EMPRES HEALTHCARE GROUP, INC. THROUGH EDEN HOSPICE AT WHATCOM COUNTY, LLC REQUESTS CERTIFICATE OF NEED (CON) APPROVAL TO EXTEND EDEN HOSPICE MEDICARE CERTIFIED AND MEDICAID HOSPICE SERVICES TO SKAGIT COUNTY

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Certificate of Need Application
Hospice Agency

Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990.

Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and WAC 246-310, rules and regulations adopted by the Washington State Department of Health. I attest that the statements made in this application are correct to the best of my knowledge and belief.

Signature and Title of Responsible Officer Jamie Brown, Vice President Eden/EmpRes Home Services **Email Address:** jbrown3@eden-health.com	**Date:** December 28, 2022 Telephone Number: 360-604-4210
Legal Name of Applicant EmpRes Healthcare Group, Inc. Eden Hospice of Whatcom County, LLC **Address of Applicant** EmpRes Healthcare Group, Inc. 2621 NE 134th St., Ste. 140, Vancouver, WA 98686	Provide a brief project description ☐ New Agency X Expansion of Existing Agency ☐ Other:_____ **Estimated capital expenditure:** $ 0.00
Identify the county proposed to be served for this project. Note: Each hospice application must be submitted for one county only. If an applicant intends to obtain a Certificate of Need to serve more than one county, then an application must submitted for each county separately. Skagit County	

Overview

EmpRes Healthcare Group, Inc. through Eden Hospice at Whatcom County, LLC requests certificate of need (CoN) approval to extend Eden hospice Medicare certified and Medicaid hospice services to Skagit County under WAC 246-310-290 (12) The department may grant a certificate of need for a new hospice agency in a planning area where there is not sufficient numeric need – an average daily census of 35 patients – to approve an additional agency.

(a) The department will consider if the applicant meets the following criteria:
(i) All applicable review criteria and standards with the exception of numeric need have been met;
(ii) The applicant commits to serving Medicare and Medicaid patients;
(iii) A specific population is underserved;

EmpRes requests approval to continue along with Skagit Hospice Services to meet the needs of Skagit County residents' for hospice services. Despite ongoing efforts by Skagit Hospice Services, Medicare dual-eligible beneficiary (Medicare and Medicaid) hospice admission rates are 23.3% below the Skagit County rate for non-dual (Medicare only) eligible hospice patients. This large disparity in access and utilization of hospice services in Skagit County among low income, dual-eligible Medicare patients would have added 36 admissions in 2021 (more in later years) and would have generated a 6-patient average daily census if disparity had been eliminated.

There is also clear ongoing ethnic and racial disparity in hospice utilization which totals about 12 patients annually with disparity determined as the differential between the average utilization rate for all Skagit County Medicare beneficiaries and beneficiaries who are Black, Asian, Native American, and Hispanic beneficiaries. While disparity rates are high, the actual number of individuals affected is mall due to the very small number of racial and ethnic minority Skagit County Medicare beneficiaries. This will be discussed later in the application.

Finally, the inability for Skagit County residents to have a choice of hospice provider has created access barriers for additional, specific underserved population cohorts. Eden Hospice at Whatcom County has demonstrated, as a hospice service provider under the Governor Inslee Covid waiver, this countywide need for additional hospice services.[1] Eden has demonstrated in a single year that approximately 40 patients acted on the choice of hospice option and chose Eden hospice in (2022) for services which are projected to grow to at least 54 hospice patients choosing Eden hospice services in 2023.

The reasons for patients selecting Eden rather than Northwest Hospice (e.g., Skagit Hospice Service) are myriad and do not reflect negatively on the services provided by Skagit Hospice Service; **instead, they point to the critical importance of Choice of Provider for Skagit County residents facing the end-of-life as well as underused channels of outreach.** As an example, Eden points to the Death with Dignity population cohort defined by Eden as individuals who are very concerned about maintaining independence in control at the end-of-life and there was ambiguity about how Skagit Hospice Service would meet their very specific needs. Our 2022 year-long experience is that 6% – 7% of our hospice patients expressed these concerns and then chose Eden. Other individuals will choose Skagit Hospice Service based on family experience or choice while a patient is in a hospital setting and is informed about the availability of hospice to immediately help them. As described throughout this application, the important point is that hospice patients and their families receive an invitation to consider hospice services in a place and at a time when they are able to consider their own end-of-life journey.

Further explaining Eden's remarkable first year growth experience, the first obvious reason is that residents were first invited and encouraged by Eden to consider hospice provided by a home health provider with a positive reputation of

1 PROCLAMATION BY THE GOVERNOR AMENDING PROCLAMATION 20-05 20-36

service in Skagit County. While Skagit Hospice Services is a hospital-based provider, it has different channels for obtaining patients although both Eden and Skagit Hospice Services conduct extensive outreach; and only through multiple community connections with Eden and Skagit Hospice Services will patients choose hospice services earlier in their end of life journey or choose hospices at all.

The good news is that the solution to all of the examples of disparity described in this application -- including disparity for the "choice" population cohort -- has already been implemented in Skagit County with the Eden response to Governor Inslee's request for "all hands" to respond to the Covid-19 challenge. Eden joined in supporting Skagit County in this time of need and now community support is more than sufficient to support the community's two, quality hospices with complementary approaches for end of life hospice care. The Department can now, formalize by CoN approval the two hospice agency approach to meeting the hospice needs of Skagit County residents.

Eden has a plan and a strategy to continue to address current unmet need as well as increasing hospice service access through outreach to the dual-eligible Medicare population; initially starting with our home health agency and our nursing home facility in Whatcom County. The latter facility will provide additional access primarily to dual-eligible Medicare beneficiaries in Whatcom County but our learnings from this statewide Eden initiative will be applied in Skagit County and Eden Hospice at Whatcom County can increase hospice referrals from home health agencies and nursing homes serving Skagit County.

Our analysis indicates that we can substantially reduce access barriers based on income for dual-eligible patients and that our approach will also reduce disparity that is based on race, ethnicity, lifestyle and other payer and income-related barriers since Medicare includes all racial, ethnic and lifestyle beneficiaries. For example, hospice admissions for our nursing home is at 20% of benchmark levels and Eden is already moving to increase referrals to hospice services. For home health admissions to hospices, EmpRes Home Health at Bellingham agency is at approximately 45% of our benchmark in Skagit County and Whatcom County. If approved, Eden expects approximately 35 non-duplicative, dual-eligible hospice admits increasing to 60 non-duplicative admits in 2026 and 95 non-duplicative admits in 2027 just from EmpRes entities as well as from other Skagit County nursing homes in the following years.

Reducing the disparity for other payer, racial, ethnic, lifestyle or income cohorts other than the dual-eligible population, will require outreach through a variety of agencies and providers including Eden outreach liaison staff, for these cohorts that face significant, documented access barriers:

- Medicaid population
- Veterans
- Black and African American cohorts
- Hispanic cohorts
- LGBTQ population
- Native American and Alaska Natives

As previously noted, to reduce disparity in access for racial and ethnic population cohorts is a challenge in outreach. Our approach is to start with the outreach channels that our unique EmpRes/Eden strengths, nursing homes and home health agencies and then expand with direct outreach. As an example of direct outreach is the Eden commitment and efforts to achieve Level III in the We Honor Veterans program, which involves hosting and providing community outreach to Veterans organizations. Regarding Medicaid and low income disparity cohorts (as previously noted), Eden will provide direct outreach to nursing homes where a large population of Medicaid patients receive residential (e.g., room and board) services. The general approaches by Eden for these cohorts is outreach with our hospice director and full-time liaison staff . Finally, Eden focuses on cultural competence in providing a care milieu that is welcoming as shown by our Death with Dignity policy and practice that is welcoming. This strategy of increasing hospice utilization to underserved Skagit County residents will only improve the quality of life for patients facing death and for their families and friends who will grieve their loss.

Eden Hospice at Whatcom County, LLC, LLC is wholly owned by EmpRes Healthcare Group, Inc. EmpRes is a 100% employee-owned organization with well-established roots in Skagit County and throughout Washington State. It currently has over 70 operating units in Washington State and regionally including nursing homes, assisted living facilities, home health agencies, home care agencies and Medicare certified hospice agencies. Eden operates a multi-county Medicare and Medicaid home health agency that serves Skagit County. EmpRes also operates a skilled nursing home within Whatcom County and has established a relationship with a nursing home in Skagit County. Eden has successfully implemented its CoN-approved hospice in Whatcom County this year, joining 10 other hospices in the Western states including opening its two hospice agencies in King County and Snohomish County in January 2023.

Need: Eden Hospice at Whatcom County, LLC will serve Medicare and Medicaid patients and employs a charity care policy that is consistent with most Washington State hospitals serving indigent patients. In addition to providing non-duplicative hospice services to reduce dual eligibility disparity in access and reducing patient- determined barriers related to perceived access issues surrounding Death with Dignity (**providing Choice)**, Eden will continue to comply with serving Pediatric hospice patients. Regarding Death with Dignity, Eden is one of only a handful of Washington hospices that fully complies with the requirements of the Death with Dignity statute operating statewide. In addition, as previously noted, Eden participates in the We Honor Veterans program and is currently submitting documentation for Level Three participation in that program

Financial Feasibility: Eden Hospice at Whatcom County, LLC (extended to include Skagit County) is co-located with EmpRes Home Health of Bellingham which will minimize start- up and continuing overhead costs associated with independent solo startups thus reducing breakeven levels. For example, there is no capital expenditure associated with the project because there is a sufficient supply of desk phone/computer setups, and the field clinicians have company-issued cell phone and table from our equipment inventory. Provision of working capital is provided through no-interest capital contributions from EmpRes with the source of capital contributions being cash generated from operations. This funding is backed up by a $40 million line of credit . Eden Hospice at Whatcom County, LLC has already initiated supportive ancillary care relationships with vendors currently under contract with EmpRes Home Health of Bellingham as well as with vendor relationships developed for the Eden Hospice at Whatcom County agency and other EmpRes entities.

Structure and Process of Care: As an established provider in the community, Eden hospice will initially collaborate with EmpRes/Eden entities located within Skagit County. It will then carry out targeted outreach with federally qualified health centers; lead agencies in the DSHS health come project; and other community agencies focused on serving Skagit County Veterans; Hispanic communities; the LGBQT population and with local hospital, physicians, skilled nursing facilities and other providers. EmpRes Home Health at Bellingham is currently working with many of these providers to ensure continuity of care obviating fragmentation. Eden Hospice at Whatcom County will leverage its existing community relationships, within Skagit County and adding respite options and other relationships necessary to support the hospice patient and family members throughout the course of care and during the period of bereavement.

Cost Containment: Hospice care reduces health care expenditures. Appendix S provides the most recent evaluations of the Washington Department of Social a & Health Services (DSHA) Fee for Service Dual-eligible project has reduced Medicare expenses by 10% per year as well as reducing overall Washington Medicaid costs. As of September 2020, 37% of the state dual-eligible program is enrolled in the State Health Home program. In the sixth Demonstration Year (2022) that included Skagit County, Medicare savings were over $54 million with total Medicare savings over the 5-year period of $166.8 million (Appendix S) Medicaid savings have not yet been calculated by the Centers for Medicaid and Medicare Services.

Preliminary total Medicare savings in Demonstration Year 6 were calculated as $54 million or 9.8 percent. Including preliminary attributed Medicare savings estimates of $5.5 million results in a grand total preliminary

Demonstration Year 6 Medicare savings estimate of $59.3 million. The current estimate of grand total Demonstration Medicare savings for all cohorts through Demonstration Year 6 is $293.0 million.

Reducing hospice disparity in utilization through outreach to special populations, primarily the dual-eligible Medicare and Medicaid population, and through integration of all long term care services with hospice, will increase the number of Skagit County hospice patients receiving hospice care, reduce Medicare and beneficiary costs and minimize or eliminate any adverse financial impact on existing providers. In fact, as disparity is reduced through targeted outreach efforts by Eden, other hospice providers and DSHS's health home demonstration project, utilization will increase for all hospices beyond the current Medicare hospice admissions per 1,000 beneficiaries' death rate. At the same time, hospice patients average-length-of-stay will increase.

Regardless of whether the average daily census need is 20, 30, 35 or 40 patients, there are internal cost containment opportunities related with co-location of services. First, in this co-location, minor equipment and remodeling costs can be eliminated. That inventory is sufficient to support the addition Eden Hospice at Whatcom County, LLC hospice staff for Skagit County. The co-shared office location is already wired with secure IT infrastructure. Co-location with the home health agency also optimizes the existing relationships between physicians in the community and the hospice service.

External cost containment can also be achieved with higher hospice utilization levels due to reduced hospital related costs, primarily in the last month of life . As noted in Table 15, a Providence Hospice study (not peer reviewed) showed that Washington State could save over $99 million annually if patients received 5 weeks of hospice care versus no hospice care.[2] Several additional analyses specific to Skagit County (Table 14) further support Washington State findings through e national studies and evaluations showing the importance of early intervention to achieve the Triple Aim of Lower Cost, Better Care and Improved Health of the population, a stated policy of Washington State. A 16-year peer-reviewed national study indicated that all expenditures for healthcare during the final 3 months of life were $10,908 per case compared with cases for patients not treated by hospice. [3] The study also found a $670 savings per family if the patient was enrolled in hospice for 30 days.[4]

[2] CN 19-44. Providence Health and Services Hospice Application. Page 53

[3] Melissa Aldridge, Ab Brody, Peter May, Jaison Moreno, Karen McKendrick, Lihua Li. Association Between Hospice Enrollment and Total Health Care Costs for Insurers and Families, 2002-2018, Jama Health Forum, Feb. 11, 2022. Page 5

[4] *Ibid.* Page 5

Applicant Description

Answers to the following questions will help the department fully understand the role of the applicant(s). Your answers in this section will provide context for the reviews under Financial Feasibility (WAC 246-310-220) and Structure and Process of Care (WAC 246- 310-230).

1. **Provide the legal name(s) and address(es)of the applicant(s).**
   Note: The term "applicant" for this purpose includes any person or individual with a ten percent or greater financial interest in the partnership or corporation or other comparable legal entity as defined in WAC 246-310-010(6).

   The legal name of the applicant is EmpRes Healthcare Group, Inc. EmpRes is a 100% employee-owned organization which currently operates Eden Home Health at Skagit County as well as

   Eden Hospice at Whatcom County
   316 McLeod Rd Suite 104,
   Bellingham, WA 98226

2. **Identify the legal structure of the applicant (LLC, PLLC, etc.) and provide the Unified Business Identifier (UBI).**

   The legal structure of EmpRes Healthcare Group, Inc is a corporation, UBI 602-848-355.

   Please see Appendix B for the Eden chart of organizations

   Eden Hospice at Whatcom County, LLC is an LLC. Its Identifier is IHSFS 61117985. As the December 2022 Letter of Intent states, EmpRes Healthcare Group, Inc. is the sole member of Eden Hospice at Whatcom County, LLC, and wholly owns Eden Hospice at Whatcom County, LLC.
   The UBI for Eden Hospice at Whatcom County is 604 561 430. See Appendix D.
   The UBI for Eden EmpRes Healthcare Group, Inc. is 602-848-355.

3. **Provide the name, title, address, telephone number, and email address of the contact person for this application.**

   Jamie Brown, Vice President of Home Services
   EmpRes Healthcare Group, Inc.
   4601 NE 77th Ave., Ste. 300
   Vancouver, WA 98662
   360-798-8298
   jbrown3@eden-health.com

4. **Provide the name, title, address, telephone number, and email address of the consultant authorized to speak on your behalf related to the screening of this application (if any).**

   Robert McGuirk
   RMC Consulting
   1606 NE 60th Ave.
   Portland, OR 97213
   503-287-4045
   Rmconsulting1@qwestoffice.net

5. **Provide an organizational chart that clearly identifies the business structure of the applicant(s).**

Appendix B provides the organizational chart that clearly identifies the business structure of EmpRes Healthcare Group, Inc. and Eden Hospice at Whatcom County, LLC

6. **Identify all healthcare facilities and agencies owned, operated by, or managed by the applicant. This should include all facilities in Washington State as well as out- of-state facilities. The following identifying information should be included:**
   - **Facility and Agency Name(s)**
   - **Facility and Agency Location(s)**
   - **Facility and Agency License Number(s)**
   - **Facility and Agency CMS Certification Number(s)**
   - **Facility and Agency Accreditation Status**

Appendix V provides the identifying information requested in this question.

1) EmpRes Healthcare Group, Inc.

EmpRes Healthcare Group, Inc. is the sole member of Eden Hospice at Whatcom County, LLC and wholly owns Eden Hospice at Whatcom County, LLC. EmpRes Healthcare Group, Inc will be the certificate of need holder.

EmpRes Healthcare Group, Inc.
4601 NE 77th Ave., Ste. 300
Vancouver, WA 98662
360-798-8298
jbrown3@eden-health.com

2) Eden Hospice at Whatcom County, LLC is the license holder.

Project Description

1. **Provide the name and address of the existing agency, if applicable**.

Eden Hospice at Whatcom County
316 McLeod Rd Suite 104,
Bellingham, WA 98226

2. **If an existing Medicare and Medicaid certified hospice agency, explain if/how this proposed project will be operated in conjunction with the existing agency.**

This question is not applicable because Eden Hospice at the Inland Northwest, LLC is a new agency.

3. **Provide the name and address of the proposed agency. If an address is not yet assigned, provide the county parcel number and the approximate timeline for assignment of the address.**

As previously noted, the address is

Eden Hospice at Whatcom County
316 McLeod Rd Suite 104,
Bellingham, WA 98226

4. Provide a detailed description of the proposed project.

Our Values and Beliefs

Hospice is medical care with an emphasis on pain management and symptom relief for patients with life-limiting illnesses, as well as emotional and spiritual support for patients and those who love and care for them. Eden believes that choosing hospice does not mean that patients or their families and caregivers give up on life. Our Eden multidisciplinary team understands the complexity of issues and feelings that surround hospice care and end of life. Our care process is designed to ***maximize*** our patient's quality of life and support the patient's and caregivers' ability to be in control of end-of-life decision making. Our caregivers can provide 24-7 on-call support, clinical and skilled care, as well as spiritual and emotional counseling continuing through the bereavement process. Eden believes that through effective and compassionate care our patients can approach the end of life with dignity and comfort and in this regard, Eden has a Death with Dignity policy that fully complies with the Washington statute. Eden also reaches out to the LGBQT population that comprises an estimated 3% of the adult population.

Symptom Management

Eden Hospice understands that the experience of someone diagnosed with end stage cardiac disease is very different than that of someone with cancer or pulmonary disease. That is why Eden offers symptom management to control symptoms and promote comfort. No matter what the disease or diagnosis, Eden believes in improving the quality of life when quantity is limited. Eden will also provide supportive therapies such as music therapy and animal-assisted therapy to improve the quality of life for our patients. These services are provided through the Volunteer component of the Eden hospice programs.

Our medical directors focus on symptom management and will work with the patients' attending physicians to order appropriate medications. Our philosophy embraces the idea of relieving pain and other symptoms so that patients are in control of their own comfort. Our goal is to make a patient as comfortable as possible.

Supplies & Equipment

Hospice home care medical equipment can dramatically improve the quality of life of those with life-limiting illnesses. Eden Hospice will manage the ordering and delivery process of the necessary equipment. Medical equipment can:

- Improve Mobility
- Make breathing easier
- Improve quality of sleep and help reduce pain

Eden Hospice will provide patients with the supplies and medical equipment related to the hospice diagnosis, including:

- Respiratory equipment including oxygen and CPAP, BIPAP and nebulizers
- Walkers
- Crutches
- Wheelchairs

Respite Care

Eden believes in supporting both the patient and caregivers. Respite care is provided to the patient when family/caregivers need time away. Patients are placed in a contracted facility for a length of time in accordance with plan benefits (typically up to 5 days). The contracted facility will provide care with the hospice interdisciplinary members to continue making visits and maintain emergency/crisis availability.

Respite care for your caregiver may help prevent:

- Burn-out
- Depression
- Stress, Illness, and Reduced Immunity due to Lack of Sleep

Bereavement Services

Bereavement care is an essential component of hospice care that includes anticipating grief reactions and providing ongoing support for a minimum of one year after the patient has passed. the patient has passed. Patients, families, and caregivers may experience grief as a mental, physical, social, or emotional reaction. Mental reactions can include anger, guilt, anxiety, sadness, and despair. Physical reactions can include sleeping problems, changes in appetite, physical problems, or illness. Eden Hospice is committed to providing information, counseling, and resources for any reaction that may be experienced.

Eden believes that each person takes their own journey through grief and healing. Allowing patients, families, and caregivers to open-up to the idea that not every person experiences and deals with the loss of a loved one in the same way. As there are many cultural and or religious practices supported in communities to help those facing loss, understand that there is no "one way" or "one plan" that can work for everybody.

Hospice bereavement programs focus on:

- Helping family members understand and move forward in the grief process by enabling their expression of thoughts and feelings and helping them identify or develop healthy coping strategies.
- Helping families problem-solve around adjustment issues.
- Providing guidance about decision-making.
- Addressing social and spiritual concerns.
- Assisting survivors to adapt to an environment without the deceased.

Volunteers

Eden recognizes that employees, patients, family members and caregivers live in a web of community-based relationships and one choice that most hospice patients elect is to remain in that community. Eden hospice volunteers facilitate that supportive network of community relationships. Eden hospice volunteers join the caregiving team for a variety of reasons. Our volunteers have various ages, professions, and life experiences. They have an earnest desire to give their time to individuals dealing with a life-limiting illness. Volunteers are fully vetted through a background check.

Hospice volunteers assist with a number of helpful and meaningful activities and support the overall outreach to the community about the benefits of hospice. See below for a complete list of what volunteers can and cannot do. Our volunteers are never asked to do something they are not comfortable doing.

Hospice volunteers can:

- Play cards and games. Watch movies or television.
- Help with light errands.
- Help with light housekeeping and meal preparation.

- Support patient interests, such as music or crafting.
- Provide animal therapy.
- Provide music therapy.
- Read aloud.
- Write letters.
- Do office work, such as data entry, mailings, answer phone calls, etc.
- Provide respite care to family members and/or caregivers.
- Offer companionship and support.
- Offer a calm and peaceful presence by being comforting and supportive.

Volunteers do not substitute for the needed specialized services provided by an experienced, trained and often licensed professional staff. Per the rules of Medicare participation, hospice volunteers may not:

1. Offer feeding assistance.
2. Transfer or transport patients.
3. Give medications.
4. Assist with personal care.
5. Provide counseling services or offer advice.

Eden Hospice is committed to providing information, counseling, and resources. Our support groups can help manage the everyday care and emotional challenges of caring for a dying loved one. Our team of professionals and volunteers address the emotional, social, and spiritual needs of patients and those who love and care for them.

Our Plan for Skagit County

As noted in the Executive Summary and throughout the application, Skagit County residents have experienced limited access to hospice services. Of particular importance in Skagit County is that the existing hospice in Skagit County has institutional constraints in addressing the Death with Dignity statute in Washington, which can restrict access. The national literature and local experience show that perceptions create barriers to access among terminally ill patients and their families concerned about a loss of control in how a patient and family will address dying. Choice also includes many other aspects such as acceptance of differing lifestyles and life experiences. Eden Hospice at Whatcom County, LLC will be co-located with EmpRes Home Health of Bellingham and its referral sources that offer new pathways of outreach to inform patients and families about the benefits of hospice and to facilitate their decisions to select the hospice option when it can provide the most benefit.

Eden Hospice at Whatcom County, LLC has four goals tailored to the unique needs and circumstances in the Skagit County service area to address barriers and resulting access disparity to support increasing hospice admissions and ALOS in hospice care. These barriers have created two unique population cohorts with disparity in utilization, the dual-eligible Medicare beneficiary cohort, and the cohort that is concerned about the means of end of life, which includes Death with Dignity choice concerns.

1. Eden will target outreach activities to dual-eligible Medicare-Medicaid beneficiaries to reduce disparity in low-income populations' access by coordinating our existing long term care resources operating in the Skagit/Whatcom region:
    - EmpRes Home Health of Bellingham, a Medicare certified home health agency
    - North Cascades Health and Rehabilitation Care Center, LLC, a skilled nursing home

    The Skagit County admission rate for hospice care for dual-eligible individuals is 23.3% lower than the non-dual Medicare admission rate per 1,000 Medicare beneficiaries. North Cascades Health and Rehabilitation Care Center has had only 2 hospice patients in 2022, well below our nursing home

benchmark given that on average 25% of nursing home convalescent patients are hospice eligible. EmpRes Hospice of Bellingham is at 45% of benchmark levels of approximately 100 hospice referrals annually from the Skagit County. Clearly, integration of EmpRes/Eden services represents the best opportunity to significantly improve access to hospice services that will benefit patients and families while reducing healthcare costs. Reaching out to nursing homes and retirement facilities will make the largest contribution to reducing access disparity for low income residents, particularly the dual-eligible long term care patients and residents. In turn, Eden will increase hospice referrals, primarily among low income, dual-eligible individuals.

To fully appreciate the burden faced by dual-eligible Medicare beneficiaries we turn to a 2020 national study that found that approximately 85% of the nearly 60 million Medicare beneficiaries qualified for Medicare on the basis of age (See Appendix S: Integrating Care for Beneficiaries Eligible for Medicare and Medicaid: An Update, April 2020 Bipartisan Policy Institute).[5] The remaining 15% were eligible based on disability. Dual-eligible individuals have poorer health and functional status than those eligible for Medicare only. According to the Medicare-Medicaid Coordination Office (MMCO), 41% have at least one mental health diagnosis, 49% receive LTSS and 60% have multiple chronic conditions. The average dual-eligible individual has six chronic conditions, while all other Medicare beneficiaries average only four. Dual-eligible individuals have greater limitations in ADLs than non-dual-eligible individuals. In 2016, 26% of dual-eligible individuals had limitations in one to two ADLs, compared to 18% of non-dual-eligible individuals and 28% had limitations in three to six ADLs, compared to 9% of non-dual-eligible individuals.[6] Addressing the hospice needs for the dying dual-eligible and other low income resident will vastly reduce the physical, psychological, emotional and financial burden that this population endures.

Reducing disparity in hospice access for dual-eligible beneficiaries will also reduce healthcare costs for the federal Medicare and federal-state funded Medicaid program. The study found, given the severity of illness and disabilities, per-capita spending on dual-eligible individuals to be more than three times higher than for Medicare-only beneficiaries. By example, the study found that the average annual spending per dual-eligible individual in 2013 was approximately $29,238.43. The average annual spending for those covered only by Medicare were considerably lower, at $8,593 per person.

In summary, dual-eligible individuals are among the most medically complex individuals with wide-ranging health care needs that require additional services and supports and generate substantial per capita health care costs, particularly if all long term care (home, residential facility, nursing home, hospital and hospice services are not carefully coordinated and available (pages 8 -10 Integrating Care for Beneficiaries Eligible for Medicare and Medicaid: An Update, April 2020 Bipartisan Policy Institute).[7]

A second study of the dual-eligible Medicare population managed through Washington State Medicaid reported in September 2021, confirmed similar findings for the nearly 30,000 fee-for-service, Medicare dual-eligible beneficiaries in the LTSS integration demonstration project. The beneficiaries received coordinated benefits (as recommended in Goal 1 - see Appendix S). The final preliminary 6-year study reported that the State Medicaid integration project saved $59 million in its last year with total Medicare savings over the 6-year period of $293 million (savings to receive further analysis by CMS).[8] On an actuarial per capita basis, the Washington State demonstration project saved approximately 10% of expected overall Medicare savings.[9]

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[5] Integrating Care for Beneficiaries of Medicare and Medicaid: A White Paper. Bipartisan Policy Center. April 2020

[6] *Ibid.* pp. 8-9)

[7] *Ibid.* Page 10

[8] Report for Washington Managed Fee-for-Service (MFFS):Final Demonstration Year 5 and Preliminary Demonstration Year 6 Medicare

[9] Savings Estimates: Medicare-Medicaid Financial Alignment Initiative. Angela M. Greene, MS, MBA, Zhanlian Feng, PhD. RTI ProjectNumber 0212790.003.002.007/008. Fall 2021. Page ES 2

2. Eden will build on its experience with EmpRes/Eden Skagit County programs to develop and ensure the integration of hospice services with other nursing homes, residential facilities, as well as the Department of Social and Health Services as it transitions its integration into a new phase.

   The intent is to focus on further reducing low income, hospice disparity in access. This approach will both increase hospice admissions with earlier admissions leading to increased average length of stay for the dying patient and will coordinate Eden efforts through working with the Department of Social and Health Services (DSHS) Long Term Services Support Dual-eligible Demonstration Project[10] and the Medicaid Apple Program as it transitions from the demonstration project to a new phase of integration.

   The demographic analysis for Skagit County shows that Skagit County racial and ethnic population cohorts face significant disparity in hospice access rates – Black, Hispanic, and American Indian/Alaska Native cohorts, but they make up only 3.9% of the overall 2020 Skagit County population over age 65. This age cohort accounts for an estimated 87% of admissions to Washington State hospices. Rather than direct outreach, Eden will reach out to other nursing homes and residential facilities as well as the Department of Social and Health services to further reduce access disparity. This effort aimed at reducing dual-eligible disparity will substantial reduce racial, ethnic, and general economic disparity in access. However, until those efforts take place, Eden is not "enumerating" additional admissions that exceed hospice admits and average daily census generated by general population increase in 2025 through 2027 although Eden anticipates that many of these referrals would come from reducing disparity in admissions.

3. Assure that all residents considering hospice are offered informed choice as required by CMS: (a) actively address and overcome any general negative views of Medicare hospice related to real and perceived loss of control about how a patient and family will address dying and (b) provide a secular hospice choice that fully complies with the Death with Dignity statute.

   Our community experience indicates that a number of Skagit County residents have questions about the Death with Dignity statute and face barriers in deciding on hospice care due to ambiguities in how the statute is implemented by hospices. Table 10 shows that the Death with Dignity participation rate for residents East of the Cascades is 54% of the rate West of the Cascades where most residents reside. This may extend to Skagit County. Religion of residents is also listed as the difference in Death with Dignity participation rates and in how the statute is implemented by hospices. Appendix S[11] and other studies report little percentage difference between King County 38.7% and Skagit County 37.8% in the number of residents who are religious, so religion does not explain the differences in participation rates. The issue is whether a lack of understanding constitutes a barrier to hospice eligible residents selecting hospice services or causes a delay in selecting hospices all due to a lack of outreach.

   Eden has a Death with Dignity policy that fully complies with the Washington State statute. Testimony provided in all recent hospice certificates of need indicate that individuals supporting compliance with the Washington Death with Dignity raised compliance concerns with nearly every hospice organization in the State. Eden's concerns focus on whether a lack of understanding among Skagit County residents create a barrier to hospice eligible residents to either delay or simply forego enrolling in hospice. As noted, our experience is that 6% - 7% of our hospice patients to date have requested information about Death with Dignity and stated that they chose Eden Hospice because Eden would support their decisions. Eden's role, in part, is to be transparent and educational about all issues related dying. Furthermore, Eden is a

[10] *Ibid*. Page ES 2

[11] Gene Balk. Washingtonians are less religious than ever, Gallup poll finds, April 2018

nonsecular hospice agency so patients can be assured there is no religious oversight and/or moral monitoring about their beliefs and choices. Table 11 estimates that Eden will serve 10 to 15 new, (non-duplicative) hospice patients per year, due to patients' expressed concerns in how the Death with Dignity statute is implemented by our agency.

Also, important to note is Eden's approach to spiritual support of families and hospice patients. Many Skagit County residents, especially over 65 years old, are religious. Eden provides chaplaincy service to any patient that requests this vital and irreplaceable aspect of hospice care. As a community-based, nonsectarian hospice agency, Eden is committed to welcoming, engaging and supporting ***all*** hospice patients and will actively support patients who value their religion. Eden will also support residents, regardless of their beliefs who wish to understand or pursue their "Death with Dignity" options as available under Washington law. As part of this effort, Eden will reach out to End of Life Washington for their advice and support in policy development, staff training and in locating needed resources within Skagit County. Welcoming has many aspects. For example, chaplaincy in the past has been largely associated with Christianity but Eden offers a broader viewpoint to patients (see footnote).[12]

4. Eden's outreach in Skagit County outside of our own EmpRes home health agency will initially start with contacting the nursing homes facility administrators and residents about the benefits of hospice and Eden's respectful, culturally competent approach. There are approximately 8 nursing homes and 7 assisted living centers in Skagit serving the current population of 121,725**.**

5. Confirm the proposed agency will be available and accessible to the entire planning area.

Eden Hospice at Whatcom County will be available and access to the entire geography of Skagit County, approximately 25% of the nursing staff lives in Skagit County.

6. With the understanding that the review of a Certificate of Need application typically takes at least six to nine months, provide an estimated timeline for project implementation, below:

Experience indicates delays including reconsideration and adjudicative review as well as extended periods for achieving licensing and certification frequently take 12 to 15 months to complete.

Event	Anticipated Month/Year
CN Approval	September 2023
Design Complete (if applicable)	Not Applicable
Construction Commenced (if applicable)	Not Applicable
Construction Completed (if applicable)	Not Applicable
Agency Prepared for Survey	Not Applicable
Agency Continues Providing Medicare and Medicaid hospice services in the Skagit County	September 2023

7. Identify the hospice services to be provided by this agency by checking all applicable boxes below. For hospice agencies, at least two of the services identified below must be provided.

[12] **Chaplain is**, traditionally, a cleric (such as a minister, priest, pastor, rabbi, purohit, or imam), or a lay representative of a religious tradition, attached to a secular institution (such as a hospital, prison, military unit, intelligence agency, embassy, school, labor union, business, police department, fire department, university, sports club), or a private chapel.

Though originally the word *chaplain* referred to representatives of the Christian faith, it is now also applied to people of other religions or philosophical traditions, as in the case of chaplains serving with military forces and an increasing number of chaplaincies at U.S. universities. In recent times, many lay people have received professional training in chaplaincy and are now appointed as chaplains in schools, hospitals, companies, universities, prisons and elsewhere to work alongside, or instead of, official members of the clergy. The concepts of a *multi-faith team*, *secular*, *generic* or *humanist* chaplaincy are also gaining increasing use, particularly within healthcare and educational settings.

X Skilled Nursing	X Durable Medical Equipment
X Home Health Aide	X IV Services
X Physical Therapy	X Nutritional Counseling
X Occupational Therapy	X Bereavement Counseling
X Speech Therapy	X Symptom and Pain Management
X Respiratory Therapy	X Pharmacy Services
X Medical Social Services	X Respite Care
X Palliative Care	X Spiritual Counseling
X Other (please describe)	
Services primarily for Alzheimer's disease and other dementias Aroma therapy – By contract Music therapy – Use of volunteers and contractors Therapeutic touch – By contract Advanced feeding techniques - By contract	

8. **If this application proposes expanding an existing hospice agency, provide the county(ies) already served by the applicant and identify whether Medicare and Medicaid services are provided in the existing county(ies).**

Eden Hospice at Whatcom County, LLC currently provides Medicare and Medicaid services to Whatcom County and under the Governor Inslee proclamation, residents of Skagit County.

9. **If this application proposes expanding the service area of an existing hospice agency, clarify if the proposed services identified above are consistent with the existing services provided by the agency in other planning areas.**

Eden Hospice at Whatcom County, LLC services in Skagit County will be consistent with services provided in Whatcom County.

10. **Provide a general description of the types of patients to be served by the agency at project completion (e.g., age range, diagnoses, special populations, etc.).**

Hospice services will be provided to terminally ill patients requiring end-of-life care with a life expectancy of 6 months or less. The proposed hospice will provide care to patients regardless of the source or availability of payment for care. **Hospice services will be provided to all patients consistent with all provisions of the Death with Dignity Act.**

Eden Hospice at Whatcom County, LLC will provide Pediatric hospice services for residents of the Skagit County service area consistent with the Department memorandum of November 29, 2022. **The estimated annual deaths for the Skagit Pediatric population are between 3 and 5 patients with natural deaths for the age 1 – age 14 population estimated at 5 patients. This represents the maximum potential population base for hospice services. Given that not all families choose hospice, referrals are estimated to be 1 or 2 patients every 3 to 5 years.**

Table 1 estimates the number of natural deaths (excluding accident, suicide and homicide deaths occurring in the Skagit Pediatric age cohort, ages 1 – 17. Pediatric hospice services are not applicable for infant deaths below age 1. The latest year for Skagit County pediatric reported deaths for the Pediatric population is 2020. Actual deaths are suppressed for all Skagit age cohorts, ages 1 – 17 because each age cohort has less than 10 deaths per national confidentiality policy. Table 1 is based on the calculated 2020 Department of Health estimated population for each age cohort in Skagit County by the statewide death rate per 100,000 persons for each age cohort, which can generate a total deaths per age cohort estimate for each cohort from age 1 through age 17, and a natural death estimate for

each age cohort from age 1 through age 14. The accident, suicide and homicide deaths for the Skagit population are consolidated for age group cohort 15 – 17, and age group 18 – 19 thus limiting the estimate for Pediatric deaths to age cohorts including the population age 1 through age 14. Table 1 provides a summary of the analysis.

Table 1
Estimated Skagit County Pediatric Deaths in 2020

	2020 State Population	Total Deaths	Total Death Rate	Natural Death Rate	Skagit 2020 Population	Skagit Total Deaths	Skagit Natural Deaths
Age 1 - 4	360,890	57	15.8	15.8	5,862	0.9	0.9
Age 5 - 9	461,674	41	8.9	8.9	7,449	0.7	0.7
Age 10- 14	486,751	77	15.8	7.4	8,410	1.3	0.6
Age 15 - 17*	279,862	99	35.4		4,740	1.7	
Total						4.6	2.2
* Accident, Suicide and Homocide category iis Age 15 - 19 and is not comparable							

(Data Source: WA Department of Health Vital Statistics)

Many Skagit patients in hospice care will have end-stage cancer, the remainder of patients will have other terminal conditions as documented in Table 2. Unique to Eden Skagit Hospice, will be the outreach and commitment to reaching dual-eligible Medicare patients. While most patients will be over age 75, outreach to dual-eligible patients is expected to result in a younger population that cannot be quantified at this time. Many dual-eligible patients are under 65 and qualify for Medicare due to physical or mental disabilities. Their dual eligibility is often because their disability limits (or halts) their ability to produce income. Of course, this very unfortunate situation leads to poverty thus dual-eligibility healthcare status.

Table 2 below provides the percentage breakdown of estimated diagnostic mix for Skagit County. However, Eden will adhere to its Patient Admission Criteria that commits to serving all patients that can benefit from hospice regardless of their age. Patients receiving in-home care includes those still living in private homes, residents of nursing homes, adult family homes and assisted living facilities. Care will be provided to patients regardless of ethnicity, culture, language, gender identity, or sensory disability. Interpretive services and assistive communication technologies will be provided as needed. Table 1 shows the national average case mix for 2019 (published by the National Hospice and Palliative Care Organization). A later report, prepared in October 2021, also focused on the 2019 diagnostic mix but with a higher level of detail. Given that Covid-19 has had such a material effect on overall death rates that may persist into the future, Eden has chosen to use the 2019 data.

Table 2
Expected Diagnostic Mix of Hospice Patients

Diagnosis	**Percent**
Cancer	30
Heart/Cardiac/Circulatory	18
Dementia	16
Lung/Respiratory	11
Stroke/Coma	9
Other	14
Chronic Kidney Disease	2
Total	**100%**

11. **Provide a copy of the letter of intent that was already submitted according to WAC 246-310-080 and WAC 246-310-290(3).**

Appendix A provides a copy of the letter of intent submitted for this project.

12. **Confirm that the agency will be licensed and certified by Medicare and Medicaid. If this application proposes the expansion of an existing agency, provide the existing agency's license number and Medicare and Medicaid numbers.**

Eden Hospice at Whatcom County, LLC is licensed and accredited as new Medicare certified agency.

IHS.FS.61117985

Medicare #: 50-1548

13. Medicaid #: 2217994**Identify whether this agency will seek accreditation. If yes, identify the accrediting body.**

The agency is accredited by the Accreditation Commission for Health Care (ACHC).

Certificate of Need Review Criteria

A. Need (WAC 246-310-210)

WAC 246-310-210 provides general criteria for an applicant to demonstrate need for healthcare facilities or services in the planning area. WAC 246-310-290 provides specific criteria for hospice agency applications. Documentation provided in this section must demonstrate that the proposed agency will be needed, available, and accessible to the community it proposes to serve. Some of the questions below only apply to existing agencies proposing to expand. For any questions that are not applicable to your project, explain why.

1. **For existing agencies, using the table below, provide the hospice agency's historical utilization broken down by county for the last three full calendar years. Add additional tables as needed.**

Table 1 provides Eden Hospice at Whatcom County, LLC 2022 hospice utilization for Whatcom and Skagit Counties.

2. **Provide the projected utilization for the proposed agency for the first three full years of operation. For existing agencies, also provide the intervening years between historical and projected. Include all assumptions used to make these projections.**

Table 3
Eden Hospice at Whatcom County, LLC for Skagit County

SKAGIT COUNTY	2022*	2023	2024	2025	2026
Total hospice admissions	40	54	114	162	178
Average Length of Stay		59.5	61.2	61.2	61.2
Total hospice days		3,215	6,977	9,911	10,892
Projected average daily census		8.81	19.11	27.15	29.84

***** Annualized data based on January through November actual utilization data

Number of Admissions: Hospice admissions are made up of three components: (a) Unmet hospice

admissions from population growth by extending admitting projections through 2026; (b) Hospice admissions from outreach to dual-eligible Medicare patients whose hospice enrollment is only 77% of the county non-dual eligible rate primarily due to economic disparity in Skagit County and (c) "Choice" hospice patients who selected Eden rather than Skagit Hospice Service.

Average Length of Stay: While average length of stay is longer nationally than in Washington State. Eden outreach to the dual-eligible in Skagit through its intensive, outreach program will likely increase length of stay as referral sources mature. To remain conservative, Eden has selected the current, statewide length of stay.

Patient Days and Average Daily Census are both products of simple algebraic equations, e.g., Patient days divided by 365 days, equals Average Daily Census in this case because no leap year is involved.

3. Identify any factors in the planning area that could restrict patient access to hospice services.

There are a variety of factors within the planning area that restrict patient access to hospice services. These are listed in order and discussed in greater detail in response to Question 4 that requires applicants to document that their applications will not result in unnecessary duplication of services.

General Population Increase: Exhibit 1 (discussed in the next section) shows there will be need for an average daily census of 6 patients in 2024, 10 patients in 2025 and 14 patients in 2026.

Dual Medicare Eligible Disparity: Dual-eligible Medicare beneficiaries' income is so low that they also qualify for Medicaid. This Medicare population is called the dual-eligible beneficiary cohort. In Skagit County dual-eligible hospice admissions make up 18% of Medicare hospice admissions. As Table 7 shows, in 2021, Skagit County, hospice utilization by dual-eligible Medicare beneficiaries was 42.9% of Medicare dual-eligible deaths, while utilization by non-dual (not Medicaid eligible) Medicare beneficiaries was 55.9% of Medicare non-dual-eligible beneficiaries. Disparity in use of hospice by dual-eligible Medicare beneficiaries is 23% lower than for non-dual-eligible beneficiaries. This disparity, using 2021 Medicare data, would account for 36 hospice admissions and an average daily census of 6 hospice patients using the current State-calculated average length of stay.

Racial and Ethnic Disparity: Race and Ethnic disparity exists in Skagit County. However, an examination of OFM population estimates (summarized in Table 5), shows that the Skagit County population age 65 and older that accounts for approximately 87% of hospice admissions contains a very low percentage of the at-risk population in racial and ethnic groups other than White. As a result, efforts to reduce racial and ethnic disparity in hospice admissions while necessary will yield limited results in Skagit County due to the small population sizes of the "at-risk" population cohorts. The Eden approach is to assure cultural competence in the delivery of services and to focus outreach on the dual-eligible population which would also include racial and ethnic minority population cohorts.

Table 6 provides hospice utilization rates for racial and ethnic groups. The data shows that the Black and North American Indian and Alaska Native cohorts have lower hospice utilization rates than the statewide average. For example, the population defined as Black have a hospice utilization rate of 35% which is 27% lower than the overall Skagit County Medicare hospice use rate. However, the 65 and older Black cohort makes up only .2% of the total Skagit County population. Results are similar for the Hispanic ethnic population whose hospice admits in 2021 in Skagit County are suppressed because the total is less than 11 hospice admissions. So, while the Hispanic population makes up nearly 6% of the overall Skagit population, less than 2% of the total Hispanic population is 65 and older.

Nursing Home and Assisted Living Facilities Disparity: Eden's extensive experience in offering a broad array of rehabilitation and long term care services in addition to hospice services provides a

different perspective and level of experience in outreach to nursing home and home health agency patients. Initially, Eden will focus on services to our home health agency in Skagit County and Whatcom County as well as our nursing home in Whatcom County that are listed below.

- Eden Home Health of Bellingham, a Medicare certified home health agency
- North Cascades Health and Rehabilitation Center, a Whatcom County nursing home

Eden's experience in evaluating Whatcom County and Spokane County Eden nursing homes and retirement facilities is that our patients have not received outreach services from existing hospices – and residents in these facilities make up a large component of the dual-eligible population. Because of our direct experience, Eden has already initiated outreach to Skagit County nursing homes since Eden does not own a nursing home in Skagit County and will not be perceived as a competitor. As Table 9 demonstrates the low percentage of referrals related to nursing home care. Based on our benchmarking approach, Eden would expect to 40 – 50 hospice patients at North Cascades yet there were only 2 hospice patients in 2022. Eden would expect the same scale of hospice-supported patients in Skagit County but has adjusted its referral expectations down to 12 – 19 hospice referrals to patients living in nursing homes to take into account developing a new outreach program. Eden's budget includes a full time outreach liaison who will reach out to other nursing home and retirement facilities instead of working solely with EmpRes/Eden programs. **Together, the principal Eden approach will reduce dual-eligible disparity in admissions without duplication of existing services and will increase the overall dual eligible hospice admission rate**

Death with Dignity Disparity: The 2021 Death with Dignity state report (See Appendix S, PDF, page 10), indicated that Skagit County registered 1 – 9 Death with Dignity participants. Tables 11 and Table 12 indicate that if Death with Dignity participation rates were the same as Washington State counties west of the Cascades, there would be approximately 7 – 8 Death with Dignity participants. Statewide, 91% of Death with Dignity participants are enrolled in a hospice program (PDF, page 5). As noted earlier, our goal is to reach out to families and patients who have questions about end-of-life control. Eden expects to serve (annually) 10 – 15 patients with Death with Dignity questions in Skagit County. **This volume of Death with Dignity hospice patients is fully non-duplicative.**

Rural Staffing Disparity: On average, 30% - 40% of nurses employed by Eden Home Health at Skagit County live in Skagit County so the ability to continuously serve rural hospice patients is facilitated.

4. Explain why this application is not considered an unnecessary duplication of services for the proposed planning area. Provide any documentation to support the response.

Exhibit 1 on a following page provides the hospice need methodology for 2024 prepared by the Department through 2025. This projection was then extended to include 2026 and 2027. All population data was provided by OFM in its 2017 growth management, medium population forecasts for under 65, and 65 years and older cohorts. This Exhibit demonstrates population-based need without considering new patient admissions for specific populations that can be identified by various characteristics that produce disparity in access; Eden's goal is to reduce disparity in access for these population cohorts from 2023, through 2026. Table 13 provides the annual number of negative admissions -- net non-duplicative hospice admissions as follows that can be sourced back to Exhibit 1:

- 2023 - 25 admissions
- 2024 - 50 admissions
- 2025 - 75 admissions
- 2026 - 96 admissions

Table 4 on the following page presents expected admits, length of stay, hospice days and average daily census. It shows that population-based admissions alone would make up about one-half of the projected hospice admissions for Skagit County before considering special populations and new, unduplicated patient admissions shown in Table 13. Table 13 shows that there is a remaining balance of unduplicated admissions available for Skagit Hospice Services or for Eden. Table 5 through Table 12 provide supporting documentation.

Table 4
Eden Hospice at Whatcom County, LLC Admits, Days and Average Daily Census
For the First Three Years of Operation

SKAGIT COUNTY	**2023**	**2024**	**2025**	**2026**
Total hospice admissions	54	114	162	178
Average Length of Stay	59.5	61.2	61.2	61.2
Total hospice days	3,215	6,977	9,911	10,892
Projected average daily census	8.81	19.11	27.15	29.84

The first three full years of operation of the Eden Hospice at Whatcom County, LLC under CoN approval for Skagit County will be from 2024 through 2026. The following steps are summarized below followed by the results of applying the statewide 2022-23 Need Projection.

WAC246-310-290(8)(a) Step 1: Calculate the following two statewide predicted hospice use rates using department of health survey and vital statistics data -- WAC 246-310-290(8)(a)(i) and WAC 246-310-290(8)(a)(ii)

WAC246-310-290(8)(b) Step 2: Calculate the average number of total resident deaths over the last three years for each planning area by age cohort.

WAC246-310-290(8)(c) Step 3.: Multiply each hospice use rate determined in Step 1 by the planning areas' average total resident deaths determined in Step 2, separated by age cohort.

WAC246-310-290(8)(d) Step 4: (65+ and under age 65) Using the projected patients calculated in Step 3, calculate a use rate by dividing projected patients by the three-year historical average population by county. Use this rate to determine the potential volume of hospice use by the projected population by age cohort using Office of Financial Management (OFM) data.

WAC246-310-290(8)(e) Step 5: Combine the two age cohorts. Subtract the average of the most recent three years hospice capacity in each planning area from the projected volumes calculated in Step 4 to determine the number of projected admissions beyond the planning area capacity.

WAC246-310-290(8)(f) Step 6: Multiply the unmet need from Step 5 by the statewide average length of stay as determined by CMS to determine unmet need patient days in the projection years.

WAC246-310-290(8)(g) Step 7: Divide the unmet patient days from Step 6 by 365 to determine the unmet need ADC.

WAC246-310-290(8)(h) Step 8: Determine the number of hospice agencies in the planning area that could support the unmet need with an ADC of thirty-five.

A. **Skagit County Medicare Dual-eligible Utilization Disparity Analysis**

Regarding population growth generating additional hospice need, the Department has accepted the population growth approach as a starting point in addressing unnecessary duplication. In recent applications, the Department expressed interested in how applicants will address barriers to care beyond simple availability of a new hospice service. The Department rationale is that applicants proposing to serve counties where there is a hospice Need of less than a 35-patient average daily census must identify **Unmet Need, not just population growth.**

In response to the evolving position of the Department, most applicants have studied the health status of individual counties – Skagit County – as well as the demographic mix of the population. We applaud the many successful efforts of existing providers to address racial and ethnic disparity in access as well as new applicants proposing to serve various counties in the State. New applicant analyses have found that there is disparity resulting in lower utilization due to income (including homelessness), race and ethnicity. **Our community analysis contained in Appendix X concurs with earlier applicant findings, but the problems identified by other applicants fundamentally misunderstand the scale of hospice utilization disparity in terms of ethnic and racial disparity and require a new array of solutions to reducing disparity in hospice utilization in Skagit County. In most previous analyses, social values, e.g., Death with Dignity or LGBQT, access disparity and have been under analyzed and remains underutilized for the LGBQT population due to an absence of demographic data.**

Ethnic and racial access disparity in Skagit County does exist as shown in Table 5. Table 5, shows that the population with the highest hospice use, aged 65 and older for Hispanic, Black, and other racial minorities is quite small compared to the overall population in these cohorts as demonstrated in Table 5. While Table 6 documents disparity in hospice admission rates per 1,000 Medicare Beneficiary Deaths is significant and also exists at the Washington State and the United States levels. In this case, the differences in these utilization rates do not translate into a large number of hospice admissions due to the lower percent and absolute population numbers in racial and ethnic groups for the population age 65 and older as shown in Table 5. For example, the Hispanic population age 65 and older makes up only 4.8% of the total Hispanic population while it makes up 25.0% of the total County population over age 65. As a result, the number of hospice referrals is low for sheer population numbers in addition to income, education, and other disparity barriers. This adds special challenges in addressing racial and ethnic disparities in hospice admissions.

Table 5
2020 Skagit Population and Percent of Total Population By Age Group (OFM/Census)

Age Cohort	**Total**	% of Total	Black	% of Total	American Indian Alaska Native	% of Total	Asian	% of Total	Hispanic	% of Total
Under Age 65	100,712	77.2%	1,263	95.8%	3,308	90.5%	2,756	85.9%	25,201	95.2%
Over Age 65	29,738	22.8%	56	4.2%	348	9.5%	453	14.1%	1,278	4.8%
Total	130,450		1,319		3,656		3,209		26,479	

As a result, Table 6 shows total hospice admissions for all racial and ethnic groups other than White is only 25 admissions. As such, outreach concentrating *solely* on racial and ethnic outreach strategies will miss curing most of the disparity existing in the county. Eden like other providers is committed to culturally competent care but will focus its outreach efforts to the dual-eligible population group focusing first on patients in

Nursing Homes and Residential Facilities where Eden has experience and where referrals to hospice is exceptionally low for all groups, as well as to eligible hospice patients who also have an interest in considering a Death with Dignity participation option.

Table 6
2021 Skagit County Medicare Hospice Utilization Rates by Race and Ethnicity
(Berg 2021 Medicare Beneficiary Data)

Gray = Less than 11 Suppression			
Race	Hospice Admissions 2021	Deaths of Beneficiaries	Utilization Rate
White	639	1,185	53.9%
Black			33.3%
Asian			50.0%
Hispanic or Latino			27.8%
North American Native			30.8%
Other			40.0%
Unknown			46.2%
Total	664	1,252	53.0%
Total Suppressed Racial and Ethnic Admissions	25	67	37%
Total Suppressed Racial and Ethnic Admissions Based on Disparity Rate Adjustment	**4**	**11**	**17%**

Barriers to hospice access vary dramatically for the dual-eligible population in Skagit County as well as the Population that Accesses Death with Dignity in all counties East of the Cascades. Table 6 provides the 2021 Utilization Rates for the Dual-eligible and Non-Dual-eligible Population in Skagit County. The dual-eligible hospice utilization rate for dual-eligible Medicare beneficiaries was 42.9% compared to 55.9% for non-dual-eligible beneficiaries. The difference in hospice utilization in Skagit County in 2021 is a full 23.2% lower for Skagit County dual-eligible beneficiaries – compared to a 16.8% lower Washington State hospice utilization rate, and 11.7% lower National utilization rate for dual-eligible Medicare beneficiaries. The 23.2% lower hospice utilization rate represents disparity due to the economic and medical challenges facing the dual-eligible beneficiary compared to the non-dual eligible patient but also is due to a lack of outreach to nursing homes and home health agencies. Curing this disparity between dual eligible and non-dual-eligible Skagit Medicare beneficiaries requires reach out and increasing utilization for at least 36 dual-eligible beneficiaries (2021) who currently die without the support of hospice services as shown in Table 8. **The 36 hospice admits, and 2,199 hospice days (6.0 Average Daily Census) represents <u>Unduplicated Need for Skagit County.</u>**

Table 7
Total Medicare Utilization for Both Dual-eligible and Non Dual-eligible Patients in 2021
(Berg Data Medicare Beneficiary 2021)

Race	Hospice Admissions 2021	Deaths of Beneficiaries	Utilization Rate
Dual	117	273	42.9%
Non-Dual	547	979	55.9%
Total	664	1,252	53.0%
Percent Dual Utilization Lower than NonDual Utilization			**23.3%**

Table 8
Average Daily Census Increase by Achieving Parity Between Skagit County Hospice Utilization For Dual-Eligible And Non-Dual-Eligible Medicare Beneficiaries
(2021 Medicare Claims Data, Berg Data)

Average Daily Census Increase by Achieving Parity Between Skagit County Hospice Admission Rates for the Dual Eligible And Non-Dual-Eligible Medicare Beneficiaries							
	Skagit County Hospice Admits	Skagit County Medicare Deaths	Hospice Admission Rate per 1,000 Beneficiaries	Dual-Eligible Percent of Non-Dual Eligible Admit Rate		Additional Admits Needed to Achieve Parity with Non-Dual Admits	Additional Hospice Days to Reach National Average Length of Stay of 61.89 Days
2021 Dual Eligible Medicare Admissions	117	273	429	76.7%		**36**	**2,199**
2021 Non-Dual Eligible Medicare Admissions	547	979	559				
Total Admissions and Average Daily Census Needed to Achieve Parity	664	1,252	530				**6.0**

The EmpRes/Eden experience in Whatcom County provides further documentation about the disparity in dual-eligible admissions for Medicare hospice patients. Empres/Eden operates two programs within Skagit County and each of these programs further documents unmet need that is principally due to disparity. The two programs are:

- Eden Home Health of Bellingham, a Medicare certified home health agency
- North Cascades Health and Rehabilitation Center, a Whatcom County Nursing Home

Table 9 provides utilization data for EmpRes operated nursing and assisted living facilities in Skagit County and Whatcom County, year-to-date for 2022. The 25% of nursing home patients on average being eligible for hospice is consistent with Eden benchmarks as well as the reported experience of Bethany in its CN 21-45 that found that 25% of its patients were transferred to hospice in these two facility categories.[13] This finding is consistent with the findings reported in a 2010 study by Monroe and Carter included in Appendix W that found that 24% of nursing home patients qualified for hospice but only 6% received hospice services.[14] Specific to nursing home referrals, the EmpRes Whatcom North Cascades facility would have 56 annual referrals per national and local benchmarks to hospices with 42 referrals being logged as disparity in access to

[13] Bethany CN 21-45; Page 53,
[14] Todd Monroe, Michael Carter. Hospice Care in US Nursing Homes: Benefits and Barriers. Page 1,

hospice services. While EmpRes currently does not operate a nursing home or retirement facility in Skagit County, it does have a new contract with a nursing home in Skagit County that is of similar size to the EmpRes North Cascades facility and as noted below additional referrals to hospice from nursing homes will take several years to develop, but Eden expects a substantial increase in hospice referrals and these referrals would represent **Unduplicated Need for Skagit County.** .

- The annual non-duplicated hospice admission volume would be realized over several years, as shown in Table 10. Table 10 estimates 16 hospice admits in 2024, 18 admits in 2025 and 19 admits in 2026 (primarily dual-eligible patients associated with a nursing home or assisted living facility with disparity associated with low income). This represents one-half of the dual eligible disparity and Eden is addressing the "other one-half" through outreach to the EmpRes Home Health of Bellingham for both Skagit County and Whatcom County. **This 38-patient dual eligible access disparity cohort is a new population, based on our analysis in Whatcom County and Spokane County. Eden notes that the Bethany reference that shows a high number of hospice referrals for nursing home patients in Snohomish County.**
- Based on the analysis included in Table 8, existing hospices' referral volume will be unaffected by the addition of the Eden Hospice program.

Table 9
Existing and Expected Hospice Referrals Based on An Analysis of EmpRes Nursing Homes

Program	Total Patients 2022	Hospice Referrals Through 2022	Percent of Hospice Referrals
Spokane County			
Royal Park SNF -- 164 Beds	245	4	1.6%
Royal Park ALF - 95 Beds	136	9	6.6%
Potential Hospice Referrals @ 25% of Beds (Benchmark)	381	66	25.5%
Unmet Need		**53**	**80.3%**
Whatcom County			
North Cascades	224	14	6.3%
Potential Hospice Referrals @ 25% of Beds (Benchmark)	224	56	25.0%
Unmet Need	**224**	**42**	**50.0%**

Table 10 provides the annual, expected hospice referrals associated with outreach to nursing and assisted living facilities based on the analysis of EmpRes/Eden hospice referrals from our facilities in Whatcom County and Spokane County. Focusing on EmpRes/Eden facilities located in Skagit County will reduce dual-eligibility beneficiary disparity by over 30%. Eden will continually monitor its progress in reducing disparity for dual-eligible patients and add additional outreach efforts as demonstrated in the Eden Hospice at Whatcom County, LLC operating budget.

Table 10
Skagit County Dual-eligible Medicare Patients Disparity Reduction General and Nursing Homes
Eden Hospice at Whatcom County, LLC Outreach

	2023	2024	2025*	2026*
Skagit County Disparity of Dual Eligible Hospice Admits Based on 2021 Rate	**36**	**37**	**37**	**38**
Eden Admissions Due to Outreach -- Dual Eligible	12	16	18	19
Eden Admissios Due to Outreach --Dual Eligible in Nursing Homes	12	16	18	19
Total Potential Dual Eligible Disparity Reduction Patients	24	32	36	38
Percent of Dual Eligible Disparity Reduction		86%	97%	100%
* Disparity estimate is stoppe to not exceed the estimated access disparity for dual eligible pts. Based on 2021 adjusted for general population increae				

B. Skagit County Death with Dignity Analysis

Eden is in full compliance with the Death with Dignity statute and supports Washington citizens who are considering Death with Dignity as an option within their hospice care. Eden's analysis documents that there is variance in use of Death with Dignity in Washington State counties – especially when the east of the Cascades is compared to west of the Cascades. Table 11shows that the Death with Dignity Death Rate per 100,000 persons residing in counties east of the Cascades was 2.7 deaths per 100,000 persons while the death rate in counties west of the Cascades was 4.8 deaths per 100,000 persons. Using the West of Cascades rate results in only 7 or 8 Skagit patients annually choosing Death with Dignity, but the population under study is the cohort troubled about end of life decisions around Death with Dignity is much greater. Eden has already admitted 8 patients in 2022 choosing Eden because of its Death with Dignity policy, which represents 6% - 7% of all Eden hospice patients in Skagit County and Whatcom County.

Eden, to remain in full compliance with the Death with Dignity statute, has examined the implications of full compliance with the Act by hospices and by Eden in Skagit County. Our analysis provided in Table 11 (based on the 2020 OFM population estimates) reveals that approximately 7 Skagit County citizens would annually request Death with Dignity. Population growth since 2020 would increase the Death with Dignity choice to by an additional patient per year. Eden would support any request for this service from Skagit County hospice patients.

Table 11
2021 Death with Dignity Expected Participation in Skagit County

	Counties East of Cascades	Counties West of Cascades	Total
2021 Total Population	1,677,575	6,089,400	7,766,975
Percent of State Population	22%	78%	100%
2021 Death with Dignity Deaths	46	341	387
Percent of Total Death with Dignity Deaths	12%	88%	100%
Participation Rate per 100,000 persons	2.7	5.6	5.0
Percent Disparity East to West Cascades Counties	N.A.	N.A.	N.A.
Expect Death with Dignity Participants to Equal West of Cascade Participants	**90**	**341**	**431**
2021 Skagit County Population (OFM)	N.A.	130,000	N.A.
Expected Skagit County Death with Dignity Particiipants in 2021	**N.A.**	**7.3**	**N.A.**

Because Eden fully complies with Death with Dignity in Washington State, it is likely that Eden Hospice at Whatcom County, LLC will have several additional referrals to its hospice program beyond the imprecise estimates of Death with Dignity utilization (presented in Table 12). , the small number of persons that will choose Eden because of concerns about Death with Dignity makes up only a portion of patients who are concerned about their ability to be in control of end of life decisions is significantly greater than the number of residents including hospice patients (90% of Death with Dignity participants are hospice patients) who ultimately select Death with Dignity.

Table 12
Death with Dignity Support and Potential Disparity Reduction in Skagit County

	2023	2024	2025	2026
Skagit County County Death with Dignity Expected Participants	7	8	9	10
Eden DWD Admissions Due to Support Policy	3	4	5	6

Table 13 summarizes Eden's estimates of Skagit County patients from 2023 through 2026 who will select Eden Hospice at Whatcom County for hospice services; and categorizes these admissions into Underserved, Non-Duplicative cohorts and general population growth-based Unduplicated hospice admissions. Eden has compared its admissions to total projected admissions and has calculated that in each year, from 2022 through 2026, there will be no duplication in admissions – the number of surplus admissions that are "available" for new admissions to Eden or Skagit Hospice Services ranges from a net annual admission total of 26 hospice admits to 50 hospice admits – depending on the year of analysis. Eden already has achieved a 60-day length of stay and has applied the statewide average length of stay to its calculation of hospice admissions and patient days. Eden Hospice at Whatcom market share for Skagit will be approximately 19% to 21%.as shown in Table 13.

Table 13
Documentation of State Methodology Need from 2025 Through 2027 With Disparity Reduction

		2022 Historical	2023 Current	2024	2025	2026
Total Eden Hospice at Whatcom County Skagit County Utilization						
Admissions Due to Outreach -- Dual Eligible		N.A.	12	16	18	19
Admissions Due to Outreach - - Death w/Dignity (Choice cohort)		N.A.	3	4	5	6
Choice Cohort (5.33% of general population)		40	41	43	44	45
Nursing Home additional outreach		N.A.	12	16	18	19
Subtotal: New Admits from Outreach		40	68	79	85	89
Total Projected Eden Hospice at Whatcom County Admits		**40**	**54**	**114**	**162**	**178**
Eden Admissions Net of Annual Population Growth		**0**	**0**	**35**	**77**	**89**
Projected population growth increases in Skagit County hospice admits state methodology		25	50	75	100	121
Duplication Impact of Eden Admits -- Total Eden admits less State Methodology population-based admit growth less Eden underserved hospice cohorts (Negative number means no duplication)		**-25**	**-50**	**-40**	**-23**	**-32**
Total Eden Hospice at Whatcom County Skagit County Utilization						
Total Skagit County Hospice Admits		**790**	**842**	**878**	**913**	**943**
Average Length of Stay		59.5	61.2	61.2	61.2	61.2
Eden Hospice at Whatcom County Hospice Days		2,380	3,305	6,977	9,914	10,894
Total Skagit Days -- State Methodology Extended and Eden New Outreach		46,418	47,965	49,512	51,059	52,359
Eden Market Share by Hospice Admits Adjusted for Outreach		**5%**	**6%**	**13%**	**18%**	**19%**
Eden Market Share by Hospice Days Adjusted for Outreach		**5%**	**7%**	**14%**	**19%**	**21%**

In Skagit County, working with existing hospice and other care providers to let them know about Eden's resource capacity will help patients access hospice earlier. Unfortunately, Covid-19 affected healthcare systems in Washington State thus generating additional, systemwide barriers to care – including hospice. Eden is a known quantity in Skagit County among many referral sources and has reached out to garner "on-the-ground" experience as it relates to hospice need in Skagit County. Eden will continue to develop and refine effective outreach strategies. To date, Eden's outreach efforts have included as to the following:

- Veterans: Studies and clinical experiences documented by palliative care providers have shown that many veterans have unspoken health needs at the end of life. By reaching out to community agencies focused on serving Veterans and has continued its membership in the "We Honor Veterans" program. Currently, Eden Hospice at Whatcom County is at Level 2 of a 5-level engagement process designed by the We Honor Veterans Program and intends to qualify

at Level 3 during 2023 – the program is aimed at supporting and engaging Veterans facing the end-of-life as well as enhancing the cultural competence of all Eden hospice employees to the unique needs of Veterans.

- LGBQT Community Residents: Local LGBQT members estimate that 3% of the Skagit County population self-identify as belonging to the LGBQT cohort (approximately 15,000 residents). As a community-based, nonsectarian hospice agency, Eden is committed to culturally competency, and is sensitive to LBGTQ issues related to their hospice care needs. Eden's goal to provide unbiased, unwavering support to anyone in hospice care, their families, and caregivers.
- As Table 5 shows, the 2020 census enumerated 3% or 3,656 residents who identify as Native American. Eden has reached out to three separate tribes in Skagit County and Whatcom County to begin establishing working relationships to support. Eden is committed to culturally competency, and sensitivity to all tribal members and issues related to their hospice care needs. Eden's goal to provide unbiased, unwavering support to anyone in hospice care, their families, and caregivers.

5. Confirm the proposed agency will be available and accessible to the entire planning area.

Eden commits to serving the entire planning area. As previously noted, Eden has available nursing staff – approximately 25% – who live in rural or unincorporated areas of Skagit. Eden also will provide Pediatric hospice services consistent with the November 29th, 2022 Department of Health e-mail memorandum.

6. Identify how this project will be available and accessible to under-served groups.

The response to Question 4 provided a comprehensive approach to the strategy and actions that Eden will initiate to reduce disparity in availability and accessibility to under-served groups.

7. Provide a copy of the following policies:

- Patient Rights policy (Appendix M)
- Non-discrimination policy (see Appendix F)
- Any other policies directly related with patient access
- The Admissions policy is included in Appendix G.
- The Charity Care policy is included in Appendix H.
- The Non-discrimination policy is part of the Admissions policy.
- The Discharge policy is included in Appendix I.
- The Patient Rights and Responsibilities policy is included in Appendix M.

8. If there is not sufficient numeric need to support approval of this project, provide documentation supporting the project's applicability under WAC 246-310-290(12). This section allows the department to approve a hospice agency in a planning area absent numeric need if it meets the following review criteria:

- **All applicable review criteria and standards with the exception of numeric need have been met.**
- **The applicant commits to serving Medicare and Medicaid patients; and**
- **A specific population is underserved; or**
- **The population of the county is low enough that the methodology has not projected need in five years, and the population of the county is not sufficient to meet an ADC of thirty-five.**

Note: The department has sole discretion to grant or deny application(s) submitted under this subsection.

- **All applicable review criteria and standards with the exception of numeric need have been met:**

  Under need, the Eden Hospice at Whatcom County, LLC has been operating throughout 2022 under the Covid-19 waiver program and will initiate CoN approved services in late 2023. The market share of hospice days generated by population increase will make up about 14% in 2024, 19% in 2025, and 21% in 2026 when the three operating and one approved hospice are serving patients that are intended to exceed the overall population growth-based need. In addition, Eden will materially reduce access disparity for low income residents, particularly the most ill, Medicare dual-eligible beneficiaries, and patients who are concerned about their ability to use the Death with Dignity statute.

  Under financial feasibility, the breakeven census for the Eden hospice will be less than a 20-patient average daily census because the hospice is co-located with the EmpRes Home Health at Bellingham agency. Eden Hospice at Whatcom County and is part of a network of home health and hospice agencies serving Washington State and other Western states.

  Under structure and process of care, Eden will continue the efforts of the Department of Social and Health Services that demonstrated the effectiveness in integrating home care, home health, hospice care, nursing home and assisted living facility care. The Department of Social and Health Services study (that took 6 years to refine), independently determined that "integration" reduces the costs of healthcare. Eden's model will be designed to support the next phase of the State model to obtain synergistic effects on health care, patient satisfaction and reduced costs for payers, patients, and families.

  Under cost containment, the Eden integrated approach should reduce Medicare expenditures for the dual-eligible hospice beneficiary by $2,000 per patient, the calculated amount for the State Medicaid dual-eligible program, which represents 10% savings to Medicare patients.

- **Eden commits to serving Medicare and Medicaid Patients:**

The Eden Hospice at Whatcom County, LLC has achieved Medicare certification and as noted throughout the application will focus on increasing hospice referrals for the Medicare dual-eligible patient (Medicare and Medicaid beneficiaries) as well as general Medicaid patients. By reaching out to nursing home care residents in EmpRes and other long term care facilities, Eden will be able to effectively generate Medicaid-only hospice admissions as well as dual-eligible Medicare hospice admissions. The presumption is that low income and Medicaid status have both been barriers to hospice access. Eden's direct outreach, supplemented by Eden's superior charity care policy will result in significant Medicare and Medicaid admissions to the Eden Hospice at Whatcom County, LLC.

- **A specific population is underserved**

Eden Hospice at Whatcom County, LLC Northwest has identified several significant underserved populations in Skagit County and has developed its application to serve those populations. Table 13 summarizes the impact of these 4 underserved populations. Together these populations will generate 68 to 89 Eden hospice admits annually beginning in 2023 through 2026.

(1) Dual-eligible Disparity Cohort: Based on an analysis of 2021 Medicare utilization, Eden Hospice at Whatcom County, LLC has a calculated 23.2% disparity in utilization of hospice services in Skagit County compared to non-dual utilization. An additional 36 Medicare dual-eligible beneficiaries *need* to be admitted annually to match the Medicare non-dual hospice utilization rate

in Skagit County Eden will reduce this disparity by a minimum of 38 patients by 2026,which is 100% of the 2021 dual-eligible disparity rate. Over time, Eden wants to do better than just equalize disparity in access between dual-eligible and non-dual-eligible Medicare beneficiaries – Eden's goal is to become a State and national leader in eliminating access barriers for all Medicare beneficiaries.

(2) Nursing Home Disparity in Access Cohort: In Washington State, Bethany through its certificate of need[15] and national studies[16] document that approximately 25% of nursing home and assisted living facility patients are eligible for hospice services. Eden will admit 12 patients in 2023 increasing to 19 nursing home-hospice patients by 2026 substantially reducing access disparity.

(3) Choice Patient Disparity in Admissions Cohort: Eden Hospice at Whatcom County is adding over 40 hospice admissions in 2022 for Skagit County residents. The state 2022-23 need methodology projected an increase of 25 patients from 725 admissions in 2021 to 750 admissions in 2022 –a growth of 25 patients. Eden's two-pronged effort in educating patients and organizations about hospice as a community agency and in supporting patients with our unambiguous, fully complying Death with Dignity policy has improved access to hospice services in Skagit County. While hospitals refer to hospice, Eden's direct community outreach in Skagit County will develop a more educated and informed population.

(4) Death with Dignity Disparity in Access Cohort: The goal of Eden is to increase hospice referrals to individuals considering Death with Dignity in this way: a patient may support, be neutral or not interested in Death with Dignity, but for some, the statute has philosophical weight and can be misunderstood by patients and others involved. Some patients may be fearful of losing control over their own death because of their inherent misunderstanding about the Death with Dignity statute. Conversely, patients who want the option available may be concerned about not being allowed to access it. Either way, Eden reduces barriers to access and reduces delays to hospice admissions because we assuage concerns about personal control over end-of-life decisions. That said, increasing Death with Dignity is not part of Eden's short or long term goals. Simply stated, Eden is non-secular and therefore complies with Washington State's Death with Dignity statute. Navigating the end of life have many people overwhelmed, caught off guard, and unprepared. Many have also been conditioned to believe that aging and death should be both feared and fought; that dying is somehow a failed outcome to be avoided at all costs rather than part of life. Eden's hospice care teams work directly with the patient and families to quell fears, reduce stress, and provides as much physical and emotional comfort as possible during this sad, albeit natural event in life.

Summary: Eden Hospice at Whatcom County, LLC fully addresses all of the criteria required for the Department under WAC 246-310-290(12) to approve this application for the Skagit County service area.

B. Financial Feasibility (WAC 246-310-220)

Financial feasibility of a hospice project is based on the criteria in WAC 246-310-220.

1. **Provide documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:**
   - **Utilization projections. These should be consistent with the projections provided under the Need section. Include all assumptions.**
   - **Pro Forma revenue and expense projections for at least the first three full calendar years of operation. Include all assumptions.**

[15] Bethany CN 21-45. Page 53

[16] Todd Monroe, Michael Carter. Hospice Care in US Nursing Homes: Benefits and Barriers. Page 1

- **Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. Include all assumptions.**
- **For existing agencies proposing addition of another county, provide historical revenue and expense statements, including the current year. Ensure these are in the same format as the projections. For incomplete years, identify whether the data is annualized.**

Appendix J, Appendix K, and Appendix L use the same core assumptions for revenue by payer as well as the costs for each FTE category. Responses to questions 1 - 3 and the outreach plan contained in Appendix N, provide support for the utilization assumptions used in the application and in Appendix J, Appendix K, and Appendix L assumptions during the Covid-19 period. Home health assumptions for established county-based operations of Eden Home Health of Washington, LLC are based on historical performance during pre-Covid-19and throughout Covid-19 period. All other line items were reviewed considering the impact of the Covid-19 pandemic disruption on normal operations.

Appendix J provides the requested pro forma – income statement, balance sheet, cash flow and assumptions for hospice services provided **solely in Skagit County.** Responses to questions 1 - 3 and the outreach plan contained in Appendix N provides documentary support for the utilization assumptions for Skagit County hospice services provided by Eden.

Existing utilization for Skagit County is provided in the response to Question 1 shows that the 2021 volume for Skagit County was 36 hospice patients. Eden did not carry out normal outreach activities described in Appendix N, which resulted in an average daily census of 8.8 patients in 2023. Under normal (second or third year of operation maturity) operating conditions, 121 hospice admissions (due to population increase only) would generate an average approximately 20 patients with an ALOS of 60 days. With 2024 being the first full year of CoN approved utilization it's evident – the expected 30-patient average daily census in 2026 (third full year of operation) will be achieved resulting in earnings (before taxes) of approximately $400,570.

Appendix K provides the historical and projected pro forma – income statement, balance sheet and cash flow statement for the entire agency, Eden Hospice at Whatcom County (includes Skagit County).

Appendix L provides the **combined** pro forma historical and projected income statement, balance sheet and cash flow statement of the existing EmpRes Hospice at Whatcom County (Appendix K and all other Eden operating hospices.

2. **Provide the following agreements/contracts:**
    - **Management agreement.**
    - **Operating agreement**
    - **Medical director agreement**
    - **Joint Venture agreement**

    Note, all agreements above must be valid through at least the first three full years following completion or have a clause with automatic renewals. <u>Any</u> <u>agreements in draft form must include a document signed by both entities</u> <u>committing to execute the agreement as submitted following CN approval.</u>

    Management and operating agreements are included in Appendix B. The Medical Director agreement is included in Appendix C.

3. **Provide documentation of site control. This could include either a deed to the site or a lease agreement for the site.**

If this is an existing hospice agency and the proposed services would be provided from an existing main or branch office, provide a copy of the deed or lease agreement for the site. If a lease agreement is provided, the agreement must extend through at least the projection year. Provide any amendments, addendums, or substitute agreements to be created as a result of this project to demonstrate site control.

If this is a new hospice agency at a new site, documentation of site control includes one of the following:

a. **An executed purchase agreement or deed for the site.**
b. **A draft purchase agreement for the site. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.**
c. **An executed lease agreement for at least three years with options to renew for not less than a total of two years.**
d. **A draft lease agreement. For Certificate of Need purposes, draft agreements are acceptable if the draft identifies all entities entering into the agreement, outlines all roles and responsibilities of the entities, identifies all costs associated with the agreement, includes all exhibits referenced in the agreement. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.**

Appendix E provides documentation of site control.

Complete the table on the following page with the estimated capital expenditure associated with this project. Capital expenditure is defined under WAC 246-310- 010(10). If you have other line items not listed in the table, include the definition of the line item. Include all assumptions used to create the capital expenditure estimate. Identify the entity responsible for the estimated capital costs identified above. If more than one entity is responsible, provide breakdown of percentages and amounts for each.

Item	Cost
a. Land Purchase	$ N.A.
b. Utilities to Lot Line	$ N.A.
c. Land Improvements	$ N.A.
d. Building Purchase	$ N.A.
e. Residual Value of Replaced Facility	$ N.A.
f. Building Construction	$ N.A.
g. Fixed Equipment (not already included in the construction contract)	$ N.A.
h. Movable Equipment	$ N.A.
i. Architect and Engineering Fees	$ N.A.
j. Consulting Fees	$ N.A.
k. Site Preparation	$ N.A.
l. Supervision and Inspection of Site	$ N.A.
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction)	$ N.A.
1. Land	$ N.A.

2. Building	$ N.A.
3. Equipment	$ 0
4. Other	$ 0
n. Washington Sales Tax	$ N.A
Total Estimated Capital Expenditure	**$** 0

EmpRes Healthcare Group, Inc. is responsible for 100% of the capital costs. Eden Hospice at Whatcom County, LLC will collocate with Eden Home Health of Bellingham which will minimize start-up and continuing overhead costs associated with independent solo startups thus reducing breakeven levels. For example, there is no capital expenditure associated with the project because there is a sufficient supply of desk phone/computer setups, and the field clinicians have company-issued cell phone and table from our equipment inventory. That inventory is sufficient to support the addition of hospice staff serving Skagit County. The co-shared office location is currently wired with secure IT infrastructure and requires no modification for this project

4. **Identify the amount of start-up costs expected to be needed for this project. Include any assumptions that went into determining the start-up costs. Start-up costs should include any non-capital expenditure expenses incurred prior to the facility opening or initiating the proposed service. If no start-up costs are expected, explain why.**

   There are no start-up costs because the agency is already serving Skagit County residents.

5. **Identify the entity responsible for the estimated start-up costs identified above. If more than one entity is responsible, provide breakdown of percentages and amounts for each.**

   Not Applicable.

6. **Explain how the project would or would not impact costs and charges for healthcare services in the planning area.**

   Various studies on the cost-effectiveness of hospice, both federally and privately sponsored, provide strong evidence that hospice is a cost-efficient approach to care for the terminally ill.

   An early study for CMS concluded that during the first three years of the hospice benefit, Medicare saved $1.26 for every $1.00 spent on hospice care. The study found that much of these savings accrue over the last month of life, which is due in large part to the substitution of home care days for inpatient days during this period.[17]

   Thee cost reductions to the Medicare and other payers have been compelling. For example, Providence estimated savings for 25,000 Washington State Medicare beneficiaries in 2017 dollars of nearly $100 million – or $4,000 per beneficiary not receiving 5 weeks of hospice care.[18] On a peer-reviewed CMS evaluation of the Washington dual diagnosis and hospice integration 6-year demonstration project, annual savings of $6 million or $2,000 per enrollee for 30,000 enrollees was calculated using a full-throated actuarial analysis[19]. Finally, the 16-year evaluation of 8,568 decedents found: total health expenditures for hospice was $6,426 at 1-month and $3,351 at 3-months per matched pair. Authors conclude that: "Our findings that hospice does not shift economic burden from Medicare to families underscores the need to promote timely access to hospice care as even those with short hospice durations experienced cost savings."[20]

[17] Kidder, D. "The effects of hospice coverage on Medicare expenditures"; Health Serv Res. 1992 Jun; 27(2): pp. 195–217
[18] *Op. cit*. Page 53
[19] *Op. cit*. Page ES-2
[20] *Op. cit*. Page 1

In this application, Eden cites the Washington Department of Social a & Health Services (DSHA) Fee for Service Dual-eligible Project that found through integrating hospice services with other home care, nursing home, assisted living and residential care that Medicare costs were reduced by 10% with savings amounting to $2,000 per enrolled dual-eligible Medicare beneficiary.[21] Eden also submitted further evidence that the integration model proposed through this project is well supported by other national studies.[22]

Additional research on hospice supports the premise that cost savings associated with hospice care are frequently unrealized because terminally ill Medicare patients often delay entering hospice care until they are within just a few weeks or days of dying, suggesting that more savings and more appropriate treatment could be achieved through earlier enrollment.

7. Explain how the costs of the project, including any construction costs, will not result in an unreasonable impact on the costs and charges for health services in the planning area.

There are no capital costs associated with the project since Eden Hospice at Whatcom County has sufficient minor equipment (laptops etc.) to support staff.

8. Provide the projected payer mix by revenue and by patients by county as well as for the entire agency using the example table below. Medicare and Medicaid managed care plans should be included within the Medicare and Medicaid lines, respectively. If "other" is a category, define what is included in "other."

Table 14-A
Projected Payer Mix for Skagit County

Payer Mix: Total	Percentage of Gross Revenue	Percentage by Patient
Medicare	93%	90%
Medicaid	4%	5%
Commercial	3%	5%
Total	100%	100%

Medicare pays approximately 91% of Medicare rates, while commercial insurance pays approximately 80% of Medicare rates. However, Medicaid and Commercial Insurance patients are each estimated to make up only 5% of total patients. Note that dual-eligible patients are categorized as Medicare in this table.

9. If this project proposes the addition of a county for an existing agency, provide the historical payer mix by revenue and patients for the existing agency. The table format should be consistent with the table shown above.

The historical payer mx is he following:

[21] Savings Estimates: Medicare-Medicaid Financial Alignment Initiative***. Op cit.***
[22] Integrating Care for Beneficiaries of Medicare and Medicaid: A White Paper. *Op cit.*

Table 14-B
Projected Payer Mix for Eden Hospice At Whatcom County

Payer Mix: Total	Percentage of Gross Revenue	Percentage by Patient
Medicare	93%	90%
Medicaid	4%	5%
Commercial	3%	5%
Total	100%	100%

10. Provide a listing of equipment proposed for this project. The list should include estimated costs for the equipment. If no equipment is required, explain.

There is no proposed capital expense estimate (sales tax included) for the hospice because all required equipment is available in the co-located with the Eden Home Health at Skagit County, LLC agency.

Furnishings	$ 0
Phones	$ 0
Computer Equipment	$ 0
Copier/other	$ 0
Total	$ 0

11. Identify the source(s) of financing (loan, grant, gifts, etc.) and provide supporting documentation from the source. Examples of supporting documentation include: a letter from the applicant's CFO committing to pay for the project or draft terms from a financial institution. If this project will be debt financed through a financial institution, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.

Financing for the project is provided by EmpRes Healthcare Group, Inc. Appendix P provides a letter of financial commitment from the CFO of EmpRes Healthcare Management, LLC. The source of the funds is from cash generated through operations of the members of EmpRes Healthcare Management, LLC backed up by a $40 million line of credit commitment, secured by accounts receivable, with MidCap Financial.

12. Provide the most recent audited financial statements for:

- **The applicant, and**
- **Any parent entity responsible for financing the project.**

Appendix Z provides the most recent audited financial statements.

C. Structure and Process (Quality) of Care (WAC 246-310-230)

Projects are evaluated based on the criteria in WAC 246-310-230 for staffing availability, relationships with other healthcare entities, relationships with ancillary and support services, and compliance with federal and state requirements. Some of the questions within this section have implications on financial feasibility under WAC 246-310-220.

1. **Provide a table that shows FTEs [full time equivalents] by category for the county proposed in this application. All staff categories should be defined.**

Table 15 -A

FTEs by Category for Eden Hospice Services in Skagit County

	2022	2023	2024	2025	2026
CLINICAL OPERATIONS					
Registered Nurse		0.88	1.91	2.72	2.98
Medical Social Worker		0.29	0.64	0.91	0.99
Hospice Aide		0.88	1.91	2.72	2.98
Spiritual Care Coord		1.00	1.00	2.00	2.00
TOTAL		**3.05**	**5.46**	**8.34**	**8.96**
ADMINISTRATIVE					
Administrator		0.50	0.50	0.50	0.50
Director of Patient Care		0.50	0.50	0.50	0.50
Clinical Manager		0.50	0.50	0.50	0.50
Business Office Manager		0.50	0.50	0.50	0.50
Clinical Support Specialist		1.00	1.00	1.00	1.00
Community Liaison		0.50	0.50	0.50	0.50
TOTAL		**3.50**	**3.50**	**3.50**	**3.50**
TOTAL FTE'S		**6.55**	**8.96**	**11.84**	**12.46**

Please see Appendix J for additional information on staffing assumptions.

2. **If this application proposes the expansion of an existing agency into another county, provide an FTE table for the entire agency, including at least the most recent three full years of operation, the current year, and the first three full years of operation following project completion. There should be no gaps in years. All staff categories should be defined.**

The Washington State Department of Health issued Eden Hospice at Whatcom County, LLC a Certificate of Need to provide Home Health Care services in Whatcom County, WA on October 2, 2020. Effective August 30, 2021, Eden Hospice at Whatcom County, LLC has achieved its Medicare-certification and Deemed Status via the Accreditation Commission for Health Care (ACHC) . This information was provided in a public information release on November 21, 2021.) Table 15-B provides staffing information for the first year of operation commencing in January 2022.

Table 15 - B
FTEs by Category for Eden Hospice at Whatcom County

TOTAL WHATCOM AGENCY	2023	2024	2025	2026
CLINICAL OPERATIONS				
Registered Nurse	3.33	4.73	5.93	6.40
Medical Social Worker	1.11	1.58	1.98	2.13
Hospice Aide	3.33	4.73	5.93	6.40
Spiritual Care Coord	1.00	1.00	2.00	2.00
Subtotal	**8.76**	**12.03**	**15.84**	**16.94**
ADMINISTRATIVE				
Administrator	1.00	1.00	1.00	1.00
Administrator Bonuses	-	-	-	-
Director of Patient Care	1.00	1.00	1.00	1.00
Clinical Manager	1.00	1.00	1.00	1.00
Business Office Manager	1.00	1.00	1.00	1.00
Clinical Support Specialist	2.00	2.00	2.00	2.00
Community Liaison	1.00	1.00	1.00	1.00
Subtotal	**7.00**	**7.00**	**7.00**	**7.00**
TOTAL FTE'S	**15.76**	**19.03**	**22.84**	**23.94**

3. Provide the assumptions used to project the number and types of FTEs identified for this project.

Table 16 provides Eden Hospice at Whatcom County, LLC Northwest staff to patient ratios.

Table 16
Eden Hospice at Whatcom County, LLC Staff / Patient Ratio

Type of Staff	Eden Hospice at Whatcom County, LLC
	Staff / Patient Ratio
Skilled Nursing (RN & LPN)	1:10
Physical Therapist	Contract only
Occupational Therapist	Contract only
Medical Social Worker	1.30
Speech Therapist	Contract only
Home Health / Hospice Aide	1:10
Chaplain	Initially Fixed then 1:40

4. Provide a detailed explanation of why the staffing for the agency is adequate for the number of patients and visits projected.

While preparing staffing ratios, Eden evaluated a sample of applications approved from 2018 through 2021 and has followed staffing patterns used in its three operating hospices outside of Washington State. Table 16 provides staffing ratios that are consistent with staffing for existing Eden Hospices as well as with the assumptions in the Certificate of Need applications that were evaluated. These ratios apply to Eden's employed clinical staffing. Co-location also provides advantages to sharing peak workloads of 2 county service areas. More generally, members of the Eden administrative staff work flexibly with each other to meet patient care needs. Eden's Administrator and Director of Patient Care are qualified and prepared to provide direct patient care or other administrative functions. Thus, the team is readily able to respond to patient needs when the growing agency experiences peaks in census.

5. **Provide the name and professional license number of the current or proposed medical director. If not already disclosed under 210(1) identify if the medical director is an employee or under contract.**

   Medical Director and license number – Kelle Brogan MD
   License #: MD 61234063

6. **If the medical director is/will be an employee rather than under contract, provide the medical director's job description.**

7. **Identify key staff by name and professional license number, if known. (nurse manager, clinical director, etc.)**

   Amy Bradley, MSW, LSWAIC (Administrator)
   Kristina Wood, Director of Patient Care Services – RN60477979

8. **For existing agencies, provide names and professional license numbers for current credentialed staff.**

The staff serving Skagit County include the following

Name	Specialty	Number	State

9. **Describe your methods for staff recruitment and retention. If any barriers to staff recruitment exist in the planning area, provide a detailed description of your plan to staff this project.**

Hospice services have been proven to reduce the demand for inpatient hospital services and the nursing and other ancillary staff needed to support hospital inpatients. As a result, hospice in general reduces the demand for hospital-based nursing staff by reducing hospital length of stay and reducing

readmissions to acute care hospitals.
As a large multi-state organization, EmpRes and Eden have employees, visibility, and contacts across numerous job markets. Specific to Skagit County, EmpRes currently operates both a home health agency and a skilled nursing facility in Skagit County, so it has local knowledge and established relationships within Skagit County for recruiting staff.

Eden Hospital at Whatcom County is an employee-owned agency. This is an added recruitment advantage in several important aspects of staffing, recruitment, and retention:

- EmpRes maintains a recruitment office to systematically recruit for employees
- Staff mobility within and between labor markets supports recruitment and enhances overall retention efforts for employees stay in the EmpRes and Eden organizations
- As an employee-owned organization, EmpRes and Eden experience lower turn-over rates than many other health care providers.
- Co-location of Eden Hospice with EmpRes Home Health at Whatcom County, LLC will reduce the need for new employees particularly in the start-up years.
- 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 again reducing turnover and making EmpRes an attractive employer.
- EmpRes maintains an Employee Referral bonus program.

10. Identify your intended hours of operation and explain how patients will have access to services outside the intended hours of operation.

The office hours will be 8 a.m. to 5 p.m. Monday through Fridays.

At all other times, Eden will have paid staff on call and accessible by telephone via a phone call to a main number. Also, hospice patients who prefer to participate in the tele-medicine option will have 24/7 access through their own dedicated electronic tele-medicine device.

11. For <u>existing</u> agencies, clarify whether the applicant currently has a method for assessing customer satisfaction and quality improvement for the hospice agency.

Not Applicable.

12. For existing agencies, provide a listing of ancillary and support service vendors already in place.

Appendix U provides a list of vendors based on Eden Home Health at Skagit and selected vendors for other home health and hospice services provided in Washington agencies.

13. Identify whether any of the existing ancillary or support agreements are expected to change as a result of this project.

Please see Appendix U for a list of proposed vendors. This list is based heavily on vendor relationships already in place for Eden home health and agencies located throughout the State and

specifically in Skagit County.

14. For new agencies, provide a listing of ancillary and support services that will be established.

Not Applicable.

15. For existing agencies, provide a listing of healthcare facilities with which the hospice agency has working relationships.

Inpatient contractors
For General Inpatient Care and for Respite Care, the proposed hospice will develop contracts with one or more local facilities.

General Inpatient Care
Eden will initiate relationships on approval of its Skagit County CON and anticipates developing "general inpatient care" contracts with local hospitals that serve the area. Eden expects to develop GIP contracts with:

- Skagit County hospitals whose physicians and discharge planners refer patients to Eden Hospice at Whatcom County, LLC the regional hospital system operated by Skagit Regional Health
- PeaceHealth?

Respite Care
- North Cascades Rehabilitation and Health Services, LLC, a skilled nursing home
- Highland Health and Rehabilitation, a skilled nursing home

In-home care for nursing home residents
In addition to arranging for General Inpatient Care and Respite Care, Eden will also plan with area nursing homes so that long term residents, for whom the facility is home, are able to receive routine in-home hospice services there, again beginning with:
- North Cascades Rehabilitation and Health Services, LLC, a skilled nursing home
- Highland Health and Rehabilitation, a skilled nursing home

Criteria for selection
In selecting inpatient providers with which to contract, Eden will apply the following criteria:

Of the potential hospital contracts available, Eden believes each provides high quality care. Eden plans to contract with each facility willing to do so. Criteria for contracting and referral of specific patients will include:

a) availability of inpatient hospice beds appropriate to GIP admissions (i.e., least restrictive environment and/or availability of a home-like setting
b) availability of appropriate clinical resources and beds for Eden's patients
c) relative geographic access of the facility for the patient's primary care team and/or potential visitors.
d) availability of a palliative care in-patient team or a hospitalist team that includes individuals with palliative care expertise
e) compatibility with Eden's adopted policies honoring a patient's End of Life choices
f) cost containment

Respite Care

a) availability of inpatient hospice beds appropriate to "respite care"
b) availability of clinical resources needed for Eden's patients
c) relative geographic access for the patient's primary care team and/or potential visitors
d) compatibility with Eden's adopted policies honoring a patient's End of Life choices
e) cost containment
f) availability of a home-like setting
g) nursing facilities already contracting with Eden for it to provide in-home hospice visits to its long-term care residents

16. Clarify whether any of the existing working relationships would change as a result of this project.

No, these relationships would be newly established relationships.

17. For a new agency, provide a listing of healthcare facilities with which the hospice agency would establish working relationships.

See the response to Question 15 in this section.

18. Identify whether any facility or practitioner associated with this application has a history of the actions listed below. If so, provide evidence that the proposed or existing facility can and will be operated in a manner that ensures safe and adequate care to the public and conforms to applicable federal and state requirements. WAC 246-310-230(3) and (5)

a. A criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a hospice care agency; or
b. A revocation of a license to operate a health care facility; or
c. A revocation of a license to practice a health profession; or
d. Decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.

There is no such history.

19. Provide a discussion explaining how the proposed project will promote continuity in the provision of health care services in the planning area, and not result in an unwarranted fragmentation of services. WAC 246-310-230

It is in the very nature of the Medicare-certified hospice to assure continuity and to avoid unwarranted fragmentation. The core purpose of the interdisciplinary hospice team is to develop the patient's plan of care, manage their care daily, and to support the patient's needs. In particular, the per diem payment to the hospice for all services puts the control of the full range of care in the hands of that core team.

As noted in the Executive Summary, the Washington Department of Social a & Health Services (DSHA) Fee for Service Dual-eligible project covering six years has reduced Medicare expenses by 10% per year as well as reducing overall Washington Medicaid costs. As of September 2020, 37% of the state dual-eligible program is enrolled in the State Health Home program. In the sixth Demonstration Year (2022) that included Skagit County, Medicare savings were over $55 million

with total Medicare savings over the 5-year period of $166.8 million (Appendix S). Medicaid savings have not yet been calculated by the Centers for Medicaid and Medicare Services. Note that the savings mentioned do not include Medicaid or family and patient health care expenditure savings.

Through this project, EmpRes and Eden Hospice at Whatcom County, LLC have the opportunity to integrate home health, hospice, nursing home, and assisted living facilities into system of care that has been *demonstrated* to improve health care, patient and family satisfaction, improve emotional health, and to reduce costs for both players such as Medicare and Medicaid and patients and their families in Skagit County.

20. Provide a discussion explaining how the proposed project will have an appropriate relationship to the service area's existing health care system as required in WAC 246-310-230.

Eden will work with its existing referral base developed for home health services and as noted earlier will reach out to Eden – owned entities including nursing home serving home and retirement facility services. Upon establishing an effective integration model for Eden entities, Eden Hospice at Whatcom County, LLC will reach out to other long term care nursing home and retirement facilities and has currently initially developed one such contract. As noted in the response to Question 19, Eden will work with community agencies involved to assure to support patients pursuing "Death with Dignity."

In selecting inpatient providers with which to contract, Eden will apply the following criteria:

Hospice Care

Of the potential hospital contracts available, Eden believes each provides high quality care. Eden plans to contract with each facility willing to do so. Criteria for contracting and referral of specific patients with hospitals will include:

a) availability of inpatient hospice beds appropriate to GIP admissions (i.e., least restrictive environment and/or availability of a home-like setting
b) availability of appropriate clinical resources and beds for Eden's patients
c) relative geographic access of the facility for the patient's primary care team and/or potential visitors.
d) availability of a palliative care in-patient team or a hospitalist team that includes individuals with palliative care expertise.
e) compatibility with Eden's adopted policies honoring a patient's End of Life choices
f) cost containment

Respite Care

g) existing Eden nursing home and assisted living facility entities
h) availability of clinical resources needed for Eden's patients
i) relative geographic access for the patient's primary care team and/or potential visitors.
j) compatibility with Eden's adopted policies honoring a patient's End of Life choices
k) cost containment
l) availability of a home-like setting

21. The department will complete a quality of care analysis using publicly available information from CMS. If any facilities or agencies owned or operated by the applicant reflect a pattern of condition-level findings, provide applicable plans of correction identifying the facility's current compliance status.

There is no pattern of condition-level findings among facilities owned by EmpRes/Eden.

Appendix V lists 77 healthcare facilities owned or operated by EmpRes/Eden. There is no pattern of condition-level findings among facilities owned by EmpRes/Eden.

"In the November 4, 2021 Certificate of Need Application #21-40 – Department's King County Evaluation, the Department reviewed the EmpRes Healthcare Group, Inc./Eden submittal wherein 79 health care facilities located in nine states were reviewed. The table below shows the breakdown:

State	Home Health	Hospice	Nursing Home	Assisted Living	Total
Arizona	2	1	0	0	**3**
California	2	0	3	0	**5**
Idaho	2	1	3	0	**6**
Montana	1	1	8	1	**11**
Nevada	1	1	4	0	**6**
Oregon	0	0	7	1	**8**
South Dakota	0	0	7	2	**9**
Washington	4	1	18	1	**24**
Wyoming	0	0	6	1	**7**
Totals	**12**	**5**	**56**	**6**	**79**

Below is a summary of the two areas reviewed for EmpRes Healthcare Group, Inc./Eden and its healthcare facilities.

Terminated Provider Counts Report
Focusing on years 2018 through 2021, none of EmpRes Healthcare Group, Inc./Eden's healthcare facilities were involuntarily terminated from participation in Medicare reimbursement.
Conformance with Medicare and Medicaid Standards Nursing Homes Focusing on years 2018 through 2021, of the 56 nursing homes, 53 were surveyed during the time frame. The department reviewed the survey information for the nursing homes and found a combined total of 385 surveys for the 53 nursing homes. The scope and severity of the deficiencies required follow up visits by the surveyors. The deficiencies ranged from patient care, charting, pain management, and infection control; many were noted as 'pattern' or 'widespread.' Each of the 53 nursing homes submitted plans of correction (POC) and corrected the deficiencies prior to the required follow up visit.

Focusing on the 18 Washington State facilities, years 2018 through 2021 showed a combined total of 175 surveys. Many of these surveys were also noted to be 'pattern' or 'widespread.' Each of the 18 nursing homes submitted plans of correction (POC) and corrected the deficiencies prior to the required follow up visit. All 18 facilities are in conformance with CMS standards at this time.

In Home Service Agencies
Of the 17 in home service agencies, 5 are hospice and 12 are home health. Focusing on years 2018 through 2021, a total 6 agencies were not surveyed during the timeframe—2 hospice agencies and 4 home health agencies. One of the Washington State home health agencies not surveyed is a new agency in Bellingham.

The 11 agencies surveyed resulted in a total of 13 surveys. All surveys resulted in minor deficiencies that required no follow up visits. All agencies are in conformance with CMS standards at this time.
. . . . In review of this sub-criterion, the department considered the total compliance history of EmpRes Healthcare Group, Inc./Eden organization. . . . . Based on the information reviewed and the lack of public comment in opposition to the project, the department concludes that EmpRes Healthcare Group, Inc./Eden has

been operating in compliance with applicable state and federal licensing and certification requirements. The department also concludes there is reasonable assurance that the applicant's establishment of a hospice agency in Washington State would not cause a negative effect on the compliance history of EmpRes Healthcare Group, Inc./Eden."[23]

22. If information provided in response to the question above shows a history of condition-level findings, provide clear, cogent and convincing evidence that the applicant can and will operate the proposed project in a manner that ensures safe and adequate care, and conforms to applicable federal and state requirements.

There is no pattern of condition-level findings among facilities owned by EmpRes/Eden.

D. Cost Containment (WAC 246-310-240)

Projects are evaluated based on the criteria in WAC 246-310-240 in order to identify the best available project for the planning area.

1. Identify all alternatives considered prior to submitting this project. At a minimum include a brief discussion of this project versus no project.

The certificate of need rules suggest criteria to be considered including:

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

The 2022-2023 State Methodology concluded that there is a need for an Average Daily Census of 6 hospice patients in Skagit County by 2024 – even with admissions and lengths of stay for hospice patients at levels substantially lower than the national average. Regarding unnecessary duplication, the 2022-2023 need methodology extended through 2026 shows an unmet need comprising a 14-patient average daily census. Need as summarized in Table 4, documents that there is substantial disparity in hospice access for Medicare dual-eligible beneficiaries and a total of three other patient cohorts including disparity in access for hospice patients considering a Death with Dignity alternative (Table 13). The volume of patients and its associated average daily census shows a net need for 23 – 64hospice patients annually depending on the year of analysis. Consequently, non-duplicative need has been established as well as unmet need for specific population cohorts necessitating the need for immediate action to add capacity.

Generally, capital costs are not applicable to hospice patients because services are delivered in the patient's residential setting in the community which may include long term care facilities. In this case, required office space is for the administrative staff and does not require special facilities and has and requires no additional capital expenditure associated with adding Skagit county to Eden Hospice at Whatcom County, LLC and then co-locating with Eden's existing home health agency offices.

In terms of selecting how to add capacity; an important factor is staffing, particularly nurse staffing during this shortage period. Eden has a distinct staffing advantage because 3of its nurses live in Skagit County or on the Skagit/Whatcom border. Of course, Eden will be incrementally adding nurses to meet volume requirements consistent with realized volume on a year-by-year basis (as projected in Table 3 and based on the staffing ratios in Table 16). Skagit and Whatcom are very popular regions to live in

[23] Certificate of Need Application #21-40 – Department's King County Evaluation, November 4, 2021. Pp 93 - 95

Western Washington, recruitment should not be an issue.

The alternatives Eden Hospice of Washington, LLC considered in developing this proposed project included:

- Postponing action – close Eden hospice services in Skagit County by YE 2023
- Continue the Choice *status quo* by operating Eden hospice services in Skagit County
- Implementing the Project through a new start-up
- Acquiring an Existing Skagit hospice agency.

Eden Hospice at Whatcom County, LLC is requesting CN approval to operate a Medicare certified and Medicaid eligible hospice agency in Skagit County. The hospice agency will be co-located with the Eden Home Health at Skagit, LLC agency.

As a certificate of need rules requirement, Eden Hospice evaluated the following alternatives:
(1) status quo: "do nothing or postpone action" , which in this case means maintaining Skagit services
(2) develop the proposed project, co-located with the existing Eden Home Health at Skagit agency
(3) Establish a new, single-purpose hospice agency location
(4) Acquire an existing hospice agency

The four alternatives for this project were evaluated using the following decision criteria:
(1) access to hospice services
(2) health outcomes
(3) quality of care
(4) health care cost control for patients and for payers
(5) operating efficiency
(6) Impact on existing hospice agencies

Each alternative identifies advantages and disadvantages. Based on the above decision criteria and the analyses of each criteria covered in Tables 17 - 22, the requested project — seek CN approval to operate a Medicare certified and Medicaid eligible, hospice that is co-located with an existing Eden home health agency is the best option.

2. **Provide a comparison of the project with alternatives rejected by the applicant. Include the rationale for considering this project to be superior to the rejected alternatives. Factors to consider can include but are not limited to: patient access to healthcare services, capital cost, legal restrictions, staffing impacts, quality of care, and cost or operation efficiency.**

Table 17
Alternative Analysis: Access to Hospice Services

Advantages/Disadvantages	
An analysis of seven hospice capacity related metrics, documents that the Snohomish Hospice is unable to provide sufficient capacity that are barriers to access and can lead to increased healthcare costs for patients and payers.	
1) Postponing action and transferring hospice patients by YE 2023 to Skagit Hospice Service	There is a disadvantage to postponing action because the status quo is to continue to service patients which has improved access given that unmet need due to disparity in access for the Medicare dual eligible, and the cohort considering Death with Dignity. Postponing action would require transferring over 50 patients by year-end 2023 placing a burden on hospice patients, families and on Spokane Hospice Services.
2) Requested Project: CN approval – to continue the ***status quo*** to operate a hospice agency co-located with the Eden Home Health at Skagit Agency	This option directly addresses and reduces unmet need due to disparity and opens access for the Medicare dual eligible, and the cohort considering a Death with Dignity option. This will be accomplished by reaching out to long term care facilities and maintaining the only fully complying Death with Dignity policy in Skagit County. By co-locating with the Eden home health agency in Skagit County outreach efforts and staff utilization can be leveraged to maximize outreach and reduce staffing burdens for Skagit Hospice Services
3) Develop an independent location to operate a separate Skagit County hospice operation	This option directly addresses and substantially reduces unmet need due to disparity in access for the Medicare dual-eligible and the cohort considering a Death with Dignity option. This will be accomplished by reaching out to long term care facilities and maintaining the only fully complying Death with Dignity policy in Skagit County. The disadvantage is duplication in capital and operating costs and recruiting for additional administrative staff while also losing flexibility in direct care staffing related to volume.
4) Acquire an existing location to operate a Skagit County hospice operation	This option is not available because there is only one hospice agency serving Skagit County, which is Skagit Hospice Services
Conclusion: The do nothing – postpone action is clearly not advantageous for the community from an access standpoint since access disparity among the dual-eligible population and the Death with Dignity population has not been addressed (since existing hospices do not offer the full array of long term care services provided by EmpRes/Eden). Further, there is current partial population-based hospice need that increases the Need for a new agency in 2026. Two agencies with different channels and approaches to outreach benefits the community and reduces disparity in access documented in this application.	

Table 18
Alternative Analysis: Improved Health Outcome Hospice

Advantages/Disadvantages	
The literature points to an ideal ALOS of 6 months. Studies cited in this application document that patients with terminal diagnoses with a longer progression of illness (the ALOS is 88 days, but the median ALOS is 18 days), live longer with reduced hospitalizations and reduce emergency room visits if they are enrolled in hospice. Appendix S provides two studies showing that Medicare dual-eligible beneficiaries have a greater number of ADL issues than other patients. Referenced research studies show that patient and families wished that they had accessed hospice services earlier during the patient's terminal illness.	
1) Postponing action and transferring hospice patients by YE 2023 to Skagit Hospice Service	There is no advantage to postponing action and shutting down by YE 2023. As noted in the application, there is substantial disparity in access for low-income Medicaid eligible residents and low income, dual-eligible Medicare beneficiaries and these populations have higher health care needs due to higher levels of disability (see Appendix S studies). Dual-eligible Medicare beneficiaries will benefit from added support that they desperately need in all care home care settings including nursing homes.
2) Requested Project: CN approval – to continue the ***status quo*** to operate a hospice agency co-located with the Eden Home Health at Skagit Agency	The requested project reduces current and future access barriers identified in the Skagit County Planning Area and directly addresses disparity in access among the dual-eligible patients and to the portion of that cohort with the greatest disability challenges because we are conducting outreach to long term care facilities. Hospice patients and families will have the full panoply of support services to aid them during the end-of-life passage, , and the family bereavement period.
3) Develop an independent location to operate a separate Skagit County hospice operation	Co-location as an alternative to the proposed project also reduces current and future access barriers identified in the Skagit County Planning Area and directly addresses disparity in access among the dual-eligible patients and to the portion of that cohort with the greatest disability challenges because we are conducting outreach to long term care facilities. Co-location coordinates the transition for patients from Eden Home Health to hospice services directly provided by Eden or for referral to Skagit Hospice Service.
4) Acquire an existing location to operate a Skagit County hospice operation	Acquiring an existing hospice could also reduce current and future access barriers identified in the Skagit County Planning Area and directly addresses disparity in access among the dual-eligible patients and to the portion of that cohort with the greatest disability challenges because we are conducting outreach to long term care facilities. However, this option does not maximize the advantages of co-location of home health and hospice.
Conclusion: The do nothing option does not support the community in Skagit County – clearly, "doing nothing" would negatively impact and hurt the community from a health outcome standpoint especially given the disparity metrics around the Medicare dual-eligible hospice population. Regarding establishing an independent hospice location, this could be carried out when volume for home health and hospice services demonstrates the advantage of multiple locations over a central Skagit County location but is unlikely given the population base of Skagit County.	

Table 19
Alternative Analysis: Quality of Care

Advantages/Disadvantages	
The literature points to an ideal ALOS of 6 months. Studies cited in this application document that patients with terminal diagnoses with a longer progression of illness (the national ALOS is 88 days, but the median ALOS is 18 days), live longer with reduced hospitalizations and use of the emergency room if they are enrolled in hospice. In addition to technical metrics, the care experience is also a quality metric. When patients and families are queried about the care experience, they often attribute quality of care issues as an issue of "not being on hospice long enough." (The literature on this point seems to be that dissatisfaction with hospice services is more related to elements of care rather than length of stay.[18] (See Appendix S)	
1) Do nothing – transferring hospice patients by YE 2023 to Skagit Hospice Service	There is no advantage to postponing action in terms of improving health outcomes. As noted in the application, there is substantial disparity in access for low-income Medicaid eligible residents and low income, dual-eligible Medicare beneficiaries and these populations have higher health care needs due to higher levels of disability (see Appendix S studies). Closing would result in disparity of access not being adequately addressed given that Skagit Hospice Services would have to re-boot to serve an additional 54 (2023) to 114 (2024) patients.
2) Requested Project: CN approval – to operate a hospice agency co-located with the Eden Home Health at Skagit Agency	The requested project should increase ALOS and should reduce delays in enrollment. These two factors alone should improve the care experience for the patient and family.
3) Develop an independent location to operate a separate Skagit County hospice operation	Adding an additional site in Skagit County would not improve the ALOS or delay reduction in enrollment because the home health and hospice staff are located throughout Skagit County.
4) Acquire an existing location to operate a Skagit County hospice operation	Adding an additional site in Skagit County would not improve the ALOS, or delay reduction in enrollment because the home health and hospice staff are located throughout Skagit County.
Conclusion: Postponing action is clearly not advantageous for the community from a health quality of care standpoint given the metrics around delays in enrollment in hospice both from hospital and home health transfers that would be expected if Skagit Hospice Services, in a compressed time period, was forced to scramble and serve an additional 54 patients (2023), and 114 patients (2024). In regard to a separate location for the Eden Hospice at Whatcom County, LLC it could be implemented at any time when there was a need for expanded space with the exception of a new agency.	

[18] Joan M. Teno, MD *et al.* Timing of Referral to Hospice and Quality of Care: Length of Stay and Bereaved Family Members' Perceptions of the Timing of Hospice Referral, Journal of Pain and Symptom Management Aug. 2007 pp 120, 123

Table 20
Alternative Analysis: Healthcare Cost Control – Patient and Payer

The literature points to an ideal ALOS of 6 months. Eden cites studies documenting patients with terminal diagnoses with a long progression of illness (ALOS 88 days, but median ALOS is 18 days), live longer with reduced hospitalizations and use of the emergency room if patients are enrolled in hospice. A Providence Hospice financial analysis in the approved CN 19-44 calculated potential statewide savings of $99 million or $3,945 per patient if all hospice eligible patients received 35 days of hospice care.[19] Appendix S shows 3 studies with reduced costs for integrating hospice services and health plans for dual-eligible Medicare beneficiaries. The Washington study showed a statewide reduction of $293 million over 6 years and 10% per year with savings of $2,000 per patient just for Medicare.[24] The national study shows Out of Pocket savings of $670 for families receiving 1-month of hospice versus no hospice service. In this study, all payers would save $10,908 per 90-day hospice patient stay versus no hospice stay.[25]	
1) Postpone action – transferring hospice patients by YE 2023 to Skagit Hospice Service	There is no advantage to maintaining the status quo in terms of reducing patient/payer healthcare costs given the substantial savings realized by the Dept. of Health Services reducing Medicare costs by nearly $50 million per year over 6 years by integrating dual-eligible Medicare and Medicaid home services. Eden's outreach for dual-eligible individuals will also reduce Medicare costs as noted in a Providence study.
2) Requested Project: CN approval – to operate a hospice agency co-located with the Eden Home Health at Skagit Agency	There ae substantial savings in patient/payer healthcare costs associated with the specific Eden approach given the savings realized by the Dept. of Health Services reducing Medicare costs statewide by nearly $50 million per year over 6 years by integrating dual-eligible Medicare and Medicaid home services. Eden's outreach for dual-eligible individuals also reduces Medicare costs as noted in a Providence study. Not reaching the dual-eligible patient cohort will cost Medicare $2,000 per patient and at uncalculated additional patient and family costs.
3) Develop an independent location to operate a separate Skagit County hospice operation	There ae substantial savings in patient/payer healthcare costs associated with the specific Eden approach given the Dept. of Health Services results reducing Medicare costs statewide by nearly $50 million per year for 6 years by integrating dual-eligible Medicare and Medicaid home services. Eden's outreach for dual-eligible individuals also reduces Medicare costs. Co-location offers of additional service integration.
4) Acquire an existing location to operate a Skagit County hospice operation	There ae substantial savings in patient/payer healthcare costs associated with the specific Eden approach given the substantial savings realized by the Dept. of Health Services reducing Medicare costs statewide by nearly $50 million per year over 6 years by integrating dual-eligible Medicare and Medicaid home services. Given that there is only one hospice agency serving Skagit County, acquisition of that agency would be at a breathtaking premium cost that disqualifies this alternative.
Conclusion: The postpone action alternative is clearly not advantageous given the cost saving opportunity ($2,000 - $10,908 per patient plus additional savings for patients and families associated with Eden's dual-eligible outreach strategy).	

[24] Report for Washington Managed Fee-for-Service (MFFS):Final Demonstration Year 5 and Preliminary Demonstration Year 6 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative**.** *Op cit.* Pag ES-2

25 Melissa Aldridge, Ab Brody, Peter May, Jaison Moreno, Karen McKendrick, Lihua Li. "Association Between Hospice Enrollment and Total Health Care Costs for Insurers and Families, 2002-2018, *op cit.* Page 5

Table 21
Alternative Analysis: Operating Efficiencies

Advantages/Disadvantages	
There are distinct advantages to having Eden Hospice co-locate with EmpRes Home Health of Skagit County; there will be no additional capital expenditure and utilities costs can be allocated to two programs rather than one program. In addition, the expense of developing multiple ancillary contracts can be avoided. Finally, co-locating should improve enrollment of hospice-eligible home health patients into hospice as well as EmpRes/Eden long term care facilities.	
1) Postpone Action – transferring hospice patients by YE 2023 to Skagit Hospice Service	There is no advantage to maintaining the status quo in terms of operating efficiencies. Recruitment costs associated with staffing for an additional 54 patients (2023) to 114 patients (2024) would necessitate registry staffing and premium pay to meet need.
2) Requested Project: CN approval – to operate a hospice agency co-located with the Eden Home Health at Skagit Agency	Eden Hospice breakeven volume should be reduced to less than an average daily census (ADC) of 20 patients in Skagit County due to no capital expenditure and with a reduction in utilities and rent and any capital expenditure. As a result, Eden can concentrate on outreach to low-income Medicaid-eligible residents and low income, dual-eligible Medicare beneficiaries. Eden home health costs would also be reduced with rent, utilities and insurance costs shared by two agencies.
3) Develop an independent location to operate a separate Skagit County hospice operation	Capital costs, rental costs, insurance costs and utilities costs would be duplicated, which would increase the breakeven ADC.
4) Acquire an existing location to operate a Skagit County hospice operation	Capital costs, rental costs, insurance costs and utilities costs would be duplicated, and acquisition costs would dramatically increase overall hospice costs in Skagit County.
Conclusion: The postpone alternative is clearly not advantageous for the community from an operating efficiency standpoint. The overall patient base in Skagit County makes a second independent alternative financially unattractive compared with the co-location alternative. As previously noted, acquiring Skagit Hospice Services as a sole provider would require a premium investment which would be disqualifying from a cost effectiveness standpoint.	

Table 22
Alternative Analysis: Impact on Other Skagit County Hospices

Advantages/Disadvantages	
As noted in this application, the Eden Hospice at Whatcom County, LLC addition of Skagit County has been demonstrated to have no impact on an existing high volume hospice because Eden is reaching out to significantly underserved populations including the dual-eligible long term care population cohort, the general long term care population cohort, the Choice cohort, and the Death with Dignity cohort. Table 13 shows that over the entire Certificate of Need period from 2022 through 2026, there will be additional patients generated by population growth that will need hospice services from Skagit Hospice Services, so Skagit's volume should increase. In short there is no duplication let alone necessary duplication.	
1) Postpone action – transferring hospice patients by YE 2023 to Skagit Hospice Service	Postponing action results in continued disparity in access for the dual-eligible Medicare population and the Death with Dignity population and abandons documented cost savings and improved quality opportunities associated with integrating hospice and long term health services. In addition, it would put a great burden on Skagit Hospice Services to have to "staff up" unreasonably fast to serve an additional 54 patients in 2023, and 114 patients in 2024.
2) Requested Project: CN approval – to operate a hospice agency co-located with the Eden Home Health at Skagit Agency	Addition of Eden Hospice at Whatcom County, LLC will have no adverse impact on existing hospice agencies while reducing disparity, improving services to long term care residents strengthening long term care programs and achieving substantial healthcare cost savings primarily for dual-eligible Medicare patients and Washington Medicaid patients.
3) Develop an independent location to operate a separate Skagit County hospice operation	Addition of Eden Hospice at Whatcom County, LLC will have no adverse impact on existing hospice agencies while reducing disparity, improving services to long term care residents strengthening long term care programs and achieving substantial healthcare cost savings primarily for dual-eligible Medicare patients and Washington Medicaid patients. An independent location will not be required by Eden in the foreseeable future due to the limited population base in Skagit County.
4) Acquire an existing location to operate a Skagit County hospice operation	Acquiring Skagit Hospice Services would come at such a high premium for a single agency that it would be disqualifying.
Conclusion: The postponing action alternative offers no benefit to existing hospice providers while increasing costs for Medicare dual-eligible beneficiaries, the Medicare program, the Medicaid program, and long term care facilities. Only by approving the Eden Hospice at Whatcom County, LLC can the stakeholders listed above receive the substantial cost savings listed in the alternatives which experiencing a higher quality of care through earlier admission to hospice services.	

Alternatives Summary

Considering the alternatives available in light of the criteria above: Maintain the *status* quo by approving the long-term operation of Eden Hospice at Whatcom County in Skagit County is the best community alternative.

If the project involves construction, provide information that supports conformance with WAC 246-310-240(2):

- **The costs, scope, and methods of construction and energy conservation are reasonable; and**
- **The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.**

Not Applicable.

The Eden response to Question 10 in the "Need" section provides an overview of improvements and innovations in service delivery that foster cost containment, quality assurance and cost effectiveness.

Hospice Agency Superiority

In the event that two or more applications meet all applicable review criteria and there is not enough need projected for more than one approval, the department uses the criteria in WAC 246-310-290(11) to determine the superior proposal.

Eden may respond to Hospice Agency Superiority Criteria after reviewing any competing applications.

Multiple Applications in One Year

In the event you are preparing more than one application for different planning areas under the same parent company – regardless of how the proposed agencies will be operated – the department will require additional financial information to assess conformance with WAC 246-310-220. The type of financial information required from the department will depend on how you propose to operate the proposed projects. **Related to this, answer the following questions:**

1. **Is the applicant (defined under WAC 246-310-010(6)) submitting any other hospice applications under either of this year's concurrent review cycles? This could include the same parent corporation or group of individuals submitting under separate LLCs under their common ownership.**

If the answer to this question is no, there is no need to complete further questions under this section.

EmpRes Healthcare Group, Inc. is submitting applications in the first and second cycles.

2. **If the answer to the previous question is yes, clarify:**
   - **Are these applications being submitted under separate companies owned by the same applicant(s); or**
   - **Are these applications being submitted under a single company/applicant?**
   - **Will they be operated under some other structure? Describe in detail.**

EmpRes Healthcare Group, Inc is submitting CoN applications for hospice services in Skagit County, Spokane County and Pierce County. The Eden Hospice at Whatcom County, LLC is submitting a Certificate of Need to add Skagit County to its agency and its existing license. The Eden Hospice at King County, LLC is submitting a CoN to add Pierce County to its agency and to its existing license upon receipt of its hospice license. The EmpRes Healthcare Group, Inc. CON application for Spokane County, Eden Hospice at the Inland Northwest, LLC will be co-located with the Eden Hospice at Spokane.

3. **Under the financial feasibility section, you should have provided a pro forma balance sheet showing the financial position of this project in the first three full calendar years of operation. Provide pro forma balance sheets for the applicant, assuming approval of this project showing the first three full calendar years of operation. In addition, provide a pro forma balance sheet for the applicant assuming approval of all proposed projects in this year's review cycles showing the first three full calendar years of operation.**

   Appendix L provides the required balance sheet.

4. **In the event that the department can approve more than one county for the same applicant, further pro forma revenue and expense statements may be required.**

   - **If your applications propose operating multiple counties under the same license, provide combined pro forma revenue and expense statements showing the first three full calendar years of operation assuming approval of all proposed counties.**
   - **If your applications propose operating multiple counties under separate licenses, there is no need to provide further pro forma revenue and expense statements.**

List of Appendices: Eden Hospice at Whatcom County, LLC

Appendix A	Letter of Intent
Appendix B	• EmpRes/Eden Organization Chart of Entities • Operating Agreement
Appendix C	Medical Director Job Description and Contract
Appendix D	Certificate of Formation, UBI Initial Report
Appendix E	• Skagit Home Health Office Lease and Extension
Appendix F	Non-Discrimination Policy
Appendix G	Admissions Policy
Appendix H	Charity Care Policy
Appendix I	Discharge Policy and Patient Referral Policy
Appendix J	• Pro Forma Financials, Skagit Assumptions • Revenue Assumptions & Staffing Summary • Skagit P&L • Skagit Balance Sheet
Appendix K	• Revenue Assumptions & Staffing Summary • Projected Statement of Operations • Balance Sheet
Appendix L	P&L Summary – 3 Year Historical Projected Statement of Operations All Hospice Balance Sheet
Appendix M	Patient Rights
Appendix N	Change Name to Skagit County Business Plan Outreach Summary
Appendix O	Eden Policy on Death with Dignity
Appendix P	Commitment letter from Chief Financial Officer
Appendix Q	Left Blank
Appendix R	Berg Data: Need and Demographic Analysis -- 2021

Appendix S	Hospice Studies 1) Integrating Care for Beneficiaries of Medicare and Medicaid: A White Paper 2) Report for Washington Managed Fee-for-Service (MFFS):Final Demonstration Year 5 and Preliminary Demonstration Year 6 3) Savings Estimates: Medicare-Medicaid Financial Alignment Initiative 4) Gene Balk. Washingtonians are less religious than ever, Gallup poll finds, 5) Bethany CN 21-45; Page 53 6) Hospice Care in US Nursing Homes: Benefits and Barriers 7) "The effects of hospice coverage on Medicare expenditures 8) Timing of Referral to Hospice and Quality of Care: Length of Stay and Bereaved Family Members' Perceptions of the Timing of Hospice Referral, Journal of Pain and Symptom Management 9) Association Between Hospice Enrollment and Total Health Care Costs for Insurers and Families, 2002- 2018
Appendix T	Left Blank
Appendix U	List of proposed Vendors
Appendix V	List of Eden Agencies – will send spreadsheet
Appendix W	Left Blank
Appendix X	Left Blank
Appendix Y	Best Practices in Reducing Hospice Utilization Disparity

Eden Hospice at Whatcom County, LLC

316 McLeod Rd., Ste. 104 Bellingham, WA 98226-6491 | Phone:360-966-8593| Fax:360-966-8926

November 29, 2022

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

Sent by E-mail: FSLCON@doh.wa.gov

Re: Eden Hospice at Whatcom County, LLC Letter of Intent for Providing Medicare and Medicaid Hospice Services to Hospice Eligible Patients in Skagit County

Dear Mr. Hernandez:

This letter of intent is issued by Eden Hospice at Whatcom County, LLC, a subsidiary of EmpRes Healthcare Group, Inc. In accordance with WAC 246-310-080, Eden Hospice at Whatcom County proposes to provide hospice services to Medicare and Medicaid Eligible hospice patients residing in Skagit County. This letter of intent is consistent with the provisions of Governor Inslee's Proclamation 20-36 and consistent with the glidepath identifying continuing hospice services beyond October 27, 2022 as required by the Department.

1. **Description of proposed service**

   EmpRes Healthcare Group, Inc., through Eden Hospice at Whatcom County, LLC requests approval to continue extending its hospice services to Medicare and Medicaid eligible residents of Skagit County.

2. **Estimated cost of the project**

   There are no capital costs associated with the proposed project because services are being provided through the existing Eden Hospice at Whatcom County agency location.

3. **Identification of the service area**

   Eden Hospice at Whatcom County, LLC will provide hospice services in the Skagit County planning area, as identified in WAC 246-310-290 (3).

APPENDIX A

Eden Hospice at Whatcom County, LLC

316 McLeod Rd., Ste. 104 Bellingham, WA 98226-6491 | Phone:360-966-8593 | Fax:360-966-8926

Please address all correspondence to:

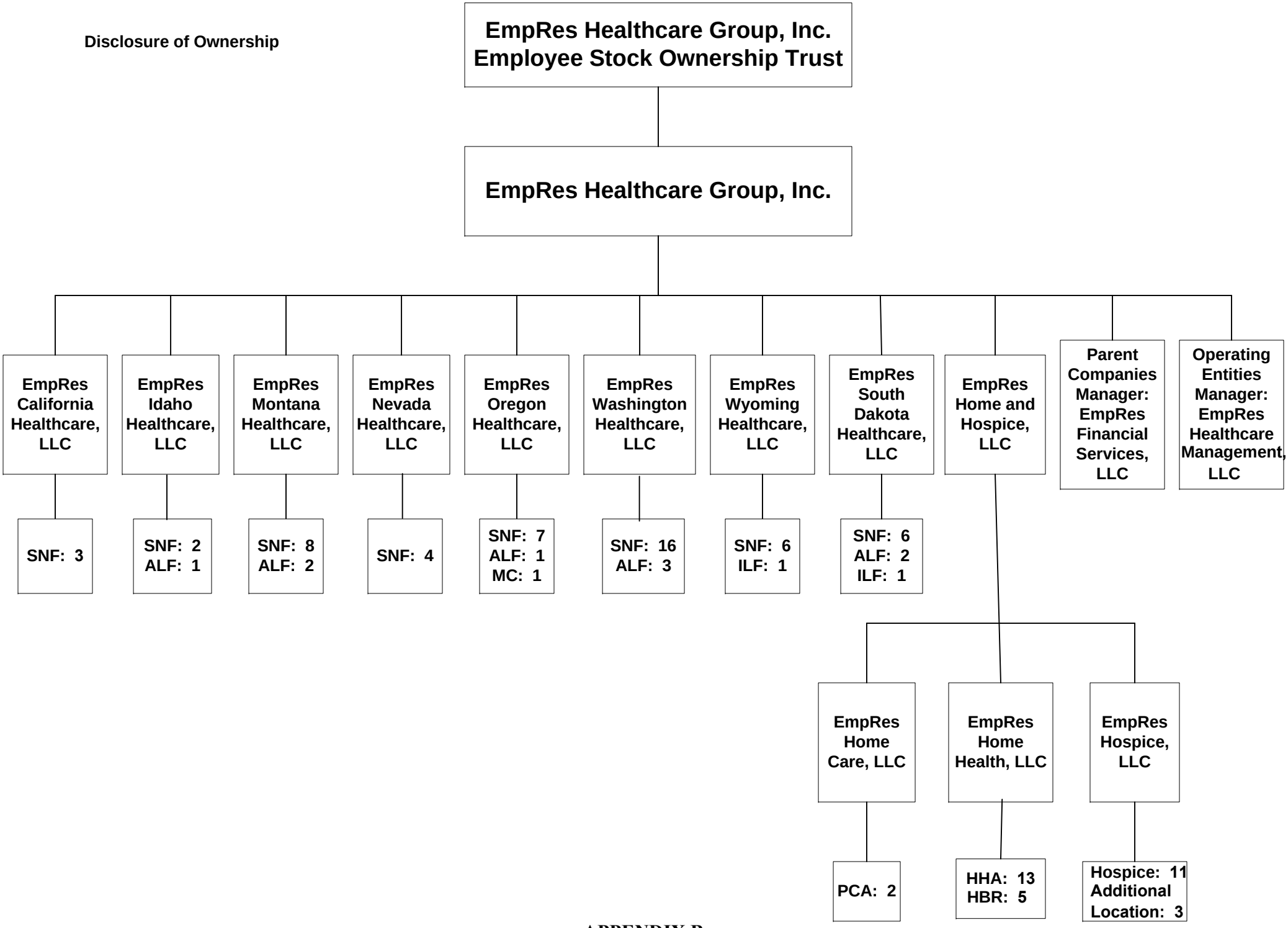
Jamie Brown, Vice President of Home Services
EmpRes Healthcare / Eden Health
4601 NE 77th Ave., Ste. 300,
Vancouver, WA 98662
360-798-8298
jbrown3@eden-health.com

Thank you for your attention.

Sincerely,

Jamie Brown
Vice President of Home Services
EmpRes Healthcare Group, Inc.

Disclosure of Ownership



APPENDIX B

MANAGEMENT AGREEMENT

Parties: EmpRes Healthcare Management, LLC ("Consultant")
4601 NE 77th Avenue, Suite 300
Vancouver, WA 98662

Eden Hospice at Whatcom County, LLC ("Company")
316 East McLeod Road, Suite 101
Bellingham, WA 98226

Date: October 2, 2020 (the "Effective Date")

A. Company operates a Hospice Agency licensed in the State of Washington.

B. Consultant is engaged in the business of providing consulting services for personal care agencies, and Company desires to have Consultant provide the consulting services set forth in this Agreement on Company's behalf, and Consultant is willing to do so pursuant to the terms and conditions hereinafter set forth.

NOW, THEREFORE, subject to the terms and conditions, and in consideration of the mutual promises and covenants herein contained, the parties agree as follows:

ARTICLE 1
RELATIONSHIP BETWEEN CONSULTANT AND COMPANY

1.1 Engagement. Subject to the terms, provisions and conditions set forth in this Agreement, and in consideration of the duties, covenants and obligations of the parties as set forth in this Agreement, Company hereby grants to Consultant the power and authority to provide the "Consulting Services" (as defined in Section 2.1 of this Agreement). Company shall, in good faith, at the request of Consultant, execute and deliver to Consultant all other documents and instruments necessary to vest in Consultant the authority required to perform Consultant's duties required under this Agreement.

1.2 General Policy Decisions. Consultant shall consult with and keep Company advised as to all general policy issues relating to the Company. Subject to the terms of Company's charter documents, all general policy decisions relating to the Company shall be made by Company and its governing body. Company shall request and receive recommendations from Consultant and shall duly consider all such recommendations prior to adopting any changes in general policies or directives concerning the operation of the Company. Authority Related to Management of the Company. Consultant shall provide the Consulting Services subject at all times to the ultimate operating and management authority of Company and its governing body. Nothing contained in this Agreement shall be construed to abrogate the ultimate authority of Company over the management and operations of the Company, and the governing body of Company shall retain authority and exercise control over the business of the Company.

1.3 Company hereby appoints Consultant (and its billing and collections agents) as true and lawful agent for Company, and hereby authorizes Consultant to collect, demand and accept on behalf of Company all amounts which become due, owing or payable to Company from any organization, entity or individual, including all federal health care programs, for Company services, and to effect receipts, releases and discharges for such amounts and collection of such amounts

ARTICLE 2
RIGHTS AND RESPONSIBILITIES OF CONSULTANT

2.1 Consulting Services. Consultant shall assist Company by providing administrative consulting services set forth in this Article 2 (the "Consulting Services").

(a) Consultant shall be responsible for the following duties:

(i) Consult with Company and keep Company advised of all matters made known to Consultant which materially affect the financial wellbeing of or delivery of care by the Company;

(ii) Provide direction to Company to assist Company in operating the Company in accordance with the Medicare Conditions of Participation; and

(iii) Assist the Company in identifying appropriate personnel to be hired by the Company to fill the roles of **Director of Nursing** and **Administrator**.

(b) Consultant shall develop operational policies and procedures necessary to ensure establishment and maintenance of patient care appropriate for the nature of the facility and to ensure continued licensure and maintenance of the business. Consultant may seek advice and/or approval concerning such policies. Consultant shall obtain Company's approval before adopting or implementing such policies which approval shall not be unreasonably withheld or delayed.

(c) Consultant shall assist Company in the keeping of full and accurate books of account and such other records reflecting the results of operation of the Company as required by law and more fully described below.

(d) Consultant shall promptly provide to Company, as and when received by Consultant, all notices, reports or correspondence from governmental agencies that assert deficiencies or charges against the Company or that otherwise relate to the suspension, revocation, or any other action adverse to any approval, authorization, certificate, determination, license or permit required or necessary to own or operate all or any part of the Company, together with a recommendation of whether or not to appeal same.

(e) Consultant shall also provide recommendations to Company with respect to the day-to-day operations of the Company, including, but not limited to:

(i) Designing and overseeing the implementation of an effective budgeting and accounting system;

(ii) Maintaining copies of all Company vendor contracts;

(iii) Provision of regulatory compliance counseling and oversight of audits and investigations;

(iv) Provision of risk management and education;

(v) Providing guidance related to maintaining adequate administrative staffing for quality management activities;

(vi) Development for review by Company template clinical and business and policy forms necessary and desirable to assist with the effective, efficient and professional operations of the Company which Licensee shall review and modify to fit unique circumstances of Company and implement as appropriate;

(vii) Provision of professional liability and other insurance consulting assistance in responding to demands for payment, allegations of liability and lawsuits. Consultant shall assist Company in identifying and obtaining all insurance policies required or appropriate to protect the financial interests of Company; and

(viii) Establish fees and charges for all services provided to patients by the Company.

(f) Consultant shall oversee the Company's human resources functions as follows:

(i) Drafting and implementing policies and procedures to comply with the Company's obligations as an employer including, but not limited to, equal opportunity laws, worker's compensation laws, wage and hour laws, age and disability discrimination laws, workplace safety laws, and any other laws applicable to an employer Company's state; provided, however, that prior to the implementation of any and all policies and procedures drafted or otherwise provided by Consultant, the policies and procedures shall be reviewed and approved by Company;

(ii) Performing criminal background checks, OIG exclusion checks and licensure or certification verifications as required by applicable state law, Medicare Conditions of Participation and other applicable federal laws;

(iii) Overseeing the benefit enrollment process for benefits approved and implemented by Company;

(iv) Assist in Company in managing labor organization activities and union or other labor related contract negotiations;

(v) Providing such other human resource-related matters as Company may refer to Consultant; and

(vi) Providing recommended compensation and benefits packages for Company's employees and contractors.

(g) Consultant shall design, implement and supervise appropriate compliant billing systems necessary for billing for the personal care services rendered by individuals who are either employed by or under contract with the Company; provided, however, that prior to the implementation of any and all policies and procedures drafted or otherwise provided by Consultant, the policies and procedures shall be reviewed and approved by Company.

(h) Consultant shall open one or more bank accounts for the Company in the name of the Consultant or its designee (the "Management Account"), the authorized signatories of which shall consist solely of persons designated by Consultant. Consultant will notify Company as to the identity of the entity in whose name the Management Account has been opened and of the names of the individuals who are authorized signers of the Management Account.

(i) Consultant shall provide the following collection services for the Company's client accounts. In order to facilitate Consultant providing such services, Consultant shall be granted access to Company's primary operating account (the "Operating Account") and shall be made a signatory to the Operating Account. Consultant shall also provide the following services:

(i) Receive, credit, deposit and record payment of invoices and claims for services, whether such payments are received in cash, check, money order or wire transfer, into the Company's Operating Account in accordance with the Company's procedures;

(ii) Reconcile all bank deposits and provide deposit records to Company;

(iii) Implement any banClark and collection procedures initiated by and approved by the Company's governing body; and

(iv) Perform such other collection activities as the Company's governing body may refer to Consultant.

(j) Consultant shall provide the following financial services related to accounts payable. Consultant shall write checks on the Company's Operating Account to pay invoices received from the Company's suppliers, professional advisors, and other parties providing goods or services to the Company.

(i) Consultant shall be responsible for preparing and paying payroll. This shall include withholding appropriate amounts and maClark quarterly tax deposits; and

(ii) Consultant shall provide the Company's governing body with monthly reports on Company's income and profitability for use in planning, budgeting, determining profit distributions to its owners, strategic planning and other aspects concerning the operation of the Company.

(k) Consultant shall assist the Company with designing and implementing an effective corporate compliance plan ("the Compliance Plan"). The Company's governing body shall review and approve the Compliance Plan.

(l) Consultant shall supervise acquisition of supplies including of medical equipment, instruments, medical fixtures, office equipment, telephones, computers, office furniture and other equipment and supplies which are necessary for the operation of the Company.

(m) Consultant shall cause Company to enter into such contracts as may be deemed necessary or advisable by Consultant for the furnishing of all ancillary services, utilities, concessions, equipment and supplies, and other services as may be needed from time to time for maintenance and operation of the Company. Consultant may negotiate or enter into contracts for group purchasing agreements for goods and services. In the event Consultant enters into group purchasing agreements for Company, the expenses for the goods and services purchased pursuant to those agreements shall be expensed directly to the Company and shall be the responsibility of the Company to pay.

(n) Consultant shall assist Company with the preparation of any documentation or applications necessary (including, but not limited to cost reports) for Company to retain: (i) certification of the Company as a personal care agency under Title XVIII (Medicare) and/or Title XIX (Medicaid) of the Social Security Act; and (ii) licensure of the Company as a personal care agency under all applicable state and federal requirements.

(o) Consultant shall provide or arrange for the provision of legal services for Company as requested by Company including, but not limited providing legal defense against third party claims, negotiating settlements of legal proceedings, and providing legal advice to minimize risk exposure and help ensure regulatory complaince. Consultant shall notify Company of all legal proceedings related to Company which Consultant becomes aware of.

ARTICLE 3
RIGHTS AND RESPONSIBILITIES OF COMPANY

3.1 Clinical Aspects of Company. Company shall remain as the responsible licensee of the Company providing all medical treatment and employing all medical staff, including, without limitation, the **Director of**

Nursing and **Administrator**. As such, Company shall be fully responsible to all patients, governmental agencies, and any others for patient care and all other clinical aspects of the Company.

3.2 Cooperation with Consultant.

(a) Company shall cooperate with Consultant in the provision of the Consultant Services for the Company's operations. Company shall provide Consultant with all authorizations, assistance, and documents necessary for Consultant to fulfill its obligations under this Agreement, including, without limitation, copies of all surveys and correspondence with governmental authorities related to the licensure or certification of the Company.

(b) Company shall notify Consultant of all legal proceedings related to Consultant.

ARTICLE 4
TERM

4.1 Term. The initial term of this Agreement (the "Initial Term") shall commence on the Effective Date, and, unless sooner terminated pursuant to this Section 4, shall remain in effect until midnight on the fifth (5th) anniversary of the Effective Date. Upon the expiration of the Initial Term, this Agreement will be automatically extended for successive additional periods of five (5) years each ("Renewal Terms") (collectively, the Initial Term and any Renewal Term(s) may be referred to herein as "Term").

4.2 Termination without Cause. This Agreement may be terminated by either Party, without cause, upon the delivery of ninety (90) days written notice of termination.

4.3 Termination for Cause. This Agreement shall terminate and, except as to liabilities or claims of either party hereto, which shall have accrued or arisen prior to such termination, the obligations of the parties hereto with respect to this Agreement shall cease and terminate upon the happening of any of the following events:

(a) if Company shall fail to keep, observe or perform any covenant, agreement, term or provision of this Agreement, including payment of the Consulting Fee, and if such default shall continue for a period of thirty (30) days after written notice thereof from Consultant, at Consultant's option, at any time thereafter while such default continues upon written notice to Company;

(b) if either party is excluded or debarred from participation in the Medicare or Medicaid programs; or

(c) if either party is convicted of a felony related to health care fraud or federally funded healthcare program abuse.

ARTICLE 5
CONSULTANT COMPENSATION

5.1 Consultant shall be entitled to a consultant fee in a sum equal to seven percent (7%) of Company revenues (the "Consultant Fee"). For purposes of this Agreement, the term Revenue shall mean gross patient charges net of contractual adjustments set forth in government and other payor contracts. Consultant shall provide Company with a monthly invoice that sets forth the Company's Revenue for the previous month and the amount of the Consultant Fee that is owed to Consultant. Company shall pay (or ensure that there is sufficient funds in the Operating Account for Consultant to pay itself) the Consultant Fee to Consultant within thirty (30) days after Company's receipt of such invoice. Consultant shall periodically reconcile the amount of the Company's gross revenues and calculation of the Consultant Fee to account for revenue overpayments, credits and recoupments, and shall furnish such reconciliation to Company.

ARTICLE 6
OWNERSHIP OF WORK PRODUCT

6.1 Consultant's Work Product. All operating procedures, protocols, information systems, operating data, computer data bases, reports and other non-public proprietary business systems or information owned by Consultant shall be and remain the exclusive property of Consultant.

ARTICLE 7
INDEMNIFICATION

7.1 Indemnification by Company.

(a) Consultant agrees to indemnify and hold Company harmless from all losses, costs, claims, judgments and expenses arising out of incident to Consultant's provision of management services to the Company during the term of this Agreement, other than such losses, costs and expenses arising out of the acts of omission of Consultant during the term of this Agreement.

(b) Company agrees to indemnify and hold Consultant harmless from all losses, costs, claims, judgments and expenses arising out of or incident to Company's operation of the Company prior to the commencement of the effective date of the term of this Agreement and for the acts and omissions of Company during the term of this Agreement.

ARTICLE 8
MISCELLANEOUS

8.1 Notices. All notices, requests, demands and other communications hereunder shall be in writing and shall be deemed to have been given: (i) when delivered personally, (ii) the next business day, if sent by a nationally-recognized overnight delivery service (unless the records of the delivery service indicate otherwise), or (iii) when sent by certified U.S. mail, postage prepaid, return receipt requested, addressed to the address of each party as set forth on the first page of this Agreement. Either party hereto may, from time to time, change such party's address for receiving notices under this Agreement by giving written notice thereof to the other party.

8.2 No Partnership or Joint Venture. It is expressly acknowledged by the parties that, for the purposes of this Agreement, Consultant is an independent contractor and nothing in this Agreement is intended, nor shall be construed, to create any employer/employee relationship, partnership or a joint venture relationship between Company, their successors or assigns, on the one hand, and Consultant, its successors or assigns, on the other hand.

8.3 Documentation and Records. Nothing in this Agreement shall be construed as limiting in any manner Consultant's or Company's obligation to retain, disclose, or produce appropriate documentation and records to any governmental agency pursuant to applicable laws and regulations. If this Agreement is determined to be a contract within the purview of Section 1861(v)(1) of Social Security Act and regulations promulgated in implementation thereof, Consultant shall, until the expiration of four (4) years after the furnishing of the Consultant Services, upon proper written request and prior written consent of Company, allow the Comptroller General of the United States, the Secretary of the Department of Health and Human Services, and their duly authorized representatives access to this Agreement and Consultant's books, documents, and records necessary to certify the nature and extent of costs of the Consultant Services provided hereunder. In accordance with the above referenced statute and regulations, if the Consultant Services are carried out by means of a subcontract with any organization related to Consultant, and such related organization provides services, the costs or value of which is Ten Thousand Dollars ($10,000) or more over a twelve (12) month period, then the subcontract between Consultant and the related organization shall contain a clause comparable to the clause in the preceding subparagraph.

8.4 Fraud and Abuse. It is the intent and belief of the parties hereto that this Agreement complies with the Medicare/Medicaid anti-kickback and civil monetary penalties statutes and regulations promulgated thereunder. It is not a purpose of this Agreement to solicit or induce the referral of patients. The parties acknowledge that, under this Agreement or any agreement between Consultant and Company there is no payment to refer, recommend or arrange and no requirement for the referral, recommendation or arrangement for any items or services paid for by Medicare or Medicaid. Subsequent to the execution of this Agreement should any provision of this Agreement be deemed by either party to be contrary to the provisions of such statutes and regulations, then the parties shall, in good faith, renegotiate the provision to the mutual satisfaction of the parties. In the event the parties are not able to mutually agree on modification of the problematic provision, then either party may terminate this Agreement upon thirty (30) days written notice to the other party if the terminating party has a good faith belief that the provision creates an unfavorable exposure under said statutes, regulations, or safe harbor provisions. Each party represents and warrants that neither it nor any of its employees, directors, owners, agents or contractors providing services under this Agreement have been sanctioned under any applicable state of federal fraud statutes nor have ever been excluded from participation in any federally funded health care program, including but not limited to Medicare and/or Medicaid programs nor have ever been listed on the Office of the Inspector General and Government Services Administration exclusion list.

8.5 Invalid Provisions. If any one or more of the provisions contained in this Agreement shall be held to be invalid, illegal or unenforceable for any reason or in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions hereof, and this Agreement shall be construed as if such provisions had never been set forth in this Agreement.

IN WITNESS WHEREOF, the parties have hereunto caused this Agreement to be duly executed, as of the date and year first above written.

COMPANY

Eden Hospice at Whatcom County, LLC
By: EmpRes Healthcare Management, LLC, Manager

By: _____
Michael J. Miller, Assistant Manager

CONSULTANT

EmpRes Healthcare Management, LLC

By: _____
Michael J. Miller, Assistant Manager

LIMITED LIABILITY COMPANY AGREEMENT OF
Eden Hospice at Whatcom County, LLC,
a Washington Limited Liability Company

THIS OPERATING AGREEMENT ("Agreement") is made and entered into effective October 2, 2020 by EmpRes Hospice, LLC, a Washington limited liability company ("EH") (referred to herein as "Member" or "Members").

ARTICLE 1
FORMATION

1.1 Name. The name of the limited liability company is Eden Hospice at Whatcom County, LLC ("LLC").

1.2 Articles of Organization. Certificate of Formation was filed with the Washington Secretary of State on January 3, 2020.

1.3 Duration. The LLC is perpetual, unless dissolved as provided in this Agreement.

1.4 Principal Place of Business. The principal place of business of the LLC is located at 4601 NE 77th Avenue, Suite 300, Vancouver, Washington 98662. The Manager may relocate the principal place of business from time to time.

1.5 Registered Office and Registered Agent. The LLC's registered office shall be at 711 Capitol Way S., Suite 204, Olympia, WA 98501 and the name of its registered agent at such address shall be CT Corporation. The Manager may change the registered office and registered agent from time to time without amendment of this Agreement.

1.6 Purpose. The LLC may conduct, promote or engage in any lawful business or purpose permitted by the Washington Limited Liability Company Act, as amended ("Act"), and shall have all powers provided for in the Act.

ARTICLE 2
MEMBERS, CONTRIBUTIONS, AND INTERESTS

2.1 Members. The name and address of the initial Member of the LLC is as follows:

Name of Members	Address
EmpRes Hospice, LLC	4601 NE 77th Ave., Ste. 300 Vancouver, WA 98662

2.2 Additional Members. Except as otherwise expressly provided herein, no additional members may be admitted to the LLC without the prior written consent of all the Members.

2.3 Initial Capital Contributions. The initial capital contribution to the LLC by the Member and the value of the property contributed is as follows:

Name of Member	Initial Capital Contribution
EmpRes Hospice, LLC	Cash: $0

2.4 Additional Capital Contributions. Additional capital contributions (including the amounts) shall be approved and made only upon the vote of fifty-one percent (51%) of the Units. If additional capital contributions are approved, the Members shall have the opportunity (but not the obligation) to make additional capital contributions on a pro rata basis in accordance with their Ownership Interests. If any Member elects to make less than the Member's pro rata share of any additional capital contributions, the other Members may contribute the difference on a pro rata basis in accordance with their Ownership Interests or upon such other basis as they may agree.

2.5 Units of Membership Interest. The interest of each Member in the capital and profits of the LLC will be in the form of units of membership interest ("Units"). There will be a total of 1,000 Units. The initial number of Units held by the Member is as follows:

Members	Units
EmpRes Hospice, LLC	1000
Total Units	1000

2.6 Ownership Interests. Each Member's percentage ownership interest in the LLC at any time shall be the ratio of that Member's initial and any additional capital contributions to all Members' initial and additional capital contributions. The Member's initial percentage ownership interest in the LLC ("Ownership Interests") is as follows:

Members	Ownership Interests
EmpRes Hospice, LLC	100%
Total	100%

2.7 Other Business of Members. Any Member may engage independently or with others in other business and investment ventures of every nature and description and

shall have no obligation to account to the LLC for such business or investments or for business or investment opportunities.

2.8 No Interest on Capital Contributions. No interest shall be paid on initial or any additional capital contributions.

2.9 Capital Accounts. An individual capital account shall be established and maintained for each Member in accordance with the following:

2.9.1 There shall be credited to each Member's capital account: (i) the amount of any money contributed by such Member to the capital of the LLC; (ii) the fair market value of any property contributed by such Member to the capital of the LLC (net of any liabilities secured by such property that the LLC is considered to assume or to take subject to under Internal Revenue Code Section 752); and (iii) such Member's share of the income and gain (and all items thereof) of the LLC (including income or gain exempt from federal income tax and income and gain described in Treasury Regulation § 1.704-1(b)(2)(iv)(g), but excluding income and gain described in Treasury Regulation § 1.704-1(b)(4)(i)).

2.9.2 There shall be charged against each Member's capital account: (i) the amount of money distributed to such Member by the LLC; (ii) the fair market value of any property distributed to such Member by the LLC (net of any liabilities secured by such distributed property that the Member is considered to assume or to take subject to under Section 752 of the Internal Revenue Code of 1986, as amended ("IRC")); (iii) such Member's share of expenditures of the LLC described in IRC § 705(a)(2)(B); and (iv) such Member's share of the losses and deductions (and all items thereof) of the LLC (including losses and deductions described in Treasury Regulation § 1.704-1(b)(2)(iv)(g), but excluding such Member's share of expenditures of the LLC described in IRC § 705(a)(2)(B) and losses and deductions described in Treasury Regulation § 1.704(b)(4)(i) and (iii)).

2.9.3 It is the intent of the Member of the LLC that the provisions of this Agreement relating to the establishment and maintenance of capital accounts comply with the requirements of Treasury Regulation § 1.704-1(b)(2)(iv) or any successor provision, and that such provisions be interpreted and applied in a manner consistent with such Treasury Regulation or successor provision.

ARTICLE 3
ALLOCATIONS AND DISTRIBUTIONS

3.1 Allocations of Income and Loss for Tax Purposes. All items of income, gain, loss, deduction, and credit shall be allocated among all Members in proportion to their Ownership Interests.

3.2 Distributions to Pay Tax Liabilities. Within 90 days after the end of each fiscal year, the LLC shall make a distribution in an amount equal to at least (a) the LLC's net taxable income during the fiscal year multiplied by (b) the sum of the maximum federal and state income tax rates of any Member in effect for the fiscal year (taClark into account the deductibility of state taxes for federal income tax purposes), less (c) the amount of any distributions made by the LLC during the fiscal year (other than distributions made during the fiscal year that were required to be made under the provisions of this Section 3.2 with respect to a prior fiscal year). For purposes of this Section 3.2, an LLC's net taxable income shall be the net excess of items of recognized income and gain over the items of recognized loss and deduction reported on the LLC's federal income tax return for the taxable year with respect to which the distribution is being made. Notwithstanding the foregoing, the LLC's obligation to make such a distribution is subject to the restrictions governing distributions under the Act.

ARTICLE 4
MEMBER MEETINGS

4.1 Meetings. A meeting of Members shall be held (a) if it is called by the Manager, or (b) if Members holding at least fifty-one percent (51%) of the Units sign, date, and deliver to the LLC's principal office a written demand for the meeting, describing the purpose or purposes for which it is to be held. All meetings of Members shall be held at the principal office of the LLC or any other place specified in the Notice of Meeting.

4.2 Notice of Meeting. The Manager shall give notice of the date, time, and place of each Members' meeting to each Member not earlier than 60 days, nor less than 10 days, before the meeting date. The notice must include a description of the purpose or purposes for which the meeting is called. A Member may waive notice of any meeting, and the sufficiency of notice may not be challenged by any Member who is present at a meeting.

4.3 Record Date. The persons entitled to notice of and to vote at a Members' meeting, and their respective number of Units, shall be determined as of the record date for the meeting. The record date for a meeting shall be a date not earlier than 60 days, nor less than 10 days, before the meeting, selected by the Manager. If the Manager does not specify a record date for a meeting, the record date shall be the date on which notice of the meeting was first mailed or otherwise transmitted to the Members.

4.4 Quorum. The presence, in person or by proxy, of Members holding at least fifty-one percent (51%) of the Units shall constitute a quorum. If a quorum is not present or represented at any meeting of the Members, the meeting shall be adjourned without conducting any business.

4.5 Proxies. A Member may be represented at a meeting in person or by written proxy. A proxy shall be in writing executed by the Member and filed with the Manager prior to the commencement of the meeting.

4.6 Voting. On each matter requiring action by the Members, each Member may vote the Member's Units. Except as otherwise stated in the Articles of Organization, this Agreement, or applicable law, a matter submitted to a vote of the Members shall be deemed approved if it receives the affirmative vote of at least fifty-one percent (51%) of the Units represented at a meeting.

4.7 Action Without Meeting. Any action required or permitted to be taken by the Members at a meeting may be taken without a meeting if a consent in writing, describing the action taken, is signed by all of the Members and is included in the LLC's records of meetings.

ARTICLE 5
MANAGEMENT

5.1 Manager. The LLC shall be managed by one (1) manager ("Manager"). The Manager shall be EmpRes Healthcare Management, LLC, a Washington limited liability company.

5.2 Authority of Manager. The Manager shall have all the rights and powers that may be possessed by a manager in a limited liability company with managers pursuant to the Act and such rights and powers as are otherwise conferred by law or are necessary, advisable, or convenient to the discharge of the Manager's duties under this Agreement and to the management of the business and affairs of the LLC. Without limiting the generality of the foregoing, subject to the limitations set forth in Section 5.3 of this Agreement, the Manager shall have the following rights and powers (which the Manager may exercise at the cost, expense, and risk of the LLC):

5.2.1 To expend the funds of the LLC in furtherance of the LLC's business;

5.2.2 To perform all acts necessary to manage and operate the LLC's business, including engaging such persons as the Manager deems advisable to manage the LLC's business;

5.2.3 To execute, deliver, and perform on behalf of and in the name of the LLC any and all agreements and documents deemed necessary or desirable by the Manager to carry out the business of the LLC, including any lease, deed, easement, bill of sale, mortgage, trust deed, security agreement, contract of sale, or other document conveying, leasing, or granting a security interest in any of the assets of the LLC, or any part thereof, whether held in the LLC's name, the name of the Manager, or otherwise, with no other signature or signatures required; and

5.2.4 To borrow or raise moneys on behalf of the LLC in the LLC's name or in the name of the Manager for the benefit of the LLC and, from time to time, to draw, make, accept, endorse, execute, and issue promissory notes, drafts, checks, and other

negotiable or nonnegotiable instruments and evidences of indebtedness, and to secure the payment thereof by mortgage, security agreement, pledge, or conveyance or assignment in trust of the whole or any part of the assets of the LLC, including contract rights.

5.3 Limitations on Authority of the Manager.

5.3.1 Without the vote of fifty-one percent (51%) of the Units, the Manager shall not have any authority to:

5.3.1.1 Appoint an additional or replacement Manager;

5.3.1.2 Borrow money, pledge the credit of the LLC, or otherwise incur indebtedness in the name of or on behalf of the LLC other than in the ordinary course of the LLC's business or, in any event, in an amount in excess of $500 in any single transaction;

5.3.1.3 Mortgage, pledge, or otherwise encumber or grant a security interest in LLC assets;

5.3.1.4 Merge the LLC with any other entity;

5.3.1.5 Sell or otherwise dispose of all or substantially all the assets of the LLC (other than sales of inventory in the ordinary course of the LLC's business); or

5.3.1.6 Dissolve the LLC.

5.3.2 Without the vote of one hundred percent (100%) of the Units, the Manager shall not have any authority to:

5.3.2.1 Amend the LLC's Articles of Organization or this Agreement;

5.3.2.2 Admit additional Members to the LLC; or

5.3.2.3 Confess a judgment against the LLC or file a voluntary petition in bankruptcy on behalf of the LLC.

5.4 Limitation on Liability of the Manager. The Manager shall not have any liability to the LLC or to any Member for any loss suffered by the LLC or any Member that arises out of any action or inaction of the Manager if the Manager, in good faith, determined that such course of conduct was in the best interest of the LLC and such course of conduct did not constitute gross negligence or misconduct of the Manager.

5.5 Indemnification of the Manager. The LLC shall indemnify the Manager against any losses, judgments, liabilities, expenses, and amounts paid in settlement of any claims sustained against the LLC or against the Manager in connection with the LLC, provided that the same were not the result of gross negligence or misconduct on the part of the Manager. The satisfaction of any indemnification of the Manager hereunder shall be from, and limited to, LLC assets, and the Members shall not have any personal liability on account thereof.

5.6 Removal of the Manager. The Members may, by a vote of fifty-one percent (51%) of the Units, remove the Manager at any time for any reason or for no reason. Removal of the Manager shall not affect the interest held by the Manager as a Member of the LLC. Upon removal of the Manager, the Members, by a vote of fifty-one percent (51%) of the Units, shall elect a replacement Manager, who need not be a Member of the LLC.

5.7 Other Activities. The Manager may have other business interests and may engage in other activities in addition to those relating to the LLC. This Section 5.7 does not, however, change the Manager's duty to act in a manner that the Manager reasonably believes to be in the best interests of the LLC.

ARTICLE 6
ACCOUNTING AND RECORDS

6.1 Books of Account. At the LLC's principal place of business, the Manager shall maintain the LLC's books and records; a register showing a current and past list of the full names and last known addresses of its Members and Managers, if any; a copy of its Certificate of Formation and all amendments thereto; a copy of its current Limited Liability Company Agreement and all amendments thereto, along with a copy of any prior agreements no longer in effect; a written statement of the amount of cash and the agreed value of the other property and services contributed by each Member (including that Member's predecessors in interest) and which each Member has agreed to contribute; a copy of the LLC's federal, state, and local tax returns and reports, if any, for the three most recent years; and a copy of any financial statements of the LLC for the three most recent years. Each Member shall have access thereto at all reasonable times. The Manager shall keep and maintain books and records of the operations of the LLC which are appropriate and adequate for the LLC's business and for the carrying out of the terms and provisions of this Agreement.

6.2 Fiscal Year. The fiscal year and the taxable year of the LLC shall be the calendar year.

6.3 Accounting Reports. Within 120 days after the end of each fiscal year of the LLC, the Manager shall furnish each Member with copies of unaudited financial statements of the LLC.

6.4 Tax Returns. The Manager shall cause all required federal and state income tax returns for the LLC to be prepared and timely filed with the appropriate authorities. Within 105 days after the end of each taxable year of the LLC, or such lesser time as prescribed by the Internal Revenue Service, each Member shall be furnished with a statement suitable for use in the preparation of the Member's income tax return, showing the amounts of any distributions, contributions, gains, losses, profits, or credits allocated to the Member during such taxable year.

6.5 Tax Matters Partner. EmpRes Hospice, LLC, shall act as the Tax Matters Partner of the LLC pursuant to IRC § 6231(a)(7). The Tax Matters Partner shall take such action as may be necessary to cause each other Member to become a notice partner within the meaning of IRC § 6223. The Tax Matters Partner may make any tax elections for the LLC allowed under the Internal Revenue Code or the tax laws of any state or other jurisdiction having taxing jurisdiction over the LLC including, but without limitation, elections:

6.5.1 To adjust the basis of LLC assets pursuant to IRC §§ 754, 734(b), and 743(b), or comparable provisions of state or local law, in connection with transfers of interests in the LLC and LLC distributions;

6.5.2 With the consent of all of the Members, to extend the statute of limitations for assessment of tax deficiencies against Members with respect to adjustments to the LLC's federal, state, or local tax returns; and

6.5.3 To the extent provided in IRC §§ 6221 through 6231, to represent the LLC and the Members before taxing authorities or courts of competent jurisdiction in tax matters affecting the LLC and the Members, and to file any tax returns and to execute any agreements or other documents relating to or affecting such tax matters, including agreements or other documents that bind the Members with respect to such tax matters or otherwise affect the rights of the LLC and Members.

ARTICLE 7
TRANSFER OF UNITS

7.1 Generally. Except as otherwise provided in this Article 7, no Member shall have the right to sell, assign, exchange, or otherwise transfer for consideration, or gift or otherwise transfer for no consideration, all or any part of the Member's Units in the LLC without the prior written consent of all the Members.

7.2 Option to Purchase. Any Member ("Transferor Member") wishing to transfer Units shall first give written notice to the other Members of the Transferor Member's intention to do so. The notice ("Transfer Notice") shall name the proposed transferee and the number of Units to be transferred, and, if the transfer is for consideration, the price per Unit and the terms of payment. For 30 days following the Transfer Notice, the other Members shall have the option to purchase the Units to be transferred at the price and on

the same terms and conditions stated in the Transfer Notice; provided, however, if the Transferor Member proposes to transfer the Units by gift, subject to the provisions of Section 7.7, the other Members shall have the option to purchase the Units to be transferred at the price and on the terms determined in accordance with Sections 7.5 and 7.6. Within 30 days after the giving of the Transfer Notice, any Member desiring to acquire any part of or all the Units offered shall give written notice of the number of Units such Member wishes to acquire to the principal office of the LLC, the Transferor Member, and each of the other Members. If the total number of Units that the other Members collectively offer to purchase exceeds the number of Units being offered, the offering Members shall purchase the offered Units in the proportion that the number of Units held by each offering Member bears to the total number of Units held by all offering Members, or in whatever other proportion the offering Members may agree upon within 30 days after the expiration of the 30 day option period. If the offering Members collectively offer to purchase fewer than all the Units proposed to be transferred, then the provisions of Section 7.3 shall govern the Units not purchased by the offering Members. Any Member acquiring Units pursuant to this Section 7.2 shall be substituted as a Member with respect to the Units transferred upon executing a counterpart to this Agreement, as amended, pursuant to which the acquiring Member agrees to be bound by all of the terms and conditions of this Agreement, as amended, with respect to the Units transferred.

7.3 Transfer of Units. To the extent the option to purchase is not exercised by any other Members, the Transferor Member may complete the proposed transfer, but only to the proposed transferee in strict accordance with the terms set forth in the Transfer Notice. Any Units not purchased by the proposed transferee in strict accordance with the terms set forth in the Transfer Notice shall continue to be subject to the terms and conditions of this Article 7. Unless substituted as a Member as hereinafter provided, a transferee under this Section 7.3 shall only be entitled to receive the distributions to which the Transferor Member would be entitled with respect to the Units transferred. No transferee under this Section 7.3 who is not already a Member may be substituted as a Member unless all the remaining Members consent in writing to the substitution and the transferee executes a counterpart of this Agreement, as amended, pursuant to which the transferee agrees to be bound by all of the terms and conditions of this Agreement, as amended. Each Member may give or withhold such consent in the Member's sole discretion.

7.4 Death, Divorce or Bankruptcy. Upon (a) the death of a Member, (b) the order of a court of competent jurisdiction to transfer Units in connection with a dissolution of a Member's marriage, or (c) the Bankruptcy of a Member (as defined below), the remaining Members shall have the option to purchase any Units owned by the effected Member ("Effected Member") at the price determined in accordance with Section 7.5 and on the terms set forth in Section 7.6. A Member shall be considered Bankrupt if the Member has filed a voluntary petition for bankruptcy, makes an assignment for the benefit of creditors, or consents to the appointment of a receiver or trustee with respect to a substantial part of the Member's assets. Upon acquiring knowledge of the occurrence of an event described in the previous two sentences, the Manager shall promptly notify the

other Members in writing of the event. Within 30 days of the giving of notice, any other Member desiring to acquire any part of or all the Units owned by the Effected Member shall give written notice of the number of Units such Member wishes to acquire to the principal office of the LLC, the Effected Member or the personal representative of the Effected Member, and each of the other Members. If the total number of Units that the remaining Members collectively offer to purchase exceeds the number of Units available for purchase, the offering Members shall purchase the available Units in the proportion that the number of Units held by each offering Member bears to the total number of Units held by all the offering Members, or in whatever other proportion the offering Members may agree upon within 30 days after the expiration of the 30 day option period. If the offering Members collectively offer to purchase fewer than all the available Units, then the unpurchased Units will pass in accordance with the Effected Member's will, trust, or otherwise. Unless substituted as a Member as hereinafter provided, a transferee under this Section 7.4 shall only be entitled to receive the distributions to which the Effected Member would be entitled with respect to the Units transferred. No transferee under this Section 7.4 who is not already a Member shall be substituted as a Member unless all the remaining Members consent in writing to the substitution and the transferee executes a counterpart of this Agreement, as amended, pursuant to which the transferee agrees to be bound by all of the terms and conditions of this Agreement, as amended. Each Member may give or withhold such consent in the Member's sole discretion. Any transferee under this Section 7.4 who is already a Member shall be substituted as a Member with respect to the Units transferred upon executing a counterpart to this Agreement, as amended, pursuant to which the transferee Member agrees to be bound by all of the terms and conditions of this Agreement, as amended, with respect to the Units transferred.

7.5 Purchase Price. Upon an election by a Member or Members to purchase the Units of a Member pursuant to Sections 7.2 or 7.4, except as otherwise provided in Section 7.2, the purchase price for the Units to be purchased shall be equal to the fair market value of the LLC divided by the total number of outstanding Units, multiplied by the number of Units to be transferred. The fair market value of the LLC shall be determined by agreement between the purchasing Member or Members (acting by majority vote, each purchasing Member having one vote) and the selling Member or the selling Member's personal representative. In the event agreement as to the fair market value of the LLC cannot be obtained within a reasonable period of time, the LLC shall be valued by a licensed appraiser acceptable to the purchasing Member or Members (acting by majority vote, each purchasing Member having one vote) and the selling Member or the selling Member's personal representative. The cost of the appraisal shall be paid by the LLC.

7.6 Payment for Units. To the extent that the purchase price for Units is determined in accordance with Section 7.5, such purchase price shall be paid to the transferring Member or to the personal representative of a deceased transferring Member in sixty (60) substantially equal monthly payments, including principal and interest at the appropriate publicly announced applicable medium term federal rate under IRC § 1274,

compounded annually, with the first payment to commence not later than 90 days following the effective date of the sale.

7.7 Permitted Transfers. Notwithstanding anything to the contrary in Sections 7.2, 7.3 and 7.4 of this Agreement, any Member may gift, during his or her lifetime, Units to other Members, or to the lineal descendants of such Member, or to a custodian, trustee, conservator, or guardian for such Member or such Member's lineal descendant. In addition, notwithstanding anything to the contrary in Sections 7.2, 7.3 and 7.4 of this Agreement, any Member may transfer, during his or her lifetime, Units to a revocable living trust for the benefit of such Member and/or such Member's spouse and/or children. Unless substituted as a Member as hereinafter provided, a transferee under this Section 7.7 shall only be entitled to receive the distributions to which the transferring Member would be entitled with respect to the Units transferred. No transferee under this Section 7.7 who is not already a Member shall be substituted as a Member unless all the remaining Members consent in writing to the substitution and the transferee executes a counterpart of this Agreement, as amended, pursuant to which the transferee agrees to be bound by all of the terms and conditions of this Agreement, as amended. Each Member may give or withhold such consent in the Member's sole discretion. Any transferee under this Section 7.7 who is already a Member shall be substituted as a Member with respect to the Units transferred upon executing a counterpart to this Agreement, as amended, pursuant to which the transferee Member agrees to be bound by all of the terms and conditions of this Agreement, as amended, with respect to the Units transferred.

ARTICLE 8
WITHDRAWAL PROHIBITED

No Member shall have the right or power to withdraw from the LLC voluntarily without the prior written consent of all other Members. A purported withdrawal in violation of this Article 8 shall constitute a breach of this Agreement for which the LLC and other Members shall have the remedies provided under applicable law. In the event a Member purports to withdraw from the LLC in violation of this Article 8, that Member shall not be entitled to receive any distribution from the LLC until the LLC has dissolved and wound up its affairs.

ARTICLE 9
DISSOLUTION AND WINDING UP OF THE LLC

9.1 Events of Dissolution. Except as otherwise provided in this Agreement, the LLC shall dissolve upon the earlier of:

9.1.1 The time for dissolution specified in the Articles of Organization;

9.1.2 The death or withdrawal of any Member;

9.1.3 Approval of dissolution of the LLC by a vote of fifty-one percent (51%) of the Units; or

9.1.4 The entry of a decree of judicial dissolution under RCW 25.15.275 or administrative dissolution under RCW 25.15.285.

9.2 Effect of Bankruptcy. The following events shall not cause the dissolution of the LLC:

9.2.1 A general assignment by a Member for the benefit of creditors;

9.2.2 A Member files a voluntary petition in bankruptcy;

9.2.3 A Member becomes the subject of an order for relief in bankruptcy proceedings;

9.2.4 A Member files a petition or answer from any reorganization, composition, readjustment, liquidation, dissolution, or similar relief under any statute, law or regulation;

9.2.5 A Member files an answer or other pleading admitting or failing to contest the material allegations of a petition filed against it in any proceeding described in 9.2.1 through 9.2.4; or

9.2.6 A Member seeks, consents to, or acquiesces in the appointment of a trustee, receiver, or liquidator of the Member or of all or any substantial part of the Member's properties.

9.3 Effect of Death of a Member. In the event of the death of a Member, if there is at least one remaining Member, the remaining Member or Members may within 120 days elect to continue the LLC. The election shall be at the sole discretion of the remaining Member or Members and shall require their unanimous written consent. If the remaining Member or Members do not so elect, the LLC shall be dissolved.

9.4 Effect of Withdrawal or Dissolution. Upon the withdrawal or dissolution of a Member, if there is at least one remaining Member, the remaining Member or Members may within 120 days, without waiving any remedies in the case of voluntary withdrawal, elect to continue the LLC. The election shall be at the sole discretion of the remaining Member or Members and shall require their unanimous written consent. If the remaining Member or Members do not so elect, the LLC shall be dissolved.

9.5 Liquidation Upon Dissolution and Winding Up. Upon the dissolution of the LLC, the Manager shall wind up the affairs of the LLC. A full account of the assets and liabilities of the LLC shall be taken. The assets shall be promptly liquidated and the proceeds thereof shall be applied as required by the Washington Limited Liability

Company Act. With the approval by a vote of fifty-one percent (51%) of the Units, the LLC may, in the process of winding up the LLC, elect to distribute certain property in kind.

ARTICLE 10
AMENDMENTS

This Agreement may only be amended by a written instrument executed by all of the Members.

ARTICLE 11
MISCELLANEOUS

11.1 Additional Documents and Actions. Each Member shall execute such additional documents and take such actions as are reasonably requested by the Manager in order to complete or confirm the transactions contemplated by this Agreement.

11.2 Arbitration. Any dispute among the Members or among the Members and the LLC concerning this Agreement shall be settled by arbitration before a single arbitrator, using the rules of commercial arbitration of the American Arbitration Association. Arbitration shall occur in Portland, Oregon. The parties shall be entitled to conduct discovery in accordance with the Federal Rules of Civil Procedure, subject to limitation by the arbitrator to secure just and efficient resolution of the dispute. If the amount in controversy exceeds $10,000, the arbitrator's decision shall include a statement specifying in reasonable detail the basis for and computation of the amount of the award, if any. A party substantially prevailing in the arbitration shall also be entitled to recover such amount for its costs and attorney fees incurred in connection with the arbitration as shall be determined by the arbitrator. Judgment upon the arbitration award may be entered in any court having jurisdiction. Nothing herein, however, shall prevent a Member from resort to a court of competent jurisdiction in those instances where injunctive relief may be appropriate.

11. Governing Law. This Agreement and the rights of the parties hereunder shall be governed by and interpreted in accordance with the laws of the State of Washington (without regard to principals of conflicts of law).

11.4 Headings. Headings in this Agreement are for convenience only and shall not affect its meaning.

11.5 Severability. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of the remaining provisions.

11.6 Third-Party Beneficiaries. The provisions of this Agreement are intended solely for the benefit of the Members and shall create no rights or obligations enforceable by any third party, including creditors of the LLC, except as otherwise provided by applicable law.

11.7 Entire Agreement. This Agreement constitutes the entire understanding and agreement among the Members with respect to the subject matter hereof, and there are no agreements, understandings, restrictions, representations, or warranties among the Members other than those set forth herein.

IN WITNESS WHEREOF, this Agreement is made and entered into by the parties hereto effective as of the date first above written.

EMPRES HOSPICE, LLC
a Washington limited liability company

By: EmpRes Financial Services, LLC, Manager

By: _____
Michael J. Miller, Manager

Medical Director Contractor Agreement

THIS MEDICAL DIRECTOR CONTRACTOR AGREEMENT ("Agreement") is between Eden Hospice at Whatcom, LLC dba Eden Hospice ("AGENCY") and Premier Hospice Physicians("PROVIDER"). In consideration of the mutual promises set forth below in the body of this Agreement, the parties agree as follows:

1. TERM

The term of this Agreement shall commence on 01/01/23and shall continue for a period of one year thereafter, with automatic one-year renewals. AGENCY may terminate the use of PROVIDER's services at any time, for any reason, upon 30 days advance written notice to PROVIDER, and without further obligations to PROVIDER except for payment due for services performed by PROVIDER prior to the contract termination date. PROVIDER may also terminate the contract at any time, for any reason, upon 30 days advance written notice to AGENCY; provided that PROVIDER agrees to continue to perform the agreed upon services for the 30 days leading up to the contract termination date. This Agreement may be terminated immediately upon the determination that any of the representations made by either party under this Agreement are false.

2. PROVIDER SERVICES

PROVIDER agrees to provide medical director services ("Services") to AGENCY's clients in accordance with all applicable requirements of federal, state or local laws, rules and/or regulations to include official interpretations of those requirements by the entities charged with implementing and enforcing them, including but not limited to the requirements of 42 C.F.R. § 418.102 and applicable CMS guidance regarding the same. PROVIDER will perform its services in accordance with accepted professional standards of practice and, in accordance with 42 C.F.R. 418.64, use only qualified duly licensed, certified or registered health care professionals in the performance of these services. PROVIDER understands and agrees that this Agreement is subject to the right of AGENCY clients, clients' insurers or payors and clients' physicians to choose services from another provider.

PROVIDER agrees to be responsible for (1) implementation of client care policies, and (2) the coordination of medical care at AGENCY.

With respect to the implementation of client care policies, PROVIDER agrees to provide clinical guidance and oversight regarding the implementation of client care policies, which includes collaborating with the AGENCY to help develop, implement and evaluate client care policies and procedures that reflect current standards of practice. "Client care policies and procedures" is further defined as the AGENCY's goals, directives and governing Statements that direct the delivery of care and services to clients. Client care procedures describe the processes by which the AGENCY provides care to clients that are consistent with current standards of practice and AGENCY policies.

With respect to the coordination of medical care, PROVIDER shares responsibility with the AGENCY for assuring AGENCY is providing appropriate care as required, which involves (1) providing oversight and supervision of physician services and medical care of clients, and

(2) helping the AGENCY identify, evaluate, and address/resolve medical and clinical issues that affect client care, medical care or qualify of life, or are related to the provision of services by physicians and other health care practitioners. PROVIDER agrees to consult with clients or their attending physicians as needed to ensure adequate care is being provided. PROVIDER will attend client care conferences and advise AGENCY on pertinent ethical and clinical issues. PROVIDER will participate in utilization reviews of AGENCY services and participate in periodic, random reviews of records for AGENCY client services.

PROVIDER shall abide by applicable AGENCY policies and procedures to contractors, respond to AGENCY's requests for services in a timely manner, and provide accurate and timely documentation to AGENCY of services provided to AGENCY's clients. PROVIDER will provide clinical input and guidance, as required, in AGENCY's hiring of and clinical evaluation of AGENCY's Director of Nursing Services or AGENCY's clinical evaluation of other health care personnel as requested. PROVIDER will also provide clinical input and guidance into other quality monitoring programs established by AGENCY, which may include periodic attendance at the AGENCY's Continuous Quality Improvement Committee and Care Planning Committee meetings.

PROVIDER shall act as AGENCY's medical representative in the community (including medical staff, referring physicians, hospitals and community and professional organizations) and be familiar with policies and programs of public health agencies that may affect client care management. PROVIDER shall communicate with federal, state and county agencies regarding AGENCY programs.

PROVIDER shall participate as a member of AGENCY's OIG Compliance Committee.

PROVIDER shall participate in clinical education programs at the AGENCY, including the in-service clinical education of AGENCY personnel and continuing client/family and community education.

PROVIDER shall provide the following:

a) Provide On-Call emergency coverage. Maximum response time for such On-Call emergency coverage will be 45 minutes from the time that On-Call PROVIDER is personally notified of the call until On-Call PROVIDER's return call to the AGENCY;

b) Be available to deliver medical services or medical treatment to any client of AGENCY within the PROVIDER's scope of practice; and

c) Perform other duties, which are reasonable and appropriate under the circumstances, which relate to the PROVIDER's delivery of professional medical services as requested by AGENCY administration.

PROVIDER and AGENCY understand and agree that, while PROVIDER may also serve as an attending physician to clients of the AGENCY, PROVIDER's roles and functions as a Medical Director under this Agreement are separate from PROVIDER's roles and functions as an attending physician, which involves primary responsibility for the medical care of individual clients.

3. COMPENSATION

INVOICE FOR WORK PROVIDED PAYABLE NET 30. PROVIDER will be paid for Services on a monthly basis at the rate of $160/hour which will be billed at ¼ hour increments rounded up to the closest ¼ hour. PROVIDER will be paid $2500.00 per month for on-call emergency coverage provided by PROVIDER under Section 2 above. All payments will be made net 30 days of receipt of an invoice for Services provided under this Agreement. Invoices shall indicate services rendered and the time expended to provide said services during the preceding month in accordance with the rates and fees set forth above, as well as sufficient documentation in support of the services provided. Payment of PROVIDER is conditioned on PROVIDER complying with all material provisions of this Agreement, providing an acceptable quality of service consistent with the requirements of all applicable federal and state requirements, and providing the AGENCY accurate and complete documentation of such services.

The parties warrant and acknowledge that the above rate of compensation constitutes fair market value for PROVIDER's services and is consistent with PROVIDER's customary services, if any.

Any and all professional service fees or retainers due to PROVIDER in his or her capacity as an attending physician or any fees owed to PROVIDER associated with any visitations, examinations or consultations to clients of AGENCY shall be the complete and sole responsibility of PROVIDER and not of AGENCY.

4. CIVIL RIGHTS

PROVIDER shall comply with Title VI and VII of the Civil Rights Act of 1964, Sections 503 and 504 of the Rehabilitation Act of 1973, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services and any other applicable agencies issued pursuant to these Acts.

5. RECORDS

5.1 AGENCY and PROVIDER will each prepare and maintain complete and detailed clinical records concerning AGENCY's clients receiving Services under this Agreement, in accordance with prudent record-keeping procedures and as required by applicable federal and state laws, regulations and program guidelines. Each clinical record shall completely, timely and accurately document all services provided to, and events concerning, each patient (including evaluations, treatments, and progress notes) (collectively, "Clinical Records") and will remain confidential. The Clinical Records, records relating to billing and payment and other records relating to this Agreement shall be retained by AGENCY and PROVIDER for 8 years from the date said service was provided.

5.2 To the extent the value or services furnished under this Agreement, or a subcontract of this Agreement, exceed $10,000 over a 12-month period, PROVIDER will make available to the Secretary of the Department of Health and Human Services, the Comptroller General, or their authorized representatives, a copy of this Agreement and such books,

documents and records that are necessary to certify the nature and extent of the costs incurred by AGENCY under this Agreement for a period of four years after the furnishing of such services. PROVIDER agrees to notify AGENCY within 3 days of the nature and scope of any request for access and to provide, or make available, copies of any books, records or documents proposed to be provided. Any disclosure under this paragraph shall not be construed as a waiver of any other legal rights to which such party may be entitled.

6. QUALIFICATIONS

6.1 AGENCY represents and warrants that it is duly licensed and certified. PROVIDER represents and warrants that it has, and will maintain at all times throughout the term of this Agreement, all the necessary qualifications, certifications and/or licenses required by applicable federal, state and local laws and regulations to provide the Services covered by this Agreement. PROVIDER will provide AGENCY with a copy of its license in effect on the effective date of this Agreement and at each successive renewal. PROVIDER shall provide notice of any changes in certifications or licensing within 15 days.

6.2 PROVIDER agrees that it shall be responsible for conducting criminal background checks on those of its employees it assigns to AGENCY, including all costs relating to conducting such investigations and testing. PROVIDER further agrees that it shall not assign any of its employees to AGENCY who have been convicted of the following crimes: theft, sexually deviant behavior, assault and/or battery, abuse of the elderly, children or vulnerable individuals or other criminal conviction related to the services being provided to the AGENCY. PROVIDER further agrees that it shall not assign any of its employees to AGENCY who are determined (after appropriate alcohol and drug testing if necessary) to be engaged in the possession, distribution, dispensation, manufacture, sale or use of alcohol or illegal drugs in the workplace (whether that workplace is the AGENCY or elsewhere). For purposes of this Agreement, the term “illegal drugs” includes the abuse or misuse of prescription medication and the use or abuse of medical and/or recreational marijuana.

6.3 .PROVIDER acknowledges and agrees that investigations into criminal backgrounds (a) will cover the previous seven years, (b) shall be conducted in accordance with applicable state and federal law, and (c) must be based on information provided by the appropriate state or local law enforcement agency if so required by applicable state law.

6.4 Each party represents and warrants that it is currently eligible for Medicare and Medicaid participation and not subject to any sanction or exclusion. The Parties agree to regularly verify such status of themselves and their employees and immediately disclose any actual or threatened federal, state or local investigations or imposed sanctions of any kind, in progress or initiated subsequent to the date of entering into this Agreement. Each party further represents and warrants that it has not been sanctioned under any applicable state or federal fraud and abuse statutes, including exclusion from any state or federal health care program. If, during the term of this Agreement, either party, any parent company of either party, or any officer, director or owner of either party, receives such a sanction or notice of a proposed sanction and the period of its duration within 15 days. Each party reserves the right to terminate the Agreement immediately upon receipt of notice that the other party, has been sanctioned under fraud and abuse statutes and/or any other federal, state or local regulation. Each party agrees to indemnify and hold the other harmless from any and all liability, loss or

expenses incurred directly or indirectly as a result of such sanctions or investigations against the indemnifying party.

7. INSURANCE AND INDEMNITY

7.1 PROVIDER shall arrange and maintain in full force and effect at all times during the term of this Agreement malpractice insurance with a carrier reasonably satisfactory to AGENCY in an amount not less than $1,000,000 per occurrence and $3,000,000 in the aggregate. Such insurance shall cover the professional medical services provided by PROVIDER in private practice, and, PROVIDER'S Services as Medical Director pursuant to this Agreement. PROVIDER represents and warrants that such insurance is in effect on the date of execution of this Agreement and shall remain in effect during the term of this Agreement. The policy shall provide that AGENCY shall be given not less than 30 days prior written notice of any reduction in coverage or any cancellation of the policy. In addition, PROVIDER shall notify AGENCY of any lapse in coverage. Prior to the commencement of this Agreement and at least 10 days prior to the expiration of any then effective policy, PROVIDER shall provide AGENCY with satisfactory written evidence of the coverage required by this paragraph.

7.2 AGENCY shall obtain and maintain in full force and effect, its own general and professional liability insurance in amounts not less than $1,000,000 per occurrence and $3,000,000, in the aggregate, either through a commercial carrier or through an adequate self-insurance program, covering its operations of the AGENCY. AGENCY represents and warrants that such insurance is in effect on the date of execution of this Agreement and shall remain in effect during the term of this Agreement.

7.3 PROVIDER agrees to save, indemnify and hold harmless AGENCY from and against any and all losses, malpractice actions, claims, suits, damages, liabilities and expenses based upon, arising out of or attributable to the negligent performance or non-performance of their respective obligations under this Agreement.

8. EQUIPMENT AND SUPPLIES

PROVIDER is expected to use its own equipment and/or supplies whenever feasible. When PROVIDER uses equipment and/or supplies provided by AGENCY, PROVIDER shall use such equipment and supplies properly and is solely responsible for injuries or damages resulting from any misuse. In addition, PROVIDER shall notify AGENCY in writing whenever equipment or supplies provided by AGENCY and used by PROVIDER for providing Services need repair or replacement. When PROVIDER uses its own equipment and/or supplies, PROVIDER agrees to save, indemnify and hold AGENCY harmless of and from the use, misuse or failure of such equipment or supplies. The parties shall maintain their equipment and/or supplies in good operating condition and repair and in accordance with manufacturer's recommendations and all applicable federal, state and local laws.

9. 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 PROVIDER or PROVIDER's

immediate family members, to the extent any such arrangements or agreements exists, is provided by PROVIDER to AGENCY and maintained by AGENCY.

10. INDEPENDENT CONTRACTOR

This Agreement does not constitute a hiring of PROVIDER as an employee of AGENCY. It is the parties' intention that PROVIDER shall be an independent contractor and not AGENCY's employee. PROVIDER shall retain discretion and judgment regarding the manner and means of providing Services to AGENCY subject to all applicable laws, regulations and AGENCY's policies. AGENCY assumes professional and administrative responsibility for the services rendered only to the extent that AGENCY will assure itself that (1) PROVIDER is qualified by education and/or experience to render the services contracted for; and (2) PROVIDER is satisfying the obligations set forth herein in a timely manner. This Agreement shall not be construed as a partnership, and AGENCY shall not be liable for any obligations incurred by PROVIDER.

The parties hereto agree that payments to be made by AGENCY to PROVIDER are for services as an independent contractor. AGENCY shall not make any deduction from the fees to be paid PROVIDER including, but not limited to, social security, withholding taxes, business taxes, unemployment insurance, and other such deductions. PROVIDER assumes full responsibility, on an independent contractor basis, for all such taxes, contributions, and assessments and for worker's compensation insurance, agrees to indemnify AGENCY with respect thereto and agrees to meet all requirements with enforcement of any relevant state or federal act or regulation. PROVIDER agrees to obtain and maintain any and all business licenses as may be required under any applicable federal or state laws for independent contractors or consultants and to provide AGENCY with proof of same immediately upon request.

PROVIDER acknowledges that since he is not an employee of the Company, the Company will not provide health insurance or any other fringe benefit of any kind to PROVIDER.

11. CONFIDENTIALITY

PROVIDER agrees to respect and abide by all federal, state and local laws pertaining to confidentiality and disclosure with regard to all information and records obtained or reviewed in the course of providing services to AGENCY and/or its clients.

12. ATTORNEY'S FEES

If suit is brought to enforce any of the terms or conditions of this Agreement, the prevailing party shall be entitled to recover such sums as the court may fix as costs and reasonable attorney's fees, in addition to any other relief to which it may be entitled.

13. NOTICES

Any notice required to be provided to any party to this Agreement shall be in writing and shall be considered effective three (3) days after the date of deposit with the United States

Postal Service by certified or registered mail, first class postage prepaid, return receipt requested, and addressed to the Parties as follows:

AGENCY: Eden Hospice at Whatcom
316 E McLeod Rd Suite 104
Bellingham, WA 98226

and to: EmpRes Healthcare Management, LLC
4601 NE 77th Avenue, Suite 300
Vancouver, WA 98662
Attention: Legal Department

PROVIDER: Premier Hospice Physicians
629 Rabbit Ridge Court
Reno, NV 89511

14. NON-ASSIGNABILITY

Neither this Agreement nor any of the Services or obligations of PROVIDER hereunder shall be assigned or delegated by PROVIDER without prior written consent of AGENCY.

15. OREGON LAW AND VENUE

This Agreement shall be governed by the laws of the State of Oregon. 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 Washington, Multnomah and Clackamas Counties in Oregon.

16. COMPLETE AGREEMENT

This Agreement and the accompanying Business Associate Agreement supersedes all previous agreements, oral or written, between the parties and embodies the complete Agreement between the parties. This Agreement may only be amended or modified by written agreement signed by both parties.

17. COMPLIANCE CERTIFICATION

PROVIDER acknowledges AGENCY's Corporate Compliance Program and receipt of AGENCY's Code of Conduct. PROVIDER 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. PROVIDER agrees to obtain and retain a signed certification from its employees 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 PROVIDER and shall be made available for review by AGENCY or AGENCY's agents upon reasonable request.

18. COMPENSATION NOT BASED ON REFERRALS

The parties acknowledge that none of the benefits granted to PROVIDER under this Agreement or in relation to the performance of services hereunder is conditioned on any requirement that PROVIDER make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the AGENCY or the affiliates of the AGENCY by common ownership. The parties further acknowledge that, except as may otherwise be provided in this Agreement, PROVIDER is not restricted from establishing staff privileges at, referring any services to, or otherwise generating any business for any other entity of PROVIDER'S choosing.

IN WITNESS WHEREOF, the parties by their duly authorized representatives have entered into thus Agreement s of the date first above written.

AGENCY by its Manager, EmpRes Healthcare Management, LLC,	PROVIDER
By: _____	By: PREMIER HOSPICE PHYSICIANS
Name: Michael Miller	Name: Reed W. Dopf / REED DOPF
Title: CFO	Title: PRESIDENT, CEO
Date: _____	Date: 12/21/2022
	UPIN #: _____

REQUIRED DOCUMENTS FOR CONTRACT COMPLETION
Office Address and Phone Number
Copy of Current State of Practice License;
Copy of applicable Business Licenses
PROVIDER-signed Business Associate Agreement

APPENDIX C

Business Associate Agreement

This **BUSINESS ASSOCIATE AGREEMENT** ("Agreement") between Eden Hospice at Whatcom, LLC dba Eden Hospice ("Covered Entity") and Premier Hospice Physicians ("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:	**BUSINESS ASSOCIATE:**
By: _____ by EmpRes Healthcare Management, LLC, Manager by Michael Miller, CFO	By: PREMIER HOSPICE PHYSICIANS Name: Reed W. Dopf / REED DOPF Title: PRESIDENT, CEO
Date: _____	Date: 12/21/2022

APPENDIX C

UNITED STATES OF AMERICA

The State of Washington

Secretary of State

I, KIM WYMAN, Secretary of State of the State of Washington and custodian of its seal, hereby issue this

CERTIFICATE OF FORMATION

to

EDEN HOSPICE AT WHATCOM COUNTY, LLC

A **WA LIMITED LIABILITY COMPANY**, effective on the date indicated below.

Effective Date: 01/03/2020
UBI Number: 604 561 430

Given under my hand and the Seal of the State of Washington at Olympia, the State Capital

Kim Wyman, Secretary of State

Date Issued: 01/03/2020

APPENDIX D

Office of the Secretary of State
Corporations & Charities Division

Filed
Secretary of State
State of Washington
Date Filed: 01/03/2020
Effective Date: 01/03/2020
UBI #: 604 561 430

CERTIFICATE OF FORMATION

UBI NUMBER

UBI Number:
604 561 430

BUSINESS NAME

Business Name
EDEN HOSPICE AT WHATCOM COUNTY, LLC

REGISTERED AGENT

Registered Agent Name	Street Address	Mailing Address
C T CORPORATION SYSTEM	711 CAPITOL WAY S STE 204, OLYMPIA, WA, 98501, UNITED STATES	711 CAPITOL WAY S STE 204, OLYMPIA, WA, 98501, UNITED STATES

REGISTERED AGENT CONSENT

Customer provided Registered Agent consent? - **Yes**

DURATION

Duration:
PERPETUAL

EFFECTIVE DATE

Effective Date:
01/03/2020

OTHER PROVISIONS

Other Provisions:

PRINCIPAL OFFICE

Phone:

Email:
LEGAL@EMPRES.COM

Street Address:
316 E MCLEOD RD STE 1 AND STE 8, BELLINGHAM, WA, 98226, UNITED STATES

Mailing Address:
4601 NE 77TH AVE, STE 300, VANCOUVER, WA, 98662, UNITED STATES

EXECUTOR

Title	Executor Type	Entity Name	First Name	Last Name	Address
EXECUTOR	INDIVIDUAL		TINA M.	NICKOLAS	4601 NE 77TH AVE, SUITE 300, VANCOUVER, WA, 98662-6736, UNITED STATES

RETURN ADDRESS FOR THIS FILING

Attention:
LEGAL DEPT

Email:
LEGAL@EMPRES.COM

Address:
4601 NE 77TH AVE STE 300, VANCOUVER, WA, 98662-6736, UNITED STATES

UPLOAD ADDITIONAL DOCUMENTS

Name	Document Type
No Value Found.	

UPLOADED DOCUMENTS

Document Type	Source	Created By	Created Date
No Value Found.			

EMAIL OPT-IN

☐ I hereby opt into receiving all notifications from the Secretary of State for this entity via email only. I acknowledge that I will no longer receive paper notifications.

AUTHORIZED PERSON - STAFF CONSOLE

☑ Document is signed.

Person Type:
ENTITY

First Name:
MICHAEL

Last Name:
MILLER, CFO AND ASSISTANT MANAGER

Entity Name:
EMPRES HEALTHCARE MANAGEMENT, LLC

Title:
MANAGER

Office of the Secretary of State
Corporations & Charities Division

Filed
Secretary of State
State of Washington
Date Filed: 01/03/2020
Effective Date: 01/03/2020
UBI #: 604 561 430

INITIAL REPORT

UBI NUMBER

UBI Number:
604 561 430

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Business Name
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REGISTERED AGENT CONSENT

Customer provided Registered Agent consent? - **Yes**

EFFECTIVE DATE

Effective Date:
01/03/2020

OTHER PROVISIONS

Other Provisions:

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Phone:

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Street Address:
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Mailing Address:
4601 NE 77TH AVE, STE 300, VANCOUVER, WA, 98662, UNITED STATES

GOVERNORS

Title	Governor Type	Entity Name	First Name	Last Name
GOVERNOR	ENTITY	EMPRES HEALTHCARE MANAGMENT, LLC		
GOVERNOR	INDIVIDUAL		BRENT	WEIL
GOVERNOR	INDIVIDUAL		MICHAEL	MILLER
GOVERNOR	INDIVIDUAL		JONATHON	ALLRED

NATURE OF BUSINESS

Nature of Business:
HEALTH CARE, SOCIAL ASSISTANCE & SERVICE ORGANIZATION

RETURN ADDRESS FOR THIS FILING

Attention:
LEGAL DEPT

Email:
LEGAL@EMPRES.COM

Address:
4601 NE 77TH AVE STE 300, VANCOUVER, WA, 98662-6736, UNITED STATES

UPLOAD ADDITIONAL DOCUMENTS

Name	Document Type
No Value Found.	

UPLOADED DOCUMENTS

Document Type	Source	Created By	Created Date
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AUTHORIZED PERSON - STAFF CONSOLE

☑ Document is signed.

Person Type:
ENTITY

First Name:
MICHAEL

Last Name:
MILLER, CFO AND ASSISTANT MANAGER

Entity Name:
EMPRES HEALTHCARE MANAGEMENT, LLC

Title:

MANAGER

COMPASS **Compass Washington**
837 N 34th St Suite 100
Seattle, WA 98103
Phone: 206-330-0314

LEASE AGREEMENT
(Multi-Tenant - Triple Net (NNN) Lease)

09/04/2021 [AC] [DC] 09/04/2021

THIS LEASE AGREEMENT (the "Lease") is entered into and effective as of this 26th day of August, 20 21 between 316 LLC, a(n) _____ ("Landlord"), and ~~EmpRes Health of Bellingham, a(n) _____~~ Eden Hospice of Whatcom County, LLC, a Washington limited liability company ("Tenant"). Landlord and Tenant agree as follows:

1. **LEASE SUMMARY.** 09/04/2021 [DC] [AC] 09/04/2021

a. **Leased Premises.** The leased commercial real estate (the "Premises") i) consists of an agreed area of 1367 rentable square feet and is outlined on the floor plan attached as Exhibit A; ii) is located on the land legally described on attached Exhibit B; and iii) is commonly known as ~~104~~ 316 E McCloud Rd, ~~104~~ Bellingham, WA 98229 (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 contain an agreed total area of 15,010 rentable square feet.

b. **Lease Commencement Date.** The term of this Lease shall commence upon (check one):

☐ Substantial completion of (choose one) ☐ Landlord's Work, or ☐ Tenant's Work as further described in the attached Exhibit C ("Work Letter"), but in no event later than _____, 20 __

☒ September 1, 20 21 09/04/2021

(the "Commencement Date"). [AC] [DC] 09/04/2021

c. **Lease Termination Date.** The term of this Lease shall terminate at midnight on ~~the last day of the~~ June 30, 2024 ~~full month following the Commencement Date~~ or such earlier or later date as otherwise provided in this Lease (the "Termination Date"). Tenant shall have no right or option to extend this Lease, unless otherwise set forth in a rider attached to this Lease (e.g., Option to Extend Rider, CBA Form OR).

d. **Base Rent.** The monthly base rent shall be (check one): ☐ $ _____, or ☒ according to the Rent Rider attached hereto ("Base Rent"). Rent shall be payable by wire transfer or 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 $ _____ as prepaid Rent, to be applied to Base Rent due for months _____ through _____ of the Lease.

f. **Security Deposit.** Upon execution of this Lease, Tenant shall deliver to Landlord the sum of $ 912 to be held as a security deposit pursuant to Section 5 below. The security deposit shall be in the form of (check one): ☒ cash, check or wire transfer, 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 business, subject to applicable zoning and other laws, and for no other purpose without the prior written consent of Landlord (the "Permitted Use").

h. **Notice and Payment Addresses:**

Landlord: 316 ILC.
4182 StoneyBrook lane
Bellingham WA 98229
Email: dancantrell1@yahoo.com

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Tenant: Eden Home Health
4601 NE 77th Avenue, Suite 300
Vancouver, WA 98662
Email: josh-mayer@eden-health.com

i. **Tenant's Pro Rata Share.** Landlord and Tenant agree that Tenant's "Pro Rata Share" is 9 %, based on the ratio of the rentable area of the Premises stated in Section 1.a to the rentable area of all buildings on the Property stated in Section 1.a. Tenant's Base Rent and Pro Rata Share shall be proportionally adjusted in the event of any adjustment to the Premises', Building's or Property's rentable floor area either by remeasurement, which measurement standard shall be selected by Landlord in its reasonable discretion, or by physical change thereto.

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 in the Work Letter attached as Exhibit C ("Landlord's Work"), Tenant shall accept the Premises and its improvements in their respective AS-IS, WHERE-IS condition, and shall further 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 adequate opportunity to investigate the Premises; acknowledges responsibility for making any corrections, alterations and repairs to the Premises (other than Landlord's Work); and acknowledges that the time needed to complete any such items shall not delay the Commencement Date.

c. **Tenant Improvements.** The Work Letter attached as Exhibit C sets forth all Landlord's Work, if any, and all tenant improvements to be completed by Tenant ("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 in the Work Letter.

3. **TERM.** The term of this Lease shall commence on the Commencement Date, and shall end on the Termination Date, subject to any option to extend the term of this Lease set forth in a rider attached hereto (the "Term").

a. **Early Possession.** Tenant shall have reasonable access to the Premises during the 0 days ((0) days if not filled in) preceding the Commencement Date for the sole purpose of installing Tenant's furniture, telecommunications, fixtures, telephone systems and computer cabling and the performance of Tenant's Work, if any. Such access shall be fully coordinated with Landlord in advance and Tenant shall not interfere with Landlord's Work. All of the terms and conditions of this Lease, including Tenant's insurance and indemnification obligations, shall apply during such time, except for payment of Base Rent. If Landlord permits Tenant to possess or occupy the Premises 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.

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. If Landlord does not deliver possession of the Premises to Tenant within _____ days ((60) days if not filled in) after the Commencement Date specified in Section 1 (check one): ☐ Tenant may elect to cancel this Lease by giving written notice to Landlord no later than _____ days ((10) days if not filled in) after such

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time period ends, or ☐ then all Base Rent and Additional Rent shall be abated for each one (1) day after the Commencement Date during which possession of the Premises has not been delivered to Tenant. If Tenant gives such notice of cancellation, as Tenant's sole and exclusive remedy, 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.

Notwithstanding anything in this Section 3(b) to the contrary, to the extent that any portions of the Landlord's Work or Tenant's Work have not been sufficiently 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 ("Tenant Delays"), the Term and Tenant's obligation to pay Base Rent and Additional Rent shall nevertheless commence on the Commencement Date set forth in Section 1, or upon the date that the Commencement Date would have occurred but for the Tenant Delays. 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 Term shall be twelve (12) months, commencing on the first day following the end of the preceding Lease Year.

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 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, including Operating Costs, due to Landlord ("Additional Rent" and together with Base Rent, "Rent") when required under this Lease. Payments for any partial month during the Term shall be prorated. All payments due to Landlord under this Lease, including late fees and interest, shall also constitute Additional Rent, and upon Tenant's failure 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. **Triple Net Lease.** This Lease is what is commonly called a "Net, Net, Net" or "triple-net" Lease, which means that Landlord shall receive all Base Rent free and clear of any and all other impositions, taxes, liens, charges or expenses of any nature whatsoever in connection with the ownership and operation of the Premises. In addition to Base Rent, Tenant shall pay to the parties respectively entitled thereto, or satisfy directly, all Additional Rent and other impositions, insurance premiums, repair and maintenance charges, and any other charges, costs, obligations, liabilities, requirements, and expenses, including without limitation the Operating Costs described in Section 8, which arise with regard to the Premises or may be contemplated under any other provision of the Lease during its term, except for costs and expenses expressly made the obligation of Landlord in this Lease.

c. **Late Charges; Default Interest.** If any sums payable by Tenant to Landlord under this Lease are not received within five (5) business days after their due date, Tenant shall pay Landlord an amount equal to the greater of $100 or 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 five (5) business days after their due date shall, at Landlord's option, bear interest at the rate of 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.

d. **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 4.

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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 defaults in the performance of any covenant or condition of this Lease, Landlord shall have the right, but not the obligation, to use or retain all or any portion of the security deposit for the payment of: (i) Base Rent, Additional Rent, or any other sum as to which Tenant is in default; or (ii) the amount Landlord spends or may become obligated to spend, or to compensate Landlord for any losses incurred by reason of Tenant's default. 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 at any time during the Term of the Lease the security deposit delivered by Tenant becomes insufficient to cover the amounts required under this Section 5, whether or not due to Landlord's application of all or a portion of the security deposit as contemplated by this Section, Tenant shall, within five (5) days after written demand therefor by Landlord, deposit with Landlord an amount sufficient to replenish the security deposit to the amount required in Section 1 above. If Tenant is not in default of any covenant or condition of this Lease at the end of the Term, Landlord shall return any unused portion of the security deposit without interest within 30 days after the surrender of the Premises by Tenant in the condition required by Section 13 of this Lease.

6. **USES.** The Premises shall be used only for the Permitted Use, and for no other business or purpose without the prior written consent of Landlord. Tenant shall not do or permit any act to be done on or around the Premises that violates any law, ordinance, governmental regulation or order 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.** Landlord represents to Tenant that, as of the Commencement Date, to Landlord's actual knowledge, but without duty of investigation, and with the exception of any Tenant's Work, the Premises comply with all applicable laws, rules, regulations, and orders, including without limitation, the Americans With Disabilities Act, 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 the 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 such changes and alterations at its expense.

8. **OPERATING COSTS.**

   a. **Definition.** 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: all taxes and assessments (including, but not limited to, real and personal property taxes and assessments, local improvement district assessments and other special purpose assessments, and taxes on rent or gross receipts); insurance premiums paid by Landlord and (to the extent used) deductibles for insurance applicable to the Property; water, sewer and all other utility charges (other than utilities separately metered and paid directly by Tenant or other tenants); janitorial and all other cleaning services; refuse and trash removal; supplies, materials, tools, and equipment used in the operation, repair, and maintenance of the Property; refurbishing and repainting; carpet replacement; to the extent serving areas other than just the Premises, heating, ventilation and air conditioning ("HVAC") service, repair and replacement when necessary; elevator service and repair and replacement of elevators when necessary; pest control; lighting systems, fire detection and security services; landscape maintenance; management (fees and/or personnel costs); parking lot, road, sidewalk and driveway patching, resurfacing and maintenance; snow and ice removal;

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repair, maintenance, and, where reasonably required, replacement of signage; amortization of capital improvements as Landlord may in the future install to comply with governmental regulations and rules or undertaken in good faith with a reasonable expectation of reducing Operating Costs (the useful life of which shall be a reasonable period of time as determined by Landlord); costs of legal services (except those incurred directly relating to a particular occupant of the Building); and accounting services, labor, supplies, materials and tools. Landlord and Tenant agree that if the Building is not 90% occupied during any calendar year (including the Base Year, if applicable), on a monthly average, then those portions of the Operating Costs that are driven by occupancy rates, as reasonably determined by Landlord, shall be increased to reflect the Operating Costs of the Building as though it were 90% occupied and Tenant's Pro Rata Share of Operating Costs shall be based upon Operating Costs as so adjusted. Operating Costs shall not include: Landlord's income tax or general corporate overhead; depreciation or amortization on the Building or equipment therein; loan or ground lease payments; real estate broker's commissions; capital improvements to or major repairs of the Building shell (i.e., the Building structure, exterior walls, roof, and structural floors and foundations), except to the extent expressly permitted above; any costs regarding the operation, maintenance and repair of the Premises, the Building, or the Property paid directly by Tenant or other tenants in the Building or otherwise reimbursed to Landlord, or other cost for which another party is required to pay Landlord (except as part of operating cost recoveries under other tenant leases) so that Landlord shall not recover any item of cost more than once. If Tenant is renting a pad separate from any other structures on the Property for which Landlord separately furnishes the services described in this paragraph, then the term "Operating Costs" shall not include those costs of operating, repairing, and maintaining the enclosed mall which can be separately allocated to the tenants of the other structures. Operating Costs which cannot be separately allocated to the tenants of other structures may include but are not limited to: insurance premiums; taxes and assessments; management (fees and/or personnel costs); exterior lighting; parking lot, road, sidewalk and driveway patching, resurfacing and maintenance; snow and ice removal; and costs of legal services and accounting services.

b. **Type of Payment.** As Additional Rent, Tenant shall pay to Landlord on the first day of each month with payment of Base Rent one-twelfth of Tenant's Pro Rata Share of Operating Costs, which amount is determined in the manner set forth in Section 8(c) below.

c. **Method of Payment.** Tenant shall pay to Landlord Operating Costs pursuant to the following procedure:

i. Landlord shall provide to Tenant, on or before the Commencement Date, a good faith estimate of annual Operating Costs for the calendar year in which the Commencement Date occurs. Landlord shall also provide to Tenant, as soon as possible following the first day of each succeeding calendar year, a good faith estimate of Tenant's annual Pro Rata Share of Operating Costs for the then-current year.

ii. Each estimate of Tenant's annual Pro Rata Share of Operating Costs determined by Landlord, as described above, shall be divided into 12 equal monthly installments. Tenant shall pay to Landlord such monthly installment of Operating Costs with each monthly payment of Base Rent. In the event the estimated amount of Tenant's Pro Rata Share of Operating Costs has not yet been determined for any calendar year, Tenant shall pay the monthly installment in the estimated amount determined for the preceding calendar year until the estimate for the current calendar year has been provided to Tenant. When the estimate for the current calendar year is received, Tenant shall then pay any shortfall or receive a credit for any surplus for the preceding months of the current calendar year and shall, thereafter, make the monthly installment payments in accordance with the current estimate.

iii. As soon as reasonably possible following the end of each calendar year during the Term, Landlord shall provide to Tenant a statement (the "Operating Costs Statement") setting forth the amount of Operating Costs actually incurred and the amount of Tenant's Pro Rata Share of Operating Costs actually payable by Tenant with respect to such calendar year. In the event the amount of Tenant's Pro Rata Share of Operating Costs exceeds the sum of the monthly installments actually paid by Tenant for such calendar year, Tenant shall pay to Landlord the difference within 30 days following receipt of the Operating Costs Statement. In the event the sum of the monthly installments actually

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paid by Tenant for such calendar year exceeds the amount of Tenant's Pro Rata Share of Operating Costs actually due and owing, the difference shall be applied as a credit to Tenant's future Pro Rata Share of Operating Costs payable by Tenant pursuant to this Section, or if the Term has expired, the excess shall be refunded to Tenant within 30 days after delivery of such Operating Costs Statement.

iv. Should Tenant dispute any amount shown on the Operating Costs Statement, Tenant may audit Landlord's books and records for the calendar year covered by such Operating Costs Statement upon written notice to Landlord given within 90 days after Tenant's receipt of such Operating Costs Statement. If Tenant fails to provide notice of dispute within such 90- day period, the Operating Costs Statement shall be final and conclusive. Any audit conducted by Tenant shall be completed within 60 days after Tenant's request therefor. If Landlord concurs with the audit results, and (x) if the audit reveals that Tenant's Pro Rata Share of Operating Costs exceeds the sum of the monthly installments actually paid by Tenant for such calendar year, Tenant shall pay to Landlord the difference within 30 days following completion of the audit; or (y) if the audit reveals that the sum of the monthly installments actually paid by Tenant for such calendar year exceeds the amount of Tenant's Pro Rata Share of Operating Costs actually due and owing, the difference shall be applied as a credit to Tenant's future Pro Rata Share of Operating Costs payable by Tenant pursuant to this Section, or if the term has expired, the excess shall be refunded to Tenant within 30 days after completion of the audit. If Landlord does not concur with the results of Tenant's audit, the parties shall within twenty (20) days thereafter agree on a neutral auditor who shall complete an audit within thirty (30) days after selection, and the decision of the neutral auditor shall be binding on the parties. The parties shall share evenly in the costs of any such neutral auditor. Landlord and Tenant shall cooperate as may be reasonably necessary in order to facilitate the timely completion of any audit. Nothing in this Section shall in any manner modify Tenant's obligations to make payments as and when provided under this Lease.

9. **UTILITIES AND SERVICES.** Landlord shall provide the following services for the Premises (7) days per week, (24) hours per day, the cost of which shall be included in the Operating Costs to the extent not separately metered to and exclusively serving the Premises (with the costs of such separately metered services to be directly billed to and paid by Tenant): (check all that apply) ☒ water; ☒ electricity; ☒ sewer; ☒ trash and/or recycling removal; and ☐ HVAC from Rent Rider includes NNN a.m. to _____ p.m. Monday through Friday; _____ a.m. to _____ p.m. on Saturday; and _____ a.m. to _____ p.m. on Sunday; ☐ janitorial service in the Premises and Building _____ nights ((5) nights if not filled in) each week, exclusive of holidays. 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.

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.

10. **TAXES AND ASSESSMENTS.** 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, all of which shall be included in Operating Costs and subject to partial reimbursement by Tenant as set forth in Section 8.

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11. **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 and other tenants of the Property 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 HVAC systems, common electrical service, equipment and facilities, and common mechanical systems, equipment and facilities. Tenant shall comply with, and shall use commercially reasonable efforts to cause its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees to comply with, reasonable rules and regulations concerning the use of the Common Areas adopted by Landlord from time to time, and shall not interfere with the use of Common Areas by others. 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 of the Building and other improvements at the Property, 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 of the Property to whom Landlord has granted or may grant such rights, to use the Common Areas.

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

12. **ALTERATIONS.** Tenant may make alterations, additions or improvements to the Premises (the "Alterations"), only with the prior written consent of Landlord, which consent, with respect to Alterations not affecting the structural components of the Premises or utility systems therein or for which the aggregate cost and expense does not exceed $10,000, shall not be unreasonably withheld, conditioned, or delayed. Landlord shall have 30 days following Tenant's request for Landlord's consent to any Alterations to respond to such request, provided that Tenant's request includes the names of Tenant's contractors and reasonably detailed plans and specifications therefor. The term "Alterations" shall not include: (i) any of Tenant's Work approved by Landlord pursuant to Exhibit C, (ii) Tenant's Signage (as further provided in Section 15), or (iii) the installation of shelves, movable partitions, Tenant's equipment and trade fixtures that may be installed and removed without damaging existing improvements or the structural integrity of the Premises, the Building, or the Property. 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 of (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. Except as otherwise provided in the Work Letter attached as Exhibit C with respect to Tenant's Work, any improvements installed as part of Tenant Work's or Alterations performed or caused to be performed by Tenant (check one): ☐ shall become the property of Landlord, or ☒ shall be removed by Tenant at its sole cost and expense upon the expiration or earlier termination of the Lease Term (unless Landlord conditioned its consent in writing 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 improvements performed as part of Tenant's Work and/or

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Alterations.

13. **REPAIRS AND MAINTENANCE; SURRENDER.** Tenant shall, at its sole cost and 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 to the extent serving more than just the Premises, and the Common Areas, the costs of which shall be included as Operating Costs unless otherwise expressly excluded pursuant to Section 8(a). 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 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 or earlier termination of the Term, Tenant shall promptly and peacefully surrender the Premises to Landlord, together with all keys, in materially as good condition as when received by Tenant from Landlord or as thereafter improved (but subject to any obligations to remove any Tenant's Work and Alterations and/or restore the same as further provided in this Lease), reasonable wear and tear and insured casualty excepted.

14. **ACCESS AND RIGHT OF ENTRY.** After 24 hours' notice from Landlord (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 180 days prior to the expiration or sooner termination of the Term; and (b) posting "for lease" signs within 180 days prior to the expiration or sooner termination of the Term.

15. **SIGNAGE.** Tenant shall obtain Landlord's written consent as to size, location, materials, method of attachment, and appearance, before installing any signs upon the Premises. Tenant shall install and maintain any approved signage ("Signage") at Tenant's sole expense and in compliance with all applicable laws. Unless as otherwise provided in Exhibit C with respect to any of Tenant's Work, any Signage installed by Tenant shall be removed from the Premises, Building and Property at Tenant's expense upon the expiration or earlier termination of the Term. 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.

16. **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 by fire or other insured casualty but not rendered untenantable, 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 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 25% or less of each of those areas are damaged. If insurance proceeds are not

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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 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 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 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 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 20 days' notice to Landlord unless Landlord, within such 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 Base 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 Base 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 of Tenant's Work identified in Exhibit C (regardless of who may have completed them); Signage; 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 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 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, provided that in no event shall Tenant's claim reduce Landlord's award.

17. **INSURANCE.**

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a. **Tenant's Liability Insurance.** During the Term, Tenant shall pay for and maintain commercial general liability insurance with broad form property damage and contractual liability endorsements. This policy shall (i) contain an endorsement identifying Landlord, its property manager (if any), and other parties designated by Landlord, as additional insureds using an endorsement form acceptable to Landlord, (ii) 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 ~~$2,000,000 per occurrence~~ $1,000,000 per occurrence, and a deductible of not more than ~~$10,000,~~ $100,000 and (iii) contain a provision requiring the insurer to deliver or mail written notice of cancellation to the named insureds at least (45) days before the effective date of the cancellation. Tenant's insurance will be primary and noncontributory with any liability insurance carried by Landlord. Landlord may also require Tenant to obtain and maintain at Tenant's sole cost 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.

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b. **Tenant's Property Insurance.** During the 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, Tenant's Work, and Alterations, 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 of Washington. 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 30 days prior written notice to Landlord. Tenant shall deliver to Landlord, prior to Tenant's first taking possession of or occupying the Premises, 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. The cost of any such insurance shall be included in Operating Costs, and if such insurance is provided by a "blanket policy" insuring other parties or locations in addition to the Building, then only the portion of the premiums allocable to the Building and Property shall be included in Operating Costs.

e. **Waiver of Subrogation.** Notwithstanding any other provision of this Lease to the contrary, 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 insurance required to be carried or otherwise carried by each of them. Each party shall provide notice to the insurance carrier or carriers of this mutual waiver of subrogation, and shall cause its respective 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 policies or to the extent of liabilities exceeding the limits of such policies.

18. **INDEMNIFICATION.**

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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 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 18 shall survive expiration or termination of this Lease.

19. **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 the same, including attorneys' fees, upon demand of Landlord, up to a maximum of $1,250.

    Any transfer of this Lease by merger, consolidation, redemption or liquidation of Tenant, 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 for the payment of Rent and performance of all obligations of Tenant under this Lease. In connection with any Transfer, Tenant shall provide Landlord with copies of all assignments, subleases and assumption agreements and related documents.

20. **LIENS.** Tenant is not authorized to subject the Landlord's assets to any liens or claims of lien. Tenant shall keep the Property and Premises free from any liens created by or through Tenant. Tenant shall indemnify, defend, and hold Landlord and the Property and Premises harmless from liability for any such liens including, without limitation, liens arising from any of Tenant's Work or Alterations. If a lien is filed against the Premises

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by any person claiming by, through or under Tenant, Tenant shall have the right to contest the correctness or validity of the lien, provided, however, within 10 days after Landlord's demand, at Tenant's expense, Tenant shall either remove the lien, or shall procure and record a lien release bond issued by a surety satisfactory to Landlord in form and amount sufficient to satisfy statutory requirements for satisfaction and release of the subject lien(s) from the Premises and Property. Tenant shall indemnify Landlord,the Premises, and the Property from and against all liabilities, costs and expenses, including attorneys' fees, which Landlord could reasonably incur as a result of such lien.

21. **DEFAULT.** Each of the following events shall be an "Event of Default" by Tenant under this Lease:

    a. **Failure To Pay.** Failure by Tenant to pay any sum, including Rent, due under this Lease following five (5) 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 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 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 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 30 days after notice by Landlord to Tenant of the breach, provided that, if the nature of such default is such that it cannot be cured within such 30 day period, no Event of Default shall occur so long as Tenant commences such cure within 30 days of notice by Landlord and diligently pursues such cure to completion, but in no event longer than 60 days from the date of Landlord's notice.

    f. **Failure to Take Possession.** Failure by Tenant to take possession of the Premises on the Commencement Date following five (5) days' notice from Landlord of Tenant's failure to take possession.

    Landlord shall not be in default unless Landlord fails to perform obligations required of Landlord within 30 days after notice by Tenant to Landlord, provided that, if the nature of such default is such that it cannot be cured within such 30 day period, Landlord shall not be in default if Landlord commences such cure within 30 days of notice by Tenant and diligently pursues such cure to completion. If Landlord fails to cure any such default within the allotted time, Tenant's sole remedy shall be to seek actual money damages (but not consequential or punitive damages) for loss arising from Landlord's failure to discharge its obligations under this Lease. Nothing herein contained shall relieve Landlord from its duty to perform any of its obligations to the standard prescribed in this Lease.

    Any notice periods granted herein shall be deemed to run concurrently with and not in addition to any default notice periods required by law.

22. **REMEDIES.** Landlord shall have the following remedies upon an Event of Default. Landlord's rights and remedies under this Lease shall be cumulative and not exclusive.

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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 Rent and other sums that would have been owing by Tenant under this Lease for the balance of the 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 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 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

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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, if any.

23. **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 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.

24. **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.

25. **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 at sufference, 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 other than any options to extend the Term. 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.

26. **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, or (ii) three (3) days after being sent by registered or certified mail to the other party at the address 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.

27. **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.

28. **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 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

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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 Term of 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 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.

29. **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.

30. **LANDLORD'S LIABILITY.** Notwithstanding anything in this Lease to the contrary, 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.

31. **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 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.

32. **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 actual knowledge without duty of investigation, there is no Hazardous Material on, in, or under the Premises as of the Commencement Date in excess of reportable quantities 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 in excess of reportable quantities 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 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 (except in de minimis quantities typical of the Permitted Use, such as in office supplies and household cleansers) and then only upon strict compliance with all applicable federal, state and local laws, regulations, codes, ordinances, and product labels. 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

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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 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 Material on the Premises or the Property or any adjacent property, Tenant shall promptly take all actions, at its sole expense, as are necessary to return the Premises or the Property or such adjacent 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 earlier termination of this Lease.

33. **QUIET ENJOYMENT.** Provided Tenant pays 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.

34. **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.

35. **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 or 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 or 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.

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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; provided in no event shall any of the foregoing events operate to extend the Term of this Lease.

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 executed by both parties.

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 affect this Lease or the obligations of Tenant hereunder or impose any liability on Landlord.

j. **Authority of Parties.** Each party to this Lease represents and warrants to the other that the person executing this Lease on behalf of such party has the authority to enter into this Lease on behalf of such party, 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 such party.

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.

36. **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: Work Letter

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
- ☐ Guaranty of Tenant's Lease Obligations Rider
- ☒ Parking Rider
- ☐ Option to Extend Rider
- ☐ Rules and Regulations

37. **AGENCY DISCLOSURE.** At the signing of this Lease, Landlord is represented by Anne Cantrell, Compass Realty (insert both the name of the Broker and the Firm as licensed) (the "Landlord's Broker"), and Tenant is represented by none (insert both the name of the Broker and the Firm as licensed) (the "Tenant's Broker").

This Agency Disclosure creates an agency relationship between Landlord, Landlord's Broker (if any such

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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 Tenant's 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."

38. **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
☐ $ _____ per square foot of the Premises
☐ Other _____

Landlord's Broker ☐ shall ☐ shall not (shall not if not filled in) be entitled to a commission upon the extension by Tenant of the 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 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).

With respect to any commission earned upon execution of this Lease or pursuant to any expansion of the Premises, Landlord shall pay one-half upon execution of the Lease or any amendment/addenda thereto expanding the Premises, and one-half upon occupancy of the Premises by Tenant. With respect to any commission earned upon extension of the Term of this Lease, Landlord shall pay one-half upon execution of any amendment/addenda to the Lease extending the Term and one-half upon the commencement date of such extended term. 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, $ _____ or _____ % (complete only one) of any commission paid to Landlord's Broker, within 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.

39. **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; COMPLIANCE OF THE

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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.

Authentisign Anne Cantrell for 316 LLC 9/4/2021 10:39:18 AM PDT LANDLORD:	TENANT:
Authentisign Dan Cantrell 9/4/2021 10:40:29 AM PDT licensed real estate broker WA State BY:	Eden Hospice of Whatcom County, LLC TENANT: By EmpRes Healthcare Mangement, LLC BY: By Michael Miller, CFO
ITS:	ITS:

APPENDIX E

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

316LLC by Anne Cantrell LANDLORD:	TENANT:
LANDLORD:	TENANT:
BY:	BY:
Owner ITS:	ITS:

(Actual Notarized page included – along with digital signing)

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STATE OF WASHINGTON

COUNTY OF Whatcom

This record was acknowledged before me on 09/09, 2021, by Douglas Ausejo as Notary Public of Bellingham.

DOUGLAS AUSEJO NOTARY My Comm. Expires August 19, 2024 No. 21011198 PUBLIC STATE OF WASHINGTON

Notary Public for the State of Washington

My commission expires: 08/19/2024

STATE OF WASHINGTON

COUNTY OF CLARK

This record was acknowledged before me on 09/30, 2021, by Michael Miller as CFO of Empres Healthcare Management, LLC

Erica L Miles
Notary Public for the State of Washington

My commission expires: 04-05-2025

ERICA L MILES COMMISSION EXPIRES 04-05-2025 NOTARY PUBLIC License Number: 21013649 STATE OF WASHINGTON

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EXHIBIT A - 1

[Outline of the Premises]

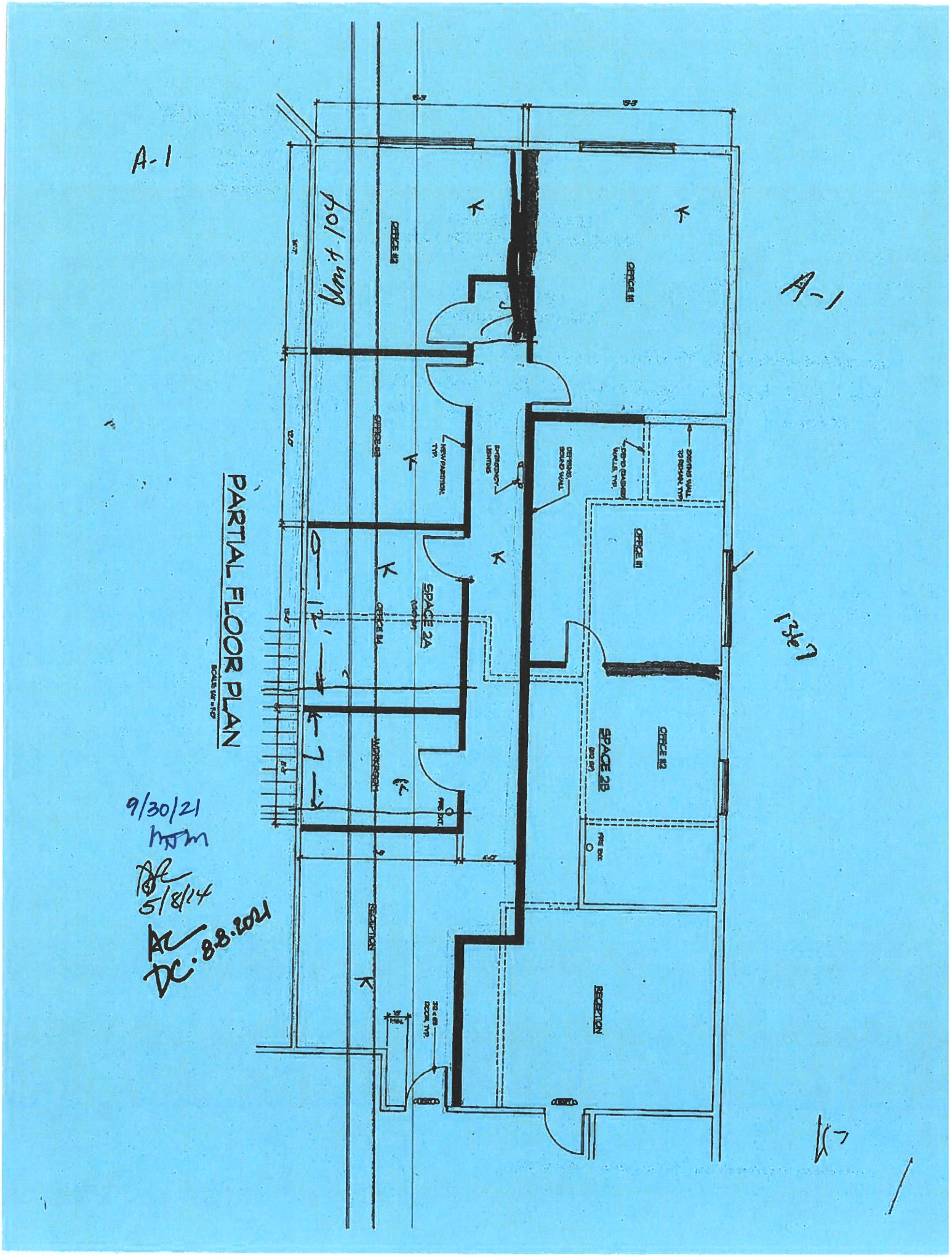
A-1
PARTIAL FLOOR PLAN
SCALE: 1/4"=1'-0"
OFFICE #2
OFFICE #3
OFFICE #4
OFFICE #1
SPACE 2A
SPACE 2B
OFFICE #2
OFFICE #1
WORKROOM
RECEPTION
9/30/21
5/8/14
DC. 8.8.2021
A-1

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EXHIBIT B

[Legal Description of the Property]

Whatcom Land Title Company, Inc.

2011 Young Street
Bellingham, Washington 98225
Phone (360) 676-8484 Toll Free 1-800-224-6314
Fax (360) 671-0902
Website www.whatcomlide.com

"Locally Owned and Operated since 1982"

~~EXHIBIT A~~ Exhibit B

LEGAL DESCRIPTION FOR PARCEL # 380318 094317

PER DEED RECORDED UNDER AUDITOR'S FILE NO. 2110102716

Legal: Unit A, McLeod Commercial Condominium, as per the declaration recorded at Auditor's File No. 2080602858, records of Whatcom County, Washington.

Situate in Whatcom County, Washington.

END OF EXHIBIT "A

8.8.21
DC

9/30/21

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[AC] [DC] 09/04/2021

PARKING RIDER

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Eden Hospice of Whatcom County, LLC
a Washington limited liability company

This Parking Rider ("Rider") is made part of and incorporated by this reference into that certain Lease Agreement dated _____, 20__ ("Lease") between 316 LLC, a(n) _____ ("Landlord") and ~~EmpRes Health of Bellingham~~, a(n) _____ ("Tenant"), as the same may be amended, concerning the leased commercial space commonly known as _____ (Premises"), which Premises are part of the real property located at 316 E McCloud Rd 104, Bellingham, WA 98229 and commonly known as _____ ("Property").

1. Tenant's Parking Rights. Tenant's right to park on the Property shall be in accordance with the following (check one):

☒ Tenant shall be entitled to use and rent parking stalls on the Property or other parking area designated by Landlord from time to time on a (check one) ☒ reserved, or ☐ unreserved, first-come, first-served (unreserved, if neither box checked) basis at the monthly rate established by Landlord from time to time, plus all applicable taxes, which monthly charge and applicable taxes shall be payable by Tenant as Additional Rent under the Lease. Tenant shall comply with the reasonable rules and regulations which Landlord and/or its parking operator may adopt from time to time for the safe and orderly operation of the parking areas, including without limitation, with respect to any Common Areas as further provided in the Lease. If parking is on a reserved basis, Landlord shall have no obligation to monitor the use of parking spaces designated as reserved for Tenant's use, to tow cars, or to ensure that such parking spaces are available for use by Tenant; provided that Landlord will take reasonable efforts to enforce such reserved parking if Tenant is unable to use and access the same during normal business hours for a period of five (5) consecutive business days, provided further that Landlord shall incur no out of pocket expense in doing so and such lack of parking access shall not constitute a default hereunder. If parking is on an unreserved basis, in no event shall Tenant use more spaces than the number derived by applying Tenant's Pro Rata Share (as defined in the Lease) to the total number of unreserved spaces in the parking area or areas designated by Landlord from time to time. The parking rights granted to Tenant under this Rider are non-assignable and shall automatically be deemed null and void upon any Transfer (as such term is defined in the Lease) of the Lease.

☒ **Free Parking.** Tenant shall be entitled to share parking on a first-come, first-served basis, in common with other tenants and occupants of the Building and Property in the designated parking areas at no charge. In no event shall Tenant use more spaces than the number derived by applying Tenant's Pro Rata Share (as defined in the Lease) to the total number of unreserved spaces in the parking area or areas designated by Landlord from time to time. Tenant shall comply 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, including without limitation, with respect to any Common Areas.

☐ **No Parking.** Tenant's rights under the Lease do not include the right to park on the Property.

2. Miscellaneous. 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: _____. Landlord specifically reserves the right to change the size, configuration, design, layout and all other aspects of the Property's parking facilities at any time and to institute valet parking and Tenant acknowledges and agrees that Landlord may, without incurring any liability to Tenant and without any abatement of Rent under the Lease, from time to time, close-off or restrict access to the Property's parking facilities for purposes of permitting or facilitating any such construction, alteration or improvements. Tenant's continued right to use the parking spaces is conditioned upon Tenant abiding by all reasonable rules and regulations which are prescribed from time to time for the orderly operation and use of the parking facilities, including any sticker or other identification system established by Landlord, Tenant's reasonable cooperation in ensuring that Tenant's employees, officers, contractors, licensees,

[DC] 09/04/2021

INITIALS: LANDLORD _____ DATE ~~09/04/2021~~ TENANT _____ DATE 9/30/21
LANDLORD [AC] DATE _____ TENANT _____ DATE 9/30/21

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agents, and invitees also comply with such rules and regulations, and Tenant not being in default under this Lease.

[DC] 09/04/2021

[AC] 09/04/2021

INITIALS: LANDLORD _____ DATE _____ TENANT MM DATE 9/30/21
LANDLORD _____ DATE _____ TENANT MM DATE 9/30/21

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09/04/2021

RENT RIDER

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09/04/2021 DC AC

Eden Hospice of Whatcom County, LLC, a Washington limited liability company

This Rent Rider ("Rider") is a part of and incorporated by this reference into that certain Lease Agreement dated _____, 20__ ("Lease") between 316 LLC, a(n) _____ ("Landlord") and ~~EmpRes Health of Bellingham~~, a(n) _____ ("Tenant"), as the same may be amended, concerning the commercial space commonly known as _____ ("Premises"), which Premises are part of the real property located at 316 E McCloud Rd, 104, Bellingham, WA 98229 and commonly known as Suite 104 ("Property").

☒ **1. BASE MONTHLY RENT SCHEDULE.** Tenant shall pay to Landlord base monthly rent during the initial Lease Term according to the following schedule:

Lease Year (Stated in Years or Months)	Base Monthly Rent Amount
Sept1 2021-June 30,2022	$ 1109 + NNN ($561 per month) = $1670.Total
July1 - June 30 2023	$ 1136 + NNN ($561 per month)= $1697 Total
July 1 2023-June 30 2024	$ 1164 + NNN ($561per month) = $1725 Total
_____	$ _____
_____	$ _____
_____	$ _____

☐ **2. CONSUMER PRICE INDEX ADJUSTMENT ON BASE MONTHLY RENT.** The base monthly rent shall be increased on the first day of the second year of the Term, which shall occur on the first day of the calendar month after the calendar month in which the Commencement Date occurs and on the first day of each year of the Term thereafter (each, an "Adjustment Date") (but not during any extended or renewal term(s) unless specifically set forth elsewhere in the Lease or set forth in this Rent Rider below). The increase shall be determined in accordance with the increase in the United States Department of Labor, Bureau of Labor Statistics, Revised Consumer Price Index for All Urban Consumers (CPI-U): U.S. Cities Average, all items index (Reference Base 1982-84 equal 100)(the "Index"). The base monthly rent payable immediately prior to the applicable Adjustment Date shall be increased by the percentage that the Index published for the date nearest preceding the applicable Adjustment Date has increased over the Index published for the date nearest preceding the first day of the Lease Year from which the adjustment is being measured. Upon the calculation of each increase, Landlord shall notify Tenant of the new base monthly rent payable hereunder. Within twenty (20) days of the date of Landlord's notice, Tenant shall pay to Landlord the amount of any deficiency in base rent paid by Tenant for the period following the subject Adjustment Date, and shall thereafter pay the increased base rent until receiving the next notice of increase from Landlord. If the components of the Index are materially changed after the Commencement Date, or if the Index is discontinued during the Lease term, Landlord shall notify Tenant of a substitute published index which, in Landlord's reasonable discretion, approximates the Index, and shall use the substitute index to make subsequent adjustments in base monthly rent. In no event shall base monthly rent be decreased pursuant to this paragraph.

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RENT RIDER

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New text inserted by licensee indicated by small capital letters.

☐ **3. EXTENDED TERM BASE MONTHLY RENT SCHEDULE.** Tenant shall pay to Landlord base monthly rent during the Extended Term of the Lease commencing upon (check one): ☐ the date that is _____ months following the Commencement Date of the initial Term, or ☐ _____, 20__, as follows (choose one):

☐ As set forth in the Option to Extend Rider attached to the Lease

☐ **BASE MONTHLY RENT SCHEDULE.** Tenant shall pay to Landlord base monthly rent during the Extended Term of the Lease according to the following schedule:

Lease Year (Stated in Years or Months)	Base Monthly Rent Amount
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____

☐ **CONSUMER PRICE INDEX ADJUSTMENT ON EXTENDED TERM BASE MONTHLY RENT.** The base monthly rent shall be increased on the first day of the first year of the Extended Term of the Lease and on the first day of each year of the Extended Term of the Lease thereafter (each, an "Adjustment Date"). The increase shall be determined in accordance with the increase in the United States Department of Labor, Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers (CPI-U): U.S. Cities Average, all items index (Reference Base 1982-84 equal 100) (the "Index"). The base monthly rent payable immediately prior to the applicable Adjustment Date shall be increased by the percentage that the Index published for the date nearest preceding the applicable Adjustment Date has increased over the Index published for the date nearest preceding the first day of the Lease Year from which the adjustment is being measured. Upon the calculation of each increase, Landlord shall notify Tenant of the new base monthly rent payable hereunder. Within twenty (20) days of the date of Landlord's notice, Tenant shall pay to Landlord the amount of any deficiency in base rent paid by Tenant for the period following the subject Adjustment Date, and shall thereafter pay the increased base rent until receiving the next notice of increase from Landlord. If the components of the Index are materially changed after the Commencement Date of the Extended Term, or if the Index is discontinued during the Extended Term, Landlord shall notify Tenant of a substitute published index which, in Landlord's reasonable discretion, approximates the Index, and shall use the substitute index to make subsequent adjustments in base monthly rent. In no event shall base monthly rent for the Extended Term be decreased pursuant to this paragraph.

INITIALS: LANDLORD DC DATE 09/04/2021 TENANT _____ DATE 9/30/21
LANDLORD AC DATE 09/04/2021 TENANT _____ DATE 9/30/21

Reference#	5006
Effective:	12/01/2014
Last Revised:	04/27/2021

NON-DISCRIMINATION POLICY

PURPOSE:

- To prevent Eden Health staff from discriminating against other staff members, patients, clients or other customers based on race, color, religion, age, sex, sexual orientation, disability, or place of national origin in compliance with federal and state regulations.

POLICY:

1. According to Title VI of the Civil Rights Act of 1964 and its implementing regulation, Eden Health will, directly or through contractual or other arrangement, admit, and treat all persons without regard to race, color, religion, sex, sexual orientation, disability, or national origin in its provision of services and benefits, including assignments or transfers within facilities.

2. According to Section 504 of the 1973 Rehabilitation Act and its implementing regulations, Eden Health will not, directly or through contractual or other arrangements, discriminate based on disability (mental or physical) in admissions, access, treatment, or employment.

3. According to the Age Discrimination Act of 1975 and its implementing regulation, Eden Health will not, directly or through contractual or other arrangements, discriminate based on age in the provision of services unless age is a factor necessary to the normal operation or the achievement of any statutory objective.

4. According to Title II of the American with Disabilities Act of 1990, Eden Health will not, based on disability, exclude or deny a qualified individual with a disability from participation in, or benefits of, the services, programs, or activities of Agency.

5. Eden Health complies with state specific regulations related to discrimination.

PROCEDURE:

1. Information regarding discrimination and grievances is provided to patients/clients as part of the Patient Admission Book.

2. Eden Health posts information regarding these federal and required state specific regulations in the office.

3. Eden Health provides patient services without regard to race, color, religion, age, sex, sexual orientation, disability (mental or physical), or place of national origin.

4. Any person who believes she or he has been subjected to discrimination or who believes he or she has witnessed discrimination based on disability, in contradiction of the policy stated above, may file a grievance under this procedure. It is against the law for Eden Health to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

5. Grievances are submitted, investigated, and responded to per the Patient Concerns and Grievances Policy or the *Employee Grievances and Complaints Policy* as applicable.

6. Files and records relating to such grievances are maintained.

7. The availability and use of the Eden Health grievance procedure does not preclude a person from filing a complaint of discrimination with the regional office for Civil Rights of the US Department of Health and Human Services.

8. Eden Health informs all Agency staff of this process during the orientation process and as needed.

APPENDIX F

Reference#	1001
Effective:	12/01/2014
Last Revised:	02/24/2021

ADMISSION POLICY

PURPOSE:

- To keep acceptance of patients consistent with Eden Hospice' mission and scope of services based on the reasonable expectation that the patient's care and service needs can be appropriately and safely met in the patient's place of residence.

POLICY:

1. The Agency admits a patient on the recommendation of the Hospice Medical Director in consultation with/with input from the patient's attending physician.

2. The Hospice Medical Director considers the following information when reaching a decision to certify that a patient is terminally ill:
   - **a.** Diagnosis of the terminal condition of the patient.
   - **b.** Other health conditions whether related or unrelated to the terminal condition.
   - **c.** Current clinically relevant information supporting diagnoses.

3. Patients with a terminal illness are accepted for care and services who meet the eligibility criteria listed below:
   - **a.** The physician is willing to sign or get another physician to sign the death certificate upon the patient's death. The physician discusses the patient's resuscitation status with the patient, family, or caregiver.
   - **b.** The patient identifies a family member, a caregiver, or a legal representative who agrees to be a primary support care person. Terminally ill patients (who are currently independent in activities of daily living) without an identified support person require the development of a specific plan for the future need of a primary support person. Staff discuss and plan for this at time of admission.
   - **c.** The patient has a life-threatening illness with a life expectancy of six months or less, as determined by the attending physician and Hospice Medical Director.
   - **d.** The patient wants hospice services and is aware of his/her diagnosis and prognosis.
   - **e.** The focus of the care wanted is palliative versus curative.
   - **f.** The patient, family, or caregiver agrees to participate in the plan of care and signs the *Hospice Consent Form*.
   - **g.** The patient, family, or caregiver understands and agrees that the Agency primarily provides care at home.
   - **h.** The physical facilities and equipment in the patient's home are adequate for safe and effective care.
   - **i.** The patient resides within the Agency's geographical area.

j. Hospice does not base eligibility for participation on the patient's race, color, creed, sex, age, disability (mental or physical), communicable disease, or place of national origin.
k. The patient meets the eligibility criteria for Medicare, Medicaid, or private Hospice benefit.
l. In order to be eligible to elect hospice care under Medicare, the patient is:
  i. Entitled to Part A of Medicare; *and*
  ii. Certified as being terminally ill.
m. The Agency accepts patients based on their care needs. The Agency considers the adequacy and suitability of staff and the resources required to provide the service. A reasonable expectation exists that the Agency can adequately take care of the patient at home.
n. The Agency accepts patients based on a patient's ability to pay for hospice services, either through state or federal assistance programs, private insurance, personal assets or the Eden Hospice charity care program. Refer to policy: HOPP 2023 Charity Care Policy.
o. The Agency reserves the right to refuse patients who do not meet the admission criteria and refers patients to other resources.
p. For Medicare patients, the physician is willing to provide a face-to-face encounter and the required written orders for care and/or services.
q. Payment Method: Eden Hospice accepts most private healthcare insurance (please refer to the Agency brochure for further details), Medicare, and Medicaid.

4. If it is determined that the Agency cannot reasonably accommodate the patient's needs, or if the patient does not meet the admission criteria, the patient/family/ referral source is notified and provided with information about other providers.

PROCEDURE:

1. Referral information provided by family, caregiver, and healthcare clinicians from other facilities, other agencies, and physicians' offices may help in the determination of eligibility for admission. If the patient's physician does not make the request for service, the Agency consults with the physician before the assessment visit.

2. Assignment of appropriate staff to conduct the initial assessment.

Reference#	2023
Effective:	08/30/2019
Last Revised:	04/25/2022

CHARITY CARE POLICY

POLICY:

1. Patients may be eligible for charity care at the time of admission to Eden Hospice or during the period when they receive hospice 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 Hospice 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

2022 National Federal Poverty Guidelines for the 48 contiguous states and the District of Columbia

Household/ Family Size	100%	200%	300%	400%
1	$13,590	$27,180	$40,770	$54,360
2	$18,310	$36,620	$54,930	$73,240
3	$23,030	$46,060	$69,090	$92,120
4	$27,750	$55,500	$83,250	$111,000
5	$32,470	$64,940	$97,410	$129,880
6	$37,190	$74,380	$111,570	$148,760
7	$41,910	$83,820	$125,730	$167,640
8	$46,630	$93,260	$139,890	$186,520
9	$51,350	$102,700	$154,050	$205,400
10	$56,070	$112,140	$168,210	$224,280
11	$60,790	$121,580	$182,370	$243,160
12	$65,510	$131,020	$196,530	$262,040
13	$70,230	$140,460	$210,690	$280,920
14	$74,950	$149,900	$224,850	$299,800

Source: HHS Poverty Guidelines for 2022

Reference#	2023
Effective:	08/30/2019
Last Revised:	04/25/2022

PROCEDURE:

1. Cases for consideration may be proposed by the patient or family, by the patient's physician, by Eden Hospice personnel, or by recognized social agencies. Application forms and instructions to complete them will be furnished to patients when charity care is requested or when need is indicated. It is preferred that the application form be completed prior to admission or upon admission. However, when circumstances prevent early completion, the application form may be completed after discharge. These application forms are available upon request to all patients.

2. Confidential financial information will be requested, including:
   - **a.** Gross income - current and prospective
   - **b.** Net worth - emphasis on liquidity
   - **c.** Employment status
   - **d.** Family size and ages of dependents
   - **e.** Other financial obligations
   - **f.** Amounts of other health care bills
   - **g.** All other support sources

3. All applications shall be accompanied by documentation to verify family income. When returned, the application shall be accompanied by one of the following types of documentation for purposes of verification. A credit reporting agency may be used.
   - **a.** W2 Withholding statements for the employment period
   - **b.** Payroll check stubs
   - **c.** IRS tax returns
   - **d.** Forms approving or denying Medicaid
   - **e.** Forms related to unemployment compensation
   - **f.** Written statements from employers or welfare agencies

5. Information is kept confidential. Copies of documents that support the application will be retained.

6. The hospice administrator will make a determination regarding eligibility within 14 days of receipt of documentation.

7. Designation of charity care, while generally determined at time of admission may occur at any time upon Eden Hospice learning of facts that would indicate medical indigence. Should charity care be provided after the patient has made full or partial payment, said payment shall be refunded to the patient within 30 days of the charity care designation.

APPEALS PROCEDURE:

1. The patient/guarantor may appeal a determination of ineligibility for charity care by providing additional information within 30 days and may appeal at a later time if conditions change.

2. The hospice administrator is responsible for making all eligibility determinations.

APPENDIX H

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

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.

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.

DESCRIPTION	INPUT	
ADMISSIONS		
HOSPICE CENSUS		
Medicare		*90%*
Insurance		*5%*
Medicaid		*5%*
HOSPICE TOTAL ADC		*100%*
HOSPICE PPD BY LOC		
Routine 0-60		*45%*
Routine 61+		*53%*
Respite		*1%*
GIP		*1%*
Continuous		*1%*
HOSPICE TOTAL PATIENT DAYS		*100%*
REVENUE		
PATIENT CARE REVENUE		
HOSP REV-MCR Lvl 1		*212.42*
HOSP REV-MCR Lvl 2		*167.85*
HOSP REV-MCR Lvl 3		*491.93*
HOSP REV-MCR Lvl 4		*1,113*
HOSP REV-MCR Lvl 5		*64*
HOSP REV-MCD Lvl 1		*212.42*
HOSP REV-MCD Lvl 2		*167.85*
HOSP REV-MCD Lvl 3		*491.93*
HOSP REV-MCD Lvl 4		*1,113.39*
HOSP REV-MCD Lvl 5		*64.37*
HOSP REV-INS Lvl 1		*212.42*
HOSP REV-INS Lvl 2		*167.85*
HOSP REV-INS Lvl 3		*491.93*
HOSP REV-INS Lvl 4		*1,113.39*
HOSP REV-INS Lvl 5		*64.37*
GROSS REVENUE		
BAD DEBT	*1% of Gross Revenue*	
SEQ 2% PART-A DEDUCT		
CHARITY ADJ	*1% of Gross Revenue*	
TOTAL ADJUSTMENTS		
NET REVENUE		
EXPENSES		
ANCILLARY EXPENSES		
HH PHARM EXPENSE		*5.00*
LAB EXPENSE		*0.12*
XRAY EXPENSE		*0.08*
PATIENT TRANSPORT/AMB		*0.40*
HH EQUIP RENT EXPENSE		*6.5*
TOTAL ANCILLARY EXPENSES		
HOSP MILEAGE-NURSE		*1.02*
HOSP MEDICAL SUPPLIES		*4.35*
HOSPICE RN WAGES-Reg		
HOSP CERT AIDE WAGE-Reg		
HOSP SPIRITUAL COUNSELG-Reg		
HOSP GIP EXPENSE		*864.5*

HOSP RESPITE EXPENSE		*381.11*
HOSP SNF R&B EXPENSE		*229.35*
HOSP MILES-SPRTL/BEREAVMT		*1.00*
SOCIAL SVCS SAL/WAGE- Reg		
HH MILEAGE-SOC SVCS		*0.75*
TOTAL EMPLOYEE BENEFITS & TAXES-		*30%*
TOTAL HOME SERVICES		
PHYSICAL THERAPY EXPENSE		*0.05*
OCCUPATIONAL THERAPY EXPENSE		*0.03*
SPEECH THERAPY EXPENSE		*0.05*
DIETARY EXPENSE		*0.09*
MEDICAL DIRECTOR FEES		*7.00*
TOTAL CONTRACT EXPENSE		
TOTAL DIRECT CARE EXPENSES		
OPERATING SUPPORT EXPENSES		
TOTAL UTILITIES		*$281 per month*
TOTAL OPERATING SUPPORT EXPENSES		
ADMIN & GENERAL EXPENSES		
HOSP DIRECTOR OF PATIENT CARE-Reg		
HOSP CLINICAL ADMN-Reg		
ADMINISTRATOR SAL- Reg		
ADMINISTRATOR SAL- Other		
BUS OFFICE WAGES-Reg		
HH CALL CTR WAGE- Reg		
COMMUNITY RELATIONS-Reg		
TOTAL EMPLOYEE BENEFITS & TAXES-		*30%*
TOTAL ADMIN COMPENSATION EXPENSES		
CONTRACT SERVICES		*lump sum*
OFFICE SUPPLIES		*lump sum*
EMP.RECRUITMT-NET&SVCS		*lump sum*
TELEPHONE & COMMUNICATNS		*1.25*
LICENSES/PERMITS		*1,856*
BUSINESS TAXES		*2.12%*
BANK CHARGES		*0.00%*
HSKPG/LAUNDRY PURCH'D SVCS		*$0*
MARKETING EXPENSE		*lump sum*
PUBLIC RELATIONS		*lump sum*
TOTAL ADMIN GENERAL EXPENSES		
TOTAL ADMIN & GENERAL EXPENSE		
PROP/CASUALTY INSURANCE		*$16 per month lump sum*
LIABILITY INSURANCE		*$104 per month lump sum*
TOTAL PROPERTY RELATED EXPENSES		
TOTAL OPERATING EXPENSES		
MGMNT FEES- EHC FAC		*5% of net revenue*
TOTAL MANAGEMENT FEES		

BUILDING LEASE	*$582 per month lump sum*
TOTAL BUILDING EXPENSES	
TOTAL DEPRECIATION & AMORTIZATI	*$239 per month lump sum*
Depreciation	*$239 per month lump sum*

Revenue Assumptions & Staffing Summary
Eden Hospice at Whatcom County, LLC -- Skagit

CENSUS	2023	2024	2025	2026	
Admissions	54	114	162	178	
Patient Days	3,215	6,977	9,911	10,892	
Average Daily Census	**8.81**	**19.11**	**27.15**	**29.84**	
PATIENT DAYS BY LEVEL OF CARE					
Routine Home Care 0-60	1,447	3,140	4,460	4,901	
Routine Home Care 61+	1,704	3,698	5,253	5,773	
Respite Care	32	70	99	109	
General Inpatient Care	16	35	50	54	
Continuous Care	16	35	50	54	
TOTAL	**3,215**	**6,977**	**9,911**	**10,892**	
PER PATIENT DAY RATES					
Routine Home Care 0-60	212.42	212.42	212.42	212.42	Per day
Routine Home Care 61+	167.85	167.85	167.85	167.85	Per day
Respite Care	491.93	491.93	491.93	491.93	Per day
General Inpatient Care	1,113.39	1,113.39	1,113.39	1,113.39	Per day
Continuous Care	64.37	64.37	64.37	64.37	Per hour
GROSS REVENUE BY LEVEL OF CARE					
Routine Home Care 0-60	307,271	666,890	947,403	1,041,164	
Routine Home Care 61+	285,967	620,654	881,719	968,979	
Respite Care	15,813	34,320	48,756	53,582	
General Inpatient Care	17,895	38,839	55,176	60,636	
Continuous Care	22,452	48,729	69,226	76,077	
TOTAL	**649,399**	**1,409,433**	**2,002,281**	**2,200,438**	
PAYER MIX					
Medicare	90%	90%	90%	90%	
Medicaid	5%	5%	5%	5%	
Commercial/Other	5%	5%	5%	5%	
TOTAL	**100%**	**100%**	**100%**	**100%**	
GROSS REVENUE BY PAYER					
Medicare	586,601	1,273,138	1,808,656	1,987,651	
Medicaid	31,399	68,147	96,812	106,393	
Commercial/Other	31,399	68,147	96,812	106,393	
TOTAL	**649,399**	**1,409,433**	**2,002,281**	**2,200,438**	
STAFFING SUMMARY FTE					
CLINICAL OPERATIONS	**SALARY**				
Registered Nurse	114,400	0.88	1.91	2.72	2.98	1 per 10 ADC
Medical Social Worker	79,040	0.29	0.64	0.91	0.99	1 per 30 ADC
Hospice Aide	43,680	0.88	1.91	2.72	2.98	1 per 10 ADC
Spiritual Care Coord	59,155	1.00	1.00	2.00	2.00	Also Vol/bereavement
TOTAL		**3.05**	**5.46**	**8.34**	**8.96**	
ADMINISTRATIVE					
Administrator	117,300	0.50	0.50	0.50	0.50	Split between Whatcom/Skagit
Administrator Bonuses	24,000					Split between Whatcom/Skagit
Director of Patient Care	110,000	0.50	0.50	0.50	0.50	Split between Whatcom/Skagit
Clinical Manager	85,280	0.50	0.50	0.50	0.50	Split between Whatcom/Skagit
Business Office Manager	39,520	0.50	0.50	0.50	0.50	Split between Whatcom/Skagit
Clinical Support Specialist	47,840	1.00	1.00	1.00	1.00	Split between Whatcom/Skagit
Community Liaison	45,000	0.50	0.50	0.50	0.50	Split between Whatcom/Skagit
TOTAL		**3.50**	**3.50**	**3.50**	**3.50**	
TOTAL FTE'S		**6.55**	**8.96**	**11.84**	**12.46**	

Projected Statement of Operations
Eden Hospice at Whatcom County, LLC --Skagit

CENSUS	2023	2024	2025	2026
Patient Days	3,215	6,977	9,911	10,892
Average Daily Census	**8.81**	**19.11**	**27.15**	**29.84**
REVENUE				
Medicare	586,601	1,273,138	1,808,656	1,987,651
Medicaid	31,399	68,147	96,812	106,393
Commercial/Other	31,399	68,147	96,812	106,393
TOTAL GROSS REVENUE	**649,399**	**1,409,433**	**2,002,281**	**2,200,438**
Deductions from Revenue				
Contractual Allowances	(11,732)	(25,463)	(36,173)	(39,753)
Bad Debt	(9,741)	(14,094)	(20,023)	(22,004)
Charity Care Adj	(9,741)	(21,142)	(30,034)	(33,007)
TOTAL NET REVENUE	**618,185**	**1,348,735**	**1,916,050**	**2,105,674**
DIRECT CARE EXPENSE				
Ancillary Expenses				
Pharmacy Expense	16,073	34,884	49,557	54,461
Lab Expense	386	837	1,189	1,307
Xray Expense	257	558	793	871
Ambulance/Transportation Expense	1,286	2,791	3,965	4,357
DME Expense	20,894	45,349	61,946	68,076
TOTAL ANCILLARY EXPENSES	**38,896**	**84,418**	**117,449**	**129,072**
Home Services Expense				
Mileage Expense	8,904	19,325	27,454	30,171
Medical Supplies	13,983	30,349	43,114	47,381
RN Expense	100,751	218,667	310,645	310,645
Hospice Aide Expense	38,469	83,491	118,610	118,610
Spiritual Counselor Expense	59,155	59,155	103,522	103,522
GIP Expense	13,895	30,157	42,842	47,081
Respite Expense	6,125	13,294	18,886	20,756
SNF Room & Board Expense	4,608	10,001	14,207	15,613
Social Services Expense	23,203	50,360	71,542	71,542
Payroll Taxes & Benefits	66,474	123,502	181,296	181,296
TOTAL HOME SERVICES EXPENSE	**335,568**	**638,302**	**932,118**	**946,617**
Contract Labor				
Medical Director	22,502	48,837	69,379	76,245
Physical Therapy	161	349	496	545
Occupational Therapy	96	209	297	327
Speech Therapy	161	349	496	545
Dietary Consulting	289	628	892	980
TOTAL CONTRACT LABOR	**23,209**	**50,372**	**71,560**	**78,642**
TOTAL DIRECT CARE EXPENSES	**397,672**	**773,092**	**1,121,127**	**1,154,331**
Utilities	**3,372**	**3,372**	**3,372**	**3,372**
A&G EXPENSE				
Administrative Compensation				
Administrator	70,650	70,650	70,650	70,650
Director of Patient Care Services	55,000	55,000	55,000	55,000

Projected Statement of Operations
Eden Hospice at Whatcom County, LLC --Skagit

Clinical Manager	42,640	42,640	42,640	42,640
Business Office Manager	19,760	19,760	19,760	19,760
Authorizations	1,656	1,656	1,656	1,656
Clinical Support Specialist	47,840	47,840	47,840	47,840
Community Liaison	22,500	22,500	22,500	22,500
Payroll Taxes & Benefits	73,917	78,014	73,917	73,917
TOTAL ADMIN COMP EXPENSES	**333,963**	**338,060**	**333,963**	**333,963**
Administrative Expenses				
Contract Services	1,872	1,872	1,872	1,872
Office Supplies	1,200	1,200	1,200	1,200
Recruiting	3,000	3,000	3,066	3,066
Telephone/Internet	4,018	8,721	12,389	13,615
Licenses/Permits	1,856	1,856	1,856	1,856
Business Taxes	13,106	28,593	40,620	44,640
Bank Fees	-	-	-	-
Office Cleaning	-	-	-	-
Marketing Expense	30,600	30,600	30,600	30,600
TOTAL	**55,652**	**75,842**	**91,603**	**96,850**
TOTAL A&G EXPENSE	**389,615**	**413,902**	**425,566**	**430,813**
INSURANCE EXPENSE	1,428	1,440	1,440	1,440
TOTAL OPERATING EXPENSES	**792,087**	**1,191,805**	**1,551,505**	**1,589,956**
MANAGEMENT FEES	30,909	67,437	95,803	105,284
BUILDING LEASE	6,984	6,984	6,984	6,984
EBITDA	**(211,796)**	**82,509**	**261,758**	**403,450**
TOTAL DEPRECIATION & AMORTIZATIC	2,868	2,880.00	2,880.00	2,880.00
INTEREST EXPENSE	-	-	-	-
TOTAL NON OPERATING EXPENSES	**40,761**	**77,301**	**105,667**	**115,148**
TOTAL EXPENSES	**832,848**	**1,269,106**	**1,657,172**	**1,705,104**
NET INCOME (LOSS)	**(214,664)**	**79,629**	**258,878**	**400,570**

Balance Sheet
Eden Hospice at Whatcom County, LLC -- Skagit

ASSETS	2023	2024	2025	2026
Current Assets				
Cash & Cash Equivalents	(184,484)	(308,013)	(127,067)	244,022
Accounts Receivable (net)	103,031	224,789	319,342	350,946
Prepaid Expenses	-	-	-	-
Total Current Assets	**(81,454)**	**(83,224)**	**192,274**	**594,967**
Property and Equipment				
Fixed Assets	-	-	-	-
Accumulated Depreciation	2,868	2,880	2,880	2,880
Total Property and Equipment	**2,868**	**2,880**	**2,880**	**2,880**
Other Assets				
Intangibles	-	-	-	-
Loan Fees	-	-	-	-
Accumulated Amortization	-	-	-	-
Total Other Assets	**-**	**-**	**-**	**-**
TOTAL ASSETS	**(78,586)**	**(80,344)**	**195,154**	**597,847**
LIABILITIES AND CAPITAL				
Current Liabilities				
Accounts Payable & Accrued Expenses	9,789	17,501	23,518	25,527
Accrued Payroll & Related Payables	26,288	37,190	47,793	47,906
Notes Payable	-	-	-	-
Current Portion LT Debt	-	-	-	-
Total Current Liabilities	**36,078**	**54,691**	**71,311**	**73,433**
Long-Term Liabilities				
Long-Term Note Payable	-	-	-	-

	2023	2024	2025	2026
Less: Current Portion of LTD	-	-	-	-
Total Long-Term Liabilities	**-**	**-**	**-**	**-**
TOTAL LIABILITIES	**36,078**	**54,691**	**71,311**	**73,433**
Capital	100,000			
Retained Earnings	-	(214,664)	(135,035)	123,843
Shareholder Equity	-	-	-	-
Net Income	(214,664)	79,629	258,878	400,570
Total Capital	**(114,664)**	**(135,035)**	**123,843**	**524,414**
TOTAL LIABILITIES AND CAPITAL	**(78,586)**	**(80,344)**	**195,154**	**597,847**
Diff. Between Assets & Liab+Equity	(0)	0	(0)	(0)

Revenue Assumptions & Staffing Summary
Eden Hospice at Whatcom County, LLC

CENSUS		2023	2024	2025	2026	
Admissions		206	282	354	382	
Patient Days		12,141	17,248	21,650	23,364	
Average Daily Census		**33.26**	**47.25**	**59.31**	**64.01**	
STAFFING SUMMARY FTE						
CLINICAL OPERATIONS	**SALARY**					
Registered Nurse	114,400	3.33	4.73	5.93	6.40	1 per 10 ADC
Medical Social Worker	79,040	1.11	1.58	1.98	2.13	1 per 30 ADC
Hospice Aide	43,680	3.33	4.73	5.93	6.40	1 per 10 ADC
Spiritual Care Coord	59,155	1.00	1.00	2.00	2.00	Also Vol/bereavement
TOTAL		**8.76**	**12.03**	**15.84**	**16.94**	
ADMINISTRATIVE						
Administrator	117,300	1.00	1.00	1.00	1.00	
Administrator Bonuses	24,000					
Director of Patient Care	110,000	1.00	1.00	1.00	1.00	
Clinical Manager	85,280	1.00	1.00	1.00	1.00	
Business Office Manager	55,000	1.00	1.00	1.00	1.00	
Clinical Support Specialist	47,840	2.00	2.00	2.00	2.00	
Community Liaison	90,000	1.00	1.00	1.00	1.00	
TOTAL		**7.00**	**7.00**	**7.00**	**7.00**	
TOTAL FTE'S		**15.76**	**19.03**	**22.84**	**23.94**	

Projected Statement of Operations
Eden Hospice at Whatcom County, LLC

CENSUS	2023	2024	2025	2026
Patient Days	12,141	17,248	21,650	23,364
Average Daily Census	**33.26**	**47.25**	**59.31**	**64.01**
REVENUE				
Medicare	2,215,555	3,147,450	3,950,727	4,263,602
Medicaid	118,592	168,474	211,471	228,218
Commercial/Other	118,592	168,474	211,471	228,218
TOTAL GROSS REVENUE	**2,452,740**	**3,484,399**	**4,373,669**	**4,720,038**
Deductions from Revenue				
Contractual Allowances	(44,311)	(62,949)	(79,015)	(85,272)
Bad Debt	(36,791)	(34,844)	(43,737)	(47,200)
Charity Care Adj	(36,791)	(52,266)	(65,605)	(70,801)
TOTAL NET REVENUE	**2,334,847**	**3,334,340**	**4,185,313**	**4,516,765**
DIRECT CARE EXPENSE				
Ancillary Expenses				
Pharmacy Expense	60,705	86,239	108,249	116,821
Lab Expense	1,457	2,070	2,598	2,804
Xray Expense	971	1,380	1,732	1,869
Ambulance/Transportation Expense	4,856	6,899	8,660	9,346
DME Expense	78,917	112,111	135,311	146,027
TOTAL ANCILLARY EXPENSES	**146,907**	**208,699**	**256,549**	**276,866**
Home Services Expense				
Mileage Expense	33,631	47,776	59,970	64,719
Medical Supplies	52,814	75,028	94,176	101,634
RN Expense	100,751	218,667	310,645	310,645
Hospice Aide Expense	38,469	83,491	118,610	118,610
Spiritual Counselor Expense	59,155	59,155	103,522	103,522
GIP Expense	52,480	74,554	93,581	100,992
Respite Expense	23,135	32,867	41,255	44,522
SNF Room & Board Expense	17,403	24,724	31,034	33,491
Social Services Expense	23,203	50,360	71,542	71,542
Payroll Taxes & Benefits	66,474	123,502	181,296	181,296
TOTAL HOME SERVICES EXPENSE	**467,515**	**790,124**	**1,105,629**	**1,130,973**
Contract Labor				
Medical Director	84,988	120,735	151,548	163,550
Physical Therapy	607	862	1,082	1,168
Occupational Therapy	364	517	649	701
Speech Therapy	607	862	1,082	1,168
Dietary Consulting	1,093	1,552	1,948	2,103
TOTAL CONTRACT LABOR	**87,659**	**124,529**	**156,311**	**168,690**
TOTAL DIRECT CARE EXPENSES	**702,081**	**1,123,351**	**1,518,489**	**1,576,529**
Utilities	**6,732**	**6,732**	**6,732**	**6,732**
A&G EXPENSE				
Administrative Compensation				
Administrator	141,300	141,300	141,300	141,300
Director of Patient Care Services	110,000	110,000	110,000	110,000

Projected Statement of Operations
Eden Hospice at Whatcom County, LLC

Clinical Manager	85,280	85,280	85,280	85,280
Business Office Manager	55,000	55,000	55,000	55,000
Authorizations	3,312	3,312	3,312	3,312
Clinical Support Specialist	47,840	47,840	47,840	47,840
Community Liaison	90,000	90,000	90,000	90,000
Payroll Taxes & Benefits	165,978	165,978	165,978	165,978
TOTAL ADMIN COMP EXPENSES	**698,710**	**698,710**	**698,710**	**698,710**
Administrative Expenses				
Contract Services	1,872	1,872	1,872	1,872
Office Supplies	1,200	1,200	1,200	1,200
Recruiting	3,000	3,000	3,066	3,066
Telephone/Internet	15,176	21,560	27,062	29,205
Licenses/Permits	1,856	1,856	1,856	1,856
Business Taxes	49,499	70,688	88,729	95,755
Bank Fees	-	-	-	-
Office Cleaning	-	-	-	-
Marketing Expense	30,600	30,600	30,600	30,600
TOTAL	**103,203**	**130,776**	**154,385**	**163,555**
TOTAL A&G EXPENSE	**801,913**	**829,486**	**853,095**	**862,265**
INSURANCE EXPENSE	2,856	2,856	2,856	2,856
TOTAL OPERATING EXPENSES	**1,513,582**	**1,962,425**	**2,381,172**	**2,448,381**
MANAGEMENT FEES	116,742	166,717	209,266	225,838
BUILDING LEASE	13,968	17,814	21,948	22,536
EBITDA	**(211,796)**	**80,586**	**257,768**	**399,166**
TOTAL DEPRECIATION & AMORTIZATIC	5,736	5,736	5,736	5,736
INTEREST EXPENSE	-	-	-	-
TOTAL NON OPERATING EXPENSES	**136,446**	**190,267**	**236,950**	**254,110**
TOTAL EXPENSES	**1,650,029**	**2,152,692**	**2,618,122**	**2,702,492**
NET INCOME (LOSS)	**684,818**	**1,181,648**	**1,567,191**	**1,814,274**

Balance Sheet
Eden Hospice at Whatcom County, LLC

ASSETS	2023	2024	2025	2026
Current Assets				
Cash & Cash Equivalents	463,383	1,399,805	2,845,132	4,607,874
Accounts Receivable (net)	389,141	555,723	697,552	752,794
Prepaid Expenses	-	-	-	-
Total Current Assets	**852,524**	**1,955,528**	**3,542,684**	**5,360,668**
Property and Equipment				
Fixed Assets	-	-	-	-
Accumulated Depreciation	2,868	2,880	2,880	2,880
Total Property and Equipment	**2,868**	**2,880**	**2,880**	**2,880**
Other Assets				
Intangibles	-	-	-	-
Loan Fees	-	-	-	-
Accumulated Amortization	-	-	-	-
Total Other Assets	**-**	**-**	**-**	**-**
TOTAL ASSETS	**855,392**	**1,958,408**	**3,545,564**	**5,363,548**
LIABILITIES AND CAPITAL				
Current Liabilities				
Accounts Payable & Accrued Expenses	28,058	38,540	47,562	51,074
Accrued Payroll & Related Payables	42,516	53,403	64,346	64,543
Notes Payable	-	-	-	-
Current Portion LT Debt	-	-	-	-
Total Current Liabilities	**70,574**	**91,942**	**111,907**	**115,617**
Long-Term Liabilities				
Long-Term Note Payable	-	-	-	-

Less: Current Portion of LTD	-	-	-	-
Total Long-Term Liabilities	**-**	**-**	**-**	**-**
TOTAL LIABILITIES	**70,574**	**91,942**	**111,907**	**115,617**
Capital	100,000			
Retained Earnings	-	684,818	1,866,466	3,433,657
Shareholder Equity	-	-	-	-
Net Income	684,818	1,181,648	1,567,191	1,814,274
Total Capital	**784,818**	**1,866,466**	**3,433,657**	**5,247,931**
TOTAL LIABILITIES AND CAPITAL	**855,392**	**1,958,408**	**3,545,564**	**5,363,548**
Diff. Between Assets & Liab+Equity	0	(0)	0	(0)

Projected Statement of Operations
Eden Hospice at Whatcom County, LLC

CENSUS	2023	2024	2025	2026
Patient Days	12,141	17,248	21,650	23,364
Average Daily Census	**33.26**	**47.25**	**59.31**	**64.01**
REVENUE				
Medicare	2,215,555	3,147,450	3,950,727	4,263,602
Medicaid	118,592	168,474	211,471	228,218
Commercial/Other	118,592	168,474	211,471	228,218
TOTAL GROSS REVENUE	**2,452,740**	**3,484,399**	**4,373,669**	**4,720,038**
Deductions from Revenue				
Contractual Allowances	(44,311)	(62,949)	(79,015)	(85,272)
Bad Debt	(36,791)	(34,844)	(43,737)	(47,200)
Charity Care Adj	(36,791)	(52,266)	(65,605)	(70,801)
TOTAL NET REVENUE	**2,334,847**	**3,334,340**	**4,185,313**	**4,516,765**
DIRECT CARE EXPENSE				
Ancillary Expenses				
Pharmacy Expense	60,705	86,239	108,249	116,821
Lab Expense	1,457	2,070	2,598	2,804
Xray Expense	971	1,380	1,732	1,869
Ambulance/Transportation Expense	4,856	6,899	8,660	9,346
DME Expense	78,917	112,111	135,311	146,027
TOTAL ANCILLARY EXPENSES	**146,907**	**208,699**	**256,549**	**276,866**
Home Services Expense				
Mileage Expense	33,631	47,776	59,970	64,719
Medical Supplies	52,814	75,028	94,176	101,634
RN Expense	100,751	218,667	310,645	310,645
Hospice Aide Expense	38,469	83,491	118,610	118,610
Spiritual Counselor Expense	59,155	59,155	103,522	103,522
GIP Expense	52,480	74,554	93,581	100,992
Respite Expense	23,135	32,867	41,255	44,522
SNF Room & Board Expense	17,403	24,724	31,034	33,491
Social Services Expense	23,203	50,360	71,542	71,542
Payroll Taxes & Benefits	66,474	123,502	181,296	181,296
TOTAL HOME SERVICES EXPENSE	**467,515**	**790,124**	**1,105,629**	**1,130,973**
Contract Labor				
Medical Director	84,988	120,735	151,548	163,550
Physical Therapy	607	862	1,082	1,168
Occupational Therapy	364	517	649	701
Speech Therapy	607	862	1,082	1,168
Dietary Consulting	1,093	1,552	1,948	2,103
TOTAL CONTRACT LABOR	**87,659**	**124,529**	**156,311**	**168,690**
TOTAL DIRECT CARE EXPENSES	**702,081**	**1,123,351**	**1,518,489**	**1,576,529**
Utilities	**6,732**	**6,732**	**6,732**	**6,732**
A&G EXPENSE				
Administrative Compensation				
Administrator	141,300	141,300	141,300	141,300
Director of Patient Care Services	110,000	110,000	110,000	110,000
Clinical Manager	85,280	85,280	85,280	85,280
Business Office Manager	55,000	55,000	55,000	55,000
Authorizations	3,312	3,312	3,312	3,312
Clinical Support Specialist	47,840	47,840	47,840	47,840
Community Liaison	90,000	90,000	90,000	90,000
Payroll Taxes & Benefits	165,978	165,978	165,978	165,978
TOTAL ADMIN COMP EXPENSES	**698,710**	**698,710**	**698,710**	**698,710**
Administrative Expenses				
Contract Services	1,872	1,872	1,872	1,872
Office Supplies	1,200	1,200	1,200	1,200
Recruiting	3,000	3,000	3,066	3,066
Telephone/Internet	15,176	21,560	27,062	29,205
Licenses/Permits	1,856	1,856	1,856	1,856
Business Taxes	49,499	70,688	88,729	95,755
Bank Fees	-	-	-	-
Office Cleaning	-	-	-	-
Marketing Expense	30,600	30,600	30,600	30,600
TOTAL	**103,203**	**130,776**	**154,385**	**163,555**
TOTAL A&G EXPENSE	**801,913**	**829,486**	**853,095**	**862,265**
INSURANCE EXPENSE	2,856	2,856	2,856	2,856
TOTAL OPERATING EXPENSES	**1,513,582**	**1,962,425**	**2,381,172**	**2,448,381**
MANAGEMENT FEES	116,742	166,717	209,266	225,838
BUILDING LEASE	13,968	17,814	21,948	22,536
EBITDA	**(211,796)**	**80,586**	**257,768**	**399,166**
TOTAL DEPRECIATION & AMORTIZATIO	5,736	5,736	5,736	5,736
INTEREST EXPENSE	-	-	-	-
TOTAL NON OPERATING EXPENSES	**136,446**	**190,267**	**236,950**	**254,110**
TOTAL EXPENSES	**1,650,029**	**2,152,692**	**2,618,122**	**2,702,492**
NET INCOME (LOSS)	**684,818**	**1,181,648**	**1,567,191**	**1,814,274**

Projected Statement of Operations
EXISTING HOSPICE OPERATIONS 3 YEAR HISTORICAL

	2020	2021	2022
TOTAL GROSS REVENUE	**7,485,161**	**9,276,322**	**12,665,154**
TOTAL NET REVENUE	**7,443,078**	**9,276,392**	**12,536,447**
TOTAL EXPENSES	**6,575,181**	**8,699,079**	**12,168,331**
NET INCOME (LOSS)	**867,897**	**577,313**	**368,116**

Projected Statement of Operations
EXISTING HOSPICE OPERATION PLUS EDEN HOSPICE AT WHATCOM COUNTY, LLC and Spokane

	2023	2024	2025	2026
TOTAL GROSS REVENUE	**14,671,746**	**17,645,910**	**22,408,561**	**28,089,281**
TOTAL NET REVENUE	**14,494,560**	**17,363,372**	**21,944,786**	**27,390,887**
TOTAL EXPENSES	**14,066,763**	**16,858,467**	**20,894,501**	**24,838,080**
NET INCOME (LOSS)	**427,797**	**504,906**	**1,050,285**	**2,552,806**

ASSUMPTIONS

2% sequestration was paused for part of 2020, all of 2021 and part of 2022 due to COVID
2021/2022 has a number of Hospice start-up Agencies which is why net income declined
2022 is annualized data through October 2022
New WA operations in 2023 forward include Whatcom-Skagit, King-Pierce and Eden Ihospice oof Inland Northwest
Start datess for King, Snohomish and Skagit are Jan 2023 with Eden Hospice at Inland Northwest Oct 2023
By January a total of 8 out of 10 hospices are active in Western States and included in the Special P & L and Balance Sheet

Balance Sheet
All Hospice Balance Sheet, LLC

ASSETS	2023	2024	2025	2026
Current Assets				
Cash & Cash Equivalents	680,764	1,613	502,145	2,824,171
Accounts Receivable (net)	2,430,141	3,041,553	4,112,038	5,512,401
Prepaid Expenses	-	-	-	-
Total Current Assets	**3,110,904**	**3,043,166**	**4,614,182**	**8,336,572**
Property and Equipment				
Fixed Assets	714,028	902,037	1,183,592	1,474,577
Accumulated Depreciation	142,806	180,407	236,718	294,915
Total Property and Equipment	571,222	721,630	946,873	1,179,662
Other Assets				
Intangibles	-	-	-	-
Loan Fees	-	-	-	-
Accumulated Amortization	-	-	-	-
Total Other Assets	**-**	**-**	**-**	**-**
TOTAL ASSETS	**3,253,710**	**3,223,574**	**4,850,901**	**8,631,488**
LIABILITIES AND CAPITAL				
Current Liabilities				
Accounts Payable & Accrued Expenses	1,047,241	1,322,988	1,735,934	2,162,713
Accrued Payroll & Related Payables	321,313	405,917	532,616	663,560
Notes Payable	-	-	-	-
Current Portion LT Debt	-	-	-	-
Total Current Liabilities	**1,368,554**	**1,728,905**	**2,268,551**	**2,826,273**
Long-Term Liabilities				
Long-Term Note Payable	-	-	-	-
Less: Current Portion of LTD	-	-	-	-
Total Long-Term Liabilities	**-**	**-**	**-**	**-**
TOTAL LIABILITIES	**1,368,554**	**1,728,905**	**2,268,551**	**2,826,273**
Capital	300,000	300,000	300,000	300,000
Retained Earnings	1,585,156	1,194,669	2,282,350	5,505,215
Shareholder Equity	-	-	-	-
Total Capital	**1,885,156**	**1,494,669**	**2,582,350**	**5,805,215**
TOTAL LIABILITIES AND CAPITAL	**3,253,710**	**3,223,574**	**4,850,901**	**8,631,488**
Diff. Between Assets & Liab+Equity	-	-	-	-

Total Depreciation Expense was set at 1% of Total Expense per Year with an assumed overall 5-year aggregate life.
Accounts Reeivable was set 60 DAYS of net revenue.
Accounts Payable was calculated to be 44% of Total Expense with a 30-day payment schedule
Payroo Payables were calculated at 55% of Total Expense with a twice a month payment 1/24.

WASHINGTON PATIENT BILL OF RIGHTS

Patients have the right to:

1. Receive effective pain management and symptom control and quality services from Eden Hospice for services identified in the plan of care;
2. Be cared for by appropriately trained or credentialed personnel, contractors, and volunteers with coordination of services;
3. A statement advising of the right to ongoing participation in the development of the plan of care;
4. Choose his or her attending physician;
5. A statement advising of the right to have access to the department's listing of licensed hospice agencies and to select any licensee to provide care, subject to the individual's reimbursement mechanism or other relevant contractual obligations;
6. A listing of the total services offered by the hospice agency and those being provided to the patient;
7. Refuse specific services;
8. The name of the individual within Eden Hospice responsible for supervising the patient's care and the manner in which that individual may be contacted;
9. Be treated with courtesy, respect, and privacy;
10. Be free from verbal, mental, sexual, and physical abuse, neglect, exploitation, discrimination, and the unlawful use of restraint or seclusion;
11. Have property treated with respect;
12. Privacy and confidentiality of personal information and health care related records;
13. Be informed of what Eden Hospice charges for services, to what extent payment may be expected from health insurance, public programs, or other sources, and what charges the patient may be responsible for paying;
14. A fully itemized billing statement upon request, including the date of each service and the charge. Agencies providing services through a managed care plan are not required to provide itemized billing statements;
15. Be informed about advanced directives and POLST and Eden Hospice's scope of responsibility;
16. Be informed of Eden Hospice's policies and procedures regarding the circumstances that may cause the agency to discharge a patient;
17. Be informed of Eden Hospice's policies and procedures for providing backup care when services cannot be provided as scheduled;
18. A description of Eden Hospice's process for patients and family to submit complaints to Eden Hospice about the services and care they are receiving and to have those complaints addressed without retaliation;
19. Be informed of the department's complaint hotline number (1-800-562-6078) to report complaints about the licensed agency or credentialed health care professionals; and
20. Be informed of the DSHS end harm hotline number (1-866-363-4276) to report suspected abuse of children or vulnerable adults.
21. Eden Hospice must ensure that the patient rights under this section are implemented and updated as appropriate.

SKAGIT COUNTY HOSPICE VOLUME PROJECTION		Market Potential	2023	2024	2025	2026
Eden Hospice -- Skagit County Admission Projections						
Total Hospice Patients		**40**	**54**	**114**	**162**	**178**
New Patient Referrals through Outreach						
FFS Dual -Eligible Medicare	Outreach to FMQCs -- 12 centers	**Market Potential**				
FFS Raise dual-eligible to county non -dual rate- new underserved cohort	36% in 2023,42% in 2024, 48% in 2025 50% in 2026	38	12	16	18	19
Continue outreach to Choice patient Cohort	Referrals through EmpRes home health and word of mouth	45	41	43	44	45
Control over end-of-life including Death with Dignity	General and Death with Dignity patients -- new patients concerned about end of life control	10	3	4	5	6
Increase SNF Referrals duals & non-duals, new underserved cohort (large Medicaid cohort)	Based on Eden, Bethany and national best practices vs. actual per Whatcom County	18	12	16	18	19
Subtotal: Reducing Disparity Among Population Cohorts Through Outreach		**111**	**68**	**79**	**85**	**89**
Eden Hospice -- Skagit County Needed in Addition to Underserved Population Cohorts						
Other Patients -- VA, LGBQT, Hospital Referrals, Minority etc. (Need and Surplus (-) Hospice Patients			**-14**	**35**	**77**	**89**
Hospice Patient Admissions from Population Growth						
Total New Patients from Population Growth Only - State Methodology	**State methodology projected forward using OFM population estimates**		**50**	**75**	**100**	**121**
Net Duplicated Need or Surplus (--)						
Net Duplicated Need or Surplus (--)			**-64**	**-40**	**-23**	**-32**

APPENDIX N

Reference#	19009
Effective:	08/10/2020
Last Revised:	08/10/2020

DEATH WITH DIGNITY ACT POLICY

PURPOSE:

- To respect the patient's wishes about his/her end-of-life care, treatment, and services in accordance with usual and acceptable standards of practice, ethics, and applicable state and federal law including state specific "Death with Dignity" acts.

POLICY:

1. Eden Health recognizes applicable state laws, commonly known as the Death with Dignity Act ("The Act"), that recognizes a qualified person's right to end his or her life through the voluntary self-administration of lethal medications, prescribed by a physician for that purpose.

2. A qualified person is defined in the Death with Dignity Act or the state in which the person demonstrates residency.

3. If a patient elects to participate in the Death with Dignity Act of a participating state, Eden Health employees and Volunteers are limited to providing information/education and will not provide, deliver, prepare, administer, assist, or participate in any manner with the administration/consumption of any medication prescribed or obtained for intended use under The Act. Upon the patient's request, Eden Health employees may be present during, but not assist in The Act in any way as outlined above.

4. Eden Health does not take any disciplinary or discriminatory action against health care providers for providing to their patients medically accurate information within scope as described, or information relating to the Death with Dignity Act.

PROCEDURE:

1. Should a patient request information regarding the Death with Dignity Act:

- **a.** Eden Health employees will provide medically accurate information within their scope and refer the patient to the patient's attending physician and/or appropriate community resources.
- **b.** Eden Health employees and volunteers will continue to provide care within the scope of services the patient has elected.

2. Should a patient make it known that he or she has requested participation or is a participant in the Death with Dignity Act:

- **a.** Eden Health employees and volunteers will continue to provide care within the scope of his or her professional role and consistent with the services the patient has elected.
- **b.** Any questions or discussion specific to The Act shall be referred back to the patient's attending physician and/or appropriate community resource.

   c. Hospice physicians employed or contracted under Eden Hospice may choose to act as the consulting physician to document terminal prognosis and decisional capacity.

3. If a patient resides in a facility, Eden Health employees will coordinate with the patient and facility to honor the facility policy regarding The Act.
   a. If the patient must change their place of residence relating to The Act, Eden Health employees and volunteers will continue to provide care within the scope of his or her professional role and consistent with the services the patient has elected.

4. If a patient should choose to stop eating or drinking or taking medication with an intended outcome similar to that under the Death with Dignity Act, Eden Health employees and volunteers will continue to provide care and support consistent with services, but may not provide, administer, or assist with administering any medication to hasten the patient's death nor knowingly participate in any activity hastening the patient's death.

5. If a patient states an intention to participate in the Death with Dignity Act, any Eden Health employee or volunteer morally opposed to The Act will have the option of transferring care responsibilities of the patient to another staff member per the *Staff Rights and Ethical Dilemmas in Patient Care Policy*.
   a. A nurse on-call may need to respond to a patient's immediate needs for care if there is no other nurse immediately available.

6. If an Eden Health employee or volunteer is contacted by a patient's family or caregiver or arrives after a patient has taken his or her medication under the Death with Dignity Act, the employee or volunteer will provide care and/or notify his or her direct supervisor as appropriate to the employee or volunteer's role. An Eden Health nurse shall not administer any comfort medications after the patient has taken the medications prescribed for intended use under The Act.
   a. If an Eden Health nurse present at the time determines the patient is in discomfort, they will contact the attending physician or Hospice Medical Director for further instruction.

7. All care provided to the patient will be documented within the clinical record.

8. For patients receiving hospice services, bereavement care will continue to be provided for the bereaved as identified by the bereavement plan of care and consistent with hospice services. Bereavement services will also be offered to employees/volunteers and consistent with hospice support services.

eden HEALTH HOSPICE
100% Employee Owned

Eden Hospice at Whatcom County, LLC

316 McLeod Rd., Ste. 104 Bellingham, WA 98226-6491 | Phone:360-966-8593 | Fax:360-966-8926

December 28, 2022

Eric Hernandez, Program Manager
Certificate of Need Program
Washington State Department of Health
111 Israel Road SE Tumwater, WA 98501

RE: Eden Hospice at Whatcom County, LLC Certificate of Need Application to add Skagit County

Dear Mr. Hernandez:

The Certificate of Need program's application instructions for a Medicare-certified hospice agency asks for a financial letter of commitment. The Members of Eden Hospice at Whatcom County, LLC have committed the necessary working capital to finance the expansion of hospice services to Skagit County.

On receipt of the Washington Certificate of Need, the members of Eden Hospice at Whatcom County, LLC will contribute sufficient funds, currently estimated at approximately $100,000, to the working capital account of Eden Hospice at Whatcom County, LLC.

Sincerely,

Michael J. Miller
Chief Financial Office
EmpRes Healthcare Management, LLC

APPENDIX Q

2021 Utilization Rates

Race

Skagit County					
Gray = Less than 11 Suppression				Additional Admissions	
Race	Hospice Admits 2021	Deaths of Beneficiaries	Utilization Rate	@ State Average	@ National Average
White	639	1,185	53.9%	-	31
Black			33.3%	-	-
Asian			50.0%	-	-
Hispanic or Latino			27.8%	-	-
North American Native			30.8%	-	-
Other			40.0%	-	-
Unknown			46.2%	-	-
Total	664	1,252	53.0%	-	31
Total Suppressed Racial and Ethnic Admissions	25	67	37%		
Total Suppressed Racial and Ethnic Admissions Based on Disparity Rate Adjustment	**4**	**11**	**17%**		

Dual and Non-Dual

Skagit County			
Race	Hospice Admissions 2021	Deaths of Beneficiaries	Utilization Rate
Dual	117	273	42.9%
Non-Dual	547	979	55.9%
Total	664	1,252	53.0%
PercentDual Utilization Lower than NonDual Utilization			**23.3%**

Skagit County					
Additional Admissions			Dual Eligible @		
@ State Average	@ National Average		County Non-Dual Rate	State Non-Dual Rate	National Non-Dual Rate
-	16		36	19	34
-	-		-	-	-
-	**16**		**36**	**19**	**34**

Washington State

Race	Hospice Admits 2021	Deaths of Beneficiaries	Utilization Rate
White	23,576	48,081	49.0%
Black	546	1,560	35.0%
Asian	723	1,774	40.8%
Hispanic or Latino	208	643	32.3%
North American Native	252	690	36.5%
Other	457	1,153	39.6%
Unknown	274	738	37.1%
Total	26,036	54,639	47.7%

Washington State

Race	Hospice Admissions 2021	Deaths of Beneficiaries	Utilization Rate
Dual			41.4%
Non-Dual			49.7%
Total	26,036	54,639	47.7%

National

Race	Hospice Admits 2021	Deaths of Beneficiaries	Utilization Rate
White	######	2,224,293	56.5%
Black	######	307,067	42.5%
Asian	23,508	53,682	43.8%
Hispanic or Latino	32,539	76,070	42.8%
North American Native	5,858	15,198	38.5%
Other	19,742	44,741	44.1%
Unknown	11,199	27,457	40.8%
Total	######	2,748,508	53.9%

National

Race	Hospice Admissions 2021	Deaths of Beneficiaries	Utilization Rate
Dual			48.9%
Non-Dual			55.4%
Total	1,480,326	2,748,508	53.9%

IDEAS
ACTION
RESULTS

Integrating Care for Beneficiaries Eligible for Medicare and Medicaid: An Update

WHITE PAPER

APRIL 2020

Bipartisan Policy Center

APPENDIX S

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HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC's Health Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The project focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

ADVISORS

The Bipartisan Policy Center staff produced this white paper in collaboration with a distinguished group of senior advisors and experts, including Sheila Burke, Jim Capretta, and Chris Jennings. BPC would also like to thank Henry Claypool and Tim Westmoreland for their contributions to this white paper.

ACKNOWLEDGMENTS

BPC would like to thank Arnold Ventures for its generous support.

DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of BPC's founders or its board of directors.

Table of Contents

Glossary of Terms

Activities of Daily Living (ADLs)

Assistant Secretary for Planning and Evaluation (ASPE)

Center for Medicare and Medicaid Innovation (CMMI)

Centers for Disease Control and Prevention (CDC)

Centers for Medicare and Medicaid Services (CMS)

Children's Health Insurance Program (CHIP)

Calendar Year (CY)

Dual-Eligible Special Needs Plan (D-SNP)

Fee-for-service (FFS)

Financial Alignment Initiative (FAI)

Fully-Integrated Dual-Eligible Special Needs Plan (FIDE-SNP)

Highly-Integrated Dual-Eligible Special Needs Plan (HIDE-SNP)

Long-Term Services and Supports (LTSS)

Managed Long-Term Services and Supports (MLTSS)

Medicaid and CHIP Payment and Access Commission (MACPAC)

Medicare Advantage (MA)

Medicare Payment and Advisory Commission (MedPAC)

Medicare-Medicaid Coordination Office (MMCO)

Medicare-Medicaid Plan (MMP)

Program of All-Inclusive Care for the Elderly (PACE)

U.S. Department of Health and Human Services (HHS)

Overview

The Bipartisan Policy Center is continuing its efforts to improve quality of care through the integration of Medicare and Medicaid services for individuals who are eligible for both programs.[i] These Medicare-Medicaid beneficiaries, commonly known as "dual-eligible individuals," must navigate two separate programs with different benefits and eligibility requirements. For most individuals, this would be daunting, but for dual-eligible individuals and their families, who are often dealing with chronic conditions and functional limitations, these challenges can be overwhelming.

In August of 2019, BPC began work on policy recommendations to improve care for dual-eligible individuals. In recent months however, the COVID-19 outbreak has become an immediate threat to this vulnerable population. According to the Centers for Disease Control and Prevention (CDC), older adults, especially those above age 65, and individuals of any age with serious underlying medical conditions, such as lung disease, heart conditions, and those undergoing cancer treatment, are at a higher risk of experiencing severe cases of COVID-19.[1] Additionally, individuals living in nursing homes or long-term care facilities are at increased risk of exposure to the virus. Because many dual-eligible individuals fall into one or more of the CDC's high-risk categories, we believe it is necessary to broaden the scope of the project to include recommendations to limit exposure to COVID-19 for this population. While not directly addressed in this white paper, we hope to include recommendations based on stakeholder feedback in our final report.

In recent years, policymakers have sought to better integrate Medicare and Medicaid services for the estimated 12.2 million dual-eligible individuals. [ii] [2] When done well, clinical health, behavioral health,

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i Previous reports from the Bipartisan Policy Center that address dual-eligible individuals include: *Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid*, September 2016. *A Policy Roadmap for Individuals with Complex Care Needs*, Jan 2018. *Next Steps in Chronic Care: Expanding Innovative Medicare Benefits*, Jul 2019.

ii For the purposes of this paper, when we use the term "integration" we are referring to alignment of Medicare and Medicaid program administrative requirements, financing, benefits, and care delivery. Integration may also mean that Medicare and Medicaid services are coordinated and are provided seamlessly to an eligible individual through a single point of contact.

social services, and LTSS are coordinated and provided seamlessly to an eligible individual. Integration efforts have included establishing the Medicare-Medicaid Coordination Office (MMCO) to coordinate programs within the Centers for Medicare & Medicaid Services (CMS), permanent authorization of Medicare Advantage plans designed to serve dual-eligible individuals, facilitating integration by states, and establishing demonstration programs. Many stakeholders, however, believe that more should be done to integrate care.

Integration for dual-eligible individuals is especially challenging, given the heterogeneity of the population and the unique and significant needs of the various sub-populations. Many have multiple chronic conditions and may need assistance with activities of daily living, or ADLs, such as bathing or dressing.[3] They may have mental illnesses, cognitive impairments, physical limitations, or a combination of these conditions. While the majority are older Americans, 39% of dual-eligible individuals are under age 65,[4] and less than 10% are enrolled in programs or care models that integrate Medicare and Medicaid services. [5]

This is the first of two white papers on the integration of care for dual-eligible individuals. The purpose of this paper is to provide necessary background on this population of low-income Medicare beneficiaries. The paper discusses important demographics, eligibility for Medicare and Medicaid, covered services under each program, and the implications of being enrolled in both programs. It also discusses different types of integration of Medicare and Medicaid services, and how state and federal policymakers have worked to make the programs function better for those who are enrolled, what has worked, and what has not. The second white paper provides options for consideration by state and federal policymakers, as well as stakeholders representing consumers, providers, and plans. BPC will issue final recommendations in the summer of 2020 and is seeking comments on the second paper.

Background on Dual-Eligible Individuals

To understand challenges associated with integrating care for dual-eligible individuals, it is helpful to review key characteristics of the population, the pathways to becoming a dual-eligible individual, how the programs are administered, and what services are covered by both programs. The following is designed to provide the necessary background on these issues.

Medicare Eligibility and Benefits

In 2018, approximately 85% of the nearly 60 million Medicare beneficiaries qualified for Medicare on the basis of age.[6] The remaining 15% were eligible based on disability.[7] For those with disabilities, Medicare eligibility is triggered for individuals who qualify for Social Security Disability Income payments for a permanent disability for at least 24 months.[8] Individuals may also qualify for Medicare coverage based on a diagnosis of End-Stage Renal Disease.[9] These individuals qualify for Medicare irrespective of their age, but make up only about one percent of the Medicare population. [10]

Medicare covers clinical health services such as inpatient hospitalization, professional office visits, outpatient surgical procedures, and in certain circumstances, home health care, skilled nursing facility care, rehabilitation services and other services. Medicare is divided into four parts, with different financing and cost-sharing requirements:[11]

- Medicare Part A is financed through employer and employee payroll taxes and generally covers inpatient services and limited stays at skilled nursing facilities.[12]
- Medicare Part B – for which individuals pay a monthly premium that covers the majority of Part B costs – covers professional services furnished by physicians and other non-physician practitioners, hospital outpatient facility and ambulatory surgical center services, certain home health services, dialysis services, and clinical-laboratory services.[13]
- Medicare Part C is Medicare's managed care program, known as Medicare Advantage, which covers services covered under Parts A, B, and may also cover Part D services, as outlined below.

- Medicare Part D covers prescription drugs and is offered through Medicare Advantage health plans or as a stand-alone plan for those who choose to remain in Medicare fee-for-service.[14]

Total Medicare spending for calendar year 2018 was $741 billion for all beneficiaries.[15] Net spending, when taking into account beneficiary premiums and cost-sharing, was $605 billion in 2018.[16]

Medicaid Eligibility and Benefits

Medicaid is a joint federal-state program that provided health care coverage to an estimated 86.7 million low-income individuals in FY 2018.[17] Medicaid serves low-income children and their parents, pregnant women, people with disabilities, and individuals age 65 and older.[18] In the 37 states, including the District of Columbia, that have expanded Medicaid eligibility under the Affordable Care Act, other low-income adults with incomes up to 138% of the federal poverty level are also covered.[19] Total Medicaid spending was $621 billion in FY 2018 for all beneficiaries. [20]

Medicare beneficiaries qualify for Medicaid if they have low incomes and are aged, blind, or have a disabling condition. For dual-eligible individuals who receive full benefits, the Medicaid program covers clinical health services that are not covered by Medicare, as well as non-clinical services, such as targeted case-management services and transportation to medical appointments. States must cover certain mandatory benefits under Medicaid, while other services are optional. Medicaid covers long-term services and supports (LTSS), which include services to address beneficiaries' deficits in ADLs in either an institutional setting for nursing facility residents or through personal-care services and other home and community-based services. [21]

Dual-Eligible Individuals

While most dual-eligible individuals are over age 65, there are 39% under age 65.[22] About half of dual-eligible individuals first qualify for Medicare based on disability and about half qualify when they turn age 65.[23] The proportion of all individuals who qualify for Medicare based on disability and who are also eligible for Medicaid has grown from 44.3% in 2006 to 52.3% in 2018, according to the Medicare-Medicaid Coordination Office (MMCO) at the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services, or CMS.[24]

Dual-eligible individuals tend to have poorer health and functional status than those eligible for Medicare only. According to the MMCO, 41% have at least one mental health diagnosis, 49% receive LTSS and 60% have multiple

chronic conditions.[25] The average dual-eligible individual receiving full Medicare and Medicaid benefits has six chronic conditions, while all other Medicare beneficiaries average only four.[26] Depression and Alzheimer's disease or related dementia were among the most prevalent conditions for full-benefit dual-eligible individuals.[27] As a result, those with multiple chronic conditions typically have higher utilization of services, such as emergency room visits, hospitalizations, and eventual need for LTSS. Accordingly, the HHS Office of the Assistant Secretary for Planning and Evaluation, or ASPE, has found that dual-eligible status was the most powerful predictor of poor Medicare outcomes among social risk factors.[28]

Dual-eligible individuals are also more likely to have greater limitations in ADLs than non-dual eligible individuals.[29] In 2016, 26% of dual-eligible individuals had limitations in one to two ADLs, compared to 18% of non-dual eligible individuals and 28% had limitations in three to six ADLs, compared to 9% of non-dual-eligible individuals.[30] As a result, dual-eligible individuals are among the most medically complex individuals and often have wide-ranging health care needs that require additional services and supports.[31]

Eligibility and Benefits

While all dual-eligible individuals are eligible for Medicare, their Medicaid benefits vary based on income. Full-benefit dual-eligible individuals are entitled to the full-range of medically-necessary Medicare benefits, as well as medically-necessary benefits covered under the Medicaid state plan. In 2018, full-benefit individuals numbered 8.7 million, or 71% of total dual-eligible individuals.[32] Partial-benefit individuals, typically with incomes at or slightly above the federal poverty level, are eligible for all Medicare-covered services, but their Medicaid benefits are limited to the assistance with Medicare premiums, deductibles, and copays through the Medicare Savings Program. They are not eligible for Medicaid-covered services.[33]

Many low-income Medicare beneficiaries who qualify as partial-benefit dual-eligible individuals are not enrolled in the Medicare Savings Program.[34] The cost of Medicare premiums, deductibles and co-payments may create a barrier to accessing care. In 2018, there were 3.5 million partial-benefit dual-eligible individuals, or 29% of total dual-eligible individuals.[35] Between 2006 and 2018, the total number of full-benefit and partial-benefit dual-eligible individuals has grown on average each year by 2.9%.[36]

For full-benefit dual-eligible beneficiaries, Medicare is the primary payer of acute care and clinical health services. Medicare covers clinical health services such as hospitalization, physician office visits, surgical procedures, and in certain circumstances, skilled home health care, skilled nursing

facility care, and rehabilitation services.[37] Medicaid is then responsible for covering Medicare premiums, cost-sharing, long-term care services and certain behavioral health services.

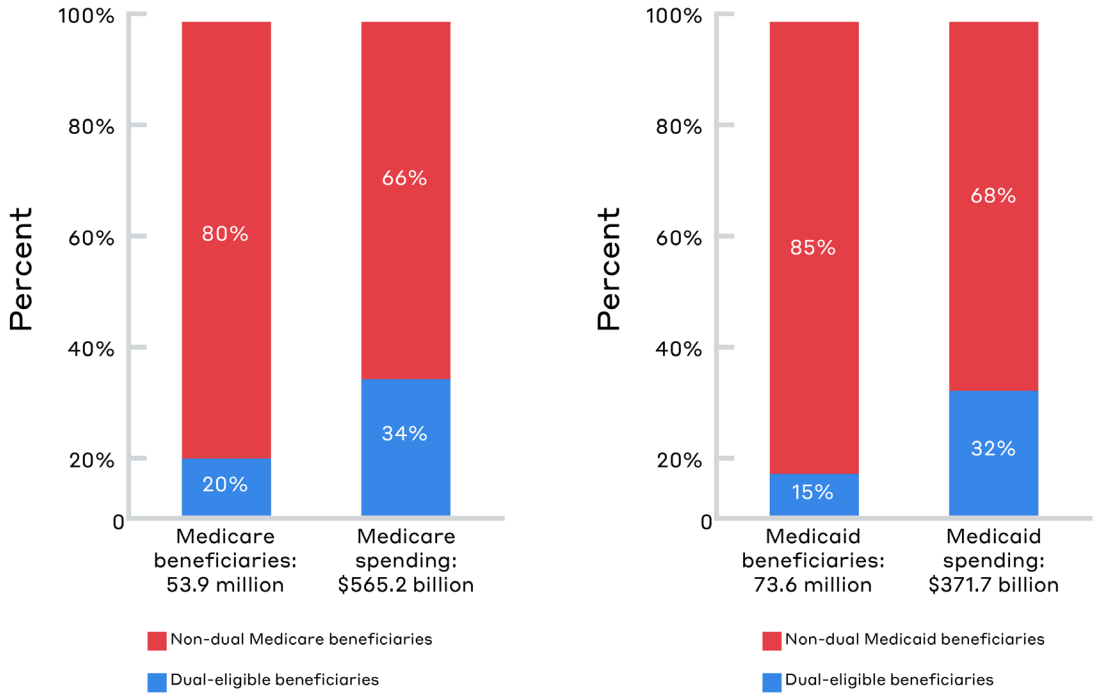
An ASPE report found that 67% of full-benefit dual-eligible individuals qualify for Medicare before also becoming eligible for Medicaid, and 27% qualify for Medicaid first.[38] Only about 5% of individuals become simultaneously eligible for both Medicare and Medicaid.[39] Of those who qualified for Medicare before Medicaid, 59% qualified for Medicare on the basis of age. For those who already had Medicare, 37% qualified for Medicaid because they met criteria established by the state based on income or another eligibility requirement. For example, states are permitted to provide Medicaid coverage to Medicare beneficiaries with incomes up to 300% of the SSI income limit. Another 22% qualified under Medicaid's Medically Needy spend-down.[40] Of those who follow the Medicaid-to-Medicare pathway to full-benefit dual-eligible status, 55% qualified for Medicare based on SSI eligibility, and 66% qualified based on disability. [41]

Spending

Given the severity of illness and disabilities, per-capita spending on dual-eligible individuals is more than three times higher than for Medicare-only beneficiaries.[42] The average annual spending per dual-eligible individual in 2013 was approximately $29,238.[43] The average annual spending for those covered only by Medicare came in significantly lower, at $8,593 per person.[44]

While dual-eligible individuals comprise 20% of the Medicare population, they account for 34% of total Medicare expenditures (see Figure 1).[45] Similarly, dual-eligible individuals comprise only 15% of the Medicaid population, but account for 32% of total Medicaid expenditures.[46] Dual-eligible individuals, including partial-benefit dual-eligible individuals, account for only 9.15% of those who have Medicare and/or Medicaid coverage, while their expenditures constitute 33.21% of total expenditures for both programs in 2012.[47] From 2012 to 2018, total expenditures for both programs have increased by 36%; the disproportionate cost of duals has likely increased accordingly but recent data is unavailable.[48]

Figure 1: Dual-Eligible Beneficiaries as a Share of Medicare & Medicaid Enrollment and Spending, CY 2013



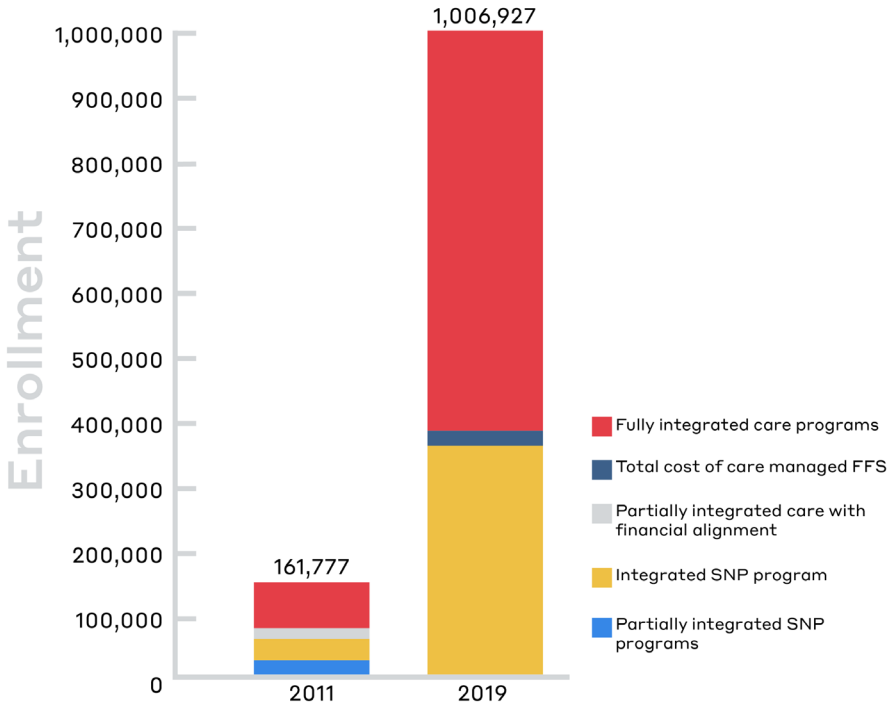
Source: MedPAC, MACPAC,Data book: *Beneficiaries dually eliable for Medicare Medicaid.* **Jan 2018**

Integration of Medicare and Medicaid Coverage and Financing

Despite the availability of models that integrate Medicare and Medicaid, many dual-eligible individuals are enrolled in separate Medicare and Medicaid managed care plans that do not provide integrated care or care coordination for all services. There are many approaches to integration that include some level of care coordination. Delivery and payment models range from Medicare Advantage D-SNPs that offer all Medicare and Medicaid-covered services, to advanced versions of D-SNPs that meet greater coordination requirements, to PACE. The Center for Medicare and Medicaid Innovation, or CMMI, and MMCO within CMS have also partnered to

allow states to test capitated and managed fee-for-service demonstration models under the FAI that feature a high level of integration. Some models in each category have excelled in providing high-quality integrated care, while others have fallen short, posing a threat to patient health and creating disruptions in long-term beneficiary-provider relationships. While the number of dual-eligible individuals in integrated programs has grown significantly between 2011 and 2019 (see Figure 2), a relatively small percentage, roughly 8.25% according to MMCO, are enrolled in integrated programs.[49]

Figure 2: Total Integrated Care Enrollment by Program Type: 2011 and 2019



Source: Medicare-Medicaid Coordination Office, *FY 2019, Report to Congress*, p. 8[iii]

iii From the report: [A]nalysis performed by the Integrated Care Resource Center, under contract with CMS. "Fully Integrated Programs/Models" include MMP, Fully Integrated Dual Eligible (FIDE) SNP, and PACE enrollment through July 2019. This category also includes the FIDE SNPs previously noted as "Legacy Medi-Medi Demo Programs" and categorized separately in previous reports. "Total Cost of Care Managed FFS" includes enrollment in the Washington Managed Fee-For-Service demonstration under the Medicare-Medicaid Financial Alignment Initiative. "Integrated SNP Program" enrollment includes programs in which a dually eligible individual receives both Medicare and Medicaid services from companion or aligned Medicare D-SNPs and Medicaid managed care plans; several state programs were reclassified from partially integrated to integrated to align with the integration standards for D-SNPs finalized in the 2020 Medicare Advantage and Part D final rule. "Partially Integrated Care with Financial Alignment" refers to the North Carolina Medicare Health Care Quality Demonstration, for which no 2019 information is included because the initiative had ended. No state data was available in July 2019 for "Partially Integrated SNP Program" enrollment. The 2019 analysis newly includes data from existing integrated care options in Oregon, select D-SNPs in California, and FIDE-SNPs and certain types of D-SNPs in Florida.

APPENDIX S

In recent years, Congress and CMS have made efforts to advance the integration of Medicare and Medicaid services for dual-eligible individuals by actively encouraging states to adopt more fully integrated programs. There are three main approaches that states can take to integrate Medicare and Medicaid:

- Dual-eligible special needs plans (D-SNPs);
- Program of All-Inclusive Care for the Elderly (PACE); and
- The Financial Alignment Initiative (FAI), a demonstration that integrates coverage and financing.

Dual-Eligible Special Needs Plans

Congress permanently authorized D-SNPs through the Bipartisan Budget Act of 2018.[50] That law also established new integration standards for D-SNPs and unified Medicare and Medicaid grievance and appeals procedures for certain D-SNPs beginning in contract year 2021.[51]

CMS released regulations in April 2019 implementing the new D-SNP requirements.[52] Under the regulations, D-SNPs must meet the integration criteria beginning CY 2021. Plans must: (1) be a fully integrated dual-eligible special needs plan, called FIDE-SNP, or a highly integrated dual-eligible special needs plan, called HIDE-SNP,[iv] or (2) notify the state Medicaid agency, or its designee, of hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual-eligible individuals.[53] Beginning CY 2021 through CY 2025, CMS will impose the intermediate sanction of prohibiting new enrollment into a D-SNP if it determines the D-SNP does not meet the new integration standards.[54]

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iv The regulation, codified at 42 CFR § 422.2, defines a FIDE-SNP as a type of D-SNP: (1) that provides dual-eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both an MA contract with CMS and a Medicaid managed care organization contract under section 1903(m) of the [SSA] with the applicable State; (2) whose capitated contract with the state Medicaid agency provides coverage, consistent with state policy, of specified primary care, acute care, behavioral health, and long-term services and supports, and provides coverage of nursing facility services for a period of at least 180 days during the plan year; (3) that coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries; and (4) that employs policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement. The regulation, codified at 42 CFR § 422.2, defines a HIDE-SNP as a type of D-SNP offered by an MA organization that provides coverage, consistent with state policy, of long-term services and supports, behavioral health services, or both, under a capitated contract that meets one of the following arrangements— (1) the capitated contract is between the MA organization the Medicaid agency; or (2) the capitated contract is between the MA organization's parent organization (or another entity that is owned and controlled by its parent organization) and the Medicaid agency.

D-SNPs must have a coordinated Medicare and Medicaid grievances and appeals process beginning CY 2020, while FIDE-SNPs and HIDE-SNPs with exclusively aligned enrollment must implement a unified Medicare and Medicaid grievances and appeals process beginning CY 2021.[55, v] The unified grievances and appeals process will allow individuals to follow one resolution pathway at the plan level when filing a complaint or contesting an adverse coverage determination for Medicare non-Part D benefits and Medicaid services.[56]

Enrollment in D-SNPs, which have the highest number of participants compared to other integrated plans, varies significantly by state, and includes both rural and urban populations. Texas, Arizona, and New Mexico – states with the largest populations residing in frontier counties – have relatively high D-SNP enrollment.[57] Yet other rural states such as North Dakota, South Dakota, and Iowa have virtually no dual-eligible individuals enrolled in D-SNPs.[58] States with significant urban areas, including Florida, California, New York, and Massachusetts, have higher percentages of eligible individuals enrolled in D-SNPs. [59]

Information on health outcome and cost measures for dual-eligible individuals is insufficient in states with low enrollment in integrated care models, making comparisons difficult.[60] Overall, Medicaid outcomes by state may be skewed by this discrepancy as well. Even states such as Texas, which have robust integrated care models, have numerous counties that lack data, presenting an issue for researchers and policymakers, especially when it comes to examining disparities within counties and states.[61]

The Affordable Care Act required D-SNPs to either have contracts with states to provide Medicaid benefits or arrange for them to be provided to dual-eligible enrollees. Fourteen states, highlighted in blue in Figure 3, require D-SNPs to align with Medicaid managed long-term services and supports, or MLTSS, programs. Similarly, other states have developed Medicaid MLTSS programs with the potential to align D-SNP and MLTSS programs. [62] [63]

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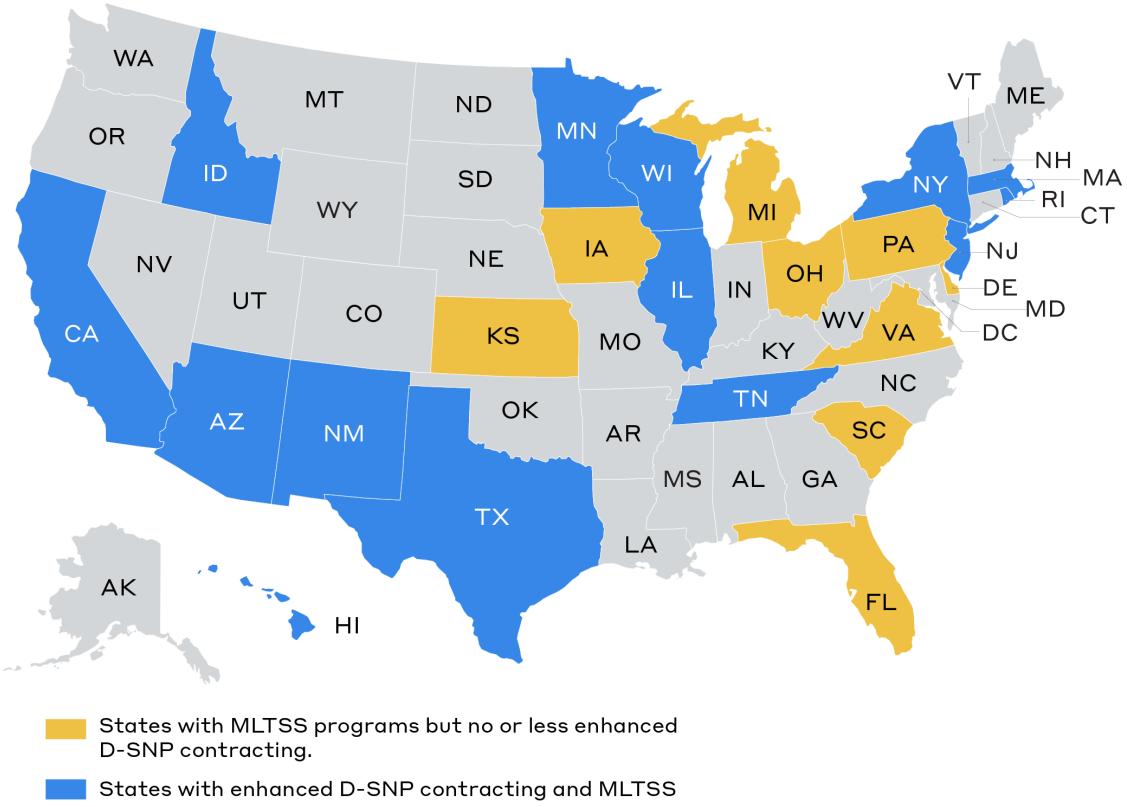
v Exclusively aligned enrollment occurs when the state limits enrollment into a D-SNP to full-benefit dual-eligible individuals who are also enrolled in a Medicaid MCO that is offered by the D-SNP's MA organization, the D-SNP's parent organization, or by another entity that is owned and controlled by the D-SNP's parent organization.

Figure 3: States with Aligned D-SNPs and Managed Long-Term Services and Supports Programs, 2017



Source: ASPE Report: U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Integrating Care through Dual Eligible Special Needs Plans D-SNPs : Opportunities and Challenges*, April 2019, 9.

Financial Alignment Initiative

Under the FAI, states may test any of three integrated care models: (1) a capitated managed care model; (2) a managed FFS model; or (3) a state-specific model.[64] Under the capitated managed care model, states enter into a single three-way contract with CMS and health plans.[65] Most states participating in the demonstration chose to implement the capitated managed care option. Plans operating under this contract, known as Medicare-Medicaid Plans, receive a blended capitated rate for all Medicaid and Medicare benefits.[66] Using this model, a plan provides all Medicare-covered and all or most Medicaid-covered services with a high level of care coordination.[67] As of December 2019, nine states are participating in the capitated managed care model.[vi] [68]

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vi California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, and Texas are participating in the capitated managed care model under the financial

In the managed FFS model, CMS and a state enter into an agreement that allows the state to provide coordinated care by building on the existing FFS delivery system.[69] Specifically, states have built on the Medicaid Health Homes model and Accountable Care Organizations.[70] Under this model, the state invests in care coordination and receives a retrospective performance payment if certain quality thresholds are met and Medicare achieves target savings levels.[71] Only Washington State and Colorado have implemented this model.[72] Colorado has ended its demonstration; Washington's demonstration is ongoing.[73]

The state-specific model allows states to implement innovative models that may include elements of demonstrations under the FAI or other types of delivery system reforms, such as alternative payment methodologies, value-based purchasing, or episode-based bundled payments.[74] As of December 2019, Minnesota is the only state participating in the state-specific model under the FAI with a focus on administrative alignment.[75]

PACE

PACE is a permanently authorized program that offers comprehensive medical and social services, including those beyond Medicare and Medicaid – if deemed necessary – to those above age 55 who need nursing home-level care. Almost all PACE enrollees are dual-eligible individuals and the care model is centered on adult day care centers with each patient taken care of by an interdisciplinary team.[76] While PACE represents a high-degree of Medicare-Medicaid integration, it is not widely available and less than 50,000 people are enrolled given the eligibility limitations and start-up costs associated with establishing adult day care centers.

Program Evaluations

Dual-eligible individuals enrolled in integrated models in some areas generally experience some reductions in health care utilization compared to their counterparts not in integrated models, according to a July 2019 MACPAC report – although evaluations of specific integrated models make it difficult to generalize about the effects of integrated care broadly.[77] According to the report, individuals in integrated models generally experienced decreases in hospitalizations and hospital readmissions.[78] That is consistent with other studies, which have reported higher beneficiary satisfaction in integrated models than in non-integrated Medicaid FFS arrangements.[79]

At the same time, findings are mixed for use of emergency department services, LTSS, other services, and beneficiary experience related to communicating with health plans and understanding benefits.[80] Care coordination between Medicare and Medicaid services can be difficult due to lack of access each program has to the other program's data,[81] but recent demonstrations under MMCO and CMMI have emphasized the

alignment initiative. Virginia participated in the capitated managed care model, but ended its demonstration in December 2017.

incorporation of care coordination into integrated models and, as mentioned earlier, CMS has issued new rules for D-SNPs that require further coordination and unification.

Early cost results are also promising but limited. Lower per-person Medicare spending was associated with some integrated care models, but few evaluations have been able to review changes in associated Medicaid spending due to lack of recent Medicaid data.[82] The new Transformed Medicaid Statistical Information System, or T-MSIS, is expected to provide more information in the near future on Medicaid spending and service use in integrated models.

The MMCO has reported increased access to care coordination within the capitated model demonstrations under its FAI through metrics including increases in completion of health risk assessments and care plans.[83] Many of the states participating in FAI faced declines in enrollment that meant participation was lower than expected.[84] Washington State did see savings, with the caveat that the savings were in Medicare and did not include the effect of the demonstration on Medicaid.[85]

Studies evaluating D-SNPs have demonstrated evidence of reductions in hospitalizations and hospital readmissions. One study compared individuals in California's SCAN plan with Medicare FFS individuals in the state, and found 14% lower rates of preventable hospitalizations and 25% lower rates of hospital readmissions.[86] Another study found a 54% decrease in hospitalizations and a 24% decrease in hospital readmissions in the Visiting Nurse Service of New York's Choice health plans.[87] D-SNPs have also been associated with reductions in long-stay and end-of-life care nursing facility entries[88] and reductions in per-person Medicare spending, such that a 1% increase in D-SNPs penetration was associated with a 0.2% reduction in Medicare spending per beneficiary.[89]

Because traditional fee-for-service providers in Medicare and Medicaid have no reporting requirements, comparing D-SNPs to FFS is not possible. However, D-SNPs consistently performed higher than MA plans. In a study conducted by the Government Accountability Office, D-SNP performed better on process of care and health outcomes with similar utilization compared to traditional Medicare Advantage Plans.[90] Specifically, they performed better on the majority of process measures and performed better on all outcomes measures.[91]

Studies evaluating PACE have demonstrated reductions in inpatient hospital use,[92, 93, 94] hospitalizations,[95] and length of stay.[96] Specifically, PACE participants compared to a matched group in one study experienced reduced hospitalization rates over a two-year period and a shorter length of stay when hospitalized, with an average reduction of 0.6 hospital days per month, even though they had higher levels of hospitalization six months prior.[97] The Assistant Secretary for Planning and Evaluation did note that limitations of PACE, like the reliance on adult day care centers, have led to slow growth in enrollment and more-scalable and permanent options were necessary for the integration of care.[98]

Conclusion

While the evidence is still outstanding on the potential for long-term savings for demonstration projects that fully integrate care for dual-eligible enrollees, it is clear this population must have a better coordinated and more seamless system of care. Even those without serious medical or functional impairment should not be asked to navigate two separate programs for services without full accountability on the programs for coordination of care. The current bifurcated system should not continue. BPC health care leaders believe states are in the best position to integrate Medicare and Medicaid services and these options encourage states to move forward with integration. Over the long-term, better integration and care coordination will lead to a better enrollee experience, improve quality of care, eliminate inefficiencies, and result in long-term savings.

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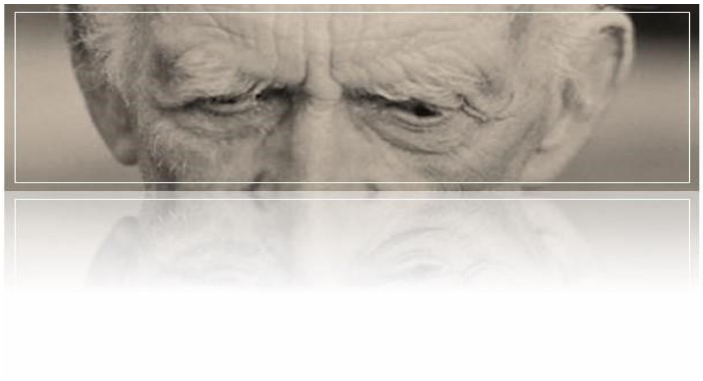
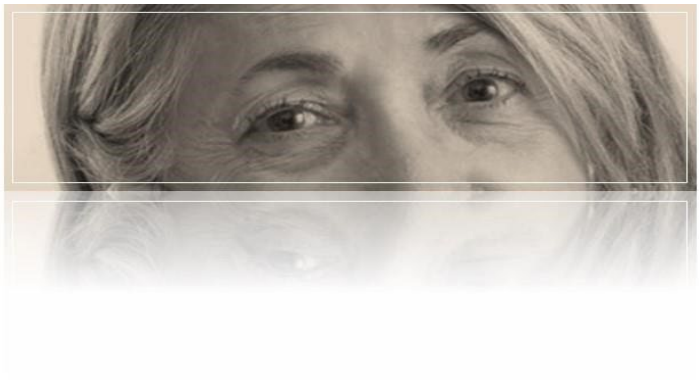
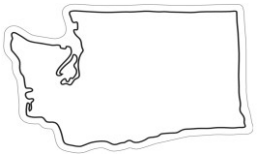



Washington State's Fee-For-Service Dual Eligible Demonstration Quarterly Report

January 14, 2022



This report provides a month-by-month look at dual Medicare-Medicaid beneficiaries' eligibility, enrollment, and engagement in Washington State's Duals Demonstration and Health Home program. A few key things to note:

- Health Homes was implemented in 14 counties in July 2013, 23 additional counties were added in October 2013, and the remaining 2 counties (King and Snohomish) joined in April 2017.
- Beneficiaries identified as "already aligned" with another Medicare shared savings program are not included among those deemed "demonstration eligible", though they are still eligible for Health Home services.
- Health Home dual beneficiaries are enrolled with one of twelve Health Home Fee-forService Lead Entities.

The report was prepared by DSHS Research and Data Analysis Division in collaboration with Washington State's Health Care Authority.

Eligibility and Enrollment updated through December 2021 Engagement updated through September 2021 Health Home Team Review Date: January 12, 2022

DATA SOURCE: Washington State Health Care Authority, ProviderOne (Medicaid) database.

Washington State Health Care Authority

Washington State Department of Social & Health Services
Transforming lives

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Washington State's Fee-For-Service Dual Eligible Demonstration Quarterly Report

EXECUTIVE SUMMARY

Eligibility, Enrollment, and Engagement Trends

- In the last year, eligibility for the demonstration has plateaued to just under 30,000 dual eligible beneficiaries. The number of duals eligible for the program had been steadily dropping 0.5% per month in 2019 through 2020. There are three known issues that contributed to this trend.

  1) There had been an increase in duals enrolled in Medicare Advantage (and thus excluded from Health Home eligibility).

  2) Clients who once met the criteria of a PRISM score of 1.5 or above but are now below a PRISM score of 1.0 for 9 months or longer and who have lost eligibility.

  3) There had been a slight decrease in overall dual Medicare-Medicaid eligibility.

- 26% of demonstration eligible dual beneficiaries are not currently participating in the program, either because they could not be reached (12%) by a Lead (meeting the due diligence outreach process), or they chose to opt out (15%) after being offered Health Home services.

  Although the percent of demonstration eligible dual beneficiaries who have opted out has increased since 2015, it is unlikely that the real proportion of those unwilling to participate has changed; it is more likely that we as a program are more effective in identifying and disenrolling those who are unwilling to participate.

  The recent drop in the monthly opt-out totals (beginning in April 2021) is due to a new program policy of ending opt-out status and re-offering Health Home services for those who have remained Health Home eligible for over a year.

- As of September 2021, 31% of enrolled duals were engaged in the month while 44% of those enrolled had been engaged in September 2021 or during a previous month. Overall engagement has remained fairly steady throughout the life of the demonstration, even as eligibility and enrollment have fluctuated at times.

COVID-19

- Currently, we have not seen drastic changes to Eligibility, Enrollment, or Engagement levels for Dual Demonstration eligible beneficiaries since the beginning of the COVID-19 pandemic. We attribute some of the stability to the actions taken by Health Home program staff to support Leads and Care Coordinators in maintaining engagement with beneficiaries. These actions include, but are not limited to…

  1) A remote version of the required 2-day Health Home Care Coordinator Basic Training was created and began being provided to new Care Coordinators in mid-March.

  2) Additional free webinars and resources on COVID-19 and self-care have been made available to Care Coordinators, including webinars developed by a cross-agency workgroup between the Department of Health, the Health Care Authority, and the Department of Social and Health Services, created to support the community based workforce.

  3) Care Coordination services began to be allowed over the phone, and beneficiaries were provided with mobile phones when needed to maintain engagement.

Other Notes

- Rate increases for the three tiers of Health Home services went into effect on July 1st, 2020.

1. Overall Summary

January 14, 2022

HIGHLIGHTS

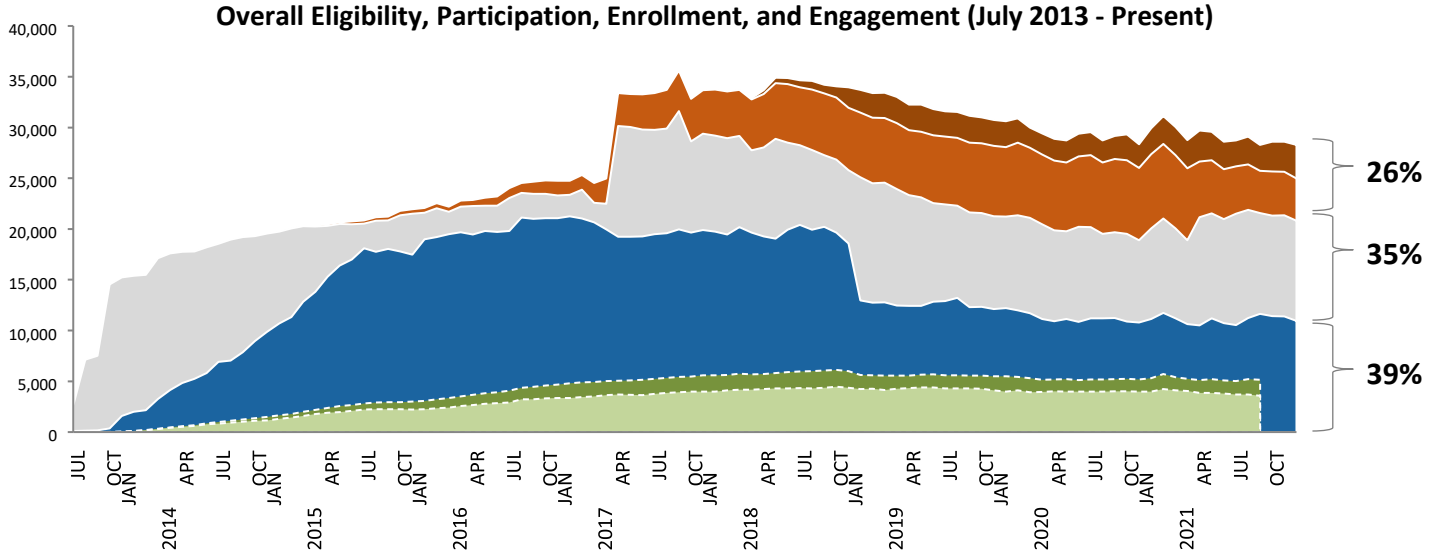
28,269 total dual beneficiaries were eligible for the demonstration as of December 2021. Of those,

- **39%** are currently enrolled with a Health Home Lead Entity.
- **35%** are NOT currently enrolled, but will be as capacity allows.
- **26%** are not currently participating in the program, either because they could not be reached (9%) by a Lead (meeting the due diligence outreach process), or they chose to opt out (15%) after being offered Health Home services.

As of September 2021 there were a total of 11,657 Dual Beneficiaries enrolled with a Health Home Lead Entity. Of those,

- **44%** had received one or more Health Home services since their initial enrollment.
- **31%** had received a Health Home service during the month.

Overall Eligibility, Participation, Enrollment, and Engagement (July 2013 - Present)



Overall Eligibility, Participation, Enrollment, and Engagement Detail (previous 12 Months)

		Total Demo Eligible	Not Currently Participating				Not Currently Enrolled		Enrolled		Engaged			
			COULD NOT BE REACHED[1]		OPT-OUT[1]		NOT ENROLLED[1]		ENROLLED[1]		ENGAGED IN MONTH[2]		ENGAGED EVER[2]	
2021	JAN	31,132	2,752	9%	7,358	24%	9,272	30%	11,750	38%	4,247	36%	5,705	49%
	FEB	30,047	2,771	9%	7,203	24%	8,859	29%	11,214	37%	4,104	37%	5,416	48%
	MAR	28,763	2,770	10%	7,087	25%	8,271	29%	10,635	37%	4,061	38%	5,244	49%
	APR	29,689	3,037	10%	5,498	19%	10,654	36%	10,500	35%	3,843	37%	5,106	49%
	MAY	29,568	2,790	9%	5,225	18%	10,340	35%	11,213	38%	3,858	34%	5,228	47%
	JUN	28,605	2,709	9%	4,921	17%	10,234	36%	10,741	38%	3,801	35%	5,083	47%
	JUL	28,720	2,553	9%	4,674	16%	10,940	38%	10,553	37%	3,691	35%	5,038	48%
	AUG	29,089	2,722	9%	4,492	15%	10,644	37%	11,231	39%	3,707	33%	5,199	46%
	SEP	28,293	2,548	9%	4,161	15%	9,927	35%	11,657	41%	3,578	31%	5,137	44%
	OCT	28,595	2,937	10%	4,341	15%	9,907	35%	11,410	40%	*pending*	-	*pending*	-
	NOV	28,590	2,959	10%	4,275	15%	9,953	35%	11,403	40%	*pending*	-	*pending*	-
	DEC	28,269	3,286	12%	4,161	15%	9,888	35%	10,934	39%	*pending*	-	*pending*	-

[1] Percent of Total Demonstration Eligible dual beneficiaries provided.

[2] Percent of Total Demonstration Eligible and Enrolled dual beneficiaries provided.

NOTES

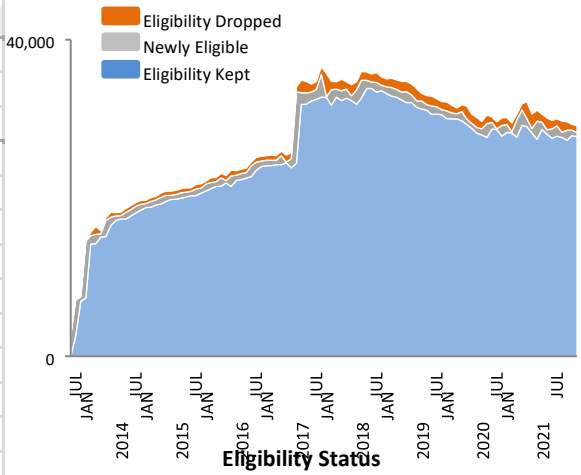
This report provides a month-by-month look at dual Medicare-Medicaid beneficiaries' eligibility, enrollment, and engagement in Washington State's Duals Demonstration and Health Home program. A few things to note:

- Dual beneficiaries identified as "already aligned" with another Medicare shared savings program have been removed.
- Health Home engagement is based on accepted encounters which can take 3 months to receive.
- Beginning in January 2017, enrolled beneficiaries who chose not to participate have been dropped from enrollment (a change in policy).
- Enrollment dropped beginning in October 2018 due to the withdrawal of Optum as a Health Home Lead. Most actively participating beneficiaries were moved to other Health Home Leads, keeping their Care Coordinator intact.

2. Additional Eligibility, Enrollment, and Engagement Details

		Eligible	Newly Eligible[1]		Eligibility Kept		Eligibility Dropped	
		NUMBER	NUMBER	PERCENT[2]	NUMBER	PERCENT[2]	NUMBER	PERCENT[3]
	OCT	29,311	1,003	3%	28,308	97%	846	3%
	NOV	28,340	137	0%	28,203	96%	1,108	4%
	DEC	29,915	2,243	7%	27,672	98%	668	2%
2021	JAN	31,132	1,969	6%	29,163	97%	752	3%
	FEB	30,047	1,042	3%	29,005	93%	2,127	7%
	MAR	28,763	548	2%	28,215	94%	1,832	6%
	APR	29,689	2,303	8%	27,386	95%	1,377	5%
	MAY	29,568	894	3%	28,674	97%	1,015	3%
	JUN	28,605	536	2%	28,069	95%	1,499	5%
	JUL	28,720	1,165	4%	27,555	96%	1,050	4%
	AUG	29,089	1,282	4%	27,807	97%	913	3%
	SEP	28,293	637	2%	27,656	95%	1,433	5%
	OCT	28,595	1,317	5%	27,278	96%	1,015	4%
	NOV	28,590	715	3%	27,875	97%	720	3%
	DEC	28,269	539	2%	27,730	97%	860	3%

Health Home Dual Beneficiary Eligibility Status



Health Home Dual Beneficiary Enrollment Status

		Enrolled	Newly Enrolled[1]		Enrollment Kept		Enrollment Dropped	
		NUMBER	NUMBER	PERCENT[2]	NUMBER	PERCENT[2]	NUMBER	PERCENT[3,4,5]
	OCT	10,878	491	5%	10,387	93%	838	7%
	NOV	10,778	344	3%	10,434	96%	444	4%
	DEC	11,133	1,015	9%	10,118	94%	660	6%
2021	JAN	11,750	1,205	10%	10,545	95%	588	5%
	FEB	11,214	734	7%	10,480	89%	1,270	11%
	MAR	10,635	429	4%	10,206	91%	1,008	9%
	APR	10,500	1,003	10%	9,497	89%	1,138	11%
	MAY	11,213	1,217	11%	9,996	95%	504	5%
	JUN	10,741	583	5%	10,158	91%	1,055	9%
	JUL	10,553	425	4%	10,128	94%	613	6%
	AUG	11,231	1,417	13%	9,814	93%	739	7%
	SEP	11,657	1,110	10%	10,547	94%	684	6%
	OCT	11,410	792	7%	10,618	91%	1,039	9%
	NOV	11,403	600	5%	10,803	95%	607	5%
	DEC	10,934	470	4%	10,464	92%	939	8%

	Total Not Reached	Newly Could Not Be Reached[1]	Could Not Be Reached Expired[4]	Total Opt-Out	Newly Opt-Out[1]	Opt-Out Ended[5]

40,000

[1] Includes beneficiaries who are eligible/enrolled/Opt-Out/Not Reached for the first time, or who returned as after a 1+ month gap.

[2] Denominator is the current month's Health Home eligible/enrolled/Opt-Out/Not Reached dual beneficiaries.

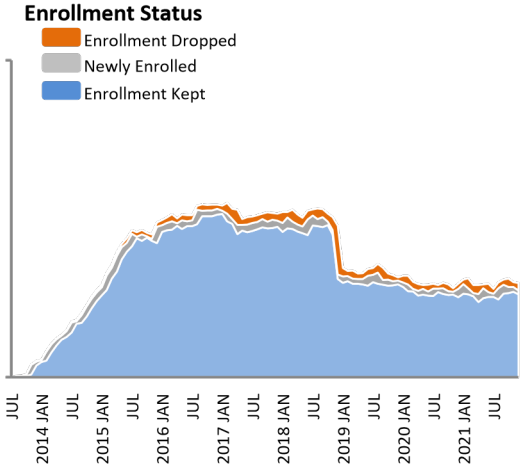
[3] Denominator is the previous month's Health Home eligible/enrolled/Opt-Out/Not Reached dual beneficiaries.

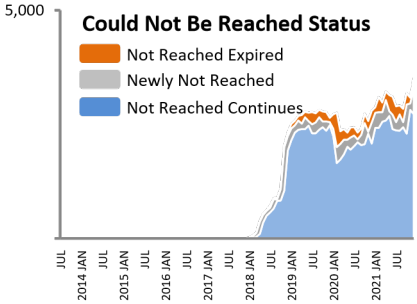
[4] Beneficiaries' "could not be reached" designation automatically expires after 15 months, after which, if they remain eligible, they will be re-assigned to a Lead.

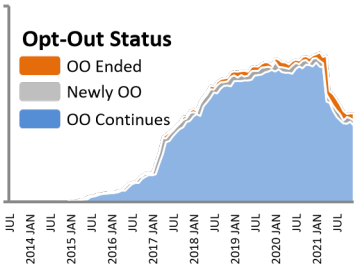
[5] Beneficiaries previously remained "opted out" permanently unless they opt back in. As a new policy we are ending opt-out stated and re-offering services again after a certain period.

		NUMBER	NUMBER	PERCENT[2]	NUMBER	PERCENT[3]	NUMBER	NUMBER	PERCENT[2]	NUMBER	PERCENT[3]
	OCT	2,528	465	18%	207	9%	7,251	244	3%	196	3%
	NOV	2,338	41	2%	231	9%	7,096	100	1%	255	4%
	DEC	2,543	461	18%	256	11%	7,314	385	5%	167	2%
2021	JAN	2,752	330	12%	121	5%	7,358	231	3%	187	3%
	FEB	2,771	347	13%	328	12%	7,203	285	4%	440	6%
	MAR	2,770	210	8%	211	8%	7,087	193	3%	309	4%
	APR	3,037	450	15%	183	7%	5,498	376	7%	1,965	28%
	MAY	2,790	104	4%	351	12%	5,225	154	3%	427	8%
	JUN	2,709	313	12%	394	14%	4,921	277	6%	581	11%
	JUL	2,553	183	7%	339	13%	4,674	325	7%	572	12%

[1] **Health Home Dual Beneficiary Could Not Be Reached and Opt-Out Status**







[2]

[3] ,000

[4]

AUG	2,722	364	13%	195	8%	4,492	311	7%	493	11%
SEP	2,548	113	4%	287	11%	4,161	148	4%	479	11%
OCT	2,937	636	22%	247	10%	4,341	333	8%	153	4%
NOV	2,959	145	5%	123	4%	4,275	177	4%	243	6%
DEC	3,286	558	17%	231	8%	4,161	252	6%	366	9%

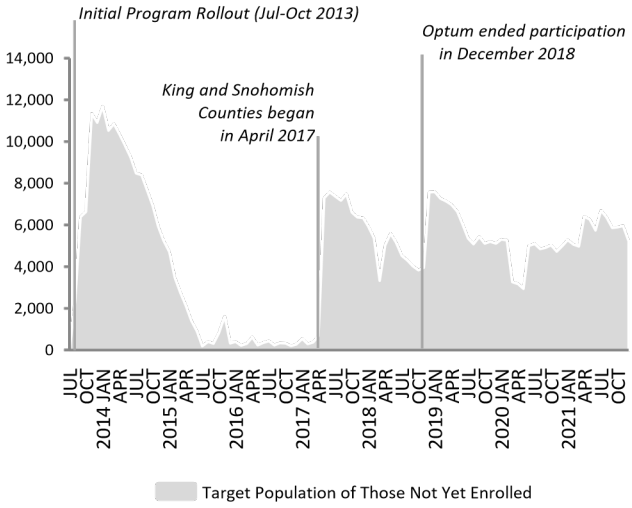
3. Identifying Target Population of Those Not Yet Enrolled

NOTES

- While a goal of the program is to increase enrollment and engagement, a particular subgroup of those not enrolled are the highest priority. This Target Population of Those Not Yet Enrolled excludes
- Beneficiaries eligible for their first month (*a month enrollment lag is required to meet 30 day notification requirements).*
- Beneficiaries with a PRISM Risk Score less than 1.5 (*an unofficial policy used to manage capacity*).
- American Indian and Alaska Native Beneficiaries (*not passively enrolled per official policy*).
- Given the exclusions, the Target Population of Those Not Yet Enrolled had consistently decreased after each expansion noted in the plot below (initial program rollout, expansion to King/Snohomish Counties, end of Optum's participation in program). Over the last year, the number has plateaued around 6,000 beneficiaries.
- Prior to this (1/14/2022) release of the report, Due Diligence clients had been included among the total of those not enrolled. They have now been removed (as are Opt-Out clients) since they are not available for enrollment while having Due Diligence status.

Target Population of Those Not Yet Enrolled

		Demonstration Eligible	Target Population		Eligible, Not Yet Enrolled	Target Population	
		NUMBER	NUMBER	PERCENT	NUMBER	NUMBER	PERCENT
	OCT	29,311	5,027	17%	8,654	5,027	58%
	NOV	28,340	4,726	17%	8,128	4,726	58%
	DEC	29,915	4,992	17%	8,925	4,992	56%
2021	JAN	31,132	5,276	17%	9,272	5,276	57%
	FEB	30,047	5,064	17%	8,859	5,064	57%
	MAR	28,763	4,968	17%	8,271	4,968	60%
	APR	29,689	6,396	22%	10,654	6,396	60%
	MAY	29,568	6,255	21%	10,340	6,255	60%
	JUN	28,605	5,732	20%	10,234	5,732	56%
	JUL	28,720	6,701	23%	10,940	6,701	61%
	AUG	29,089	6,363	22%	10,644	6,363	60%
	SEP	28,293	5,864	21%	9,927	5,864	59%
	OCT	28,595	5,888	21%	9,907	5,888	59%
	NOV	28,590	5,957	21%	9,953	5,957	60%
	DEC	28,269	5,221	18%	9,888	5,221	53%



Target Population of Those Not Yet Enrolled, by Residential County

Total Count of Target Population of Those Not Yet Enrolled, December 2021

Top 10 Counties

501 - 1,787	
251 - 500	
101 - 250	
11 - 100	
0 - 10	

RANK	COUNTY	Count
1	KING	1,787
2	THURSTON	435
3	KITSAP	401
4	GRAYS HARBOR	393
5	SPOKANE	350
6	CLALLAM	275
7	PIERCE	246
8	LEWIS	236
9	MASON	210
10	PACIFIC	144

Target Population of Those Not Yet Enrolled as Percent of Demonstration Eligible Beneficiaries, December 2021

RANK	COUNTY	% OF ELIGIBLE
1	LEWIS	60.1%
2	MASON	57.5%
3	PACIFIC	54.3%
4	KITSAP	51.9%

50.1% - 61.0%
30.1% - 50.0%
20.1% - 30.0%
10.1% - 20.0%
0.0% - 10.0%

Top 10 Counties

5	THURSTON	47.2%
6	JEFFERSON	43.9%
7	CLALLAM	39.3%
8	GRAYS HARBOR	37.8%
9	KING	29.4%
10	STEVENS	23.4%

4. Lead Entity Detail

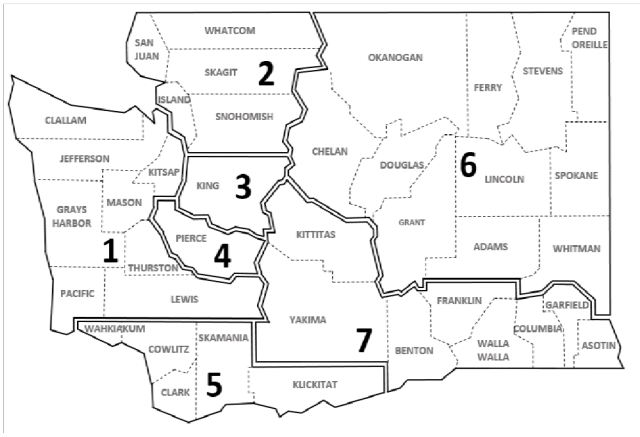
NOTES

- Health Home dual beneficiaries are enrolled with one of the twelve Health Home Lead Entities.
- There are three types of Health Home Lead Entities.
  - Area Agencies on Aging (AAA)
  - Community-Based Organizations (CBO)
  - Managed Care Organizations (MCO)
- Optum stopped participation in the Health Home program in December 2018.

Health Home Lead Entity Coverage Area Map for Dual Beneficiaries

Type	Lead Entity	HH Start Date	HH Coverage Area 1	2	3	4	5	6	7
AAA	Northwest Regional Council AAA	OCT 2013							
	Olympic AAA	FEB 2019							
	Pierce County AAA	DEC 2018							
	Southeast WA Aging and LTC AAA	JUL 2013							
	Southwest AAA	DEC 2018							
CBO	Community Choice	OCT 2013							
	Full Life Care	APR 2017							
	Elevate Health	Aug 2019							
MCO	Community Health Plan of Washington	JUL 2013							
	Coordinated Care	JAN 2018							
	Molina	JUL 2016							
	United Health Care Community Plan	JUL 2013							

Health Home Coverage Areas



Health Home Dual Beneficiary Enrollment and Engagement Summary by Lead Entity

Type	Lead Entity	Enrollment Summary September 2021 ENROLLED	% OF TOTAL ENROLLED BY LEAD	RANK	Engagement Summary September 2021 ENGAGED	% OF ENROLLED ENGAGED IN MONTH	% OF TOTAL ENGAGED BY LEAD	RANK
AAA	Northwest Regional Council AAA	2,237	19%	1	738	33%	21%	1
	Olympic AAA	389	3%	8	157	40%	4%	7
	Pierce County AAA	791	7%	7	193	24%	5%	6
	Southeast WA Aging and LTC AAA	1,757	15%	2	458	26%	13%	4
	Southwest AAA	1,373	12%	5	624	45%	17%	2
CBO	Community Choice	1,702	15%	3	603	35%	17%	3
	Full Life Care	1,700	15%	4	451	27%	13%	5
	Elevate Health	1,007	9%	6	119	12%	3%	8
		248	2%	10	54	22%	2%	11
		<11	-	12	<11	-	-	12
		176	2%	11	96	55%	3%	9

MCO								
Community Health Plan of Washington	274	2%	9	79	29%	2%	10
Coordinated Care[1]							
Molina							
United Health Care Community Plan							

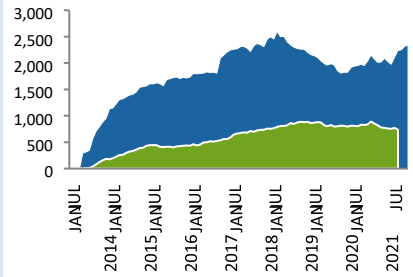
[1]Coordinated Care only serves Fee-for-Service Duals under special circumstances.

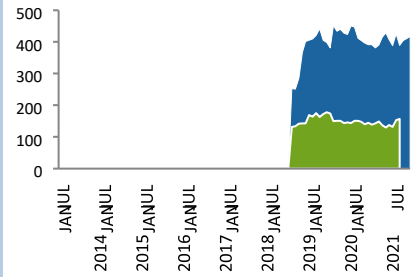
Distribution of Enrolled Dual Beneficiaries by Lead Entity

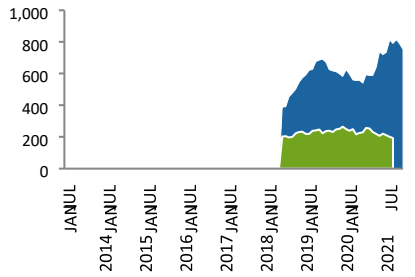
Distribution of Dual Engaged Beneficiaries by Lead Entity

Health Home Dual Beneficiary Enrollment and Engagement by Lead Entity

		Northwest Regional Council AAA			Olympic AAA			Pierce County AAA		
		ENROLLED	ENGAGED	PERCENT	ENROLLED	ENGAGED	PERCENT	ENROLLED	ENGAGED	PERCENT
	OCT	1,981	834	42%	404	148	37%	556	217	39%
	NOV	1,953	827	42%	396	140	35%	558	225	40%
	DEC	2,047	838	41%	391	145	37%	540	230	43%
2021	JAN	2,152	893	41%	391	139	36%	593	258	44%
	FEB	2,073	850	41%	381	143	38%	588	254	43%
	MAR	2,012	823	41%	390	149	38%	588	232	39%
	APR	2,020	780	39%	416	137	33%	642	219	34%
	MAY	2,096	773	37%	429	130	30%	738	206	28%
	JUN	2,024	759	38%	408	138	34%	721	221	31%
	JUL	1,981	756	38%	388	132	34%	734	211	29%
	AUG	2,115	771	36%	426	153	36%	814	201	25%
	SEP	2,237	738	33%	389	157	40%	791	193	24%
	OCT	2,249	*pending*	-	404	*pending*	-	815	*pending*	-
	NOV	2,319	*pending*	-	411	*pending*	-	789	*pending*	-
	DEC	2,345	*pending*	-	418	*pending*	-	753	*pending*	-



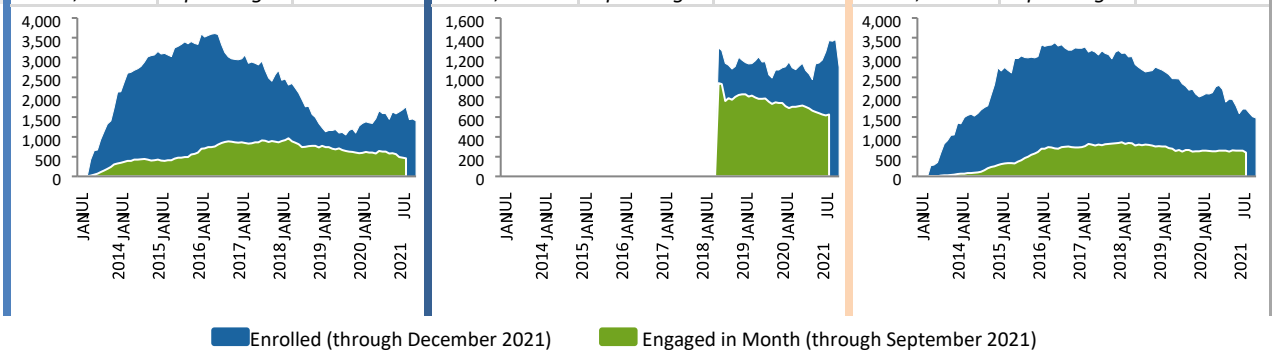




Enrolled (through December 2021) Engaged in Month (through September 2021)

		Southeast WA Aging and LTC AAA			Southwest AAA			Community Choice		
		ENROLLED	ENGAGED	PERCENT	ENROLLED	ENGAGED	PERCENT	ENROLLED	ENGAGED	PERCENT
	OCT	1,354	600	44%	1,097	704	64%	2,078	640	31%
	NOV	1,334	598	45%	1,078	702	65%	2,110	630	30%
	DEC	1,461	576	39%	1,109	710	64%	2,267	637	28%
2021	JAN	1,659	645	39%	1,141	715	63%	2,295	648	28%
	FEB	1,590	627	39%	1,070	702	66%	2,191	646	29%
	MAR	1,591	626	39%	1,032	687	67%	1,876	651	35%
	APR	1,439	576	40%	979	665	68%	1,953	628	32%
	MAY	1,630	583	36%	1,137	651	57%	1,940	655	34%
	JUN	1,581	559	35%	1,146	638	56%	1,782	649	36%
	JUL	1,626	490	30%	1,176	626	53%	1,585	648	41%

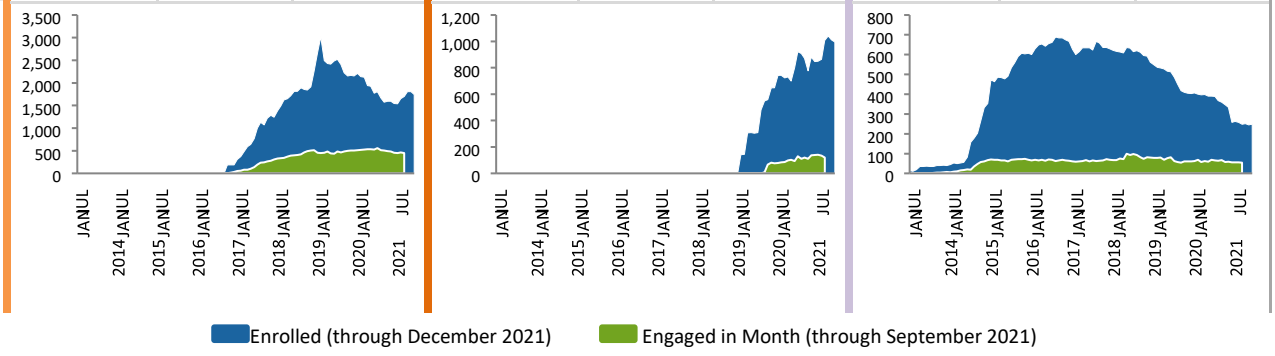
AUG	1,682	475	28%	1,258	617	49%	1,702	650	38%
SEP	1,757	458	26%	1,373	624	45%	1,702	603	35%
OCT	1,430	*pending*	-	1,365	*pending*	-	1,592	*pending*	-
NOV	1,453	*pending*	-	1,383	*pending*	-	1,508	*pending*	-
DEC	1,404	*pending*	-	1,104	*pending*	-	1,472	*pending*	-



Enrolled (through December 2021) Engaged in Month (through September 2021)

Health Home Dual Beneficiary Enrollment and Engagement by Lead Entity (cont.)

		Full Life Care			Elevate Health			Community Health Plan of Washington		
		ENROLLED	ENGAGED	PERCENT	ENROLLED	ENGAGED	PERCENT	ENROLLED	ENGAGED	PERCENT
	OCT	1,940	530	27%	730	99	14%	398	62	16%
	NOV	1,929	535	28%	699	104	15%	390	59	15%
	DEC	1,769	523	30%	800	93	12%	391	69	18%
2021	JAN	1,806	558	31%	922	130	14%	388	66	17%
	FEB	1,666	509	31%	907	111	12%	367	64	17%
	MAR	1,575	507	32%	872	120	14%	360	67	19%
	APR	1,592	491	31%	778	111	14%	346	57	16%
	MAY	1,592	482	30%	882	136	15%	334	59	18%
	JUN	1,547	457	30%	848	140	17%	257	55	21%
	JUL	1,534	445	29%	849	141	17%	263	55	21%
	AUG	1,654	464	28%	864	135	16%	257	55	21%
	SEP	1,700	451	27%	1,007	119	12%	248	54	22%
	OCT	1,803	*pending*	-	1,041	*pending*	-	252	*pending*	-
	NOV	1,804	*pending*	-	1,011	*pending*	-	245	*pending*	-
	DEC	1,741	*pending*	-	994	*pending*	-	249	*pending*	-

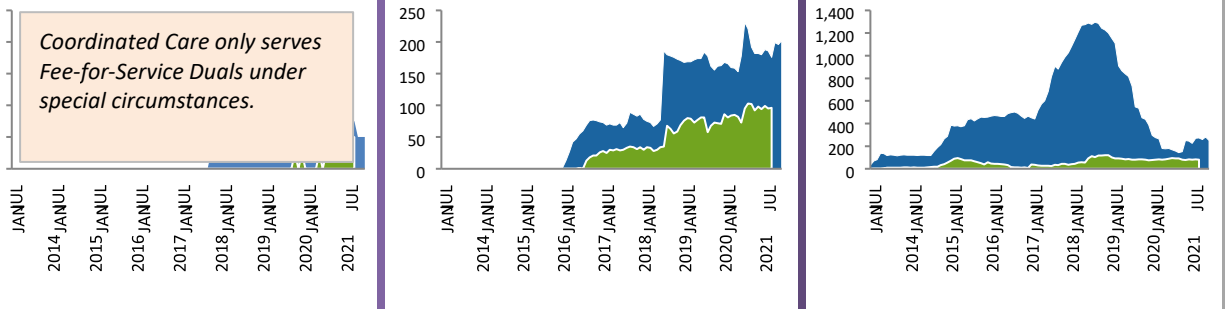


Enrolled (through December 2021) Engaged in Month (through September 2021)

		Coordinated Care			Molina			United Health Care Community Plan		
		ENROLLED	ENGAGED	PERCENT	ENROLLED	ENGAGED	PERCENT	ENROLLED	ENGAGED	PERCENT
	OCT	<11	0	0%	159	85	53%	179	80	45%
	NOV	<11	<11	50%	153	82	54%	176	83	47%
	DEC	<11	0	0%	178	73	41%	178	88	49%
2021	JAN	<11	<11	33%	231	95	41%	169	95	56%
	FEB	<11	<11	33%	221	103	47%	157	92	59%
	MAR	<11	<11	33%	192	102	53%	144	91	63%

APR	<11	<11	50%	182	92	51%	151	80	53%
MAY	<11	<11	50%	182	98	54%	251	78	31%
JUN	<11	<11	50%	180	94	52%	245	83	34%
JUL	<11	<11	67%	188	99	53%	226	79	35%
AUG	<11	<11	67%	186	95	51%	270	84	31%
SEP	<11	<11	67%	176	96	55%	274	79	29%
OCT	<11	*pending*	-	199	*pending*	-	258	*pending*	-
NOV	<11	*pending*	-	196	*pending*	-	282	*pending*	-
DEC	<11	*pending*	-	202	*pending*	-	250	*pending*	-

Coordinated Care only serves Fee-for-Service Duals under special circumstances.

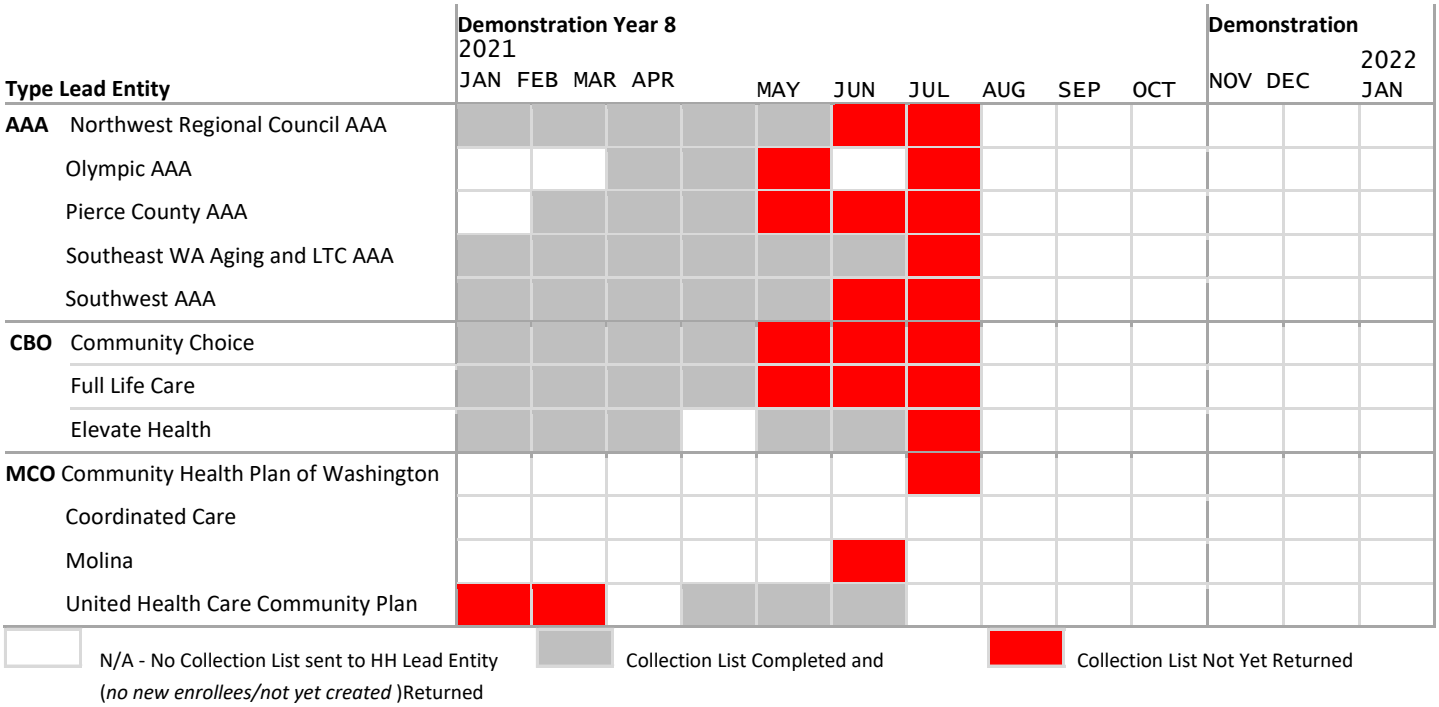


5. Government Accountability Office (GAO) Measure Tracking and Results

NOTES

- The tracking grid below reflects the status of the GAO Measure Collection Lists returned by each Health Home Lead.
- The Measure Results reflect GAO Measure 4 as calculated on the Final GAO Results Lists distributed to the Health Home Leads.
- For Demonstration Year 5 (the period of November 2017 through October 2018), the state was deemed to pass the quality performance goal as all Health Home Leads reported their GAO measure. For Demonstration Year 6, the benchmark for GAO Measures was either 63%/44% for Assessment Completed/Care Plan Completed (not met), or a 21%/20% improvement from the previous year (met).

Health Home Lead Entity GAO Measure Collection List Tracking



Health Home Lead Entity GAO Measure Results (Demonstration Year 5, 6, and Partial Year 7 Results)

GAO Measure 4: The percentage of Demonstration eligible Medicare-Medicaid enrollees who are willing to participate and could be reached, or who had fewer than 3 documented outreach attempts within 90 days, who had a health action plan completed within 90 days of initial enrollment.

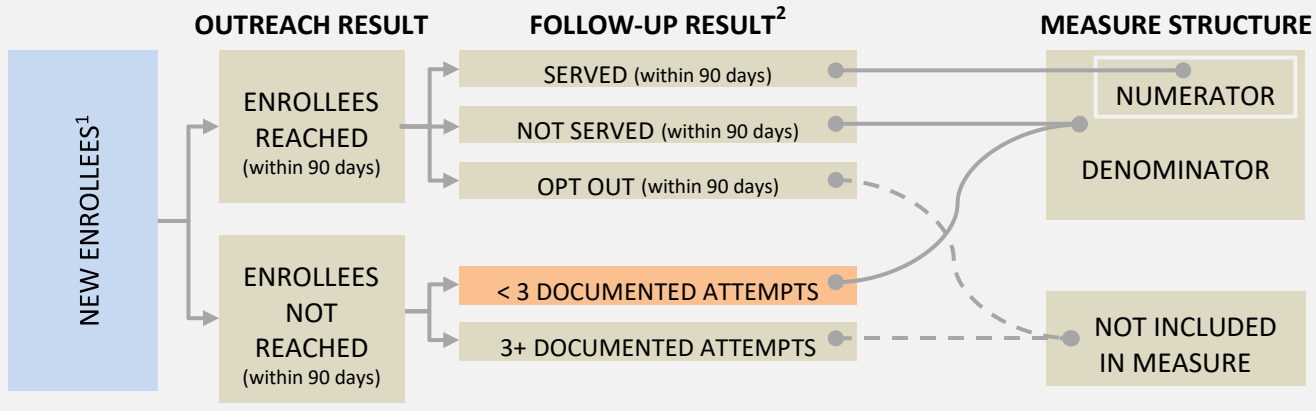
Type Lead Entity		Demonstration Year 5 (Nov 2017 - Oct 2018)			Demonstration Year 6 (Nov 2018 - Oct 2019)			Demonstration Year 7 (Nov 2019 - Oct 2020)		
		NUM	DEN	RATE	NUM	DEN	RATE	NUM	DEN	RATE
AAA	Northwest Regional Council AAA	126	622	20.3%	140	347	40.3%	113	213	53.1%
	Olympic AAA	-	-	-	<11	65	-	14	42	33.3%
	Pierce County AAA	-	-	-	27	91	29.7%	19	48	39.6%
	Southeast WA Aging and LTC AAA	180	525	34.3%	76	118	64.4%	21	77	27.3%
	Southwest AAA	-	-	-	99	134	73.9%	55	104	52.9%
CBO	Community Choice	141	543	26.0%	52	356	14.6%	34	103	33.0%
	Full Life Care	227	1,047	21.7%	180	507	35.5%	97	164	59.1%
	Elevate Health	-	-	-	0	107	0.0%	13	102	12.7%
	Optum (*ended participation in Dec 18*)	119	1,658	7.2%	-	-	-	-	-	-
MCO	Community Health Plan of Washington	<11	69	-	0	<11	0.0%	0	<11	0.0%
	Coordinated Care	-	0	-	-	0	-	-	0	-
	Molina	0	<11	0.0%	<11	<11	-	0	<11	0.0%
	United Health Care Community Plan	33	489	6.7%	<11	100	-	0	<11	0.0%
	TOTAL	832	4,957	16.8%	589	1,830	32.2%	366	856	42.8%

Health Home Lead Entity Outreach and GAO Measure Improvement

NOTES

- This portion of the GAO Measure section explores the subset of new enrollees who could not be reached with fewer than 3 documented attempts (based on information obtained via the GAO tracking lists). We are highlighting this subset because reducing the number of clients in this group is a meaningful way to improve outreach and a straightforward way to improve the GAO measure results.
- As seen in the Outreach Scenarios diagram below, the new enrollees not reached with fewer than 3 attempts are treated the same as new enrollees who are reached but not served within 90 days, for the purposes of the GAO Measure. That is, they are included in the denominator, but not in the numerator. If additional contact attempts are made and the client is reached, but not served within 90 days, the GAO Measure will remain the same.
- In all other scenarios the GAO Measure will increase. Either the client will be added to the numerator (if they are reached and served within 90 days), or the client will be removed from the denominator if they were reached and opted out within 90 days, or if they could not be contacted with 3+ documented attempts).
- The lead-specific tables and charts below show the number of new enrollees and the number (and percent) of those new enrollees who could not be reached with fewer than 3 attempts. It is the goal of the program to minimize this group.

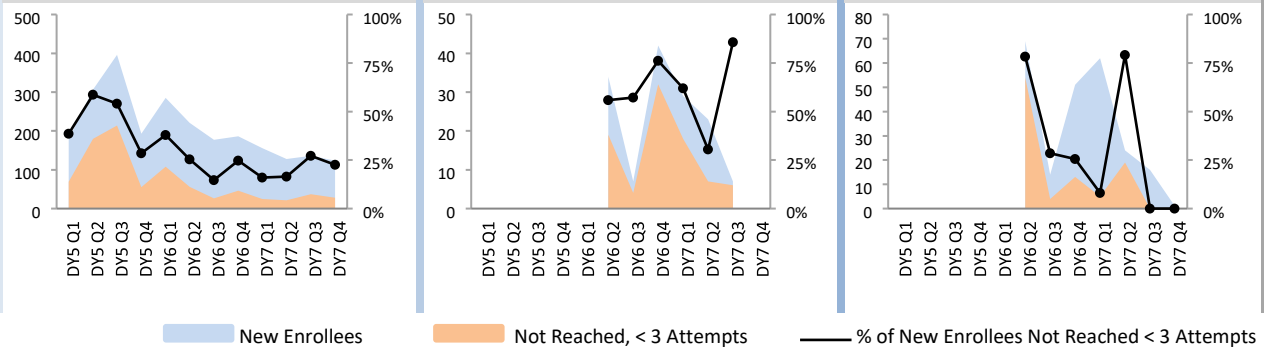
OUTREACH SCENARIOS



[1]New Enrollees who meet the GAO List inclusion criteria. [2]The Follow-Up Result definitions are based on information provided and received via the GAO Lists.

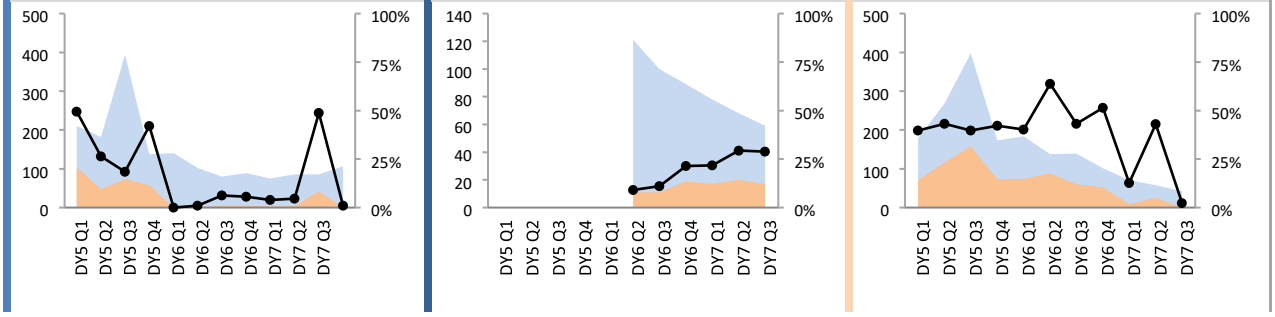
Health Home Lead Entity Outreach Detail

	Northwest Regional Council AAA			Olympic AAA			Pierce County AAA		
	New Enrollees	Not Reached < 3 Attempts	Percent	New Enrollees	Not Reached < 3 Attempts	Percent	New Enrollees	Not Reached < 3 Attempts	Percent
DY7 Q1	156	25	16%	29	18	62%	62	<11	-
DY7 Q2	128	21	16%	23	<11	-	24	19	79%
DY7 Q3	136	37	27%	<11	<11	86%	16	0	0%
DY7 Q4	124	28	23%	0	-	-	<11	0	0%

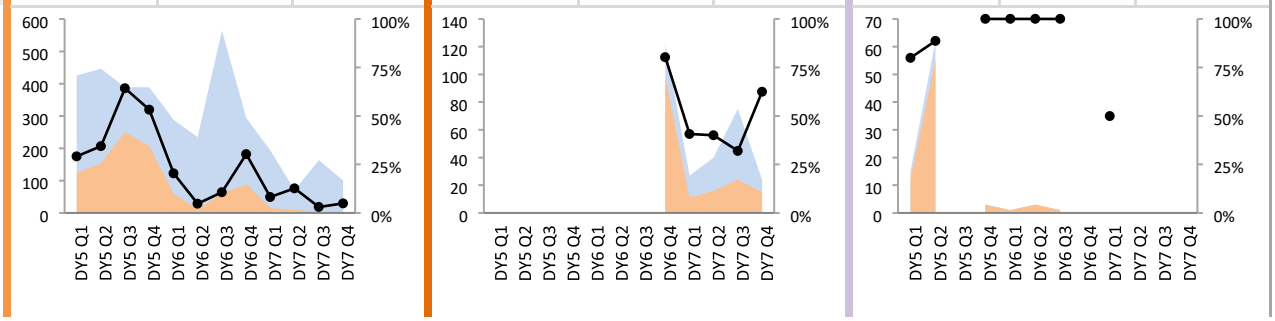


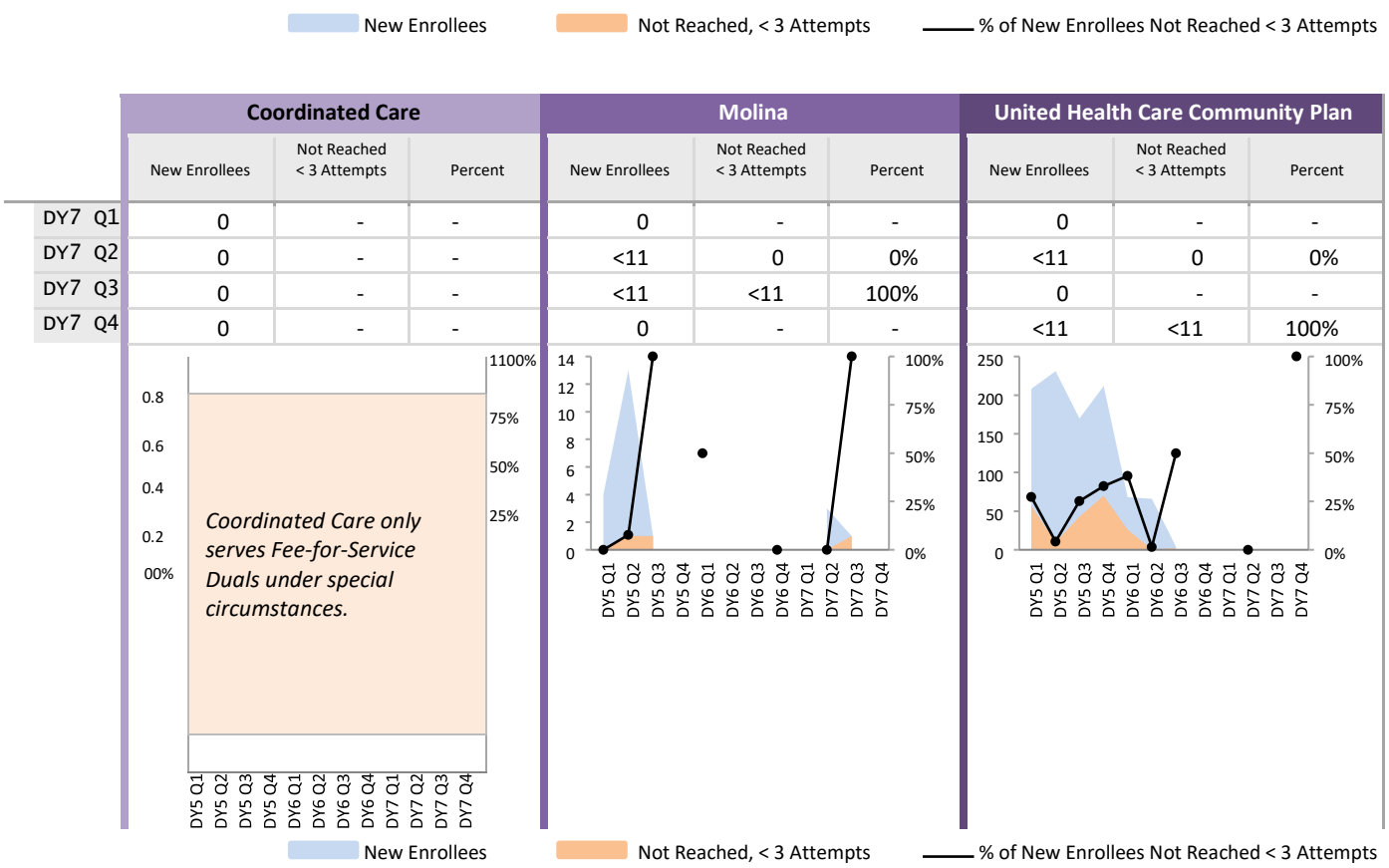
Health Home Lead Entity Outreach Detail (cont.)

	Southeast WA Aging and LTC AAA			Southwest AAA			Community Choice		
	New Enrollees	Not Reached < 3 Attempts	Percent	New Enrollees	Not Reached < 3 Attempts	Percent	New Enrollees	Not Reached < 3 Attempts	Percent
DY7 Q1	75	<11	-	78	17	22%	71	<11	-
DY7 Q2	86	<11	-	68	20	29%	58	25	43%
DY7 Q3	86	42	49%	59	17	29%	42	<11	-
DY7 Q4	106	<11	-	100	27	27%	82	16	20%



	Full Life Care			Elevate Health			Community Health Plan of Washington		
	New Enrollees	Not Reached < 3 Attempts	Percent	New Enrollees	Not Reached < 3 Attempts	Percent	New Enrollees	Not Reached < 3 Attempts	Percent
DY7 Q1	194	16	8%	27	11	41%	<11	<11	50%
DY7 Q2	71	<11	-	40	16	40%	0	-	-
DY7 Q3	163	<11	-	75	24	32%	0	-	-
DY7 Q4	101	<11	-	24	15	63%	0	-	-



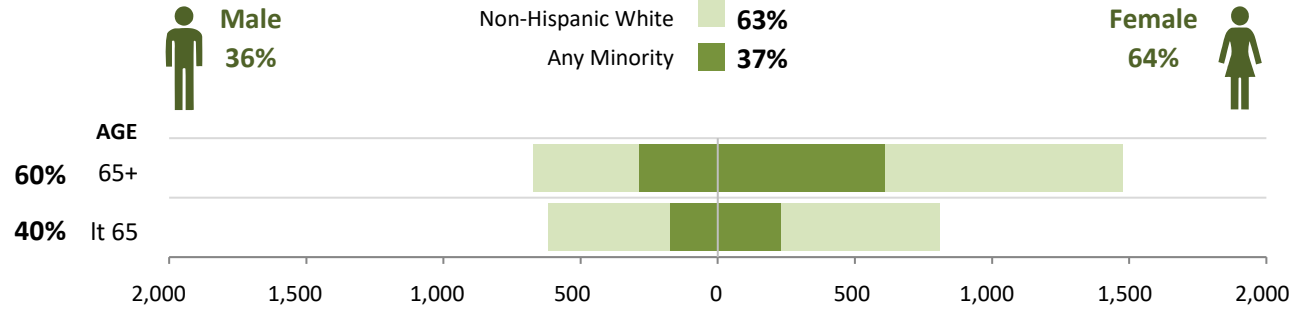


6. Demographic Details and Serious Mental Illness

NOTES

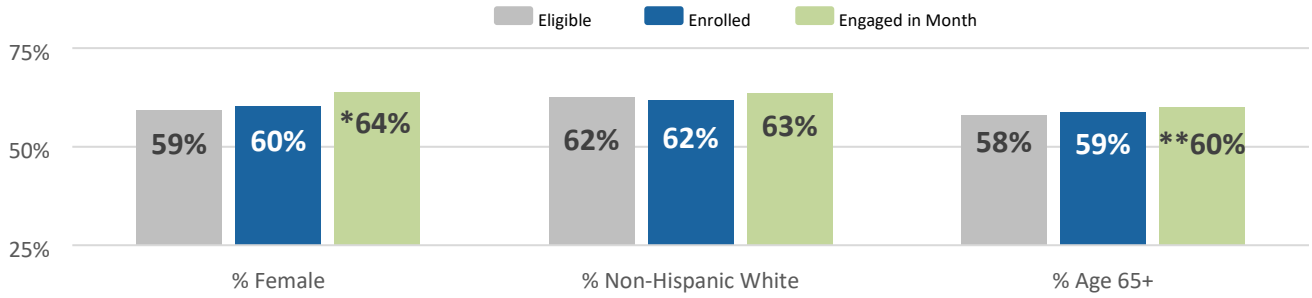
- A Minority Engagement Workgroup made up of staff from the Health Care Authority, the Department of Social and Health Services, and the Health Home Leads has been created to address engaging clients from underserved communities (including those with Serious Mental Illness).
- Demographic information is obtained from the ProviderOne (Medicaid) database.
- Any Minority includes any category besides Non-Hispanic White (including Hispanic, Other, and Unknown/Not Provided).

Demographic Breakdown of Engaged Dual Beneficiaries, September 2021



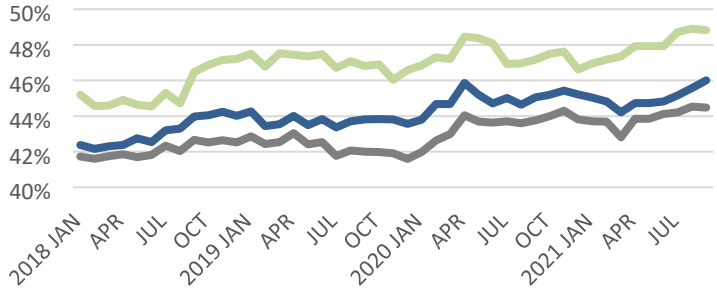
The percentage of Female, and Age 65+ clients are higher in the Engaged population than in the Eligible, or Enrolled populations in September 2021 (*p<0.001; **p<0.01).

The percentage of Non-Hispanic White clients was previously higher in the Engaged population, but has become more consistent between these populations.



Is the Duals Demonstration reaching those with Serious Mental Illness? Yes. In fact, the percentage of Dual Beneficiaries with an indication of Serious Mental Illness in the last 15 months is higher* in the Engaged population than in the Eligible, or Enrolled populations in September 2021 (*p<0.001).

This trend has held since January 2018 when Serious Mental Illness Indication was first tracked.



NOTES

- Serious Mental Illness is indicated by a diagnosis in the CDPS psychiatric risk groups characterized by the following representative conditions: schizophrenia and related psychotic disorders; mania and bipolar disorders; major recurrent depression.
- The indication of SMI is based on Medicaid and Medicare data, and has been extracted from PRISM beginning in 2018.

Fall 2021

Report for Washington Managed Fee-for-Service (MFFS)

Final Demonstration Year 5 and Preliminary Demonstration Year 6 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative

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RTI Project Number 0212790.003.002.007/008

REPORT FOR WASHINGTON MANAGED FEE-FOR-SERVICE (MFFS) FINAL DEMONSTRATION YEAR 5 AND PRELIMINARY DEMONSTRATION YEAR 6 MEDICARE SAVINGS ESTIMATES: MEDICARE-MEDICAID FINANCIAL ALIGNMENT INITIATIVE

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Fall 2021

This project was funded by the Centers for Medicare & Medicaid Services under contract no. HHSM-500-2014-00037i TO#7/#8. 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.

APPENDIX S (2)

Contents

List of Tables

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Executive Summary

The Washington Health Homes Managed Fee-for-Service (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 long-term services and supports (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 Years 4 (DY4), 5 (DY5) and 6 (DY6) include beneficiaries from all counties.

This report includes an analysis of Medicare Parts A & B savings during the 24-month period from January 1, 2018 through December 31, 2019: final Medicare savings estimates for DY5 (January 1, 2018 through December 31, 2018) and preliminary Medicare savings estimates for DY6 (January 1, 2019 through December 31, 2019). Final Medicare savings estimates for DY1, DY2, DY3, and DY4 and preliminary Medicare savings estimates for DY5 appeared in previously released Washington Medicare savings reports.

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.

- Total Medicare savings in Demonstration Year 5 were calculated as $55.1 million or 9.9 percent. An additional $11.1 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 5 Medicare savings amount of $66.2 million.

- Preliminary total Medicare savings in Demonstration Year 6 were calculated as $53.8 million or 9.8 percent. Including preliminary attributed Medicare savings estimates of $5.5 million results in a grand total preliminary Demonstration Year 6 Medicare savings estimate of $59.3 million.

- Per the previous Washington Medicare Savings reports,[1] total Demonstration Year 1 Medicare savings were calculated as $34.9 million, total Demonstration Year 2 savings were calculated as $30.2 million, total Demonstration Year 3 savings were calculated as $46.6 million and total Demonstration Year 4 savings were calculated as $56.0 million.

- The current estimate of grand total Demonstration Medicare savings for all cohorts through Demonstration Year 6 is $293.0 million.

[1] Previous actuarial savings reports are available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Washington.

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.

Washington began enrollment on July 1, 2013. During the first three Demonstration Years, Washington enrolled beneficiaries in the demonstration in all but two counties in the State (King and Snohomish). Effective April 1, 2017, the demonstration began to serve King and Snohomish counties, extending the demonstration service area statewide. Demonstration Year 4 onward includes beneficiaries from all counties in the state.

This report provides a final Medicare Parts A & B savings analysis of the Washington managed fee-for-service (MFFS) demonstration for Demonstration Year 5 (January 1, 2018 through December 31, 2018) and a preliminary analysis of Medicare data for Demonstration Year 6 (January 1, 2019 through December 31, 2019) under the Medicare-Medicaid Financial Alignment Initiative. CMS previously released four Medicare savings reports [2] by RTI entitled:

1. Final Demonstration Year 1 and Preliminary Demonstration Year 2 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative;

2. Final Demonstration Year 2 and Preliminary Demonstration Year 3 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative;

3. Final Demonstration Year 3 and Preliminary Demonstration Year 4 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative; and

4. Final Demonstration Year 4 and Preliminary Demonstration Year 5 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative.

This report provides *final* Medicare savings estimates for Demonstration Year 5 and *preliminary* Medicare savings estimates for Demonstration Year 6, the additional 12-month period spanning from January 1, 2019 through December 31, 2019. With this report, Demonstration Years 1, 2, 3, 4 and 5 experience and Medicare savings calculations are considered complete.[3]

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 is 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 performs as part of the evaluation. The Centers for Medicare & Medicaid Services (CMS) will use the results of the actuarial method to

[2] Previous actuarial savings reports are available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Washington.

[3] Any reference to Demonstration Years 1, 2, 3 and 4 experience and savings included in this report is pulled directly from the previous report and does not incorporate any new information or calculations.

determine whether Washington is eligible for a performance payment under the MFFS Financial Alignment Model.

The Medicare results presented in this report should be viewed as final for Demonstration Year 5, but preliminary for Demonstration Year 6. The Demonstration Year 6 Medicare Parts A and B expenditure data includes 10 months of claims runout (i.e., through October 2020). Note that 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. This final Medicare savings report for Demonstration Year 5 has been updated to include any retroactive adjustments to eligibility data and additional claims runout for beneficiaries in both the intervention and comparison groups since the publication of the preliminary results in the previous report.

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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 November 2020, to construct an analytic file that contains eligibility occurrences for:

- Part A and Part B coverage;
- primary payer status;
- eligibility occurrences for State/county codes of residence;
- date of death when applicable;
- 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 for all Demonstration Years. Thus, these new eligibility data were used to produce the final estimate of Medicare savings for Demonstration Year 5 and preliminary Medicare savings estimates for Demonstration Year 6.

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 6 will include updated values for all months in Demonstration Year 6.

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, 2019 and processed by CMS through October 2020. 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 2020. We have assumed the claims runout is effectively 100 percent complete for Demonstration Year 5.

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 (Washington state rolled out eligibility by county over the course of 6 months) for 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
- Cohort 6A: Those who met the requirements for eligibility on January 1, 2018 residing in all counties other than King and Snohomish (and are not in Cohorts 1, 2, 3, 4 or 5A)
- Cohort 6B: Those residing in King and Snohomish counties who met the requirements for eligibility on January 1, 2018 (and are not in Cohort 5B)
- Cohort 7A: Those who met requirements for eligibility on January 1, 2019 residing in all counties other than King and Snohomish (and are not in Cohorts 1, 2, 3, 4, 5A or 6A)
- Cohort 7B: Those residing in King and Snohomish counties who met the requirements for eligibility on January 1, 2019 (and are not in Cohorts 5B or 6B)

Note that 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 (which spans April 2017 through December 2017). Beginning in Demonstration Year 5 (which spans January 2018 through December 2018) and for all subsequent Demonstration Years, the time periods of experience will be identical, but beneficiaries in King and Snohomish counties will continue to be kept in separate sub-cohorts and there was a separate comparison group constructed for these individuals.

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).[4] 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 Medicare 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 Metropolitan Statistical Area (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 11th quarter of the demonstration for Cohort 4, in the 15th quarter of the demonstration for Cohort 5A and in the 16th quarter of the demonstration for Cohort 5B, in the 19th quarter of the demonstration for Cohorts 6A and 6B and in the 23rd quarter of the demonstration for Cohorts 7A and 7B.

[4] The PRISM score is based on a proprietary algorithm developed by the state of Washington.

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.[5] The use of a separate comparison group for these two counties reflects how they are notably different in composition from other regions of Washington.

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 Year 3 and onward 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 57–58 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 39 percent prevalence of SPMI compared with 45 percent in the comparison group. In the intervention group, 41 percent of members used HCBS, and 12 percent used facility-based LTSS, whereas the prevalence in the comparison group was 16 percent HCBS and 29 percent facility-based services. Such difference in the distribution by institutional status is addressed in the actuarial savings model in which the savings were calculated for each facility status category separately and weighted according to the intervention group distribution.

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 each new 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, 4, and 5, the savings percentage experienced by Cohorts 2, 3, 4, 5A, 5B, 6A and 6B were attributed to these few months for Cohorts 3, 4, 5A, 6A, 6B, 7A and 7B, respectively. Cohorts 8A and 8B will consist of those who were eligible for the demonstration in January 2020 in the original demonstration area and who were not in Cohorts 1, 2, 3, 4, 5A, 6A or 7A and those who were eligible for the demonstration in January 2020 in King and Snohomish counties who were not in Cohorts 5B, 6B or 7B.

For this report, we have tabulated the eligible member months in Demonstration Year 6 (January 2019 through December 2019) of preliminary Cohorts 8A and 8B and attribute the PMPM savings achieved for Cohorts 7A and 7B, respectively, to these first few months of

[5] A description of the comparison group selection methodology will be included in the Washington annual report.

eligibility of Cohorts 8A and 8B. 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.
- Cohort 6A: January through December 2017.
- Cohort 6B: January through December 2017.
- Cohort 7A: January through December 2018.

- Cohort 7B: January through December 2018.

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, 2020.
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.

12. For Cohorts 1, 2, 3, 4, 5A and 5B, January 1, 2018 if the beneficiary was part of a Medicare shared savings program in 2018, but had not been part of a shared savings program prior to 2018.

13. For Cohorts 1, 2, 3, 4, 5A, 5B, 6A and 6B, January 1, 2019 if the beneficiary was part of a Medicare shared savings program in 2019, but had not been part of a shared savings program prior to 2019.

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, 6A, 6B, 7A and 7B, the member months are calculated beginning on January 1, 2014 through 2019 respectively, and accrue until one of the above termination events or the end of the analytic period. April 1, 2017 is the starting date applied for Cohort 5B. 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 State and to ensure that calculated savings result only from the demonstration and not from differences in these other factors. For Medicare expenditures, the only necessary adjustment is applying an Average Geographic Adjustment (AGA) factor.[6] The AGA factor reflects varying FFS cost trends in each county over time compared with the costs of the entire nation. 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.

[6] Other adjustments will have to be made to the Medicaid expenditures, e.g., to account for differences in Medicaid coverage between comparison and intervention states.

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 13,975 Medicare-Medicaid enrollees in the intervention group and 23,234 Medicare-Medicaid enrollees in the comparison group. After 78 months of operations, there were 4,126 eligible intervention group members and 3,820 eligible comparison group members as of December 31, 2019. The monthly attrition rates for the intervention and comparison groups were 1.62 percent and 2.25 percent, respectively. The most common reason for attrition was death and the monthly death rate for the intervention group was 0.76 percent, which was lower than the monthly death rate of 1.03 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 demonstration eligibility attrition (0.43 percent vs. 0.19 percent[7]) from (1) loss of dual eligibility (i.e., loss of Medicare or Medicaid eligibility) and (2) when Washington indicated that the beneficiary was no longer eligible.

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 1 composition

Subgroup	Number of beneficiaries	Monthly death rate	Total monthly attrition rate
1A	2,215	0.97%	1.70%
1B	3,845	0.62%	1.51%
1C	388	0.75%	1.84%
1D	6,013	0.80%	1.64%
1E	726	0.69%	1.65%
1F	788	0.58%	1.60%
Total	13,975		

[7] 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.

Reasons for ineligibility are summarized in Table 1.A–Table 1.J. Table 1.A summarizes the reasons for ineligibility for members of Cohort 1 who became ineligible during the first 78 months of demonstration operations. Table 1.B summarizes the reasons for ineligibility for members of Cohort 2 who became ineligible during their 72 months of demonstration operations. Tables 1.C-J summarize the reasons for ineligibility for members of Cohorts 3, 4, 5A, 5B, 6A/B and 7A/B who became ineligible during their 60, 48, 36, 33, 24 and 12 months of demonstration operations, respectively. Cohort 2 consists of 694 Medicare-Medicaid enrollees in the intervention group and 4,356 Medicare-Medicaid enrollees in the comparison group. After 72 months, there were 188 eligible intervention group members and 769 eligible comparison group members. The monthly attrition rates for the intervention and comparison groups were 2.02 percent and 2.41 percent, respectively.

Cohort 3 consists of 5,648 Medicare-Medicaid enrollees in the intervention group and 6,456 Medicare-Medicaid enrollees in the comparison group. After 60 months of operations, there were 1,806 eligible intervention group members and 1,313 eligible comparison group members. The monthly attrition rates for the intervention and comparison groups were 1.95 percent and 2.60 percent, respectively.

Cohort 4 consists of 5,833 Medicare-Medicaid enrollees in the intervention group and 7,237 Medicare-Medicaid enrollees in the comparison group. After 48 months of operations, there were 1,991 eligible intervention group members and 1,853 eligible comparison group members. The monthly attrition rates for the intervention and comparison groups were 2.30 percent and 2.75 percent, respectively.

Cohort 5A consists of 6,173 Medicare-Medicaid enrollees in the intervention group and 5,476 Medicare-Medicaid enrollees in the comparison group. After 36 months of operations, there were 2,622 eligible intervention group members and 1,685 eligible comparison group members. The monthly attrition rates for the intervention and comparison groups were 2.46 percent and 3.22 percent, respectively.

Cohort 5B consists of 5,938 Medicare-Medicaid enrollees in the intervention group and 20,475 Medicare-Medicaid enrollees in the comparison group. After 33 months of operations, there were 2,719 eligible intervention group members and 5,724 eligible comparison group members. The monthly attrition rates for the intervention and comparison groups were 2.40 percent and 3.92 percent, respectively.

Cohort 6A consists of 4,872 Medicare-Medicaid enrollees in the intervention group and 4,782 Medicare-Medicaid enrollees in the comparison group. After 24 months of operations, there were 2,497 eligible intervention group members and 1,870 eligible comparison group members. The monthly attrition rates for the intervention and comparison groups were 2.80 percent and 3.99 percent, respectively.

Cohort 6B consists of 3,321 Medicare-Medicaid enrollees in the intervention group and 5,388 Medicare-Medicaid enrollees in the comparison group. After 24 months of operations, there were 1,765 eligible intervention group members and 1,944 eligible comparison group members. The monthly attrition rates for the intervention and comparison groups were 2.62 percent and 4.33 percent, respectively.

Cohort 7A consists of 4,427 Medicare-Medicaid enrollees in the intervention group and 3,443 Medicare-Medicaid enrollees in the comparison group. After 12 months of operations, there were 3,045 eligible intervention group members and 2,303 eligible comparison group members. The monthly attrition rates for the intervention and comparison groups were 3.19 percent and 3.44 percent, respectively.

Cohort 7B consists of 2,125 Medicare-Medicaid enrollees in the intervention group and 3,722 Medicare-Medicaid enrollees in the comparison group. After 12 months of operations, there were 1,433 eligible intervention group members and 2,484 eligible comparison group members. The monthly attrition rates for the intervention and comparison groups were 3.32 percent and 3.42 percent, respectively.

Table 1.A
Reasons for ineligibility for Cohort 1

	Intervention group		Comparison group	
Final ineligibility reason	**Number of events**	**Monthly attrition rate**	**Number of events**	**Monthly attrition rate**
Death	4,603	0.76%	8,942	1.03%
Loss of Part A or B	52	0.01%	85	0.01%
GHO enrollment	1,674	0.28%	2,778	0.32%
Medicare secondary payer	239	0.04%	370	0.04%
Moved out of service area	416	0.07%	933	0.11%
Participation in SSP	237	0.04%	4,699	0.54%
Loss of eligibility	2,628	0.43%	1,607	0.19%
All ineligibles[8]	9,849	1.62%	19,414	2.25%
Beneficiaries as of 7/1/2013	13,975		23,234	
Beneficiaries as of 12/31/2019	4,126		3,820	
Total member months	608,549.74		864,372.94	

GHO = Group Health Organization.

[8] For Cohorts 1, 2, 3, 4 and 5 we included attrition experience from Demonstration Years 1, 2, 3 and 4 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, 2, 3 and 4 experience was finalized, it was not re-run, but the total beneficiary counts for first day eligible and eligible as of 12/31/2019 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	178	0.71%	1,410	0.95%
Loss of Part A or B	5	0.02%	16	0.01%
GHO enrollment	82	0.33%	522	0.35%
Medicare secondary payer	14	0.06%	67	0.04%
Moved out of service area	32	0.13%	220	0.15%
Participation in SSP	18	0.07%	916	0.61%
Loss of eligibility	177	0.71%	436	0.29%
All ineligibles	506	2.02%	3,587	2.41%
Beneficiaries as of 1/1/2014	694		4,356	
Beneficiaries as of 12/31/2019	188		769	
Total member months	25,048.54		149,124.79	

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	1,318	0.67%	1,982	1.00%
Loss of Part A or B	13	0.01%	32	0.02%
GHO enrollment	733	0.37%	691	0.35%
Medicare secondary payer	95	0.05%	93	0.05%
Moved out of service area	175	0.09%	279	0.14%
Participation in SSP	79	0.04%	1,480	0.75%
Loss of eligibility	1,429	0.72%	586	0.30%
All ineligibles	3,842	1.95%	5,143	2.60%
Beneficiaries as of 1/1/2015	5,648		6,456	
Beneficiaries as of 12/31/2019	1,806		1,313	
Total member months	197,272.41		197,792.90	

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	1,153	0.69%	1,976	1.01%
Loss of Part A or B	25	0.01%	23	0.01%
GHO enrollment	836	0.50%	897	0.46%
Medicare secondary payer	89	0.05%	88	0.04%
Moved out of service area	197	0.12%	268	0.14%
Participation in SSP	106	0.06%	1,478	0.76%
Loss of eligibility	1,436	0.86%	654	0.33%
All ineligibles	3,842	2.30%	5,384	2.75%
Beneficiaries as of 1/1/2016	5,833		7,237	
Beneficiaries as of 12/31/2019	1,991		1,853	
Total member months	166,731.44		195,675.61	

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	915	0.63%	1,330	1.13%
Loss of Part A or B	19	0.01%	20	0.02%
GHO enrollment	794	0.55%	776	0.66%
Medicare secondary payer	81	0.06%	46	0.04%
Moved out of service area	144	0.10%	130	0.11%
Participation in SSP	94	0.07%	999	0.85%
Loss of eligibility	1,504	1.04%	490	0.42%
All ineligibles	3,551	2.46%	3,791	3.22%
Beneficiaries as of 1/1/2017	6,173		5,476	
Beneficiaries as of 12/31/2019	2,622		1,685	
Total member months	144,450.27		117,572.92	

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	986	0.74%	3,794	1.01%
Loss of Part A or B	19	0.01%	57	0.02%
GHO enrollment	976	0.73%	3,161	0.84%
Medicare secondary payer	72	0.05%	220	0.06%
Moved out of service area	193	0.14%	618	0.16%
Participation in SSP	56	0.04%	5,424	1.44%
Loss of eligibility	917	0.68%	1,477	0.39%
All ineligibles	3,219	2.40%	14,751	3.92%
Beneficiaries as of 4/1/2017	5,938		20,475	
Beneficiaries as of 12/31/2019	2,719		5,724	
Total member months	133,998.09		375,896.43	

Table 1.G
Reasons for ineligibility for Cohort 6A

Final ineligibility reason	Intervention group		Comparison group	
	Number of events	Monthly attrition rate	Number of events	Monthly attrition rate
Death	589	0.69%	876	1.20%
Loss of Part A or B	7	0.01%	10	0.01%
GHO enrollment	538	0.63%	575	0.79%
Medicare secondary payer	54	0.06%	34	0.05%
Moved out of service area	153	0.18%	106	0.15%
Participation in SSP	29	0.03%	835	1.14%
Loss of eligibility	1,005	1.19%	476	0.65%
All ineligibles	2,375	2.80%	2,912	3.99%
Beneficiaries as of 1/1/2018	4,872		4,782	
Beneficiaries as of 12/31/2019	2,497		1,870	
Total member months	84,782.24		73,049.43	

Table 1.H
Reasons for ineligibility for Cohort 6B

Final ineligibility reason	Intervention group		Comparison group	
	Number of events	Monthly attrition rate	Number of events	Monthly attrition rate
Death	404	0.68%	957	1.20%
Loss of Part A or B	8	0.01%	20	0.03%
GHO enrollment	448	0.75%	941	1.18%
Medicare secondary payer	32	0.05%	47	0.06%
Moved out of service area	106	0.18%	132	0.17%
Participation in SSP	11	0.02%	851	1.07%
Loss of eligibility	547	0.92%	496	0.62%
All ineligibles	1,556	2.62%	3,444	4.33%
Beneficiaries as of 1/1/2018	3,321		5,388	
Beneficiaries as of 12/31/2019	1,765		1,944	
Total member months	59,469.77		79,494.93	

Table 1.I
Reasons for ineligibility for Cohort 7A[9]

Final ineligibility reason	Intervention group		Comparison group	
	Number of events	Monthly attrition rate	Number of events	Monthly attrition rate
Death	375	0.87%	440	1.33%
Loss of Part A or B	8	0.02%	14	0.04%
GHO enrollment	299	0.69%	358	1.08%
Medicare secondary payer	22	0.05%	18	0.05%
Moved out of service area	71	0.16%	61	0.18%
Loss of eligibility	607	1.40%	249	0.75%
All ineligibles	1,382	3.19%	1,140	3.44%
Beneficiaries as of 1/1/2019	4,427		3,443	
Beneficiaries as of 12/31/2019	3,045		2,303	
Total member months	43,336.23		33,187.56	

[9] Note that "Participation in a SSP" is never a possible reason for attrition for the most recently added cohort because it is based on prior year's status.

Table 1.J
Reasons for ineligibility for Cohort 7B

	Intervention group		Comparison group	
Final ineligibility reason	**Number of events**	**Monthly attrition rate**	**Number of events**	**Monthly attrition rate**
Death	149	0.72%	455	1.26%
Loss of Part A or B	6	0.03%	8	0.02%
GHO enrollment	194	0.93%	407	1.12%
Medicare secondary payer	9	0.04%	27	0.07%
Moved out of service area	61	0.29%	85	0.23%
Loss of eligibility	273	1.31%	256	0.71%
All ineligibles	692	3.32%	1,238	3.42%
Beneficiaries as of 1/1/2019	2,125		3,722	
Beneficiaries as of 12/31/2019	1,433		2,484	
Total member months	20,821.27		36,182.04	

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, i.e., 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-J. 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), Cohort 5B (Table 2.F), Cohort 6A (Table 2.G), Cohort 6B (Table 2.H), Cohort 7A (Table 2.I) and Cohort 7B (Table 2.J) for the baseline period and for Demonstration Years 5 and 6 by category of beneficiary.

- For comparison group Cohort 1, the PMPM increases by 15.0 percent from $1,600 during the baseline period to $1,840 during Demonstration Year 5 and by 21.9 percent to $1,951 during Demonstration Year 6.

- For comparison group Cohort 2, the PMPM decreases by 9.6 percent from $1,607 to $1,453 during Demonstration Year 5 and increases by 3.8 percent to $1,669 during Demonstration Year 6.

- For comparison group Cohort 3, the PMPM decreases by 9.5 percent from $1,674 to $1,515 during Demonstration Year 5 and by 11.6 percent to $1,480 during Demonstration Year 6.

- For comparison group Cohort 4, the PMPM decreases by 11.5 percent from $1,738 to $1,534 during Demonstration Year 5 and by 6.9 percent to $1,618 during Demonstration Year 6.

- For comparison group Cohort 5A, the PMPM decreases by 8.4 percent from $1,813 to $1,660 during Demonstration Year 5 and by 8.4 percent to $1,660 during Demonstration Year 6.

- For comparison group Cohort 5B, the PMPM increases by 3.7 percent from $1,582 to $1,641 during Demonstration Year 5 and by 8.4 percent to $1,715 during Demonstration Year 6.

- For comparison group Cohort 6A, the PMPM decreases by 6.0 percent from $2,001 to $1,880 during Demonstration Year 5 and by 5.4 percent to $1,893 during Demonstration Year 6.

- For comparison group Cohort 6B, the PMPM decreases by 9.2 percent from $1,779 to $1,615 during Demonstration Year 5 and by 8.0 percent to $1,637 during Demonstration Year 6.

- For comparison group 7A, the PMPM decreases by 12.8 percent from $2,155 to $1,879 during Demonstration Year 6.

- For comparison group 7B, the PMPM decreases by 9.4 percent from $1,923 to $1,742 during Demonstration Year 6.

Note: Cohorts 7A and 7B have no experience during Demonstration Year 5.

One significant difference between Cohorts 1 and 5B as compared to Cohorts 2, 3, 4, 5A, 6A, 6B, 7A and 7B is that Cohorts 1 and 5B represent a cross-section of demonstration-eligible beneficiaries, whereas Cohorts 2, 3, 4, 5A, 6A, 6B, 7A and 7B 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, 5A, 6A, 6B, 7A and 7B beneficiaries first met the requirements for demonstration eligibility more recently (otherwise they would have been included in the corresponding previous cohorts depending on where they reside).

Prior to comparison with the intervention group, as will be shown in subsequent tables, the PMPMs in each cell (i.e., the cohort, 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 (Washington and comparison states combined).

Table 2.A.1 MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 5, by category of beneficiary: Cohort 1

Category of beneficiary	Baseline period			Demonstration Year 5			Trend (D/B)[a]
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**495,181.0**	**$792,439,622**	**$1,600.30**	**78,141.1**	**$143,783,704**	**$1,840.05**	**1.14982**
Facility, age 65+, with SPMI	32,115.2	$66,311,502	$2,064.80	3,447.3	$6,401,789	$1,857.02	0.89937
Facility, age 65+, no SPMI	80,858.8	$139,945,392	$1,730.74	5,239.0	$7,646,958	$1,459.62	0.84335
HCBS, age 65+, with SPMI	10,838.8	$20,539,243	$1,894.97	1,670.3	$3,878,491	$2,322.06	1.22538
HCBS, age 65+, no SPMI	51,925.0	$84,282,667	$1,623.16	6,156.8	$14,382,882	$2,336.08	1.43922
Community, age 65+, with SPMI	12,587.9	$16,488,055	$1,309.84	2,657.3	$4,791,368	$1,803.09	1.37657
Community, age 65+, no SPMI	92,332.0	$108,551,869	$1,175.67	14,856.6	$26,738,474	$1,799.78	1.53085
Facility, age <65, with SPMI	10,531.3	$26,564,713	$2,522.45	2,153.6	$3,612,706	$1,677.53	0.66504
Facility, age <65, no SPMI	12,082.5	$28,804,414	$2,383.97	2,013.6	$3,112,819	$1,545.89	0.64845
HCBS, age <65, with SPMI	18,074.4	$30,515,893	$1,688.35	3,520.1	$5,803,110	$1,648.58	0.97645
HCBS, age <65, no SPMI	28,593.8	$55,535,580	$1,942.22	5,633.6	$12,347,849	$2,191.83	1.12852
Community, age <65, with SPMI	58,269.0	$76,748,751	$1,317.15	13,005.1	$18,921,608	$1,454.94	1.10462
Community, age <65, no SPMI	86,972.3	$138,151,543	$1,588.45	17,787.8	$36,145,649	$2,032.05	1.27926

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Table 2.A.2 MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 6, by category of beneficiary: Cohort 1

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**495,181.0**	**$792,439,622**	**$1,600.30**	**51,787.7**	**$101,047,501**	**$1,951.19**	**1.21926**
Facility, age 65+, with SPMI	32,115.2	$66,311,502	$2,064.80	2,138.5	$4,229,042	$1,977.59	0.95776
Facility, age 65+, no SPMI	80,858.8	$139,945,392	$1,730.74	3,206.9	$5,242,919	$1,634.86	0.94461
HCBS, age 65+, with SPMI	10,838.8	$20,539,243	$1,894.97	1,131.2	$2,798,568	$2,473.91	1.30551
HCBS, age 65+, no SPMI	51,925.0	$84,282,667	$1,623.16	3,749.6	$8,641,565	$2,304.64	1.41985
Community, age 65+, with SPMI	12,587.9	$16,488,055	$1,309.84	1,660.9	$3,451,813	$2,078.33	1.58671
Community, age 65+, no SPMI	92,332.0	$108,551,869	$1,175.67	9,620.4	$17,443,394	$1,813.17	1.54224
Facility, age <65, with SPMI	10,531.3	$26,564,713	$2,522.45	1,603.5	$2,915,224	$1,817.99	0.72072
Facility, age <65, no SPMI	12,082.5	$28,804,414	$2,383.97	1,404.6	$2,500,710	$1,780.40	0.74682
HCBS, age <65, with SPMI	18,074.4	$30,515,893	$1,688.35	2,526.7	$4,750,335	$1,880.06	1.11355
HCBS, age <65, no SPMI	28,593.8	$55,535,580	$1,942.22	3,529.1	$9,292,671	$2,633.12	1.35573
Community, age <65, with SPMI	58,269.0	$76,748,751	$1,317.15	8,582.5	$13,650,307	$1,590.48	1.20752
Community, age <65, no SPMI	86,972.3	$138,151,543	$1,588.45	12,633.7	$26,130,952	$2,068.35	1.30212

Table 2.B.1 MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 5, by category of beneficiary: Cohort 2

Category of beneficiary	Baseline period			Demonstration Year 5			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**42,008.3**	**$67,515,192**	**$1,607.19**	**16,165.3**	**$23,480,080**	**$1,452.50**	**0.90375**
Facility, age 65+, with SPMI	2,059.8	$5,419,492	$2,631.14	516.7	$919,506	$1,779.69	0.67640
Facility, age 65+, no SPMI	6,716.7	$14,724,625	$2,192.23	1,364.5	$1,918,720	$1,406.15	0.64143
HCBS, age 65+, with SPMI	613.4	$1,053,551	$1,717.67	311.8	$599,798	$1,923.82	1.12002
HCBS, age 65+, no SPMI	3,544.0	$5,267,521	$1,486.32	1,159.3	$2,440,731	$2,105.29	1.41644
Community, age 65+, with SPMI	1,074.8	$1,446,270	$1,345.67	402.8	$670,352	$1,664.20	1.23671
Community, age 65+, no SPMI	9,976.7	$13,004,722	$1,303.52	3,903.8	$5,166,341	$1,323.42	1.01527
Facility, age <65, with SPMI	668.8	$2,180,795	$3,260.87	254.4	$398,018	$1,564.57	0.47980
Facility, age <65, no SPMI	794.5	$2,553,958	$3,214.35	386.0	$825,594	$2,138.84	0.66541
HCBS, age <65, with SPMI	1,076.6	$1,473,625	$1,368.80	459.6	$481,015	$1,046.49	0.76453
HCBS, age <65, no SPMI	1,902.1	$2,801,867	$1,473.05	938.5	$1,567,832	$1,670.60	1.13411
Community, age <65, with SPMI	5,313.9	$6,380,978	$1,200.82	2,749.6	$2,814,659	$1,023.65	0.85246
Community, age <65, no SPMI	8,267.2	$11,207,788	$1,355.69	3,718.3	$5,677,515	$1,526.92	1.12630

Table 2.B.2 MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 6, by category of beneficiary: Cohort 2

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**42,008.3**	**$67,515,192**	**$1,607.19**	**10,472.4**	**$17,473,432**	**$1,668.53**	**1.03817**
Facility, age 65+, with SPMI	2,059.8	$5,419,492	$2,631.14	391.7	$567,917	$1,449.74	0.55099
Facility, age 65+, no SPMI	6,716.7	$14,724,625	$2,192.23	701.5	$1,010,870	$1,440.97	0.65731
HCBS, age 65+, with SPMI	613.4	$1,053,551	$1,717.67	179.0	$438,187	$2,448.41	1.42542
HCBS, age 65+, no SPMI	3,544.0	$5,267,521	$1,486.32	686.9	$1,981,835	$2,885.22	1.94118
Community, age 65+, with SPMI	1,074.8	$1,446,270	$1,345.67	253.3	$401,568	$1,585.19	1.17799
Community, age 65+, no SPMI	9,976.7	$13,004,722	$1,303.52	2,353.7	$3,908,905	$1,660.72	1.27403
Facility, age <65, with SPMI	668.8	$2,180,795	$3,260.87	174.9	$474,910	$2,716.06	0.83292
Facility, age <65, no SPMI	794.5	$2,553,958	$3,214.35	297.3	$662,514	$2,228.52	0.69330
HCBS, age <65, with SPMI	1,076.6	$1,473,625	$1,368.80	358.5	$320,643	$894.50	0.65350
HCBS, age <65, no SPMI	1,902.1	$2,801,867	$1,473.05	657.4	$846,797	$1,288.10	0.87444
Community, age <65, with SPMI	5,313.9	$6,380,978	$1,200.82	1,928.5	$2,355,117	$1,221.21	1.01699
Community, age <65, no SPMI	8,267.2	$11,207,788	$1,355.69	2,489.7	$4,504,170	$1,809.13	1.33447

Table 2.C.1 MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 5, by category of beneficiary: Cohort 3

Category of beneficiary	Baseline period			Demonstration Year 5			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**65,614.5**	**$109,816,298**	**$1,673.66**	**28,838.1**	**$43,694,525**	**$1,515.17**	**0.90530**
Facility, age 65+, with SPMI	4,878.2	$11,042,653	$2,263.65	1,687.4	$2,762,208	$1,636.97	0.72315
Facility, age 65+, no SPMI	12,137.4	$26,728,998	$2,202.20	3,435.0	$5,506,670	$1,603.10	0.72795
HCBS, age 65+, with SPMI	1,111.6	$1,593,577	$1,433.58	500.6	$752,992	$1,504.22	1.04927
HCBS, age 65+, no SPMI	4,599.1	$7,305,283	$1,588.42	1,883.3	$3,807,348	$2,021.63	1.27273
Community, age 65+, with SPMI	2,510.0	$3,725,198	$1,484.15	1,140.5	$1,254,696	$1,100.17	0.74128
Community, age 65+, no SPMI	12,485.8	$16,640,967	$1,332.79	5,491.3	$8,029,320	$1,462.20	1.09709
Facility, age <65, with SPMI	1,125.0	$3,949,081	$3,510.30	422.5	$771,915	$1,827.01	0.52047
Facility, age <65, no SPMI	1,435.9	$4,985,720	$3,472.12	572.1	$991,576	$1,733.25	0.49919
HCBS, age <65, with SPMI	2,068.1	$2,424,892	$1,172.54	1,316.5	$1,393,966	$1,058.84	0.90303
HCBS, age <65, no SPMI	2,938.7	$3,982,170	$1,355.08	1,855.8	$3,214,494	$1,732.15	1.27826
Community, age <65, with SPMI	10,202.2	$11,555,501	$1,132.64	5,402.5	$6,151,887	$1,138.72	1.00537
Community, age <65, no SPMI	10,122.4	$15,882,259	$1,569.02	5,130.7	$9,057,453	$1,765.34	1.12513

Table 2.C.2 MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 6, by category of beneficiary: Cohort 3

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**65,614.5**	**$109,816,298**	**$1,673.66**	**18,093.6**	**$26,771,826**	**$1,479.63**	**0.88407**
Facility, age 65+, with SPMI	4,878.2	$11,042,653	$2,263.65	947.6	$1,381,385	$1,457.75	0.64398
Facility, age 65+, no SPMI	12,137.4	$26,728,998	$2,202.20	2,006.8	$2,994,093	$1,492.00	0.67751
HCBS, age 65+, with SPMI	1,111.6	$1,593,577	$1,433.58	444.2	$714,806	$1,609.02	1.12238
HCBS, age 65+, no SPMI	4,599.1	$7,305,283	$1,588.42	1,051.5	$2,638,138	$2,508.83	1.57944
Community, age 65+, with SPMI	2,510.0	$3,725,198	$1,484.15	773.8	$1,061,115	$1,371.33	0.92398
Community, age 65+, no SPMI	12,485.8	$16,640,967	$1,332.79	3,371.3	$5,630,312	$1,670.09	1.25307
Facility, age <65, with SPMI	1,125.0	$3,949,081	$3,510.30	269.5	$221,865	$823.30	0.23454
Facility, age <65, no SPMI	1,435.9	$4,985,720	$3,472.12	399.1	$561,476	$1,406.86	0.40519
HCBS, age <65, with SPMI	2,068.1	$2,424,892	$1,172.54	1,017.5	$905,734	$890.13	0.75915
HCBS, age <65, no SPMI	2,938.7	$3,982,170	$1,355.08	1,095.3	$2,073,810	$1,893.42	1.39727
Community, age <65, with SPMI	10,202.2	$11,555,501	$1,132.64	3,575.9	$3,322,732	$929.21	0.82039
Community, age <65, no SPMI	10,122.4	$15,882,259	$1,569.02	3,141.1	$5,266,359	$1,676.61	1.06858

Table 2.D.1 MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 5, by category of beneficiary: Cohort 4

Category of beneficiary	Baseline period			Demonstration Year 5			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**74,886.5**	**$130,154,124**	**$1,738.02**	**40,169.6**	**$61,820,318**	**$1,538.98**	**0.88548**
Facility, age 65+, with SPMI	8,799.9	$23,177,043	$2,633.77	3,703.7	$6,591,776	$1,779.78	0.67575
Facility, age 65+, no SPMI	10,464.5	$21,506,946	$2,055.23	4,403.1	$5,866,599	$1,332.36	0.64828
HCBS, age 65+, with SPMI	2,013.0	$3,798,610	$1,887.04	1,062.9	$1,887,375	$1,775.67	0.94098
HCBS, age 65+, no SPMI	4,656.9	$6,769,043	$1,453.55	2,327.6	$5,036,615	$2,163.91	1.48871
Community, age 65+, with SPMI	3,872.4	$6,423,922	$1,658.90	2,296.8	$3,502,708	$1,525.02	0.91930
Community, age 65+, no SPMI	13,747.0	$17,606,796	$1,280.78	7,897.7	$11,631,105	$1,472.72	1.14986
Facility, age <65, with SPMI	2,039.5	$7,820,424	$3,834.53	1,037.9	$2,722,845	$2,623.39	0.68415
Facility, age <65, no SPMI	1,184.9	$4,054,838	$3,422.18	653.9	$1,549,556	$2,369.60	0.69243
HCBS, age <65, with SPMI	2,214.7	$2,946,358	$1,330.34	1,277.9	$1,996,312	$1,562.19	1.17428
HCBS, age <65, no SPMI	2,526.6	$3,932,951	$1,556.63	1,558.0	$2,740,205	$1,758.85	1.12990
Community, age <65, with SPMI	11,399.1	$13,242,226	$1,161.69	6,984.2	$7,014,999	$1,004.41	0.86462
Community, age <65, no SPMI	11,968.0	$18,874,966	$1,577.12	6,965.9	$11,280,223	$1,619.35	1.02678

Table 2.D.2 MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 6, by category of beneficiary: Cohort 4

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**74,886.5**	**$130,154,124**	**$1,738.02**	**25,246.2**	**$40,851,436**	**$1,618.12**	**0.93102**
Facility, age 65+, with SPMI	8,799.9	$23,177,043	$2,633.77	2,271.0	$4,359,511	$1,919.68	0.72887
Facility, age 65+, no SPMI	10,464.5	$21,506,946	$2,055.23	2,502.6	$4,281,225	$1,710.73	0.83238
HCBS, age 65+, with SPMI	2,013.0	$3,798,610	$1,887.04	618.1	$1,096,697	$1,774.18	0.94019
HCBS, age 65+, no SPMI	4,656.9	$6,769,043	$1,453.55	1,417.5	$2,867,309	$2,022.84	1.39165
Community, age 65+, with SPMI	3,872.4	$6,423,922	$1,658.90	1,475.4	$2,186,413	$1,481.88	0.89329
Community, age 65+, no SPMI	13,747.0	$17,606,796	$1,280.78	5,051.3	$7,293,040	$1,443.79	1.12727
Facility, age <65, with SPMI	2,039.5	$7,820,424	$3,834.53	611.3	$1,320,639	$2,160.27	0.56337
Facility, age <65, no SPMI	1,184.9	$4,054,838	$3,422.18	416.0	$622,169	$1,495.44	0.43698
HCBS, age <65, with SPMI	2,214.7	$2,946,358	$1,330.34	773.8	$1,503,583	$1,943.05	1.46057
HCBS, age <65, no SPMI	2,526.6	$3,932,951	$1,556.63	1,067.8	$1,932,741	$1,809.96	1.16274
Community, age <65, with SPMI	11,399.1	$13,242,226	$1,161.69	4,580.9	$5,142,210	$1,122.53	0.96629
Community, age <65, no SPMI	11,968.0	$18,874,966	$1,577.12	4,460.3	$8,245,899	$1,848.72	1.17221

Table 2.E.1 MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 5, by category of beneficiary: Cohort 5A

Category of beneficiary	Baseline period			Demonstration Year 5			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**55,234.5**	**$100,113,666**	**$1,812.52**	**37,832.1**	**$62,786,817**	**$1,659.62**	**0.91564**
Facility, age 65+, with SPMI	9,699.9	$22,110,254	$2,279.44	6,140.4	$11,411,282	$1,858.40	0.81529
Facility, age 65+, no SPMI	5,768.6	$12,028,564	$2,085.19	3,660.4	$7,101,490	$1,940.10	0.93042
HCBS, age 65+, with SPMI	1,794.4	$3,717,937	$2,071.96	1,491.2	$3,806,331	$2,552.55	1.23195
HCBS, age 65+, no SPMI	2,470.4	$3,972,554	$1,608.09	1,807.3	$3,493,418	$1,933.00	1.20205
Community, age 65+, with SPMI	4,508.5	$7,350,151	$1,630.30	3,425.0	$4,776,484	$1,394.59	0.85542
Community, age 65+, no SPMI	8,094.0	$9,210,465	$1,137.94	5,483.8	$5,675,531	$1,034.97	0.90951
Facility, age <65, with SPMI	2,106.1	$7,470,590	$3,547.09	1,287.1	$4,509,328	$3,503.55	0.98772
Facility, age <65, no SPMI	957.5	$3,328,035	$3,475.88	697.8	$2,269,242	$3,251.94	0.93557
HCBS, age <65, with SPMI	2,203.2	$3,920,524	$1,779.45	1,653.8	$2,957,901	$1,788.51	1.00509
HCBS, age <65, no SPMI	1,620.6	$2,444,637	$1,508.51	1,275.1	$2,131,329	$1,671.47	1.10803
Community, age <65, with SPMI	9,316.4	$12,525,536	$1,344.46	6,341.9	$7,051,303	$1,111.86	0.82699
Community, age <65, no SPMI	6,695.1	$12,034,419	$1,797.49	4,568.4	$7,603,178	$1,664.31	0.92591

Table 2.E.2 MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 6, by category of beneficiary: Cohort 5A

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**55,234.5**	**$100,113,666**	**$1,812.52**	**23,152.5**	**$38,432,394**	**$1,659.97**	**0.91583**
Facility, age 65+, with SPMI	9,699.9	$22,110,254	$2,279.44	3,822.0	$6,295,289	$1,647.13	0.72260
Facility, age 65+, no SPMI	5,768.6	$12,028,564	$2,085.19	1,996.8	$3,924,235	$1,965.25	0.94248
HCBS, age 65+, with SPMI	1,794.4	$3,717,937	$2,071.96	837.2	$2,668,129	$3,186.90	1.53811
HCBS, age 65+, no SPMI	2,470.4	$3,972,554	$1,608.09	1,134.2	$2,347,401	$2,069.73	1.28707
Community, age 65+, with SPMI	4,508.5	$7,350,151	$1,630.30	2,098.3	$2,802,113	$1,335.45	0.81915
Community, age 65+, no SPMI	8,094.0	$9,210,465	$1,137.94	3,477.0	$4,023,811	$1,157.25	1.01697
Facility, age <65, with SPMI	2,106.1	$7,470,590	$3,547.09	763.3	$2,102,459	$2,754.53	0.77656
Facility, age <65, no SPMI	957.5	$3,328,035	$3,475.88	442.3	$1,075,103	$2,430.61	0.69928
HCBS, age <65, with SPMI	2,203.2	$3,920,524	$1,779.45	935.5	$1,970,951	$2,106.73	1.18392
HCBS, age <65, no SPMI	1,620.6	$2,444,637	$1,508.51	886.2	$1,068,829	$1,206.09	0.79952
Community, age <65, with SPMI	9,316.4	$12,525,536	$1,344.46	3,800.3	$4,296,180	$1,130.47	0.84083
Community, age <65, no SPMI	6,695.1	$12,034,419	$1,797.49	2,959.4	$5,857,895	$1,979.45	1.10123

Table 2.F.1 MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 5, by category of beneficiary: Cohort 5B

Category of beneficiary	Baseline period			Demonstration Year 5			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**210,281.7**	**$332,690,142**	**$1,582.12**	**128,192.8**	**$210,346,049**	**$1,640.86**	**1.03713**
Facility, age 65+, with SPMI	24,578.5	$46,576,524	$1,895.01	15,828.2	$28,161,579	$1,779.20	0.93889
Facility, age 65+, no SPMI	10,335.3	$17,577,714	$1,700.74	6,431.7	$9,934,210	$1,544.57	0.90817
HCBS, age 65+, with SPMI	5,802.8	$12,529,769	$2,159.27	3,779.8	$8,742,909	$2,313.06	1.07122
HCBS, age 65+, no SPMI	6,670.5	$11,370,351	$1,704.57	4,335.2	$10,533,482	$2,429.78	1.42545
Community, age 65+, with SPMI	26,146.3	$42,479,059	$1,624.67	15,653.1	$27,327,384	$1,745.81	1.07457
Community, age 65+, no SPMI	34,850.4	$41,713,161	$1,196.92	18,741.1	$27,753,779	$1,480.91	1.23726
Facility, age <65, with SPMI	5,902.3	$15,354,462	$2,601.42	4,255.9	$9,684,871	$2,275.62	0.87476
Facility, age <65, no SPMI	2,785.0	$4,054,836	$1,455.96	2,045.9	$2,625,993	$1,283.55	0.88159
HCBS, age <65, with SPMI	7,250.9	$12,543,076	$1,729.86	5,030.2	$8,668,860	$1,723.36	0.99624
HCBS, age <65, no SPMI	4,331.2	$7,234,071	$1,670.21	3,147.8	$5,807,689	$1,844.97	1.10463
Community, age <65, with SPMI	57,206.1	$81,825,914	$1,430.37	34,920.5	$47,415,851	$1,357.82	0.94928
Community, age <65, no SPMI	24,422.3	$39,431,205	$1,614.56	14,023.4	$23,689,443	$1,689.28	1.04628

Table 2.F.2 MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 6, by category of beneficiary: Cohort 5B

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**210,281.7**	**$332,690,142**	**$1,582.12**	**80,098.8**	**$137,402,034**	**$1,715.41**	**1.08425**
Facility, age 65+, with SPMI	24,578.5	$46,576,524	$1,895.01	9,529.4	$17,729,497	$1,860.51	0.98180
Facility, age 65+, no SPMI	10,335.3	$17,577,714	$1,700.74	3,712.8	$5,935,343	$1,598.63	0.93996
HCBS, age 65+, with SPMI	5,802.8	$12,529,769	$2,159.27	2,054.0	$5,343,086	$2,601.30	1.20471
HCBS, age 65+, no SPMI	6,670.5	$11,370,351	$1,704.57	2,333.7	$5,071,222	$2,173.01	1.27481
Community, age 65+, with SPMI	26,146.3	$42,479,059	$1,624.67	10,065.6	$18,997,879	$1,887.40	1.16171
Community, age 65+, no SPMI	34,850.4	$41,713,161	$1,196.92	11,428.0	$18,342,460	$1,605.05	1.34098
Facility, age <65, with SPMI	5,902.3	$15,354,462	$2,601.42	3,221.8	$6,406,354	$1,988.45	0.76437
Facility, age <65, no SPMI	2,785.0	$4,054,836	$1,455.96	1,544.5	$1,850,130	$1,197.90	0.82276
HCBS, age <65, with SPMI	7,250.9	$12,543,076	$1,729.86	3,085.6	$6,098,371	$1,976.40	1.14252
HCBS, age <65, no SPMI	4,331.2	$7,234,071	$1,670.21	1,918.0	$4,330,472	$2,257.75	1.35177
Community, age <65, with SPMI	57,206.1	$81,825,914	$1,430.37	22,679.2	$32,668,728	$1,440.47	1.00706
Community, age <65, no SPMI	24,422.3	$39,431,205	$1,614.56	8,526.2	$14,628,490	$1,715.71	1.06265

Table 2.G.1 MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 5, by category of beneficiary: Cohort 6A

Category of beneficiary	Baseline period			Demonstration Year 5			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**48,146.2**	**$96,337,228**	**$2,000.93**	**47,388.4**	**$89,091,211**	**$1,880.02**	**0.93957**
Facility, age 65+, with SPMI	9,767.7	$23,702,945	$2,426.66	9,627.6	$19,563,479	$2,032.01	0.83737
Facility, age 65+, no SPMI	4,958.5	$9,755,842	$1,967.49	5,105.9	$8,164,877	$1,599.11	0.81277
HCBS, age 65+, with SPMI	1,685.3	$3,551,857	$2,107.56	1,724.2	$4,341,212	$2,517.83	1.19466
HCBS, age 65+, no SPMI	1,716.9	$3,400,100	$1,980.33	1,750.2	$3,828,130	$2,187.20	1.10446
Community, age 65+, with SPMI	4,220.9	$8,520,127	$2,018.58	4,097.2	$7,043,649	$1,719.15	0.85167
Community, age 65+, no SPMI	7,106.5	$10,648,158	$1,498.38	6,843.2	$11,154,738	$1,630.04	1.08787
Facility, age <65, with SPMI	2,027.2	$6,011,790	$2,965.53	2,142.3	$5,960,956	$2,782.48	0.93827
Facility, age <65, no SPMI	611.2	$1,798,045	$2,941.86	612.4	$1,378,975	$2,251.79	0.76543
HCBS, age <65, with SPMI	1,302.7	$2,856,009	$2,192.44	1,370.3	$3,264,444	$2,382.27	1.08658
HCBS, age <65, no SPMI	1,275.8	$2,021,794	$1,584.75	1,331.2	$2,042,358	$1,534.19	0.96810
Community, age <65, with SPMI	7,915.5	$14,247,500	$1,799.94	7,382.4	$11,798,313	$1,598.16	0.88790
Community, age <65, no SPMI	5,558.0	$9,823,061	$1,767.36	5,401.5	$10,550,080	$1,953.19	1.10515

Table 2.G.2 MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 6, by category of beneficiary: Cohort 6A

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**48,146.2**	**$96,337,228**	**$2,000.93**	**25,661.0**	**$48,572,919**	**$1,892.87**	**0.94599**
Facility, age 65+, with SPMI	9,767.7	$23,702,945	$2,426.66	5,064.6	$10,356,445	$2,044.87	0.84267
Facility, age 65+, no SPMI	4,958.5	$9,755,842	$1,967.49	2,570.9	$4,508,575	$1,753.71	0.89134
HCBS, age 65+, with SPMI	1,685.3	$3,551,857	$2,107.56	923.2	$2,309,687	$2,501.87	1.18709
HCBS, age 65+, no SPMI	1,716.9	$3,400,100	$1,980.33	971.1	$2,192,769	$2,258.05	1.14024
Community, age 65+, with SPMI	4,220.9	$8,520,127	$2,018.58	2,113.3	$3,949,296	$1,868.82	0.92581
Community, age 65+, no SPMI	7,106.5	$10,648,158	$1,498.38	4,093.1	$6,177,762	$1,509.30	1.00729
Facility, age <65, with SPMI	2,027.2	$6,011,790	$2,965.53	1,108.6	$3,084,151	$2,781.94	0.93809
Facility, age <65, no SPMI	611.2	$1,798,045	$2,941.86	306.1	$700,711	$2,289.40	0.77821
HCBS, age <65, with SPMI	1,302.7	$2,856,009	$2,192.44	741.4	$1,327,551	$1,790.51	0.81667
HCBS, age <65, no SPMI	1,275.8	$2,021,794	$1,584.75	720.0	$1,248,765	$1,734.49	1.09449
Community, age <65, with SPMI	7,915.5	$14,247,500	$1,799.94	4,066.1	$5,983,615	$1,471.60	0.81758
Community, age <65, no SPMI	5,558.0	$9,823,061	$1,767.36	2,982.7	$6,733,591	$2,257.57	1.27737

Table 2.H.1 MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 5, by category of beneficiary: Cohort 6B

Category of beneficiary	Baseline period			Demonstration Year 5			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**54,424.9**	**$96,838,525**	**$1,779.31**	**52,323.2**	**$84,514,118**	**$1,615.23**	**0.90779**
Facility, age 65+, with SPMI	7,406.7	$17,936,369	$2,421.63	7,470.2	$13,725,210	$1,837.33	0.75872
Facility, age 65+, no SPMI	3,502.1	$7,628,312	$2,178.22	3,494.1	$5,172,118	$1,480.24	0.67956
HCBS, age 65+, with SPMI	1,523.2	$3,546,533	$2,328.39	1,501.4	$4,049,752	$2,697.41	1.15848
HCBS, age 65+, no SPMI	1,913.0	$3,585,759	$1,874.42	1,812.4	$3,846,909	$2,122.57	1.13239
Community, age 65+, with SPMI	6,899.0	$12,403,562	$1,797.87	6,658.9	$11,446,703	$1,719.01	0.95614
Community, age 65+, no SPMI	9,172.2	$11,800,787	$1,286.59	8,429.7	$10,239,983	$1,214.75	0.94416
Facility, age <65, with SPMI	1,437.1	$5,049,052	$3,513.48	1,484.9	$3,761,538	$2,533.11	0.72097
Facility, age <65, no SPMI	717.0	$1,285,178	$1,792.44	735.8	$850,327	$1,155.67	0.64475
HCBS, age <65, with SPMI	1,514.3	$2,766,356	$1,826.87	1,526.8	$2,712,848	$1,776.81	0.97260
HCBS, age <65, no SPMI	1,151.1	$1,445,239	$1,255.57	1,123.9	$1,384,967	$1,232.33	0.98149
Community, age <65, with SPMI	12,960.2	$19,697,076	$1,519.81	12,368.9	$17,347,691	$1,402.53	0.92283
Community, age <65, no SPMI	6,229.1	$9,694,302	$1,556.29	5,716.3	$9,976,072	$1,745.21	1.12139

Table 2.H.2 MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 6, by category of beneficiary: Cohort 6B

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**54,424.9**	**$96,838,525**	**$1,779.31**	**27,171.7**	**$44,492,257**	**$1,637.45**	**0.92027**
Facility, age 65+, with SPMI	7,406.7	$17,936,369	$2,421.63	3,988.8	$7,327,882	$1,837.11	0.75862
Facility, age 65+, no SPMI	3,502.1	$7,628,312	$2,178.22	1,910.7	$3,072,955	$1,608.29	0.73835
HCBS, age 65+, with SPMI	1,523.2	$3,546,533	$2,328.39	568.3	$1,565,350	$2,754.36	1.18294
HCBS, age 65+, no SPMI	1,913.0	$3,585,759	$1,874.42	800.6	$1,515,256	$1,892.60	1.00970
Community, age 65+, with SPMI	6,899.0	$12,403,562	$1,797.87	3,651.1	$7,785,505	$2,132.39	1.18606
Community, age 65+, no SPMI	9,172.2	$11,800,787	$1,286.59	4,149.0	$5,095,664	$1,228.16	0.95459
Facility, age <65, with SPMI	1,437.1	$5,049,052	$3,513.48	965.2	$2,863,737	$2,966.97	0.84445
Facility, age <65, no SPMI	717.0	$1,285,178	$1,792.44	563.7	$629,815	$1,117.19	0.62328
HCBS, age <65, with SPMI	1,514.3	$2,766,356	$1,826.87	781.5	$1,296,224	$1,658.74	0.90797
HCBS, age <65, no SPMI	1,151.1	$1,445,239	$1,255.57	531.1	$686,759	$1,293.02	1.02983
Community, age <65, with SPMI	12,960.2	$19,697,076	$1,519.81	6,573.9	$8,556,004	$1,301.51	0.85636
Community, age <65, no SPMI	6,229.1	$9,694,302	$1,556.29	2,687.7	$4,097,105	$1,524.38	0.97950

Table 2.I MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 6, by category of beneficiary: Cohort 7A

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**34,209.1**	**$73,733,739**	**$2,155.38**	**33,187.6**	**$62,371,319**	**$1,879.36**	**0.87194**
Facility, age 65+, with SPMI	6,953.9	$18,019,761	$2,591.33	7,083.8	$13,952,455	$1,969.63	0.76009
Facility, age 65+, no SPMI	4,049.1	$10,651,927	$2,630.67	4,166.4	$9,029,564	$2,167.21	0.82382
HCBS, age 65+, with SPMI	1,377.9	$2,856,622	$2,073.21	1,417.6	$3,838,016	$2,707.33	1.30587
HCBS, age 65+, no SPMI	1,425.0	$2,110,953	$1,481.37	1,437.0	$2,906,872	$2,022.89	1.36555
Community, age 65+, with SPMI	2,748.4	$4,602,266	$1,674.53	2,570.8	$4,012,735	$1,560.87	0.93213
Community, age 65+, no SPMI	5,030.6	$7,834,777	$1,557.42	4,610.3	$5,654,176	$1,226.41	0.78746
Facility, age <65, with SPMI	1,085.2	$4,612,561	$4,250.32	1,072.8	$3,102,157	$2,891.69	0.68035
Facility, age <65, no SPMI	524.2	$1,950,666	$3,721.04	548.6	$1,669,829	$3,044.07	0.81807
HCBS, age <65, with SPMI	1,227.1	$3,314,576	$2,701.09	1,185.8	$2,410,064	$2,032.49	0.75247
HCBS, age <65, no SPMI	874.8	$1,799,957	$2,057.65	911.2	$1,731,095	$1,899.80	0.92329
Community, age <65, with SPMI	5,041.2	$8,136,402	$1,613.98	4,403.1	$6,372,143	$1,447.19	0.89666
Community, age <65, no SPMI	3,871.7	$7,843,270	$2,025.80	3,780.1	$7,692,212	$2,034.92	1.00450

Table 2.J MEDICARE
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 6, by category of beneficiary: Cohort 7B

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**38,695.1**	**$74,399,516**	**$1,922.71**	**36,182.0**	**$63,011,330**	**$1,741.51**	**0.90576**
Facility, age 65+, with SPMI	6,470.0	$14,577,875	$2,253.16	6,305.4	$11,783,334	$1,868.77	0.82940
Facility, age 65+, no SPMI	2,884.3	$7,207,326	$2,498.78	2,713.5	$4,910,808	$1,809.78	0.72426
HCBS, age 65+, with SPMI	1,144.7	$2,632,808	$2,300.05	1,057.3	$2,409,370	$2,278.76	0.99075
HCBS, age 65+, no SPMI	1,161.8	$2,281,127	$1,963.41	1,104.9	$2,354,906	$2,131.32	1.08552
Community, age 65+, with SPMI	4,873.3	$9,397,098	$1,928.29	4,503.0	$8,786,439	$1,951.23	1.01190
Community, age 65+, no SPMI	5,877.2	$8,911,281	$1,516.25	5,444.4	$8,000,863	$1,469.55	0.96920
Facility, age <65, with SPMI	1,348.7	$4,751,869	$3,523.42	1,282.2	$3,291,811	$2,567.24	0.72862
Facility, age <65, no SPMI	573.0	$1,008,315	$1,759.71	556.3	$445,638	$801.03	0.45521
HCBS, age <65, with SPMI	806.7	$1,648,239	$2,043.19	770.4	$1,953,984	$2,536.26	1.24132
HCBS, age <65, no SPMI	820.0	$904,370	$1,102.93	793.8	$949,085	$1,195.64	1.08405
Community, age <65, with SPMI	8,763.3	$14,550,456	$1,660.38	8,029.5	$10,309,952	$1,284.01	0.77333
Community, age <65, no SPMI	3,972.2	$6,528,752	$1,643.61	3,621.2	$7,815,140	$2,158.14	1.31305

Table 2.K
Comparison group summary (all cohorts)

	Baseline period			Demonstration Year 5				Demonstration Year 6			
Cohort	Number of eligible months	Medicare incurred claims	PMPM	Number of eligible months	Medicare incurred claims	PMPM	Cost trend (demo year 4/ baseline period)	Number of eligible months	Medicare incurred claims	PMPM	Cost trend (demo year 5/ baseline period)
Cohort 1	495,181.0	$792,439,622	$1,600.30	78,141.1	$143,783,704	$1,840.05	1.14982	51,787.7	$101,047,501	$1,951.19	1.21926
Cohort 2	42,008.3	$67,515,192	$1,607.19	16,165.3	$23,480,080	$1,452.50	0.90375	10,472.4	$17,473,432	$1,668.53	1.03817
Cohort 3	65,614.5	$109,816,298	$1,673.66	28,838.1	$43,694,525	$1,515.17	0.90530	18,093.6	$26,771,826	$1,479.63	0.88407
Cohort 4	74,886.5	$130,154,124	$1,738.02	40,169.6	$61,820,318	$1,538.98	0.88548	25,246.2	$40,851,436	$1,618.12	0.93102
Cohort 5A	55,234.5	$100,113,666	$1,812.52	37,832.1	$62,786,817	$1,659.62	0.91564	23,152.5	$38,432,394	$1,659.97	0.91583
Cohort 5B	210,281.7	$332,690,142	$1,582.12	128,192.8	$210,346,049	$1,640.86	1.03713	80,098.8	$137,402,034	$1,715.41	1.08425
Cohort 6A	48,146.2	$96,337,228	$2,000.93	47,388.4	$89,091,211	$1,880.02	0.93957	25,661.0	$48,572,919	$1,892.87	0.94599
Cohort 6B	54,424.9	$96,838,525	$1,779.31	52,323.2	$84,514,118	$1,615.23	0.90779	27,171.7	$44,492,257	$1,637.45	0.92027
Cohort 7A	34,209.1	$73,733,739	$2,155.38	0.0	$0	$0.00	0.00000	33,187.6	$62,371,319	$1,879.36	0.87194
Cohort 7B	38,695.1	$74,399,516	$1,922.71	0.0	$0	$0.00	0.00000	36,182.0	$63,011,330	$1,741.51	0.90576

Tables 3.A–3.P 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 month by month by cohort and category of beneficiary. Thus, the comparison group PMPMs in Tables 3.A–3.P 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.P, 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.A show the results for the entire Cohort 1 for Demonstration Years 5 and 6 separately. Table 3.A.1 shows that, for Demonstration Year 5, the PMPM for the comparison group increased by 22.2 percent from the baseline period, whereas that of the intervention group increased by only 19.6 percent, a difference of 2.6 percentage points. Similarly, Table 3.A.2 shows that, for Demonstration Year 6, the PMPM for the comparison group increased by 31.4 percent from the baseline period, whereas that of the intervention group increased by 21.6 percent, a difference of 9.8 percentage points.

Tables 3.H show the results for Cohort 2. From the baseline period to Demonstration Year 5, the PMPM for the comparison group decreased by 11.9 percent and the PMPM for the intervention group decreased by 17.3 percent, a difference of 5.4 percentage points. From the baseline period to Demonstration Year 6, the PMPM for the comparison group decreased by 1.6 percent whereas the PMPM for the intervention group decreased by 22.1 percent, a difference of 20.5 percentage points.

Tables 3.I show the results for Cohort 3. From the baseline period to Demonstration Year 5, the PMPM for the comparison group increased by 4.1 percent, and the PMPM for the intervention group decreased by 1.7 percent, a difference of 5.8 percentage points. From the baseline period to Demonstration Year 6, the PMPM for the comparison group increased by 8.8 percent and the PMPM for the intervention group increased by 3.8 percent, a difference of 5.0 percentage points.

Table 3.J shows the results for Cohort 4. From the baseline period to Demonstration Year 5, the PMPM for the comparison group increased by 4.7 percent, while the PMPM for the intervention group decreased by 2.7 percent, a difference of 7.4 percentage points. From the baseline period to Demonstration Year 6, the PMPM for the comparison group increased by 8.4 percent, while the intervention group decreased by 1.9 percent, a difference of 10.3 percentage points.

Table 3.K shows the results for Cohort 5A. From the baseline period to Demonstration Year 5, the PMPM for the comparison group increased by 0.1 percent, while the PMPM for the intervention group decreased by 12.0 percent, a difference of 12.1 percentage points. From the baseline period to Demonstration Year 6, the PMPM for the comparison group increased by 7.1

percent, while the PMPM for the intervention group decreased by 4.6 percent, a difference of 11.7 percentage points.

Table 3.L shows the results for Cohort 5B. From the baseline period to Demonstration Year 5, the PMPM for the comparison group increased by 11.2 percent, while the PMPM for the intervention group increased by 1.1 percent, a difference of 10.1 percentage points. From the baseline period to Demonstration Year 6, the PMPM for the comparison group increased by 17.5 percent, while the PMPM for the intervention group increased by 9.4 percent, a difference of 8.1 percentage points.

Table 3.M shows the results for Cohort 6A. From the baseline period to Demonstration Year 5, the PMPM for the comparison group increased by 0.8 percent, while the PMPM for the intervention group decreased by 17.6 percent, a difference of 18.4 percentage points. From the baseline period to Demonstration Year 6, the PMPM for the comparison group decreased by 0.7 percent, while the PMPM for the intervention group decreased by 19.5 percent, a difference of 18.8 percentage points.

Table 3.N shows the results for Cohort 6B. From the baseline period to Demonstration Year 5, the PMPM for the comparison group decreased by 0.6 percent, while the PMPM for the intervention group decreased by 12.0 percent, a difference of 11.4 percentage points. From the baseline period to Demonstration Year 6, the PMPM for the comparison group decreased by 0.2 percent, while the PMPM for the intervention group decreased by 8.2 percent, a difference of 8.0 percentage points.

Table 3.O shows the results for Cohort 7A. From the baseline period to Demonstration Year 6, the PMPM for the comparison group decreased by 3.8 percent, while the PMPM for the intervention group decreased by 8.8 percent, a difference of 5.0 percentage points. Table 3.P shows the results for Cohort 7B. From the baseline period to Demonstration Year 5, the PMPM for the comparison group decreased by 2.4 percent, while the PMPM for the intervention group decreased by 15.1 percent, a difference of 12.7 percentage points.

Tables 4.A and 4.B summarize the results of Tables 3.A–3.P 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 1B, 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 substantial. Cohort 3 shows moderate Medicare savings, and Cohorts 4, 5A, 5B, 6A, 6B, 7A and 7B all show more substantial 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 5, by category of beneficiary: Cohort 1 Total

	Baseline period			Demonstration Year 5			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)
Re-weighted comparison group	**300,541.1**	**$478,511,235**	**$1,592.17**	**65,777.2**	**$127,974,708**	**$1,945.58**	**1.222**
Facility, age 65+, with SPMI	8,034.5	$16,534,542	$2,057.93	810.9	$1,506,770	$1,858.17	0.903
Facility, age 65+, no SPMI	20,695.7	$35,690,181	$1,724.52	1,641.4	$2,394,059	$1,458.56	0.846
HCBS, age 65+, with SPMI	12,692.4	$24,055,314	$1,895.25	2,566.6	$5,957,081	$2,321.04	1.225
HCBS, age 65+, no SPMI	57,590.4	$93,564,252	$1,624.65	10,033.5	$23,442,342	$2,336.42	1.438
Community, age 65+, with SPMI	7,196.4	$9,442,825	$1,312.15	1,527.1	$2,745,123	$1,797.66	1.370
Community, age 65+, no SPMI	54,777.7	$64,461,342	$1,176.78	10,850.4	$19,525,011	$1,799.47	1.529
Facility, age <65, with SPMI	2,328.6	$5,874,283	$2,522.69	513.0	$860,241	$1,677.00	0.665
Facility, age <65, no SPMI	2,819.8	$6,751,321	$2,394.22	624.3	$967,255	$1,549.27	0.647
HCBS, age <65, with SPMI	21,022.7	$35,496,599	$1,688.49	6,541.6	$10,794,468	$1,650.13	0.977
HCBS, age <65, no SPMI	40,606.4	$78,915,525	$1,943.43	11,758.5	$25,779,457	$2,192.42	1.128
Community, age <65, with SPMI	29,285.3	$38,589,730	$1,317.72	7,663.8	$11,150,939	$1,455.02	1.104
Community, age <65, no SPMI	43,491.1	$69,135,320	$1,589.64	11,246.3	$22,851,962	$2,031.95	1.278
Intervention group	**300,541.1**	**$484,510,829**	**$1,612.13**	**65,777.2**	**$126,814,776**	**$1,927.94**	**1.196**
Facility, age 65+, with SPMI	8,034.5	$17,576,967	$2,187.68	810.9	$751,629	$926.92	0.424
Facility, age 65+, no SPMI	20,695.7	$39,145,639	$1,891.49	1,641.4	$1,942,205	$1,183.28	0.626
HCBS, age 65+, with SPMI	12,692.4	$24,018,817	$1,892.37	2,566.6	$4,426,587	$1,724.72	0.911
HCBS, age 65+, no SPMI	57,590.4	$90,235,491	$1,566.85	10,033.5	$21,046,938	$2,097.68	1.339
Community, age 65+, with SPMI	7,196.4	$9,895,987	$1,375.13	1,527.1	$2,348,106	$1,537.67	1.118
Community, age 65+, no SPMI	54,777.7	$66,727,404	$1,218.15	10,850.4	$21,675,251	$1,997.64	1.640
Facility, age <65, with SPMI	2,328.6	$7,974,151	$3,424.47	513.0	$970,121	$1,891.21	0.552
Facility, age <65, no SPMI	2,819.8	$11,926,346	$4,229.44	624.3	$1,196,726	$1,916.82	0.453
HCBS, age <65, with SPMI	21,022.7	$35,119,181	$1,670.54	6,541.6	$10,902,955	$1,666.71	0.998
HCBS, age <65, no SPMI	40,606.4	$72,535,248	$1,786.30	11,758.5	$25,398,572	$2,160.02	1.209
Community, age <65, with SPMI	29,285.3	$37,682,667	$1,286.74	7,663.8	$12,513,752	$1,632.84	1.269
Community, age <65, no SPMI	43,491.1	$71,672,932	$1,647.99	11,246.3	$23,641,933	$2,102.19	1.276

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 6, by category of beneficiary: Cohort 1 Total

	Baseline period			Demonstration Year 6			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)
Re-weighted comparison group	**300,541.1**	**$478,511,235**	**$1,592.17**	**54,347.9**	**$113,701,931**	**$2,092.11**	**1.314**
Facility, age 65+, with SPMI	8,034.5	$16,534,542	$2,057.93	512.4	$1,007,386	$1,966.00	0.955
Facility, age 65+, no SPMI	20,695.7	$35,690,181	$1,724.52	1,058.1	$1,728,660	$1,633.80	0.947
HCBS, age 65+, with SPMI	12,692.4	$24,055,314	$1,895.25	2,124.5	$5,273,925	$2,482.45	1.310
HCBS, age 65+, no SPMI	57,590.4	$93,564,252	$1,624.65	7,752.7	$17,914,332	$2,310.73	1.422
Community, age 65+, with SPMI	7,196.4	$9,442,825	$1,312.15	1,236.2	$2,574,387	$2,082.58	1.587
Community, age 65+, no SPMI	54,777.7	$64,461,342	$1,176.78	8,780.7	$15,913,723	$1,812.34	1.540
Facility, age <65, with SPMI	2,328.6	$5,874,283	$2,522.69	414.6	$753,953	$1,818.59	0.721
Facility, age <65, no SPMI	2,819.8	$6,751,321	$2,394.22	547.2	$973,539	$1,779.24	0.743
HCBS, age <65, with SPMI	21,022.7	$35,496,599	$1,688.49	5,618.4	$10,547,542	$1,877.33	1.112
HCBS, age <65, no SPMI	40,606.4	$78,915,525	$1,943.43	10,232.1	$26,894,219	$2,628.41	1.352
Community, age <65, with SPMI	29,285.3	$38,589,730	$1,317.72	6,473.0	$10,290,897	$1,589.82	1.207
Community, age <65, no SPMI	43,491.1	$69,135,320	$1,589.64	9,598.1	$19,829,368	$2,065.96	1.300
Intervention group	**300,541.1**	**$484,510,829**	**$1,612.13**	**54,347.9**	**$106,534,101**	**$1,960.23**	**1.216**
Facility, age 65+, with SPMI	8,034.5	$17,576,967	$2,187.68	512.4	$703,008	$1,371.98	0.627
Facility, age 65+, no SPMI	20,695.7	$39,145,639	$1,891.49	1,058.1	$1,539,692	$1,455.20	0.769
HCBS, age 65+, with SPMI	12,692.4	$24,018,817	$1,892.37	2,124.5	$4,180,888	$1,967.95	1.040
HCBS, age 65+, no SPMI	57,590.4	$90,235,491	$1,566.85	7,752.7	$16,294,628	$2,101.81	1.341
Community, age 65+, with SPMI	7,196.4	$9,895,987	$1,375.13	1,236.2	$1,634,157	$1,321.97	0.961
Community, age 65+, no SPMI	54,777.7	$66,727,404	$1,218.15	8,780.7	$16,458,870	$1,874.43	1.539
Facility, age <65, with SPMI	2,328.6	$7,974,151	$3,424.47	414.6	$520,263	$1,254.91	0.366
Facility, age <65, no SPMI	2,819.8	$11,926,346	$4,229.44	547.2	$1,145,150	$2,092.88	0.495
HCBS, age <65, with SPMI	21,022.7	$35,119,181	$1,670.54	5,618.4	$9,664,878	$1,720.23	1.030
HCBS, age <65, no SPMI	40,606.4	$72,535,248	$1,786.30	10,232.1	$20,827,624	$2,035.51	1.140
Community, age <65, with SPMI	29,285.3	$37,682,667	$1,286.74	6,473.0	$11,585,737	$1,789.86	1.391
Community, age <65, no SPMI	43,491.1	$71,672,932	$1,647.99	9,598.1	$21,979,206	$2,289.95	1.390

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 5, by category of beneficiary: Cohort 1A

	Baseline period			Demonstration Year 5			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)
Re-weighted comparison group	**48,488.0**	**$78,754,198**	**$1,624.20**	**9,903.2**	**$19,681,818**	**$1,987.42**	**1.224**
Facility, age 65+, with SPMI	1,352.5	$2,783,905	$2,058.35	107.2	$198,923	$1,856.30	0.902
Facility, age 65+, no SPMI	2,903.2	$4,986,268	$1,717.53	149.3	$217,930	$1,459.90	0.850
HCBS, age 65+, with SPMI	2,269.5	$4,300,359	$1,894.85	417.5	$966,721	$2,315.77	1.222
HCBS, age 65+, no SPMI	10,415.6	$16,922,467	$1,624.72	1,623.0	$3,793,491	$2,337.27	1.439
Community, age 65+, with SPMI	1,044.6	$1,366,976	$1,308.56	201.2	$360,321	$1,790.74	1.368
Community, age 65+, no SPMI	8,618.5	$10,152,870	$1,178.03	1,542.0	$2,774,227	$1,799.14	1.527
Facility, age <65, with SPMI	479.0	$1,208,097	$2,521.97	70.0	$117,262	$1,675.17	0.664
Facility, age <65, no SPMI	596.9	$1,420,117	$2,379.14	151.0	$233,248	$1,544.69	0.649
HCBS, age <65, with SPMI	3,601.9	$6,081,141	$1,688.33	990.0	$1,635,504	$1,652.00	0.978
HCBS, age <65, no SPMI	8,245.1	$16,023,110	$1,943.35	2,282.0	$5,003,327	$2,192.54	1.128
Community, age <65, with SPMI	2,682.4	$3,530,797	$1,316.26	750.0	$1,089,906	$1,453.17	1.104
Community, age <65, no SPMI	6,278.7	$9,978,092	$1,589.20	1,620.1	$3,290,958	$2,031.36	1.278
Intervention group	**48,488.0**	**$128,622,626**	**$2,652.67**	**9,903.2**	**$26,728,247**	**$2,698.95**	**1.017**
Facility, age 65+, with SPMI	1,352.5	$4,491,706	$3,321.06	107.2	$195,928	$1,828.34	0.551
Facility, age 65+, no SPMI	2,903.2	$7,189,174	$2,476.33	149.3	$170,410	$1,141.57	0.461
HCBS, age 65+, with SPMI	2,269.5	$6,589,879	$2,903.67	417.5	$1,166,954	$2,795.42	0.963
HCBS, age 65+, no SPMI	10,415.6	$24,885,794	$2,389.27	1,623.0	$4,236,451	$2,610.19	1.092
Community, age 65+, with SPMI	1,044.6	$2,160,270	$2,067.95	201.2	$477,871	$2,374.95	1.148
Community, age 65+, no SPMI	8,618.5	$18,306,257	$2,124.06	1,542.0	$4,137,170	$2,683.04	1.263
Facility, age <65, with SPMI	479.0	$2,542,110	$5,306.80	70.0	$47,764	$682.34	0.129
Facility, age <65, no SPMI	596.9	$2,844,227	$4,764.97	151.0	$222,571	$1,473.98	0.309
HCBS, age <65, with SPMI	3,601.9	$10,014,768	$2,780.44	990.0	$2,167,999	$2,189.87	0.788
HCBS, age <65, no SPMI	8,245.1	$22,193,360	$2,691.70	2,282.0	$6,632,155	$2,906.31	1.080
Community, age <65, with SPMI	2,682.4	$6,561,637	$2,446.14	750.0	$2,428,337	$3,237.69	1.324
Community, age <65, no SPMI	6,278.7	$20,843,442	$3,319.71	1,620.1	$4,844,638	$2,990.38	0.901

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 6, by category of beneficiary: Cohort 1A

	Baseline period			Demonstration Year 6			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)
Re-weighted comparison group	**48,488.0**	**$78,754,198**	**$1,624.20**	**7,920.6**	**$17,109,366**	**$2,160.11**	**1.330**
Facility, age 65+, with SPMI	1,352.5	$2,783,905	$2,058.35	47.1	$92,670	$1,968.55	0.956
Facility, age 65+, no SPMI	2,903.2	$4,986,268	$1,717.53	87.0	$142,328	$1,636.14	0.953
HCBS, age 65+, with SPMI	2,269.5	$4,300,359	$1,894.85	344.2	$856,859	$2,489.30	1.314
HCBS, age 65+, no SPMI	10,415.6	$16,922,467	$1,624.72	1,249.9	$2,889,589	$2,311.87	1.423
Community, age 65+, with SPMI	1,044.6	$1,366,976	$1,308.56	189.7	$395,736	$2,085.75	1.594
Community, age 65+, no SPMI	8,618.5	$10,152,870	$1,178.03	1,138.1	$2,065,723	$1,814.99	1.541
Facility, age <65, with SPMI	479.0	$1,208,097	$2,521.97	50.0	$90,899	$1,817.98	0.721
Facility, age <65, no SPMI	596.9	$1,420,117	$2,379.14	135.4	$240,896	$1,778.94	0.748
HCBS, age <65, with SPMI	3,601.9	$6,081,141	$1,688.33	789.4	$1,481,531	$1,876.78	1.112
HCBS, age <65, no SPMI	8,245.1	$16,023,110	$1,943.35	1,955.4	$5,138,013	$2,627.64	1.352
Community, age <65, with SPMI	2,682.4	$3,530,797	$1,316.26	590.1	$938,059	$1,589.76	1.208
Community, age <65, no SPMI	6,278.7	$9,978,092	$1,589.20	1,344.3	$2,777,062	$2,065.83	1.300
Intervention group	**48,488.0**	**$128,622,626**	**$2,652.67**	**7,920.6**	**$20,531,587**	**$2,592.18**	**0.977**
Facility, age 65+, with SPMI	1,352.5	$4,491,706	$3,321.06	47.1	$97,718	$2,075.77	0.625
Facility, age 65+, no SPMI	2,903.2	$7,189,174	$2,476.33	87.0	$119,539	$1,374.16	0.555
HCBS, age 65+, with SPMI	2,269.5	$6,589,879	$2,903.67	344.2	$713,838	$2,073.81	0.714
HCBS, age 65+, no SPMI	10,415.6	$24,885,794	$2,389.27	1,249.9	$3,235,783	$2,588.85	1.084
Community, age 65+, with SPMI	1,044.6	$2,160,270	$2,067.95	189.7	$199,633	$1,052.18	0.509
Community, age 65+, no SPMI	8,618.5	$18,306,257	$2,124.06	1,138.1	$3,030,685	$2,662.83	1.254
Facility, age <65, with SPMI	479.0	$2,542,110	$5,306.80	50.0	$46,559	$931.19	0.175
Facility, age <65, no SPMI	596.9	$2,844,227	$4,764.97	135.4	$456,541	$3,371.42	0.708
HCBS, age <65, with SPMI	3,601.9	$10,014,768	$2,780.44	789.4	$1,838,495	$2,328.97	0.838
HCBS, age <65, no SPMI	8,245.1	$22,193,360	$2,691.70	1,955.4	$4,651,479	$2,378.82	0.884
Community, age <65, with SPMI	2,682.4	$6,561,637	$2,446.14	590.1	$1,754,649	$2,973.66	1.216
Community, age <65, no SPMI	6,278.7	$20,843,442	$3,319.71	1,344.3	$4,386,668	$3,263.20	0.983

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 5, by category of beneficiary: Cohort 1B

	Baseline period			Demonstration Year 5			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)
Re-weighted comparison group	**83,567.1**	**$131,605,106**	**$1,574.84**	**19,132.6**	**$37,050,672**	**$1,936.52**	**1.230**
Facility, age 65+, with SPMI	2,625.5	$5,399,392	$2,056.49	311.0	$578,022	$1,858.52	0.904
Facility, age 65+, no SPMI	5,728.2	$9,863,362	$1,721.89	423.2	$619,566	$1,463.89	0.850
HCBS, age 65+, with SPMI	3,563.5	$6,749,830	$1,894.18	839.1	$1,944,443	$2,317.26	1.223
HCBS, age 65+, no SPMI	15,666.1	$25,409,746	$1,621.96	3,031.9	$7,083,059	$2,336.17	1.440
Community, age 65+, with SPMI	2,079.3	$2,725,280	$1,310.68	454.8	$820,385	$1,803.87	1.376
Community, age 65+, no SPMI	16,756.0	$19,691,126	$1,175.17	3,484.9	$6,271,090	$1,799.50	1.531
Facility, age <65, with SPMI	707.2	$1,783,893	$2,522.57	224.2	$375,373	$1,674.57	0.664
Facility, age <65, no SPMI	436.0	$1,056,112	$2,422.27	101.7	$158,002	$1,554.33	0.642
HCBS, age <65, with SPMI	6,710.7	$11,329,713	$1,688.31	2,245.2	$3,702,982	$1,649.32	0.977
HCBS, age <65, no SPMI	9,528.3	$18,510,143	$1,942.64	2,983.5	$6,542,150	$2,192.80	1.129
Community, age <65, with SPMI	8,555.1	$11,262,998	$1,316.53	2,209.2	$3,215,946	$1,455.71	1.106
Community, age <65, no SPMI	11,211.2	$17,823,513	$1,589.79	2,824.0	$5,739,654	$2,032.46	1.278
Intervention group	**83,567.1**	**$108,476,913**	**$1,298.08**	**19,132.6**	**$33,855,821**	**$1,769.54**	**1.363**
Facility, age 65+, with SPMI	2,625.5	$4,153,377	$1,581.91	311.0	$249,631	$802.64	0.507
Facility, age 65+, no SPMI	5,728.2	$9,679,939	$1,689.87	423.2	$604,928	$1,429.30	0.846
HCBS, age 65+, with SPMI	3,563.5	$5,032,372	$1,412.22	839.1	$1,089,176	$1,298.01	0.919
HCBS, age 65+, no SPMI	15,666.1	$18,456,030	$1,178.09	3,031.9	$5,443,082	$1,795.27	1.524
Community, age 65+, with SPMI	2,079.3	$2,370,627	$1,140.11	454.8	$620,048	$1,363.37	1.196
Community, age 65+, no SPMI	16,756.0	$16,271,631	$971.09	3,484.9	$6,113,818	$1,754.37	1.807
Facility, age <65, with SPMI	707.2	$2,294,483	$3,244.58	224.2	$431,463	$1,924.79	0.593
Facility, age <65, no SPMI	436.0	$1,627,921	$3,733.76	101.7	$196,993	$1,937.91	0.519
HCBS, age <65, with SPMI	6,710.7	$9,300,631	$1,385.95	2,245.2	$3,836,034	$1,708.58	1.233
HCBS, age <65, no SPMI	9,528.3	$14,182,694	$1,488.47	2,983.5	$6,709,874	$2,249.02	1.511
Community, age <65, with SPMI	8,555.1	$9,515,214	$1,112.23	2,209.2	$3,006,653	$1,360.97	1.224
Community, age <65, no SPMI	11,211.2	$15,591,994	$1,390.75	2,824.0	$5,554,122	$1,966.76	1.414

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 6, by category of beneficiary: Cohort 1B

	Baseline period			Demonstration Year 6			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)
Re-weighted comparison group	**83,567.1**	**$131,605,106**	**$1,574.84**	**15,489.8**	**$32,115,928**	**$2,073.36**	**1.317**
Facility, age 65+, with SPMI	2,625.5	$5,399,392	$2,056.49	237.5	$468,535	$1,972.96	0.959
Facility, age 65+, no SPMI	5,728.2	$9,863,362	$1,721.89	253.1	$413,990	$1,635.44	0.950
HCBS, age 65+, with SPMI	3,563.5	$6,749,830	$1,894.18	716.5	$1,777,029	$2,480.21	1.309
HCBS, age 65+, no SPMI	15,666.1	$25,409,746	$1,621.96	2,363.0	$5,462,816	$2,311.80	1.425
Community, age 65+, with SPMI	2,079.3	$2,725,280	$1,310.68	344.7	$717,025	$2,080.28	1.587
Community, age 65+, no SPMI	16,756.0	$19,691,126	$1,175.17	2,895.6	$5,247,441	$1,812.22	1.542
Facility, age <65, with SPMI	707.2	$1,783,893	$2,522.57	192.0	$349,733	$1,821.52	0.722
Facility, age <65, no SPMI	436.0	$1,056,112	$2,422.27	106.0	$189,318	$1,786.02	0.737
HCBS, age <65, with SPMI	6,710.7	$11,329,713	$1,688.31	1,901.5	$3,572,314	$1,878.73	1.113
HCBS, age <65, no SPMI	9,528.3	$18,510,143	$1,942.64	2,447.5	$6,438,993	$2,630.87	1.354
Community, age <65, with SPMI	8,555.1	$11,262,998	$1,316.53	1,794.9	$2,855,386	$1,590.80	1.208
Community, age <65, no SPMI	11,211.2	$17,823,513	$1,589.79	2,237.5	$4,623,348	$2,066.27	1.300
Intervention group	**83,567.1**	**$108,476,913**	**$1,298.08**	**15,489.8**	**$27,517,708**	**$1,776.51**	**1.369**
Facility, age 65+, with SPMI	2,625.5	$4,153,377	$1,581.91	237.5	$301,796	$1,270.83	0.803
Facility, age 65+, no SPMI	5,728.2	$9,679,939	$1,689.87	253.1	$474,145	$1,873.08	1.108
HCBS, age 65+, with SPMI	3,563.5	$5,032,372	$1,412.22	716.5	$1,435,116	$2,003.00	1.418
HCBS, age 65+, no SPMI	15,666.1	$18,456,030	$1,178.09	2,363.0	$4,014,808	$1,699.02	1.442
Community, age 65+, with SPMI	2,079.3	$2,370,627	$1,140.11	344.7	$513,424	$1,489.58	1.307
Community, age 65+, no SPMI	16,756.0	$16,271,631	$971.09	2,895.6	$4,682,706	$1,617.19	1.665
Facility, age <65, with SPMI	707.2	$2,294,483	$3,244.58	192.0	$304,182	$1,584.28	0.488
Facility, age <65, no SPMI	436.0	$1,627,921	$3,733.76	106.0	$137,106	$1,293.45	0.346
HCBS, age <65, with SPMI	6,710.7	$9,300,631	$1,385.95	1,901.5	$3,172,992	$1,668.72	1.204
HCBS, age <65, no SPMI	9,528.3	$14,182,694	$1,488.47	2,447.5	$5,263,844	$2,150.73	1.445
Community, age <65, with SPMI	8,555.1	$9,515,214	$1,112.23	1,794.9	$2,678,249	$1,492.11	1.342
Community, age <65, no SPMI	11,211.2	$15,591,994	$1,390.75	2,237.5	$4,539,340	$2,028.72	1.459

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 5, by category of beneficiary: Cohort 1C

	Baseline period			Demonstration Year 5			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)
Re-weighted comparison group	**7,946.8**	**$12,115,020**	**$1,524.51**	**1,567.5**	**$3,009,601**	**$1,919.99**	**1.259**
Facility, age 65+, with SPMI	78.0	$162,290	$2,080.64	12.0	$22,254	$1,854.52	0.891
Facility, age 65+, no SPMI	509.6	$883,213	$1,733.25	36.0	$52,211	$1,450.31	0.837
HCBS, age 65+, with SPMI	415.4	$787,714	$1,896.19	95.0	$220,430	$2,320.31	1.224
HCBS, age 65+, no SPMI	1,567.7	$2,541,768	$1,621.34	248.8	$580,776	$2,334.38	1.440
Community, age 65+, with SPMI	286.6	$380,569	$1,327.67	98.2	$176,173	$1,793.55	1.351
Community, age 65+, no SPMI	2,225.3	$2,627,533	$1,180.74	295.1	$530,903	$1,798.98	1.524
Facility, age <65, with SPMI	55.0	$139,181	$2,530.57	11.0	$18,392	$1,671.98	0.661
Facility, age <65, no SPMI	21.0	$55,877	$2,660.81	23.0	$35,614	$1,548.44	0.582
HCBS, age <65, with SPMI	422.7	$715,949	$1,693.58	168.0	$276,771	$1,647.45	0.973
HCBS, age <65, no SPMI	710.1	$1,381,750	$1,945.94	183.0	$400,149	$2,186.60	1.124
Community, age <65, with SPMI	731.4	$963,007	$1,316.70	192.7	$279,877	$1,452.57	1.103
Community, age <65, no SPMI	924.0	$1,476,169	$1,597.59	204.7	$416,052	$2,032.50	1.272
Intervention group	**7,946.8**	**$7,898,710**	**$993.94**	**1,567.5**	**$2,776,143**	**$1,771.05**	**1.782**
Facility, age 65+, with SPMI	78.0	$190,149	$2,437.80	12.0	$4,964	$413.69	0.170
Facility, age 65+, no SPMI	509.6	$823,008	$1,615.10	36.0	$62,266	$1,729.60	1.071
HCBS, age 65+, with SPMI	415.4	$406,330	$978.12	95.0	$95,810	$1,008.53	1.031
HCBS, age 65+, no SPMI	1,567.7	$1,419,597	$905.53	248.8	$361,839	$1,454.38	1.606
Community, age 65+, with SPMI	286.6	$432,595	$1,509.16	98.2	$112,550	$1,145.83	0.759
Community, age 65+, no SPMI	2,225.3	$1,691,547	$760.14	295.1	$536,837	$1,819.09	2.393
Facility, age <65, with SPMI	55.0	$241,153	$4,384.61	11.0	$43,416	$3,946.87	0.900
Facility, age <65, no SPMI	21.0	$210,854	$10,040.68	23.0	$46,630	$2,027.39	0.202
HCBS, age <65, with SPMI	422.7	$312,759	$739.84	168.0	$60,852	$362.22	0.490
HCBS, age <65, no SPMI	710.1	$625,225	$880.51	183.0	$463,155	$2,530.90	2.874
Community, age <65, with SPMI	731.4	$608,832	$832.44	192.7	$211,300	$1,096.65	1.317
Community, age <65, no SPMI	924.0	$936,659	$1,013.70	204.7	$776,524	$3,793.47	3.742

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 6, by category of beneficiary: Cohort 1C

	Baseline period			Demonstration Year 6			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)
Re-weighted comparison group	**7,946.8**	**$12,115,020**	**$1,524.51**	**1,227.0**	**$2,532,040**	**$2,063.55**	**1.354**
Facility, age 65+, with SPMI	78.0	$162,290	$2,080.64	13.0	$25,360	$1,950.77	0.938
Facility, age 65+, no SPMI	509.6	$883,213	$1,733.25	16.4	$27,087	$1,653.50	0.954
HCBS, age 65+, with SPMI	415.4	$787,714	$1,896.19	72.7	$181,203	$2,493.62	1.315
HCBS, age 65+, no SPMI	1,567.7	$2,541,768	$1,621.34	186.5	$428,625	$2,297.66	1.417
Community, age 65+, with SPMI	286.6	$380,569	$1,327.67	81.7	$170,402	$2,086.28	1.571
Community, age 65+, no SPMI	2,225.3	$2,627,533	$1,180.74	189.2	$344,008	$1,818.60	1.540
Facility, age <65, with SPMI	55.0	$139,181	$2,530.57	0.0	$0	$0.00	0.000
Facility, age <65, no SPMI	21.0	$55,877	$2,660.81	24.0	$42,823	$1,784.27	0.671
HCBS, age <65, with SPMI	422.7	$715,949	$1,693.58	129.1	$242,570	$1,879.45	1.110
HCBS, age <65, no SPMI	710.1	$1,381,750	$1,945.94	155.4	$408,229	$2,627.72	1.350
Community, age <65, with SPMI	731.4	$963,007	$1,316.70	168.0	$266,879	$1,588.57	1.206
Community, age <65, no SPMI	924.0	$1,476,169	$1,597.59	191.2	$394,855	$2,065.40	1.293
Intervention group	**7,946.8**	**$7,898,710**	**$993.94**	**1,227.0**	**$1,631,819**	**$1,329.89**	**1.338**
Facility, age 65+, with SPMI	78.0	$190,149	$2,437.80	13.0	$15,737	$1,210.57	0.497
Facility, age 65+, no SPMI	509.6	$823,008	$1,615.10	16.4	$59,545	$3,634.96	2.251
HCBS, age 65+, with SPMI	415.4	$406,330	$978.12	72.7	$177,794	$2,446.71	2.501
HCBS, age 65+, no SPMI	1,567.7	$1,419,597	$905.53	186.5	$200,839	$1,076.61	1.189
Community, age 65+, with SPMI	286.6	$432,595	$1,509.16	81.7	$101,887	$1,247.43	0.827
Community, age 65+, no SPMI	2,225.3	$1,691,547	$760.14	189.2	$200,426	$1,059.55	1.394
Facility, age <65, with SPMI	55.0	$241,153	$4,384.61	0.0	$0	$0.00	0.000
Facility, age <65, no SPMI	21.0	$210,854	$10,040.68	24.0	$32,968	$1,373.67	0.137
HCBS, age <65, with SPMI	422.7	$312,759	$739.84	129.1	$74,312	$575.77	0.778
HCBS, age <65, no SPMI	710.1	$625,225	$880.51	155.4	$264,362	$1,701.67	1.933
Community, age <65, with SPMI	731.4	$608,832	$832.44	168.0	$95,487	$568.38	0.683
Community, age <65, no SPMI	924.0	$936,659	$1,013.70	191.2	$408,461	$2,136.57	2.108

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 5, by category of beneficiary: Cohort 1D

	Baseline period			Demonstration Year 5			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)
Re-weighted comparison group	**129,399.2**	**$207,882,769**	**$1,606.52**	**27,937.6**	**$54,313,191**	**$1,944.09**	**1.210**
Facility, age 65+, with SPMI	3,449.1	$7,099,156	$2,058.27	320.5	$595,012	$1,856.39	0.902
Facility, age 65+, no SPMI	9,573.0	$16,530,797	$1,726.81	843.3	$1,228,095	$1,456.31	0.843
HCBS, age 65+, with SPMI	5,666.9	$10,738,746	$1,895.01	1,032.9	$2,397,235	$2,320.89	1.225
HCBS, age 65+, no SPMI	24,215.1	$39,358,354	$1,625.36	4,182.9	$9,772,298	$2,336.26	1.437
Community, age 65+, with SPMI	2,995.7	$3,929,249	$1,311.61	638.4	$1,147,124	$1,796.91	1.370
Community, age 65+, no SPMI	19,735.0	$23,217,237	$1,176.45	3,934.4	$7,080,533	$1,799.66	1.530
Facility, age <65, with SPMI	850.9	$2,145,788	$2,521.68	131.9	$220,821	$1,674.58	0.664
Facility, age <65, no SPMI	1,455.9	$3,482,455	$2,391.90	276.7	$427,808	$1,546.23	0.646
HCBS, age <65, with SPMI	8,850.4	$14,942,652	$1,688.37	2,617.7	$4,319,807	$1,650.21	0.977
HCBS, age <65, no SPMI	18,671.7	$36,297,579	$1,943.99	5,204.0	$11,409,814	$2,192.49	1.128
Community, age <65, with SPMI	13,939.8	$18,378,011	$1,318.39	3,592.2	$5,224,928	$1,454.54	1.103
Community, age <65, no SPMI	19,995.6	$31,762,746	$1,588.48	5,162.8	$10,489,717	$2,031.79	1.279
Intervention group	**129,399.2**	**$219,493,469**	**$1,696.25**	**27,937.6**	**$53,895,988**	**$1,929.16**	**1.137**
Facility, age 65+, with SPMI	3,449.1	$8,089,951	$2,345.53	320.5	$256,407	$799.97	0.341
Facility, age 65+, no SPMI	9,573.0	$19,529,844	$2,040.09	843.3	$956,884	$1,134.70	0.556
HCBS, age 65+, with SPMI	5,666.9	$11,401,735	$2,012.00	1,032.9	$1,624,459	$1,572.72	0.782
HCBS, age 65+, no SPMI	24,215.1	$41,155,717	$1,699.59	4,182.9	$9,139,984	$2,185.10	1.286
Community, age 65+, with SPMI	2,995.7	$4,345,812	$1,450.66	638.4	$864,650	$1,354.43	0.934
Community, age 65+, no SPMI	19,735.0	$26,698,339	$1,352.84	3,934.4	$8,550,337	$2,173.24	1.606
Facility, age <65, with SPMI	850.9	$2,783,711	$3,271.35	131.9	$347,886	$2,638.16	0.806
Facility, age <65, no SPMI	1,455.9	$6,939,015	$4,766.02	276.7	$667,302	$2,411.84	0.506
HCBS, age <65, with SPMI	8,850.4	$14,556,363	$1,644.72	2,617.7	$4,459,675	$1,703.64	1.036
HCBS, age <65, no SPMI	18,671.7	$33,932,964	$1,817.35	5,204.0	$10,374,677	$1,993.58	1.097
Community, age <65, with SPMI	13,939.8	$18,504,005	$1,327.43	3,592.2	$5,959,875	$1,659.14	1.250
Community, age <65, no SPMI	19,995.6	$31,556,013	$1,578.14	5,162.8	$10,693,852	$2,071.33	1.313

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 6, by category of beneficiary: Cohort 1D

	Baseline period			Demonstration Year 6			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)
Re-weighted comparison group	**129,399.2**	**$207,882,769**	**$1,606.52**	**23,762.1**	**$49,767,772**	**$2,094.42**	**1.304**
Facility, age 65+, with SPMI	3,449.1	$7,099,156	$2,058.27	193.9	$380,070	$1,960.32	0.952
Facility, age 65+, no SPMI	9,573.0	$16,530,797	$1,726.81	587.7	$958,689	$1,631.13	0.945
HCBS, age 65+, with SPMI	5,666.9	$10,738,746	$1,895.01	871.7	$2,163,535	$2,481.85	1.310
HCBS, age 65+, no SPMI	24,215.1	$39,358,354	$1,625.36	3,276.5	$7,573,894	$2,311.57	1.422
Community, age 65+, with SPMI	2,995.7	$3,929,249	$1,311.61	490.1	$1,019,255	$2,079.83	1.586
Community, age 65+, no SPMI	19,735.0	$23,217,237	$1,176.45	3,244.7	$5,875,268	$1,810.71	1.539
Facility, age <65, with SPMI	850.9	$2,145,788	$2,521.68	113.0	$205,134	$1,815.34	0.720
Facility, age <65, no SPMI	1,455.9	$3,482,455	$2,391.90	212.8	$376,773	$1,770.96	0.740
HCBS, age <65, with SPMI	8,850.4	$14,942,652	$1,688.37	2,349.9	$4,410,312	$1,876.84	1.112
HCBS, age <65, no SPMI	18,671.7	$36,297,579	$1,943.99	4,705.6	$12,361,340	$2,626.97	1.351
Community, age <65, with SPMI	13,939.8	$18,378,011	$1,318.39	3,141.2	$4,993,825	$1,589.78	1.206
Community, age <65, no SPMI	19,995.6	$31,762,746	$1,588.48	4,575.1	$9,449,677	$2,065.47	1.300
Intervention group	**129,399.2**	**$219,493,469**	**$1,696.25**	**23,762.1**	**$48,321,790**	**$2,033.57**	**1.199**
Facility, age 65+, with SPMI	3,449.1	$8,089,951	$2,345.53	193.9	$281,965	$1,454.32	0.620
Facility, age 65+, no SPMI	9,573.0	$19,529,844	$2,040.09	587.7	$763,258	$1,298.62	0.637
HCBS, age 65+, with SPMI	5,666.9	$11,401,735	$2,012.00	871.7	$1,518,609	$1,742.04	0.866
HCBS, age 65+, no SPMI	24,215.1	$41,155,717	$1,699.59	3,276.5	$7,593,790	$2,317.64	1.364
Community, age 65+, with SPMI	2,995.7	$4,345,812	$1,450.66	490.1	$666,692	$1,360.41	0.938
Community, age 65+, no SPMI	19,735.0	$26,698,339	$1,352.84	3,244.7	$6,648,826	$2,049.12	1.515
Facility, age <65, with SPMI	850.9	$2,783,711	$3,271.35	113.0	$93,587	$828.20	0.253
Facility, age <65, no SPMI	1,455.9	$6,939,015	$4,766.02	212.8	$463,163	$2,177.02	0.457
HCBS, age <65, with SPMI	8,850.4	$14,556,363	$1,644.72	2,349.9	$4,235,996	$1,802.66	1.096
HCBS, age <65, no SPMI	18,671.7	$33,932,964	$1,817.35	4,705.6	$9,293,100	$1,974.92	1.087
Community, age <65, with SPMI	13,939.8	$18,504,005	$1,327.43	3,141.2	$6,205,077	$1,975.39	1.488
Community, age <65, no SPMI	19,995.6	$31,556,013	$1,578.14	4,575.1	$10,557,728	$2,307.67	1.462

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 5, by category of beneficiary: Cohort 1E

Category of beneficiary	Baseline period			Demonstration Year 5			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**15,153.3**	**$23,465,894**	**$1,548.56**	**3,353.5**	**$6,380,605**	**$1,902.67**	**1.229**
Facility, age 65+, with SPMI	279.0	$573,525	$2,055.64	29.0	$54,340	$1,873.78	0.912
Facility, age 65+, no SPMI	1,143.7	$1,980,257	$1,731.43	102.7	$149,534	$1,456.64	0.841
HCBS, age 65+, with SPMI	297.0	$563,184	$1,896.24	36.2	$86,905	$2,398.98	1.265
HCBS, age 65+, no SPMI	3,090.8	$5,031,005	$1,627.75	508.4	$1,187,737	$2,336.38	1.435
Community, age 65+, with SPMI	352.0	$462,917	$1,315.11	52.5	$94,343	$1,795.36	1.365
Community, age 65+, no SPMI	3,588.7	$4,220,750	$1,176.13	697.7	$1,255,303	$1,799.29	1.530
Facility, age <65, with SPMI	137.2	$347,384	$2,531.06	39.9	$67,930	$1,700.99	0.672
Facility, age <65, no SPMI	211.0	$502,282	$2,380.48	44.0	$68,570	$1,558.41	0.655
HCBS, age <65, with SPMI	755.0	$1,273,188	$1,686.34	297.0	$489,936	$1,649.61	0.978
HCBS, age <65, no SPMI	1,481.9	$2,878,416	$1,942.35	484.3	$1,061,811	$2,192.58	1.129
Community, age <65, with SPMI	1,654.5	$2,183,008	$1,319.43	510.7	$744,960	$1,458.59	1.105
Community, age <65, no SPMI	2,162.5	$3,449,978	$1,595.37	551.1	$1,119,237	$2,030.93	1.273
Intervention group	**15,153.3**	**$10,288,068**	**$678.93**	**3,353.5**	**$4,817,178**	**$1,436.46**	**2.116**
Facility, age 65+, with SPMI	279.0	$340,940	$1,222.01	29.0	$20,355	$701.89	0.574
Facility, age 65+, no SPMI	1,143.7	$983,611	$860.02	102.7	$52,371	$510.15	0.593
HCBS, age 65+, with SPMI	297.0	$202,815	$682.88	36.2	$37,431	$1,033.26	1.513
HCBS, age 65+, no SPMI	3,090.8	$2,497,709	$808.12	508.4	$924,333	$1,818.24	2.250
Community, age 65+, with SPMI	352.0	$271,496	$771.30	52.5	$148,593	$2,827.74	3.666
Community, age 65+, no SPMI	3,588.7	$1,918,612	$534.63	697.7	$1,030,537	$1,477.12	2.763
Facility, age <65, with SPMI	137.2	$57,996	$422.56	39.9	$77,084	$1,930.21	4.568
Facility, age <65, no SPMI	211.0	$260,623	$1,235.18	44.0	$61,442	$1,396.40	1.131
HCBS, age <65, with SPMI	755.0	$439,693	$582.37	297.0	$206,738	$696.09	1.195
HCBS, age <65, no SPMI	1,481.9	$849,446	$573.21	484.3	$740,452	$1,528.99	2.667
Community, age <65, with SPMI	1,654.5	$1,149,973	$695.05	510.7	$498,239	$975.53	1.404
Community, age <65, no SPMI	2,162.5	$1,315,153	$608.17	551.1	$1,019,605	$1,850.14	3.042

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 6, by category of beneficiary: Cohort 1E

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**15,153.3**	**$23,465,894**	**$1,548.56**	**2,716.7**	**$5,494,124**	**$2,022.34**	**1.306**
Facility, age 65+, with SPMI	279.0	$573,525	$2,055.64	7.0	$13,237	$1,899.80	0.924
Facility, age 65+, no SPMI	1,143.7	$1,980,257	$1,731.43	65.0	$105,990	$1,631.43	0.942
HCBS, age 65+, with SPMI	297.0	$563,184	$1,896.24	20.0	$50,481	$2,524.05	1.331
HCBS, age 65+, no SPMI	3,090.8	$5,031,005	$1,627.75	337.7	$777,422	$2,302.04	1.414
Community, age 65+, with SPMI	352.0	$462,917	$1,315.11	59.0	$123,684	$2,096.34	1.594
Community, age 65+, no SPMI	3,588.7	$4,220,750	$1,176.13	560.6	$1,015,889	$1,812.02	1.541
Facility, age <65, with SPMI	137.2	$347,384	$2,531.06	24.6	$44,786	$1,821.99	0.720
Facility, age <65, no SPMI	211.0	$502,282	$2,380.48	36.0	$64,234	$1,784.27	0.750
HCBS, age <65, with SPMI	755.0	$1,273,188	$1,686.34	264.0	$495,887	$1,878.36	1.114
HCBS, age <65, no SPMI	1,481.9	$2,878,416	$1,942.35	417.0	$1,098,364	$2,633.66	1.356
Community, age <65, with SPMI	1,654.5	$2,183,008	$1,319.43	437.5	$694,980	$1,588.49	1.204
Community, age <65, no SPMI	2,162.5	$3,449,978	$1,595.37	488.3	$1,009,170	$2,066.75	1.295
Intervention group	**15,153.3**	**$10,288,068**	**$678.93**	**2,716.7**	**$4,161,054**	**$1,531.65**	**2.256**
Facility, age 65+, with SPMI	279.0	$340,940	$1,222.01	7.0	$1,392	$199.77	0.163
Facility, age 65+, no SPMI	1,143.7	$983,611	$860.02	65.0	$28,911	$445.00	0.517
HCBS, age 65+, with SPMI	297.0	$202,815	$682.88	20.0	$82,144	$4,107.21	6.015
HCBS, age 65+, no SPMI	3,090.8	$2,497,709	$808.12	337.7	$726,402	$2,150.96	2.662
Community, age 65+, with SPMI	352.0	$271,496	$771.30	59.0	$81,535	$1,381.95	1.792
Community, age 65+, no SPMI	3,588.7	$1,918,612	$534.63	560.6	$933,746	$1,665.50	3.115
Facility, age <65, with SPMI	137.2	$57,996	$422.56	24.6	$54,570	$2,220.03	5.254
Facility, age <65, no SPMI	211.0	$260,623	$1,235.18	36.0	$12,409	$344.70	0.279
HCBS, age <65, with SPMI	755.0	$439,693	$582.37	264.0	$147,761	$559.70	0.961
HCBS, age <65, no SPMI	1,481.9	$849,446	$573.21	417.0	$822,774	$1,972.85	3.442
Community, age <65, with SPMI	1,654.5	$1,149,973	$695.05	437.5	$357,143	$816.31	1.174
Community, age <65, no SPMI	2,162.5	$1,315,153	$608.17	488.3	$912,268	$1,868.29	3.072

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 5, by category of beneficiary: Cohort 1F

	Baseline period			Demonstration Year 5			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)
Re-weighted comparison group	**15,986.6**	**$24,688,247**	**$1,544.31**	**3,882.8**	**$7,538,821**	**$1,941.57**	**1.257**
Facility, age 65+, with SPMI	250.4	$516,275	$2,061.64	31.2	$58,219	$1,866.37	0.905
Facility, age 65+, no SPMI	838.0	$1,446,285	$1,725.88	86.9	$126,723	$1,457.88	0.845
HCBS, age 65+, with SPMI	480.2	$915,481	$1,906.48	145.9	$341,348	$2,340.13	1.227
HCBS, age 65+, no SPMI	2,635.0	$4,300,912	$1,632.22	438.5	$1,024,980	$2,337.62	1.432
Community, age 65+, with SPMI	438.1	$577,833	$1,318.94	81.9	$146,777	$1,792.46	1.359
Community, age 65+, no SPMI	3,854.1	$4,551,826	$1,181.02	896.4	$1,612,955	$1,799.31	1.524
Facility, age <65, with SPMI	99.2	$249,940	$2,519.72	36.0	$60,464	$1,679.55	0.667
Facility, age <65, no SPMI	99.0	$234,480	$2,368.48	28.0	$44,013	$1,571.89	0.664
HCBS, age <65, with SPMI	682.0	$1,153,956	$1,691.97	223.7	$369,469	$1,651.79	0.976
HCBS, age <65, no SPMI	1,969.2	$3,824,528	$1,942.14	621.7	$1,362,207	$2,191.09	1.128
Community, age <65, with SPMI	1,722.2	$2,271,910	$1,319.22	409.0	$595,322	$1,455.55	1.103
Community, age <65, no SPMI	2,919.1	$4,644,822	$1,591.19	883.7	$1,796,345	$2,032.77	1.278
Intervention group	**15,986.6**	**$9,731,043**	**$608.70**	**3,882.8**	**$4,741,399**	**$1,221.12**	**2.006**
Facility, age 65+, with SPMI	250.4	$310,844	$1,241.30	31.2	$24,345	$780.44	0.629
Facility, age 65+, no SPMI	838.0	$940,063	$1,121.79	86.9	$95,347	$1,096.92	0.978
HCBS, age 65+, with SPMI	480.2	$385,684	$803.19	145.9	$412,757	$2,829.69	3.523
HCBS, age 65+, no SPMI	2,635.0	$1,820,644	$690.94	438.5	$941,250	$2,146.66	3.107
Community, age 65+, with SPMI	438.1	$315,186	$719.43	81.9	$124,395	$1,519.12	2.112
Community, age 65+, no SPMI	3,854.1	$1,841,018	$477.67	896.4	$1,306,552	$1,457.51	3.051
Facility, age <65, with SPMI	99.2	$54,697	$551.42	36.0	$22,508	$625.24	1.134
Facility, age <65, no SPMI	99.0	$43,706	$441.48	28.0	$1,788	$63.85	0.145
HCBS, age <65, with SPMI	682.0	$494,966	$725.74	223.7	$171,656	$767.43	1.057
HCBS, age <65, no SPMI	1,969.2	$751,558	$381.65	621.7	$478,260	$769.27	2.016
Community, age <65, with SPMI	1,722.2	$1,343,004	$779.84	409.0	$409,348	$1,000.85	1.283
Community, age <65, no SPMI	2,919.1	$1,429,671	$489.77	883.7	$753,193	$852.32	1.740

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 6, by category of beneficiary: Cohort 1F

	Baseline period			Demonstration Year 6			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)
Re-weighted comparison group	**15,986.6**	**$24,688,247**	**$1,544.31**	**3,231.7**	**$6,682,701**	**$2,067.88**	**1.339**
Facility, age 65+, with SPMI	250.4	$516,275	$2,061.64	14.0	$27,513	$1,965.25	0.953
Facility, age 65+, no SPMI	838.0	$1,446,285	$1,725.88	48.8	$80,577	$1,649.76	0.956
HCBS, age 65+, with SPMI	480.2	$915,481	$1,906.48	99.4	$244,817	$2,463.54	1.292
HCBS, age 65+, no SPMI	2,635.0	$4,300,912	$1,632.22	339.0	$781,986	$2,306.74	1.413
Community, age 65+, with SPMI	438.1	$577,833	$1,318.94	71.0	$148,284	$2,088.51	1.583
Community, age 65+, no SPMI	3,854.1	$4,551,826	$1,181.02	752.5	$1,365,394	$1,814.49	1.536
Facility, age <65, with SPMI	99.2	$249,940	$2,519.72	35.0	$63,402	$1,811.49	0.719
Facility, age <65, no SPMI	99.0	$234,480	$2,368.48	33.0	$59,496	$1,802.89	0.761
HCBS, age <65, with SPMI	682.0	$1,153,956	$1,691.97	184.6	$344,928	$1,868.57	1.104
HCBS, age <65, no SPMI	1,969.2	$3,824,528	$1,942.14	551.3	$1,449,281	$2,628.69	1.354
Community, age <65, with SPMI	1,722.2	$2,271,910	$1,319.22	341.3	$541,768	$1,587.52	1.203
Community, age <65, no SPMI	2,919.1	$4,644,822	$1,591.19	761.8	$1,575,255	$2,067.90	1.300
Intervention group	**15,986.6**	**$9,731,043**	**$608.70**	**3,231.7**	**$4,370,142**	**$1,352.29**	**2.222**
Facility, age 65+, with SPMI	250.4	$310,844	$1,241.30	14.0	$4,400	$314.29	0.253
Facility, age 65+, no SPMI	838.0	$940,063	$1,121.79	48.8	$94,294	$1,930.61	1.721
HCBS, age 65+, with SPMI	480.2	$385,684	$803.19	99.4	$253,387	$2,549.77	3.175
HCBS, age 65+, no SPMI	2,635.0	$1,820,644	$690.94	339.0	$523,006	$1,542.79	2.233
Community, age 65+, with SPMI	438.1	$315,186	$719.43	71.0	$70,987	$999.82	1.390
Community, age 65+, no SPMI	3,854.1	$1,841,018	$477.67	752.5	$962,481	$1,279.06	2.678
Facility, age <65, with SPMI	99.2	$54,697	$551.42	35.0	$21,365	$610.42	1.107
Facility, age <65, no SPMI	99.0	$43,706	$441.48	33.0	$42,963	$1,301.92	2.949
HCBS, age <65, with SPMI	682.0	$494,966	$725.74	184.6	$195,322	$1,058.11	1.458
HCBS, age <65, no SPMI	1,969.2	$751,558	$381.65	551.3	$532,064	$965.05	2.529
Community, age <65, with SPMI	1,722.2	$1,343,004	$779.84	341.3	$495,131	$1,450.86	1.860
Community, age <65, no SPMI	2,919.1	$1,429,671	$489.77	761.8	$1,174,742	$1,542.13	3.149

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 5, by category of beneficiary: Cohort 2

Category of beneficiary	Baseline period			Demonstration Year 5			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**4,220.4**	**$7,342,975**	**$1,739.88**	**2,826.7**	**$4,333,084**	**$1,532.91**	**0.881**
Facility, age 65+, with SPMI	69.3	$194,922	$2,811.37	29.2	$51,121	$1,753.06	0.624
Facility, age 65+, no SPMI	224.1	$559,070	$2,494.36	106.7	$150,051	$1,406.76	0.564
HCBS, age 65+, with SPMI	143.3	$268,777	$1,875.10	110.0	$211,033	$1,918.48	1.023
HCBS, age 65+, no SPMI	667.3	$1,128,010	$1,690.47	380.6	$804,041	$2,112.51	1.250
Community, age 65+, with SPMI	112.9	$181,213	$1,605.69	69.2	$114,450	$1,652.77	1.029
Community, age 65+, no SPMI	715.1	$1,136,725	$1,589.61	512.5	$682,983	$1,332.65	0.838
Facility, age <65, with SPMI	48.6	$188,821	$3,883.32	36.0	$56,217	$1,561.59	0.402
Facility, age <65, no SPMI	49.0	$186,028	$3,796.49	12.0	$25,362	$2,113.50	0.557
HCBS, age <65, with SPMI	258.8	$412,435	$1,593.54	195.1	$203,944	$1,045.17	0.656
HCBS, age <65, no SPMI	572.9	$962,097	$1,679.28	474.8	$787,158	$1,657.86	0.987
Community, age <65, with SPMI	329.2	$441,888	$1,342.48	255.4	$262,200	$1,026.62	0.765
Community, age <65, no SPMI	1,029.8	$1,682,991	$1,634.24	645.2	$984,525	$1,525.93	0.934
Intervention group	**4,220.4**	**$9,945,769**	**$2,356.60**	**2,826.7**	**$5,512,243**	**$1,950.06**	**0.827**
Facility, age 65+, with SPMI	69.3	$438,707	$6,327.51	29.2	$42,654	$1,462.69	0.231
Facility, age 65+, no SPMI	224.1	$1,196,636	$5,338.95	106.7	$193,624	$1,815.26	0.340
HCBS, age 65+, with SPMI	143.3	$256,776	$1,791.38	110.0	$87,162	$792.38	0.442
HCBS, age 65+, no SPMI	667.3	$1,545,012	$2,315.40	380.6	$906,715	$2,382.28	1.029
Community, age 65+, with SPMI	112.9	$289,402	$2,564.32	69.2	$189,597	$2,737.96	1.068
Community, age 65+, no SPMI	715.1	$1,450,968	$2,029.05	512.5	$710,391	$1,386.14	0.683
Facility, age <65, with SPMI	48.6	$110,141	$2,265.17	36.0	$8,340	$231.67	0.102
Facility, age <65, no SPMI	49.0	$450,522	$9,194.32	12.0	$6,011	$500.91	0.054
HCBS, age <65, with SPMI	258.8	$748,549	$2,892.19	195.1	$398,101	$2,040.20	0.705
HCBS, age <65, no SPMI	572.9	$1,300,020	$2,269.10	474.8	$1,053,466	$2,218.75	0.978
Community, age <65, with SPMI	329.2	$674,242	$2,048.38	255.4	$259,087	$1,014.43	0.495
Community, age <65, no SPMI	1,029.8	$1,484,795	$1,441.79	645.2	$1,657,094	$2,568.35	1.781

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 6, by category of beneficiary: Cohort 2

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**4,220.4**	**$7,342,975**	**$1,739.88**	**2,414.2**	**$4,135,064**	**$1,712.79**	**0.984**
Facility, age 65+, with SPMI	69.3	$194,922	$2,811.37	24.0	$35,145	$1,464.39	0.521
Facility, age 65+, no SPMI	224.1	$559,070	$2,494.36	61.5	$86,058	$1,400.42	0.561
HCBS, age 65+, with SPMI	143.3	$268,777	$1,875.10	110.3	$267,699	$2,427.93	1.295
HCBS, age 65+, no SPMI	667.3	$1,128,010	$1,690.47	266.0	$764,835	$2,875.67	1.701
Community, age 65+, with SPMI	112.9	$181,213	$1,605.69	55.3	$85,636	$1,547.63	0.964
Community, age 65+, no SPMI	715.1	$1,136,725	$1,589.61	496.2	$824,735	$1,662.25	1.046
Facility, age <65, with SPMI	48.6	$188,821	$3,883.32	36.0	$99,154	$2,754.29	0.709
Facility, age <65, no SPMI	49.0	$186,028	$3,796.49	12.0	$26,378	$2,198.14	0.579
HCBS, age <65, with SPMI	258.8	$412,435	$1,593.54	154.3	$136,475	$884.29	0.555
HCBS, age <65, no SPMI	572.9	$962,097	$1,679.28	464.0	$596,231	$1,284.98	0.765
Community, age <65, with SPMI	329.2	$441,888	$1,342.48	203.7	$250,663	$1,230.75	0.917
Community, age <65, no SPMI	1,029.8	$1,682,991	$1,634.24	531.1	$962,055	$1,811.57	1.109
Intervention group	**4,220.4**	**$9,945,769**	**$2,356.60**	**2,414.2**	**$4,430,479**	**$1,835.15**	**0.779**
Facility, age 65+, with SPMI	69.3	$438,707	$6,327.51	24.0	$51,917	$2,163.21	0.342
Facility, age 65+, no SPMI	224.1	$1,196,636	$5,338.95	61.5	$58,697	$955.17	0.179
HCBS, age 65+, with SPMI	143.3	$256,776	$1,791.38	110.3	$222,884	$2,021.48	1.128
HCBS, age 65+, no SPMI	667.3	$1,545,012	$2,315.40	266.0	$251,202	$944.48	0.408
Community, age 65+, with SPMI	112.9	$289,402	$2,564.32	55.3	$179,641	$3,246.53	1.266
Community, age 65+, no SPMI	715.1	$1,450,968	$2,029.05	496.2	$627,092	$1,263.90	0.623
Facility, age <65, with SPMI	48.6	$110,141	$2,265.17	36.0	$16,016	$444.89	0.196
Facility, age <65, no SPMI	49.0	$450,522	$9,194.32	12.0	$8,003	$666.90	0.073
HCBS, age <65, with SPMI	258.8	$748,549	$2,892.19	154.3	$255,803	$1,657.47	0.573
HCBS, age <65, no SPMI	572.9	$1,300,020	$2,269.10	464.0	$1,001,559	$2,158.53	0.951
Community, age <65, with SPMI	329.2	$674,242	$2,048.38	203.7	$496,630	$2,438.45	1.190
Community, age <65, no SPMI	1,029.8	$1,484,795	$1,441.79	531.1	$1,261,036	$2,374.56	1.647

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 5, by category of beneficiary: Cohort 3

Category of beneficiary	Baseline period			Demonstration Year 5			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**61,200.6**	**$93,045,998**	**$1,520.35**	**29,370.2**	**$46,476,966**	**$1,582.45**	**1.041**
Facility, age 65+, with SPMI	1,249.3	$2,839,727	$2,273.12	425.0	$696,399	$1,638.47	0.721
Facility, age 65+, no SPMI	4,252.8	$9,447,994	$2,221.61	960.5	$1,537,945	$1,601.27	0.721
HCBS, age 65+, with SPMI	2,628.5	$3,772,984	$1,435.39	1,265.9	$1,903,260	$1,503.51	1.047
HCBS, age 65+, no SPMI	11,866.5	$18,638,532	$1,570.68	4,930.5	$10,003,831	$2,028.97	1.292
Community, age 65+, with SPMI	1,951.3	$2,888,862	$1,480.46	1,078.0	$1,184,861	$1,099.18	0.742
Community, age 65+, no SPMI	11,506.7	$15,358,114	$1,334.72	5,749.9	$8,407,545	$1,462.20	1.096
Facility, age <65, with SPMI	423.5	$1,488,014	$3,513.99	233.3	$425,684	$1,824.50	0.519
Facility, age <65, no SPMI	696.3	$2,415,969	$3,469.81	440.5	$759,655	$1,724.47	0.497
HCBS, age <65, with SPMI	3,460.0	$4,039,095	$1,167.38	2,278.6	$2,415,222	$1,059.97	0.908
HCBS, age <65, no SPMI	6,699.9	$9,106,677	$1,359.22	4,265.8	$7,379,279	$1,729.87	1.273
Community, age <65, with SPMI	6,565.4	$7,436,908	$1,132.75	3,026.8	$3,444,857	$1,138.11	1.005
Community, age <65, no SPMI	9,900.5	$15,613,122	$1,577.00	4,715.4	$8,318,428	$1,764.09	1.119
Intervention group	**61,200.6**	**$103,440,434**	**$1,690.19**	**29,370.2**	**$48,816,683**	**$1,662.12**	**0.983**
Facility, age 65+, with SPMI	1,249.3	$3,181,407	$2,546.62	425.0	$683,278	$1,607.60	0.631
Facility, age 65+, no SPMI	4,252.8	$9,034,621	$2,124.41	960.5	$1,384,646	$1,441.66	0.679
HCBS, age 65+, with SPMI	2,628.5	$5,191,095	$1,974.89	1,265.9	$2,151,044	$1,699.25	0.860
HCBS, age 65+, no SPMI	11,866.5	$21,031,541	$1,772.34	4,930.5	$8,914,752	$1,808.09	1.020
Community, age 65+, with SPMI	1,951.3	$2,712,797	$1,390.23	1,078.0	$1,662,632	$1,542.40	1.109
Community, age 65+, no SPMI	11,506.7	$14,881,472	$1,293.29	5,749.9	$8,592,037	$1,494.29	1.155
Facility, age <65, with SPMI	423.5	$1,956,037	$4,619.24	233.3	$534,526	$2,290.99	0.496
Facility, age <65, no SPMI	696.3	$3,042,252	$4,369.28	440.5	$807,498	$1,833.07	0.420
HCBS, age <65, with SPMI	3,460.0	$6,775,101	$1,958.15	2,278.6	$4,153,225	$1,822.73	0.931
HCBS, age <65, no SPMI	6,699.9	$12,516,956	$1,868.23	4,265.8	$8,373,762	$1,962.99	1.051
Community, age <65, with SPMI	6,565.4	$8,598,440	$1,309.66	3,026.8	$4,229,253	$1,397.26	1.067
Community, age <65, no SPMI	9,900.5	$14,518,716	$1,466.46	4,715.4	$7,330,031	$1,554.48	1.060

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 6, by category of beneficiary: Cohort 3

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**61,200.6**	**$93,045,998**	**$1,520.35**	**23,794.6**	**$39,365,826**	**$1,654.40**	**1.088**
Facility, age 65+, with SPMI	1,249.3	$2,839,727	$2,273.12	308.5	$449,965	$1,458.65	0.642
Facility, age 65+, no SPMI	4,252.8	$9,447,994	$2,221.61	701.3	$1,049,505	$1,496.56	0.674
HCBS, age 65+, with SPMI	2,628.5	$3,772,984	$1,435.39	867.9	$1,384,549	$1,595.28	1.111
HCBS, age 65+, no SPMI	11,866.5	$18,638,532	$1,570.68	3,703.3	$9,266,699	$2,502.30	1.593
Community, age 65+, with SPMI	1,951.3	$2,888,862	$1,480.46	899.8	$1,236,677	$1,374.46	0.928
Community, age 65+, no SPMI	11,506.7	$15,358,114	$1,334.72	4,574.8	$7,631,329	$1,668.12	1.250
Facility, age <65, with SPMI	423.5	$1,488,014	$3,513.99	204.4	$166,362	$814.08	0.232
Facility, age <65, no SPMI	696.3	$2,415,969	$3,469.81	384.9	$539,230	$1,401.10	0.404
HCBS, age <65, with SPMI	3,460.0	$4,039,095	$1,167.38	2,047.1	$1,821,061	$889.60	0.762
HCBS, age <65, no SPMI	6,699.9	$9,106,677	$1,359.22	3,659.6	$6,929,783	$1,893.58	1.393
Community, age <65, with SPMI	6,565.4	$7,436,908	$1,132.75	2,565.8	$2,381,517	$928.17	0.819
Community, age <65, no SPMI	9,900.5	$15,613,122	$1,577.00	3,877.4	$6,509,150	$1,678.73	1.065
Intervention group	**61,200.6**	**$103,440,434**	**$1,690.19**	**23,794.6**	**$41,733,736**	**$1,753.91**	**1.038**
Facility, age 65+, with SPMI	1,249.3	$3,181,407	$2,546.62	308.5	$466,920	$1,513.61	0.594
Facility, age 65+, no SPMI	4,252.8	$9,034,621	$2,124.41	701.3	$724,093	$1,032.53	0.486
HCBS, age 65+, with SPMI	2,628.5	$5,191,095	$1,974.89	867.9	$1,635,317	$1,884.22	0.954
HCBS, age 65+, no SPMI	11,866.5	$21,031,541	$1,772.34	3,703.3	$6,297,264	$1,700.46	0.959
Community, age 65+, with SPMI	1,951.3	$2,712,797	$1,390.23	899.8	$1,360,814	$1,512.42	1.088
Community, age 65+, no SPMI	11,506.7	$14,881,472	$1,293.29	4,574.8	$8,370,316	$1,829.66	1.415
Facility, age <65, with SPMI	423.5	$1,956,037	$4,619.24	204.4	$241,651	$1,182.51	0.256
Facility, age <65, no SPMI	696.3	$3,042,252	$4,369.28	384.9	$791,011	$2,055.32	0.470
HCBS, age <65, with SPMI	3,460.0	$6,775,101	$1,958.15	2,047.1	$3,230,984	$1,578.35	0.806
HCBS, age <65, no SPMI	6,699.9	$12,516,956	$1,868.23	3,659.6	$7,246,956	$1,980.25	1.060
Community, age <65, with SPMI	6,565.4	$8,598,440	$1,309.66	2,565.8	$3,696,567	$1,440.70	1.100
Community, age <65, no SPMI	9,900.5	$14,518,716	$1,466.46	3,877.4	$7,671,844	$1,978.59	1.349

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 5, by category of beneficiary: Cohort 4

Category of beneficiary	Baseline period			Demonstration Year 5			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**62,395.6**	**$96,865,182**	**$1,552.44**	**33,927.6**	**$55,152,829**	**$1,625.60**	**1.047**
Facility, age 65+, with SPMI	2,453.0	$6,453,449	$2,630.84	1,064.6	$1,893,334	$1,778.50	0.676
Facility, age 65+, no SPMI	2,527.9	$5,282,819	$2,089.78	897.6	$1,195,311	$1,331.63	0.637
HCBS, age 65+, with SPMI	4,306.6	$8,037,334	$1,866.30	2,480.7	$4,388,850	$1,769.20	0.948
HCBS, age 65+, no SPMI	9,921.7	$14,424,152	$1,453.79	5,030.0	$10,892,929	$2,165.58	1.490
Community, age 65+, with SPMI	2,937.0	$4,882,376	$1,662.39	1,701.5	$2,596,608	$1,526.07	0.918
Community, age 65+, no SPMI	13,051.3	$16,756,974	$1,283.93	6,793.9	$10,006,834	$1,472.92	1.147
Facility, age <65, with SPMI	701.0	$2,687,764	$3,834.18	265.8	$700,102	$2,633.91	0.687
Facility, age <65, no SPMI	435.0	$1,496,911	$3,441.17	219.2	$518,349	$2,365.26	0.687
HCBS, age <65, with SPMI	4,420.2	$5,880,332	$1,330.34	3,007.7	$4,685,357	$1,557.80	1.171
HCBS, age <65, no SPMI	5,763.7	$9,009,151	$1,563.09	4,015.9	$7,062,859	$1,758.73	1.125
Community, age <65, with SPMI	7,698.0	$8,968,160	$1,165.00	4,011.8	$4,029,741	$1,004.47	0.862
Community, age <65, no SPMI	8,180.2	$12,985,760	$1,587.47	4,439.0	$7,182,556	$1,618.08	1.019
Intervention group	**62,395.6**	**$108,719,430**	**$1,742.42**	**33,927.6**	**$57,515,586**	**$1,695.25**	**0.973**
Facility, age 65+, with SPMI	2,453.0	$8,183,909	$3,336.29	1,064.6	$1,437,899	$1,350.69	0.405
Facility, age 65+, no SPMI	2,527.9	$5,640,529	$2,231.28	897.6	$1,223,046	$1,362.52	0.611
HCBS, age 65+, with SPMI	4,306.6	$10,380,911	$2,410.48	2,480.7	$4,688,183	$1,889.86	0.784
HCBS, age 65+, no SPMI	9,921.7	$16,659,970	$1,679.14	5,030.0	$9,068,596	$1,802.89	1.074
Community, age 65+, with SPMI	2,937.0	$5,604,559	$1,908.28	1,701.5	$3,456,741	$2,031.58	1.065
Community, age 65+, no SPMI	13,051.3	$15,923,824	$1,220.09	6,793.9	$9,857,681	$1,450.97	1.189
Facility, age <65, with SPMI	701.0	$3,135,378	$4,472.72	265.8	$772,010	$2,904.44	0.649
Facility, age <65, no SPMI	435.0	$1,415,092	$3,253.09	219.2	$366,363	$1,671.74	0.514
HCBS, age <65, with SPMI	4,420.2	$7,918,350	$1,791.41	3,007.7	$5,502,863	$1,829.61	1.021
HCBS, age <65, no SPMI	5,763.7	$10,787,145	$1,871.58	4,015.9	$7,907,205	$1,968.99	1.052
Community, age <65, with SPMI	7,698.0	$11,310,650	$1,469.29	4,011.8	$4,879,191	$1,216.20	0.828
Community, age <65, no SPMI	8,180.2	$11,759,112	$1,437.51	4,439.0	$8,355,808	$1,882.38	1.309

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 6, by category of beneficiary: Cohort 4

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**62,395.6**	**$96,865,182**	**$1,552.44**	**26,423.4**	**$44,473,985**	**$1,683.13**	**1.084**
Facility, age 65+, with SPMI	2,453.0	$6,453,449	$2,630.84	787.9	$1,508,150	$1,914.06	0.728
Facility, age 65+, no SPMI	2,527.9	$5,282,819	$2,089.78	593.6	$1,007,973	$1,698.02	0.813
HCBS, age 65+, with SPMI	4,306.6	$8,037,334	$1,866.30	1,826.4	$3,195,459	$1,749.56	0.937
HCBS, age 65+, no SPMI	9,921.7	$14,424,152	$1,453.79	3,773.8	$7,627,075	$2,021.07	1.390
Community, age 65+, with SPMI	2,937.0	$4,882,376	$1,662.39	1,332.2	$1,972,317	$1,480.46	0.891
Community, age 65+, no SPMI	13,051.3	$16,756,974	$1,283.93	5,190.9	$7,484,592	$1,441.87	1.123
Facility, age <65, with SPMI	701.0	$2,687,764	$3,834.18	217.4	$476,529	$2,192.38	0.572
Facility, age <65, no SPMI	435.0	$1,496,911	$3,441.17	177.4	$265,579	$1,496.78	0.435
HCBS, age <65, with SPMI	4,420.2	$5,880,332	$1,330.34	2,694.3	$5,165,422	$1,917.18	1.441
HCBS, age <65, no SPMI	5,763.7	$9,009,151	$1,563.09	3,490.4	$6,307,471	$1,807.10	1.156
Community, age <65, with SPMI	7,698.0	$8,968,160	$1,165.00	3,129.7	$3,524,253	$1,126.06	0.967
Community, age <65, no SPMI	8,180.2	$12,985,760	$1,587.47	3,209.3	$5,939,166	$1,850.61	1.166
Intervention group	**62,395.6**	**$108,719,430**	**$1,742.42**	**26,423.4**	**$45,185,845**	**$1,710.07**	**0.981**
Facility, age 65+, with SPMI	2,453.0	$8,183,909	$3,336.29	787.9	$1,032,858	$1,310.84	0.393
Facility, age 65+, no SPMI	2,527.9	$5,640,529	$2,231.28	593.6	$914,858	$1,541.16	0.691
HCBS, age 65+, with SPMI	4,306.6	$10,380,911	$2,410.48	1,826.4	$3,161,248	$1,730.83	0.718
HCBS, age 65+, no SPMI	9,921.7	$16,659,970	$1,679.14	3,773.8	$6,659,436	$1,764.66	1.051
Community, age 65+, with SPMI	2,937.0	$5,604,559	$1,908.28	1,332.2	$1,885,082	$1,414.98	0.741
Community, age 65+, no SPMI	13,051.3	$15,923,824	$1,220.09	5,190.9	$7,810,641	$1,504.68	1.233
Facility, age <65, with SPMI	701.0	$3,135,378	$4,472.72	217.4	$478,116	$2,199.68	0.492
Facility, age <65, no SPMI	435.0	$1,415,092	$3,253.09	177.4	$367,523	$2,071.33	0.637
HCBS, age <65, with SPMI	4,420.2	$7,918,350	$1,791.41	2,694.3	$4,478,994	$1,662.41	0.928
HCBS, age <65, no SPMI	5,763.7	$10,787,145	$1,871.58	3,490.4	$7,469,727	$2,140.09	1.143
Community, age <65, with SPMI	7,698.0	$11,310,650	$1,469.29	3,129.7	$4,911,350	$1,569.26	1.068
Community, age <65, no SPMI	8,180.2	$11,759,112	$1,437.51	3,209.3	$6,016,011	$1,874.55	1.304

Table 3.K.1 MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 5, by category of beneficiary: Cohort 5A

Category of beneficiary	Baseline period			Demonstration Year 5			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**65,796.4**	**$107,612,835**	**$1,635.54**	**46,063.6**	**$75,424,214**	**$1,637.39**	**1.001**
Facility, age 65+, with SPMI	2,862.0	$6,538,294	$2,284.49	1,658.5	$3,087,179	$1,861.41	0.815
Facility, age 65+, no SPMI	2,190.1	$4,588,613	$2,095.20	1,129.4	$2,191,789	$1,940.63	0.926
HCBS, age 65+, with SPMI	6,603.4	$13,633,279	$2,064.59	4,676.1	$11,954,349	$2,556.49	1.238
HCBS, age 65+, no SPMI	8,400.5	$13,349,568	$1,589.14	6,002.6	$11,565,241	$1,926.71	1.212
Community, age 65+, with SPMI	5,113.6	$8,331,575	$1,629.28	3,431.6	$4,785,855	$1,394.65	0.856
Community, age 65+, no SPMI	11,806.2	$13,441,078	$1,138.48	7,938.3	$8,214,826	$1,034.83	0.909
Facility, age <65, with SPMI	768.5	$2,724,718	$3,545.43	587.3	$2,049,194	$3,489.39	0.984
Facility, age <65, no SPMI	321.0	$1,106,626	$3,447.43	270.7	$886,015	$3,272.65	0.949
HCBS, age <65, with SPMI	5,810.6	$10,301,608	$1,772.91	4,727.0	$8,450,218	$1,787.63	1.008
HCBS, age <65, no SPMI	4,143.8	$6,256,237	$1,509.79	3,690.5	$6,173,403	$1,672.79	1.108
Community, age <65, with SPMI	10,167.6	$13,655,351	$1,343.02	6,908.3	$7,686,581	$1,112.66	0.828
Community, age <65, no SPMI	7,609.1	$13,685,889	$1,798.62	5,043.3	$8,379,563	$1,661.53	0.924
Intervention group	**65,796.4**	**$110,831,462**	**$1,684.46**	**46,063.6**	**$68,293,534**	**$1,482.59**	**0.880**
Facility, age 65+, with SPMI	2,862.0	$9,052,081	$3,162.82	1,658.5	$2,130,338	$1,284.48	0.406
Facility, age 65+, no SPMI	2,190.1	$4,385,773	$2,002.58	1,129.4	$863,187	$764.27	0.382
HCBS, age 65+, with SPMI	6,603.4	$15,018,129	$2,274.31	4,676.1	$9,779,953	$2,091.49	0.920
HCBS, age 65+, no SPMI	8,400.5	$14,823,067	$1,764.55	6,002.6	$10,799,996	$1,799.22	1.020
Community, age 65+, with SPMI	5,113.6	$8,819,180	$1,724.64	3,431.6	$4,408,011	$1,284.54	0.745
Community, age 65+, no SPMI	11,806.2	$12,552,136	$1,063.18	7,938.3	$9,366,668	$1,179.93	1.110
Facility, age <65, with SPMI	768.5	$4,002,047	$5,207.50	587.3	$1,312,695	$2,235.27	0.429
Facility, age <65, no SPMI	321.0	$1,146,659	$3,572.15	270.7	$384,370	$1,419.74	0.397
HCBS, age <65, with SPMI	5,810.6	$12,307,623	$2,118.15	4,727.0	$8,319,533	$1,759.99	0.831
HCBS, age <65, no SPMI	4,143.8	$5,751,726	$1,388.04	3,690.5	$5,652,701	$1,531.70	1.103
Community, age <65, with SPMI	10,167.6	$13,782,730	$1,355.55	6,908.3	$7,879,833	$1,140.63	0.841
Community, age <65, no SPMI	7,609.1	$9,190,309	$1,207.80	5,043.3	$7,396,249	$1,466.55	1.214

Table 3.K.2 MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 6, by category of beneficiary: Cohort 5A

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**65,796.4**	**$107,612,835**	**$1,635.54**	**35,027.4**	**$61,378,077**	**$1,752.29**	**1.071**
Facility, age 65+, with SPMI	2,862.0	$6,538,294	$2,284.49	1,101.1	$1,809,886	$1,643.74	0.720
Facility, age 65+, no SPMI	2,190.1	$4,588,613	$2,095.20	736.3	$1,443,203	$1,960.19	0.936
HCBS, age 65+, with SPMI	6,603.4	$13,633,279	$2,064.59	3,646.3	$11,574,292	$3,174.22	1.537
HCBS, age 65+, no SPMI	8,400.5	$13,349,568	$1,589.14	4,361.4	$9,035,597	$2,071.72	1.304
Community, age 65+, with SPMI	5,113.6	$8,331,575	$1,629.28	2,640.1	$3,526,633	$1,335.79	0.820
Community, age 65+, no SPMI	11,806.2	$13,441,078	$1,138.48	5,852.3	$6,778,962	$1,158.34	1.017
Facility, age <65, with SPMI	768.5	$2,724,718	$3,545.43	508.7	$1,402,387	$2,756.58	0.778
Facility, age <65, no SPMI	321.0	$1,106,626	$3,447.43	212.2	$516,056	$2,431.63	0.705
HCBS, age <65, with SPMI	5,810.6	$10,301,608	$1,772.91	3,999.6	$8,388,978	$2,097.48	1.183
HCBS, age <65, no SPMI	4,143.8	$6,256,237	$1,509.79	3,052.6	$3,679,897	$1,205.48	0.798
Community, age <65, with SPMI	10,167.6	$13,655,351	$1,343.02	5,186.4	$5,845,704	$1,127.12	0.839
Community, age <65, no SPMI	7,609.1	$13,685,889	$1,798.62	3,730.3	$7,376,482	$1,977.43	1.099
Intervention group	**65,796.4**	**$110,831,462**	**$1,684.46**	**35,027.4**	**$56,260,564**	**$1,606.19**	**0.954**
Facility, age 65+, with SPMI	2,862.0	$9,052,081	$3,162.82	1,101.1	$1,843,176	$1,673.97	0.529
Facility, age 65+, no SPMI	2,190.1	$4,385,773	$2,002.58	736.3	$713,102	$968.55	0.484
HCBS, age 65+, with SPMI	6,603.4	$15,018,129	$2,274.31	3,646.3	$6,714,752	$1,841.51	0.810
HCBS, age 65+, no SPMI	8,400.5	$14,823,067	$1,764.55	4,361.4	$8,247,303	$1,890.98	1.072
Community, age 65+, with SPMI	5,113.6	$8,819,180	$1,724.64	2,640.1	$4,256,640	$1,612.30	0.935
Community, age 65+, no SPMI	11,806.2	$12,552,136	$1,063.18	5,852.3	$7,386,320	$1,262.12	1.187
Facility, age <65, with SPMI	768.5	$4,002,047	$5,207.50	508.7	$1,394,767	$2,741.60	0.526
Facility, age <65, no SPMI	321.0	$1,146,659	$3,572.15	212.2	$532,880	$2,510.91	0.703
HCBS, age <65, with SPMI	5,810.6	$12,307,623	$2,118.15	3,999.6	$7,002,430	$1,750.80	0.827
HCBS, age <65, no SPMI	4,143.8	$5,751,726	$1,388.04	3,052.6	$5,959,071	$1,952.10	1.406
Community, age <65, with SPMI	10,167.6	$13,782,730	$1,355.55	5,186.4	$5,763,417	$1,111.25	0.820
Community, age <65, no SPMI	7,609.1	$9,190,309	$1,207.80	3,730.3	$6,446,706	$1,728.18	1.431

Table 3.L.1 MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 5, by category of beneficiary: Cohort 5B

Category of beneficiary	Baseline period			Demonstration Year 5			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**65,414.5**	**$107,080,977**	**$1,636.96**	**49,203.2**	**$89,555,043**	**$1,820.10**	**1.112**
Facility, age 65+, with SPMI	4,136.0	$7,818,931	$1,890.46	2,743.7	$4,883,797	$1,780.03	0.942
Facility, age 65+, no SPMI	2,322.6	$3,940,959	$1,696.81	1,583.9	$2,442,932	$1,542.34	0.909
HCBS, age 65+, with SPMI	8,071.3	$17,537,844	$2,172.88	6,180.3	$14,312,020	$2,315.76	1.066
HCBS, age 65+, no SPMI	9,022.6	$15,430,790	$1,710.23	6,793.5	$16,550,336	$2,436.22	1.424
Community, age 65+, with SPMI	6,083.6	$9,863,360	$1,621.31	4,482.0	$7,828,233	$1,746.60	1.077
Community, age 65+, no SPMI	14,579.5	$17,434,468	$1,195.82	10,457.1	$15,497,232	$1,481.99	1.239
Facility, age <65, with SPMI	1,284.5	$3,347,273	$2,605.80	943.8	$2,146,638	$2,274.35	0.873
Facility, age <65, no SPMI	579.0	$843,478	$1,456.78	514.4	$659,777	$1,282.66	0.880
HCBS, age <65, with SPMI	5,481.1	$9,483,022	$1,730.13	4,685.9	$8,074,447	$1,723.13	0.996
HCBS, age <65, no SPMI	3,758.0	$6,270,810	$1,668.64	3,193.6	$5,889,324	$1,844.07	1.105
Community, age <65, with SPMI	6,450.3	$9,221,719	$1,429.66	4,870.4	$6,617,937	$1,358.80	0.950
Community, age <65, no SPMI	3,646.1	$5,888,326	$1,614.98	2,754.7	$4,652,369	$1,688.91	1.046
Intervention group	**65,414.5**	**$113,207,213**	**$1,730.61**	**49,203.2**	**$86,106,616**	**$1,750.02**	**1.011**
Facility, age 65+, with SPMI	4,136.0	$11,235,848	$2,716.60	2,743.7	$4,915,478	$1,791.57	0.659
Facility, age 65+, no SPMI	2,322.6	$4,959,944	$2,135.54	1,583.9	$2,932,043	$1,851.14	0.867
HCBS, age 65+, with SPMI	8,071.3	$15,592,008	$1,931.80	6,180.3	$11,711,243	$1,894.94	0.981
HCBS, age 65+, no SPMI	9,022.6	$12,101,533	$1,341.24	6,793.5	$13,798,746	$2,031.18	1.514
Community, age 65+, with SPMI	6,083.6	$10,289,715	$1,691.40	4,482.0	$7,422,156	$1,656.00	0.979
Community, age 65+, no SPMI	14,579.5	$17,589,282	$1,206.44	10,457.1	$12,909,118	$1,234.49	1.023
Facility, age <65, with SPMI	1,284.5	$5,382,129	$4,189.90	943.8	$2,427,991	$2,572.45	0.614
Facility, age <65, no SPMI	579.0	$1,328,071	$2,293.73	514.4	$1,202,171	$2,337.12	1.019
HCBS, age <65, with SPMI	5,481.1	$11,153,684	$2,034.93	4,685.9	$8,721,002	$1,861.11	0.915
HCBS, age <65, no SPMI	3,758.0	$5,231,307	$1,392.03	3,193.6	$6,579,244	$2,060.10	1.480
Community, age <65, with SPMI	6,450.3	$11,304,842	$1,752.61	4,870.4	$7,667,339	$1,574.26	0.898
Community, age <65, no SPMI	3,646.1	$7,038,850	$1,930.53	2,754.7	$5,820,086	$2,112.81	1.094

Table 3.L.2 MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 6, by category of beneficiary: Cohort 5B

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**65,414.5**	**$107,080,977**	**$1,636.96**	**36,727.0**	**$70,612,648**	**$1,922.63**	**1.175**
Facility, age 65+, with SPMI	4,136.0	$7,818,931	$1,890.46	1,745.1	$3,247,022	$1,860.64	0.984
Facility, age 65+, no SPMI	2,322.6	$3,940,959	$1,696.81	948.1	$1,514,375	$1,597.21	0.941
HCBS, age 65+, with SPMI	8,071.3	$17,537,844	$2,172.88	4,544.6	$11,912,146	$2,621.17	1.206
HCBS, age 65+, no SPMI	9,022.6	$15,430,790	$1,710.23	4,812.8	$10,442,899	$2,169.81	1.269
Community, age 65+, with SPMI	6,083.6	$9,863,360	$1,621.31	3,279.6	$6,188,772	$1,887.07	1.164
Community, age 65+, no SPMI	14,579.5	$17,434,468	$1,195.82	7,823.1	$12,533,108	$1,602.07	1.340
Facility, age <65, with SPMI	1,284.5	$3,347,273	$2,605.80	736.2	$1,473,298	$2,001.15	0.768
Facility, age <65, no SPMI	579.0	$843,478	$1,456.78	412.3	$491,706	$1,192.47	0.819
HCBS, age <65, with SPMI	5,481.1	$9,483,022	$1,730.13	3,958.4	$7,842,580	$1,981.27	1.145
HCBS, age <65, no SPMI	3,758.0	$6,270,810	$1,668.64	2,694.7	$6,061,161	$2,249.32	1.348
Community, age <65, with SPMI	6,450.3	$9,221,719	$1,429.66	3,629.5	$5,230,320	$1,441.04	1.008
Community, age <65, no SPMI	3,646.1	$5,888,326	$1,614.98	2,142.6	$3,675,262	$1,715.33	1.062
Intervention group	**65,414.5**	**$113,207,213**	**$1,730.61**	**36,727.0**	**$69,566,362**	**$1,894.15**	**1.094**
Facility, age 65+, with SPMI	4,136.0	$11,235,848	$2,716.60	1,745.1	$3,490,320	$2,000.06	0.736
Facility, age 65+, no SPMI	2,322.6	$4,959,944	$2,135.54	948.1	$1,716,628	$1,810.52	0.848
HCBS, age 65+, with SPMI	8,071.3	$15,592,008	$1,931.80	4,544.6	$8,693,512	$1,912.94	0.990
HCBS, age 65+, no SPMI	9,022.6	$12,101,533	$1,341.24	4,812.8	$10,025,862	$2,083.16	1.553
Community, age 65+, with SPMI	6,083.6	$10,289,715	$1,691.40	3,279.6	$5,023,879	$1,531.88	0.906
Community, age 65+, no SPMI	14,579.5	$17,589,282	$1,206.44	7,823.1	$12,206,300	$1,560.29	1.293
Facility, age <65, with SPMI	1,284.5	$5,382,129	$4,189.90	736.2	$1,684,623	$2,288.19	0.546
Facility, age <65, no SPMI	579.0	$1,328,071	$2,293.73	412.3	$943,527	$2,288.21	0.998
HCBS, age <65, with SPMI	5,481.1	$11,153,684	$2,034.93	3,958.4	$7,744,615	$1,956.52	0.961
HCBS, age <65, no SPMI	3,758.0	$5,231,307	$1,392.03	2,694.7	$6,386,843	$2,370.18	1.703
Community, age <65, with SPMI	6,450.3	$11,304,842	$1,752.61	3,629.5	$6,328,063	$1,743.49	0.995
Community, age <65, no SPMI	3,646.1	$7,038,850	$1,930.53	2,142.6	$5,322,190	$2,483.98	1.287

Table 3.M.1 MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 5, by category of beneficiary: Cohort 6A

Category of beneficiary	Baseline period			Demonstration Year 5			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**51,245.5**	**$100,075,043**	**$1,952.86**	**49,698.6**	**$97,813,676**	**$1,968.14**	**1.008**
Facility, age 65+, with SPMI	2,983.4	$7,275,051	$2,438.54	2,698.0	$5,483,702	$2,032.51	0.833
Facility, age 65+, no SPMI	1,780.9	$3,501,971	$1,966.38	1,540.3	$2,460,709	$1,597.55	0.812
HCBS, age 65+, with SPMI	5,934.9	$12,433,792	$2,095.03	5,680.2	$14,286,998	$2,515.22	1.201
HCBS, age 65+, no SPMI	6,235.3	$12,364,008	$1,982.90	5,897.0	$12,880,601	$2,184.27	1.102
Community, age 65+, with SPMI	3,535.9	$7,176,174	$2,029.49	3,475.9	$5,968,932	$1,717.22	0.846
Community, age 65+, no SPMI	7,629.4	$11,448,086	$1,500.51	7,687.3	$12,535,007	$1,630.61	1.087
Facility, age <65, with SPMI	1,446.6	$4,284,949	$2,962.09	1,391.3	$3,870,866	$2,782.23	0.939
Facility, age <65, no SPMI	1,110.7	$3,308,099	$2,978.45	1,093.9	$2,447,235	$2,237.19	0.751
HCBS, age <65, with SPMI	5,162.9	$11,356,161	$2,199.59	5,165.8	$12,275,461	$2,376.32	1.080
HCBS, age <65, no SPMI	3,228.4	$5,124,319	$1,587.25	3,457.4	$5,302,553	$1,533.70	0.966
Community, age <65, with SPMI	7,216.3	$12,968,802	$1,797.17	6,671.8	$10,658,947	$1,597.61	0.889
Community, age <65, no SPMI	4,980.8	$8,833,631	$1,773.54	4,939.7	$9,642,664	$1,952.07	1.101
Intervention group	**51,245.5**	**$102,206,255**	**$1,994.44**	**49,698.6**	**$81,716,565**	**$1,644.24**	**0.824**
Facility, age 65+, with SPMI	2,983.4	$10,028,144	$3,361.36	2,698.0	$4,497,920	$1,667.13	0.496
Facility, age 65+, no SPMI	1,780.9	$4,091,617	$2,297.47	1,540.3	$2,043,020	$1,326.37	0.577
HCBS, age 65+, with SPMI	5,934.9	$15,182,148	$2,558.12	5,680.2	$11,454,444	$2,016.55	0.788
HCBS, age 65+, no SPMI	6,235.3	$11,287,100	$1,810.19	5,897.0	$10,243,096	$1,737.00	0.960
Community, age 65+, with SPMI	3,535.9	$7,139,268	$2,019.05	3,475.9	$5,477,324	$1,575.79	0.780
Community, age 65+, no SPMI	7,629.4	$10,590,533	$1,388.11	7,687.3	$9,626,122	$1,252.21	0.902
Facility, age <65, with SPMI	1,446.6	$4,054,834	$2,803.02	1,391.3	$2,467,312	$1,773.41	0.633
Facility, age <65, no SPMI	1,110.7	$1,264,106	$1,138.14	1,093.9	$1,106,735	$1,011.74	0.889
HCBS, age <65, with SPMI	5,162.9	$12,719,808	$2,463.72	5,165.8	$11,399,675	$2,206.78	0.896
HCBS, age <65, no SPMI	3,228.4	$4,799,057	$1,486.50	3,457.4	$5,189,949	$1,501.13	1.010
Community, age <65, with SPMI	7,216.3	$13,988,314	$1,938.45	6,671.8	$10,419,236	$1,561.68	0.806
Community, age <65, no SPMI	4,980.8	$7,061,327	$1,417.71	4,939.7	$7,791,731	$1,577.36	1.113

Table 3.M.2 MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 6, by category of beneficiary: Cohort 6A

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**51,245.5**	**$100,075,043**	**$1,952.86**	**35,083.7**	**$68,050,038**	**$1,939.65**	**0.993**
Facility, age 65+, with SPMI	2,983.4	$7,275,051	$2,438.54	1,672.2	$3,418,768	$2,044.42	0.838
Facility, age 65+, no SPMI	1,780.9	$3,501,971	$1,966.38	936.5	$1,646,424	$1,758.04	0.894
HCBS, age 65+, with SPMI	5,934.9	$12,433,792	$2,095.03	3,882.9	$9,715,617	$2,502.15	1.194
HCBS, age 65+, no SPMI	6,235.3	$12,364,008	$1,982.90	3,998.3	$9,035,112	$2,259.73	1.140
Community, age 65+, with SPMI	3,535.9	$7,176,174	$2,029.49	2,492.0	$4,644,975	$1,863.98	0.918
Community, age 65+, no SPMI	7,629.4	$11,448,086	$1,500.51	5,363.6	$8,130,034	$1,515.77	1.010
Facility, age <65, with SPMI	1,446.6	$4,284,949	$2,962.09	1,107.8	$3,077,628	$2,778.07	0.938
Facility, age <65, no SPMI	1,110.7	$3,308,099	$2,978.45	966.9	$2,222,806	$2,298.82	0.772
HCBS, age <65, with SPMI	5,162.9	$11,356,161	$2,199.59	4,026.2	$7,171,702	$1,781.25	0.810
HCBS, age <65, no SPMI	3,228.4	$5,124,319	$1,587.25	2,717.9	$4,693,516	$1,726.90	1.088
Community, age <65, with SPMI	7,216.3	$12,968,802	$1,797.17	4,525.4	$6,659,770	$1,471.65	0.819
Community, age <65, no SPMI	4,980.8	$8,833,631	$1,773.54	3,393.8	$7,633,685	$2,249.28	1.268
Intervention group	**51,245.5**	**$102,206,255**	**$1,994.44**	**35,083.7**	**$56,359,839**	**$1,606.44**	**0.805**
Facility, age 65+, with SPMI	2,983.4	$10,028,144	$3,361.36	1,672.2	$2,822,119	$1,687.63	0.502
Facility, age 65+, no SPMI	1,780.9	$4,091,617	$2,297.47	936.5	$1,338,129	$1,428.84	0.622
HCBS, age 65+, with SPMI	5,934.9	$15,182,148	$2,558.12	3,882.9	$7,598,510	$1,956.91	0.765
HCBS, age 65+, no SPMI	6,235.3	$11,287,100	$1,810.19	3,998.3	$6,746,346	$1,687.30	0.932
Community, age 65+, with SPMI	3,535.9	$7,139,268	$2,019.05	2,492.0	$4,183,560	$1,678.82	0.831
Community, age 65+, no SPMI	7,629.4	$10,590,533	$1,388.11	5,363.6	$6,243,950	$1,164.13	0.839
Facility, age <65, with SPMI	1,446.6	$4,054,834	$2,803.02	1,107.8	$1,498,886	$1,353.00	0.483
Facility, age <65, no SPMI	1,110.7	$1,264,106	$1,138.14	966.9	$1,133,972	$1,172.75	1.030
HCBS, age <65, with SPMI	5,162.9	$12,719,808	$2,463.72	4,026.2	$7,542,622	$1,873.37	0.760
HCBS, age <65, no SPMI	3,228.4	$4,799,057	$1,486.50	2,717.9	$4,439,165	$1,633.31	1.099
Community, age <65, with SPMI	7,216.3	$13,988,314	$1,938.45	4,525.4	$6,763,020	$1,494.46	0.771
Community, age <65, no SPMI	4,980.8	$7,061,327	$1,417.71	3,393.8	$6,049,560	$1,782.51	1.257

Table 3.N.1 MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 5, by category of beneficiary: Cohort 6B

Category of beneficiary	Baseline period			Demonstration Year 5			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**36,877.4**	**$64,261,823**	**$1,742.58**	**34,503.2**	**$59,745,018**	**$1,731.58**	**0.994**
Facility, age 65+, with SPMI	1,661.3	$4,014,399	$2,416.43	1,441.7	$2,656,683	$1,842.73	0.763
Facility, age 65+, no SPMI	1,114.5	$2,401,017	$2,154.35	917.3	$1,363,275	$1,486.16	0.690
HCBS, age 65+, with SPMI	4,645.1	$10,776,546	$2,319.98	4,392.0	$11,904,415	$2,710.49	1.168
HCBS, age 65+, no SPMI	5,075.5	$9,483,790	$1,868.54	4,682.5	$9,985,878	$2,132.58	1.141
Community, age 65+, with SPMI	3,969.4	$7,044,648	$1,774.76	3,753.9	$6,452,800	$1,718.95	0.969
Community, age 65+, no SPMI	8,806.0	$11,292,981	$1,282.42	8,235.8	$10,032,355	$1,218.14	0.950
Facility, age <65, with SPMI	618.0	$2,135,696	$3,455.66	590.3	$1,495,956	$2,534.37	0.733
Facility, age <65, no SPMI	497.5	$883,628	$1,776.19	481.3	$558,155	$1,159.63	0.653
HCBS, age <65, with SPMI	2,770.0	$5,053,178	$1,824.25	2,642.1	$4,666,353	$1,766.13	0.968
HCBS, age <65, no SPMI	2,222.3	$2,780,808	$1,251.33	2,199.5	$2,701,695	$1,228.33	0.982
Community, age <65, with SPMI	3,449.6	$5,209,670	$1,510.24	3,196.1	$4,486,087	$1,403.63	0.929
Community, age <65, no SPMI	2,048.2	$3,185,461	$1,555.21	1,970.7	$3,441,368	$1,746.27	1.123
Intervention group	**36,877.4**	**$69,409,748**	**$1,882.18**	**34,503.2**	**$57,118,474**	**$1,655.45**	**0.880**
Facility, age 65+, with SPMI	1,661.3	$5,090,470	$3,064.17	1,441.7	$2,644,380	$1,834.20	0.599
Facility, age 65+, no SPMI	1,114.5	$3,548,559	$3,184.00	917.3	$1,790,458	$1,951.85	0.613
HCBS, age 65+, with SPMI	4,645.1	$9,859,451	$2,122.54	4,392.0	$7,279,161	$1,657.38	0.781
HCBS, age 65+, no SPMI	5,075.5	$7,956,973	$1,567.72	4,682.5	$7,588,544	$1,620.61	1.034
Community, age 65+, with SPMI	3,969.4	$6,757,915	$1,702.52	3,753.9	$5,158,592	$1,374.19	0.807
Community, age 65+, no SPMI	8,806.0	$10,622,370	$1,206.27	8,235.8	$10,323,586	$1,253.50	1.039
Facility, age <65, with SPMI	618.0	$3,152,460	$5,100.83	590.3	$1,202,108	$2,036.55	0.399
Facility, age <65, no SPMI	497.5	$526,891	$1,059.11	481.3	$706,708	$1,468.27	1.386
HCBS, age <65, with SPMI	2,770.0	$6,815,495	$2,460.47	2,642.1	$5,728,089	$2,167.98	0.881
HCBS, age <65, no SPMI	2,222.3	$3,955,957	$1,780.13	2,199.5	$4,480,321	$2,036.99	1.144
Community, age <65, with SPMI	3,449.6	$6,575,663	$1,906.23	3,196.1	$6,798,119	$2,127.03	1.116
Community, age <65, no SPMI	2,048.2	$4,547,544	$2,220.21	1,970.7	$3,418,408	$1,734.62	0.781

Table 3.N.2 MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 6, by category of beneficiary: Cohort 6B

Category of beneficiary	Baseline period			Demonstration year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**36,877.4**	**$64,261,823**	**$1,742.58**	**24,966.5**	**$43,402,053**	**$1,738.41**	**0.998**
Facility, age 65+, with SPMI	1,661.3	$4,014,399	$2,416.43	918.3	$1,681,231	$1,830.78	0.758
Facility, age 65+, no SPMI	1,114.5	$2,401,017	$2,154.35	568.0	$911,305	$1,604.47	0.745
HCBS, age 65+, with SPMI	4,645.1	$10,776,546	$2,319.98	3,214.3	$8,837,677	$2,749.50	1.185
HCBS, age 65+, no SPMI	5,075.5	$9,483,790	$1,868.54	3,254.2	$6,169,093	$1,895.71	1.015
Community, age 65+, with SPMI	3,969.4	$7,044,648	$1,774.76	2,773.9	$5,918,813	$2,133.79	1.202
Community, age 65+, no SPMI	8,806.0	$11,292,981	$1,282.42	5,594.1	$6,869,864	$1,228.06	0.958
Facility, age <65, with SPMI	618.0	$2,135,696	$3,455.66	455.1	$1,343,488	$2,952.07	0.854
Facility, age <65, no SPMI	497.5	$883,628	$1,776.19	360.4	$398,539	$1,105.77	0.623
HCBS, age <65, with SPMI	2,770.0	$5,053,178	$1,824.25	2,156.0	$3,578,422	$1,659.76	0.910
HCBS, age <65, no SPMI	2,222.3	$2,780,808	$1,251.33	1,860.4	$2,403,868	$1,292.12	1.033
Community, age <65, with SPMI	3,449.6	$5,209,670	$1,510.24	2,313.2	$3,011,680	$1,301.93	0.862
Community, age <65, no SPMI	2,048.2	$3,185,461	$1,555.21	1,498.7	$2,278,072	$1,520.08	0.977
Intervention group	**36,877.4**	**$69,409,748**	**$1,882.18**	**24,966.5**	**$43,116,549**	**$1,726.97**	**0.918**
Facility, age 65+, with SPMI	1,661.3	$5,090,470	$3,064.17	918.3	$1,801,701	$1,961.97	0.640
Facility, age 65+, no SPMI	1,114.5	$3,548,559	$3,184.00	568.0	$1,402,192	$2,468.74	0.775
HCBS, age 65+, with SPMI	4,645.1	$9,859,451	$2,122.54	3,214.3	$5,480,008	$1,704.89	0.803
HCBS, age 65+, no SPMI	5,075.5	$7,956,973	$1,567.72	3,254.2	$5,754,925	$1,768.44	1.128
Community, age 65+, with SPMI	3,969.4	$6,757,915	$1,702.52	2,773.9	$3,324,584	$1,198.54	0.704
Community, age 65+, no SPMI	8,806.0	$10,622,370	$1,206.27	5,594.1	$8,585,806	$1,534.81	1.272
Facility, age <65, with SPMI	618.0	$3,152,460	$5,100.83	455.1	$1,572,069	$3,454.34	0.677
Facility, age <65, no SPMI	497.5	$526,891	$1,059.11	360.4	$397,797	$1,103.71	1.042
HCBS, age <65, with SPMI	2,770.0	$6,815,495	$2,460.47	2,156.0	$4,733,353	$2,195.44	0.892
HCBS, age <65, no SPMI	2,222.3	$3,955,957	$1,780.13	1,860.4	$3,165,672	$1,701.61	0.956
Community, age <65, with SPMI	3,449.6	$6,575,663	$1,906.23	2,313.2	$3,716,532	$1,606.63	0.843
Community, age <65, no SPMI	2,048.2	$4,547,544	$2,220.21	1,498.7	$3,181,911	$2,123.17	0.956

Table 3.O MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 6, by category of beneficiary: Cohort 7A

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**46,261.5**	**$92,782,347**	**$2,005.60**	**43,336.2**	**$83,652,193**	**$1,930.31**	**0.962**
Facility, age 65+, with SPMI	3,789.7	$9,869,463	$2,604.25	3,098.5	$6,113,512	$1,973.09	0.758
Facility, age 65+, no SPMI	2,203.8	$5,878,877	$2,667.61	1,930.3	$4,181,840	$2,166.44	0.812
HCBS, age 65+, with SPMI	6,978.0	$14,292,060	$2,048.16	6,315.0	$17,085,001	$2,705.46	1.321
HCBS, age 65+, no SPMI	6,768.5	$9,950,022	$1,470.06	6,340.2	$12,792,342	$2,017.67	1.373
Community, age 65+, with SPMI	3,003.8	$5,033,889	$1,675.81	2,764.6	$4,307,192	$1,557.96	0.930
Community, age 65+, no SPMI	6,461.0	$10,139,136	$1,569.29	6,184.3	$7,577,695	$1,225.31	0.781
Facility, age <65, with SPMI	815.1	$3,552,916	$4,358.90	755.6	$2,197,966	$2,908.93	0.667
Facility, age <65, no SPMI	408.1	$1,535,898	$3,763.39	426.5	$1,313,956	$3,081.11	0.819
HCBS, age <65, with SPMI	3,622.0	$9,776,636	$2,699.24	3,701.8	$7,488,155	$2,022.81	0.749
HCBS, age <65, no SPMI	2,706.3	$5,591,603	$2,066.17	2,892.5	$5,487,083	$1,897.03	0.918
Community, age <65, with SPMI	5,603.0	$9,097,720	$1,623.72	5,186.2	$7,503,559	$1,446.83	0.891
Community, age <65, no SPMI	3,902.2	$8,064,127	$2,066.54	3,740.8	$7,603,893	$2,032.67	0.984
Intervention group	**46,261.5**	**$86,769,395**	**$1,875.63**	**43,336.2**	**$74,147,974**	**$1,710.99**	**0.912**
Facility, age 65+, with SPMI	3,789.7	$8,325,041	$2,196.73	3,098.5	$5,134,551	$1,657.13	0.754
Facility, age 65+, no SPMI	2,203.8	$5,228,923	$2,372.69	1,930.3	$2,467,694	$1,278.41	0.539
HCBS, age 65+, with SPMI	6,978.0	$15,697,104	$2,249.51	6,315.0	$13,541,379	$2,144.32	0.953
HCBS, age 65+, no SPMI	6,768.5	$10,968,491	$1,620.53	6,340.2	$10,927,062	$1,723.47	1.064
Community, age 65+, with SPMI	3,003.8	$4,983,082	$1,658.90	2,764.6	$4,538,336	$1,641.57	0.990
Community, age 65+, no SPMI	6,461.0	$9,240,528	$1,430.21	6,184.3	$9,805,569	$1,585.56	1.109
Facility, age <65, with SPMI	815.1	$2,410,579	$2,957.42	755.6	$1,776,622	$2,351.29	0.795
Facility, age <65, no SPMI	408.1	$1,308,200	$3,205.47	426.5	$495,418	$1,161.71	0.362
HCBS, age <65, with SPMI	3,622.0	$8,967,579	$2,475.87	3,701.8	$6,991,328	$1,888.60	0.763
HCBS, age <65, no SPMI	2,706.3	$4,077,210	$1,506.58	2,892.5	$4,166,648	$1,440.52	0.956
Community, age <65, with SPMI	5,603.0	$9,269,861	$1,654.45	5,186.2	$7,853,573	$1,514.32	0.915
Community, age <65, no SPMI	3,902.2	$6,292,799	$1,612.61	3,740.8	$6,449,794	$1,724.16	1.069

Table 3.P MEDICARE
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 6, by category of beneficiary: Cohort 7B

Category of beneficiary	Baseline period			Demonstration Year 6			Trend (D/B)
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Re-weighted comparison group	**22,532.1**	**$42,213,582**	**$1,873.48**	**20,821.3**	**$38,068,927**	**$1,828.37**	**0.976**
Facility, age 65+, with SPMI	1,456.3	$3,292,072	$2,260.58	1,211.3	$2,253,811	$1,860.62	0.823
Facility, age 65+, no SPMI	922.9	$2,307,438	$2,500.27	815.1	$1,472,171	$1,806.21	0.722
HCBS, age 65+, with SPMI	2,798.1	$6,458,338	$2,308.10	2,563.6	$5,818,312	$2,269.60	0.983
HCBS, age 65+, no SPMI	3,057.5	$6,032,828	$1,973.14	2,756.7	$5,886,625	$2,135.38	1.082
Community, age 65+, with SPMI	2,226.3	$4,293,558	$1,928.56	1,894.8	$3,705,518	$1,955.58	1.014
Community, age 65+, no SPMI	5,439.7	$8,256,546	$1,517.83	5,286.3	$7,762,900	$1,468.49	0.967
Facility, age <65, with SPMI	285.9	$1,010,533	$3,534.13	234.8	$603,055	$2,568.43	0.727
Facility, age <65, no SPMI	179.5	$323,120	$1,800.27	159.9	$131,412	$821.78	0.456
HCBS, age <65, with SPMI	1,660.8	$3,374,561	$2,031.95	1,598.3	$4,069,910	$2,546.39	1.253
HCBS, age <65, no SPMI	1,106.3	$1,223,440	$1,105.90	1,149.5	$1,370,605	$1,192.40	1.078
Community, age <65, with SPMI	2,255.7	$3,747,160	$1,661.21	2,065.3	$2,651,659	$1,283.93	0.773
Community, age <65, no SPMI	1,143.2	$1,893,988	$1,656.74	1,085.7	$2,342,950	$2,158.02	1.303
Intervention group	**22,532.1**	**$45,299,170**	**$2,010.43**	**20,821.3**	**$35,521,409**	**$1,706.02**	**0.849**
Facility, age 65+, with SPMI	1,456.3	$5,206,040	$3,574.85	1,211.3	$2,833,008	$2,338.77	0.654
Facility, age 65+, no SPMI	922.9	$2,459,352	$2,664.88	815.1	$1,571,014	$1,927.48	0.723
HCBS, age 65+, with SPMI	2,798.1	$6,071,805	$2,169.96	2,563.6	$4,561,146	$1,779.21	0.820
HCBS, age 65+, no SPMI	3,057.5	$5,845,031	$1,911.72	2,756.7	$4,558,425	$1,653.57	0.865
Community, age 65+, with SPMI	2,226.3	$4,235,484	$1,902.48	1,894.8	$3,631,715	$1,916.63	1.007
Community, age 65+, no SPMI	5,439.7	$7,380,705	$1,356.82	5,286.3	$7,243,958	$1,370.32	1.010
Facility, age <65, with SPMI	285.9	$1,462,879	$5,116.12	234.8	$638,812	$2,720.73	0.532
Facility, age <65, no SPMI	179.5	$1,146,709	$6,388.92	159.9	$454,518	$2,842.32	0.445
HCBS, age <65, with SPMI	1,660.8	$3,453,668	$2,079.58	1,598.3	$2,640,135	$1,651.84	0.794
HCBS, age <65, no SPMI	1,106.3	$1,705,266	$1,541.43	1,149.5	$2,115,790	$1,840.69	1.194
Community, age <65, with SPMI	2,255.7	$3,895,705	$1,727.07	2,065.3	$3,236,230	$1,566.97	0.907
Community, age <65, no SPMI	1,143.2	$2,436,526	$2,131.32	1,085.7	$2,036,658	$1,875.90	0.880

Table 4.A
Summary by cohort of per member per month (PMPM), baseline versus Demonstration Year 5

Cohort	Group (comparison/ Intervention)	Baseline period			Demonstration Year 5			Cost trend (demonstration year/baseline period)
		Number of eligible months (intervention group)	Medicare incurred claims	PMPM	Number of eligible months (intervention group)	Medicare incurred claims	PMPM	
1A	C	48,488.0	$78,754,198	$1,624.20	9,903.2	$19,681,818	$1,987.42	1.224
	I	48,488.0	$128,622,626	$2,652.67	9,903.2	$26,728,247	$2,698.95	1.017
1B	C	83,567.1	$131,605,106	$1,574.84	19,132.6	$37,050,672	$1,936.52	1.230
	I	83,567.1	$108,476,913	$1,298.08	19,132.6	$33,855,821	$1,769.54	1.363
1C	C	7,946.8	$12,115,020	$1,524.51	1,567.5	$3,009,601	$1,919.99	1.259
	I	7,946.8	$7,898,710	$993.94	1,567.5	$2,776,143	$1,771.05	1.782
1D	C	129,399.2	$207,882,769	$1,606.52	27,937.6	$54,313,191	$1,944.09	1.210
	I	129,399.2	$219,493,469	$1,696.25	27,937.6	$53,895,988	$1,929.16	1.137
1E	C	15,153.3	$23,465,894	$1,548.56	3,353.5	$6,380,605	$1,902.67	1.229
	I	15,153.3	$10,288,068	$678.93	3,353.5	$4,817,178	$1,436.46	2.116
1F	C	15,986.6	$24,688,247	$1,544.31	3,882.8	$7,538,821	$1,941.57	1.257
	I	15,986.6	$9,731,043	$608.70	3,882.8	$4,741,399	$1,221.12	2.006
1 total	C	300,541.1	$478,511,235	$1,592.17	65,777.2	$127,974,708	$1,945.58	1.222
	I	300,541.1	$484,510,829	$1,612.13	65,777.2	$126,814,776	$1,927.94	1.196
2	C	4,220.4	$7,342,975	$1,739.88	2,826.7	$4,333,084	$1,532.91	0.881
	I	4,220.4	$9,945,769	$2,356.60	2,826.7	$5,512,243	$1,950.06	0.827
3	C	61,200.6	$93,045,998	$1,520.35	29,370.2	$46,476,966	$1,582.45	1.041
	I	61,200.6	$103,440,434	$1,690.19	29,370.2	$48,816,683	$1,662.12	0.983
4	C	62,395.6	$96,865,182	$1,552.44	33,927.6	$55,152,829	$1,625.60	1.047
	I	62,395.6	$108,719,430	$1,742.42	33,927.6	$57,515,586	$1,695.25	0.973
5A	C	65,796.4	$107,612,835	$1,635.54	46,063.6	$75,424,214	$1,637.39	1.001
	I	65,796.4	$110,831,462	$1,684.46	46,063.6	$68,293,534	$1,482.59	0.880

(continued)

Table 4.A (continued)
Summary by cohort of per member per month (PMPM), baseline versus Demonstration Year 5

Cohort	Group (comparison/ Intervention)	Baseline period			Demonstration Year 5			Cost trend (demonstration year/baseline period)
		Number of eligible months (intervention group)	Medicare incurred claims	PMPM	Number of eligible months (intervention group)	Medicare incurred claims	PMPM	
5B	C	65,414.5	$107,080,977	$1,636.96	49,203.2	$89,555,043	$1,820.10	1.112
	I	65,414.5	$113,207,213	$1,730.61	49,203.2	$86,106,616	$1,750.02	1.011
6A	C	51,245.5	$100,075,043	$1,952.86	49,698.6	$97,813,676	$1,968.14	1.008
	I	51,245.5	$102,206,255	$1,994.44	49,698.6	$81,716,565	$1,644.24	0.824
6B	C	36,877.4	$64,261,823	$1,742.58	34,503.2	$59,745,018	$1,731.58	0.994
	I	36,877.4	$69,409,748	$1,882.18	34,503.2	$57,118,474	$1,655.45	0.880

Table 4.B
Summary by cohort of per member per month (PMPM), baseline versus Demonstration Year 6

		Baseline period			Demonstration Year 6			
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	7,920.6	$17,109,366	$2,160.11	1.330
	I	48,488.0	$128,622,626	$2,652.67	7,920.6	$20,531,587	$2,592.18	0.977
1B	C	83,567.1	$131,605,106	$1,574.84	15,489.8	$32,115,928	$2,073.36	1.317
	I	83,567.1	$108,476,913	$1,298.08	15,489.8	$27,517,708	$1,776.51	1.369
1C	C	7,946.8	$12,115,020	$1,524.51	1,227.0	$2,532,040	$2,063.55	1.354
	I	7,946.8	$7,898,710	$993.94	1,227.0	$1,631,819	$1,329.89	1.338
1D	C	129,399.2	$207,882,769	$1,606.52	23,762.1	$49,767,772	$2,094.42	1.304
	I	129,399.2	$219,493,469	$1,696.25	23,762.1	$48,321,790	$2,033.57	1.199
1E	C	15,153.3	$23,465,894	$1,548.56	2,716.7	$5,494,124	$2,022.34	1.306
	I	15,153.3	$10,288,068	$678.93	2,716.7	$4,161,054	$1,531.65	2.256
1F	C	15,986.6	$24,688,247	$1,544.31	3,231.7	$6,682,701	$2,067.88	1.339
	I	15,986.6	$9,731,043	$608.70	3,231.7	$4,370,142	$1,352.29	2.222
1 total	C	300,541.1	$478,511,235	$1,592.17	54,347.9	$113,701,931	$2,092.11	1.314
	I	300,541.1	$484,510,829	$1,612.13	54,347.9	$106,534,101	$1,960.23	1.216
2	C	4,220.4	$7,342,975	$1,739.88	2,414.2	$4,135,064	$1,712.79	0.984
	I	4,220.4	$9,945,769	$2,356.60	2,414.2	$4,430,479	$1,835.15	0.779
3	C	61,200.6	$93,045,998	$1,520.35	23,794.6	$39,365,826	$1,654.40	1.088
	I	61,200.6	$103,440,434	$1,690.19	23,794.6	$41,733,736	$1,753.91	1.038
4	C	62,395.6	$96,865,182	$1,552.44	26,423.4	$44,473,985	$1,683.13	1.084
	I	62,395.6	$108,719,430	$1,742.42	26,423.4	$45,185,845	$1,710.07	0.981
5A	C	65,796.4	$107,612,835	$1,635.54	35,027.4	$61,378,077	$1,752.29	1.071
	I	65,796.4	$110,831,462	$1,684.46	35,027.4	$56,260,564	$1,606.19	0.954

(continued)

Table 4.B (continued)
Summary by cohort of per member per month (PMPM), baseline versus Demonstration Year 6

		Baseline period			Demonstration Year 6			
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)
5B	C	65,414.5	$107,080,977	$1,636.96	36,727.0	$70,612,648	$1,922.63	1.175
	I	65,414.5	$113,207,213	$1,730.61	36,727.0	$69,566,362	$1,894.15	1.094
6A	C	51,245.5	$100,075,043	$1,952.86	35,083.7	$68,050,038	$1,939.65	0.993
	I	51,245.5	$102,206,255	$1,994.44	35,083.7	$56,359,839	$1,606.44	0.805
6B	C	36,877.4	$64,261,823	$1,742.58	24,966.5	$43,402,053	$1,738.41	0.998
	I	36,877.4	$69,409,748	$1,882.18	24,966.5	$43,116,549	$1,726.97	0.918
7A	C	46,261.5	$92,782,347	$2,005.60	43,336.2	$83,652,193	$1,930.31	0.962
	I	46,261.5	$86,769,395	$1,875.63	43,336.2	$74,147,974	$1,710.99	0.912
7B	C	22,532.1	$42,213,582	$1,873.48	20,821.3	$38,068,927	$1,828.37	0.976
	I	22,532.1	$45,299,170	$2,010.43	20,821.3	$35,521,409	$1,706.02	0.849

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).[10] Tables 5.A and 5.B show the results of the calculations for Demonstration Years 5 and 6, 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 5, the AGA factor increased by 0.24 percent (a factor of 1.0024) for the comparison group and increased by 4.62 percent (a factor of 1.0462) for the intervention group. If the AGA had increased by the same 4.62 percent in the comparison area as it did in the intervention area, instead of increasing by 0.24 percent, then the trend of the comparison group would have increased by an additional 4.37 percent (1.0462/1.0024 = 1.0437), which is the AGA adjustment factor that we apply to the comparison group trend. For Cohort 2, the corresponding AGA adjustment factor is 1.00307, for Cohort 3 it is 1.00926, for Cohort 4 it is 1.0059, for Cohort 5A it is 0.9996, for Cohort 5B it is 0.9930, for Cohort 6A it is 0.9945 and for Cohort 6B it is 0.9937.

Table 5.A
Average AGA factor by group for baseline period and Demonstration Year 5

Cohort	Group comparison intervention	Baseline period	Demonstration Year 5	Trend in AGA factor	Adjustment to comparison group trend
1 total	C	0.89646	0.89860	1.00239	1.04366
	I	0.88374	0.92453	1.04616	
2	C	0.89647	0.90676	1.01148	1.03073
	I	0.89107	0.92900	1.04256	
3	C	0.88723	0.89609	1.00998	1.00926
	I	0.90748	0.92503	1.01934	

(continued)

[10] 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.

Table 5.A (continued)
Average AGA factor by group for baseline period and Demonstration Year 5

Cohort	Group comparison intervention	Baseline period	Demonstration Year 5	Trend in AGA factor	Adjustment to comparison group trend
4	C	0.88806	0.89932	1.01268	1.00591
	I	0.90803	0.92498	1.01867	
5A	C	0.89184	0.89696	1.00574	0.99959
	I	0.92374	0.92866	1.00533	
5B	C	0.90563	0.90398	0.99818	0.99293
	I	0.89981	0.89182	0.99112	
6A	C	0.90383	0.90546	1.00181	0.99454
	I	0.93245	0.92904	0.99634	
6B	C	0.90539	0.90499	0.99956	0.99374
	I	0.89743	0.89141	0.99330	

For Demonstration Year 6, the corresponding calculations produced AGA adjustment factors of 1.0393 for Cohort 1, 1.0306 for Cohort 2, 1.0028 for Cohort 3, 0.9969 for Cohort 4, 0.9885 for Cohort 5A, 0.9959 for Cohort 5B, 0.9937 for Cohort 6A, 0.9973 for Cohort 6B, 0.9966 for Cohort 7A and 1.0061 for Cohort 7B.

Table 5.B
Average AGA factor by group for baseline period and Demonstration Year 6

Cohort	Group Comparison Intervention	Baseline period	Demonstration Year 6	Trend in AGA factor	Adjustment to comparison group trend
1 total	C	0.89646	0.90311	1.00741	1.03928
	I	0.88374	0.92527	1.04699	
2	C	0.89647	0.91125	1.01649	1.03063
	I	0.89107	0.93352	1.04763	
3	C	0.88723	0.90400	1.01890	1.00275
	I	0.90748	0.92718	1.02170	
4	C	0.88806	0.90598	1.02018	0.99688
	I	0.90803	0.92347	1.01700	
5A	C	0.89184	0.90515	1.01493	0.98845
	I	0.92374	0.92670	1.00321	
5B	C	0.90563	0.90833	1.00298	0.99585
	I	0.89981	0.89874	0.99882	
6A	C	0.90383	0.90830	1.00494	0.99369
	I	0.93245	0.93114	0.99860	

(continued)

Table 5.B (continued)
Average AGA factor by group for baseline period and Demonstration Year 6

Cohort	Group Comparison Intervention	Baseline period	Demonstration Year 6	Trend in AGA factor	Adjustment to comparison group trend
6B	C	0.90539	0.90896	1.00395	0.99733
	I	0.89743	0.89857	1.00127	
7A	C	0.90667	0.91010	1.00379	0.99655
	I	0.93096	0.93127	1.00033	
7B	C	0.90401	0.90633	1.00257	1.00611
	I	0.89072	0.89846	1.00869	

Tables 6.A–6.P 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 trend 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.

Tables 6.G.1–2 displays the Medicare savings calculation for Cohort 1 in total. The baseline PMPM was $1,612.13. For Demonstration Year 5, the AGA adjusted trend from the comparison group was 1.239, resulting in a target PMPM of $1,997.13. The actual PMPM for the intervention group was $1,927.94, an increase of 19.6 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 $69.19, a savings rate of 3.5 percent. The total calculated Medicare savings dollar amount was $4,551,022. For Demonstration Year 6, we estimate a PMPM Medicare savings of $168.69, or 7.9 percent, with total calculated dollar savings of $9,168,113.

For Demonstration Year 5, the same calculations for Cohort 2 (as shown in Table 6.H.1) result in a PMPM Medicare savings of $86.05, or 4.2 percent, and a savings dollar amount of $243,228. For Demonstration Year 6 (as shown in Table 6.H.2,) the savings is $366.25 on a PMPM basis, 16.6 percent, and $884,214 total dollars.

For Cohort 3, Demonstration Year 5 savings (as shown in Table 6.I.1) is $151.78 PMPM, or 8.4 percent, and $4,457,725 in total dollars. Demonstration Year 6 savings (as shown in Table 6.I.2) is $127.54 PMPM, or 6.8 percent, and $3,034,760 in total dollars.

For Cohort 4, Demonstration Year 5 savings (as shown in Table 6.J.1) is $142.77 PMPM, or 7.8 percent, and $4,843,805 in total dollars. Demonstration Year 6 savings (as shown in Table 6.J.2) is $191.07 PMPM, or 10.1 percent, and $5,048,821 in total dollars.

For Cohort 5A, Demonstration Year 5 savings (as shown in Table 6.K.1) is $211.86 PMPM, or 12.5 percent, and $9,759,075 in total dollars. Demonstration Year 6 savings (as shown in Table 6.K.2) is $186.05, or 10.4 percent, and $6,516,979 in total dollars.

For Cohort 5B, Demonstration Year 5 savings (as shown in Table 6.L.1) is $111.26 PMPM, or 6.0 percent, and $5,474,301 in total dollars. Demonstration Year 6 savings (as shown in Table 6.L.2) is $77.85, or 3.9 percent, and $2,859,312 in total dollars.

For Cohort 6A, Demonstration Year 5 savings (as shown in Table 6.M.1) is $349.89 PMPM, or 17.5 percent, and $17,388,933 in total dollars. Demonstration Year 6 savings (as shown in Table 6.M.2) is $328.18 PMPM, or 17.0 percent, and $11,513,800 in total dollars.

For Cohort 6B, Demonstration Year 5 savings (as shown in Table 6.N.1) is $175.05, or 9.6 percent, and $6,039,863 in total dollars. Demonstration Year 6 savings (as shown in Table 6.N.2) is $127.72 PMPM, or 6.9 percent, and $3,188,635 in total dollars.

For Cohort 7A, Demonstration Year 6 savings (as shown in Table 6.O) is $126.68 PMPM, or 6.9 percent, and $5,489,772 in total dollars. For Cohort 7B, Demonstration Year 6 savings (as shown in Table 6.P) is $231.64 PMPM, or 12.0 percent, and $4,823,092 in total dollars.

Table 6.A.1 MEDICARE Demonstration Year 5
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	**9,903.2**	**$2,652.67**	**1.290**	**$3,421.92**	**$2,698.95**	**$722.98**	**$7,159,779**	**21.1%**
Facility, age 65+, with SPMI	107.2	$3,321.06	0.937	$3,110.44	$1,828.34	$1,282.10	$137,392	41.2%
Facility, age 65+, no SPMI	149.3	$2,476.33	0.883	$2,186.31	$1,141.57	$1,044.74	$155,955	47.8%
HCBS, age 65+, with SPMI	417.5	$2,903.67	1.272	$3,693.58	$2,795.42	$898.15	$374,936	24.3%
HCBS, age 65+, no SPMI	1,623.0	$2,389.27	1.499	$3,580.66	$2,610.19	$970.47	$1,575,115	27.1%
Community, age 65+, with SPMI	201.2	$2,067.95	1.427	$2,951.08	$2,374.95	$576.13	$115,925	19.5%
Community, age 65+, no SPMI	1,542.0	$2,124.06	1.592	$3,381.05	$2,683.04	$698.01	$1,076,304	20.6%
Facility, age <65, with SPMI	70.0	$5,306.80	0.692	$3,673.60	$682.34	$2,991.25	$209,388	81.4%
Facility, age <65, no SPMI	151.0	$4,764.97	0.677	$3,225.01	$1,473.98	$1,751.03	$264,406	54.3%
HCBS, age <65, with SPMI	990.0	$2,780.44	1.020	$2,837.15	$2,189.87	$647.28	$640,817	22.8%
HCBS, age <65, no SPMI	2,282.0	$2,691.70	1.177	$3,167.41	$2,906.31	$261.10	$595,816	8.2%
Community, age <65, with SPMI	750.0	$2,446.14	1.152	$2,818.13	$3,237.69	−$419.56	−$314,679	−14.9%
Community, age <65, no SPMI	1,620.1	$3,319.71	1.334	$4,427.60	$2,990.38	$1,437.22	$2,328,406	32.5%

Table 6.A.2 MEDICARE Demonstration Year 6
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	**7,920.6**	**$2,652.67**	**1.386**	**$3,676.00**	**$2,592.18**	**$1,083.82**	**$8,584,481**	**29.5%**
Facility, age 65+, with SPMI	47.1	$3,321.06	0.990	$3,288.95	$2,075.77	$1,213.17	$57,111	36.9%
Facility, age 65+, no SPMI	87.0	$2,476.33	0.988	$2,445.66	$1,374.16	$1,071.50	$93,210	43.8%
HCBS, age 65+, with SPMI	344.2	$2,903.67	1.363	$3,958.14	$2,073.81	$1,884.33	$648,618	47.6%
HCBS, age 65+, no SPMI	1,249.9	$2,389.27	1.476	$3,527.64	$2,588.85	$938.79	$1,173,393	26.6%
Community, age 65+, with SPMI	189.7	$2,067.95	1.655	$3,422.31	$1,052.18	$2,370.13	$449,692	69.3%
Community, age 65+, no SPMI	1,138.1	$2,124.06	1.599	$3,396.72	$2,662.83	$733.89	$835,267	21.6%
Facility, age <65, with SPMI	50.0	$5,306.80	0.748	$3,972.11	$931.19	$3,040.92	$152,046	76.6%
Facility, age <65, no SPMI	135.4	$4,764.97	0.776	$3,698.46	$3,371.42	$327.04	$44,286	8.8%
HCBS, age <65, with SPMI	789.4	$2,780.44	1.154	$3,207.72	$2,328.97	$878.75	$693,685	27.4%
HCBS, age <65, no SPMI	1,955.4	$2,691.70	1.404	$3,780.04	$2,378.82	$1,401.22	$2,739,900	37.1%
Community, age <65, with SPMI	590.1	$2,446.14	1.255	$3,070.10	$2,973.66	$96.44	$56,903	3.1%
Community, age <65, no SPMI	1,344.3	$3,319.71	1.351	$4,483.46	$3,263.20	$1,220.26	$1,640,370	27.2%

Table 6.B.1 MEDICARE Demonstration Year 5
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	**19,132.6**	**$1,298.08**	**1.262**	**$1,637.85**	**$1,769.54**	**−$131.68**	**−$2,519,418**	**−8.0%**
Facility, age 65+, with SPMI	311.0	$1,581.91	0.939	$1,484.71	$802.64	$682.07	$212,131	45.9%
Facility, age 65+, no SPMI	423.2	$1,689.87	0.883	$1,492.25	$1,429.30	$62.95	$26,641	4.2%
HCBS, age 65+, with SPMI	839.1	$1,412.22	1.273	$1,798.18	$1,298.01	$500.17	$419,703	27.8%
HCBS, age 65+, no SPMI	3,031.9	$1,178.09	1.500	$1,767.70	$1,795.27	−$27.57	−$83,584	−1.6%
Community, age 65+, with SPMI	454.8	$1,140.11	1.435	$1,636.28	$1,363.37	$272.92	$124,121	16.7%
Community, age 65+, no SPMI	3,484.9	$971.09	1.596	$1,549.84	$1,754.37	−$204.53	−$712,764	−13.2%
Facility, age <65, with SPMI	224.2	$3,244.58	0.692	$2,244.67	$1,924.79	$319.89	$71,706	14.3%
Facility, age <65, no SPMI	101.7	$3,733.76	0.669	$2,497.57	$1,937.91	$559.66	$56,891	22.4%
HCBS, age <65, with SPMI	2,245.2	$1,385.95	1.019	$1,411.93	$1,708.58	−$296.65	−$666,036	−21.0%
HCBS, age <65, no SPMI	2,983.5	$1,488.47	1.177	$1,752.39	$2,249.02	−$496.63	−$1,481,687	−28.3%
Community, age <65, with SPMI	2,209.2	$1,112.23	1.154	$1,283.35	$1,360.97	−$77.62	−$171,478	−6.0%
Community, age <65, no SPMI	2,824.0	$1,390.75	1.334	$1,855.19	$1,966.76	−$111.57	−$315,063	−6.0%

Table 6.B.2 MEDICARE Demonstration Year 6
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	**15,489.8**	**$1,298.08**	**1.347**	**$1,748.31**	**$1,776.51**	**−$28.20**	**−$436,843**	**−1.6%**
Facility, age 65+, with SPMI	237.5	$1,581.91	0.993	$1,571.60	$1,270.83	$300.77	$71,426	19.1%
Facility, age 65+, no SPMI	253.1	$1,689.87	0.985	$1,663.82	$1,873.08	−$209.26	−$52,972	−12.6%
HCBS, age 65+, with SPMI	716.5	$1,412.22	1.359	$1,918.65	$2,003.00	−$84.35	−$60,435	−4.4%
HCBS, age 65+, no SPMI	2,363.0	$1,178.09	1.479	$1,742.30	$1,699.02	$43.28	$102,263	2.5%
Community, age 65+, with SPMI	344.7	$1,140.11	1.648	$1,878.80	$1,489.58	$389.22	$134,156	20.7%
Community, age 65+, no SPMI	2,895.6	$971.09	1.601	$1,554.34	$1,617.19	−$62.85	−$181,999	−4.0%
Facility, age <65, with SPMI	192.0	$3,244.58	0.750	$2,432.75	$1,584.28	$848.47	$162,906	34.9%
Facility, age <65, no SPMI	106.0	$3,733.76	0.765	$2,857.66	$1,293.45	$1,564.21	$165,807	54.7%
HCBS, age <65, with SPMI	1,901.5	$1,385.95	1.155	$1,600.61	$1,668.72	−$68.11	−$129,508	−4.3%
HCBS, age <65, no SPMI	2,447.5	$1,488.47	1.407	$2,093.65	$2,150.73	−$57.08	−$139,699	−2.7%
Community, age <65, with SPMI	1,794.9	$1,112.23	1.256	$1,396.57	$1,492.11	−$95.55	−$171,501	−6.8%
Community, age <65, no SPMI	2,237.5	$1,390.75	1.350	$1,877.98	$2,028.72	−$150.74	−$337,287	−8.0%

Table 6.C.1 MEDICARE Demonstration Year 5
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 interventio n 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	**1,567.5**	**$993.94**	**1.314**	**$1,306.06**	**$1,771.05**	**−$464.99**	**−$728,881**	**−35.6%**
Facility, age 65+, with SPMI	12.0	$2,437.80	0.926	$2,256.42	$413.69	$1,842.73	$22,113	81.7%
Facility, age 65+, no SPMI	36.0	$1,615.10	0.869	$1,403.79	$1,729.60	−$325.81	−$11,729	−23.2%
HCBS, age 65+, with SPMI	95.0	$978.12	1.274	$1,245.73	$1,008.53	$237.19	$22,534	19.0%
HCBS, age 65+, no SPMI	248.8	$905.53	1.500	$1,358.21	$1,454.38	−$96.18	−$23,928	−7.1%
Community, age 65+, with SPMI	98.2	$1,509.16	1.409	$2,126.00	$1,145.83	$980.17	$96,278	46.1%
Community, age 65+, no SPMI	295.1	$760.14	1.588	$1,207.08	$1,819.09	−$612.01	−$180,612	−50.7%
Facility, age <65, with SPMI	11.0	$4,384.61	0.689	$3,019.14	$3,946.87	−$927.72	−$10,205	−30.7%
Facility, age <65, no SPMI	23.0	$10,040.68	0.607	$6,091.12	$2,027.39	$4,063.72	$93,466	66.7%
HCBS, age <65, with SPMI	168.0	$739.84	1.014	$750.51	$362.22	$388.29	$65,233	51.7%
HCBS, age <65, no SPMI	183.0	$880.51	1.172	$1,031.95	$2,530.90	−$1,498.95	−$274,309	−145.3%
Community, age <65, with SPMI	192.7	$832.44	1.151	$958.32	$1,096.65	−$138.33	−$26,653	−14.4%
Community, age <65, no SPMI	204.7	$1,013.70	1.327	$1,345.66	$3,793.47	−$2,447.82	−$501,068	−181.9%

Table 6.C.2 MEDICARE Demonstration Year 6
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	**1,227.0**	**$993.94**	**1.425**	**$1,416.83**	**$1,329.89**	**$86.93**	**$106,671**	**6.1%**
Facility, age 65+, with SPMI	13.0	$2,437.80	0.971	$2,366.80	$1,210.57	$1,156.23	$15,031	48.9%
Facility, age 65+, no SPMI	16.4	$1,615.10	0.989	$1,597.49	$3,634.96	−$2,037.47	−$33,377	−127.5%
HCBS, age 65+, with SPMI	72.7	$978.12	1.365	$1,334.70	$2,446.71	−$1,112.01	−$80,806	−83.3%
HCBS, age 65+, no SPMI	186.5	$905.53	1.470	$1,331.51	$1,076.61	$254.90	$47,552	19.1%
Community, age 65+, with SPMI	81.7	$1,509.16	1.631	$2,462.19	$1,247.43	$1,214.76	$99,218	49.3%
Community, age 65+, no SPMI	189.2	$760.14	1.599	$1,215.20	$1,059.55	$155.65	$29,442	12.8%
Facility, age <65, with SPMI	0.0	$4,384.61	0.000	$0.00	$0.00	$0.00	$0	0.0%
Facility, age <65, no SPMI	24.0	$10,040.68	0.696	$6,989.03	$1,373.67	$5,615.36	$134,769	80.3%
HCBS, age <65, with SPMI	129.1	$739.84	1.152	$852.10	$575.77	$276.33	$35,664	32.4%
HCBS, age <65, no SPMI	155.4	$880.51	1.402	$1,234.92	$1,701.67	−$466.75	−$72,511	−37.8%
Community, age <65, with SPMI	168.0	$832.44	1.254	$1,043.65	$568.38	$475.27	$79,846	45.5%
Community, age <65, no SPMI	191.2	$1,013.70	1.343	$1,361.59	$2,136.57	−$774.98	−$148,157	−56.9%

Table 6.D.1 MEDICARE Demonstration Year 5
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	**27,937.6**	**$1,696.25**	**1.232**	**$2,089.63**	**$1,929.16**	**$160.47**	**$4,483,220**	**7.7%**
Facility, age 65+, with SPMI	320.5	$2,345.53	0.937	$2,196.93	$799.97	$1,396.96	$447,754	63.6%
Facility, age 65+, no SPMI	843.3	$2,040.09	0.876	$1,787.12	$1,134.70	$652.41	$550,175	36.5%
HCBS, age 65+, with SPMI	1,032.9	$2,012.00	1.275	$2,564.79	$1,572.72	$992.06	$1,024,697	38.7%
HCBS, age 65+, no SPMI	4,182.9	$1,699.59	1.497	$2,544.95	$2,185.10	$359.86	$1,505,231	14.1%
Community, age 65+, with SPMI	638.4	$1,450.66	1.429	$2,072.48	$1,354.43	$718.05	$458,392	34.6%
Community, age 65+, no SPMI	3,934.4	$1,352.84	1.594	$2,156.95	$2,173.24	−$16.30	−$64,120	−0.8%
Facility, age <65, with SPMI	131.9	$3,271.35	0.692	$2,264.00	$2,638.16	−$374.16	−$49,340	−16.5%
Facility, age <65, no SPMI	276.7	$4,766.02	0.674	$3,211.71	$2,411.84	$799.87	$221,305	24.9%
HCBS, age <65, with SPMI	2,617.7	$1,644.72	1.019	$1,676.40	$1,703.64	−$27.24	−$71,296	−1.6%
HCBS, age <65, no SPMI	5,204.0	$1,817.35	1.176	$2,137.79	$1,993.58	$144.20	$750,438	6.7%
Community, age <65, with SPMI	3,592.2	$1,327.43	1.151	$1,528.27	$1,659.14	−$130.87	−$470,110	−8.6%
Community, age <65, no SPMI	5,162.8	$1,578.14	1.335	$2,106.22	$2,071.33	$34.88	$180,093	1.7%

Table 6.D.2 MEDICARE Demonstration Year 6
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	**23,762.1**	**$1,696.25**	**1.313**	**$2,226.33**	**$2,033.57**	**$192.77**	**$4,580,519**	**8.7%**
Facility, age 65+, with SPMI	193.9	$2,345.53	0.986	$2,313.18	$1,454.32	$858.86	$166,517	37.1%
Facility, age 65+, no SPMI	587.7	$2,040.09	0.979	$1,997.74	$1,298.62	$699.11	$410,899	35.0%
HCBS, age 65+, with SPMI	871.7	$2,012.00	1.359	$2,734.20	$1,742.04	$992.16	$864,906	36.3%
HCBS, age 65+, no SPMI	3,276.5	$1,699.59	1.476	$2,508.04	$2,317.64	$190.39	$623,819	7.6%
Community, age 65+, with SPMI	490.1	$1,450.66	1.646	$2,388.36	$1,360.41	$1,027.95	$503,762	43.0%
Community, age 65+, no SPMI	3,244.7	$1,352.84	1.598	$2,161.21	$2,049.12	$112.09	$363,691	5.2%
Facility, age <65, with SPMI	113.0	$3,271.35	0.747	$2,445.32	$828.20	$1,617.11	$182,734	66.1%
Facility, age <65, no SPMI	212.8	$4,766.02	0.769	$3,663.08	$2,177.02	$1,486.06	$316,159	40.6%
HCBS, age <65, with SPMI	2,349.9	$1,644.72	1.154	$1,897.49	$1,802.66	$94.83	$222,837	5.0%
HCBS, age <65, no SPMI	4,705.6	$1,817.35	1.404	$2,550.66	$1,974.92	$575.74	$2,709,170	22.6%
Community, age <65, with SPMI	3,141.2	$1,327.43	1.253	$1,663.36	$1,975.39	−$312.02	−$980,131	−18.8%
Community, age <65, no SPMI	4,575.1	$1,578.14	1.351	$2,131.97	$2,307.67	−$175.70	−$803,844	−8.2%

Table 6.E.1 MEDICARE Demonstration Year 5
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	**3,353.5**	**$678.93**	**1.237**	**$839.98**	**$1,436.46**	**−$596.48**	**−$2,000,309**	**−71.0%**
Facility, age 65+, with SPMI	29.0	$1,222.01	0.947	$1,156.89	$701.89	$455.00	$13,195	39.3%
Facility, age 65+, no SPMI	102.7	$860.02	0.874	$751.52	$510.15	$241.37	$24,778	32.1%
HCBS, age 65+, with SPMI	36.2	$682.88	1.317	$899.20	$1,033.26	−$134.06	−$4,856	−14.9%
HCBS, age 65+, no SPMI	508.4	$808.12	1.495	$1,208.36	$1,818.24	−$609.88	−$310,044	−50.5%
Community, age 65+, with SPMI	52.5	$771.30	1.424	$1,098.01	$2,827.74	−$1,729.72	−$90,894	−157.5%
Community, age 65+, no SPMI	697.7	$534.63	1.594	$852.45	$1,477.12	−$624.67	−$435,808	−73.3%
Facility, age <65, with SPMI	39.9	$422.56	0.700	$295.96	$1,930.21	−$1,634.24	−$65,264	−552.2%
Facility, age <65, no SPMI	44.0	$1,235.18	0.682	$842.94	$1,396.40	−$553.47	−$24,353	−65.7%
HCBS, age <65, with SPMI	297.0	$582.37	1.020	$594.09	$696.09	−$101.99	−$30,292	−17.2%
HCBS, age <65, no SPMI	484.3	$573.21	1.177	$674.87	$1,528.99	−$854.13	−$413,631	−126.6%
Community, age <65, with SPMI	510.7	$695.05	1.154	$801.81	$975.53	−$173.71	−$88,721	−21.7%
Community, age <65, no SPMI	551.1	$608.17	1.328	$807.82	$1,850.14	−$1,042.32	−$574,420	−129.0%

Table 6.E.2 MEDICARE Demonstration Year 6
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 interventio n 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	**2,716.7**	**$678.93**	**1.287**	**$873.69**	**$1,531.65**	**−$657.96**	**−$1,787,497**	**−75.3%**
Facility, age 65+, with SPMI	7.0	$1,222.01	0.957	$1,169.15	$199.77	$969.38	$6,754	82.9%
Facility, age 65+, no SPMI	65.0	$860.02	0.977	$839.93	$445.00	$394.93	$25,658	47.0%
HCBS, age 65+, with SPMI	20.0	$682.88	1.381	$943.34	$4,107.21	−$3,163.87	−$63,277	−335.4%
HCBS, age 65+, no SPMI	337.7	$808.12	1.467	$1,185.86	$2,150.96	−$965.11	−$325,927	−81.4%
Community, age 65+, with SPMI	59.0	$771.30	1.655	$1,276.54	$1,381.95	−$105.41	−$6,219	−8.3%
Community, age 65+, no SPMI	560.6	$534.63	1.599	$854.94	$1,665.50	−$810.57	−$454,436	−94.8%
Facility, age <65, with SPMI	24.6	$422.56	0.747	$315.85	$2,220.03	−$1,904.18	−$46,806	−602.9%
Facility, age <65, no SPMI	36.0	$1,235.18	0.778	$961.02	$344.70	$616.32	$22,188	64.1%
HCBS, age <65, with SPMI	264.0	$582.37	1.156	$673.23	$559.70	$113.53	$29,972	16.9%
HCBS, age <65, no SPMI	417.0	$573.21	1.408	$807.23	$1,972.85	−$1,165.62	−$486,121	−144.4%
Community, age <65, with SPMI	437.5	$695.05	1.251	$869.56	$816.31	$53.25	$23,297	6.1%
Community, age <65, no SPMI	488.3	$608.17	1.346	$818.55	$1,868.29	−$1,049.75	−$512,580	−128.2%

Table 6.F.1 MEDICARE Demonstration Year 5
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	**3,882.8**	**$608.70**	**1.226**	**$746.37**	**$1,221.12**	**−$474.75**	**−$1,843,369**	**−63.6%**
Facility, age 65+, with SPMI	31.2	$1,241.30	0.940	$1,167.04	$780.44	$386.60	$12,059	33.1%
Facility, age 65+, no SPMI	86.9	$1,121.79	0.877	$984.29	$1,096.92	−$112.63	−$9,790	−11.4%
HCBS, age 65+, with SPMI	145.9	$803.19	1.278	$1,026.13	$2,829.69	−$1,803.56	−$263,079	−175.8%
HCBS, age 65+, no SPMI	438.5	$690.94	1.492	$1,030.87	$2,146.66	−$1,115.79	−$489,242	−108.2%
Community, age 65+, with SPMI	81.9	$719.43	1.417	$1,019.55	$1,519.12	−$499.57	−$40,908	−49.0%
Community, age 65+, no SPMI	896.4	$477.67	1.588	$758.50	$1,457.51	−$699.01	−$626,615	−92.2%
Facility, age <65, with SPMI	36.0	$551.42	0.695	$383.06	$625.24	−$242.18	−$8,718	−63.2%
Facility, age <65, no SPMI	28.0	$441.48	0.692	$305.43	$63.85	$241.58	$6,764	79.1%
HCBS, age <65, with SPMI	223.7	$725.74	1.018	$738.85	$767.43	−$28.58	−$6,392	−3.9%
HCBS, age <65, no SPMI	621.7	$381.65	1.177	$449.08	$769.27	−$320.19	−$199,064	−71.3%
Community, age <65, with SPMI	409.0	$779.84	1.151	$897.89	$1,000.85	−$102.96	−$42,112	−11.5%
Community, age <65, no SPMI	883.7	$489.77	1.333	$652.85	$852.32	−$199.47	−$176,272	−30.6%

Table 6.F.2 MEDICARE Demonstration Year 6
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	**3,231.7**	**$608.70**	**1.266**	**$770.79**	**$1,352.29**	**−$581.50**	**−$1,879,218**	**−75.4%**
Facility, age 65+, with SPMI	14.0	$1,241.30	0.987	$1,225.32	$314.29	$911.03	$12,754	74.4%
Facility, age 65+, no SPMI	48.8	$1,121.79	0.991	$1,111.76	$1,930.61	−$818.85	−$39,994	−73.7%
HCBS, age 65+, with SPMI	99.4	$803.19	1.341	$1,076.88	$2,549.77	−$1,472.89	−$146,371	−136.8%
HCBS, age 65+, no SPMI	339.0	$690.94	1.466	$1,013.20	$1,542.79	−$529.59	−$179,532	−52.3%
Community, age 65+, with SPMI	71.0	$719.43	1.644	$1,182.79	$999.82	$182.97	$12,991	15.5%
Community, age 65+, no SPMI	752.5	$477.67	1.595	$761.73	$1,279.06	−$517.33	−$389,285	−67.9%
Facility, age <65, with SPMI	35.0	$551.42	0.746	$411.63	$610.42	−$198.80	−$6,958	−48.3%
Facility, age <65, no SPMI	33.0	$441.48	0.790	$348.81	$1,301.92	−$953.10	−$31,452	−273.2%
HCBS, age <65, with SPMI	184.6	$725.74	1.146	$831.80	$1,058.11	−$226.31	−$41,776	−27.2%
HCBS, age <65, no SPMI	551.3	$381.65	1.406	$536.51	$965.05	−$428.54	−$236,269	−79.9%
Community, age <65, with SPMI	341.3	$779.84	1.250	$975.18	$1,450.86	−$475.68	−$162,333	−48.8%
Community, age <65, no SPMI	761.8	$489.77	1.350	$661.29	$1,542.13	−$880.84	−$670,993	−133.2%

Table 6.G.1 MEDICARE Demonstration Year 5
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	**65,777.2**	**$1,612.13**	**1.239**	**$1,997.13**	**$1,927.94**	**$69.19**	**$4,551,022**	**3.5%**
Facility, age 65+, with SPMI	810.9	$2,187.68	0.900	$1,968.55	$926.92	$1,041.63	$844,644	52.9%
Facility, age 65+, no SPMI	1,641.4	$1,891.49	0.863	$1,631.70	$1,183.28	$448.42	$736,030	27.5%
HCBS, age 65+, with SPMI	2,566.6	$1,892.37	1.235	$2,337.97	$1,724.72	$613.25	$1,573,934	26.2%
HCBS, age 65+, no SPMI	10,033.5	$1,566.85	1.477	$2,314.31	$2,097.68	$216.63	$2,173,549	9.4%
Community, age 65+, with SPMI	1,527.1	$1,375.13	1.434	$1,971.79	$1,537.67	$434.11	$662,914	22.0%
Community, age 65+, no SPMI	10,850.4	$1,218.15	1.569	$1,910.67	$1,997.64	−$86.97	−$943,616	−4.6%
Facility, age <65, with SPMI	513.0	$3,424.47	0.636	$2,178.88	$1,891.21	$287.68	$147,567	13.2%
Facility, age <65, no SPMI	624.3	$4,229.44	0.687	$2,907.44	$1,916.82	$990.63	$618,479	34.1%
HCBS, age <65, with SPMI	6,541.6	$1,670.54	0.991	$1,656.32	$1,666.71	−$10.39	−$67,966	−0.6%
HCBS, age <65, no SPMI	11,758.5	$1,786.30	1.161	$2,073.07	$2,160.02	−$86.95	−$1,022,437	−4.2%
Community, age <65, with SPMI	7,663.8	$1,286.74	1.156	$1,487.52	$1,632.84	−$145.33	−$1,113,753	−9.8%
Community, age <65, no SPMI	11,246.3	$1,647.99	1.326	$2,185.92	$2,102.19	$83.73	$941,677	3.8%

Table 6.G.2 MEDICARE Demonstration Year 6
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	**54,347.9**	**$1,612.13**	**1.321**	**$2,128.92**	**$1,960.23**	**$168.69**	**$9,168,113**	**7.9%**
Facility, age 65+, with SPMI	512.4	$2,187.68	0.921	$2,015.21	$1,371.98	$643.23	$329,594	31.9%
Facility, age 65+, no SPMI	1,058.1	$1,891.49	0.971	$1,836.49	$1,455.20	$381.29	$403,425	20.8%
HCBS, age 65+, with SPMI	2,124.5	$1,892.37	1.329	$2,515.21	$1,967.95	$547.25	$1,162,634	21.8%
HCBS, age 65+, no SPMI	7,752.7	$1,566.85	1.460	$2,287.75	$2,101.81	$185.94	$1,441,568	8.1%
Community, age 65+, with SPMI	1,236.2	$1,375.13	1.664	$2,287.55	$1,321.97	$965.58	$1,193,601	42.2%
Community, age 65+, no SPMI	8,780.7	$1,218.15	1.558	$1,897.51	$1,874.43	$23.08	$202,679	1.2%
Facility, age <65, with SPMI	414.6	$3,424.47	0.679	$2,325.69	$1,254.91	$1,070.77	$443,922	46.0%
Facility, age <65, no SPMI	547.2	$4,229.44	0.776	$3,284.03	$2,092.88	$1,191.15	$651,755	36.3%
HCBS, age <65, with SPMI	5,618.4	$1,670.54	1.116	$1,864.55	$1,720.23	$144.33	$810,875	7.7%
HCBS, age <65, no SPMI	10,232.1	$1,786.30	1.387	$2,476.72	$2,035.51	$441.21	$4,514,470	17.8%
Community, age <65, with SPMI	6,473.0	$1,286.74	1.252	$1,611.60	$1,789.86	−$178.27	−$1,153,920	−11.1%
Community, age <65, no SPMI	9,598.1	$1,647.99	1.337	$2,203.21	$2,289.95	−$86.73	−$832,491	−3.9%

Table 6.H.1 MEDICARE Demonstration Year 5
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	**2,826.7**	**$2,356.60**	**0.864**	**$2,036.10**	**$1,950.06**	**$86.05**	**$243,228**	**4.2%**
Facility, age 65+, with SPMI	29.2	$6,327.51	0.641	$4,056.93	$1,462.69	$2,594.24	$75,651	63.9%
Facility, age 65+, no SPMI	106.7	$5,338.95	0.579	$3,089.71	$1,815.26	$1,274.45	$135,939	41.2%
HCBS, age 65+, with SPMI	110.0	$1,791.38	1.055	$1,889.14	$792.38	$1,096.76	$120,643	58.1%
HCBS, age 65+, no SPMI	380.6	$2,315.40	1.286	$2,976.46	$2,382.28	$594.18	$226,150	20.0%
Community, age 65+, with SPMI	69.2	$2,564.32	1.058	$2,712.50	$2,737.96	−$25.46	−$1,763	−0.9%
Community, age 65+, no SPMI	512.5	$2,029.05	0.863	$1,751.98	$1,386.14	$365.84	$187,494	20.9%
Facility, age <65, with SPMI	36.0	$2,265.17	0.413	$935.14	$231.67	$703.47	$25,325	75.2%
Facility, age <65, no SPMI	12.0	$9,194.32	0.574	$5,275.74	$500.91	$4,774.83	$57,298	90.5%
HCBS, age <65, with SPMI	195.1	$2,892.19	0.676	$1,955.23	$2,040.20	−$84.96	−$16,579	−4.3%
HCBS, age <65, no SPMI	474.8	$2,269.10	1.017	$2,307.40	$2,218.75	$88.66	$42,094	3.8%
Community, age <65, with SPMI	255.4	$2,048.38	0.788	$1,614.17	$1,014.43	$599.73	$153,173	37.2%
Community, age <65, no SPMI	645.2	$1,441.79	0.962	$1,387.01	$2,568.35	−$1,181.34	−$762,198	−85.2%

Table 6.H.2 MEDICARE Demonstration Year 6
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	**2,414.2**	**$2,356.60**	**0.934**	**$2,201.41**	**$1,835.15**	**$366.25**	**$884,214**	**16.6%**
Facility, age 65+, with SPMI	24.0	$6,327.51	0.535	$3,385.69	$2,163.21	$1,222.48	$29,339	36.1%
Facility, age 65+, no SPMI	61.5	$5,338.95	0.576	$3,073.14	$955.17	$2,117.97	$130,152	68.9%
HCBS, age 65+, with SPMI	110.3	$1,791.38	1.334	$2,389.21	$2,021.48	$367.73	$40,545	15.4%
HCBS, age 65+, no SPMI	266.0	$2,315.40	1.750	$4,052.02	$944.48	$3,107.53	$826,503	76.7%
Community, age 65+, with SPMI	55.3	$2,564.32	0.992	$2,544.21	$3,246.53	−$702.32	−$38,862	−27.6%
Community, age 65+, no SPMI	496.2	$2,029.05	1.076	$2,183.64	$1,263.90	$919.73	$456,330	42.1%
Facility, age <65, with SPMI	36.0	$2,265.17	0.729	$1,651.24	$444.89	$1,206.35	$43,429	73.1%
Facility, age <65, no SPMI	12.0	$9,194.32	0.597	$5,486.11	$666.90	$4,819.21	$57,830	87.8%
HCBS, age <65, with SPMI	154.3	$2,892.19	0.572	$1,654.11	$1,657.47	−$3.36	−$518	−0.2%
HCBS, age <65, no SPMI	464.0	$2,269.10	0.789	$1,789.35	$2,158.53	−$369.18	−$171,301	−20.6%
Community, age <65, with SPMI	203.7	$2,048.38	0.945	$1,935.02	$2,438.45	−$503.42	−$102,530	−26.0%
Community, age <65, no SPMI	531.1	$1,441.79	1.142	$1,646.39	$2,374.56	−$728.17	−$386,704	−44.2%

Table 6.I.1 MEDICARE Demonstration Year 5
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	**29,370.2**	**$1,690.19**	**1.073**	**$1,813.90**	**$1,662.12**	**$151.78**	**$4,457,725**	**8.4%**
Facility, age 65+, with SPMI	425.0	$2,546.62	0.724	$1,844.69	$1,607.60	$237.09	$100,771	12.9%
Facility, age 65+, no SPMI	960.5	$2,124.41	0.722	$1,534.44	$1,441.66	$92.78	$89,108	6.0%
HCBS, age 65+, with SPMI	1,265.9	$1,974.89	1.054	$2,081.69	$1,699.25	$382.44	$484,129	18.4%
HCBS, age 65+, no SPMI	4,930.5	$1,772.34	1.302	$2,307.63	$1,808.09	$499.54	$2,462,966	21.6%
Community, age 65+, with SPMI	1,078.0	$1,390.23	0.748	$1,040.58	$1,542.40	−$501.82	−$540,939	−48.2%
Community, age 65+, no SPMI	5,749.9	$1,293.29	1.104	$1,428.33	$1,494.29	−$65.96	−$379,268	−4.6%
Facility, age <65, with SPMI	233.3	$4,619.24	0.524	$2,420.92	$2,290.99	$129.93	$30,315	5.4%
Facility, age <65, no SPMI	440.5	$4,369.28	0.500	$2,182.82	$1,833.07	$349.74	$154,068	16.0%
HCBS, age <65, with SPMI	2,278.6	$1,958.15	0.915	$1,792.02	$1,822.73	−$30.72	−$69,991	−1.7%
HCBS, age <65, no SPMI	4,265.8	$1,868.23	1.285	$2,399.91	$1,962.99	$436.92	$1,863,803	18.2%
Community, age <65, with SPMI	3,026.8	$1,309.66	1.014	$1,327.63	$1,397.26	−$69.62	−$210,736	−5.2%
Community, age <65, no SPMI	4,715.4	$1,466.46	1.128	$1,654.90	$1,554.48	$100.41	$473,499	6.1%

Table 6.I.2 MEDICARE Demonstration Year 6
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	**23,794.6**	**$1,690.19**	**1.113**	**$1,881.45**	**$1,753.91**	**$127.54**	**$3,034,760**	**6.8%**
Facility, age 65+, with SPMI	308.5	$2,546.62	0.641	$1,631.30	$1,513.61	$117.69	$36,305	7.2%
Facility, age 65+, no SPMI	701.3	$2,124.41	0.673	$1,429.00	$1,032.53	$396.46	$278,031	27.7%
HCBS, age 65+, with SPMI	867.9	$1,974.89	1.111	$2,194.55	$1,884.22	$310.33	$269,338	14.1%
HCBS, age 65+, no SPMI	3,703.3	$1,772.34	1.593	$2,823.78	$1,700.46	$1,123.32	$4,159,970	39.8%
Community, age 65+, with SPMI	899.8	$1,390.23	0.930	$1,292.90	$1,512.42	−$219.52	−$197,516	−17.0%
Community, age 65+, no SPMI	4,574.8	$1,293.29	1.252	$1,618.75	$1,829.66	−$210.91	−$964,868	−13.0%
Facility, age <65, with SPMI	204.4	$4,619.24	0.232	$1,072.08	$1,182.51	−$110.43	−$22,566	−10.3%
Facility, age <65, no SPMI	384.9	$4,369.28	0.404	$1,764.58	$2,055.32	−$290.74	−$111,895	−16.5%
HCBS, age <65, with SPMI	2,047.1	$1,958.15	0.763	$1,494.33	$1,578.35	−$84.02	−$172,001	−5.6%
HCBS, age <65, no SPMI	3,659.6	$1,868.23	1.396	$2,608.74	$1,980.25	$628.50	$2,300,053	24.1%
Community, age <65, with SPMI	2,565.8	$1,309.66	0.821	$1,075.49	$1,440.70	−$365.21	−$937,060	−34.0%
Community, age <65, no SPMI	3,877.4	$1,466.46	1.067	$1,565.17	$1,978.59	−$413.43	−$1,603,030	−26.4%

Table 6.J.1 MEDICARE Demonstration Year 5
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	**33,927.6**	**$1,742.42**	**1.055**	**$1,838.01**	**$1,695.25**	**$142.77**	**$4,843,805**	**7.8%**
Facility, age 65+, with SPMI	1,064.6	$3,336.29	0.676	$2,256.70	$1,350.69	$906.01	$964,507	40.1%
Facility, age 65+, no SPMI	897.6	$2,231.28	0.639	$1,424.80	$1,362.52	$62.27	$55,897	4.4%
HCBS, age 65+, with SPMI	2,480.7	$2,410.48	0.951	$2,292.38	$1,889.86	$402.52	$998,531	17.6%
HCBS, age 65+, no SPMI	5,030.0	$1,679.14	1.496	$2,511.72	$1,802.89	$708.83	$3,565,445	28.2%
Community, age 65+, with SPMI	1,701.5	$1,908.28	0.923	$1,760.45	$2,031.58	−$271.14	−$461,338	−15.4%
Community, age 65+, no SPMI	6,793.9	$1,220.09	1.153	$1,406.60	$1,450.97	−$44.37	−$301,422	−3.2%
Facility, age <65, with SPMI	265.8	$4,472.72	0.691	$3,088.82	$2,904.44	$184.38	$49,008	6.0%
Facility, age <65, no SPMI	219.2	$3,253.09	0.690	$2,245.07	$1,671.74	$573.32	$125,644	25.5%
HCBS, age <65, with SPMI	3,007.7	$1,791.41	1.177	$2,108.56	$1,829.61	$278.96	$839,005	13.2%
HCBS, age <65, no SPMI	4,015.9	$1,871.58	1.131	$2,116.17	$1,968.99	$147.19	$591,091	7.0%
Community, age <65, with SPMI	4,011.8	$1,469.29	0.867	$1,273.86	$1,216.20	$57.65	$231,291	4.5%
Community, age <65, no SPMI	4,439.0	$1,437.51	1.025	$1,473.76	$1,882.38	−$408.62	−$1,813,855	−27.7%

Table 6.J.2 MEDICARE Demonstration Year 6
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	**26,423.4**	**$1,742.42**	**1.091**	**$1,901.14**	**$1,710.07**	**$191.07**	**$5,048,821**	**10.1%**
Facility, age 65+, with SPMI	787.9	$3,336.29	0.723	$2,412.43	$1,310.84	$1,101.59	$867,982	45.7%
Facility, age 65+, no SPMI	593.6	$2,231.28	0.808	$1,802.88	$1,541.16	$261.72	$155,359	14.5%
HCBS, age 65+, with SPMI	1,826.4	$2,410.48	0.932	$2,246.26	$1,730.83	$515.43	$941,393	22.9%
HCBS, age 65+, no SPMI	3,773.8	$1,679.14	1.384	$2,323.85	$1,764.66	$559.19	$2,110,269	24.1%
Community, age 65+, with SPMI	1,332.2	$1,908.28	0.887	$1,692.65	$1,414.98	$277.67	$369,919	16.4%
Community, age 65+, no SPMI	5,190.9	$1,220.09	1.118	$1,364.59	$1,504.68	−$140.09	−$727,172	−10.3%
Facility, age <65, with SPMI	217.4	$4,472.72	0.570	$2,547.55	$2,199.68	$347.87	$75,613	13.7%
Facility, age <65, no SPMI	177.4	$3,253.09	0.434	$1,410.56	$2,071.33	−$660.78	−$117,244	−46.8%
HCBS, age <65, with SPMI	2,694.3	$1,791.41	1.437	$2,573.57	$1,662.41	$911.17	$2,454,945	35.4%
HCBS, age <65, no SPMI	3,490.4	$1,871.58	1.152	$2,155.63	$2,140.09	$15.54	$54,237	0.7%
Community, age <65, with SPMI	3,129.7	$1,469.29	0.963	$1,415.40	$1,569.26	−$153.86	−$481,537	−10.9%
Community, age <65, no SPMI	3,209.3	$1,437.51	1.162	$1,670.47	$1,874.55	−$204.08	−$654,943	−12.2%

Table 6.K.1 MEDICARE Demonstration Year 5
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	**46,063.6**	**$1,684.46**	**1.006**	**$1,694.45**	**$1,482.59**	**$211.86**	**$9,759,075**	**12.5%**
Facility, age 65+, with SPMI	1,658.5	$3,162.82	0.811	$2,566.06	$1,284.48	$1,281.57	$2,125,514	49.9%
Facility, age 65+, no SPMI	1,129.4	$2,002.58	0.922	$1,846.88	$764.27	$1,082.60	$1,222,717	58.6%
HCBS, age 65+, with SPMI	4,676.1	$2,274.31	1.235	$2,808.74	$2,091.49	$717.25	$3,353,917	25.5%
HCBS, age 65+, no SPMI	6,002.6	$1,764.55	1.209	$2,134.16	$1,799.22	$334.94	$2,010,512	15.7%
Community, age 65+, with SPMI	3,431.6	$1,724.64	0.855	$1,473.90	$1,284.54	$189.36	$649,811	12.8%
Community, age 65+, no SPMI	7,938.3	$1,063.18	0.907	$964.30	$1,179.93	−$215.63	−$1,711,748	−22.4%
Facility, age <65, with SPMI	587.3	$5,207.50	0.984	$5,122.14	$2,235.27	$2,886.87	$1,695,358	56.4%
Facility, age <65, no SPMI	270.7	$3,572.15	0.949	$3,390.23	$1,419.74	$1,970.50	$533,479	58.1%
HCBS, age <65, with SPMI	4,727.0	$2,118.15	1.007	$2,133.55	$1,759.99	$373.57	$1,765,867	17.5%
HCBS, age <65, no SPMI	3,690.5	$1,388.04	1.106	$1,535.48	$1,531.70	$3.78	$13,959	0.2%
Community, age <65, with SPMI	6,908.3	$1,355.55	0.828	$1,122.33	$1,140.63	−$18.30	−$126,416	−1.6%
Community, age <65, no SPMI	5,043.3	$1,207.80	0.923	$1,114.82	$1,466.55	−$351.73	−$1,773,895	−31.6%

Table 6.K.2 MEDICARE Demonstration Year 6
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	**35,027.4**	**$1,684.46**	**1.064**	**$1,792.24**	**$1,606.19**	**$186.05**	**$6,516,979**	**10.4%**
Facility, age 65+, with SPMI	1,101.1	$3,162.82	0.709	$2,241.32	$1,673.97	$567.34	$624,688	25.3%
Facility, age 65+, no SPMI	736.3	$2,002.58	0.922	$1,846.95	$968.55	$878.40	$646,731	47.6%
HCBS, age 65+, with SPMI	3,646.3	$2,274.31	1.517	$3,450.70	$1,841.51	$1,609.20	$5,867,675	46.6%
HCBS, age 65+, no SPMI	4,361.4	$1,764.55	1.287	$2,270.70	$1,890.98	$379.73	$1,656,141	16.7%
Community, age 65+, with SPMI	2,640.1	$1,724.64	0.810	$1,396.19	$1,612.30	−$216.11	−$570,557	−15.5%
Community, age 65+, no SPMI	5,852.3	$1,063.18	1.004	$1,067.58	$1,262.12	−$194.55	−$1,138,536	−18.2%
Facility, age <65, with SPMI	508.7	$5,207.50	0.768	$3,999.13	$2,741.60	$1,257.53	$639,758	31.4%
Facility, age <65, no SPMI	212.2	$3,572.15	0.697	$2,488.43	$2,510.91	−$22.48	−$4,770	−0.9%
HCBS, age <65, with SPMI	3,999.6	$2,118.15	1.169	$2,475.48	$1,750.80	$724.68	$2,898,403	29.3%
HCBS, age <65, no SPMI	3,052.6	$1,388.04	0.789	$1,094.54	$1,952.10	−$857.57	−$2,617,844	−78.3%
Community, age <65, with SPMI	5,186.4	$1,355.55	0.829	$1,124.33	$1,111.25	$13.08	$67,842	1.2%
Community, age <65, no SPMI	3,730.3	$1,207.80	1.086	$1,311.99	$1,728.18	−$416.20	−$1,552,551	−31.7%

Table 6.L.1 MEDICARE Demonstration Year 5
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	**49,203.2**	**$1,730.61**	**1.076**	**$1,861.28**	**$1,750.02**	**$111.26**	**$5,474,301**	**6.0%**
Facility, age 65+, with SPMI	2,743.7	$2,716.60	0.936	$2,543.50	$1,791.57	$751.93	$2,063,035	29.6%
Facility, age 65+, no SPMI	1,583.9	$2,135.54	0.904	$1,930.28	$1,851.14	$79.14	$125,346	4.1%
HCBS, age 65+, with SPMI	6,180.3	$1,931.80	1.059	$2,046.14	$1,894.94	$151.19	$934,420	7.4%
HCBS, age 65+, no SPMI	6,793.5	$1,341.24	1.415	$1,898.23	$2,031.18	−$132.95	−$903,201	−7.0%
Community, age 65+, with SPMI	4,482.0	$1,691.40	1.070	$1,810.59	$1,656.00	$154.59	$692,868	8.5%
Community, age 65+, no SPMI	10,457.1	$1,206.44	1.232	$1,485.97	$1,234.49	$251.49	$2,629,830	16.9%
Facility, age <65, with SPMI	943.8	$4,189.90	0.867	$3,633.12	$2,572.45	$1,060.67	$1,001,108	29.2%
Facility, age <65, no SPMI	514.4	$2,293.73	0.875	$2,006.48	$2,337.12	−$330.64	−$170,075	−16.5%
HCBS, age <65, with SPMI	4,685.9	$2,034.93	0.989	$2,012.57	$1,861.11	$151.46	$709,728	7.5%
HCBS, age <65, no SPMI	3,193.6	$1,392.03	1.097	$1,527.69	$2,060.10	−$532.41	−$1,700,341	−34.9%
Community, age <65, with SPMI	4,870.4	$1,752.61	0.944	$1,654.16	$1,574.26	$79.90	$389,142	4.8%
Community, age <65, no SPMI	2,754.7	$1,930.53	1.038	$2,004.79	$2,112.81	−$108.02	−$297,559	−5.4%

Table 6.L.2 MEDICARE Demonstration Year 6
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	**36,727.0**	**$1,730.61**	**1.139**	**$1,972.00**	**$1,894.15**	**$77.85**	**$2,859,312**	**3.9%**
Facility, age 65+, with SPMI	1,745.1	$2,716.60	0.982	$2,666.75	$2,000.06	$666.69	$1,163,446	25.0%
Facility, age 65+, no SPMI	948.1	$2,135.54	0.939	$2,005.30	$1,810.52	$194.77	$184,671	9.7%
HCBS, age 65+, with SPMI	4,544.6	$1,931.80	1.202	$2,322.22	$1,912.94	$409.28	$1,860,028	17.6%
HCBS, age 65+, no SPMI	4,812.8	$1,341.24	1.264	$1,695.69	$2,083.16	−$387.47	−$1,864,841	−22.9%
Community, age 65+, with SPMI	3,279.6	$1,691.40	1.160	$1,961.99	$1,531.88	$430.11	$1,410,584	21.9%
Community, age 65+, no SPMI	7,823.1	$1,206.44	1.336	$1,611.26	$1,560.29	$50.97	$398,713	3.2%
Facility, age <65, with SPMI	736.2	$4,189.90	0.765	$3,205.74	$2,288.19	$917.55	$675,526	28.6%
Facility, age <65, no SPMI	412.3	$2,293.73	0.815	$1,869.72	$2,288.21	−$418.49	−$172,562	−22.4%
HCBS, age <65, with SPMI	3,958.4	$2,034.93	1.140	$2,320.80	$1,956.52	$364.28	$1,441,961	15.7%
HCBS, age <65, no SPMI	2,694.7	$1,392.03	1.343	$1,869.42	$2,370.18	−$500.76	−$1,349,389	−26.8%
Community, age <65, with SPMI	3,629.5	$1,752.61	1.004	$1,759.41	$1,743.49	$15.92	$57,776	0.9%
Community, age <65, no SPMI	2,142.6	$1,930.53	1.058	$2,042.18	$2,483.98	−$441.80	−$946,601	−21.6%

Table 6.M.1 MEDICARE Demonstration Year 5
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 6A

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	**49,698.6**	**$1,994.44**	**1.000**	**$1,994.13**	**$1,644.24**	**$349.89**	**$17,388,933**	**17.5%**
Facility, age 65+, with SPMI	2,698.0	$3,361.36	0.828	$2,783.68	$1,667.13	$1,116.55	$3,012,440	40.1%
Facility, age 65+, no SPMI	1,540.3	$2,297.47	0.807	$1,854.41	$1,326.37	$528.03	$813,332	28.5%
HCBS, age 65+, with SPMI	5,680.2	$2,558.12	1.194	$3,054.28	$2,016.55	$1,037.73	$5,894,537	34.0%
HCBS, age 65+, no SPMI	5,897.0	$1,810.19	1.094	$1,980.04	$1,737.00	$243.04	$1,433,204	12.3%
Community, age 65+, with SPMI	3,475.9	$2,019.05	0.841	$1,698.43	$1,575.79	$122.64	$426,302	7.2%
Community, age 65+, no SPMI	7,687.3	$1,388.11	1.080	$1,499.26	$1,252.21	$247.05	$1,899,134	16.5%
Facility, age <65, with SPMI	1,391.3	$2,803.02	0.934	$2,617.76	$1,773.41	$844.35	$1,174,731	32.3%
Facility, age <65, no SPMI	1,093.9	$1,138.14	0.747	$849.65	$1,011.74	−$162.10	−$177,316	−19.1%
HCBS, age <65, with SPMI	5,165.8	$2,463.72	1.075	$2,647.39	$2,206.78	$440.62	$2,276,109	16.6%
HCBS, age <65, no SPMI	3,457.4	$1,486.50	0.961	$1,428.63	$1,501.13	−$72.50	−$250,669	−5.1%
Community, age <65, with SPMI	6,671.8	$1,938.45	0.884	$1,713.55	$1,561.68	$151.87	$1,013,238	8.9%
Community, age <65, no SPMI	4,939.7	$1,417.71	1.095	$1,551.83	$1,577.36	−$25.53	−$126,108	−1.6%

Table 6.M.2 MEDICARE Demonstration Year 6
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 6A

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	**35,083.7**	**$1,994.44**	**0.970**	**$1,934.62**	**$1,606.44**	**$328.18**	**$11,513,800**	**17.0%**
Facility, age 65+, with SPMI	1,672.2	$3,361.36	0.831	$2,793.23	$1,687.63	$1,105.60	$1,848,831	39.6%
Facility, age 65+, no SPMI	936.5	$2,297.47	0.887	$2,037.03	$1,428.84	$608.19	$569,575	29.9%
HCBS, age 65+, with SPMI	3,882.9	$2,558.12	1.185	$3,031.68	$1,956.91	$1,074.77	$4,173,256	35.5%
HCBS, age 65+, no SPMI	3,998.3	$1,810.19	1.130	$2,046.42	$1,687.30	$359.12	$1,435,864	17.5%
Community, age 65+, with SPMI	2,492.0	$2,019.05	0.912	$1,841.81	$1,678.82	$162.99	$406,176	8.8%
Community, age 65+, no SPMI	5,363.6	$1,388.11	1.003	$1,392.34	$1,164.13	$228.21	$1,224,030	16.4%
Facility, age <65, with SPMI	1,107.8	$2,803.02	0.931	$2,610.98	$1,353.00	$1,257.99	$1,393,632	48.2%
Facility, age <65, no SPMI	966.9	$1,138.14	0.765	$870.69	$1,172.75	−$302.07	−$292,077	−34.7%
HCBS, age <65, with SPMI	4,026.2	$2,463.72	0.805	$1,982.65	$1,873.37	$109.28	$439,971	5.5%
HCBS, age <65, no SPMI	2,717.9	$1,486.50	1.081	$1,606.52	$1,633.31	−$26.79	−$72,806	−1.7%
Community, age <65, with SPMI	4,525.4	$1,938.45	0.814	$1,577.11	$1,494.46	$82.65	$374,023	5.2%
Community, age <65, no SPMI	3,393.8	$1,417.71	1.260	$1,786.44	$1,782.51	$3.93	$13,327	0.2%

Table 6.N.1 MEDICARE Demonstration Year 5
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 6B

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	**34,503.2**	**$1,882.18**	**0.973**	**$1,830.51**	**$1,655.45**	**$175.05**	**$6,039,863**	**9.6%**
Facility, age 65+, with SPMI	1,441.7	$3,064.17	0.759	$2,324.80	$1,834.20	$490.60	$707,304	21.1%
Facility, age 65+, no SPMI	917.3	$3,184.00	0.686	$2,185.16	$1,951.85	$233.31	$214,020	10.7%
HCBS, age 65+, with SPMI	4,392.0	$2,122.54	1.161	$2,465.01	$1,657.38	$807.63	$3,547,103	32.8%
HCBS, age 65+, no SPMI	4,682.5	$1,567.72	1.134	$1,778.46	$1,620.61	$157.85	$739,153	8.9%
Community, age 65+, with SPMI	3,753.9	$1,702.52	0.963	$1,639.92	$1,374.19	$265.73	$997,530	16.2%
Community, age 65+, no SPMI	8,235.8	$1,206.27	0.944	$1,139.31	$1,253.50	−$114.19	−$940,437	−10.0%
Facility, age <65, with SPMI	590.3	$5,100.83	0.729	$3,718.49	$2,036.55	$1,681.95	$992,799	45.2%
Facility, age <65, no SPMI	481.3	$1,059.11	0.649	$687.07	$1,468.27	−$781.20	−$376,007	−113.7%
HCBS, age <65, with SPMI	2,642.1	$2,460.47	0.962	$2,367.17	$2,167.98	$199.19	$526,278	8.4%
HCBS, age <65, no SPMI	2,199.5	$1,780.13	0.975	$1,736.13	$2,036.99	−$300.85	−$661,723	−17.3%
Community, age <65, with SPMI	3,196.1	$1,906.23	0.924	$1,760.91	$2,127.03	−$366.13	−$1,170,161	−20.8%
Community, age <65, no SPMI	1,970.7	$2,220.21	1.116	$2,477.50	$1,734.62	$742.89	$1,464,004	30.0%

Table 6.N.2 MEDICARE Demonstration Year 6
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 6B

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	**24,966.5**	**$1,882.18**	**0.985**	**$1,854.69**	**$1,726.97**	**$127.72**	**$3,188,635**	**6.9%**
Facility, age 65+, with SPMI	918.3	$3,064.17	0.757	$2,319.15	$1,961.97	$357.18	$328,003	15.4%
Facility, age 65+, no SPMI	568.0	$3,184.00	0.743	$2,366.56	$2,468.74	−$102.18	−$58,034	−4.3%
HCBS, age 65+, with SPMI	3,214.3	$2,122.54	1.183	$2,511.34	$1,704.89	$806.45	$2,592,166	32.1%
HCBS, age 65+, no SPMI	3,254.2	$1,567.72	1.013	$1,587.37	$1,768.44	−$181.07	−$589,250	−11.4%
Community, age 65+, with SPMI	2,773.9	$1,702.52	1.200	$2,043.63	$1,198.54	$845.08	$2,344,143	41.4%
Community, age 65+, no SPMI	5,594.1	$1,206.27	0.956	$1,153.17	$1,534.81	−$381.64	−$2,134,930	−33.1%
Facility, age <65, with SPMI	455.1	$5,100.83	0.852	$4,345.78	$3,454.34	$891.44	$405,696	20.5%
Facility, age <65, no SPMI	360.4	$1,059.11	0.621	$657.61	$1,103.71	−$446.10	−$160,781	−67.8%
HCBS, age <65, with SPMI	2,156.0	$2,460.47	0.907	$2,232.63	$2,195.44	$37.19	$80,173	1.7%
HCBS, age <65, no SPMI	1,860.4	$1,780.13	1.030	$1,832.91	$1,701.61	$131.30	$244,279	7.2%
Community, age <65, with SPMI	2,313.2	$1,906.23	0.860	$1,639.31	$1,606.63	$32.68	$75,603	2.0%
Community, age <65, no SPMI	1,498.7	$2,220.21	0.975	$2,164.26	$2,123.17	$41.08	$61,568	1.9%

Table 6.O MEDICARE Demonstration Year 6
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 7A

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	**43,336.2**	**$1,875.63**	**0.980**	**$1,837.67**	**$1,710.99**	**$126.68**	**$5,489,772**	**6.9%**
Facility, age 65+, with SPMI	3,098.5	$2,196.73	0.754	$1,656.55	$1,657.13	−$0.58	−$1,808	0.0%
Facility, age 65+, no SPMI	1,930.3	$2,372.69	0.809	$1,918.86	$1,278.41	$640.45	$1,236,238	33.4%
HCBS, age 65+, with SPMI	6,315.0	$2,249.51	1.315	$2,958.74	$2,144.32	$814.42	$5,143,043	27.5%
HCBS, age 65+, no SPMI	6,340.2	$1,620.53	1.365	$2,212.56	$1,723.47	$489.09	$3,100,941	22.1%
Community, age 65+, with SPMI	2,764.6	$1,658.90	0.926	$1,536.28	$1,641.57	−$105.29	−$291,087	−6.9%
Community, age 65+, no SPMI	6,184.3	$1,430.21	0.778	$1,112.37	$1,585.56	−$473.19	−$2,926,356	−42.5%
Facility, age <65, with SPMI	755.6	$2,957.42	0.665	$1,966.59	$2,351.29	−$384.70	−$290,675	−19.6%
Facility, age <65, no SPMI	426.5	$3,205.47	0.816	$2,615.79	$1,161.71	$1,454.07	$620,097	55.6%
HCBS, age <65, with SPMI	3,701.8	$2,475.87	0.747	$1,848.57	$1,888.60	−$40.04	−$148,206	−2.2%
HCBS, age <65, no SPMI	2,892.5	$1,506.58	0.915	$1,378.34	$1,440.52	−$62.19	−$179,870	−4.5%
Community, age <65, with SPMI	5,186.2	$1,654.45	0.888	$1,468.90	$1,514.32	−$45.42	−$235,561	−3.1%
Community, age <65, no SPMI	3,740.8	$1,612.61	0.980	$1,580.61	$1,724.16	−$143.55	−$536,983	−9.1%

Table 6.P MEDICARE Demonstration Year 6
Savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 7B

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	**20,821.3**	**$2,010.43**	**0.964**	**$1,937.66**	**$1,706.02**	**$231.64**	**$4,823,092**	**12.0%**
Facility, age 65+, with SPMI	1,211.3	$3,574.85	0.828	$2,961.40	$2,338.77	$622.63	$754,203	21.0%
Facility, age 65+, no SPMI	815.1	$2,664.88	0.727	$1,938.20	$1,927.48	$10.72	$8,739	0.6%
HCBS, age 65+, with SPMI	2,563.6	$2,169.96	0.990	$2,148.13	$1,779.21	$368.93	$945,779	17.2%
HCBS, age 65+, no SPMI	2,756.7	$1,911.72	1.089	$2,082.36	$1,653.57	$428.79	$1,182,044	20.6%
Community, age 65+, with SPMI	1,894.8	$1,902.48	1.021	$1,941.48	$1,916.63	$24.85	$47,092	1.3%
Community, age 65+, no SPMI	5,286.3	$1,356.82	0.974	$1,321.19	$1,370.32	−$49.14	−$259,749	−3.7%
Facility, age <65, with SPMI	234.8	$5,116.12	0.731	$3,741.40	$2,720.73	$1,020.68	$239,650	27.3%
Facility, age <65, no SPMI	159.9	$6,388.92	0.459	$2,934.21	$2,842.32	$91.88	$14,693	3.1%
HCBS, age <65, with SPMI	1,598.3	$2,079.58	1.261	$2,622.08	$1,651.84	$970.24	$1,550,738	37.0%
HCBS, age <65, no SPMI	1,149.5	$1,541.43	1.085	$1,672.23	$1,840.69	−$168.47	−$193,643	−10.1%
Community, age <65, with SPMI	2,065.3	$1,727.07	0.778	$1,343.05	$1,566.97	−$223.92	−$462,466	−16.7%
Community, age <65, no SPMI	1,085.7	$2,131.32	1.311	$2,793.30	$1,875.90	$917.39	$996,011	32.8%

Tables 7.A–7.C summarize the savings calculation (before the attributed savings and the outlier adjustment) by cohort for the entire Demonstration (Years 1, 2, 3, 4, 5 and 6 combined) and Demonstration Years 5 and 6 separately. Table 7.A shows that for all six Demonstration Years so far combined, the total savings before the outlier adjustment are $263.3 million or 9.6 percent.

Table 7.B shows that for Demonstration Year 5, the total savings were $4.5 million for Cohort 1, with the largest contributions to savings coming from Cohorts 1A and 1D. The other four sub-cohorts (1B, 1C, 1E, and 1F) produced negative savings. For Cohort 2, the savings were $243,000; for Cohort 3, the savings were $4.5 million; for Cohort 4, the savings were $4.8 million; for Cohort 5A, the savings were $9.8 million; for Cohort 5B, the savings were $5.5 million; for Cohort 6A, the savings were $17.4 million, and for Cohort 6B, the savings were $6.0 million. The total savings before the outlier adjustment for Demonstration Year 5 were $52.8 million.

Table 7.C indicates that for Demonstration Year 6, the total savings before the outlier adjustment by cohort were $9.2 million (Cohort 1), $884,000 (Cohort 2), $3.0 million (Cohort 3), $5.0 million (Cohort 4), $6.5 million (Cohort 5A), $2.9 million (Cohort 5B), $11.5 million (Cohort 6A), $3.2 million (Cohort 6B), $5.5 million for Cohort 7A and $4.8 million for Cohort 7B, for a total of $52.5 million. Per the previous Washington Medicare Savings reports, total Demonstration Year 1 savings were $35.4 million, total Demonstration Year 2 savings were $30.4 million, total Demonstration Year 3 savings were $43.0 million, and total Demonstration Year 4 savings were $49.2 million.

Table 7.A MEDICARE
Summary of Demonstration Years 1, 2, 3, 4, 5 and 6 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	95,203.8	$2,652.67	1.223	$3,245.92	$2,586.59	$659.32	$62,770,228	20.3%
1B	176,116.4	$1,298.08	1.201	$1,559.49	$1,509.41	$50.08	$8,819,737	3.2%
1C	16,085.6	$993.94	1.242	$1,234.48	$1,365.71	−$131.23	−$2,110,956	−10.6%
1D	256,930.0	$1,696.25	1.192	$2,022.47	$1,781.65	$240.83	$61,875,283	11.9%
1E	31,331.0	$678.93	1.195	$811.06	$1,174.68	−$363.63	−$11,392,821	−44.8%
1F	33,740.3	$608.70	1.180	$718.57	$1,113.45	−$394.88	−$13,323,372	−55.0%
1 total	609,407.1	$1,612.13	1.201	$1,936.48	$1,752.64	$183.84	$112,031,569	9.5%
2	25,100.7	$2,356.60	0.854	$2,011.36	$1,928.06	$83.30	$2,090,925	4.1%
3	197,513.3	$1,690.19	0.963	$1,627.24	$1,526.99	$100.25	$19,801,156	6.2%
4	166,827.3	$1,742.42	1.027	$1,789.61	$1,572.85	$216.77	$36,162,492	12.1%
5A	144,497.3	$1,684.46	1.020	$1,718.63	$1,524.13	$194.50	$28,105,082	11.3%
5B	134,058.1	$1,730.61	1.090	$1,887.12	$1,763.10	$124.02	$16,625,608	6.6%
6A	84,782.2	$1,994.44	0.987	$1,969.51	$1,628.60	$340.91	$28,902,733	17.3%
6B	59,469.8	$1,882.18	0.978	$1,840.66	$1,685.48	$155.18	$9,228,498	8.4%
7A	43,336.2	$1,875.63	0.980	$1,837.67	$1,710.99	$126.68	$5,489,772	6.9%
7B	20,821.3	$2,010.43	0.964	$1,937.66	$1,706.02	$231.64	$4,823,092	12.0%
Total 1, 2, 3, 4, 5A/B,6A/B&7A/B	1,485,813.2	$1,713.33			$1,672.51	$177.18	$263,260,927	9.6%

Table 7.B MEDICARE
Summary of Demonstration Year 5 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	9,903.2	$2,652.67	1.290	$3,421.92	$2,698.95	$722.98	$7,159,779	21.1%
1B	19,132.6	$1,298.08	1.262	$1,637.85	$1,769.54	−$131.68	−$2,519,418	−8.0%
1C	1,567.5	$993.94	1.314	$1,306.06	$1,771.05	−$464.99	−$728,881	−35.6%
1D	27,937.6	$1,696.25	1.232	$2,089.63	$1,929.16	$160.47	$4,483,220	7.7%
1E	3,353.5	$678.93	1.237	$839.98	$1,436.46	−$596.48	−$2,000,309	−71.0%
1F	3,882.8	$608.70	1.226	$746.37	$1,221.12	−$474.75	−$1,843,369	−63.6%
1 total	65,777.2	$1,612.13	1.239	$1,997.13	$1,927.94	$69.19	$4,551,022	3.5%
2	2,826.7	$2,356.60	0.864	$2,036.10	$1,950.06	$86.05	$243,228	4.2%
3	29,370.2	$1,690.19	1.073	$1,813.90	$1,662.12	$151.78	$4,457,725	8.4%
4	33,927.6	$1,742.42	1.055	$1,838.01	$1,695.25	$142.77	$4,843,805	7.8%
5A	46,063.6	$1,684.46	1.006	$1,694.45	$1,482.59	$211.86	$9,759,075	12.5%
5B	49,203.2	$1,730.61	1.076	$1,861.28	$1,750.02	$111.26	$5,474,301	6.0%
6A	49,698.6	$1,994.44	1.000	$1,994.13	$1,644.24	$349.89	$17,388,933	17.5%
6B	34,503.2	$1,882.18	0.973	$1,830.51	$1,655.45	$175.05	$6,039,863	9.6%
Total 1, 2, 3, 4, 5A/B&6A/B	311,370.4				$1,708.24	$169.44	$52,757,951	9.0%

Table 7.C MEDICARE
Summary of Demonstration Year 6 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	7,920.6	$2,652.67	1.386	$3,676.00	$2,592.18	$1,083.82	$8,584,481	29.5%
1B	15,489.8	$1,298.08	1.347	$1,748.31	$1,776.51	−$28.20	−$436,843	−1.6%
1C	1,227.0	$993.94	1.425	$1,416.83	$1,329.89	$86.93	$106,671	6.1%
1D	23,762.1	$1,696.25	1.313	$2,226.33	$2,033.57	$192.77	$4,580,519	8.7%
1E	2,716.7	$678.93	1.287	$873.69	$1,531.65	−$657.96	−$1,787,497	−75.3%
1F	3,231.7	$608.70	1.266	$770.79	$1,352.29	−$581.50	−$1,879,218	−75.4%
1 total	54,347.9	$1,612.13	1.321	$2,128.92	$1,960.23	$168.69	$9,168,113	7.9%
2	2,414.2	$2,356.60	0.934	$2,201.41	$1,835.15	$366.25	$884,214	16.6%
3	23,794.6	$1,690.19	1.113	$1,881.45	$1,753.91	$127.54	$3,034,760	6.8%
4	26,423.4	$1,742.42	1.091	$1,901.14	$1,710.07	$191.07	$5,048,821	10.1%
5A	35,027.4	$1,684.46	1.064	$1,792.24	$1,606.19	$186.05	$6,516,979	10.4%
5B	36,727.0	$1,730.61	1.139	$1,972.00	$1,894.15	$77.85	$2,859,312	3.9%
6A	35,083.7	$1,994.44	0.970	$1,934.62	$1,606.44	$328.18	$11,513,800	17.0%
6B	24,966.5	$1,882.18	0.985	$1,854.69	$1,726.97	$127.72	$3,188,635	6.9%
7A	43,336.2	$1,875.63	0.980	$1,837.67	$1,710.99	$126.68	$5,489,772	6.9%
7B	20,821.3	$2,010.43	0.964	$1,937.66	$1,706.02	$231.64	$4,823,092	12.0%
Total 1, 2, 3, 4, 5A/B,6A/B&7A/B	302,942.3			$1,932.33	$1,758.94	$173.39	$52,527,497	9.0%

5.3 Outlier Adjustment

To ensure that a small number of high-cost beneficiaries were not having a disproportionate impact on the PMPM of 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, i.e., 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.

As shown below in Table 8, 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 5 is 1.1498 (= $1,840.05 / $1,600.30) for the untruncated PMPMs, and it is 1.0976 (= $1,719.00 / $1,566.21) for the truncated PMPMs. The ratio of these trend factors is the outlier adjustment factor 0.9545 (= 1.0976 / 1.1498) that is to be applied to the comparison group trend. For Demonstration Year 6, the resulting outlier adjustment factor is 0.9284.

- For Cohort 2, the corresponding outlier adjustment factor for the comparison group trend is 0.9423 for Demonstration Year 5 and 0.9108 for Demonstration Year 6.

- For Cohort 3, the outlier adjustment factor is 0.9512 for Demonstration Year 5 and 0.9618 for Demonstration Year 6.

- For Cohort 4, the outlier adjustment factor is 0.9833 for Demonstration Year 5 and 0.9516 for Demonstration Year 6.

- For Cohort 5A, the outlier adjustment factor is 0.9794 for Demonstration Year 5 and 0.9774 for Demonstration Year 6.

- For Cohort 5B, the outlier adjustment factor is 0.9996 for Demonstration Year 5 and 0.9816 for Demonstration Year 6.

- For Cohort 6A, the outlier adjustment factor is 0.9968 for Demonstration Year 5 and 0.9767 for Demonstration Year 6.

- For Cohort 6B, the outlier adjustment factor is 1.0004 for Demonstration Year 5 and 0.9759 for Demonstration Year 6.

- For Cohort 7A, the outlier adjustment factor is 0.9981 for Demonstration Year 6 and for Cohort 7B, the outlier adjustment is 0.9926 for Demonstration Year 6.

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 5	13,979	192	$1,927.94	$1,791.46	92.92%
Comparison – Demo Year 5	23,233	181	$1,840.05	$1,719.00	93.42%
Comparison group trend factor DY5			1.1498	1.0976	0.9545
Intervention – Demo Year 6	13,979	201	$1,960.23	$1,783.45	90.98%
Comparison – Demo Year 6	23,233	172	$1,951.19	$1,772.95	90.87%
Comparison group trend factor DY6			1.2193	1.1320	0.9284
		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 5	690	5	$1,950.06	$1,825.76	93.63%
Comparison – Demo Year 5	4,331	46	$1,452.50	$1,333.09	91.78%
Comparison group trend factor DY5			0.9038	0.8516	0.9423
Intervention – Demo Year 6	690	7	$1,835.15	$1,715.74	93.49%
Comparison – Demo Year 6	4,331	44	$1,668.53	$1,480.11	88.71%
Comparison group trend factor DY6			1.0382	0.9456	0.9108
		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 5	5,645	68	$1,662.12	$1,568.87	94.39%
Comparison – Demo Year 5	6,444	54	$1,515.17	$1,415.47	93.42%
Comparison group trend factor DY5			0.9053	0.8612	0.9512
Intervention – Demo Year 6	5,645	83	$1,753.91	$1,582.60	90.23%
Comparison – Demo Year 6	6,444	39	$1,479.63	$1,397.56	94.45%
Comparison group trend factor DY6			0.8841	0.8503	0.9618

(continued)

Table 8 MEDICARE (continued)
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 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 5	5,823	67	$1,695.25	$1,575.96	92.96%
Comparison – Demo Year 5	7,219	64	$1,538.98	$1,476.91	95.97%
Comparison group trend factor DY5			0.8855	0.8707	0.9833
Intervention – Demo Year 6	5,823	74	$1,710.07	$1,558.51	91.14%
Comparison – Demo Year 6	7,219	57	$1,618.12	$1,502.70	92.87%
Comparison group trend factor DY6			0.9310	0.8859	0.9516
		Cohort 5A			
Intervention – Baseline	6,166	70	$1,684.46	$1,627.86	96.64%
Comparison – Baseline	5,465	47	$1,812.52	$1,765.67	97.41%
Intervention – Demo Year 5	6,166	60	$1,482.59	$1,415.88	95.50%
Comparison – Demo Year 5	5,465	57	$1,659.62	$1,583.42	95.41%
Comparison group trend factor DY5			0.9156	0.8968	0.9794
Intervention – Demo Year 6	6,166	74	$1,606.19	$1,506.78	93.81%
Comparison – Demo Year 6	5,465	43	$1,659.97	$1,580.59	95.22%
Comparison group trend factor DY6			0.9158	0.8952	0.9774
		Cohort 5B			
Intervention – Baseline	5,930	98	$1,730.61	$1,663.65	96.13%
Comparison – Baseline	20,453	166	$1,582.12	$1,529.13	96.65%
Intervention – Demo Year 5	5,930	92	$1,750.02	$1,639.53	93.69%
Comparison – Demo Year 5	20,453	173	$1,640.86	$1,585.23	96.61%
Comparison group trend factor DY5			1.0371	1.0367	0.9996
Intervention – Demo Year 6	5,930	115	$1,894.15	$1,707.80	90.16%
Comparison – Demo Year 6	20,453	150	$1,715.41	$1,627.51	94.88%

(continued)

Table 8 MEDICARE (continued)
Outlier adjustment data

Comparison group trend factor DY6	1.0842	1.0643	0.9816

	Number of	PMPM after	

(continued)

Table 8 MEDICARE (continued)
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 6A			
Intervention – Baseline	4,872	56	$1,994.44	$1,923.45	96.44%
Comparison – Baseline	4,782	41	$2,000.93	$1,951.03	97.51%
Intervention – Demo Year 5	4,872	35	$1,644.24	$1,579.70	96.07%
Comparison – Demo Year 5	4,782	62	$1,880.02	$1,827.28	97.19%
Comparison group trend factor DY5			0.9396	0.9366	0.9968
Intervention – Demo Year 6	4,872	53	$1,606.44	$1,509.32	93.95%
Comparison – Demo Year 6	4,782	44	$1,892.87	$1,802.72	95.24%
Comparison group trend factor DY6			0.9460	0.9240	0.9767
		Cohort 6B			
Intervention – Baseline	3,321	51	$1,882.18	$1,816.26	96.50%
Comparison – Baseline	5,388	37	$1,779.31	$1,739.74	97.78%
Intervention – Demo Year 5	3,321	43	$1,655.45	$1,582.04	95.57%
Comparison – Demo Year 5	5,388	45	$1,615.23	$1,579.97	97.82%
Comparison group trend factor DY5			0.9078	0.9082	1.0004
Intervention – Demo Year 6	3,321	45	$1,726.97	$1,618.34	93.71%
Comparison – Demo Year 6	5,388	43	$1,637.45	$1,562.52	95.42%
Comparison group trend factor DY6			0.9203	0.8981	0.9759
		Cohort 7A			
Intervention – Baseline	4,427	46	$1,875.63	$1,831.22	97.63%
Comparison – Baseline	3,443	33	$2,155.38	$2,110.32	97.91%
Intervention – Demo Year 6	4,427	50	$1,710.99	$1,644.28	96.10%
Comparison – Demo Year 6	3,443	29	$1,879.36	$1,836.58	97.72%

(continued)

Table 8 MEDICARE (continued)
Outlier adjustment data

Comparison group trend factor DY6	0.8719	0.8703	0.9981

	Number of	PMPM after	

(continued)

Table 8 MEDICARE (continued)
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 7B			
Intervention – Baseline	2,125	29	$2,010.43	$1,881.95	93.61%
Comparison – Baseline	3,722	30	$1,922.71	$1,881.73	97.87%
Intervention – Demo Year 6	2,125	32	$1,706.02	$1,612.56	94.52%
Comparison – Demo Year 6	3,722	27	$1,741.51	$1,691.72	97.14%
Comparison group trend factor DY6			0.9058	0.8990	0.9926

Table 9 MEDICARE
Summary of Demonstration Years 5 and 6 Medicare 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, 4, 5 and 6 combined								
Cohort 1 – total	609,407.1	$1,612.13	1.201	$1,936.48	$1,752.64	$183.84	$112,031,569	9.5%
Outlier adjusted	609,407.1	$1,568.46	1.170	$1,835.60	$1,667.57	$168.03	$102,399,277	9.2%
Cohort 2	25,100.7	$2,356.60	0.854	$2,011.36	$1,928.06	$83.30	$2,090,925	4.1%
Outlier adjusted	25,100.7	$2,284.44	0.830	$1,896.31	$1,812.94	$83.36	$2,092,507	4.4%
Cohort 3	197,513.3	$1,690.19	0.963	$1,627.24	$1,526.99	$100.25	$19,801,156	6.2%
Outlier adjusted	197,513.3	$1,628.51	0.940	$1,530.04	$1,448.71	$81.33	$16,062,945	5.3%
Cohort 4	166,827.3	$1,742.42	1.027	$1,789.61	$1,572.85	$216.77	$36,162,492	12.1%
Outlier adjusted	166,827.3	$1,688.50	1.010	$1,705.20	$1,490.55	$214.66	$35,810,304	12.6%
Cohort 5A	144,497.3	$1,684.46	1.020	$1,718.63	$1,524.13	$194.50	$28,105,082	11.3%
Outlier adjusted	144,497.3	$1,627.86	1.007	$1,639.45	$1,451.60	$187.84	$27,142,709	11.5%
Cohort 5B	134,058.1	$1,730.61	1.090	$1,887.12	$1,763.10	$124.02	$16,625,608	6.6%
Outlier adjusted	134,058.1	$1,663.65	1.085	$1,805.70	$1,644.68	$161.01	$21,585,211	8.9%
Cohort 6A	84,782.2	$1,994.44	0.987	$1,969.51	$1,628.60	$340.91	$28,902,733	17.3%
Outlier adjusted	84,782.2	$1,923.45	0.976	$1,877.84	$1,530.14	$347.70	$29,478,666	18.5%
Cohort 6B	59,469.8	$1,882.18	0.978	$1,840.66	$1,685.48	$155.18	$9,228,498	8.4%
Outlier adjusted	59,469.8	$1,816.26	0.968	$1,758.54	$1,579.46	$179.08	$10,649,951	10.2%
Cohort 7A	43,336.2	$1,875.63	0.980	$1,837.67	$1,710.99	$126.68	$5,489,772	6.9%
Outlier adjusted	43,336.2	$1,831.22	0.978	$1,790.76	$1,644.28	$146.49	$6,348,135	8.2%
Cohort 7B	20,821.3	$2,010.43	0.964	$1,937.66	$1,706.02	$231.64	$4,823,092	12.0%
Outlier adjusted	20,821.3	$1,881.95	0.957	$1,800.35	$1,612.56	$187.79	$3,910,098	10.4%
Cohorts 1+2+3+4+ 5A/B+6A/B+7A/B	1,485,813.2			$1,849.69	$1,672.51	$177.18	$263,260,927	9.6%
Outlier adjusted	1,485,813.2			$1,757.12	$1,585.17	$171.95	$255,479,803	9.8%

(continued)

Table 9 MEDICARE (continued)
Summary of Demonstration Years 5 and 6 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 Year 5				
Cohort 1 – total	65,777.2	$1,612.13	1.239	$1,997.13	$1,927.94	$69.19	$4,551,022	3.5%
Outlier adjusted	65,777.2	$1,570.53	1.183	$1,857.17	$1,791.46	$65.72	$4,322,573	3.5%
Cohort 2	2,826.7	$2,356.60	0.864	$2,036.10	$1,950.06	$86.05	$243,228	4.2%
Outlier adjusted	2,826.7	$2,280.88	0.814	$1,857.06	$1,825.76	$31.30	$88,489	1.7%
Cohort 3	29,370.2	$1,690.19	1.073	$1,813.90	$1,662.12	$151.78	$4,457,725	8.4%
Outlier adjusted	29,370.2	$1,628.93	1.021	$1,662.91	$1,568.87	$94.04	$2,762,026	5.7%
Cohort 4	33,927.6	1,742.4	1.055	$1,838.01	$1,695.25	$142.77	$4,843,805	7.8%
Outlier adjusted	33,927.6	$1,688.50	1.037	$1,751.44	$1,575.96	$175.48	$5,953,656	10.0%
Cohort 5A	46,063.6	1,684.5	1.006	1,694.5	1,482.6	$211.86	$9,759,075	12.5%
Outlier adjusted	46,063.6	$1,627.86	0.985	$1,603.79	$1,415.88	$187.91	$8,655,675	11.7%
Cohort 5B	49,203.2	1,730.6	1.076	1,861.3	1,750.0	$111.26	$5,474,301	6.0%
Outlier adjusted	49,203.2	$1,663.65	1.075	$1,788.50	$1,639.53	$148.96	$7,329,539	8.3%
Cohort 6A	49,698.6	1,994.4	1.000	1,994.1	1,644.2	$349.89	$17,388,933	17.5%
Outlier adjusted	49,698.6	$1,923.45	0.997	$1,917.01	$1,544.84	$372.17	$18,496,432	19.4%
Cohort 6B	34,503.2	1,882.2	0.973	1,830.5	1,655.5	$175.05	$6,039,863	9.6%
Outlier adjusted	34,503.2	$1,816.26	0.973	$1,767.13	$1,551.32	$215.81	$7,445,979	12.2%
Cohorts 1+2+3+4+5A/B	311,370.4	$1,760.82	1.066	$1,877.68	$1,708.24	$169.44	$52,757,951	9.0%
Outlier adjusted	311,370.4	$1,702.10	1.045	$1,778.56	$1,601.75	$176.81	$55,054,370	9.9%

(continued)

Table 9 MEDICARE (continued)
Summary of Demonstration Years 5 and 6 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 Year 6								
Cohort 1 – total	54,347.9	$1,612.13	1.321	$2,128.92	$1,960.23	$168.69	$9,168,113	7.9%
Outlier adjusted	54,347.9	$1,570.53	1.226	$1,925.56	$1,783.45	$142.11	$7,723,409	7.4%
Cohort 2	2,414.2	$2,356.60	0.934	$2,201.41	$1,835.15	$366.25	$884,214	16.6%
Outlier adjusted	2,414.2	$2,280.88	0.851	$1,940.64	$1,715.74	$224.90	$542,961	11.6%
Cohort 3	23,794.6	$1,690.19	1.113	$1,881.45	$1,753.91	$127.54	$3,034,760	6.8%
Outlier adjusted	23,794.6	$1,628.93	1.071	$1,743.91	$1,582.60	$161.32	$3,838,469	9.3%
Cohort 4	26,423.4	$1,742.42	1.091	$1,901.14	$1,710.07	$191.07	$5,048,821	10.1%
Outlier adjusted	26,423.4	$1,688.50	1.038	$1,753.08	$1,558.51	$194.57	$5,141,226	11.1%
Cohort 5A	35,027.4	1,684.5	1.064	1,792.2	1,606.2	$186.05	$6,516,979	10.4%
Outlier adjusted	35,027.4	$1,627.86	1.040	$1,692.95	$1,506.78	$186.17	$6,521,151	11.0%
Cohort 5B	36,727.0	1,730.6	1.139	1,972.0	1,894.1	$77.85	$2,859,312	3.9%
Outlier adjusted	36,727.0	$1,663.65	1.119	$1,860.88	$1,707.80	$153.08	$5,622,091	8.2%
Cohort 6A	35,083.7	1,994.4	0.970	1,934.6	1,606.4	$328.18	$11,513,800	17.0%
Outlier adjusted	35,083.7	$1,923.45	0.947	$1,822.35	$1,509.32	$313.03	$10,982,234	17.2%
Cohort 6B	24,966.5	1,882.2	0.985	1,854.7	1,727.0	$127.72	$3,188,635	6.9%
Outlier adjusted	24,966.5	$1,816.26	0.962	$1,746.67	$1,618.34	$128.33	$3,203,972	7.3%
Cohort 7A	43,336.2	$1,875.63	0.980	$1,837.67	$1,710.99	$126.68	$5,489,772	6.9%
Outlier adjusted	43,336.2	$1,831.22	0.978	$1,790.76	$1,644.28	$146.49	$6,348,135	8.2%
Cohort 7B	20,821.3	$2,010.43	0.964	$1,937.66	$1,706.02	$231.64	$4,823,092	12.0%
Outlier adjusted	20,821.3	$1,881.95	0.957	$1,800.35	$1,612.56	$187.79	$3,910,098	10.4%
Cohorts 1+2+3+4+5A/B+6A/B	302,942.3	$1,789.89	$1.09	$1,932.33	$1,758.94	$173.39	$52,527,497	9.0%
Outlier adjusted	302,942.3	$1,728.80	$1.05	$1,807.05	$1,629.35	$177.70	$53,833,746	9.8%

Table 10 MEDICARE
Summary of Demonstration Years 5 and 6 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, 4, 5 and 6 combined (outlier adjusted)								
Cohort 1	609,407.1	$1,568.46	1.170	$1,835.60	$1,667.57	$168.03	$102,399,277	9.15%
Cohort 2	25,100.7	$2,284.44	0.830	$1,896.31	$1,812.94	$83.36	$2,092,507	4.40%
Cohort 3	197,513.35	$1,628.51	0.940	$1,530.04	$1,448.71	$81.33	$16,062,945	5.32%
Cohort 4	166,827.25	$1,688.50	1.010	$1,705.20	$1,490.55	$214.66	$35,810,304	12.59%
Cohort 5A	144,497.27	$1,627.86	1.007	$1,639.45	$1,451.60	$187.84	$27,142,709	11.46%
Cohort 5B	134,058.09	$1,663.65	1.085	$1,805.70	$1,644.68	$161.01	$21,585,211	8.92%
Cohort 6A	84,782.24	$1,923.45	0.976	$1,877.84	$1,530.14	$347.70	$29,478,666	18.52%
Cohort 6B	59,469.77	$1,816.26	0.968	$1,758.54	$1,579.46	$179.08	$10,649,951	10.18%
Cohort 7A	43,336.23	$1,831.22	0.978	$1,790.76	$1,644.28	$146.49	$6,348,135	8.18%
Cohort 7B	20,821.27	$1,881.95	0.957	$1,800.35	$1,612.56	$187.79	$3,910,098	10.43%
Cohorts 1 to 7A/B	1,485,813.22			$1,757.12	$1,585.17	$171.95	$255,479,803	**9.79%**
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	27,064.66	$1,671.23				$192.81	$5,218,234	11.54%
Cohort 6B	19,508.55	$1,549.92				$156.10	$3,045,268	10.07%
Cohort 7A	27,334.22	$1,594.40				$309.54	$8,461,037	19.41%
Cohort 7B	13,017.97	$1,669.53				$203.89	$2,654,185	12.21%
Cohort 8A estimate	23,429.14					$146.49	$3,432,033	
Cohort 8B estimate	10,809.11					$187.79	$2,029,880	
Cohorts 1 to 8A/B	1,716,412.47						**$293,043,287**	

(continued)

Table 10 MEDICARE (continued)
Summary of Demonstration Years 5 and 6 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			
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%
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%
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%

(continued)

Table 10 MEDICARE (continued)
Summary of Demonstration Years 5 and 6 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			
Demonstration Year 4 (outlier adjusted)								
Cohort 1	82,584.16	$1,570.53	1.179	$1,851.21	$1,689.80	$161.41	$13,329,513	8.72%
Cohort 2	3,500.82	$2,280.88	0.830	$1,893.73	$1,785.95	$107.78	$377,329	5.69%
Cohort 3	37,705.64	$1,628.93	0.924	$1,504.90	$1,395.19	$109.71	$4,136,655	7.29%
Cohort 4	46,007.77	$1,688.50	0.967	$1,633.56	$1,432.34	$201.22	$9,257,529	12.32%
Cohort 5A	63,406.24	$1,627.86	1.005	$1,635.79	$1,447.07	$188.72	$11,965,884	11.54%
Cohort 5B	48,127.82	$1,663.65	1.071	$1,781.17	$1,601.78	$179.39	$8,633,581	10.07%
Cohorts 1+2+3+4+5A/B	281,332.45			$1,709.20	$1,539.65	$169.55	$47,700,491	9.92%
Demonstration Year 5 (outlier adjusted)								
Cohort 1	65,777.25	$1,570.53	1.183	$1,857.17	$1,791.46	$65.72	$4,322,573	3.54%
Cohort 2	2,826.71	$2,280.88	0.814	$1,857.06	$1,825.76	$31.30	$88,489	1.69%
Cohort 3	29,370.17	$1,628.93	1.021	$1,662.91	$1,568.87	$94.04	$2,762,026	5.66%
Cohort 4	33,927.59	$1,688.50	1.037	$1,751.44	$1,575.96	$175.48	$5,953,656	10.02%
Cohort 5A	46,063.63	$1,627.86	0.985	$1,603.79	$1,415.88	$187.91	$8,655,675	11.72%
Cohort 5B	49,203.23	$1,663.65	1.075	$1,788.50	$1,639.53	$148.96	$7,329,539	8.33%
Cohort 6A	49,698.57	$1,923.45	0.997	$1,917.01	$1,544.84	$372.17	$18,496,432	19.41%
Cohort 6B	34,503.22	$1,816.26	0.973	$1,767.13	$1,551.32	$215.81	$7,445,979	12.21%
Cohorts 1 to 6A/B	311,370.37			$1,778.56	$1,601.75	$176.81	$55,054,370	9.94%

(continued)

Table 10 MEDICARE (continued)
Summary of Demonstration Years 5 and 6 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 6 (outlier adjusted)								
Cohort 1	54,347.87	$1,570.53	1.226	$1,925.56	$1,783.45	$142.11	$7,723,409	7.38%
Cohort 2	2,414.23	$2,280.88	0.851	$1,940.64	$1,715.74	$224.90	$542,961	11.59%
Cohort 3	23,794.63	$1,628.93	1.071	$1,743.91	$1,582.60	$161.32	$3,838,469	9.25%
Cohort 4	26,423.40	$1,688.50	1.038	$1,753.08	$1,558.51	$194.57	$5,141,226	11.10%
Cohort 5A	35,027.40	$1,627.86	1.040	$1,692.95	$1,506.78	$186.17	$6,521,151	11.00%
Cohort 5B	36,727.04	$1,663.65	1.119	$1,860.88	$1,707.80	$153.08	$5,622,091	8.23%
Cohort 6A	35,083.67	$1,923.45	0.947	$1,822.35	$1,509.32	$313.03	$10,982,234	17.18%
Cohort 6B	24,966.55	$1,816.26	0.962	$1,746.67	$1,618.34	$128.33	$3,203,972	7.35%
Cohort 7A	43,336.23	$1,831.22	0.978	$1,790.76	$1,644.28	$146.49	$6,348,135	8.18%
Cohort 7B	20,821.27	$1,881.95	0.957	$1,800.35	$1,612.56	$187.79	$3,910,098	10.43%
Cohorts 1 to 7A/B	302,942.27			$1,807.05	$1,629.35	$177.70	$53,833,746	9.83%
Attributed savings								
Cohort 8A estimate	23,429.14					$146.49	$3,432,033	
Cohort 8B estimate	10,809.11					$187.79	$2,029,880	
Cohorts 1 to 8A/B	337,180.52					$175.86	**$59,295,659**	

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. For Cohorts 7A and 7B, this consists of the months January through December 2018. For Cohorts 8A and 8B, this consists of the months January through December 2019.

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, 5A, 6A, 6B, 7A and 7B. 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 35,488.6 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 35,843.1 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 experienced 27,064.7 months of eligibility during the period of January through December 2017 and a PMPM of $1,671.23. The savings percentage for Cohort 5A during this period was 11.54 percent. Applying this percentage to Cohort 6A experience yields a PMPM savings of $192.81 and an aggregate attributed savings of $5,218,234.

Cohort 6B experienced 19,508.55 months of eligibility during the period of January through December 2017 and a PMPM of $1,549.92. The savings percentage for Cohort 5B during this period was 10.07 percent. Applying this percentage to Cohort 6B experience yields a PMPM savings of $156.10 and aggregate attributed savings of $3,045,268.

Cohort 7A experienced 27,334.22 months of eligibility during the period of January through December 2018 and a PMPM of $1,594.40. The savings percentage for Cohort 6A during this period was 19.41 percent. Applying this percentage to Cohort 7A experience yields a PMPM savings of $309.54 and aggregate attributed savings of $8,461,037.

Cohort 7B experienced 13,017.97 months of eligibility during the period of January through December 2018 and a PMPM of $1,669.53. The savings percentage for Cohort 6B during this period was 12.21 percent. Applying this percentage to Cohort 7B experience yields a PMPM savings of $203.89 and aggregate attributed savings of $2,654,185.

Cohort 8A consists of those individuals whose experience will be added to the Demonstration Year 7 savings calculation on January 1, 2020, after becoming eligible for the demonstration during calendar year 2019 and Cohort 8B consists of those individuals whose experience will be added to the Demonstration Year 7 savings calculation on January 1, 2020, after becoming eligible for the demonstration during the period of January 2019 through December 2019. Cohort 8A has an estimated 3,560 beneficiaries who had 23,429.14 months of eligibility during calendar year 2019 and the PMPM savings determined for Cohort 7A was $146.49. This results in $3,432,033 savings being preliminarily attributed to Cohort 8A. Cohort 8B has an estimated 1,679 beneficiaries who had 10,809.11 months of eligibility during the period January 2019 through December 2019 and the PMPM savings determined for Cohort 7B was $187.79. This results in $2,029,880 savings being preliminarily attributed to Cohort 8B. Additionally, please note the preliminary nature of the attributed savings for Cohorts 8A and 8B.

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 six Demonstration Years to date combined, the outlier adjustment reduced the total Medicare savings by about $7.8 million. Medicare savings dollars were reduced for Cohorts 1, 3, 4, 5A and 7B, but increased for Cohorts 2, 5B, 6A, 6B and 7A. The reduction was $8.6 million

for Cohort 1 ($112.0 million to $102.4 million), $3.7 million for Cohort 3 ($19.8 million to $16.1 million), $352,000 for Cohort 4, $962,000 for Cohort 5A and $913,000 for Cohort 7B. The increase was $2,000 for Cohort 2, $5.0 million for Cohort 5B ($16.6 million to $21.6 million), $576,000 for Cohort 6A, $1.4 million for Cohort 6B ($9.2 million to $10.6 million) and $858,000 for Cohort 7A. The total reduction across all cohorts 1-6B in Table 9 was $7.8 million ($263.3 million to $255.5 million). Across all seven cohorts and all six Demonstration Years, total Medicare savings after the outlier adjustment was $255.5 million, or 9.8 percent.

Table 10 summarizes total gross Medicare savings calculations, including the attributed savings from Cohorts 2, 3, 4, 5A, 6A, 6B, 7A, 7B, 8A and 8B. Attributed savings are $0.3 million, $2.7 million, $2.0 million, $7.7 million, $5.2 million, $3.0 million, $8.5 million and $2.7 million for Cohorts 2, 3, 4, 5A, 6A, 6B, 7A and 7B and estimated to be $3.4 million and $2.0 million for Cohorts 8A and 8B, respectively, bringing the total Medicare savings for all eight cohorts to $293.0 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, $56.0 million was for Demonstration Year 4, $66.2 million was for Demonstration Year 5, and $59.3 million was for Demonstration Year 6.

The Medicare savings for Demonstration Year 5, $66,169,591 (Table 10), is now considered to be final. The Medicare savings for Demonstration Year 6 is considered to be preliminary and will be updated in a future report. Demonstration Year 6 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, D, E, F, G, H, I and J) show additional analysis of the savings by month for Demonstration Years 5 and 6 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 shows, 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 0.94 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 0.90 and the average over the last 6 months is 0.84. For Cohort 3, the average over the 24 months of operations is 0.92 and over the last 6 months is 0.96. For Cohort 4, the ratio is consistently less than 1.00. The average over the 24 months of operation is 0.91 and over the last 6 months is 0.99. For Cohort 5A, the ratio is consistently less than 1.00. The average over the last 24 months of operation is 0.88. For Cohort 5B, the ratio is consistently less than 1.00. The average over the last 24 months of operation is 0.95. For Cohort 6A, the ratio is consistently less than 1.00. The average over the 24 months of operation is 0.83. For Cohort 6B, the average over the 24 months of operation is 0.92. For Cohort 7A, the average of the 12 months is 0.93. For Cohort 7B, the average over the 12 months is 0.88.

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 5 and Demonstration Year 6, and in line with what was previously seen in Demonstration Years 1, 2, 3 and 4.

Table 11.A MEDICARE
PMPM costs for intervention and comparison groups, by month: Cohort 1

	Intervention group		PMPM			Ratio
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	(D/T)
Baseline	$484,510,829	300,541.1	$1,612	$1,592	$1,612	1.00
Jan-18	$12,336,482	5,945.8	$2,075	$1,954	$2,008	1.03
Feb-18	$10,786,653	5,855.3	$1,842	$1,785	$1,833	1.01
Mar-18	$11,624,388	5,726.0	$2,030	$2,050	$2,118	0.96
Apr-18	$10,636,718	5,673.9	$1,875	$1,873	$1,924	0.97
May-18	$10,917,909	5,597.3	$1,951	$2,146	$2,197	0.89
Jun-18	$10,416,591	5,509.8	$1,891	$2,004	$2,058	0.92
Jul-18	$10,622,705	5,413.5	$1,962	$1,835	$1,893	1.04
Aug-18	$10,562,726	5,353.4	$1,973	$1,953	$2,002	0.99
Sep-18	$9,312,061	5,278.3	$1,764	$1,926	$1,968	0.90
Oct-18	$10,240,374	5,227.0	$1,959	$2,042	$2,090	0.94
Nov-18	$10,334,101	5,128.8	$2,015	$1,910	$1,954	1.03
Dec-18	$9,024,067	5,068.1	$1,781	$1,868	$1,915	0.93
Jan-19	$10,028,943	4,988.9	$2,010	$2,281	$2,314	0.87
Feb-19	$8,342,909	4,907.7	$1,700	$2,039	$2,076	0.82
Mar-19	$9,849,456	4,808.9	$2,048	$2,022	$2,063	0.99
Apr-19	$9,124,067	4,711.3	$1,937	$2,105	$2,144	0.90
May-19	$9,402,419	4,638.8	$2,027	$2,207	$2,249	0.90
Jun-19	$8,385,123	4,540.1	$1,847	$2,009	$2,025	0.91
Jul-19	$9,021,406	4,479.4	$2,014	$2,146	$2,182	0.92
Aug-19	$8,992,772	4,405.7	$2,041	$1,980	$2,020	1.01
Sep-19	$8,172,542	4,309.9	$1,896	$1,998	$2,035	0.93
Oct-19	$8,326,980	4,233.4	$1,967	$2,322	$2,366	0.83
Nov-19	$8,680,789	4,188.5	$2,073	$2,013	$2,053	1.01
Dec-19	$8,206,696	4,135.3	$1,985	$1,962	$1,999	0.99
Total	$233,348,876	120,125.1	$1,943	$2,012	$2,057	0.94

Table 11.B MEDICARE
PMPM costs for intervention and comparison groups, by month: Cohort 2

	Intervention group		PMPM			Ratio
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	(D/T)
Baseline	$9,945,769	4,220.4	$2,357	$1,740	$2,357	1.00
Jan-18	$522,919	246.5	2,121.5	1,512.9	$1,955	1.09
Feb-18	$580,178	242.9	2,388.3	1,438.9	$1,914	1.25
Mar-18	$575,940	241.5	2,385.3	1,779.3	$2,355	1.01
Apr-18	$488,859	241.0	2,028.5	1,461.2	$1,990	1.02
May-18	$421,609	241.9	1,743.1	1,559.1	$2,108	0.83
Jun-18	$321,219	241.8	1,328.6	1,498.9	$2,020	0.66
Jul-18	$472,478	237.4	1,990.1	1,535.3	$2,068	0.96
Aug-18	$560,420	235.4	2,381.2	1,456.5	$1,933	1.23
Sep-18	$448,417	231.2	1,939.8	1,606.7	$2,153	0.90
Oct-18	$466,782	229.0	2,038.6	1,432.6	$1,874	1.09
Nov-18	$325,011	221.3	1,468.6	1,636.9	$2,157	0.68
Dec-18	$328,413	217.0	1,513.4	1,476.4	$1,898	0.80
Jan-19	$396,962	219.1	1,811.8	1,480.2	$1,900	0.95
Feb-19	$416,428	217.0	1,919.3	1,879.1	$2,326	0.83
Mar-19	$381,391	207.5	1,837.6	1,604.0	$2,055	0.89
Apr-19	$392,794	205.2	1,913.9	1,921.0	$2,420	0.79
May-19	$355,323	202.5	1,754.8	1,643.6	$2,108	0.83
Jun-19	$312,545	199.0	1,570.6	1,455.2	$1,944	0.81
Jul-19	$344,602	198.9	$1,733	$1,779	$2,279	0.76
Aug-19	$453,411	196.3	$2,310	$1,937	$2,491	0.93
Sep-19	$287,742	196.9	$1,461	$1,445	$1,930	0.76
Oct-19	$392,889	192.9	$2,037	$1,734	$2,238	0.91
Nov-19	$359,661	190.0	$1,893	$1,344	$1,732	1.09
Dec-19	$336,731	189.0	$1,782	$2,357	$3,039	0.59
Total	$9,942,722	5,240.9	$1,897	$1,616	$2,112	0.90

Table 11.C MEDICARE
PMPM costs for intervention and comparison groups, by month: Cohort

Month/Year	Intervention group		PMPM			Ratio (D/T)
	Incurred claims	Eligible months	Intervention	Comparison	Target	
Baseline	$103,440,434	61,200.6	$1,690	$1,520	$1,690	1.00
Jan-18	$4,478,119	2,671.6	1,676.2	1,443.6	$1,649	1.02
Feb-18	$4,168,208	2,640.9	1,578.3	1,397.3	$1,595	0.99
Mar-18	$4,366,597	2,542.8	1,717.2	1,581.6	$1,790	0.96
Apr-18	$3,888,931	2,532.0	1,535.9	1,581.8	$1,817	0.85
May-18	$4,099,986	2,503.8	1,637.5	1,682.6	$1,965	0.83
Jun-18	$3,751,807	2,455.5	1,527.9	1,538.4	$1,792	0.85
Jul-18	$4,084,036	2,417.5	1,689.3	1,498.7	$1,751	0.96
Aug-18	$3,716,560	2,387.8	1,556.5	1,690.2	$1,915	0.81
Sep-18	$4,217,395	2,346.0	1,797.7	1,941.5	$2,169	0.83
Oct-18	$4,478,502	2,338.5	1,915.1	1,530.3	$1,747	1.10
Nov-18	$4,063,039	2,289.9	1,774.3	1,672.5	$1,897	0.94
Dec-18	$3,503,505	2,243.7	1,561.5	1,466.5	$1,720	0.91
Jan-19	$3,621,013	2,188.2	1,654.8	1,644.2	$1,868	0.89
Feb-19	$3,091,363	2,163.4	1,428.9	1,431.7	$1,622	0.88
Mar-19	$4,437,904	2,124.3	2,089.2	1,957.2	$2,227	0.94
Apr-19	$3,733,804	2,065.0	1,808.1	1,812.7	$2,062	0.88
May-19	$3,653,486	2,018.9	1,809.7	1,789.1	$2,060	0.88
Jun-19	$3,221,687	1,978.0	1,628.7	1,455.0	$1,671	0.97
Jul-19	$3,390,241	1,950.3	$1,738	$1,660	$1,890	0.92
Aug-19	$3,266,474	1,912.9	$1,708	$1,587	$1,769	0.97
Sep-19	$3,097,853	1,882.0	$1,646	$1,504	$1,690	0.97
Oct-19	$3,419,082	1,861.0	$1,837	$1,708	$1,936	0.95
Nov-19	$3,110,786	1,836.2	$1,694	$1,635	$1,835	0.92
Dec-19	$3,690,044	1,814.4	$2,034	$1,649	$1,928	1.06
Total	$90,550,419	53,164.8	$1,703	$1,615	$1,844	0.92

Table 11.D MEDICARE
PMPM costs for intervention and comparison groups, by month: Cohort

Month/Year	Intervention group		PMPM			Ratio (D/T)
	Incurred claims	Eligible months	Intervention	Comparison	Target	
Baseline	$108,719,430	62,395.6	$1,742	$1,552	$1,742	1.00
Jan-18	$4,534,819	3,164.9	1,432.8	1,531.2	$1,715	0.84
Feb-18	$4,537,212	3,117.1	1,455.6	1,483.6	$1,657	0.88
Mar-18	$4,500,292	2,979.2	1,510.6	1,520.2	$1,711	0.88
Apr-18	$5,543,729	2,938.2	1,886.8	1,556.4	$1,763	1.07
May-18	$5,271,728	2,887.7	1,825.6	1,769.0	$2,034	0.90
Jun-18	$4,758,621	2,850.8	1,669.2	1,719.9	$1,962	0.85
Jul-18	$4,945,846	2,804.3	1,763.7	1,456.5	$1,644	1.07
Aug-18	$5,117,831	2,745.2	1,864.3	1,824.8	$2,066	0.90
Sep-18	$4,326,028	2,687.1	1,609.9	1,586.9	$1,775	0.91
Oct-18	$4,804,036	2,675.1	1,795.8	1,684.0	$1,904	0.94
Nov-18	$5,072,621	2,566.1	1,976.8	1,698.7	$1,932	1.02
Dec-18	$4,102,823	2,512.0	1,633.3	1,730.3	$1,957	0.83
Jan-19	$4,262,156	2,473.3	1,723.3	1,689.6	$1,895	0.91
Feb-19	$3,371,643	2,425.7	1,390.0	1,757.9	$2,036	0.68
Mar-19	$4,023,641	2,362.8	1,702.9	2,055.4	$2,329	0.73
Apr-19	$3,790,944	2,301.8	1,646.9	1,798.5	$2,031	0.81
May-19	$3,981,441	2,257.3	1,763.8	1,727.2	$1,936	0.91
Jun-19	$3,626,827	2,201.3	1,647.6	1,466.3	$1,652	1.00
Jul-19	$3,916,001	2,166.0	$1,808	$1,578	$1,762	1.03
Aug-19	$4,171,707	2,117.9	$1,970	$1,677	$1,910	1.03
Sep-19	$3,729,236	2,079.0	$1,794	$1,493	$1,648	1.09
Oct-19	$3,664,663	2,032.0	$1,803	$1,704	$1,925	0.94
Nov-19	$3,291,454	2,008.1	$1,639	$1,532	$1,737	0.94
Dec-19	$3,356,131	1,998.2	$1,680	$1,649	$1,868	0.90
Total	$102,701,431	60,351.0	$1,702	$1,651	$1,866	0.91

Table 11.E MEDICARE
PMPM costs for intervention and comparison groups, by month: Cohort 5A

	Intervention group		PMPM			Ratio
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	(D/T)
Baseline	$110,831,462	65,796.4	$1,684	$1,636	$1,684	1.00
Jan-18	$6,047,105	4,341.7	1,392.8	1,595.6	$1,667	0.84
Feb-18	$5,876,069	4,269.9	1,376.2	1,478.6	$1,534	0.90
Mar-18	$6,390,927	4,096.6	1,560.1	1,647.9	$1,717	0.91
Apr-18	$6,072,292	4,028.6	1,507.3	1,875.8	$1,925	0.78
May-18	$5,911,945	3,935.0	1,502.4	1,601.9	$1,657	0.91
Jun-18	$5,730,129	3,864.9	1,482.6	1,577.4	$1,638	0.91
Jul-18	$5,757,860	3,805.5	1,513.0	1,681.2	$1,737	0.87
Aug-18	$6,086,460	3,718.3	1,636.9	1,683.2	$1,740	0.94
Sep-18	$4,866,549	3,636.2	1,338.4	1,676.2	$1,735	0.77
Oct-18	$5,379,800	3,576.3	1,504.3	1,801.2	$1,861	0.81
Nov-18	$4,845,145	3,425.0	1,414.6	1,535.5	$1,593	0.89
Dec-18	$5,329,252	3,365.6	1,583.5	1,492.6	$1,522	1.04
Jan-19	$5,084,116	3,268.5	1,555.5	1,790.4	$1,815	0.86
Feb-19	$4,926,970	3,207.7	1,536.0	1,754.2	$1,822	0.84
Mar-19	$4,943,294	3,154.0	1,567.3	1,743.0	$1,781	0.88
Apr-19	$4,682,379	3,057.0	1,531.7	1,836.7	$1,884	0.81
May-19	$4,654,331	3,004.0	1,549.4	1,867.9	$1,930	0.80
Jun-19	$4,248,397	2,920.3	1,454.8	1,556.7	$1,577	0.92
Jul-19	$5,036,285	2,869.3	$1,755	$2,007	$2,065	0.85
Aug-19	$4,835,398	2,800.0	$1,727	$1,833	$1,893	0.91
Sep-19	$4,341,726	2,749.6	$1,579	$1,708	$1,741	0.91
Oct-19	$4,598,227	2,694.5	$1,707	$1,873	$1,897	0.90
Nov-19	$3,979,830	2,670.5	$1,490	$1,393	$1,389	1.07
Dec-19	$4,929,611	2,632.0	$1,873	$1,625	$1,666	1.12
Total	$124,554,098	81,091.0	$1,536	$1,687	$1,737	0.88

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	$113,207,213	65,414.5	$1,731	$1,637	$1,731	1.00
Jan-18	$7,866,863	4,608.6	1,707.0	1,809.0	$1,868	0.91
Feb-18	$7,370,830	4,519.3	1,631.0	1,722.8	$1,782	0.92
Mar-18	$8,099,051	4,411.9	1,835.7	1,854.6	$1,887	0.97
Apr-18	$7,417,590	4,331.9	1,712.3	1,788.7	$1,830	0.94
May-18	$7,579,612	4,243.0	1,786.4	1,748.2	$1,807	0.99
Jun-18	$7,378,747	4,150.0	1,778.0	1,705.7	$1,751	1.02
Jul-18	$6,902,669	4,040.3	1,708.4	1,920.3	$1,963	0.87
Aug-18	$7,115,772	3,950.7	1,801.1	1,871.9	$1,903	0.95
Sep-18	$6,460,468	3,847.8	1,679.0	1,795.7	$1,827	0.92
Oct-18	$7,230,324	3,802.9	1,901.3	1,884.6	$1,915	0.99
Nov-18	$6,499,888	3,693.6	1,759.8	1,952.9	$1,976	0.89
Dec-18	$6,184,802	3,603.2	1,716.5	1,821.0	$1,852	0.93
Jan-19	$6,288,114	3,521.8	1,785.5	1,978.0	$2,007	0.89
Feb-19	$5,634,727	3,352.8	1,680.6	1,675.0	$1,709	0.98
Mar-19	$6,246,757	3,283.1	1,902.7	2,098.3	$2,174	0.88
Apr-19	$5,595,608	3,200.0	1,748.6	1,958.9	$2,008	0.87
May-19	$5,924,558	3,136.2	1,889.1	2,115.3	$2,152	0.88
Jun-19	$5,591,650	3,076.4	1,817.6	1,833.9	$1,893	0.96
Jul-19	$5,562,325	3,012.7	$1,846	$1,869	$1,933	0.96
Aug-19	$6,512,624	2,928.0	$2,224	$1,906	$1,953	1.14
Sep-19	$5,192,980	2,876.2	$1,805	$1,926	$1,983	0.91
Oct-19	$6,361,029	2,824.6	$2,252	$2,014	$2,063	1.09
Nov-19	$5,627,128	2,780.0	$2,024	$1,854	$1,920	1.05
Dec-19	$5,028,864	2,735.3	$1,839	$1,830	$1,858	0.99
Total	$155,672,978	85,930.3	$1,812	$1,864	$1,909	0.95

Table 11.G MEDICARE
PMPM costs for intervention and comparison groups, by month: Cohort 6A

Month/Year	Intervention group		PMPM			Ratio (D/T)
	Incurred claims	Eligible months	Intervention	Comparison	Target	
Baseline	$102,206,255	51,245.5	$1,994	$1,953	$1,994	1.00
Jan-18	$9,201,971	4,848.1	1,898.1	1,963.4	$1,986	0.96
Feb-18	$7,609,717	4,673.8	1,628.2	1,911.3	$1,939	0.84
Mar-18	$8,286,958	4,489.7	1,845.8	2,066.0	$2,097	0.88
Apr-18	$8,015,795	4,386.8	1,827.3	2,040.9	$2,043	0.89
May-18	$7,007,188	4,274.5	1,639.3	2,108.2	$2,146	0.76
Jun-18	$6,784,875	4,168.4	1,627.7	1,892.2	$1,926	0.85
Jul-18	$6,276,057	4,058.3	1,546.5	1,776.3	$1,799	0.86
Aug-18	$6,081,918	3,956.5	1,537.2	1,852.5	$1,921	0.80
Sep-18	$5,436,915	3,845.9	1,413.7	1,966.6	$1,994	0.71
Oct-18	$5,787,008	3,772.9	1,533.8	2,230.2	$2,261	0.68
Nov-18	$5,869,138	3,663.0	1,602.3	1,919.1	$1,923	0.83
Dec-18	$5,359,024	3,560.7	1,505.1	1,878.4	$1,881	0.80
Jan-19	$5,843,588	3,398.8	1,719.3	1,882.6	$1,891	0.91
Feb-19	$4,484,646	3,315.6	1,352.6	2,037.8	$2,094	0.65
Mar-19	$5,734,777	3,233.0	1,773.8	1,930.9	$1,919	0.92
Apr-19	$5,419,865	3,121.0	1,736.6	1,946.0	$1,913	0.91
May-19	$4,859,790	3,028.4	1,604.8	2,121.6	$2,067	0.78
Jun-19	$4,487,938	2,955.8	1,518.4	1,866.9	$1,844	0.82
Jul-19	$4,814,866	2,883.4	$1,670	$1,922	$1,949	0.86
Aug-19	$4,446,641	2,779.5	$1,600	$2,042	$2,026	0.79
Sep-19	$3,845,096	2,707.4	$1,420	$1,717	$1,710	0.83
Oct-19	$4,874,038	2,607.7	$1,869	$2,070	$2,091	0.89
Nov-19	$3,798,573	2,551.6	$1,489	$1,773	$1,766	0.84
Dec-19	$3,750,022	2,501.4	$1,499	$1,938	$1,911	0.78
Total	$138,076,404	84,782.2	$1,629	$1,956	$1,970	0.83

Table 11.H MEDICARE
PMPM costs for intervention and comparison groups, by month: Cohort 6B

Month/Year	Intervention group		PMPM			Ratio (D/T)
	Incurred claims	Eligible months	Intervention	Comparison	Target	
Baseline	$69,409,748	36,877.4	$1,882	$1,743	$1,882	1.00
Jan-18	$6,482,605	3,306.9	1,960.3	1,656.5	$1,799	1.09
Feb-18	$5,377,290	3,211.5	1,674.4	1,546.8	$1,635	1.02
Mar-18	$5,328,513	3,090.1	1,724.4	1,587.5	$1,689	1.02
Apr-18	$4,841,035	3,024.0	1,600.9	1,747.3	$1,850	0.87
May-18	$4,475,317	2,938.2	1,523.1	1,975.0	$2,120	0.72
Jun-18	$4,651,358	2,887.4	1,610.9	1,672.3	$1,765	0.91
Jul-18	$4,672,120	2,825.6	1,653.5	1,870.6	$1,997	0.83
Aug-18	$4,458,438	2,760.6	1,615.0	1,850.4	$1,945	0.83
Sep-18	$4,370,325	2,695.5	1,621.4	1,780.9	$1,853	0.88
Oct-18	$4,144,384	2,656.7	1,559.9	1,861.3	$1,950	0.80
Nov-18	$4,216,223	2,589.6	1,628.2	1,470.3	$1,547	1.05
Dec-18	$4,100,866	2,517.0	1,629.2	1,800.4	$1,837	0.89
Jan-19	$4,616,367	2,445.2	1,887.9	1,757.1	$1,882	1.00
Feb-19	$3,743,656	2,347.0	1,595.1	1,697.9	$1,769	0.90
Mar-19	$3,960,011	2,300.7	1,721.2	1,610.8	$1,771	0.97
Apr-19	$4,157,353	2,235.2	1,859.9	1,731.3	$1,871	0.99
May-19	$3,980,752	2,155.6	1,846.7	1,951.1	$2,034	0.91
Jun-19	$3,344,575	2,092.7	1,598.2	1,614.8	$1,722	0.93
Jul-19	$3,505,686	2,036.4	$1,722	$1,735	$1,822	0.94
Aug-19	$3,138,167	1,968.5	$1,594	$1,767	$1,874	0.85
Sep-19	$3,017,717	1,915.9	$1,575	$1,786	$1,953	0.81
Oct-19	$3,462,617	1,862.9	$1,859	$1,718	$1,851	1.00
Nov-19	$3,136,541	1,827.2	$1,717	$1,825	$1,957	0.88
Dec-19	$3,053,106	1,779.3	$1,716	$1,681	$1,766	0.97
Total	$100,235,022	59,469.8	$1,685	$1,734	$1,841	0.92

Table 11.I MEDICARE
PMPM costs for intervention and comparison groups, by month: Cohort 7A

	Intervention group		PMPM			Ratio
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	(D/T)
Baseline	$86,769,395	46,261.5	$1,876	$2,006	$1,876	1.00
Jan-19	$7,296,187	4,402.4	1,657.3	2,142.8	$2,024	0.82
Feb-19	$6,941,929	4,182.1	1,659.9	1,923.0	$1,835	0.90
Mar-19	$7,463,750	4,016.9	1,858.1	2,121.4	$2,048	0.91
Apr-19	$6,807,737	3,854.3	1,766.3	1,749.5	$1,674	1.05
May-19	$6,566,601	3,699.3	1,775.1	2,151.3	$2,082	0.85
Jun-19	$5,853,912	3,588.4	1,631.3	1,745.0	$1,648	0.99
Jul-19	$6,243,187	3,494.2	1,786.7	1,869.2	$1,771	1.01
Aug-19	$5,440,030	3,381.4	1,608.8	1,897.8	$1,796	0.90
Sep-19	$5,052,614	3,308.3	1,527.3	1,721.5	$1,625	0.94
Oct-19	$5,883,740	3,215.7	1,829.7	2,019.8	$1,916	0.95
Nov-19	$4,953,003	3,133.6	1,580.6	1,943.0	$1,844	0.86
Dec-19	$5,645,285	3,059.6	1,845.1	1,786.0	$1,693	1.09
Total	$74,147,974	43,336.2	$1,711	$1,930	$1,838	0.93

Table 11.J MEDICARE
PMPM costs for intervention and comparison groups, by month: Cohort 7B

	Intervention group		PMPM			Ratio
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	(D/T)
Baseline	$45,299,170	22,532.1	$2,010	$1,873	$2,010	1.00
Jan-19	$3,553,207	2,111.2	1,683.0	1,885.6	$2,015	0.84
Feb-19	$3,103,722	1,995.3	1,555.5	1,726.0	$1,826	0.85
Mar-19	$3,214,444	1,934.5	1,661.6	1,796.2	$1,915	0.87
Apr-19	$3,444,677	1,867.6	1,844.4	1,777.8	$1,891	0.98
May-19	$3,153,016	1,814.5	1,737.7	1,786.7	$1,903	0.91
Jun-19	$3,326,044	1,735.6	1,916.4	2,058.2	$2,146	0.89
Jul-19	$2,831,016	1,697.6	1,667.6	1,751.5	$1,859	0.90
Aug-19	$3,026,162	1,627.3	1,859.6	1,865.2	$1,954	0.95
Sep-19	$2,847,234	1,588.0	1,793.0	1,613.0	$1,702	1.05
Oct-19	$2,419,773	1,522.9	1,588.9	2,046.7	$2,159	0.74
Nov-19	$2,207,208	1,485.3	1,486.1	1,721.0	$1,826	0.81
Dec-19	$2,394,905	1,441.4	1,661.5	1,936.7	$2,077	0.80
Total	$35,521,409	20,821.3	$1,706	$1,828	$1,938	0.88

Table 12.A MEDICARE
PMPM costs for Demonstration Year 5 based on incurred Medicare claims for Cohorts 1, 2, 3, 4, 5A/B and 6A/B

Type of service	Intervention		PMPM			Ratio (D/T)	PMPM savings	Dollar savings
	Incurred claims	Member months	Intervention (D)	Comparison	Target (T)			
Baseline	$1,234,339,704	716,485.0			$1,722.77	1.00		
Durable medical equipment	$19,325,715	311,370.4	$62.07	$70.52	$73.76	0.84	$11.69	$3,640,867
Home health agency	$22,870,923	311,370.4	$73.45	$100.59	$104.21	0.70	$30.76	$9,577,583
Hospice	$5,457,597	311,370.4	$17.53	$68.73	$71.83	0.24	$54.30	$16,906,965
Inpatient	$201,910,300	311,370.4	$648.46	$649.06	$682.18	0.95	$33.72	$10,499,999
Outpatient	$134,290,164	311,370.4	$431.29	$374.57	$392.45	1.10	-$38.84	-$12,094,372
Professional	$101,240,787	311,370.4	$325.15	$377.02	$397.74	0.82	$72.59	$22,603,112
SNF	$46,798,990	311,370.4	$150.30	$146.69	$155.52	0.97	$5.22	$1,623,797
Total	$531,894,476	311,370.4	$1,708.24	$1,787.18	$1,877.68	0.91	$169.44	$52,757,951

Table 12.B MEDICARE
PMPM costs for Demonstration Year 6 based on incurred Medicare claims for Cohorts 1, 2, 3, 4, 5A/B, 6A/B and 7A/B

Type of service	Intervention		PMPM			Ratio (D/T)	PMPM savings	Dollar savings
	Incurred claims	Member months	Intervention (D)	Comparison	Target (T)			
Baseline	$1,234,339,704	716,485.0			$1,722.77	1.00		
Durable medical equipment	$21,092,006	302,942.3	$69.62	$72.15	$73.98	0.94	$4.36	$1,319,346
Home health agency	$22,630,589	302,942.3	$74.70	$100.82	$103.44	0.72	$28.74	$8,705,472
Hospice	$5,321,634	302,942.3	$17.57	$89.76	$92.59	0.19	$75.03	$22,729,025
Inpatient	$200,877,572	302,942.3	$663.09	$669.17	$690.54	0.96	$27.45	$8,316,796
Outpatient	$135,276,304	302,942.3	$446.54	$395.17	$405.93	1.10	-$40.61	-$12,303,918
Professional	$99,811,804	302,942.3	$329.47	$390.60	$405.30	0.81	$75.83	$22,971,042
SNF	$47,846,948	302,942.3	$157.94	$153.44	$160.55	0.98	$2.61	$789,734
Total	$532,856,858	302,942.3	$1,758.94	$1,871.12	$1,932.33	0.91	$173.39	$52,527,497

Table 13.A
PMPM costs by category of beneficiary for Demonstration Year 5 based on incurred Medicare claims for Cohorts 1, 2, 3, 4, 5A/B and 6A/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	$169.44	$52,757,951	$11.69	$3,640,867	$30.76	$9,577,583	$54.30	$16,906,965	$33.72	$10,499,999	-$38.84	-$12,094,372	$72.59	$22,603,112	$5.22	$1,623,797
Fac 65+ SPMI	$910.07	$9,893,867	-$8.38	-$91,122	-$16.69	-$181,477	$223.88	$2,433,885	$136.43	$1,483,217	$200.84	$2,183,388	$204.44	$2,222,560	$169.56	$1,843,415
Fac 65+ nonSPMI	$386.51	$3,392,388	-$17.23	-$151,195	-$12.51	-$109,814	$180.56	$1,584,804	-$27.34	-$239,977	$149.58	$1,312,889	$122.95	$1,079,107	-$9.51	-$83,427
HCBS 65+ SPMI	$618.14	$16,907,214	$32.10	$877,877	$66.30	$1,813,518	$91.60	$2,505,365	$231.23	$6,324,599	$30.43	$832,242	$126.25	$3,453,152	$40.23	$1,100,460
HCBS 65+ nonSPMI	$267.61	$11,707,779	$11.92	$521,636	$35.35	$1,546,603	$83.50	$3,652,974	$51.05	$2,233,297	-$23.29	-$1,018,872	$94.84	$4,149,379	$14.23	$622,763
Com 65+ SPMI	$124.26	$2,425,386	$10.02	$195,502	$61.08	$1,192,249	$56.71	$1,106,928	-$20.55	-$401,180	-$35.91	-$700,860	$61.75	$1,205,283	-$8.84	-$172,535
Com 65+ nonSPMI	$7.56	$439,967	$14.19	$826,017	$33.50	$1,950,439	$51.03	$2,971,431	-$24.59	-$1,431,625	-$70.78	-$4,121,445	$16.19	$942,824	-$11.98	-$697,674
Fac <65 SPMI	$1,121.79	$5,116,212	$13.93	$63,529	-$0.21	-$975	$60.19	$274,505	$271.27	$1,237,182	$199.44	$909,598	$332.60	$1,516,884	$244.59	$1,115,490
Fac <65 nonSPMI	$209.38	$765,570	-$33.44	-$122,253	-$2.35	-$8,605	$73.94	$270,366	$55.31	$202,223	-$53.01	-$193,829	$82.99	$303,422	$85.95	$314,246
HCBS <65 SPMI	$203.89	$5,962,451	-$12.50	-$365,598	$31.08	$908,927	$27.23	$796,195	$126.33	$3,694,389	-$24.38	-$713,054	$75.00	$2,193,374	-$18.87	-$551,782
HCBS <65 nonSPMI	-$34.01	-$1,124,223	$27.74	$916,991	$35.49	$1,173,204	$21.61	$714,223	-$13.48	-$445,460	-$155.28	-$5,132,967	$78.08	$2,580,871	-$28.17	-$931,084
Com <65 SPMI	-$22.79	-$834,223	$16.99	$621,895	$25.02	$915,780	$7.57	$277,204	-$40.61	-$1,486,432	-$75.62	-$2,768,108	$49.40	$1,808,126	-$5.54	-$202,688
Com <65 nonSPMI	-$52.98	-$1,894,435	$9.72	$347,588	$10.56	$377,733	$8.92	$319,085	-$18.75	-$670,234	-$75.05	-$2,683,353	$32.11	$1,148,130	-$20.51	-$733,385

Table 13.B
PMPM costs by category of beneficiary for Demonstration Year 6 based on incurred Medicare claims for Cohorts 1, 2, 3, 4, 5A/B, 6A/B and 7A/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	$173.39	$52,527,497	$4.36	$1,319,346	$28.74	$8,705,472	$75.03	$22,729,025	$27.45	$8,316,796	-$40.61	-$12,303,918	$75.83	$22,971,042	$2.61	$789,734
Fac 65+ SPMI	$525.57	$5,980,582	-$4.27	-$48,598	-$16.69	-$189,930	$230.91	$2,627,644	-$36.68	-$417,389	$163.98	$1,865,998	$136.29	$1,550,878	$52.02	$591,979
Fac 65+ nonSPMI	$425.80	$3,554,887	-$21.15	-$176,604	-$8.61	-$71,877	$162.57	$1,357,215	$43.12	$360,017	$131.73	$1,099,767	$112.71	$940,939	$5.44	$45,429
HCBS 65+ SPMI	$790.35	$22,995,857	$17.41	$506,449	$48.37	$1,407,255	$157.98	$4,596,498	$284.18	$8,268,422	$78.06	$2,271,156	$142.24	$4,138,583	$62.12	$1,807,494
HCBS 65+ nonSPMI	$328.12	$13,459,208	$7.61	$312,265	$38.96	$1,597,992	$125.77	$5,158,832	$69.67	$2,857,680	$44.58	$1,828,679	$61.45	$2,520,710	-$19.92	-$816,948
Com 65+ SPMI	$241.29	$4,673,493	$10.41	$201,535	$67.63	$1,309,895	$87.64	$1,697,393	$32.03	$620,327	-$61.96	-$1,200,079	$77.17	$1,494,594	$28.39	$549,828
Com 65+ nonSPMI	-$106.44	-$5,869,860	$10.08	$555,607	$23.66	$1,304,858	$68.06	$3,753,026	-$72.34	-$3,989,220	-$143.89	-$7,935,198	$17.70	$976,314	-$9.71	-$535,248
Fac <65 SPMI	$771.64	$3,603,984	-$11.80	-$55,122	-$15.95	-$74,504	$59.40	$277,419	$126.10	$588,959	$221.03	$1,032,322	$249.63	$1,165,925	$143.23	$668,984
Fac <65 nonSPMI	$132.54	$485,047	-$52.36	-$191,611	$2.26	$8,274	$67.50	$247,023	-$62.17	-$227,519	$14.19	$51,925	$86.87	$317,922	$76.24	$279,033
HCBS <65 SPMI	$312.35	$9,356,341	-$14.12	-$422,821	$47.82	$1,432,559	$32.84	$983,759	$170.39	$5,103,960	-$61.06	-$1,828,960	$108.62	$3,253,744	$27.85	$834,101
HCBS <65 nonSPMI	$78.48	$2,528,185	$3.97	$127,844	$37.17	$1,197,448	$40.71	$1,311,568	$66.60	$2,145,391	-$131.46	-$4,234,878	$95.62	$3,080,292	-$34.13	-$1,099,479
Com <65 SPMI	-$79.31	-$2,797,830	$6.75	$238,054	$15.33	$540,948	$10.19	$359,487	-$73.59	-$2,595,969	-$102.19	-$3,605,017	$63.31	$2,233,589	$0.88	$31,077
Com <65 nonSPMI	-$165.89	-$5,442,396	$8.30	$272,349	$7.39	$242,554	$10.95	$359,163	-$134.05	-$4,397,863	-$50.28	-$1,649,633	$39.55	$1,297,551	-$47.75	-$1,566,516

The Seattle Times

Washingtonians are less religious than ever, Gallup poll finds

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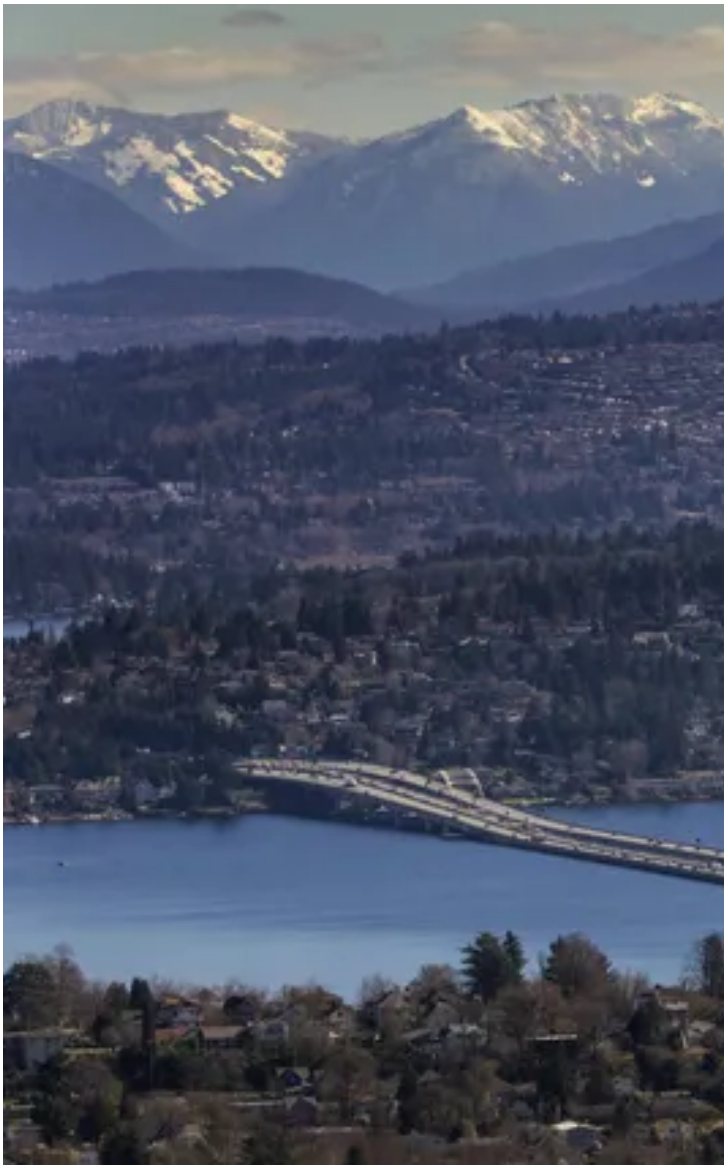


Washington is tied with Alaska as the sixth-least religious state in the country. (Ellen M. Banner / The Seattle Times)

Since Gallup began tracking religiosity at the state level, Washington has been among the least religious in the union. Forty-seven percent of adults in the state say they are not religious, and seldom or never attend services.

By Gene Balk / FYI Guy

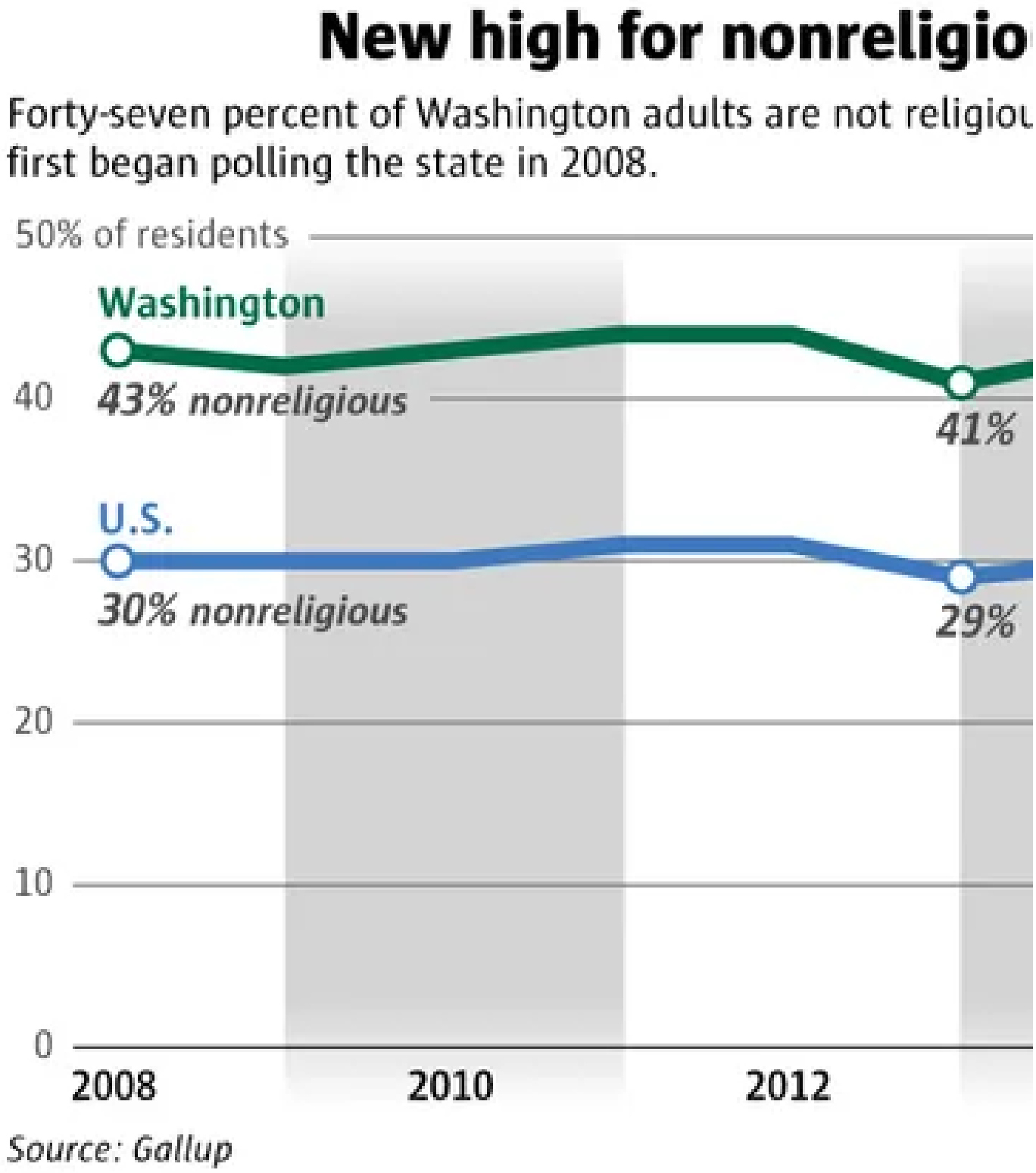
Seattle Times columnist

Ever since pollsters began asking Americans about their faith, Washington has ranked among the less-religious states in the country. But Washington has never been as secular as it is right now.

A record number of state residents didn't identify with any religion in 2017, according to polling giant Gallup. Forty-seven percent of adults in the state say they are not religious, and seldom or never attend services.

When Gallup began polling about religious belief at the state level in 2008, 43 percent of Washingtonians identified as nonreligious. That number didn't change much year-to-year, except for a hard-to-explain dip to 41 percent in 2013 (the nation as a whole also saw the percentage of nonreligious drop that year).

After that, the number started to rise. That's true for many other states as well. In fact, the U.S. as a whole is also at a record high, with 33 percent saying they are not religious.



It's primarily young people who are beefing up the numbers of the nonreligious in the U.S. The poll data show that just 28 percent of those younger than 30 are very religious, compared with 47 percent of those aged 65 and older. And it's possible that the influx of young newcomers to the Seattle area is the driving force behind the change in Washington's numbers.

Washington ranks as the sixth-least-religious state, in a tie with Alaska. Oregon has tended to poll just slightly less religious than Washington, and that held true in 2017. Forty-eight percent in the Beaver State have no religion.

Washington is one of 19 states, plus the District of Columbia, where the plurality of adults are nonreligious (as opposed to very religious or moderately religious). Just 28 percent of adults in Washington identify as highly religious, and say they attend services weekly — 19 percentage points lower than those who are nonreligious.

In fact, in all the other Western states — Oregon, California, Alaska and Hawaii — the percentage of adults who are not religious also outweighs the percentage who are very religious by double digits.

The most- and least-religious states are, perennially, Mississippi and Vermont — and I'm sure you can guess which one is which without me telling you. In 2017, 59 percent of Vermonters had no religion, while only 12 percent of Mississippians did.

New England is the least-religious part of the country, claiming the top four states, but the Western U.S. is right behind. The Southern "Bible Belt" states are the most religious, although Utah ranks up there too. It's one of just four states where the majority of residents identify as highly religious.

That make sense because the polling shows that Mormons are the most devout religious group in the U.S., with 73 percent identifying as very religious. They're followed by Protestants (50 percent), Muslims (45 percent) and Catholics (40 percent). Jews are far and away the least devout group, with just 18 percent saying they're very religious.

In terms of race and ethnicity, blacks are a more likely group to be very religious (48 percent) compared with whites and Hispanics (both at 36 percent).

The data comes from Gallup's daily tracking poll, which is conducted throughout the year. In 2017, about 129,000 U.S. adults were interviewed, including nearly 3,400 in Washington. The margin of error is +/- 2 from 2013 to 2017, and +/- 1 from 2008 to 2012.

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Bethany Hospice Assumptions

Utilization Assumptions

Baseline Reference – Utilization Assumptions	Assumption	Estimated Annual Admissions		
		2023	2024	2025
In 2020, approximately 72 patients residing in one of our facilities enrolled in hospice. An additional 36 Bethany short-term facility patients were discharged home to hospice, for a total of 108 in 2020. This number has been increasing about 2% per year.	65% would choose Bethany in Year 1; 75% in Year 2; 85% in Year 3. After 2023, we have assumed a 2% annual growth based on historical experience	70	83	96
Bethany is sponsored by 32 churches, of which 26 are located in Snohomish County. Bethany meets monthly to discuss health care needs of these church communities and the community at large. In fact, the submittal of this CN application was in part, in response to a request from our sponsors. The membership of these churches have significant outreach to the underserved in our community and therefore, and in addition to referring congregants, the churches will be an important connection to the underserved or otherwise needy for Bethany Hospice.	Very conservatively, we have assumed 2 referrals per month in Year 1; 4 in Year 2, and 6 in Year 3.	24	48	72
Focused outreach and marketing to the general community and key payers and providers	Here, we conservatively assumed less than one admission per month in the first year as marketing and outreach is expanded. We increased this to approximately 7 in Year 2 and 8 in year 3.	20	88	101

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Hospice care in US nursing homes: benefits and barriers

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About a quarter of adult deaths in the USA occur in nursing homes.[1,2] Previous research has concluded that the residents of these homes do not receive adequate pain management or high-quality palliative care at the end of life.[1,3,4] Dementia can make the provision of adequate pain management difficult, in that residents with dementia may have difficulty in reporting their pain. Magaziner *etal* found that almost 50% of all nursing home residents had dementia.[5] Another study found that 83% of nursing home residents with dementia had painful conditions.[6]

One way to improve pain management for nursing home residents with dementia would be to use hospice services in the nursing home. Yet, hospices services are not widely used in nursing homes, even for those residents who qualify for it. Currendy, 24% of nursing home residents who die in nursing homes qualify for hospice services, but only 6% are enrolled.[7] Pain management at the end of life for nursing home residents could be improved by greater use of hospice seivices.

US Medicare hospice services

In 1996, Medicare, the US government-administered programme that provides health insurance for people aged 65-plus, extended its hospice services to cover terminally ill older adults with severe cognitive impairment.[8] Under the new rules, many nursing home residents who were not previously eligible for hospice care became eligible. Severe cognitive impairment, including that caused by Alzheimer's disease, is the fifth leading cause of death among the over-65s in the USA.[9] Hospice seivices can provide support to older adults with cognitive impairment, by helping to manage pain, providing comfort and easing the transition to death.

Since the approval, in 1982, of Medicare hospice benefits, nursing homes have been able to offer a wide range of hospice services to dying residents (see Box 1).[10,11] However, according to Munn *et al,* fewer than half of the residents who are eligible actually receive the benefits.[11] Miller *etal* found that 24% of nursing home residents qualified for hospice

Todd B Monroe and **Michael A Carter** review the literature on the use of hospice services in US nursing homes. They find there are many benefits, both to the residents and the healthcare system, but also that many people, especially those with dementia, are missing out

Greater hospice enrolment may help to reduce costs in the US healthcare system by reducing the use nursing home residents make of acute care services

Conflicts between hospice and nursing home staff are another barrier to the use of hospice services in nursing homes

services, but that only 6% used them.[7] Evans reported that only 1% of nursing home residents were using the benefits,[12] and Petrisek and Mor showed that only 30% of nursing homes had residents enrolled for hospice care.[13]

Benefits of the use of hospice care in nursing homes

Better pain and symptom management

The management of pain experienced by nursing home residents has been a concern for nearly 30 years.[14] Reynolds *etal* reported that 86% of dying nursing home residents experienced pain, and that more than half of those experienced moderate-to-severe pain.[15]

Hospice care improves pain management. One study showed that nursing home residents enrolled in a hospice for seven days or more had a greater chance than those not enrolled of receiving opioid treatment and were more likely to be given an opioid dose twice a day.[16] Wu *et al* found that residents receiving hospice care were generally more likely to be given opioids for pain management than residents not receiving hospice care.[17] Miller *etal* reported that the use of analgesic medication was 50% greater in nursing home residents receiving hospice care than in those who were not.[7] Munn *et al* found that 85% of nursing home residents who did not receive hospice care experienced moderate-to-severe pain, compared with 52% of those receiving hospice care; and that 82% of hospice-enrolled residents received pain medications, compared with 50% of non-enrolled residents.[11] Nursing home residents receiving hospice care are also 93% more likely to have their pain management documented.[18]

Munn *et al* found that alternative pain management strategies, such as ice packs and massage, were more often used among nursing home residents receiving hospice care, who were also more likely to receive assistance with eating and oral hygiene, than those not receiving hospice care.[11] A meta-analysis of 19 hospice and palliative care studies concluded that hospice and palliative care teams managed pain better, and all other symptoms moderately better, than nursing home teams.[19]

Better management of pain and of medication is a recognised benefit for nursing home residents using hospice services. Miller *et al* reported that nursing home residents receiving hospice care received fewer inappropriate medications than those not enrolled in hospice care, as recommended by the American Medical Directors Association.[7]

Pain management may be better for all nursing home residents when hospice care is provided in the facility - a phenomenon identified as the ‘hospice effect’. Patients who did not receive hospice care, but who resided in a nursing home where hospice care was offered, were more likely to have their pain assessed.[17]

On behalf of the US Department of Health and Human Services (DHHS), Gage *et al* compared nursing home residents who were receiving hospice care (n=l,982) with nursing home residents who were not (n=6,392).[20] They found that the detection of daily pain was different between the two groups. Daily pain was detected in 28.1% of residents with cancer and no dementia receiving hospice care (n=430), and in 16.8% of residents with cancer

APPENDIX S (6)

and no dementia not receiving hospice care (n=l,529). Daily pain was detected in 16% of residents with cancer and dementia receiving hospice care (n=717), and in 8.9% of residents with cancer and dementia not receiving hospice care (n=2,293). This would seem to show that pain in individuals with dementia may be underdetected, but that enrolment in hospice care results in increased pain detection among these patients.

Financial benefits for the healthcare system

Greater hospice enrolment may help to reduce costs in the US healthcare system by reducing the use nursing home residents make of acute care services.

According to the DHHS, nursing home residents who use hospice services are significantly less likely to be hospitalised at the end of life than those residents who do not. Gage *et al* found that the number of hospitalisations of nursing home residents not enrolled for hospice care decreased as hospice enrolment increased. They also found that the reduction in hospitalisations in the last 30 days of life translated into acute medical care savings of $2,909 for every nursing home resident.[20]

A study of people aged 65-plus with advanced dementia found that 43.7% of nursing home residents were hospitalised at least once during the last 90 days of life, compared with 31.5% of those receiving home-care services.[21] Nursing home residents with cognitive impairments are taken to hospital more frequently than those without cognitive impairments, when available hospice care could help to relieve pain and provide support to the resident and their family.[22,23] According to Kronman, decreasing just one hospital day per beneficiary of Medicare hospice benefit could save millions of dollars.[22]

Among nursing home residents receiving hospice care, 25% had been enrolled for less than one week[20,24] and 50% for less than 30 days before dying.[20] By using hospice services, individuals with cancer save Medicare $7,000 over the course of the illness, while those with other primary conditions help save $3,500.[24] Nursing home residents enrolling in hospice care who received information about palliative care, and subsequent assistance, had fewer acute care admissions and spent fewer days in hospital.[25] Thus, efforts to increase short-term hospice care offer a greater opportunity to save Medicare money than attempts to reduce long-term hospice care.[20,24] However, increasing the length of hospice enrolment of seven out of ten nursing home residents would also greatly increase savings.[24]

Barriers to the use of hospice care in nursing homes

Patient and family attitudes

The family's culture and religion may influence the decision about hospice enrolment. According to Jablonski and Wyatt, Hispanic and African-American families generally favour life-sustaining measures over palliative care, which may conflict with professional carers' attempts to offer pain relief.[26]

Another barrier to hospice enrolment is the patient's own preference for life-sustaining treatment, which may indicate a lack of understanding, by the patient and/or the family, of the terminal nature of the diagnosis[27] (or possibly a desire not to surrender to the disease).

APPENDIX S (6)

Casarett *et al* found that 56% of patients and families were reluctant to accept a terminal diagnosis, and that 91% of hospice-eligible older adults did not enrol until late in the course of a six-month illness.[28] Among nursing home residents enrolled for hospice care, one-third had been receiving it for less than two weeks and one-fifth for less than one week before dying.[16,29] These figures suggest that patients may not be benefiting fully from hospice care because of late enrolment.

There may be barriers to hospice enrolment that are specific to nursing home residents with dementia. One study found that only one in every ten nursing home residents dying with dementia was enrolled in hospice care.[30] This could be the result of communication problems between residents and staff.

According to one survey, 17% of nursing home nurses believe that hospice staff do not have the skills to care for residents with dementia.[31] This finding is interesting, given that 59% of nursing home residents receiving hospice care have some cognitive impairment.[15] Mitchell *et al* reported that nursing home residents with cognitive impairment had more functional disability, behaviour problems and tube feedings than those who were mentally sound. They also found that this population is often not recognised as terminally ill and infrequently (5.4%) referred for hospice care.[32]

The majority of hospice nurses (88%) and 45% of nursing home nurses believe that the lack of knowledge about hospice care on the part of residents and families is a barrier to its use.[31] In a randomised, controlled trial, hospice enrolment increased after a brief structured interview between a clinician and nursing home residents and their families.[25] Another study reported that 85% of patients and families decided to enrol for hospice care after one conversation with a professional carer such as a doctor or nurse with specialised training in palliative care.[28]

Lack of knowledge and education of nursing home staff

Lack of knowledge about, and unfamiliarity with, hospice and palliative care prevents nursing home staff from using it fully. One survey found that 92% of hospice nurses and 26% of nursing home nurses believed that a lack of knowledge about hospice care on the part of nursing home staff was a barrier to hospice enrolment.[31]

Symptom relief is a major tenet of palliative care, and the overall symptom burden is higher in nursing homes than in residential care or assisted-living facilities.[33] Jablonski and Wyatt explained that the problem of symptom relief in nursing homes may be exacerbated by the large numbers of unlicensed personnel, who lack palliative care education but provide the majority of the care.[26] One survey revealed that nearly 20% of nursing homes did not provide formal training in end-of-life pain and symptom management, and that more than 50% of nursing home administrators believed that lack of education was the single greatest obstacle to providing quality end-of-life care.[34] Hanson *et al* found that 87% of nursing home staff did not know how to relieve pain, and that 89% did not know how to relieve dyspnoea, in residents at the end of life.[33]

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Organisational and system issues

Another barrier to hospice enrolment is rooted in the core philosophical differences between traditional nursing home care, which concentrates on maintaining health, and established hospice practice, which is palliative.

These differences are heightened by the requirements of the Minimum Data Set (MDS), the documentation system used in US nursing homes that must be completed on each admission and quarterly thereafter. The MDS focuses on restorative rather than palliative care.[12,31] It centres on health and functional indicators,[35] not on symptom management (such as control of pain, dyspnoea or fatigue) or on end-of-life issues and spiritual needs.[12] For example, the MDS requires that, if there is any evidence that a resident is malnourished, this should be addressed; however, a decreased food intake may be part of the dying process and the prolongation of life through forceful feeding may increase the person's suffering.[12,31,35] Clearly, palliative care is not supported by the current MDS, and changes to this documentation system are needed.

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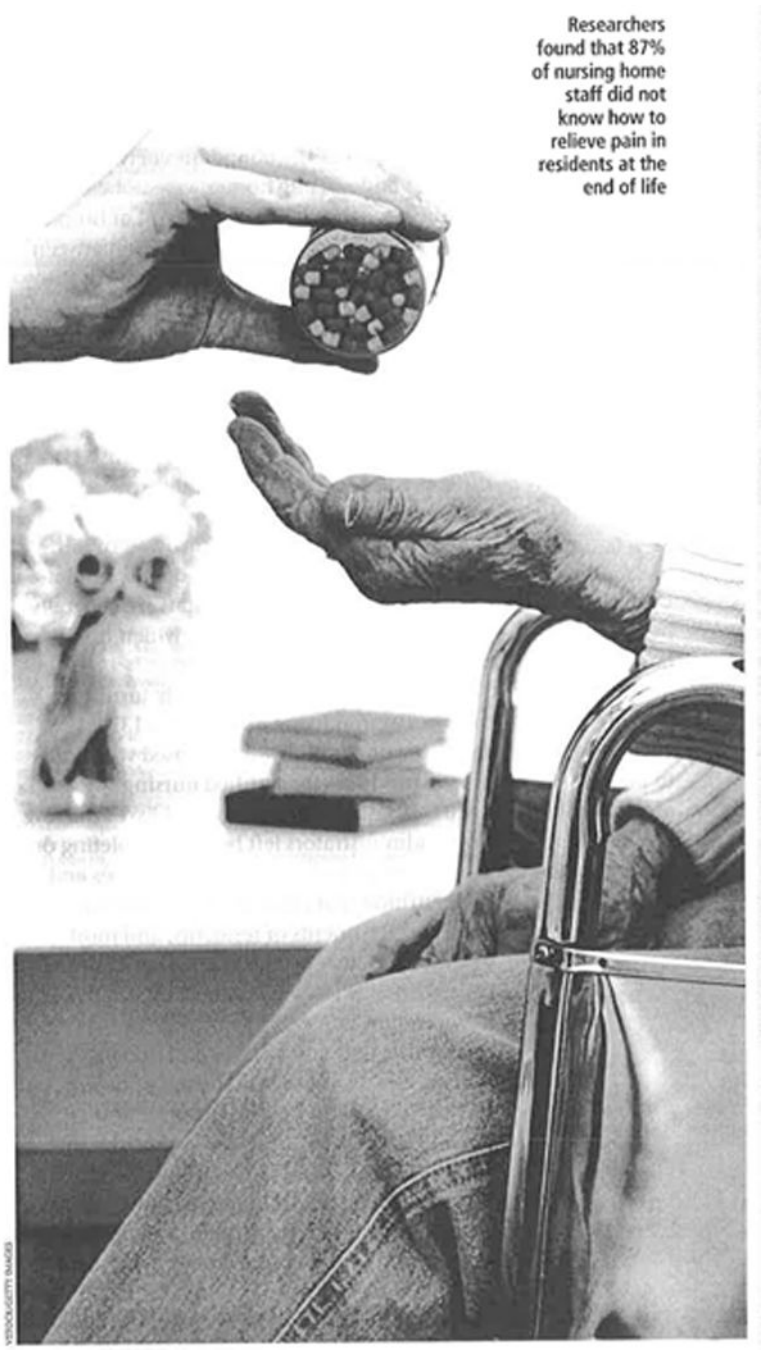

Confusion about, and lack of understanding of, who is ultimately responsible for the residents' care potentially create another significant barrier to hospice enrolment. Parker-Oliver and Bickel found that there was confusion, among the 60 administrators and directors of nursing homes that they surveyed, about who had the ultimate responsibility for the patients' palliative care plan; 40% believed it was the responsibility of the nursing home; 36% believed it was both the nursing home and the hospice, 18% thought it was the hospice; and 6% did not know. Only 38% thought they understood how hospice care was reimbursed and 15% felt that the boundaries between hospices and nursing homes were not clear.[36]

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Another study found that one-third of hospice nurses identified miscommunication between nursing home and hospice staff as one of the biggest problems when working with hospice patients in nursing homes.[37] Lack of understanding about hospice and nursing home care plans may lead to gaps or overlaps in care or reimbursements. For example, the nursing home and hospice may establish two different and competing wound-care plans for the same patient.

Staff shortages and a high turnover of staff contribute significantly to low-quality end-of-life care.[1,2,12,34] Nursing home staff are generally the lowest paid in the industry, which makes recruitment and retention difficult.[4]

One study found that the yearly turnover rates in Texan nursing homes were 133% for registered nurses, 108% for licensed vocational nurses and 160% for certified nursing assistants.[38] Clarkin reports that 43% of nursing home administrators left before completing one year of employment.[39] Staffing shortages and high attrition make it difficult to carry out detailed assessments of residents, and most of the care is provided by licensed practical nurses who are less well trained, especially in end-of-life care.

Conflicts between hospice and nursing home staff are another barrier to the use of hospice services in nursing homes. Hospices and nursing homes are both regulated by the state (and to a lesser degree the federal government through federal reimbursement), but each has a different organisational structure and culture. Hospices provide 'relational care', whereas nursing homes provide 'routinised care'.[40] Relational care is more democratic, giving residents and their families more choice, while routinised care is very structured and bureaucracy-driven.[40] As a result, relationships between hospice and nursing home staff can become strained.

Tarzian and Hoffmann found that many nursing home staff believed that hospice staff were not familiar with nursing home policies and that most hospice staff rarely did anything that they did not do. Nursing home nurses felt that hospice nurses think they 'know everything' and tend to 'take over' rather than work in a collaborative effort.[31] Parker-Oliver found that nursing home nurses had the following perceptions about hospice nurses: 70% believed that 'hospice staff come and tell us what to do, yet we are here 24 hours a day', 54% that 'hospice puts everyone on morphine' and 53% that 'hospice just lets residents die'.[37]

Financial problems

Financial problems are another potential barrier to hospice enrolment, particularly with regard to reimbursement and billing for specific services.[29, 31] Medicare Skilled Nursing Facilities pay for room and board, but these items are not covered by Medicare hospice benefits. This means that residents using the latter must find other resources to pay for room and board, resulting in a complicated (and potentially lower) reimbursement to the nursing home.[26]

Reimbursement methods are also an issue. Where nursing homes are reimbursed by hospice agencies, the money takes longer to reach the nursing homes than when it comes directly from government healthcare agencies, such as Medicare and Medicaid.[12] For example, if a

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resident is eligible for Medicaid, Medicaid will pay the hospice 95% or more of the state's daily nursing home rate, and then the hospice will reimburse the nursing home for room and board, which complicates and delays the payment to the nursing home.[40] Another concern is that nursing homes receive more money for rehabilitative care than for palliative care, so the revenues will be higher in nursing homes not using hospice services.[26]

Disease progression and prognosis

The US federal reimbursement system requires that a six-month prognosis is made before a patient is deemed eligible for Medicare hospice benefits (see Box 1). Difficulty in determining this six-month 'window to death' may also be a barrier to hospice enrolment.[41] Many doctors are uncomfortable estimating when residents will die, especially residents with dementia,[9,12] congestive heart failure or chronic obstructive pulmonary disease (as opposed to residents with cancer, who typically follow a more predictable trajectory).[41]

One instrument used to establish the eligibility for hospice care of individuals with dementia is the Functional Assessment Staging (FAST) scale.[42] The scale has a number of stages of severity, ranging from stage 1 ('No objective or subjective difficulties') to stage 7f ('Cannot hold head up independently'). In the USA, stage 7a ('Speech limited to fewer than six intelligible words during an average day') and stage 7c ('Unable to ambulate independently') are considered points of hospice eligibility. However, in one study, 40% of residents could not be evaluated using this method because their disease progression did not match that of the FAST scale.[43]

Alternating episodes of deterioration and recovery are common in nursing home residents, making it difficult to ascertain when they are in their final six months of life, which in turn makes it difficult to determine their eligibility for hospice care. Although, in theory, the entitlement can be renewed if the resident does not die within the six-month period, meeting the conditions for enrolment over and over again can be a problem.

Conclusion

In the USA, hospices have been helping people in the transition from life to death, with as little pain and discomfort as possible, for nearly 30 years. However, more nursing home residents could be receiving the benefits of hospice care. Nurses and healthcare professionals working in nursing homes should be encouraged to overcome the barriers to the hospice enrolment of their residents, so that these are given the best possible care at the end of life.

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Box 1.

Who is eligible for US Medicare hospice benefits? What are these benefits?*

To be eligible for Medicare hospice benefits, it is necessary to meet all of tde following conditions:

- The patient must be eligible for Medicare Part A (hospital insurance)
- The doctor and the hospice medical director must certify that the patient has a terminal illness with a life expectancy of six months or less
- The patient must sign a written statement saying that they choose hospice care to treat their terminal illness
- Care must come from a Medicare-approved hospice programme

The Medicare hospice benefits include:

- Doctor and advanced-practice nursing services (on call 24 hours a day)
- Medical care provided by the hospice medical director
- Nursing care (on call 24 hours a day)
- Case management
- Medical equipment and supplies
- Medications for terminal illness and palliative care (small patient co-payment may be required)
- Speech and language therapists
- Short-term inpatient and respite care (small patient co-payment may be required)
- Physical and occupational therapy
- Dietary counselling
- Home health aide services
- Continuous care
- Counselling and social work services
- Spiritual care
- Help from volunteers
- Grief and loss counselling

* Adapted from Medicare Hospice Benefits[10]

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Key points

- In the USA, many nursing home residents do not receive adequate palliative care.
- The Medicare hospice benefits scheme allows US nursing homes to offer a wide range of hospice services to their dying residents; however, many eligible residents are not enrolled for hospice care.
- Hospice care has proven benefits for nursing home residents, who get better pain and symptom management, and for the US healthcare system as a whole, in the form of savings on acute care costs.
- Many barriers prevent more US nursing home residents from receiving hospice care, incuding a lack of knowledge about hospice care among nursing home staff.
- Another barrier to the use of hospice care in US nursing homes is a bias, in the nursing home documentation, towards restorative rather than palliative care.

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The Effects of Hospice Coverage on Medicare Expenditures

David Kidder

This article reports on the findings of a study of the effects of the hospice program on Medicare Part A expenditures during the first three years of the program. The analysis compared treatment costs between hospice beneficiaries and nonbenefit patients with diagnosis of malignant cancer during their last seven months of life. It was estimated that during the first three years of the hospice program, Medicare saved $1.26 for every dollar spent on Part A expenditures. While the methodology included use of data from Medicare claims to adjust for confounding factors, including self-selection bias, our estimated savings might still have been overstated due to persistent selection effects. The extent of savings also varied according to the hospice's organization. Freestanding hospices, in contrast to those affiliated with either a hospital, nursing home, or home health agency, achieved the greatest savings by utilizing home care more extensively. However, we note that payment rates are increasing and the limits on the benefit period are being lifted, making it possible that the savings related to the hospice program found in this study will not continue. Of greater importance may be the long-term access and quality effects engendered by the benefit's preference for home care.

THE MEDICARE HOSPICE BENEFIT

In the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA), Congress added a hospice benefit to the Medicare program. The hospice model of care, which stresses pain relief for terminally ill patients and

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counseling for their families, spread rapidly in the United States during the early 1980s. The federal government began seriously to consider the implications of a Medicare hospice benefit in 1980, with the implementation of demonstrations in 26 hospice programs. Well before findings from the evaluation of this demonstration were available (in the "National Hospice Study"), Congress mandated hospice coverage for all eligible Medicare beneficiaries. This article reports findings on the effects of the hospice benefit on Medicare expenditures.[1]

The hospice benefit incorporates many traditional Medicare features. Reimbursable services can be provided only through Medicare-certified programs; Medicare-certified hospices must meet standards similar to those used to certify other Medicare providers.

However, the benefit is also unique in several respects. Medicare pays one of four fixed, prospective per diem rates for every day of hospice benefit coverage. Each rate is defined by a service level and setting: a "routine home care" rate that covers days when the patient is at home but not receiving continuous skilled nursing services; a "continuous home care" rate for crisis days when the patient needs constant skilled nursing attention; a "general inpatient care" rate for medically necessary days in a hospital; an "inpatient respite care" rate for institutional days provided for the relief of the patient's primary informal caregiver. Copayments may be collected for inpatient respite care and prescription drugs provided by the hospice program; few hospices have bothered with copayments since the cost of collection outweighs the gain in revenue in most cases.

Utilization controls are imposed on providers as conditions both of certification and reimbursement. These include an annual aggregate Medicare reimbursement limit for each participating hospice, based on the average costs of treating terminally ill patients in nonhospice settings, and a limit on total provider inpatient days (general plus respite) to 20 percent of each provider's total reimbursable days.

During the years covered by this study, providers were reimbursed by Medicare for a maximum of 210 days for each enrolled hospice benefit recipient. Congress subsequently removed this limit in 1989 (through the Medicare Catastrophic Coverage Act), reimposed it after one year (when the Act was repealed), and removed it again in the Omnibus Budget Reconciliation Act of 1990.

Two years after implementation, total reimbursements under the benefit did not exceed 1 percent of estimated total Parts A and B reimbursements for the care of all terminally ill Medicare cancer patients. More recently, however, the annual growth of hospice benefit expenditures has accelerated, a trend which should continue with the

lifting of restrictions on benefit payments and recent increases in payment rates.

From the beginning, the hospice benefit has provoked interest and controversy out of proportion to its share of Medicare expenditures. The hospice approach continues to challenge maintained beliefs about medical practice in the care of dying patients. In addition, responding to a widely held conviction that hospice care should be less costly than traditional methods, Congress constrained the benefit with caps and limits. These limits, and payment rates roundly criticized by the industry as inadequate, were alleged to have discouraged participation during the first three years of the benefit.

SELECTION BIAS AND SAMPLING METHODS

Early research, including findings from the evaluation of Medicare's hospice demonstration (the National Hospice Study), generally showed hospice patients incurring lower costs than terminally ill patients in traditional settings (Mor, Greer, and Kastenbaum 1988; Mor and Masterson-Allen 1987; Mor and Kidder 1985). Hospice patients were more likely to be treated at home in the last month of life than patients in traditional care (Birnbaum and Kidder 1984; Brooks and Smyth-Staruch 1984; Greer, Mor, Morris, et al. 1986; Mor, Greer, and Kastenbaum 1988). Evidence also showed that average expenditure varied by hospice type, independent of patient mix.

Generalizing from this evidence has been difficult, because researchers have chosen divergent typologies of hospice providers to fit various conceptual models or to conform to data limitations. The National Hospice Study simplified the array of options to two categories and found significant differences in expenditure between hospital-based hospices (those that provide inpatient services directly) and home care–based hospices (those that make arrangements with other providers for inpatient care) (Mor, Greer, and Kastenbaum 1988). Expenditures in home care–based hospices were lower, due mainly to greater reliance on home care in the final month of life. Congress, convinced by the evidence from research and prompted by industry lobby groups, included inpatient day limits in the benefit and mandated "core services" to support the medical and social needs of benefit recipients in an effort to encourage home care and cost containment.

Selection Bias

Critics maintain that researchers have consistently underestimated the potential for self-selection bias in hospice cost savings estimates. The

"hospice selection" argument is relatively straightforward. Terminally ill individuals are assumed to select hospice care to avoid aggressive medical interventions and for support in their intention to die at home. It is further necessary to assume that these same individuals would choose to reject aggressive therapy and remain at home even if hospice were *not* available. Hospices are thus able to enroll those among the terminally ill least likely to use expensive medical services. As a consequence, the "savings" attributed to the hospice intervention are overstated because observed expenditure differences between hospice and "comparison" patients are due partly to the special preferences and behaviors of the hospice enrollee. Not surprisingly, therefore, criticism has tended to focus on criteria used in past studies to define sampling frames for comparison patients (Brooks 1983; Mor and Masterson-Allen 1987; Kane, Wales, Bernstein, et al. 1984; Zimmer, Groth-Junker, and McCusker 1984).

For researchers who must work within the limits of quasi-experimental research designs, the standard approach to selection bias is first to sample in a way that minimizes differences between treatment and comparison groups regarding the most serious potential sources of bias and then to use multivariate statistical techniques to control further for selection effects. Some with the courage (and the data) to model selection statistically employ a two-step procedure, first estimating a regression that predicts the choice and then adding to the right-hand side of a linear regression predictions from the selection model. Others incorporate variables assumed to be related to selection behavior directly into the linear regression equation.

For the Medicare hospice benefit evaluation, the complexity of the selection process and limitations on data severely restricted the available options. Two choices are made in electing the Medicare hospice benefit:

- Hospice care is selected over traditional care, a decision that requires both acceptance of a general philosophy and technique of care, and choice of a specific hospice provider.
- The Medicare hospice benefit is selected over other methods of financing hospice care. Choice of a financing method might coincide with or precede choice of hospice care.

Presumably, the choice of hospice care is driven principally by the preferences of patients and their families constrained by provider availability, hospice admissions criteria, and attitudes of family physi-

cians. Research into hospice choice is thin and inconclusive, limited by reliance on proxy measures of attitudes and behaviors. For example, findings from a recent population-based study of cancer reported by Moinpour and Polissar (1989) suggest that patients who elect hospice have had cancer for a longer time than those who elect traditional care, have different types of cancer, have relatively strong informal supports, and come from relatively comfortable economic circumstances. However, without some understanding of how attitudes and philosophies of terminally ill individuals interact with objective health events, efforts to model hospice choice will always relegate critical influences (attitudes toward dying at home, for example) to an unmeasured residual.

Adding a financing decision to hospice choice magnifies the potential for selection effects and adds behavioral complexity to modeling efforts. There are reasons to believe that the direction of bias in both choice processes may be the same, tending toward overstating the potential cost savings of hospice.

The incentives implicit in alternative financing mechanisms shape the advice providers give patients and their families about enrolling in the benefit. Hospice providers have an incentive, under the benefit's prospective per diem payment system, to recommend enrollment to individuals with relatively limited needs for expensive (inpatient) care. In addition, the seven-month restriction on benefit payments that applied during the first years of the program created an incentive for providers to encourage enrollment late in the disease process, to avoid making extended commitments for unreimbursed care. Taken together, these incentives imply selection into the benefit of patients with home supports and other resources sufficient to minimize use of inpatient services during the final weeks when the terminally ill are at highest risk for institutionalization.

Data limitations restricted efforts to model selection effects associated with patient and provider behavior. The evaluation had access only to Medicare claims and eligibility data. Detailed information on ways in which certified hospice providers address financing issues with their patients was unavailable, and the literature offered no guidance on proxy indicators of provider behavior. Therefore, efforts to control for selection bias were confined to implementing a broad, inclusive sampling design for choosing comparison group members and to using specific variables, such as health services utilization before the last months of life, as adjustors in multivariate expenditure regressions.

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Sampling Design

Comparison patients were sampled from a frame that included all Medicare beneficiaries with at least one malignant cancer-related hospital claim in the last two years of life, who died during the three years covered by the evaluation, and who had never been enrolled in the hospice benefit.[2] Noncancer hospice benefit and comparison patients were excluded from the expenditure analyses. Over 90 percent of all hospice patients in certified and noncertified programs have a primary diagnosis of cancer, a ratio that has remained relatively constant for many years.

This sample was used in estimates of the net costs to Medicare of the hospice benefit, with one further adjustment. Each year, a number of beneficiaries disenrolled and then reenrolled in the program, with average gaps of about two months (the first gap occurring between the first two 90-day benefit periods, and the second, lasting from 2.0 to 2.5 months, between the second and last benefit periods). Some also left and died outside the program, within an average of 100 days from disenrollment. Although the reasons behind disenrollment have not been documented, misdiagnosis is the most plausible explanation. These individuals made up roughly 7 percent of all beneficiaries in 1986, up slightly from 6 percent in 1985. In age, gender, race, types of conditions, and enrollment patterns by type of hospice, these patients were no different from beneficiaries continuously enrolled until death. It is difficult to categorize these "cross-over" beneficiaries or to compare them with one or the other "pure" groups: beneficiaries who enrolled and died within the benefit program, and those who never enrolled. For this reason, cross-overs were excluded from expenditure analyses. Because there were so few cross-overs during the years studied, this exclusion did not significantly change estimates of average Part A expenditure for hospice beneficiaries. However, cross-overs incurred from $1,000 to $3,000 more in total expenditures in the last year of life than did the average hospice beneficiary.

Salient characteristics of cancer patients in the two samples are presented in Table 1. Hospice beneficiaries tended to be somewhat younger, were more likely to be white, and were less likely than comparison group members to have an initial hospital claim with a diagnosis of malignant cancer within the last month of life. Although true clinical length of illness measures were unavailable, the evidence from Medicare claims suggests that hospice beneficiaries were also more likely to know of their condition for several months before death.

Table 1: Characteristics of Hospice Beneficiaries and Comparison Sample Cancer Patients (1985, 1986)

	1985		*1986*	
Characteristic	*Hospice (N = 5,991)*	*Comparison (N = 7,467)*	*Hospice (N = 12,366)*	*Comparison (N = 7,174)*
Age				
<75	54%	47%	52%	47%
≥75	46	53	48	53
Gender				
Male	53%	54%	54%	53%
Female	47	46	46	47
Race				
White	91%	87%	90%	88%
Other	9	13	10	12
*Diagnosis**				
Colon cancer	29%	21%	28%	20%
Lung cancer	26	21	26	22
Breast cancer	6	4	6	4
Prostate cancer	11	9	11	10
Urinary cancer	3	4	4	4
Leukemia	1	4	1	4
Other cancer	24	38	24	36
Length of stay	32.1 days	—	35.9 days	—
Length of illness (percent <30 days)	13.6%	20.7%	13.9%	20.6%

Source: Abt Associates Inc./Health Care Financing Administration (AAI/HCFA) Hospice Benefit Enrollment File.

*Percentages represent proportions of all cancer diagnoses. Noncancer percentages in the benefit were 6 and 7 percent (FY 1985, FY 1986). Note that sample sizes may differ among tables. This table includes all sample members, with or without complete reimbursement and utilization data.

METHODS AND DATA

This evaluation tests two null hypotheses: first, that no difference in total average Medicare Part A expenditures exists between terminally ill beneficiaries enrolled in the hospice benefit and otherwise comparable individuals who were not enrolled,[3] and second, that expenditures on hospice beneficiaries do not vary by type of hospice. The literature suggests alternative hypotheses: that the benefit would generate savings for Medicare and that hospice type does make a difference, with lower expenditures in hospices that emphasize home care.

Comparisons of (Table 2) expenditures unadjusted for patient mix

Table 2: Total 1986 Average Monthly Medicare Part A Reimbursement for Hospice Beneficiaries and Comparison Sample

	*Hospice** (N = 9,738)			*Comparison* (N = 3,624)
Time Period	*Hospice Benefit (1)*	*Part A (2)*	*Total Part A (3)*	*Total Part A (4)*
Last month	$1497	$1572	$3069	$4071
Month 2	426	1584	2010	1757
Month 3	139	1341	1480	1194
Month 4	48	1054	1102	883
Month 5	31	838	869	815
Month 6	16	696	712	661
Months 8–12	34	2233	2267	2253
Last year of life	2202	9953	12155	12179

Source: AAI/HCFA Hospice Benefit Monthly File.

*Hospice sample includes all who enrolled and incurred some benefit expenditures, including those with gaps and those who disenrolled before death.

and program characteristics show that the average hospice beneficiary who died of cancer in 1986 incurred only $24 less in total Medicare spending than the average comparison patient over the last year of life. Data for the last month of life show hospice beneficiaries' expenditures to be $1,000 lower than those of nonbenefit patients. In months 2–4, however, the pattern was reversed, with hospice beneficiaries incurring higher expenditures. However, a valid test of the net expenditure hypothesis requires adjustment to isolate the benefit "effect."

An ideal model for estimating the net costs or savings to Medicare of a hospice benefit would compare hospice benefit enrollees both to terminally ill patients in hospice (but not enrolled in the benefit) and to patients not enrolled in hospice over comparable periods before death, adjusting for selection bias and other confounding factors. There are various possible analytic constructs of "time before death," including the following:

- Compare expenditures over the period from initial diagnosis of malignant cancer until death, matching benefit and comparison group members on length of illness.

  This model defines clinically meaningful episodes, with well-articulated start and end dates, and incorporates directly a variable (length of the terminal illness) that many have viewed as an important covariate in the hospice enrollment

decision. However, it was not considered to be a practical choice for this evaluation, because clinically valid dates of the initial diagnosis were not available.

- Compare expenditures over fixed, standardized periods before death for both hospice and comparison patients.

  This model, used for similar purposes in the National Hospice Study, was selected for the hospice benefit evaluation. It is a reasonable choice that concedes the difficulty of defining a starting point for comparing expenditures of hospice and nonhospice patients. Entry into the hospice, or enrollment in the benefit in this case, marks the obvious beginning of an "episode." No similar starting point can be defined for comparison patients. Therefore, defining time by months before death permits standardized comparisons of expenditures within a time frame.

Estimates of net costs of the benefit in this evaluation were based on differences in Medicare Part A–reimbursed expenditures of hospice benefit enrollees (including both benefit and regular Part A expenditures) and expenditures of comparison group members living in counties with certified hospices over the last seven months of life (the maximum benefit period during the study), adjusted statistically for patient and program characteristics. To define net expenditures relative to the timing of enrollment, separate estimates were generated for the last (seventh) month, the second-to-last month (sixth), and earlier months through the first month before death. Comparison group members were contrasted to hospice enrollees categorized by length of enrollment. Separate monthly expenditure estimates were computed for each enrollment cohort.

For example, the final month's expenditures of those hospice beneficiaries enrolled for one month or less were compared to expenditures of those comparison group members who had been diagnosed with cancer at least one month or more before death. Seven separate estimates were generated for the final month. In each, data were pooled from cancer-diagnosed comparison group members and hospice beneficiaries in one of the seven length-of-enrollment cohorts. Data used in estimates for the second month before death excluded comparison group members whose first cancer claim appeared within the last two months of life. Estimates for the second month were similarly generated separately for the seven benefit enrollment cohorts. Altogether, 28 separate ordinary least squares (OLS) regression estimates were computed, for each length-of-enrollment and month-before-death combi-

nation. The adjustment regressions were specified in the following general form:

$$Y_{11}^{i} = B_{i} + B_{2}(H)_{11}^{i} + B_{3}(T)_{11}^{i} + B_{4}(H*T)_{11}^{i} + B_{5}(X)_{11}^{i} + B_{6}(C)_{11}^{i} + B_{7}(E)_{11}^{i} + e_{11}^{i}$$

where

Y is monthly Medicare Part A expenditures.

H (= 0,1) is a categorical indicator of enrollment in the Medicare hospice benefit.

X denotes variables included to adjust for confounding influences and selection bias using beneficiary data, including:

Demographic (age, gender) variables;

Medical diagnosis variables (colon, lung, breast, prostate, urinary, leukemia and "other" cancers);

Indicators of prior utilization (one or more Medicare inpatient or home health claims in two periods, 8–12 and 13–18 months before death, as categorical variables), and the total reimbursements paid in these periods for beneficiaries with prior utilization; and

Measures of access to certified hospice programs,[4] include:

C (= 0,1), which measures whether or not a beneficiary lives in a county with at least one certified hospice;

E, which measures the intensity of exposure to the Medicare hospice benefit, defined as the sum of the total days in operation of all certified hospices in the county, measured from the initial date of certification.

T (0 = 1985, 1 = 1986) is a categorical time indicator.[5]

Bs are regression coefficients, and e is a random error term; i indexes the observation.

Subscripts denote the month and length-of-enrollment cohort—in this instance, the last month of life (month 1), in which hospice patients with benefit enrollments of one month or less (cohort 1) are pooled with comparison group members with initial cancer claims before one month.

The benefit "effect," defined as the difference in average patient mix-adjusted expenditures between benefit and comparison groups with equal access to certified hospice care in the last month of life is B_2

in 1985 and $B_2 + B_4$ in 1986. Table 3 presents the regression through which the effect for the cohort enrolled one month or less was estimated. The regression model shown here had low explanatory power, with an adjusted R-square statistic of .0242. None of the 28 estimated regressions explained more than 5 percent of total variation in monthly expenditure. Given the paucity of independent variables, this result, though disappointing, was not unexpected. Similar results from similar data were obtained in the National Hospice Study.

Hospice benefit enrollment was clearly associated with a net cost saving for this cohort. The hospice coefficient was negative, as hypothesized, and highly significant. In 1985, expenditures on terminally ill patients with and without one month or less of the hospice benefit differed by roughly $942 (within an estimated range from $849 to $1,034) in the last month of life. Estimated savings remained at this level in 1986 (the coefficient of hospice interacted with time was statistically insignificant).

Age was positively correlated with expenditure, at a decreasing rate. The included cancer groups, excepting leukemia, were generally less costly on average than the excluded group ("other" cancers).

Estimates of access effects suggest that average costs of caring for both benefit and comparison group members were higher in counties with certified hospices than in other areas. This finding is supported by evidence on Medicare reimbursements for terminally ill cancer care *before* the hospice benefit was implemented in 1983. Total average Medicare charges per case in 1983 were $7,913 in counties that subsequently gained certified hospices; $7,397 in counties with noncertified hospices; and $5,904 in counties with no hospice programs (Medicare Hospice Benefit Program Evaluation 1986). Counties with certified hospices tended to be more urbanized, with more sophisticated and complex health care systems than the average.

Patients who used inpatient services before their last seven months of life incurred lower expenditures in the last month, as the highly significant, negative coefficient estimates in Table 3 suggest. Prior utilization measures were included to help adjust for factors assumed to be related to the enrollment decision.

In addition to estimates of average benefit effects, regressions were estimated to demonstrate the influence of hospice *type* on expenditure differentials. For this study, hospice types were defined by affiliation with a Medicare-certified provider. Some certified hospices are affiliated with home health agencies, hospitals or, less frequently, skilled nursing facilities (SNFs). Freestanding hospices have no separate affiliation. This typology was chosen to conform to Medicare

Table 3: Total Expenditures Regression Last Month of Life*

Explanatory Variable	*Coefficient*	*Standard Error*	t-*Statistic*
Intercept	2388.90	1194.41	2.00
Hospice Beneficiary (Yes = 1)	-941.69	92.33	-10.20
Died in 1986 (Yes = 1)	75.53	77.40	0.98
Hospice/Died in 1986	-162.65	109.20	-1.49
Gender (Female = 1)	48.79	55.38	0.88
Age at death	64.12	32.16	1.99
Age-squared	-0.56	0.22	-2.58
Colon cancer	-93.32	72.60	-1.29
Lung cancer	-237.64	73.93	-3.21
Breast cancer	-495.08	136.35	-3.63
Prostate cancer	-407.26	97.00	-4.20
Urinary cancer	-96.10	135.48	-0.71
Leukemia	639.71	168.34	3.80
Total certified hospice days in county	0.08	0.04	2.07
Live in certified county (Yes = 1)	437.27	79.24	5.52
Part A inpatient services 8-12 months before death (Yes = 1)	-410.28	77.88	-5.27
Part A inpatient reimbursement 8-12 months before death	0.03	0.01	2.97
Part A inpatient services 13-18 months before death (Yes = 1)	-343.05	82.52	-4.16
Part A inpatient reimbursement 13-18 months before death	0.04	0.01	3.67
Part A home health services 8-12 months before death (Yes = 1)	-274.01	123.52	-2.22
Part A home health reimbursement 8-12 months before death	0.20	0.09	2.18
Part A home health services 13-18 months before death (Yes = 1)	203.38	143.18	1.42
Part A home health reimbursement 13-18 months before death	0.11	0.10	1.11
N = 16,218			
F-value = 19.25			
R^2 = 0.026			
$\bar{R}^2$ = 0.024			

*Estimated on pooled data: hospice beneficiaries with lengths of enrollment of 30 days or less, and all comparison group members.

APPENDIX S (7)

practice. It does not map readily into typologies used in earlier research. In particular, provider affiliation is not conclusive evidence of how inpatient services are arranged, even though it was the criterion used in the National Hospice Study model. However, it is reasonable to hypothesize that freestanding and home health agency–affiliated hospices, with no direct institutional commitments to fill beds, would be less likely to care for their patients in institutional settings than hospices affiliated with hospitals or nursing homes.

FINDINGS

ADJUSTED ESTIMATES OF NET EXPENDITURE EFFECTS

After adjusting for demographic, medical, and program-related influences, hospice beneficiary expenditures in the last month of life were significantly lower than expenditures of the comparison group for six out of seven length-of-enrollment cohorts. In Table 4, regression coefficient estimates are converted into ratios of comparison group to hospice benefit expenditures adjusted to a common set of beneficiary characteristics. The ratios can be interpreted as dollars saved (in reduced expenditures on a nonbenefit patient) for every dollar spent (on a hospice beneficiary), and they range, in the last month, from \$0.93 (an apparent net cost, based on statistically insignificant coefficient estimates) to \$3.77 (for the few hospice beneficiaries with enrollments between six and seven months).

Earlier months show no clear evidence of a hospice benefit expenditure advantage. For example, hospice enrollment of a Medicare beneficiary three months before death produced a savings ratio of \$1.48 in the last month of life but added expenditure in months 2 (\$0.91) and 3 (\$0.73). Lengths of enrollment over three months were not "cost effective" for Medicare, as the last line in Table 4 shows, except, possibly, for the longest enrollment cohort.

Overall, however, these findings suggest that the benefit did save Medicare expenditures. A weighted sum of savings ratios across all length-of-enrollment and month cells yields an average expenditure ratio of \$1.26. Even though the benefit adds Medicare expenditures over long enrollment periods, this bottom-line calculation of savings for Medicare reflects the fact that most participants were enrolled in the benefit for one month or less, the period of maximum saving. The average length of benefit enrollment barely exceeded 30 days (32 days

Table 4: Adjusted† Medicare Reimbursement Saved per Dollar of Hospice Expenditure by Length of Enrollment and Month

	Length of Enrollment‡						
	<1 Month	*30–59 Days*	*60–89 Days*	*90–119 Days*	*120–149 Days*	*150–179 Days*	*180–209 Days*
Last month of life	1.32*	1.49*	1.48*	1.42*	1.50*	0.93	3.77*
Month 2		0.82*	0.91	0.88	0.88	0.67	1.35
Month 3			0.73*	0.72	0.71	0.61	0.86
Month 4				0.84	0.71	0.46	0.73
Month 5					0.83	0.65	0.61
Month 6						0.92	0.56
Month 7							0.75
Total for all months after hospice entry	1.32*	1.14*	1.04	0.99	0.96	0.72*	1.06*

Source: AAI/HCFA Hospice Benefit Monthly File.

*Ratio is significantly different from 1 at 10 percent level of significance or better.

†Adjustment for demographic factors and medical condition, through multivariate regression.

‡Comparison patients' enrollment cohort is determined by the date of the first cancer diagnosis. For example, patient's diagnosed 80 days before death would be included in estimates reported in the first three columns, since they could have been enrolled for any of those periods. Hospice patients are included only in the column in which their actual enrollment falls. The savings ratio is the ratio of comparison to hospice mean reimbursement.

Table 5: Adjusted* Medicare Reimbursement Saved per Dollar of Hospice Expenditure in the Last Month of Life in Certified Hospice Counties by Length of Enrollment and Hospice Type (1986)

	Hospice Type		
Length of Enrollment	*Freestanding*	*Home Health Agency-Based*	*Hospital/Skilled Nursing Facility-Based*
<30 days	1.45	1.04	0.94
30-59 days	1.59	1.19	1.09
60-89 days	1.63	1.13	1.15
90-119 days	2.71	0.78	0.82
120-149 days	3.24	1.03	0.79
150-179 days	0.38	4.55	2.07
180-209 days	0.76	2.92	2.92

Source: AAI/HCFA Hospice Benefit Monthly File.

*Adjustment for demographic factors and medical condition, through multivariate regression.

in 1985 and 35 days in 1986), with a median stay of around 20 days in both years.

EXPENDITURES BY HOSPICE TYPE

Medicare expenditures for beneficiaries in freestanding hospices were generally lower than in hospices affiliated with "traditional" providers. As shown in Table 5, average adjusted expenditure ratios in the last month of life during 1986 ranged from $1.45 in freestanding hospices to $0.94 in programs affiliated with hospitals and skilled nursing facilities. The benefit barely broke even in home health agency-based hospices, with a ratio of $1.04.

As in the National Hospice Study, provider type, inpatient utilization, and the net expenditure advantage of hospice care were closely associated. Hospital-based and SNF-based hospice beneficiaries used more inpatient services than beneficiaries in freestanding and home health agency-based programs. As Table 6 shows, 24 percent of hospice beneficiaries used general inpatient services after enrollment in 1986. In freestanding programs, only 19 percent used any inpatient care. Fifty-eight percent of the beneficiaries in SNF-based programs used inpatient services. Levels of inpatient utilization varied by provider type as well. In freestanding hospices, 10 percent of all hospice days were billed as general inpatient or inpatient respite care. SNF-based hospices averaged 28 percent. Finally, a minority of all hospice

Table 6: Medicare Hospice Benefit Inpatient Utilization by Hospice Type (1986)

	All (N = 10,510)	*Freestanding (N = 6,137)*	*Hospital-Based (N = 1,681)*	*Skilled Nursing Facility-Based (N = 190)*	*Home Health Agency-Based (N = 2,502)*
Percent using inpatient services	24	19	37	58	25
Percent using only inpatient services	7	6	10	17	7
Percent inpatient to total benefit days					
All patients	12	10	18	28	13
Patients with inpatient utilization	49	52	44	48	48

Source: AAI/HCFA Hospice Benefit Utilization File.

beneficiaries (7 percent on average) used *only* inpatient services while enrolled. Again, the percentage was lowest in freestanding hospices, averaging 6 percent, and highest in SNF-based hospices, averaging 17 percent.

DISCUSSION

THE EXPENDITURE EFFECT AND THE ROLE OF SELECTION BIAS

In transition from a movement to an industry, hospice has continued to emphasize home care in the very last weeks of life, a practice closely associated with the "savings" researchers have attributed to the hospice intervention. The benefit seems to have reinforced this pattern. In the hospice benefit evaluation, adjusted expenditure estimates showed a hospice benefit "effect," in terms of lower Part A expenditures in the last seven months of life for Medicare hospice beneficiaries relative to a nonbenefit comparison group. The effect was pronounced for beneficiaries in freestanding hospices.

Efforts were made, within the constraints imposed by the research design and the available data, to control for self-selection bias through careful sampling techniques and statistical adjustment. These efforts were bound to be partially successful at best, given the available data.

Despite the plausibility of the selection argument, it is prudent to remain skeptical about the direction of selection effects relative to predisposing variables, such as "length of illness," "preference for home care," or "strength of informal supports." Evidence from the evaluation suggests that benefit enrollees were terminally ill and heavy users of health services longer than the average nonbenefit patient. Benefit enrollees apparently had more time to experience the frustration of curative therapies and to weigh the alternatives than did individuals who died soon after diagnosis.

However, careful research shows no evidence that those who elect hospice or the Medicare hospice benefit are predisposed toward home care, whatever their utilization patterns become once enrolled. More important, there is no evidence that, whatever the preferences of hospice benefit enrollees for dying at home, these preferences can be realized inexpensively and without the hospice intervention. The standard selection argument assumes that hospice can truly succeed only with certain highly motivated and well-supported patients. However, at least some of these patients may be able to achieve their goals only with the help of hospice care. Data from the hospice benefit evaluation

show that hospice programs were remarkably successful in maintaining their patients at home until death. Most hospice beneficiaries (88 percent) died at home, whereas most comparison patients (63 percent) died in a hospital.[6] Moinpour and Polissar (1989) note that hospice was a statistically significant and positive influence on the probability of dying at home, and that the strength of the hospice effect increased the shorter the time from diagnosis (of terminal cancer) to death.

Without hospice or the benefit, many potential hospice users and their families, already burdened by a long and draining illness, might surrender and accept institutionalization in the last weeks, forgoing their intentions for death at home. Further research is needed to define the effectiveness of the hospice intervention and benefit coverage for patients with varied attitudes toward care, prior medical histories, and informal support networks.

The Role of Hospice Type

Some types of hospice appear to have been more successful than others in caring for patients at home. This success generates lower expenditures, under both cost-based reimbursement systems of the kind implemented in the National Hospice Study and prospective payment through the Medicare hospice benefit. Freestanding and home health agency-based certified hospices emphasized a home-oriented care regime, as did home care-based hospices in the National Hospice Study. Affiliation was the distinguishing feature in both instances. Home orientation was associated with no affiliation or affiliation with traditional providers *without* beds. However, the extent to which expenditure differentials relate to practice patterns as opposed to patient mix is still unclear.

Part of the confusion rests on lack of consistency in the typologies used in different studies. More research into hospice provider decision making and organizational behavior could help clarify the reasons why affiliation or the nature of arrangements to provide inpatient care affect average expenditure levels.

The role of patient mix in explaining variations in expenditures among hospice types is also poorly understood. Patient-mix differences clearly exist. The National Hospice Study showed that the percentage of hospice patients who lived alone was higher among those admitted to hospices with inpatient capacity: 15.4 percent compared to 5.4 percent in hospices without beds (Mor, Greer, and Kastenbaum 1988, 115). However, effects on expenditures of those variables that capture care resource needs appear to vary over a hospice episode. The National

Hospice Study also found that the needs of terminally ill patients for relief of physical pain and other symptoms tended to converge near death, regardless of the underlying medical condition. Further research is needed, both to define consistent and meaningful hospice typologies and to separate provider practice patterns from patient-mix influences on expenditures.

Future Net Expenditure Effects of the Benefit

In spite of the evidence presented in this article, the hospice benefit is unlikely to be an important tool for containing the costs of terminally ill Medicare beneficiaries. Since the benefit was implemented, Congress has raised payment rates twice, most recently (in the Omnibus Budget Reconciliation Act of 1989) in across-the-board increases of 20 percent in all rates. In addition, Congress has reinstated the unlimited benefit period created in the Medicare Catastrophic Coverage Act. The benefit clearly adds Medicare expenditure the longer a beneficiary remains enrolled.

Forces at work within the hospice establishment should also generate inflationary pressure. Although no more than a third of all U.S. hospices were certified during the evaluation period, rate increases and other regulatory changes have stimulated growth: certified hospices now constitute nearly half of all active U.S. hospice programs (Davis 1991). Further growth seems likely. The General Accounting Office (1989, 43), reporting on a survey of certified and noncertified hospices, noted that inadequacy of the general inpatient and routine home care reimbursement rates ranked first of 27 items of concern among respondents in 1987. Newly certified hospices, attracted by more generous rates, will come increasingly from areas formerly unserved or served only by noncertified programs. The hospice benefit evaluation showed that the expenditure-reducing effects of the benefit would be attenuated in these areas, which tend to have lower average costs of medical care, than in areas already served by certified hospices.

Preliminary evidence suggests that lengths of enrollment have risen steadily, and that they should rise at a more rapid rate after full implementation of the unlimited benefit period. The analyses reported in this article show that longer average enrollment periods work against cost savings through the benefit.

Issues for Further Study

The success of the Medicare hospice benefit may eventually be judged on grounds other than cost. Even if the benefit does increase Medicare

expenditure, the program will not, under any reasonable assumptions about the pool of eligible (and interested) beneficiaries, expand to become a significant drain on federal funds in the near future. Although the hospice benefit enlarges the selection of care options open to Medicare beneficiaries, most terminally ill beneficiaries continue to select traditional modalities over hospice care.

Access to hospice and to the hospice benefit is a concern that merits attention. Terminally ill hospice applicants may face barriers related to medical condition and socioeconomic status. Cancer remains the dominant condition in hospice programs. Benefit enrollment must be preceded by a physician's determination that the applicant has at most six months to live. Many physicians seem willing to render this prognosis for certain cancers, but not for other life-threatening conditions. In addition, hospice professionals increasingly see hospice care as terminal *cancer* care, as a casual review of the trade journals shows.

Nonwhite beneficiaries are underrepresented in certified hospices relative to their numbers among terminally ill Medicare beneficiaries. Access to hospice and to the hospice benefit may be constrained more by inequalities in the use of primary- and secondary-level medical services than by specific barriers associated with hospice eligibility criteria or location. Farley and Flannery (1989) note a relationship between the socioeconomic status (SES), stage of disease at diagnosis, and utilization of early detection (mammography utilization among women diagnosed with breast cancer). They argue that racial differences in late-stage breast cancer diagnosis disappear after controlling for SES. The relatively high rate of late-stage diagnosis among African-American women is related to a lower average SES in this group. These authors conclude that knowledge (of the availability of mammography) and attitudes (regarding the need for and effectiveness of mammography) are important correlates of utilization. However, whether attitudes are shaped by real or perceived barriers to health care access or by other influences remains unclear.

Quality of service also merits study, in the context of a benefit that implements powerful incentives to provide care to patients in the home. Although home care was the model most favored by U.S. hospices before the benefit was established, opinion on appropriate practice has never been unanimous. Hospice programs in Europe developed around institutions where dying patients stayed to receive palliative care. The first major hospice program in the United States implemented an inpatient model of care. Certain patients, particularly those without adequate informal supports, may require an inpatient setting to benefit from hospice care. If these patients are denied access,

or become enrolled but are treated inappropriately at home, Congress may come under pressure to modify current incentives in the benefit so that hospice care can become a true option for all terminally ill Medicare beneficiaries.

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NOTES

1. The evaluation of the Medicare hospice benefit, conducted by Abt Associates Inc. under contract to the Health Care Financing Administration (HCFA), also reported patterns of growth in the hospice industry, and used a forecasting model to project future levels of Medicare expenditure for terminally ill beneficiaries under various assumptions. Related HCFA contracts included a study of the processes of hospice care in Medicare-certified and noncertified hospices, conducted by the Joint Commission for Accreditation of Health Care Organizations, and a study of costs, utilization, patient characteristics, and administrator attitudes toward the Medicare benefit in a sample of noncertified hospices, conducted by Jack Martin and Company.
2. Some "comparison" beneficiaries in this study may have been enrolled in noncertified hospice programs when they died. Medicare claims do not identify such individuals as hospice patients, because hospices are identified as such on a claim only if they have been certified to provide services under the Medicare benefit. Therefore, the contrasts in this article are between benefit and "nonbenefit" cases, rather than between hospice and "traditional" care.
3. Those who elect the hospice benefit are required to give up their regular Part A coverage for care related to the terminal condition. However, many enrollees incur some regular Part A–reimbursed expenditures after enrollment, presumably for "unrelated" care. Enrollees do not have to surrender their Part B coverage. They may receive benefit-reimbursed (Part A) physician services from a physician on staff of the hospice provider. Alternatively, they may continue to receive Part B–reimbursable services from

their own physicians. Although the evaluation compared total Part B expenditures for beneficiaries and comparison group members who died in 1985, the data were not available in sufficient detail for integration into the adjusted expenditure analyses. Further, the benefit was designed to substitute for regular Part A coverage of expensive inpatient services.

4. No reliable measures of area exposure to certified or noncertified hospice services are available, because information needed to date program startup is missing in all current provider lists. Even if the date of certification were known, some ambiguity would exist about what constitutes exposure to the benefit. Many hospices gained certification but did not enroll any beneficiaries or submit hospice benefit claims for several months.
5. Data for federal fiscal year 1984 were collected and analyzed in the first annual report of the evaluation. However, they were excluded from the analyses presented in this article, to minimize the effects of data idiosyncracies in the early implementation period.
6. In the absence of information from death certificates or other reliable sources, place of death was inferred from claims data. For comparison group members, if the final date on the individual's last inpatient claim was within two days of the date of death, place of death was assumed to be the hospital. For hospice beneficiaries, if all or all but one of the days covered by the final claim under the benefit was reimbursed at general inpatient or inpatient respite rates, the beneficiary was assumed to have died as an inpatient.

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APPENDIX S (7)

Timing of referral to hospice and quality of care: length of stay and bereaved family members' perceptions of the timing of hospice referral

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Abstract

Previous research has noted that many persons are referred to hospice in the last days of life. The National Hospice and Palliative Care Organization collaborated with Brown Medical School to create the Family Evaluation of Hospice Care (FEHC) data repository. In 2005, 106,514 surveys from 631 hospices were submitted with complete data on the hospice length of stay and bereaved family member perceptions of the timing of hospice care. Of these surveys, 11.4% of family members believed that they were referred "too late" to hospice. This varied from 0 to 28.1% among the participating hospice programs with 30 or more surveys. Among those with hospice lengths of stay of less than a month, only 16.2% reported they were referred "too late." Although the bereaved family member perceptions of the quality of end-of-life care did not vary by length of stay for each of the FEHC domains, the perception of being referred "too late" was associated with more unmet needs, higher reported concerns, and lower satisfaction. Our results suggest that family members' perception of the timing of hospice referral-not the length of stay-is associated with the quality of hospice care. This perception varies substantially among the participating hospice programs. Future research is needed to understand this variation and how hospice programs are delivering high quality of care despite short length of stay

JAMA Health Forum™

Original Investigation

Association Between Hospice Enrollment and Total Health Care Costs for Insurers and Families, 2002-2018

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Abstract

IMPORTANCE Use of hospice has been demonstrated to be cost saving to the Medicare program and yet the extent to which hospice saves money across all payers, including whether it shifts costs to families, is unknown.

OBJECTIVE To estimate the association between hospice use and total health care costs including family out-of-pocket health care spending.

DESIGN, SETTING, AND PARTICIPANTS This retrospective cohort study of health care spending in the last 6 months of life used data from the nationally representative Medicare Current Beneficiary Survey (MCBS) between the years 2002 and 2018. Participants were MCBS participants who resided in the community and died between 2002 and 2018.

EXPOSURES Covariate balancing propensity scores were used to compare participants who used hospice (n = 2113) and those who did not (n = 3351), stratified by duration of hospice use.

MAIN OUTCOMES AND MEASURES Total health care expenditures were measured across payers (family out-of-pocket, Medicare, Medicare Advantage, Medicaid, private insurance, private health maintenance organizations, Veteran's Administration, and other) and by expenditure type (inpatient care, outpatient care, medical visits, skilled nursing, home health, hospice, durable medical equipment, and prescription drugs).

RESULTS The study population included 5464 decedents (mean age 78.7 years; 48% female) and 38% enrolled with hospice. Total health care expenditures were lower for those who used hospice compared with propensity score weighted non-hospice control participants for the last 3 days of life ($2813 lower; 95% CI, $2396-$3230); last week of life ($6806 lower; 95% CI, $6261-$7350); last 2 weeks of life ($8785 lower; 95% CI, $7971-$9600); last month of life ($11 747 lower; 95% CI, $10 072-$13 422); and last 3 months of life ($10 908 lower; 95% CI, $7283-$14 533). Family out-of-pocket expenditures were lower for hospice enrollees in the last 3 days of life ($71; 95% CI, $43-$100); last week of life ($216; 95% CI, $175-$256); last 2 weeks of life ($265; 95% CI, $149-$382); and last month of life ($670; 95% CI, $530-$811) compared with those who did not use hospice. Health care savings were associated with reductions in inpatient care.

CONCLUSIONS AND RELEVANCE In this population-based cohort study of community-dwelling Medicare beneficiaries, hospice enrollment was associated with lower total health care costs for the last 3 days to 3 months of life. Importantly, we found no evidence of cost shifting from Medicare to families related to hospice enrollment. The magnitude of lower out-of-pocket spending to families who enrolled with hospice is meaningful to many Americans, particularly those with lower socioeconomic status.

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Key Points

Question Does hospice enrollment save money across all payers including families and does hospice shift costs from Medicare to families?

Findings In this cohort study, hospice use by community-dwelling Medicare beneficiaries was associated with significantly lower total health care costs across all payers in the last 3 days to last 3 months of life. We found no evidence of cost shifting from Medicare to families and families had significantly lower out-of-pocket health care costs in the last 3 days to last month of life when patients enrolled with hospice.

Meaning The findings of this study suggest that hospice care is associated with financial benefits to the health care system and families through lower health care costs at the end of life.

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

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Introduction

Hospice has expanded to become the dominant model of home care for those with terminal illness and their families. Use of hospice has risen in the past 2 decades from 10% to 50%[1] of Medicare decedents concurrent with the rise of in-home death and is considered to be an indicator of high-quality end-of-life care.[2,3] Hospice is a comprehensive model of care that focuses on quality of life and provides an alternative to burdensome interventions.

Evidence from the early 2000s demonstrated that hospice was cost saving to the Medicare program.[4-7] From 2002 to 2008, hospice use was found to save Medicare money across a range of hospice enrollment durations primarily owing to lower rates of hospital admission and in-hospital death for hospice users. Given that intensity of care at the end of life (outside of hospice) continues to rise,[2,3,8,9] the cost savings to Medicare from hospice enrollment are likely even higher today.

A critical gap in this evidence, however, is how hospice use affects total health care costs, across all payers, including spending by patients and families. Use of hospice may shift economic burden onto families through higher out-of-pocket spending that may be required to care for patients at home. To the extent that hospice is not meeting patient needs adequately, families may face increased pressure to pay for supplemental care, services, medication, or other health care expenditures as has been found outside the hospice setting.[2,10-13] The financial burden of family caregiving for hospice enrollees may be particularly high for patients with prolonged and substantial personal care needs (ie, those with advanced heart or lung disease or with dementia) and out-of-pocket expenditures for these populations can be substantial.[14-18] Nevertheless, we know little about the drivers of costs to families of those at the end of life and whether hospice use provides health care savings in total, or merely shifts the financial burden from Medicare to families.

To address these questions, we used the Medicare Current Beneficiary Survey (MCBS), a nationally representative survey of Medicare beneficiaries, linked to Medicare administrative and claims data. We estimated total health care spending by payer (including family out-of-pocket, Medicare, Medicare Advantage, Medicaid, private insurance, private health maintenance organizations (HMOs), Veteran's Administration, and other) at the end of life for hospice decedents compared with matched decedents who did not receive hospice. We estimated family health care spending using validated self-report of out-of-pocket spending. As hospice use increases and health care continues to shift from the hospital to community settings, the effect on family finances needs to be understood.

Methods

Study Population

We conducted a retrospective cohort study using data from the MCBS from 2002 through 2018. These data exclude survey results from 2014, which were not released by Centers for Medicare & Medicaid Services. The MCBS sample is representative of the Medicare population by age group with oversampling for the oldest old (85 and over), and includes Medicare Advantage enrollees. Of 9118 decedents, 8813 had spending data. We excluded individuals in nursing homes (n = 3059), as our focus is on community-based hospice use. We also excluded those who disenrolled from hospice prior to death (n = 290) because our outcomes are cumulative spending retrospectively from death and assignment to hospice vs no hospice for such individuals is not clear. Our final sample consisted of 5464 MCBS participants living in the community who died between 2002 and 2018 (eTable 1 in the Supplement). The Mount Sinai Institutional Review Board determined that this study was exempt secondary research for which patient informed consent was not required.

Measures

Medicare Current Beneficiary Survey surveys are conducted in person, 3 times per year. All measures are self- or proxy-reported. The response rate for the MCBS in 2018 was 65.4%.[19] All measured

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variables are as of an individual's last MCBS interview date prior to death or the after-death proxy interview, which occurred an average of 69.6 days following death. We measured age at death, sex, education (college degree or less than college degree), marital status (married, not married), Medicaid coverage (yes/no), metropolitan area, and census region. Race was self-reported and categorized in MCBS as American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, and White. Ethnicity was self-reported and categorized as Hispanic (yes/no). We categorized race and ethnicity as Hispanic, Non-Hispanic Black, Non-Hispanic White, and Other/multiracial. We identified medical conditions using self-report of having ever had the illness and claims data diagnostic codes for heart disease, stroke, lung disease, cancer, and diabetes. For dementia, we used an inclusive case definition developed for use with MCBS data.[20] We measured functional status based on self- or proxy-reported difficulty with 3 or more basic activities of daily living (ADLs): walking, feeding, dressing, toileting, bathing, and transferring.

We categorized hospice decedents by mutually exclusive periods of hospice enrollment based on the number of days prior to death that enrollment occurred, as follows: 0 to 7 days, 8 to 14 days, 15 to 28 days, 29 to 91 days, 92 to 182 days, and more than 182 days.

We measured total health care spending as the sum of family out-of-pocket, Medicare, Medicare Advantage, Medicaid, private insurance, private HMOs, Veteran's Administration, and other. The MCBS team employs numerous strategies to improve the accuracy of self-reported spending data. Respondents are requested to record medical events on calendars provided by the interviewer and to save Explanation of Benefit forms from Medicare and receipts and statements from Medicaid and other public or private health insurers. To assist in reporting data on prescription medications, respondents are asked to bring to the interview bottles, tubes, and prescription bags provided by the pharmacy. All health care services paid for by Medicare are verified through linkage with Medicare claims.[21] Family health care spending includes insurance deductibles, copays, prescription drugs, over-the-counter medications, medical devices and equipment, private duty nurses, social workers, and therapists. Expenditures were measured for the last 3 days, 1 week, 2 weeks, 1 month, 3 months, and 6 months of life. All costs were adjusted for inflation using the medical care component of the Consumer Price Index to 2018 dollars.

Statistical Analysis

For each hospice enrollment period, we estimated covariate balancing propensity scores (CBPS)[22] to estimate each decedent's likelihood of hospice enrollment during the specified period (last 7, 8-14, 15-28, 29-91, 92-182, and >182 days of life). Variables in the CBPS were age, dementia, cancer, help with 3 or more ADLs, and region. Standardized differences are shown in eTable 2 in the Supplement. We used the CBPS-type weight in conjunction with the MCBS survey weights in all analytic comparisons.[22] We used generalized linear models (GLMs) with a gamma distribution and log link function to analyze health care expenditures, adjusting for age, sex, race and ethnicity, education, marital status, survey year, Medicaid status, census region, metropolitan area, serious illness, and help with 3 or more ADLs. Decedents missing 1 or more covariates (n = 644) and were excluded from the analytic sample. We report the adjusted mean health care spending between groups of hospice enrollees and non-hospice control participants. We conducted sensitivity analyses stratifying by year of death (2002-2009 and 2010-2018) and including individuals who disenrolled from hospice in the hospice group.

Results

The study population included 5464 community-dwelling decedents with mean age of 78.7 years at death representing 20 961 442 million Medicare beneficiary decedents. A total of 48% were female, 77.8% were non-Hispanic White, and 53.6% received help with 3 or more ADLs (**Table 1**). A total of 2113 (37.9%) decedents enrolled with hospice (median 12 days, mean 36 [SD 119] days). Hospice use by year is in eTable 3 in the Supplement.

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Total Health Care Cost Savings Associated With Hospice Use

Mean total (SD) health care costs in the last 3 days of life, week of life, 2 weeks of life, month of life, 3 months of life, and 6 months of life were $3879 ($6722), $7073 ($10 682), $10 874 ($15 331), $17 929 ($24 132), $29 048 ($36 916), and $40 843 ($46 747), respectively. Individuals who used hospice incurred significantly lower health care costs for the last 3 days of life ($2813 lower; 95% CI, $2396-$3230); last week of life ($6806 lower; 95% CI, $6261-$7350); last 2 weeks of life ($8785 lower; 95% CI, $7971-$9600); last month of life ($11 747 lower; 95% CI, $10 072-$13 422); and last 3 months of life ($10 908 lower; 95% CI, $7283-$14 533) compared with those who did not use hospice (**Table 2**). There was no significant difference in health care costs in the last 6 months of life between those who used hospice and those who did not. Health care cost savings for those who used hospice were driven by statistically significant reductions in expenditures for inpatient care ($3476 lower in the last 3 days of life; $7404 lower in the last week of life; $10 365 lower in the last 2 weeks of life; $14 175 lower in the last month of life; $21 047 lower in the last 3 months of life; and $24 953 lower in the last 6 months of life) (**Figure 1**). For each comparison group, differences in inpatient care were most apparent in the last week of life. Sensitivity analyses including individuals who disenrolled from hospice prior to death in the hospice group (eTable 4 in the Supplement) and stratifying by year of death (2002-2009 and 2010-2018) yielded similar results (eTable 5 in the Supplement).

Family Out-of-Pocket Health Care Cost Savings Associated With Hospice Use

Family out-of-pocket mean (SD) health care costs in the last 3 days of life, week of life, 2 weeks of life, month of life, 3 months of life, and 6 months of life were $106 ($521), $222 ($946), $388 ($1233), $883 ($2273), $1893 ($4185), and $3276 ($7097), respectively. Out-of-pocket spending in the last 3 days of life, last week of life, last 2 weeks of life, and last month of life were highest for inpatient care

Table 1. Characteristics of Medicare Decedents, 2002-2018[a]

Characteristic	% Total (N = 5464)	Decedents who used hospice (n = 2113)	Decedents who did not use hospice (n = 3351)	*P* value
Age, mean (SD), y	78.7 (10.9)	81.2 (10.5)	77.1 (11.2)	<.001
Race/ethnicity				.001
Hispanic	6.5	6.3	6.5	
Non-Hispanic				
Black	10.2	7.6	11.8	
White	77.8	81.3	75.7	
Other/multiracial[b]	5.5	4.8	6.0	
Female sex	48.4	51.0	46.8	.01
Married	44.3	43.8	44.6	.59
Education: college degree	13.9	13.8	14.0	.89
Medicaid coverage	23.2	18.7	26.0	<.001
Serious illness				
Cancer	43.0	53.2	36.8	<.001
Dementia	30.4	38.4	25.5	<.001
Diabetes	35.9	32.9	37.7	.002
Heart disease	42.3	41.8	42.5	.66
Lung disease	33.1	32.2	33.7	.29
Stroke	22.7	22.4	22.8	.80
Receive help with ≥3 ADLs	53.6	62.6	48.2	<.001
Metropolitan area	76.0	80.1	73.5	.002
Region				.01
Northeast	18.4	14.6	20.7	
Midwest	23.2	25.0	22.1	
South	39.3	42.2	37.6	
West	19.1	18.2	19.6	

Abbreviation: ADLs, activities of daily living.

[a] Table depicts characteristics of the study sample prior to propensity score weighting. All percentages incorporate Medicare Current Beneficiary Survey weights and weighted values exceed 1 million.

[b] Other/Multiracial includes American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, and anyone who self-reported more than 1 race.

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and in the last 3 and 6 months of life were highest for care in non-nursing home facilities (eg, in assisted living facilities) followed by costs for prescription drugs, durable medical equipment, and inpatient care (**Figure 2**).

Decedents who used hospice incurred significantly lower out-of-pocket costs for the last 3 days ($71 lower; 95% CI, $43-$100), 1 week ($216 lower; 95% CI, $175-$256), 2 weeks ($265 lower; 95% CI, $149-$382), and 1 month ($670 lower; 95% CI, $530-$811) of life (Table 2). There was no significant difference in out-of-pocket health care costs in the last 3 or 6 months of life between those who used hospice and those who did not.

Medicare Cost Savings Associated With Hospice Use

Medicare costs in the last 3 days of life, week of life, 2 weeks of life, month of life, 3 months of life, and 6 months of life were $3187 (SD, $5902), $5785 (SD, $9169), $8910 (SD, $13 613), $14 520 (SD, $22 085), $22 798 (SD, $34 054), and $30 872 (SD, $42 742), respectively. Individuals who used

Table 2. Adjusted Health Care Expenditures at the End of Life for Individuals Enrolled With Hospice and Non-Hospice Control Individuals, 2002-2018

Characteristic	Adjusted mean, $		Difference	*P* value
	Hospice group	Propensity score weighted controls		
Total expenditures				
Last 3 d[a]	2473	5285	−2831	<.001
Last wk[b]	2106	8911	−6806	<.001
Last 2 wks[c]	4083	12 869	−8785	<.001
Last mo[d]	8558	20 305	−11 747	<.001
Last 3 mos[e]	20 908	31 816	−10 908	<.001
Last 6 mos[f]	43 679	43 357	322	.93
Family out of pocket				
Last 3 d[a]	67	139	−71	<.001
Last wk[b]	46	262	−216	<.001
Last 2 wks[c]	159	424	−265	<.001
Last mo[d]	241	912	−670	<.001
Last 3 mos[e]	2412	1763	649	.41
Last 6 mos[f]	4096	2988	1109	.55
Medicare				
Last 3 d[a]	2121	4389	−2267	<.001
Last wk[b]	2029	7337	−5308	<.001
Last 2 wks[c]	3824	10 576	−6752	<.001
Last mo[d]	7835	16 559	−8724	<.001
Last 3 mos[e]	17 523	25 250	−7727	<.001
Last 6 mos[f]	36 208	33 036	3171	.26
Private insurance				
Last 3 d[a]	90	207	−117	<.001
Last wk[b]	3	347	−345	<.001
Last 2 wks[c]	11	567	−556	<.001
Last mo[d]	52	918	−866	<.001
Last 3 mos[e]	165	1499	−1334	<.001
Last 6 mos[f]	105	2252	−2147	<.001
All other payers				
Last 3 d[a]	231	568	−337	<.001
Last wk[b]	80	992	−912	<.001
Last 2 wks[c]	64	1408	−1344	<.001
Last mo[d]	213	2175	−1962	<.001
Last 3 mos[e]	500	3518	−3018	<.001
Last 6 mos[f]	1152	5422	−4270	<.001

Abbreviation: GLM, generalized linear models.

[a] Sample sizes vary due to hospice enrollment period: hospice enrollment in the last week of life and comparison group (n = 3781).

[b] Sample sizes vary due to hospice enrollment period: hospice enrollment 8-14 days before death and comparison group (n = 3242).

[c] Sample sizes vary due to hospice enrollment period: hospice enrollment 15-28 days before death and comparison group (n = 3223).

[d] Sample sizes vary due to hospice enrollment period: hospice enrollment 29-91 days before death and comparison group (n = 3202).

[e] Sample sizes vary due to hospice enrollment period: hospice enrollment 92-182 days before death and comparison group (n = 2832).

[f] Sample sizes vary due to hospice enrollment period: hospice enrollment >182 days before death and comparison group (n = 2551).

Variables included in the covariate balancing propensity score: age, dementia, cancer, help with 3+ activities of daily living, region. Variables included in the GLM model: age, sex, race/ethnicity, education, marital status, survey year, Medicaid status, census region, census metropolitan area, serious illness (dementia, heart disease, stroke, lung disease, cancer, and diabetes), and if the respondent needed help with 3 or more activities of daily living. All other payers includes Medicare Advantage, Medicaid, private health maintenance organizations, Veteran's Administration, and other.

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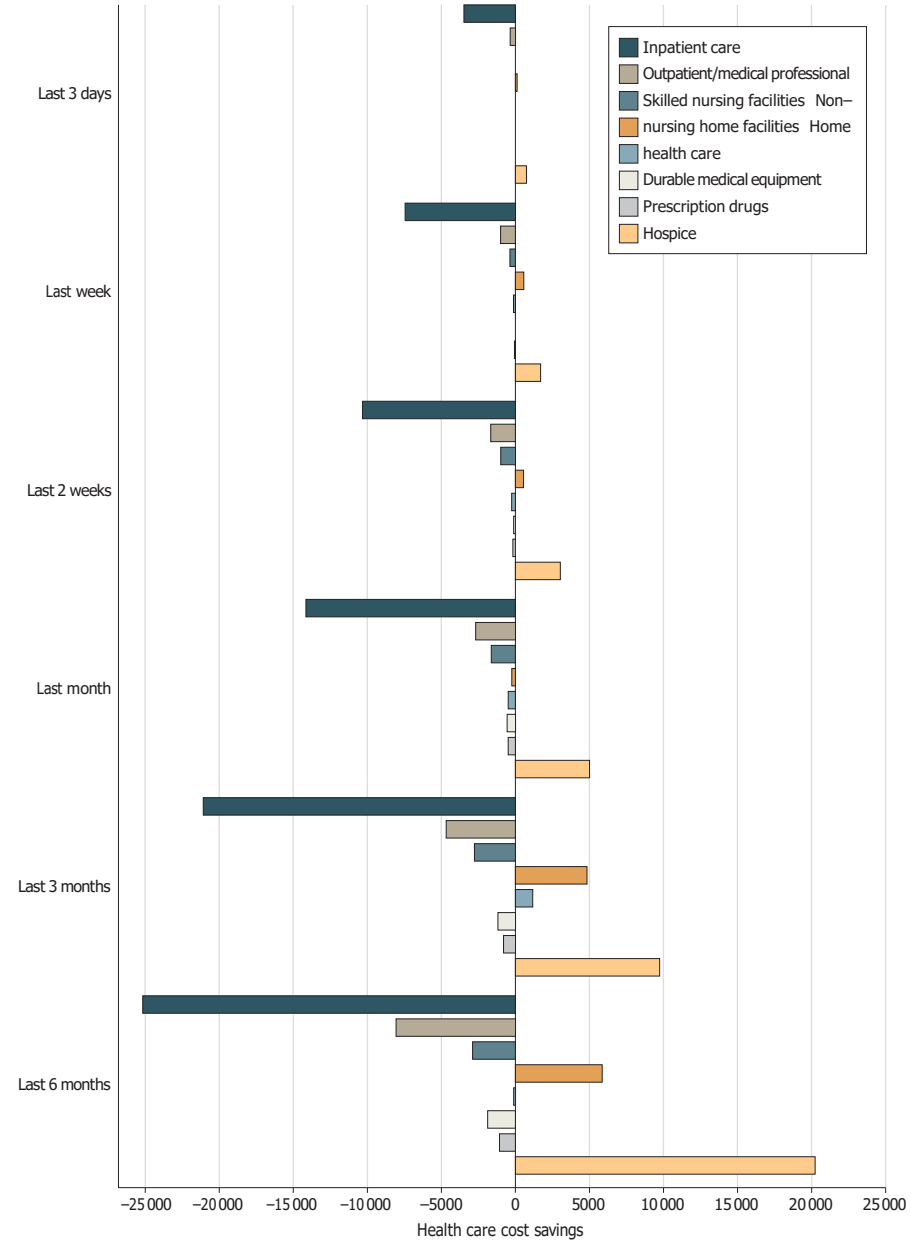
hospice incurred significantly lower Medicare costs for the last 3 days ($2267 lower; 95% CI, $1864-$2671), last week ($5308 lower; 95% CI, $4771-$5845), last 2 weeks ($6752 lower; 95% CI, $5989-$7515), 1 month ($8724 lower; 95% CI, $7135-$10 313), and 3 months ($7727 lower; 95% CI, $4721-$10 733) of life (Table 2). There was no significant difference in Medicare costs associated with hospice enrollment for the last 6 months of life.

Costs Savings Associated With Hospice Use for Private Insurance and All Other Payers

Private insurance expenditures were lower for those who enrolled with hospice compared with those who did not enroll with hospice for all periods examined (Table 2). Unlike Medicare and families, private insurance and all other payers combined (Medicare Advantage, Medicaid, private HMOs, Veteran's Administration, and other) had evidence of cost savings associated with hospice in the last

Figure 1. Adjusted Health Care Cost Savings for Individuals Enrolled With Hospice Compared With Non-Hospice Control Participants by Health Care Event, 2002-2018



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6 months of life ($2147 lower for private insurance; 95% CI, $1905-$2388; and $4270 lower for all other payers; 95% CI, $3296-$5245).

Discussion

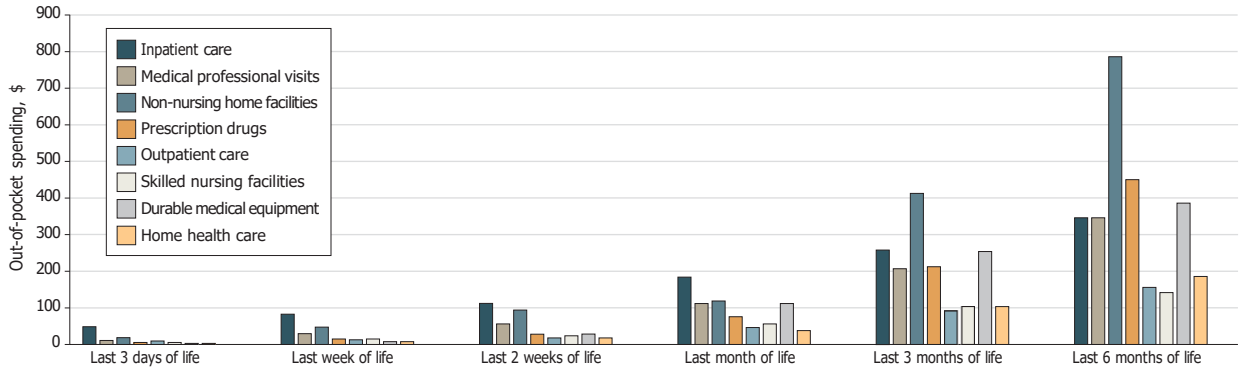
To our knowledge, this is the first examination of the association between hospice use and total health care costs across all payers. We found that hospice use was associated with lower total health care costs in the last 3 days to last 3 months of life. Given that more than 80% of community-dwelling hospice enrollees in our sample received care for 3 months or less, cost savings are attributable to the vast majority of the community-dwelling hospice population. We found no difference in total health care expenditures in the last 6 months of life associated with hospice use.

Importantly, we found that use of hospice did not shift costs from Medicare to families through higher family out-of-pocket spending. Health care costs were lower for patients and families receiving hospice for each time period examined up to 1 month prior to death compared with health care costs of patients and families who did not receive hospice. The magnitude of out-of-pocket savings owing to hospice are meaningful to many Americans, particularly those with lower socioeconomic status, including the 23% in the present study sample who were Medicaid eligible. The estimated 1-month out-of-pocket savings associated with hospice is $670, which represents roughly 20% of the monthly income of the lowest third of older adults in the US.[23] Further, the $670 estimated savings represents an almost 75% reduction in out-of-pocket costs compared with older adults who did not receive hospice care.

The present study provides new details regarding family out-of-pocket spending at the end of life. In the last month of life, families paid the highest amount in out-of-pocket health care expenses for inpatient care compared with what they spent for outpatient care, medical provider visits, prescription drugs, and other health care needs. In the last 3 months and 6 months of life, family health care spending was driven by care received in non-nursing home facilities such as assisted living facilities. Family spending for health care in these facilities averages $413 in the last 3 months of life and $789 in the last 6 months of life. These types of community-based residential settings comprise a wide range of environments with differing amounts of built-in services and high rates of hospice use.[24] The type of health care received in these settings and the financial burden for those residing there is an important emerging area of research.

Hospice was associated with lower total health care expenditures across all payers and families primarily owing to lower spending for inpatient care, consistent with prior work.[4] A primary goal of hospice is to manage pain and other symptoms in the home setting and avoid hospitalization. Exacerbations in clinical conditions can be addressed through higher levels of hospice care including continuous home care, which provides a minimum of 8 hours of licensed nursing care per day in the

Figure 2. Family Out-of-Pocket Health Care Expenditures of the Entire Study Population at the End of Life (N = 5464), 2002-2018



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home. Although use of continuous home care by hospices is more expensive to Medicare, its association with reductions in hospitalizations may be contributing to our finding of health care savings.[25]

Medicare incurred lower health care costs for all measured time periods up to 3 months prior to death for community-dwelling individuals who enrolled with hospice. Cost savings were evident even for those who only enrolled with hospice in their last week of life, which is the case for approximately 25% of all hospice users in the US.[1] Although even a single day of hospice care may be beneficial to patients and families, many advocate for patients to receive at least 2 weeks of hospice care to experience the benefits. Greater cost savings from longer enrollment align with this quality metric. For those who enroll with hospice for 6 months of more prior to death, the cost of hospice care itself offsets the reductions in inpatient spending, mostly owing to high inpatient costs that occur near the end of life.

It will be important to evaluate the effect of the 2016 hospice payment reform on Medicare hospice spending. The 2-tiered per diem payment methodology implemented in 2016 pays higher per diem amounts for the first 60 days of hospice care and lower per diem amounts for each day beyond 60 days, as well as a service intensity add-on payment for visits in the last week of life. Although this change does not effect family out-of-pocket spending or spending by insurers other than Medicare, its effect on Medicare spending, differentially across length of hospice enrollment category, is a key area for future research.

Limitations

The present study limitations include the inability to adjust for unmeasured characteristics of those who do and do not use hospice. In particular, preferences among people with serious illness, their family members, and their health care professionals are likely associated with both the exposure and outcome of interest. Given that preferences are not measured in MCBS or any of our linked data, we were unable to control for them. Although tools such as instrumental variables could help address unmeasured confounders such as preferences for care,[26] we did not identify a valid instrument in the data set. While imperfect, propensity score weighting is among the most rigorous tools available to compare groups outside of a randomized trial and it has been used in a wide range of studies to inform policy-relevant questions with observational data. Our analyses yield important, new information regarding spending at end of life across all payers, including families, in a large, population-based sample that could not otherwise be achieved for ethical and practical reasons with a randomized trial design. Second, we include only monetary costs and do not include unpaid caregiving by family members, which may be higher for those who are not receiving the interdisciplinary care of hospice teams. In addition, owing to sample size limitations, our examination of expenditures in the last 3 days of life is for hospice users who enrolled with hospice 0 to 7 days prior to death and therefore inflates the expenditures associated with hospice for those who enrolled with hospice 0 to 2 days prior to death. Despite this conservative approach, hospice use was associated with cost savings for all payers in the last 3 days of life. Finally, we are unable to account for payments that Medicare receives from hospices owing to the Hospice Aggregate Cap, which 10% to 15% of hospices incur each year.[27,28] Its inclusion would decrease estimates of Medicare spending for hospice enrollees and increase cost savings owing to hospice enrollment.

Conclusions

The findings of this cohort study suggest that hospice use is an example of a health care model that demonstrates both components of the value proposition: it improves the quality of end-of-life care and is associated with lower health care costs. Moreover, unlike many other aspects of our health care system, cost reductions to insurers in the present study did not translate into higher costs for patients and their families.

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ARTICLE INFORMATION

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Author Contributions: Dr Aldridge had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: Aldridge, Moreno, McKendrick, Brody, May.

Acquisition, analysis, or interpretation of data: All authors.

Drafting of the manuscript: All authors.

Critical revision of the manuscript for important intellectual content: All authors.

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Obtained funding: Aldridge, Brody.

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Supervision: Aldridge.

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SUPPLEMENT.

eTable 1. Sample Derivation, Medicare Current Beneficiary Survey, 2002-2018

APPENDIX S (9)

APPENDIX S (9)

APPENDIX T

Eden Hospice Vendor Listing

1. Medical Supplies – Medline
2. Quality and Outcomes Vendor – Strategic Healthcare Partners (SHP)
3. CAHPS – Strategic Healthcare Partners (SHP)
4. Electronic Health Record – Homecare Homebase
5. Referral Management – Allscripts, NaviHealth
6. Clearing House – Zirmed/E-Solutions
7. Telephone/Internet Services – Verizon Wireless and Comcast
8. Shredding – Iron Mountain
9. Answering Service (after-hours) – TeleMed
10. Virtual Care Technology/Telehealth – Healthcare Recovery Services (HRS)
11. Learning Management System – Relias
12. Online Patient Education – Krames
13. Shipping/Postage – FedEx
14. HR/Payroll 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/Paycor
19. Background Checks – Assure Hire, WSP
20. OIG Searches – Certiphino Screening
21. Office Supplies/Promotional Products – Office Depot, Millennium, DocuMart
22. Pharmacy – Ectara Pharmacia

Legal Name	DBA	Facility #s	# of Employees	Address	County	Phone	Fax	State and Date of Formation	UBI	EIN	NPI	Medicare	Medicaid	CLIA	State Nursing Home License
OPERATING ENTITIES															
ARIZONA															
Eden Hospice at Sierra Vista, LLC	Eden Hospice	422	22	Home Office: 1491 West Thatcher Blvd. Suite 108 Safford, AZ 85546 Branch Office: 4066 East Monsanto Drive Unit F Sierra Vista, AZ 85650	Graham	Home: 928-432-6255 Branch: 520-335-6118	Home: 928-227-0477 Branch: 520-338-6736	WA - 04/17/18	604-259-763	82-5200228	1487131215	03-1522	00-4621	03D2156786 (Home) 03D2202541 (Branch) NO STATE CLIA	HSPC9395 (Home) HSPC10352 (Branch)
Eden Home Health of Sierra Vista, LLC	Eden Home Health	425	51	Home Office: 4066 East Monsanto Drive, Unit E Sierra Vista, AZ 85650 Branch Office: 1661 N. Swan Road, Suite 208 Tucson, AZ 85712	Cochise Pima	520-335-6118	888-504-1425	WA - 12/24/18	604-375-155	83-2904097	1568936334	03-7099	00-4613	03D0697976 (Home) 03D2237566 (Branch) NO STATE CLIA	HHA9998 (license number for both)
Eden Home Health of Safford, LLC	Eden Home Health of Safford	426	26	1491 West Thatcher Blvd. Suite 104 Safford, AZ 85546	Graham	520-335-6118	888-504-1425	WA - 12/24/18	604-375-156	83-2904175	1649744418	03-7294	085791	03D2187361 NO STATE CLIA	HHA10005
CALIFORNIA															
Evergreen at Salinas, L.L.C.	Katherine Healthcare	120	59	315 Alameda Avenue Salinas, CA 93901	Monterey	831-424-1878	831-424-3149	WA - 10/12/98	601-906-864	91-1931160	1811945652	05-5311	ZZR05311J	05D0892128 (CMS) CLR 00324989 (STATE)	070000058
Evergreen at Heartwood Avenue, L.L.C.	Heartwood Avenue Healthcare	123	49	1044 Heartwood Avenue Vallejo, CA 94591	Solano	707-643-2267	707-643-5209	WA - 10/12/98	601-906-853	91-1931163	1245288083	55-5184	LTC55184H	05D0704897 (CMS) CLR 00309991 (STATE)	110000020
Evergreen at Springs Road, L.L.C.	Springs Road Healthcare	125	82	1527 Springs Road Vallejo, CA 94591	Solano	707-643-2793	707-554-2876	WA - 10/12/98	601-906-866	91-1931162	1023066966	05-5222	ZZR05222J	05D0705760 (CMS) CLR-0031066 (STATE)	110000003
Eden Home Health of Elk Grove, LLC	Eden Home Health	418	35	9299 East Stockton Blvd. Suite 10 Elk Grove, CA 95624	Sacramento	916-681-4949	916-681-4888	WA - 08/10/16	604-023-071	81-3541439	1497200745	05-8314	1497200745	05D1060248 (CMS) CLR-00335079 (STATE)	100000640
IDAHO															
Eden Home Health of Idaho Falls, LLC	Eden Home Health	412	34	2540 Channing Way, Idaho Falls, ID 83404	Bonneville	208-523-1980	208-523-4024	WA - 10/22/13	603-343-174	46-3977015	1649683582	13-7119	1649683582	13D2019972 NO STATE CLIA	HH-248
Eden Hospice at Idaho Falls, LLC	Eden Hospice	416	7	2540 Channing Way, Idaho Falls, ID 83404	Bonneville	208-523-1980	208-529-4013	WA - 01/26/16 Old WA - 06/17/20	603-580-154 Old 604-631-303 New	81-1215541	1669839395	13-1584	1669839395	13D2192343 NO STATE CLIA	NO LICENSE FOR HOSPICE
Eden Home Health of Sandpoint, LLC	Eden Home Health	428	60	Home Office: 204 Triangle Drive Ponderay, ID 83852 Branch Office: 296 W. Sunset Ave. Suite 20 Coeur d' Alene, Idaho 83815	Bonner	208-255-1640	208-263-9210	WA - 07/26/19	604-498-334	84-2528556	1346898830	13-7122	1346898830	13D2031781 (Home) 13D2237040 (Branch) NO STATE CLIA	HH-247 (Home & Branch)
Eden Hospice at the Inland Northwest, LLC	Eden Hospice	438		204 Triangle Drive Ponderay, ID 83852	Bonner	208-255-1640	208-263-9210	WA-07/08/22	604-940-470	88-2974010	1245962471			13D2264485 NO STATE CLIA	NO LICENSE FOR HOSPICE
MONTANA															
Evergreen at Polson, L.L.C.	Polson Health and Rehabilitation Center	65	57	Nine 14th Avenue West Polson, MT 59860	Lake	406-883-4378	406-883-0039	WA - 02/25/97	601-771-966	84-1395919	1093763419	27-5049	310622	27D0677491 NO STATE CLIA	13551
Evergreen at Hot Springs, L.L.C.	Hot Springs Health and Rehabilitation Center	66	34	600 First Avenue North Hot Springs, MT 59845	Sanders	406-741-2992	406-741-2994	WA - 02/25/97	601-771-969	84-1395917	1689623357	27-5069	310635	27D0707122 NO STATE CLIA	13488
Evergreen at Missoula, L.L.C.	Missoula Health and Rehabilitation Center	70	48	3018 Rattlesnake Drive Missoula, MT 59802	Missoula	406-549-0988	406-549-0111	WA - 03/31/97	601-780-502	91-1818902	1538117940 SNF 1447703533 ALF	27-5035	310029	27D0410969 NO STATE CLIA	13453 SNF 13184 ALF
Evergreen at Laurel, L.L.C.	Laurel Health and Rehabilitation Center	71	48	820 3rd Avenue Laurel, MT 59044	Yellowstone	406-628-8251	406-628-8253	WA - 03/31/97	601-780-456	91-1818226	1750339149	27-5111	310114	27D0686103 NO STATE CLIA	12861
Evergreen at Livingston, L.L.C.	Livingston Health and Rehabilitation Center	143	26	510 South 14th Street Livingston, MT 59047	Park	406-222-0672	406-222-1406	WA - 12/04/03	602-347-324	20-0480727	1497703896	27-5047	310862	27D0409425 NO STATE CLIA	12545
EmpRes at Lewistown, LLC	Central Montana Nursing & Rehabilitation Center	154	26	410 Wendell Avenue Lewistown, MT 59457	Fergus	406-535-6225	406-535-6325	WA - 09/17/14	603-437-044	47-1980392	1336546811	27-5064	395044	27D093584 NO STATE CLIA	13023
EmpRes at Billings, LLC	Aspen Meadows Health and Rehabilitation Center	166	68	3155 Avenue C Billings, MT 59102	Yellowstone	406-656-8818	406-656-9552	WA - 04/26/17	604-117-975	82-1316107	1619402765	27-5140	522561	27D2151877 NO STATE CLIA	13565
Aspen Meadows Assisted Living, LLC	Aspen Meadows Assisted Living	167	5	3155 Avenue C Billings, MT 59102	Yellowstone	406-656-8818	406-656-9552	WA - 05/03/17	604-121-195	82-1408417	1700312931			**NO CLIA**	31502
Eden Home Health of Bozeman, LLC	Eden Home Health	431	36	2075 Charlotte St., Suite 2 Bozeman, MT 59718	Gallatin	406-587-8710	406-587-0627	WA - 01/26/21	604 705 930	86-1606318	1659963999	27-7078		27D2221569 NO STATE CLIA	13565
Eden Hospice at Western Montana, LLC	Eden Hospice	432	3	2075 Charlotte St., Suite 2 Bozeman, MT 59718	Gallatin	406-587-8710	406-587-0627	WA - 03/26/21	604-732-957	86-2818663	1912670795	27-1540		27D2238715 NO STATE CLIA	13580
NEVADA															
Evergreen at Pahrump, L.L.C.	Pahrump Health and Rehabilitation Center	88	75	4501 N Blagg Road Pahrump, NV 89060	Nye	775-751-6600	775-751-6644	WA - 11/08/01	602-160-690	91-2165423	1568410884	29-5075	1912881	29D0966904 (CMS) 10495-EXL-0 (STATE)	2770-SNF-44
Evergreen at Carson City, L.L.C.	Ormsby Post Acute Rehab	89	59	3050 North Ormsby Blvd. Carson City, NV 89703	Carson City	775-841-4646	775-841-4650	WA - 11/08/01	602-160-692	91-2165422	1558319889	29-5067	1913305	29D0959896 (CMS) 9137-EXL-1 (STATE)	2355-SNF-39
Evergreen at Mountain View, L.L.C.	Mountain View Health and Rehabilitation Center	134	69	201 Koontz Lane Carson City, NV 89701	Carson City	775-883-3622	775-883-3744	WA - 08/26/02	602-229-498	73-1659060	1144279472	29-5079	1913700	29D0907924 (CMS) 10524-EXL-0 (STATE)	3331-SNF-46
Evergreen at Gardnerville, L.L.C.	Gardnerville Health and Rehabilitation Center	138	38	1573 South Muller Parkway Gardnerville, NV 89410	Douglas	775-782-6620	775-782-6945	WA - 05/28/03	602-299-654	91-2190795	1083662514	29-5082	100503498	29D1024368 (CMS) 10494-EXL-0 (STATE)	3995-SNF-38
EmpRes Personal Care Nevada, LLC	Eden Home Care	411	50	907 Mountain Street Carson City, NV 89703	Carson City	775-392-2000	866-920-6465	WA - 06/13/13	603-310-107	80-0934945	1427578418			**NO CLIA**	7175-PCS-10
Quality Health Care Corporation	Eden Home Health	414	130	Home Office: 500 Damonte Ranch Parkway Suite 929 Reno, NV 89521 Branch Office: 907 Mountain Street Carson City, NV 89703	Washoe	775-432-0831 775-828-1000 775-687-1530	775-828-1012 775-828-1029 775-687-1535	NV - 11/13/90		88-0265275	1497746226	29-7035	2916050	29D1084683(CMS H) 29D2089590 (CMS B) 8054-EXL-2 (STATE H) 8221-EXL-0 (STATE B)	548-HHA-27 546-HBR-27
Eden Hospice at Carson City, LLC	Eden Hospice	415	78	907 Mountain Street Carson City, NV 89703	Carson City	775-841-6123	775-841-6125	WA - 11/28/14	603-450-017	47-2330802	1487051728	29-1515	T64: 100504255 T65: 100546106	**NO CLIA**	6275-HPC-11
OREGON									**OR Registry**						
Evergreen Oregon Healthcare Mountain Vista, L.L.C.	LaGrande Post Acute Rehab	56	52	91 Aries Lane La Grande, OR 97850	Union	541-963-8678	541-963-5024	OR - 02/12/97	558569-84 LLC 539494-90 ABN	91-1784025	1801844501	38-5211	801035	38D0628677 NO STATE CLIA	1825618921
Evergreen Oregon Healthcare Independence, L.L.C.	Independence Health and Rehabilitation Center	58	51	1525 Monmouth Avenue Independence, OR 97351	Polk	503-838-0001	503-838-7826	OR - 02/12/97	558561-82 LLC 822076-98 Indep.ABN	91-1783801	1497703201	38-5188	801030	38D0626140 NO STATE CLIA	1240315675
Evergreen Oregon Healthcare Tualatin, L.L.C.	EmpRes Hillsboro Health and Rehabilitation Center	59	77	1778 NE Cornell Road Hillsboro, OR 97124	Washington	503-648-6621	503-648-4443	OR - 02/12/97	558575-86 LLC 874847-97 ABN	91-1785170	1780632471	38-5217	801043	38D0867104 NO STATE CLIA	1001406013
Evergreen Oregon Healthcare Orchards Rehabilitation, L.L.C.	Milton Freewater Health and Rehabilitation Center	60	49	120 Elzora Street Milton Freewater, OR 97862	Umatilla	541-938-3318	541-938-4657	OR - 02/12/97	558570-81 LLC 573776-90 ABN	91-1785010	1407804198	38-5161	801048	38D0923709 NO STATE CLIA	1368282496
Evergreen Oregon Healthcare Orchards Retirement, L.L.C.	Cascade Valley Assisted Living and Memory Care Cascade Valley Assisted Living Cascade Valley Memory Care	61	30	1010 NE Third Milton Freewater, OR 97862	Umatilla	541-938-5693	541-938-4490	OR - 02/12/97	44906683 LLC 129226593 MC ABN 129225496 ALF ABN 926595-99 MC&ALF ABN	93-1241876	1710296793		~~526588(Terminated)~~ 502086 (ALF) 526773 (MC) 29430418 (DD) 104332 (SPD)	38D2261029	1208675563 ALF 1473705768 MC

Legal Name	DBA	Facility #s	# of Employees	Address	County	Phone	Fax	State and Date of Formation	UBI	EIN	NPI	Medicare	Medicaid	CLIA	State Nursing Home License
Evergreen Oregon Healthcare Valley Vista, L.L.C.	The Dalles Health and Rehabilitation Center	62	56	1023 West 25th The Dalles, OR 97058	Wasco	541-298-5158	541-298-3864	OR - 02/12/97	558566-87 LLC 753428-90 ABN	91-1785073	1487602173	38-5172	801055	38D0622383 NO STATE CLIA	1317989527
Evergreen Oregon Healthcare Portland, L.L.C.	Portland Health and Rehabilitation Center	74	56	12441 SE Stark Street Portland, OR 97233	Multnomah	503-255-7040	503-255-0555	OR - 02/12/97	558573-88 LLC 573788-96 ABN	91-1784037	1497703110	38-5228	800000	38D0625258 NO STATE CLIA	1395692050
Evergreen Oregon Healthcare Salem, L.L.C.	Windsor Health and Rehabilitation Center	75	49	820 Cottage Street NE Salem, OR 97301	Marion	503-399-1135	503-399-7273	OR - 01/04/00	60058386 LLC 57379399 ABN	93-1231193	1760430482	38-5224	800001	38D0625547 NO STATE CLIA	1873152135
Eden Hospice at Portland, LLC	Eden Hospice	433	5	**Home Office:** 221 Molalla Avenue Suite 102 & 120 Oregon City, OR 97045 **Branch Office:** 2621 NE 134th Street Suite 140 Vancouver, WA 98686	Clackamas Clark	971-256-6642	971-256-6643	WA-06/14/21	604-772-403 WA LLC	87-1056879	1902579840	38-1579	500805049 (OR) 2220598 (WA)	38D2254988 (OR) NO STATE CLIA	OR 16-1094 WA IHS.FS.61290232
Eden Home Health of Bend, LLC	Eden Home Health	436		2546 NE Conners Avenue Suite 100 Bend, Oregon, 97701	Deschutes	541-640-7920	541-640-7922	WA-11/16/21	604-837-231	87-3544927	1811654825				
Eden Hospice at Bend, LLC	Eden Hospice	437		2546 NE Conners Avenue Suite 100 Bend, Oregon, 97701	Deschutes	541-640-7920	541-640-7922	WA-11/16/21	604-830-356	87-3561837	1437816451				
SOUTH DAKOTA															
EmpRes at Mitchell, LLC	Firesteel Healthcare Center	170	82	1120 East 7th Avenue Mitchell, SD 57301	Davison	605-996-6526	605-996-8290	WA - 12/12/18	604-372-689	83-2751702	1922570894	43-5109	1922570894	43D0684181 NO STATE CLIA	10653
EmpRes at Rapid City, LLC	Fountain Springs Healthcare Center	171	87	2000 Wesleyan Blvd. Rapid City, SD 57702	Pennington	605-343-3555	605-721-1457	WA - 12/12/18	604-372-690	83-2753608	1558833426	43-5110	1558833426	43D0705041 NO STATE CLIA	10723
Rapid City Assisted Living, LLC	Fountain Springs Assisted Living	172		2000 Wesleyan Blvd. Rapid City, SD 57702	Pennington	605-343-3555	605-721-1457	WA - 12/13/18	604-363-274	83-2807325	1811469687			**NO CLIA**	10757
Sturgis Assisted Living, LLC	Aspen Grove Assisted Living	173	29	2065 Moose Drive Sturgis, SD 57785	Meade	605-720-4738	605-720-1072	WA - 12/12/18	604-362-961	83-2753677	1447722210			43D2084837 NO STATE CLIA	65673
EmpRes at Garretson, LLC	Palisade Healthcare Center	174	40	920 4th Street Garretson, SD 57030	Minnehaha	605-594-3466	605-594-6661	WA - 12/12/18	604-362-961	83-2762067	1083186852	43-5115	1083186852	43D0681305 NO STATE CLIA	10623
EmpRes at Woonsocket, LLC	Prairie View Healthcare Center	175	52	401 South 1st Avenue P.O. Box 68 Woonsocket, SD 57385-0068	Sanborn	605-796-4467	605-796-4497	WA - 12/12/18	604-372-244	83-2762230	1164994943	43-5118	1164994943	43D0697734 NO STATE CLIA	10714
EmpRes at Flandreau, LLC	Riverview Healthcare Center	176	56	611 East 2nd Avenue Flandreau, SD 57028	Moody	605-997-2481	605-997-2988	WA - 12/12/18	604-368-328	83-2762409	1982176764	43-5086	1982176764	43D0683930 NO STATE CLIA	10620
Flandreau Independent Living, LLC	Riverview Care Center	177		610 East Pipestone Avenue Flandreau, SD 57430	Moody	605-997-2481	605-997-2988	WA - 12/13/18	604-363-273	83-2807448	1861964645			**NO CLIA**	N/A
EmpRes at Britton, LLC	Wheatcrest Hills Healthcare Center	178	52	1311 Vander Horck Street Britton, SD 57430	Marshall	605-448-2251	605-448-5583	WA - 12/12/18	604-362-959	83-2780802	1306318183	43-5105	1306318183	43D0680687 NO STATE CLIA	10599
EmpRes at Sturgis, LLC	Dolan Creek Senior Living	181		2171 Moose Drive, Sturgis, SD 57785	Meade			WA - 04/29/21	604-746-172	86-3516133	1255077889				
WASHINGTON															
Evergreen Washington Healthcare Frontier, L.L.C.	Frontier Rehabilitation and Extended Care	51	111	1500 3rd Avenue Longview, WA 98632	Cowlitz	360-423-8800	360-636-3421	WA - 01/29/97	601-765-215	91-1784789	1104811207	50-5276	WA 4116051	50D0637496 MTSW.FS.00002289	1605
Evergreen Washington Healthcare Americana, L.L.C.	Americana Health and Rehabilitation Center	52	57	917 7th Avenue Longview, WA 98632	Cowlitz	360-425-5910	360-425-0318	WA - 01/29/97	601-765-213	91-1785409	1063461325	50-5361	WA 4116041	50D2170763 MTSW.FS.60997074	1604
Evergreen Washington Healthcare Seattle, L.L.C.	Seattle Medical Post Acute Care	68	105	555 16th Avenue Seattle, WA 98122	King	206-324-8200	206-709-8457	WA - 02/24/97	601-771-724	91-1784000	1851386957	50-5311	WA 4116111 AK LT400WA/1007141	50D0883691 MTSW.FS 00001644	1611
Evergreen Washington Healthcare Enumclaw, L.L.C.	Enumclaw Health and Rehabilitation Center	78	53	2323 Jensen Street Enumclaw, WA 98022	King	360-825-2541	360-825-4351	WA - 04/01/98	601-866-073	91-1896293	1457346785	50-5400	Old 4112660 New 4116021	50D0891847 MTSW.FS.00002780	1602
Evergreen Washington Healthcare Auburn, L.L.C.	Canterbury House	81	99	502 29th Street SE Auburn, WA 98002	King	253-939-0090	253-939-0095	WA - 08/10/98	601-894-247	91-1923290	1235187931	50-5344	Old 4112694 New 4116061	50D0882772 MTSW.FS.00002468	1606
Evergreen at Shelton, L.L.C.	Shelton Health and Rehabilitation Center	87	61	153 Johns Court Shelton, WA 98584	Mason	360-427-2575	360-427-2563	WA - 04/23/01	602-122-492	91-2134798	1427006220	50-5507	Old 4113247 New 4116081	50D0957409 MTSW.FS.00003540	1608
Evergreen at Bellingham, L.L.C.	North Cascades Health and Rehabilitation Center	136	110	4680 Cordata Parkway Bellingham, WA 98226	Whatcom	360-398-1966	360-398-9346	WA - 03/21/03	602-281-546	91-2183734	1174572432	50-5393	WA 4116071 AK LT007WA/1579144	50D0883392 MTSW.FS.00002789	1607
Spokane Royal Park Care, LLC	Royal Park Health and Rehabilitation	150	150	7411 North Nevada Street Spokane, WA 99208	Spokane	509-489-2273	509-483-3041	WA - 06/30/14	603-416-172	47-1269844	1376538637	50-5379	Old 4114712 New 4116121	50D0857635 MTSW.FS.60505037	1612
Spokane Royal Park Retirement, LLC	Royal Park Retirement Center	151	48	302 E. Wedgewood Avenue Spokane, WA 99208	Spokane	509-483-7136	509-483-5161	WA - 06/30/14	603-416-165	47-1279997	1801251566		2039158	**50D2197121 MTSW.FS.61116043**	2533
EmpRes at Colville, LLC	Buena Vista Healthcare	155	80	151 Buena Vista Drive Colville, WA 99114	Stevens	509-684-4539	509-685-0582	WA - 11/05/14	603-450-228	47-2263615	1477950954	50-5329	Old 4115021 New 4116011	50D0638787 MTSW.FS.60542515	1601 SNF 2534 ALF
Fort Vancouver Assisted Living, LLC	Fort Vancouver Assisted Living	157	24	8422 NE 8th Way Vancouver, WA 98664	Clark	360-256-2980	360-256-1909	WA - 04/07/15	603-495-209	47-3655216	1730575267			**NO CLIA**	2537
EmpRes at Seattle, LLC	Transitional Care Center of Seattle	180	130	2611 South Dearborn Street Seattle, WA 98144	King	206-712-6500	206-328-5150	WA - 04/08/20	604-595-856	85-0656915	1952921124	50-5534	2155326	50D2192671 MTSW.FS.61104603	1621
EmpRes Home Health of Bellingham, LLC	Eden Home Health	413	118	Home Office: 316 E. McLeod Road Suite 101 Bellingham, WA 98226-6491 Branch Office: 1315 East Division Street Mount Vernon, WA 98273	Whatcom	360-734-5410	360-734-5435	WA - 02/09/14	603-375-240	46-4898286	1316031230	50-7105	2046013	50D2082437 MTSW.FS.60498963	IHS.FS.60491681
EmpRes Home Care of Bellingham, LLC	Eden Home Care	417	14	316 E. McLeod Road Suite 101 Bellingham, WA 98226-6491	Whatcom	360-734-5410	360-734-5435	WA - 03/02/16	603-591-861	81-1668683	1831550144			**NO CLIA**	IHS.FS.60651755
Eden Home Health of King County, LLC	Eden Home Health	421	30	Parkade Plaza 733 7th Avenue Suite 110 Kirkland, WA 98033	King	206-717-8161	206-899-1641	WA - 02/15/17	604-069-995	81-5371141	1003356403	50-7128	2145416	50D2165564 MTSW.FS.60959281	IHS.FS.60871865
Eden Home Health of Clark County, LLC	Eden Home Health	423	44	Home Office: 2621 NE 134th Street Suite 140 Vancouver, WA 98686 Branch Office: 221 Molalla Avenue Suite 102 & 120 Oregon City, OR 97045	Clark Clackamas	360-504-0122	360-859-1354	WA - 09/11/18	604-332-868	83-1652742	1538778295	50-7133	500807648 (OR) 2217996 (WA)	CMS 50D2196116 WA MTSW.FS.61114363 OR (Branch) 38D2263067	IHS.FS.61097918(WA) 16-1096 (OR)
Eden Home Health of Spokane County, LLC	Eden Home Health	424	46	1225 N Argonne Road, Suite 100 Spokane Valley, WA 99212	Spokane	509-505-5315	509-530-2837	WA - 09/11/18	604-331-802	83-1652806	1588212641	50-7130	2174015	50D2187143 MTSW.FS.61084607	IHS.FS.61014910
Eden Hospice at Whatcom County, LLC	Eden Hospice	427	15	316 E. McLeod Road Suite 104 Bellingham, WA 98226-6491	Whatcom	360-966-8593	360-966-8926	WA - 01/03/20	604-561-430	84-4039145	1275130098	50-1548	2217994	50D2211455 MTSW.FS.61143519	IHS.FS.61117985
Eden Hospice at Snohomish County, LLC	Eden Hospice	429		Parkade Plaza 733 7th Avenue Suite 108 Kirkland, WA 98033	Snohomish	425-448-7607	425-448-7608	WA - 01/06/21	604 684 777	86-1271734	1215526686			**NO CLIA**	**NONE**

Legal Name	DBA	Facility #s	# of Employees	Address	County	Phone	Fax	State and Date of Formation	UBI	EIN	NPI	Medicare	Medicaid	CLIA	State Nursing Home License
Eden Hospice at King County, LLC	Eden Hospice	430		Parkade Plaza 733 7th Avenue Suite 110 Kirkland, WA 98033	King	425-448-7607	425-448-7608	WA - 12/23/20	604 693 901	85-4367601	1255922720			**NO CLIA**	IHS.FS61293991
WYOMING															
EmpRes at Rock Springs, LLC	Sage View Care Center	159	59	1325 Sage Street Rock Springs, WY 82901	Sweetwater	307-362-3780	307-363-9671	WA - 05/13/15	603-506-235	47-4005909	1760860241	53-5056	139993400	53D2097676 NO STATE CLIA	15198
EmpRes at Cheyenne, LLC	Granite Rehabilitation and Wellness	161	118	3128 Boxelder Drive Cheyenne, WY 82001	Laramie	307-634-7901	307-634-7910	WA - 07/23/15	603-527-290	47-4604270	1093190688	53-5013	WY 141198500 NE 10026590800	53D2110344 NO STATE CLIA	15200
EmpRes at Rawlins, LLC	Rawlins Rehabilitation and Wellness	162	53	542 16th Street Rawlins, WY 82301	Carbon	307-324-2759	307-324-7579	WA - 07/23/15	603-527-306	47-4609173	1619352242	53-5036	141199300	53D0902235 NO STATE CLIA	15201
EmpRes at Riverton, LLC	Wind River Rehabilitation and Wellness	163	79	1002 Forest Drive Riverton WY 82501	Fremont	307-856-9471	307-856-1749	WA - 07/23/15	603-527-428	47-4623411	1508241977	53-5031	141200100	53D2107223 NO STATE CLIA	15199
EmpRes at Thermopolis, LLC	Thermopolis Rehabilitation and Wellness	165	27	1210 Canyon Hills Road Thermopolis, WY 82443	Hot Springs	307-864-5591	307-864-2847	WA - 11/04/16	604-055-180	81-4307219	1013459965	53-5051	145629600	53D2147190 NO STATE CLIA	15229
EmpRes at Casper, LLC	Shepherd of the Valley Rehabilitation and Wellness	168	178	60 Magnolia Street Casper, WY 82604	Natrona	307-234-9381	307-472-3510	WA - 12/12/18	604-362-960	83-2721102	1306318274	53-5042	152257400	53D0520001 NO STATE CLIA	15306
Eden Home Health of Cheyenne, LLC	Eden Home Health	434	15	Aspen Ridge Building 2232 Dell Range Blvd. Suite 100 Cheyenne, WY 82009	Laramie	307-400-5200	307-400-5201	WA-06/14/21	604-764-145	87-1014908	1497428338			53D2254641	15396
Eden Hospice at Cheyenne, LLC	Eden Hospice	435		Aspen Ridge Building 2232 Dell Range Blvd. Suite 100 Cheyenne, WY 82009	Laramie	307-400-5200	307-400-5201	WA-06/14/21	604-764-147	87-1048946	1285307124				P-962
			4141												

APPENDIX W BLANK

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Independent News on
HEMATOLOGY / ONCOLOGY

Addressing Disparities in Hospice & Palliative Care

BY CATLIN NALLEY

Access to hospice and palliative care is a vital aspect of oncology and yet, despite the proven benefits, racial and ethnic minorities as well as individuals with lower socioeconomic status still face a number of barriers when it comes to accessing these services

"Disparities in advance care planning, palliative [care], and end-of-life care are vast. It is well-established in the literature that advance directives aren't completed as often and end-of-life care is underutilized among minority patients," said Rebecca Cammy, MSW, LCSW, Supervisor in Oncology Support Services at the Sidney Kimmel Cancer Center at Thomas Jefferson University. "Various factors can heighten and exacerbate these trends, such as health literacy, communication with

Continued on page 10

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Onconephrology: How the Kidneys & Cancer Affect Patient Outcomes

BY RICHARD SIMONEAUX

For many cancer patients, their kidneys, even if not directly involved in the malignancy, are often affected by the patient's disease. These effects can result from electrolyte imbalances arising from tumor cell lysis or from nephrotoxicity-inducing anticancer therapies. As a result of this, at the intersection of two realms, cancer and the kidneys, a new field has taken shape—onconephrology. A recent review article by Mitchell Rosner, MD, Chair of the University of Virginia Department of Medicine described the emergence of this new subspecialty (*CA Cancer J Clin* 2021; https://doi.org/10.3322/caac.21636).

When discussing how this field arose, Rosner stated, "There really have not been discoveries or developments that have led to onconephrology; it has been more of a realization that patients with cancer often either have kidney disease or develop kidney-related complications of their cancer or associated treatments. These kidney-related

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Advances in the Treatment of Patients With R/R Follicular Lymphoma

BY DIBASH KUMAR DAS, PHD

With approximately 14,000 cases per year, follicular lymphoma (FL) is the most common indolent lymphoma diagnosed in the United States. It is a highly heterogeneous disease with varying prognosis, influenced by differences in clinical, laboratory, and disease parameters between patients (*Blood Cancer J* 2020; https://doi.org/10.1038/s41408-020-00340-z).

Although FL is considered an incurable disease, improvements in diagnosis and therapeutic advances have improved outcomes. Clinicians may choose to treat their patients with FL by a method of watch and wait for those with indolent disease. In more advanced stages, such as for patients with grades 3A and 3B FL, clinicians may use one or more chemotherapy drugs or the monoclonal antibody rituximab, alone or in combination with other agents.

Common combination regimens include:

- R-Bendamustine (rituximab and bendamustine);
- R-CHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone); and
- R-CVP (rituximab, cyclophosphamide, vincristine, and prednisone).

A Difficult-to-Treat Population

Presently, median survival ranges from 8 to 15 years (*American Cancer Society: Cancer Facts and Figures 2021*). Unfortunately, most patients

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PERIODICALS

continued from page 1

providers, perceived or experienced discrimination with health care systems, mistrust in health care providers, access to care, and health care coverage."

ASCO recommends the integration of supportive care as a standard practice early in the trajectory of patient's oncologic care, Cammy noted. "Rather than responding to a health care crisis, supportive care services can proactively improve quality of life and patient satisfaction," she explained. "A reduction in symptom burden and avoidance of futile interventions directly decreases unnecessary acute care and end-of-life expenditure."

> "One interesting finding is that, while Black patients are less likely to enroll in hospice, among those who enroll, Black patients spend longer on hospice. This suggests that effective goal setting can improve the time people benefit from hospice services."
>
> *— Rebecca Cammy, MSW, LCSW, at the Sidney Kimmel Cancer Center at Thomas Jefferson University*

To ensure every patient can benefit from these services, a deeper understanding of current disparities and barriers to care is needed, as well as a commitment to address these issues at a system-wide level.

"The social determinants of health inform my practice as an oncology social worker with a highly disenfranchised oncology patient population in an urban setting. Patient's basic needs—economic stability, housing and food insecurity, community and social context—all impact their ability to navigate care," said Cammy. "If these basic needs aren't met, it creates challenges and can exacerbate true barriers in health care access. Financial toxicity associated with a cancer diagnosis and treatment, including lack of or inadequate health insurance coverage, can dissuade patients from complying with treatment regimens and care and necessary follow-up."

Structural factors as well as local resources and interpersonal communication can all create challenges in providing equitable care, noted Jennifer J. Griggs, MD, MPH, Professor in the University of Michigan Department of Internal Medicine, Hematology & Oncology Division, and in the Department of Health Management & Policy.

"Insurance status limits access to clinical care and to expensive medications," she said. "Expanding insurance coverage is essential. In addition, telemedicine, if equitably applied and supported by, for example, paid family members, can overcome geographic barriers to care."

Addressing Disparities

Culturally sensitive education and training for providers and care teams is necessary to acknowledge the existence and raise awareness of health care disparities, according to Cammy.

"The delivery of health care services needs to be transformed to address the needs of the underserved. Innovative multidisciplinary interventions must be tailored to assess knowledge, attitudes, and resources and respond to these differences, barriers, and access needs among various patient populations," she noted.

Geography, race, ethnicity, socioeconomic status, and gender identity and sexual orientation all play a role in who can access hospice care, explained Griggs. "We know that the transition to hospice requires alignment of goals between clinicians and their patients," she said. "Given the disparities in the quality of information support and clinician-patient interactions, it is likely that improvements in cultural humility, the ability to ask questions that center the patient's goals, and support for clinicians to take more time with families are all likely to improve discussions around place and manner of death.

"One interesting finding is that, while Black patients are less likely to enroll in hospice, among those who enroll, Black patients spend longer on hospice," she continued. "This suggests that effective goal setting can improve the time people benefit from hospice services."

Disparities in palliative care are somewhat more complicated depending on the symptom that one studies, Griggs acknowledged. "It appears that insurance status mediates access to high-quality symptom management more than race with the exception of pain," she explained. "Many studies have shown that pain management is inferior when there is greater social distance between clinicians and their patients."

Recognizing the need to address disparities, the Sidney Kimmel Cancer Center at Thomas Jefferson University launched the Supportive Medicine program in July 2017 to meet the needs of cancer patients experiencing barriers and distress throughout the course of their cancer care.

"Proactive, biopsychosocial screening is one mechanism used to identify and respond to unmet patient needs and distress," noted Cammy. "The Supportive Cancer Care program deploys a unique model of care delivery, which offers a multidisciplinary outpatient supportive program to cancer patients early in their disease trajectory including social work, navigation, financial advocacy, nutrition, and pharmacy.

"Our oncology social workers also partner with numerous community organizations to fill the gaps and respond to patient's basic needs influenced by the social determinants of health," she continued. "For example, Legacy of Hope has teamed up with Philadelphia police department to delivers groceries to 24 oncology patients/families who experience food insecurity."

To assist with appointment adherence, another non-profit organization, the Breathing Room Foundation, offers 20 Lyft rides to patients who would otherwise be unable to get transportation to their appointments, Cammy said.

"Lastly, Bringing Hope Home responds to the financial toxicity of a cancer diagnosis by covering non-medical household expenses and utility bills," she explained. "These collaborative community relationships along with internal philanthropic funds are critical in providing additional financial support to patients."

Looking Forward

Bridging these gaps in care and ensuring that all patients have access to the necessary services requires work from all providers as well as their institutions and community partners.

"Palliative symptoms related to cancer and its treatment are a social justice issue. Without management of these symptoms, people are deprived of living the fullest life possible—whether in the short term or over the remaining days that they have," noted Griggs. "In order to preserve dignity and comfort, we should do all that we can to treat each person to the best of our abilities.

"If the system is not able to provide high-quality care to all, we need to change the system," she concluded. "Disrupting the status quo in service of our patients is part of our jobs as physician citizens." OT

Catlin Nalley is a contributing writer.

REPORT OF INDEPENDENT AUDITORS
AND CONSOLIDATED FINANCIAL STATEMENTS

EMPRES HEALTHCARE GROUP, INC. AND SUBSIDIARIES

December 31, 2021 and 2020

MOSSADAMS

APPENDIX Y

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MOSSADAMS

Report of Independent Auditors

The Board of Directors
EmpRes Healthcare Group, Inc. and Subsidiaries

Report on the Audit of the Financial Statements

Opinion

We have audited the consolidated financial statements of EmpRes Healthcare Group, Inc. and Subsidiaries which comprise the consolidated balance sheet as of December 31, 2021, and the related consolidated statements of operations, changes in stockholders' deficit, and cash flows for the year then ended, and the related notes to the consolidated financial statements.

In our opinion, based on our audits and the report of the other auditors, the accompanying 2021 consolidated financial statements present fairly, in all material respects, the financial position of EmpRes Healthcare Group, Inc. and Subsidiaries as of December 31, 2021, and the results of their operations and their cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

We did not audit the financial statements of Columbia Indemnity Company Ltd., a wholly-owned subsidiary, which statements reflect total assets of $20,361,956 as of December 31, 2021 and total revenues of $5,509,045 for the year then ended. Those statements were audited by other auditors, whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Columbia Indemnity Company Ltd., is based solely on the report of the other auditors.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of EmpRes Healthcare Group, Inc. and Subsidiaries and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Prior Period Financial Statements

The consolidated financial statements of EmpRes Healthcare Group, Inc. and Subsidiaries as of December 31, 2020 were audited by other auditors whose report dated May 24, 2021 expressed an unmodified opinion on those statements.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about EmpRes Healthcare Group, Inc. and Subsidiaries' ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of EmpRes Healthcare Group, Inc. and Subsidiaries' internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about EmpRes Healthcare Group, Inc. and Subsidiaries' ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Moss Adams LLP

Portland, Oregon
August 4, 2022

EmpRes Healthcare Group, Inc. and Subsidiaries
Consolidated Balance Sheets

ASSETS

	December 31, 2021	December 31, 2020
CURRENT ASSETS		
Cash and cash equivalents	$ 15,507,455	$ 61,246,745
Fixed deposits	11,727,760	11,732,300
Patient trust cash	975,632	1,214,692
Accounts receivable, net	51,182,703	50,495,118
Other receivables	533,440	1,089,487
Prepaid expenses and other current assets	9,106,587	13,553,457
Total current assets	89,033,577	139,331,799
Property, plant, and equipment, net	50,076,824	52,212,625
Leasehold and loan acquisition costs, net	1,268,322	1,410,813
Goodwill	13,807,809	13,657,809
Other assets	6,031,949	7,142,436
Total assets	$ 160,218,481	$ 213,755,482

LIABILITIES AND STOCKHOLDERS' DEFICIT

CURRENT LIABILITIES		
Accounts payable	$ 33,633,985	$ 29,973,996
Accrued expenses	32,313,644	39,725,773
Line of credit	9,682,903	4,426,018
Current portion of long-term debt	1,941,206	19,849,989
Current portion of long-term debt – ESOT	572,676	26,958,030
Current portion of insurance loss reserves	3,028,726	3,870,795
Current portion of Medicare advance payments	8,062,875	16,463,640
Other current liabilities	7,560,735	12,818,073
Total current liabilities	96,796,750	154,086,314
Long-term debt, less current portion	35,001,791	45,614,946
Long-term portion of insurance loss reserves	6,973,614	7,000,159
Long-term portion of Medicare advance payments	-	6,781,935
Other noncurrent liabilities	11,689,655	15,450,280
Total liabilities	150,461,810	228,933,634
Shareholders' equity (deficit)	9,756,671	(15,178,152)
Total liabilities and stockholders' equity (deficit)	$ 160,218,481	$ 213,755,482

See accompanying notes.

EmpRes Healthcare Group, Inc. and Subsidiaries
Consolidated Statements of Operations

	Year Ended December 31, 2021	2020
REVENUES		
Patient service revenue, net	$ 405,820,892	$ 441,436,824
Other revenue	27,075,582	21,817,376
Total revenues, net	432,896,474	463,254,200
OPERATING EXPENSES		
Salaries, payroll taxes, and benefits	234,966,761	240,722,399
Supplies and food	23,461,718	23,611,123
Ancillary expenses	37,322,693	44,177,897
Purchased services	33,988,773	25,371,621
Building rent expense	35,432,221	39,464,323
Utilities	11,057,906	11,415,753
Equipment rentals	2,827,271	3,392,203
Provider tax	15,715,785	17,944,092
Property tax	3,178,963	3,054,686
Insurance	2,410,226	2,420,199
Consultants and professionals	5,797,647	5,811,028
Business taxes	3,460,678	3,415,492
Computer license and equipment maintenance	7,178,756	5,778,614
Depreciation and amortization	5,303,478	5,898,655
Other operating expenses	17,815,189	16,733,491
Total operating expenses	439,918,065	449,211,576
Operating income (loss)	(7,021,591)	14,042,624
OTHER (EXPENSE) INCOME		
Gain on forgiveness of debt	38,717,360	-
Interest expense	(3,312,027)	(4,090,786)
Impairment of assets	(3,343,812)	-
Loss on disposal of assets	-	(179,352)
Total other (expense) income	32,061,521	(4,270,138)
NET INCOME	$ 25,039,930	$ 9,772,486

See accompanying notes.

EmpRes Healthcare Group, Inc. and Subsidiaries
Consolidated Statements of Stockholders' Deficit

	Common Stock				Treasury Stock			
	Outstanding Shares	Guaranteed ESOP Benefit	Additional Cost of ESOP	Amount	Shares	Amount	Retained Earnings	Total Stockholders' Deficit
BALANCE, December 31, 2019	14,685,895	$ (21,698,451)	$ (27,975,289)	$ (49,673,740)	314,105	$ (483,722)	$ 25,206,824	$ (24,950,638)
Allocation of ESOP shares	-	-	-	-	-	-	-	-
Net income	-	-	-	-	-	-	9,772,486	9,772,486
BALANCE, December 31, 2020	14,685,895	(21,698,451)	(27,975,289)	(49,673,740)	314,105	(483,722)	34,979,310	(15,178,152)
Purchase of treasury stock	(419,601)	-	-	-	419,601	(360,857)	-	(360,857)
Allocation of ESOP shares		1,086,937	(831,187)	255,750	-	-	-	255,750
Net income	-	-	-	-	-	-	25,039,930	25,039,930
BALANCE, December 31, 2021	14,266,294	$ (20,611,514)	$ (28,806,476)	$ (49,417,990)	733,706	$ (844,579)	$ 60,019,240	$ 9,756,671

See accompanying notes.

EmpRes Healthcare Group, Inc. and Subsidiaries
Consolidated Statements of Cash Flows

	Years Ended December 31, 2021	2020
CASH FLOWS FROM OPERATING ACTIVITIES		
Net income	$ 25,039,930	$ 9,772,486
Adjustments to reconcile net income to net cash provided by operating activities		
Depreciation and amortization	5,303,478	5,898,655
Gain on forgiveness of debt	(38,717,360)	-
Impairment of assets	3,343,812	-
Issuance of debt for SEIU pension liability	1,093,541	-
Loss on disposal of assets	-	49,835
Purchase of treasury stock	(360,857)	-
Allocation of ESOP shares	255,750	-
Change in certain assets and liabilities		
Accounts receivable	(687,585)	644,280
Other receivables and patient trust cash	799,647	1,012,359
Prepaids and other current assets	4,446,870	(6,714,995)
Other assets	1,110,487	(995,913)
Accounts payable, accrued expenses, and insurance reserves	2,791,375	2,560,498
Medicare advance payments	(15,182,700)	23,746,754
Other current and noncurrent liabilities	(16,287,601)	25,388,527
Net cash (used in) provided by operating activities	(27,051,213)	61,362,486
CASH FLOWS FROM INVESTING ACTIVITIES		
Acquisition of property, plant, and equipment	(6,511,489)	(4,749,265)
Cash paid for acquired entities	(150,000)	(900,000)
Proceeds from fixed deposits, net	-	92,902
Net cash used in investing activities	(6,661,489)	(5,556,363)
CASH FLOWS FROM FINANCING ACTIVITIES		
Net activity on line of credit	5,256,885	(18,748,664)
Proceeds from issuance of long-term debt	-	33,351,200
Payments on long-term debt	(17,283,473)	(15,874,954)
Net cash used in financing activities	(12,026,588)	(1,272,418)
NET (DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS	(45,739,290)	54,533,705
CASH AND CASH EQUIVALENTS, beginning of year	61,246,745	6,713,040
CASH AND CASH EQUIVALENTS, end of year	$ 15,507,455	$ 61,246,745
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid for interest during the year	$ 2,530,302	$ 2,918,101

See accompanying notes.

Note 1 – Background and Significant Accounting Policies

EmpRes Healthcare Group, Inc. and subsidiaries (the Company) is a group of commonly controlled subsidiaries engaged in the operation of care centers, which provide post-acute, skilled, rehabilitative, and intermediate nursing care, residential care, personalized services, and related support activities. At December 31, 2021, the Company operated 61 care centers (52 skilled nursing care centers and 9 assisted living and retirement centers) with an aggregate of 5,174 beds and home service companies. At December 31, 2020, the Company operated 64 care centers (55 skilled nursing care centers and 9 assisted living and retirement centers) with an aggregate of 5,456 beds and 15 home service companies. In 2021, 51 care centers were operated under long term leases and 8 care centers were owned by the Company. The care centers are located throughout California, Oregon, Washington, Montana, Nevada, Idaho, South Dakota and Wyoming, and serve residents of those states. The home service companies are located in Washington, Idaho, California, Nevada, Oregon, Montana, Wyoming and Arizona.

The Company is also the 100% owner of Columbia Indemnity Co. LTD. (Columbia Indemnity). Columbia Indemnity was incorporated under the laws of Bermuda on May 11, 2007. The principal business of Columbia Indemnity is the reinsurance of workers' compensation, employers' liability, general liability, professional liability, and auto liability risks of the Company through reinsurance agreements with various members of the Ace American Insurance Group.

In July 2008, EmpRes Healthcare Group, Inc. (fka B13, Inc. and EmpRes Healthcare, Inc.) was created to be the parent of the group of commonly controlled limited liability companies. Andrew V. Martini exchanged his 100% ownership in the limited liability companies for 100% of the shares of EmpRes Healthcare, Inc. In December 2008, EmpRes Healthcare, Inc. established an Employee Stock Ownership Trust (ESOT) under an ERISA Employee Stock Ownership Plan (ESOP). Simultaneously, EmpRes Healthcare Group, Inc. entered into an agreement to purchase 100% of the Company's shares from Andrew V. Martini for debt and cash.

Basis of accounting
The consolidated financial statements have been prepared on the accrual basis of accounting in accordance with GAAP.

Principles of consolidation and basis of presentation – The accompanying consolidated financial statements include the accounts of the Company. All significant intercompany balances and transactions have been eliminated upon consolidation. The consolidated financial statements include the accounts of the following types of companies under the ownership of the Company as of December 31, 2021 and 2020:

SNF = Skilled Nursing Facility
ALF = Assisted Living Facility
MC = Management Company
HC = Holding Company
LSE = Leasing Company
HP = Healthcare Property Company
HS = Home Services Company
ILF = Independent Living Facility

Note 1 – Background and Significant Accounting Policies (continued)

Affiliate	State	Date Organized	Operations Commenced	Termination Date	Number of Beds	Type of Facility
EmpRes Healthcare Group, Inc.	WA	07/31/08	07/31/08	-	N/ A	HC
EmpRes Healthcare Management:						
EmpRes Financial Services, LLC	WA	04/28/97	04/28/97	-	N/ A	MC
EmpRes Healthcare Management, LLC	WA	03/29/00	03/29/00	-	N/ A	MC
Evergreen Master Tenant I, L. L. C.	WA	07/07/06	08/01/06	-	N/ A	LSE
ELC Master Tenant, LLC	WA	09/01/14	09/01/14	-	N/ A	LSE
Master Tenant Four, LLC	WA	07/01/15	07/01/15	-	N/ A	LSE
Vallejo Master Tenant	CA	12/16/16	12/16/16	-	N/ A	LSE
H.P. – Holding-LLC	WA	12/20/04	12/20/04	-	N/ A	HC
H.P. – Salem, LLC (fka White Sands)	OR	12/12/96	12/28/12	-	N/ A	HP
H.P. – Missoula, LLC	MT	05/08/12	05/08/12	-	N/ A	HP
H.P. – Laurel, LLC	MT	10/22/12	10/22/12	-	N/ A	HP
H.P. – Salinas, LLC	WA	11/20/12	11/20/12	-	N/ A	HP
H.P. – Thermopolis, LLC	WY	12/02/16	02/01/17	-	N/ A	HP
H.P. – Americana LLC	WA	10/11/17	10/11/17	-	N/ A	HP
H.P. – Frontier, LLC	WA	10/11/17	10/11/17	-	N/ A	HP
H.P. – Independence, LLC	OR	10/11/17	10/11/17	-	N/ A	HP
EmpRes Home Care, LLC	WA	05/31/13	05/31/13	-	N/ A	HC
EmpRes Home Health, LLC	WA	04/03/14	04/03/14	-	N/ A	HC
EmpRes Hospice, LLC	WA	04/03/14	04/03/14	-	N/ A	HC
Washington:						
EmpRes Washington Healthcare, L.L.C.	WA	01/29/97	05/01/97	-	N/ A	HC
Frontier Rehabilitation & Extended Care Center	WA	01/29/97	05/01/97	-	140	SNF
Americana Health & Rehabilitation Center	WA	01/29/97	05/01/97	-	74	SNF
Whitman Health & Rehabilitation Center	WA	02/24/98	04/01/98	-	55	SNF
Seattle Medical & Rehabilitation Center	WA	02/24/97	05/01/97	-	103	SNF
Enumclaw Health & Rehabilitation	WA	04/01/98	08/01/98	-	92	SNF
Canterbury House	WA	08/10/98	10/01/98	-	100	SNF
Shelton Health & Rehabilitation Center	WA	09/01/01	09/01/01	-	76	SNF
North Cascades Health & Rehabilitation Center	WA	03/21/03	08/01/03	-	122	SNF
Alaska Gardens Health & Rehabilitation Center	WA	05/16/06	08/01/06	7/1/2021	123	SNF
Alderwood Park Health & Rehabilitation Center	WA	09/01/14	09/01/14	-	102	SNF
Highland Health & Rehabilitation Center	WA	09/01/14	09/01/14	-	44	SNF
Snohomish Health & Rehabilitation Center	WA	09/01/14	09/01/14	-	91	SNF
Royal Park Health & Rehabilitation Center	WA	09/01/14	09/01/14	-	164	SNF
Royal Park Retirement Center	WA	09/01/14	09/01/14	-	120	ALF
Buena Vista Healthcare	WA	01/01/15	02/01/15	-	61	SNF& ALF
Ft. Vancouver Post-Acute	WA	07/01/15	07/01/15	-	92	SNF
Ft. Vancouver Assisted Livg	WA	07/01/15	07/01/15	-	45	ALF
Advanced Post Acute (Auburn)	WA	12/01/16	12/01/16	2/1/2021	96	SNF
Transitional Care Unit of Seattle	WA	04/08/20	09/01/20	-	165	SNF
EmpRes Home Health of Bellingham	WA	08/01/14	08/01/14	-	N/ A	HS

Note 1 – Background and Significant Accounting Policies (continued)

Affiliate	State	Date Organized	Operations Commenced	Termination Date	Number of Beds	Type of Facility
Eden Home Care of Bellingham	WA	09/01/16	09/01/16	-	N/ A	HS
Eden Home Health of King County	WA	07/01/18	07/01/18	-	N/ A	HS
Eden Home Health of Spokane County	WA	09/11/19	12/01/19	-	N/ A	HS
Eden Home Health of Clark County	WA	09/11/18	09/01/20	-	N/ A	HS
Eden Hospice at Whatcom County	WA	01/03/20	10/01/20	-	N/ A	HS
Oregon:						
EmpRes Oregon Healthcare, L.L.C.	OR	02/12/97	05/01/97	-	N/ A	HC
LaGrande Post- Acute Rehab	OR	02/12/97	05/01/97	-	76	SNF
Independence Health & Rehabilitation Center	OR	02/12/97	05/01/97	-	80	SNF
Hillsboro Health & Rehabilitation Center	OR	02/12/97	05/01/97	-	78	SNF
Milton-Freewater Health & Rehabilitation Center	OR	02/12/97	05/01/97	-	70	SNF
Oregon Retirement Center	OR	02/12/97	05/01/97	-	82	ALF
The Dalles Health & Rehabilitation Center	OR	02/12/97	05/01/97	-	83	SNF
Portland Health & Rehabilitation Center	OR	02/12/97	01/01/98	-	105	SNF
Windsor Health & Rehabilitation Center	OR	10/01/97	01/01/98	-	100	SNF
Eden Hospice at Portland, LLC	OR	06/14/21	10/01/21	-	N/A	HS
Montana:						
EmpRes Montana Healthcare, L.L.C.	MT	02/25/97	05/01/97	-	N/ A	HC
Polson Health & Rehabilitation Center	MT	02/25/97	05/01/97	-	70	SNF
Hot Springs Health & Rehabilitation Center	MT	02/25/97	05/01/97	-	40	SNF
Missoula Health & Rehabilitation Center	MT	03/31/97	06/01/97	-	75	SNF& ALF
Laurel Health & Rehabilitation Center	MT	03/31/97	09/01/97	-	79	SNF
Livingston Health & Rehabilitation Center	MT	12/04/03	02/01/04	-	115	SNF
Central Montana Nursing & Rehabilitation Center	MT	01/01/15	01/01/15	-	85	SNF
Marias Care Center	MT	01/01/16	01/01/16	5/8/2021	63	SNF
Aspen Meadows Health & Rehabilitation Center	MT	07/01/17	07/01/17	-	90	SNF
Aspen Meadow s Assisted Living	MT	07/01/17	07/01/17	-	55	ALF
Eden Home Health of Bozeman, LLC	MT	01/25/21	05/01/21	-	N/A	HS
Eden Hospice of Western Montana, LLC	MT	03/26/21	11/01/21	-	N/A	HS
Idaho:						
EmpRes Idaho Healthcare, LLC	ID	12/28/99	10/09/98	-	N/A	HC
EmpRes at Idaho Falls	ID	06/01/13	61/13	-	88	SNF
Lewiston Royal Plaza Care	ID	09/01/14	09/01/14	-	56	SNF
Lewiston Royal Plaza Retirement	ID	11/01/14	11/01/14	-	110	ALF
Eden Home Health of Idaho Falls	ID	04/01/14	04/01/14	-	N/A	HS
Eden Home Health of Sandpoint	ID	08/01/19	08/01/19	-	N/A	HS
Eden Hospice at Idaho Falls	ID	06/17/20	09/01/20	-	N/A	HS

Note 1 – Background and Significant Accounting Policies (continued)

California:						
EmpRes California Healthcare, L. L. C.	CA	08/20/98	08/20/98	-	N/A	HC
Petaluma Health & Rehabilitation	CA	10/12/98	01/01/03	44,196	98	SNF
Katherine Healthcare	CA	10/12/98	01/01/00	-	51	SNF
New Hope Post- AcuteCare	CA	10/13/98	01/01/00	44,196	99	SNF
Heartwood Avenue Healthcare	CA	10/14/98	01/01/03	-	60	SNF
Springs Road Healthcare	CA	10/15/98	01/01/03	-	65	SNF
Eden Home Health of Elk Grove	CA	09/01/16	09/01/16	-	N/A	HS
Nevada:						
EmpRes Nevada Healthcare, LLC	NV	11/08/01	11/08/01	-	N/A	HC
Pahrump Health & Rehabilitation Center	NV	12/01/01	12/01/01	-	120	SNF
Ormsby Post-Acute Rehab	NV	12/01/01	12/01/01	-	120	SNF
Mountain View Health & Rehabilitation Center	NV	12/01/02	12/01/02	-	146	SNF
Gardnervile Health & Rehabilitation Center	NV	05/02/03	06/01/14	-	60	SNF
EmpRes Personal Care Nevada	NV	06/13/13	07/01/13	-	N/A	HS
Quality Health Care Corp	NV	07/01/14	07/01/14	-	N/A	HS
Eden Hospice at Carson City	NV	12/01/14	12/01/14	-	N/A	HS
Wyoming:						
EmpRes Wyoming Healthcare	WY	05/01/15	05/01/15	-	N/A	HC
Sage View Care Center	WY	05/19/15	05/19/15	-	82	SNF
Granite Rehabilitation and Welness	WY	10/01/15	10/01/15	-	146	SNF
Raw lins Rehabilitation and Wellness	WY	10/01/15	10/01/15	-	62	SNF
Wind River Rehabilitation and Welness	WY	10/01/15	10/01/15	-	81	SNF
Thermopolis Rehabilitation and Wellness	WY	11/04/16	02/01/17	-	60	SNF
EmpRes at Casper	WY	02/01/19	02/01/19	-	192	SNF
Casper Independent Living	WY	02/01/19	02/01/19	-	26	ILF
Eden Home Health of Cheyenne, LLC	WY	06/14/21	10/01/21	-	N/A	HS
Eden Hospice of Cheyenne, LLC	WY	06/14/21	10/01/21	-	N/A	HS
South Dakota:						
EmpRes South Dakota Healthcare	SD	12/12/18	02/01/19	-	N/A	HC
EmpRes at Mitchell	SD	02/01/19	02/01/19	-	150	SNF
EmpRes at Rapid City	SD	02/01/19	02/01/19	-	90	SNF
Rapid City Assisted Living	SD	02/01/19	02/01/19	-	10	ALF
Sturgis Assisted Living	SD	02/01/19	02/01/19	-	40	ALF
EmpRes at Garretson	SD	02/01/19	02/01/19	-	55	SNF
EmpRes at Woonsocket	SD	02/01/19	02/01/19	-	52	SNF
EmpRes at Flandreau	SD	02/01/19	02/01/19	-	63	SNF
Flandreau Independent Living	SD	02/01/19	02/01/19	-	11	ILF
EmpRes at Britton	SD	02/01/19	02/01/19	-	52	SNF
Arizona:						
Eden Hospice at Sierra Vista	AZ	08/01/18	08/01/18	-	N/A	HS

Note 1 – Background and Significant Accounting Policies (continued)

Management's assessment and plans – Accounting Standards Update (ASU) No. 2014-15, *Disclosure of Uncertainties about an Entity's Ability to Continue as a Going Concern*, requires management to evaluate an entity's ability to continue as a going concern within one year after the date that the consolidated financial statements are available to be issued. Management concluded there are not any items present that would raise substantial doubt about the Company's ability to continue as a going concern.

Cash and cash equivalents and fixed deposits – The Company considers all highly liquid investments with an original maturity of 90 days or less at the time of purchase to be cash equivalents. At December 31, 2021 and 2020, cash and cash equivalents include cash in banks, short-term fixed deposits, and investments with original maturities of 90 days or less at the time of purchase.

Fixed deposits with original maturities of greater than 90 days are not considered cash and cash equivalents and consist of certificates of deposit. As of December 31, 2021 and 2020, the Company held two fixed deposits totaling $11,727,760 and $11,723,300, respectively. Interest receivable on the fixed deposits as of December 31, 2021 and 2020 was $3,627 and $8,412, respectively. The maturity dates for the fixed deposits held as of December 31, 2021 were as follows: June 21, 2022 ($5,000,245) and June 21, 2022 ($6,723,888) with interest rates of 0.09% and 0.27%, respectively, per annum.

Assets supporting letter of credit – The fixed deposits totaling $11,727,760 have been designated as collateral to support a letter of credit issued by the Company's bankers in connection with the operations of Columbia Indemnity as of December 31, 2021 and 2020, respectively.

Patient trust cash – Patient trust accounts represent residents personal funds being held by the care centers and are used only for the individual residents personal use. A corresponding liability is also recognized by the care centers and is recorded in other current liabilities in the accompanying consolidated balance sheets.

Accounts receivable, net – Accounts receivable are recorded net of contractual adjustments at the time revenue is recorded. Resident accounts receivable represents receivables from government payors, primary insurance, and resident accounts where the primary insurance payor has paid, but resident responsibility amounts remain outstanding. Amounts collected on resident accounts receivable are included in net cash provided by operating activities in the accompanying consolidated statements of cash flows.

Property, plant, and equipment – Property, plant, and equipment are stated at cost less accumulated depreciation, or for assets under capital leases, the lesser of the present value of the related capital lease obligation or fair value of the asset at date of acquisition less accumulated depreciation. Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the assets ranging from 3 to 30 years. Assets under capital leases and leasehold improvements are amortized over the shorter of the estimated useful life of the asset or the lease term. Expenditures for maintenance and repairs necessary to maintain property, plant, and equipment in operating condition are expensed when incurred.

Note 1 – Background and Significant Accounting Policies (continued)

Leasehold and loan acquisition costs, net – Costs of $23,604,241 and $23,606,027 at December 31, 2021 and 2020, respectively, have been incurred to assume leases on various care centers acquired from prior owners, which have been capitalized and are being amortized on the straight-line basis over the term of each respective care center's lease. Accumulated amortization on these intangible assets was $22,330,675 and $22,195,214 as of December 31, 2021 and 2020, respectively. Included in leasehold and loan acquisition costs, net, are loan acquisition costs of $3,381,019 at December 31, 2021 and 2020, respectively. Accumulated amortization of $2,173,743 and $2,045,027 has been recorded related to these loan acquisition costs as of December 31, 2021 and 2020, respectively. Amortization expense related to leasehold acquisition costs and loan acquisition costs were $135,460 and $138,173 for the years ended December 31, 2021 and 2020, respectively, and is included in depreciation and amortization in the accompanying consolidated statements of operations.

Goodwill – The Company had goodwill of $13,807,809 and $13,657,809 as of December 31, 2021 and 2020, respectively. As goodwill has an indefinite life, it is not subject to amortization. The Company's management evaluates goodwill for impairment under Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Subtopic 350-20, *Goodwill*, based on a qualitative analysis to assess whether it is more likely than not that goodwill is impaired. As of both December 31, 2021 and 2020, management's analysis indicated goodwill was not impaired.

Concentration of credit risk – A significant portion of the Company's revenue is derived from the Medicare and Medicaid programs. There have been, and the Company expects that there will continue to be, a number of proposals to limit reimbursements to care centers under these programs.

The Company extends credit to various parties in the form of accounts receivable, which are collected from residents, federal and state agencies, and other third-party payors. The care centers collect room fees from private pay residents in advance; however, on occasion, due to unusual circumstances, the Company will extend credit. These resident receivables are minimal and uncollateralized.

The Company maintains cash accounts at a variety of banks. At various times throughout the year, the balances on deposit exceeded the Federal Deposit Insurance Corporation's (FDIC) insured limit of $250,000 per depositor, thereby creating a possible loss to the Company of the amounts in excess of the insured limit.

Assessment of long-lived assets – In accordance with FASB ASC Subtopic 360-10, management reviews the carrying values of the Company's long-lived assets whenever events or circumstances provide evidence that suggests that the carrying amounts may not be recoverable. If these reviews indicate that long-lived assets may not be recoverable, management reviews the expected undiscounted future net operating cash flows from the use of these assets. If such assets are considered to be impaired, the impairment is recognized as a charge against earnings in the consolidated statements of operations. For the year ended December 31, 2021, the Company recorded an impairment of assets for $3,343,812 related to buildings which transferred management subsequent to year end (see Note 14). No impairment was recorded for the year ended December 31, 2020.

In addition to consideration of impairment due to the events or changes in circumstances described above, management regularly evaluates the remaining lives of its long-lived assets. If estimates are revised, the carrying value of affected assets is depreciated or amortized over the remaining lives.

Note 1 – Background and Significant Accounting Policies (continued)

Self-insurance health and dental programs – The Company maintains a self-insured medical and dental plan for its employees. Liabilities have been recorded to cover known claims and an estimate for those claims incurred but not reported, which is included in accrued expenses in the accompanying consolidated balance sheets. At December 31, 2021 and 2020, these amounts were $1,556,945 and $1,492,483, respectively.

Insurance loss reserves – Insurance loss reserves are determined on the basis of the losses reported by the ceding insurer on reinsurance business assumed and on the basis of losses reported by the Company. Reserves comprise an estimate of the amount of reported losses and loss expenses plus a provision for losses incurred but not reported, based on management's best estimate for the ultimate development of losses reported. The Company has established accruals for the self-insurance portion and claims in excess of insurance coverage of general and professional liability insurance.

Management believes that the provision for insurance loss reserves and loss expenses will be adequate to cover the ultimate cost of losses and expenses incurred up to the balance sheet date. However, the provision is an estimate and may ultimately be settled for a significantly greater or lesser amount. In particular, ultimate settlements of professional liability claims depend, among other things, on the resolution of litigation and coverage issues, the outcome of which is difficult to predict. In addition, these claims tend to be incurred relatively infrequently with the potential for significant variability in settlement amounts and associated expenses. It is possible that management may revise this estimate significantly in the near term. Any subsequent differences arising in the estimate or upon settlement are recorded in the period in which they are determined.

Effective June 1, 2009 through December 31, 2021, Columbia Indemnity assumed the first $1,000,000 for each accident, for workers compensation and employers liability, with no aggregate limit; $250,000 for each accident for automobile liability, including a pro rata share of all allocated loss adjustment expenses with no aggregate limit; and $1,000,000 per occurrence/medical incident for general and professional liability, in excess of a self-insured retention of $100,000 per occurrence/medical incident including allocated loss adjustment expenses with a $6,000,000 aggregate limit per policy year. The general and professional liability policy is written on a claims-made basis.

Employee Stock Ownership Plan – The Company sponsors a defined-contribution leveraged Employee Stock Ownership Plan (ESOP). The Company applies the provisions of FASB ASC Subtopic 718-40, Employee Stock Ownership Plans. The compensation cost associated with the release of shares to employees is based on the fair value of the shares rather than cost. The charge for the difference between the fair value and cost is offset by an increase to stockholders deficit. The ESOP is more fully described in Note 10.

Stockholders' equity – The Company began in 2008 as a group of commonly controlled limited liability companies. During 2008, the Company completed an assignment of member interest agreement to transfer all of the ownership of the various limited liability companies in exchange for 15,000,000 shares of common stock in a subchapter S corporation, which was later named EmpRes Healthcare Group, Inc. As of December 31, 2021, the Company is authorized to issue 100,000,000 shares of common stock (no par value), 15,000,000 shares have been issued, 14,266,294 shares are outstanding, and the Company owns 733,706 shares of treasury stock.

Note 1 – Background and Significant Accounting Policies (continued)

Advertising – The Company expenses the costs of advertising when incurred. Advertising expense was $971,642 and $785,805 for the years ended December 31, 2021 and 2020, respectively, and is included in other operating expenses in the accompanying consolidated statements of operations.

Income taxes – The Company is taxed as an S corporation for both federal and state income tax purposes. Under this election, the primary responsibility for payment of taxes on the Company's taxable income passes through to its sole stockholder. Therefore, no provision or liability for federal or state income taxes has been included in the consolidated financial statements. EmpRes' sole stockholder is an ESOP; as such the ESOP is exempt from federal and state income taxes as employee participants are taxed as distributions from the ESOP are made.

With respect to Columbia Indemnity, there is currently no taxation imposed on income or premiums by the government of Bermuda. The income of Columbia Indemnity is taxable to the stockholder, therefore, no provision for income taxes is provided in the accompanying consolidated financial statements.

The Company recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured at the largest amount that is greater than 50% likely of being realized. Changes in recognition or measurement are reflected in the period in which the change in judgment occurs.

Use of estimates – The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenue and expenses during the reporting period. Significant items subject to such estimates and assumptions include the useful lives of fixed assets; the carrying amount of property, plant, and equipment; leasehold acquisition costs; goodwill; and other implicit price concessions; third-party payor settlements; liability for unpaid medical claims and professional liabilities; and valuation of company stock. Actual results could differ from those estimates.

New accounting pronouncements – In February 2016, the FASB established ASC Topic 842, *Leases* (ASC 842), by issuing ASU No. 2016-02, which requires lessees to recognize leases on-balance sheet and disclose key information about leasing arrangements. The new standard established a right-of-use (ROU) model that requires a lessee to recognize a ROU asset and lease liability on the balance sheet for all leases with a term longer than 12 months. Leases will be classified as finance or operating, with classification affecting the pattern and classification of expense recognition in the statement of operations. In April 2020, the FASB proposed a deferral of ASC 842 for an additional year. The Company plans to adopt the new standard effective January 1, 2022. While the Company is currently assessing the potential future impact of adopting ASU No. 2016-02, because of the number of leases the Company utilizes to support its operations, the adoption of ASU No. 2016-02 is expected to have a significant impact on the Company's financial position and results from operations. The Company expects the primary impact will be the recognition, on a discounted basis, of its minimum commitments under noncancelable operating leases on its consolidated balance sheets, resulting in the recording of right-of-use assets and lease obligations. The Company's minimum undiscounted commitments under noncancelable operating leases are disclosed in Note 7.

Note 1 – Background and Significant Accounting Policies (continued)

Reclassification
Certain accounts were reclassified in the prior year for consistency and comparison purposes with the current year presentation. Such reclassifications have no effect on previously reported net income.

Subsequent events
Subsequent events are events or transactions that occur after the balance sheet date but before financial statements are available to be issued. The Company recognizes in the consolidated financial statements, the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the consolidated balance sheet, including the estimates inherent in the process of preparing the financial statements. The Company's consolidated financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the balance sheet but arose after the consolidated balance sheet date and before consolidated financial statements are available to be issued.

The Company has evaluated subsequent events through August 4, 2022, which is the date the consolidated financial statements were available to be issued.

Note 2 – Revenue Recognition

Patient service revenue is recorded based on contracted rates applicable to all residents and patients and includes charges for room and board, rehabilitation therapies, pharmacy, medical supplies, subacute care, home health and hospice care, and other programs provided to residents and patients in skilled nursing care centers, assisted living care centers, and home service companies. In accordance with ASC Topic 606, patient service revenues, net, are recorded at the transaction price estimated by the Company to reflect the total consideration due from patients and third-party payors. Revenue is recognized over time as performance obligations are satisfied in exchange for providing goods and services in patient care. Revenue is recorded as these good and services are provided. The services provided during a stay represent a bundle of goods and services that are distinct and accounted for as a single performance obligation. The Company's estimate of the transaction price includes the Company's standard charges for goods and services provided to its patients with reductions related to implicit price concessions for items such as contractual allowances and other amounts that become uncollectible.

The Company determines the transaction price based on level of care in accordance with CMS guidelines and criteria and provider contracts, reduced by contractual adjustments provided to third-parties. The Company determines its estimates of contractual adjustments based on contractual agreements and historical experience. Agreements with third-party payors provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors follows:

Medicaid – The Company's reimbursement methodology is determined based on prospective rates similar to the Medicare methodology. Certain services are paid based on a cost-reimbursement methodologies subject to certain limits or are paid based upon established fee schedules.

Medicare – Certain health care services are paid at prospectively determined rates per level of care based on clinical, diagnostic or other factors. Certain services are paid based on a cost-reimbursement methodologies subject to certain limits or are paid based upon established fee schedules.

Third-party payors and Veterans – Payment agreements with certain commercial insurance carriers, health maintenance organizations, preferred provider organizations, and Veterans insurance provide for payment using prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Private – Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Company estimates the transaction price for patients with deductibles and coinsurance based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments determined on a resident by resident basis. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to health services revenue in the period of the change. Subsequent changes that are determined to be the result of an adverse change in the residents' ability to pay are recorded as bad debt expense.

Note 2 – Revenue Recognition (continued)

Revenue from the Medicare and Medicaid programs represented the following percentages of total net revenue for the years ended December 31, 2021 and 2020:

	2021	2020
Medicaid	47%	50%
Medicare	41%	37%

Patient service revenue, net by payor type is broken out by payor, line of business, and geographical location is the following tables as of December 31, 2021 and 2020.

	2021 – by Payor	2020 – by Payor
Medicare	$ 166,191,918	$ 165,058,436
Medicaid	189,924,409	219,302,999
Commercial	5,650,940	4,899,295
Private pay	31,950,342	36,038,694
Other	12,103,283	16,137,400
Total patient service revenue, net	$ 405,820,892	$ 441,436,824

	2021 – by Line of Business	2020 – by Line of Business
Skilled nursing	$ 317,842,564	$ 366,549,330
Assisted living	15,083,402	15,481,522
Home services	61,073,122	47,168,800
Ancillary	11,821,804	12,237,172
Total patient service revenue, net	$ 405,820,892	$ 441,436,824

	2021 – by State	2020 – by State
Washington	$ 146,707,493	$ 154,879,525
California	18,590,553	38,550,889
Oregon	38,531,520	35,635,517
Montana	35,187,794	38,293,433
Wyoming	48,278,432	53,489,975
Idaho	20,980,604	19,582,260
Nevada	60,478,763	60,240,427
South Dakota	33,207,287	37,629,362
Arizona	3,858,446	3,135,436
Total patient service revenue, net	$ 405,820,892	$ 441,436,824

Note 2 – Revenue Recognition (continued)

The Company has agreements with third-party payors that provide for payments at amounts different from its established rates. Patient service revenue is recognized at the time services are provided to patients. Revenue is recorded in the amount which the Company expects to collect, which may include variable components. Variable consideration is included in the transaction price to the extent that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the variable consideration is subsequently resolved. Adjustments from finalization of prior years' cost reports and other third-party settlement estimates have not resulted in any significant changes to patient services revenues during the years ended December 31, 2021 and 2020.

Grant revenue
The Company follows International Accounting Standard 20, *Accounting for Government Grants and Disclosures of Government Assistance* ("IAS 20"), to account for government grant funds received. Upon receipt of grant funds, the Company records the receipt to deferred revenue. Once it is reasonably assured that the entity will comply with the conditions of the grant, the grant money is recognized on a systematic basis over the periods in which the Company recognizes the related expenses or losses for which the grant money is intended to compensate.

Note 3 – Fair Value of Financial Instruments

The Company applies the provisions of FASB ASC Topic 820, *Fair Value Measurement*, for fair value measurements of financial assets and financial liabilities and for fair value measurements of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis. ASC Topic 820 defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC Topic 820 also establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

Level 1 – inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that the Company has the ability to access at the measurement date.

Level 2 – inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.

Level 3 – inputs are unobservable inputs for the asset or liability.

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest-level input that is significant to the fair value measurement in its entirety. All of the assets measured at fair value on a recurring basis have Level 1 measurements and are included in cash and cash equivalents and fixed deposits in the accompanying consolidated balance sheets at December 31, 2021 and 2020.

Note 3 – Fair Value of Financial Instruments (continued)

The estimated fair value of certain financial instruments is reflected in the accompanying consolidated balance sheets. The carrying amounts of cash and cash equivalents, fixed deposits, restricted cash, accounts receivable, other receivables, prepaid expenses, and other current assets; and accounts payable, accrued expenses, other current liabilities, and the line of credit approximate the fair value of these instruments due to their short-term maturities.

Note 4 – Accounts Receivable

Accounts receivable, net, are due from the following payors as of December 31, 2021 and 2020:

	2021	2020
Medicare A	$ 15,350,195	$ 16,365,198
MCR Advantage	10,898,141	8,931,703
Wyoming Medicaid	3,830,542	3,826,274
Washington Medicaid	3,540,703	3,610,310
Insurance	3,040,918	3,522,829
Montana Medicaid	2,896,396	1,548,312
All others	2,780,940	1,253,706
Managed Medicaid	1,977,518	2,932,961
Nevada Medicaid	1,943,238	3,676,518
Oregon Medicaid	1,694,511	1,378,707
Various private paying patients	1,300,949	669,301
South Dakota Medicaid	923,610	1,053,971
Medicare B	683,777	815,787
California Medi-Cal	267,084	843,948
Arizona Medicaid	54,181	65,593
Accounts receivable, net	$ 51,182,703	$ 50,495,118

Note 5 – Property, Plant, and Equipment

Property, plant, and equipment, net consist of the following as of December 31, 2021 and 2020:

	2021	2020
Leasehold improvements	$ 27,346,116	$ 26,440,808
Equipment	32,802,734	31,282,737
Buildings	33,603,448	33,603,448
Land	5,887,900	5,887,900
Construction in progress	3,661,001	3,059,335
	103,301,199	100,274,228
Less accumulated depreciation and amortization	(53,224,375)	(48,061,603)
	$ 50,076,824	$ 52,212,625

Note 6 – Lines of Credit

As of December 31, 2021, the Company has a $40,000,000 line of credit with MidCap Financial Services maturing April 30, 2024. Interest is calculated at London Interbank Offered Rate (LIBOR) plus 4.0% with a LIBOR floor rate of 1.0%. An annual fee of 0.5% is applied to the unused portion of the line. The Company also has one additional $3,000,000 line of credit with MidCap maturing April 22, 2024 that is related to specific facilities. The interest rate at December 31, 2021 was 4.53%. The Company's available accounts receivable borrowing base, which is the total amount the Company is allowed to borrow, as calculated in accordance with its agreements with MidCap at December 31, 2021 and 2020 was $19,084,564 and $28,902,237, respectively. The outstanding balance at December 31, 2021 and 2020 on these lines of credit was $9,682,903 and $4,426,018, respectively. The amount available for draw under all the lines of credit at December 31, 2021 and 2020 was $9,401,661 and $24,476,219, respectively, based on the line-of-credit commitment, and the Company s available accounts receivable borrowing base, which is used as collateral for the line of credit.

As of December 31, 2021, the outstanding balances of $7,540,432 and $2,142,471 on the two lines of credit with MidCap are classified as current liabilities. Due to lock-box provisions within the line-of-credit agreements, the outstanding balances are required to be classified as a current liability under generally accepted accounting principles. While these lock-box provisions require the Company's daily cash receipts to be apportioned to the outstanding balance on the line of credit, the Company has the ability to immediately draw down on the line of credit up to the accounts receivable base noted above. The line of credit with MidCap provides funds available for the Company to access until its maturity date on April 30, 2022.

Note 6 – Lines of Credit (continued)

The Company has certain financial covenants associated with the lines of credit, primarily related to maintaining certain liquidity and fixed charge coverage ratios. At December 31, 2021, the only required ratio covenant related to liquidity. Management determined that the Company was in compliance with these covenants. Certain additional future debt covenant calculations begin during 2022.

Note 7 – Leases

The Company leases certain buildings and equipment under noncancelable operating leases. Future minimum annual operating lease payments as of December 31, 2021 are as follows:

2022	$ 35,689,900
2023	35,767,500
2024	34,466,700
2025	32,030,000
2026	33,280,500
Later years, through 2033	167,643,400
Total minimum lease payments	$ 338,878,000

At December 31, 2021, the Company has 51 buildings under noncancelable operating lease agreements. The leases provide for monthly base rental payments and may include the payment of real estate taxes, repairs, and normal operating costs of the care centers. The monthly base rent on certain care centers increases between 2% and 3% per year, compounded annually. The fixed escalating rental expense is recorded on a straight-line basis over the term of the lease in the accompanying consolidated financial statements. The Company has recorded a deferred rent liability to reflect the excess of rent expense over cash payments since the inception of the leases. At December 31, 2021 and 2020, there was $11,689,655 and $11,150,876, respectively, of deferred rent liability, which is included in other noncurrent liabilities in the accompanying consolidated balance sheets. Additionally, the Company has various other noncancelable operating leases for equipment that expire at various dates through 2022. For the year ended December 31, 2021, total rent expense for operating leases was $37,354,945, which is comprised of rent expense only related to continuing operations. For the year ended December 31, 2020, total rent expense for operating leases was $40,985,894, which is comprised of rent expense only related to continuing operations.

Note 8 – Long-Term-Debt

Long-term debt at December 31, 2021 and 2020 consists of the following:

	2021	2020
Note payable to Andrew V. Martini: prime plus 1.25% interest per annum; note matured December 15, 2020, modified in July 2021	$ -	$ 26,958,030
Note payable to Andrew V. Martini: 3.50% interest per annum payable over a fifteen year term, due September 2036	10,859,931	-
Note payable to Berkadia (Missoula bldg-HUD): 3.46% interest per annum; principal and interest payments due in monthly installments through October 1, 2049	6,554,590	6,747,200
Note payable to Berkadia (Missoula bldg-HUD): 2.27% interest per annum; principal and interest payments due in monthly installments through December 1, 2046	2,025,689	2,068,259
Note payable to Bank of Oklahoma (various bldgs-Bridge): Libor plus 3.75% interest per annum; interest only payments due in monthly installments, paid in full April 2021	-	17,455,450
Note payable to Orix (Independence bldg-HUD): 4.23% interest per annum; principal and interest payments due in monthly installments through April 1, 2049	3,964,291	4,039,391
Note payable to Berkadia (Katherine bldg-HUD): 2.88% interest per annum; principal and interest payments due in monthly installments through July 1, 2050	6,403,490	6,545,884
Note payable to MidCap (Thermopolis bldg-HUD): 4.01% interest per annum; principal and interest payments due in monthly installments through July 1, 2054	5,267,665	5,346,791
Note payable to MidCap; Libor plus 6.50% interest per annum; principal and interest payments due in monthly installments through April 30, 2022	1,350,000	3,150,000
SIEU pension liability: 2.48% interest per annum; principal and interest payments of $5,784 due monthly through November 2041.	1,090,017	-

Note 8 – Long-Term-Debt (continued)

	2021	2020
Note payable to Hewlett-Packard: 6.17% interest per annum. Paid in full during 2021	-	111,959
Paycheck Protection Program Loan to Bank of Oklahoma Forgiven during 2021	-	20,000,000
	37,515,673	92,422,964
Less current portion	(2,513,882)	(46,808,019)
	$ 35,001,791	$ 45,614,945

At December 31, 2021, the aggregate maturities of long-term debt for the next five years and thereafter are as follows:

Years ending December 31,	2022	$ 2,513,882
	2023	122,414
	2024	1,242,262
	2025	1,283,524
	2026	5,326,097
	Thereafter	27,027,494
		$ 37,515,673

In October 2021, the Company entered into a loan modification agreement with Andrew Martini. As a result of the modification, the loan was reduced from $26,958,030 to $15,000,000 and all unpaid accrued interest of $6,515,514 was reduced to zero.

On May 6, 2020, the Company entered into a Paycheck Protection Program (the PPP) Term Loan (the PPP Loan) with Bank of Oklahoma in an aggregate principal amount of $20,000,000 pursuant to the paycheck Protection program under the Coronavirus Aid, relief, and Economic Security (CARES) Act. The PPP Loan bears interest at a fixed rate of 1% per annum. The Company used the proceeds from the PPP Loan for qualifying expenses as defined in the PPP Loan. The Company received full forgiveness of these PPP loans in 2021, including interest of $243,816.

Note 9 – Retirement Plan

The Company has a defined-contribution retirement plan under Section 401(k) of the Internal Revenue Code, covering all employees aged 18 or older having completed six months of service. Employee elective contributions are made on a voluntary basis, not to exceed statutory limits. Discretionary employer matching contributions are provided for in the plan. The Company made no contributions to the plan during 2021 or 2020.

Note 10 – Employee Stock Ownership Plan

On December 30, 2008, the Company established an ESOP for its employees. On December 30, 2008, the ESOP Trust purchased 100% of the shares of the Company from Andrew V. Martini for $58,600,000 in exchange for $10,000,000 of cash and $48,600,000 of debt (Acquisition Debt). This transaction resulted in a liability of $48,600,000 and an increase to guaranteed ESOP benefit of $58,600,000. The Company is obligated to contribute sufficient cash to the ESOP to enable repayment of principal and interest due under the borrowings.

In October 2021, the Company entered into a loan modification agreement with Andrew Martini. As a result of the modification, the loan was reduced from the outstanding balance of $26,958,030 to $15,000,000 and all unpaid accrued interest of $6,515,514 was reduced to zero. The parties agreed that the Trust, the Company, and the Seller would modify the original ESOT loan by assigning the ESOT Note and related ESOT Pledge and the Seller's entire rights under the ESOT Pledge Agreement (including all share certificates held by Seller), and the ESOT Loan Agreement to the Company. The Company made a $4,000,000 payment and revised the Martini note to $11,000,000 at 3.5% interest over 15 years. Under the ESOP, the Company intends to allocate the 5,282,107 unallocated shares as of December 31, 2021 to employees as the new ESOT debt is serviced.

The ESOP Loan is repaid based on annual payments amortized over a 20-year period with interest at 1.74%. The Company recognizes compensation expense based on shares allocated from the ESOP in the current period as defined in the ESOP plan document and the associated fair value of the ESOP shares, which is included in salaries, payroll taxes, and benefits in the accompanying consolidated statements of operations. The shares earned in 2021 and 2020 were allocated to participants' ESOP accounts on December 31, 2021 and 2020, respectively. The cost of unallocated shares is reflected as guaranteed ESOP benefit, which increases total stockholders' deficit. A summary of ESOP activities for the years ended December 31, 2021 and 2020 is as follows:

	2021	2020
Total issued shares of common stock	15,000,000	15,000,000
Total outstanding shares of common stock	14,266,294	14,685,895
Total allocated shares of common stock	8,984,187	9,125,799
Total unallocated shares of common stock	5,282,107	5,560,096
Total shares of treasury stock	733,706	314,105
Estimated fair value per share of common stock	$ 0.92	$ 0.86
Total ESOP compensation expense	530,934	480,132
Estimated fair value of unallocated shares of common stock	4,859,538	4,781,683
Cost of unallocated shares of common stock	20,611,514	21,698,451
Cost of shares of treasury stock	844,579	483,722

In addition to the Company's obligation to contribute sufficient cash to the ESOP to enable repayment of its debt obligations, the Company is obligated to fund the cash requirements of the ESOP created by the repurchase obligation associated with shares that have been allocated and vested. The total repurchase obligation is equal to the vested allocated shares multiplied by the then current share value as determined pursuant to the Company's annual valuation analysis. This repurchase obligation is payable when employees terminate and become eligible to receive the vested portion of their account.

Note 10 – Employee Stock Ownership Plan (continued)

Participants of the ESOP with vested account balances of $5,000 or less as of their termination for reasons other than death are generally eligible to receive, as soon as practicable, a lump-sum cash distribution from the Company equal to the fair value of their respective vested account balances.

Generally, participants with a vested account balance of more than $5,000 upon termination will receive commence no later than the valuation date of the Plan Year following (a) the Plan Year in which the participant terminates employment by reason of death or disability or has attained the Normal Retirement Age (age 65) or (b) the sixth Plan Year after the participant terminated employment for other reasons.

The ESOP is not insured by the Pension Benefit Guaranty Corporation, the Company, or any other party.

Note 11 – Contingencies

Litigation –
The Company is involved in various legal actions arising in the ordinary course of business. In the opinion of management, the ultimate disposition of these matters will not have a material adverse effect on the Company's consolidated financial position, results of operations, or liquidity.

Industry Regulations –
The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for resident services, and Medicare and Medicaid fraud and abuse. Government activity continues with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs, together with the imposition of significant fines and penalties, as well as significant repayments for resident services previously billed. Management believes that the Company is in compliance with the fraud and abuse regulations as well as other applicable government laws and regulations.

Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

Cyber security –
Health care providers and insurers are highly dependent upon integrated electronic medical record and other information systems to deliver high quality, coordinated and cost-effective care.

These systems necessarily hold large quantities of highly sensitive protected health information. As a result, the electronic systems and networks of health care providers are considered likely targets for cyberattacks and other potential breaches of their systems. In addition to regulatory fines and penalties, health care entities subject to breaches may be liable for the costs of remediating the breaches, damages to individuals (or classes) whose information has been breached, reputational damage and business loss, and damage to the information technology infrastructure. Management does not believe there are any material outstanding liabilities for breaches of their systems.

Note 11 – Contingencies (continued)

COVID-19 –

The Company's management has been closely monitoring the impact of COVID-19 on the Company's operations, including the impact on its patients and employees. The duration and intensity of the pandemic is uncertain but may influence resident decisions and may also negatively impact collections of the Company's receivables.

Collective bargaining agreements –

19 of the 58 skilled nursing homes are under collective bargaining agreements. The agreements require the entities to pay specified wages, provide certain benefits to union employees and contribute certain amounts to pension plans and employee benefit trusts. The employer pension plan contribution rates are determined annually and are assessed on a "pay-as-you go" basis based on union employee payrolls, which cannot be determined for future periods because the location and number of union employees that the entities have employ at any given time and the plans in which the entities may participate vary depending on projects ongoing at any time and the need for union resources in connection with those projects. The collective bargaining agreements expire at various times and have typically been renegotiated and renewed on terms similar to the ones contained in the expiring agreements.

Note 12 – Provider relief funds (PRF)

On March 27, 2020, the United States Congress passed the Coronavirus Aid, Relief, and Economic Securities ("CARES") Act. The CARES Act included provisions for health care under the Provider Relief Fund. The Company received funds under the Provider Relief Fund, administered by the U.S. Department of Health & Human Services (HHS) of approximately $7,826,954 and $32,396,015 for the years ended December 31, 2021 and 2020, respectively. The Company was required to timely sign attestations agreeing to the terms and conditions of payment. Those terms and conditions include measures to prevent fraud and misuse. Documentation is required to ensure that these funds are to be used for healthcare-related expenses or lost revenue attributable to COVID-19, limitations of out-of-pocket payments from certain patients, and the acceptance of several other reporting and compliance requirements. It is noted that anti-fraud monitoring and auditing will be performed by HHS and the Office of the Inspector General. For the year ended December 31, 2021, the Company has recognized approximately $17,382,796 of the Provider Relief Fund on its consolidated statements of income and approximately $7,826,054 is included in other current liabilities on the consolidated balance sheet as of December 31, 2021. For the year ended December 31, 2020, the Company has recognized approximately $15,252,138 of the Provider Relief Fund on its consolidated statements of income and approximately $17,113,877 was included in other current liabilities on the consolidated balance sheet as of December 31, 2020.

The CARES Act also provided for deferred payment of the employer potion of social security taxes between March 27, 2020 and December 31, 2020, with 50% of the deferred amount due December 31, 2021 and 50% due December 31, 2022. The Company began deferring the employer portion of social security taxes in April 2020. As of December 31, 2021 and 2020, the Company deferred $4,199,430 and $8,598,808 in social security taxes which are included in other current liabilities and other non-current liabilities, respectively.

Note 13 – Acquisitions and Other Significant Transactions

During 2020, the Company added three new Home Services agencies and one skilled nursing facility. Home Services included two Hospice start-ups in Washington and Idaho and a home services facility in Washington. The Skilled Nursing Facility was a startup of a 165-bed unit in Washington.

Note 14 – Subsequent Events

On February 1, 2022, the Company transferred management of 6 skilled nursing facilities to another unrelated operator. This transfer would have impacted the following line items on the Company's 2021 consolidated financial statements:

	December 31, 2021
Cash	$ 12,950
Accounts receivable	3,177,649
Inventory, prepaid expenses and other	404,725
Total current assets	3,595,324
Net property and equipment	2,942,000
Other assets	2,637
Total long-term assets	2,944,637
Total assets	$ 6,539,961
Accounts payable and accrued liabilities	$ 2,783,747
Other current liabilities	2,975,255
Total current liabilities	5,759,002
Other liabilities	13,806,245
Total long-term debt	13,806,245
Members' equity	(13,025,286)
Total liabilities and members' equity	$ 6,539,961

	2021
Revenue	$ 42,078,564
Expenses	48,071,770
Net loss	$ (5,993,206)

MOSSADAMS

APPENDIX Y