$253.78**	**$25,244,175**	**13.3**
Facility, age 65+, with SPMI	1,653.5	$2,187.68	0.848	$1,855.30	$1,289.32	$565.98	$935,834	30.5
Facility, age 65+, no SPMI	3,709.3	$1,891.49	0.976	$1,846.62	$1,247.43	$599.19	$2,222,589	32.4
HCBS, age 65+, with SPMI	3,929.2	$1,892.37	1.230	$2,327.50	$1,985.91	$341.59	$1,342,187	14.7
HCBS, age 65+, no SPMI	16,853.1	$1,566.85	1.424	$2,231.95	$1,873.69	$358.26	$6,037,821	16.1
Community, age 65+, with SPMI	2,436.7	$1,375.13	1.390	$1,911.16	$1,419.89	$491.27	$1,197,081	25.7
Community, age 65+, no SPMI	18,255.9	$1,218.15	1.390	$1,693.26	$1,467.22	$226.03	$4,126,435	13.3
Facility, age <65, with SPMI	714.9	$3,424.47	0.735	$2,517.24	$1,850.66	$666.58	$476,550	26.5
Facility, age <65, no SPMI	1,006.1	$4,229.44	0.779	$3,293.40	$2,435.27	$858.13	$863,336	26.1
HCBS, age <65, with SPMI	8,178.9	$1,670.54	0.987	$1,649.37	$1,575.67	$73.70	$602,780	4.5
HCBS, age <65, no SPMI	15,822.9	$1,786.30	1.269	$2,266.91	$1,860.47	$406.43	$6,430,954	17.9
Community, age <65, with SPMI	10,735.7	$1,286.74	1.029	$1,324.24	$1,307.92	$16.32	$175,152	1.2
Community, age <65, no SPMI	16,177.8	$1,647.99	1.091	$1,797.16	$1,745.64	$51.52	$833,456	2.9

Table 6.G.2 — MEDICARE Demonstration Year 4
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 1 total

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**82,564.3**	**$1,612.13**	**1.212**	**$1,953.92**	**$1,790.00**	**$163.92**	**$13,533,660**	**8.4**
Facility, age 65+, with SPMI	1,170.2	$2,187.68	0.845	$1,849.13	$1,610.33	$238.80	$279,456	12.9
Facility, age 65+, no SPMI	2,442.6	$1,891.49	0.944	$1,784.72	$1,357.35	$427.37	$1,043,895	23.9
HCBS, age 65+, with SPMI	3,105.7	$1,892.37	1.276	$2,415.54	$1,972.86	$442.67	$1,374,831	18.3
HCBS, age 65+, no SPMI	13,390.5	$1,566.85	1.529	$2,395.35	$2,001.10	$394.25	$5,279,176	16.5
Community, age 65+, with SPMI	1,981.4	$1,375.13	1.452	$1,997.02	$1,434.03	$562.98	$1,115,472	28.2
Community, age 65+, no SPMI	14,491.1	$1,218.15	1.536	$1,870.90	$1,778.18	$92.72	$1,343,656	5.0
Facility, age <65, with SPMI	596.8	$3,424.47	0.738	$2,527.74	$1,485.08	$1,042.66	$622,290	41.2
Facility, age <65, no SPMI	758.3	$4,229.44	0.829	$3,508.21	$1,985.14	$1,523.07	$1,154,922	43.4
HCBS, age <65, with SPMI	7,529.7	$1,670.54	0.902	$1,506.93	$1,420.98	$85.95	$647,214	5.7
HCBS, age <65, no SPMI	13,859.7	$1,786.30	1.200	$2,144.05	$1,922.09	$221.96	$3,076,235	10.4
Community, age <65, with SPMI	9,267.9	$1,286.74	1.009	$1,298.24	$1,582.46	−$284.22	−$2,634,159	−21.9
Community, age <65, no SPMI	13,970.4	$1,647.99	1.168	$1,924.94	$1,908.43	$16.51	$230,673	0.9

Table 6.H.1 — MEDICARE Demonstration Year 3
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 2

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**4,312.1**	**$2,356.60**	**0.794**	**$1,872.28**	**$1,882.97**	**−$10.69**	**−$46,097**	**−0.6**
Facility, age 65+, with SPMI	32.0	$6,327.51	0.766	$4,845.90	$778.23	$4,067.67	$130,166	83.9
Facility, age 65+, no SPMI	139.5	$5,338.95	0.524	$2,799.02	$520.65	$2,278.37	$317,870	81.4
HCBS, age 65+, with SPMI	143.4	$1,791.38	0.988	$1,770.65	$2,088.66	−$318.02	−$45,599	−18.0
HCBS, age 65+, no SPMI	633.3	$2,315.40	1.123	$2,599.24	$1,900.73	$698.51	$442,358	26.9
Community, age 65+, with SPMI	137.9	$2,564.32	1.093	$2,802.52	$2,294.13	$508.38	$70,092	18.1
Community, age 65+, no SPMI	781.1	$2,029.05	0.890	$1,806.54	$1,123.69	$682.85	$533,363	37.8
Facility, age <65, with SPMI	53.0	$2,265.17	0.573	$1,297.63	$925.56	$372.07	$19,720	28.7
Facility, age <65, no SPMI	30.0	$9,194.32	0.562	$5,170.17	$2,589.28	$2,580.88	$77,427	49.9
HCBS, age <65, with SPMI	276.8	$2,892.19	0.606	$1,753.52	$2,095.07	−$341.55	−$94,544	−19.5
HCBS, age <65, no SPMI	718.1	$2,269.10	0.920	$2,087.04	$2,094.48	−$7.45	−$5,347	−0.4
Community, age <65, with SPMI	315.5	$2,048.38	0.685	$1,403.29	$999.59	$403.70	$127,373	28.8
Community, age <65, no SPMI	1,051.5	$1,441.79	0.778	$1,121.92	$2,661.59	−$1,539.67	−$1,618,973	−137.2

Table 6.H.2 — MEDICARE Demonstration Year 4
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 2

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**3,476.8**	**$2,356.60**	**0.865**	**$2,037.40**	**$2,007.42**	**$29.98**	**$104,218**	**1.5**
Facility, age 65+, with SPMI	36.0	$6,327.51	0.505	$3,194.46	$1,170.39	$2,024.08	$72,867	63.4
Facility, age 65+, no SPMI	125.4	$5,338.95	0.636	$3,394.24	$668.88	$2,725.36	$341,637	80.3
HCBS, age 65+, with SPMI	105.0	$1,791.38	1.213	$2,173.04	$1,324.68	$848.36	$89,078	39.0
HCBS, age 65+, no SPMI	492.2	$2,315.40	1.079	$2,498.51	$2,930.04	−$431.54	−$212,422	−17.3
Community, age 65+, with SPMI	98.5	$2,564.32	1.128	$2,891.36	$2,593.63	$297.73	$29,326	10.3
Community, age 65+, no SPMI	620.5	$2,029.05	1.094	$2,218.83	$1,446.74	$772.09	$479,044	34.8
Facility, age <65, with SPMI	50.0	$2,265.17	0.338	$766.42	$606.08	$160.34	$8,011	20.9
Facility, age <65, no SPMI	23.9	$9,194.32	0.439	$4,033.81	$7,509.35	−$3,475.54	−$83,189	−86.2
HCBS, age <65, with SPMI	261.0	$2,892.19	0.760	$2,198.40	$2,075.04	$123.36	$32,197	5.6
HCBS, age <65, no SPMI	571.3	$2,269.10	0.967	$2,195.02	$1,648.39	$546.63	$312,317	24.9
Community, age <65, with SPMI	268.3	$2,048.38	0.905	$1,853.20	$958.27	$894.93	$240,081	48.3
Community, age <65, no SPMI	824.8	$1,441.79	0.810	$1,168.54	$2,629.25	−$1,460.71	−$1,204,728	−125.0

Table 6.I.1 — MEDICARE Demonstration Year 3
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 3

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**47,319.8**	**$1,690.19**	**0.878**	**$1,483.35**	**$1,452.37**	**$30.99**	**$1,466,241**	**2.1**
Facility, age 65+, with SPMI	769.1	$2,546.62	0.718	$1,828.00	$1,306.85	$521.15	$400,810	28.5
Facility, age 65+, no SPMI	2,098.4	$2,124.41	0.676	$1,435.52	$977.92	$457.59	$960,206	31.9
HCBS, age 65+, with SPMI	2,019.5	$1,974.89	1.194	$2,358.46	$1,909.93	$448.53	$905,814	19.0
HCBS, age 65+, no SPMI	8,656.1	$1,772.34	1.024	$1,814.79	$1,740.36	$74.44	$644,321	4.1
Community, age 65+, with SPMI	1,654.6	$1,390.23	0.791	$1,099.90	$1,199.57	−$99.68	−$164,922	−9.1
Community, age 65+, no SPMI	9,526.2	$1,293.29	1.026	$1,326.32	$1,316.50	$9.82	$93,507	0.7
Facility, age <65, with SPMI	334.5	$4,619.24	0.595	$2,746.41	$2,605.01	$141.40	$47,292	5.1
Facility, age <65, no SPMI	555.5	$4,369.28	0.562	$2,455.24	$1,875.37	$579.86	$322,143	23.6
HCBS, age <65, with SPMI	3,041.2	$1,958.15	0.722	$1,414.41	$1,456.73	−$42.31	−$128,685	−3.0
HCBS, age <65, no SPMI	5,895.0	$1,868.23	0.864	$1,614.02	$1,706.13	−$92.11	−$542,983	−5.7
Community, age <65, with SPMI	4,904.2	$1,309.66	0.778	$1,019.24	$1,111.82	−$92.58	−$454,023	−9.1
Community, age <65, no SPMI	7,865.6	$1,466.46	0.845	$1,239.58	$1,318.05	−$78.47	−$617,241	−6.3

Table 6.I.2 — MEDICARE Demonstration Year 4
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 3

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**37,725.3**	**$1,690.19**	**0.949**	**$1,604.42**	**$1,456.76**	**$147.66**	**$5,570,452**	**9.2**
Facility, age 65+, with SPMI	585.9	$2,546.62	0.638	$1,624.09	$1,508.63	$115.46	$67,646	7.1
Facility, age 65+, no SPMI	1,329.2	$2,124.41	0.710	$1,507.64	$1,242.65	$264.99	$352,223	17.6
HCBS, age 65+, with SPMI	1,648.4	$1,974.89	1.165	$2,301.10	$1,734.07	$567.03	$934,664	24.6
HCBS, age 65+, no SPMI	6,588.3	$1,772.34	1.214	$2,151.82	$1,662.33	$489.49	$3,224,899	22.7
Community, age 65+, with SPMI	1,336.1	$1,390.23	0.763	$1,061.23	$1,126.15	−$64.92	−$86,740	−6.1
Community, age 65+, no SPMI	7,504.0	$1,293.29	1.032	$1,334.93	$1,229.25	$105.68	$793,046	7.9
Facility, age <65, with SPMI	288.2	$4,619.24	0.321	$1,484.39	$2,394.44	−$910.05	−$262,245	−61.3
Facility, age <65, no SPMI	474.7	$4,369.28	0.458	$1,999.39	$2,366.58	−$367.19	−$174,296	−18.4
HCBS, age <65, with SPMI	2,710.2	$1,958.15	0.770	$1,508.13	$1,460.70	$47.43	$128,546	3.1
HCBS, age <65, no SPMI	5,102.9	$1,868.23	0.982	$1,834.98	$1,687.57	$147.42	$752,244	8.0
Community, age <65, with SPMI	4,017.9	$1,309.66	0.860	$1,125.95	$1,253.81	−$127.87	−$513,757	−11.4
Community, age <65, no SPMI	6,139.7	$1,466.46	0.979	$1,435.71	$1,378.02	$57.69	$354,223	4.0

Table 6.J.1 — MEDICARE Demonstration Year 3
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 4

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**60,468.5**	**$1,742.42**	**1.019**	**$1,776.35**	**$1,506.50**	**$269.85**	**$16,317,609**	**15.2**
Facility, age 65+, with SPMI	2,161.3	$3,336.29	0.782	$2,608.35	$1,861.43	$746.91	$1,614,289	28.6
Facility, age 65+, no SPMI	2,128.4	$2,231.28	0.785	$1,750.47	$1,126.46	$624.01	$1,328,154	35.6
HCBS, age 65+, with SPMI	4,115.4	$2,410.48	1.111	$2,677.12	$2,048.60	$628.52	$2,586,606	23.5
HCBS, age 65+, no SPMI	9,486.1	$1,679.14	1.234	$2,071.30	$1,622.19	$449.11	$4,260,276	21.7
Community, age 65+, with SPMI	2,898.9	$1,908.28	0.907	$1,731.72	$1,474.73	$256.99	$744,969	14.8
Community, age 65+, no SPMI	12,887.2	$1,220.09	0.961	$1,172.78	$1,185.38	−$12.60	−$162,431	−1.1
Facility, age <65, with SPMI	614.6	$4,472.72	0.758	$3,389.34	$3,114.66	$274.68	$168,816	8.1
Facility, age <65, no SPMI	339.6	$3,253.09	0.682	$2,218.07	$3,368.37	−$1,150.29	−$390,620	−51.9
HCBS, age <65, with SPMI	4,454.0	$1,791.41	1.174	$2,102.43	$1,730.89	$371.54	$1,654,851	17.7
HCBS, age <65, no SPMI	6,053.6	$1,871.58	1.104	$2,065.70	$1,588.30	$477.40	$2,889,957	23.1
Community, age <65, with SPMI	7,159.5	$1,469.29	1.010	$1,483.36	$1,227.40	$255.96	$1,832,538	17.3
Community, age <65, no SPMI	8,169.9	$1,437.51	1.015	$1,459.62	$1,485.30	−$25.68	−$209,796	−1.8

Table 6.J.2 — MEDICARE Demonstration Year 4
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 4

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**46,028.7**	**$1,742.42**	**0.977**	**$1,701.59**	**$1,492.08**	**$209.52**	**$9,643,731**	**12.3**
Facility, age 65+, with SPMI	1,450.9	$3,336.29	0.714	$2,381.93	$1,310.30	$1,071.63	$1,554,856	45.0
Facility, age 65+, no SPMI	1,411.5	$2,231.28	0.664	$1,482.50	$997.70	$484.80	$684,287	32.7
HCBS, age 65+, with SPMI	3,182.4	$2,410.48	0.947	$2,281.63	$1,883.30	$398.33	$1,267,642	17.5
HCBS, age 65+, no SPMI	6,946.6	$1,679.14	1.248	$2,095.06	$1,717.94	$377.12	$2,619,701	18.0
Community, age 65+, with SPMI	2,257.1	$1,908.28	0.751	$1,432.37	$1,558.84	−$126.47	−$285,455	−8.8
Community, age 65+, no SPMI	9,837.2	$1,220.09	1.081	$1,318.90	$1,239.03	$79.87	$785,663	6.1
Facility, age <65, with SPMI	417.2	$4,472.72	0.637	$2,848.47	$2,490.96	$357.52	$149,156	12.6
Facility, age <65, no SPMI	252.1	$3,253.09	0.626	$2,036.39	$1,628.80	$407.59	$102,738	20.0
HCBS, age <65, with SPMI	3,765.4	$1,791.41	1.009	$1,808.16	$1,708.87	$99.29	$373,865	5.5
HCBS, age <65, no SPMI	5,013.5	$1,871.58	1.115	$2,086.01	$1,636.43	$449.57	$2,253,911	21.6
Community, age <65, with SPMI	5,408.1	$1,469.29	0.910	$1,336.38	$1,160.30	$176.08	$952,239	13.2
Community, age <65, no SPMI	6,086.7	$1,437.51	0.978	$1,405.69	$1,539.57	−$133.88	−$814,871	−9.5

Table 6.K — MEDICARE Demonstration Year 4
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 5A

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**63,414.2**	**$1,685.80**	**1.007**	**$1,697.52**	**$1,507.92**	**$189.60**	**$12,023,413**	**11.2**
Facility, age 65+, with SPMI	2,529.2	$3,172.02	0.841	$2,669.13	$1,727.07	$942.06	$2,382,680	35.3
Facility, age 65+, no SPMI	1,872.9	$2,002.58	0.840	$1,683.16	$1,107.63	$575.53	$1,077,892	34.2
HCBS, age 65+, with SPMI	6,299.1	$2,290.32	1.038	$2,378.03	$2,125.35	$252.68	$1,591,662	10.6
HCBS, age 65+, no SPMI	8,231.0	$1,765.13	1.217	$2,148.83	$1,694.06	$454.78	$3,743,247	21.2
Community, age 65+, with SPMI	4,813.2	$1,722.55	0.848	$1,460.35	$1,509.51	−$49.16	−$236,623	−3.4
Community, age 65+, no SPMI	11,384.8	$1,063.21	1.051	$1,117.17	$1,229.44	−$112.27	−$1,278,150	−10.0
Facility, age <65, with SPMI	767.7	$5,200.17	0.928	$4,823.20	$2,614.89	$2,208.31	$1,695,271	45.8
Facility, age <65, no SPMI	328.5	$3,572.15	0.686	$2,450.77	$2,038.33	$412.44	$135,501	16.8
HCBS, age <65, with SPMI	5,901.4	$2,114.39	1.233	$2,607.91	$1,792.55	$815.36	$4,811,789	31.3
HCBS, age <65, no SPMI	4,410.6	$1,390.02	1.022	$1,419.99	$1,536.83	−$116.84	−$515,352	−8.2
Community, age <65, with SPMI	9,590.5	$1,352.37	0.873	$1,180.33	$1,197.24	−$16.91	−$162,163	−1.4
Community, age <65, no SPMI	7,285.4	$1,206.74	0.893	$1,077.29	$1,245.07	−$167.78	−$1,222,342	−15.6

Table 6.L — MEDICARE Demonstration Year 4
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 5B

Category of beneficiary	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Percent savings
Total	**48,134.7**	**$1,729.10**	**1.056**	**$1,826.30**	**$1,675.35**	**$150.95**	**$7,266,147**	**8.3**
Facility, age 65+, with SPMI	3,032.1	$2,720.73	0.918	$2,497.49	$1,981.30	$516.18	$1,565,143	20.7
Facility, age 65+, no SPMI	1,729.1	$2,131.24	0.919	$1,957.70	$1,622.19	$335.51	$580,145	17.1
HCBS, age 65+, with SPMI	5,905.3	$1,931.80	1.049	$2,027.09	$1,850.10	$176.99	$1,045,173	8.7
HCBS, age 65+, no SPMI	6,539.3	$1,331.10	1.179	$1,569.52	$1,470.71	$98.81	$646,120	6.3
Community, age 65+, with SPMI	4,393.1	$1,691.40	1.042	$1,762.70	$1,562.85	$199.86	$877,999	11.3
Community, age 65+, no SPMI	10,565.1	$1,206.44	1.185	$1,429.10	$1,243.30	$185.80	$1,963,001	13.0
Facility, age <65, with SPMI	973.6	$4,189.90	0.807	$3,379.88	$2,821.54	$558.34	$543,619	16.5
Facility, age <65, no SPMI	455.5	$2,293.73	1.237	$2,837.06	$1,845.13	$991.93	$451,844	35.0
HCBS, age <65, with SPMI	4,197.3	$2,034.88	1.067	$2,171.71	$2,110.14	$61.57	$258,443	2.8
HCBS, age <65, no SPMI	2,831.0	$1,392.03	1.116	$1,554.04	$1,733.56	−$179.53	−$508,245	−11.6
Community, age <65, with SPMI	4,799.9	$1,752.61	0.996	$1,744.80	$1,746.94	−$2.13	−$10,228	−0.1
Community, age <65, no SPMI	2,713.2	$1,930.53	1.031	$1,990.73	$2,044.86	−$54.13	−$146,866	−2.7

Tables 7.A–7.C summarize the savings calculation (before the attributed savings and the outlier adjustment) by cohort for the entire Demonstration Year (1, 2, 3, and 4 combined) and Demonstration Years 3 and 4 separately.

Table 7.A shows that for all four Demonstration Years so far combined, the total savings before the outlier adjustment is $156.9 million or 9.9 percent.

Table 7.B shows that for Demonstration Year 3, the total savings was $25.2 million for Cohort 1, with the largest contributions to savings coming from Cohorts 1A and 1D. The three small sub-cohorts (1C, 1E, and 1F) produced negative savings. For Cohort 2, the savings was negative $46 thousand, for Cohort 3, the savings was $1.5 million and for Cohort 4, the savings was $16.3 million. The total savings before the outlier adjustment for Demonstration Year 3 was $43.0 million or 11.4 percent.

Table 7.C indicates that for Demonstration Year 4, the total savings before the outlier adjustment by cohort was $13.5 million (Cohort 1), $104 thousand (Cohort 2), $5.6 million (Cohort 3), $9.6 million (Cohort 4), $12.0 million (Cohort 5A) and $7.3 million (Cohort 5B) for a total of $48.1 million or 9.6 percent. Per the previous Washington Medicare Savings reports, total Demonstration Year 1 savings was $35.4 million or 9.4 percent and total Demonstration Year 2 savings was $30.4 million or 9.4 percent.

Table 7.A — MEDICARE
Summary of Demonstration Years 1, 2, 3 and 4 savings by cohort not including attributed savings and outlier adjustment

Cohort	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Savings percent = f/d
1A	77,387.2	$2,652.67	1.208	$3,205.45	$2,560.67	$644.78	$49,897,690	20.1
1B	141,482.1	$1,298.08	1.187	$1,540.37	$1,445.81	$94.56	$13,378,963	6.1
1C	13,291.0	$993.94	1.227	$1,219.54	$1,280.49	−$60.95	−$810,062	−5.0
1D	205,229.1	$1,696.25	1.182	$2,005.59	$1,744.30	$261.30	$53,625,420	13.0
1E	25,246.9	$678.93	1.184	$804.17	$1,110.48	−$306.31	−$7,733,414	−38.1
1F	26,625.8	$608.70	1.168	$711.19	$1,084.68	−$373.49	−$9,944,350	−52.5
1 total	489,262.0	$1,612.13	1.183	$1,907.05	$1,705.91	$201.15	$98,412,830	10.5
2	19,835.8	$2,356.60	0.843	$1,986.22	$1,935.15	$51.06	$1,012,874	2.6
3	144,368.2	$1,690.19	0.915	$1,546.80	$1,462.08	$84.72	$12,231,556	5.5
4	106,497.2	$1,742.42	1.001	$1,744.04	$1,500.27	$243.77	$25,961,340	14.0
5A	63,414.2	$1,685.80	1.007	$1,697.52	$1,507.92	$189.60	$12,023,413	11.2
5B	48,134.7	$1,729.10	1.056	$1,826.30	$1,675.35	$150.95	$7,266,147	8.3
Total 1,2,3,4&5A/B	871,512.1			$1,809.55	$1,629.51	$180.04	$156,911,038	9.9

Table 7.B — MEDICARE
Summary of Demonstration Year 3 savings by cohort not including attributed savings and outlier adjustment

Cohort	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Savings percent = f/d
1A	14,540.4	$2,652.67	1.235	$3,275.81	$2,479.39	$796.42	$11,580,231	24.3
1B	28,211.3	$1,298.08	1.205	$1,564.15	$1,418.47	$145.68	$4,109,802	9.3
1C	2,723.6	$993.94	1.238	$1,230.97	$1,252.11	−$21.14	−$57,574	−1.7
1D	42,529.9	$1,696.25	1.195	$2,026.82	$1,722.38	$304.44	$12,947,823	15.0
1E	5,500.6	$678.93	1.195	$811.32	$1,064.57	−$253.25	−$1,393,018	−31.2
1F	5,968.2	$608.70	1.166	$709.68	$1,035.26	−$325.57	−$1,943,089	−45.9
1 total	99,473.9	$1,612.13	1.185	$1,910.14	$1,656.37	$253.78	$25,244,175	13.3
2	4,312.1	$2,356.60	0.794	$1,872.28	$1,882.97	−$10.69	−$46,097	−0.6
3	47,319.8	$1,690.19	0.878	$1,483.35	$1,452.37	$30.99	$1,466,241	2.1
4	60,468.5	$1,742.42	1.019	$1,776.35	$1,506.50	$269.85	$16,317,609	15.2
Total 1,2,3&4	211,574.3			$1,775.68	$1,572.53	$203.15	$42,981,927	11.4

Table 7.C — MEDICARE
Summary of Demonstration Year 4 savings by cohort not including attributed savings and outlier adjustment

Cohort	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Savings percent = f/d
1A	12,196.5	$2,652.67	1.263	$3,351.18	$2,553.58	$797.59	$9,727,900	23.8
1B	23,641.9	$1,298.08	1.234	$1,601.55	$1,593.22	$8.33	$196,932	0.5
1C	2,117.5	$993.94	1.294	$1,286.45	$1,276.44	$10.02	$21,208	0.8
1D	35,278.5	$1,696.25	1.214	$2,059.03	$1,846.13	$212.90	$7,510,627	10.3
1E	4,418.6	$678.93	1.217	$826.36	$1,217.64	−$391.28	−$1,728,929	−47.4
1F	4,911.2	$608.70	1.195	$727.45	$1,174.20	−$446.75	−$2,194,077	−61.4
1 total	82,564.3	$1,612.13	1.212	$1,953.92	$1,790.00	$163.92	$13,533,660	8.4
2	3,476.8	$2,356.60	0.865	$2,037.40	$2,007.42	$29.98	$104,218	1.5
3	37,725.3	$1,690.19	0.949	$1,604.42	$1,456.76	$147.66	$5,570,452	9.2
4	46,028.7	$1,742.42	0.977	$1,701.59	$1,492.08	$209.52	$9,643,731	12.3
5A	63,414.2	$1,685.80	1.007	$1,697.52	$1,507.92	$189.60	$12,023,413	11.2
5B	48,134.7	$1,729.10	1.056	$1,826.30	$1,675.35	$150.95	$7,266,147	8.3
Total 1,2,3,4&5A/B	281,344.0			$1,787.18	$1,616.07	$171.11	$48,141,623	9.6

5.3 Outlier Adjustment

To ensure that a disproportionate number of high-cost beneficiaries were not having a disproportionate impact on either the intervention or the comparison group, we tabulated the costs of each beneficiary separately for the baseline and all Demonstration Years in order to identify outliers. We combined beneficiaries in the intervention and comparison groups for each cohort, ranked the per-beneficiary total Medicare expenditures and identified the threshold amount, the expenditure level which represented the 99th percentile per-beneficiary expenditures for each cohort in each of the analysis periods. The expenditures for any individual that exceed this threshold amount are truncated to the threshold amount. The costs above the threshold are subtracted from the total costs, and the PMPMs are recalculated by excluding the amounts above the threshold. ***Table 8*** shows the results of this tabulation. These results are used to make the outlier adjustment as shown in ***Table 9***, which has the same column headings as ***Table 7***. ***Table 9*** shows the outlier adjustment for each cohort and each Demonstration Year. For the intervention group PMPM in the baseline period and in the Demonstration Year, the truncated PMPMs are substituted for the untruncated PMPMs.

The comparison group trend is modified by a factor that is derived from the ratio of the trend for the truncated PMPMs to that of the untruncated PMPMs. For Cohort 1, the trend factor calculated from the comparison group from the baseline period to Demonstration Year 3 is 1.0789 (= $1,726.51 / $1,600.30) for the untruncated PMPMs, and it is 1.0434 (= $1,634.25 / $1,566.21) for the truncated PMPMs. The ratio of these trend factors is the outlier adjustment factor 0.96717 (= 1.0434 / 1.0789) that is to be applied to the comparison group trend. For Demonstration Year 4, the resulting outlier adjustment factor is 0.9729. For Cohort 2, the corresponding outlier adjustment factor for the comparison group trend is 0.9708 for Demonstration Year 3 and 0.9614 for Demonstration Year 4. For Cohort 3, the outlier adjustment factor is 0.9885 for Demonstration Year 3 and 0.9719 for Demonstration Year 4. For Cohort 4, the outlier adjustment factor is 0.9950 for Demonstration Year 3 and 0.9878 for Demonstration Year 4. For Cohort 5A, the outlier adjustment factor is 0.9973 for Demonstration Year 4 and for Cohort 5B, the outlier adjustment factor is 1.0015 for Demonstration Year 4.

Table 8 — MEDICARE Outlier adjustment data

Group / Year	Total number of beneficiaries	Number of beneficiaries in the top 1 percentile	Total PMPM	PMPM after truncating costs to the 99th percentile	Truncated PMPM/ total PMPM
		Cohort 1			
Intervention – Baseline	13,979	153	$1,612.13	$1,570.53	97.42%
Comparison – Baseline	23,233	219	$1,600.30	$1,566.21	97.87%
Intervention – Demo Year 3	13,979	158	$1,656.37	$1,585.47	95.72%
Comparison – Demo Year 3	23,233	215	$1,726.51	$1,634.25	94.66%
Comparison group trend factor DP3			1.07886	1.04344	0.96717
Intervention – Demo Year 4	13,979	183	$1,790.00	$1,689.56	94.39%
Comparison – Demo Year 4	23,233	190	$1,773.42	$1,688.56	95.21%
Comparison group trend factor DP4			1.10818	1.07812	0.97288
		Cohort 2			
Intervention – Baseline	690	10	$2,356.60	$2,280.88	96.79%
Comparison – Baseline	4,331	41	$1,607.19	$1,565.31	97.39%
Intervention – Demo Year 3	690	16	$1,882.97	$1,748.62	92.86%
Comparison – Demo Year 3	4,331	35	$1,353.00	$1,279.28	94.55%
Comparison group trend factor DP3			0.84184	0.81727	0.97081
Intervention – Demo Year 4	690	16	$2,007.42	$1,781.52	88.75%
Comparison – Demo Year 4	4,331	35	$1,459.82	$1,366.91	93.64%
Comparison group trend factor DP4			0.90831	0.87326	0.96141
		Cohort 3			
Intervention – Baseline	5,645	75	$1,690.19	$1,628.93	96.38%
Comparison – Baseline	6,444	46	$1,673.66	$1,643.68	98.21%
Intervention – Demo Year 3	5,645	77	$1,452.37	$1,370.64	94.37%
Comparison – Demo Year 3	6,444	44	$1,312.11	$1,273.79	97.08%
Comparison group trend factor DP3			0.78398	0.77496	0.98850

(continued)

Table 8 — MEDICARE Outlier adjustment data (continued)

Group / Year	Total number of beneficiaries	Number of beneficiaries in the top 1 percentile	Total PMPM	PMPM after truncating costs to the 99th percentile	Truncated PMPM/ total PMPM
Intervention – Demo Year 4	5,645	70	$1,456.76	$1,395.08	95.77%
Comparison – Demo Year 4	6,444	51	$1,364.04	$1,301.94	95.45%
Comparison group trend factor DP4			0.81500	0.79209	0.97188
		Cohort 4			
Intervention – Baseline	5,823	65	$1,742.42	$1,688.50	96.91%
Comparison – Baseline	7,219	66	$1,738.02	$1,696.19	97.59%
Intervention – Demo Year 3	5,823	54	$1,506.50	$1,457.21	96.73%
Comparison – Demo Year 3	7,219	77	$1,587.04	$1,541.16	97.11%
Comparison group trend factor DP3			0.91313	0.90860	0.99504
Intervention – Demo Year 4	5,823	63	$1,492.08	$1,433.26	96.06%
Comparison – Demo Year 4	7,219	68	$1,487.84	$1,434.32	96.40%
Comparison group trend factor DP4			0.85605	0.84561	0.98780
		Cohort 5A			
Intervention – Baseline	6,165	69	$1,685.80	$1,629.26	96.65%
Comparison – Baseline	5,469	48	$1,817.10	$1,769.83	97.40%
Intervention – Demo Year 4	6,165	51	$1,507.92	$1,446.23	95.91%
Comparison – Demo Year 4	5,469	66	$1,683.90	$1,635.75	97.14%
Comparison group trend factor DP4			0.92670	0.92424	0.99735
		Cohort 5B			
Intervention – Baseline	5,930	98	$1,729.10	$1,661.88	96.11%
Comparison – Baseline	20,441	166	$1,580.88	$1,527.80	96.64%
Intervention – Demo Year 4	5,930	81	$1,675.35	$1,600.68	95.54%
Comparison – Demo Year 4	20,441	183	$1,645.63	$1,592.70	96.78%
Comparison group trend factor DP4			1.04096	1.04248	1.00146

Table 9 — MEDICARE
Summary of Demonstration Years 3 and 4 savings by cohort, including the outlier adjustment but excluding attributed savings

Cohort	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Savings percent = f/d
Demonstration Years 1, 2, 3 and 4 Combined								
Cohort 1 – total	489,262.0	$1,612.13	1.182	$1,905.41	$1,704.27	$201.15	$98,414,181	10.6
Outlier adjusted	489,262.0	$1,570.53	1.159	$1,819.55	$1,634.73	$184.82	$90,425,060	10.2
Cohort 2	19,835.8	$1,612.13	1.232	$1,985.37	$1,934.30	$51.06	$1,012,897	2.6
Outlier adjusted	19,835.8	$1,570.53	1.207	$1,895.83	$1,821.15	$74.67	$1,481,163	3.9
Cohort 3	144,368.2	$1,612.13	0.959	$1,546.80	$1,462.08	$84.72	$12,231,556	5.5
Outlier adjusted	144,368.2	$1,570.53	0.934	$1,467.20	$1,402.17	$65.04	$9,389,073	4.4
Cohort 4	106,497.2	$1,742.42	1.001	$1,744.04	$1,500.27	$243.77	$25,961,340	14.0
Outlier adjusted	106,497.2	$1,688.50	0.993	$1,676.53	$1,446.86	$229.67	$24,459,283	13.7
Cohort 5A	63,414.2	$1,685.80	1.007	$1,697.52	$1,507.92	$189.60	$12,023,413	11.2
Outlier adjusted	63,414.2	$1,629.26	1.004	$1,636.23	$1,446.23	$190.00	$12,048,892	11.6
Cohort 5B	48,134.7	$1,729.10	1.056	$1,826.30	$1,675.35	$150.95	$7,266,147	8.3
Outlier adjusted	48,134.7	$1,661.88	1.058	$1,757.86	$1,600.68	$157.18	$7,565,731	8.9
Cohorts 1+2+3+4+5A/B	871,512.1			$1,808.61	$1,628.57	$180.04	$156,909,535	10.0
Outlier Adjusted	871,512.1			$1,728.69	$1,561.89	$166.80	$145,369,202	9.6
Demonstration Year 3								
Cohort 1 – total	99,473.9	$1,612.13	1.185	$1,910.14	$1,656.37	$253.78	$25,244,175	13.3
Outlier adjusted	99,473.9	$1,570.53	1.146	$1,799.76	$1,585.47	$214.29	$21,316,089	11.9
Cohort 2	4,312.1	$2,356.60	0.794	$1,872.28	$1,882.97	−$10.69	−$46,097	−0.6
Outlier adjusted	4,312.1	$2,280.88	0.771	$1,759.23	$1,748.62	$10.61	$45,754	0.6
Cohort 3	47,319.8	$1,690.19	0.878	$1,483.35	$1,452.37	$30.99	$1,466,241	2.1
Outlier adjusted	47,319.8	$1,628.93	0.868	$1,413.15	$1,370.64	$42.52	$2,011,822	3.0

(continued)

Table 9 — MEDICARE (continued)
Summary of Demonstration Years 3 and 4 savings by cohort,
including the outlier adjustment but excluding attributed savings

Cohort	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Savings percent = f/d
Cohort 4	60,468.5	1,742.4	1.019	$1,776.35	$1,506.50	$269.85	$16,317,609	15.2
Outlier adjusted	60,468.5	$1,688.50	1.014	$1,712.85	$1,457.21	$255.64	$15,457,893	14.9
Cohorts 1+2+3+4	211,574.3			$1,775.68	$1,572.53	$203.15	$42,981,927	11.4
Outlier Adjusted	211,574.3			$1,687.63	$1,504.09	$183.54	$38,831,557	10.9
				Demonstration Year 4				
Cohort 1 – total	82,564.3	$1,612.13	1.212	$1,953.92	$1,790.00	$163.92	$13,533,660	8.4
Outlier adjusted	82,564.3	$1,570.53	1.179	$1,851.87	$1,689.56	$162.31	$13,401,278	8.8
Cohort 2	3,476.8	$2,356.60	0.865	$2,037.40	$2,007.42	$29.98	$104,218	1.5
Outlier adjusted	3,476.8	$2,280.88	0.831	$1,895.83	$1,781.52	$114.31	$397,435	6.0
Cohort 3	37,725.3	$1,690.19	0.949	$1,604.42	$1,456.76	$147.66	$5,570,452	9.2
Outlier adjusted	37,725.3	$1,628.93	0.923	$1,502.79	$1,395.08	$107.71	$4,063,279	7.2
Cohort 4	46,028.7	1,742.4	0.977	$1,701.59	$1,492.08	$209.52	$9,643,731	12.3
Outlier adjusted	46,028.7	$1,688.50	0.965	$1,628.82	$1,433.26	$195.56	$9,001,390	12.0
Cohort 5A	63,414.2	1,685.8	1.007	$1,697.52	$1,507.92	$189.60	$12,023,413	11.2
Outlier adjusted	63,414.2	$1,629.26	1.004	$1,636.23	$1,446.23	$190.00	$12,048,892	11.6
Cohort 5B	48,134.7	$1,729.10	1.056	$1,826.30	$1,675.35	$150.95	$7,266,147	8.3
Outlier adjusted	48,134.7	$1,661.88	1.058	$1,757.86	$1,600.68	$157.18	$7,565,731	8.9
Cohorts 1+2+3+4+5A/B	281,344.0			$1,787.18	$1,616.07	$171.11	$48,141,623	9.6
Outlier Adjusted	281,344.0			$1,704.43	$1,539.23	$165.20	$46,478,006	9.7

Table 10 — MEDICARE
Summary of Demonstration Years 3 and 4 savings by cohort,
After all adjustments including the outlier adjustment and attributed savings

Cohort	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Savings percent = f/d
Demonstration Years 1, 2, 3 and 4 Combined (outlier adjusted)								
Cohort 1	489,262.0	$1,570.53	1.159	$1,819.55	$1,634.73	$184.82	$90,425,060	10.2
Cohort 2	19,835.77	$1,570.53	1.207	$1,895.83	$1,821.15	$74.67	$1,481,163	3.94
Cohort 3	144,368.23	$1,570.53	0.934	$1,467.20	$1,402.17	$65.04	$9,389,073	4.43
Cohort 4	106,497.18	$1,688.50	0.993	$1,676.53	$1,446.86	$229.67	$24,459,283	13.70
Cohort 5A	63,414.24	$1,629.26	1.004	$1,636.23	$1,446.23	$190.00	$12,048,892	11.61
Cohort 5B	48,134.66	$1,661.88	1.058	$1,757.86	$1,600.68	$157.18	$7,565,731	8.94
Cohorts 1+2+3+4+5A/B	871,512.12			$1,728.69	$1,561.89	$166.80	$145,369,202	**9.65**
Attributed Savings								
Cohort 2	1,809.40	$1,817.45				$161.78	$292,723	8.90
Cohort 3	36,294.60	$1,365.18				$75.52	$2,740,977	5.50
Cohort 4	35,488.55	$1,478.37				$55.51	$1,970,085	3.76
Cohort 5A	35,843.05	$1,442.97				$215.36	$7,719,063	14.92
Cohort 6A Estimate	28,745.64					$190.00	$5,461,756	
Cohort 6B Estimate	20,497.17					$157.18	$3,221,713	
Cohorts 1+2+3+4	1,030,190.53						**$166,775,519**	
Demonstration Year 1 (outlier adjusted)								
Cohort 1	190,783.10	$1,566.42	1.169	$1,830.64	$1,667.68	$162.96	$31,089,525	8.90
Cohort 2	6,799.00	$2,288.30	0.893	$2,043.13	$1,930.11	$113.02	$768,444	5.50
Cohorts 1+2	197,582.10			$1,837.95	$1,676.71	$161.24	$31,857,968	8.80

(continued)

Table 10 — MEDICARE (continued)
Summary of Demonstration Years 3 and 4 savings by cohort,
After all adjustments including the outlier adjustment and attributed savings

Cohort	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Savings percent = f/d
Attributed Savings								
Cohort 2	1,809.40	$1,817.45				$161.78	$292,723	8.90
Cohort 3	36,294.60	$1,365.18				$75.52	$2,740,977	5.50
Cohorts 1+2+3	235,686.10	$1,558.18				$148.04	**$34,891,668**	
Demonstration Year 2 (outlier adjusted)								
Cohort 1	116,440.81	$1,566.42	1.155	$1,809.13	$1,597.70	$211.42	$24,618,168	11.69
Cohort 2	5,247.88	$2,288.30	0.796	$1,821.17	$1,769.81	$51.36	$269,530	2.82
Cohort 3	59,323.07	$1,627.53	0.914	$1,487.69	$1,431.82	$55.86	$3,313,972	3.76
Cohorts 1+2+3	181,011.76			$1,704.13	$1,548.33	$155.80	$28,201,670	9.14
Attributed Savings								
Cohort 4	35,488.55	$1,478.37				$55.51	$1,970,085	3.76
Cohorts 1+2+3+4	216,500.31					$139.36	**$30,171,755**	
Demonstration Year 3 (outlier adjusted)								
Cohort 1	99,473.87	$1,570.53	1.146	$1,799.76	$1,585.47	$214.29	$21,316,089	11.91
Cohort 2	4,312.07	$2,280.88	0.771	$1,759.23	$1,748.62	$10.61	$45,754	0.60
Cohort 3	47,319.84	$1,628.93	0.868	$1,413.15	$1,370.64	$42.52	$2,011,822	3.01
Cohort 4	60,468.49	$1,688.50	1.014	$1,712.85	$1,457.21	$255.64	$15,457,893	14.92
Cohorts 1+2+3+4	211,574.27			$1,687.63	$1,504.09	$183.54	$38,831,557	10.88
Attributed Savings								
Cohort 5A	35,843.05	$1,442.97				$215.36	$7,719,063	14.92
Cohorts 1+2+3+4+5	247,417.32					$188.15	**$46,550,620**	

(continued)

Table 10 — MEDICARE (continued)
Summary of Demonstration Years 3 and 4 savings by cohort,
After all adjustments including the outlier adjustment and attributed savings

Cohort	(a) Number of eligible months	(b) Baseline period PMPM from intervention group	(c) AGA adjusted cost trend from comparison group	(d) Target Demonstration Year PMPM	(e) Actual Demonstration Year PMPM for intervention group	(f) PMPM savings = (d) – (e)	(g) Total savings = (a) * (f)	(h) Savings percent = f/d
Demonstration Year 4 (outlier adjusted)								
Cohort 1	82,564.26	$1,570.53	1.179	$1,851.87	$1,689.56	$162.31	$13,401,278	8.76
Cohort 2	3,476.82	$2,280.88	0.831	$1,895.83	$1,781.52	$114.31	$397,435	6.03
Cohort 3	37,725.32	$1,628.93	0.923	$1,502.79	$1,395.08	$107.71	$4,063,279	7.17
Cohort 4	46,028.69	$1,688.50	0.965	$1,628.82	$1,433.26	$195.56	$9,001,390	12.01
Cohort 5A	63,414.24	$1,629.26	1.004	$1,636.23	$1,446.23	$190.00	$12,048,892	11.61
Cohort 5B	48,134.66	$1,661.88	1.058	$1,757.86	$1,600.68	$157.18	$7,565,731	8.94
Cohorts 1+2+3+4+5A/B	281,343.99			$1,704.43	$1,539.23	$165.20	$46,478,006	9.69
Attributed Savings								
Cohort 6A Estimate	28,745.64					$190.00	$5,461,756	
Cohort 6B Estimate	20,497.17					$157.18	$3,221,713	
Cohorts 1 to 6A/B	330,586.80					$166.86	**$55,161,475**	

5.4 Attributed Medicare Savings

Cohort 1 consists of those who are eligible for the demonstration on the start date of July 1, 2013. On every successive January 1, a new cohort is formed from those newly eligible for the demonstration. According to the Final Demonstration Agreement, for each cohort after the first, the savings percentage calculated for beneficiaries in the prior cohort will be attributed to those months in the current cohort that are during the demonstration and for which beneficiaries are eligible for the demonstration but prior to the start date of the current cohort. For Cohort 2, this consists of the months July through December 2013. For Cohort 3, this consists of the months January 2014 through December 2014. For Cohort 4, this consists of the months January through December 2015. For Cohort 5A, this consists of the months January through December 2016. For Cohort 6A, this consists of the months January through December 2017. For Cohort 6B, this consists of the months April through December 2017.

Note that there is no potential attributed savings for Cohort 5B beneficiaries. They were all immediately eligible upon expansion of the demonstration to the new service area. As there is no attributed savings for Cohort 1 prior to the start of Demonstration Year 1, there is also no attributed savings for Cohort 5B. During the baseline period, all months for which a beneficiary meets the basic eligibility requirements are included in determining the baseline PMPMs, and those months for which WA also flagged demonstration eligibility are included in the attributed savings calculation for newly eligible cohorts.

Table 10 shows the amount of attributed Medicare savings for Cohorts 2, 3, 4 and 5. For Cohort 2, there were 1,809.4 months of eligibility during the months July through December 2013 and the PMPM during those months was $1,817.45. The savings percentage for Cohort 1 during Demonstration Year 1 was 8.9 percent. Applying the 8.9 percent to the $1,817.45 PMPM yields attributed Medicare savings of $161.78 PMPM. Multiplying this savings PMPM by the months of eligibility results in $292,723 of attributed Medicare savings.

Cohort 3 experienced 36,294.6 months of eligibility during the period January through December 2014 and a PMPM of $1,365.18. The savings percentage for Cohort 2 during this period was 5.5 percent. Applying a similar calculation as was done for Cohort 2 results in a PMPM savings of $75.52 and aggregate attributed savings of $2,740,977.

Cohort 4 experienced 35,488.55 months of eligibility during the period of January through December 2015 and a PMPM of $1,478.37. The savings percentage for Cohort 3 during this period was 3.76 percent. Applying this percentage to Cohort 4 experience yields a PMPM savings of $55.51 and aggregate attributed savings of $1,970,085.

Cohort 5A experienced 35,843.05 months of eligibility during the period of January through December 2016 and a PMPM of $1,442.97. The savings percentage for Cohort 4 during this period was 14.92 percent. Applying this percentage to Cohort 5A experience yields a PMPM savings of $215.36 and aggregate attributed savings of $7,719,063.

Cohort 6A consists of those individuals whose experience will be added to the Demonstration Year 5 savings calculation on January 1, 2018, after becoming eligible for the demonstration during calendar year 2017 and Cohort 6B consists of those individuals whose experience will be added to the Demonstration Year 4 savings calculation on January 1, 2018,

after becoming eligible for the demonstration during the period of April 1, 2017 through December 31, 2017. Cohort 6A has an estimated 4,726 beneficiaries who had 28,745.64 months of eligibility during calendar year 2017 and the PMPM savings determined for Cohort 5A was $190.00. This results in $5,461,756 savings being preliminarily attributed to Cohort 6A. Cohort 6B has an estimated 3,279 beneficiaries who had 20,497.17 months of eligibility during the period April 1, 2017 through December 31, 2017 and the PMPM savings determined for Cohort 5B was $157.18. This results in $3,221,713 savings being preliminarily attributed to Cohort 6B. Additionally, please note the preliminary nature of the attributed savings for Cohorts 6A and 6B.

The attributed savings methodology has greater potential volatility than all other aspects of the savings analysis between the preliminary and final results due to the fact that there is not yet a PMPM with which to apply the previous cohort savings percentage and we instead are applying the previous cohort PMPM savings to the estimated number of eligible months. This may provide a rough estimation of the attributed savings that will eventually be calculated with adequate claims runout and retroactive eligibility adjustment but should not be relied on as a precise estimate of attributed savings.

5.5 Summary of Total Gross Medicare Savings

Table 9 summarizes the savings calculation by cohort including the outlier adjustment. For the four Demonstration Years to date combined, the outlier adjustment reduced the total Medicare savings by about $11.5 million. Medicare savings were reduced for Cohorts 1, 3 and 4, but increased for Cohorts 2 and 5B, and remained effectively constant for Cohort 5A. The reduction was $8.0 million for Cohort 1 ($98.4 million to $90.4 million), $2.8 million for Cohort 3 ($12.2 million to $9.4 million), $1.5 million for Cohort 4 ($26.0 million to $24.5 million). The increase was $468 thousand for Cohort 2 and $300 thousand for Cohort 5B. The total reduction across all cohorts 1–5B in ***Table 9*** was $11.5 million ($156.9 million to $145.4 million). Across all five cohorts and all four Demonstration Years, total Medicare savings after the outlier adjustment was $145.4 million, or 9.6 percent.

Table 10 summarizes total gross Medicare savings calculations, including the attributed savings from Cohorts 2, 3, 4, 5A, 6A and 6B. Attributed savings are $0.3 million, $2.7 million, $2.0 million, and $7.7 million for Cohorts 2, 3, 4 and 5A and estimated to be $5.5 million and $3.2 million for Cohorts 6A and 6B, respectively, bringing the total Medicare savings for all five cohorts to $166.8 million, of which $34.9 million was for Demonstration Year 1, $30.2 million was for Demonstration Year 2, $46.6 million was for Demonstration Year 3 and $55.2 million was for Demonstration Year 4.

The Medicare savings for Demonstration Year 3, $46,550,620 (*Table 10*), is now considered to be final. The Medicare savings for Demonstration Year 4 is considered to be preliminary and will be updated in a future report. Demonstration Year 4 savings will be updated to include any retroactive adjustments to claims and eligibility for beneficiaries in both the intervention and comparison groups.

5.6 Additional Analysis

Tables 11 (A, B, C and D) show additional analysis of the savings by month for Demonstration Years 3 and 4 for each cohort. ***Tables 12 (A and B)*** show additional results of the savings by type of service for all cohorts combined for each Demonstration Year. These tables include the AGA adjustment but not the outlier adjustment (which cannot be applied by month or by type of service) nor the attributed savings. ***Tables 11*** show, for each month of the Demonstration Year, the target PMPM, the actual intervention PMPM, and the ratio of the demonstration PMPM to the target PMPM (or, the D/T ratio). A ratio less than 1.00 shows savings, whereas a ratio greater than 1.00 shows negative savings.

It can be seen that the D/T ratio is significantly under 1.00 for Cohort 1 in most months. The average over all 24 months is 0.89 and the average for the last 6 months is 0.95. The D/T ratio for Cohort 2 varies widely, and is not surprising given the small size of the cohort. The average over the 24 months of Cohort 2 is 1.00 and the average over the last 6 months is 1.01. For Cohort 3, the D/T ratio shows one outlier month on the high side of 1.10 in November 2016 and on the low side of 0.74 in February 2017 but is otherwise generally close to 1.00. The average over the 24 months of operations is 0.95 and over the last 6 months is 0.91. For Cohort 4, the ratio is consistently less than 1.00. The average over the 24 months of operation is 0.86 and over the last 6 months is 0.89. For Cohort 5A, the ratio is consistently less than 1.00. The average over the 12 months of operation is 0.89. For Cohort 5B, the ratio is consistently less than 1.00. The average over the 9 months of operation is 0.92.

Table 12 shows the D/T ratio by type of service. For all cohorts and both Demonstration Years, the lowest D/T ratio is for hospice services. However, in dollar terms, significant savings were achieved for home health agency costs, inpatient hospital costs, and professional services. Increased costs were experienced for outpatient hospital services and SNF services.

Tables 13.A and ***B*** show more detail on the savings by type of service by Demonstration Year and category of beneficiary for all cohorts combined. The savings by type of service are similar for Demonstration Year 3 and Demonstration Year 4, and in line with what was previously seen in Demonstration Years 1 and 2.

Table 11.A — MEDICARE
PMPM costs for intervention and comparison groups, by month: Cohort 1

	Intervention group		PMPM			
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	Ratio (D/T)
Baseline	$484,510,829	300,541.1	$1,612	$1,592	$1,612	1.00
Jan-2016	$14,775,101	8,944.8	$1,652	$1,807	$1,870	0.88
Feb-2016	$13,817,364	8,813.7	$1,568	$1,856	$1,915	0.82
Mar-2016	$15,432,436	8,702.0	$1,773	$1,950	$2,015	0.88
Apr-2016	$14,363,894	8,588.2	$1,673	$1,982	$2,043	0.82
May-2016	$14,954,834	8,470.6	$1,765	$1,818	$1,874	0.94
Jun-2016	$13,313,939	8,338.8	$1,597	$1,986	$2,040	0.78
Jul-2016	$12,700,467	8,132.8	$1,562	$1,819	$1,866	0.84
Aug-2016	$13,516,533	8,054.7	$1,678	$1,902	$1,958	0.86
Sep-2016	$13,162,083	7,942.7	$1,657	$1,779	$1,835	0.90
Oct-2016	$13,324,288	7,941.7	$1,678	$1,747	$1,797	0.93
Nov-2016	$12,493,618	7,832.9	$1,595	$1,767	$1,823	0.88
Dec-2016	$12,910,565	7,710.8	$1,674	$1,813	$1,864	0.90
Jan-2017	$12,842,571	7,636.7	$1,682	$1,856	$1,913	0.88
Feb-2017	$11,730,194	7,488.7	$1,566	$1,763	$1,819	0.86
Mar-2017	$13,650,526	7,455.5	$1,831	$2,023	$2,074	0.88
Apr-2017	$12,781,675	7,406.5	$1,726	$1,936	$1,981	0.87
May-2017	$13,148,493	7,056.5	$1,863	$2,018	$2,075	0.90
Jun-2017	$12,638,870	6,815.9	$1,854	$1,970	$2,031	0.91
Jul-2017	$12,303,194	6,703.0	$1,835	$1,764	$1,823	1.01
Aug-2017	$12,719,103	6,622.9	$1,920	$1,994	$2,061	0.93
Sep-2017	$11,614,466	6,512.3	$1,783	$1,843	$1,908	0.93
Oct-2017	$12,452,203	6,383.8	$1,951	$1,995	$2,060	0.95
Nov-2017	$11,403,287	6,295.1	$1,811	$1,725	$1,794	1.01
Dec-2017	$10,505,564	6,187.3	$1,698	$1,837	$1,896	0.90
Total	$312,555,264	182,038.1	$1,717	$1,873	$1,930	0.89

Table 11.B — MEDICARE
PMPM costs for intervention and comparison groups, by month: Cohort 2

Month/Year	Intervention group		PMPM			Ratio (D/T)
	Incurred claims	Eligible months	Intervention	Comparison	Target	
Baseline	$9,945,769	4,220.4	$2,357	$1,740	$2,357	1.00
Jan-2016	$888,447	389.6	2,280.3	1,227.7	$1,670	1.37
Feb-2016	$686,917	385.0	1,784.2	1,447.2	$1,989	0.90
Mar-2016	$754,802	381.6	1,977.9	1,429.7	$1,935	1.02
Apr-2016	$679,991	377.0	1,803.7	1,382.6	$1,820	0.99
May-2016	$733,640	376.5	1,948.7	1,325.6	$1,795	1.09
Jun-2016	$729,222	366.9	1,987.3	1,401.1	$1,852	1.07
Jul-2016	$610,822	354.4	1,723.4	1,532.9	$2,064	0.83
Aug-2016	$674,175	348.6	1,933.7	1,297.1	$1,728	1.12
Sep-2016	$776,457	342.3	2,268.1	1,419.6	$1,869	1.21
Oct-2016	$626,949	335.1	1,870.8	1,291.1	$1,764	1.06
Nov-2016	$556,325	329.8	1,686.9	1,447.3	$1,971	0.86
Dec-2016	$401,746	325.1	1,235.8	1,475.2	$2,035	0.61
Jan-2017	$642,059	322.6	1,990.0	1,329.4	$1,788	1.11
Feb-2017	$600,940	316.4	1,899.1	1,193.3	$1,708	1.11
Mar-2017	$581,120	310.9	1,868.9	1,767.3	$2,420	0.77
Apr-2017	$567,267	305.9	1,854.6	1,653.8	$2,301	0.81
May-2017	$725,179	288.8	2,510.7	1,781.3	$2,486	1.01
Jun-2017	$607,428	282.5	2,150.2	1,414.3	$1,928	1.12
Jul-2017	$665,382	283.0	$2,351	$1,298	$1,743	1.35
Aug-2017	$462,130	278.8	$1,658	$1,593	$2,082	0.80
Sep-2017	$452,174	276.0	$1,638	$1,240	$1,709	0.96
Oct-2017	$557,963	271.7	$2,054	$1,585	$2,126	0.97
Nov-2017	$481,570	272.9	$1,765	$1,540	$2,104	0.84
Dec-2017	$636,242	267.3	$2,381	$1,511	$2,057	1.16
Total	$15,098,947	7,788.9	$1,939	$1,434	$1,946	1.00

Table 11.C — MEDICARE
PMPM costs for intervention and comparison groups, by month: Cohort 3

	Intervention group		PMPM			Ratio
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	(D/T)
Baseline	$103,440,434	61,200.6	$1,690	$1,520	$1,690	1.00
Jan-2016	$5,897,208	4,330.1	1,361.9	1,260.6	$1,434	0.95
Feb-2016	$5,923,845	4,254.3	1,392.4	1,188.9	$1,350	1.03
Mar-2016	$7,305,830	4,183.5	1,746.3	1,450.3	$1,646	1.06
Apr-2016	$6,369,944	4,114.2	1,548.3	1,386.7	$1,567	0.99
May-2016	$6,309,502	4,032.3	1,564.7	1,320.0	$1,511	1.04
Jun-2016	$5,159,471	3,959.3	1,303.1	1,289.8	$1,457	0.89
Jul-2016	$5,034,560	3,857.2	1,305.2	1,306.3	$1,486	0.88
Aug-2016	$6,015,218	3,807.1	1,580.0	1,425.0	$1,642	0.96
Sep-2016	$5,024,006	3,734.8	1,345.2	1,218.6	$1,391	0.97
Oct-2016	$5,153,305	3,729.4	1,381.8	1,306.6	$1,480	0.93
Nov-2016	$5,541,076	3,677.1	1,506.9	1,224.1	$1,370	1.10
Dec-2016	$4,991,850	3,640.5	1,371.2	1,295.9	$1,462	0.94
Jan-2017	$5,035,137	3,620.9	1,390.6	1,289.1	$1,426	0.98
Feb-2017	$4,171,651	3,538.2	1,179.0	1,389.5	$1,591	0.74
Mar-2017	$4,879,614	3,507.7	1,391.1	1,304.7	$1,455	0.96
Apr-2017	$4,651,959	3,471.2	1,340.1	1,228.5	$1,389	0.96
May-2017	$5,753,037	3,280.6	1,753.7	1,566.5	$1,791	0.98
Jun-2017	$4,578,624	3,065.5	1,493.6	1,451.0	$1,693	0.88
Jul-2017	$4,579,122	2,994.6	$1,529	$1,326	$1,509	1.01
Aug-2017	$4,459,208	2,943.7	$1,515	$1,567	$1,803	0.84
Sep-2017	$3,895,953	2,895.0	$1,346	$1,426	$1,651	0.81
Oct-2017	$4,713,994	2,838.9	$1,661	$1,598	$1,814	0.92
Nov-2017	$3,988,809	2,806.7	$1,421	$1,501	$1,752	0.81
Dec-2017	$4,249,562	2,762.5	$1,538	$1,329	$1,473	1.04
Total	$123,682,488	85,045.2	$1,454	$1,352	$1,537	0.95

Table 11.D — MEDICARE
PMPM costs for intervention and comparison groups, by month: Cohort 4

	Intervention group		PMPM			Ratio
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	(D/T)
Baseline	$108,719,430	62,395.6	$1,742	$1,552	$1,742	1.00
Jan-2016	$9,653,760	5,783.5	1,669.2	1,610.7	$1,850	0.90
Feb-2016	$8,531,659	5,600.1	1,523.5	1,586.1	$1,818	0.84
Mar-2016	$9,273,085	5,432.1	1,707.1	1,751.1	$1,995	0.86
Apr-2016	$7,732,387	5,301.3	1,458.6	1,546.1	$1,766	0.83
May-2016	$8,346,486	5,177.1	1,612.2	1,657.4	$1,896	0.85
Jun-2016	$7,565,700	5,065.6	1,493.5	1,550.3	$1,748	0.85
Jul-2016	$7,565,092	4,923.3	1,536.6	1,413.9	$1,601	0.96
Aug-2016	$7,322,080	4,810.4	1,522.1	1,540.1	$1,745	0.87
Sep-2016	$6,307,854	4,686.6	1,345.9	1,533.8	$1,736	0.78
Oct-2016	$6,488,855	4,657.6	1,393.2	1,462.1	$1,662	0.84
Nov-2016	$6,308,593	4,561.6	1,383.0	1,512.3	$1,705	0.81
Dec-2016	$6,000,340	4,469.3	1,342.6	1,531.7	$1,732	0.78
Jan-2017	$6,214,704	4,398.1	1,413.0	1,583.3	$1,787	0.79
Feb-2017	$5,450,747	4,277.6	1,274.3	1,470.5	$1,656	0.77
Mar-2017	$6,973,165	4,262.8	1,635.8	1,513.1	$1,705	0.96
Apr-2017	$6,131,445	4,206.7	1,457.5	1,424.9	$1,617	0.90
May-2017	$6,321,027	4,031.8	1,567.8	1,501.7	$1,692	0.93
Jun-2017	$5,724,467	3,802.5	1,505.4	1,498.6	$1,701	0.88
Jul-2017	$5,386,388	3,697.2	$1,457	$1,509	$1,716	0.85
Aug-2017	$5,524,257	3,623.7	$1,524	$1,596	$1,795	0.85
Sep-2017	$5,411,694	3,538.7	$1,529	$1,534	$1,754	0.87
Oct-2017	$5,790,579	3,455.8	$1,676	$1,429	$1,590	1.05
Nov-2017	$4,665,350	3,392.8	$1,375	$1,475	$1,655	0.83
Dec-2017	$5,084,452	3,340.9	$1,522	$1,578	$1,751	0.87
Total	$159,774,164	106,497.2	$1,500	$1,539	$1,744	0.86

Table 11.E — MEDICARE
PMPM costs for intervention and comparison groups, by month: Cohort 5A

Month/Year	Intervention group		PMPM			Ratio (D/T)
	Incurred claims	Eligible months	Intervention	Comparison	Target	
Baseline	$110,905,078	65,787.6	$1,686	$1,638	$1,686	1.00
Jan-2017	$9,793,012	6,136.0	1,596.0	1,638.1	$1,677	0.95
Feb-2017	$8,938,610	5,913.1	1,511.7	1,525.1	$1,558	0.97
Mar-2017	$8,923,496	5,812.4	1,535.3	1,786.5	$1,821	0.84
Apr-2017	$8,422,603	5,663.6	1,487.1	1,644.2	$1,676	0.89
May-2017	$8,020,163	5,437.8	1,474.9	1,582.2	$1,625	0.91
Jun-2017	$7,725,167	5,280.0	1,463.1	1,655.5	$1,710	0.86
Jul-2017	$7,655,589	5,138.6	1,489.8	1,554.7	$1,598	0.93
Aug-2017	$8,109,281	5,042.2	1,608.3	1,913.3	$1,985	0.81
Sep-2017	$7,221,704	4,923.2	1,466.9	1,589.1	$1,620	0.91
Oct-2017	$7,659,287	4,777.7	1,603.1	1,877.6	$1,963	0.82
Nov-2017	$6,386,559	4,689.4	1,361.9	1,452.4	$1,505	0.90
Dec-2017	$6,768,105	4,600.3	1,471.2	1,596.7	$1,643	0.90
Total	$95,623,575	63,414.2	$1,508	$1,651	$1,698	0.89

Table 11.F — MEDICARE
PMPM costs for intervention and comparison groups, by month: Cohort 5B

Month/Year	Intervention group		PMPM			Ratio (D/T)
	Incurred claims	Eligible months	Intervention	Comparison	Target	
Baseline	$113,102,577	65,411.2	$1,729	$1,635	$1,729	1.00
Apr-2017	$10,087,731	5,907.2	1,707.7	1,636.7	$1,700	1.00
May-2017	$10,767,397	5,718.3	1,883.0	1,825.3	$1,898	0.99
Jun-2017	$9,446,911	5,603.7	1,685.8	1,766.8	$1,830	0.92
Jul-2017	$8,566,031	5,483.4	1,562.2	1,754.8	$1,810	0.86
Aug-2017	$9,006,876	5,343.5	1,685.6	1,862.8	$1,907	0.88
Sep-2017	$8,033,446	5,214.9	1,540.5	1,642.9	$1,684	0.91
Oct-2017	$8,676,096	5,071.4	1,710.8	1,843.5	$1,903	0.90
Nov-2017	$8,549,901	4,964.7	1,722.1	1,800.5	$1,829	0.94
Dec-2017	$7,507,808	4,827.6	1,555.2	1,865.5	$1,890	0.82
Total	$80,642,197	48,134.7	$1,675	$1,775	$1,826	0.92

Table 12.A — MEDICARE
PMPM costs for Demonstration Year 3 based on incurred Medicare claims for Cohorts 1, 2, 3 and 4

	Intervention		PMPM					
Type of service	Incurred Claims	Member Months	Intervention (D)	Comparison	Target (T)	Ratio (D/T)	PMPM Savings	Dollar Savings
Baseline	$930,624,118	559,556.5	$1,663.15	$1,591.41				
Durable medical equipment	$12,828,231	211,574.3	$60.63	$67.86	$73.05	0.83	$12.42	$2,628,107
Home health agency	$13,704,153	211,574.3	$64.77	$92.80	$101.70	0.64	$36.93	$7,813,824
Hospice	$3,980,986	211,574.3	$18.82	$55.97	$58.83	0.32	$40.01	$8,465,679
Inpatient	$128,171,443	211,574.3	$605.80	$595.31	$646.58	0.94	$40.78	$8,628,093
Outpatient	$82,767,598	211,574.3	$391.20	$354.88	$381.13	1.03	−$10.07	−$2,130,534
Professional	$62,050,183	211,574.3	$293.28	$359.34	$390.35	0.75	$97.07	$20,537,141
SNF	$29,203,724	211,574.3	$138.03	$112.44	$124.04	1.11	−$13.99	−$2,960,382
Total	$332,706,318	211,574.3	$1,572.53	$1,638.59	$1,775.68	0.89	$203.15	$42,981,927

Table 12.B — MEDICARE
PMPM costs for Demonstration Year 4 based on incurred Medicare claims for Cohorts 1, 2, 3, 4 and 5A/B

	Intervention		PMPM					
Type of service	Incurred Claims	Member Months	Intervention (D)	Comparison	Target (T)	Ratio (D/T)	PMPM Savings	Dollar Savings
Baseline	$930,624,118	559,556.5	$1,663.15	$1,591.41				
Durable medical equipment	$15,314,194	281,344.0	$54.43	$60.81	$63.87	0.85	$9.43	$2,654,137
Home health agency	$19,825,534	281,344.0	$70.47	$100.85	$105.87	0.67	$35.40	$9,960,490
Hospice	$4,365,406	281,344.0	$15.52	$60.00	$63.39	0.24	$47.87	$13,468,277
Inpatient	$176,543,875	281,344.0	$627.50	$615.02	$653.19	0.96	$25.69	$7,228,244
Outpatient	$111,588,100	281,344.0	$396.63	$356.08	$373.76	1.06	−$22.86	−$6,432,096
Professional	$87,342,385	281,344.0	$310.45	$367.88	$390.43	0.80	$79.98	$22,502,724
SNF	$39,690,825	281,344.0	$141.08	$125.53	$136.67	1.03	−$4.41	−$1,240,154
Total	$454,670,318	281,344.0	$1,616.07	$1,686.17	$1,787.18	0.90	$171.11	$48,141,623

Table 13.A —
PMPM costs by category of beneficiary for Demonstration Year 3 based on incurred Medicare claims for Cohorts 1, 2, 3 and 4

	Total		Durable Medical Equipment		Home Health Agency		Hospice		Inpatient		Outpatient		Professional		SNF	
Category of beneficiary	PMPM Saving	Dollar Savings	PMPM Saving	Dollar Savings	PMPM Saving	Dollar Savings	PMPM Saving	Dollar Savings	PMPM Saving	Dollar Savings	PMPM Saving	Dollar Savings	PMPM Saving	Dollar Savings	PMPM Saving	Dollar Savings
Total	$203.15	$42,981,927	$12.42	$2,628,107	$36.93	$7,813,824	$40.01	$8,465,679	$40.78	$8,628,093	−$10.07	−$2,130,534	$97.07	$20,537,141	−$13.99	−$2,960,382
Fac 65+ SPMI	$667.50	$3,081,098	$0.30	$1,383	−$10.94	−$50,501	$137.14	$633,022	$141.17	$651,624	$149.91	$691,982	$147.74	$681,939	$102.18	$471,651
Fac 65+ xSPMI	$597.95	$4,828,819	−$3.75	−$30,266	−$5.74	−$46,356	$167.92	$1,356,028	$164.90	$1,331,655	$50.90	$411,057	$128.99	$1,041,669	$94.73	$765,033
HCBS 65+ SPMI	$469.16	$4,789,008	$16.39	$167,286	$45.86	$468,100	$75.03	$765,866	$111.51	$1,138,241	$64.20	$655,284	$148.99	$1,520,785	$7.20	$73,446
HCBS 65+ xSPMI	$319.54	$11,384,776	$8.42	$300,169	$69.43	$2,473,594	$85.33	$3,040,184	$53.32	$1,899,810	−$5.66	−$201,769	$125.11	$4,457,359	−$16.41	−$584,572
Com 65+ SPMI	$259.15	$1,847,219	$13.05	$93,042	$27.31	$194,685	$27.89	$198,777	$120.91	$861,818	−$42.83	−$305,306	$95.38	$679,859	$17.44	$124,345
Com 65+ xSPMI	$110.76	$4,590,874	$12.69	$526,188	$37.05	$1,535,672	$24.83	$1,029,371	$12.65	$524,332	−$35.48	−$1,470,660	$79.37	$3,289,920	−$20.36	−$843,948
Fac <65 SPMI	$414.90	$712,378	−$5.66	−$9,716	−$31.28	−$53,714	$53.16	$91,268	$1.86	$3,198	$69.59	$119,484	$269.50	$462,728	$57.74	$99,130
Fac <65 xSPMI	$451.68	$872,285	$5.97	$11,524	−$22.65	−$43,744	$110.50	$213,391	−$151.95	−$293,452	$113.41	$219,020	$342.16	$660,781	$54.25	$104,765
HCBS <65 SPMI	$127.54	$2,034,401	$13.33	$212,628	$34.12	$544,306	$26.23	$418,349	$54.19	$864,326	−$42.37	−$675,794	$81.55	$1,300,837	−$39.51	−$630,250
HCBS <65 xSPMI	$307.92	$8,772,581	$27.58	$785,698	$70.75	$2,015,700	$13.37	$380,881	$107.81	$3,071,484	$2.48	$70,524	$107.48	$3,062,051	−$21.54	−$613,756
Com <65 SPMI	$72.73	$1,681,041	$10.92	$252,483	$17.39	$401,927	$6.13	$141,759	$52.85	$1,221,626	−$34.57	−$799,111	$65.09	$1,504,561	−$45.09	−$1,042,204
Com <65 xSPMI	−$48.48	−$1,612,554	$9.55	$317,687	$11.25	$374,157	$5.92	$196,784	−$79.56	−$2,646,568	−$25.41	−$845,243	$56.36	$1,874,653	−$26.58	−$884,022

Table 13B —
PMPM costs by category of beneficiary for Demonstration Year 4 based on incurred Medicare claims for Cohorts 1, 2, 3, 4 and 5A/B

	Total		Durable Medical Equipment		Home Health Agency		Hospice		Inpatient		Outpatient		Professional		SNF	
Category of beneficiary	PMPM Saving	Dollar Savings	PMPM Saving	Dollar Savings	PMPM Saving	Dollar Savings	PMPM Saving	Dollar Savings	PMPM Saving	Dollar Savings	PMPM Saving	Dollar Savings	PMPM Saving	Dollar Savings	PMPM Saving	Dollar Savings
Total	$171.11	$48,141,623	$9.43	$2,654,137	$35.40	$9,960,490	$47.87	$13,468,277	$25.69	$7,228,244	−$22.86	−$6,432,096	$79.98	$22,502,724	−$4.41	−$1,240,154
Fac 65+ SPMI	$672.69	$5,922,648	$2.48	$21,875	−$20.17	−$177,567	$161.67	$1,423,391	$54.00	$475,464	$192.92	$1,698,520	$194.31	$1,710,760	$87.48	$770,204
Fac 65+ xSPMI	$457.89	$4,080,078	−$3.37	−$30,019	−$7.69	−$68,503	$169.93	$1,514,202	$20.76	$185,000	$98.84	$880,758	$112.13	$999,151	$67.28	$599,488
HCBS 65+ SPMI	$311.33	$6,303,049	$26.30	$532,453	$77.40	$1,567,047	$71.81	$1,453,889	$57.90	$1,172,318	$13.85	$280,334	$97.08	$1,965,487	−$33.02	−$668,479
HCBS 65+ xSPMI	$362.68	$15,300,722	$9.67	$407,850	$58.38	$2,462,804	$92.87	$3,917,838	$80.92	$3,413,963	−$32.78	−$1,383,019	$126.64	$5,342,872	$26.98	$1,138,414
Com 65+ SPMI	$95.03	$1,413,980	$10.57	$157,229	$47.93	$713,159	$29.28	$435,631	−$7.15	−$106,353	−$30.00	−$446,402	$58.65	$872,746	−$14.25	−$212,030
Com 65+ xSPMI	$75.11	$4,086,260	$12.89	$701,446	$36.31	$1,975,178	$29.57	$1,608,704	−$6.16	−$334,862	−$42.44	−$2,308,848	$53.15	$2,891,718	−$8.22	−$447,077
Fac <65 SPMI	$890.94	$2,756,101	$31.66	$97,943	−$27.62	−$85,437	$62.14	$192,221	$156.20	$483,198	$95.21	$294,530	$364.13	$1,126,434	$209.22	$647,212
Fac <65 xSPMI	$692.33	$1,587,521	−$4.10	−$9,391	−$16.85	−$38,630	$137.67	$315,683	$243.57	$558,512	−$33.25	−$76,243	$299.98	$687,853	$65.30	$149,738
HCBS <65 SPMI	$256.60	$6,252,055	−$0.42	−$10,273	$48.87	$1,190,688	$28.00	$682,275	$150.18	$3,659,215	−$27.05	−$659,035	$71.49	$1,741,781	−$14.47	−$352,597
HCBS <65 xSPMI	$168.96	$5,371,110	$2.26	$71,930	$46.63	$1,482,410	$41.94	$1,333,189	$44.00	$1,398,655	−$43.43	−$1,380,445	$88.48	$2,812,654	−$10.92	−$347,283
Com <65 SPMI	−$63.80	−$2,127,987	$10.43	$347,928	$17.45	$582,029	$4.17	$139,211	−$53.60	−$1,787,533	−$54.83	−$1,828,606	$51.09	$1,704,105	−$38.53	−$1,285,122
Com <65 xSPMI	−$75.74	−$2,803,912	$9.86	$365,166	$9.65	$357,312	$12.21	$452,042	−$51.04	−$1,889,332	−$40.62	−$1,503,641	$17.48	$647,163	−$33.30	−$1,232,623

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT U



Community Health Assessment

Pierce County
2019



Overview

In 2018, Tacoma-Pierce County Health Department, MultiCare Health System, CHI Franciscan Health and Kaiser Permanente launched a comprehensive community health planning and assessment process. Undertaken in collaboration with a wide range of community partners, the overall aim of this work was to identify key areas where the community can act to improve community health and address health equity. The assessment also fulfills public health accreditation and healthcare regulatory requirements.

Vision

Building healthy and fair spaces and places for all.

Mission

We will lead the region in growing healthier spaces and places.

Process Principle

Our processes will be collaborative, communicative, data-driven and based on listening, engagement and observation.

Leaders

CHI Franciscan Health:
Laurie Brown and Doug Baxter.

Kaiser Permanente:
Victoria Garcia.

MultiCare Health System:
Lois Bernstein, Kristin Gilman and Dr. Jamilia Sherls.

Tacoma-Pierce County Health Department:
Tommy George, Cindan Gizzi, Karen Meyer, Ingrid Payne and Emily Turk.

Acknowledgements

We thank the many community members who gave their time to complete surveys and participate in community workshops.

We acknowledge the following individuals and organizations who contributed to this report:

- Pierce County Accountable Communities of Health Community Voice Council.
- Bates Technical College.
- Black Infant Health Program (Tacoma-Pierce County Health Department).
- City of Tacoma.
- City of Lakewood.
- City of Puyallup.
- Community Health Care.
- Eatonville Community Coalition.
- Exceptional Families Network.
- Foundation for Healthy Generations, Community Health Advocates.
- Graham Community Coalition.
- Key Peninsula Violence Prevention Coalition.
- Korean Women's Association.
- Pacific Lutheran University.
- Pierce College.
- Pierce County.
- Pierce County Cities and Towns Association.
- Pierce County Human Services.
- Pierce County Community Health Workers Collaborative.
- Pierce County Library System.
- Pierce Transit.
- Prairie Ridge Coalition.
- Rainbow Center.
- Tacoma Pierce County League of Women Voters.
- University of Puget Sound.

This list includes organizations who supported community workshops and/or promoted the 2018 Community Survey. We apologize if we unintentionally missed anyone.

Executive Summary

Tacoma-Pierce County Health Department, in partnership with CHI Franciscan, MultiCare Health System, Kaiser Permanente and University of Washington – Tacoma conducted a Community Health Assessment to identify key health issues based on current data. This Community Health Assessment includes the results of a comprehensive review of key health indicator data and community input, to understand and address the needs of this specific community.

Within this report, the term "community" refers to residents who live, learn, work or play in Pierce County.

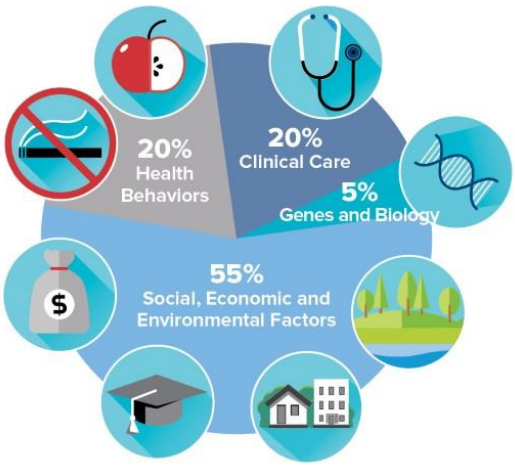
This report presents data on:

- Community demographics.
- Life expectancy and leading causes of death.
- Chronic illness, including behavioral health.
- Injury and violence.

Additionally, the Community Health Assessment process included asking community members about the health of their community, what they need in their neighborhoods to be healthy and what they think could be improved. These community engagement activities included 10 community workshops with residents, 10 interviews with local organizational leaders and an online community survey. MultiCare Health System, CHI Franciscan and Tacoma-Pierce County Health Department pledge to engage community stakeholders throughout the Community Health Assessment process, not simply as sources of input, but as equal partners with shared accountability and investment in addressing health concerns.

Commitment to Health Equity

Throughout the CHA process, social determinants of health provided the framework for both the community engagement process and to focus attention on the importance of neighborhood and community conditions. Income, education, housing and transportation create opportunities or barriers to health. Health should not be determined by zip code, income, race or any other factor. Healthy choices should be easy choices for everyone in Pierce County.



Contents

Introduction **1**
Purpose 1
Methods 1
Limitations 2
Community Engagement 2
Community Workshops 3
Community Survey 4

Description of Pierce County **6**
Demographic Characteristics 6
Socioeconomic Characteristics 7
Behavioral Health 12
Substance Abuse and Dependency 22
Life Expectancy 27
Chronic Disease 31
Health Behaviors 36
Social Connections 43
Access to Care and Use of Clinical Preventive Services 44
Injury and Violence Prevention 47

Supplement **54**
Quantitative Data Sources 54
Quantitative Methods 56
Selection of Priority Health Needs 58

Appendix 1—Community Workshop Summary **59**
Workshop Methods 59
Participant Selection Criteria 59
What We Heard—Major Themes 59

Appendix—2 Forces of Change **62**
Overview 62

Appendix—3 Communities of Focus **64**
Health Equity in Action 64
Community Snapshots 64

Introduction

The Community Health Assessment (CHA) process included quantitative analysis and qualitative interviews and focus groups with community leaders and residents of Pierce County representing many sectors and population groups, including low-income residents and others affected by health disparities.

Purpose

The purpose of this report is to share the emerging health needs of Pierce County, including:

- What residents have to say about health and community perceptions.
- Health behaviors and health outcomes of residents.
- This report contains information that can be used to respond to an evolving community and new challenges.

Methods

To develop this report, an array of data sources was analyzed to describe the health of the community. These included:

- Community workshops.
- Community survey.
- Forces of change assessment.
- Selected health indicators.

The report summarizes:

- Community characteristics.
- Life expectancy.
- Leading causes of death.
- Leading causes of hospitalizations.
- Levels of chronic illness.
- Access to healthcare and use of preventive services.
- Maternal and child health.
- Injury and violence prevention.
- Behavioral health.

Details about the sources and methods used to develop this report can be found in the Supplement.

Limitations

For this report, we highlighted data from focus groups, interviews and surveys. While some survey results can be weighted to improve generalizability, focus group and interview results are not entirely generalizable and there are limitations to the strength of the conclusions. Survey data often have issues arising from how, where and from whom the data were collected. For example, stratifying estimates sometimes cannot be done due to small sample sizes.

Community Engagement

We used 3 methods of community engagement to gather input from Pierce County residents about what makes their community healthy, what they need in their neighborhoods and what they think could be improved:

- Community workshops.
- Forces of change assessment workshops.
- Online surveys.

Activities included 10 community workshops with residents, 10 interviews with local organizational leaders and an online community survey. The online survey was available to residents in English, Spanish and Korean.

Top findings across the 3 community engagement activities included the following important issues.

- Community characteristics seen as vital to health:
    - Equitable access to community resources (information, services, activities, parks).
    - Diversity is celebrated.
    - People working together.

- What residents need in their neighborhood or community to be healthy:
    - Affordable housing.
    - Access to healthy food.
    - Transportation.
    - Access to healthcare (emphasizing behavioral health services).

Residents played an active role in community engagement activities, like reviewing questions used for workshops and community surveys and reviewing the summary of results from the interviews and workshops, they participated in. Professional translation services were used to provide the first survey drafts in Korean and Spanish. The drafts were then shared with community members who speak Korean and Spanish natively to confirm contextual accuracy.

Community Workshops

The purpose of the community workshops was to hear directly from residents. Ten community workshops (focus groups) were held throughout Pierce County and were facilitated by trained community residents and Health Department staff.

Tacoma-Pierce County Health Department selected participants from geographic areas identified as "communities of focus" in the 2015 Tacoma-Pierce County Health Department Health Equity Assessment. These communities showed poorer health outcomes and readiness to work collectively to improve these outcomes. Specific populations were identified based on their geographic location and/or health outcomes. Analysts considered literature on stakeholder selection for CHAs produced by the Health Research and Educational Trust, in partnership with Hospitals in Pursuit of Excellence. Tacoma-Pierce County Health Department recruited participants, and, in some cases, participants invited others to attend (i.e., snowball sampling method). Those who attended were promised confidentiality and consented to participate by attending the workshop.

Data analysis of workshop notes was performed simultaneously by the workshop group facilitator and a Tacoma-Pierce County Health Department analyst using coding to identify emergent themes. Analysis was then compared, and themes were mutually identified.

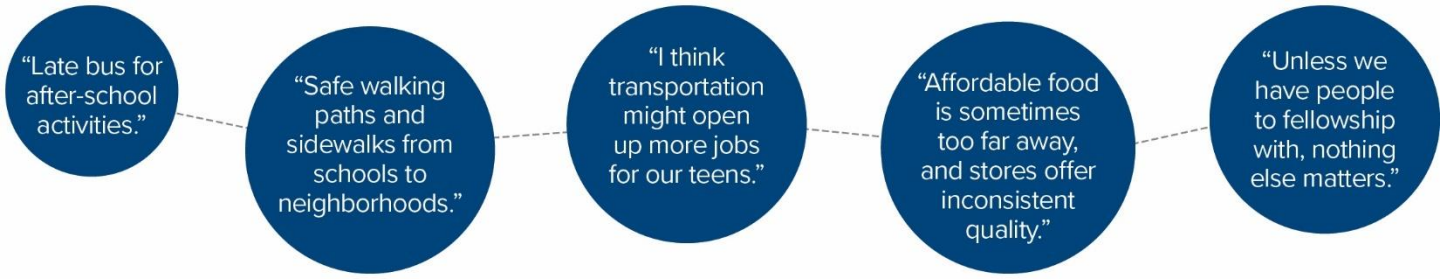
What do you think makes an ideal neighborhood or community?

- Opportunities to give and receive social support.
- Diversity is valued.
- Community resources.
- Organizations and groups willing to partner.



What needs to change about your community or neighborhood?

- Safe sidewalks and trails.
- Buses that meet people where they live, learn, work and shop.
- Access to healthy food.
- Opportunities for physical and social activities.



Community Survey

The purpose of the community survey is to hear directly from residents for the Pierce County Community Survey (see Methods section). The purpose of the survey was to better understand the community's views on issues related to healthcare services, economic opportunity, health problems and concerns, and other issues that impact community health. When asked to rate the overall health of the community, 78% of survey participants rated it as healthy (ranging from somewhat healthy to very healthy). Perceptions of community health can be associated with many factors, like education, poverty, health systems, public and social services and other conditions.

1,620 Pierce County residents responded to the community survey.[1]

Nearly ⅔ of those who participated selected **safe neighborhoods and affordable housing as their most important community needs**, followed by access to healthcare services. When asked about resources available to meet these needs, residents identified parks and outdoor spaces, easily accessible grocery stores and markets as well as safety resources like street lighting and police presence. Survey participants were also asked what is lacking to meet identified needs. From the list provided, residents selected **policies that address local needs, accessible public transit and community resources that contribute to safety** like street lighting, police presence and neighborhood watches. Residents also indicated that policies to protect air and water quality are important and needed.

Residents reported that the top issues facing children and youth include **exposure to crime and violence, poverty and lack of positive relationships**.

Most Important Community Needs

Community Perceptions

Question	Responses				
	Very healthy	Healthy	Somewhat healthy	Somewhat unhealthy	Very unhealthy
How would you rate your community's overall health?	2.7%	27.0%	51.9%	17.1%	2.0%

Question	Responses				
	Very satisfied	Somewhat satisfied	Neutral	Somewhat unsatisfied	Very unsatisfied
How satisfied are you with your community?	28.8%	46.0%	11.8%	10.4%	3.0%

[1] Community Survey respondents by language—English: 1,565; Korean: 41; Spanish: 14.

Question	Responses				
	Very connected	Somewhat connected	Neutral	Somewhat unconnected	Very unconnected
How connected do you feel to your community?	22.5%	45.6%	16.0%	10.5%	5.4%

Who answered the survey?

Respondents' most common zip codes were:

- 98405 (Central Tacoma)— 6%.
- 98406 (North Tacoma)—6%.
- 98391 (Lake Tapps, Bonney Lake)—5%.
- 98404 (East Tacoma)—5%.
- 98407 (North Tacoma, Ruston)—5%.

Efforts were made to distribute the survey to a representative sample of Pierce County residents (by age, race, gender, ethnicity). However, survey participants were disproportionately female and 30 to 60 years old. The n value of demographics for survey respondents is 1,620.

Description of Pierce County

This section describes the entirety of Pierce County using demographic and socioeconomic characteristics. Residents are mostly white (67%), followed by Hispanic (10%), Asian (6%), black (6%) and multiracial (6%) with an increasing number of adults 55 to 74 years old. Immigrants in Pierce County originate from Asia, Latin America and Europe.

8% of Pierce County residents experience poverty versus 13% statewide with significant variations geographically.

Poverty is most prevalent among residents who are American Indian or Alaska Native (25%), Hispanic (24%), and among those who selected “other” for race/ethnicity (27%). These groups are twice as likely as white residents (11%) to experience poverty and reported having high housing costs (greater than 30% of household income) contributing to their poverty status. 43.3% of students last year were eligible for free or reduced-price lunch. This was just slightly higher the state average (42.3%).

The percent of community members living with a disability (13%) is also slightly higher than the state average (12%).

Demographic Characteristics

The characteristics of a community inform what health behaviors and outcomes may be future concerns or help us further understand existing populations health issues.

Race and Ethnicity

This community is primarily white (67.0%) and Hispanic (10.6%). The next largest groups are black (6.8%), Asian (6.5%) and multiracial (6.5%).

Age and Sex

Since 2007, the percent of the population in the 55 to 64 and 65 to 74 year age groups has increased by 2.6% and 3.2%, respectively. The proportion of males to females has remained approximately 1:1.

Demographics (%), Pierce County, 2016

Race and Ethnicity	Count	Percent
American Indian or Alaskan Native (AIAN)	9,646	1.1%
Asian	55,867	6.5%
Black	58,512	6.8%
Hispanic	91,042	10.6%
Multiracial	55,446	6.5%
Native Hawaiian or Pacific Islander (NHOPI)	12,833	1.5%
White	576,054	67.0%

Sex	Count	Percent
Female	435,513	50.7%
Male	423,887	49.3%

Age (Years)	Count	Percent
Under 1	11,995	1.4%
1-4	47,938	5.6%
5-14	115,754	13.5%
15-24	108,888	12.7%
25-34	117,140	13.6%
35-44	109,851	12.8%
45-54	114,446	13.3%
55-64	112,966	13.1%
65-74	74,921	8.7%
75-84	31,772	3.7%
85+	13,730	1.6%

Source: Washington State Office of Fiscal Management, Forecasting Division.

Socioeconomic Characteristics

The social and economic characteristics of a community help public health stakeholders understand available resources and improve community health. Poverty, homelessness and the cost of housing are some examples of important socioeconomic characteristics.

On-Time Graduation

The graduation rate helps describe the educational wellbeing of a community. A higher educational level helps people take advantage of employment opportunities and earn higher incomes, which helps to diminish the burden of poverty on a community.

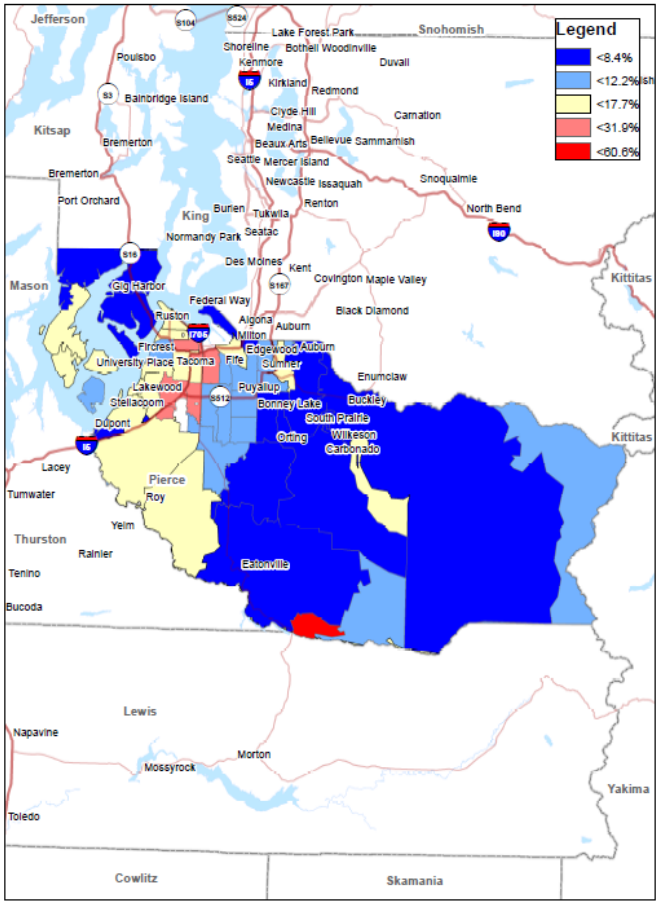
The 2017 4-year graduation rate, gathered from Office of Superintendent of Public Instruction (OSPI) data, in Pierce County was higher (82%) than Washington State (79%).

Poverty and Near Poverty

Poverty—household income less than 100% of the federal poverty limit (FPL)—and near poverty—household income less than 200% of FPL—is a significant burden on households and communities, hindering access to resources promoting good health.

8% of Pierce County residents experienced poverty versus 13% statewide with significant variations geographically.

Poverty by Zip Code, Pierce County, 2016



Source: United States Census Bureau, 2016 American Community Survey (ACS) 5-year estimates, S1701.

High Housing Costs

Seattle was one of the fastest growing United States cities in 2018, driving up housing prices and displacing lower-income residents throughout the area, including Tacoma[2] and Pierce County. A housing cost greater than 30% of household income can be a hardship on individuals and families, especially as persistent poverty continues amidst rising property costs. Housing costs are typically more burdensome among renters.

Poverty and Housing Costs (%), Pierce County, 2016

Income Level	Count	Percent
Poverty (<100% PL)	103,562	13%
Near Poverty (>200% FPL)	237,408	29%

[2] www.census.gov/newsroom/press-releases/2018/estimates-cities.html.

Poverty Racial Breakdown	Count	Percent
AIAN	2,477	25%
Asian	6,556	13%
Black	9,304	17%
Hispanic	19,454	24%
Multiracial	10,033	17%
NHOPI	1,782	16%
White	67,039	11%
Other	6,371	27%

Population with Burdensome Housing Costs	Count	Percent
Renters	59,755	52%
Owners with mortgage	46,085	34%
Owners without mortgage	6,948	14%

Source: United States Census Bureau, 2016 ACS 5-year estimates, S1701 and DP04.

Homelessness

In 2017, City of Tacoma declared a public health emergency related to homelessness. Tacoma joined other west coast cities in this emergency declaration, including Seattle, Portland and Los Angeles. The Homelessness Housing and Assistance Act requires each county in the state to conduct an annual Point in Time count of sheltered and unsheltered people living homeless to estimate the number of people experiencing homelessness.

Overall in Pierce County, 1,628 people living homeless were counted in 2017.

The top 3 zip codes where homeless people were found included 98405 (n=200, 28%), 98402 (n=151, 21%) and 98372 (n=58, 8%). This is primarily north of I-5 in the Central Tacoma and Hilltop areas and Puyallup/Sumner/Bonney Lake.

Free and Reduced-Price Lunch

The free and reduced-price meal program is a federal program for students whose household income is less than or equal to 130% of the FPL (free) or between 130% and 185% of the FPL (reduced-price). This program helps ensure children have access to food with adequate nutritional value.

In Pierce County, 43% of students in the 2016-2017 school year were eligible for free or reduced-price lunch. This is similar to Washington State (42%).

Foster Care

Foster care placement and support services are provided to children who need short-term or temporary protection because they are abused, neglected or involved in family conflict. Foster care placement services are served exclusively out of home, while support services may be in or outside of the child's own home.

Of the 6,200 children who entered out-of-home care in Washington state in 2017, 1,009 were in Pierce County, making it the county with the highest number of children entering care.

Within Pierce County, the rate of children living in out-of-home care was 7.4 per 1,000, which was 35% higher than the Washington State rate of 5.5 kids per 1,000.[3]

Immigrants (Foreign-Born)

Immigrants are a sizable proportion of Washington's population, contributing to diverse community demographics. Estimates of the number of immigrants currently in the United States vary widely depending on their immigration status. Data collected as part of the United States Census help estimate this number.

Foreign-Born Residents (%), Pierce County, 2012-2016

Region of Birth	Count	Estimate	95% Confidence Interval (CI)
Asia	34,729	43.8%	(42.7%-45.0%)
Latin America	21,532	27.2%	(25.8%-28.6%)
Europe	15,527	19.6%	(18.3%-20.9%)
Africa	2,841	3.6%	(2.9%-4.3%)
North America	2,840	3.6%	(3.1%-4.0%)
Oceania	1,771	2.2%	(1.8%-2.7%)
Total*	79,240	9.2%	n/a

*Percent of total population in Pierce County.
Source: United States Census Bureau, 2016 ACS 5-year estimates, DP02 (foreign-born population, excluding born at sea).

Languages Spoken

English continues to be the most common language spoken in the community, followed by Spanish.

Top 10 Languages Spoken (%), Pierce County, 2012-2016

Language	Estimate	95% CI
English	81.1%	(81.0%-81.2%)
Spanish	8.4%	(8.3%-8.4%)
Chinese	1.4%	(1.3%-1.4%)
Vietnamese	0.9%	(0.9%-1.0%)
Russian	0.9%	(0.8%-0.9%)
Tagalog	0.9%	(0.8%-0.9%)
Korean	0.7%	(0.7%-0.8%)
African Language	0.6%	(0.6%-0.7%)
German	0.5%	(0.4%-0.5%)
Other Pacific Island Language	0.5%	(0.4%-0.5%)

Source: United States Census Bureau, 2016 ACS 5-year estimates, B16001.

[3] Partners for our children. pocdata.org/content-data/data/county-reports/county_report_Pierce.pdf. Accessed Dec. 28, 2018.

Limited English Proficiency

While many individuals are multilingual (speak 1 or more languages other than English), some report they either do not speak English or speak English "less than very well." In Pierce County, 6% speak English “less than very well,” compared to 8% statewide.

Speaks English “Less Than Very Well” by Primary Language Spoken (%), Pierce County, 2012-2016

Language	Estimate	95% CI
Vietnamese	67.5%	(57.6%-77.4%)
Arabic	64.1%	(27.9%-100%)
Korean	60.4%	(53.5%-67.2%)
Thai	55.3%	(17.4%-93.2%)
Other Slavic Language	43.5%	(30.4%-56.7%)
Chinese	43.0%	(31.9%-54.1%)
Russian	42.3%	(34.0%-50.5%)
Japanese	41.4%	(32.5%-50.3%)
Other Indo-European Language	37.7%	(18.8%-56.5%)
Laotian	36.8%	(20.8%-52.7%)

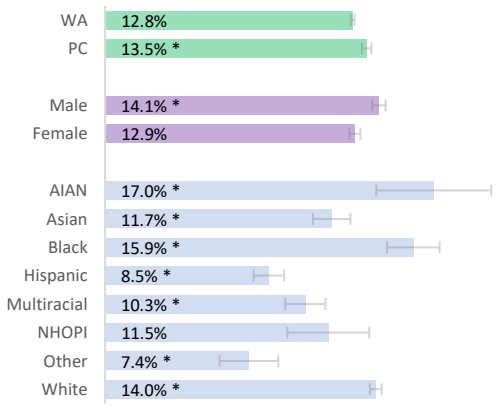
Source: United States Census Bureau, 2016 ACS 5-year estimates, B16001.

Disability

Disabilities can involve or relate to any of five functions: hearing, vision, cognition, ambulatory self-care and independence.

Pierce County disability rates are higher than the state. More males than females in Pierce County are disabled. Disability is more common among American Indian or Alaska Native, black and white people in Pierce County.

Disabled (%), Pierce County, 2012-2016



* Value significantly different than in Washington.
Source: United States Census Bureau, ACS 5-year estimates, S1810 (disability characteristics).

Behavioral Health

Mental health is essential to a person's wellbeing and ability to live a full and productive life. People of all ages, including children and adolescents, with untreated mental health disorders are at an elevated risk for co-occurring disorders, including substance abuse and dependency. Continuing to support systems and policies committed to addressing these concerns can help improve the lives of those who experience mental health issues and strengthen our community. As part of these efforts, Wellfound Behavioral Health Hospital was developed by partners MultiCare Health System and CHI Franciscan, in direct response to increasing rates of mental health and substance abuse disorders (including opiate abuse) among Pierce County residents.

In Pierce County, 5% of adults have experienced, or are experiencing, serious mental illness, which is higher than the Washington State average (3%).

Youth are experiencing depression at rates comparable to Washington State, while adults in Pierce County are experiencing depression at rates higher than the state average. Females are reporting depression at about twice the rate of males (among youth and adults).

Pierce County youth reported similar levels of suicidal ideation as the state average. Females are more likely than males to report suicidal ideation in the past year. Suicide ideation is more common among Multiracial youth, American Indian or Alaska Native and Native Hawaiian or Pacific Islander youth. Pierce County youth reported receiving less education about suicide than the state average. There is no difference in the percent of youth reporting suicide attempts in Pierce County than in Washington.

Youth bullying in Pierce County occurs at similar rates as the state. Female youth reported more frequently being a victim of bullying than male youth. American Indian or Alaska Native and multiracial youth reported being a victim of bullying most frequently.

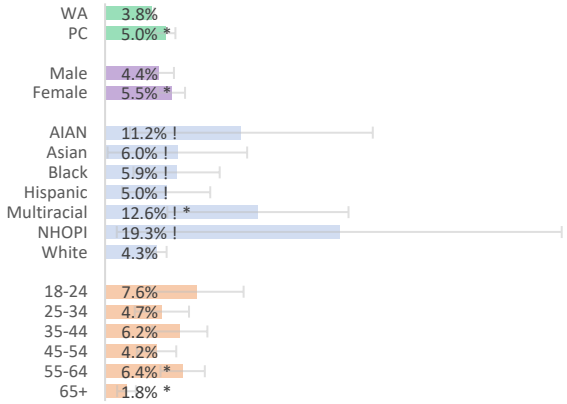
It is important to note that the Wellfound Behavioral Health Hospital was cooperatively proposed and developed in direct response to increasing mental health and substance abuse disorder needs. Reported binge drinking occurred at higher rates by Hispanic and white adults, and among those 25 to 34 years old. Reported marijuana use is highest among adults 18 to 24 years old. Males, multiracial and Native Hawaiian or Pacific Islander adults are more likely to consume marijuana. Black youth are more likely to consume marijuana than their peers.

Serious Mental Illness

The percent of adults with serious mental illness (SMI) is estimated based on a Kepler-6 (K-6) psychological distress scale score of 14 or higher.

SMI is more common in Pierce County than Washington. There are no significant differences by gender or race. Adults older than 65 years are less likely to report SMI than all other age groups.

Serious Mental Illness—Adults (%), Pierce County, 2012-2016



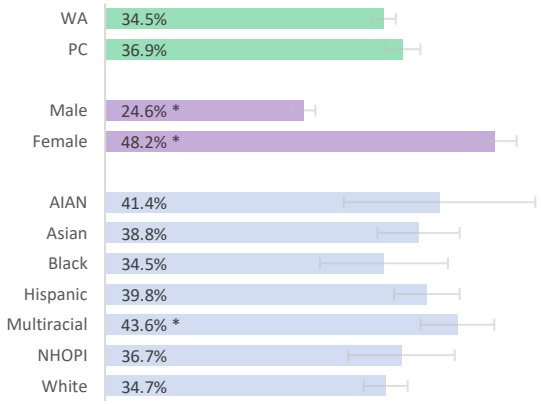
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: Behavioral Risk Factor Surveillance System (BHRFSS).

Depression—Youth

Youth are considered to have been depressed when they reported feeling so sad or hopeless almost every day for 2 weeks in a row or more that they stopped doing some usual activities in the past 12 months.

The prevalence of reported youth depression is not significantly different between Pierce County and the state. Females are more likely than males to report depression. There is no significant difference between races.

Self-Reported Depression—Youth (%), Pierce County, 2016



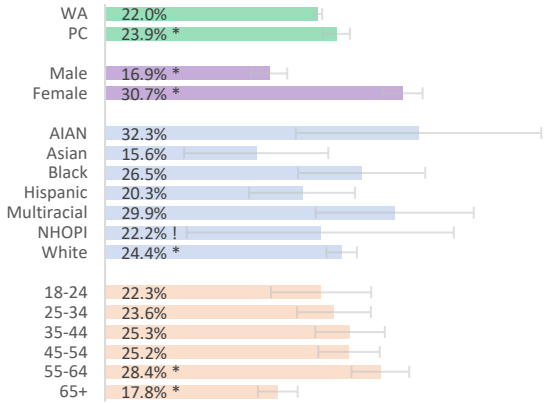
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: Healthy Youth Survey (HYS) (10th graders).

Depression—Adults

Depression diagnoses among adults are self-reported through the BHRFSS.

Adult depression is more common in Pierce County than in Washington. Females are more likely to report depression than males. There is no significant difference by race. Adults 65 years and older are less likely than all other age groups to have diagnosed depression.

Diagnosed Depression—Adults (%), Pierce County, 2012-2016



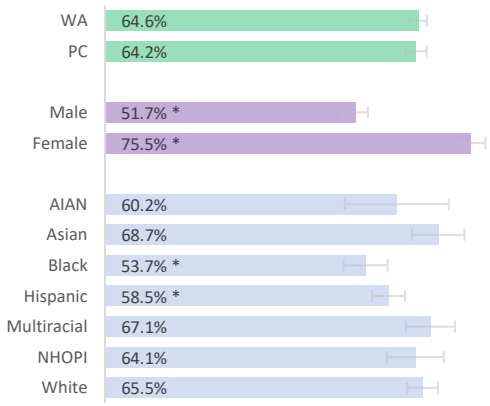
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: BHRFSS.

Anxiety—Youth

Anxiety among youth is measured as feeling nervous, anxious or on edge in the past 2 weeks using the HYS.

Youth anxiety prevalence is not significantly different in Pierce County than in the state. Females are more likely to report anxiety than males. Black and Hispanic youth are less likely than Asian and white youth to report anxiety.

Anxiety Some to All Days (%), Pierce County, 2012-2016



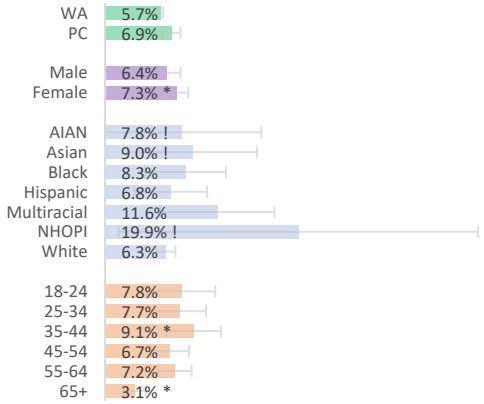
* Value significantly different than in Washington.
Source: HYS (10th graders).

Anxiety—Adults

Anxiety on most or all days is estimated among adults through the BHRFSS.

Anxiety prevalence in Pierce County is not significantly different than in Washington. There are no significant differences by race or gender. Adults 65 years and older report lower levels of anxiety than all other age groups.

Anxiety Most to All Days (%), Pierce County, 2012-2016



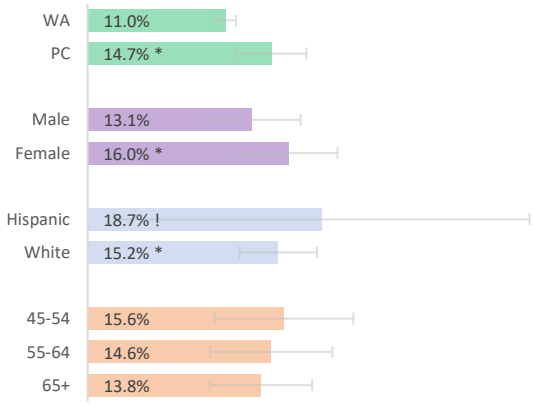
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: BHRFSS.

Confusion and Memory Loss

Adults 45 years and older are asked about worsening confusion and memory loss in the past 12 months through the BHRFSS.

Adults in Pierce County report more confusion and memory loss than in the state. There are no significant differences by gender, race or age.

Confusion and Memory Loss (%), Pierce County, 2012-2016



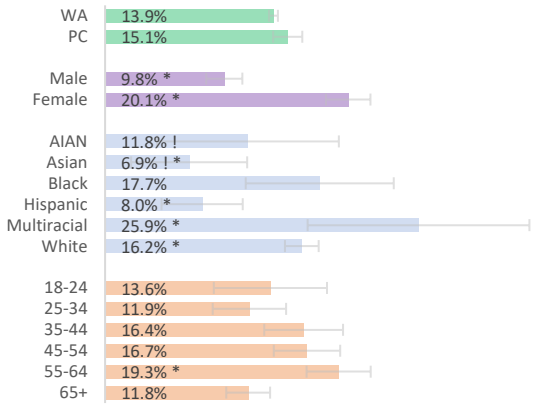
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Race groups excluded due to limited sample size.
Source: BHRFSS.

Mental Health Medication

Adults are asked about medication use for mental health conditions through BRFSS.

There is no significant difference in self-reported mental health medication use between Pierce County and the state. Males are less likely to use mental health medication than females. Asian and Hispanic adults are less likely than white and multiracial adults to use mental health medications.

Mental Health Medication Use (%), Pierce County, 2012-2016



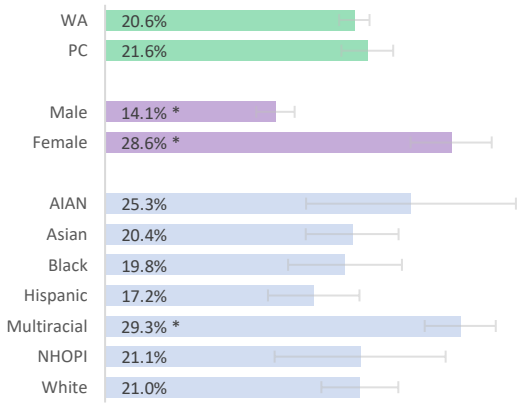
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
NHOPI excluded due to limited sample size.
Source: BHRFSS.

Suicidal Ideation—Youth

The percent of youth reporting suicidal thoughts in the past 12 months is measured from data in HYS.

Youth in Pierce County report similar levels of suicidal ideation as in the state. Females are more likely than males to report suicidal ideation in the past year. Multiracial youth are significantly more likely than all groups except for American Indian Alaska Native, Native Hawaiian or Pacific Islander youth.

Suicidal Ideation in Past Year (%), Pierce County, 2016



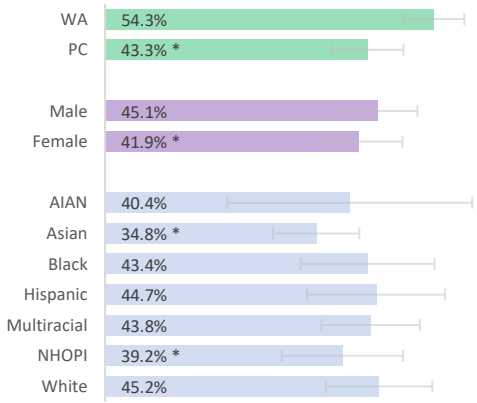
* Value significantly different than in Washington.
Source: HYS (10th graders).

Suicide Education for Youth

The percent of youth who have seen or heard information at school about the warning signs of suicide and how to get help for suicidal thoughts is estimated using the HYS.

Pierce County youth report receiving less education about suicide than the state. There are no significant differences by gender or race.

Suicide Education (%), Pierce County, 2016



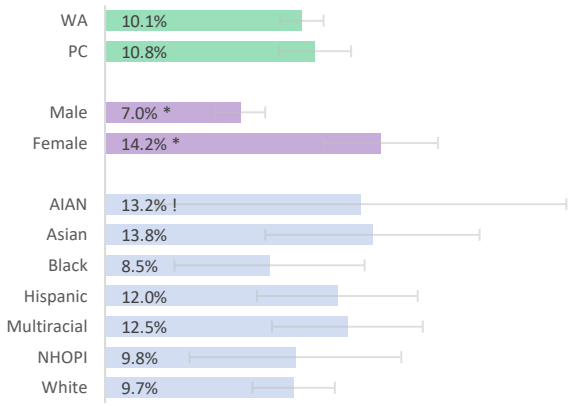
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: HYS (10th graders).

Suicide Attempts—Youth

The percent of youth reporting suicide attempts in the past 12 months is measured using the HYS.

There is no difference in the percent of youth reporting suicide attempts between Pierce County and Washington. Females are more likely to attempt suicide than males. There are no significant differences by race.

Suicide Attempts in Past Year (%), Pierce County, 2016



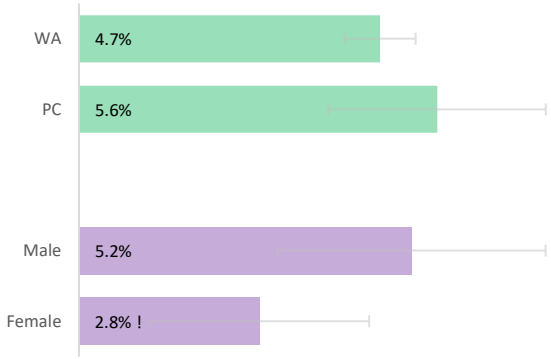
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: HYS (10th graders).

Social Support

Adults were asked in BRFSS about how many people they could count on to come help them if they asked for practical help, like help grocery shopping or providing a family member with care.

There is no significant difference in the amount of reported social support between Pierce County and the state. There is no significant difference among Pierce County residents by gender.

No Social Support (%), Pierce County, 2016



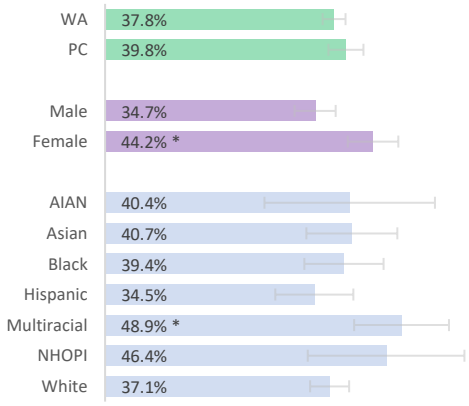
! Relative standard error greater than 30%.
Source: BHRFSS.

Verbally Abused Youth

The percent of youth who were verbally abused by an adult (sworn at, insulted or put down verbally) sometimes, often or very often is estimated using the HYS.

There is no significant difference in the percent of youth who were verbally abused by adults between Pierce County and the state. Females are more likely than males to be verbally abused as youth. There is no significant difference by race.

Verbally Abused (%), Pierce County, 2011-2015



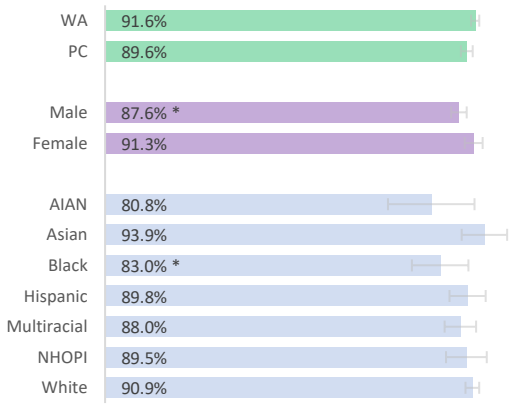
* Value significantly different than in Washington.
Source: HYS (10th graders).

Social-Emotional Skills—Youth

One measure for healthy social-emotional development includes how successfully individuals can understand how others feel and think. This is estimated in HYS.

There was no significant difference between Pierce County and the state. Females reported understanding how others feel and think more often than males. There was no significant difference by race.

Youth Agreed They Understand How Others Feel and Think (%), Pierce County, 2011-2015



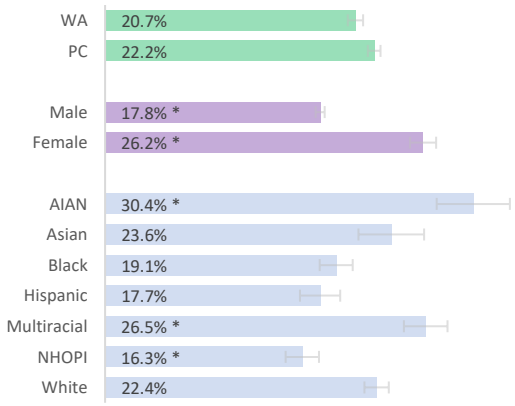
* Value significantly different than in Washington.
Source: HYS (10th graders).

Youth Bullying

The percent of youth reporting being bullied in the past 12 months is measured using the HYS.

Youth bullying in Pierce County occurs at similar rates as the state. Female youth reported more frequently being a victim of bullying than male youth. American Indian or Alaska Native, Asian, multiracial and white youth report being a victim of bullying the most frequently.

Youth Bullied in Past Year (%), Pierce County, 2016



* Value significantly different than in Washington.
Source: HYS (10th graders).

Substance Abuse and Dependency

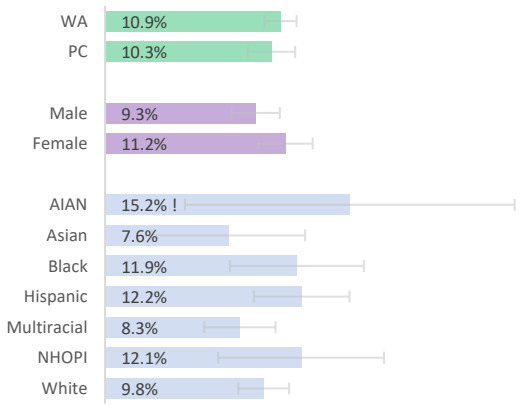
The inappropriate use of substances—legal and illegal—presents major challenges to a community. Alcohol and opioids are well-known contributors to substance abuse and dependency issues. Alcohol and marijuana use among youth, or driving while under the influence of either, are public health concerns. Ensuring an adequate system to assist individuals dealing with substance abuse and dependency issues is key.

Binge Drinking—Youth

Binge drinking among youth is self-reported through HYS. Youth who reported consuming 5 or more drinks in a row in the past 2 weeks were considered to have engaged in binge drinking.

Youth binge drinking rates are not significantly different between Pierce County and Washington. There are no significant differences in binge drinking by gender or race among youth.

Binge Drinking Among Youth, Pierce County, 2016



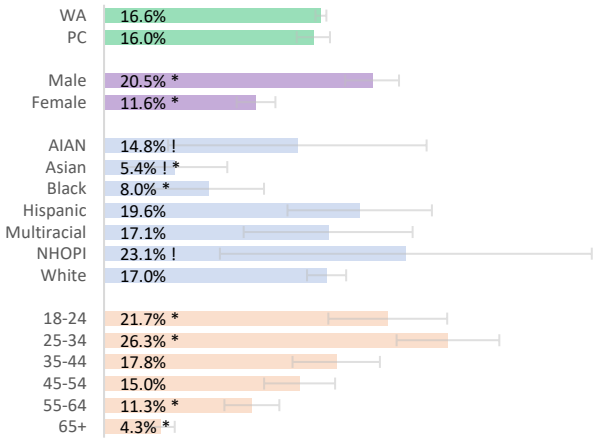
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: HYS (10th graders).

Binge Drinking—Adults

Binge drinking among adults is self-reported through BRFSS.

There is no significant difference in binge drinking between Pierce County and the state. Males are more likely than females to binge drink. White and Hispanic adults are more likely to report binge drinking than Asian and black adults. Binge drinking is highest among adults 25 to 34 years old.

Binge Drinking Among Adults, Pierce County, 2016



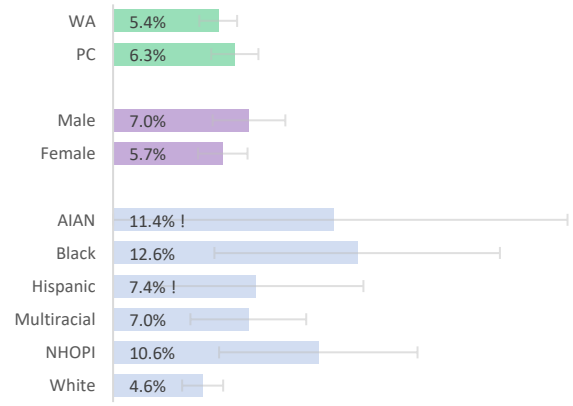
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: BHRFSS.

DUI Alcohol—Youth

Driving under the influence (DUI) of alcohol among youth is self-reported using the HYS.

Driving after drinking alcohol reported by Pierce County youth is not significantly different than in Washington. There are no significant differences by gender or race.

DUI Alcohol—Youth (%), Pierce County, 2016



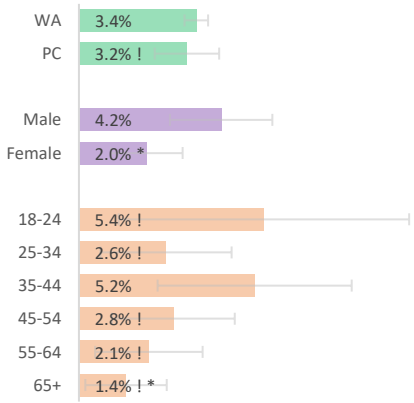
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Asian race excluded due to limited sample size.
Source: HYS (10th graders).

DUI Alcohol—Adults

Driving under the influence of alcohol among adults is self-reported using BRFSS.

There was no significant difference in adults reporting driving after drinking alcohol between Pierce County and the state. There were no significant differences by gender or age. Race data were excluded due to small sample sizes.

DUI Alcohol—Adults (%), Pierce County, 2016



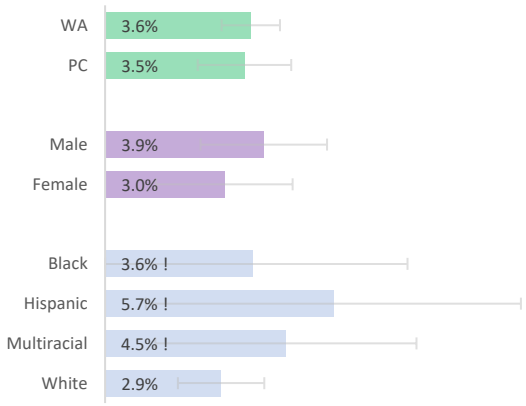
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Race excluded due to limited sample size.
Source: BRFSS.

Opiate Use—Youth

Lifetime heroin use among youth is measured using the HYS.

Lifetime heroin among youth use is not significantly different between Pierce County and Washington. There are no significant differences by gender or race.

Lifetime Heroin Use—Youth, Pierce County, 2016



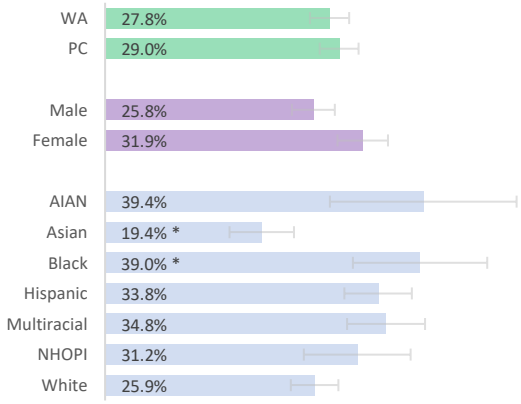
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Some races excluded due to limited sample sizes.
Source: HYS (10th graders).

Marijuana Use—Youth

Lifetime marijuana use among youth is measured using the HYS.

There are no significant differences between Pierce County and Washington or within Pierce County by gender. Asian youth are the least likely group to report lifetime marijuana use.

Lifetime Marijuana Use—Youth, Pierce County, 2016



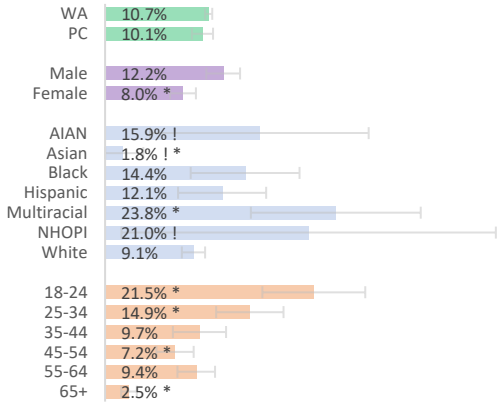
* Value significantly different than in Washington.
Source: HYS (10th graders).

Marijuana Use—Adults

Marijuana use in the past 30 days among adults is measured using BRFSS.

The percent of adults reporting current marijuana use in Pierce County is not significantly different than in Washington. Females are less likely to consume marijuana than males. Asian and white adults are less likely than multiracial adults to consume marijuana. The highest rate of marijuana use by age occurs among adults 18 to 24 years old.

Current Marijuana Use, Pierce County, 2016



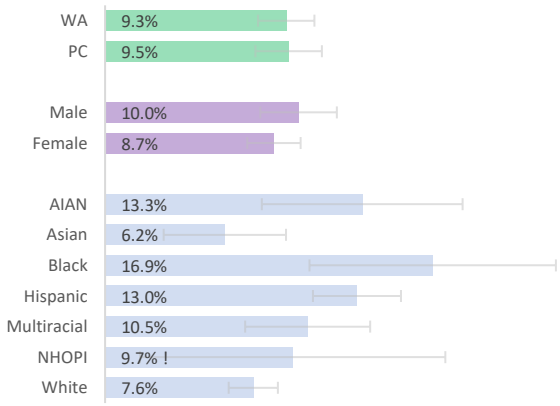
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: BHRFSS.

DUI Marijuana—Youth

Driving under the influence of marijuana among youth is self-reported using the HYS.

There are no significant differences in the percent of youth who consume marijuana and drive when comparing Pierce County to Washington. Black and Hispanic youth are significantly more likely than Asian and white youth to report consuming marijuana and driving.

DUI Marijuana Prevalence (%), Pierce County, 2016



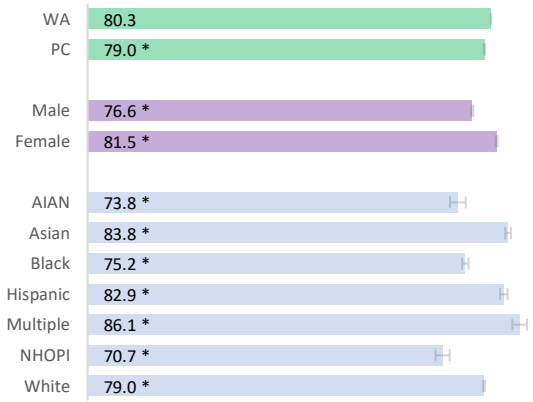
* Value significantly different than in Washington.
Source: HYS (10th graders).

Life Expectancy

Life expectancy—the average number of years a person at birth can expect to live, given current death rates—is a widely used measure of the overall health of a population.

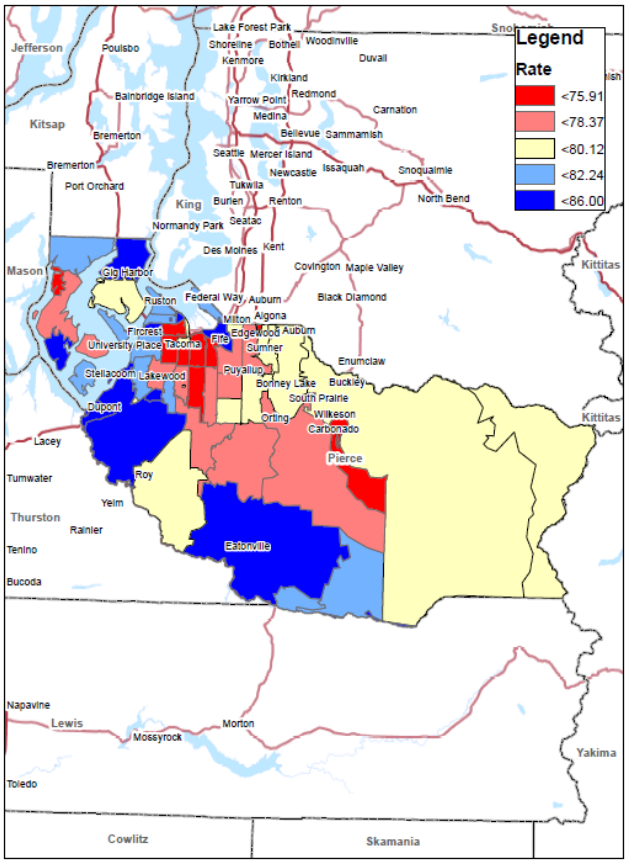
Life expectancy in Pierce County is significantly lower than in Washington. Within Pierce County, females have a higher life expectancy than males. Black, American Indian or Alaska Native and Native Hawaiian or Pacific Islander life expectancies are lower than Asian, Hispanic and white life expectancies.

Life Expectancy by Demographics, Pierce County, 2012-2016



Source: Washington State Department of Health Center for Health Statistics (CHS), Death Certificate Data, 1990-2016, Community Health Assessment Tool (CHAT), October 2017.

Life Expectancy by Zip Code, Pierce County, 2012-2016



Source: Washington State Department of Health CHS, Death Certificate Data, 1990-2016, CHAT, October 2017.

Leading Causes of Death

The leading causes of death in our community are important in planning future public health solutions. Life expectancy is another important indicator for the health of a community. Variation in life expectancy can be explained by differences in socioeconomic status and race/ethnicity, along with behavioral and metabolic risk factors (risk factors that raises your risk for heart disease and other health problems, like diabetes and stroke).[4]

Chronic diseases like cancer, heart disease and lower respiratory disease are the leading causes of death in Pierce County. The leading causes of hospitalization are injury, diseases of the digestive system and diseases of the circulatory system (like strokes and heart disease).

[4] Dwyer-Lindgren L, Bertozzi-Villa A, Stubbs RW, et al. Inequalities in Life Expectancy Among US Counties, 1980 to 2014 Temporal Trends and Key Drivers. *JAMA Intern Med.* 2017;177(7):1003–1011.

Pierce County has a significantly lower life expectancy (79 years) than Washington state (80 years). Native Hawaiian/Pacific Islanders have the lowest life expectancy (70 years) followed by American Indian/Alaska Native (73 years) and black residents (75)—revealing racial disparities.

Diabetes prevalence in the community is twice as high among black residents (16%) compared to Washington State (8%) and white residents (9%).

Lung cancer incidence is higher among American Indian and Alaska Native, Native Hawaiian and Pacific Islander and white residents. Breast cancer incidence is more common among black, white and Native Hawaiian or Pacific Islander residents.

Asthma prevalence is significantly higher among black residents (16%) compared to white residents (10%) and the Washington State average (9%).

Top 10 Causes of Death, Pierce County, 2012-2016

Cause of Death	Rate*
Cancer	168.10
Heart disease	157.30
Chronic lower respiratory disease (asthma, emphysema, COPD)	45.19
Alzheimer's disease	42.34
Unintentional injuries	40.56
Stroke	40.13
Diabetes	22.24
Suicide	17.74
Influenza and pneumonia	11.67
Chronic liver disease	11.18

* Age-adjusted death rate per 100,000 people
Source: Washington State Department of Health CHS, Death Certificate Data, 1990-2016, CHAT, October 2017.

Top 10 Causes of Death by Gender, Pierce County, 2012-2016

Cause of Death	Rate* in Males
Heart disease	207.49
Cancer	197.95
Unintentional injuries	52.66
Chronic lower respiratory disease (asthma, emphysema, COPD)	48.21
Stroke	41.28
Alzheimer's disease	35.48
Diabetes	28.07
Suicide	26.64
Chronic liver disease	16.15
Influenza and pneumonia	13.60

Cause of Death	Rate* in Females
Cancer	146.40
Heart disease	117.39
Alzheimer's disease	46.16
Chronic lower respiratory disease (i.e. asthma, emphysema, COPD)	43.09
Stroke	38.66
Unintentional injuries	28.85
Diabetes	17.59
Influenza and pneumonia	10.08
Suicide	9.27
Hypertension	7.88

* Age-adjusted death rate per 100,000 people
Source: Washington State Department of Health CHS, Death Certificate Data, 1990-2016, CHAT, October 2017.

Leading Causes of Hospitalizations

Hospitalizations occur due to a wide array of health concerns. Understanding these hospitalizations is crucial to prioritizing how we allocate resources, what types of interventions are undertaken and where these interventions should be focused.

Males are more likely than females to be hospitalized due to injury and circulatory system diseases, like stroke and heart disease. The leading causes of hospitalizations for females, excluding pregnancy-related hospitalizations, are diseases of the circulatory and digestive systems.

Top 10 Leading Causes of Hospitalization by Gender, Pierce County, 2011-2015

Cause of Hospitalization	Rate* in Males
Diseases of the circulatory system	1614.34
Diseases of the digestive system	887.27
Injury and poisoning	806.38
Diseases of the respiratory system	756.32
Diseases of the musculoskeletal system and connective tissue	583.40
Infectious and parasitic diseases	555.76
Mental illness	426.18
Cancer	369.52
Diseases of the genitourinary system	346.57
Endocrine, nutritional, and metabolic diseases and immunity disorders	304.12

Cause of Hospitalization	Rate* in Females
Diseases of the circulatory system	1211.98
Diseases of the digestive system	948.41
Injury and poisoning	763.46
Diseases of the respiratory system	751.62
Diseases of the musculoskeletal system and connective tissue	657.87
Infectious and parasitic diseases	501.43
Diseases of the genitourinary system	501.13
Mental illness	476.08
Cancer	389.25
Endocrine; nutritional; and metabolic diseases and immunity disorders	356.13

* Age-adjusted rate per 100,000 people
Source: Washington Hospital Discharge Data, Comprehensive Hospitalization Abstract Reporting System (CHARS).

Chronic Disease

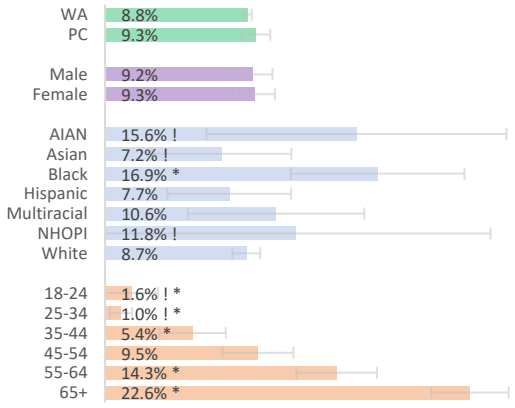
Chronic diseases and conditions—like diabetes, cancer and heart disease—encompass many of the most common, costly and preventable health concerns in our communities.

Diabetes—Adults

The prevalence of diabetes diagnoses among adults is self-reported as part of BRFSS.

Diabetes in Pierce County is not significantly different than in Washington. Black residents have a significantly higher rate than white residents.

Adults with Diabetes (%), Pierce County, 2012-2016



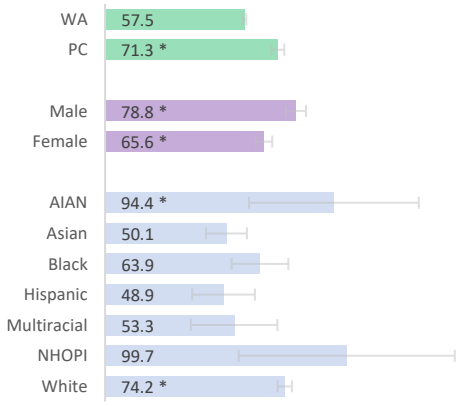
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Groups excluded if cell size less than 10.

Lung Cancer

The number of new cases, or incidence, of lung cancer is available through the Washington State Cancer Registry.

The incidence of lung cancer in Pierce County is significantly higher than in Washington. Lung cancer is more common among males compared to females. Asian residents have a significantly lower lung cancer incidence compared to white residents.

Lung Cancer Incidence, Pierce County, 2011-2015



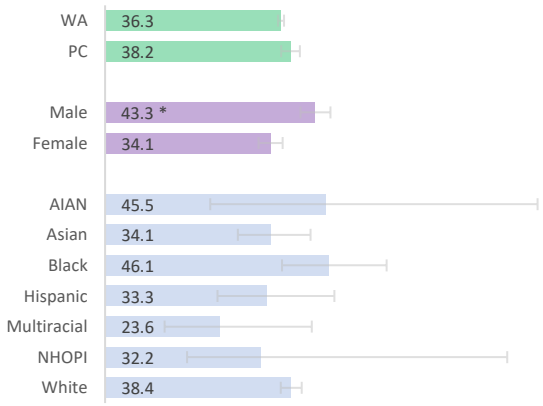
* Value significantly different than in Washington.
Rate: New cancer cases per 100,000 residents.
Source: Washington State Cancer Registry.

Colorectal Cancer

Cancer of the colon or rectum is a common cancer that, when detected early, can often be successfully treated.

Colorectal cancer incidence is similar in Pierce County and Washington. Males have a higher colorectal cancer incidence than females. There are no significant differences by race.

Colorectal Cancer Incidence, Pierce County, 2011-2015



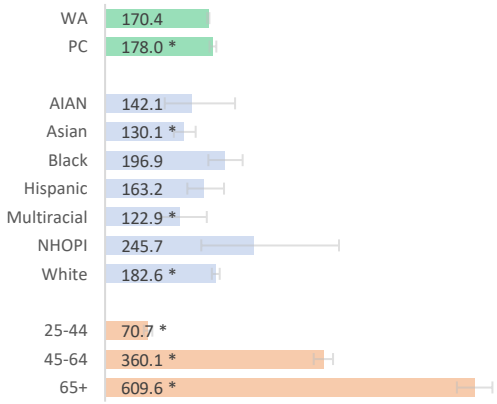
* Value significantly different than in Washington.
Rate: New cancer cases per 100,000 residents.
Source: Washington State Cancer Registry.

Breast Cancer

Cancer of the breast is a common cancer among females. Regular screening can detect this early and increase the chance of successful treatment.

Breast cancer is more common in Pierce County than in Washington. Breast cancer is more common among black and white adults compared to Asian adults.

Breast Cancer Incidence, Pierce County, 2011-2015



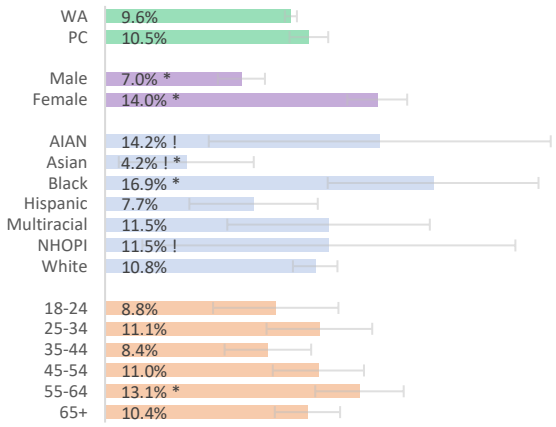
* Value significantly different than in Washington.
Rate: New cancer cases per 100,000 residents.
Source: Washington State Cancer Registry.

Asthma—Adults

Among adults, asthma prevalence is the proportion of adults reporting they have ever been diagnosed with asthma by a healthcare professional.

Asthma prevalence in Pierce County is not significantly different than in Washington. Females are more likely to have asthma than males. Asian adults are significantly less likely to have asthma compared to white and black adults.

Current Asthma—Adults (%), Pierce County, 2012-2016



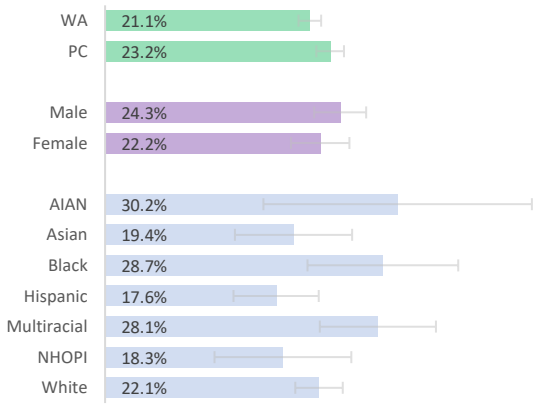
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Groups excluded if cell size less than 10.
Source: BHRFSS.

Asthma—Youth

Asthma affects people of all ages, but most often starts in childhood. Asthma prevalence among children in Washington is estimated using the HYS, where students report if a doctor had ever diagnosed them with asthma.

Youth asthma prevalence in Pierce County is not significantly different than in Washington. There are no significant differences within Pierce County.

Current Asthma—Youth (%), Pierce County, 2016



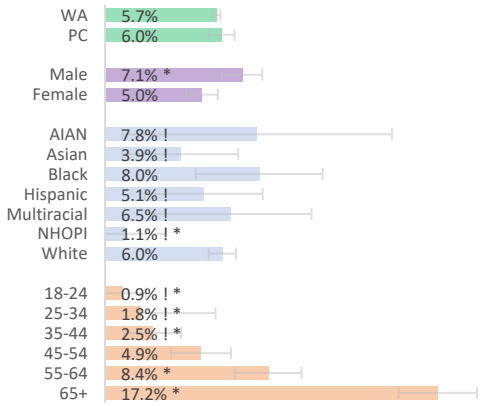
* Value significantly different than in Washington.
Source: HYS (10th graders).

Heart Disease

Heart disease is one of the leading causes of hospitalizations and deaths in Pierce County. BRFSS provides estimates of heart disease diagnoses among adults 18 years and older.

Heart disease prevalence is not different in Pierce County than in Washington. Males are more likely to have heart disease than females.

Heart Disease Prevalence (%), Pierce County, 2016



* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Groups excluded if cell size less than 10.
Source: BHRFSS.

Health Behaviors

A healthy and active lifestyle has been shown to have a profound impact on reducing the burden of chronic illness described in the previous section. A healthy diet and regular physical activity are protective factors promoting our health and wellbeing, while tobacco use, and a multitude of environmental exposures are some factors that may lead to negative health outcomes.

Across Pierce County, obesity among adults is significantly more prevalent than in Washington. Black adults are significantly more likely to be obese than white or Asian adults.

Obesity prevalence among Native Hawaiian or Pacific Islander youth is 3 times higher than among white youth. Obesity prevalence among multiracial youth is twice as high as white youth.

Females are more likely to avoid sugar-sweetened beverages than males. Black youth were the most likely to consume these beverages, while Asian youth were the least likely.

The percent of adults currently smoking is significantly higher in this area than in Washington. The percent of Alaska Native and American Indian adults who smoke cigarettes (42%) is significantly higher than that of white adults (18%) and the state (15%).

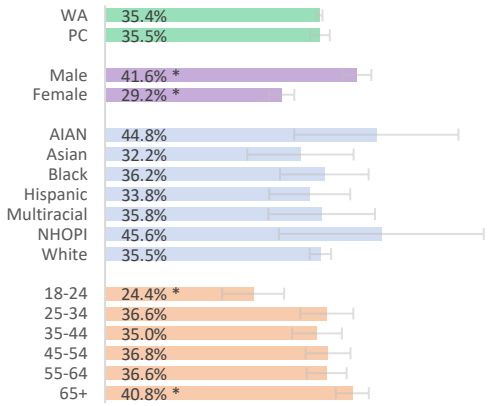
Obesity, Physical Activity and Nutrition

Many chronic diseases discussed in the previous section share the same root causes, like high-calorie diets with low nutritional value and lack of physical activity. Negative behaviors (risk factors) balanced with positive behaviors (protective factors) across a person's lifetime have a profound role in the development of chronic disease.

Overweight—Adults

Body mass index (BMI) is a measure of body fat based on height and weight. It is associated with a wide array of poor health outcomes. Adults are overweight if their BMI is greater than or equal to 25 but less than 30. The percent of adults who are overweight is not significantly different in Pierce County than in Washington. Males are more likely to be overweight compared to females.

Overweight Adults (%), Pierce County, 2012-2016



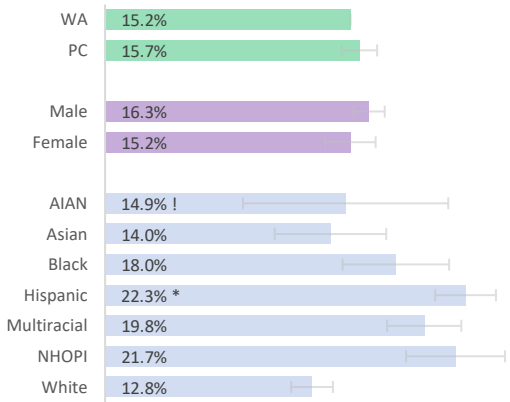
* Value significantly different than in Washington.
Source: BHRFSS.

Overweight—Youth

BMI groups are determined using the HYS responses from students in 6th through 12th grade. "Overweight" includes students who are in the top 15% for BMI by age and gender, but not the top 5%, based on growth charts from the Centers for Disease Control and Prevention (CDC).

The percent of overweight youth in Pierce County is not significantly different than in Washington. White youth are significantly less likely to be overweight when compared to black, Hispanic, multiracial and Native Hawaiian or Pacific Islander youth.

Overweight Youth (%), Pierce County, 2016



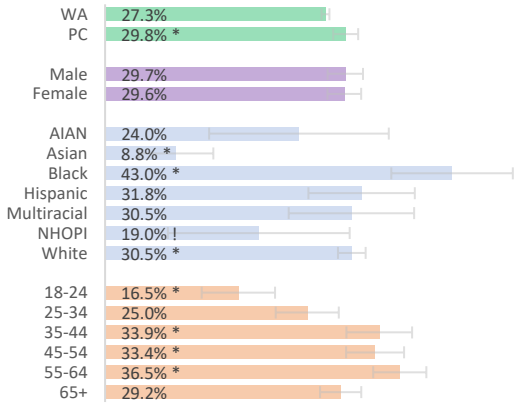
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: HYS (10th graders).

Obesity—Adults

Adults are classified as obese when their BMI is greater than or equal to 30. People whose BMI is in this category are at a significantly greater risk for heart disease and a host of other chronic diseases.

Obesity is more common in Pierce County than in Washington. Black adults in Pierce County are significantly more likely than white and Asian adults to be obese.

Adult Obesity (%), Pierce County, 2012-2016



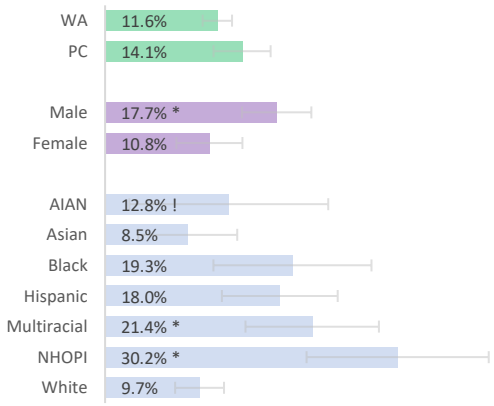
* Value significantly different than in Washington.
Source: BHRFSS.

Obesity—Youth

Youth are classified as obese when they are in the top 5% for BMI by age and gender based on growth charts developed by CDC. The percent of obese youth in Pierce County is not significantly different than in Washington.

Male youth are more likely than female youth to be obese. Asian and white youth are significantly less likely than Native Hawaiian or Pacific Islander youth to be obese.

Youth Obesity (%), Pierce County, 2016



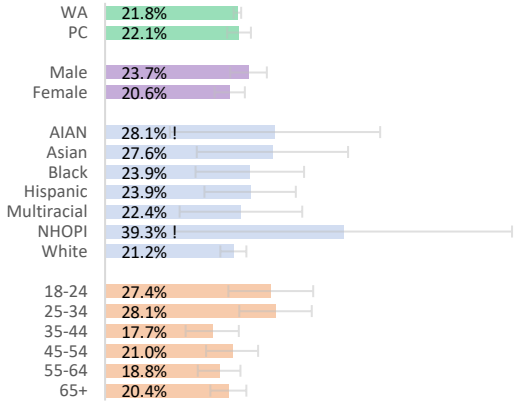
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: HYS (10th graders).

Physical Activity—Adults

Meeting recommended physical activity guidelines for aerobic exercise and strength conditioning helps reduce the burden of chronic disease related to fitness.

The percent of adults meeting physical activity recommendations is not significantly different between Pierce County and Washington. There are no significant differences by gender, race or age.

Met Physical Activity Recommendations (%), Pierce County, 2011-2015 (odd years)



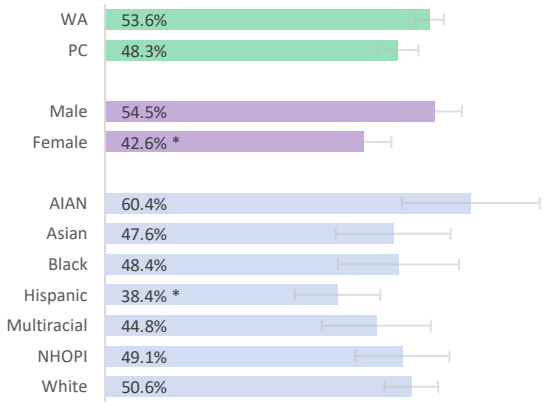
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: BHRFSS.

Physical Activity—Youth

Engaging in physical activity in youth is important for developing a healthy lifestyle as an adult. Physical activity reported among Pierce County youth is not significantly different than in Washington.

Males are more likely to be physically active compared to females. There are no significant differences in physical activity by race.

1 Hour of Physical Activity 5 Days a Week (%), Pierce County, 2016



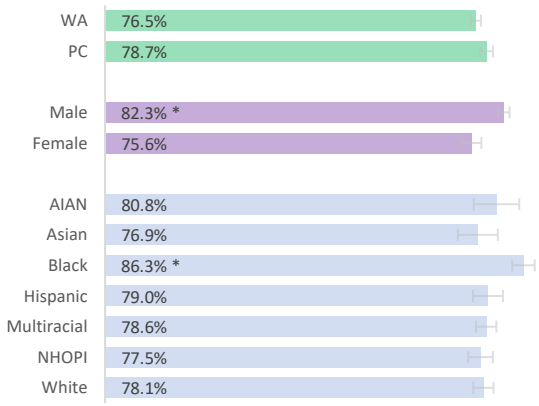
* Value significantly different than in Washington.
Source: HYS (10th graders).

Sugar-Sweetened Beverages

The availability and consumption of sugar-sweetened beverages by youth can lead to the development of unhealthy behaviors and chronic disease later in life. Sugar-sweetened beverage consumption among Pierce County youth is not significantly different than in Washington.

Males are more likely to consume sugar-sweetened beverages compared to females. Asian youth are significantly less likely than black youth to consume sugar-sweetened beverages.

No Sugar-Sweetened Beverage Consumption (%), Pierce County, 2016



* Value significantly different than in Washington.
Source: HYS (10th graders).

Tobacco

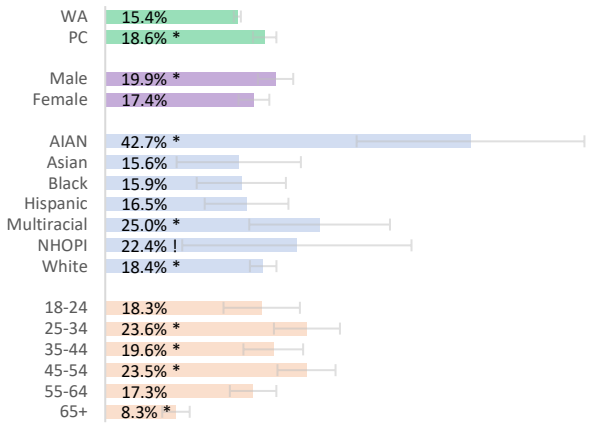
Tobacco use remains one of the most prevalent risky behaviors in communities across the United States, despite a robust body of evidence that tobacco use increases the risk of heart disease, cancer and many other negative health outcomes. Despite a general trend of decreasing tobacco use nationwide, an increase in electronic cigarette availability, attempts to replace traditional cigarettes with electronic cigarettes and vaping product popularity among youth continue to be a concern.

Current Cigarette Use—Adults

Current cigarette use among adults is estimated using responses from BRFSS. Current smoking is more common in Pierce County than in Washington.

Current cigarette use is more common among males compared to females. American Indian or Alaska Native adults are significantly more likely to currently use cigarettes than all other groups, except Native Hawaiian or Pacific Islander and multiracial adults.

Current Cigarette Use—Adults (%), Pierce County, 2012-2016



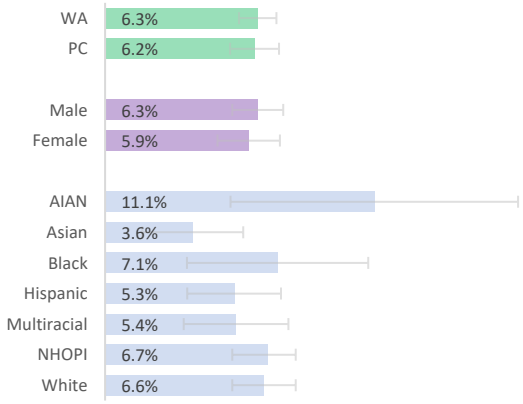
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: BHRFSS.

Current Cigarette Use—Youth

While the rate of tobacco use initiation is declining nationwide, tobacco use among youth remains a concern. Preventing youth from forming a smoking habit reduces the risk of smoking in adulthood.

Cigarette use among youth in Pierce County is not significantly different than in Washington. There are no significant differences by gender or race.

Cigarette Use in the Past 30 Days—Youth (%), Pierce County, 2016



* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: HYS (10th graders).

Social Connections

One-third of the United States population reports they are socially isolated (have 2 or less people they can count on in times of need).[5] People with stronger social relationships had a reduced risk of dying (i.e., 50% increased likelihood of survival) than those with weaker social relationships.[6]

Neighborhoods with stronger belonging and trust have lower obesity, hypertension and diabetes rates.[7] [8] [9]

Pierce County residents reported having people they could count on, and connectedness with their community members at similar frequencies as the state.

Further qualitative research may provide more evidence of the types and number of connections people are experiencing, to supplement this data.

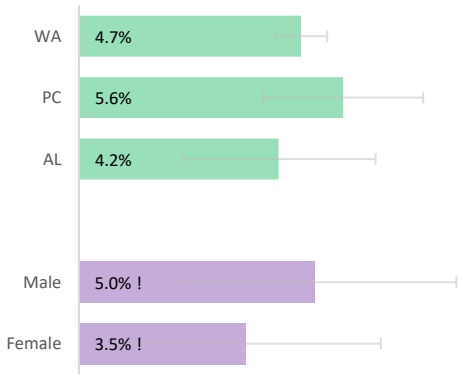
Social Support

Adults were asked about how many people they could count on to come help them if they asked for practical help, like grocery shopping or caring for a family member.

The percent of adults in Pierce County who report no social support is not significantly different than in Washington. There is no significant difference by gender.

[5] Perissinotto CM, Stijacic Cenzer I, Covinsky KE. Loneliness in older persons: a predictor of functional decline and death. Arch Intern Med. 2012;172(14):1078–1083.
[6] Holt-Lunstad J, Smith TB, Layton JB. Social relationships and mortality risk: a meta-analytic review. PLoS Med. 2010;7(7):e1000316. Published July 27, 2010.
[7] Chang VW, Hillier AE, Mehta NK. Neighborhood racial isolation, disorder and obesity. Soc Forces. 2009;87(4):2063-2092.
[8] Kaiser, P., Diez Roux, A., Mujahid, M., Carnethon, M., Bertoni, A., Adar, S. et al. (2016). Neighborhood environments and incident hypertension in the multi-ethnic study of atherosclerosis. American Journal of Epidemiology, 183 (11) p. 988–997.
[9] Liu L, Núñez AE. Multilevel and urban health modeling of risk factors for diabetes mellitus: a new insight into public health and preventive medicine. Adv Prev Med.

No Social Support (%), Pierce County 2016



! Relative standard error greater than 30%.
Source: BHRFSS.

Access to Care and Use of Clinical Preventive Services

This section includes information about access to care, like percentages of residents who are have medical insurance, a usual primary care physician, and the general availability of physicians and healthcare workforce capacity in the geographic area. This section also includes statistics on oral healthcare and preventable care services, like vaccinations and cancer screening.

Pierce County residents generally have insurance coverage rates comparable to state rates—with people 25 to 34 years old being the least likely age group to be insured. Hispanic residents were insured at significantly lower rates than the state. The percent of people who did not see a doctor due to cost was higher (15%) than Washington (13%), with significantly higher percentages among Hispanic (23%) and black (20%) residents.

The percentages of residents reporting not having a usual primary care provider ("medical home") were highest among Native Hawaiian and Pacific Islander residents (46%), followed by Hispanic residents (45%). These percentages were significantly higher than white residents (22%) and Washington (24%).

Pierce County has 5 health professional shortage areas (HPSAs): 3 primary care, 1 mental health and 1 oral health. All HPSAs are on Key Peninsula (see Workforce Capacity section).

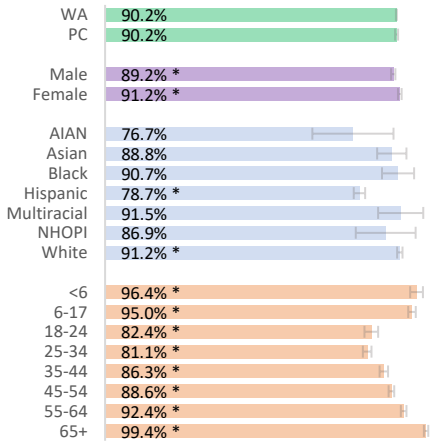
The lack of healthcare access can be particularly burdensome for individuals who don't have adequate health insurance. Following the implementation of the Patient Protection and Affordable Care Act, the proportion of residents reporting no insurance decreased significantly.

Insurance Coverage

The availability of insurance coverage can impact how likely somebody is to get important medical care. Insurance coverage also allows individuals to engage the healthcare system before conditions develop and reduce the cost of neglected health. Unfortunately, segments of our population continue to be uninsured and have trouble accessing care.

The percent of people with insurance coverage in Pierce County is not significantly different than in Washington. Females are significantly more likely to be insured compared to males. Hispanic are the least likely group to be insured.

Insurance Coverage (%), Pierce County, 2012-2016



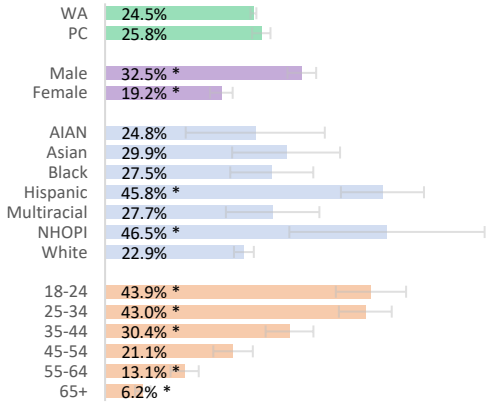
* Value significantly different than in Washington.
Source: United States Census, 2012-2016, ACS 5-year estimates, S2701.

Medical Home—Adults

A medical home is defined in this report as having a primary care provider. The prevalence of individuals with a medical home is estimated as the percent of people with a usual primary care provider.

The percent of adults with no medical home is higher in Pierce County than in Washington. Males are more likely than females to not have a medical home. White and black adults are significantly more likely than Native Hawaiian or Pacific Islander adults to have a medical home.

No Usual Primary Care Provider—Adults (%), Pierce County, 2012-2016



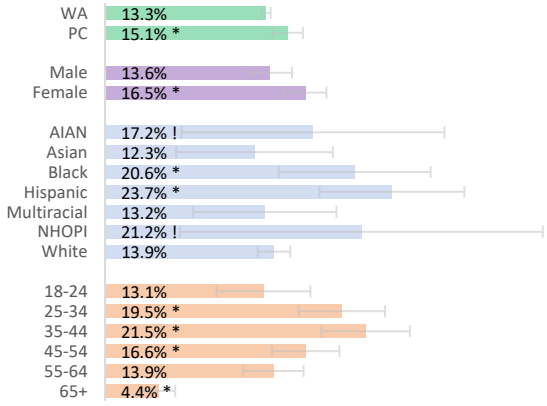
* Value significantly different than in Washington.
Source: BHRFSS.

Cost and Healthcare Access

When an individual needs healthcare, cost can often be a factor in whether they obtain care. Adults are asked if they needed to see a doctor but could not because of cost.

The percent of adults who could not see a doctor due to cost was higher in Pierce County than in Washington. Females are more likely than males to report not being able to see a doctor due to cost. Hispanic residents are more likely than white residents to not be able to see a doctor due to cost.

Did Not See a Doctor Due to Cost (%), Pierce County, 2012-2016



* Value significantly different than in Washington.
Source: BHRFSS.

Workforce Capacity

Another important factor in preventing, treating and rehabilitating negative health outcomes is the workforce capacity of our medical community—including long-term, dental, mental and primary care providers. Ensuring an adequate workforce is available to serve the community is a crucial component of an effective public health system.

Health Professional Shortage Areas

HPSAs are identified by the Health Resources and Services Administration for primary care, mental health and oral health. All Pierce County HPSAs are on Key Peninsula (Gig Harbor and Longbranch).

- 3 primary care HSPAs, all on Key Peninsula.
- 1 mental health HSPA, on Key Peninsula.
- 1 oral health HSPA, on Key Peninsula.

Injury and Violence Prevention

Injuries and violence adversely affect everyone, regardless of background. Injuries and violence are leading causes of death and disability at all levels of our society but are preventable. Those who survive these traumatic experiences may face lifelong mental and physical problems.

This section includes information on intentional and unintentional injuries that have occurred in Pierce County.

Suicide rates are higher in Pierce County compared to Washington State, and more common among males, and American Indian or Alaska Native and White residents.

Homicide rates are also higher in Pierce County compared to Washington State averages. Males are more likely than females to die of homicide. Black residents are nearly 5 times as likely to die of homicide than white residents.

Accidental injuries are higher among males, people older than 65 years (most likely due to falls) and American Indian or Alaska Native residents. American Indian or Alaska Native die from accidental injuries (77%) at nearly the twice the rate of white residents (41%).

Accidental hospitalizations caused by unintentional injuries (motor vehicle accidents, falls or poisonings) are significantly higher than the Washington State average and are more common among men, increase with age and are significantly more common in people over age 65 years of age (most likely due to falls).

Intentional Injuries

Injuries that are intentional, both fatal and non-fatal, are prevalent in Pierce County communities. Hospitalizations and deaths—suicide or homicide—are often preventable.

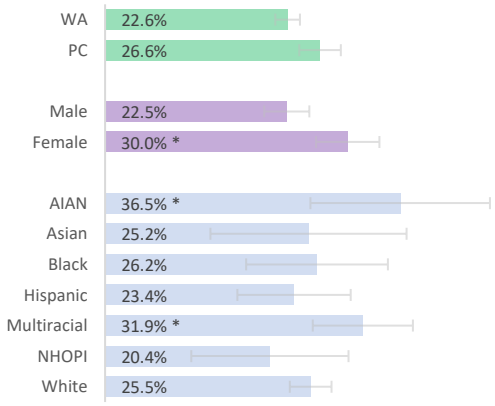
Intentional injuries are described as self-inflicted, assault and other.

Physically Abused Youth

The percent of youth who are physically abused by an adult is estimated using the HYS.

The percent of Pierce County youth reporting physical abuse was not significantly different than in Washington. Females are more likely than males to be physically abused. There is no significant difference in physical abuse rates by race.

Physically Abused Youth (%), Pierce County, 2011-2015



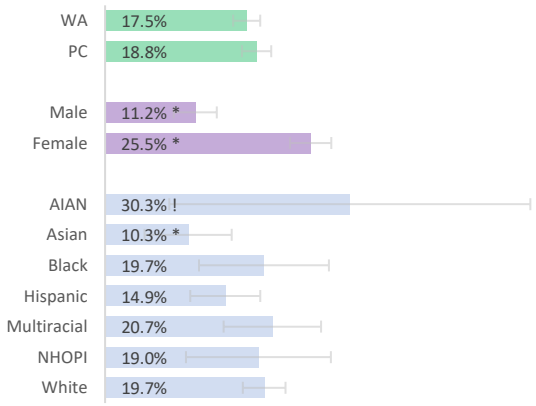
* Value significantly different than in Washington.
Source: HYS (10th graders).

Sexually Abused Youth

The percent of youth who were sexually abused is estimated using the HYS.

There is no significant difference between sexually abused youth in Pierce County than in Washington. Females are more likely to be sexually abused than males and white youth are more likely to be sexually abused than Asian youth.

Sexually Abused Youth (%), Pierce County, 2011-2015



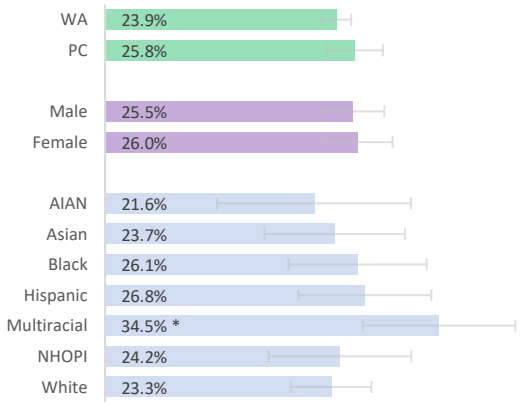
* Value significantly different than in Washington.
Source: HYS (10th graders).

Witnessed Physical Violence—Youth

The percent of youth who witnessed physical violence in the past 12 months is estimated using the HYS.

The percent of youth witnessing physical violence in Pierce County is not significantly different than in Washington. There are no significant differences by gender or race.

Witnessed Physical Violence—Youth (%), Pierce County, 2011-2015



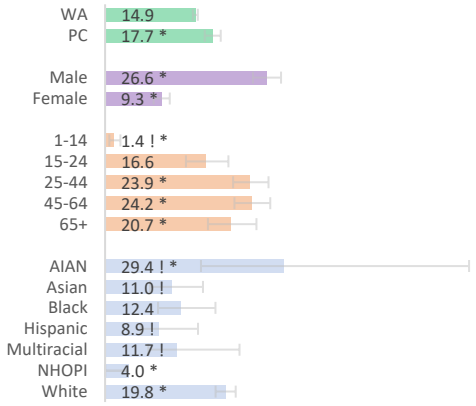
* Value significantly different than in Washington.
Source: HYS (10th graders).

Suicide

Suicide is one of the leading causes of death. The rate of suicide is the number of deaths due to intentional self-harm per 100,000 people.

Suicide rates in Pierce County are higher than in Washington. Males are more likely to die from suicide compared to females. White residents are significantly more likely than Asian and black residents to die from suicide.

Suicides per 100,000 People, Pierce County, 2012-2016



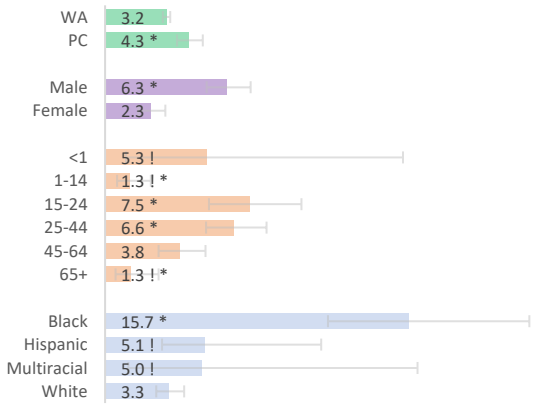
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Excluded 0-1 years, no suicide deaths.
Source: Washington State Department of Health CHS, Death Certificate Data, 1990–2016, CHAT, June 2017.

Homicide

The rate of homicide is the number of deaths due to intentional harm by another person per 100,000 people.

Homicide is more common in Pierce County than in Washington. Males are more likely than females to die of homicide. Black residents are nearly 5 times as likely to die of homicide than white residents.

Homicides per 100,000 People, Pierce County, 2012-2016



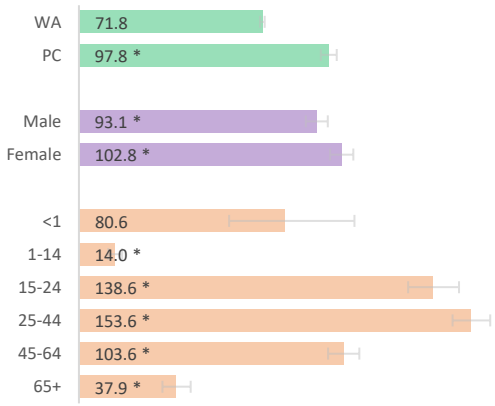
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Groups with cell size less than 10 excluded.
Source: Washington State Department of Health CHS, Death Certificate Data, 1990–2016, CHAT, June 2017.

Hospitalizations

Intentional injuries are primarily self-inflicted or assault but can also fall into an “other” category. Hospitalization rates due to intentional injuries are generated using the same 3 categories.

Pierce County residents are hospitalized due to self-harm at higher rates than the state. Females are more likely than males and people 15 to 44 years old are more likely than other ages to be hospitalized due to self-harm.

Intentional Injury Hospitalizations, Pierce County, 2011-2015



* Value significantly different than in Washington.
Source: WA Hospital Discharge Data, CHARS 1987-2015. Washington State Department of Health CHS, CHAT, August 2016.

Unintentional Injuries

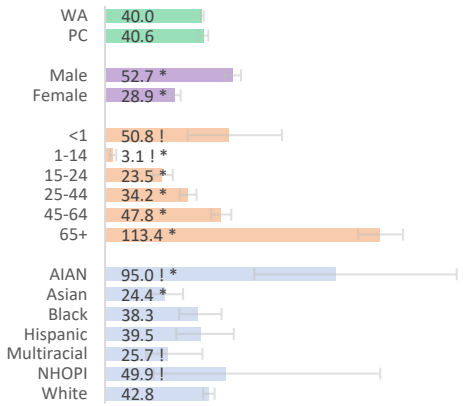
Accidental injuries are 1 of the leading causes of hospitalization and death nationwide. Typically, unintentional injuries are due to poisonings, motor vehicle crashes and falls.

Accidental Deaths

The rate of accidental deaths is the number of unintentional deaths per 100,000 people, which is measured using death certificate data.

Accidental deaths occur at similar rates in Pierce County and Washington. Males are more likely to die from unintentional injuries. American Indian and Alaska Native residents are more likely than all groups except Native Hawaiian or Pacific Islander residents to die from unintentional injuries.

Accidental Deaths per 100,000 People, Pierce County, 2012-2016



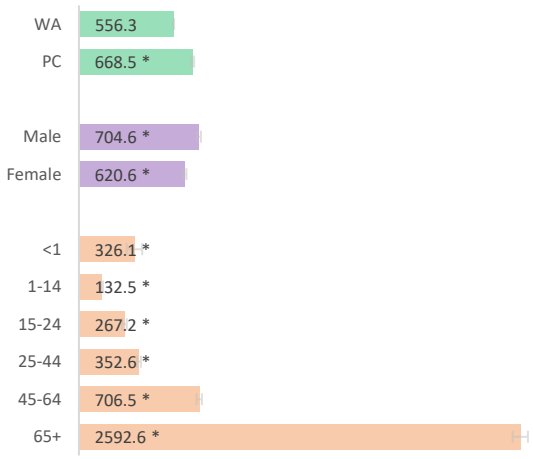
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: Washington State Department of Health CHS, Death Certificate Data, 1990–2016, CHAT, June 2017.

Accidental Hospitalizations

Hospitalizations caused by unintentional injuries are reported as a rate per 100,000 people from hospital discharge data.

Hospitalizations due to accidental injuries are more common in Pierce County than in Washington. Hospitalizations due to unintentional injuries are more common among males and with increasing age.

Unintentional Injury Hospitalizations, Pierce County, 2011-2015



* Value significantly different than in Washington.
Source: WA Hospital Discharge Data, CHARS 1987-2015. Washington State Department of Health CHS, CHAT, August 2016.

Supplement

Quantitative Data Sources

The data sources included in the quantitative analysis range from those providing aggregate results for the populations of interest to those with raw data available for analysis where estimates were generated by Tacoma-Pierce County Health Department.

American Community Survey

American Community Survey (ACS) is a mailed survey is an annual supplement to the 10-year census. The ACS location of residence is based on census tracts, which are converted to zip code tabulation area (ZCTA) for analysis.

Agency for Healthcare Research and Quality

Prevention quality indicators (PQIs) are a set of measures generated using hospital discharge data (CHARS) based on guidance from the Agency for Healthcare Research and Quality (AHRQ).

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) is the largest, continuously conducted telephone health survey in the world. The survey collects information on a vast array of health conditions, health-related behaviors and risk and protective factor about individual adults. In 2011, a new data weighting approach was implemented, making data before 2011 unreliable for comparison to 2011 and later data.

Comprehensive Hospitalization Abstract Reporting System

Comprehensive Hospitalization Abstract Reporting System (CHARS) houses hospital discharge data, including records on inpatient and observation patient hospital stays.

Community Health Assessment Tool

Community Health Assessment Tool (CHAT) is a web application that allows authorized users to generate estimates for different geographies depending on the data source. Data from an array of data sources is used to generate estimates by zip code, county and state.

Washington State Department of Social and Human Services

Foster care placement services, foster care support services and Child Protective Services aggregate estimates at the county level and school district level are available using the online reporting system available through Washington State Department of Social and Human Services (DSHS).

Enhanced HIV/AIDS Reporting System

The Enhanced HIV/AIDS Reporting System (eHARS) reporting system was developed by CDC and is managed by the Washington State Department of Health. It collects and stores HIV/AIDS case surveillance data. Reported case counts from these data are generated for Pierce County upon request.

Health Resources and Services Administration

Health Professional Shortage Areas (HPSA) information was obtained through the Health Resources and Services Administration (HRSA) Data Warehouse and Map Tool available online, including shapefiles of polygon and point data for HPSAs in mental, dental and primary care.

Healthy Youth Survey

The Healthy Youth Survey (HYS) is a school-based survey is administered in even-numbered years throughout Washington State to students in 6th, 8th, 10th and 12th grades. 10th grade data is used to approximate each indicator for all 8th through 12th grade youth.

Office of Superintendent of Public Instruction

The Washington State Office of Superintendent of Public Instruction (OSPI) provides data on graduation and free or reduced-price meal data through the Comprehensive Education Data and Research System (CEDARS), an online system that captures information regarding student graduation, transfers and drop-outs. The adjusted cohort method follows a single cohort of students for 4 years based on when they first entered 9th grade. The cohort is adjusted by adding in students who transfer into the school and subtracting students who transfer out of the school.

Point-in-Time Count

The Homeless Housing and Assistance Act (ESSHB 2163-2005) requires each county to conduct an annual point-in-time count (PIT) of sheltered and unsheltered homeless people (RCW 43.185C.030) in accordance with the requirement of the United States Department of Housing and Urban Development (HUD). Data was made available for this assessment by Pierce County; however, data for zip codes outside Pierce County were not available. Estimates were generated using data with a geographic identifier (city or zip code).

Birth Certificate Data

The birth certificate record system contains records on all births occurring in the state and nearly all births to residents of Washington State. Information is gathered about the mother, father, pregnancy and child. The information is collected at hospitals and birth centers through forms completed by parents or medical staff, a review of medical charts or a combination of both. Midwives and family members who deliver the baby complete the birth certificate and collect the information from a parent or from their records. Data are compiled by the Washington State Department of Health Center for Health Statistics (CHS).

Death Certificate Data

Funeral directors collect information about the deceased person from an informant who is usually a family member or close friend of the deceased. A certifying physician, medical examiner or coroner generally provides cause of death information. Cause of death data is derived from underlying causes of death. For example, if a person dies of a complication or metastasis of breast cancer, breast cancer would be the underlying cause of death. Data are compiled by the Washington State Department of Health CHS

Washington State Cancer Registry

Washington State Cancer Registry (WSCR) monitors the incidence of cancer in the state to better understand, control and reduce the occurrence of cancer. In 1995, WSCR received funding through CDC's National Program of Central Cancer Registries. This program is designed to standardize data collection and provide information for cancer prevention and control programs. Estimates based on this data were obtained through the Washington State Department of Health's CHAT.

Washington State Immunization Information System

Washington State Immunization Information System (WSIIS) is a lifetime registry that keeps track of immunization records for people of all ages. Estimates were acquired from WSIIS. Immunization reports included data on children 19 to 35 months old, 13 to 17 years old and 15 to 17 years old.

Washington Tracking Network

Washington Tracking Network (WTN) is a collection of environmental public health data. Estimates available through this resource are collected from an array of data sources and serve as a single location to see various measures affecting environmental public health.

Quantitative Methods

Estimates are generated for Washington and Pierce County. In most cases we use SAS 9.4 software to analyze data. In some cases, estimates are provided from an external source. Estimates for sub-populations are also generated and maps are displayed when possible and appropriate. The following definitions help understand the contents of this report:

Rate

A rate is a standardized proportion (or ratio) expressed as the number of events (e.g., live births per year) that have occurred with respect to a standard population, within a defined time period (usually 1 year). Rates help compare disease risk between groups while controlling for differences in population size. The size of the standard population used can vary depending on whether the events are common or rare. For example, since HIV is a rare condition in Washington, HIV incidence rates are expressed as new cases per 100,000. Crude rates are rates calculated for a total population, while age-specific rates are calculated for specific age groups.

Age-Adjustment

All age-adjusted mortality and disease rates in this report are adjusted to the 2000 United States population. The risk of death and disease is affected primarily by age. As a population ages, its collective risk of death and disease increases. As a result, a population with a higher proportion of older residents will have higher crude death and disease rates. To control for differences in the age compositions of the communities being compared, death and certain specific disease rates are age-adjusted. This aids in making comparisons across populations.

Averages

Multiyear average estimates were used in order to increase sample sizes and to minimize widely fluctuating frequencies from year to year.

Confidence Intervals

Pierce County comparisons to Washington State and comparisons among subpopulations were calculated using 95% confidence intervals (CIs). CIs (error bars on graphs) indicate the margin of error for the value estimated by describing an upper and lower limit of an estimate. Using CIs is an approach to determine if differences among groups are statistically significant. If the confidence interval of 2 different estimates do not overlap, we most often can conclude that the difference is statistically significant and not due to chance.

Standard Error

Standard errors (SEs) are used to determine significance between groups in the analysis. Unless noted, these are based on 95% CIs, or an alpha of 0.05. Relative standard error (RSE) is used to determine what statistics are reported. If the RSE is greater than 30% and/or the sample size is too limited to have confidence in these estimates, then they are excluded. If the RSE is greater than 30%, but the estimates may still be reliable, then they are presented but with a "!" to draw attention to this concern.

Stratification

Where possible (i.e., population size or counts were adequate to determine significance and protect anonymity), we analyzed the indicators by race/ethnicity or gender. We used the following terms to describe race/ethnicity:

- NH: Non-Hispanic.
- Asian: Non-Hispanic Asian.
- AIAN: Non-Hispanic American Indian/Alaska Native.
- Black: Non-Hispanic black or African American.
- Hispanic: Hispanic as a race.
- Multiracial: More than 1 race.
- NHOPI: Non-Hispanic Native Hawaiian or Pacific Islander.
- White: Non-Hispanic white or Caucasian.

For some indicators, these stratification levels may not have a sample size adequate to draw reliable conclusions about that population and are therefore excluded from this report. Groups are typically not combined due to concerns about over-generalizations made based on those results.

Selection of Priority Health Needs

Key findings were identified as priority health needs using 4 criteria. A public health epidemiologist reviewed data from each CHA and applied the following criteria:

1. When compared to Washington State, Pierce County numbers are statistically significantly worse (1 point).
2. Existing estimates present a trend in the negative direction (1 point).
3. The measure is related to listed themes from community engagement activities (1 point).
4. There is an appearance of inequity by gender or by race (2 points).

All health indicators and themes are scored and ranked using the above criteria. Based on the results of the ranking, at least 3 and no more than 6 key findings are identified per CHA report.

Appendix 1—Community Workshop Summary

Workshop Methods

The purpose of the community workshops was to hear directly from residents. Ten community workshops (focus groups) were held throughout Pierce County. The same questions were used at all workshops. Four workshops were facilitated by trained community residents. The remainder were facilitated by Tacoma-Pierce County Health Department staff. Notes were handwritten on flip charts or typed on laptops. Participants were promised confidentiality and gave their consent to participate by attending the workshop.

Participant Selection Criteria

Participants from 10 geographies and populations were identified based, in part, on priority communities identified in the 2015 Tacoma-Pierce County Health Department Health Equity Assessment. Specific populations were identified based their geographic location and health outcomes. We also referred to literature on stakeholder selection for Community Health Needs Assessments (CHNAs) produced by the Health Research and Educational Trust, in partnership with Hospitals in Pursuit of Excellence. Participants were recruited by facilitators or Tacoma-Pierce County Health Department staff and some workshops were held at scheduled activities (e.g., community dinner, support group). In some cases, participants invited others to attend (i.e., snowball sampling method).

What We Heard—Major Themes

Question 1: What do you think makes an "ideal" community/neighborhood? What do you like about your community/neighborhood? What do you need?

- **Opportunities to give and receive social support.**
  - People know and care for each other.
  - Cultural knowledge and traditions are shared.
  - Residents care about issues and volunteer often.





- **Diversity is valued.**
  - All people are accepted.
  - Ethnic and cultural diversity are celebrated.
  - Everyone is respected for the value they bring.





- **Community resources.**
  - Reliable source of community information.
  - Parks and other opportunities for physical activities.
  - Unique physical setting of community.
  - Access to services.
  - Behavioral health services and support, including opportunities for training.





- **Organizations and groups willing to partner.**
  - Groups, coalitions and others who provide active leadership.
  - Questions are answered in layman's terms.
  - Regular consensus-building feedback.





Question 2: What needs to change about your community/neighborhood? What is missing? What do you need?

- **Safe sidewalks and trails.**
  - Trails for biking and walking.
  - Americans with Disabilities Act- (ADA-) compliant sidewalks and trails.
  - Connections to schools and services.



- **Buses that meet people where they live, learn, work and shop.**
  - More transit and public transportation.
  - Free bus passes for those who need it.
  - More bus stops.



- **Access to healthy food.**
  - Grocery stores.
  - Healthy eating and cooking education.
  - Farmers markets.



- **Opportunities for physical and social activities.**
  - More parks.
  - Sharing of cultural knowledge—music, dance, drama.
  - Teen-friendly places to hang out.



- **Reliable source of community resource information.**
  - Youth and family support.
  - Programs to meet seniors' needs.
  - Parent training and involvement opportunities.



- **Behavioral health resources.**
  - Substance abuse treatment.
  - Mental health services.
  - Anti-stigma efforts related to mental health.



Appendix—2 Forces of Change

Overview

The Forces of Change Assessment is 1 of 4 assessments conducted as a part of the Community Health Assessment/Community Health Improvement Plan process. This assessment focuses on identifying factors that affect Pierce County residents' health.

Four assessment workshops were held:

- Key Peninsula (rural community partners).
- Tacoma-Pierce County Board of Health.
- Tacoma (urban community partners).
- Tacoma-Pierce County Health Department staff.

The workshops used 4 social determinants as a framework:

- Transportation.
- Food.
- Jobs.
- Housing.

Participants were asked to consider the question: What happened in the past, is happening now or may happen in the future that can affect Pierce County residents' quality of life?

- Trends—Patterns over time, like migration in and out of a community or a growing disillusionment with government.
- Factors—Discrete elements, like a community's large ethnic population, an urban or rural setting or the community's proximity to a major waterway.
- Events—One-time occurrences, like a business or hospital closing, a natural disaster or the passage of new legislation.

Transportation

- + Link light rail expanding in Tacoma.
- Lack of comprehensive transit options.
- Roads are at or near capacity.
- Lack of public transit options in many places.
- Increased commute times contribute to CO^2 emissions.
- Lack of safe sidewalks and crosswalks in some neighborhoods.

Food

- + Food bank network.
- + Trend toward community gardens as source of local fresh produce and community gathering.
- Poverty is a driving force; unhealthy choices are cheaper.
- Time pressures—i.e., families don't have time to prepare healthy meals.
- Disparities related to healthy food access between neighborhoods. Quality of choices vary by area.
- Increase in obesity, diabetes and heart disease.

Jobs

- + Innovative programs and partnerships—e.g., Tacoma Public Schools/MultiCare, Tacoma-Pierce County Health Department/University of Washington—Tacoma.
- + Community colleges offer trade skills and a pathway to 4-year degrees.
- Lack of family-wage jobs.
- Emphasis on 4-year degrees vs. trade schools/programs. This limits those entering the workforce and creates a culture that isn't an appropriate expectation or realistic for all students.
- Cost of commuting.
- Aging workforce.

Housing

- + Trend toward walkable communities.
- Homelessness.
- Housing affordability.
- Challenge for those wanting to own homes and build wealth.
- Housing costs too great a percentage of income.
- Gentrification in some communities.
- Lack of rental options; cost of renting.
- Pierce County residents work in King County (Tacoma and Pierce County as bedroom communities).

General comments

- We are not giving opportunities for everyone to "get in the room at the same time" (to talk about needs and issues). Need high-level, as well as the individual affected by it personally.
- Immigrants moving into Pierce County and the result of the housing squeeze in King County are a perceived driver in the housing market.
- Displacement from King County (due to cost) is causing many issues.
- Access to community resources—e.g., informational resources. Making sure community members know who to talk to, and how to advocate for yourself to improve your conditions. And understand the legislative process.

Appendix—3 Communities of Focus

Health Equity in Action

In 2015, Tacoma-Pierce County Health Department looked at Pierce County data by zip codes to see if any patterns were identifiable. This Health Equity Assessment Report showed which zip codes had the worst health outcomes in the county.

Based on this assessment, Tacoma-Pierce County Health Department established Communities of Focus as an initiative to prioritize efforts in areas of the county with the worst health outcomes. The communities were selected based on health outcome data and if the community has established partnerships and current Health Department programs that could be built on.

In 2015, East Tacoma (98404) was established as the first Community of Focus. In 2017, Key Peninsula (98394 and surrounding areas) and Springbrook (98439) were added. In 2018, work was started in White River (98391 and surrounding areas), Parkland (98444) and South Tacoma (98409).

Communities of Focus is one of the ways Tacoma-Pierce County Health Department demonstrates health equity. Specifically, we direct investments to communities, coordinate Health Department programs to maximize effectiveness and collaborate with partners to improve equity outcomes. Community empowerment is central to Communities of Focus work. An example of this strategy is to empower communities by working directly with residents to help draw out and identify the issues of greatest importance and to facilitate action planning with community driven priorities.

Community Snapshots

Assessments have been prepared for each community to understand key health data, existing partnerships and other important background information. These assessments, or “snapshots,” are intended to be iterative. Tacoma-Pierce County Health Department and each community can use them to mutually update and share important issues and actions:

- East Tacoma.
- Key Peninsula.
- Parkland.
- South Tacoma.
- Springbrook.
- White River.

Each community is in a different phase of development (e.g., little community input received, community engagement in process, priorities established). Working with residents and local leaders to share information and determine important issues and needs will take different levels of effort and engagement within each community. These reports will be updated at regular intervals.

Eden Home Health of King County, LLC
Certificate of Need Application Proposing to Serve
Medicare/Medicaid Patients in Pierce County

ATTACHMENT V

EDEN HOSPICE SURVEY

PLAN OF CORRECTION (POC)

FOR PROVIDERS. BY PROVIDERS.

Organization: Eden Home Health of Spokane County LLC	Company ID: 78724	Application ID: 28175
Address: 13305 E Trent Ave, Spokane, WA		Date Generated: 07/23/2020
Services Reviewed: HHA, MSS, OT, PT, SN, ST	Date of Survey 07/13/2020	Surveyor: Rebecca O'Donnell

INSTRUCTIONS:

- The standards to be addressed are already listed in the first column; the rest should be filled out accordingly. Please see the sample below.
- For Home Health and Hospice, date of compliance for Condition of Participation (CoP) standard-level and ACHC deficiencies must be within 30 calendar days from receipt of Summary of Findings (SOF) and date of compliance for condition-level deficiencies must be within 10 calendar days from receipt of the SOF.
- For Private Duty, Ambulatory Care and Behavioral Health, date of compliance for ACHC deficiencies must be within 30 calendar days from receipt of Summary of Findings (SOF).
- For corrective action measures that require chart audits, please be sure to include the percentage of charts to be audited, frequency of the audit, and target threshold. Ten records or 10% of daily census (whichever is greater) on **at least a monthly basis** is required until threshold is met. Include actions for continued compliance once threshold is met.
- Do not send any Protected Health Information (PHI) or other confidential information with the POC or when submitting evidence to your Account Advisor.
- If you need any assistance, contact your Account Advisor.

SAMPLE: Below is a sample on how to correctly fill out your POC.

ONCE COMPLETED, PLEASE EMAIL THIS FORM TO THE ATTENTION OF YOUR ACCOUNT ADVISOR

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH5-3A, §484.60	Staff will be in-serviced on how to document a complete and individualized plan of care that specifies the care and services necessary to meet the patient's needs.	mo/dd/yr	Clinical Manager	Audit 10% of all active patients to ensure the plan of care is individualized, complete and addresses the care and services necessary to meet the needs of the patient for at least 5 weeks. Target threshold is 95%. Once threshold is met, will continue to audit 10% of all patient records quarterly.	ACHC INTERNAL USE ONLY (LEAVE THIS AREA BLANK)			
HH4-2C.01	Appropriate staff will be in-serviced on requirements of the initial TB screening and annual verification.	mo/dd/yr	Administrator	100% of newly hired, direct care personnel records will be audited within 30 days of hire for evidence that an initial baseline TB screen using TST or BAMT was completed. Threshold is 100% compliance. Once threshold is met, 50% of direct care personnel records will be audited annually.				

PLAN OF CORRECTION (POC)

FOR PROVIDERS. BY PROVIDERS. ACHC

ONCE COMPLETED, PLEASE EMAIL THIS FORM TO THE ATTENTION OF YOUR ACCOUNT ADVISOR

Organization: Eden Home Health of Spokane County LLC

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH1-10A	-Reviewed the policy for contract employees -Regional Director of Operations updated the contract and the employee -Employee signed updated contract and was completed before the surveyor left the site	7/13/2020 Educated Staff 7/27/20 (email)	Business Office Manager (BOM)	-Business Office Manager (BOM) review 100% of contractors contracts at least once a year on their eval date to make sure they are getting an annual evaluation to correlate with contract in place and Eden Policy -Currently is and will continued to be reviewed by Business Office Manger upon hire of the contractor and signed appropriately by contract staff and employer at that time with the known need for yearly evaluation -Email the contract staff to make sure they know that an evaluation will be done at least once a year. Completed on 7/27/20	Yes	No	N/A	
HH7-3C (484.102(c)(2), E-0031)	-Reviewed the policy for Emergency Preparedness -Obtained the contact information for tribal, state and federal agencies(this is in the front pocket of the emergency book for patient acuity kept at the black desk inside front door. -Educated the staff on where to find this information on 7/2720	7/13/20 Educated Staff 7/27/20(email)	Director of Patient Care Services (DPCS) Business Office Manager (BOM)	-We will educate new hires of where to find the information in the office and that they complete the new hire education that is required. (BOM) -We will update phone numbers at least yearly in January and sooner if phone number changes (DPCS)	Yes	No	N/A	

PLAN OF CORRECTION (POC)

FOR PROVIDERS. BY PROVIDERS. ACHC

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH7-3C (484.102(c)(3), E-0032)	-Reviewed the policy for Emergency Preparedness -Obtained the contact information for tribal, state and federal agencies(this is in the front pocket of the emergency book for patient acuity kept at the black desk inside front door. -Educated the staff on where to find this information on 7/2720 -Located the Greater Spokane Comprehensive Emergency management plan(which is available at (https://www.spokanecounty.org/DocumentCenter/View/10508/Greater-Spokane-Comprehensive-Emergency-Management) -Also located the Strategic Plan for the Spokane Valley Fire Department found online good thru 2023(https://www.spokanevalleyfire.com/wp-content/uploads/2018/06/Final-Strat-Plan.pdf)	7/13/20 Educated Staff 7/27/20(email)	Director of Patient Care Services (DPCS) Business Office Manager (BOM)	-We will educate new hires of where to find the information in the office immediately. (BOM) -We will update phone numbers at least yearly in January and sooner if phone number changes to our federal, state, tribal, and local staff (DPCS). Will have employee sign Emergency update form that will be in the front of the patient emergency binder -We will update the staff at least yearly and immediately by email if changes to - Make sure staff knows where to find the websites annually in January and will have them sign an Emergency Plan update form that will be kept with the emergency patient binder	Yes	No	N/A	
	-Reviiewed and updated phone list and tree These were all completed before the surveyor left the site as well.		ED (Executive Director), DPCS, BOM	-Employee Tree and phone numbers of all employees will be in the patient emergency binder All staff are educated regarding the Emergency Phone Tree upon hire and with each Emergency Preparedness				

PLAN OF CORRECTION (POC)

FOR PROVIDERS. BY PROVIDERS.

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
				exercise. -Each ED, DPCS, BOM will call the people under them in the phone tree in case of an emergency and never text patient data via text meassage to communicate if phones are down as it is not secure. Email is also an option but no patient information unless it is encrypted.				

FOR PROVIDERS.
BY PROVIDERS.

August 10, 2020

Eden Home Health of Spokane County LLC, DBA Eden Home Health
Mr. Paul Johnson
13305 E Trent Ave
Spokane, WA 99216

Branch Listing:
N/A

Dear Mr. Paul Johnson:

On behalf of Accreditation Commission for Health Care (ACHC), I am pleased to inform you that Eden Home Health of Spokane County LLC has been ***approved for accreditation*** for Home Health with a recommendation for initial Deemed Status. The services approved are Home Health Aide Services, Medical Social Services, Occupational Therapy Services, Physical Therapy Services, Speech Therapy Services, Skilled Nursing Services. Your accreditation is effective July 28, 2020 through July 28, 2023.

By achieving ACHC Accreditation, your company demonstrates its commitment to delivering the highest quality of products and services by complying with ACHC Accreditation Standards and the Centers for Medicare & Medicaid Services' (CMS) Conditions of Participation (CoPs). Maintaining accreditation is contingent upon ongoing compliance with the above requirements during your accreditation period.

ACHC has submitted your regulatory paperwork to the appropriate state and regional offices. The CMS Regional Office (RO) will then make the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13.

ACHC has approved your Plan of Correction (POC) received on July 28, 2020 related to the deficiencies found during your on-site survey, and has concluded that all deficiencies have been resolved. If your POC indicates that evidence is required, submit your evidence of compliance supporting your POC within 60 days of the date of your initial survey decision letter.

Again, congratulations to Eden Home Health of Spokane County LLC for being awarded accreditation. It is an achievement of which your organization can be proud, and one that reflects your dedication to meeting standards that facilitate quality in the provision of care.

If you have any questions, please contact your Account Advisor Valarie Thayer.

Sincerely,

Susan Mills, RN

Susan Mills, RN
Clinical Director

FOR PROVIDERS.
BY PROVIDERS.
ACHC

August 10, 2020

CMS Central Office
CMS R10 - Seattle
State of Washington

RE:
Eden Home Health of Spokane County LLC, DBA Eden Home Health
Mr. Paul Johnson
13305 E Trent Ave
Spokane, WA 99216

Program Type: HH
CCN#: Pending
AOID#: 7872403

Survey Type: Initial
Survey Dates: July 13, 2020 - July 14, 2020
Accreditation Dates: July 28, 2020 - July 28, 2023
Accreditation Decision: Full
Plan of Correction Received Date: July 28, 2020

Accreditation Commission for Health Care (ACHC) has ***approved*** Eden Home Health of Spokane County LLC for the Home Health program with a recommendation for initial Deemed Status. Services approved are Home Health Aide Services, Medical Social Services, Occupational Therapy Services, Physical Therapy Services, Speech Therapy Services, Skilled Nursing Services.

ACHC received an acceptable Plan of Correction for any standard-level or ACHC deficiencies found during your survey. ACHC is recommending initial Deemed Status effective July 28, 2020 through July 28, 2023. The Centers for Medicare & Medicaid Services Regional Office (RO) makes the final determination regarding Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13.

Branch Listing
N/A

Sincerely,

Susan Mills, RN

Susan Mills, RN
Clinical Director

Attachments: ACHC Summary of Findings
CMS-1572
CMS-1515

CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT:

Eden Home Health of Spokane County LLC
d/b/a Eden Home Health
SPOKANE, WASHINGTON

HAS DEMONSTRATED A COMMITMENT TO PROVIDING QUALITY CARE AND SERVICES TO CONSUMERS THROUGH COMPLIANCE WITH ACHC'S NATIONALLY RECOGNIZED STANDARDS FOR ACCREDITATION AND IS THEREFORE GRANTED ACCREDITATION FOR THE FOLLOWING:

HOME HEALTH

FROM *July 28, 2020* THROUGH *July 28, 2023*

PRESIDENT & CHIEF EXECUTIVE OFFICER

CHAIRMAN OF THE BOARD OF COMMISSIONERS

ACCREDITATION COMMISSION FOR HEALTH CARE
ACHC

Attachment 12: Medicare Certification Documentation		
State and Provider	**Medicare Provider Number**	**Comments If Necessary**
Arizona		
Eden Home Health of Sierra Vista, LLC	037099	Change of Ownership, no survey required
Eden Hospice at Sierra Vista, LLC	31522	Change of Ownership, no survey required
Eden Home Health of Safford, LLC	037294	Change of Ownership, no survey required
Eden Hospice at Cochise County, LLC		Not operational
California		
Eden Home Health of Elk Grove, LLC	058314	Survey completed,Plan of Correction (POC)
Idaho		
Eden Home Health of Idaho Falls, LLC	137119	Certificate of Accreditation
Eden Home Health of Sandpoint, LLC	137122	Change of Ownership, no survey required
Nevada		
Quality Health Care Corp. Home Health	297035	Certificate of Accreditation, POC
Eden Hospice at Carson City, LLC	291515	Certificate of Accreditation, POC
Washington		
EmpRes Home Health of Bellingham, LLC	507105	Certificate of Accreditation, POC
Eden Home Health of King County, LLC	507128	Certificate of Accreditation, POC
Eden Home Health of Spokane County, LLC		State license just issued
Eden Home Health of Clark County, LLC		CON review in process

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AZ037099	A. BUILDING: _____ B. WING _____	01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOME HEALTH	4066 EAST MONSANTO DRIVE, UNIT E SIERRA VISTA, AZ 85650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments Based on substantive Administrative review and final approval of the Change of Ownership application, it has been determined the Change of Ownership is effective on January 1, 2020, and no on-site survey was conducted. Jennifer Dick 1/23/2020	Y 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

ATTACHMENT V
Survey Documents

ARIZONA DEPARTMENT OF HEALTH SERVICES
LICENSING

Division of Licensing Services
Bureau of Medical Facilities Licensing

150 North 18th Avenue, Suite 450
Phoenix, Arizona 85007-3242
(602) 364-3030
(602) 792-0466 Fax

DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

January 24, 2020

Cheryl Bellomy
Eden Home Health of Sierra Vista, LLC
4601 Ne 77th Avenue, Suite 300
Vancouver, WA 98662

RE: **HHA9998**
Eden Home Health
4066 East Monsanto Drive, Unit E
Sierra Vista, Arizona 85650

Dear Cheryl Bellomy:

Enclosed is the license to operate a(n) Home Health Agency. The license:

- Is the property of the Department of Health Services;
- Is not transferable to another party; and
- Is valid only at the location indicated on the license.

The licensed capacity and classification of services which you are authorized to provide are specified on the license and cannot be changed without prior approval by the Arizona Department of Health Services. A change in location or ownership of the facility requires an application and licensure prior to the change.

Arizona laws and rules require that a license be conspicuously posted in the reception area of the facility. The law additionally requires that you notify the Department in writing at least thirty (30) days prior to termination of operation.

Should you have any questions, or need more information, please contact our office at (602) 364-3030.

REMINDER: Health Care Institution licensing fees are processed via the online portal system **only**. It is your responsibility to register and access the online portal system. The address to the portal is: https://licensing.azdhs.gov/LicensingOnline/MED. Pursuant to Arizona Revised Statutes (A.R.S.) 36-425 (C)(2), a health care institution's license becomes invalid if the fees are not paid before the licensing fee due date. It is a violation of A.R.S. 36-407(a) to operate a health care institution without a current and valid license. Once your license is no longer valid, an initial application is required to recommence operations.

Sincerely,

Kathryn McCanna

Kathryn McCanna, RN, BSN, CPHQ
Branch Chief, Health Care Institution Licensing
Division of Public Health Licensing

KM:jd

PROPERTY OF THE

ARIZONA DEPARTMENT OF HEALTH SERVICES

Eden Home Health of Sierra Vista, LLC, dba
Eden Home Health
4066 East Monsanto Drive, Unit E
Sierra Vista, AZ 85650

This facility is licensed to operate as a(n) Home Health Agency

Effective: January 1, 2020

Kathryn McCanna

Recommended By: Kathryn McCanna, Branch Chief

License: HHA9998
Change of Ownership

Issued By: Colby Bower, Assistant Director

HEALTH AND WELLNESS FOR ALL ARIZONANS

PURSUANT TO A.R.S. §41-1092.11 (A), UPON SUBMITTAL OF A TIMELY AND SUFFICIENT APPLICATION
THIS LICENSE WILL REMAIN IN EFFECT UNTIL REISSUED OR REVOKED
TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE

ADHS (Rev. 8/02)

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MED4633	A. BUILDING: _____ B. WING _____	01/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOME HEALTH	1491 WEST THATCHER BOULEVARD, SUITE 104 SAFFORD, AZ 85546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments Based on substantive Administrative review and final approval of the Change of Ownership application, it has been determined the Change of Ownership is effective on January 1, 2020, and no on-site survey was conducted. Stacey Kelloway 01/27/2020	Y 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ATTACHMENT V
Survey Documents

ARIZONA DEPARTMENT OF HEALTH SERVICES
LICENSING

Division of Licensing Services
Bureau of Medical Facilities Licensing

150 North 18th Avenue, Suite 450
Phoenix, Arizona 85007-3242
(602) 364-3030
(602) 792-0466 Fax

DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

January 27, 2020

Joseph Maillard
Eden Home Health
4066 E. Monsanto, Suite E
Sierra Vista, Arizona 85560

RE: **HHA10005**
Eden Home Health
1491 West Thatcher Boulevard, Suite 104
Safford, Arizona 85546

Dear Joseph Maillard:

Enclosed is the license to operate a(n) Home Health Agency. The license:

- Is the property of the Department of Health Services;
- Is not transferable to another party; and
- Is valid only at the location indicated on the license.

The licensed capacity and classification of services which you are authorized to provide are specified on the license and cannot be changed without prior approval by the Arizona Department of Health Services. A change in location or ownership of the facility requires an application and licensure prior to the change.

Arizona laws and rules require that a license be conspicuously posted in the reception area of the facility. The law additionally requires that you notify the Department in writing at least thirty (30) days prior to termination of operation.

Should you have any questions, or need more information, please contact our office at (602) 364-3030.

REMINDER: Health Care Institution licensing fees are processed via the online portal system **only**. It is your responsibility to register and access the online portal system. The address to the portal is: https://licensing.azdhs.gov/LicensingOnline/MED. Pursuant to Arizona Revised Statutes (A.R.S.) 36-425 (C)(2), a health care institution's license becomes invalid if the fees are not paid before the licensing fee due date. It is a violation of A.R.S. 36-407(a) to operate a health care institution without a current and valid license. Once your license is no longer valid, an initial application is required to recommence operations.

Sincerely,

Kathryn McCanna

Kathryn McCanna, RN, BSN, CPHQ
Branch Chief, Health Care Institution Licensing
Division of Public Health Licensing

KM:sk

PROPERTY OF THE

ARIZONA DEPARTMENT OF HEALTH SERVICES

Eden Home Health Of Safford, LLC, dba
Eden Home Health
1491 West Thatcher Boulevard, Suite 104
Safford, AZ 85546

This facility is licensed to operate as a(n) Home Health Agency

Effective: January 1, 2020

Kathryn McCanna

Recommended By: Kathryn McCanna, Branch Chief

License: HHA10005

Change of Owership

Issued By: Colby Bower, Assistant Director

HEALTH AND WELLNESS FOR ALL ARIZONANS

PURSUANT TO A.R.S. §41-1092.11 (A), UPON SUBMITTAL OF A TIMELY AND SUFFICIENT APPLICATION
THIS LICENSE WILL REMAIN IN EFFECT UNTIL REISSUED OR REVOKED
TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE

ADHS (Rev. 8/02)

ATTACHMENT V
Survey Documents

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MED7451	A. BUILDING: _____ B. WING _____	07/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOSPICE	1491 WEST THATCHER BOULEVARD, SUITE 104 SAFFORD, AZ 85546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 000	INITIAL COMMENTS Based on substantive Administrative review and final approval of the Change of Ownership application, it has been determined the Change of Ownership is effective on June 1, 2018, and no on-site survey was conducted. Jennifer Dick 7/2/18	B 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

ARIZONA DEPARTMENT OF HEALTH SERVICES
LICENSING

Division of Licensing Services
Bureau of Medical Facilities Licensing

150 North 18th Avenue, Suite 450
Phoenix, Arizona 85007-3242
(602) 364-3030
(602) 792-0466 Fax

DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

July 2, 2018

Janice Davenport
Eden Hospice at Sierra Vista, LLC
4601 Ne 77th Avenue, Suite 300
Vancouver, WA 98662

RE: **HSPC9013**
Eden Hospice
1491 West Thatcher Boulevard, Suite 104
Safford, Arizona 85546

Dear Janice Davenport:

Enclosed is the license to operate a(n) Hospice Service Agency. The license:

- Is the property of the Department of Health Services;
- Is not transferable to another party; and
- Is valid only at the location indicated on the license.

The licensed capacity and classification of services which you are authorized to provide are specified on the license and cannot be changed without prior approval by the Arizona Department of Health Services. A change in location or ownership of the facility requires an application and licensure prior to the change.

Arizona laws and rules require that a license be conspicuously posted in the reception area of the facility. The law additionally requires that you notify the Department in writing at least thirty (30) days prior to termination of operation.

Should you have any questions, or need more information, please contact our office at (602) 364-3030.

REMINDER: Renewal Applications are processed via the online portal system **only**. It is your responsibility to register and access the online portal system to renew your license, refer to rules 9 A.A.C. 10, Article 1 regarding "renewal license application". Pursuant to Arizona Revised Statutes (A.R.S.) 36-425 (C)(2), a health care institution's license becomes invalid if the fees are not paid before the licensing fee due date. It is a violation of A.R.S. 36-407(a) to operate a health care institution without a current and valid license. Once your license is no longer valid, an initial application is required to recommence operations.

Sincerely,

William Alcock, R.N., J.D.
Bureau Chief
Bureau of Medical Facilities Licensing

WA:jd

PROPERTY OF THE

ARIZONA DEPARTMENT OF HEALTH SERVICES

Eden Hospice at Sierra Vista, LLC, dba
Eden Hospice
1491 West Thatcher Boulevard, Suite 104
Safford, AZ 85546

This facility is licensed to operate as a(n) Hospice Service Agency

Total Capacity: 0

From: June 1, 2018 To: May 31, 2019

Issued: July 2, 2018

Recommended By: William Alcock, Bureau Chief

Issued By: Colby Bower, Assistant Director

License: HSPC9013

Change of Ownership

HEALTH AND WELLNESS FOR ALL ARIZONANS

PURSUANT TO A.R.S. §41-1092.11 (A), UPON SUBMITTAL OF A TIMELY AND SUFFICIENT APPLICATION THIS LICENSE WILL REMAIN IN EFFECT UNTIL REISSUED OR REVOKED

TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE

ADHS (Rev. 8/02)

State of California—Health and Human Services Agency
California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

January 15, 2020

Russel Ramos, Administrator
Eden Home Health
9299 E. Stockton Blvd, Suite 10
Elk Grove, CA 95758

Dear Administrator,

Your plan of correction from the recertification survey conducted December 5, 2019, has been accepted and you have corrected all deficiencies noted during the survey.

If you have any questions concerning this letter, please contact Rhonda Schmitt, Health Facilities Evaluator Supervisor, at (916) 263-5800.

Sincerely,

AGPA

for: Jacqueline Phillips
District Manager

Licensing and Certification Program, Sacramento District Office
3901 Lennane Drive, Suite 210, Sacramento, CA 95834
PHONE (916) 263-5800 • (916) 263-5840 FAX
Internet Address: www.cdph.ca.gov

ATTACHMENT V
Survey Documents

State of California—Health and Human Services Agency
California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

December 11, 2019

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Eden Home Health
Russel Ramos, Administrator
9299 E. Stockton Blvd, Suite 10
Elk Grove, CA 95758

Dear Administrator:

On December 5, 2019, a standard survey was conducted at your agency by the California Department of Public Health, Licensing and Certification Program, to determine if your agency was in compliance with federal participation requirements for home health agencies participating in the Medicare and/or Medicaid programs.

This survey found standard level deficiencies exist in the agency's compliance with conditions of participation. The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS-2567), documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)

A POC for the deficiencies must be submitted within ten (10) calendar days from receipt of the CMS-2567. Your POC must be submitted on the enclosed CMS-2567 form and must contain the following:

- How corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice;
- How the agency will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes the agency will make to ensure that the deficient practice does not recur;

- How the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness; and
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.

Informal Dispute Resolution (IDR)

In accordance with Title 42, Code of Federal Regulations §488.745, you have one opportunity to question cited condition level deficiencies through an IDR process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies and if counsel will be accompanying you, to Jacqueline Phillips, District Manager, California Department of Public Health, Licensing and Certification Program, Sacramento District Office, 3901 Lennane Drive, Suite 210, Sacramento, CA 95834. Upon receipt of request, an IDR meeting will be scheduled, to be conducted by teleconference, written communication, or in person, with the District Manager, District Administrator, or his/her designee.

This request must be sent during the same ten (10) calendar days you have for submitting a POC for the cited deficiencies. An IDR for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have questions concerning the instructions contained in this letter, please contact Rhonda Schmitt, Health Facilities Evaluator Supervisor, at (916) 263-5800.

Sincerely,

Handra Koukl, RFOM

(for) Jacqueline Phillips
District Manager

Enclosure: CMS-2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	058314	A. BUILDING _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOME HEALTH	9299 E STOCKTON BLVD, SUITE 10 ELK GROVE, CA 95624

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Recertification Survey from 12/3/19 through 12/5/19. Representing the Department of Public Health: Health Facilities Evaluator Nurse (HFEN), 38834 HFEN, 36738 HFEN, 40214. The agency reported 729 unduplicated admissions in the previous 12 months, the sample size was 17, and 7 home visits were conducted.	G 000	In effort to avoid future incidence and to ensure that deficient practices do not recur the following measures are implemented immediately. 1. Staff indepth education by DPCS on Medication Reconciliation including Oxygen. 2. QA Staff will review 100% of SOC/ROC documentation to determine if Oxygen is noted in referral documents/MD orders and that orders are appropriately written.	12-18-19 Initiated 12-19-19 and Ongoing
G 580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician. This ELEMENT is not met as evidenced by: Based on interview and record review, the agency failed to ensure the drugs and treatments were administered only as ordered by a physician for one of 17 sampled patients (Patient 1), when he received an oxygen treatment without a physician's order. This failure had the potential for Patient 1 to receive inaccurate care. Findings: Patient 1 had a Start of Care date of 10/9/19 with a primary diagnosis of wound to his lower back. Patient 1's other pertinent diagnoses included high blood pressure and congestive heart failure	G 580	3. Staff joint visits will be conducted by DPCS/Clinical RN manager for all clinicians over the next 3 month with focus to include medication reconciliation Joint visit will continue there after at 10% of active clinicians until 95% or greater compliance with appropriate medication reconciliation. 4. Ongoing education to be provided on quarterly basis for one year on appropriate medication reconciliation and oxygen safety.	Monthly 1-1-20 thru 4-1-20 and ongoing prn 2-29-20 5-31-20 8-31-20 11-30-20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: B Stevenson | TITLE: EXECUTIVE DIRECTOR | (X6) DATE: 1.14.20

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	058314	A. BUILDING _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOME HEALTH	9299 E STOCKTON BLVD, SUITE 10 ELK GROVE, CA 95624

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 580	Continued From page 1 (CHF, a condition when the heart muscle doesn't work well; it pumps less oxygen-rich blood through the body leading to severe shortness of breath). Review of Patient 1's Initial Comprehensive Assessment, dated 10/9/19 included a nursing report, which indicated patient received oxygen to help with his "severe breathlessness." The nurse documented Patient 1 received oxygen at 2 liters per minute via nasal cannula (a lightweight tube with two prongs which are placed in the nostrils and used to deliver supplemental oxygen). Review of Patient 1's physician orders recorded in the Plan of Care (POC), dated 10/9/19, indicated the nurses were to instruct patient regarding oxygen management, care of equipment, and safety. There was no documented evidence Patient 1's clinical records contained a physician order for the oxygen with prescribed liter flow, hours of usage (continuous, with activity, etc.), and delivery mode. A review of the agency's "Verbal Orders Policy," dated 12/17, indicated the purpose was, "To guarantee that physician orders are obtained according to applicable law and regulation." The policy indicated, "Drugs, services, and treatments are administered only as ordered by physician." During a concurrent interview and record review, on 12/5/19, at 12:50 p.m., with the Divisional Manager of Clinical Operations (DMOCO), Patient 1's clinical record, including the Initial Comprehensive Assessment and POC, dated 10/9/19 were reviewed. The DMOCO stated that Patient 1's POC should contain a physician's order for oxygen administration and confirmed	G 580	4, Results and identified trends of Staff joint visits will be reported to Quality Assurance Committee by end of first quarter along with Plan for Improvement prn.	By 4-30-20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	058314	A. BUILDING _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOME HEALTH	9299 E STOCKTON BLVD, SUITE 10 ELK GROVE, CA 95624

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 580	Continued From page 2 there was none.	G 580		
G 682	Infection Prevention CFR(s): 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the agency failed to ensure infection control practices for one of 17 sampled patients (Patient 11) were followed to prevent the spread of infection, when the agency staff did not perform hand hygiene in between multiple glove changes, while conducting wound care treatment. This failure had the potential to place the patient at risk for another wound infection due to contamination (transfer of bacteria to an open wound), and further delay the healing process of the patient's wound. Findings: During a review of Patient 11's "Plan of Care" (POC) record for the recertification period from 11/5/19 to 1/3/20, the "POC" indicated, Patient 11 was admitted to the agency with a Start of Care (SOC) date of November 5th 2019 and had a diagnosis of infection after a surgical procedure. The "physician's order" dated 11/5/19, indicated, "...cleanse wound to lower abdomen with normal saline. Prepare peri-wound area. Fill entire cavity	G 682	1. Staff indepth education by DPCS on infection control Including Hand Hygiene. 2. Staff joint visits will be conducted by DPCS/Clinical RN manager for all clinicians over the next 3 month with focus to include infection control measures and hand hygiene. Joint visits will continue thereafter at 10% of active clinicians until 95% or greater compliance with infection control measures. 3. Ongoing education to be provided on quarterly basis for one year on infection control measures and hand hygiene. 4, Results and identified trends of Staff joint visits will be reported to Quality Assurance Committee by end of first quarter along with Plan for Improvement prn.	12-18-19 Monthly 1-1-20 thru 4-1-20 and ongoing prn 2-29-20 5-31-20 8-31-20 11-30-20 By 4-30-20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	058314	A. BUILDING _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOME HEALTH	9299 E STOCKTON BLVD, SUITE 10 ELK GROVE, CA 95624

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 682	Continued From page 3 with black foam. Apply tubing and cover with transparent drape...Change dressing three times a week and PRN [as needed]..." A Home Visit observation for Patient 11 on 12/4/19 at 11 a.m., was conducted with the director of patient care services (DPCS) and licensed nurse (LN 1). Patient 11 was awake, alert, laying on the couch for a dressing change by LN 1. LN 1 was observed to remove the dirty dressing on Patient 11's lower abdomen, LN 1 removed her gloves however, she did not wash or sanitize her hands after removing the gloves. LN 1 proceeded to put on new gloves and measured the wound. LN 1 again removed her gloves and put on new gloves without washing or sanitizing her hands before she applied the new wound dressing. During an interview on 12/4/19 at 11:20 a.m., with DPCS and LN 1, LN 1 stated she did not wash or sanitize her hands after multiple glove changes. The DPCS stated that the home health agency policy was to sanitize [hands] after every glove change. DPCS further stated that LN 1 forgot to sanitize her hands. During a review of the agency's policy and procedure (P & P) titled, "Hand Hygiene Policy", dated 1/13/17, the P & P indicated, "Staff uses the hand-hygiene techniques...Always after removing gloves..." During a review of the agency's P & P titled, "Standard Precautions Policy", dated 1/6/17, the P & P indicated, "...Hands are washed after removing gloves..."	G 682		
G 710	Provide services in the plan of care	G 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	058314	A. BUILDING _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOME HEALTH	9299 E STOCKTON BLVD, SUITE 10 ELK GROVE, CA 95624

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 4 CFR(s): 484.75(b)(3) Providing services that are ordered by the physician as indicated in the plan of care; This ELEMENT is not met as evidenced by: Based on interview and record review, the agency failed to ensure care provided followed a written Plan of Care (POC) for one of 17 sampled patients (Patient 1), when his oxygen level was not assessed on every visit. This failure placed Patient 1 at risk for complications related to low oxygen level and potentially cause a decline in his medical condition. Findings: Patient 1 had a Start of Care date of 10/9/19 with a primary diagnosis of wound to his lower back. Patient 1's other pertinent diagnoses included high blood pressure and congestive heart failure (CHF, a condition when the heart muscle doesn't work well; it pumps less oxygen-rich blood through the body leading to severe shortness of breath). Review of Patient 1's individualized POC, dated 10/9/19, indicated skilled nurses (SN) were to visit patient twice a week to provide a wound care and manage complications of CHF. The POC directed nurses to observe and assess Patient 1's vital signs and respiratory system to identify changes and intervene to minimize complications. The POC indicated the clinicians were to report to the physician if Patient 1's vital signs were abnormal and were falling outside of the physician established parameters, including oxygen saturation level that was less than 95%	G 710	1. Staff indepth education by DPCS on oxygen including requirement of oxygen saturation measurements every visit. 2. Staff reeducation on MD Orders, requirement for all Interventions and the requirement to follow all MD orders. 3. Staff joint visits will be conducted by DPCS/Clinical RN manager for all clinicians over the next 3 month with focus to include oxygen saturation measurements as ordered by MD. Joint visits will continue thereafter at 10% of active 4. Current EMR provides alerts for VS outside of parameters. These alerts will continue to be processed daily to assure compliance and MD notification.	12-18-19 12-18-19 Monthly 1-1-20 thru 4-1-20 and ongoing prn Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	058314	A. BUILDING _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOME HEALTH	9299 E STOCKTON BLVD, SUITE 10 ELK GROVE, CA 95624

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 5 (normal level is greater than 95%). The POC goal indicated that Patient 1's respiratory exacerbations (worsening, increased shortness of breath) will be identified promptly and abnormal oxygen levels will be reported to physician. Review of Patient 1's Initial Comprehensive Assessment, dated 10/9/19 included a nursing report, which indicated patient had a "severe breathlessness" for which he received the oxygen. The nurse documented Patient 1 received the oxygen at 2 liters per minute via nasal canula (a lightweight tube with two prongs which are placed in the nostrils and used to deliver supplemental oxygen). A review of the clinical record indicated the SN visited Patient 1 on the following days - 10/30, 11/1, 11/12, 11/15, 11/21, 11/25, and 12/3/19. There was no documented evidence Patient 1's oxygen saturation level was measured or assessed on the above dates to determine if there were any changes. A review of the agency's 'Care Planning Policy,' dated 12/17, indicated the purpose was, "To plan and provide individualized care, treatment, and/or services appropriate to the goals and needs of the patients ...to promote positive patient outcome ...Clinical Services are implemented in accordance with a plan of care that is established by a physician's written orders ...Interventions to address the identified patient needs ...consistent with relevant clinical practice guidelines." During a concurrent interview and record review, on 12/5/19, at 12:50 p.m., with the Divisional Manager of Clinical Operations (DMOCO), Patient 1's clinical record was reviewed. The	G 710	5. QA staff will review 100% of SOC/ROC/Recert documentation to assure all parameters are correctly entered. 6. Chart audits for review of Oxygen saturation documenttation on 20% of all visits for 30 day . Once compliance is >90%, chart audits will continue at 10% of active and discharged charts each quarter. 7, Results and identified trends of Staff joint visits and chart audits will be reported to Quality Assurance Committee by end of first quarter along with Plan for Improvement prn.	Initiated 12-19-19 and Ongoing 12-19-19 thru 1-19-20 and prn/ongoing By 4-30-20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	058314	A. BUILDING _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOME HEALTH	9299 E STOCKTON BLVD, SUITE 10 ELK GROVE, CA 95624

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 6 DMOCO stated she did not see Patient 1's saturation level was assessed and documented on 10/30, 11/1, 11/12, 11/15, 11/21, 11/25, and 12/3/19. The DMOCO stated the SN should of followed the physician order and POC and the oxygen saturation level should be assessed and documented on every visit.	G 710	1. Education and review of policy on bedbath provided to HHA.	12-20-19
G 800	Services provided by HH aide CFR(s): 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. This ELEMENT is not met as evidenced by: Based on observation, interview, and record review, the agency failed to ensure the provided services were consistent with the agency's procedure guidance for one of 17 sampled patients (Patient 6), when a full body bed bath was done without changing the water and rinsing the patient. Findings: A review of Patient 6's Plan of Care (POC), dated 10/11/19 through 12/9/19, indicated she was admitted by the agency with multiple diagnoses which included after care for bilateral hip fractures. The POC indicated the Home Health Aide (HHA) was to visit Patient 6 to assist with bathing, personal hygiene, and dressing once a week effective 11/27/19. The 'Aide Care Plan', dated 12/3/19, indicated Patient 6 was to receive a bed bath every visit.	G 800	2. Joint visits by DPCS/RN clinical manager on all bedbath patients x 1 month. If compliance with policy at <90%, will require on going joint visits until compliance met and then annual review. 3. Agency will maintain appropriate supply of basins to allow for compliance with policy. 4, Results and identified trends of Staff joint visits will be reported to Quality Assurance Committee by end of first quarter 2020 along with Plan for Improvement prn.	By 1-20-20 and ongoing prn 12-13-19 By 4-30-20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	058314	A. BUILDING _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOME HEALTH	9299 E STOCKTON BLVD, SUITE 10 ELK GROVE, CA 95624

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 800	Continued From page 7 During a Home Visit on 12/4/19 starting at 11 a.m., the HHA was observed giving a bed bath to Patient 6. The HHA was observed as she filled the wash basin 1/4 full of warm water and started a bed bath. The HHA was observed to apply the soap onto the washcloth and wash Patient 6's right arm and chest. The HHA then placed the washcloth in the basin and wiped the washed area with another washcloth which she then placed in the same wash basin with soapy water. The HHA then proceeded to wash Patient 6's right leg and foot with soap and used the washcloth from soapy water to wipe the washed area. HHA used the same water and the same 2 washcloths to wash and wipe patient's left side, including arm, chest, back, leg, and foot. The HHA did not change the water for the entire body bath which included cleaning the peri-area (groin) and wiped the Patient 6's body with the same washcloth from the soapy water. During an interview on 12/4/19 at 12 p.m., with HHA, she confirmed the washcloth she used for wiping Patient 6's body was rinsed in the same soapy water she used for washing the patient. The HHA stated, "I should of have 2 basins- one for washing and one for rinsing. I forgot to bring the second wash basin." The HHA stated she should of had changed the bath water too. During a review of the agency's HHA's bed bath procedure guidelines, dated February 2018, the guidelines indicated, "Fill wash basin 2/3 full of water...Wash the arm, shoulder, and underarm ...Rinse...Complete with other arm ...Change bath water ..." The guidelines directed the HHA to change the bath water three times during a full body bath.	G 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	058314	A. BUILDING _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOME HEALTH	9299 E STOCKTON BLVD, SUITE 10 ELK GROVE, CA 95624

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 800	Continued From page 8 During an interview on 12/5/19 at 12:50 p.m., Patient 6's bed bath observation was shared with the Divisional Manager of Clinical Operations (DMOCO). The DMOCO stated the wash basin filled with 1/4 of water was not a sufficient amount to give patient a full body bath. The DMOCO stated the HHA should have changed the dirty water at least three times as per agency's procedure guidance.	G 800		

Minutes for Case Conference 1-8-2020

1. Announcements:
    a. New Hires: Christine Spellman, PTA, Coming PD PT on Monday 1-13-20
    b. Census: 75 Goal is 130
    c. Other good news – success stories-
2. General Education:
    a. New SOC booklet: Staff are introduced to new SOC booklet and areas where education is located and to be used. Staff are reminded to document all education in coordination note or narrative.
    b. NOMNC – Staff are reminded of requirements for NOMNC and when and how to complete form.
    c. DX CODES – Staff are instructed that all dx codes even for Kaiser FFS requires all pertinent diagnosis to be added.
    d. PDGM – Staff are educated that PDGM went into effect 1-1-20. Staff are reminded to be mindful of length of episodes and to provide only medically necessary frequency.
    e. PRN MEDICATIONS: Staff are reminded that the frequency has to be included with AS NEEDED MEDICATIONS i.e. every 8 hours as needed and not just "as needed". Staff reminded to continue to provide rationale for PRN medications.
    f. Oxygen Saturations: Staff are reminded to do O2 saturations on all patients. Staff reminded were to document this on their tablets. Staff are aware to request replacement equipment if they have lost they O2 saturations meter.
    g. Treatment Plans/Medication Lists: Staff are reminded that all patients must have up-to-date lists in their homes (usually kept in Eden folder). When supervisors out doing visits with all clinicians over the next 3 months this will be reviewed and if we find we are in compliance 95% of the time, we can stop sending these out to patients. They are costly to print and send as well as take hours of office staff time to stuff into envelopes.
    h. Change in intake on weekend: Staff are informed of the change from Intake being done on Saturdays to now being done on Sundays. Staff who are on call and receive phone calls on status of patients, they are to reach out to Admin on Call if they do not have access to this information.
    i. Staff supervisory visits: Staff are informed that as part of annual competencies and as part of our plan for corrections from survey, all staff will have a supervisory visit performed with emphasis on:
        i. Medication Reconciliation
        ii. Hand Hygiene and Equipment Sanitation
        iii. Oxygen
        iv. Treatment plans being up-to-date
        v. Medication Lists up-to-date and availabile.
    j. Warfarin: Staff are reminded that on medications that change periodically, the medications are to be added to the written list and crossed off when they change. Staff reminded of dosing sheet provide at last conference of a way to accomplish this goal without crowding their medication list with all the frequent changes.

k. Urgent MD visits: Staff are encouraged to consider using urgent care rather than ER for patient need for MD evaluation rather than ED. It will increase patient satisfaction and reduce our ER "dings".
l. Patient satisfaction: Staff are reminded on how to leave a patient – "Is there anything else I can do for you". Establish rapport and value early to improve patient compliance with visits. If they find value in the visits, they will be available when visits are scheduled.
m. Case Conference notes – Staff reminded of need to enter case conference note at least 2 times during an episode to address patient progress towards goals. Staff are informed that chart audits will be including this into the review process to assess compliance with this condition of participation.
n. PDGM and frequencies: Staff are reminded that there will be alerts for LUPA with the new billing model. Staff are reminded to only plot medically necessary visits but to be mindful of this. Staff are further reminded to add all appropriate diagnosis and to be mindful of the order they are placed in. Staff reminded that all co-morbities need to be included since this is now tied to reimbursement and more appropriately reflects the patient condition/situation.
o. M1340 – Staff are provided with a sheet to educate on what conditions constitute wounds.
p. 401K Open Enrollment: Staff are informed that now is open enrollment for qualified staff members to opt in on 401K if they haven't already. Open enrollment ends Friday 1-10-20.
q. Out of Office: Staff informed that Belinda will be out of the office 1-9-20 and 1-10-20. Ashley and Lisa will be available in the office to assist staff prn.

3. Patient Conversations:
   a. Recert/Discharge List reviewed
   b. New SOC patient review
   c. Patient with specific issues discuss

Minutes for Case Conference 12-18-19

1. Announcements:
    a. Welcome New Hires: Gurnam Singh, LVN MSW to start on Thursday
    b. Census: Goal is 130
    c. Other good news – success stories-
    d. Upcoming events: Christmas Party 12.21.19

2. General Education:
    a. Survey findings: Staff are informed of the report from State Survey conducted 12-3-19 to 12-5-19.
    b. Medication Reconciliation: In-depth education provided on how to do a medication reconciliation. Policy reviewed. Medication list requirements further discussed. Quiz provided for teach back. Staff are provided a sample form for use with Warfarin Patients whose doses change frequently. Staff are reminded that the dose needs to updated on the home MAR with each dosage change.
    c. Hand Hygiene and Equipment Sanitation: Policies reviewed and staff reminded of required process when providing patient care.
    d. Oxygen: Staff are reminded that oxygen must be listed as a Medication. Staff reminded that patients on oxygen are to have an evacuation code of Priority 1. Oxygen saturation measurements are also required every visit for patients on oxygen. Best practice is to do oxygen saturation measurements with all VS.
    e. Late documentation: Staff are reminded of policy on documentation guidelines. Staff informed that if visits are not completed, clinicians will not be able to see new patients until this is completed.
    f. Case Conference notes – Staff reminded of need to enter case conference note at least 2 times during an episode to address patient progress towards goals. Staff are informed that chart audits will be including this into the review process to assess compliance with this condition of participation.
    g. Lab orders: Staff are informed of a new process for Lab orders. In addition to putting the order into the usual form i.e. physician order or 485 order, clinicians will add a point of care alert on the frequency of that lab and what labs are needed. INR checks are to be included so the Point Care Alerts will need to be updated regularly. This step is needed to assure that no required labs are missed and that clinicians assigned are aware of that procedure if they are schedule.
    h. Discharge summaries- Staff are reminded that discharge summaries need to recap the entire episode of care – including number of recertification, hospitalizations, falls, adverse events, if any, and the condition at discharge and if patient goals were met. If patient discharged and goals not met, then summary needs to explain why the discharge prior to goals met. Staff are instructed in to use SBAR format. Staff are informed if the discharge summary does not include all aspects required, the clinician will be asked to do a coordination note by coming into the office because once the patient is discharged, they are no longer available on the tablet to the clinician. Clinicians are reminded to add the Discharge Summary to

coordination notes (i.e. copy and paste Narrative if all components are present.) Example provided.

i. Referral dates- Staff are reminded that if the SOC is more than 48 hours from the referral date (i.e. the patient pushes the visit out 2 days or more past the date of original SOC) then the MD must be contacted before the end of the 48 hours to get a verbal order. If the office is aware of the >48 hours post referral, Belinda, Ashley, or Lisa will call for the new order and enter it. If it is the clinician has received the email, it is expectation that the clinician being notified of the delay in SOC to contact the MD for that new SOC order. If clinicians need assistance with this task they can reach out to the office for assistance.

j. Discharge charting- Staff is reminded that interventions such as diabetic foot care, falls, pain, etc should be either yes or N/A. These questions should never be answered no. No means the intervention was appropriate but not provided.

k. PT/INR orders- Staff are reminded to add the PT/INR and dosing orders are to be entered as soon as received from Coumadin clinic. Clinicians will be provided with a verification email but the order should be written as soon as the clinician receives it from the Coumadin clinic. The order from the clinic by phone is the verbal order. Staff were also provided with a blank form to use to provide patients with the dosing instructions while they are in the home.

l. Documentation: Staff are reminded that every narrative needs to be specific to that visit and are cautioned about copy and pasting the narratives and changing only a few words. Staff are reminded that the only portion of the narrative that should be copied from visit to visit is the background. Everything else should be specific to that visit and does not need to be extensive.

m. Documenting PRN orders for Medications: Staff are reminded that all prn medications must have a reason for when the patient should take them and if there is a variable dose such as 1-2 tablets, the reason needs to say when to take 1 and when to take 2.

n. Consents: Staff are remimnded that they cannot provide any care without consents being signed first. If DPOA is not available, then SOC visit will need to be reschedule to allow for signature of appropriate forms.

o. Forcura Mobile Secure Communication: Staff instructed on downloading app for Forcura to work phones to allow for secure texting that can include patient sensitive information without violating HIPPA compliance. Staff present downloaded and accessed App and reviewed.

3. Patient Conversations:
    a. Recert/Discharge List reviewed
    b. New SOC patient review
    c. Patient with specific issues discuss

Medication Reconciliation Quiz

1. When conducting medication reconciliation what step should not be included?

   a) Have patient pull out all medications (including OTC, eye drops, ointments vitamins)
   b) Ask the patient leading questions .. "What would you take if you had..."
   c) Look around the room for any medications in plain site
   (d) Enter the discharge med list from the hospital into PointCare * ONLY
   e) Document all discrepancies between what the patient is taking and what is ordered. Call MD to clarify.

   MEDICATIONS ON LISTED ONLY ON DISCHARGE MED LIST.

2. Home Oxygen Safety Assessment should be done at SOV visits only

   a) True
   (b) False

3. What task is NOT done when conducting a Home Oxygen Risk Assessment?

   a) Check to ensure smoke detectors are present and asking when the last time they were tested
   b) Identify all potential oxygen risks in the home setting
   c) Instruct and document instructions provided to address all risks and the patient's response to instruction.
   (d) Hold a lighter or match near the smoke detector to test to see if it's working properly.

4. Name 5 common items that oxygen patients should avoid using due to increased risk of a fire

   PETROLEUM PRODUCTS; OPEN FLAMES WITHIN 15'; SMOKING; AVOID ELECTRICAL EQUIPMENT NEAR (SPARK RISK); STORE TANKS IN WELL VENTILATED AREA.

5. Scenario – You are a home health clinician conducting an oxygen safety assessment at SOC. Your patient takes you to their hall closet where they store oxygen. The space is cramped with 3 oxygen tanks mixed in with several household items and cleaners. What next step would you take to address this oxygen safety hazard?

1. IMMEDIATELY HAVE THEM REMOVE TANKS FROM CLOSET
2. INSTRUCT IN PROPER STORAGE
3. INSTRUCT ON ~~SE~~ RISK OF FIRE ASSOC W/ CHEMICALS IN CLOSED SPACE
4. INSTRUCT

6. How far away should any open flame be from any source of oxygen (patient, tubing, concentrator, tank)?

a) 3 feet
b) 5 feet
c) 15 feet
d) 20 feet

7. Your patient reports that they take Hawthorne, Echinacea and Ginkgo Biloba sometimes but not regularly. Should these go in the medication profile?

(YES) or NO AS PRN

Should MD be notified?

(YES) or NO

8. While doing a pain assessment patient reports that they take Aleve once or twice a year for a Headache. Should this go in the mediation profile?

(YES) or NO AS PRN

9. Your patient reports that she got some antibiotics while she was in Mexico and she is taking them for an occasional cough. What should be done about this?

DOCUMENT ON MEDICATION LIST OR INSTRUCT NOT TO TAKE UNTIL MD APPROVES

Should MD be notified?

(YES) or NO

INSTRUCT ON RISK OF USE OF ANTIBIOTICS & MD APPR

10. Your patient is taking prednisone and was taking them prior to admission but this is not on the discharge instructions from the hospital. What should you do?

CONTACT MD FOR ORDERS.

ATTACHMENT V
Survey Documents

Medication Reconciliation Process

Before Your Visit:

- ☐ Explain that medication management is our #1 safety concern and that carefully checking medications is the best way to prevent re-hospitalizations and complications
- ☐ Ask patient to gather all medications in one place
- ☐ Ask patient to gather any written instructions received recently (dc summary, MD visit note)

During visit, ask the following:

- ☐ Where all of your medications are located? – Please show me (nightstand, cabinet, refrigerator, car)
- ☐ **Let's review ALL of your medications together** (review each medication bottle)
  - ☐ Can you read the medication label to me?
  - ☐ Can you **Show Me** how you currently take this medication?
    - o How many times per day? At what time?
    - o How many pills do you take each time? With food or without?
    - o Do you take it regularly or as needed?
  - ☐ Do you know why you take this medication? Do you know what it is for?
    - o If patient is unaware, explain medication purpose
  - ☐ Can you tell me about any **precautions** the pharmacist or doctor gave about this medication?
    - o If patient does not recall any instructions, teach most important precautions and problems to report and ask for them to **Teach Back**
  - ☐ Can you open the bottle and close it for me?
  - ☐ If not taking medication – Why not? Did you tell your doctor?
  - ☐ Is there anything that prevents you from taking your medications as prescribed?
    - o Unwanted side effects (Discuss with MD)
    - o I forget to take them (Discuss with MD and family/cg)
    - o It is hard to open and close the bottles (Refer to OT)
    - o Lack of money – Lack of Transportation – Lack of Caregiver (Refer to MSW)
- ☐ **Where are your medications that you are no longer taking?**
- ☐ **Do you take any over-the-counter medication for any of the following?**
  - ☐ Aches/Pains
  - ☐ Headaches
  - ☐ Heartburn
  - ☐ Constipation
  - ☐ Congestion
  - ☐ Cough
  - ☐ Allergies
  - ☐ Insomnia
  - ☐ Dry Eyes
- ☐ **Do you use any of the following?**
  - ☐ Aspirin
  - ☐ Tylenol
  - ☐ Motrin
  - ☐ Vitamins
  - ☐ Herbs
  - ☐ Eye Drops
  - ☐ Inhalers
  - ☐ Resp Txs
  - ☐ Nasal Sprays
  - ☐ Oxygen
  - ☐ Insulin
  - ☐ Creams
  - ☐ Ointments
  - ☐ Suppositories
- ☐ **Do you receive ANY medications (Shots, IV, etc) at your doctor's office or outpatient clinics**
- ☐ Call MD to report discrepancies [illegible] medications – document response
- ☐ Document all discrepancies [illegible]

DATE:_____

INR:_____
COUMADIN DOSING:

SUNDAY:_____

MONDAY:_____

TUESDAY:_____

WEDNESDAY:_____

THURSDAY:_____

FRIDAY:_____

SATURDAY:_____

NEXT INR CHECK:_____

DATE:_____

INR:_____
COUMADIN DOSING:

SUNDAY:_____

MONDAY:_____

TUESDAY:_____

WEDNESDAY:_____

THURSDAY:_____

FRIDAY:_____

SATURDAY:_____

NEXT INR CHECK:_____

DATE:_____

INR:_____
COUMADIN DOSING:

SUNDAY:_____

MONDAY:_____

TUESDAY:_____

WEDNESDAY:_____

THURSDAY:_____

FRIDAY:_____

SATURDAY:_____

NEXT INR CHECK:_____

DATE:_____

INR:_____
COUMADIN DOSING:

SUNDAY:_____

MONDAY:_____

TUESDAY:_____

WEDNESDAY:_____

THURSDAY:_____

FRIDAY:_____

SATURDAY:_____

NEXT INR CHECK:_____

EDEN HOME HEALTH
ITEM G710
SURVEY DATE: 12-5-2019
COLLECTION PERIOD 12-20-19 THRU 1-20-20

OXYGEN SATURATIONS EVERY VISIT

MEDICAL RECORDS AUDIT ROLL UP

Date of Visit PATIENT	# OF YES	# OF NO	TOTAL	% MARKED YES (# OF YES/TOTAL # OF YES/NO)	COMMENTS
12-20-19	37	12	49	76%	
12-27-19	44	11	55	80%	
1-3-20	47	10	57	79%	Audits continue. Identified Clinicians re-educated
1-10-20					
1-17-20					
1-20-20					

ATTACHMENT V
Survey Documents

EDEN HOME HEALTH
ITEM G580
SURVEY DATE: 12-5-2019
COLLECTION PERIOD 12-20-19 THRU 1-20-20

OXYGEN ON MAR/ORDERS

MEDICAL RECORDS AUDIT ROLL UP

Date of Visit PATIENT	# NA	# OF YES	# OF NO	TOTAL	% MARKED YES (# OF YES/TOTAL # OF YES/NO)	COMMENTS
12-20-19	38	3	0	41	100%	NA=NO OXYGEN ORDER
12-27-19	37	4	2*	43	95%	*Missing orders/MAR errors corrected
1-3-20	42	1	1*	44	98%	
1-10-20						
1-17-20						
1-20-20						

ATTACHMENT V
Survey Documents

ONE MEDLINE PLACE
Mundelein, IL 60060–4466
For Customer Service Call:
1–866–356–4997
FAX: 800–351–1512
www.medline.com

ANY SHORTAGES/DAMAGES MUST BE REPORTED TO MEDLINE WITHIN 2 DAYS OF RECEIPT

SHIPPING LOCATION:
MEDLINE INDUSTRIES INC.
42500 WINCHESTER RD
TEMECULA CA B49
TEMECULA, CA 92590

PACKING LIST

SHIPPED TO:
0001636691
418 PRO CARE– ELK GROVE (PHD)
9299 E STOCKTON BLVD STE 10
ELK GROVE, CA 95624

SOLD TO:
0001636691
418 PRO CARE– ELK GROVE (PHD)
9299 E STOCKTON BLVD STE 10
ELK GROVE, CA 95624

Order Date: 12/06/2019

Sales Order: 0716830769
Buyer: 0
Customer PO: BRANCH

Shipping Instructions:

DELIVERY #	SHIP DATE	SALES REP	SHIPPED VIA	BILL OF LADING
0976487567	12/06/2019	603	FDXG	

* – Some or all of this item may be packed in mixed product boxes

REC'D	ORD QTY	SHIP QTY			LINE	PO LINE	ITEM	DESCRIPTION
	3	3	BX of 24 EA	*	10	10	BID7797826160	STRIPS,COAGUCHEK XS,1VL/BX,24CT,PA
	1	1	CS of 50 EA		20	20	VLRH36010	WASHBASIN,RECTANGULAR,MAUVE,6 QT

Organization: EmpRes Home Care of Idaho Falls, LLC	Company ID: 66132	Application ID: 17558
Address: 1480 Midway Ave, #7, Ammon, ID		
Services Reviewed: HHA, MSS, OT, PT, SN, ST	Date of Survey 03/21/2017	Surveyor: Debra Nowlin

INSTRUCTIONS

- Standards are already listed under the "Standard" column on the following pages and should be filled out accordingly. There is a sample below.
- Date of compliance for CoP standard level and ACHC deficiencies must be within 30 calendar days from receipt of Summary of Findings.

For Home Health and Hospice, date of compliance for Condition level deficiencies must be within 10 calendar days from receipt of Summary of Findings.

- For corrective action measures that require chart audits, please be sure to include the percentage of charts to be audited, frequency of the audit, and target threshold.

The greater of 10 records or 10% of daily census on at least a monthly basis is required until threshold is met. Include actions for continued compliance once threshold is met.

- Do not send any PHI or other confidential information with the Plan of Correction or when submitting evidence to the Account Advisor.
- Contact your Account Advisor for any questions or if you need help filling out your POC.

SAMPLE

Below is a sample on how to correctly fill out your POC.

ONCE COMPLETED, PLEASE EMAIL THIS FORM TO THE ATTENTION OF YOUR ACCOUNT ADVISOR

ACHC INTERNAL USE ONLY

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual Responsible for Correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant	Evidence Required	Evidence Approved	Comments
HH5-12A (484.30 (a), G177)	Staff will be in-serviced for requirements of documentation of patient response to care, treatment and teaching provided.	18-Jan-15	Branch Director	Audit 10% of visit notes weekly for at least 6 weeks assessing presence of documentation of patient response to care, treatment and teaching provided. Target threshold is 95%. Once threshold is met, will continue to audit 10% of visit notes quarterly.	ACHC INTERNAL USE ONLY. LEAVE THIS AREA BLANK.			
HH4-2C.01	Direct care staff will be in-serviced for requirements of the initial TB screening and annual verification that they are free of symptoms.	8-Jan-15	Administrator	100% of direct care staff personnel records will be audited for evidence of a negative chest x-ray or negative PPD on hire and a negative PPD in the previous 12 months. If no evidence then new hire direct care staff will have an initial PPD and another PPD in 2-3 weeks. Threshold is 100% compliance. Once threshold is met, 50% of direct care staff personnel records will be audited bi-annually.				

Organization: EmpRes Home Care of Idaho Falls, LLC

ACHC INTERNAL USE ONLY

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual Responsible for Correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant	Evidence Required	Evidence Approved	Comments
HH7-1A.01	LPN was re-educated on proper infection control procedures. Staff will be re-educated on proper infection control process by the Clinical Manager or designee on or before 4/13/17	4/13/17	Clinical Manager	Joint visits will occur beginning the week of 4/17/17, 1w3 to ensure compliance with aseptic technique while preparing materials and providing treatment. Once compliance is reached Joint Visits with all employees will occur semi-annually.	Select One	Select One	Select One	
HH5-7A	MD notifications of Discipline Discharge have been sent in a timely manner. Staff will be educated to ensure that Discharge Summaries are sent in a timely manner to the physician at Discipline Discharge and Agency Discharge, by the Clinical Manager, or designee on or before 4/13/17.	4/13/17	Clinical Manager	Audit 95% of Discharge notes will begin the week of 4/17/17; and audit of 95% of patient charts weekly for 2 weeks, then 75% for 2 weeks, 50% for 2 weeks, and 25% for 2 weeks, will be completed by the Clinical Manager or designee to validate that Agency follows Discharge Policy. Once 95% compliance is reached, 10% chart audits will be completed quarterly, per Agency policy.	Select One	Select One	Select One	
HH5-11C	The affected 30 day Re-assessment was found in the patient record, completed on time by the therapist. A review of 30 days assessments from the last 30 days has been reviewed for completeness. Re-education will be provided on or before 4/13/17 to all Therapists (PT,OT,ST) that functional reassessments are completed every 30 days.	4/13/17	Clinical Manager	Audits of 95% of therapy records will begin the week of 4/17/17 , and audits of 95% of patient charts weekly for 2 weeks, then 75% for 2 weeks, 50% for 2 weeks, and 25% for 2 weeks will be completed, by the Clinical Manager or designee to validate that 30-Day Reassessments are completed. After 95% compliance is reached 10% chart audits will be completed quarterly, per Agency policy.	Select One	Select One	Select One	

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual Responsible for Correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant	Evidence Required	Evidence Approved	Comments
HH1-6A (484.14, G123)	The Organizational chart was updated on 3/22/17 to show job duties down to the patient care level. Education will be provided to the HHA staff on the new organizational chart on or before 4/13/17.	4/13/17	Administrator	The Org chart will be reviewed quarterly for needed changes/additions. The Org chart is currently included in the New Hire Orientation process.	Select One	Select One	Select One	
HH5-3A (484.18(a), G159)	Patients identified have had corrections to their plans of care for the types of services and medications, including frequency, duration, and PRN reasons. Staff will be re-educated to ensure that patient specific plans of care are completed for types of services and medications, including frequency, durations, and PRN reasons by the Clinical Manager, or designee on or before 4/13/17.	4/13/17	Clinical Manager	Chart audits of 95% of all admissions, recerts, and resumptions will begin the week of 4/17/17 and audits of 95% of patient charts weekly for 2 weeks, then 75% for 2 weeks, 50% for 2 weeks, and 25% for 2 weeks will be completed, by the Clinical Manager or designee to validate that patient specific plan of care is completed for types of services, medications, including frequency, dosage and PRN reason. After 95% compliance is reached, 10% chart audits will be completed quarterly per Agency policy.	Select One	Select One	Select One	
HH5-11F (484.36(c)(1), G224)	The identified record has had the Home Health Aide plan of care corrected. A review of Home Health Aide Care Plans have been reviewed and corrected to ensure the Care plan does not include the use of PRN of any task or “Per Patient Choice”. Staff re-education will be given on how to properly create a Home Health Aide plan of care,	4/13/17	Clinical Manager	Chart audits of 95% of all Home Health Aide Plans of Care will begin the week of 4/17/17 and audits of 95% of patient charts weekly for 2 weeks, then 75% for 2 weeks, 50% for 2 weeks, and 25% for 2 weeks will be completed, by the Clinical Manager or designee to validate the Home Health Aide Care Plan will not	Select One	Select One	Select One	

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual Responsible for Correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant	Evidence Required	Evidence Approved	Comments
	by the Clinical Manager, or designee on or before 4/13/17			include the use of PRN for any task or "Per Patient Choice". After 100% compliance is reached 10% chart audits will be completed quarterly per Agency policy.				
HH5-6A (484.48(a), G238)	Transfer summaries since 3/22/17 have been sent to the receiving facility upon a patient transfer. Staff will be re-educated on when a transfer summary should be completed and sent to appropriate provider by the Clinical Manager or designee on or before 4/13/17	4/13/17	Clinical Manager	Audit 95% of Patient charts with "hold" status will begin the week of 4/17/17 and audits of 95% of patient charts weekly for 2 weeks, then 75% for 2 weeks, 50% for 2 weeks, and 25% for 2 weeks will be completed by the Clinical Manager or designee to validate that Agency follows Transfer Policy. Once 95% compliance is reached, 10% chart audits will be completed quarterly per Agency policy.	Select One	Select One	Select One	
HH5-2F (484.55(c), G337)	Beginning 3/25/17 with all Re-Certification and all Start of Care, the Drug Regimen is reviewed as part of the comprehensive assessment and all PRN medications are reviewed for frequency, dosage and reason. All staff re-educated to ensure that a drug regimen review is a part of the initial comprehensive assessment and ongoing throughout the period of care, by the Clinical Manager or designee on or before 4/13/17.	4/13/17	Clinical Manager	Chart audits of 95% of all admission, recerts, and resumptions will begin the week of 4/17/17 and audits of 95% of patient charts weekly for 2 weeks, then 75% for 2 weeks, 50% for 2 weeks, and 25% for 2 weeks will be completed, by the Clinical Manager or designee to validate that Drug Regimen is completed and ongoing throughout the period of care as part of the comprehensive assessment and all PRN	Select One	Select One	Select One	

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual Responsible for Correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant	Evidence Required	Evidence Approved	Comments
				medications are reviewed for frequency, dosage and reason. After 95% compliance is reached, 10% chart audits will be completed quarterly per Agency policy.				

CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT:

Eden Home Health of Idaho Falls, LLC
d/b/a Eden Home Health
AMMON, IDAHO

HAS DEMONSTRATED A COMMITMENT TO PROVIDING QUALITY CARE AND SERVICES TO CONSUMERS THROUGH COMPLIANCE WITH ACHC'S NATIONALLY RECOGNIZED STANDARDS FOR ACCREDITATION AND IS THEREFORE GRANTED ACCREDITATION FOR THE FOLLOWING:

HOME HEALTH

FROM *April 12, 2017* THROUGH *April 12, 2020*

CHIEF EXECUTIVE OFFICER

CHAIRMAN OF THE BOARD OF COMMISSIONERS

ACHC ACCREDITED · ACHC ACCREDITED · ACHC ACCREDITED · ACHC ACCREDITED

ACHC

June 12, 2018

FOR PROVIDERS.
BY PROVIDERS.™

Quality Health Care Corporation, DBA Eden Home Health
Mrs. Marjo Magboo
1201 Corporate Blvd., Ste. 130
Reno, NV 89502

Branch Listing:
Quality Health Care Corporation, DBA Eden Home Health, 907 Mountain Street, Carson City, NV 89703

Dear Mrs. Marjo Magboo:

On behalf of Accreditation Commission for Health Care (ACHC), I am pleased to inform you that Quality Health Care Corporation has been ***approved for accreditation*** for Home Health with a recommendation for initial Deemed Status. The services approved are Home Health Aide Services, Medical Social Services, Occupational Therapy Services, Physical Therapy Services, Speech Therapy Services, Skilled Nursing Services. Your accreditation is effective May 31, 2018 through May 31, 2021.

By achieving ACHC Accreditation, your company demonstrates its commitment to delivering the highest quality of products and services by complying with ACHC Accreditation Standards and the Centers for Medicare & Medicaid Services' (CMS) Conditions of Participation (CoPs). Maintaining accreditation is contingent upon ongoing compliance with the above requirements during your accreditation period.

ACHC has submitted your regulatory paperwork to the appropriate state and regional offices. The CMS Regional Office (RO) will then make the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13.

ACHC has approved your Plan of Correction (POC) received on May 31, 2018 related to the deficiencies found during your on-site survey, and has concluded that all deficiencies have been resolved. Please remember to submit your evidence of compliance supporting your POC within 60 days of the date of your initial survey decision letter.

Again, congratulations to Quality Health Care Corporation for being awarded accreditation. It is an achievement of which your organization can be proud, and one that reflects your dedication to meeting standards that facilitate quality in the provision of care.

If you have any questions, please contact your Account Advisor Katherine Mitchell.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Program Director

ATTACHMENT V
Survey Documents

FOR PROVIDERS.
BY PROVIDERS.™

June 12, 2018

CMS Central Office
CMS R09 - San Francisco
State of Nevada

RE:
Quality Health Care Corporation, DBA Eden Home Health
Mrs. Marjo Magboo
1201 Corporate Blvd., Ste. 130
Reno, NV 89502

Program Type: HH
CCN#: 297035
AOID#: 7452103

Survey Type: Initial
Survey Dates: May 15, 2018 - May 18, 2018
Accreditation Dates: May 31, 2018 - May 31, 2021
Accreditation Decision: Full
Plan of Correction Received Date: May 31, 2018

Accreditation Commission for Health Care (ACHC) has ***approved*** Quality Health Care Corporation for the Home Health program with a recommendation for initial Deemed Status. Services approved are Home Health Aide Services, Medical Social Services, Occupational Therapy Services, Physical Therapy Services, Speech Therapy Services, Skilled Nursing Services.

ACHC received an acceptable Plan of Correction for any standard-level or ACHC deficiencies found during your survey. ACHC is recommending initial Deemed Status effective May 31, 2018 through May 31, 2021. The Centers for Medicare & Medicaid Services Regional Office (RO) makes the final determination regarding Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13.

Branch Listing
Quality Health Care Corporation, DBA Eden Home Health, 907 Mountain Street, Carson City, NV 89703

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Program Director

Attachments: ACHC Summary of Findings
CMS-1572
CMS-1515

ATTACHMENT V
Survey Documents

CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT:

Quality Health Care Corporation
d/b/a Eden Home Health
RENO, NEVADA

HAS DEMONSTRATED A COMMITMENT TO PROVIDING QUALITY CARE AND SERVICES TO CONSUMERS THROUGH COMPLIANCE WITH ACHC'S NATIONALLY RECOGNIZED STANDARDS FOR ACCREDITATION AND IS THEREFORE GRANTED ACCREDITATION FOR THE FOLLOWING:

HOME HEALTH

FROM *May 31, 2018* THROUGH *May 31, 2021*

CHIEF EXECUTIVE OFFICER

CHAIRMAN OF THE BOARD OF COMMISSIONERS

ACHC ACCREDITED • ACHC ACCREDITED • ACHC ACCREDITED • ACHC

CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT:

Quality Health Care Corporation
d/b/a Eden Home Health
CARSON CITY, NEVADA

HAS DEMONSTRATED A COMMITMENT TO PROVIDING QUALITY CARE AND SERVICES TO CONSUMERS THROUGH COMPLIANCE WITH ACHC'S NATIONALLY RECOGNIZED STANDARDS FOR ACCREDITATION AND IS THEREFORE GRANTED ACCREDITATION FOR THE FOLLOWING:

HOME HEALTH

FROM *May 31, 2018* THROUGH *May 31, 2021*

CHIEF EXECUTIVE OFFICER

CHAIRMAN OF THE BOARD OF COMMISSIONERS

ACHC ACCREDITED · ACHC ACCREDITED · ACHC ACCREDITED · ACHC ACCREDITED

ACHC

Organization: Quality Health Care Corporation	Company ID: 74521	Application ID: 22451
Address: 1201 Corporate Blvd., Ste. 130, Reno, NV		Date Generated: 05/23/2018
Services Reviewed: HHA, MSS, OT, PT, SN, ST	Date of Survey 05/15/2018	Surveyor: Sandra Stephenson

INSTRUCTIONS:

- The standards to be addressed are already listed in the first column; the rest should be filled out accordingly. Please see the sample below.
- For Home Health and Hospice, date of compliance for Condition of Participation (CoP) standard-level and ACHC deficiencies must be within 30 calendar days from receipt of Summary of Findings (SOF) and date of compliance for condition-level deficiencies must be within 10 calendar days from receipt of the SOF.
- For Private Duty and Behavioral Health, date of compliance for ACHC deficiencies must be within 30 calendar days from receipt of Summary of Findings (SOF).
- For corrective action measures that require chart audits, please be sure to include the percentage of charts to be audited, frequency of the audit, and target threshold. Ten records or 10% of daily census (whichever is greater) on **at least a monthly basis** is required until threshold is met. Include actions for continued compliance once threshold is met.
- Do not send any Protected Health Information (PHI) or other confidential information with the POC or when submitting evidence to your Account Advisor.
- If you need any assistance, contact your Account Advisor.

SAMPLE: Below is a sample on how to correctly fill out your POC.

-

ONCE COMPLETED, PLEASE EMAIL THIS FORM TO THE ATTENTION OF YOUR ACCOUNT ADVISOR

Organization: Quality Health Care Corporation

Standard	**Plan of Correction** (Specific action taken to bring standard into compliance)	**Date of Compliance** (Date correction to be completed)	**Title** (Individual responsible for correction)	**Process to Prevent Recurrence** (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	**POC Compliant** (ACHC internal use only)	**Evidence Required** **(ACHC internal use only)**	**Evidence Approved** **(ACHC internal use only)**	**Comments** (ACHC internal use only)
HH2-2A	The Patients rights for Eden Home Health has been updated to include thestatement that the patient has the right to identify visiting members through agency generated photo	05/23/2018	Marjo Magboo RN,ED	The patient rights has been updated to include the statement that the patient has the right to identify exisiting members trough agency generated photo effective 05/23/2018 .It will be distributed by all home health personnel to all new patients effective 5/23/2018. 90% of all patients records will be audited x 5 weeks. Once 90% of threshold is achieved, we will complete 10% of records quarterly to assure that Patients rights that include statement on identifying visiting members through	Yes	No	N/A	5/29/18 Process to prevent recurrence should also include at least an annual review of the statement to ensure all inclusive.

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
				agency generated photo is completed. An annual review of statement of patient rights will be completed to ensure that the statements are current and in compliance with the conditions of participation and ACHC guidelines.				6/1/18-Corrected
HH2-6A (484.50(c)(4), G434)	The Service Agreement Consent has been corrected to show evidence of the disciplines that will provide care and the estimated visit frequencies for each discipline visit. A copy signed by the patient is now uploaded to the chart and a copy is left in the patient folder.	05/15/2018	Jenni Jones RN, DPCS	The new Service Agreement was updated on 5/15/2018 and was distributed to all patient folders and clinicians perfoming start of care. Immediate training was done to all staff. All patients , their caregivers and Medical Power of attorney will have written information about their provision of care. 90% of all patient records will be audited x 5 weeks. Once 90% of threshold is achieved, we will complete 10% record review quarterly to assure compliance of service agreements notifying patients of estimated visits of each home health discipline.	Yes	Yes	Select One	
HH3-4C (484.50(c)(7), G440)	Upon identification of this Deficiency on 5/15/2018. All patients admiited effective 5/16/18 has been provided with documentation of charges for SN, PT, OT, SLP, HHA, PTA, COTA, MSW	5/15/2018	Marjo Magboo, RN ED	The charges for PT, OT, HHA SN, SLP, HHA, PTA, MSW has been provided to all patients in writing effective 5/15/2018.90% of all admission charts will be audited in the next 5 weeks to assure that the patient has written documentation of charges. All clinicians (PT, OT, HHA, SN, SLP, PTA, HHA MSW) has been educated with the requirement to provide documentation of charges on 5/16/18 and 5/24/18. Target threshold 95%. Once threshold is achieved, we will audit 10% of the patient charts quarterly to assure that	Yes	Yes	Select One	5/29/18 Was staff educated on this requirement? 6/1/18-Corrected

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
				documentation of charges are completed.				
HH5-2C (484.55(c)(2), G530)	Patient stengths, goals and preferences must be considered within all comprehensive assessments. Immediate training to all clinicians performing comprehensive assessments to assess client strengths and any personal client preferences and record in the EMR in the form of a Narrative Coordination Note	5/24/2018	Jenni Jones RN, DPCS	Our quality assurance and electronic medical record vendor, Home Care Home Base have added patient strengths and preferences to the comprehensive assessment within our system effective 5/24/2018 .Education was provided to all clinicians who perform comprehensive assessments. 90% of all patient records will be audited x 5 weeks. Once 90% of threshold is achieved, we will complete 10% record review quarterly to assure compliance that patients strengths and preferences are also included with the patient goals.	Yes	Yes	Select One	
HH5-2F (484.55(c)(5), G536)	Medication review is an ongoing part of the care to the patient. Immediate training was done to all clinicans to review all medications each visit and update Medication Profile with each change in the home and within the EMR.	5/17/2018	Jenni Jones RN, DPCS	The clinical manager has provided education to all clinicians regarding Medications on 5/17/2018 . Ongoing education to clinicians regarding medication audits will be provided during staff meetings. 90% of all patient records will be audited x 5 weeks. Once 90% of threshold is achieved, we will complete 10% medical record audits quarterly to assure that medications are updated in the patient's home records and patient medical records.	Yes	Yes	Select One	

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH5-3A (484.60(a)(2), G574)	Staff was immediately educated on how to document and complete an individualized plan of care and a complete medication review.	5/17/2018	Jenni Jones RN,DPCS	Our leadership team will provide ongoing education to clinicians regarding medication audits. 90% of all patient records will be audited x 5 weeks. Once 90% of threshold is achieved, we will complete 10% record review to assure compliance that patients medication profiles will match	Yes	Yes	Select One	
HH5-11A (484.75(b)(3), G710)	Staff was immediately educated on importance of MD ordered visit frequencies and how to document missed visits and notify MD of missed visits.	5/17/2018	Jenni Jones RN,DPCS	Our Electronic medical record was corrected on 5/17/2018 to ensure that plan of care and visit frequencies are followed correctly and that appropriate documentation of missed visits are implemented and sent to MDs. 90% of all patient records will be audited x 5 weeks. Once 90% of threshold is achieved, we will complete 10% of record review to assure compliance that Plan of care and visit frequencies are being followed correctly and MDs are notified of missed visits.	Yes	Yes	Select One	
HH5-11F (484.80(g)(1), G798)	All RNs were immediately trained on preparing patient specific HHA careplans for the HHA to follow and that no choices were left for the HHA to decide. RNs were educated that if there are 2 bath choices for the patient, that the documentation contains the statement “patient is cognitively and physically able to choose between 2 baths.”	5/17/2018	Jenni Jones RN,DPCS	Ongoing education for staff by the clinical managers regarding patient specific HHA care plans. 90% of all patient records will be audited x 5 weeks. Once 90% of threshold is achieved, we will complete 10% record review to assure compliance HHA careplans are correct and that HHAs are documenting visits correctly.	Yes	Yes	Select One	

FOR PROVIDERS.
BY PROVIDERS.™

August 21, 2017

CMS Central Office
CMS R09 - San Francisco
State of Nevada

RE:
Eden Hospice at Carson City, LLC, DBA Eden Hospice
Ms. Marj Magboo
907 Mountain Street
Carson City, NV 89703

Program Type: HSP
CCN#: 291515
AOID#: 7076505

Survey Type: Initial
Survey Dates: July 11, 2017 - July 13, 2017
Accreditation Dates: August 10, 2017 - August 10, 2020
Accreditation Decision: Full
Plan of Correction Received Date: August 10, 2017

Accreditation Commission for Health Care (ACHC) has ***approved*** Eden Hospice at Carson City, LLC for the Hospice program with a recommendation for initial Deemed Status. Services approved are Hospice Care Services.

ACHC received an acceptable Plan of Correction for any standard-level or ACHC deficiencies found during your survey. ACHC is recommending initial Deemed Status effective August 10, 2017 through August 10, 2020. The Centers for Medicare & Medicaid Services Regional Office (RO) makes the final determination regarding Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13.

Branch Listing
N/A

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Program Director

Attachments: ACHC Summary of Findings
CMS-643
CMS-417

August 21, 2017

FOR PROVIDERS.
BY PROVIDERS.™

Eden Hospice at Carson City, LLC, DBA Eden Hospice
Ms. Marj Magboo
907 Mountain Street
Carson City, NV 89703

Branch Listing:
N/A

Dear Ms. Marj Magboo:

On behalf of Accreditation Commission for Health Care (ACHC), I am pleased to inform you that Eden Hospice at Carson City, LLC has been ***approved for accreditation*** for Hospice with a recommendation for initial Deemed Status. The services approved are Hospice Care Services. Your accreditation is effective August 10, 2017 through August 10, 2020.

By achieving ACHC Accreditation, your company demonstrates its commitment to delivering the highest quality of products and services by complying with ACHC Accreditation Standards and the Centers for Medicare & Medicaid Services' (CMS) Conditions of Participation (CoPs). Maintaining accreditation is contingent upon ongoing compliance with the above requirements during your accreditation period.

ACHC has submitted your regulatory paperwork to the appropriate state and regional offices. The CMS Regional Office (RO) will then make the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13.

ACHC has approved your Plan of Correction (POC) received on August 10, 2017 related to the deficiencies found during your on-site survey, and has concluded that all deficiencies have been resolved. Please remember to submit your evidence of compliance supporting your POC within 60 days of the date of your initial survey decision letter.

Again, congratulations to Eden Hospice at Carson City, LLC for being awarded accreditation. It is an achievement of which your organization can be proud, and one that reflects your dedication to meeting standards that facilitate quality in the provision of care.

If you have any questions, please contact your Account Advisor Katherine Mitchell.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Program Director

CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT:

Eden Hospice at Carson City, LLC
d/b/a Eden Hospice

CARSON CITY, NEVADA

HAS DEMONSTRATED A COMMITMENT TO PROVIDING QUALITY CARE AND SERVICES TO CONSUMERS THROUGH COMPLIANCE WITH ACHC'S NATIONALLY RECOGNIZED STANDARDS FOR ACCREDITATION AND IS THEREFORE GRANTED ACCREDITATION FOR THE FOLLOWING:

HOSPICE

FROM *August 10, 2017* THROUGH *August 10, 2020*

CHIEF EXECUTIVE OFFICER

CHAIRMAN OF THE BOARD OF COMMISSIONERS

ACHC ACCREDITED · ACHC ACCREDITED · ACHC ACCREDITED · ACHC ACCREDITED

ACHC

Organization: Eden Hospice at Carson City, LLC	Company ID: 70765	Application ID: 18884
Address: 907 Mountain Street, Carson City, NV		Date Generated: 07/24/2017
Services Reviewed: HSP	Date of Survey 07/11/2017	Surveyor: Patricia MacDonald

INSTRUCTIONS:

- The standards to be addressed are already listed in the first column; the rest should be filled out accordingly. Please see the sample below.
- For Home Health and Hospice, date of compliance for Condition of Participation (CoP) standard-level and ACHC deficiencies must be within 30 calendar days from receipt of Summary of Findings (SOF) and date of compliance for condition-level deficiencies must be within 10 calendar days from receipt of the SOF.
- For Private Duty, date of compliance for ACHC deficiencies must be within 30 calendar days from receipt of Summary of Findings (SOF).
- For corrective action measures that require chart audits, please be sure to include the percentage of charts to be audited, frequency of the audit, and target threshold. Ten records or 10% of daily census (whichever is greater) on **at least a monthly basis** is required until threshold is met. Include actions for continued compliance once threshold is met.
- Do not send any Protected Health Information (PHI) or other confidential information with the POC or when submitting evidence to your Account Advisor.
- If you need any assistance, contact your Account Advisor.

SAMPLE: Below is a sample on how to correctly fill out your POC.

-

ONCE COMPLETED, PLEASE EMAIL THIS FORM TO THE ATTENTION OF YOUR ACCOUNT ADVISOR

Organization: Eden Hospice at Carson City, LLC

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HSP1-1A.01	All documents will be completed and locked within 48 hours.	24-Sep-17	Jackie Carpenter RN, Clinical Manager	Education of all staff on completion and locking of all electronic medical record visit documentation within 48 hours. Audit 50% of all documentation in the next 5 weeks to ensure that all visit documentation is completed and locked within 48 hours. Target threshold 95%. Once threshold is met, continue to audit 20% of the visit notes quarterly.	Yes	No	N/A	

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HSP1-4B (418.100(b), L651)	A job description and orientation in the personnel records of the alternate administrator was established on July12, 2017.	12-Jul-17	Marjo Magboo, Executive Director	An alternate administrator will be given an orientation, a job description of responsibilities as an alternate administrator, signed by the employee. A quarterly and annual review of HR records will be done in order to audit completion of this requirement.	Yes	Yes	Select One	
HSP4-11A (418.102(a), L666)	An alternate medical director will be specified under the contract agreement with Dr. Steven Phillips. The alternate medical director in the absence of Dr. Steven Phillips is identified as Dr. Reed Dopf.	15-Aug-17	Marjo Magboo, RN Executive Director	All contracts related to assignment of Medical director will specify the name of an alternate medical director. Review of medical director contract will be performed quarterly. Updates or changes to medical director staffing/ alternate will be made in the contract as soon as the agency is informed by the medical director.	Yes	Yes	Select One	
HSP5-8B (418.104(e)(2), L683)	All staff will be educated on Discharge Planning and communication to physicians and other providers regarding patient's live discharge. The primary care physician will be informed of reason for live discharge from hospice-revocation, aggressive treatment. A discharge report form will be completed by RN.	24- Sep-17	Jackie Carpenter, RN Clinical manager	90% of live discharges will be audited for completion of Discharge report, notification of primary care physician for reason of live discharge. This audit will be completed in the next 4 weeks. Target threshold 90%. Once threshold is achieved, 20% of all discharges will be audited quarterly for documentation of discharge hand off to patients attending physician.	Yes	Yes	Select One	
HSP1-10A (418.106(d)(1), L692)	Eden Hospice has created a Medication Administration and Safety Form to be added to every admission packet (which includes safe medication destruction). Patients/Patient representative will be educated and will sign proof that education on medication administration, medication safety, and safe medication destruction was completed by RN.	24-Sep-17	Jennifer Kirkpatrick, RN , Clinical Supervisor	90% of admission documentation will be audited for signature acknowledging verification of teaching of medication administration, medication safety, and medication destruction in the next 5 weeks. Target threshold 95%. Once threshold is met, continue to audit 20% of admission documentation regarding medication administration, safety and destruction.	Yes	Yes	Select One	

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HSP1-12A (418.114(b)(1), L785)	All physician providing orders will undergo verification of license under the state of Nevada licensing board. All hospice staff will be educated on verification of physician board licensure when obtaining orders.	24-Sep -17	Marjo Magboo, RN, Executive Director	All hospice personnel will follow policy and procedure on physician licensure verification on the state of Nevada board of Medicine when processing a referral. Monthly verification of all state of Nevada Medical licenses on all active physicians providing hospice orders licenses will be completed.	Yes	Yes	Select One	
HSP5-3C (418.54(b), L523)	On 7/24/17 Clinical Manager reviewed/ reeducated Medical Social Worker (MSW) and Chaplain on condition of participation requirement of completion of assessment within 5 days of admission. An Admission Audit was created to verify and assure that MSW and chaplain visits are done within 5 days of start of care.	24-Aug-17	Jacqueline Carpenter, RN, Clinical Manager	Audit 80% of all admissions and discharges in the next 5 weeks to assure that Medical social work and Chaplain assessments are completed within 5 days from start of care. Threshold: 90% compliance. Once threshold is achieved, 20% electronic medical records will be audited quarterly.	Yes	Yes	Select One	
HSP5-3C (418.54(c)(4), L528)	Current EMR documentation uses prognosis of poor, guarded, fair, good, and excellent. Additional documentation regarding imminence of death will be included on all documentation.	24-Aug-17	Jacqueline Carpenter, RN, Clinical Manager	Audit 80% of All admission and recertification and comprehensive assessment documentation weekly in the next 5 weeks. Audit will assess for compliance with documentation of imminence of death. Threshold is 90% compliance. Once threshold is met, 20% of the records will be audited every month for compliance.	No	Yes	Select One	8/2/17 – How long will the agency initially monitor? At least a month is required.

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HSP5-4A (418.56(c)(4), L549)	Nurses will audit all current patients for indication of PRN orders. Eden Hospice will audit all patients admitted in 2017 for PRN indications within the next month.	24-Aug-17	Jennifer Kirkpatrick, RN, Clinical Supervisor	100% of all active patient medical records will be audited for compliance of documentation of indication of all PRN medication for the next 5 weeks. Target threshold 90%. Once threshold is achieved, 20% of all medical records will be audited quarterly for compliance.	No	Yes	Select One	8/2/17 – How long will the agency initially monitor? At least a month is required.
HSP5-4B (418.56(e)(2), L555)	All staff educated on July 24, 2017 on compliance of written plan of care specifically on Chaplain, Medical social worker, skilled nursing visits, Volunteer visits frequency, assurance that an order is in place before a visit is made.	24-Sep-17	Jacqueline Carpenter, RN, Clinical Manager	Audit 80% of all active charts to review the accuracy of all plans of care and medical orders for the next 5 weeks. Target threshold 90%. Once threshold is achieved, 20% of medical records will be audited quarterly.	No	Yes	Select One	8/2/17 – How long will the agency initially monitor? At least a month is required.
HSP4-13A (418.76(g)(2), L626)	RN and Hospice aide Educational in-service on July 24, 2017 regarding compliance with following the correct ordered frequency of all hospice aide visits.	24-Sep-17	Jennifer Kirkpatrick, RN Clinical Supervisor	Audit 80% of all active patients receiving hospice aide assistance. The audit will focus on frequency and consistency and compliance with physician orders .The audit will be done for the next 5 weeks.Target threshold: 90% compliance. Once threshold is achieved, 20% of medical records will be audited quarterly.	No	Yes	Select One	8/2/17 – How long will the agency initially monitor? At least a month is required.
HSP4-13B (418.76(h)(1), L629)	The registered nurse will make an on-site visit to the patient's residence q 14 days to assess quality of care and assure that hospice aide provides quality of care and follows the Hospice aide care plan. An educational in-service was done on July 24, 2017 to all nurses to remind and educate them of compliance with every 14 days hospice aide supervisory visit.	24-Sep-17	Jennifer Kirkpatrick, RN , Clinical Supervisor	The RN case manager will keep a written schedule and calendar that will identify when the RN supervisory visit for hospice is to occur. Every 14 days on IDG meeting, a list of supervisory visits that are due will be given to all staff as a reminder to complete due supervision. This process will be done for the next 5 weeks. Target threshold 90% compliance. Once threshold is achieved, 20% of all medical records	No	Yes	Select One	8/2/17 – How long will the agency initially monitor? At least a month is required.

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
				will be audited for compliance quarterly.				

Organization: Eden Home Health of King County, LLC	Company ID: 75134	Application ID: 25142
Address: 733 7th Ave., Ste. 110, Kirkland, WA		Date Generated: 05/13/2019
Services Reviewed: HHA, MSS, OT, PT, SN, ST	Date of Survey 05/01/2019	Surveyor: Jayne "Kim" Hall

INSTRUCTIONS:

- The standards to be addressed are already listed in the first column; the rest should be filled out accordingly. Please see the sample below.
- For Home Health and Hospice, date of compliance for Condition of Participation (CoP) standard-level and ACHC deficiencies must be within 30 calendar days from receipt of Summary of Findings (SOF) and date of compliance for condition-level deficiencies must be within 10 calendar days from receipt of the SOF.
- For Private Duty and Behavioral Health, date of compliance for ACHC deficiencies must be within 30 calendar days from receipt of Summary of Findings (SOF).
- For corrective action measures that require chart audits, please be sure to include the percentage of charts to be audited, frequency of the audit, and target threshold. Ten records or 10% of daily census (whichever is greater) on **at least a monthly basis** is required until threshold is met. Include actions for continued compliance once threshold is met.
- Do not send any Protected Health Information (PHI) or other confidential information with the POC or when submitting evidence to your Account Advisor.
- If you need any assistance, contact your Account Advisor.

SAMPLE: Below is a sample on how to correctly fill out your POC.

ONCE COMPLETED, PLEASE EMAIL THIS FORM TO THE ATTENTION OF YOUR ACCOUNT ADVISOR

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH5-3A, §484.60	Staff will be in-serviced on how to document a complete and individualized plan of care that specifies the care and services necessary to meet the patient's needs.	mo/dd/yr	Clinical Manager	Audit 10% of all active patients to ensure the plan of care is individualized, complete and addresses the care and services necessary to meet the needs of the patient for at least 5 weeks. Target threshold is 95%. Once threshold is met, will continue to audit 10% of all patient records quarterly.	ACHC INTERNAL USE ONLY (LEAVE THIS AREA BLANK)			
HH4-2C.01	Appropriate staff will be in-serviced on requirements of the initial TB screening and annual verification.	mo/dd/yr	Administrator	100% of newly hired, direct care personnel records will be audited within 30 days of hire for evidence that an initial baseline TB screen using TST or BAMT was completed. Threshold is 100% compliance. Once threshold is met, 50% of direct care personnel records will be audited annually.				

ONCE COMPLETED, PLEASE EMAIL THIS FORM TO THE ATTENTION OF YOUR ACCOUNT ADVISOR

Organization: Eden Home Health of King County, LLC

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH5-1A	We have provided education to all field clinicians the need to follow our policy on timeliness of documentation. All field clinicians have understanding of the importance of this policy and we will continue to educate and reinforce on this policy. We also addressed tablet issues and set up the clinician with a new tablet.	05/17/2019	Director of Patient Care Services (DPCS)	We will audit 100% of clinical notes for 30 days. Once threshold of 90% has been reached we will audit 10% of notes for timely submission. We will also continue to educate field clinicians on the importance of following our policy and submitting notes within 24 hours of visit end time per our policy.	No	Yes	Select One	5/24/19- The information you listed will address HH5-1A. The standard you have listed is also HH5-1A but with the G tag 1016. This deficiency is in regard to care/services provided and appropriate goals in the POC. Please see your SOF for exact detail of both deficiencies cited.
HH3-4C (484.50(c)(7), G440)	All field clinicians have been educated that they must inform patient verbally and in writing of costs of Home Health Services. We have clarified that this is required for all patients. Clinicians have been trained to have patient sign understanding during SOC.	05/17/2019	DPCS	We will audit 100% of all new admissions for 30 days and once threshold of 100% has been reached we will audit 10% of all new admissions paperwork to ensure ongoing compliance and specifically that the patient was informed verbally and in writing as required.	Yes	Yes	Select One	

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH5-2F (484.55(c)(5), G536)	We have reviewed requirements and educated all clinicians to ensure they complete a comprehensive assessment of all medications each visit to ensure medication list is up to date including new medications added, discontinued medication removed, and prn medications will have reason and timing documented. This assessment will review potential adverse side effects, drug reactions and all required elements.	05/17/2019	DPCS	We will audit 100% of new admissions for 30 days. Once threshold of 100% has been reached we will audit 10% of all admissions to ensure ongoing compliance.	Yes	Yes	Select One	
HH5-3A (484.60(a)(2), G574)	All clinicians have been educated that each patient's written plan of care with all required documentation, including an accurate medication profile, including end dates and PRN reasoning as appropriate, as well as specific orders for non-pharmacological modalities.	05/17/2019	DPCS	We will audit 100% of new admissions for 30 days. Once threshold of 100% has been reached we will audit 10% of all admissions to ensure ongoing compliance.	Yes	Yes	Select One	
HH5-11A (484.75(b)(6), G716)	Clinicians were educated on the importance of making sure clinical documentation is complete, accurate and consistent, as well as addressing the patient's specific skilled need.	05/17/19	DPCS	We will audit 100% of visit notes for 30 days. Once threshold of 90% has been reached we will audit 10% of patients to ensure ongoing compliance.	Yes	Yes	Select One	

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH5-1A (484.110(a)(3), G1016)	Clinicians were educated on the importance of making sure their documentation captured all care and services provided as well as making sure that documentation captured the progression toward goals supporting that the patient was ready for discharge. They were also educated that if goals were unable to be met that they documented why the patient was still being discharged with goals that were not met.	5/29/19	DPCS	We will audit 100% of all Discharges for 30 days. Once threshold of 100% has been reached we will audit 10% of all admissions to ensure ongoing compliance.				

June 21, 2019

FOR PROVIDERS. BY PROVIDERS.
ACHC

Eden Home Health of King County, LLC, DBA Eden Home Health
Mr. Paul Johnson
733 7th Ave., Ste. 110
Kirkland, WA 98033

Branch Listing:
N/A

Dear Mr. Paul Johnson:

On behalf of Accreditation Commission for Health Care (ACHC), I am pleased to inform you that Eden Home Health of King County, LLC has been ***approved for accreditation*** for Home Health with a recommendation for initial Deemed Status. The services approved are Home Health Aide Services, Medical Social Services, Occupational Therapy Services, Physical Therapy Services, Speech Therapy Services, Skilled Nursing Services. Your accreditation is effective May 29, 2019 through May 29, 2022.

By achieving ACHC Accreditation, your company demonstrates its commitment to delivering the highest quality of products and services by complying with ACHC Accreditation Standards and the Centers for Medicare & Medicaid Services' (CMS) Conditions of Participation (CoPs). Maintaining accreditation is contingent upon ongoing compliance with the above requirements during your accreditation period.

ACHC has submitted your regulatory paperwork to the appropriate state and regional offices. The CMS Regional Office (RO) will then make the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13.

ACHC has approved your Plan of Correction (POC) received on May 29, 2019 related to the deficiencies found during your on-site survey, and has concluded that all deficiencies have been resolved. Please remember to submit your evidence of compliance supporting your POC within 60 days of the date of your initial survey decision letter.

Again, congratulations to Eden Home Health of King County, LLC for being awarded accreditation. It is an achievement of which your organization can be proud, and one that reflects your dedication to meeting standards that facilitate quality in the provision of care.

If you have any questions, please contact your Account Advisor Valarie Thayer.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Program Director

FOR PROVIDERS. BY PROVIDERS.

June 21, 2019

CMS Central Office
CMS R10 - Seattle
State of Washington

RE:
Eden Home Health of King County, LLC, DBA Eden Home Health
Mr. Paul Johnson
733 7th Ave., Ste. 110
Kirkland, WA 98033

Program Type: HH
CCN#: Pending
AOID#: 7513403

Survey Type: Initial
Survey Dates: May 1, 2019 - May 2, 2019
Accreditation Dates: May 29, 2019 - May 29, 2022
Accreditation Decision: Full
Plan of Correction Received Date: May 29, 2019

Accreditation Commission for Health Care (ACHC) has ***approved*** Eden Home Health of King County, LLC for the Home Health program with a recommendation for initial Deemed Status. Services approved are Home Health Aide Services, Medical Social Services, Occupational Therapy Services, Physical Therapy Services, Speech Therapy Services, Skilled Nursing Services.

ACHC received an acceptable Plan of Correction for any standard-level or ACHC deficiencies found during your survey. ACHC is recommending initial Deemed Status effective May 29, 2019 through May 29, 2022. The Centers for Medicare & Medicaid Services Regional Office (RO) makes the final determination regarding Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13.

Branch Listing
N/A

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Program Director

Attachments: ACHC Summary of Findings
CMS-1572
CMS-1515

CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT:

Eden Home Health of King County, LLC
d/b/a Eden Home Health
KIRKLAND, WASHINGTON

HAS DEMONSTRATED A COMMITMENT TO PROVIDING QUALITY CARE AND SERVICES TO CONSUMERS THROUGH COMPLIANCE WITH ACHC'S NATIONALLY RECOGNIZED STANDARDS FOR ACCREDITATION AND IS THEREFORE GRANTED ACCREDITATION FOR THE FOLLOWING:

HOME HEALTH

FROM *May 29, 2019* THROUGH *May 29, 2022*

PRESIDENT & CHIEF EXECUTIVE OFFICER

CHAIRMAN OF THE BOARD OF COMMISSIONERS

ACCREDITATION COMMISSION FOR HEALTH CARE
ACHC

ATTACHMENT V
Survey Documents

Organization: EmpRes Home Health of Bellingham	Company ID: 76967	Application ID: 25612
Address: 316 E McLeaod Rd, Ste. 101, Bellingham, WA		Date Generated: 11/04/2019
Services Reviewed: HHA, MSS, OT, PT, SN, ST	Date of Survey 10/21/2019	Surveyor: Diane Richards

INSTRUCTIONS:

- The standards to be addressed are already listed in the first column; the rest should be filled out accordingly. Please see the sample below.
- For Home Health and Hospice, date of compliance for Condition of Participation (CoP) standard-level and ACHC deficiencies must be within 30 calendar days from receipt of Summary of Findings (SOF) and date of compliance for condition-level deficiencies must be within 10 calendar days from receipt of the SOF.
- For Private Duty and Behavioral Health, date of compliance for ACHC deficiencies must be within 30 calendar days from receipt of Summary of Findings (SOF).
- For corrective action measures that require chart audits, please be sure to include the percentage of charts to be audited, frequency of the audit, and target threshold. Ten records or 10% of daily census (whichever is greater) on **at least a monthly basis** is required until threshold is met. Include actions for continued compliance once threshold is met.
- Do not send any Protected Health Information (PHI) or other confidential information with the POC or when submitting evidence to your Account Advisor.
- If you need any assistance, contact your Account Advisor.

SAMPLE: Below is a sample on how to correctly fill out your POC.

ONCE COMPLETED, PLEASE EMAIL THIS FORM TO THE ATTENTION OF YOUR ACCOUNT ADVISOR

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH5-3A, §484.60	Staff will be in-serviced on how to document a complete and individualized plan of care that specifies the care and services necessary to meet the patient's needs.	mo/dd/yr	Clinical Manager	Audit 10% of all active patients to ensure the plan of care is individualized, complete and addresses the care and services necessary to meet the needs of the patient for at least 5 weeks. Target threshold is 95%. Once threshold is met, will continue to audit 10% of all patient records quarterly.	ACHC INTERNAL USE ONLY (LEAVE THIS AREA BLANK)			
HH4-2C.01	Appropriate staff will be in-serviced on requirements of the initial TB screening and annual verification.	mo/dd/yr	Administrator	100% of newly hired, direct care personnel records will be audited within 30 days of hire for evidence that an initial baseline TB screen using TST or BAMT was completed. Threshold is 100% compliance. Once threshold is met, 50% of direct care personnel records will be audited annually.				

ONCE COMPLETED, PLEASE EMAIL THIS FORM TO THE ATTENTION OF YOUR ACCOUNT ADVISOR

Organization: EmpRes Home Health of Bellingham

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH5-6A	Educated Medical Records staff about sending Transfer summary Using HBHC Fax now option to be able to capture the Time and Date as well as the recipient of the summary and the summary shows the transfer reason, location and date of transfer in the coordination note portion of the report. If unable to fax from HCHB, they need to attach the manual fax and the confirmation page to the patient's episode attachments. Educated staff about entering a "Clinical" Coordination note with the date, reason, and location of transfer. When note is entered from the back office they will need to check the boxes to pull to the Episode summary, Transfer/DC Summary and the episode detail report.	11/13/19	Director of Patient Care Services	Audit 20 transfers or 25% (whichever is greater) of Transferred patients over at least 30 days. Once the threshold of 90% is met we will audit 10% of our charts quarterly to ensure that our transfer summaries are sent with the correct information and in a timely manner.	Select One	Select One	Select One	
HH5-11A	Skilled Therapy Professionals and RNs will be re-educated that they must provide supervision consistent with State and federal requirements and that supervision is documented appropriately. Educating Schedulers and Clinical Managers that missed visits and rescheduled visits need to be reviewed to ensure that supervision regulations are being met.	11/8/19	Assistant Director of Patient Care Services	Audit 50 charts or 25% of Discharged patients (whichever is greater) for at least 30 days. Once the threshold of 90% is met we will audit 10% of our charts quarterly to ensure that we are in compliance with supervision of our LPNs, Assistants, and Aides.	Select One	Select One	Select One	

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
	Re-educating QA staff about ensuring the supervision visits are plotted with the correct frequency when approving the Plan of Care and the Orders.							
HH5-6A (484.110(a)(6)(i), G1022)	Educated Medical Records that Discharge summaries are required to be sent out within 5 Business days of discharge to the MD.	11/1/19	Director of Patient Care Services	Audit 50 charts or 25% of Discharged patients (whichever is greater) over at least 30 days. Once the threshold of 90% is met we will audit 10% of our charts quarterly to ensure that we are in compliance with Discharge summaries being sent out with in 5 business days of discharge	Select One	Select One	Select One	
HH5-6A (484.110(a)(6)(ii), G1022)	Educated Medical Records that Transfer Summaries are required to be sent out within 2 business days of a planned transfer or within 2 business days of finding out about an unplanned transfers	11/1/19	Director of Patient Care Services	Audit 20 transfers or 25% (whichever is greater) of Transferred patients over at least 30 days. Once the threshold of 90% is met we will audit 10% of our charts quarterly to ensure that we are in compliance with Transfer summaries being sent out with in 2 business days of transfer or of finding out about the transfer	Select One	Select One	Select One	

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH2-6A (484.50(c)(4), G434)	Educate Clinicians about the need to complete the estimated frequency of visits and disciplines providing care on the financial consents.	11.8.19	Assistant Director of Patient Care Services	90% of admits will be audited for at least 30 days. Once we reach a threshold of 90% we will audit 10% of our charts quarterly to ensure that we are in compliance with Frequency and disciplines being listed on the financial consent.	Select One	Select One	Select One	
HH5-6A (484.50(c)(8), G442)	Re-educate Clinical Staff about the need for providing and completing the NOMNC at least 48 hrs prior to Discharge from Agency.	11.13.19	Director of Patient Care Services	Audit 50 charts or 25% of Discharged patients (whichever is greater) over at least 30 days. Once the threshold of 90% is met we will audit 10% of our charts quarterly to ensure that we are in compliance with NOMNCs being completed at least 48 hours prior to Discharge.	Select One	Select One	Select One	
HH5-2F (484.55(c)(5), G536)	Re-educate Clinical Staff about the ongoing need for Medication Regimen Review throughout the episode.	11.13.19	Director of Patient Care Services	Audit 25% of all patients on service over at least 30 days to ensure Medication Regimen Review is ongoing as evidenced by Medications are reconciled, reflect correct dosages without duplications, reasons and frequencies for PRN medications, and specific dosages. Once threshold of 90% is met we will audit 10% of charts quarterly to ensure Medication Regimen Review has taken place.	Select One	Select One	Select One	

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH5-3A (484.60(a)(2), G574)	Educate Clinical Staff regarding required elements within the POC, Software update completed to ensure there is evidence of individualized POC that contains all required elements.	11.13.19	Director of Patient Care Services	Audit 50% of SOC/RC charts over at least 30 days. Software update to provide Nursing goals/outcomes with measureable time frames for outcomes. DME listed in assessment will carry over to POC. Medication Regimen Review to carry over to POC correctly. Safety measures to protect against injury, patients risk for ED visits and hospitalizations. SN to provide parameters for Blood Sugars in Vital Sign parameters as appropriate for patient condition and POC. . Once threshold of 90% is met we will audit 10% of charts quarterly.	Select One	Select One	Select One	
HH5-11A (484.75(b)(3), G710)	Agency staff will be educated that all disciplines ordered will be seen or documented as appropriate. Educate QA to review all services ordered are on POC, educate Clinicians to review referrals to make sure appropriate disiciplines documented within the note reflects on the POC.	11.13.19	Director of Patient Care Services	Audit 20% of SOC charts for at least 30 days that all services ordered have been completed or documented as to why visit was not completes and that physician was notified. Agency will ensure there is evidence that providing services that are ordered by the physician as indicated in the plan of care. Once threshold of 90% is met we will audit 10% of charts quarterly to ensure all ordered services	Select One	Select One	Select One	

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
				are provided or documented.				
HH5-11A (484.75(b)(6), G716)	Educate all Skilled Nurses on how to properly enter wound care provided within HCHB and how to review what the wound care treatment is as well as how to document lab work, including where the lab work was taken, how the procedure was performed, and how the patient tolerated.	11.13.19	Director of Patient Care Services	Audit 20% of all Nursing patients on service over at least 30 days to ensure properly documented wound care and lab draws. Skilled Nurses will be documenting wound care provided in the appropriate section, documenting how labs were drawn, how the patient tolerated and where lab work was taken to or called in to. Once threshold of 90% is met we will audit 10% of charts quarterly to ensure documentation is provided accurately.	Select One	Select One	Select One	
HH4-14A (484.80(h)(1)(i), G808)	Educate Clinical Staff regarding supervision of the Home Health Aide.	11.13.19	Director of Patient Care Services	Audit 50 charts or 25% of Discharged patients' charts (whichever is more), over at least 30 days to ensure we are in compliance with supervision of the Home Health Aides at least every 14 days. Once threshold of 90% is met we will audit 10% of charts quarterly to ensure supervision has taken place per required frequency.	Select One	Select One	Select One	

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH5-11F (484.80(g)(1), G798)	Educate Clinical Staff regarding definition of the duties of the Home Health Aide to ensure implementation of patient care	11.13.19	Director of Patient Care Services	Audit 25 charts or 25% (whichever is higher) of all patients with Home Health Aides that are on service over at least 30 days to ensure the Home Health Aide is assigned the specific patient care instructions prepared by the RN or other appropriate skilled professional. Once threshold of 90% is met we will audit 10% of charts quarterly to ensure Home Health Aides have required patient care instructions.	Select One	Select One	Select One	
HH5-11F (484.80(g)(2), G800)	Educate all Supervising Clinicians and Home Health Aides regarding duties of following the established plan of care as ordered, including obtaining all Vital Signs as ordered (including pulse oximetry). Educate ordering clinician to check box: “Patient is cognitively and physically able to choose between 2 bath types” when applicable for appropriate patients, and choosing 2 separate bath types per patient request/safety.	11.13.19	Director of Patient Care Services	Audit 25 charts or 25% (whichever is higher) of all patients with Home Health Aides that are on service over at least 30 days to ensure the Home Health Aide is following the ordered plan of care prepared by the appropriate skilled professional. Ensure Home Health Aide plan of care states “Patient is cognitively and physically able to choose between 2 bath types” when applicable for appropriate patients. Ensure plan of care frequency and duration is followed as ordered and missed visits are	Select One	Select One	Select One	

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
				completed appropriately. Ensure pulse oximetry and vital signs is being documented appropriately. Once threshold of 90% is met we will audit 10% of charts quarterly to ensure Home Health Aide plan of cares are being followed as ordered.				

November 22, 2019

FOR PROVIDERS. BY PROVIDERS.
ACHC

EmpRes Home Health of Bellingham, DBA Eden Home Health
Ms. Jamie Brown
316 E McLeaod Rd, Ste. 101
Bellingham, WA 98226

Branch Listing:
EmpRes Home Health of Bellingham, DBA Eden Home Health, 1315 E Division, Mt. Vernon, WA 98274

Dear Ms. Jamie Brown:

On behalf of Accreditation Commission for Health Care (ACHC), I am pleased to inform you that EmpRes Home Health of Bellingham has been ***approved for accreditation*** for Home Health with a recommendation for initial Deemed Status. The services approved are Home Health Aide Services, Medical Social Services, Occupational Therapy Services, Physical Therapy Services, Speech Therapy Services, Skilled Nursing Services. Your accreditation is effective November 19, 2019 through November 19, 2022.

By achieving ACHC Accreditation, your company demonstrates its commitment to delivering the highest quality of products and services by complying with ACHC Accreditation Standards and the Centers for Medicare & Medicaid Services' (CMS) Conditions of Participation (CoPs). Maintaining accreditation is contingent upon ongoing compliance with the above requirements during your accreditation period.

ACHC has submitted your regulatory paperwork to the appropriate state and regional offices. The CMS Regional Office (RO) will then make the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13.

ACHC has approved your Plan of Correction (POC) received on November 19, 2019 related to the deficiencies found during your on-site survey, and has concluded that all deficiencies have been resolved. Please remember to submit your evidence of compliance supporting your POC within 60 days of the date of your initial survey decision letter.

Again, congratulations to EmpRes Home Health of Bellingham for being awarded accreditation. It is an achievement of which your organization can be proud, and one that reflects your dedication to meeting standards that facilitate quality in the provision of care.

If you have any questions, please contact your Account Advisor Valarie Thayer.

Sincerely,

Susan Mills, RN

Susan Mills, RN
Clinical Director

FOR PROVIDERS.
BY PROVIDERS.

November 22, 2019

CMS Central Office
CMS R10 - Seattle
State of Washington

RE:
EmpRes Home Health of Bellingham, DBA Eden Home Health
Ms. Jamie Brown
316 E McLeaod Rd, Ste. 101
Bellingham, WA 98226

Program Type: HH
CCN#: 507105
AOID#: 7696703

Survey Type: Initial
Survey Dates: October 21, 2019 - October 24, 2019
Accreditation Dates: November 19, 2019 - November 19, 2022
Accreditation Decision: Full
Plan of Correction Received Date: November 19, 2019

Accreditation Commission for Health Care (ACHC) has ***approved*** EmpRes Home Health of Bellingham for the Home Health program with a recommendation for initial Deemed Status. Services approved are Home Health Aide Services, Medical Social Services, Occupational Therapy Services, Physical Therapy Services, Speech Therapy Services, Skilled Nursing Services.

ACHC received an acceptable Plan of Correction for any standard-level or ACHC deficiencies found during your survey. ACHC is recommending initial Deemed Status effective November 19, 2019 through November 19, 2022. The Centers for Medicare & Medicaid Services Regional Office (RO) makes the final determination regarding Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13.

Branch Listing
EmpRes Home Health of Bellingham, DBA Eden Home Health, 1315 E Division, Mt. Vernon, WA 98274

Sincerely,

Susan Mills, RN

Susan Mills, RN
Clinical Director

Attachments: ACHC Summary of Findings
CMS-1572
CMS-1515

CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT:

EmpRes Home Health of Bellingham
d/b/a Eden Home Health
BELLINGHAM, WASHINGTON

HAS DEMONSTRATED A COMMITMENT TO PROVIDING QUALITY CARE AND SERVICES TO CONSUMERS THROUGH COMPLIANCE WITH ACHC'S NATIONALLY RECOGNIZED STANDARDS FOR ACCREDITATION AND IS THEREFORE GRANTED ACCREDITATION FOR THE FOLLOWING:

HOME HEALTH

FROM *November 19, 2019* THROUGH *November 19, 2022*

PRESIDENT & CHIEF EXECUTIVE OFFICER

CHAIRMAN OF THE BOARD OF COMMISSIONERS

ACCREDITATION COMMISSION FOR HEALTH CARE
ACHC

ATTACHMENT V
Survey Documents

CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT:

EmpRes Home Health of Bellingham
d/b/a Eden Home Health
MT. VERNON, WASHINGTON

HAS DEMONSTRATED A COMMITMENT TO PROVIDING QUALITY CARE AND SERVICES TO CONSUMERS THROUGH COMPLIANCE WITH ACHC'S NATIONALLY RECOGNIZED STANDARDS FOR ACCREDITATION AND IS THEREFORE GRANTED ACCREDITATION FOR THE FOLLOWING:

HOME HEALTH

FROM *November 19, 2019* THROUGH *November 19, 2022*

PRESIDENT & CHIEF EXECUTIVE OFFICER

CHAIRMAN OF THE BOARD OF COMMISSIONERS

ACCREDITATION COMMISSION FOR HEALTH CARE
ACHC

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

December 13, 2019

Cynthia Krall
Paul Johnson
Eden Home Health
316 McLeod Rd STE 101
Bellingham, WA 98226-6491

Re: CMS ID #507105

Dear Mr. Johnson and Ms. Krall:

Your Plan of Correction for the survey ending November 21, 2019 is accepted. No further reports will be necessary. Thank you for your cooperation with the survey process.

Sincerely,

Sarah Benson BSN, RN
Nurse Consultant
Office of Health Systems Oversight
Phone: (360) 236-4665
Fax: (360)586-0123
Email: sarah.benson@doh.wa.gov

cc: File