Home Health Agency Certificate of Need
Application Packet

Contents:

Application submission must include:

- One electronic copy of your application, including any applicable addendum – no paper copy is required.
- A check or money order for the review fee of **$24,666** payable to **Department of Health.**

Include copy of the signed cover sheet with the fee if you submit the application and fee separately. This allows us to connect your application to your fee. We also strongly encourage sending payment with a tracking number.

- Mail or deliver the application and review fee to:

Mailing Address:

Department of Health
Certificate of Need Program
P O Box 47852
Olympia, Washington 98504-7852

Other Than By Mail:

Department of Health
Certificate of Need Program
111 Israel Road SE
Tumwater, Washington 98501

Contact Us:
Certificate of Need Program Office 360-236-2955 or FSLCON@doh.wa.gov.

Application Instructions

The Certificate of Need Program will use the information in your application to determine if your project meets the applicable review criteria. These criteria are included in state law and rules. Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310.

General Instructions:

- Include a table of contents for application sections and appendices/exhibits
- Number **all** pages consecutively
- Make the narrative information complete and to the point.
- Cite all data sources.
- Provide copies of articles, studies, etc. cited in the application.
- Place extensive supporting data in an appendix.
- Provide a detailed listing of the assumptions you used for all of your utilization and financial projections, as well as the bases for these assumptions.
- Under no circumstance should your application contain any patient identifying information.
- Use **non-inflated** dollars for **all** cost projections
- **Do not** include a general inflation rate for these dollar amounts.
- **Do** include current contract cost increases such as union contract staff salary increases. You must identify each contractual increase in the description of assumptions included in the application.
- **Do not** include a capital expenditure contingency.
- If any of the documents provided in the application are in draft form, a draft is only acceptable if it includes the following elements:
  a. identifies all entities associated with the agreement,
  b. outlines all roles and responsibilities of all entities,
  c. identifies all costs associated with the agreement,
  d. includes all exhibits that are referenced in the agreement, and
  e. any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

Do not skip any questions in this application. If you believe a question is not applicable to your project, explain why it is not applicable.

Answer the following questions in a manner that makes sense for your project. In some cases, a table may make more sense than a narrative. The department will follow up in screening if there are questions.

Program staff members are available to provide technical assistance (TA) at no cost to you before submitting your application. While TA isn't required, it's highly recommended and can make any required review easier. To request a TA meeting, call 360-236-2955 or email us at FSLCON@doh.wa.gov.

Washington State Department of Health

Certificate of Need Application
Home Health 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, Chief Operating Officer Jamie Brown jamie.brown@eden-health.com	Date March 17, 2025 Telephone Number 360-947-9988
Legal Name of Applicant Eden Home Health of Spokane, LLC **Address of Applicant** Eden Health 4601 NE 77th Ave. Suite 300 Vancouver, WA. 98662	**Provide a brief project description** ☐ New Agency X Expansion of Existing Agency ☐ Other: _____ Estimated capital expenditure: $ 0
Identify the county proposed to be served for this project. Note: Each home health 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. Benton County	

Table of Contents

Table of Tables

LIST of APPENDICES

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).

This application is submitted by Eden Health, Inc. which owns 100% of EmpRes Home Health and Hospice, LLC, which in turn owns 100% of Eden Home Health of Spokane County. If a Certificate of Need is issued for this project, the department will issue an In Home Service license to Eden Home Health of Spokane County, LLC to serve Benton County. For this review, references to the applicant will identify "Eden Home Health of Spokane County, LLC" as the applicant.

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

The applicant recognized by the Program is EmpRes Healthcare Group, Inc. Eden Home Health of Spokane County, LLC is a limited liability company. The UBI for Eden Home Health of Spokane County, LLC County is 604-331-802

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

   Jamie Brown, Chief Operating Officer
   Eden Health, 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, Principal
   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 1 provides the Eden Health organizational chart.

6. 1the 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 2 provides the list of healthcare facilities owned, operated, or managed by the applicant.

Project Description

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

Eden Home Health of Spokane County, LLC
13305 E Trent Ave
Spokane Valley, WA 99216

2. If an existing Medicare and Medicaid certified home health agency, explain how this proposed project will be operated in conjunction with the existing agency.

Eden Home Health of Spokane County, LLC will utilize its central office to coordinate and deliver home health services. To serve Benton County, Eden will employ dedicated teams of nursing and therapy professionals, including registered nurses, physical therapists, speech therapists, occupational therapists, and social workers. Additional resources will be available through contracts or shared staffing with Eden Health Inc.

All intake, scheduling, billing, and clinical oversight will be managed from the Spokane central office. Field clinicians in Benton County will be equipped with laptops for electronic documentation via an EMR system, ensuring timely submission of patient records. The application outlines various support systems designed to assist field clinicians in providing home-based care, including:

- Learning Management System: Healthstream
- Online Patient Education: Ignite Healthcare
- Medical Supplies: Medline
- Shipping/Postage: FedEx
- Interpretation Services: Language Line Service
- Website Services – Yolocare
- Office Supplies/Promotional Products – Office Depot

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.

   Eden Home Health of Spokane County, LLC
   13305 E. Trent Ave
   Spokane Valley, WA 99216

4. Provide a detailed description of the proposed project.

Eden Home Health of Spokane County proposes to add Benton County to its Spokane County service area for Medicare and Medicaid certified patients. The office location will be unchanged. The details of the operation are described in response to the comprehensive set of questions for a home health agency application.

5. Confirm that this agency will be available and accessible to the entire geography of the county proposed to be served.

The agency will be accessible and available to serve the entire geographic area of Benton County as proposed.

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:

Event	**Anticipated Month/Year**
CN Approval	August 2025
Design Complete (if applicable)	N.A.
Construction Commenced (if applicable)	N.A.
Construction Completed (if applicable)	N.A.
Agency Prepared for Survey (paperwork approved)	N.A
Agency providing Medicare and Medicaid home health services in the proposed county.	October 2025

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

x Skilled Nursing	x Occupational Therapy
x Home Health Aide	x Nutritional Counseling
x Durable Medical Equipment	x Bereavement Counseling
x Speech Therapy	x Physical Therapy
x Respiratory Therapy	x IV Services
x Medical Social Services	x Applied Behavioral Analysis
□ Other (please describe)	

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

Eden Home Health of Spokane County, LLC provides all the services described in the Question 7 response within Spokane County. It will provide the same set of services in Benton County.

9. If this application proposes expanding an existing home health 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 Home Health of Spokane County, LLC is currently authorized to provide home health services in Spokane County, including care for Medicare and Medicaid patients. In the future, Eden may seek approval to expand its services to Stevens, Pend Oreille, and Whitman counties. If approved, Eden will offer comprehensive home health services, including care for Medicare and Medicaid patients, in these additional areas.

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

The National Institutes of Health periodically analyzes data on patients served by nursing homes. More detailed information is available on the diagnostic mix of Medicare-only patients, who account for over 70% of skilled nursing home admissions in Spokane County.

For an industry overview please see:

https://media.market.us/home-healthcare-statistics/

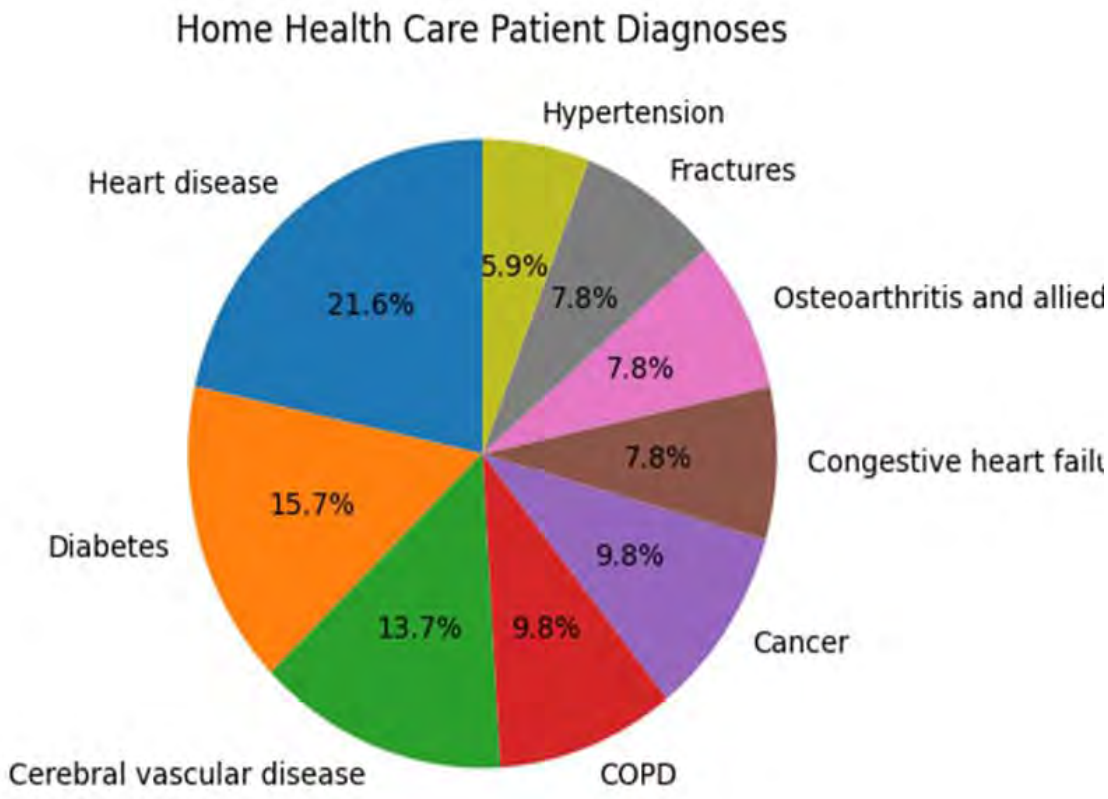
Medical and skilled nursing services are primarily required for managing chronic health conditions. Since individuals aged 65 and older make up the majority of home health care patients, it is not surprising that conditions common among the aging population are among the most frequently managed. According to the U.S. Department of Health and Human Services (2000), the most common admission diagnoses for home health care patients include:

- Heart disease (11%)
- Diabetes (8%)
- Cerebrovascular disease (7%)
- Chronic obstructive pulmonary disease (COPD) (5%)
- Malignant neoplasms (5%)
- Congestive heart failure (4%)
- Osteoarthritis and related disorders (4%)
- Fractures (4%)
- Hypertension (3%)

These conditions highlight the critical role of home health care in supporting the aging population and managing chronic illnesses.

Table 1, based on Year 2000 data shows the diagnostic mix as shown below.

Table 1
Diagnostic Mix of Home Health Care Patients by Diagnosis



A third more current study focused solely on all Medicare Only admissions from the 20 most frequent DRG categories for 2022.[1] As an example of how the patient population can change note that although Cancer is normally reported as 5% - 10% of the entire home care population, it does not appear in the top 20 ICD-10 diagnoses. Diabetes and heart disease are well represented in the top 20 diagnoses as are most of the other top 20 diagnoses.

Table 2.3: Top 20 Primary International Classification of Diseases, Version 10 (ICD-10) Diagnoses for All Home Health Claims, 2022

Clinical Profile of Home Health Users

Primary ICD-10 Diagnoses	Number of Home Health Claims	Percent of Total Home Health Claims
TYPE 2 DIABETES MELLITUS	668,712	7.7%
ENCOUNTER FOR OTHER POSTPROCEDURAL AFTERCARE	469,948	5.4%
ORTHOPEDIC AFTERCARE	456,811	5.2%
HYPERTENSIVE HEART DISEASE	355,737	4.1%
PRESSURE ULCER	332,964	3.8%
ESSENTIAL (PRIMARY) HYPERTENSION	316,158	3.6%
SEQUELAE OF CEREBROVASCULAR DISEASE	291,818	3.3%
HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE	280,469	3.2%
OTHER CHRONIC OBSTRUCTIVE PULMONARY DISEASE	242,296	2.8%
FRACTURE OF FEMUR	188,179	2.2%
ATRIAL FIBRILLATION AND FLUTTER	163,691	1.9%
PARKINSON'S DISEASE	163,617	1.9%
EMERGENCY USE OF COVID-19 DIAGNOSIS	162,771	1.9%
ENCOUNTER FOR FITTING AND ADJUSTMENT OF OTHER DEVICES	140,036	1.6%
OTHER DISORDERS OF URINARY SYSTEM	133,279	1.5%
OSTEOARTHRITIS OF KNEE	133,181	1.5%
HYPERTENSIVE CHRONIC KIDNEY DISEASE	122,469	1.4%
OTHER DISORDERS OF VEINS	122,429	1.4%
UNSPECIFIED DEMENTIA	111,316	1.3%
ALZHEIMER'S DISEASE	107,225	1.2%
Total for Top 20 Primary ICD-10 Diagnoses	**4,963,106**	**56.8%**

Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
Note: Cohort includes all Home Health claims in 2022 Standard Analytic File.

Table 2 provides additional information indicating the size of the Medicaid and uninsured (low income) population residing in Benton County compared with the State drawn from the 2022 Community Health Needs Assessment Table 7.

Table 2

Residents Uninsured and Residents with Medicaid (Drawn from Table 7, CHNA)

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Percent Residents Uninsured*	7.1%	14.1%	9.3%	6.2%
Percent Residents with Medicaid**				23.98%
Percent Residents with Medicaid***	21.9%	36.1%	26.4%	19.8%

[1] See Appendix 18 for complete Medicare study by KNG Health Consulting 2023 - Research Institute for Home Care

*US Census Bureau, 2020
**Data.medicaid.gov, 2020
***BentonFranklinTrends.org, 2019.

Table 3 provides the leading causes of death which closely match the NIH studies of patients making up home healthcare services. As previously noted, for skilled nursing home facilities, cancer diagnoses are not listed among the top 20 ICD-10 diagnostic codes.

Table 3
Leading Cause of Death Rates Drawn from Table 27 CHNA 2022 Study

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Major Cardiovascular Diseases Mortality Rate per 100,000 Population	187.51	186.44	186.31	180.27
Malignant Neoplasms Mortality Rate per 100,000 Population	137.37	122.69	133.24	135.74
COVID-19 Mortality Rate per 100,000 Population	60.42	89.02	67.33	35.82
Alzheimer's Disease per 100,000 Population	67.56	42.42	62.26	41.71
Unintentional Injuries per 100,000 Population	52.40	42.22	49.50	51.42
Chronic Lower Respiratory Disease per 100,000 Population	32.05	37.57	33.40	28.89
Diabetes Mellitus per 100,000 Population	16.93	26.94	19.07	22.23
Chronic Liver Disease and Cirrhosis per 100,000 Population	14.30	15.26	13.90	14.12
Intentional Self-Harm (Suicide) per 100,000 Population*	18.22			15.39
Parkinson's Disease per 100,000 Population*	9.04			9.25

Benton County's years of potential life lost (YPLL) per 100,000 population is slightly higher than the average for Washington State. See: countyhealthrankings.org

Table 4
Life Expectancy and Years of Potential Life Lost Drawn from Table 24 CHNA Study

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Life Expectancy	78.70	79.80	79.08	79.85

Years of Potential Life Lost**	4,402 Years	3,520 Years	4,106 Years	3,860 Years

Source: CHAT, 2020
***A cumulative estimation of the average time a person would have lived had they not died prematurely (before the age of 65)*

The CHNA study shows that chronic illness is a greater driver of home health admissions in Benton County than in the State as a whole.

Table 5
Chronic Illness Drawn from Table 23 CHNA Study

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Age-Adjusted All Cancer Incidence Rate per 100,000 Population	343.95	321.14	336.23	474.59
Adults Reporting Having Ever Been Told They Had Coronary Heart Disease and/or a Heart Attack**	6.32%	4.84%	5.70%	4.61%
Adults Reporting Having Ever Been Told They Had Diabetes (Excludes Gestational and Pre-Diabetes)**	8.35%	8.72%	8%	8.02%
Age-Adjusted Hospitalization Rate per 100,000 Population Due to Chronic Obstructive Pulmonary Disease (COPD) and Bronchiectasis*	112.23	94.64	107.26	60.66

** Source: CHAT, 2019*
*** Source: BRFSS, 2020*

Table 6 shows that Benton County has a substantially higher rate of falls for individuals over age 65 that routinely require home health services as part of their course of treatment.

Table 6
Injuries (Drawn from CHNA Study Table 21

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Hospitalization Rate per 100,000 Population Due to Falls for People Aged <65	129.74	60.31	106.57	118.65
Hospitalization Rate per 100,000 Population Due to Falls for People Aged 65+	2222.45	1627.43	2088.72	1789.26

Age-Adjusted Hospitalization Rate per 100,000 Population for Unintentional Injuries	654.4	536.53	624.41	574.36
Age-Adjusted Non-Fatal Intentional Self-Harm/Suicide Rate per 100,000 Population	53.59	23.26	43.85	49.83

Source: CHAT, 2019

Table 7 shows that the population age 65 and older reflects the Statewide population at the time of the CHNA study so can be expected to reasonably represent the Need methodology that relies on population.

Table 7
Population by Age (Drawn from CHNA Table 2

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Population that is <1 Years Old	1.27%	1.62%	1.38%	1.16%
Population that is 1-14 Years Old	20.26%	24.95%	21.76%	17.35%
Population that is 15-24 Years Old	12.72%	15.37%	13.57%	12.61%
Population that is 25-44 Years Old	24.40%	27.05%	25.25%	27.25%
Population that is 45-64 Years Old	24.82%	20.74%	23.52%	24.89%
Population that is 65+ Years Old	16.53%	10.28%	14.53%	16.74%

Source: WA OFM, 2020

Provide a copy of the applicable letter of intent that was submitted according to WAC 246-310-080.

Appendix 4 provides a copy of the letter of intent for this project.

11. 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 Home Health of Spokane County is licensed and certified by Medicare and Medicaid to provide home health services. It will do so in Benton County. The license, Medicare and Medicaid numbers are as follows:

IHS.FS. IHS. FS.61014910

Medicare #: 50-7130

Medicaid #: 2174015

12. Identify whether this agency will seek accreditation. If yes, identify the accrediting body.

The accrediting agency is the Accreditation Commission for Healthcare, Inc.
(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. 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 applicableto your project, explain why.

1. List all home health providers currently operating in the planning area.

Table 8 identifies CoN or grandfathered home health agencies authorized to serve Benton County. Medicare and Medicaid patients. Appendix 3 includes 84 entities licensed as home care providers serving Benton County.

Table 8
Home Health Agencies Identified as Potentially Serving Benton County

License #	Agency Name	Rationale for Exclusion/Modification
IHS.FS.00000352	Tri-Cities Home Health Agency	Certificate of Need approved to provide Home Health services to Benton County
IHS.FS.60724314	Astria Sunnyside Home Health	Certificate of Need approved to provide Home Health services to Benton County and currently serves only West Benton County Prosser in Benton County and Sunnyside which is part of Benton and Yakima counties
IHS.FS.60875683	Columbia River Home Health	Certificate of Need approved to provide Home Health services to Benton County
HIS.FS.61385337	Vue Home Health LLC	CN #1991 approved January 2, 2024

2. Complete the numeric methodology outlined in Appendix B. [make sure that Appendix B includes reference to template on website]

The numeric need methodology for Benton County is described next:

Step one: Project the population of the planning area, broken down by age cohort

Table 9
Benton County Population

Age Cohort	2025	2026	2027	2028
0-64	182,019	183,656	186,275	187,584
65-79	30,291	30,831	31,911	32,127
80+	8,581	9,262	10,623	10,895
Total	220,891	223,748	228,808	230,606

Step two: Project the number of home health patients
This is done by multiplying each projected population age cohort by their corresponding userate.

Age Cohort	Use Rate
0-64	0.005
65-79	0.044
80+	0.183

Step three: Project number of patient visits
This is done by multiplying each age cohorts' number of patients by their correspondingnumber of visits.

Age Cohort	Use Rate	Visits
0-64	0.005	10
65-79	0.044	14
80+	0.183	21

Step four: Determine the total projected home health agency need
This is done by dividing the total projected number of visits by 10,000, which is described in the SHP as the "*target minimum operating volume for a home health agency*." The resulting number represents the maximum projected number of agencies needed in a planning area. TheSHP states fractions are rounded down to the nearest whole number.

Step 4 shows that the maximum number of agencies that are needed in Benton County are 6.98 agencies in 2027 rounded down to six (6) home health agencies. In 2028, the third full year of operation, the maximum number of agencies that are needed is 7.10 agencies rounded down to seven (7) home health agencies.

Table 10
Unadjusted Home Health Agency Need for Benton County

1987 State Health Plan Methodology - Home Health									
County:	**Benton**								
Years:	**2024 -2027**								
2024		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		180,477		0.005		10		9,024
		65-79		29,371		0.044		14		18,093
		80+		8,239		0.183		21		31,664
								TOTAL:		**58,781**
						Number of Expected Visits per Agency				*10,000*
						Projected Number of Needed Agencies				**5.88**
2025		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		182,019		0.005		10		9,101
		65-79		30,291		0.044		14		18,659
		80+		8,581		0.183		21		32,977
								TOTAL:		**60,737**
						Number of Expected Visits per Agency				*10,000*
						Projected Number of Needed Agencies				**6.07**
2026		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		183,656		0.005		10		9,183
		65-79		30,831		0.044		14		18,992
		80+		9,262		0.183		21		35,592
								TOTAL:		**63,767**
						Number of Expected Visits per Agency				*10,000*
						Projected Number of Needed Agencies				**6.38**
2027		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		186,275		0.005		10		9,314
		65-79		31,911		0.044		14		19,657
		80+		10,623		0.183		21		40,823
								TOTAL:		**69,794**
						Number of Expected Visits per Agency				*10,000*
						Projected Number of Needed Agencies				**6.98**
2028		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		187,584		0.005		10		9,379
		65-79		32,127		0.044		14		19,790
		80+		10,895		0.183		21		41,870
								TOTAL:		**71,039**
						Number of Expected Visits per Agency				*10,000*
						Projected Number of Needed Agencies				**7.10**

Step Four (b)

To assess whether more than two home health agencies should be permitted in each home health planning area to promote competition and consumer choice. If the projected aggregate need is less than 10,000 visits per year, a proposed new home health agency must demonstrate that increased competition will enhance efficiency, effectiveness, and equity within the market. Notably, Table 4 projects a total of 71,039 visits by 2028.

Subsection (d) defines home health services as the provision of nursing services with at least one other therapeutic service or with a supervised home health aide service. Subsection d (5) lists exception criteria in the State Health Plan that add to the basis of exclusionary criteria included include:

5 (a) Meets CoN and certification conditions
5 (b) Develops formal agreements with providers in the planning area
5 (c) Establishes a complying charity care policy and a budget to support the policy
5 (d) Supports lower charges per visit compared to other agencies
5 (e) Assures continuity of care by having formal linkages
5 (f) Provides charity care directly or by arrangement
5 (g) Measures and responds to community/patient concerns

Table 4 documents that the overall, unadjusted need in 2027 is 69,794 visits or a total need of six (6) agencies. In 2028 the need totals are 71,039 visits or a total need for seven (7) agencies.

Currently, four agencies are CoN-approved to serve Benton County, as shown in Table 2. However, of these four agencies, only three provide services across the entire county. Astria Home Health has indicated that its service area in Benton County extends only to Prosser, excluding the eastern section of the county. This area, which includes Prosser and residents living west of it, accounts for 20% of Benton County's total population. In 2023, Astria served fewer than 11 Medicare fee-for-service home health patients in Benton County, as noted in Table 11. Consequently, Astria is not included in the existing base of four home health agencies, leading to a projected need for two agencies in 2027 and three in 2028. Please see pages 592 - 593 for map of Benton County.

Table 11
Astria Home Health Patients by County

	2023 Patients
Yakima County Patients	99
Patients from All Other Counties (location suppressed)	12
Total Home Health Patients	103

Table 12 presents a comprehensive list of home health agencies holding a home care license, compiled through an Eden query and supplemented by the list included in the VUE CN 24-03 application, which will be discussed later.

Table 12
Home Health Agencies Identified as Potentially Serving Benton County

Credential Number	Facility Name	CN Approved	Description	Include/Exclude in Supply
Medicare and Medicaid Certificate of Need Approved Agencies				
IHS.FS.00000352	*Tri Cities Home Health*	*Yes*	*Comprehensive HH services*	*Include*
IHS.FS.60724314	*Astria Sunnyside Home Health*	*Yes*	*Comprehensive home health services but only to Prosser in Western Benton County*	*Exclude*
IHS.FS.60875683	*Columbia River Home Health*	*Yes*	*Comprehensive home health services*	*Include*
IHS.FS.61385337	Vue Home Health LLC	Yes	Comprehensive home health services	Include
Department of Energy EEOICPA Occuppational Health Services				
IHS.FS.60474800	*Professional Case Management of Washington*	*Benton*	*EEOICPA health services, limited to Nuclear Weapons and Uranium Workers, Department of Labor insureds, or persons with spinal/brain injuries*	*Exclude*
IHS.FS.60593988	*United Energy Workers Healthcare, LLC*	*Benton*	*In home care to EEOICPA*	*Exclude*
IHS.FS.60670421	*Nuclear Care Partners LLC*	*Benton*	*In home care to EEOICPA*	*Exclude*
IHS.FS.60689285	*Energy Employee Home Health Services*	*Benton*	*No website found; No way to verify services, service area, or admits.*	*Exclude*
IHS.FS.60830680	*Twilight Health*	*Benton*	*In home care to EEOICPA*	*Exclude*
IHS.FS.60851874	Reliable Healthcare	*Benton*	Home care provider only	Exclude
IHS.FS.60852239	*Critical Nurse Staffing LLC a/k/a CNSCares*	*Benton*	*Home care and home health services for veterans and EEOICPA*	*Exclude*
IHS.FS.60593988	*United Energy Workers Healthcare, LLC*	*Benton*	*In home care to EEOICPA*	*Exclude*
IHS.FS.60261599	*Critical Nurse Staffing Inc*	*Richland*	*Energy Workers Only EEOICPA*	*Exclude*
IHS.FS.60689285	Energy Employee Home Health Services	Kennewick	Energy Workers Only EEOICPA	Exclude
IHS.FS.60830680	*Twilight Health*	*Richland*	*In home care to EEOICPA*	*Exclude*
IHS.FS.60851874	*Reliable Healthcare*	*Richland*	*In home care to EEOICPA*	*Exclude*
IHS.FS.60973773	*Atomic Home Health*	*Richland*	*In home care to EEOICPA*	*Exclude*
IHS.FS.60880389	*Haven Home Health Care*	*Richland*	*Website only lists Seattle, WA in Washington State.*	*Exclude*
IHS.FS.61259508	*National Nuclear Energy Healthcare,*	*Kennewick*	*In home care to EEOICPA*	*Exclude*
IHS.FS.61333270	*Positive Nature Homecare LLC*	*Kennewick*	*In home care to EEOICPA*	*Exclude*
IHS.FS.60917192	*Priority Home Health*	*Kennewick*	*HH Services limited to EEOICPA*	*Exclude*
Sprecialty Services or Special Populations				
IHS.FS.00000059	*Lincare*	*Benton*	*Appears limited to DME*	*Exclude*
IHS.FS.00000065	*Lincare Inc.*	*Benton*	*Appears limited to DME*	*Exclude*
IHS.FS.00000097	*Seattle Childrens Hospital Home Care Service*	*Benton*	*Services are only available to children.*	*Exclude*
IHS.FS.00000223	*Apria Healthcare LLC*	*Benton*	*Respiratory therapy, durable medical*	*Exclude*
IHS.FS.00000227	*Ashley House*	*Benton*	*Services limited by age*	*Exclude*
IHS.FS.60073462	*Optum Women's and Children's Health LLC*	*Benton*	*Health plan with relationships to providers and healthcare*	*Exclude*
IHS.FS.60083889	*Popes Kids Place*	*Benton*	*Services only available to persons from birth to early adults*	*Exclude*
IHS.FS.60344780	*Providence Infusion and Pharmacy Services*	*Benton*	*Services, and nutritional counseling*	*Exclude*

Table 12 Continued

Credential Number	Facility Name	CN Approved	Description	Include/Exclude in Supply
IHS.FS.60277946	*Coram CVS/Specialty Infusion Services*	*Benton*	*Skilled nursing, nutritional*	*Exclude*
IHS.FS.60034694	*Accredo Health Group*	*Benton*	*Specialty pharmacy*	*Exclude*
IHS.FS.00000100	Service Alternatives	Kennewick	Developmental Disabilities	Exclude
IHS.FS.00000455	Tri-Cities Residiential Services	Kennewick	Developmental Disabilities	Exclude
IHS.FS.00000100	Service Alternatives	Kennewick	Developmental Disability Serives	Exclude
IHS.FS.00000397	Option Care	Kennewick	Infusion care	Exclude
IHS.FS.00000397	Option Care	Kennewick	Home infusion services	Exclude
IHS.FS.00000456	Chaplaincy Health Care	Richland	Hospice Care	Exclude
IHS.FS.60077716	Serenity Personal Care	Kennewick	Assisted Living Facility	Exclude
IHS.FS.60266919	Child Enrichment Center	Kennewick	Pediatric	Exclude
IHS.FS.60534639	Agape Pediatric In-Home Therapy	Richland	Pediatric	Exclude
IHS.FS.60673756	Winn Fusion	Kennewick	Infusion Services Only	Exclude
IHS.FS.61534590	Absolute Home Healthcare LLC	Richland	Home health to individuals with insurance or Workers comp.	Exclude
Other Agencies or Individuals or Franchises				
IHS.FS.60282684	*Maxim Healthcare Services*	*Benton*	*Private duty nursing, long-term, not 'iintermittent SHP*	*Exclude*
IHS.FS.00000452	*Aveanna Healthcare*	*Benton*	*Private duty nursing, long-term, not 'intermittentSHP*	*Exclude*
IHS.FS.60450347	*Chinook Home Health Care*	*Benton*	*Limited skilled nursing / medical services. Appears to be primarily non-medical home care services (available jobs as of 06/15/23 all centered on CNA,HCA, RN, and NAR grandfathered positions) and EEOICPA*	*Exclude*
IHS.FS.60857773	Family Resource Home Care	Kennewick	Private duty nursing, long-term, not 'ntermittent SHP	Exclude
IHS.FS.00000133	Visiting Angels	Kennewick	Activities of Daily Living, CNA Managed	Exclude
IHS.FS.00000212	Alternative Residential Services, Inc.	Kennewick	No website, delinquent annual reports	Exclude
IHS.FS.00000212	Alternative Residential Services, Inc.	Kennewick	No website, delinquent annual reports	Exclude
IHS.FS.00000414	Prosser Memorial Hospital Home Health (place for mom)	Prosser	Residential Support	Exclude
IHS.FS.00000120	Aamori Home Care	Richland	Personal Service, Private nursing no Ical	Exclude
IHS.FS.00000357	TRIOS Home Health Care	Kennewick	Assisted Living Facility, sold home healt	Exclude
IHS.FS.00000434	Senior Life Resources NW	Richland	Meals on Wlheels and Home Care call	Exclude
IHS.FS.00000455	Tri-Cities Residential Services	Kennewick	Developmental Disability Residential Ser	Exclude
IHS.FS.60198469	Kellys Loving Care	Kennewick	Non acute home care	Exclude
IHS.FS.60210599	Columbia Basin Companion Care	Kennewick	Residential support	Exclude
IHS.FS.60356820	Kelly's Loving Care, Inc	Kennewick	Non acute home care	Exclude
IHS.FS.60466264	Home Instead Senior Care	Kennewick	Personal Care, no Medicare mentioned	Exclude
IHS.FS.60475471	Conscious Home Health Care	Kennewick	No internet presence	Exclude
IHS.FS.60530050	Interim Healthcare	Kennewick	Staffing, home care , home health,perso	Exclude
IHS.FS.60563884	Visiting Angels	Kennewick	Activities of Daily Living, CNA Managed	Exclude
IHS.FS.60613164	Allied Care Givers	Kennewick	No information available on the web	Exclude
IHS.FS.60615292	Victory Medical Solutions LLC	Richland	No service description, no Medicare	Exclude
IHS.FS.60617039	Solutions In Home Care	Kennewick	Personal care, nursing, no Medicare	Exclude
IHS.FS.60635750	Right at Home	Kennewick	Home health and companion services, n	Exclude
IHS.FS.60685201	Amada Senior Care	Kennewick	Care coordination, personal care	Exclude
IHS.FS.60901060	Live in Peace Home Care Services	Prosser	Support independent living, private pay	Exclude
IHS.FS.60983552	Compass Home Health Care	Richland	Discontinued phone number	Exclude

Table 12 Continued

Credential Number	Facility Name	CN Approved	Description	Include/Exclude in Supply
IHS.FS.61048466	*Caring Hearts Agency*	*Kennewick*	*Non-medical, personal health care*	*Exclude*
IHS.FS.61064639	Reach Home Care Incorporated	Kennewick	Personal Care, Home Care	Exclude
IHS.FS.61082704	Home Care Solutions	Kennewick	In home nursing and companionship	Exclude
IHS.FS.61094957	Day-To-Day Home Care	Kennewick	Personal Care, Home Care	Exclude
IHS.FS.61120596	*Strategic Home Health PLLC*	*Prosser*	*Personal care and nurse visits*	*Exclude*
IHS.FS.61137176	Senior Helpers	Richland	In home services, no Medicare or Medica	Exclude
IHS.FS.61225793	*Tri Cities Ultimate Care*	*Benton City*	*Home phone rejected 509-836-9652*	*Exclude*
IHS.FS.61232562	Heart-Felt Home Care, LLC	Kennewick	Individual service provider	Exclude
IHS.FS.61385324	*Vue Home Care LLC*	*Kennewick*	*No Medicaid or Medicare*	*Exclude*
IHS.FS.61427582	Affordable at Home Care - Kennewick	Kennewick	Personal care, private insurance only	Exclude
IHS.FS.61518419	*Synergy HomeCare of Tri-Cities*	*Kennewick*	*Non skilled nursing care*	*Exclude*
IHS.FS.61307052	*LTCI Home Care Inc*		*No website found.*	*Exclude*
IHS.FS.61343843	*At Home Staffing, LLC*		*No website found.*	*Exclude*
IHS.FS.61078302	*Inland Home Healthcare*	*Benton*	*No website found. Not shown as CMS certified agency serving Kennewick,*	*Exclude*
IHS.FS.00000231	*Avail Home Health*	*Benton*	*Private duty nursing, long-term, not 'intermittent SHP*	*Exclude*
IHS.FS.00000344	*Aveanna Healthcare*	*Benton*	*Skilled nursing and respite care*	*Exclude*
IHS.FS.00000374	Maxim Healthcare Services Inc	*Benton*	Private duty nursing, long-term, not 'intermittent SHP	*Exclude*
IHS.FS.00000375	Maxim Healthcare Services	*Benton*	(SHP).	Exclude
IHS.FS.00000431	*S and S Health Care*	*Benton*	*Private duty nursing, long-term, not intermittent SHP*	*Exclude*
IHS.FS.60617039	*Home Care Solutions*	*Benton*	*Provides home care and care management only*	*Exclude*

Italicized rows have already been adjudicated as not to be included in the home health agency count in the Vue CN 24-03 application review.

3. If applicable, provide a discussion identifying which agencies identified in response to question 1 should be excluded from the numeric need methodology and why. Examples for exclusion could include but are not limited to: not serving the entire geography of the planning area, being exclusively dedicated to DME, infusion, or respiratory care, or only serving limited groups.

In the Department review of the Vue application, 42 agencies were reviewed using the following criteria:

- CN approved or grandfathered agencies are approved if they serve the entire county
- Agency services are limited to a special population or to only parts of Benton County that exclude the agency from being counted
- Website research shows services exclude the agency from the SHP definition of a home health agency
- No recent surveys were submitted
- Agencies with applications pending

Except for the CoN approved/grandfathered agencies, all other agencies were excluded. [2] This same methodology was followed in this analysis for the 88 licensees identified in Table 12. Please note that the same agency might have multiple license numbers.

As outlined in Table 8, Astria Home Health is one of the four approved home health agencies serving Benton County; however, its coverage is limited to West Benton County, ending at Prosser. Data from Table 5 indicates that fewer than 11 patients (due to data suppression) reside in Benton County. As a result, Astria Home Health is excluded as a provider for the county, as it does not serve the entire planning area and offers only limited coverage.

The remaining licensees, previously excluded in the adjudicated Vue analysis, along with any additional licensees, were excluded for various reasons. However, all but two were disqualified because they had not been previously CoN-approved or grandfathered to provide Medicare-Medicaid home health services, or they had not submitted home care surveys. This left Professional Case Management of Washington and United Energy Workers Healthcare, LLC—both contractors under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA)—as the only two agencies that submitted survey data, including home health care and other services. These agencies were also ultimately rejected, as discussed below.

Special consideration is given to the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). This federal program, administered by the Department of Labor, provides compensation for former energy workers with work-related health conditions. It covers current and former employees of Atomic Weapons Employer facilities who develop qualifying conditions such as radiogenic cancer, chronic beryllium disease, beryllium sensitivity, or scoliosis.

While there are 14 or potentially 15 EEOICPA-licensed home care providers under the Department of Health (DOH), only two—Professional Case Management of Washington and United Energy Workers Healthcare, LLC—submitted survey responses confirming they provide in-home services. Eden contacted both agencies, which confirmed they each serve approximately 85 patients annually.

However, CoN regulations specify that agencies serving a narrowly defined population—such as those limited to a single employment contract or specific diagnoses—do not qualify as general home health providers. Given the stringent eligibility criteria of the EEOICPA program, which significantly restricts access to a small patient population, all EEOICPA providers were excluded from consideration. This decision aligns with the CN 24-03 analysis. Table 13 further evaluates Benton County's home care agencies, concluding that four agencies will be needed by 2028.

[2] CN 24 -03. CORRECTED EVALUATION DATED DECEMBER 26, 2023, OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED BY VUE HOME CARE, LLC PROPOSING TO PROVIDE MEDICARE AND MEDICAID-CERTIFIED HOME HEALTH SERVICES TO THE RESIDENTS OF BENTON COUNTY Pages 6-7. December 26, 2023

Table 13
Adjusted Net Home Health Agency Need for Benton County

County:	**Benton**									
Years:	**2024 -2028**									
2024		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		180,477		0.005		10		9,024
		65-79		29,371		0.044		14		18,093
		80+		8,239		0.183		21		31,664
									TOTAL:	**58,781**
								Number of Expected Visits per Agency		*10,000*
					Projected Number of Needed Agencies					5.88
					Existing agencies					3.00
					NET NEW AGENCIES NEEDED					**2.00**
2025		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		182,019		0.005		10		9,101
		65-79		30,291		0.044		14		18,659
		80+		8,581		0.183		21		32,977
									TOTAL:	**60,737**
								Number of Expected Visits per Agency		*10,000*
					Projected Number of Needed Agencies					6.07
					Existing agencies					3.00
					NET NEW AGENCIES NEEDED					**3.00**
2026		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		183,656		0.005		10		9,183
		65-79		30,831		0.044		14		18,992
		80+		9,262		0.183		21		35,592
									TOTAL:	**63,767**
								Number of Expected Visits per Agency		*10,000*
					Projected Number of Needed Agencies					6.38
					Existing agencies					3.00
					NET NEW AGENCIES NEEDED					**3.00**
2027		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		186,275		0.005		10		9,314
		65-79		31,911		0.044		14		19,657
		80+		10,623		0.183		21		40,823
									TOTAL:	**69,794**
								Number of Expected Visits per Agency		*10,000*
					Projected Number of Needed Agencies					6.98
					Existing agencies					3.00
					NET NEW AGENCIES NEEDED					**3.00**
2028		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		187,584		0.005		10		9,379
		65-79		32,127		0.044		14		19,790
		80+		10,895		0.183		21		41,870
									TOTAL:	**71,039**
								Number of Expected Visits per Agency		*10,000*
								Number of Expected Visits per Agency		*10,000*
					Projected Number of Needed Agencies					7.20
					Existing agencies					3.00
					NET NEW AGENCIES NEEDED					**4.00**

4. If applicable, provide a discussion identifying which agencies identified in response to question 1 should be excluded from the numeric need methodology and why. Examples for exclusion could include but are not limited to: not serving the entire geography of the planning area, being exclusively dedicated to DME, infusion, or respiratory care, or only serving limited groups.

The response to question 3 provides a thorough response to this question.

5. If the answer to question 2 shows no numeric need in the planning area, explain why this application should not be considered an unnecessary duplication of services for the proposed planning area. Provide any documentation to support the response.

Not Applicable, Numeric Need is shown in Table 13.

6. For existing agencies, using the table below, provide the home health agency's historical utilization broken down by county for the last three full calendar years.

SPOKANE COUNTY	**2022**	**2023**	**2024**
Total number of admissions	1,404	1,219	N.A.
Total number of visits	20,941	24,854	N.A.
Average number of visits/patient	14.9	20.4	N.A.

7. 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.

SPOKANE – BENTON COUNTY	**2025***	**2026**	**2027**	**2028**
Total number of admissions	1,824	1,926	2,235	2,610
Total number of visits	26,211	27,677	32,117	37,506
Average number of visits/admissions	14.37	14.37	14.37	14.37

8. Identify any factors in the planning area that could restrict patient access to home health services.

The recently approved Vue Home Health application was largely based on a thorough and well-researched assessment conducted by various community agencies, as outlined in the 2022 Community Health Needs Assessment (CHNA). This assessment provided a comprehensive analysis of factors affecting access to home health services. Following a summary of the Vue findings accepted by the Department, Eden will present additional insights into patient access to home health services. Below is an excerpt from the Vue application:

"There exists considerable unmet need for additional home health agencies in

Benton County. Thus, resident demand for home health programs currently outstrips the present supply, thereby constraining resident access to these necessary services. Furthermore, since home health services are, by definition, provided in the home, it is not possible for Benton County residents to out-migrate to other areas.

One of the key inputs of the 2022 CHNA by Benton-Franklin health systems was an April 2022 community health survey of Benton and Franklin adults. The survey revealed that 16% of persons 55+ year old reported that they or someone in their household had a challenge in meeting needs for 'In-home support for seniors or people with disabilities'. In-home support was identified as the second most prevalent challenge for the 55+ age cohort (at 16%) and was within the top three main challenges for the $50K-$100K income group (12%) as well. And even though in-home support wasn't listed within the top three main challenges for the lowest income group, under $50K, in absolute terms the lower income group reported greater challenges in meeting needs (16% for under $50K compared to 12% for $50K-$100K. "

(See page 16 of the Vue Application and Benton Franklin Health District - Community Health Survey. April 2022. P. 21.)

Another significant barrier to access is that one of the home health agencies identified by the Department does not serve the majority of Benton County residents. During Eden's evaluation of available home health providers, Astria Home Health confirmed that its services are limited to the Prosser area and do not extend to the rest of the county. This lack of countywide coverage further restricts healthcare accessibility for residents in need of home health services.

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

A critical issue is the overall lack of home health agency capacity in Benton County, which has negatively impacted the county's two largest home health providers. These agencies struggle to register and serve patients referred from hospitals and nursing homes — the two primary sources of home health referrals.

Figures 1 and 2 illustrate that in 2023, Benton County patients faced significantly longer wait times for home health services compared to national standards. National guidelines recommend placing eligible patients into service within two days of eligibility. However, both Tri-Cities Home Health and Columbia River Home Health fall well below this standard, whereas Eden Home Health of Spokane, which serves Spokane County, successfully meets the two-day placement benchmark.

Figure 1: Berg Data Solutions 2023 Data
Percentage of Hospital Discharge Patients Admitted Within 2 Days of Home Health Eligibility

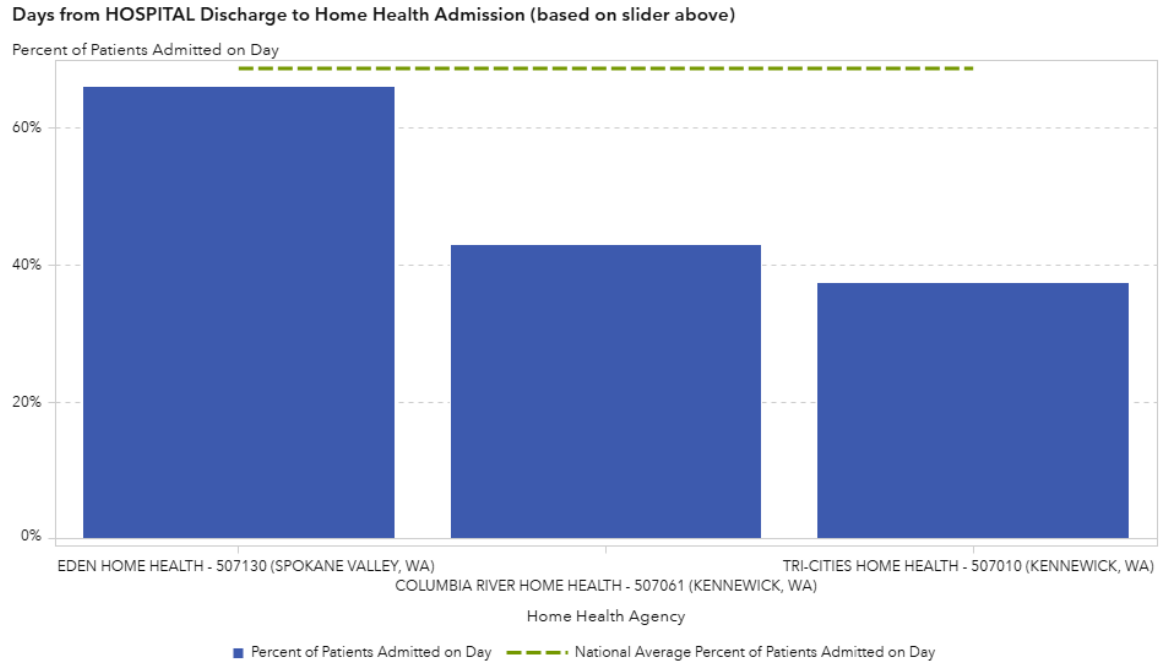
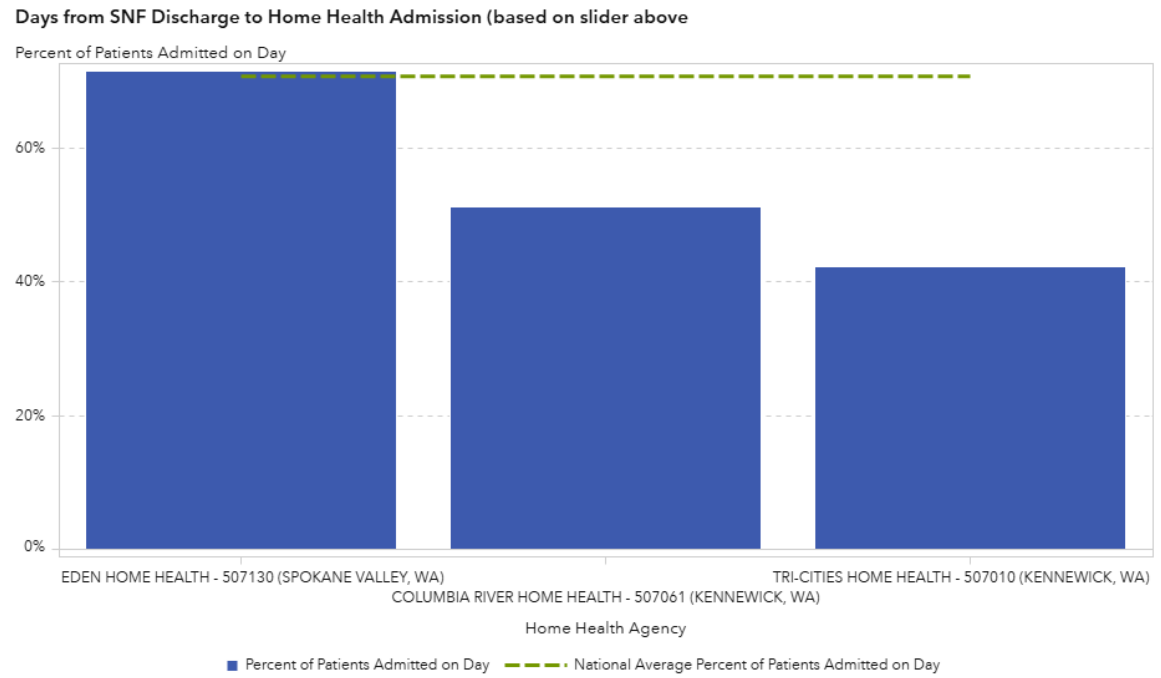


Figure 2: Berg Data Solutions 2023 Data
Percentage of SNF Discharge Patients Admitted Within 2 Days of Home Health Eligibility



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

Eden Home Health of Spokane County will be available and accessible to the **entire** Benton County planning area.

11. Identify how this project will be available and accessible to underserved groups.

Eden Home Health will prioritize enrolling patients to ensure they receive services within two days, aligning with the national average for both hospital and skilled nursing home referrals. Additionally, Eden's charity care policy, which offers free or discounted care to patients up to 400% of the poverty level, aligns with industry leaders. This policy supports Eden's Admissions and Non-Discrimination policies, ensuring that eligible individuals are not denied care based on income or other discriminatory factors. Need policies listed below.

12. Provide a copy of the following policies:
    - Admissions policy
    - Charity care or financial assistance policy
    - Patient Rights and Responsibilities policy
    - Non-discrimination policy
    - Any other policies directly related with patient access (example, involuntary discharge)

The Admissions Policy is in Appendix 5, the Charity Care and Financial Assistance Policy in Appendix 6, the Patient Rights and Responsibilities Policy in Appendix 7, and the Non-Discrimination Policy in Appendix 8.

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

Financial feasibility of a home health 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. Example provided in Appendix A.
    - Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. Include all assumptions. Example provided in Appendix A.

- 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 pro forma projections. For incomplete years, identify whether the data is annualized.

  Appendix 11 provides the required financial forms.

2. Provide the following agreements/contracts:
   - Management agreement
   - Operating agreement
   - Medical director agreement
   - Joint Venture agreement - not applicable

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

   The Management Agreement is in Appendix 13. The Operating Agreement is in Appendix 14. The Medical Director Agreement in Appendix 15.

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 home health 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 first three years of operation. Provide any amendments, addenda, or substitute agreements to be created as a result of this project to demonstrate site control.

   Appendix 10 contains a copy of the lease agreement confirming and extending site control for the Eden Health Spokane home health agency.

4. Complete the table below 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 below, include the definition of the line item. Include all assumptions used to create the capital expenditure estimate.

Item	Cost
a. Land Purchase	$ 0
b. Utilities to Lot Line	$ 0
c. Land Improvements	$ 0
d. Building Purchase	$ 0
e. Residual Value of Replaced Facility	$ 0
f. Building Construction	$ 0
g. Fixed Equipment (not already included in the construction contract)	$ 0
h. Movable Equipment	$ 0
i. Architect and Engineering Fees	$ 0
j. Consulting Fees	$ 0
k. Site Preparation	$ 0
l. Supervision and Inspection of Site	$ 0
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction)	
1. Land	$ 0
2. Building	$ 0
3. Equipment	$ 0
4. Other	$ 0
n. Washington Sales Tax	$ 0
Total Estimated Capital Expenditure	**$ 0**

5. 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

This application has no associated capital costs. Eden Home Health, Inc. is responsible for any estimated capital expenses.

6. 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 startup costs associated with Medicare certification, facility leasing, remodeling, or the addition of key administrative staff. Eden's recruitment strategy for Benton County residents includes remote learning, orientation, and training for experienced home health employees or contractors, as well as in-person training in Spokane County for those requiring additional instruction. Experienced new hires complete their orientation and training remotely while actively serving patients, categorizing these efforts as ongoing support rather than startup costs. For licensed employees needing further training, including job-shadowing, this process takes place in either Spokane or Benton County while they provide direct services, ensuring these activities are not considered startup expenses.

7. Identify the entity responsible for the start-up costs. If more than one entity is responsible, provide a breakdown of percentages and amounts for each.

Not Applicable.

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

In Benton County, approximately 75% to 79% of charges are based on fixed reimbursement rates from Medicare and Medicaid, with an estimated 2% allocated to charity care. Charges for commercial and other patients are comparable to Medicare rates after accounting for contractual adjustments. Although Medicaid reimbursement operates on a lower "blended rate" than Medicare, Medicaid patients make up a relatively small portion of the population, accounting for about 6%. Eden anticipates that approximately 6% of its patients will be covered by Medicaid.

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

One strength of this project is being able to initiate operations without the added expense of a branch office or satellite office, thus avoiding construction-related costs.

10. 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
Payer Mix: Benton County

Payer Mix: Benton County	Percentage of Gross Revenue	Percentage by Patient
Medicare	72%	68%
Medicaid	5%	7%
Commercial/Other	22%	25%
Charity Care	2%	2%
Total	100%	100%

Table 15
Payer Mix Spokane County

Payer Mix: Spokane County	Percentage of Gross Revenue	Percentage by Patient
Medicare	72%	68%
Medicaid	5%	7%
Commercial/Other	22%	25%
Charity Care	2%	2%
Total	100%	100%

Table 16
Payer Mix Spokane Agency

Payer Mix: Overall Agency	Percentage of Gross Revenue	Percentage by Patient
Medicare	72%	68%
Medicaid	4%	7%
Commercial/Other	22%	25%
Charity Care	2%	2%
Total	100%	68%

Eden determined the payer mix based on patient distribution across Medicare, Medicaid, and Commercial/Other categories, using three years of cost report data from Benton County (2021–2023). While Medicaid payer mix varied by year and provider, approximately 4% of unduplicated visits in 2023 were Medicaid patients, ranging from 1% to 6%. Over the three-year period, Medicaid representation fluctuated from a low of 0.9% for one provider to a high of 9.3% for another. Also important to note that the State Medicaid program through its now 11-year Medicaid Transformation Project (MTP) is shifting more long term care patients to its Medicaid insurance network and many providers are categorizing Medicaid payments under Commercial or Other categories (See Appendix 19 that covers the first 6 years of the MTP project).

As a new provider in Benton County, Eden anticipates a relatively higher proportion of Medicaid and Medicare patient visits compared to larger, more established agencies. Consequently, the pro forma payer mix is set at 7% Medicaid, 68% Medicare, and 25% Commercial/Other.
On a revenue basis, Medicare accounts for a slightly higher share due to Medicaid's lower blended reimbursement rate per patient visit.

To maintain a conservative revenue projection, Eden applied the same payer mix assumptions to Spokane County, considering the recent approval of several new agencies in the area.

11. 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.

Table 17 on the next page is based on the 2023 Cost Report for Eden Home Health of Spokane County and estimates of blended revenue for Medicaid. This is only the third full year for this agency's cost report.

Table 17
Payer Mix

Payer Mix: Agency	Percentage of Gross Revenue	Percentage by Patient
Medicare	39%	43%
Medicaid	0%	0%
Commercial/Other	61%	55%
Charity Care	0%	2%
Total	100%	100%

As noted, Eden's actual payer mix in Benton County includes a lower percentage of both Medicaid and Medicare patients and a higher percentage of Commercial/Other patients. Given that Eden is a new agency, these percentages have fluctuated significantly and are expected to remain variable, especially with the recent approval and turnover of new agencies in Spokane County. To ensure a more conservative approach for future revenue projections, Eden chose to base all feasibility-based pro formas on the Benton County payer mix rather than the current payer mix in Spokane, which reflects a higher share of Commercial/Other patients.

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

The existing inventory of equipment for the Eden Home Health of Spokane is sufficient to support the project. There is no additional equipment required for the project.

13. 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.

Expanding home health services to Benton County will be funded by operating revenues for the Eden Spokane Home Health agency supplemented by funding from Eden Health, Inc. A letter confirming funding support from the CFO is included in Appendix 11.

14. 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.

Not Applicable.

15. Provide the most recent audited financial statements for:
    - The applicant, and
    - Any parent entity responsible for financing the project.

Appendix 12 provides the most recent audited financial statement for Eden Health, Inc.

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 18
Staffing for Benton County

Staffing Summary - Eden HHA Benton County FTE's

STAFFING INPUT - BY FTE'S	2025	2026	2027	2028
OPERATIONS				
Physician (Medical Director)				
Director of Professional Services	0.50	0.50	0.50	0.50
Clinical Supervisor	-	1.00	1.00	1.00
Home Care Specialist	0.50	1.00	1.00	1.00
RN	0.31	0.74	1.80	3.24
PT	0.37	0.88	2.14	3.84
OT	0.14	0.33	0.84	1.51
ST	0.03	0.05	0.16	0.28
MSW	0.02	0.03	0.10	0.19
HHaide	0.00	0.04	0.01	0.01
SUBTOTAL	**1.87**	**4.58**	**7.54**	**11.57**
ADMINISTRATIVE				
Administrator	0.33	0.33	0.36	0.50
Office Manager	0.50	1.00	1.00	1.00
Home Care Specialist	0.50	1.00	1.00	1.00
Team Assistant	0.50	1.00	1.00	1.00
Data Entry Clerk	-	-	-	-
Community Outreach	1.00	1.00	2.00	2.00
SUBTOTAL	**2.83**	**4.33**	**5.36**	**5.50**
TOTAL FTE'S	**4.70**	**8.91**	**12.90**	**17.07**

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.

Table 18
Staffing for the Overall Spokane Agency

Staffing Summary -Spokane Overall Agency FTE's								
STAFFING INPUT - BY FTE'S	**2021**	**2022**	**2023**	**2024**	**Current**	**2026**	**2027**	**2028**
OPERATIONS								
Physician (Medical Director)	Contract	Contract	Contract	Contract	Contract	Contract	Contract	Contract
Director of Professional Services	0.6	1.0	1.0		1.0	1.0	1.0	1.0
Clinical Supervisor	0.5	1.0	1.0		2.0	3.0	3.0	3.0
Home Care Specialist	0.5	0.7	0.6		6.0	7.0	7.0	7.0
RN*	1.6	3.0	2.7		7.3	7.6	8.9	10.4
LPN	0.1	1.3	1.8					
PT & PT Asst.	0.5	5.2	6.7		8.7	9.1	10.6	12.4
OT & OT Asst.	0.2	3.0	2.6		3.4	3.4	4.2	4.9
Speech Therapy	0.1	0.2	0.3		0.6	0.5	0.8	0.9
MSW	0.2	0.3	0.3		0.4	0.4	0.5	0.6
HHaide	0.0	0.0	0.0		0.0	0.0	0.0	0.0
SUBTOTAL	**4.4**	**15.7**	**16.9**		**29.4**	**32.0**	**36.0**	**40.2**
ADMINISTRATIVE								
Administrator	0.0	0.0	0.5		0.5	0.5	0.6	1.0
Office Manager	1.0	1.0	1.0		1.0	2.0	2.0	2.0
Home Care Specialist	2.0	2.8	2.0		6.0	7.0	7.0	7.0
Team Assistant	1.0	2.0	3.7		1.0	1.0	1.0	2.0
Data Entry Clerk	0.0	0.0	0.0		0.0	0.0	0.0	0.0
Community Outreach	1.7	2.0	2.0		3.0	3.0	4.0	4.0
SUBTOTAL	**5.7**	**7.8**	**9.2**		**11.5**	**13.5**	**14.6**	**16.0**
TOTAL FTE'S	**10.1**	**23.6**	**26.2**		**40.9**	**45.5**	**50.6**	**56.2**

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

Five key assumptions were used to project the number and types of full-time equivalents (FTEs) involved in direct care:

1. Patient visits categorized by clinical discipline.
2. Number of visits per discipline within an 8-hour shift (productivity).
3. Total visits calculated for each variable treatment volume discipline.
4. Inclusion of semi-variable volume clinical treatment FTEs.
5. Addition of administrative positions.

Step 1: Patient Visits by Clinical Discipline

STAFFING INPUT - BY VISITS		2025	2026	2027	2028
Total Visits		278	2,673	6,467	11,640
RN	36.2%	101	968	2,342	4,216
PT	43.0%	119	1,149	2,781	5,006
OT	16.9%	47	452	1,094	1,968
ST	2.5%	7	67	162	292
MSW	1.3%	3	33	81	146
HHaide	0.1%	0	3	7	12
SUBTOTAL		**278**	**2,673**	**6,467**	**11,640**

Step 2: Visits Per Discipline in an 8-Hour Shift

		2025	2026	2027	2028
VISITS PER 8 HOUR SHIFT		**278**	**2,673**	**6,467**	**11,640**
Skilled Nursing	5.0	5.0	5.0	5.0	5.0
Physical Therapy	5.0	5.0	5.0	5.0	5.0
Occupational Therapy	5.0	5.0	5.0	5.0	5.0
Speech Pathology	4.0	4.0	4.0	4.0	4.0
Medical Social Service	3.0	3.0	3.0	3.0	3.0
Home Health Aide	5.0	5.0	5.0	5.0	5.0

Step 3: Calculate Total Visits in Each Variable Treatment .Volume Discipline per Year by Multiplying Visits per Discipline in Step 1 by Visits per Shift and Divide by 260.4 Shifts per Year

FTES PER YEAR		2025	2026	2027	2028
	260.4 Clinical Shifts				
Skilled Nursing		0.1	0.7	1.8	3.2
Physical Therapy		0.1	0.9	2.1	3.8
Occupational Therapy		0.0	0.3	0.8	1.5
Speech Pathology		0.0	0.1	0.2	0.3
Medical Social Service		0.0	0.0	0.1	0.2
Home Health Aide		0.0	0.0	0.0	0.0
SUBTOTAL: DIRECT		**0.2**	**2.1**	**5.0**	**9.1**

Step 4: Add Semi-variable Clinical Staffing

STAFFING INPUT - BY FTE'S	2025	2026	2027	2028
OPERATIONS				
Physician (Medical Director)				
Director of Professional Services	0.50	0.50	0.50	0.50
Clinical Supervisor	-	1.00	1.00	1.00
Home Care Specialist	0.50	1.00	1.00	1.00
Subtotal Semi-volume based Clinical	1.00	2.50	2.50	2.50

Step 5: Add Administrative and Support Staff

ADMINISTRATIVE	2025	2026	2027	2028
Administrator	0.33	0.33	0.36	0.50
Office Manager	0.50	1.00	1.00	1.00
Home Care Specialist	0.50	1.00	1.00	1.00
Team Assistant	0.50	1.00	1.00	1.00
Data Entry Clerk	-	-	-	-
Community Outreach	1.00	1.00	2.00	2.00
SUBTOTAL	**2.83**	**4.33**	**5.36**	**5.50**
TOTAL FTE'S	**4.70**	**8.91**	**12.90**	**17.07**

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

   Eden used the same staffing ratios that it uses for the Eden Home Health of Spokane and other Eden home health agencies in Washington State as described in the previous step.

5. If you intend to have a medical director, 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 undercontract.

   Gilson Girotto, D.O., License No. OP00002078 (Washington).

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

   The Medical Director is not an employee.

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

   Rhett Nilson, Executive Director
   Teresa Hall, Director of Patient Care Services, RN0122555

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

Most agencies when adding a county have not provided a roster of employees by name and license number for a variety of critical reasons including the following:

1. The information is readily available to the Department of Health in its recurring licensing surveys.
2. Agencies are committed to providing a high level of privacy and safety for all employees.
3. With staff shortages post-Covid 19, agencies protect their employee complement as a vital resource.

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.

As a large multi-state organization, Eden has extensive visibility and connections across various job markets within the home health and hospice sectors. Specifically in Benton County, Eden leverages both local recruitment strategies and its broader industry expertise to attract and retain qualified staff.

- As an employee-owned organization, Eden experiences lower turnover rates compared to many other healthcare providers.
- The EmpRes commitment to both employees and residents, reflected in its company name,

is also a core management principle, prioritizing staff, and patient well-being as key to overall success.

Since this application seeks to expand Eden Health Spokane's Medicare-Medicaid certified service area to include Benton County, central office recruitment will be incremental. This approach ensures that existing providers are not adversely affected, and that Eden can effectively serve home health patients in Benton County.

To recruit, train, and retain staff while maintaining compliance with federal and state healthcare regulations, Eden utilizes a comprehensive suite of employment resources, including:

1. **Learning Management System** – Healthstream
2. **Online Patient Education** – Ignite Healthcare
3. **Recruiting Platforms** – Indeed, Facebook, LinkedIn, and other social media channels
4. **Applicant Tracking System** – Paycor
5. **Background Checks** – Assure Hire
6. **OIG Compliance Screening** – Certiphino Screening

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

Office hours are from 8:30 a.m. to 5:00 p.m., with 24-hour phone access provided through Telemed Answering Service for after-hours support.

11. For existing agencies, clarify whether the applicant currently has a method for assessing customer satisfaction and quality improvement for the home health agency.

Eden Home Health of Spokane utilizes the Home Health Care CAHPS (HHCAHPS) Survey, a standardized national tool designed to assess the experiences of patients receiving home health care from Medicare-certified agencies. This survey is the first of its kind to provide publicly reported data on patients' perspectives regarding skilled home care services. It is one of the services provided to Eden through its partnership with Strategic Healthcare Partners (SHP).

Eden Health partners with SHP as its performance improvement and outcomes vendor, specializing in support for modern post-acute care providers, hospitals, and physician groups.

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

Appendix 16 provides a list of ancillary and support service vendors in place.

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

No ancillary or support agreements are expected to change as a result of this project.

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 home health agency has working relationships. Clarify whether any of the existing working relationships would change as a result of this project.

The Eden Home Health of Spokane agency currently works with the following facilities in Spokane:

- Assisted Living Facilities
    - Avamere at South Hill
    - Bethany Place
    - Brookdale Nine Mile
    - Cherrywood
    - Colonial Court
    - Fairwinds
    - Fields Senior Living
    - Northpoint Village
    - Orchard Crest
    - Riverview Memory Care
    - Rockwood Retirement
    - Royal Park Retirement Center
    - The Cottages of Spokane
- Hospital
    - Kootenai Medical Center
    - VA Hospital
    - Multicare
    - Newport Hospital
    - Providence
    - Pullman Regional Hospital
    - Valley Medical Center
- SNF/Rehab/Nursing Home
    - Aurora Valley Care
    - Alderwood Manor
    - Avalon Care Center
    - Cheney Care Center
    - Coeur d'Alene Health of Cascadia
    - Life Care Center Post Falls
    - North Central Care Center
    - Olympus Living at Spokane
    - Spokane Falls Care
    - Spokane Health and Rehab
    - St Joseph Care Center

- Sullivan Park
- Sunshine Health and Rehab
- Touchmark
- Ivy Court
- Regency at Northpointe
- Royal Park Health and Rehab
- St Lukes Rehabilitation

As Eden implements its project, it will expand its network to include Assisted Living Facilities, Hospitals, and SNF/Rehab/Nursing Homes within Benton County (See Appendix 20).

16. For a new agency, provide a listing of healthcare facilities with which the home health agency would establish working relationships.

Appendix 20 provides the list of healthcare providers that Eden will establish relationships with.

17. 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 health care facility; or
    b. A revocation of a license to operate a healthcare facility; or
    c. A revocation of a license to practice as 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 history of actions described above.

18. 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

Overview:
Building awareness in smaller metropolitan and rural areas requires a strategic, multi-faceted approach that prioritizes personal outreach, trust-building, and consistent messaging. By collaborating with local healthcare providers, engaging in community events, utilizing both traditional and digital media, and sharing impactful patient stories, Eden can establish a strong presence in south-central Washington's rural communities. The key is to become a trusted local resource—the first choice for individuals seeking home healthcare guidance and support. Over time, this trust and visibility will foster steady growth and solidify Eden's reputation as a reliable and compassionate provider in the community.

1. Develop Local Partnerships and Referrals

a. Collaborate with Local Medical Providers

- Coordinate with physicians, clinics, hospitals, and rehabilitation centers in the area.
- Provide educational materials about our services (e.g., brochures, flyers).
- Offer to host or participate in continuing education sessions or health seminars at local clinics.

b. Build Relationships with Social Service Agencies

- Partner with agencies such as senior centers, churches, and non-profit organizations that work with older adults, individuals with disabilities, and other populations needing home health.
- Present services during their events or meetings to reach potential clients and caregivers.

c. Connect with Pharmacies and Medical Supply Stores

- Place brochures or business cards at pharmacies and stores that sell home medical equipment.
- Offer to share educational content about medication management or safe-home setups.

2. Engage in Community Outreach

a. Attend and Sponsor Local Events

- Look for health fairs, county fairs, or community festivals where you can set up a booth.
- Provide free blood pressure checks, glucose screenings, or simple wellness tips to demonstrate value and generate leads.
- Sponsor or co-sponsor small local events to show our commitment to the community.

b. Host Informational Seminars or Workshops

- Organize workshops on topics such as caring for aging parents, diabetes management, fall prevention, and more.
- Invite local experts (e.g., dietitians, physical therapists) to speak alongside our staff.
- Offer these sessions at libraries, community centers, churches, or even virtually (for those with limited mobility).

c. Volunteer and Join Community Groups

- Encourage staff to volunteer with local charities or community organizations; wearing company-branded T-shirts can gently reinforce brand awareness.

- Participate in service clubs such as Rotary or Lions Clubs to expand networks and visibility.

3. Leverage Local Media Outlets

a. Regional Newspapers and Radio Stations

- Pitch human-interest stories to local newspapers or radio stations highlighting how home healthcare services help families in rural areas (e.g., stories about clients whose quality of life has improved).
- Purchase print or radio ad spots focusing on the unique benefits of receiving care at home.

b. Community Newsletters and Bulletins

- Many small towns have newsletters, church bulletins, or community magazines. Offering an article, ad, or sponsored content can be highly effective.
- Keep the language simple, clear, and directly relevant to community needs.

4. Optimize Digital Presence

a. Local SEO (Search Engine Optimization)

- Ensure Eden's HH website is optimized for local searches: use location-specific keywords (e.g., "home healthcare in south-central Washington").
- Register Eden Health with Google Business Profile and keep it updated with current hours, contact information, and customer reviews.
- Encourage satisfied clients or their family members to leave reviews online.

b. Targeted Social Media Advertising

- Facebook and Instagram ads can be targeted by location and demographics (e.g., adult children of seniors, individuals with certain health conditions).
- Share patient success stories (with permission), staff spotlights, and educational content.

c. Informational Content Marketing

- Post blog articles or short videos about home health tips, caregiver support, and healthcare resources specific to rural living.
- This positions your organization as an authority and a trusted resource.

5. Cultivate a Positive Reputation

a. Collect and Publicize Testimonials

- Ask clients or their family members for written or video testimonials that detail their experiences with your services.
- Share these testimonials on your website, social media, and in printed promotional materials (with permission).

b. Demonstrate Community Investment

- Showcase any charitable activities or sponsorships.
- Highlight how you employ local residents, thus contributing to economic development.

c. Word-of-Mouth and Caregiver Advocacy

- Encourage Eden's caregivers and staff to talk about our services in the community.

- Offer referral incentives for existing clients who recommend new clients.

6. Provide Education and Resources

a. Create "Aging in Place" Guides

- Develop simple, easy-to-read guides on home safety and general caregiving tips.
- Distribute these guides at local community centers, libraries, and medical offices.

b. Host Free "Ask a Nurse" or "Ask a Caregiver" Sessions

- Schedule virtual Q&A sessions or in-person drop-in hours at a community facility.
- This allows potential clients or their families to meet staff and learn what services are offered.

c. Participate in Telehealth Initiatives

- Rural communities often benefit from telehealth services if in-person care is limited.
- Partner with telehealth providers or local hospital networks to offer integrated healthcare solutions.

7. Maintain Consistent Branding and Messaging

a. Highlight Your Unique Value

- Emphasize the convenience of in-home care and the specialized expertise of your staff.
- Underscore any programs or certifications that set Eden apart (e.g., specialized memory care, post-surgical rehabilitation, or palliative care).

b. Use Clear, Person-Centered Language

- Rural communities often rely on trust and personal relationships. Use language that is compassionate and easy to understand.
- Focus on how services can improve patients' quality of life and relieve caregiver stress.

c. Share Stories and Faces

- Showcase photos of real staff (with permission).
- Humanize brand by showing the people behind the company, not just the company logo.

Conclusions:

The summary above highlights how Eden's model differs from those of many other agencies. While the model concept itself is not proprietary, the specific strategy Eden will implement in Benton County is unique to the organization. No single agency can immediately execute activities across all these areas; however, Eden's skilled outreach coordinators carefully select the most effective mix of approaches based on initial research and ongoing feedback. Supported by a robust needs assessment methodology, any home health care provider that engages in these seven key areas will be well-positioned to achieve its utilization and service goals.

19. 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.

Most importantly, there is a need for either two or three additional home health agencies and Eden will serve the entire county to meet the countywide need. Most importantly, Eden through its Charity Care policy will not only serve Medicaid patients but all low income residents with its generous free and discounted care policy that extends to 400% of the Federal Poverty Level. The model presented above and documentation by Eden of the extensive array of providers other than home health agencies shows that Eden will enhance continuity of care.

20. 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 facilities current compliance status.

No Eden agency reflects a pattern of condition-level findings.

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

No Eden agency reflects a pattern of condition-level findings.

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.

Alternative 1: Add Benton County to the Eden Home Health of Spokane Medicare certified agency service area operated with staff residing in Benton County but fully supported as well as directed by the Spokane central home health agency office.

Alternative 2: Add Benton County to the Eden Home Health of Spokane Medicare certified agency service area operated with staff residing in Benton County with a branch office in Benton County but fully directed by the Spokane central home health agency office.

Alternative 3: Do not add Benton County to the Eden Home Health of Spokane certified agency.

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.

Patient Access
To ensure seamless home health access for patients, Eden's outreach staff, trained and managed by the Spokane agency office, maintains frequent communication with hospital discharge planning teams in every hospital and nursing home across Benton County. This proactive approach facilitates rapid referrals to home health services. Additionally, outreach staff collaborates with primary care providers and select specialists to reinforce Eden's commitment to promptly registering patients and initiating home health services within two days of eligibility.

As previously shown in Figures 1 and 2, Eden Home Health of Spokane has consistently registered patients more quickly than the two established home health providers, Tri-Cities Home Health and Columbia River Home Health. Meanwhile, Vue's performance remains untested due to a lack of publicly available data.

Regarding patient access, both Alternative 1 and Alternative 2 would enhance access to hospice services by reducing the time between eligibility determination and service initiation. In contrast, Alternative 3 would maintain the existing delays in Benton County, where the time to service remains significantly longer than the statewide average.

Capital Costs
Following discussions with the Department of Licensing staff, Eden has determined that Alternative 1 presents no legal restrictions regarding capital costs, as it does not involve establishing a Branch Office. Even if supplemental space was added in the future, the capital impact would be minimal due to Eden's existing equipment inventory. From a capital cost perspective, Alternative 1 is slightly more favorable than Alternative 2. In either scenario, capital costs would not necessitate an amendment to the application, and both Alternative 1 and Alternative 2 are clearly preferable to Alternative 3, which involves taking no action.

Quality of Care
In a competitive environment, agencies must continuously improve the quality of care to secure referrals and maintain service demand. Given the significant need for additional home health services, long-term differences in quality of care are unlikely. Overall, both Alternative 1 and Alternative 2 are significantly superior to Alternative 3, the "do nothing" approach.

Staffing Impacts
The addition of Eden Home Health of Spokane is expected to enhance staffing efficiency, as the Medicare-certified administrative and central office staff supporting both Eden Hospice of Spokane alternatives will remain the same. With more eligible patients being admitted more quickly in Benton County, overall service volume will increase. For Eden Spokane specifically, patients are also likely to receive care for a longer duration, allowing administrative and support staff hours to be distributed across a larger number of care episodes.

Regarding direct care staff, most agencies follow similar staffing hour standards, which are expected to remain unchanged.

Cost Reduction and Operational Effectiveness

Alternative 1 offers slightly lower costs, as it does not require a Branch or satellite office. From both a cost and operational effectiveness standpoint, both Alternative 1 and Alternative 2 are far superior to Alternative 3, the "do nothing" approach.

Returning to Eden's superior wait time statistics, Eden Home Health of Spokane can help reduce hospital care costs by minimizing the wait time between a patient's hospital discharge and the initiation of home health services—a current issue in Benton County. Ensuring that patients do not experience a decline in their rehabilitation status while waiting for care, whether in a hospital, nursing home, or at home, is crucial for achieving positive health outcomes. In this regard, both Alternative 1 and Alternative 2 are vastly more cost-effective than Alternative 3.

3. 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.

4. Identify any aspects of the project that will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment and which promote quality assurance and cost effectiveness.

Eden is exploring innovative outreach strategies to enhance access and awareness for all residents, with a particular focus on reaching low-income communities. The Eden response to Q-18: Provide a discussion explaining how the proposed project will promote continuity in the provision of health care services in the planning area, and notresult in an unwarranted fragmentation of services. WAC 246-310-230 shows that Eden has a carefully set strategy to enhance outreach and promote quality insurance and cost effectiveness.

Home Health Agency Tie Breakers (1987 State Health Plan, Volume II, page B35-36)
If two or more applicants meet all applicable review criteria and there is not enough need projected for all applications to be approved, the department will approve the agency that better improves patient care, reduces costs, and improves population health through increased access to services in the planning area. Ensure that sufficient documentation and discussion of these items is included throughout the application under the relevant sections.

Certificate of Need Program Revised Code of Washington (RCW) and Washington Administrative Code (WAC)

Certificate of Need Program laws RCW 70.38

Certificate of Need Program rules WAC 246-310

Commonly Referenced Rules for Home Health Projects:

WAC Reference	Title/Topic
246-310-010	Certificate of Need Definitions
246-310-200	Bases for findings and action on applications
246-310-210	Determination of Need
246-310-220	Determination of Financial Feasibility
246-310-230	Criteria for Structure and Process of Care
246-310-240	Determination of Cost Containment

Certificate of Need Contact Information:
Certificate of Need Program Web Page
Phone: (360) 236-2955
Email: FSLCON@doh.wa.gov

Licensing Resources:
In-Home Services Agencies Laws, RCW 70.127
In-Home Services Agencies Rules, WAC 246-335
Home Health Agencies Program Web Page

Home Health Agency Certificate of Need
Application Packet

Contents:

Application submission must include:

- One electronic copy of your application, including any applicable addendum – no paper copy is required.
- A check or money order for the review fee of **$24,666** payable to **Department of Health.**

Include copy of the signed cover sheet with the fee if you submit the application and fee separately. This allows us to connect your application to your fee. We also strongly encourage sending payment with a tracking number.

- Mail or deliver the application and review fee to:

Mailing Address:

Department of Health
Certificate of Need Program
P O Box 47852
Olympia, Washington 98504-7852

Other Than By Mail:

Department of Health
Certificate of Need Program
111 Israel Road SE
Tumwater, Washington 98501

Contact Us:
Certificate of Need Program Office 360-236-2955 or FSLCON@doh.wa.gov.

Application Instructions

The Certificate of Need Program will use the information in your application to determine if your project meets the applicable review criteria. These criteria are included in state law and rules. Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310.

General Instructions:

- Include a table of contents for application sections and appendices/exhibits
- Number **all** pages consecutively
- Make the narrative information complete and to the point.
- Cite all data sources.
- Provide copies of articles, studies, etc. cited in the application.
- Place extensive supporting data in an appendix.
- Provide a detailed listing of the assumptions you used for all of your utilization and financial projections, as well as the bases for these assumptions.
- Under no circumstance should your application contain any patient identifying information.
- Use **non-inflated** dollars for **all** cost projections
- **Do not** include a general inflation rate for these dollar amounts.
- **Do** include current contract cost increases such as union contract staff salary increases. You must identify each contractual increase in the description of assumptions included in the application.
- **Do not** include a capital expenditure contingency.
- If any of the documents provided in the application are in draft form, a draft is only acceptable if it includes the following elements:
  a. identifies all entities associated with the agreement,
  b. outlines all roles and responsibilities of all entities,
  c. identifies all costs associated with the agreement,
  d. includes all exhibits that are referenced in the agreement, and
  e. any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

Do not skip any questions in this application. If you believe a question is not applicable to your project, explain why it is not applicable.

Answer the following questions in a manner that makes sense for your project. In some cases, a table may make more sense than a narrative. The department will follow up in screening if there are questions.

Program staff members are available to provide technical assistance (TA) at no cost to you before submitting your application. While TA isn't required, it's highly recommended and can make any required review easier. To request a TA meeting, call 360-236-2955 or email us at FSLCON@doh.wa.gov.

Certificate of Need Application
Home Health 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, Chief Operating Officer Email Address jbrown3@eden-health.com	Date March 17, 2025 Telephone Number 360-798-8298
Legal Name of Applicant Eden Home Health of Spokane, LLC **Address of Applicant** Eden Health 4601 NE 77th Ave. Suite 300 Vancouver, WA. 98662	**Provide a brief project description** ☐ New Agency X Expansion of Existing Agency ☐ Other: _____ Estimated capital expenditure: $_0_____
Identify the county proposed to be served for this project. Note: Each home health 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. Benton County	

Table of Contents

Table of Tables

LIST of APPENDICES

Appendix 1	Organization Chart
Appendix 2	See Table 12: Benton County Home Care Agencies
Appendix 3	List of Eden Health Agencies
Appendix 4	Letter of Intent
Appendix 5	Admissions Policy
Appendix 6	Charity Care and Financial Policy
Appendix 7	Patient Bill of Rights
Appendix 8	Non-discrimination Policy
Appendix 9	Financial Statements
Appendix 10	Lease Agreement
Appendix 11	CFO Letter of Commitment
Appendix 12	Audited Financial Statement
Appendix 13	Management Agreement
Appendix 14	Operating Agreement
Appendix 15	Medical Director Contract
Appendix 16	List of Ancillary and Support Vendors
Appendix 17	Benton-Franklin CHA Report
Appendix 18	KNG Health Consulting 2023 - Research Institute for Home Care
Appendix 19	DSHS 6th Year Summary Report
Appendix 20	Hospital and ALF Referral Agencies

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).

This application is submitted by Eden Health, Inc. which owns 100% of EmpRes Home Health and Hospice, LLC, which in turn owns 100% of Eden Home Health of Spokane County. If a Certificate of Need is issued for this project, the department will issue an In Home Service license to Eden Home Health of Spokane County, LLC to serve Benton County. For this review, references to the applicant will identify "Eden Home Health of Spokane County, LLC" as the applicant.

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

The applicant recognized by the Program is EmpRes Healthcare Group, Inc. Eden Home Health of Spokane County, LLC is a limited liability company. The UBI for Eden Home Health of Spokane County, LLC County is 604-331-802

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

   Jamie Brown, Chief Operating Officer
   Eden Health, 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, Principal
   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 1 provides the Eden Health organizational chart.

6. 1the 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 2 provides the list of healthcare facilities owned, operated, or managed by the applicant.

Project Description

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

Eden Home Health of Spokane County, LLC
13305 E Trent Ave
Spokane Valley, WA 99216

2. If an existing Medicare and Medicaid certified home health agency, explain how this proposed project will be operated in conjunction with the existing agency.

Eden Home Health of Spokane County, LLC will utilize its central office to coordinate and deliver home health services. To serve Benton County, Eden will employ dedicated teams of nursing and therapy professionals, including registered nurses, physical therapists, speech therapists, occupational therapists, and social workers. Additional resources will be available through contracts or shared staffing with Eden Health Inc.

All intake, scheduling, billing, and clinical oversight will be managed from the Spokane central office. Field clinicians in Benton County will be equipped with laptops for electronic documentation via an EMR system, ensuring timely submission of patient records. The application outlines various support systems designed to assist field clinicians in providing home-based care, including:

- Learning Management System: Healthstream
- Online Patient Education: Ignite Healthcare
- Medical Supplies: Medline
- Shipping/Postage: FedEx
- Interpretation Services: Language Line Service
- Website Services – Yolocare
- Office Supplies/Promotional Products – Office Depot

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.

   Eden Home Health of Spokane County, LLC
   13305 E. Trent Ave
   Spokane Valley, WA 99216

4. Provide a detailed description of the proposed project.

Eden Home Health of Spokane County proposes to add Benton County to its Spokane County service area for Medicare and Medicaid certified patients. The office location will be unchanged. The details of the operation are described in response to the comprehensive set of questions for a home health agency application.

5. Confirm that this agency will be available and accessible to the entire geography of the county proposed to be served.

The agency will be accessible and available to serve the entire geographic area of Benton County as proposed.

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:

Event	**Anticipated Month/Year**
CN Approval	August 2025
Design Complete (if applicable)	N.A.
Construction Commenced (if applicable)	N.A.
Construction Completed (if applicable)	N.A.
Agency Prepared for Survey (paperwork approved)	N.A
Agency providing Medicare and Medicaid home health services in the proposed county.	October 2025

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

x Skilled Nursing	x Occupational Therapy
x Home Health Aide	x Nutritional Counseling
x Durable Medical Equipment	x Bereavement Counseling
x Speech Therapy	x Physical Therapy
x Respiratory Therapy	x IV Services
x Medical Social Services	x Applied Behavioral Analysis
□ Other (please describe)	

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

Eden Home Health of Spokane County, LLC provides all the services described in the Question 7 response within Spokane County. It will provide the same set of services in Benton County. **Check list for services not provided.**

9. If this application proposes expanding an existing home health 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 Home Health of Spokane County, LLC is currently authorized to provide home health services in Spokane County, including care for Medicare and Medicaid patients. In the future, Eden may seek approval to expand its services to Stevens, Pend Oreille, and Whitman counties. If approved, Eden will offer comprehensive home health services, including care for Medicare and Medicaid patients, in these additional areas.

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

The National Institutes of Health periodically analyzes data on patients served by nursing homes. More detailed information is available on the diagnostic mix of Medicare-only patients, who account for over 70% of skilled nursing home admissions in Spokane County.

https://media.market.us/home-healthcare-statistics/
(U.S. Dept. of Health and Human Services, 2000)

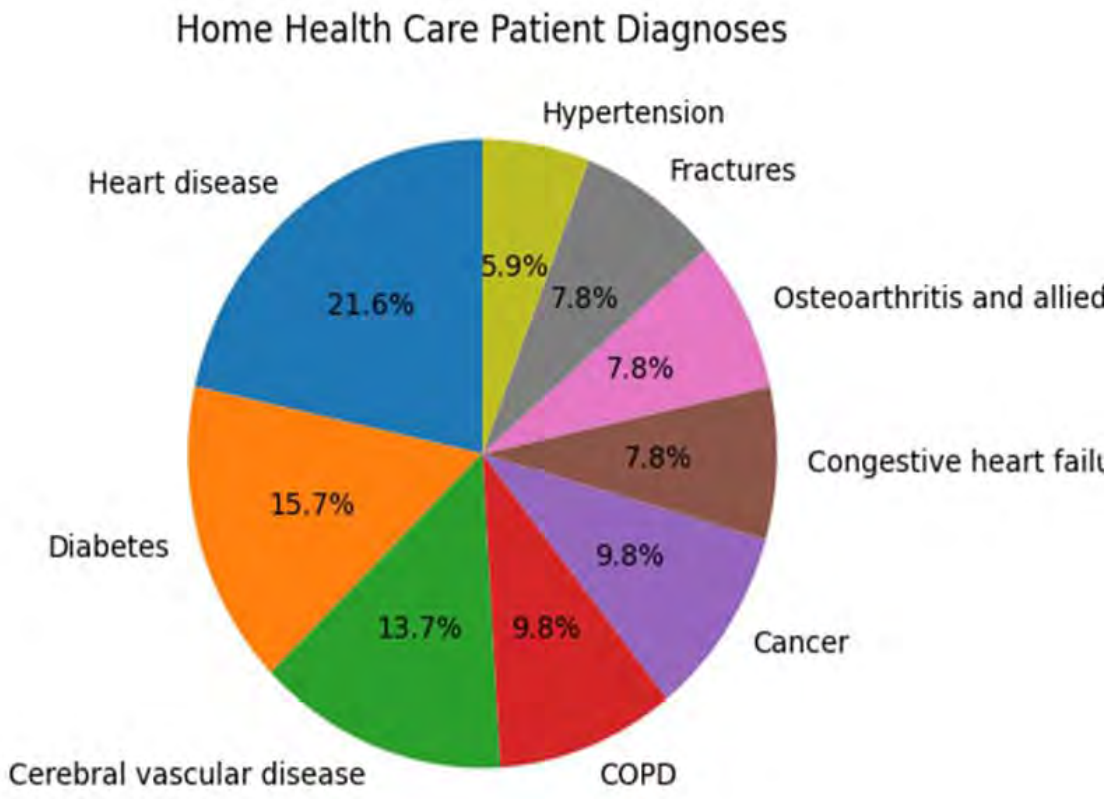
Medical and skilled nursing services are primarily required for managing chronic health conditions. Since individuals aged 65 and older make up the majority of home health care patients, it is not surprising that conditions common among the aging population are among the most frequently managed. According to the U.S. Department of Health and Human Services (2000), the most common admission diagnoses for home health care patients include:

- Heart disease (11%)
- Diabetes (8%)
- Cerebrovascular disease (7%)
- Chronic obstructive pulmonary disease (COPD) (5%)
- Malignant neoplasms (5%)
- Congestive heart failure (4%)
- Osteoarthritis and related disorders (4%)
- Fractures (4%)
- Hypertension (3%)

These conditions highlight the critical role of home health care in supporting the aging population and managing chronic illnesses.

Table 1, based on Year 2000 data shows the diagnostic mix as shown below.

Table 1
Diagnostic Mix of Home Health Care Patients by Diagnosis



A third more current study focused solely on all Medicare Only admissions from the 20 most frequent DRG categories for 2022.[1] As an example of how the patient population can change note that although Cancer is normally reported as 5% - 10% of the entire home care population, it does not appear in the top 20 ICD-10 diagnoses. Diabetes and heart disease are well represented in the top 20 diagnoses as are most of the other top 20 diagnoses.

Table 2.3: Top 20 Primary International Classification of Diseases, Version 10 (ICD-10) Diagnoses for All Home Health Claims, 2022

Clinical Profile of Home Health Users

Primary ICD-10 Diagnoses	Number of Home Health Claims	Percent of Total Home Health Claims
TYPE 2 DIABETES MELLITUS	668,712	7.7%
ENCOUNTER FOR OTHER POSTPROCEDURAL AFTERCARE	469,948	5.4%
ORTHOPEDIC AFTERCARE	456,811	5.2%
HYPERTENSIVE HEART DISEASE	355,737	4.1%
PRESSURE ULCER	332,964	3.8%
ESSENTIAL (PRIMARY) HYPERTENSION	316,158	3.6%
SEQUELAE OF CEREBROVASCULAR DISEASE	291,818	3.3%
HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE	280,469	3.2%
OTHER CHRONIC OBSTRUCTIVE PULMONARY DISEASE	242,296	2.8%
FRACTURE OF FEMUR	188,179	2.2%
ATRIAL FIBRILLATION AND FLUTTER	163,691	1.9%
PARKINSON'S DISEASE	163,617	1.9%
EMERGENCY USE OF COVID-19 DIAGNOSIS	162,771	1.9%
ENCOUNTER FOR FITTING AND ADJUSTMENT OF OTHER DEVICES	140,036	1.6%
OTHER DISORDERS OF URINARY SYSTEM	133,279	1.5%
OSTEOARTHRITIS OF KNEE	133,181	1.5%
HYPERTENSIVE CHRONIC KIDNEY DISEASE	122,469	1.4%
OTHER DISORDERS OF VEINS	122,429	1.4%
UNSPECIFIED DEMENTIA	111,316	1.3%
ALZHEIMER'S DISEASE	107,225	1.2%
Total for Top 20 Primary ICD-10 Diagnoses	**4,963,106**	**56.8%**

Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
Note: Cohort includes all Home Health claims in 2022 Standard Analytic File.

Table 2 provides additional information indicating the size of the Medicaid and uninsured (low income) population residing in Benton County compared with the State drawn from the 2022 Community Health Needs Assessment Table 7.

Table 2

Residents Uninsured and Residents with Medicaid (Drawn from Table 7, CHNA)

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Percent Residents Uninsured*	7.1%	14.1%	9.3%	6.2%
Percent Residents with Medicaid**				23.98%
Percent Residents with Medicaid***	21.9%	36.1%	26.4%	19.8%

[1] See Appendix 18 for complete Medicare study by KNG Health Consulting 2023 - Research Institute for Home Care

*US Census Bureau, 2020
**Data.medicaid.gov, 2020
***BentonFranklinTrends.org, 2019.

Table 3 provides the leading causes of death which closely match the NIH studies of patients making up home healthcare services. As previously noted, for skilled nursing home facilities, cancer diagnoses are not listed among the top 20 ICD-10 diagnostic codes.

Table 3
Leading Cause of Death Rates Drawn from Table 27 CHNA 2022 Study

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Major Cardiovascular Diseases Mortality Rate per 100,000 Population	187.51	186.44	186.31	180.27
Malignant Neoplasms Mortality Rate per 100,000 Population	137.37	122.69	133.24	135.74
COVID-19 Mortality Rate per 100,000 Population	60.42	89.02	67.33	35.82
Alzheimer's Disease per 100,000 Population	67.56	42.42	62.26	41.71
Unintentional Injuries per 100,000 Population	52.40	42.22	49.50	51.42
Chronic Lower Respiratory Disease per 100,000 Population	32.05	37.57	33.40	28.89
Diabetes Mellitus per 100,000 Population	16.93	26.94	19.07	22.23
Chronic Liver Disease and Cirrhosis per 100,000 Population	14.30	15.26	13.90	14.12
Intentional Self-Harm (Suicide) per 100,000 Population*	18.22			15.39
Parkinson's Disease per 100,000 Population*	9.04			9.25

Benton County's years of potential life lost (YPLL) per 100,000 population is slightly higher than the average for Washington State. See: countyhealthrankings.org

Table 4
Life Expectancy and Years of Potential Life Lost Drawn from Table 24 CHNA Study

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Life Expectancy	78.70	79.80	79.08	79.85

Years of Potential Life Lost**	4,402 Years	3,520 Years	4,106 Years	3,860 Years

Source: CHAT, 2020
***A cumulative estimation of the average time a person would have lived had they not died prematurely (before the age of 65)*

The CHNA study shows that chronic illness is a greater driver of home health admissions in Benton County than in the State as a whole.

Table 5
Chronic Illness Drawn from Table 23 CHNA Study

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Age-Adjusted All Cancer Incidence Rate per 100,000 Population	343.95	321.14	336.23	474.59
Adults Reporting Having Ever Been Told They Had Coronary Heart Disease and/or a Heart Attack**	6.32%	4.84%	5.70%	4.61%
Adults Reporting Having Ever Been Told They Had Diabetes (Excludes Gestational and Pre-Diabetes)**	8.35%	8.72%	8%	8.02%
Age-Adjusted Hospitalization Rate per 100,000 Population Due to Chronic Obstructive Pulmonary Disease (COPD) and Bronchiectasis*	112.23	94.64	107.26	60.66

** Source: CHAT, 2019*
*** Source: BRFSS, 2020*

Table 6 shows that Benton County has a substantially higher rate of falls for individuals over age 65 that routinely require home health services as part of their course of treatment.

Table 6
Injuries (Drawn from CHNA Study Table 21

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Hospitalization Rate per 100,000 Population Due to Falls for People Aged <65	129.74	60.31	106.57	118.65
Hospitalization Rate per 100,000 Population Due to Falls for People Aged 65+	2222.45	1627.43	2088.72	1789.26

Age-Adjusted Hospitalization Rate per 100,000 Population for Unintentional Injuries	654.4	536.53	624.41	574.36
Age-Adjusted Non-Fatal Intentional Self-Harm/Suicide Rate per 100,000 Population	53.59	23.26	43.85	49.83

Source: CHAT, 2019

Table 7 shows that the population age 65 and older reflects the Statewide population at the time of the CHNA study so can be expected to reasonably represent the Need methodology that relies on population.

Table 7
Population by Age (Drawn from CHNA Table 2

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Population that is <1 Years Old	1.27%	1.62%	1.38%	1.16%
Population that is 1-14 Years Old	20.26%	24.95%	21.76%	17.35%
Population that is 15-24 Years Old	12.72%	15.37%	13.57%	12.61%
Population that is 25-44 Years Old	24.40%	27.05%	25.25%	27.25%
Population that is 45-64 Years Old	24.82%	20.74%	23.52%	24.89%
Population that is 65+ Years Old	16.53%	10.28%	14.53%	16.74%

Source: WA OFM, 2020

Provide a copy of the applicable letter of intent that was submitted according to WAC 246-310-080.

Appendix 4 provides a copy of the letter of intent for this project.

11. 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 Home Health of Spokane County is licensed and certified by Medicare and Medicaid to provide home health services. It will do so in Benton County. The license, Medicare and Medicaid numbers are as follows:

IHS.FS. IHS. FS.61014910

Medicare #: 50-7130

Medicaid #: 2174015

12. Identify whether this agency will seek accreditation. If yes, identify the accrediting body.

The accrediting agency is the Accreditation Commission for Healthcare, Inc.
(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. 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 applicableto your project, explain why.

1. List all home health providers currently operating in the planning area.

Table 8 identifies CoN or grandfathered home health agencies authorized to serve Benton County. Medicare and Medicaid patients. Appendix 3 includes 84 entities licensed as home care providers serving Benton County.

Table 8
Home Health Agencies Identified as Potentially Serving Benton County

License #	Agency Name	Rationale for Exclusion/Modification
IHS.FS.00000352	Tri-Cities Home Health Agency	Certificate of Need approved to provide Home Health services to Benton County
IHS.FS.60724314	Astria Sunnyside Home Health	Certificate of Need approved to provide Home Health services to Benton County and currently serves only West Benton County Prosser in Benton County and Sunnyside which is part of Benton and Yakima counties
IHS.FS.60875683	Columbia River Home Health	Certificate of Need approved to provide Home Health services to Benton County
HIS.FS.61385337	Vue Home Health LLC	CN #1991 approved January 2, 2024

2. Complete the numeric methodology outlined in Appendix B. [make sure that Appendix B includes reference to template on website]

The numeric need methodology for Benton County is described next:

Step one: Project the population of the planning area, broken down by age cohort

Table 9
Benton County Population

Age Cohort	2025	2026	2027	2028
0-64	182,019	183,656	186,275	187,584
65-79	30,291	30,831	31,911	32,127
80+	8,581	9,262	10,623	10,895
Total	220,891	223,748	228,808	230,606

Step two: Project the number of home health patients
This is done by multiplying each projected population age cohort by their corresponding userate.

Age Cohort	Use Rate
0-64	0.005
65-79	0.044
80+	0.183

Step three: Project number of patient visits
This is done by multiplying each age cohorts' number of patients by their correspondingnumber of visits.

Age Cohort	Use Rate	Visits
0-64	0.005	10
65-79	0.044	14
80+	0.183	21

Step four: Determine the total projected home health agency need
This is done by dividing the total projected number of visits by 10,000, which is described in the SHP as the "*target minimum operating volume for a home health agency*." The resulting number represents the maximum projected number of agencies needed in a planning area. TheSHP states fractions are rounded down to the nearest whole number.

Step 4 shows that the maximum number of agencies that are needed in Benton County are 6.98 agencies in 2027 rounded down to six (6) home health agencies. In 2028, the third full year of operation, the maximum number of agencies that are needed is 7.10 agencies rounded down to seven (7) home health agencies.

Table 10
Unadjusted Home Health Agency Need for Benton County

1987 State Health Plan Methodology - Home Health									
County:	**Benton**								
Years:	**2024 -2027**								
2024		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		180,477		0.005		10		9,024
		65-79		29,371		0.044		14		18,093
		80+		8,239		0.183		21		31,664
								TOTAL:		**58,781**
						Number of Expected Visits per Agency				*10,000*
						Projected Number of Needed Agencies				**5.88**
2025		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		182,019		0.005		10		9,101
		65-79		30,291		0.044		14		18,659
		80+		8,581		0.183		21		32,977
								TOTAL:		**60,737**
						Number of Expected Visits per Agency				*10,000*
						Projected Number of Needed Agencies				**6.07**
2026		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		183,656		0.005		10		9,183
		65-79		30,831		0.044		14		18,992
		80+		9,262		0.183		21		35,592
								TOTAL:		**63,767**
						Number of Expected Visits per Agency				*10,000*
						Projected Number of Needed Agencies				**6.38**
2027		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		186,275		0.005		10		9,314
		65-79		31,911		0.044		14		19,657
		80+		10,623		0.183		21		40,823
								TOTAL:		**69,794**
						Number of Expected Visits per Agency				*10,000*
						Projected Number of Needed Agencies				**6.98**
2028		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		187,584		0.005		10		9,379
		65-79		32,127		0.044		14		19,790
		80+		10,895		0.183		21		41,870
								TOTAL:		**71,039**
						Number of Expected Visits per Agency				*10,000*
						Projected Number of Needed Agencies				**7.10**

Step Four (b)

To assess whether more than two home health agencies should be permitted in each home health planning area to promote competition and consumer choice. If the projected aggregate need is less than 10,000 visits per year, a proposed new home health agency must demonstrate that increased competition will enhance efficiency, effectiveness, and equity within the market. Notably, Table 4 projects a total of 71,039 visits by 2028.

Subsection (d) defines home health services as the provision of nursing services with at least one other therapeutic service or with a supervised home health aide service. Subsection d (5) lists exception criteria in the State Health Plan that add to the basis of exclusionary criteria included include:

5 (a) Meets CoN and certification conditions
5 (b) Develops formal agreements with providers in the planning area
5 (c) Establishes a complying charity care policy and a budget to support the policy
5 (d) Supports lower charges per visit compared to other agencies
5 (e) Assures continuity of care by having formal linkages
5 (f) Provides charity care directly or by arrangement
5 (g) Measures and responds to community/patient concerns

Table 4 documents that the overall, unadjusted need in 2027 is 69,794 visits or a total need of six (6) agencies. In 2028 the need totals are 71,039 visits or a total need for seven (7) agencies.

Currently, four agencies are CoN-approved to serve Benton County, as shown in Table 2. However, of these four agencies, only three provide services across the entire county. Astria Home Health has indicated that its service area in Benton County extends only to Prosser, excluding the eastern section of the county. This area, which includes Prosser and residents living west of it, accounts for 20% of Benton County's total population. In 2023, Astria served fewer than 11 Medicare fee-for-service home health patients in Benton County, as noted in Table 11. Consequently, Astria is not included in the existing base of four home health agencies, leading to a projected need for two agencies in 2027 and three in 2028.

Table 11
Astria Home Health Patients by County

	2023 Patients
Yakima County Patients	99
Patients from All Other Counties (location suppressed)	12
Total Home Health Patients	103

Table 12 presents a comprehensive list of home health agencies holding a home care license, compiled through an Eden query and supplemented by the list included in the VUE CN 24-03 application, which will be discussed later.

Table 12
Home Health Agencies Identified as Potentially Serving Benton County

Credential Number	Facility Name	CN Approved	Description	Include/Exclude in Supply
Medicare and Medicaid Certificate of Need Approved Agencies				
IHS.FS.00000352	Tri Cities Home Health	Yes	Comprehensive HH services	Include
IHS.FS.60724314	Astria Sunnyside Home Health	Yes	Comprehensive home health services but only to Prosser in Western Benton County	Exclude
IHS.FS.60875683	Columbia River Home Health	Yes	Comprehensive home health services	Include
IHS.FS.61385337	Vue Home Health LLC	Yes	Comprehensive home health services	Include
Department of Energy EEOICPA Occuppational Health Services				
IHS.FS.60474800	Professional Case Management of Washington	Benton	EEOICPA health services, limited to Nuclear Weapons and Uranium Workers, Department of Labor insureds, or persons with spinal/brain injuries	Exclude
IHS.FS.60593988	United Energy Workers Healthcare, LLC	Benton	In home care to EEOICPA	Exclude
IHS.FS.60670421	Nuclear Care Partners LLC	Benton	In home care to EEOICPA	Exclude
IHS.FS.60689285	Energy Employee Home Health Services	Benton	No website found; No way to verify services, service area, or admits.	Exclude
IHS.FS.60830680	Twilight Health	Benton	In home care to EEOICPA	Exclude
IHS.FS.60851874	Reliable Healthcare	Benton	Home care provider only	Exclude
IHS.FS.60852239	Critical Nurse Staffing LLC a/k/a CNSCares	Benton	Home care and home health services for veterans and EEOICPA	Exclude
IHS.FS.60593988	United Energy Workers Healthcare, LLC	Benton	In home care to EEOICPA	Exclude
IHS.FS.60261599	Critical Nurse Staffing Inc	Richland	Energy Workers Only EEOICPA	Exclude
IHS.FS.60689285	Energy Employee Home Health Services	Kennewick	Energy Workers Only EEOICPA	Exclude
IHS.FS.60830680	Twilight Health	Richland	In home care to EEOICPA	Exclude
IHS.FS.60851874	Reliable Healthcare	Richland	In home care to EEOICPA	Exclude
IHS.FS.60973773	Atomic Home Health	Richland	In home care to EEOICPA	Exclude
IHS.FS.60880389	Haven Home Health Care	Richland	Website only lists Seattle, WA in Washington State.	Exclude
IHS.FS.61259508	National Nuclear Energy Healthcare,	Kennewick	In home care to EEOICPA	Exclude
IHS.FS.61333270	Positive Nature Homecare LLC	Kennewick	In home care to EEOICPA	Exclude
IHS.FS.60917192	Priority Home Health	Kennewick	HH Services limited to EEOICPA	Exclude
Sprecialty Services or Special Populations				
IHS.FS.00000059	Lincare	Benton	Appears limited to DME	Exclude
IHS.FS.00000065	Lincare Inc.	Benton	Appears limited to DME	Exclude
IHS.FS.00000097	Seattle Childrens Hospital Home Care Service	Benton	Services are only available to children.	Exclude
IHS.FS.00000223	Apria Healthcare LLC	Benton	Respiratory therapy, durable medical	Exclude
IHS.FS.00000227	Ashley House	Benton	Services limited by age	Exclude
IHS.FS.60073462	Optum Women's and Children's Health LLC	Benton	Health plan with relationships to providers and healthcare	Exclude
IHS.FS.60083889	Popes Kids Place	Benton	Services only available to persons from birth to early adults	Exclude
IHS.FS.60344780	Providence Infusion and Pharmacy Services	Benton	Services, and nutritional counseling	Exclude

Table 12 Continued

Credential Number	Facility Name	CN Approved	Description	Include/Exclude in Supply
IHS.FS.60277946	*Coram CVS/Specialty Infusion Services*	*Benton*	*Skilled nursing, nutritional*	*Exclude*
IHS.FS.60034694	*Accredo Health Group*	*Benton*	*Specialty pharmacy*	*Exclude*
IHS.FS.00000100	Service Alternatives	Kennewick	Developmental Disabilities	Exclude
IHS.FS.00000455	Tri-Cities Residiential Services	Kennewick	Developmental Disabilities	Exclude
IHS.FS.00000100	Service Alternatives	Kennewick	Developmental Disability Serives	Exclude
IHS.FS.00000397	Option Care	Kennewick	Infusion care	Exclude
IHS.FS.00000397	Option Care	Kennewick	Home infusion services	Exclude
IHS.FS.00000456	Chaplaincy Health Care	Richland	Hospice Care	Exclude
IHS.FS.60077716	Serenity Personal Care	Kennewick	Assisted Living Facility	Exclude
IHS.FS.60266919	Child Enrichment Center	Kennewick	Pediatric	Exclude
IHS.FS.60534639	Agape Pediatric In-Home Therapy	Richland	Pediatric	Exclude
IHS.FS.60673756	Winn Fusion	Kennewick	Infusion Services Only	Exclude
IHS.FS.61534590	Absolute Home Healthcare LLC	Richland	Home health to individuals with insurance or Workers comp.	Exclude
Other Agencies or Individuals or Franchises				
IHS.FS.60282684	*Maxim Healthcare Services*	*Benton*	*Private duty nursing, long-term, not 'iintermittent SHP*	*Exclude*
IHS.FS.00000452	*Aveanna Healthcare*	*Benton*	*Private duty nursing, long-term, not 'intermittentSHP*	*Exclude*
IHS.FS.60450347	*Chinook Home Health Care*	*Benton*	*Limited skilled nursing / medical services. Appears to be primarily non-medical home care services (available jobs as of 06/15/23 all centered on CNA,HCA, RN, and NAR grandfathered positions) and EEOICPA*	*Exclude*
IHS.FS.60857773	Family Resource Home Care	Kennewick	Private duty nursing, long-term, not 'ntermittent SHP	Exclude
IHS.FS.00000133	Visiting Angels	Kennewick	Activities of Daily Living, CNA Managed	Exclude
IHS.FS.00000212	Alternative Residential Services, Inc.	Kennewick	No website, delinquent annual reports	Exclude
IHS.FS.00000212	Alternative Residential Services, Inc.	Kennewick	No website, delinquent annual reports	Exclude
IHS.FS.00000414	Prosser Memorial Hospital Home Health (place for mom)	Prosser	Residential Support	Exclude
IHS.FS.00000120	Aamori Home Care	Richland	Personal Service, Private nursing no Ical	Exclude
IHS.FS.00000357	TRIOS Home Health Care	Kennewick	Assisted Living Facility, sold home healtl	Exclude
IHS.FS.00000434	Senior Life Resources NW	Richland	Meals on Wlheels and Home Care call	Exclude
IHS.FS.00000455	Tri-Cities Residential Services	Kennewick	Developmental Disability Residential Ser	Exclude
IHS.FS.60198469	Kellys Loving Care	Kennewick	Non acute home care	Exclude
IHS.FS.60210599	Columbia Basin Companion Care	Kennewick	Residential support	Exclude
IHS.FS.60356820	Kelly's Loving Care, Inc	Kennewick	Non acute home care	Exclude
IHS.FS.60466264	Home Instead Senior Care	Kennewick	Personal Care, no Medicare mentioned	Exclude
IHS.FS.60475471	Conscious Home Health Care	Kennewick	No internet presence	Exclude
IHS.FS.60530050	Interim Healthcare	Kennewick	Staffing, home care , home health,perso	Exclude
IHS.FS.60563884	Visiting Angels	Kennewick	Activities of Daily Living, CNA Managed	Exclude
IHS.FS.60613164	Allied Care Givers	Kennewick	No information available on the web	Exclude
IHS.FS.60615292	Victory Medical Solutions LLC	Richland	No service description, no Medicare	Exclude
IHS.FS.60617039	Solutions In Home Care	Kennewick	Personal care, nursing, no Medicare	Exclude
IHS.FS.60635750	Right at Home	Kennewick	Home health and companion services, n	Exclude
IHS.FS.60685201	Amada Senior Care	Kennewick	Care coordination, personal care	Exclude
IHS.FS.60901060	Live in Peace Home Care Services	Prosser	Support independent living, private pay	Exclude
IHS.FS.60983552	Compass Home Health Care	Richland	Discontinued phone number	Exclude

Table 12 Continued

Credential Number	Facility Name	CN Approved	Description	Include/Exclude in Supply
IHS.FS.61048466	*Caring Hearts Agency*	*Kennewick*	*Non-medical, personal health care*	*Exclude*
IHS.FS.61064639	Reach Home Care Incorporated	Kennewick	Personal Care, Home Care	Exclude
IHS.FS.61082704	Home Care Solutions	Kennewick	In home nursing and companionship	Exclude
IHS.FS.61094957	Day-To-Day Home Care	Kennewick	Personal Care, Home Care	Exclude
IHS.FS.61120596	*Strategic Home Health PLLC*	*Prosser*	*Personal care and nurse visits*	*Exclude*
IHS.FS.61137176	Senior Helpers	Richland	In home services, no Medicare or Medica	Exclude
IHS.FS.61225793	*Tri Cities Ultimate Care*	*Benton City*	*Home phone rejected 509-836-9652*	*Exclude*
IHS.FS.61232562	Heart-Felt Home Care, LLC	Kennewick	Individual service provider	Exclude
IHS.FS.61385324	*Vue Home Care LLC*	*Kennewick*	*No Medicaid or Medicare*	*Exclude*
IHS.FS.61427582	Affordable at Home Care - Kennewick	Kennewick	Personal care, private insurance only	Exclude
IHS.FS.61518419	*Synergy HomeCare of Tri-Cities*	*Kennewick*	*Non skilled nursing care*	*Exclude*
IHS.FS.61307052	*LTCI Home Care Inc*		*No website found.*	*Exclude*
IHS.FS.61343843	*At Home Staffing, LLC*		*No website found.*	*Exclude*
IHS.FS.61078302	*Inland Home Healthcare*	*Benton*	*No website found. Not shown as CMS certified agency serving Kennewick,*	*Exclude*
IHS.FS.00000231	*Avail Home Health*	*Benton*	*Private duty nursing, long-term, not 'intermittent SHP*	*Exclude*
IHS.FS.00000344	*Aveanna Healthcare*	*Benton*	*Skilled nursing and respite care*	*Exclude*
IHS.FS.00000374	Maxim Healthcare Services Inc	*Benton*	Private duty nursing, long-term, not 'intermittent SHP	*Exclude*
IHS.FS.00000375	Maxim Healthcare Services	*Benton*	(SHP).	Exclude
IHS.FS.00000431	*S and S Health Care*	*Benton*	*Private duty nursing, long-term, not intermittent SHP*	*Exclude*
IHS.FS.60617039	*Home Care Solutions*	*Benton*	*Provides home care and care management only*	*Exclude*

Italicized rows have already been adjudicated as not to be included in the home health agency count in the Vue CN 24-03 application review.

3. If applicable, provide a discussion identifying which agencies identified in response to question 1 should be excluded from the numeric need methodology and why. Examples for exclusion could include but are not limited to: not serving the entire geography of the planning area, being exclusively dedicated to DME, infusion, or respiratory care, or only serving limited groups.

In the Department review of the Vue application, 42 agencies were reviewed using the following criteria:

- CN approved or grandfathered agencies are approved if they serve the entire county
- Agency services are limited to a special population or to only parts of Benton County that exclude the agency from being counted
- Website research shows services exclude the agency from the SHP definition of a home health agency
- No recent surveys were submitted,
- Agencies with applications pending

Except for the CoN approved/grandfathered agencies, all other agencies were excluded. [2] This same methodology was followed in this analysis for the 88 licensees identified in Table 12. Please note that the same agency might have multiple license numbers.

As outlined in Table 8, Astria Home Health is one of the four approved home health agencies serving Benton County; however, its coverage is limited to West Benton County, ending at Prosser. Data from Table 5 indicates that fewer than 11 patients (due to data suppression) reside in Benton County. As a result, Astria Home Health is excluded as a provider for the county, as it does not serve the entire planning area and offers only limited coverage.

The remaining licensees, previously excluded in the adjudicated Vue analysis, along with any additional licensees, were excluded for various reasons. However, all but two were disqualified because they had not been previously CoN-approved or grandfathered to provide Medicare-Medicaid home health services, or they had not submitted home care surveys. This left Professional Case Management of Washington and United Energy Workers Healthcare, LLC—both contractors under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA)—as the only two agencies that submitted survey data, including home health care and other services. These agencies were also ultimately rejected, as discussed below.

Special consideration is given to the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). This federal program, administered by the Department of Labor, provides compensation for former energy workers with work-related health conditions. It covers current and former employees of Atomic Weapons Employer facilities who develop qualifying conditions such as radiogenic cancer, chronic beryllium disease, beryllium sensitivity, or scoliosis.

While there are 14 or potentially 15 EEOICPA-licensed home care providers under the Department of Health (DOH), only two—Professional Case Management of Washington and United Energy Workers Healthcare, LLC—submitted survey responses confirming they provide in-home services. Eden contacted both agencies, which confirmed they each serve approximately 85 patients annually.

However, CoN regulations specify that agencies serving a narrowly defined population—such as those limited to a single employment contract or specific diagnoses—do not qualify as general home health providers. Given the stringent eligibility criteria of the EEOICPA program, which significantly restricts access to a small patient population, all EEOICPA providers were excluded from consideration. This decision aligns with the CN 24-03 analysis. Table 13 further evaluates Benton County's home care agencies, concluding that four agencies will be needed by 2028.

[2] CN 24 -03. CORRECTED EVALUATION DATED DECEMBER 26, 2023, OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED BY VUE HOME CARE, LLC PROPOSING TO PROVIDE MEDICARE AND MEDICAID-CERTIFIED HOME HEALTH SERVICES TO THE RESIDENTS OF BENTON COUNTY Pages 6-7. December 26, 2023

Table 13
Adjusted Net Home Health Agency Need for Benton County

County:	**Benton**									
Years:	**2024 -2028**									
2024		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		180,477		0.005		10		9,024
		65-79		29,371		0.044		14		18,093
		80+		8,239		0.183		21		31,664
									TOTAL:	**58,781**
								Number of Expected Visits per Agency		*10,000*
					Projected Number of Needed Agencies					5.88
					Existing agencies					3.00
					NET NEW AGENCIES NEEDED					**2.00**
2025		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		182,019		0.005		10		9,101
		65-79		30,291		0.044		14		18,659
		80+		8,581		0.183		21		32,977
									TOTAL:	**60,737**
								Number of Expected Visits per Agency		*10,000*
					Projected Number of Needed Agencies					6.07
					Existing agencies					3.00
					NET NEW AGENCIES NEEDED					**3.00**
2026		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		183,656		0.005		10		9,183
		65-79		30,831		0.044		14		18,992
		80+		9,262		0.183		21		35,592
									TOTAL:	**63,767**
								Number of Expected Visits per Agency		*10,000*
					Projected Number of Needed Agencies					6.38
					Existing agencies					3.00
					NET NEW AGENCIES NEEDED					**3.00**
2027		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		186,275		0.005		10		9,314
		65-79		31,911		0.044		14		19,657
		80+		10,623		0.183		21		40,823
									TOTAL:	**69,794**
								Number of Expected Visits per Agency		*10,000*
					Projected Number of Needed Agencies					6.98
					Existing agencies					3.00
					NET NEW AGENCIES NEEDED					**3.00**
2028		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		187,584		0.005		10		9,379
		65-79		32,127		0.044		14		19,790
		80+		10,895		0.183		21		41,870
									TOTAL:	**71,039**
								Number of Expected Visits per Agency		*10,000*
								Number of Expected Visits per Agency		*10,000*
					Projected Number of Needed Agencies					7.20
					Existing agencies					3.00
					NET NEW AGENCIES NEEDED					**4.00**

4. If applicable, provide a discussion identifying which agencies identified in response to question 1 should be excluded from the numeric need methodology and why. Examples for exclusion could include but are not limited to: not serving the entire geography of the planning area, being exclusively dedicated to DME, infusion, or respiratory care, or only serving limited groups.

The response to question 3 provides a thorough response to this question.

5. If the answer to question 2 shows no numeric need in the planning area, explain why this application should not be considered an unnecessary duplication of services for the proposed planning area. Provide any documentation to support the response.

Not Applicable, Numeric Need is shown in Table 13.

6. For existing agencies, using the table below, provide the home health agency's historical utilization broken down by county for the last three full calendar years.

SPOKANE COUNTY	**2022**	**2023**	**2024**
Total number of admissions	1,404	1,219	N.A.
Total number of visits	20,941	24,854	N.A.
Average number of visits/patient	14.9	20.4	N.A.

7. 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.

SPOKANE – BENTON COUNTY	**2025***	**2026**	**2027**	**2028**
Total number of admissions	1,824	1,926	2,235	2,610
Total number of visits	26,211	27,677	32,117	37,506
Average number of visits/admissions	14.37	14.37	14.37	14.37

8. Identify any factors in the planning area that could restrict patient access to home health services.

The recently approved Vue Home Health application was largely based on a thorough and well-researched assessment conducted by various community agencies, as outlined in the 2022 Community Health Needs Assessment (CHNA). This assessment provided a comprehensive analysis of factors affecting access to home health services. Following a summary of the Vue findings accepted by the Department, Eden will present additional insights into patient access to home health services. Below is an excerpt from the Vue application:

"There exists considerable unmet need for additional home health agencies in

Benton County. Thus, resident demand for home health programs currently outstrips the present supply, thereby constraining resident access to these necessary services. Furthermore, since home health services are, by definition, provided in the home, it is not possible for Benton County residents to out-migrate to other areas.

One of the key inputs of the 2022 CHNA by Benton-Franklin health systems was an April 2022 community health survey of Benton and Franklin adults. The survey revealed that 16% of persons 55+ year old reported that they or someone in their household had a challenge in meeting needs for 'In-home support for seniors or people with disabilities'. In-home support was identified as the second most prevalent challenge for the 55+ age cohort (at 16%) and was within the top three main challenges for the $50K-$100K income group (12%) as well. And even though in-home support wasn't listed within the top three main challenges for the lowest income group, under $50K, in absolute terms the lower income group reported greater challenges in meeting needs (16% for under $50K compared to 12% for $50K-$100K. "

(See page 16 of the Vue Application and Benton Franklin Health District - Community Health Survey. April 2022. P. 21.)

Another significant barrier to access is that one of the home health agencies identified by the Department does not serve the majority of Benton County residents. During Eden's evaluation of available home health providers, Astria Home Health confirmed that its services are limited to the Prosser area and do not extend to the rest of the county. This lack of countywide coverage further restricts healthcare accessibility for residents in need of home health services.

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

A critical issue is the overall lack of home health agency capacity in Benton County, which has negatively impacted the county's two largest home health providers. These agencies struggle to register and serve patients referred from hospitals and nursing homes — the two primary sources of home health referrals.

Figures 1 and 2 illustrate that in 2023, Benton County patients faced significantly longer wait times for home health services compared to national standards. National guidelines recommend placing eligible patients into service within two days of eligibility. However, both Tri-Cities Home Health and Columbia River Home Health fall well below this standard, whereas Eden Home Health of Spokane, which serves Spokane County, successfully meets the two-day placement benchmark.

Figure 1: Berg Data Solutions 2023 Data
Percentage of Hospital Discharge Patients Admitted Within 2 Days of Home Health Eligibility

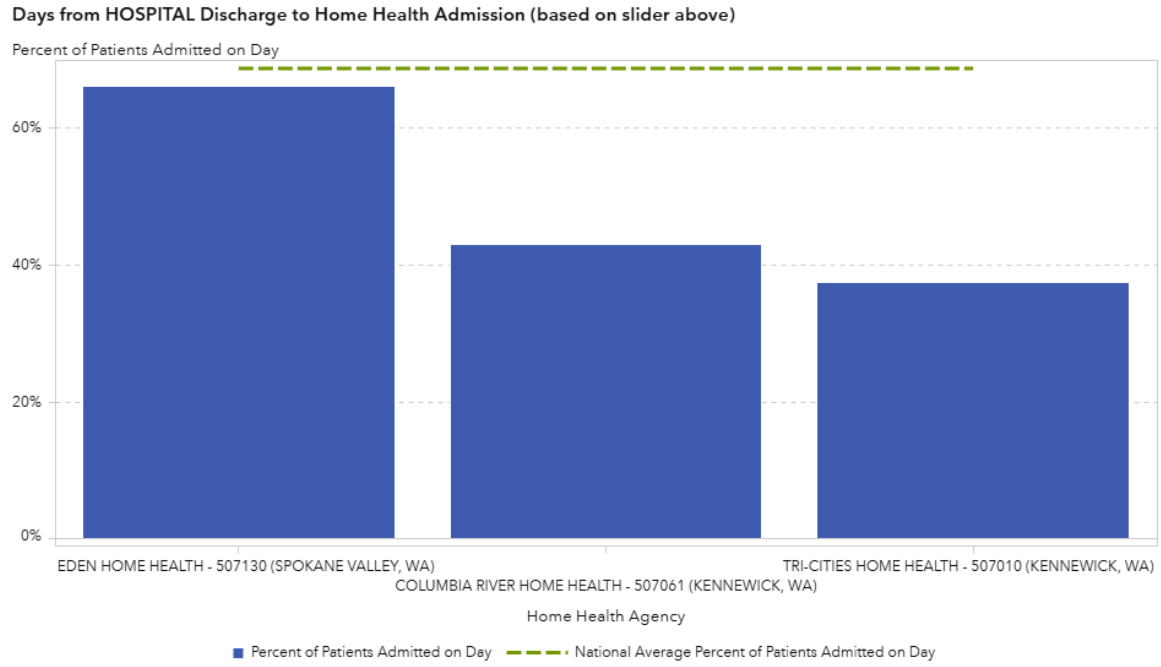
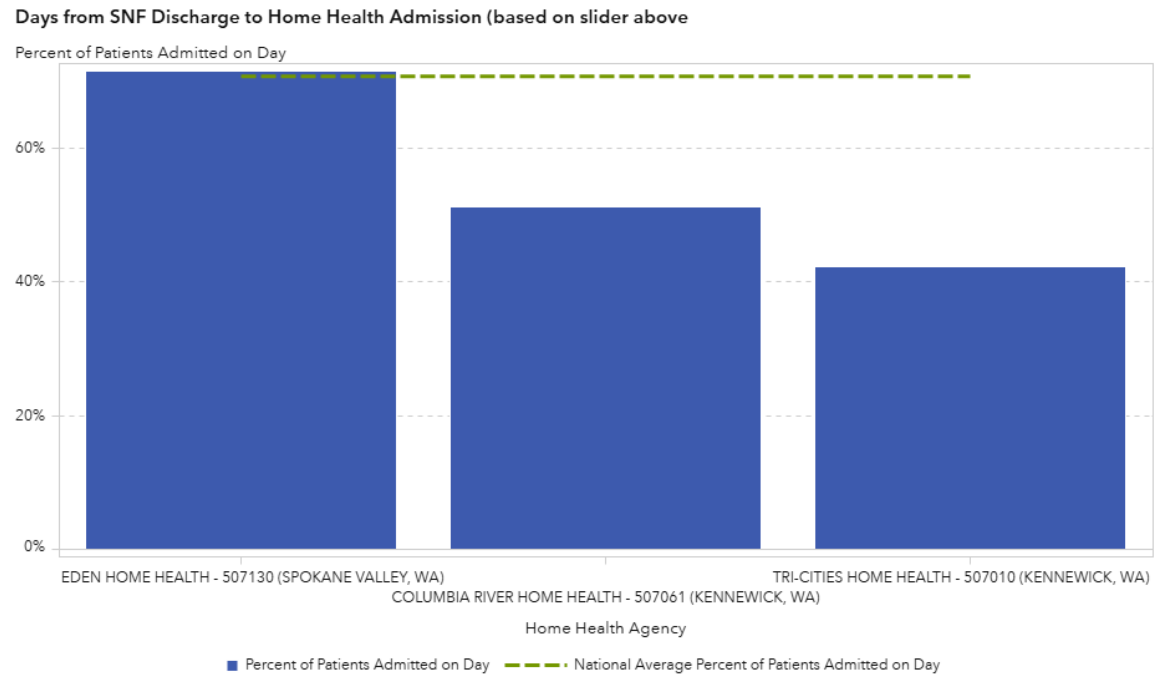


Figure 2: Berg Data Solutions 2023 Data
Percentage of SNF Discharge Patients Admitted Within 2 Days of Home Health Eligibility



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

Eden Home Health of Spokane County will be available and accessible to the **entire** Benton County planning area.

11. Identify how this project will be available and accessible to underserved groups.

Eden Home Health will prioritize enrolling patients to ensure they receive services within two days, aligning with the national average for both hospital and skilled nursing home referrals. Additionally, Eden's charity care policy, which offers free or discounted care to patients up to 400% of the poverty level, aligns with industry leaders. This policy supports Eden's Admissions and Non-Discrimination policies, ensuring that eligible individuals are not denied care based on income or other discriminatory factors. Need policies listed below.

12. Provide a copy of the following policies:
    - Admissions policy
    - Charity care or financial assistance policy
    - Patient Rights and Responsibilities policy
    - Non-discrimination policy
    - Any other policies directly related with patient access (example, involuntary discharge)

The Admissions Policy is in Appendix 5, the Charity Care and Financial Assistance Policy in Appendix 6, the Patient Rights and Responsibilities Policy in Appendix 7, and the Non-Discrimination Policy in Appendix 8.

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

Financial feasibility of a home health 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. Example provided in Appendix A.
    - Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. Include all assumptions. Example provided in Appendix A.

- 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 pro forma projections. For incomplete years, identify whether the data is annualized.

  Appendix 11 provides the required financial forms.

2. Provide the following agreements/contracts:
   - Management agreement
   - Operating agreement
   - Medical director agreement
   - Joint Venture agreement - not applicable

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

   The Management Agreement is in Appendix 13. The Operating Agreement is in Appendix 14. The Medical Director Agreement in Appendix 15. There is no separate Operating Agreement.

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 home health 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 first three years of operation. Provide any amendments, addenda, or substitute agreements to be created as a result of this project to demonstrate site control.

   Appendix 10 contains a copy of the lease agreement confirming and extending site control for the Eden Health Spokane home health agency.

4. Complete the table below 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 below, include the definition of the line item. Include all assumptions used to create the capital expenditure estimate.

Item	Cost
a. Land Purchase	$ 0
b. Utilities to Lot Line	$ 0
c. Land Improvements	$ 0
d. Building Purchase	$ 0
e. Residual Value of Replaced Facility	$ 0
f. Building Construction	$ 0
g. Fixed Equipment (not already included in the construction contract)	$ 0
h. Movable Equipment	$ 0
i. Architect and Engineering Fees	$ 0
j. Consulting Fees	$ 0
k. Site Preparation	$ 0
l. Supervision and Inspection of Site	$ 0
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction)	
1. Land	$ 0
2. Building	$ 0
3. Equipment	$ 0
4. Other	$ 0
n. Washington Sales Tax	$ 0
Total Estimated Capital Expenditure	**$ 0**

5. 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

This application has no associated capital costs. Eden Home Health, Inc. is responsible for any estimated capital expenses.

6. 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 startup costs associated with Medicare certification, facility leasing, remodeling, or the addition of key administrative staff. Eden's recruitment strategy for Benton County residents includes remote learning, orientation, and training for experienced home health employees or contractors, as well as in-person training in Spokane County for those requiring additional instruction. Experienced new hires complete their orientation and training remotely while actively serving patients, categorizing these efforts as ongoing support rather than startup costs. For licensed employees needing further training, including job-shadowing, this process takes place in either Spokane or Benton County while they provide direct services, ensuring these activities are not considered startup expenses.

7. Identify the entity responsible for the start-up costs. If more than one entity is responsible, provide a breakdown of percentages and amounts for each.

Not Applicable.

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

In Benton County, approximately 75% to 79% of charges are based on fixed reimbursement rates from Medicare and Medicaid, with an estimated 2% allocated to charity care. Charges for commercial and other patients are comparable to Medicare rates after accounting for contractual adjustments. Although Medicaid reimbursement operates on a lower "blended rate" than Medicare, Medicaid patients make up a relatively small portion of the population, accounting for about 6%. Eden anticipates that approximately 6% of its patients will be covered by Medicaid.

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

One strength of this project is being able to initiate operations without the added expense of a branch office or satellite office, thus avoiding construction-related costs.

10. 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
Payer Mix: Benton County

Payer Mix: Benton County	Percentage of Gross Revenue	Percentage by Patient
Medicare	72%	68%
Medicaid	5%	7%
Commercial/Other	22%	25%
Charity Care	2%	2%
Total	100%	100%

Table 15
Payer Mix Spokane County

Payer Mix: Spokane County	Percentage of Gross Revenue	Percentage by Patient
Medicare	72%	68%
Medicaid	5%	7%
Commercial/Other	22%	25%
Charity Care	2%	2%
Total	100%	100%

Table 16
Payer Mix Spokane Agency

Payer Mix: Overall Agency	Percentage of Gross Revenue	Percentage by Patient
Medicare	72%	68%
Medicaid	4%	7%
Commercial/Other	22%	25%
Charity Care	2%	2%
Total	100%	68%

Eden determined the payer mix based on patient distribution across Medicare, Medicaid, and Commercial/Other categories, using three years of cost report data from Benton County (2021–2023). While Medicaid payer mix varied by year and provider, approximately 4% of unduplicated visits in 2023 were Medicaid patients, ranging from 1% to 6%. Over the three-year period, Medicaid representation fluctuated from a low of 0.9% for one provider to a high of 9.3% for another. Also important to note that the State Medicaid program through its now 11-year Medicaid Transformation Project (MTP) is shifting more long term care patients to its Medicaid insurance network and many providers are categorizing Medicaid payments under Commercial or Other categories (See Appendix 19 that covers the first 6 years of the MTP project).

As a new provider in Benton County, Eden anticipates a relatively higher proportion of Medicaid and Medicare patient visits compared to larger, more established agencies. Consequently, the pro forma payer mix is set at 7% Medicaid, 68% Medicare, and 25% Commercial/Other.
On a revenue basis, Medicare accounts for a slightly higher share due to Medicaid's lower blended reimbursement rate per patient visit.

To maintain a conservative revenue projection, Eden applied the same payer mix assumptions to Spokane County, considering the recent approval of several new agencies in the area.

11. 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.

Table 17 on the next page is based on the 2023 Cost Report for Eden Home Health of Spokane County and estimates of blended revenue for Medicaid. This is only the third full year for this agency's cost report.

Table 17
Payer Mix

Payer Mix: Agency	Percentage of Gross Revenue	Percentage by Patient
Medicare	39%	43%
Medicaid	0%	0%
Commercial/Other	61%	55%
Charity Care	0%	2%
Total	100%	100%

As noted, Eden's actual payer mix in Benton County includes a lower percentage of both Medicaid and Medicare patients and a higher percentage of Commercial/Other patients. Given that Eden is a new agency, these percentages have fluctuated significantly and are expected to remain variable, especially with the recent approval and turnover of new agencies in Spokane County. To ensure a more conservative approach for future revenue projections, Eden chose to base all feasibility-based pro formas on the Benton County payer mix rather than the current payer mix in Spokane, which reflects a higher share of Commercial/Other patients.

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

The existing inventory of equipment for the Eden Home Health of Spokane is sufficient to support the project. There is no additional equipment required for the project.

13. 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.

Expanding home health services to Benton County will be funded by operating revenues for the Eden Spokane Home Health agency supplemented by funding from Eden Health, Inc. A letter confirming funding support from the CFO is included in Appendix 11.

14. 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.

Not Applicable.

15. Provide the most recent audited financial statements for:
    - The applicant, and
    - Any parent entity responsible for financing the project.

Appendix 12 provides the most recent audited financial statement for Eden Health, Inc.

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 18
Staffing for Benton County

Staffing Summary - Eden HHA Benton County FTE's

STAFFING INPUT - BY FTE'S	2025	2026	2027	2028
OPERATIONS				
Physician (Medical Director)				
Director of Professional Services	0.50	0.50	0.50	0.50
Clinical Supervisor	-	1.00	1.00	1.00
Home Care Specialist	0.50	1.00	1.00	1.00
RN	0.31	0.74	1.80	3.24
PT	0.37	0.88	2.14	3.84
OT	0.14	0.33	0.84	1.51
ST	0.03	0.05	0.16	0.28
MSW	0.02	0.03	0.10	0.19
HHaide	0.00	0.04	0.01	0.01
SUBTOTAL	**1.87**	**4.58**	**7.54**	**11.57**
ADMINISTRATIVE				
Administrator	0.33	0.33	0.36	0.50
Office Manager	0.50	1.00	1.00	1.00
Home Care Specialist	0.50	1.00	1.00	1.00
Team Assistant	0.50	1.00	1.00	1.00
Data Entry Clerk	-	-	-	-
Community Outreach	1.00	1.00	2.00	2.00
SUBTOTAL	**2.83**	**4.33**	**5.36**	**5.50**
TOTAL FTE'S	**4.70**	**8.91**	**12.90**	**17.07**

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.

Table 18
Staffing for the Overall Spokane Agency

Staffing Summary -Spokane Overall Agency FTE's								
STAFFING INPUT - BY FTE'S	**2021**	**2022**	**2023**	**2024**	**Current**	**2026**	**2027**	**2028**
OPERATIONS								
Physician (Medical Director)	Contract	Contract	Contract	Contract	Contract	Contract	Contract	Contract
Director of Professional Services	0.6	1.0	1.0		1.0	1.0	1.0	1.0
Clinical Supervisor	0.5	1.0	1.0		2.0	3.0	3.0	3.0
Home Care Specialist	0.5	0.7	0.6		6.0	7.0	7.0	7.0
RN*	1.6	3.0	2.7		7.3	7.6	8.9	10.4
LPN	0.1	1.3	1.8					
PT & PT Asst.	0.5	5.2	6.7		8.7	9.1	10.6	12.4
OT & OT Asst.	0.2	3.0	2.6		3.4	3.4	4.2	4.9
Speech Therapy	0.1	0.2	0.3		0.6	0.5	0.8	0.9
MSW	0.2	0.3	0.3		0.4	0.4	0.5	0.6
HHaide	0.0	0.0	0.0		0.0	0.0	0.0	0.0
SUBTOTAL	**4.4**	**15.7**	**16.9**		**29.4**	**32.0**	**36.0**	**40.2**
ADMINISTRATIVE								
Administrator	0.0	0.0	0.5		0.5	0.5	0.6	1.0
Office Manager	1.0	1.0	1.0		1.0	2.0	2.0	2.0
Home Care Specialist	2.0	2.8	2.0		6.0	7.0	7.0	7.0
Team Assistant	1.0	2.0	3.7		1.0	1.0	1.0	2.0
Data Entry Clerk	0.0	0.0	0.0		0.0	0.0	0.0	0.0
Community Outreach	1.7	2.0	2.0		3.0	3.0	4.0	4.0
SUBTOTAL	**5.7**	**7.8**	**9.2**		**11.5**	**13.5**	**14.6**	**16.0**
TOTAL FTE'S	**10.1**	**23.6**	**26.2**		**40.9**	**45.5**	**50.6**	**56.2**

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

Five key assumptions were used to project the number and types of full-time equivalents (FTEs) involved in direct care:

1. Patient visits categorized by clinical discipline.
2. Number of visits per discipline within an 8-hour shift (productivity).
3. Total visits calculated for each variable treatment volume discipline.
4. Inclusion of semi-variable volume clinical treatment FTEs.
5. Addition of administrative positions.

Step 1: Patient Visits by Clinical Discipline

STAFFING INPUT - BY VISITS		2025	2026	2027	2028
Total Visits		278	2,673	6,467	11,640
RN	36.2%	101	968	2,342	4,216
PT	43.0%	119	1,149	2,781	5,006
OT	16.9%	47	452	1,094	1,968
ST	2.5%	7	67	162	292
MSW	1.3%	3	33	81	146
HHaide	0.1%	0	3	7	12
SUBTOTAL		**278**	**2,673**	**6,467**	**11,640**

Step 2: Visits Per Discipline in an 8-Hour Shift

		2025	2026	2027	2028
VISITS PER 8 HOUR SHIFT		**278**	**2,673**	**6,467**	**11,640**
Skilled Nursing	5.0	5.0	5.0	5.0	5.0
Physical Therapy	5.0	5.0	5.0	5.0	5.0
Occupational Therapy	5.0	5.0	5.0	5.0	5.0
Speech Pathology	4.0	4.0	4.0	4.0	4.0
Medical Social Service	3.0	3.0	3.0	3.0	3.0
Home Health Aide	5.0	5.0	5.0	5.0	5.0

Step 3: Calculate Total Visits in Each Variable Treatment .Volume Discipline per Year by Multiplying Visits per Discipline in Step 1 by Visits per Shift and Divide by 260.4 Shifts per Year

FTES PER YEAR		2025	2026	2027	2028
	260.4 Clinical Shifts				
Skilled Nursing		0.1	0.7	1.8	3.2
Physical Therapy		0.1	0.9	2.1	3.8
Occupational Therapy		0.0	0.3	0.8	1.5
Speech Pathology		0.0	0.1	0.2	0.3
Medical Social Service		0.0	0.0	0.1	0.2
Home Health Aide		0.0	0.0	0.0	0.0
SUBTOTAL: DIRECT		**0.2**	**2.1**	**5.0**	**9.1**

Step 4: Add Semi-variable Clinical Staffing

STAFFING INPUT - BY FTE'S	2025	2026	2027	2028
OPERATIONS				
Physician (Medical Director)				
Director of Professional Services	0.50	0.50	0.50	0.50
Clinical Supervisor	-	1.00	1.00	1.00
Home Care Specialist	0.50	1.00	1.00	1.00
Subtotal Semi-volume based Clinical	1.00	2.50	2.50	2.50

Step 5: Add Administrative and Support Staff

ADMINISTRATIVE	2025	2026	2027	2028
Administrator	0.33	0.33	0.36	0.50
Office Manager	0.50	1.00	1.00	1.00
Home Care Specialist	0.50	1.00	1.00	1.00
Team Assistant	0.50	1.00	1.00	1.00
Data Entry Clerk	-	-	-	-
Community Outreach	1.00	1.00	2.00	2.00
SUBTOTAL	**2.83**	**4.33**	**5.36**	**5.50**
TOTAL FTE'S	**4.70**	**8.91**	**12.90**	**17.07**

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

   Eden used the same staffing ratios that it uses for the Eden Home Health of Spokane and other Eden home health agencies in Washington State as described in the previous step.

5. If you intend to have a medical director, 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 undercontract.

   Gilson Girotto, D.O., License No. OP00002078 (Washington).

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

   The Medical Director is not an employee.

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

   Rhett Nilson, Executive Director
   Teresa Hall, Director of Patient Care Services, RN0122555

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

Most agencies when adding a county have not provided a roster of employees by name and license number for a variety of critical reasons including the following:

1. The information is readily available to the Department of Health in its recurring licensing surveys.
2. Agencies are committed to providing a high level of privacy and safety for all employees.
3. With staff shortages post-Covid 19, agencies protect their employee complement as a vital resource.

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.

As a large multi-state organization, Eden has extensive visibility and connections across various job markets within the home health and hospice sectors. Specifically in Benton County, Eden leverages both local recruitment strategies and its broader industry expertise to attract and retain qualified staff.

- As an employee-owned organization, Eden experiences lower turnover rates compared to many other healthcare providers.
- The EmpRes commitment to both employees and residents, reflected in its company name,

is also a core management principle, prioritizing staff, and patient well-being as key to overall success.

Since this application seeks to expand Eden Health Spokane's Medicare-Medicaid certified service area to include Benton County, central office recruitment will be incremental. This approach ensures that existing providers are not adversely affected, and that Eden can effectively serve home health patients in Benton County.

To recruit, train, and retain staff while maintaining compliance with federal and state healthcare regulations, Eden utilizes a comprehensive suite of employment resources, including:

1. **Learning Management System** – Healthstream
2. **Online Patient Education** – Ignite Healthcare
3. **Recruiting Platforms** – Indeed, Facebook, LinkedIn, and other social media channels
4. **Applicant Tracking System** – Paycor
5. **Background Checks** – Assure Hire
6. **OIG Compliance Screening** – Certiphino Screening

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

Office hours are from 8:30 a.m. to 5:00 p.m., with 24-hour phone access provided through Telemed Answering Service for after-hours support.

11. For existing agencies, clarify whether the applicant currently has a method for assessing customer satisfaction and quality improvement for the home health agency.

Eden Home Health of Spokane utilizes the Home Health Care CAHPS (HHCAHPS) Survey, a standardized national tool designed to assess the experiences of patients receiving home health care from Medicare-certified agencies. This survey is the first of its kind to provide publicly reported data on patients' perspectives regarding skilled home care services. It is one of the services provided to Eden through its partnership with Strategic Healthcare Partners (SHP).

Eden Health partners with SHP as its performance improvement and outcomes vendor, specializing in support for modern post-acute care providers, hospitals, and physician groups.

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

Appendix 16 provides a list of ancillary and support service vendors in place.

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

No ancillary or support agreements are expected to change as a result of this project.

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 home health agency has working relationships. Clarify whether any of the existing working relationships would change as a result of this project.

The Eden Home Health of Spokane agency currently works with the following facilities in Spokane:

- Assisted Living Facilities
    - Avamere at South Hill
    - Bethany Place
    - Brookdale Nine Mile
    - Cherrywood
    - Colonial Court
    - Fairwinds
    - Fields Senior Living
    - Northpoint Village
    - Orchard Crest
    - Riverview Memory Care
    - Rockwood Retirement
    - Royal Park Retirement Center
    - The Cottages of Spokane
- Hospital
    - Kootenai Medical Center
    - VA Hospital
    - Multicare
    - Newport Hospital
    - Providence
    - Pullman Regional Hospital
    - Valley Medical Center
- SNF/Rehab/Nursing Home
    - Aurora Valley Care
    - Alderwood Manor
    - Avalon Care Center
    - Cheney Care Center
    - Coeur d'Alene Health of Cascadia
    - Life Care Center Post Falls
    - North Central Care Center
    - Olympus Living at Spokane
    - Spokane Falls Care
    - Spokane Health and Rehab
    - St Joseph Care Center

- Sullivan Park
- Sunshine Health and Rehab
- Touchmark
- Ivy Court
- Regency at Northpointe
- Royal Park Health and Rehab
- St Lukes Rehabilitation

As Eden implements its project, it will expand its network to include Assisted Living Facilities, Hospitals, and SNF/Rehab/Nursing Homes within Benton County (See Appendix 20).

16. For a new agency, provide a listing of healthcare facilities with which the home health agency would establish working relationships.

Appendix 20 provides the list of healthcare providers that Eden will establish relationships with.

17. 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 health care facility; or
    b. A revocation of a license to operate a healthcare facility; or
    c. A revocation of a license to practice as 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 history of actions described above.

18. 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

Overview:
Building awareness in smaller metropolitan and rural areas requires a strategic, multi-faceted approach that prioritizes personal outreach, trust-building, and consistent messaging. By collaborating with local healthcare providers, engaging in community events, utilizing both traditional and digital media, and sharing impactful patient stories, Eden can establish a strong presence in south-central Washington's rural communities. The key is to become a trusted local resource—the first choice for individuals seeking home healthcare guidance and support. Over time, this trust and visibility will foster steady growth and solidify Eden's reputation as a reliable and compassionate provider in the community.

1. Develop Local Partnerships and Referrals

a. Collaborate with Local Medical Providers

- Coordinate with physicians, clinics, hospitals, and rehabilitation centers in the area.
- Provide educational materials about our services (e.g., brochures, flyers).
- Offer to host or participate in continuing education sessions or health seminars at local clinics.

b. Build Relationships with Social Service Agencies

- Partner with agencies such as senior centers, churches, and non-profit organizations that work with older adults, individuals with disabilities, and other populations needing home health.
- Present services during their events or meetings to reach potential clients and caregivers.

c. Connect with Pharmacies and Medical Supply Stores

- Place brochures or business cards at pharmacies and stores that sell home medical equipment.
- Offer to share educational content about medication management or safe-home setups.

2. Engage in Community Outreach

a. Attend and Sponsor Local Events

- Look for health fairs, county fairs, or community festivals where you can set up a booth.
- Provide free blood pressure checks, glucose screenings, or simple wellness tips to demonstrate value and generate leads.
- Sponsor or co-sponsor small local events to show our commitment to the community.

b. Host Informational Seminars or Workshops

- Organize workshops on topics such as caring for aging parents, diabetes management, fall prevention, and more.
- Invite local experts (e.g., dietitians, physical therapists) to speak alongside our staff.
- Offer these sessions at libraries, community centers, churches, or even virtually (for those with limited mobility).

c. Volunteer and Join Community Groups

- Encourage staff to volunteer with local charities or community organizations; wearing company-branded T-shirts can gently reinforce brand awareness.

- Participate in service clubs such as Rotary or Lions Clubs to expand networks and visibility.

3. Leverage Local Media Outlets

a. Regional Newspapers and Radio Stations

- Pitch human-interest stories to local newspapers or radio stations highlighting how home healthcare services help families in rural areas (e.g., stories about clients whose quality of life has improved).
- Purchase print or radio ad spots focusing on the unique benefits of receiving care at home.

b. Community Newsletters and Bulletins

- Many small towns have newsletters, church bulletins, or community magazines. Offering an article, ad, or sponsored content can be highly effective.
- Keep the language simple, clear, and directly relevant to community needs.

4. Optimize Digital Presence

a. Local SEO (Search Engine Optimization)

- Ensure Eden's HH website is optimized for local searches: use location-specific keywords (e.g., "home healthcare in south-central Washington").
- Register Eden Health with Google Business Profile and keep it updated with current hours, contact information, and customer reviews.
- Encourage satisfied clients or their family members to leave reviews online.

b. Targeted Social Media Advertising

- Facebook and Instagram ads can be targeted by location and demographics (e.g., adult children of seniors, individuals with certain health conditions).
- Share patient success stories (with permission), staff spotlights, and educational content.

c. Informational Content Marketing

- Post blog articles or short videos about home health tips, caregiver support, and healthcare resources specific to rural living.
- This positions your organization as an authority and a trusted resource.

5. Cultivate a Positive Reputation

a. Collect and Publicize Testimonials

- Ask clients or their family members for written or video testimonials that detail their experiences with your services.
- Share these testimonials on your website, social media, and in printed promotional materials (with permission).

b. Demonstrate Community Investment

- Showcase any charitable activities or sponsorships.
- Highlight how you employ local residents, thus contributing to economic development.

c. Word-of-Mouth and Caregiver Advocacy

- Encourage Eden's caregivers and staff to talk about our services in the community.

- Offer referral incentives for existing clients who recommend new clients.

6. Provide Education and Resources

a. Create "Aging in Place" Guides

- Develop simple, easy-to-read guides on home safety and general caregiving tips.
- Distribute these guides at local community centers, libraries, and medical offices.

b. Host Free "Ask a Nurse" or "Ask a Caregiver" Sessions

- Schedule virtual Q&A sessions or in-person drop-in hours at a community facility.
- This allows potential clients or their families to meet staff and learn what services are offered.

c. Participate in Telehealth Initiatives

- Rural communities often benefit from telehealth services if in-person care is limited.
- Partner with telehealth providers or local hospital networks to offer integrated healthcare solutions.

7. Maintain Consistent Branding and Messaging

a. Highlight Your Unique Value

- Emphasize the convenience of in-home care and the specialized expertise of your staff.
- Underscore any programs or certifications that set Eden apart (e.g., specialized memory care, post-surgical rehabilitation, or palliative care).

b. Use Clear, Person-Centered Language

- Rural communities often rely on trust and personal relationships. Use language that is compassionate and easy to understand.
- Focus on how services can improve patients' quality of life and relieve caregiver stress.

c. Share Stories and Faces

- Showcase photos of real staff (with permission).
- Humanize brand by showing the people behind the company, not just the company logo.

Conclusions:

The summary above highlights how Eden's model differs from those of many other agencies. While the model concept itself is not proprietary, the specific strategy Eden will implement in Benton County is unique to the organization. No single agency can immediately execute activities across all these areas; however, Eden's skilled outreach coordinators carefully select the most effective mix of approaches based on initial research and ongoing feedback. Supported by a robust needs assessment methodology, any home health care provider that engages in these seven key areas will be well-positioned to achieve its utilization and service goals.

19. 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.

Most importantly, there is a need for either two or three additional home health agencies and Eden will serve the entire county to meet the countywide need. Most importantly, Eden through its Charity Care policy will not only serve Medicaid patients but all low income residents with its generous free and discounted care policy that extends to 400% of the Federal Poverty Level. The model presented above and documentation by Eden of the extensive array of providers other than home health agencies shows that Eden will enhance continuity of care.

20. 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 facilities current compliance status.

No Eden agency reflects a pattern of condition-level findings.

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

No Eden agency reflects a pattern of condition-level findings.

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.

Alternative 1: Add Benton County to the Eden Home Health of Spokane Medicare certified agency service area operated with staff residing in Benton County but fully supported as well as directed by the Spokane central home health agency office.

Alternative 2: Add Benton County to the Eden Home Health of Spokane Medicare certified agency service area operated with staff residing in Benton County with a branch office in Benton County but fully directed by the Spokane central home health agency office.

Alternative 3: Do not add Benton County to the Eden Home Health of Spokane certified agency.

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.

Patient Access
To ensure seamless home health access for patients, Eden's outreach staff, trained and managed by the Spokane agency office, maintains frequent communication with hospital discharge planning teams in every hospital and nursing home across Benton County. This proactive approach facilitates rapid referrals to home health services. Additionally, outreach staff collaborates with primary care providers and select specialists to reinforce Eden's commitment to promptly registering patients and initiating home health services within two days of eligibility.

As previously shown in Figures 1 and 2, Eden Home Health of Spokane has consistently registered patients more quickly than the two established home health providers, Tri-Cities Home Health and Columbia River Home Health. Meanwhile, Vue's performance remains untested due to a lack of publicly available data.

Regarding patient access, both Alternative 1 and Alternative 2 would enhance access to hospice services by reducing the time between eligibility determination and service initiation. In contrast, Alternative 3 would maintain the existing delays in Benton County, where the time to service remains significantly longer than the statewide average.

Capital Costs
Following discussions with the Department of Licensing staff, Eden has determined that Alternative 1 presents no legal restrictions regarding capital costs, as it does not involve establishing a Branch Office. Even if supplemental space was added in the future, the capital impact would be minimal due to Eden's existing equipment inventory. From a capital cost perspective, Alternative 1 is slightly more favorable than Alternative 2. In either scenario, capital costs would not necessitate an amendment to the application, and both Alternative 1 and Alternative 2 are clearly preferable to Alternative 3, which involves taking no action.

Quality of Care
In a competitive environment, agencies must continuously improve the quality of care to secure referrals and maintain service demand. Given the significant need for additional home health services, long-term differences in quality of care are unlikely. Overall, both Alternative 1 and Alternative 2 are significantly superior to Alternative 3, the "do nothing" approach.

Staffing Impacts
The addition of Eden Home Health of Spokane is expected to enhance staffing efficiency, as the Medicare-certified administrative and central office staff supporting both Eden Hospice of Spokane alternatives will remain the same. With more eligible patients being admitted more quickly in Benton County, overall service volume will increase. For Eden Spokane specifically, patients are also likely to receive care for a longer duration, allowing administrative and support staff hours to be distributed across a larger number of care episodes.

Regarding direct care staff, most agencies follow similar staffing hour standards, which are expected to remain unchanged.

Cost Reduction and Operational Effectiveness

Alternative 1 offers slightly lower costs, as it does not require a Branch or satellite office. From both a cost and operational effectiveness standpoint, both Alternative 1 and Alternative 2 are far superior to Alternative 3, the "do nothing" approach.

Returning to Eden's superior wait time statistics, Eden Home Health of Spokane can help reduce hospital care costs by minimizing the wait time between a patient's hospital discharge and the initiation of home health services—a current issue in Benton County. Ensuring that patients do not experience a decline in their rehabilitation status while waiting for care, whether in a hospital, nursing home, or at home, is crucial for achieving positive health outcomes. In this regard, both Alternative 1 and Alternative 2 are vastly more cost-effective than Alternative 3.

3. 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.

4. Identify any aspects of the project that will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment and which promote quality assurance and cost effectiveness.

Eden is exploring innovative outreach strategies to enhance access and awareness for all residents, with a particular focus on reaching low-income communities. The Eden response to Q-18: Provide a discussion explaining how the proposed project will promote continuity in the provision of health care services in the planning area, and notresult in an unwarranted fragmentation of services. WAC 246-310-230 shows that Eden has a carefully set strategy to enhance outreach and promote quality insurance and cost effectiveness.

Home Health Agency Tie Breakers (1987 State Health Plan, Volume II, page B35-36)
If two or more applicants meet all applicable review criteria and there is not enough need projected for all applications to be approved, the department will approve the agency that better improves patient care, reduces costs, and improves population health through increased access to services in the planning area. Ensure that sufficient documentation and discussion of these items is included throughout the application under the relevant sections.

Certificate of Need Program Revised Code of Washington (RCW) and Washington Administrative Code (WAC)

Certificate of Need Program laws RCW 70.38

Certificate of Need Program rules WAC 246-310

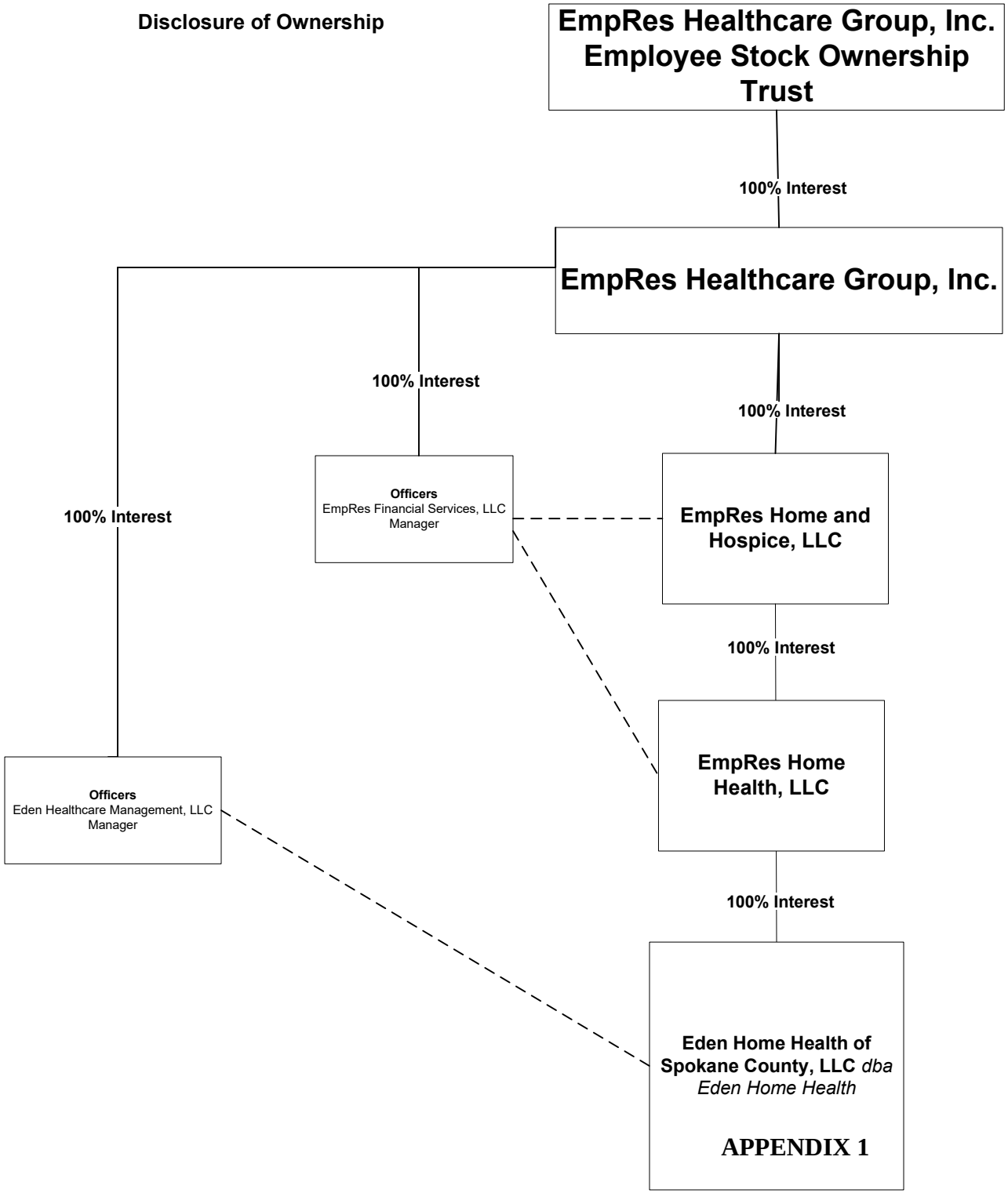
Commonly Referenced Rules for Home Health Projects:

WAC Reference	Title/Topic
246-310-010	Certificate of Need Definitions
246-310-200	Bases for findings and action on applications
246-310-210	Determination of Need
246-310-220	Determination of Financial Feasibility
246-310-230	Criteria for Structure and Process of Care
246-310-240	Determination of Cost Containment

Certificate of Need Contact Information:
Certificate of Need Program Web Page
Phone: (360) 236-2955
Email: FSLCON@doh.wa.gov

Licensing Resources:
In-Home Services Agencies Laws, RCW 70.127
In-Home Services Agencies Rules, WAC 246-335
Home Health Agencies Program Web Page

Disclosure of Ownership



APPENDIX 1

APPENDIX 2

SEE PAGES 20-22

Legal Name	DBA
ARIZONA	
Eden Hospice at Sierra Vista, LLC	Eden Hospice
Eden Home Health of Sierra Vista, LLC	Eden Home Health
CALIFORNIA	
Eden Home Health of Elk Grove, LLC	Eden Home Health
IDAHO	
Eden Home Health of Idaho Falls, LLC	Eden Home Health
Eden Hospice at Idaho Falls, LLC	Eden Hospice
Eden Home Health of Sandpoint, LLC	Eden Home Health
Eden Hospice at the Inland Northwest, LLC	Eden Hospice
MONTANA	
Eden Home Health of Bozeman, LLC	Eden Home Health
Eden Hospice at Western Montana, LLC	Eden Hospice
NEVADA	
EmpRes Personal Care Nevada, LLC	Eden Home Care
Quality Health Care Corporation	Eden Home Health
Eden Hospice at Carson City, LLC	Eden Hospice
OREGON	
Eden Hospice at Portland, LLC	Eden Hospice
Eden Home Health of Bend, LLC	Eden Home Health
Eden Hospice at Bend, LLC	Eden Hospice
WASHINGTON	
EmpRes Home Health of Bellingham, LLC	Eden Home Health
EmpRes Home Care of Bellingham, LLC	Eden Home Care
Eden Home Health of King County, LLC	Eden Home Health
Eden Home Health of Clark County, LLC	Eden Home Health
Eden Home Health of Spokane County, LLC	Eden Home Health
Eden Hospice at Whatcom County, LLC	Eden Hospice
Eden Hospice at Snohomish County, LLC	Eden Hospice
Eden Hospice at King County, LLC	Eden Hospice
WYOMING	
Eden Home Health of Cheyenne, LLC	Eden Home Health
Eden Hospice at Cheyenne, LLC	Eden Hospice

Legal Name	DBA
ARIZONA	
Eden Hospice at Sierra Vista, LLC	Eden Hospice
Eden Home Health of Sierra Vista, LLC	Eden Home Health
CALIFORNIA	
Eden Home Health of Elk Grove, LLC	Eden Home Health
IDAHO	
Eden Home Health of Idaho Falls, LLC	Eden Home Health
Eden Hospice at Idaho Falls, LLC	Eden Hospice
Eden Home Health of Sandpoint, LLC	Eden Home Health
Eden Hospice at the Inland Northwest, LLC	Eden Hospice
MONTANA	
Eden Home Health of Bozeman, LLC	Eden Home Health
Eden Hospice at Western Montana, LLC	Eden Hospice
NEVADA	
EmpRes Personal Care Nevada, LLC	Eden Home Care
Quality Health Care Corporation	Eden Home Health
Eden Hospice at Carson City, LLC	Eden Hospice
OREGON	
Eden Hospice at Portland, LLC	Eden Hospice
Eden Home Health of Bend, LLC	Eden Home Health
Eden Hospice at Bend, LLC	Eden Hospice
WASHINGTON	
EmpRes Home Health of Bellingham, LLC	Eden Home Health
EmpRes Home Care of Bellingham, LLC	Eden Home Care
Eden Home Health of King County, LLC	Eden Home Health
Eden Home Health of Clark County, LLC	Eden Home Health
Eden Home Health of Spokane County, LLC	Eden Home Health
Eden Hospice at Whatcom County, LLC	Eden Hospice
Eden Hospice at Snohomish County, LLC	Eden Hospice
Eden Hospice at King County, LLC	Eden Hospice
WYOMING	
Eden Home Health of Cheyenne, LLC	Eden Home Health
Eden Hospice at Cheyenne, LLC	Eden Hospice

December 27, 2024

Eric Hernandez, Program Manager
Office of Community Health Systems – Certificate of Need
Washington State Department of Health

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

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

Dear Mr. Hernandez:

This letter of intent is issued on behalf of Eden Home Health of Spokane County, LLC, an affiliate of Eden Healthcare Management, LLC. Eden Home Health of Spokane County, LLC in accordance with WAC 246-310-080, intends to submit a certificate of need application (CN) to provide Medicare and Medicaid home health services to residents of Benton County.

1. Description of proposed service
   Eden Healthcare Management, LLC, as Manager of Eden Home Health of Spokane County, LLC, requests CN approval to extend the service area of Eden Home Health of Spokane County, LLC, to provide Medicare and Medicaid home health services to residents of Benton County.

2. Estimated cost of the project
   There are no estimated capital expenditures associated with the project because services are being provided through the existing Eden Home Health of Spokane County, LLC agency location.

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

Please address all correspondence to:

Jamie Brown, Chief Operating Officer
4601 NE 77th Ave., Ste. 300,
Vancouver, WA 98662
jamie.brown@eden-health.com

Sincerely,

Jamie Brown

Jamie Brown, Chief Operating Officer

Reference #:	1021
Effective:	03/16/18
Last Revised:	10/04/19

ADMISSIONS POLICY

PURPOSE:

- The agency develops and maintains written policies and processes governing referrals/admissions.

PROCEDURE:

1. The referral/admission policies establish uniform guidelines for personnel to follow when admitting patients to the agency.

2. The referral/admission policies apply to all patients admitted to the Agency without regard to race, color, creed, sex, age, handicap (mental or physical), communicable disease(s), veteran status/history, or place of national origin.

3. The objectives of the Agency's admission/referral policies are to:

- **a.** Provide uniform guidelines in the admission of patients to the Agency.
- **b.** Admit patients who can be adequately cared for by the Agency.
- **c.** Reduce patient and family fears and anxieties during the admission process.
- **d.** Inform the patient and/or the patient's responsible party regarding the Agency's policies and processes relating to patient rights, patient care, financial obligations, etc. Receive appropriate medical and financial records relating to the patient prior to or at admission.

4. The Executive Director (ED) or designee validates that the Agency and the patient follow established admission policies as applicable.

5. The policies outlined within this section reflect the needs and operational requirements in the admission of patients to the Agency while meeting regulatory requirements.

6. Referral/Admission policies and processes are reviewed for revisions and updates as necessary, but at least annually.

Reference#	2023
Effective:	08/30/2019
Last Revised:	02/04/2025

CHARITY CARE POLICY

POLICY:

1. Patients will not be refused admission based on ability to pay and may be eligible for charity care at the time of admission to Eden Home Health or during the period when they receive home health services, consistent with the Income Guidelines set out below.

2. Eden Health staff notify patients of the option for charity care as the need is identified. Notification may occur in person, via telephone or mail/e-mail.

3. Admitted Patients can appeal charity care determinations according to the Patient Concerns and Grievances policy.

4. Eligibility for charity care under this policy is at all times contingent upon the patient's cooperation with the application process, including the timely submission of all information that Eden Home Health deems necessary or appropriate to enable it to make a charity care determination.

5. 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 2025 Poverty Guidelines: 48 Contiguous States

Household/ Family Size	100%	200%	300%	400%
1	15,650.00	31,300.00	46,950.00	62,600.00
2	21,150.00	42,300.00	63,450.00	84,600.00
3	26,650.00	53,300.00	79,950.00	106,600.00
4	32,150.00	64,300.00	96,450.00	128,600.00
5	37,650.00	75,300.00	112,950.00	150,600.00
6	43,150.00	86,300.00	129,450.00	172,600.00
7	48,650.00	97,300.00	145,950.00	194,600.00
8	54,150.00	108,300.00	162,450.00	216,600.00
9	59,650.00	119,300.00	178,950.00	238,600.00
10	65,150.00	130,300.00	195,450.00	260,600.00
11	70,650.00	141,300.00	211,950.00	282,600.00
12	76,150.00	152,300.00	228,450.00	304,600.00
13	81,650.00	163,300.00	244,950.00	326,600.00
14	87,150.00	174,300.00	261,450.00	348,600.00

Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

PROCEDURE:

1. Cases for consideration may be proposed by the patient or family, by the patient's physician, by Eden Home Health 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

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

5. The home health administrator will make a determination regarding eligibility within 14 days of receipt of documentation.

6. Designation of charity care, while generally determined at time of admission may occur at any time upon Eden Home Health 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 home health administrator is responsible for making all eligibility determinations.

WASHINGTON HOME HEALTH PATIENT BILL OF RIGHTS

Patients have the right to:

1. Receive effective treatment and quality services from Eden Home Health 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. Ongoing participation in the development of the plan of care;
4. Have access to the department's listing of licensed home health agencies and to select any licensee to provide care, subject to the individual's reimbursement mechanism or other relevant contractual obligations;
5. A listing of the total services offered by the home health agency and those being provided to the patient;
6. Refuse specific treatments or services;
7. The name of the individual within Eden Home Health responsible for supervising the patient's care and the manner in which that individual may be contacted;
8. Be treated with courtesy, respect, and privacy;
9. Be free from verbal, mental, sexual, and physical abuse, neglect, exploitation, and discrimination;
10. Have property treated with respect;
11. Privacy and confidentiality of personal information and health care related records;
12. Be informed of Eden Home Health 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;
13. 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;
14. Be informed about advanced directives and POLST and Eden Home Health's scope of responsibility;
15. Be informed of Eden Home Health's policies and procedures regarding the circumstances that may cause Eden Home Health to discharge a patient;
16. Be informed of Eden Home Health's policies and procedures for providing back-up care when services cannot be provided as scheduled;
17. A description of Eden Home Health's process for patients and family to submit complaints to Eden Home Health about the services and care they are receiving and to have those complaints addressed without retaliation;
18. Be informed of the Department of Health's complaint hotline number (1-800-633-6828) to report complaints about the licensed agency or credentialed health care professionals; and
19. Be informed of the DSHS end harm hotline number (1-866-363-4276) to report suspected abuse of children or vulnerable adults.
20. Eden Home Health must ensure that the patient rights under this section are implemented and updated as appropriate.

EDEN HEALTH HOME HEALTH 100% Employee Owned

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 they have been subjected to discrimination or who believes they have 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.

Proforma Operating Statement - Eden HHA - Benton County ONLY

	2025	2026	2027	2028
Unduplicated Patients	*21*	*186*	*450*	*810*
REVENUE				
Medicare	51,197	543,251	1,314,316	2,365,769
Medicaid	3,481	33,490	81,025	145,845
Commercial/Other	23,059	159,728	386,438	695,588
Charity Care	1,280	13,581	32,858	59,144
Total Gross Revenue	**79,017**	**750,050**	**1,814,637**	**3,266,347**
Deductions from Revenue				
Contractual Allowances	17,879	169,388	409,809	737,657
Bad Debt	1,197	15,001	36,293	65,327
Adj. For Charity Care	1,280	13,581	32,858	59,144
Total Net Revenue	**58,660**	**552,080**	**1,335,677**	**2,404,219**
PATIENT CARE COSTS				
Salaries and Benefits:				
Director of Professional Services	16,250	65,000	65,000	65,000
Clinical Manager	-	95,000	95,000	95,000
Home Care Specialist	5,850	46,800	46,800	46,800
RN	18	57,733	140,535	252,963
PT	25	79,303	191,889	345,400
OT	10	29,080	74,358	133,844
ST	3	5,666	17,172	30,910
MSW	2	2,299	6,966	12,539
HHaide	0	1,604	203	365

CONT.	2025	2026	2027	2028
Benefits	5,866	55,208	133,568	240,422
Total Salaries and Benefits	**28,024**	**437,692**	**771,490**	**1,223,242**
Contract Labor:				
Physician (Medical Director)	300	1,200	1,200	1,200
PT	0	0	0	0
OT	0	0	0	0
Speech	-	-	-	-
MSW	-	-	-	-
HHA	-	-	-	-
Other	-	-	-	-
Total Contract Labor	**300**	**1,200**	**1,200**	**1,200**
Medical Supplies	704	6,625	16,028	28,851
Mileage & Medical transportation	1,472	13,857	33,526	60,346
Total Patient Care Costs	**30,500**	**459,375**	**822,244**	**1,313,639**
Gross Patient Margin	**28,160**	**92,705**	**513,434**	**1,090,580**

CONT.	2025	2026	2027	2028
ADMINISTRATIVE COSTS				
Advertising	**1,500**	**6,000**	**6,000**	**6,000**
Allocated Costs	**2,933**	**27,604**	**66,784**	**120,211**
B & O Taxes	**1,291**	**12,146**	**24,042**	**43,276**
Dues & Subscriptions	-	-	-	-
Employee Benefits	**13,275**	**72,080**	**94,435**	**99,960**
Information Tech/Computers/R&M	**540**	**5,079**	**12,288**	**22,119**
Insurance	-	-	-	-
Legal & Professional	-	-	-	-
Licenses & Fees	**1,783**	**1,783**	**1,916**	**1,916**
Lease Agreement	-	-	-	-
Administrative S & W non variable	**53,100**	**288,320**	**377,740**	**399,840**
Supplies and Expensed Equipment	**7,800**	**6,000**	**6,000**	**6,000**
Mileage - admin/sales	**1,500**	**6,000**	**6,000**	**6,000**
Misc Operating Expenses	-	-	-	-
Total Administrative Costs	**77,421**	**425,012**	**595,205**	**705,322**
Total Costs	**107,921**	**884,387**	**1,417,449**	**2,018,961**

	2025	2026	2027	2028
EBITDA	**$ (49,261)**	**$ (332,307)**	**$ (81,772)**	**$ 385,259**
Depreciation	**-**	**-**	**-**	**-**
Amortization	**-**	**-**	**-**	**-**
EBIT	**(49,261)**	**(332,307)**	**(81,772)**	**385,259**
Interest Expense	**-**	**-**	**-**	**-**
Earnings before Taxes	**(49,261)**	**(332,307)**	**(81,772)**	**385,259**
	-62.34%	**-44.30%**	**-4.51%**	**11.79%**

ASSUMPTIONS	
VISITS	
Medicare	68% of visits assumed to be Medicare based on Eden experience
Medicaid	7% of visits assumed to be Medicaid based on Eden experience
Commercial/Other (a)	25% of visits assumed to be Commercial based on Eden experience
GROSS REVENUE	
Medicare	Medicare visits multiplied by Reimbursement rate of $271
Medicaid	Medicaid visits multiplied by Reimbursement rate of $179
Commercial/Other (a)	Commercial visits multiplied by Reimbursement rate of $332
Charity Care (2.5% x Medicare)	Charity Care at 2.5% of Medicare Revenue
Total Gross Revenue	
Deductions from Revenue (b)	
Contractual allowances	Contractual allowance set at 23% of Gross Revenue less Charity Care
Bad debt	Bad Debt at 2% of Gross Revenue less Charity Care
Charity Care Adjustment	Charity Care Adjustment at 2.5%
Total Net Revenues	
EXPENSES: Variable Clinical Expense	
Salaries and Benefits:	See Supplemental Table with Salaries, Visits per Discipline multiplied by visits per Discipline
Director of Professional Services	See supplemental Table
Clinical Supervisor	See supplemental Table
Home Care Specialist	See supplemental Table
RN	See supplemental Table
PT	See supplemental Table
OT	See supplemental Table

ST	See supplemental Table
MSW	See supplemental Table
HHaide	See supplemental Table
Payroll Taxes & Benefits 25%	Payroll Taxes and Benefits set at 25%
Contract Labor:	
Physician Services	Medical Director Expense at $300 per Quarter
Total Contract Labor	
Other Expense: Variable	Other expenses based on a per visit level
Pharmacy (IV therapy)	No separate calculated IV Therapy expense
DME & Oxygen	No separate calculated DME & Oxygen expense
Medical Supplies	Medical Supplies set at 2.5% of visits
Mileage & Medical transportation	Mileage and Medical transportation set at 2.5% per visit
Total Patient Care Costs	
Gross Patient Margin	
EXPENSES: Fixed & Administrative	
Advertising	Advertising set at $500 per month
Allocated Costs	Allocated Eden Cost Overhead at 5% of Net Revenue
B & O Taxes	B & O taxes set at 2.2% of Net Revenue
Dues & Subscriptions	No separate Cost Estimate
Employee Benefits	Employee Benefits set at 25% for Administrative S & W too
Information Tech/Computers/R&M	Information Tech Repair and Maintenance set at .92% of net revenue
Insurance	Not separately calculated with no separate office
Legal & Professional	Not separately calculated with no separate office
Licenses & Fees & Accreditation	Licensing estimate of $1783 for 2025&26 and !916 for 2027&2028
Lease agreement	No separate office in Benton County
Administrative S & W non variable	See Supplemental Table
Supplies and Equipment (expensed)	Fixed cost of $500 per month
Mileage - admin/sales	Fixed Cost of $500 per month

Miscellaneous Operating Expenses	No separate estimate for Miscellaneous Expense
Total Administrative Costs	
Total Costs	
EBITDA	
Depreciation	No additional equipment
Amortization	No formation costs to be amortized

		2025	2026	2027	2028
Total Visits		278	2,673	6,467	11,640
Mix of Visits					
Nursing		101	968	2,342	4,216
PT		119	1,149	2,781	5,006
OT		47	452	1,094	1,968
Speech		7	67	162	292
MSW		3	33	81	146
HHaide		0	3	7	12
TOTAL		278	2,673	6,467	11,640

STAFFING RATIOS visits per 8 hrs					
Nursing		5.00	5.0	5.0	5.0
PT		5.00	5.0	5.0	5.0
OT		5.00	5.0	5.0	5.0
Speech		4.00	4.0	4.0	4.0
MSW		3.00	3.0	3.0	3.0
HHaide		5.00	5.0	5.0	5.0

STAFFING INPUT - BY FTE'S OPERATIONS		**2025**	**2026**	**2027**	**2028**
Physician (Medical Director)	contracted				
Director of Professional Services	$ 130,000	0.50	0.50	0.50	0.50
Clinical Supervisor	$ 95,000	-	1.00	1.00	1.00
Home Care Specialist	$ 46,800	0.50	1.00	1.00	1.00
RN	60.00	0.31	0.74	1.80	3.24
PT	69.00	0.37	0.88	2.14	3.84
OT	68.00	0.14	0.33	0.84	1.51

ST	106.00	0.03	0.05	0.16	0.28
MSW	86.00	0.02	0.03	0.10	0.19
HHaide	30.00	0.00	0.04	0.01	0.01
TOTAL		1.87	4.58	**7.54**	11.57

ADMINISTRATIVE

Administrator	156,000	0.33	0.33	0.36	0.50
Office Manager	58,240	0.50	1.00	1.00	1.00
Home Care Specialist	46,800	0.50	1.00	1.00	1.00
Team Assistant	46,800	0.50	1.00	1.00	1.00
Data Entry Clerk	-	-	-	-	-
Community Outreach	85,000	1.00	1.00	2.00	2.00
TOTAL		2.83	4.33	5.36	5.50

TOTAL FTE'S		**4.70**	**8.91**	**12.90**	**17.07**

Eden HHA Benton County
Proforma Balance Sheet

	2025	2026	2027	2028
ASSETS				
Current Assets				
Cash & Cash Equivalents	(33,087)	(417,216)	(597,862)	(357,739)
Accounts Receivable (Net)	4,888	92,013	222,613	400,703
Prepaid Expenses				
Total Current Assets	**(28,198)**	**(325,202)**	**(375,249)**	**42,964**
Property and Equipment				
Fixed Assets				
Accumulated Depreciation	-	-	-	-
Total Property and Equipment	-	-	-	-
Other Assets				
Intangibles	-	-	-	-
Loan Fees				
Accumulated Amortization	-	-	-	-
Total Other Assets	-	-	-	-
Total Assets	(28,198)	(325,202)	(375,249)	42,964
LIABILITIES AND CAPITAL				
Current Liabilities				
Accounts Payable & Accrued Expenses	15,980	37,225	53,830	66,310
Accrued Payroll & Related Payables	5,083	19,141	34,260	54,735
Notes Payable Current Portion LT Debt				-
Total Current Liabilities	21,063	56,365	88,090	121,045

Long-Term Liabilities				
Long Term Note Payable	-	-	-	-
Less: Current Portion of LTD				
Total Long-Term Liabilities	-	-	-	-
Total Liabilities	21,063	56,365	88,090	121,045
Capital				
Retained Earnings Shareholder Equity	-	(49,261)	(381,568)	(463,339)
Net Income	(49,261)	(332,307)	(81,772)	385,259
Total Capital	(49,261)	(381,568)	(463,339)	(78,081)
Total Liabilities & Capital	(28,198)	(325,202)	(375,249)	42,964
Diff. between Assets & Liab+Equity	-	-	-	0

Proforma Operating Statement - Eden HHA - Benton County with Spokane County

	2025	2026	2027	2028
	456	*1926*	*2235*	*2610*
REVENUE		*322%*	*16%*	*17%*
Medicare	1,207,535	5,625,273	6,527,770	7,623,034
Medicaid	82,106	346,788	402,425	469,946
Commercial/Other	543,876	1,653,955	1,919,309	2,241,341
Charity Care	30,188	140,632	163,194	190,576
Total Gross Revenue	**1,863,705**	**7,766,648**	**9,012,699**	**10,524,896**
Deductions from Revenue				
Contractual Allowances	421,709	1,753,984	2,035,386	2,376,894
Bad Debt	28,236	155,333	180,254	210,498
Adj. For Charity Care	30,188	140,632	163,194	190,576
Total Net Revenue	**1,383,572**	**5,716,699**	**6,633,864**	**7,746,929**
PATIENT CARE COSTS				
Salaries and Benefits:				
Director of Professional Services	32,500	130,000	130,000	130,000
Clinical Manager	47,500	285,000	285,000	285,000
Home Care Specialist	70,200	327,600	327,600	327,600
RN	438	597,815	697,991	815,103
PT	597	821,165	953,049	1,112,956
OT	231	301,122	369,311	431,276
ST	67	58,674	85,288	99,598
MSW	36	23,802	34,598	40,403
HHaide	1	16,606	1,006	1,175
Benefits	138,357	571,670	663,386	774,693
Total Salaries and Benefits	**289,927**	**3,133,454**	**3,547,228**	**4,017,803**
Contract Labor:				

	2025	2026	2027	2028
Physician (Medical Director)	300	1,200	1,200	1,200
PT	0	0	0	0
OT	0	0	0	0
Speech	-	-	-	-
MSW	-	-	-	-
HHA	-	-	-	-
Other	-	-	-	-
Total Contract Labor	**300**	**1,200**	**1,200**	**1,200**
Medical Supplies	16,603	68,600	79,606	92,963
Mileage & Medical transportation	34,728	143,489	166,510	194,448
Total Patient Care Costs	**341,558**	**3,346,744**	**3,794,545**	**4,306,414**
Gross Patient Margin	**341,879**	**2,369,956**	**2,839,320**	**3,440,514**
ADMINISTRATIVE COSTS				
Advertising	9,000	36,000	36,000	36,000
Allocated Costs	69,179	285,835	331,693	387,346
B & O Taxes	30,439	125,767	119,410	139,445
Dues & Subscriptions	-	-	-	-
Employee Benefits	53,913	205,970	230,470	258,420
Information Tech/Computers/R&M	27,671	52,594	61,032	71,272
Insurance	5,832	23,328	23,328	23,328
Legal & Professional	2,055	8,220	8,220	8,220
Licenses & Fees	1,783	1,783	1,916	1,916
Lease Agreement	15,900	63,600	63,600	63,600
Administrative S & W non variable	179,710	823,880	921,880	1,033,680
Supplies and Expensed Equipment	7,800	6,000	6,000	6,000
Mileage - admin/sales	3,300	15,600	18,000	21,600

	2025	2026	2027	2028
Misc Operating Expenses	13,923	-	-	-
Total Administrative Costs	**420,505**	**1,648,577**	**1,821,548**	**2,050,827**
Total Costs	**762,062**	**4,995,321**	**5,616,093**	**6,357,241**
EBITDA	**$ 621,509**	**$ 721,379**	**$ 1,017,772**	**$ 1,389,688**
Depreciation	-	-	-	-
Amortization	-	-	-	-
EBIT	**621,509**	**721,379**	**1,017,772**	**1,389,688**
Interest Expense	-	-	-	-
Earnings before Taxes	**621,509**	**721,379**	**1,017,772**	**1,389,688**
	33.35%	9.29%	11.29%	13.20%

ASSUMPTIONS	
VISITS	
Medicare	68% of visits assumed to be Medicare based on Eden experience
Medicaid	7% of visits assumed to be Medicaid based on Eden experience
Commercial/Other (a)	25% of visits assumed to be Commercial based on Eden experience
GROSS REVENUE	
Medicare	Medicare visits multiplied by Reimbursement rate of $271
Medicaid	Medicaid visits multiplied by Reimbursement rate of $179
Commercial/Other (a)	Commercial visits multiplied by Reimbursement rate of $332
Charity Care (2.5% x Medicare)	Charity Care at 2.5% of Medicare Revenue
Total Gross Revenue	
Deductions from Revenue (b)	
Contractual allowances	Contractual allowance set at 23% of Gross Revenue less Charity Care
Bad debt	Bad Debt at 2% of Gross Revenue less Charity Care
Charity Care Adjustment	Charity Care Adjustment at 2.5%
Total Net Revenues	
EXPENSES: Variable Clinical Expense	
Salaries and Benefits:	See Supplemental Table with Salaries, Visits per Discipline multiplied by visits per Discipline
Director of Professional Services	See supplemental Table
Clinical Supervisor	See supplemental Table
Home Care Specialist	See supplemental Table
RN	See supplemental Table
PT	See supplemental Table
OT	See supplemental Table
ST	See supplemental Table
MSW	See supplemental Table
HHaide	See supplemental Table
Payroll Taxes & Benefits 25%	Payroll Taxes and Benefits set at 25%
Total Salaries and Benefits	
Contract Labor:	
Physician Services	Medical Director Expense at $300 per Quarter
PT	
OT	
Speech	
MSW	
HHA	
Other	
Total Contract Labor	

Other Expense: Variable	Other expenses based on a per visit level
Pharmacy (IV therapy)	No separated calculated IV Therapy expense
DME & Oxygen	No separate calculated DME & Oxygen expense
Medical Supplies	Medical Supplies set at 2.5% of visits
Mileage & Medical transportation	Mileage and Medical transportation set at 2.5% per visit
Total Patient Care Costs	
Gross Patient Margin	
EXPENSES: Fixed & Administrative	
Advertising	Advertising set at $3000 per month
Allocated Costs	Allocated Eden Cost Overhead at 5% of Net Revenue
B & O Taxes	B & O taxes set at 2.2% of Net Revenue decreasing to 1.8% in 2027
Dues & Subscriptions	No separate Cost Estimate
Employee Benefits	Employee Benefits set at 25% for Administrative S & W too
Information Tech/Computers/R&M	Information Tech Repair and Maintenance set at .92% of net revenue
Insurance	Insurance at $1944 per month not allocated
Legal & Professional	Legal at $685 per month, not allocated
Licenses & Fees & Accreditation	Licensing estimate of $1783 for 2025&26 and !916 for 2027&2028
Lease agreement	Lease set at $5300 per month
Administrative S & W non variable	See Supplemental Table
Supplies and Equipment (expensed)	Fixed cost of $500 per month
Mileage - admin/sales	$1100 per month, increasing up to $1800 per month in 2028
Miscellaneous Operating Expenses	No separate estimate for Miscellaneous Expense
Total Administrative Costs	
Total Costs	
EBITDA	
Depreciation	$1779 per month depreciation
Amortization	No formation costs to be amortized

		2025	2026	2027	2028
Total Visits		6,553	27,677	32,117	37,506
Mix of Visits					
Nursing		2,373	10,025	11,633	13,585
PT		2,818	11,903	13,812	16,130
OT		1,108	4,680	5,431	6,342
Speech		164	693	805	940
MSW		82	347	402	470
HHaide		7	29	34	39
TOTAL		6,553	27,677	32,117	37,506

STAFFING RATIOS visits per 8 hrs					
Nursing		5.00	5.0	5.0	5.0
PT		5.00	5.0	5.0	5.0
OT		5.00	5.0	5.0	5.0
Speech		4.00	4.0	4.0	4.0
MSW		3.00	3.0	3.0	3.0
HHaide		5.00	5.0	5.0	5.0

STAFFING INPUT - BY FTE'S OPERATIONS		2025	2026	2027	2028
Physician (Medical Director)	contracted				
Director of Professional Services	$130,000	1.00	1.00	1.00	1.00
Clinical Supervisor	$95,000	2.00	3.00	3.00	3.00
Home Care Specialist	$46,800	6.00	7.00	7.00	7.00
RN	$60	7.29	7.65	8.93	10.43
PT	$69	8.66	9.14	10.61	12.39
OT	$68	3.40	3.40	4.17	4.87
ST	$106	0.63	0.53	0.77	0.90

MSW	$86	0.42	0.35	0.51	0.60
HHaide	$30	0.02	0.43	0.03	0.03
TOTAL		29.43	32.51	36.03	40.23

		2025	**2026**	**2027**	**2028**
ADMINISTRATIVE					
Administrator	$156,000	0.50	0.50	0.58	1.00
Office Manager	$58,240	1.00	2.00	2.00	2.00
Home Care Specialist	$46,800	6.00	7.00	7.00	7.00
Team Assistant	$46,800	1.00	1.00	1.00	2.00
Data Entry Clerk	$0	-	-	-	-
Community Outreach	$85,000	3.00	3.00	4.00	4.00
TOTAL		11.50	13.50	14.58	16.00
TOTAL FTE'S		**40.93**	**46.01**	**50.61**	**56.23**

Eden HHA Benton County
Proforma Balance Sheet

	2025	2026	2027	2028
ASSETS				
Current Assets				
Cash & Cash Equivalents	643,984	1,313,540	2,232,437	3,476,989
Accounts Receivable (Net)	4,888	92,013	222,613	400,703
Prepaid Expenses				
Total Current Assets	**648,872**	**1,405,553**	**2,455,050**	**3,877,692**
Property and Equipment				
Fixed Assets				
Accumulated Depreciation	-	-	-	-
Total Property and Equipment	-	-	-	-
Other Assets				
Intangibles	-	-	-	-
Loan Fees				
Accumulated Amortization	-	-	-	-
Total Other Assets	-	-	-	-
Total Assets	648,872	1,405,553	2,455,050	3,877,692
LIABILITIES AND CAPITAL				
Current Liabilities				
Accounts Payable & Accrued Expenses	15,980	37,225	53,830	66,310
Accrued Payroll & Related Payables	5,083	19,141	34,260	54,735
Notes Payable				-
Current Portion LT Debt				
Total Current Liabilities	21,063	56,365	88,090	121,045
Long-Term Liabilities				
Long Term Note Payable	-	-	-	-
Less: Current Portion of LTD				
Total Long-Term Liabilities	-	-	-	-

	2025	2026	2027	2028
Total Liabilities	21,063	56,365	88,090	121,045
Capital				
Retained Earnings	-	(49,261)	(381,568)	(463,339)
Shareholder Equity				
Net Income	(49,261)	(332,307)	(81,772)	385,259
Total Capital	(49,261)	(381,568)	(463,339)	(78,081)
Total Liabilities & Capital	(28,198)	(325,202)	(375,249)	42,964
Diff. between Assets & Liab+Equity	(677,070)	(1,730,756)	(2,830,299)	(3,834,728)

EXISTING OPERATIONS - Eden HHA - Spokane County Historical

	2022	2023	2024
TOTAL GROSS REVENUE	**5,772,209**	**7,112,172**	**7,417,376**
TOTAL NET REVENUE	**4,160,530**	**5,160,570**	**5,822,872**
TOTAL EXPENSES	**3,582,719**	**4,259,029**	**4,573,511**
NET INCOME (LOSS)	**577,811**	**901,541**	**1,249,361**

LEASE AMENDMENT #2

The parties to a Lease Agreement dated 7/18/21 between SEBCO, Inc., Landlord, and Eden Home Health of Spokane County, LLC dba Eden Home Health, a Wa LLC, Tenant for 3,520 square feet of office space at 1225 N. Argonne Rd, suites 100 and 101, Spokane, WA., subsequently modified in that First (1st) Amendment to Lease dated January 3, 2023, is hereby desire to amend the Lease Agreement as follows:

1. **TENANT:** In addition to Eden Home Health of Spokane County, LLC, Eden Hospice at the Inland Northwest, LLC shall be added to the Lease Agreement as Tenant.

2. **PREMISES:** As depicted on the attached Exhibit A, Tenant shall vacate and relocate to the north half of 1227 N Argonne Road containing approximately 3,530 SF. Tenant shall retain Suite 100 located in 1225 N Argonne Road containing approximately 386 SF.

3. **1227 N. ARGONNE ROAD – LEASE TERM:** The lease term for 1227 N Argonne Road shall be five (5) years commencing on December 1, 2024, and expiring on November 30, 2029.

4. **1225 N. ARGONNE ROAD – LEASE TERM:** The lease term for Suite 100 located in 1225 N. Argonne Road shall be one (1) year commencing on December 1, 2024, and expiring on November 30, 2025.

5. **RENT:** The monthly rent for 1227 N Argonne Road shall be as follows:

   December 1, 2024 – November 30, 2025: $5,295.00
   December 1, 2025 – November 30, 2026: $5454.00
   December 1, 2026 – November 30, 2027: $5617.00
   December 1, 2027 – November 30, 2028: $5786.00
   December 1, 2028 – November 30, 2029: $5960.00

   The monthly Rent for Suite 100 located in 1225 N. Argonne Road shall be $600.00.

6. **1227 N. ARGONNE ROAD – OPTION TO EXTEND:** This shall be considered a modified exercise of the first (1st) option to extend in the original Lease Agreement. Tenant shall continue to have the right to a second (2nd) option as defined in the original Option to Extend Rider with rent to be negotiated at that time.

7. **1225 N. ARGONNE ROAD – OPTION TO EXTEND:** Tenant shall have subsequent one (1) year options to extend through the timelines outlined above for the 1227 N Argonne Road Premises. Rent shall increase three percent (3.0%) annually. Tenant shall continue to have the right to a second (2nd) option as defined in the original Option to Extend Rider with rent to be negotiated at that time. The term of lease for 1225 N Argonne shall not extend longer than the term of lease for 1227 N Argonne.

8. **1227 N. ARGONNE ROAD – TENANT IMPROVEMENTS:** Landlord, at its sole cost and expense, shall demise the space and replace any stained carpet tiles located within the Premises.

9. **1225 N. ARGONNE ROAD – TENANT IMPROVEMENTS:** Tenant, at its sole cost and expense, shall demise Suite 100 located in 1225 N Argonne Road.

10. **SIGNAGE:** Tenant shall be allowed to retain its signage on existing building monument sign as well as install new building signage on façade directly above the Premises entrance. All signage to be approved by Landlord prior to installation. Tenant shall remove placard sign on 1225 N Argonne.

11. **ADDRESS:** So long as Tenant continues to lease Suite 100, Tenant shall have the exclusive right to list Suite 100, 1225 N. Argonne Road, Spokane Valley, WA. 99212 as its primary address.

All other lease terms and conditions remain unchanged.

Landlord:
SEBCO, Inc.

By: _____

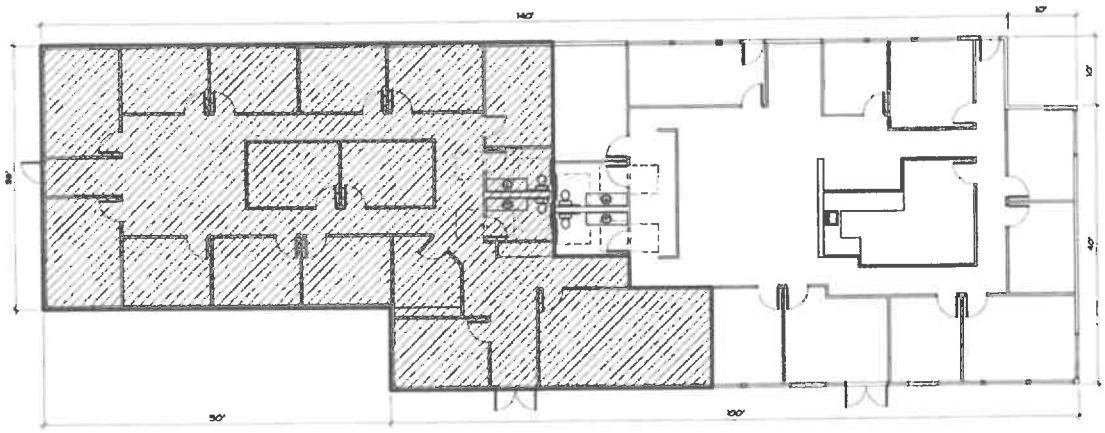
Dated: 11.18.24

Tenant:
Eden Healthcare Management, LLC
On behalf of Tenant as its Manager

By: Jamie Brown

EXHIBIT A

Space plans depict the north half of 1227 and suite 100 in 1225 N Argonne.

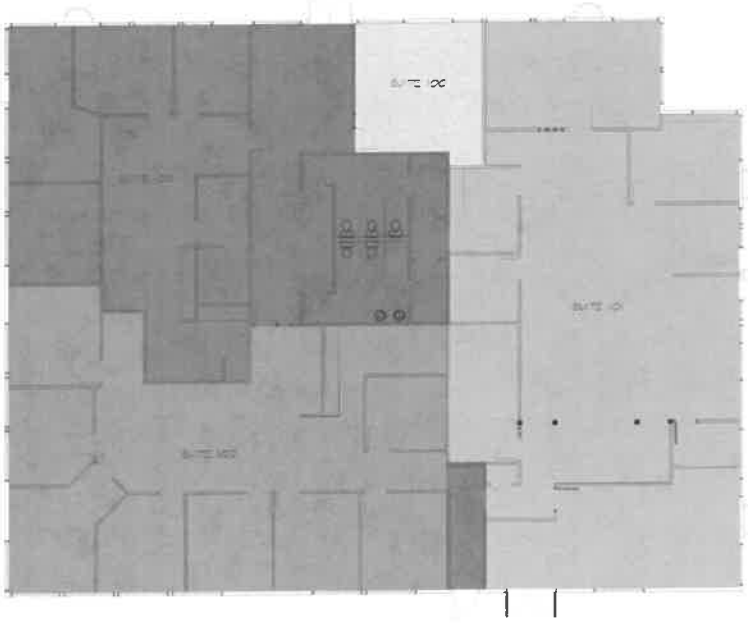


PFP.~~01b~~ EXISTING FLOOR PLAN - WITH CONFERENCE

SCALE: 3/32"=1'-0" • 05/22/2011 • 10-127

0 5' 10' 20'

BERNARDO | WILLS ARCHITECTS PC



NORTH ARGONNE PROFESSIONAL OFFICE - BOMA PLAN

SCALE: 3/32"=1'-0" • 05/31/2013 • 13-188

0 10' 20' 40'

BERNARDO | WILLS ARCHITECTS PC

EDEN HEALTH
HOME HEALTH
100% Employee Owned

December 30, 2024

Eric Hernandez, Program Manager
Office of Community Health Systems – Certificate of Need
Washington State Department of Health

Dear Mr. Hernandez:

The Certificate of Need program's application instructions for a Medicare-certified home health agency asks for a financial letter of commitment. The members of Eden Home Health of Spokane County, LLC have committed the necessary working capital to finance the expansion of home health services in Benton County.

On receipt of the Washington Certificate of Need, the members of Eden Home Health of Spokane County, LLC will contribute sufficient funds, currently estimated at approximately $100,000, to the working capital account of Eden Home Health of Spokane County, LLC.

Sincerely,

Signed by:
Mike Miller
D4930EB5617C4BF...

Michael J. Miller
Executive Vice President and Chief Financial Officer
Eden Healthcare Management, LLC

Report of Independent Auditors and
Consolidated Financial Statements

EmpRes Healthcare Group, Inc., and Subsidiaries

December 31, 2023

MOSSADAMS

Table of Contents

MOSSADAMS

Report of Independent Auditors

The Board of Directors
EmpRes Healthcare Group, Inc. and Subsidiaries

Report on the Audit of the Financial Statements

Qualified Opinion

We have audited the consolidated financial statements of EmpRes Healthcare Group, Inc. and Subsidiaries (the Company) which comprise the consolidated balance sheet as of December 31, 2023, and the related consolidated statements of operations, changes in stockholders' equity, and cash flows for the year then ended, and the related notes to the consolidated financial statements.

In our opinion, except for the matter described in the Basis for Qualified Opinion paragraph, and based on our audit and the report of the other auditors, the consolidated financial statements present fairly, in all material respects, the financial position of EmpRes Healthcare Group, Inc. and Subsidiaries as of December 31, 2023, 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 $16,142,035 as of December 31, 2023 and total revenues of $2,842,448 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 Qualified Opinion

Accounting principles generally accepted in the United States of America require leases to be accounted for in accordance with FASB ASC 842, Leases, which requires (a) all leases to be recorded on the balance sheet of lessees by recognizing a right-of-use asset and a lease liability based on the present value of the remaining lease payments and (b) disclosure of certain qualitative and quantitative information about leasing arrangements. The effective date for the adoption of this standard was January 1, 2022. The Company adopted the standard for the on-going operations effective January 1, 2023. The Company did not adopt the standard for the discontinued operations. The delayed adoption for the on-going operations and the lack of adoption for the discontinued operations would impact rent expense and the gain on disposal of the discontinued operations. Quantification of the effects of these departures from generally accepted accounting principles on financial position, results of operations, and cash flows is not practicable.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS). 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 qualified audit opinion.

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
November 22, 2024

Financial Statements

EmpRes Healthcare Group, Inc., and Subsidiaries
Consolidated Balance Sheet
December 31, 2023

ASSETS

CURRENT ASSETS	
Cash and cash equivalents	$ 9,649,699
Fixed deposits	8,859,808
Accounts receivable, net	11,946,028
Other receivables	991,326
Prepaid expenses and other current assets	2,072,042
Current assets of discontinued operations	3,230,040
Total current assets	36,748,943
NON-CURRENT ASSETS	
Property, plant, and equipment, net	1,223,556
Right-of-use lease assets	4,609,618
Goodwill	15,072,809
Intangibles - certificate of need licenses	2,700,000
Deposits	97,687
Noncurrent assets of discontinued operations	5,951,000
Total non-current assets	29,654,670
Total assets	$ 66,403,613

LIABILITIES AND STOCKHOLDERS' EQUITY

CURRENT LIABILITIES	
Accounts payable	$ 9,604,732
Accrued expenses	6,353,826
Current portion of long-term debt	1,528,061
Current portion of insurance loss reserves	2,318,614
Current portion of operating lease liabilities	1,257,513
Current portion of finance lease liabilities	250,462
Current liabilities of discontinued operations	11,455,680
Total current liabilities	32,768,888
NON-CURRENT LIABILITIES	
Long-term debt, less current portion	8,810,014
Long-term portion of insurance loss reserves	7,452,350
Acquisition liability	300,000
Operating lease liabilities, net of current portion	3,072,583
Finance lease liabilities, net of current portion	41,997
Noncurrent liabilities of discontinued operations	972,810
Total non-current liabilities	20,649,754
Total liabilities	53,418,642
Stockholders' equity	12,984,971
Total liabilities and stockholders' equity	$ 66,403,613

See accompanying notes.

EmpRes Healthcare Group, Inc., and Subsidiaries
Consolidated Statement of Operations
Year Ended December 31, 2023

REVENUES	
Patient service revenue, net	$ 79,251,016
Other revenue	120,505
Total revenues, net	79,371,521
OPERATING EXPENSES	
Salaries and wages	53,865,546
Employment taxes and benefits	9,713,200
Purchased services	2,812,164
Direct care mileage	2,555,478
Consultants and professionals	984,750
Computer license and equipment maintenance	2,125,860
Supplies and food	2,028,293
Medical director fees	1,882,499
Utilities	1,391,487
Ancillary expenses	1,380,303
Equipment rentals, maintenance and repair	1,292,554
Building rent expense	1,212,128
Provider tax	981,207
Business travel and meals	787,173
Advertising and marketing	710,008
Employee training and recruitment	603,645
Dues and licenses	561,352
Depreciation and amortization	310,958
Other expenses	775,047
Total operating expenses	85,973,652
Operating loss	(6,602,131)
OTHER (EXPENSE) INCOME	
Investment and interest income	805,115
Interest expense	(965,267)
Impairment of goodwill	(3,085,000)
Total other (expense) income	(3,245,152)
Loss from continuing operations	(9,847,283)
DISCONTINUED OPERATIONS	
Income from operations of the discontinued component, includes gain on sale of $56,065,277 and gain on termination of leases of $11,830,546	30,220,309
NET INCOME	$ 20,373,026

See accompanying notes.

EmpRes Healthcare Group, Inc., and Subsidiaries
Consolidated Statement of Stockholders' Equity
Year Ended December 31, 2023

	Common Stock				Treasury Stock			
	Outstanding Shares	Guaranteed ESOP Benefit	Additional Cost of ESOP	Amount	Shares	Amount	Retained Earnings	Total Stockholders' Equity (Deficit)
BALANCE, January 1, 2023	14,266,294	$ (19,524,577)	$ (29,857,272)	$ (49,381,849)	733,706	$ (844,579)	$ 42,850,265	$ (7,376,163)
Allocation of ESOP shares	-	1,086,937	(928,541)	158,396	-	-	-	158,396
Purchase of treasury stock	(1,309,906)	-	-	-	1,309,906	(170,288)	-	(170,288)
Net income	-	-	-	-	-	-	20,373,026	20,373,026
BALANCE, December 31, 2023	12,956,388	$ (18,437,640)	$ (30,785,813)	$ (49,223,453)	2,043,612	$ (1,014,867)	$ 63,223,291	$ 12,984,971

See accompanying notes.

EmpRes Healthcare Group, Inc., and Subsidiaries
Consolidated Statement of Cash Flows
Year Ended December 31, 2023

CASH FLOWS FROM OPERATING ACTIVITIES	
Net income	$ 20,373,026
Adjustments to reconcile net (loss) income to net cash used in operating activities	
Depreciation and amortization - continuing operations	310,958
Depreciation and amortization - discontinued operations	3,569,886
Gain on sale of SNF/ALF entities	(56,065,277)
Gain on termination of leases	(11,830,546)
Impairment of goodwill	3,085,000
Non-cash lease related expense	12,937
Allocation of ESOP shares	158,396
Purchase of treasury stock	(170,288)
Change in certain assets and liabilities	
Accounts receivable	(833,769)
Other receivables and patient trust cash	(472,011)
Prepaids and other current assets	(829,022)
Other assets	12,181
Accounts payable, accrued expenses, and insurance reserves	9,338,606
Discontinued operations	2,740,588
Other current and noncurrent liabilities	1,397,424
Net cash used in operating activities	(29,201,911)
CASH FLOWS FROM INVESTING ACTIVITIES	
Acquisition of property, plant, and equipment	(286,348)
Cash paid for acquired entities	(900,000)
Cash proceeds from sale of SNF/ALF entities	96,290,173
Net cash provided by investing activities	95,103,825
CASH FLOWS FROM FINANCING ACTIVITIES	
Net activity on line of credit	(31,195,069)
Payments on long-term debt	(30,681,226)
Net cash used in financing activities	(61,876,295)
NET INCREASE IN CASH AND CASH EQUIVALENTS	4,025,619
CASH AND CASH EQUIVALENTS, beginning of year	5,624,080
CASH AND CASH EQUIVALENTS, end of year	$ 9,649,699
SUPPLEMENTAL DISCLOSURE OF:	
CASH FLOW INFORMATION	
Cash paid for interest during the year	$ 4,861,619
NON-CASH INFORMATION	
Seller note issued for acquired entities	$ 6,000,000
Recognition of right-of-use assets and operating lease liability	$ 6,404,459
Recognition of right-of-use assets and finance lease liability	$ 785,639

See accompanying notes.

Note 1 – Business and Organization

In July 2008, EmpRes Healthcare Group, Inc. (the Company) was created to be the parent of the group of commonly controlled limited liability companies. The Company 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. Andrew V. Martini exchanged his 100% ownership in the various limited liability companies for 100% of the shares of the Company. In December 2008, the Company established an Employee Stock Ownership Trust (ESOT) under an ERISA Employee Stock Ownership Plan (ESOP). Simultaneously, the Company entered into an agreement to purchase 100% of the Company's shares from Andrew V. Martini for debt and cash.

Eden Healthcare Management, LLC (Eden) is a subsidiary of the Company that provides home care, home health, and home hospice services to patients as well as support for the families of patients. As of December 31, 2023, Eden owns and operates 23 agencies (11 Home Health agencies, 10 Home Hospice agencies, and 2 Home Care agencies) with over 3,300 patients served daily and 39,600 patients served annually. The agencies are located throughout Idaho, Arizona, Montana, Wyoming, California, Oregon, and Washington.

Prior to August 31, 2023, the Company also operated Skilled Nursing Facilities (SNF) and Assisted Living Facility (ALF) operations. As of August 31, 2023, the Company executed a sale of all SNF/ALF operations to Evergreen Healthcare (Couve). The SNF and ALF activity has been reported as discontinued operations as of and for the year ended December 31, 2023.

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.

The consolidated financial statements include the accounts of the following types of companies under the ownership of the Company during the year ended December 31, 2023:

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

Affiliate	State	Date organized	Operations commenced	Terminated Operations date	Number of beds	Type of facility
Continuing Operations						
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
Eden Healthcare Management, LLC	WA	03/30/22	03/30/22	—	N/A	MC
EmpRes Home and Hopsice, LLC	WA	04/03/14	04/03/14	—	N/A	MC
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
EmpRes Washington Healthcare, L.L.C	WA	01/29/97	05/01/97	—	N/A	HC
EmpRes Home Health of Bellingham	WA	08/01/14	08/01/14	—	N/A	HS
EmpRes 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, LL	WA	09/11/18	09/01/20	—	N/A	HS
Eden Hospice at Snohomish County, LL	WA	01/06/21	07/01/23	—	N/A	HS
Eden Hospice at King County, LLC	WA	12/23/20	04/01/23	—	N/A	HS
Eden Hospice of Whatcom County	WA	01/03/20	10/01/20	—	N/A	HS
EmpRes Oregon Healthcare, L.L.C.	OR	02/12/97	05/01/97	—	N/A	HC
EmpRes Oregon Healthcare, L.L.C.	OR	02/12/97	05/01/97	—	N/A	HC
Eden Home Health of Bend, LLC	OR	11/16/21	—	—	N/A	HS
Eden Hospice of Bend, LLC	OR	11/16/21	—	—	N/A	HS
EmpRes Montana Healthcare, L.L.C.	MT	02/25/97	05/01/97	—	N/A	HC
Eden Home Health of Bozeman, LLC	MT	01/25/21	05/01/21	—	N/A	HS
Eden Hospice of Western Montana, LL	MT	03/26/21	11/01/21	—	N/A	HS
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
Eden Hospice at the Inland Northwest,	ID	07/08/22	07/08/22	—	N/A	HS
EmpRes California Healthcare, L.L.C.	CA	08/20/98	08/20/98	—	N/A	HC
Eden Home Health of Elk Grove	CA	09/01/16	09/01/16	—	N/A	HS
EmpRes Nevada Healthcare, LLC	NV	11/08/01	11/08/01	—	N/A	HC
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
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
EmpRes Wyoming Healthcare	WY	05/01/15	05/01/15	—	N/A	HC
Eden Home Health of Cheyenne, LLC	WY	6/14/21	10/01/21	—	N/A	HS
Eden Hospice of Cheyenne, LLC	WY	6/14/21	10/01/21	—	N/A	HS
EmpRes South Dakota Healthcare	SD	12/12/18	02/01/19	—	N/A	HC
Eden Hospice at Sierra Vista	AZ	08/01/18	08/01/18	—	N/A	HS
Eden Home Health of Sierra Vista	AZ	12/24/18	1/1/2020	—	N/A	HS

Affiliate	State	Date organized	Operations commenced	Terminated Operations date	Number of beds	Type of facility
Divested Operations (Discontinued Operations)						
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	8/31/2023	N/A	LSE
ELC Master Tenant, LLC	WA	09/01/14	09/01/14	8/31/2023	N/A	LSE
Master Tenant Four, LLC	WA	07/01/15	07/01/15	8/31/2023	N/A	LSE
Vallejo Master Tenant	CA	12/16/16	12/16/16	8/31/2023	N/A	LSE
H.P. – Holding-LLC	WA	12/20/04	12/20/04	8/31/2023	N/A	HC
H.P. – Salem, LLC (fka White Sands)	OR	12/12/96	12/28/12	8/31/2023	N/A	HP
H.P. – Missoula, LLC	MT	05/08/12	05/08/12	8/31/2023	N/A	HP
H.P. – Laurel, LLC	MT	10/22/12	10/22/12	8/31/2023	N/A	HP
H.P. – Salinas, LLC	WA	11/20/12	11/20/12	8/31/2023	N/A	HP
H.P. – Thermopolis, LLC	WY	12/02/16	02/01/17	8/31/2023	N/A	HP
H.P. – Americana, LLC	WA	10/11/17	10/11/17	8/31/2023	N/A	HP
H.P. – Frontier, LLC	WA	10/11/17	10/11/17	8/31/2023	N/A	HP
H.P. – Independence, LLC	OR	10/11/17	10/11/17	8/31/2023	N/A	HP
Frontier Rehabilitation & Extended Care	WA	01/29/97	05/01/97	8/31/2023	140	SNF
Americana Health & Rehabilitation Cent	WA	01/29/97	05/01/97	8/31/2023	74	SNF
Seattle Medical & Rehabilitation Center	WA	02/24/97	05/01/97	8/31/2023	103	SNF
Enumclaw Health & Rehabilitation	WA	04/01/98	08/01/98	8/31/2023	92	SNF
Canterbury House	WA	08/10/98	10/01/98	8/31/2023	100	SNF
Shelton Health & Rehabilitation Center	WA	09/01/01	09/01/01	8/31/2023	76	SNF
North Cascades Health & Rehabilitation	WA	03/21/03	08/01/03	8/31/2023	122	SNF
Royal Park Health & Rehabilitation Cen	WA	09/01/14	09/01/14	8/31/2023	164	SNF
Royal Park Retirement Center	WA	09/01/14	09/01/14	8/31/2023	120	ALF
Buena Vista Healthcare	WA	01/01/15	02/01/15	8/31/2023	61	SNF&ALF
Ft.Vancouver Assisted Livg	WA	07/01/15	07/01/15	8/31/2023	45	ALF
Transitional Care Center of Seattle	WA	04/08/20	09/01/20	8/31/2023	165	SNF
LaGrande Post-Acute Rehab	OR	02/12/97	05/01/97	8/31/2023	76	SNF
Independence Health & Rehabilitation C	OR	02/12/97	05/01/97	8/31/2023	80	SNF
EmpRes Hillsboro Health & Rehabilitati	OR	02/12/97	05/01/97	8/31/2023	78	SNF
Milton-Freewater Health & Rehabilitatio	OR	02/12/97	05/01/97	8/31/2023	70	SNF
Oregon Retirement Center	OR	02/12/97	05/01/97	8/31/2023	82	ALF
The Dalles Health & Rehabilitation Cent	OR	02/12/97	05/01/97	8/31/2023	83	SNF
Portland Health & Rehabilitation Center	OR	02/12/97	01/01/98	8/31/2023	105	SNF
Windsor Health & Rehabilitation Center	OR	10/01/97	01/01/98	8/31/2023	100	SNF
Polson Health & Rehabilitation Center	MT	02/25/97	05/01/97	8/31/2023	70	SNF
Hot Springs Health & Rehabilitation Cer	MT	02/25/97	05/01/97	8/31/2023	40	SNF
Missoula Health & Rehabilitation Cente	MT	03/31/97	06/01/97	8/31/2023	75	SNF&ALF
Laurel Health & Rehabilitation Center	MT	03/31/97	09/01/97	8/31/2023	79	SNF
Livingston Health & Rehabilitation Cent	MT	12/04/03	02/01/04	8/31/2023	115	SNF
Central Montana Nursing & Rehabilitati	MT	01/01/15	01/01/15	8/31/2023	85	SNF
Aspen Meadows Health & Rehabilitation	MT	07/01/17	07/01/17	8/31/2023	90	SNF
Aspen Meadows Assisted Living	MT	07/01/17	07/01/17	8/31/2023	55	ALF
Katherine Healthcare	CA	10/12/98	01/01/00	6/30/2023	51	SNF
Heartwood Avenue Healthcare	CA	10/12/98	01/01/03	2/1/2023	60	SNF
Springs Road Healthcare	CA	10/12/98	01/01/03	2/1/2023	65	SNF
EmpRes Nevada Healthcare, LLC	NV	11/08/01	11/08/01	8/31/2023	N/A	HC
Pahrump Health & Rehabilitation Cente	NV	12/01/01	12/01/01	8/31/2023	120	SNF
Ormsby Post-Acute Rehab	NV	12/01/01	12/01/01	8/31/2023	120	SNF
Mountain View Health & Rehabilitation C	NV	12/01/02	12/01/02	8/31/2023	146	SNF
Gardnerville Health & Rehabilitation Ce	NV	05/02/03	06/01/04	8/31/2023	60	SNF
EmpRes Wyoming Healthcare	WY	05/01/15	05/01/15	8/31/2023	N/A	HC
Sage View Care Center	WY	05/19/15	05/19/15	8/31/2023	82	SNF
Granite Rehabilitation and Wellness	WY	10/01/15	10/01/15	8/31/2023	146	SNF
Rawlins Rehabilitation and Wellness	WY	10/01/15	10/01/15	8/31/2023	62	SNF
Wind River Rehabilitation and Wellness	WY	10/01/15	10/01/15	8/31/2023	81	SNF
Thermopolis Rehabilitation and Wellnes	WY	11/04/16	02/01/17	8/31/2023	60	SNF

Affiliate	State	Date organized	Operations commenced	Terminated Operations date	Number of beds	Type of facility
Divested Operations (Discontinued Operations)						
EmpRes at Casper	WY	02/01/19	02/01/19	8/31/2023	192	SNF
EmpRes at Sturgis	SD	04/29/21	04/29/21	8/31/2023	181	SNF
EmpRes at Mitchell	SD	02/01/19	02/01/19	8/31/2023	150	SNF
EmpRes at Rapid City	SD	02/01/19	02/01/19	8/31/2023	90	SNF
Rapid City Assisted Living	SD	02/01/19	02/01/19	8/31/2023	10	ALF
Sturgis Assisted Living	SD	02/01/19	02/01/19	8/31/2023	40	ALF
EmpRes at Garretson	SD	02/01/19	02/01/19	8/31/2023	55	SNF
EmpRes at Woonsocket	SD	02/01/19	02/01/19	8/31/2023	52	SNF
EmpRes at Flandreau	SD	02/01/19	02/01/19	8/31/2023	63	SNF
Flandreau Independent Living	SD	02/01/19	02/01/19	8/31/2023	11	ILF
Eden Home Health of Safford	AZ	12/24/18	1/1/2020	12/31/2023	N/A	HS

Note 2 – Summary of Significant Accounting Policies

Basis of accounting – The consolidated financial statements have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America (GAAP). See Note 7 for GAAP departure for leases.

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.

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.

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.

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, 2023, 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, 2023, the Company held two fixed deposits totaling: $8,773,680, with interest rates of 5.70% per annum. The fixed deposits held as of December 31, 2023 mature April 30, 2024. The certificates of deposit are held with one A+ rated financial institution in the Isle of Man. Interest receivable on the fixed deposits at December 31, 2023, amounts to $86,128.

Assets supporting letter of credit – The fixed deposits totaling $8,773,680 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, 2023.

Accounts receivable, net – The Company grants credit in the normal course of business to private individuals, other businesses, governmental agencies, and insurance companies. The Company performs ongoing credit evaluations and generally does not require collateral. The Company receives payment for services rendered from private pay payors, Medicare and Medicaid programs, Veterans Administration, and third-party payors. Management does not believe there are any credit risks associated with receivables from governmental agencies. Private and other receivables consist of receivables from a large number of payors involved in diverse activities and subject to differing economic conditions, which do not represent any concentrated credit risks to the Company.

At each balance sheet date, the Company recognizes an expected allowance for credit losses. In addition, also at each reporting date, this estimate is updated to reflect any changes in credit risk since the receivable was initially recorded. This estimate is calculated on a pooled basis where similar risk characteristics exist.

The allowance estimate is derived from a review of the Company's historical losses based on the aging of receivables. This estimate is adjusted for management's assessment of current conditions, reasonable and supportable forecasts regarding future events, and any other factors deemed relevant by the Company. The Company believes historical loss information is a reasonable starting point in which to calculate the expected allowance for credit losses as the Company's payor mix has remained constant since the Company's inception.

Significant changes in payor mix, business office operations, economic conditions, or trends in federal and state governmental health care coverage could affect the Company's collection of patient accounts receivable, cash flows, and results of operations.

The opening and closing balances for accounts receivable, including discontinued operations, were as follows:

	December 31,	
	2023	2022
Accounts receivable	$ 14,599,705	$ 48,953,482
Less discontinued operations	(2,653,677)	(37,841,223)
	$ 11,946,028	$ 11,112,259

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.

Leases –The Company determines if an arrangement is a lease at inception of the contract. For each lease, the Company records a right-of-use asset (representing the right to use the underlying asset for the lease term) and a lease liability (representing the obligation to make lease payments required under the terms of the lease). Right-of-use assets and lease liabilities are recognized at the lease commencement date based on the present value of lease payments over the lease term. The Company's leases typically do not contain a discount rate implicit in the lease contract. As an alternative, the Company uses the risk-free rate commensurate with the lease term.

Goodwill and intangible assets – The Company had goodwill of $15,072,809 as of December 31, 2023. 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 December 31, 2023, management determined an impairment of goodwill existed for certain assets acquired within the Home Health business and has elected to record a charge of $3,085,000 at December 31, 2023, to reflect a change in goodwill value. Additionally, the Company acquired the assets of Community Home Health and Hospice in 2023 and recognized an addition to goodwill of $4,300,000 and an addition to intangible assets of $2,700,000. The intangible assets represent purchased certificate of need licenses, indefinite lived assets, which are assessed annually for impairment. There was no impairment determined related to the intangible assets for the year ended December 31, 2023.

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 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. No impairment was recorded for the year ended December 31, 2023.

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.

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 sheet. At December 31, 2023, the amount was $499,841.

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, 2023, 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' equity. 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, 2023, the Company is authorized to issue 100,000,000 shares of common stock (no par value), 15,000,000 shares have been issued, 12,956,388 shares are outstanding, and the Company owns 2,043,612 shares of treasury stock.

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 patient by patient 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 credit loss expense.

Revenue from the Medicare and Medicaid programs represented the following percentages of total net revenue for the year ended December 31, 2023:

Medicare	87.9%
Medicaid	2.6%

Patient service revenue, net is broken out by payor, line of business, and geographical location in the following tables as of December 31, 2023.

Medicare	$ 69,637,688
Medicaid	2,049,116
Commercial	3,261,252
Private pay	2,707,044
Other	1,595,916
Total patient service revenue, net	$ 79,251,016

Home health	$ 55,345,887
Hospice	21,503,905
Home care	2,401,224
Total patient service revenue, net	$ 79,251,016

Washington	$ 26,392,002
Nevada	25,337,277
Idaho	9,526,677
Oregon	7,065,888
Arizona	4,165,738
California	3,051,407
Montana	2,532,346
Wyoming	1,179,681
Total patient service revenue, net	$ 79,251,016

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 year ended December 31, 2023.

Payments from Federal and State Health Care Programs – Entities doing business with governmental payors, including Medicare and Medicaid, are subject to risks unique to the government-contracting environment that are difficult to anticipate and quantify. Revenues are subject to adjustment as a result of examination by government agencies as well as auditors, contractors, and intermediaries retained by the federal, state, or local governments. Resolution of such audits or reviews often extends (and in some cases does not even commence until) several years beyond the year in which services were rendered and/or fees received. In accordance with GAAP, to account for the uncertainty around governmental payor regulations and audits, the Company estimates the amount of revenue that will ultimately be received under these programs. The result of future examinations or audits could vary from these estimates.

Advertising – The Company expenses the costs of advertising when incurred. Advertising expense was $825,122 for the year ended December 31, 2023, 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.

New accounting pronouncements – In June 2016, the FASB issued Accounting Standards Update (ASU) 2016-13, *Financial Instruments—Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments*, which significantly changed how entities will measure credit losses for most financial assets and certain other instruments that are not measured at fair value through net income. The most significant change in this standard is a shift from the incurred loss model to the expected loss model. Under Topic 326, disclosures are required to provide users of the financial statements with useful information in analyzing an entity's exposure to credit risk and the measurement of credit losses. Financial assets held by the Company that are subject to the guidance in FASB ASC 326 were accounts receivable. The Company adopted the standard effective January 1, 2023. The impact of the adoption was not considered material to the consolidated financial statements and primarily resulted in new/enhanced disclosures only.

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 November 22, 2024, which is the date the consolidated financial statements were available to be issued.

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, 2023.

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, 2023:

Medicare	$ 8,836,542
Medicare (ADV)	5,883,175
Commercial Insurance	998,673
Medicaid	345,330
Other	246,952
VA	228,115
Managed Medicaid	223,926
Self Pay	202,683
Allowance for credit losses	(2,365,691)
Accounts receivable, net	$ 14,599,705

Accounts receivable - continuing operations	$ 11,946,028
Accounts receivable - discontinued operations	2,653,677
	$ 14,599,705

Note 5 – Property, Plant, and Equipment

Property, plant, and equipment, net consist of the following as of December 31, 2023:

Leasehold improvements	$	269,226
Equipment		458,885
Vehicles		331,941
Computer hardware		1,722,621
Fixed asset holdings		383,856
		3,166,529
Less accumulated depreciation and amortization		(1,942,973)
Net property and equipment	$	1,223,556

Note 6 – Lines of Credit

As of December 31, 2023, the Company did not have any outstanding lines of credit. See Subsequent Events section (Note 14) for discussion of Line of Credit put in place in 2024.

Note 7 – Leases

Accounting principles generally accepted in the United States of America require leases to be accounted for in accordance with FASB ASC 842, Leases, which requires (a) all leases to be recorded on the balance sheet of lessees by recognizing a right-of-use asset and a lease liability based on the present value of the remaining lease payments and (b) disclosure of certain qualitative and quantitative information about leasing arrangements. The effective date for the adoption of this standard was January 1, 2022. The Company adopted the standard for the on-going operations effective January 1, 2023. The Company did not adopt the standard for the discontinued operations (see Note 12). This GAAP departure did not have a material impact on the financial statements as of and for the year ended December 31, 2023.

At December 31, 2023, the Company has 17 operating lease agreements for office spaces in support of the Home Health agencies. 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 agencies increases between 1% 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. Additionally, the Company has various other noncancelable finance leases for equipment that expire at various dates through 2025.

For the year ended December 31, 2023, total rent expense for operating leases was $20,746,223, which is comprised of rent expense related to both continuing ($1,212,128) and discontinued operations ($19,264,304).

Future minimum annual lease payments as of December 31, 2023 are as follows:

	Operating Leases	Finance Leases
2024	$ 1,341,820	$ 252,093
2025	1,173,179	42,016
2026	838,666	-
2027	416,425	-
2028	292,918	-
Thereafter	514,244	-
Total undiscounted cash flows	4,577,252	294,109
Less present value discount	(247,156)	(1,650)
Total lease liabilities	$ 4,330,096	$ 292,459

The weighted average remaining lease term and discount rate for the operating and finance leases as of December 31, 2023 were as follows:

Operating cash flows from operating leases	$ 1,198,409
Operating and financing cash flow from finance leases	$ 252,093
ROU assets obtained in exchange for new finance lease liabilities	$ 785,639
ROU assets obtained in exchange for new operating lease liabilities	$ 6,404,459
Weighted-average remaining lease term in years for finance leases	1.17
Weighted-average remaining lease term in years for operating leases	4.47
Weighted-average discount rate for finance leases	1.04%
Weighted-average discount rate for operating leases	2.34%

Note 8 – Long-Term Debt

Long-term debt at December 31, 2023 consists of the following:

Note payable to Andrew V. Martini: 3.50% interest per annum due August 2029.	$ 4,807,438
Note payable to Community Health: 6.00% interest per annum; principal and interest payments of $87,651 due in monthly installments with $3.7M balloon due April 2026	5,530,637
	10,338,075
Less current portion	(1,528,061)
	$ 8,810,014

At December 31, 2023, the aggregate maturities of long-term debt for the next five years and thereafter are as follows:

Years ending December 31,	2024	$ 1,528,061
	2025	1,601,735
	2026	4,849,764
	2027	875,051
	2028	906,174
	Thereafter	577,290
		$ 10,338,075

In September 2023, as a result of proceeds from sale of SNL/ALF operations (Note 12), the Company made a large payment of $4,800,000 on the note with Andrew Martini to bring the remaining balance of the note at that time to $5,000,000.

In April 2023, the Company purchased several Home Health and Hospice operations from Community Health in Washington (Note 12). As a result of the purchase, arose a note payable in the amount of $6,000,000 with a 6% interest factor. The Company began making monthly payments on this note in April 2023 and as of December 31, 2023, $5,500,000 is still due. Monthly payments of $87,000 are due through April 2026 where a balloon payment of $3,700,000 is due at that time to rectify the note.

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 2023.

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.

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 2023 were allocated to participants' ESOP accounts on December 31, 2023. 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, 2023 is as follows:

Total issued shares of common stock		15,000,000
Total outstanding shares of common stock		12,956,388
Total allocated shares of common stock		8,230,306
Total unallocated shares of common stock		4,726,082
Total shares of treasury stock		2,043,612
Estimated fair value per share of common stock	$	0.57
Total ESOP compensation expense	$	225,504
Estimated fair value of unallocated shares of common stock	$	2,693,867
Cost of unallocated shares of common stock	$	18,431,720
Cost of shares of treasury stock	$	1,014,867

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.

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. The accompanying consolidated financial statements include a charge of $1,250,000 at December 31, 2023, in the form of litigation reserve in connection with the *Johnson-Moulton v. EmpRes Healthcare Management, LLC, et al.* action. The action was filed against various of the discontinued operations within the State of California. Management believes the recorded amount to be reflective of a reasonable estimate of the anticipated settlement value.

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.

Cybersecurity – 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.

Collective bargaining agreements – Prior to August 31, 2023, the Company was party to several collective bargaining agreements. All standing in those agreements terminated effective August 31, 2023, and at December 31, 2023, the Company was no longer party to any collective bargaining agreements.

Note 12 – Dispositions and Acquisitions

Sale – The Company sold the assets and the operations of Katherine Healthcare in June 2023 and Heartwood Avenue Healthcare and Springs Road Healthcare in February 2023. The total sale price was $900,000 and included the transfer of the related long-term debt.

Sale – On August 31, 2023, the Company concluded the sale of assets and operations of all remaining Skilled Nursing Facilities and Assisted Living Facilities along with associated holdings. Entities with a termination date of August 31, 2023, within Note 1 were included in this transaction. The total sale price was $104,000,000, resulting in a gain on the transaction of approximately $56,000,000. Approximately $63,000,000 of the proceeds from the sale were utilized to pay off the line of credit and long-term debt.

Acquisition – On May 1, 2023, the Company purchased the assets of Community Home Health and Hospice for $7,000,000, expanding its service capacity in the Portland Metro and Southwest Washington markets. The purchase was financed with a seller note of $6,000,000 and resulted in the increase of goodwill and intangible assets totaling $7,000,000. As part of the transaction, the Company also incurred an acquisition liability for funds held in escrow of $300,000.

Note 13 – Discontinued Operations

As a result of the sale of the skilled nursing facilities and assisted living facilities on August 31, 2023, the Company presented the results of those entities within discontinued operations.

While the operations of the entities were sold and discontinued, the Company continues to hold certain assets and liabilities of the sold entities. The combined balance sheet of the discontinued entities as of December 31, 2023, was as follows:

CURRENT ASSETS	
Accounts receivable, net	$ 2,653,677
Other receivables	576,363
Total current assets	3,230,040
Note receivable and other assets	5,951,000
Total assets	$ 9,181,040
CURRENT LIABILITIES	
Accounts payable	$ 10,685,784
Accrued expenses	769,896
Total current liabilities	11,455,680
SEIU pension liability	972,810
Total liabilities	12,428,490
Shareholders' deficit	(3,247,450)
Total liabilities and stockholders' deficit	$ 9,181,040

The note receivable and other assets includes a $5,000,000 note receivable, accruing interest at 1.5%, as a result of the sale of the entities (see Note 12). The amount is due to the Company as follows:

$2,000,000	Due August 2024
$1,500,000	Due August 2025
$1,500,000	Due August 2026

The SEIU pension liability is payable in monthly payments of $5,784 including principal and interest at 2.48% through November 2041.

The combined income statements of the discontinued entities for the year ended December 31, 2023, was as follows:

REVENUES	
Patient service revenue, net	$ 229,056,564
Credit losses	(10,856,657)
Other revenue	(3,934,212)
Total revenues, net	214,265,695
OPERATING EXPENSES	
Salaries and wages	99,815,318
Purchased services	33,545,354
Employment taxes and benefits	25,080,417
Ancillary expenses	20,005,777
Provider tax	10,587,594
Supplies and food	9,194,640
Building rent expense	19,264,304
Utilities	6,161,910
Equipment rentals, maintenance and repair	4,282,656
Computer licenses and equipment maintenance	4,189,416
Insurance	4,826,248
Depreciation and amortization	3,569,886
Business travel and meals	1,541,274
Dues and licenses	2,893,919
Employee training and recruitment	1,118,341
Property tax	874,217
Advertising and marketing	209,869
Consultants and professionals	1,410,191
Other	(380,232)
Total operating expenses	248,191,099
Operating loss from discontinued operations	(33,925,404)
OTHER (EXPENSE) INCOME	
Interest expense	(3,750,110)
Gain on sale of skilled and assisted living facilities	56,065,277
Gain on termination of leases	11,830,546
Total other (expense) income	64,145,713
Net income from discontinued operations	$ 30,220,309

The combined cash flows of the discontinued entities for the year ended December 31, 2023, was as follows:

CASH FLOWS FROM OPERATING ACTIVITIES	
Net income from discontinued operations	$ 30,220,309
Depreciation and amortization	3,569,886
Gain on sale of skilled and assisted living facilities	(56,065,277)
Gain on termination of leases	(11,830,546)
Change in certain assets and liabilities	2,740,588
Net cash used in operating activities - discontinued operations	(31,365,040)
CASH FLOWS FROM INVESTING ACTIVITIES	
Cash proceeds from sale of SNF/ALF entities	96,290,173
Net cash from investing activities - discontinued operations	96,290,173
CASH FLOWS FROM FINANCING ACTIVITIES	
Net activity on line of credit	(31,195,069)
Payments on long-term debt	(30,681,226)
Net cash used in financing activities - discontinued operations	(61,876,295)
CHANGE IN CASH AND CASH EQUIVALENTS	3,048,838
CASH TRANSFERRED TO ON-GOING OPERATIONS	(7,794,826)
CASH AND CASH EQUIVALENTS, beginning of year	4,745,988
CASH AND CASH EQUIVALENTS, end of year	$ -

Note 14 – Subsequent Events

On January 5, 2024, the Company signed a new credit agreement with Midcap Financial Services for a $15,000,000 line of credit having a maturity date of January 5, 2027. Interest is calculated at SOFR plus 4.25% with a SOFR floor rate of 1.5%. An annual fee of 0.5% is applied to the unused portion of the line. Funds availability is adjusted daily according to a borrowing base formula outlined in the agreement. The Company also has one additional term loan commitment with Midcap Financial Services of $5,000,000 that bears an interest rate at SOFR plus 5.5%.

MANAGEMENT AGREEMENT

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

Eden Home Health of Spokane County, LLC ("Company")
1225 N Argonne Road, Suite 100
Spokane Valley, WA 99212

Date: January 1, 2023 (the "Effective Date")

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

B. Consultant is engaged in the business of providing consulting services for Home Health 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 banSpokane 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 maSpokane 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 five percent (5%) 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 Home Health of Spokane County, LLC
By: Eden Healthcare Management, LLC, Manager

By: _____
Michael J. Miller, Assistant Manager

CONSULTANT

Eden Healthcare Management, LLC

By: _____
Michael J. Miller, Assistant Manager

LIMITED LIABILITY COMPANY AGREEMENT OF
Eden Home Health of Spokane County, LLC,
a Washington Limited Liability Company

THIS OPERATING AGREEMENT ("Agreement") is made and entered into effective September 11, 2018 by EmpRes Home Health, LLC, a Washington limited liability company ("EHH") (referred to herein as "Member" or "Members").

ARTICLE 1
FORMATION

1.1 Name. The name of the limited liability company is Eden Home Health of Spokane County, LLC ("LLC").

1.2 Articles of Organization. Certificate of Formation was filed with the Washington Secretary of State on September 11, 2018.

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 Home Health, 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 Home Health, 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 Home Health, 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 Home Health, 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 (taSpokane 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 Home Health, 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 seeSpokane 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 HOME HEALTH, LLC
a Washington limited liability company

By: EmpRes Financial Services, LLC, Manager

By: _____
Michael J. Miller, Manager

DIRECTORSHIP INDEPENDENT CONTRACTOR AGREEMENT

THIS DIRECTORSHIP INDEPENDENT CONTRACTOR AGREEMENT ("Agreement"), entered into effective as of the 1 day of May 2020 ("Effective Date"), is by and between Eden Home Health of Spokane County, LLC ("Agency"), and Gilson R. Girotto, DO ("Physician").

RECITALS:

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

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

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

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

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

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

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

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

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

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

2. **COVENANTS OF PHYSICIAN**

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

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

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

Services:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. COVENANTS OF AGENCY

3.1. Amount of Compensation. In consideration of the Medical Director Services rendered each month by Physician pursuant to this Agreement, Agency shall pay to Physician the amount of $150 per hour, rounded up to the nearest quarter hour. Physician agrees that such amount shall be Physician's sole compensation for Medical Director Services furnished pursuant to this Agreement. Physician's provision of professional medical services to patients, regardless of whether patient is also a patient of agency, and the compensation therefore, shall not be governed by this Agreement.

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

4. TERM AND TERMINATION OF AGREEMENT

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

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

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

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

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

5. MISCELLANEOUS

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

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

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

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

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

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

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

Agency.

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

5.8. Additional Assurances. The provisions of this Agreement shall be self-operative and shall not require further agreement by the parties, except as may be herein specifically provided to the contrary; provided, however, Physician and Agency each shall promptly and duly execute and deliver to the other such additional documents and assurances and take any and all other actions as either party may reasonably request in order to carry out the intent and purpose of this Agreement during the Term hereof.

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

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

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

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

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

5.14. Severability. If any term, covenant, or condition of this Agreement, or the application thereof to any person or circumstance, shall be invalid or unenforceable, the remainder of this

Agreement, and the application of any term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and all other terms shall be valid and enforceable to the fullest extent permitted by the law.

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

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

5.17. COVID-19. If, during the term of this Agreement, Physician, any affiliate of Physician, or any employee, agent, independent contractor, officer, director or owner of Physician (collectively, "Physician Representatives") tests positive for COVID-19, shows signs or symptoms of COVID-19, works in another facility or location that has a positive case of COVID-19, has been in travel quarantine or other COVID-19 related quarantine, or has otherwise in any way been exposed to the COVID-19 virus and that person is going to enter one of Agency's buildings or will otherwise come into contact with Agency's employees or residents, Physician shall prior to said contact immediately provide written and oral notice to Agency and provide a full explanation of the situation so that Agency can take proper precautions to protect Agency and its Residents. The Parties agree that under such circumstances, the Agency may initiate any safety protocols it deems in its sole discretion necessary to limit the spread of COVID-19 within the Agency's Buildings and work area, including but not limited to, prohibiting the Physician Representatives from entering/visiting the Agency's buildings or work area.

Physician, any affiliate of Physician, or any employee, officer, director or owner of Physician agrees to comply with all PPE, screening, and other preventative measures requested by the Agency.

_____/_____/06/05/2020
Initials/Date

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

[SIGNATURE PAGE FOLLOWS ON NEXT PAGE]

AGENCY

by its Manager, EmpRes Healthcare Management, LLC,

By: _____

Name: Brent Weil

Title: CEO

Date: 05/05/2020

PROVIDER

By: _____, DO

Name: Gilson R. Giratto, DO

Title: Physician

Date: 5/27/2020

UPIN #: H40154

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

Business Associate Agreement

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

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

Recitals

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

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

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

Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10. **Term and Termination**.

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

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

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

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

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

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

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

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

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

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

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

COVERED ENTITY:

By: _____
by EmpRes Healthcare Management, LLC,
Manager
by Brent Weil, CEO

Date: 06/05/2020

BUSINESS ASSOCIATE:

By: _____, DO

Name: Gilson R. Girotto, DO

Title: Physician

Date: 5/27/2020

Eden Home Health Vendor Listing

1. Medical Supplies – Medline
2. Quality and Outcomes Vendor – Strategic Healthcare Partners (SHP)
3. HHCAHPS – Strategic Healthcare Partners (SHP)
4. Electronic Health Record – Homecare Homebase
5. Clearing House – Waystar
6. Telephone/Internet Services – AT&T and Comcast
7. Shredding/Medical Waste – Shred-It/Stericycle
8. Answering Service (after-hours) – TeleMed
9. Coding – The Coding Company
10. Learning Management System – Healthstream
11. Online Patient Education – Ignite Healthcare
12. Shipping/Postage – FedEx
13. Payroll Syste m – UKG Dimensions
14. Interpretation – Language Line Services
15. Website Services – Yolocare
16. Recruiting – Indeed, Social Media Platforms (Facebook, LinkedIn, etc.)
17. Applicant Tracking System – Paycor
18. Background Checks – Assure Hire
19. OIG Searches – Certiphino Screening
20. Office Supplies/Promotional Products – Office Depot

2022

COMMUNITY HEALTH NEEDS ASSESSMENT

Benton & Franklin Counties, WA

This CHNA was conducted as a collaboration between Benton-Franklin Health District, Benton-Franklin Community Health Alliance, Prosser Memorial Health, and Kadlec Regional Medical Center. To provide feedback on this CHNA or obtain a printed copy free of charge, email info@BFCHA.org or CHI@providence.org.

CHNA STEERING COMMITTEE

AMY PERSON, MD
Health Officer
Benton-Franklin Health District

CARLA PROCK, RN, BSN
Senior Manager
Healthy People & Communities
Benton-Franklin Health District

CHRISTY WANG, BSN, RN, MPH
Epidemiologist
Benton-Franklin Health District

HAZEL KWAK, BHSC, NCMA
Community Health Investment Coordinator
Kadlec Regional Medical Center/Providence

KAREN HAYES, MA
Community Health Investment Manager
Kadlec Regional Medical Center/Providence

KELLY HARNISH, MPH, MCHES
Public Health Educator
Community Health Improvement Plan Coordinator
Benton-Franklin Health District

KIRK WILLIAMSON
Program Manager
Benton-Franklin
Community Health Alliance

KRISTI MELLEMA, BSN, RN
Chief Quality and Compliance Officer
Prosser Memorial Health

PERNELL HODGES
Epidemiologist
Benton-Franklin Health District

SEAN DOMAGALSKI, RN, BSN, MHA
Performance Manager
Benton-Franklin Health District

CONTENTS

EXECUTIVE SUMMARY

Purpose

The Community Health Needs Assessment (CHNA) helps determine which critical health needs the community will focus on over the next three to five years. It is a systematic and shared process for identifying and analyzing community needs and assets throughout Benton and Franklin Counties.

Methods

The CHNA steering committee began meeting weekly in January of 2022. The committee includes representatives of Benton-Franklin Health District (BFHD), Benton-Franklin Community Health Alliance (BFCHA), Kadlec Regional Medical Center (Kadlec), and Prosser Memorial Health (PMH). Providence Community Health Investment staff provided invaluable technical assistance and qualitative data analysis.

Quantitative and qualitative data were used to identify community needs through a mixed-methods approach. Quantitative data sources include a community survey, Behavioral Risk Factor Surveillance System (BRFSS), Community Health Assessment Tool (CHAT), and the Healthy Youth Survey (HYS) as well as Centers for Disease Control and Prevention (CDC), Child Care Aware of America, County Health Rankings and Roadmaps, Washington State Department of Children, Youth & Families (WA DCYF), Washington Statistical Analysis Center (WA SAC), Washington Association of Sheriffs and Police Chiefs (WASPC), and Washington Tracking Network (WTN). Quantitative data is presented through a life course perspective.

Qualitative data includes twenty-one interviews with working partners and community collaborators (partners), ten listening sessions, two behavioral health forums, two housing and homelessness forums, and two general forums.

The COVID-19 pandemic impacted our nation and communities. The focus became one of crisis response that required the concentration of resources and resulted in pandemic-related challenges that impacted data collection causing data limitations and information gaps.

Results

CHNA steering committee members met weekly in July and August 2022 to apply the prioritization criteria to the identified needs. Criteria included worsening trend over time, disproportionate impact on low income and/or Black, Brown, Indigenous, and People of Color (BBIPOC) communities, community rates worse than state average, the opportunity to impact based on community partnerships, severity of the need and/or scale of need. The following Community Health Improvement Plan Guiding Concepts also informed the prioritization process: Equity, Life-course wellness, Health in All Policies (HiAP), Evidenced-based, and Collective Impact. The list below summarizes the significant health needs identified through the 2022 Community Health Needs Assessment process in no particular order:

BEHAVIORAL HEALTH

The 2019 Benton & Franklin Counties Community Health Needs Assessment (CHNA) identified that our community needed to better understand the behavioral health gaps and needs within the community. An assessment was completed in the spring of 2022 through a partnership with Eastern Washington University (EWU). The assessment identified significant needs for behavioral health response and prevention. Behavioral health, which encompasses mental health and substance use/misuse, was identified as a need in all areas of this CHNA. With the serious behavioral health workforce shortage, increase in need, and existing coalitions working towards solutions, our steering committee identified behavioral health as a priority area.

HOUSING AND HOMELESSNESS

The 2019 CHNA also identified that our community needed to better understand the housing and homelessness gaps and needs within the community. The assessment was completed in the spring of 2022 through a partnership with EWU. On housing, the assessment identified a low supply of affordable housing, low supply of multi-family units, low vacancy rates for rentals, and increased rental costs. Housing increases in Benton and Franklin Counties are not keeping up with population growth and demand. Regarding homelessness, the assessment identified a shortage of low-barrier housing options for residents experiencing homelessness. Additionally, there has been a greater than two-fold increase in the average number of days a person experiences homelessness in Benton and Franklin Counties. Stable housing has consistently been shown to improve both physical and mental health outcomes. For this reason and because the Benton and Franklin regions are experiencing rapid growth, a lack of affordable housing, a lack of low-barrier solutions to homelessness, and the complexity of solving these issues through effective community partnerships, our steering committee identified these issues as priorities for the upcoming Community Health Improvement Plan (CHIP).

ACCESS TO HEALTH

This 2022 CHNA identified a need for access to not only healthcare, but also access to community supports that enable health. It is understood that optimal health is influenced by access and quality of healthcare, health promoting behaviors, the physical environment, and socioeconomic factors. Access to Health will include a focus on addressing barriers to medical care, including healthcare provider to patient ratios and linguistically appropriate, culturally responsive, and accessible care. In addition, the steering committee broadened this priority to include needs identified in the CHNA, such as access to safe and nutritious food; transportation; safe, licensed, and affordable childcare; health education; chronic disease prevention; and resource awareness.

COMMUNITY PARTNERSHIP DEVELOPMENT

Benton and Franklin Counties are fortunate to have numerous community coalitions and committees aimed at improving and supporting community health. This region also has a business community which is quite supportive of promoting local health and social initiatives. However, this CHNA identified that strengthening partnerships and coordinating efforts has the potential to improve outcomes through shared goals and resources. This priority area will impact the other three priority areas by improving communications, clarifying coalition functions, and expanding the work of community health improvement to non-traditional partnerships.

These priorities were approved by the Kadlec Community Mission Board on October 19, 2022; the Benton Franklin Health District on October 20, 2022; the Benton-Franklin Health Alliance on October 21; and Prosser Memorial Health on October 28, 2022.

Benton-Franklin Health District, Benton-Franklin Community Health Alliance, Kadlec Regional Medical Center, and Prosser Memorial Health, in collaboration with community partners will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs.

Kadlec will also develop its three-year CHIP to respond to these prioritized needs in collaboration with community partners. The 2023-2025 Kadlec CHIP will be approved and made publicly available no later than May 15, 2023.

Measuring Our Success: Results from the 2020 Benton & Franklin Counties CHIP

While striving to achieve the goals outlined in the 2020 CHIP, the COVID-19 pandemic impacted our community and the focus became one of crisis response. In spite of the pandemic, outcomes were achieved, and a few key outcomes are listed below:

- Benton-Franklin Health District, Kadlec Regional Medical Center, Prosser Memorial Health, the Hispanic Chamber of Commerce, and many other community partners came together to expand access to health care services related to the COVID-19 pandemic.
- In the spring of 2022, a sales tax in Benton and Franklin Counties went into effect, providing one penny per every $10 to go towards behavioral healthcare and access in the two counties.
- Columbia Basin Health Associates established primary care facilities in rural areas of north Franklin County. Prosser Memorial Health (PMH) hired multiple new providers in urgent/after-hours care, pediatrics, family practice, obstetrics and women's health, emergency medicine, and behavioral health. PMH also expanded clinic hours where appropriate.
- Benton-Franklin Health District established the Food Access and Security Coalition which began meeting in April of 2022.
- Benton-Franklin Health District contracted with the Institute of Public Policy and Economic Analysis at Eastern Washington University to conduct a more comprehensive needs assessment regarding homelessness and behavioral health. The report was completed in June of 2022 completing two CHIP objectives and providing data to inform the 2022 CHNA and 2023 CHIP.

To read the Benton & Franklin Counties 2020 CHIP, click here.

Measuring Our Success: Results from the 2020-2022 Kadlec Regional Medical Center CHIP

The priorities identified in the 2019 Benton & Franklin Counties CHNA were behavioral health challenges, access and cost of health care, and social determinants of health. While striving to achieve the goals outlined in the 2020-2022 Kadlec CHIP, the COVID-19 pandemic impacted our community and therefore responding to COVID-19 became Kadlec's priority. A few key outcomes are listed below:

- Telemedicine services expanded rapidly in response to the pandemic, and 48,291 telemedicine visits were completed in 2020 and 37,260 telemedicine visits were completed in 2021.
- Kadlec established the Community Resource Desk (CRD), which is a free service that connects people with community resources they need, including establishing a primary care provider, dental care, medical equipment, eye care, alcohol or drug recovery, health insurance, mental health counseling, and basic needs such as food, transportation, clothing, work, or housing aid. The CRD was instrumental in helping community members access COVID-19 vaccines and testing.
- Four of the eight of Kadlec's Family Medicine Residency program residents that graduated in 2022 are staying within Kadlec.
- Kadlec integrated behavioral health in primary care by embedding social workers in three clinics.
- Between January 2020 and September 2022, 669 people were trained in Mental Health First Aid and other mental health and suicide prevention programs.
- As part of Kadlec's commitment to addressing health equity, three bilingual/bicultural Spanish-speaking Community Health Workers (CHW) were hired in 2021 to be frontline agents of change, helping to reduce health disparities in underserved communities, working alongside their clients as they navigate health care services and access resources.

To read the Kadlec Regional Medical Center 2020-2022 CHIP, click here.

INTRODUCTION

As a collaboration between Benton-Franklin Health District (BFHD), Benton-Franklin Community Health Alliance (BFCHA), Kadlec Regional Medical Center (Kadlec), and Prosser Memorial Health (PMH), this CHNA covers Benton and Franklin Counties.

Who We Are: Benton-Franklin Health District

The Benton-Franklin Health District (BFHD) has been serving the growing community of Benton and Franklin counties for over 75 years. Made up of more than one hundred dedicated staff members, BFHD serves the bi-county population of over 300,000 residents, thousands of visitors, and covers almost 3,000 square miles within its jurisdiction. BFHD is poised and ready to address current and emerging public health concerns. In addition to providing many services directly, BFHD works collaboratively with dozens of community partners and organizations to address health needs of people living, working, and visiting the bi-county region.

Mission BFHD provides all people in our community the opportunity to live full, productive lives by promoting healthy lifestyles, preventing disease and injury, advancing equity, and protecting our environment.

Vision BFHD is a proactive leader uniting knowledgeable staff and proven practices with strong partners and informed residents to form a resilient, healthy community where all of us can learn, work, play, and thrive to our greatest potential.

Values Excellence – Diversity – Communication and Collaboration – Integrity and Accountability – Effectiveness

Equity BFHD believes everyone in the community should have the opportunity to attain their highest level of health. BFHD values and serves all people regardless of age, race, ethnicity, gender identity, sexual orientation, religion, socioeconomic status, or physical and mental abilities.

Who We Are: Benton-Franklin Community Health Alliance

The Benton Franklin Community Health Alliance (BFCHA) began in 1993 as a task force of community leaders from Benton and Franklin Counties who believed that the community needed a cancer treatment facility, but that funding needs were too large for any one hospital to absorb alone. The hospitals worked together to finance and operate the Tri-Cities Cancer Center, which has become a world class cancer treatment facility associated with the Seattle Cancer Care Alliance. Today, BFCHA serves as a “neutral convener” bringing healthcare and community leaders together to address a variety of issues related to health and quality of life in Benton and Franklin Counties.

Who We Are: Kadlec Regional Medical Center

Our Mission Provide safe, compassionate care.
Our Vision Health for a better world.
Our Promise "Know me, care for me, ease my way."
Our Values Safety—Compassion—Respect—Integrity—Stewardship—Excellence—Collaboration

Kadlec Regional Medical Center (KRMC) is a not-for-profit serving residents in Southeast Washington and Northeast Oregon. Founded in 1944, KRMC is an acute-care hospital located in Richland, Washington. The hospital has 337 licensed beds and is approximately eleven acres in size.
More than 3600 employees work in the hospital, the freestanding Emergency Department, and in primary and specialty care clinics throughout the region. Kadlec is part of the family of mission-driven organizations that make up Providence, serving communities across a seven-state footprint.
Major programs and services offered to the community include the following: comprehensive, award-winning cardiac care program; neurosurgery and neurology; all-digital outpatient imaging center; pediatrics, rural and emergency care; telehealth services in partnership with clinics and hospitals in Southeast Washington and Northeast Oregon and is the region's only Level III Neonatal Intensive Care Unit. KRMC is a Level III Trauma Center.

Kadlec dedicates resources to improve the health and quality of life for the communities they serve. During 2021, Kadlec provided $63,900,000 in Community Benefit[1] in response to unmet needs and to improve the health and well-being of those we serve in Benton and Franklin Counties and beyond. Kadlec further demonstrates organizational commitment to community health through the allocation of staff time, financial resources, participation, and collaboration to address community identified needs.

[1] Per federal reporting and guidelines from the Catholic Health Association.

Who We Are: Prosser Memorial Health

For 75 years, Prosser Memorial Health has provided high-quality, compassionate, and comprehensive healthcare services to our communities. Service lines include: 24/7 Emergency Department; Orthopedics; Cardiology; Dermatology; General Surgery and ENT/Allergy; Gastroenterology; Urology; Obstetrics and Family Birthplace; Therapy Services; and Primary Care through our local clinics.

Prosser has also expanded their Community Health Programs to include a Community Paramedic Program which helps to provide care the vulnerable, promote health and wellness, and lower the cost of healthcare.

Prosser Memorial Health's Mission is to "improve the health of our community," and they further demonstrate this by offering the best quality medical care using their six organizational Values: Accountability, Services, Promote Teamwork, Integrity, Respect and Excellence.

Prosser's Chief Quality and Compliance Officer participated in this CHNA process.

Health Equity

We acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by striving to address the underlying causes of racial and economic inequities and health disparities. We believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes (see Figure 1[2]).

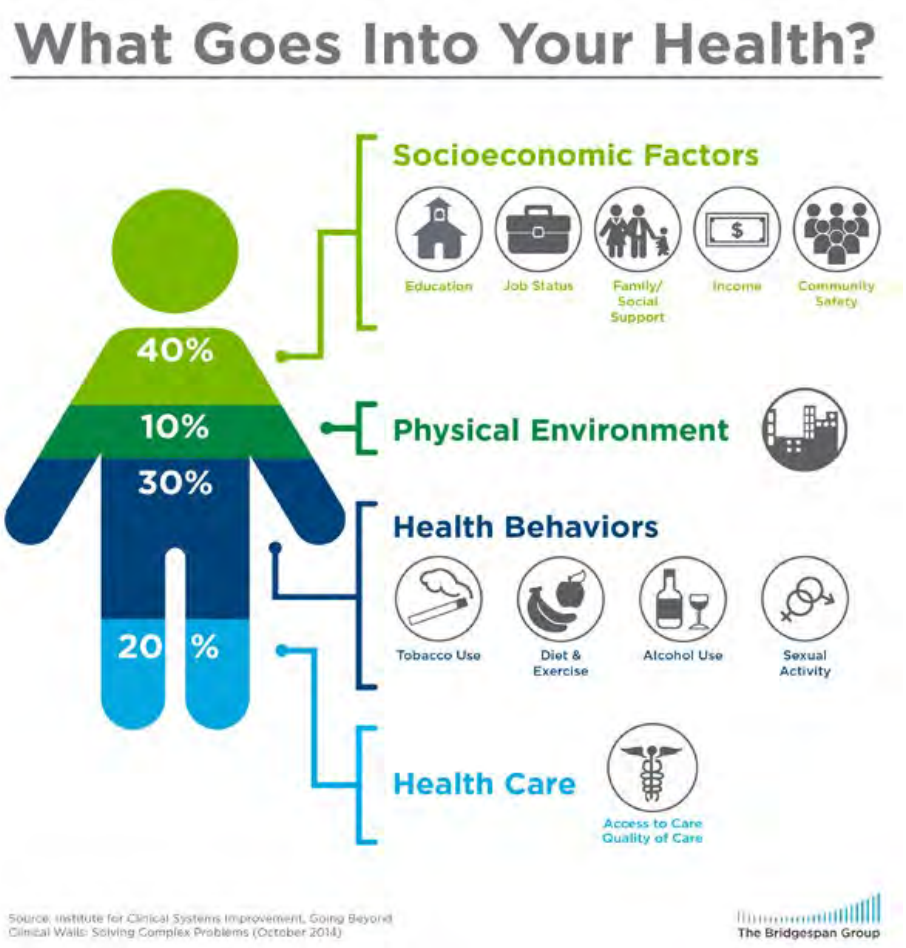


Figure 1. Factors contributing to overall health and well-being

[2] Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2013)

The CHNA is a valuable tool we use to better understand health disparities and inequities within the communities we serve, as well as community strengths and assets (see Figure 2 for definition of terms[3]). Through the literature and our community partners, we know that racism and discrimination have detrimental effects on community health and well-being. We recognize that racism and discrimination prevent equitable access to opportunities and the ability of all community members to thrive. We name racism as contributing to the inequitable access to all the determinants of health that help people live their best lives, such as safe housing, nutritious food, responsive health care, and more.

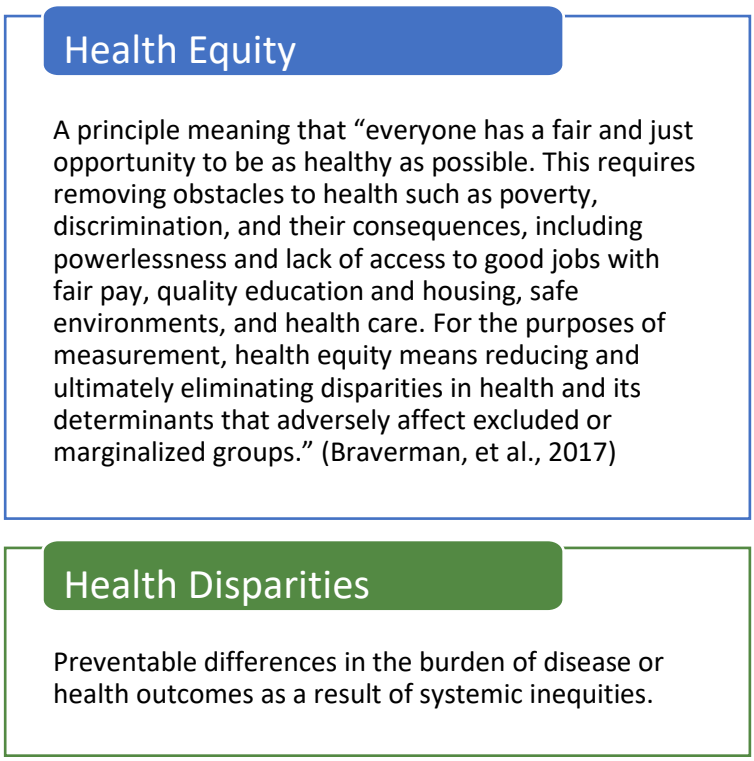


Figure 2. Definitions of key terms

Efforts taken to center equity in community engagement included interviewing stakeholders who represent organizations serving various demographic groups that are historically marginalized. Populations included were aging adults, people experiencing homelessness, Spanish-speaking communities, immigrants, and families of those living with disabilities. Listening sessions were designed to include participants from under-represented groups and included family members and caregivers of those living with disabilities, aging community members, veterans, and youth and adults experiencing homelessness. The community survey was distributed in English and Spanish.

When possible, data categories were broken down into more specific sub-groups to better identify unique differences. Restrictions in data sharing and small numbers limited the range of data available for disaggregation.

[3] Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What is Health Equity? And what Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

OUR COMMUNITY

Description of Community Served

Benton and Franklin Counties are located in south central Washington just west of the confluence of the Columbia and Snake Rivers. Pasco is the county seat of Franklin County while Prosser, located 30 miles west, is the Benton County seat. Many county facilities are located in Kennewick. With a combined population of more than 300,000, the area is Washington's third largest metro area and among of the fastest growing. The area's three largest cities, Kennewick, Pasco, and Richland became known as the "Tri-Cities" not long after WWII. Other principal cities in Benton County are West Richland and Benton City. Outside of Pasco, Franklin County's small towns support some of the country's most productive farmland irrigated by the Columbia Basin Project. They include Eltopia, Basin City, Mesa, Connell, and Kahlotus. The rich agricultural opportunities provide residents with access to fresh and locally grown food. In fact, for five months of the year, there are farmers' markets open throughout the region nearly daily. Additionally, multiple local farms offer you-pick and roadside produce sales. With over 300 days of sunshine per year, multiple paved and natural trails, and numerous community parks, this region offers opportunities for outdoor recreation for all ages and ability levels in a high-desert climate.

Hospital systems serving Benton and Franklin Counties and beyond include Kadlec Regional Medical Center, Trios Health, Lourdes Health, and Prosser Memorial Health. Federally Qualified Health Centers serving the area are Miramar Health Centers, Tri-Cities Community Health, and Columbia Basin Health Association. Based on the availability of data, geographic access to these facilities, and other hospitals in neighboring counties, Benton and Franklin Counties serve as the boundary for the service area.

Community Demographics

The tables below provide basic demographic and socioeconomic information about Benton and Franklin Counties and how they compare to Washington State.

POPULATION TOTALS

Table 1. Population Totals

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
2020 Total Population	205,700	96,760	302,460	7,656,200
Female Population	102,198	47,071	149,269	3,835,105
Male Population	103,502	49,689	153,191	3,821,095

Source: WA OFM, 2020

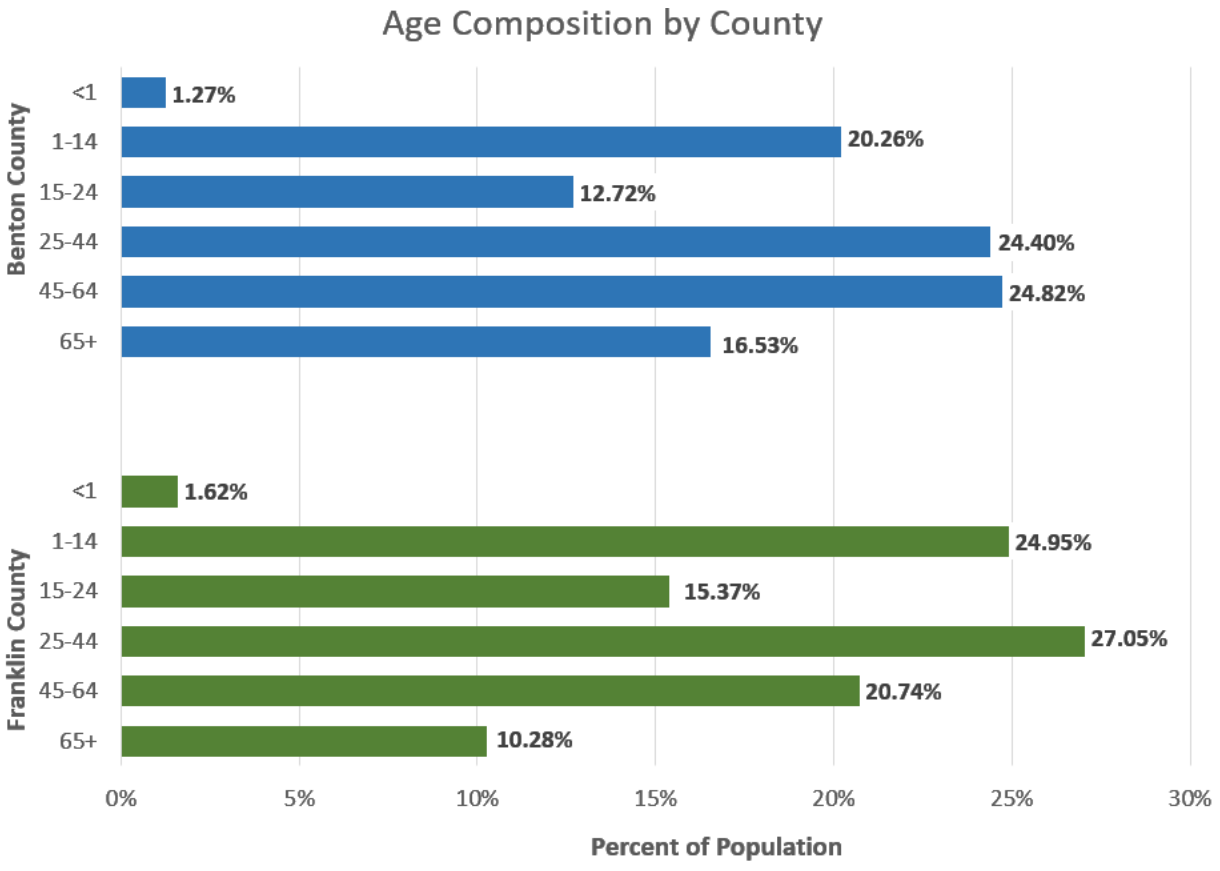
POPULATION BY AGE

Table 2. Population by Age

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Population that is <1 Years Old	1.27%	1.62%	1.38%	1.16%
Population that is 1-14 Years Old	20.26%	24.95%	21.76%	17.35%
Population that is 15-24 Years Old	12.72%	15.37%	13.57%	12.61%
Population that is 25-44 Years Old	24.40%	27.05%	25.25%	27.25%
Population that is 45-64 Years Old	24.82%	20.74%	23.52%	24.89%
Population that is 65+ Years Old	16.53%	10.28%	14.53%	16.74%

Source: WA OFM, 2020

Figure 3. Age Composition by County



Source: WA OFM, 2020

POPULATION BY RACE AND ETHNICITY

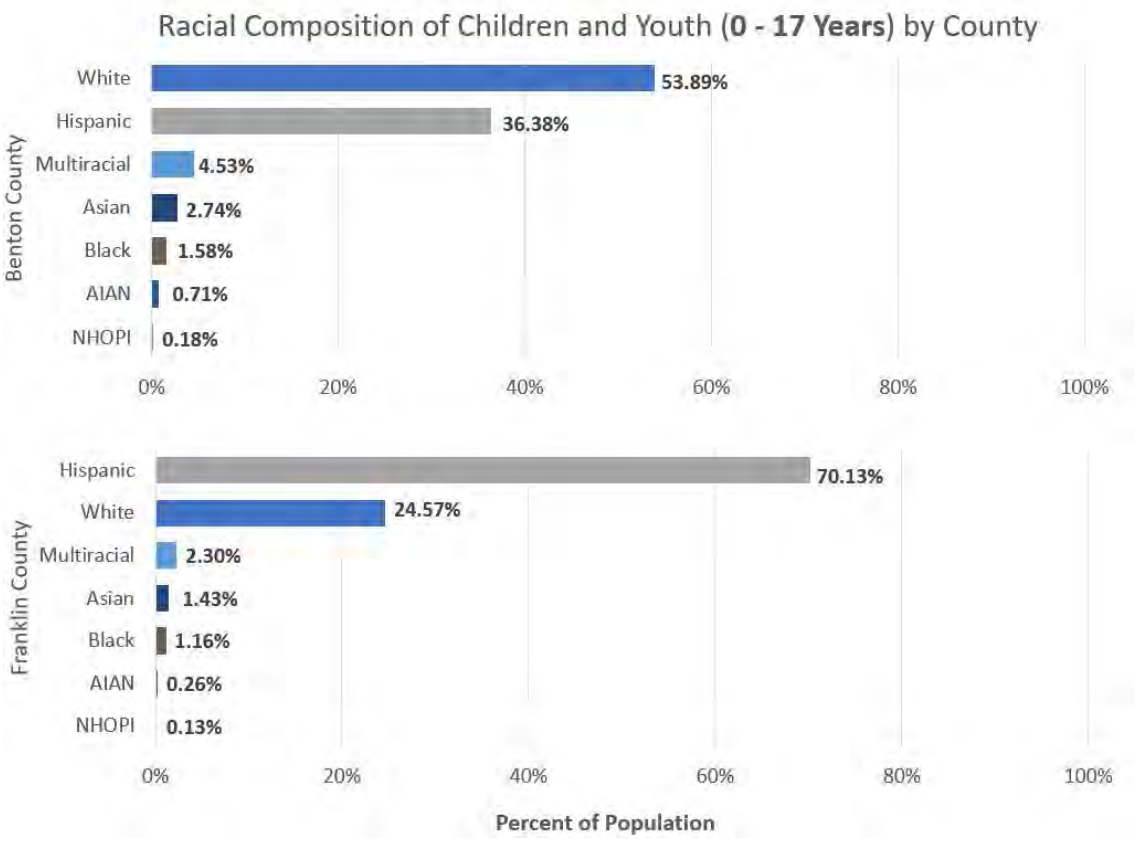
Table 3. Population by Race and Ethnicity

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Youth (0-17) who identify as American Indian & Alaska Native, Not Hispanic	0.71%	0.26%	0.55%	1.40%
Youth (0-17) who identify as Asian, not Hispanic	2.74%	1.43%	2.26%	8.22%
Youth (0-17) who identify as Black, not Hispanic	1.58%	1.16%	1.43%	4.45%
Youth (0-17) who identify as Hispanic	36.38%	70.13%	48.77%	22.71%
Youth (0-17) who identify as Multiracial, not Hispanic	4.53%	2.30%	3.71%	9.15%
Youth (0-17) who identify as Native Hawaiian or Pacific Islander, not Hispanic	0.18%	0.13%	0.16%	0.97%
Youth (0-17) who identify as White, not Hispanic	53.89%	24.57%	43.13%	53.10%
Adults (18-64) who identify as American Indian & Alaska Native, Not Hispanic	0.79%	0.56%	0.72%	1.28%
Adults (18-64) who identify as Asian, not Hispanic	3.62%	2.34%	3.21%	10.44%
Adults (18-64) who identify as Black, not Hispanic	1.50%	1.97%	1.65%	4.27%
Adults (18-64) who identify as Hispanic	21.96%	53.77%	32.17%	12.60%
Adults (18-64) who identify as Multiracial, not Hispanic	2.05%	1.36%	1.83%	3.51%
Adults (18-64) who identify as Native Hawaiian or Pacific Islander, not Hispanic	0.17%	0.18%	0.18%	0.77%
Adults (18-64) who identify as White, not Hispanic	69.90%	53.77%	60.25%	67.13%

Adults (65+) who identify as American Indian & Alaska Native, Not Hispanic	0.44%	0.36%	0.42%	0.89%
Adults (65+) who identify as Asian, not Hispanic	3.26%	2.90%	3.17%	7.09%
Adults (65+) who identify as Black, not Hispanic	0.67%	1.86%	0.94%	2.11%
Adults (65+) who identify as Hispanic	6.22%	24.07%	10.26%	3.71%
Adults (65+) who identify as Multiracial, not Hispanic	1.29%	.088%	1.20%	1.37%
Adults (65+) who identify as Native Hawaiian or Pacific Islander, not Hispanic	0.10%	0.04%	0.08%	0.27%
Adults (65+) who identify as White, not Hispanic	88.02%	69.88%	83.92%	84.56%

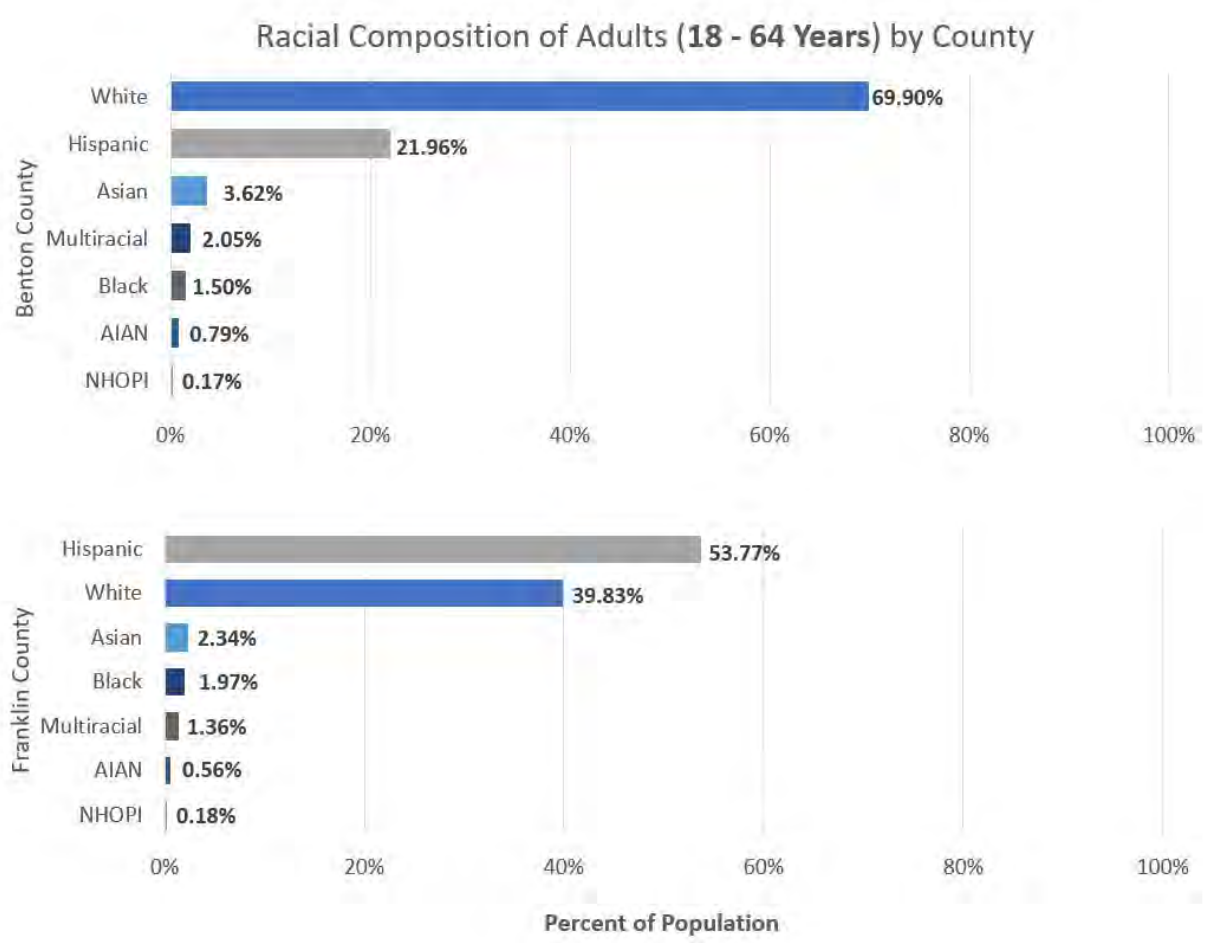
Source: WA OFM, 2020

Figure 4. Racial Composition of Children and Youth (0-17 Years) by County



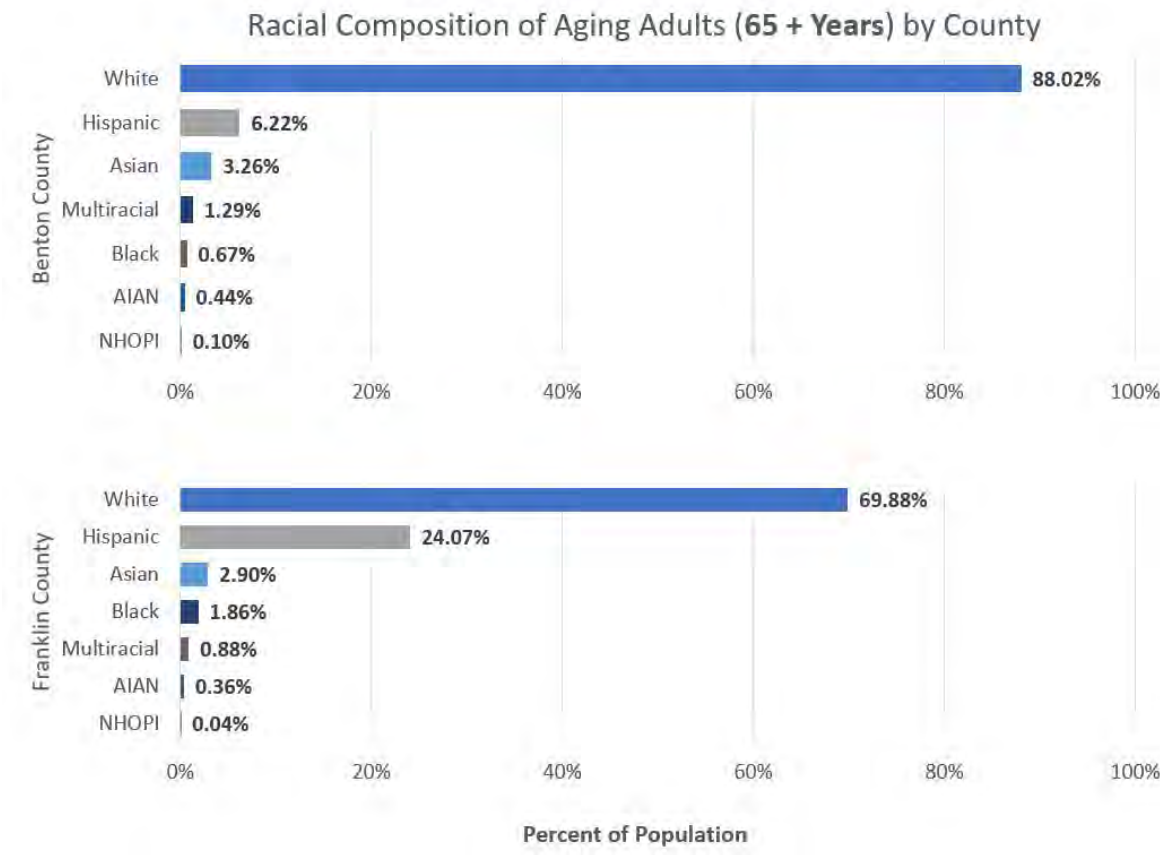
Source: WA OFM, 2020
AIAN—American Indian and Alaska Native
NHOPI—Native Hawaiian or Pacific Islander

Figure 3. Racial Composition of Adults (18-64 Years) by County



Source: WA OFM, 2020
AIAN—American Indian and Alaska Native
NHOPI—Native Hawaiian or Pacific Islander

Figure 6. Racial Composition of Older Adults (65+ Years) by County



Source: WA OFM, 2020
AIAN—American Indian and Alaska Native
NHOPI—Native Hawaiian or Pacific Islander

MEDIAN INCOME

Table 4. Median Household Income

Indicator	Benton County	Franklin County	Washington State
Median Household Income*	$72,847	$63,575	$80,319
Median Household Income (Preliminary Estimate)**	$75,882	$73,656	$81,998

**Source: WA OFM, 2019*
***Source: WA OFM, 2020*
BentonFranklinTrends.org, 2019—no owners paying 50%+ metric

HOUSING COST BURDEN

Table 5. Percent of Residents with Severe Housing Cost Burden

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Renters Paying 30%+ of Income on Shelter	44.1%	42.7%	43.7%	45.3%
Renters Paying 50%+ of Income on Shelter	20.7%	16.2%	19.4%	20.5%
Owners Paying 30%+ of Income on Shelter	15.5%	19.2%	16.5%	23%

INCOME BELOW FEDERAL POVERTY LEVEL (FPL)

Table 6. Percent of Residents with Income Below FPL by Age Group

Indicator	Benton County	Franklin County	Washington State
Total Residents Living Below FPL	10.2%	14.2%	10.2%
<5 Years	15.80%	15.20%	13.40%
5-17 Years	14.20%	20.60%	12.30%
18-34 Years	11.90%	12.80%	13.10%
35-64 Years	7.30%	11%	8.20%
65+ Years	7.10%	11.70%	7.50%

Source: US Census, 2020

INSURANCE ESTIMATES

Table 7. Residents Uninsured and Residents with Medicaid

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Percent Residents Uninsured*	7.1%	14.1%	9.3%	6.2%
Percent Residents with Medicaid**				23.98%
Percent Residents with Medicaid***	21.9%	36.1%	26.4%	19.8%

**US Census Bureau, 2020*
***Data.medicaid.gov, 2020*
****BentonFranklinTrends.org, 2019*

HEALTH PROFESSIONAL SHORTAGE AREA

Benton and Franklin Counties are designated by the Health Resources & Services Administration (HRSA) as Health Professional Shortage Areas (HPSA) having shortages of primary care, dental, and mental health providers meaning there are not enough providers for the population, service area, or facilities.

Franklin County is also designated by HRSA as a Medically Underserved Area (MUA) having too few primary care providers, high infant mortality, high poverty or a high elderly population.

Definitions and additional information can be on the HRSA website.

See Appendix 1 for additional details on HPSA and Medically Underserved Areas and Medically Underserved Populations.

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

The CHNA process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering community information, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited working partners, community collaborators, and community members to provide additional context to the quantitative data through qualitative data in the form of interviews and listening sessions.

Quantitative and qualitative data were used to identify community needs through a mixed-methods approach. Quantitative data sources include Behavioral Risk Factor Surveillance System (BRFSS), Community Health Assessment Tool (CHAT), and the Healthy Youth Survey (HYS) as well as Centers for Disease Control and Prevention (CDC), Child Care Aware of America, County Health Rankings and Roadmaps, Washington State Department of Children, Youth & Families (WA DCYF), Washington Statistical Analysis Center (WA SAC), Washington Association of Sheriffs and Police Chiefs (WASPC), and Washington Tracking Network (WTN). Quantitative data is presented through a life course perspective.

Qualitative data includes twenty-one interviews with working partners and community collaborators (partners) were conducted, ten listening sessions, a community survey, two behavioral health forums, two housing/homelessness forums, and two general forums. Partners interviewed and listening session participants represent members of medically underserved, low-income, and minority populations in the community.

Process for Gathering Comments on CHNA and Summary of Comments Received

The 2019 Benton & Franklin Counties CHNA, Kadlec Executive Summary, and the 2020-2022 Kadlec CHIP were made widely available to the public via posting on the internet in December 2019 (CHNA) and May 2020 (CHIP) as well as through various channels with our community-based organization partners. Two requests for hard copies were made to Kadlec and copies were sent via United States Postal Service mail at no charge. No comments were received. The CHNA will be posted on Kadlec's website and remain there through two subsequent CHNA cycles.

HEALTH INDICATORS

The 2022 CHNA health indicators were primarily selected based on four factors: one or both Benton and Franklin Counties' values were significantly higher than Washington State's value; a significant disparity between Benton County and Franklin County was identified; there was a significant change from previous years in Benton or Franklin Counties; or the indicator was identified in the 2020 CHIP as a goal metric to measure.

Pregnancy, Birth & Sexual Health

PRENATAL CARE INITIATION

Table 8. First Prenatal Care Visit

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Pregnancies with First Prenatal Care Visit in the 1st Trimester	74.85%	76.36%	75.39%	81.82%
Pregnancies with First Prenatal Care Visit in the 2nd Trimester	17.61%	16%	17.03%	13.19%
Pregnancies with First Prenatal Care Visit in the 3rd Trimester	5.29%	4.71%	5.08%	4.38%
Pregnancies Receiving No Prenatal Care	2.25%	2.93%	2.19%	1.18%

Source: Community Health Assessment Tool (CHAT), 2020

BIRTH STATISTICS

Table 9. Birth Rates and Infant Mortality

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Birth Rate (per 1,000 Population)	12.09	15.26	13.10	10.85
Birth Rate (per 1,000 Population) to Women Aged 10-19 Years	12.15	14.33	12.95	8.7
Births with a Low Birthweight (<2500g)	6.31%	6.77%		6.71%
Infant Mortality Rate (per 1,000 Births)			6.56	4.49

Source: CHAT, 2020

YOUTH CONDOM USE

Table 10. Youth Condom Use

Indicator	Benton & Franklin Counties Combined	Washington State
Sexually Active Youth Reporting Condom Use During Last Sexual Encounter – 8th Grade	34.54%	31.24%
Sexually Active Youth Reporting Condom Use During Last Sexual Encounter – 10th Grade	62.25%	58.43%
Sexually Active Youth Reporting Condom Use During Last Sexual Encounter – 12th Grade	62.91%	54.72%

Source: Healthy Youth Survey (HYS), 2021

Family & Community

CHILD CARE COSTS AND AVAILABILITY

Table 11. Child Care Cost and Need Met

Indicator	Benton County	Franklin County	Washington State
Average Child Care Cost per Child per Month	$894	$899	$1,044
Average Child Care Cost per Child per Month as Percentage of Median Household Income	17%	19%	18%
Estimated Percent Child Care Need met by Licensed Child Care (<35 Months)	11%	14%	17%
Estimated Percent Child Care Need met by Licensed Child Care (35 Months to School Aged)	25%	34%	53.30%

Source: Child Care Aware of America, 2021

YOUTH PHYSICAL AND VERBAL ABUSE

Table 12. Youth Surveyed Report Physical and Verbal Abuse

Indicator	Benton & Franklin Counties Combined	Washington State
Youth Surveyed Report they are Sworn at, Humiliated, or Insulted by an Adult in their Home Often or Very Often – 8th grade	30.70%	31.20%
Youth Surveyed Report they are Sworn at, Humiliated, or Insulted by an Adult in their Home Often or Very Often – 10th grade	33%	30.80%

Youth Surveyed Report they are Sworn at, Humiliated, or Insulted by an Adult in their Home Often or Very Often – 12th grade	32.10%	34%
Youth Surveyed Report Having Ever Been Physically Abused by an Adult – 8th grade	15.80%	17.50%
Youth Surveyed Report Having Ever Been Physically Abused by an Adult – 10th grade	20.90%	21.60%
Youth Surveyed Report Having Ever Been Physically Abused by an Adult – 12th grade	19%	19.90%

Source: HYS, 2021

Activity, Nutrition & Weight

YOUTH PHYSICAL ACTIVITY

Table 13. Youth Physical Activity

Indicator	Benton & Franklin Counties Combined	Washington State
Youth Reporting Not Meeting Physical Activity Recommendations – 6th Grade	82.40%	81.30%
Youth Reporting Not Meeting Physical Activity Recommendations – 8th Grade	78.20%	80.90%
Youth Reporting Not Meeting Physical Activity Recommendations – 10th Grade	76.70%	78%
Youth Reporting Not Meeting Physical Activity Recommendations – 12th Grade	77.80%	77.30%

Source: HYS, 2021

YOUTH BMI

Table 14. Youth BMI

Indicator	Benton & Franklin Counties Combined	Washington State
Youth in Top 15% BMI by Reported Height and Weight – 8th Grade	16.60%	17.30%
Youth in Top 15% BMI by Reported Height and Weight –10th Grade	18.10%	15.80%
Youth in Top 15% BMI by Reported Height and Weight – 12th Grade	17.70%	15.30%

Source: HYS, 2021

Access to Healthcare & Use of Preventative Services

ACCESS TO HEALTHCARE

Table 15. Access to Healthcare Resources

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Adults (18-64) Reporting Having Any Kind of Medical Coverage*	88.05%	68.54%	80.31%	88.45%
Adults (18-64) Reporting Having a Primary Care Provider*	77.22%	61.83%	71.10%	73.96%
Primary Care Provider to Population Ratio**	1430:1	4720:1		1180:1
Dentist to Population Ratio**	1390:1	2030:1		1200:1
Mental Health Providers to Population Ratio**	350:1	720:1		250:1

**Source: Behavioral Risk Factor Surveillance System (BRFSS), 2020*
***Source: County Health Rankings and Roadmaps, 2021*

Mental & Behavioral Health

ADULT AND YOUTH MENTAL HEALTH

Table 16. Adult and Youth Mental Health

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Adults Reporting Poor Mental Health for 14+ Days for the Last 30 Days*	13.38%	10.90%	12.63%	14.23%
Youth Reporting Ever Feeling Sad or Hopeless Almost Every Day for 2 Weeks or More in a Row – 8th Grade**			35.80%	35.30%
Youth Reporting Ever Feeling Sad or Hopeless Almost Every Day for 2 Weeks or More in a Row – 10th Grade*			41.60%	38.20%
Youth Reporting Ever Feeling Sad or Hopeless Almost Every Day for 2 Weeks or More in a Row – 12th Grade*			48.60%	44.50%

**Source: BRFSS, 2020*
**Source: HYS, 2021*

YOUTH MENTAL HEALTH (SUICIDE)

Table 17. Youth Mental Health (Suicide)

Indicator	Benton & Franklin Counties Combined	Washington State
Youth Reporting Having Seriously Contemplated Suicide in the Last Year – 8th Grade	18.80%	19.30%
Youth Reporting Having Seriously Contemplated Suicide in the Last Year – 10th Grade	20.40%	19.50%
Youth Reporting Having Seriously Contemplated Suicide in the Last Year – 12th Grade	21.30%	20.20%

Source: HYS, 2021

Substance Use

OPIOID STATISTICS

Table 18. Opioid Statistics

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Opioid Prescriptions per 100 Residents*	72.9	12.4		39.5
Opioid Overdose Hospitalization Rate (per 100,000 Population)**			14.18	14.47
Opioid Overdose Mortality Rate (per 100,000 Population)**			15.71	15.30

**Source: Center for Disease Control and Prevention (CDC), 2020*
***Source: CHAT, 2019*

YOUTH VAPING

Table 19. Youth Vaping

Indicator	Benton & Franklin Counties Combined	Washington State
Youth Report Using E-Cigarettes in Past 30 Days – 6th Grade	3.80%	3.20%
Youth Report Using E-Cigarettes in Past 30 Days – 8th Grade	6.50%	5.10%

Youth Report Using E-Cigarettes in Past 30 Days – 10th Grade	9.40%	8%
Youth Report Using E-Cigarettes in Past 30 Days – 12th Grade	11.70%	15.50%

Source: HYS, 2021

Violence & Injury Prevention

CRIME STATISTICS

Table 20. Crime Statistics

Indicator	Benton County	Franklin County	Washington State
Violent Crime Rate per 1,000 Residents*			3.4
Rate of Reported Domestic Violence Offenses per 100,000 Residents**	875.55	635.59	774.39
Total youth (12-17) Arrest Rate per 10,000 Youth***	336.20	202.36	121.24

**Source: Washington Association of Sheriffs and Police Chiefs (WASPC), 2020*

***Source: WASPC, 2020*

**** Source: Washington Statistical Analysis Center (WA SAC), 2020*

INJURIES

Table 21. Injuries

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Hospitalization Rate per 100,000 Population Due to Falls for People Aged <65	129.74	60.31	106.57	118.65
Hospitalization Rate per 100,000 Population Due to Falls for People Aged 65+	2222.45	1627.43	2088.72	1789.26
Age-Adjusted Hospitalization Rate per 100,000 Population for Unintentional Injuries	654.4	536.53	624.41	574.36
Age-Adjusted Non-Fatal Intentional Self-Harm/Suicide Rate per 100,000 Population	53.59	23.26	43.85	49.83

Source: CHAT, 2019

YOUTH SEXUAL ASSAULT

Table 22. Youth Experiencing Sexual Assault

Indicator	Benton & Franklin Counties Combined	Washington State
Youth Surveyed Report Having Ever Seen Someone Else Forced into a Sexual Situation – 8th Grade	18.40%	20%
Youth Surveyed Report Having Ever Seen Someone Else Forced into a Sexual Situation – 10th Grade	27.90%	24.80%
Youth Surveyed Report Having Ever Seen Someone Else Forced into a Sexual Situation – 12th Grade	31.40%	27.20%
Youth Surveyed Report Having Ever Been Forced into a Sexual Situation – 8th Grade	9.30%	9.90%
Youth Surveyed Report Having Ever Been Forced into a Sexual Situation – 10th Grade	18.80%	13.80%
Youth Surveyed Report Having Ever Been Forced into a Sexual Situation – 12th Grade	19.50%	22%

Source: HYS, 2021

Chronic Illness

Table 23. Chronic Illness

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Age-Adjusted All Cancer Incidence Rate per 100,000 Population	343.95	321.14	336.23	474.59
Adults Reporting Having Ever Been Told They Had Coronary Heart Disease and/or a Heart Attack**	6.32%	4.84%	5.70%	4.61%
Adults Reporting Having Ever Been Told They Had Diabetes (Excludes Gestational and Pre-Diabetes)**	8.35%	8.72%	8%	8.02%
Age-Adjusted Hospitalization Rate per 100,000 Population Due to Chronic Obstructive Pulmonary Disease (COPD) and Bronchiectasis*	112.23	94.64	107.26	60.66

** Source: CHAT, 2019*
*** Source: BRFSS, 2020*

Life Expectancy, Leading Causes of Death & Quality of Life

LIFE EXPECTANCY & YEARS OF POTENTIAL LIFE LOST

Table 24. Life Expectancy and Years of Potential Life Lost

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Life Expectancy	78.70	79.80	79.08	79.85
Years of Potential Life Lost**	4,402 Years	3,520 Years	4,106 Years	3,860 Years

Source: CHAT, 2020
***A cumulative estimation of the average time a person would have lived had they not died prematurely (before the age of 65)*

Table 25. Life Expectancy and Years of Potential Life Lost by County

County	Population	Years of Potential Life Lost (YPLL) Rate	Estimated Years Lost
Benton County	205,700	4,402 Years per 100,000 Population	9,055 Years
Franklin County	96,760	3,520 Years per 100,000 Population	3,406 Years

Table 26. Life Expectancy by Zip Code

Indicator	Life Expectancy Years
Benton City (99320)	78.41
Kennewick (99336)	74.59
Kennewick (99337)	79.75
Kennewick (99338)	85.77
Plymouth (99346)	67.68
Prosser (99350)	79.06

Richland (99352)	79.38
West Richland (99320)	80.30
Richland (99354)	80.14
Pasco (99301)	78.86
Connell (99326)	85.88
Eltopia (99330)	78.96
Mesa (99343)	89.91

Source: CHAT, 2020

LEADING CAUSES OF DEATH

Table 27. Leading Causes of Death

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Major Cardiovascular Diseases Mortality Rate per 100,000 Population	187.51	186.44	186.31	180.27
Malignant Neoplasms Mortality Rate per 100,000 Population	137.37	122.69	133.24	135.74
COVID-19 Mortality Rate per 100,000 Population	60.42	89.02	67.33	35.82
Alzheimer's Disease per 100,000 Population	67.56	42.42	62.26	41.71
Unintentional Injuries per 100,000 Population	52.40	42.22	49.50	51.42
Chronic Lower Respiratory Disease per 100,000 Population	32.05	37.57	33.40	28.89
Diabetes Mellitus per 100,000 Population	16.93	26.94	19.07	22.23
Chronic Liver Disease and Cirrhosis per 100,000 Population	14.30	15.26	13.90	14.12
Intentional Self-Harm (Suicide) per 100,000 Population*	18.22			15.39
Parkinson's Disease per 100,000 Population*	9.04			9.25

Source: CHAT, 2020
**To protect personal health information, rates from counts <10 will be suppressed. If counts are zero, "0" will be recorded.*

SUICIDE MORTALITY

Table 28. Age-Specific Suicide Mortality Rates by Age

Indicator	Benton & Franklin Counties Combined	Washington State
Population Aged 0-17	2.71	2.68
Population Aged 18-34	15.39	19.31
Population Aged 35-64	19.65	21.42
Population Aged 65+	25.27	20.25

Source: CHAT, 2016-2020
To protect personal health information, multiple years and large groups were combined.

See Appendix 1: Quantitative Data

COMMUNITY INPUT

Interviews and Listening Sessions

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, Benton-Franklin CHNA steering committee members conducted 21 interviews with working partners and community collaborators (partners) including 33 participants. They also conducted 10 listening sessions with a total of 67 community members. Interviews and listening sessions were conducted between March and May 2022. Below is a high-level summary of the findings of these sessions; **full details on the protocols, findings, and attendees are available in Appendix 2.**

VISION FOR A HEALTHY COMMUNITY

Listening session participants were asked to describe their vision of a healthy community. This question is important for understanding what matters to community members and how they define health and wellness for themselves, their families, and their communities. The primary theme shared was "community engagement and connection" and participants noted the importance of people working together towards common goals, having meaningful conversations, and volunteering. The following is a list of all the themes that emerged:

- Community engagement and connection
- Easy access to health care, including mental health services, for everyone
- Safety
- Diversity, inclusion, and respect
- Opportunities for recreation and a healthy lifestyle
- Economic security, including affordable housing and employment

COMMUNITY STRENGTHS

While a CHNA is primarily used to identify gaps in services and challenges in the community, we want to ensure that we highlight and leverage the community strengths that already exist, including the following identified by partners:

Community engagement and willingness to help

Partners identified the greatest strength of Benton and Franklin Counties as the community engagement and people's willingness to show up to help one another. They shared that people care for one another, support one another, welcome new folks to the community, and volunteer to meet the needs of others. People care deeply about the community and many people have remained in the community for many years and are giving back.

A spirit of collaboration and partnership

Partners spoke to a strong spirit of collaboration and partnership in Benton and Franklin Counties. There is a lot of commitment to working together to make meaningful change towards shared goals. They shared examples of collaborations between law enforcement agencies, nonprofits, faith-based organizations, health care, government, emergency response teams, and community members.

Strong network of community organizations to meet needs

Partners shared there are many local organizations to meet people's health and Social Determinant of Health needs. There are multiple hospitals, clinics, urgent care centers, and specialists in the community to give patients options. There are strong school districts which are connected to many of the families and serve as a trusted partner. The Hanford site employs many people.

Diversity of cultures and community knowledge

Partners shared the people of Benton and Franklin Counties are a strength. There are many cultures represented in the communities and opportunities to build relationships with people of different backgrounds.

COMMUNITY NEEDS

Listening session participants discussed a variety of needs, but the four most common were **mental health, homelessness and housing instability, access to health care services, and substance use/misuse.** Mental health was the most frequently discussed need. Long wait times for appointments, provider turnover, and insurance barriers prevent people from accessing timely, high-quality mental health, primary care, and specialty care. Groups that may experience additional barriers to responsive care include young people, older adults, Spanish-speaking people, veterans, and people with developmental disabilities. Participants discussed the importance of more culturally responsive health care services, and providers with empathy for patients' situations. Participants were concerned about the high cost of housing and lack of affordable housing in the area. Substance use/misuse was also identified as a community challenge and the lack of detox services was frequently identified as a gap.

Other needs discussed in detail by listening session participants include **community resources, safety, transportation, and family support and resources.**

Mental health	Mental health was overwhelmingly identified as the most pressing community need. Most partners spoke to needing more mental health treatment services, including mental health counselors and facilities at all clinical levels. Specifically, they noted a need for improved crisis services and pediatric inpatient services. Contributing to the community needs are workforce challenges, noting high burnout, testing and supervision barriers, and low wages for entry level roles as contributors. Transportation can be especially challenging for people living in more rural parts of the counties when accessing mental health supports. Language is also a barrier for people whose primary language is not English. Partners were particularly concerned about young people, including youth in foster care, noting that mental health needs have only increased during the COVID-19 pandemic. They noted seeing an increase in anxiety, depression, and social isolation, as well as an increase in behavioral issues with students, potentially connected to a lack of stability during the pandemic. People with developmental disabilities have few options for accessing behavior support specific to their needs locally, noting a need to provide more intentional support for this group and their caregivers. Partners spoke to the COVID-19 pandemic as exacerbating mental health needs for everyone and contributing to a lot of stress for families, and a lack of connection for many people, including older adults. Health care providers also experienced increased stress and mental health needs during the pandemic. Telehealth services improved access for some people but created challenges for others, particularly people with a developmental disability or people lacking access to or comfort with technology.
Substance use/misuse	Partners highly prioritized substance use/misuse because of how it affects whole families and communities. They shared there are not enough substance use disorder (SUD) treatment services in the community, although there are many great efforts underway, including the Recovery Center, to meet the need. There is specifically a need for inpatient SUD treatment services and a detox center for withdrawal management. Partners emphasized how critical it is to have a detox center within the community. There is insufficient behavioral health workforce to meet the need, potentially due to low wages for people without advanced degrees and burnout in the field. Partners identified young people, older adults, and people experiencing homelessness as groups that may not receive the support needed in accessing support for substance use/misuse issues. During the COVID-19 pandemic, partners have seen substance use/misuse increase for both adults and young people.

Access to health care services	Partners shared that while there are many health care services in the two counties, there is still a need for more primary care providers and specialists to reduce wait times. Access to preventive care is especially important for ensuring people receive timely and appropriate care, avoiding unnecessary calls to EMS or avoidable ED visits. In addition to preventive care, partners spoke to a need for improved discharge planning, including medication management, particularly for people experiencing homelessness. For people needing a skilled nursing facility or hospice, there are also limited options in the community. Partners shared it can be challenging to recruit health care professionals from outside of the area, particularly with the high cost of housing. The health care system can be challenging for people to navigate, particularly for older adults, people whose primary language is not English, and people with a disability. Transportation was highlighted as a primary barrier for people, particularly if they live in a rural area or have mobility issues. Other barriers include cost of care, language, childcare, and appointment times during work hours. Partners highlighted the following populations as experiencing additional barriers to care: people with developmental disabilities, older adults, young people, the Latino/a community, and people experiencing homelessness. Due to the COVID-19 pandemic, some people delayed preventive health care services or were not able to access the health care services they needed. Telehealth improved access for some patients but is challenging for those without access to or comfort with technology. COVID-19 vaccine disinformation and the politicization of public health practices put additional strain on the health care system and providers. Positively, the pandemic created more opportunities for education and outreach with communities, and increased awareness of the role of health care and public health in the community.
Homelessness and housing instability	Partners prioritized homelessness and housing instability because of its connection to so many other needs and because of the importance of people first being stably housed before addressing their other needs. They described homelessness as a symptom of other issues and noted concern for folks not just living unsheltered, but also those living in their cars or RVs, couch surfing, and moving frequently. They spoke to needing more homelessness services in the community to address hygiene issues and care coordination needs. They emphasized a need for more housing in general, but in particular low-barrier permanent supportive housing, transitional housing, and workforce housing. Partners emphasized the importance of taking a Housing First approach. The high cost of housing and low housing stock have made finding affordable housing a challenge for many people in the community, both wanting to buy and rent homes. They spoke to very low vacancy rates, leading to competition for rentals, increases in rent, and overcrowding. For people with low incomes, a behavioral health condition, or any negative rental history, finding affordable, stable housing can be more challenging. Older adults and families with children with special needs also lack housing that meets their needs, including skilled nursing facilities.

The following needs were frequently prioritized, but with lower priority by partners. They represent the **medium-priority health-related needs,** based on community input:

Economic insecurity, education, and job skills	Partners discussed the need for more financial stability for many families, ensuring there are living wage jobs, job skill trainings, and investments in education. With high cost of housing, families may spend a substantial portion of their income on rent, especially for seasonal and agricultural workers. To address these needs, partners advocated for more equitable funding of public education and support for higher education, increased job skill training particularly for students in more rural districts, and support for skilled work training. Partners identified single parents with a special needs child, seasonal workers, and the Latino/a community as being disproportionately affected by economic insecurity. The pandemic affected businesses and workers, particularly in the service and hospitality industries.
Affordable childcare and preschools	Partners emphasized affordable and flexible childcare as crucial for stable families and a strong workforce. Without addressing this need, people will not be able to participate fully in the workforce and there will continue to be staffing challenges. There is very little affordable childcare in the community and limited free preschool spots. For families working non-traditional hours, finding flexible childcare can be very difficult. For families with a child with a disability, there is very little childcare that can meet the child's needs. This prevents parents from working. The pandemic highlighted how important childcare is for keeping people staffed and for businesses being able to recruit and retain employees.
Food insecurity	Many partners shared that the community is working to ensure people have access to food, although the food options may not always be the healthiest and programs may not address what is causing food insecurity. They shared that food pantries often provide non-perishable foods, which are often not as nutritional as fresh foods. Fresh and healthy foods can be challenging for families with low incomes to afford. Families new to the United States may not be familiar with reading the food labels and identifying healthy foods for their children. Workers on the Hanford site have little access to food on-site besides what they bring. The pandemic exacerbated food insecurity more many people. While there have been additional supports to provide food to families, partners noted there are often a lot of cars lined up waiting to receive food assistance at events, underscoring the need.
Community safety	Partners shared that while they do not think Benton and Franklin Counties overall are unsafe, they are concerned about increased community violence and neighborhoods where residents do not feel safe. This might contribute to people not feeling comfortable accessing parks or recreation. Partners spoke to seeing a large increase in gun violence in 2021, as well as people manifesting anger and stress into violence. They emphasized that addressing community safety needs to be a collaboration between law enforcement and the community.

Community Survey

Benton-Franklin Health District contracted with Zencity, a well-respected community input and insights platform, to conduct a community health survey. The survey was conducted in English and Spanish, respondents were recruited via the internet, and was fielded from March 17-April 11, 2022. The sample survey of Benton and Franklin Counties adults, 18+ was 657. The data was weighted to represent the population in Benton and Franklin Counties. Key findings:

- Just over half the respondents (54%) are satisfied with the quality of life.
- Around half the respondents rate their physical, mental, and dental health as good.
- Fifty-seven percent of respondents reported getting all the health care they needed with no delay, 73% reported getting all the mental health care they need, and 67% responded that they got all the dental health care they needed. Cost and not having a regular provider were leading reasons for not getting enough care.
- Respondents feel that a healthy community is one in which health care and services are accessible to all. They think mental health services are the most important thing the community needs.
- Four groups consistently reported lower quality of life, lower overall health, and less access to health care than other groups: respondents aged 18-34, Hispanic/Latino/a respondents living in Franklin County, and respondents with low incomes.

See Appendix 1: Community Survey

Trends in Behavioral Health

The Institute for Public Policy & Economic Analysis completed "An Analysis of Trends in Behavioral Health of Residents in Benton & Franklin Counties." A survey of mental health providers was conducted and two behavioral health forums were held in person in May of 2022. Forum participants included representatives from community service and non-profit organizations, health care, businesses, government agencies, community members. Relevant data was shared and participant input sought to help identify current needs and gaps in community behavioral health.

KEY FINDINGS FROM THE BEHAVIORAL HEALTH FORUMS

- Significant workforce shortages, more services, more providers, more coordination across organizations and broader social supports are important behavioral health needs in the community today.

KEY FINDINGS FROM THE DATA PRESENTATION

- In adults and youth data alike, rates of mental health issues, substance use/misuse, and the need for treatment is undeniable. If left untreated, many of these issues can lead to higher rates of thoughts of suicide and reliance on substances.
- Suicide rates for the total population have increased slightly over past 25 years while youth suicides and attempts have likely grown over past 20 years. Depression in adults and youth alike

are rising, and the rate of prescribing depression medication is growing, at least among the Medicaid population.

- On a positive note, there has been a steep drop in alcohol and marijuana usage in 10th graders, and rates of binge drinking in adults have slightly decreased.
- Opioid prescribing has declined steeply over past few years, although the lethality of the drugs appears to have climbed.
- Community protective factors declined to 50% in Benton County in 2021, which is 10% lower than WA benchmark. These are conditions or attributes in communities that promote the health and well-being of children, ultimately leading to the development of healthy young adults in the community. These factors include access to economic and financial resources, safe and stable housing, safe childcare, along with medical care and mental health services. On the other hand, school and family protective factors have shown overall increases through 2010-2021 in Benton County and WA.

KEY FINDINGS FROM THE SURVEY OF MENTAL HEALTH PROVIDERS

- Issues with insurance companies significantly impair the ability of providers to care for their patients. For example, having access to other Medicaid insurance carriers like Amerigroup and Molina, along with greater accessibility to medications from insurance companies, were mentioned. Additionally, some providers had specific concerns that some mental health issues are not being recognized by insurance companies for treatment. When insurance companies are willing to work with providers, there are delays in reimbursements and complications with filing paperwork.
- Survey respondents expressed a strong desire for more coordination across organizations to help reduce significant wait times they are currently experiencing.

Click here for "An Analysis of Trends in Behavioral Health of Residents in Benton & Franklin Counties."

Trends in the Continuum of Housing

The Institute for Public Policy & Economic Analysis completed "An Analysis of Trends in the Continuum of Housing for Homeless & Low-Income Residents in Benton & Franklin Counties."

A survey of housing providers was conducted and two housing and homelessness forums were held in person in May of 2022. Forum participants included representatives from community service and non-profit organizations, health care, businesses, government agencies, community members. Relevant data was shared, and participant input sought to help identify current needs and gaps in the continuum of housing availability for residents with low incomes and experiencing homelessness.

KEY FINDINGS FROM THE HOUSING AND HOMELESSNESS FORUMS

According to the participants at the forums, the four greatest needs in helping to reduce challenges for residents with low incomes and experiencing homelessness to secure housing include:

(1) Removing barriers,
(2) Greater availability of housing options,
(3) Need for more coordination, and
(4) Need for stronger social supports.

KEY FINDINGS FROM THE REVIEW OF THE DATA

- A review of the housing data indicates that total housing units have not been meeting population demand, but there are efforts to build up units, specifically multi-family units.
- Increasing rental rates are a challenge for renters because the growth rate of household income is about one-third of the growth rate of rent.
- The greater Tri-Cities (Kennewick, Pasco, Richland, West Richland, and surrounding towns) has consistently been in a very tight market for rental housing, as the vacancy rate is below 2% for most years from 2016 to 2021.
- Persons experiencing homelessness and unstable housing are growing in Tri-Cities, whereas the WA number is decreasing. There are currently almost 4,000 people in the Homeless Management Information System (HMIS) system in the greater Tri-Cities. The length of days someone is homeless in the greater Tri-Cities has nearly doubled and the rate of those returning to homelessness is still increasing.

KEY FINDINGS FROM THE SURVEY OF HOUSING OPTIONS

- The most significant obstacles facing housing facilities that serve residents with low incomes and experiencing homelessness are lack of financial resources, drug use, and workforce challenges. Relations with neighbors and ability to attract potential clients are ranked lower.

Click here for "An Analysis of Trends in the Continuum of Housing for Homeless & Low-Income Residents in Benton & Franklin Counties."

Community Forums

Two general forums were convened in July to share qualitative and quantitative data with community members and to ask them to identify additional community health needs that may be present in Benton and Franklin Counties. The first general forum was held in person on July 12, 2022, with 41 participants, and the second was held virtually on July 14, 2022, with 35 participants. They were asked to consider the following:

- What is going well?
- What are the most significant community health issues?

- What is most concerning to you?
- What do you think this community is ready, able, willing to work on?
- What else would you like to know?

Forum participants believe that there is a willingness to collaborate and find solutions as a community, that people care and are willing and invested in creating a better community. An increase in the number of Community Health Workers and the impact they are making was noted. Participants want to know the results of the current CHIP, how programs are funded, and who the champions are for each major challenge. The one-tenth of one percent local sales tax that went into effect in April of 2022 for chemical dependency or mental health purposes was noted as a positive development for future program funding. The need for increased awareness of community resources was noted especially for youth. There is an interest in improving transportation as it can be a barrier to accessing healthcare. Childcare costs and the nursing shortage were identified as priorities. Top priorities identified include behavioral health, access to care, workforce, and housing. Participants believe that the community is ready, willing, and able to work on mental health, substance use and abuse, access to healthcare, and housing and homelessness.

Challenges in Obtaining Community Input

The COVID-19 pandemic continues to present barriers and challenges to collecting community input. Rather than being held in person, partner interviews were held virtually presenting technological challenges for some participants and decreasing the opportunities for in person, interpersonal communication. Technology presented challenges in one listening session and participation was limited for the in person older adult listening session, likely due to the pandemic. While video conferencing does facilitate information sharing, there are challenges creating the level of dialogue that would take place in person.

SIGNIFICANT HEALTH NEEDS

Prioritization Process and Criteria

CHNA steering committee members reviewed the qualitative and quantitative data independently, in steering committee meetings, and by participating in the three community forums. Committee members met weekly in July and August 2022 to apply the prioritization criteria to the identified needs and reached consensus through discussion and debate. Prioritization criteria included worsening trend over time, disproportionate impact on low income and/or Black, Brown, Indigenous, and People of Color (BBIPOC) communities, community rates worse than state average, the opportunity to impact based on community partnerships, severity of the need and/or scale of need. The following Community Health Improvement Plan Guiding Concepts also informed the prioritization process: Equity, Life-course wellness, Health in All Policies (HiAP), Evidenced-based, and Collective Impact.

See Appendix 3: Community Health Improvement Plan Guiding Concepts

2022 Priority Needs

The list below summarizes the significant health needs identified through the 2022 Community Health Needs Assessment process in no particular order:

BEHAVIORAL HEALTH

The 2019 Benton & Franklin Counties Community Health Needs Assessment (CHNA) identified that our community needed to better understand the behavioral health gaps and needs within the community. The 2020 Benton & Franklin Counties Community Health Improvement Plan (CHIP) included an objective (BH 2.1.1) to complete a comprehensive behavioral health needs assessment. The assessment was completed in the spring of 2022 through a partnership with Eastern Washington University (EWU). The assessment identified significant needs for behavioral health response and prevention. In fact, in all areas of the CHNA, behavioral health was identified as a need. Behavioral health includes mental health and substance use/misuse. With the serious behavioral health workforce shortage, increase in need, and existing coalitions working towards solutions, our steering committee identified behavioral health as a priority area.

HOUSING AND HOMELESSNESS

The 2019 CHNA identified that our community needed to better understand the housing and homelessness gaps and needs within the community. The 2020 Benton & Franklin Counties Community Health Improvement Plan (CHIP) included an objective (SDOH 2.1.1) to complete a comprehensive housing and homelessness needs assessment. The assessment was completed in the spring of 2022 through a partnership with EWU. On housing, the assessment identified a low supply of affordable housing, low supply of multi-family units, low vacancy rates for rentals, and increased rental costs. Housing increases in Benton and Franklin Counties are not keeping up with population growth and

demand. Regarding homelessness, the assessment identified a shortage of low-barrier housing options for residents experiencing homelessness. Additionally, there has been a greater than two-fold increase in the average number of days a person experiences homelessness in Benton and Franklin Counties. Stable housing has consistently been shown to improve both physical and mental health outcomes. For this reason and because the Benton and Franklin regions are experiencing rapid growth, a lack of affordable housing, a lack of low-barrier solutions to homelessness, and the complexity of solving these issues through effective community partnerships, our steering committee identified these issues as priorities for the upcoming CHIP.

ACCESS TO HEALTH

The 2019 CHNA identified a need for access to not only healthcare, but also access to community supports that enable health. It is understood that optimal health is influenced by access and quality of healthcare, health promoting behaviors, the physical environment, and socioeconomic factors. Access to Health will include a focus on addressing barriers to medical care, including healthcare provider to patient ratios and linguistically appropriate, culturally responsive, and accessible care. In addition, the steering committee broadened this priority to include needs identified in the CHNA, such as access to safe and nutritious food; transportation; safe, licensed, and affordable childcare; health education; chronic disease prevention; and resource awareness.

COMMUNITY PARTNERSHIP DEVELOPMENT

Benton and Franklin Counties are fortunate to have numerous community coalitions and committees aimed at improving and supporting community health. This region also has a business community which is quite supportive of promoting local health and social initiatives. However, the CHNA identified that strengthening partnerships and coordinating efforts has the potential to improve outcomes through shared goals and resources. This priority area will impact the other three priority areas by improving communications, clarifying coalition functions, and expanding the work of community health improvement to non-traditional partnerships.

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized health care delivery systems include the Benton-Franklin Health District, Trios Health, Lourdes Health, Prosser Memorial Health, Miramar Health Center, and Tri-Cities Community Health. In addition, there are numerous social service non-profit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. As noted in the Community Partnership Development priority section above, the CHNA identified that strengthening partnerships and coordinating efforts has the potential to improve outcomes through shared goals and resources and expanding the work of community health improvement to non-traditional partnerships to address the needs identified in this CHNA.

See table on page 101 in Appendix 2, "Organizations and Initiatives Addressing Community Needs in Benton and Franklin Counties."

EVALUATION OF 2020 BENTON & FRANKLIN COUNTIES CHIP IMPACT

Table 29. Outcomes from BFHD 2020 CHIP

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Social Determinants of Health	Housing and Homelessness Community Health Needs Assessment	Complete a comprehensive housing and homelessness assessment.	BFHD contracted with the Institute of Public Policy and Economic Analysis at Eastern Washington University to conduct a comprehensive housing and homelessness needs assessment. The assessment included analysis of data, a survey of housing providers, and two community forums attended by over 60 participants. The assessment meets a 2020 CHIP objective, and the results are incorporated in this 2022 CHNA.
Social Determinants of Health	Built for Zero (BFZ) Model	BFZ is an initiative that utilizes real-time, by-name data to secure housing resources and target them for the greatest possible reduction in homelessness.	Built for Zero presentation was made at the Housing Continuum of Care Task Force meeting in April of 2022 to introduce the model to community partners.
Social Determinants of Health	People have access to nutritious foods	Establish a Food Access Coalition.	BFHD and BFCHA formed an Access and Security Coalition (FASC) that started meeting in March of 2022.
Social Determinants of Health	Health and social determinants of health are considered and evaluated in community-level initiatives and agency-wide policies.	Apply for and attend the Washington Walkability/Movability Action Institute with interdisciplinary team.	BFHD partnered with BFCOG and Benton-Franklin Transit (BFT) to submit a proposal to attend the Washington Walkability/Movability Action Institute (WA WAI). The WA WAI is a multi-day, multi-disciplinary course focused on equitable policies, systems, and environmental interventions to enhance active transportation opportunities. The team from BFHD, BFCOG, and BFT were joined by representatives from the City of Pasco and Southeast Washington Aging & Long-Term Care (SEWALTC). The team will continue to meet, expand, and receive support from the faculty at the

			National Association of Chronic Disease Directors and the Centers for Disease Control and Prevention (CDC).
Access and Cost of All Healthcare	Health Equity and Access Team (HEAT)	HEAT serves to innovate on ways to increase the provider/population ratio and expand resources to the community.	HEAT has connected with TRIDEC, the Chamber of Commerce and Hispanic Chamber of Commerce, and Visit Tri-Cities on recruitment and retention of providers in primary care.
Access and Cost of All Healthcare	COVID-19 Response	Coordinated and comprehensive infectious disease management	BFHD, Kadlec, PMH, the Hispanic Chamber of Commerce, and many other community partners came together to expand COVID-19 testing and vaccination sites. In addition, BFHD provided community COVID-19 surveillance, served to educate the public about COVID-19 risks and precautions, provided recommendations to businesses, schools, and healthcare organizations, and worked with Washington State Department of Health for a state-wide, coordinated response.
Access and Cost of All Healthcare	Clinical expansion	Expansion of access through increased regional clinical capacity	To expand into rural communities, Columbia Basin Health Associates established primary care facilities in rural areas of north Franklin County. PMH hired multiple new providers in urgent/after-hours care, pediatrics, family practice, obstetrics and women's health, emergency medicine, and behavioral health. PMH also expanded clinic hours where appropriate. Kadlec Clinic hired numerous specialty providers, family medicine physicians, and primary care Nurse Practitioners (NP).
Access and Cost of All Healthcare	Data sharing	Coordinated sharing of community health data	Kadlec and PMH are engaged in data sharing with the coordinated use of MyChart, by Epic.
Access and Cost of All Healthcare	Resource connection	Community Resource Desk (CRD)	Kadlec established the CRD in October of 2020. It is a free service that connects people with community resources including establishing a primary care provider, dental care,

			medical equipment, eye care, alcohol or drug recovery, health insurance, mental health counseling, and basic needs such as food, transportation, clothing, work, or housing aid. By connecting people with resources, a barrier to access is removed.
Behavioral Health Challenges	Tax policy	Sales tax revenue for behavioral health	In the spring of 2022, a sales tax in Benton and Franklin Counties went into effect, providing one penny per every $10 to go towards behavioral healthcare and access in the two counties. This is sustainable funding that will result in about $1.4 million annually to address the needs identified. Work is being done to establish the plan for prioritizing the spending towards the greatest need.
Behavioral Health Challenges	Washington Youth Safety and Wellbeing Taskforce	Advocacy, testimony, and representation	Another policy-level activity related to behavioral health support was BFCHA's involvement in advocating and testifying on the Washington Youth Safety and Wellbeing Taskforce, which recommended a statewide Tip Line. The Tip Line, which is expected to come online in the 2022-23 school year, will be a resource for anyone to call with a tip related to a risk of harm to self or others, including suicide, domestic violence, or other risks. BFCHA has printed and distributed more than 50,000 credit-card size Mental Health Resource handouts in English and Spanish. These are distributed through schools, health fairs, and other venues.
Behavioral Health Challenges	Positive Messaging	Messages to reinforce resilience and positive thinking	Key Connection, the Behavioral Health Committee of BFCHA, BFHD, Educational Service District (ESD) 123, Kadlec, and school districts partnered to develop positive messaging signs to support youth mental health and resilience. BFHD supported a Mental Health Mondays campaign and hosted Trauma Informed Training for school staff to increase awareness of behavioral health issues and provide tools for educators. Greater Columbia

			Accountable Community of Health (GCACH) established "Practice the Pause" campaign, which has run several times during the COVID-19 pandemic and is undergoing a refresh to branding and content for continued use. Partners who provide community education on behavioral health issues and/or suicide prevention include Catholic Charities, Lutheran Social, ESD123, the National Alliance on Mental Illness (NAMI), and Kadlec.
Behavioral Health Challenges	Means Restrictions	Firearm lock boxes and education	Kadlec partnered with Ranch & Home retailer to provide 500 free firearm lock boxes and safe storage education as a means of preventing suicide. The project was funded by Kadlec Foundation.
Behavioral Health Challenges	Behavioral Health Needs Assessment	Comprehensive community-wide assessment of behavioral health needs	BFHD contracted with the Institute of Public Policy and Economic Analysis at Eastern Washington University to conduct a comprehensive behavioral health needs assessment. The assessment included analysis of data, a survey of behavioral health providers, and two community forums attended by over 35 participants. The assessment meets a 2020 CHIP objective and the results are incorporated in this 2022 CHNA.

EVALUATION OF 2020-2022 KADLEC REGIONAL MEDICAL CENTER CHIP IMPACT

This report evaluates the impact of the 2020-2022 Kadlec Community Health Improvement Plan (CHIP). Kadlec responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

Table 30. Outcomes from Kadlec 2020-2022 CHIP

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Behavioral Health Challenges	Integrated Behavioral Health	Behavioral health integrated in primary care clinics	Three social workers are embedded in three Kadlec Clinics.
Behavioral Health Challenges	Mental Health First Aid	Community education programs	Between January 2020 and September 2022, 669 people were trained in Mental Health First Aid and other mental health and suicide prevention programs.
Behavioral Health Challenges	Positive Messaging Campaign	Messages to reinforce resilience and positive thinking	Kadlec, Key Connection, the Behavioral Health Committee of BFCHA, BFHD, ESD 123, and school districts partnered to develop positive messaging signs to support youth mental health and resilience. Kadlec housed, coordinated, and distributed signs throughout the community.
Behavioral Health Challenges	Means Restrictions	Firearm lock boxes and education	Kadlec partnered with Ranch & Home retailer to provide 500 free firearm lock boxes and safe storage education as a means of preventing suicide. The project was funded by Kadlec Foundation.
Access and Cost of Health Care	Telemedicine Services	Expand telemedicine services	Expanded telemedicine services completed 48,291 telemedicine visits in 2020 and 37,260 telemedicine visits in 2021.
Access and Cost of Health Care	Family Medicine Residency program		Kadlec's Family Medicine Residency program residents graduated in 2022 with four of the eight staying within Kadlec.
Access and Cost of Health Care	Healthy Ages	Provide Medicare education and consultations	Between January 2020 and August 2022, 1079 people participated in Medicare education programs and/or consultations.

Access and Cost of Health Care	Community Outreach	Community Health Workers (CHW)	As part of Kadlec's commitment to addressing health equity, three bilingual/bicultural Spanish-speaking CHWs joined the Population Health team in 2021.
Access and Cost of Health Care	Medication Assistance Program (MAP)	Medication assistance to Kadlec patients who qualify	MAP started in March of 2020. In 2021, 161 patients were served.
Access and Cost of Health Care	Community Resource Desk (CRD)	Awareness of, and access to, community resources	Kadlec established the CRD in October of 2020. It is a free service that connects people with community resources including establishing a primary care provider, dental care, medical equipment, eye care, alcohol or drug recovery, health insurance, mental health counseling, and transportation.
Social Determinants of Health (SDOH)	Community Resource Desk (CRD)	Awareness of, and access to, community resources	The CRD connects people with community resources to meet basic needs such as food, transportation, clothing, work, or housing aid.
Social Determinants of Health	Community Outreach	Community Health Workers	As part of Kadlec's commitment to addressing health equity, three bilingual/bicultural Spanish-speaking CHWs joined the Population Health team in 2021.
Social Determinants of Health	Built for Zero (BFZ) Model	BFZ is an initiative that utilizes real-time, by-name data to secure housing resources and target them for the greatest possible reduction in homelessness.	BFZ presentation was made at the Housing Continuum of Care Task Force meeting in April of 2022 to introduce the model to community partners.

Addressing Identified Needs

The Community Health Improvement Plan developed for Benton and Franklin Counties will consider the prioritized health needs identified in this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing plans to address the health needs. If the need will not be addressed or have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions that will be taken, but also the anticipated impact of these actions and the resources needed to address the need.

Because partnership is important when addressing health needs, the Benton and Franklin Counties CHIP will describe any planned collaborations between BFHD, BFCHA, Kadlec and community-based organizations in addressing the health need.

In addition to the Benton and Franklin Counties CHIP that will be developed, Kadlec will develop a Kadlec CHIP that will be approved and made publicly available no later than May 15, 2023.

2022 CHNA GOVERNANCE APPROVAL

Kadlec Regional Medical Center

10/19/22

Reza Kaleel — Date
Chief Executive, Providence Southeast Washington

10/19/22

Ted Samsell, MD — Date
Community Board Chair

11/15/22

Joel S. Gilbertson — Date
Divisional Chief Executive — Central, Providence

Benton-Franklin Health District

10/20/22

Jason Zacarria — Date
District Administrator

Benton-Franklin Community Health Alliance

10/21/22

Kirk Williamson — Date
Program Manager

Prosser Memorial Health

10/28/22

Craig J. Marks — Date
Chief Executive Officer

To request a printed paper copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email info@BFCHA.org or CHI@providence.org

APPENDICES

Appendix 1: Quantitative Data

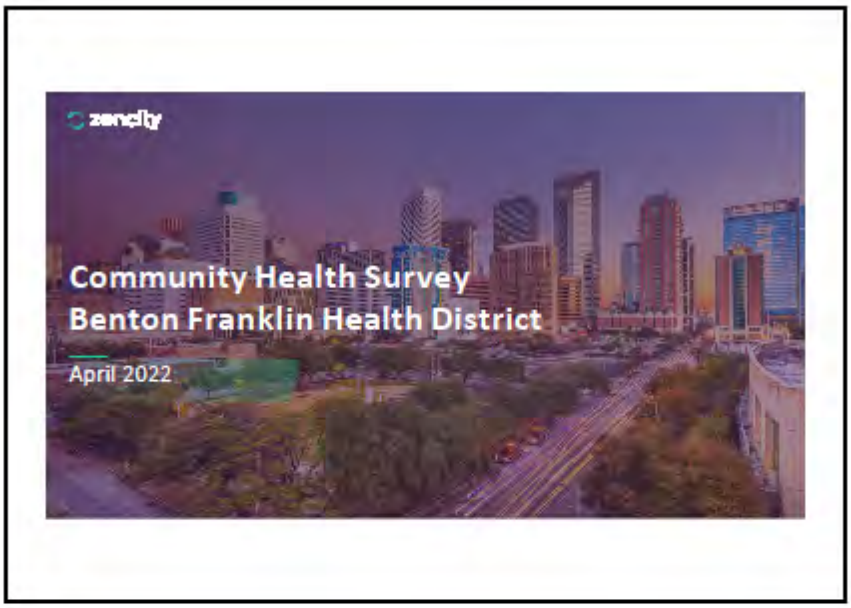
Appendix 2: Community Input

Appendix 3: Community Health Improvement Plan Guiding Concepts

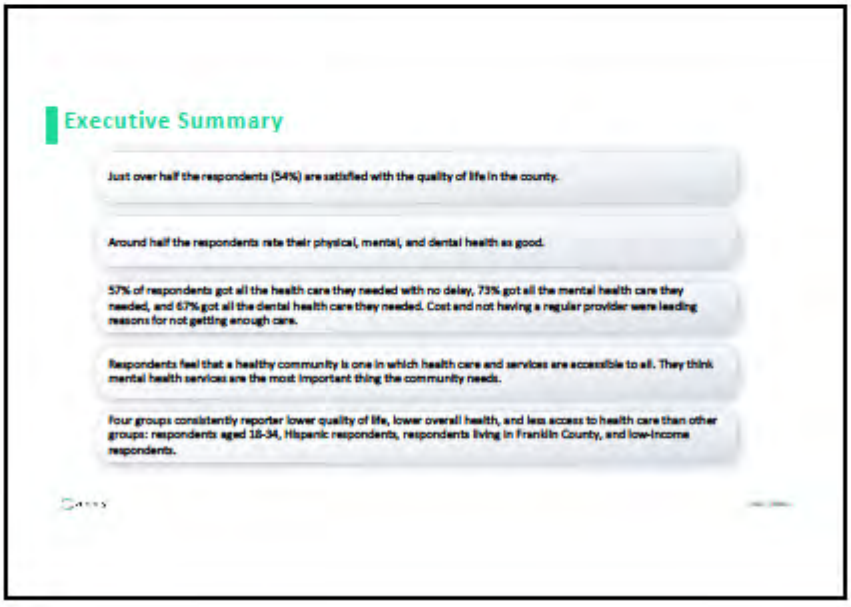
Appendix 4: Community Health Needs Assessment Steering Committee

Appendix 1: Quantitative Data

PRIMARY DATA COLLECTION SURVEY RESULTS



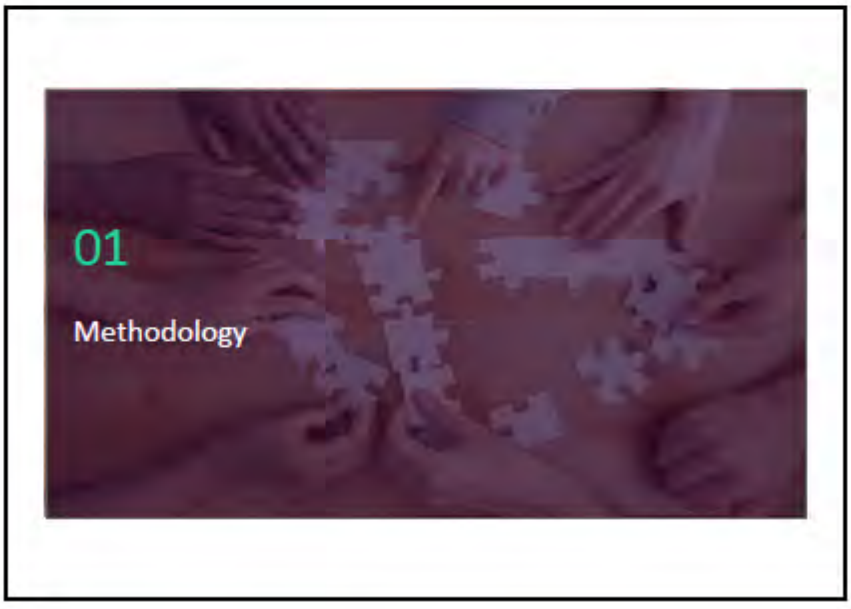
1



2


The structure of the report
01. Methodology
The sample, distribution method, and research tools
02. Overall Health
How to respondents rate their overall quality of life and their health?
03. Individual Health
Do respondents receive all the care they need?
What are they missing and why?
04. Community Health
What do respondents think makes a healthy community?
What do they think their community is missing?
Summary

3


01
Methodology

4


Methodology
657 sample survey of Benton and Franklin adults, 18+
Respondents recruited via internet
Fielded March 17th–April 11th, 2022
Survey was conducted in English and Spanish
Data was weighted to represent the population in Benton and Franklin Counties

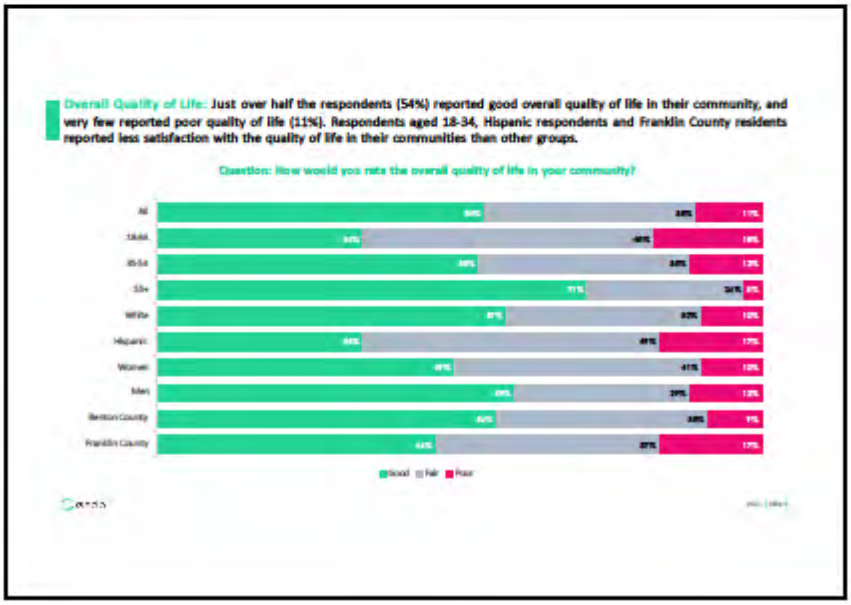
5


Methodology – how we ensure the sample is statistically valid
657 respondents were recruited online between March 17th and April 11th, 2022, using targeted ads on various platforms (e.g., social media, apps for Android and IOS) as well as online survey panels.
Using data from the Census Bureau, this survey employed quotas to match the distribution of race, ethnicity, age, and gender in Benton and Franklin, ensuring that the sample represents residents of both counties.
To make sure our sample is representative, a technique called rake-weighting was used to balance out any remaining differences between the makeup of the survey respondents and the community. This process serves as a statistical safeguard against any demographic group being overrepresented or underrepresented in the final score calculations by giving overrepresented groups a lower weight and underrepresented groups a higher weight in the analysis.

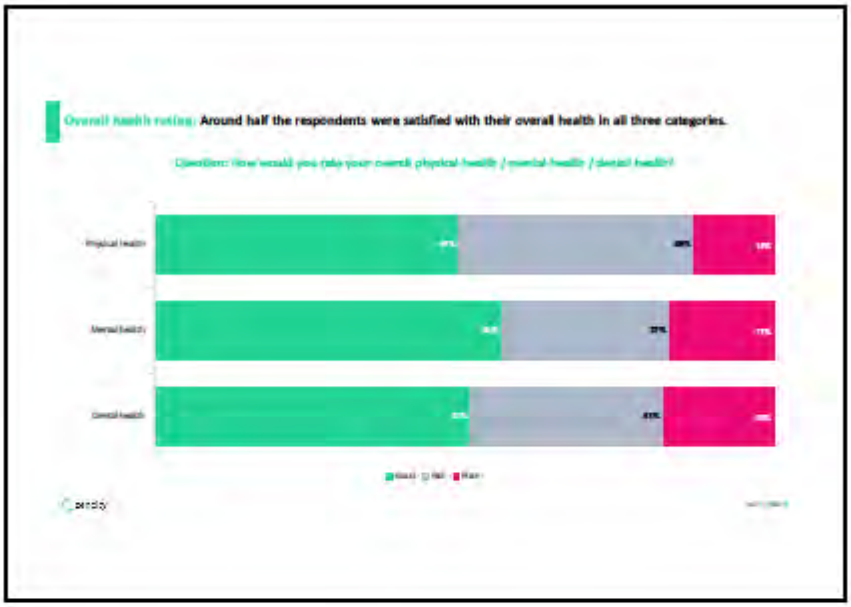
6


02
Overall Health

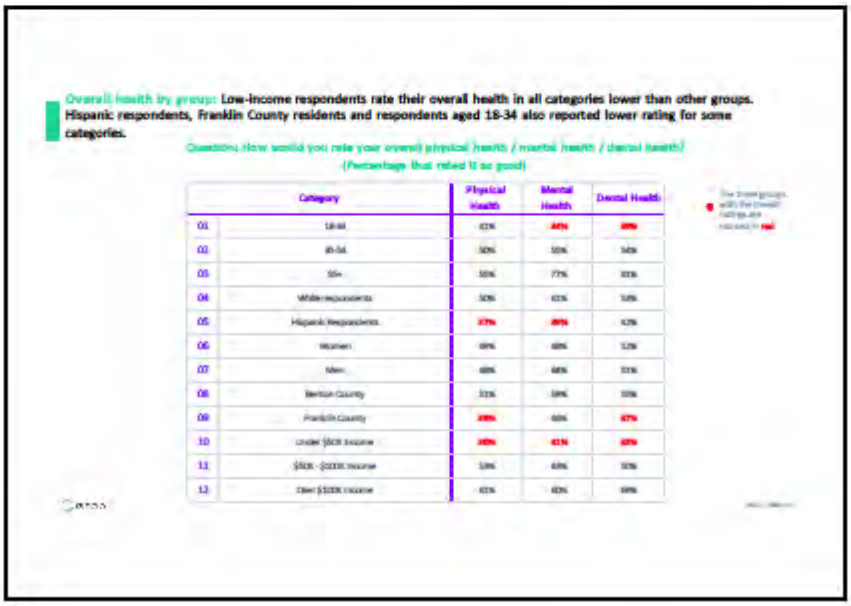
7


Overall Quality of Life: Just over half the respondents (54%) reported good overall quality of life in their community, and very few reported poor quality of life (11%). Respondents aged 18-34, Hispanic respondents and Franklin County residents reported less satisfaction with the quality of life in their communities than other groups.
Question: How would you rate the overall quality of life in your community?

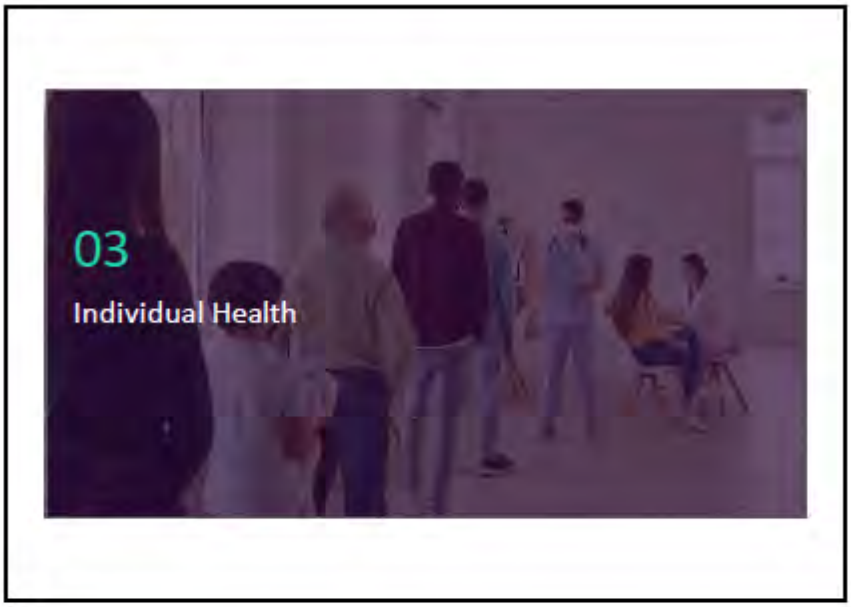
8


Overall health rating: Around half the respondents were satisfied with their overall health in all three categories.
Question: How would you rate your overall physical health / mental health / dental health?

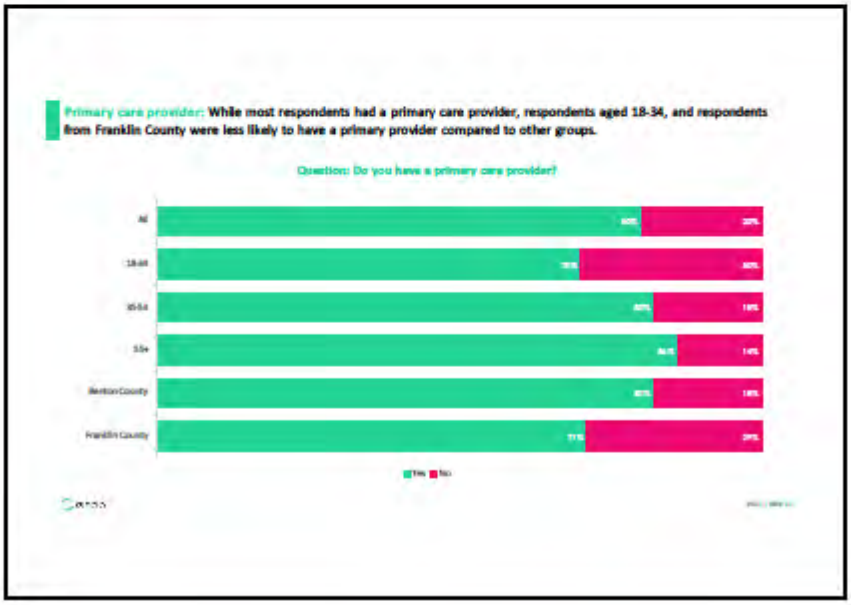
9


Overall health by group: Low-income respondents rate their overall health in all categories lower than other groups. Hispanic respondents, Franklin County residents and respondents aged 18-34 also reported lower rating for some categories.
Question: How would you rate your overall physical health / mental health / dental health?
(Percentage that rated it as good)
Category
Physical Health
Mental Health
Dental Health
01
02
03
04
05
06
07
08
09
10
11
12

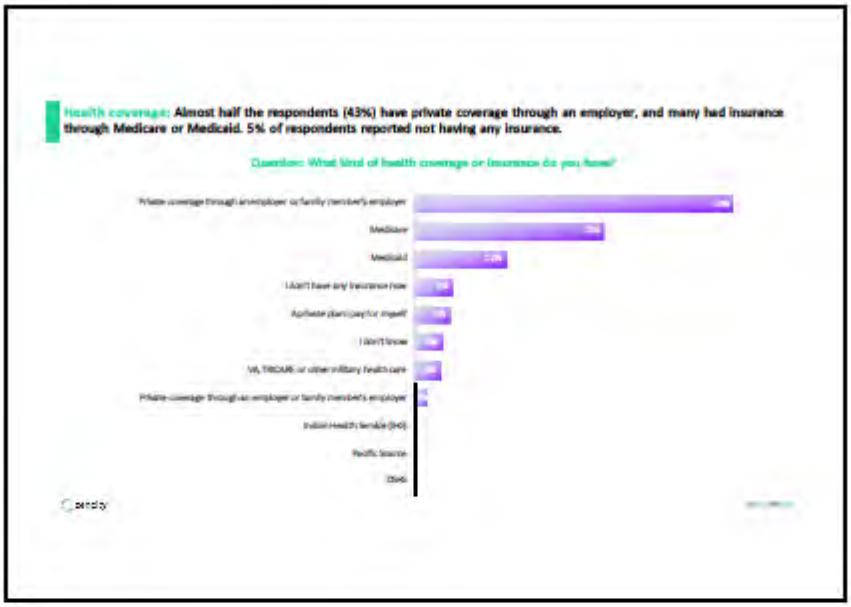
10


03
Individual Health

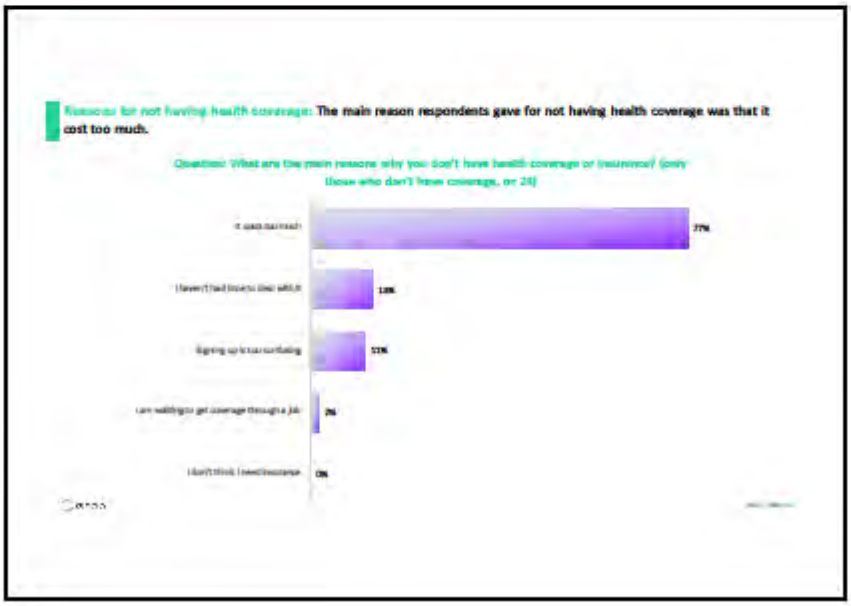
11


Primary care provider: While most respondents had a primary care provider, respondents aged 18-34, and respondents from Franklin County were less likely to have a primary provider compared to other groups.
Question: Do you have a primary care provider?
All
18-44
45-64
65+
Benton County
Franklin County
Yes
No

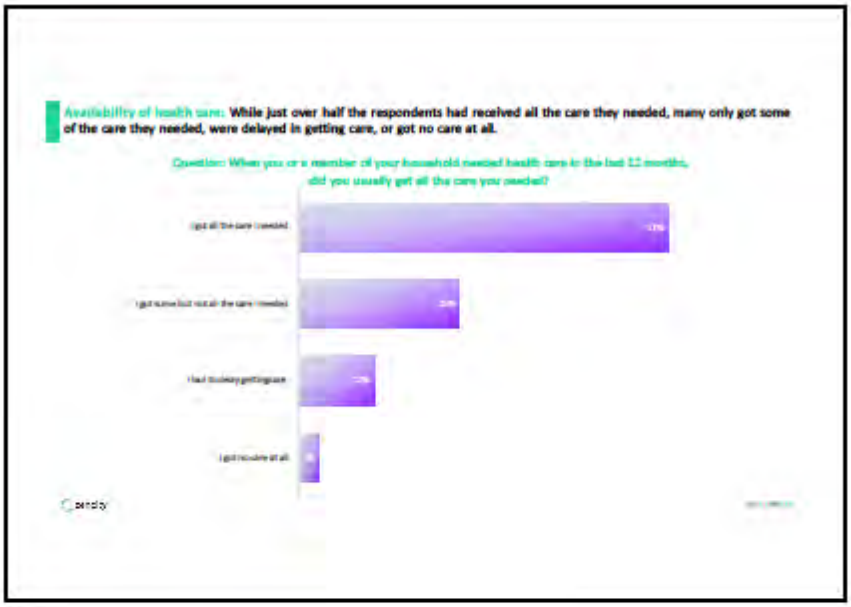
12


Health coverage: Almost half the respondents (43%) have private coverage through an employer, and many had insurance through Medicare or Medicaid. 5% of respondents reported not having any insurance.
Question: What kind of health coverage or insurance do you have?

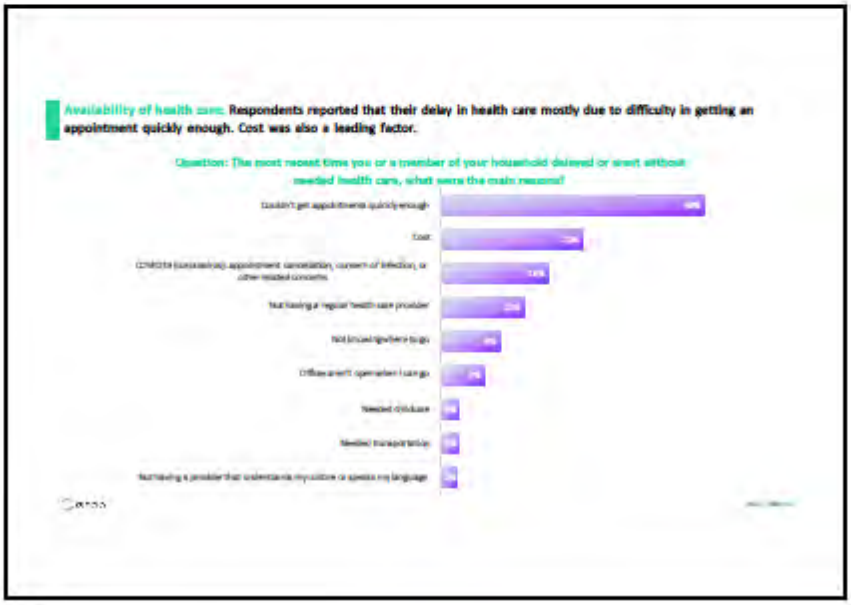
13


Reasons for not having health coverage: The main reason respondents gave for not having health coverage was that it cost too much.
Question: What are the main reasons why you don't have health coverage or insurance? (only those who don't have coverage, or 28)
37%
13%
11%
2%
0%

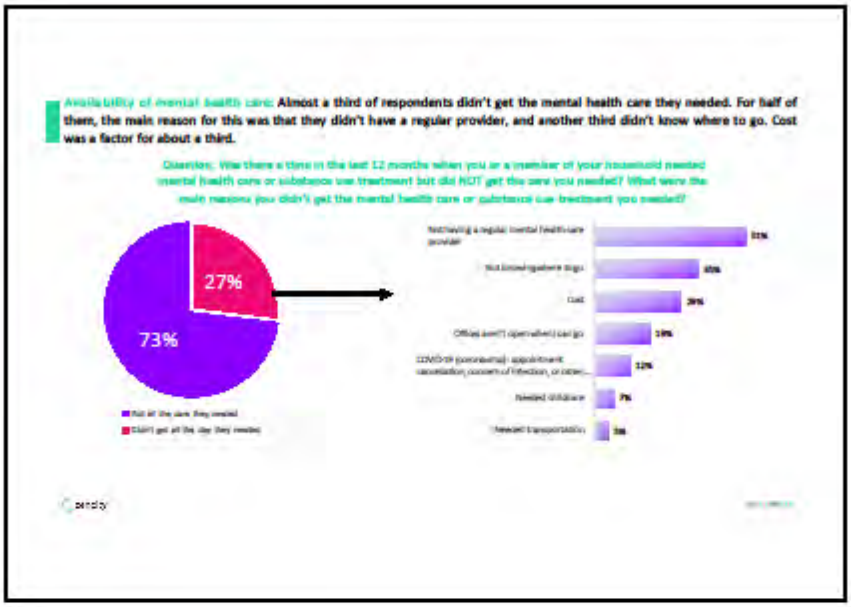
14


Availability of health care: While just over half the respondents had received all the care they needed, many only got some of the care they needed, were delayed in getting care, or got no care at all.
Question: When you or a member of your household needed health care in the last 12 months, did you usually get all the care you needed?

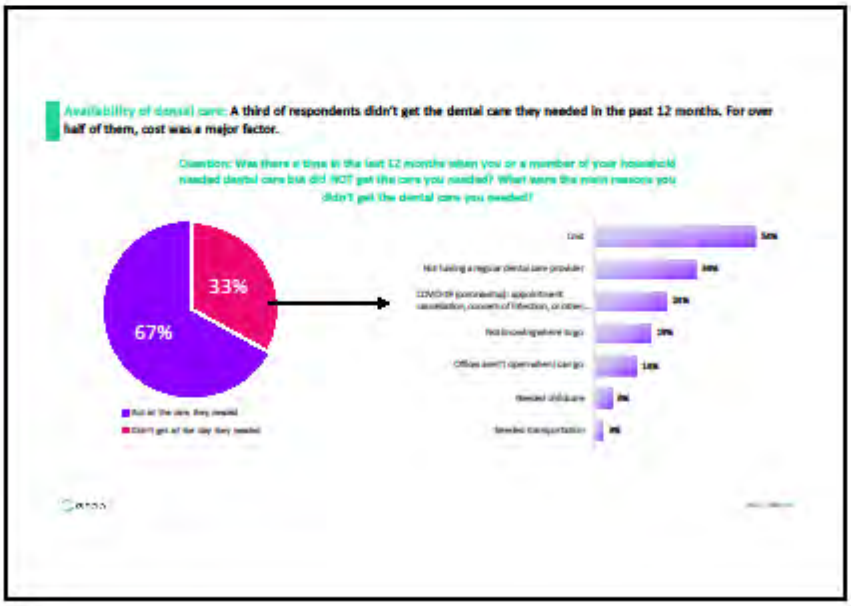
15


Availability of health care: Respondents reported that their delay in health care mostly due to difficulty in getting an appointment quickly enough. Cost was also a leading factor.
Question: The most recent time you or a member of your household delayed or went without needed health care, what were the main reasons?

16


Availability of mental health care: Almost a third of respondents didn't get the mental health care they needed. For half of them, the main reason for this was that they didn't have a regular provider, and another third didn't know where to go. Cost was a factor for about a third.
27%
73%

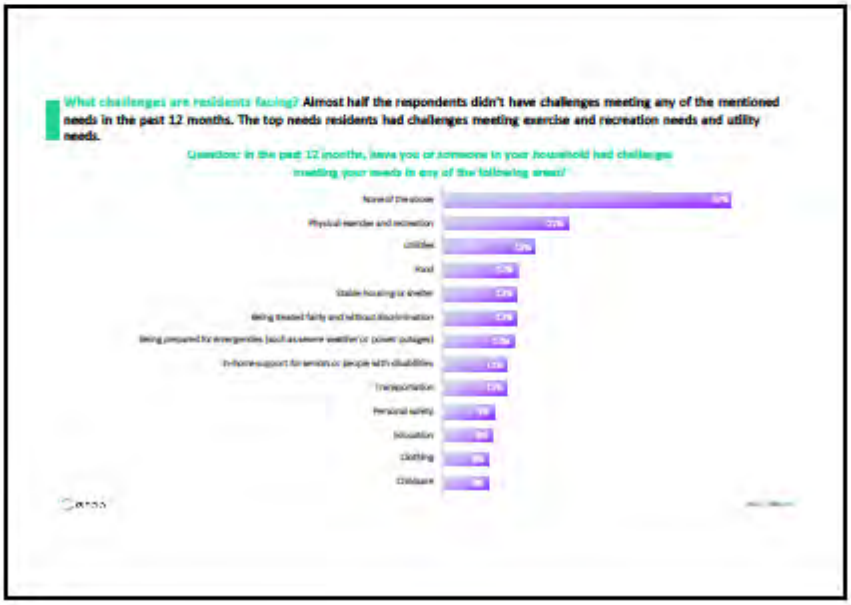
17


Availability of dental care: A third of respondents didn't get the dental care they needed in the past 12 months. For over half of them, cost was a major factor.
33%
67%

18


Availability of dental care and mental health care by group: Many low-income residents reported not getting the care they needed in all three categories.
Category
% who didn't get the physical care they need
% who didn't get the mental care they need
% who didn't get the dental care they need
01 18-44 27%
02 45-64 33%
03 65+ 24%
04 White respondents 20%
05 Hispanic Respondents 23%
06 Women 32%
07 Men 28%
08 BentonCounty 30%
09 FranklinCounty 22%
10 Under $50K income 31%
11 $50K - $100K income 30%
12 Over $100K income 24%

19


What challenges are residents facing? Almost half the respondents didn't have challenges meeting any of the mentioned needs in the past 12 months. The top needs residents had challenges meeting exercise and recreation needs and utility needs.
Question: In the past 12 months, have you or someone in your household had challenges meeting your needs in any of the following areas?

20

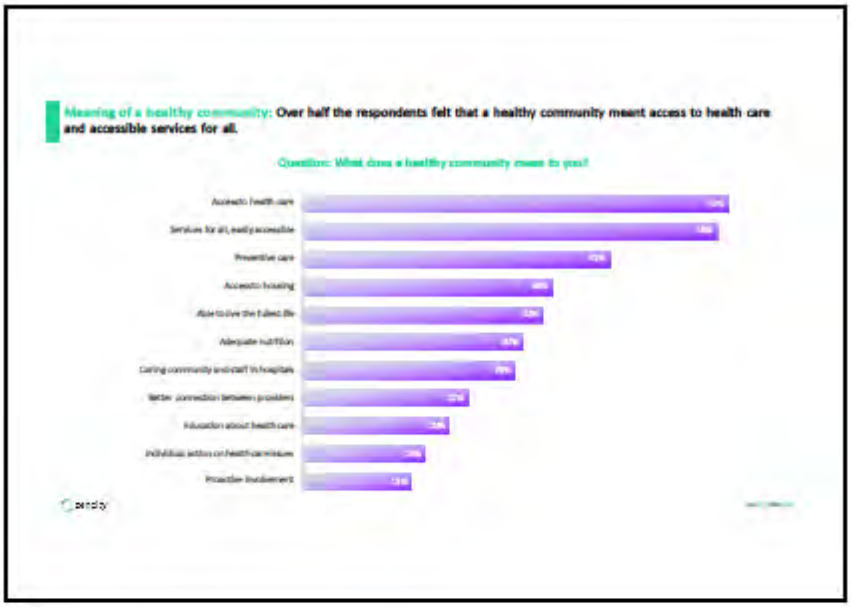
Main challenges for each group

	Category	18-34	35-54	55+	White	Hispanic	Benton County	Franklin County	Under $50K	$50K - $100K	Over $100K
01	Physical exercise and recreation	21%	24%	17%	18%	28%	20%	28%	28%	19%	14%
02	Utilities	18%	18%	8%	14%	20%	16%	12%	32%	11%	2%
03	Food	14%	16%	7%	13%	18%	15%	10%	27%	8%	4%
04	Stable housing or shelter	13%	16%	7%	12%	15%	11%	17%	26%	9%	4%
05	Being treated fairly and without discrimination	12%	15%	10%	11%	15%	13%	11%	17%	12%	8%
06	Being prepared for emergencies	13%	14%	6%	10%	15%	12%	10%	19%	11%	5%
07	In-home support for seniors or people with disabilities	6%	10%	16%	11%	9%	11%	10%	16%	12%	5%
08	Transportation	10%	10%	7%	10%	12%	11%	8%	21%	8%	5%
09	Personal safety	7%	10%	8%	9%	10%	9%	7%	12%	9%	4%
10	Education	15%	8%	2%	5%	15%	6%	17%	14%	5%	1%
11	Clothing	11%	8%	4%	6%	13%	6%	12%	19%	4%	1%
12	Childcare	12%	9%	2%	7%	12%	6%	12%	9%	9%	0%

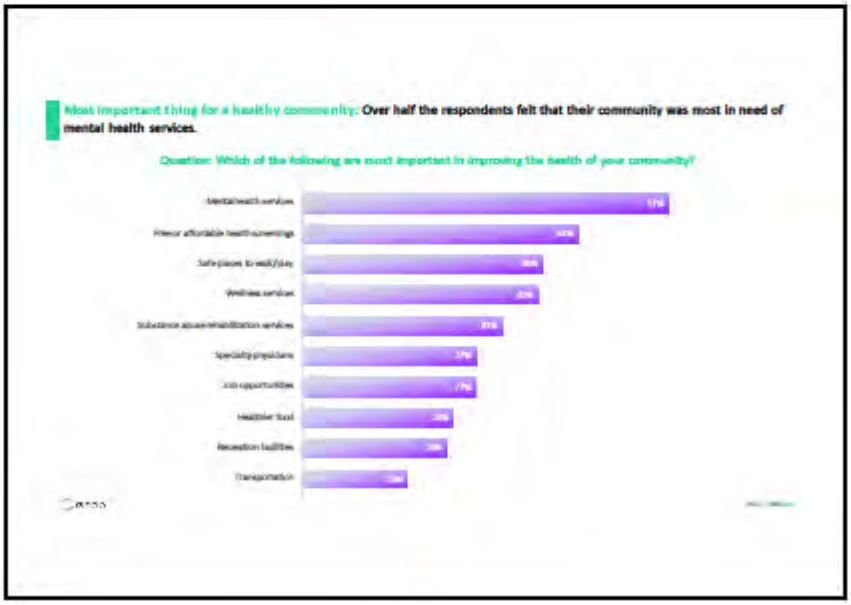
The top three challenges for each group are marked in green.

21

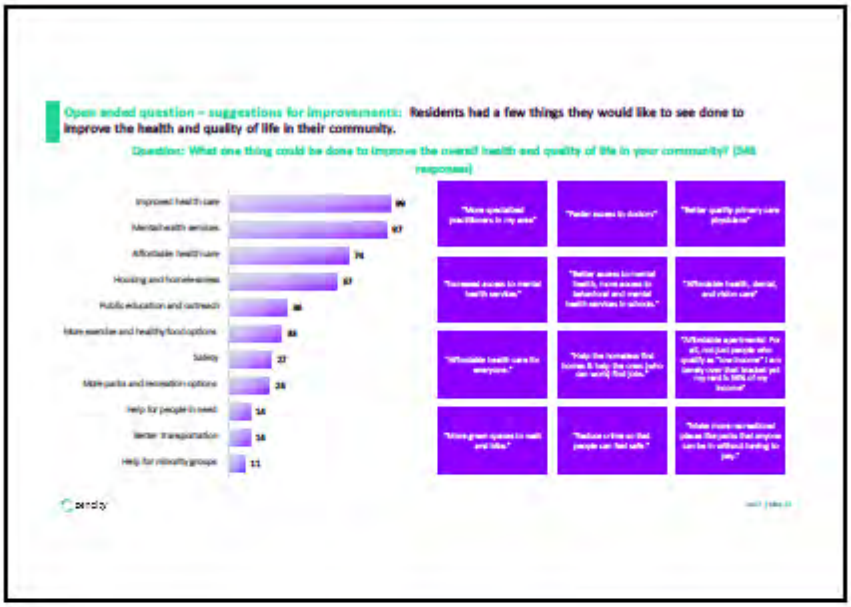
22


Meaning of a healthy community: Over half the respondents felt that a healthy community meant access to health care and accessible services for all.
Question: What does a healthy community mean to you?

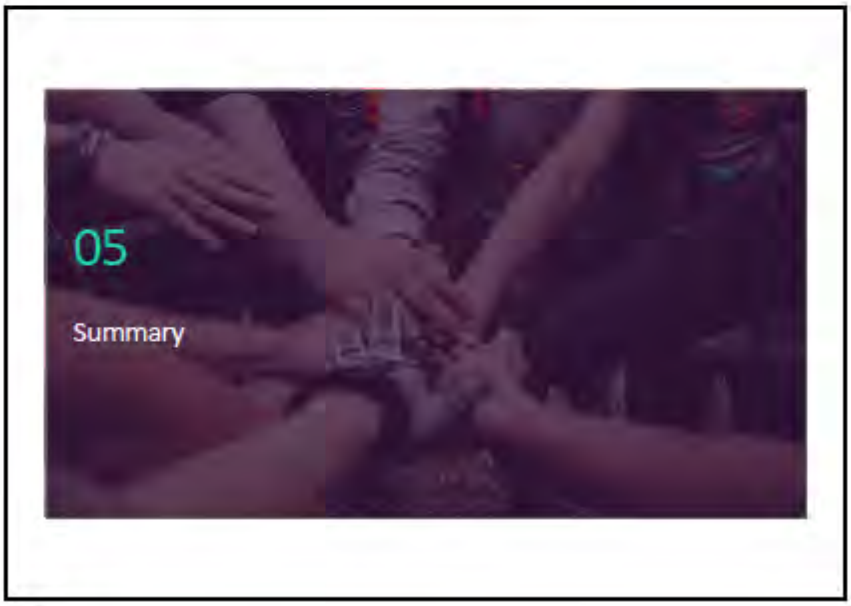
23


Most important thing for a healthy community: Over half the respondents felt that their community was most in need of mental health services.
Question: Which of the following are most important in improving the health of your community?

24


Open ended question – suggestions for improvements: Residents had a few things they would like to see done to improve the health and quality of life in their community.
Question: What one thing could be done to improve the overall health and quality of life in your community? (348 responses)
Improved health care
Mental health services
Affordable health care
Housing and homelessness
Public education and outreach
More exercise and healthy food options
Safety
More parks and recreation options
Help for people in need
Better transportation
Help for minority groups
99
97
74
67
48
44
27
26
16
16
11
"More specialized practitioners in my area"
"Faster access to doctors"
"Better quality primary care providers"
"Increased access to mental health services"
"Better access to mental health, more access to behavioral and mental health services in schools."
"Affordable health, dental, and vision care"
"Affordable health care for everyone."
"Help the homeless find homes & help the ones [who] can work find jobs."
"Affordable apartments. For all, not just people who qualify as "low income" I am barely over that bracket yet my rent is 50% of my income"
"More green spaces to walk and hike."
"Reduce crime so that people can feel safe."
"Make more recreational places that parks that anyone can be in without having to pay."

25


05
Summary

26

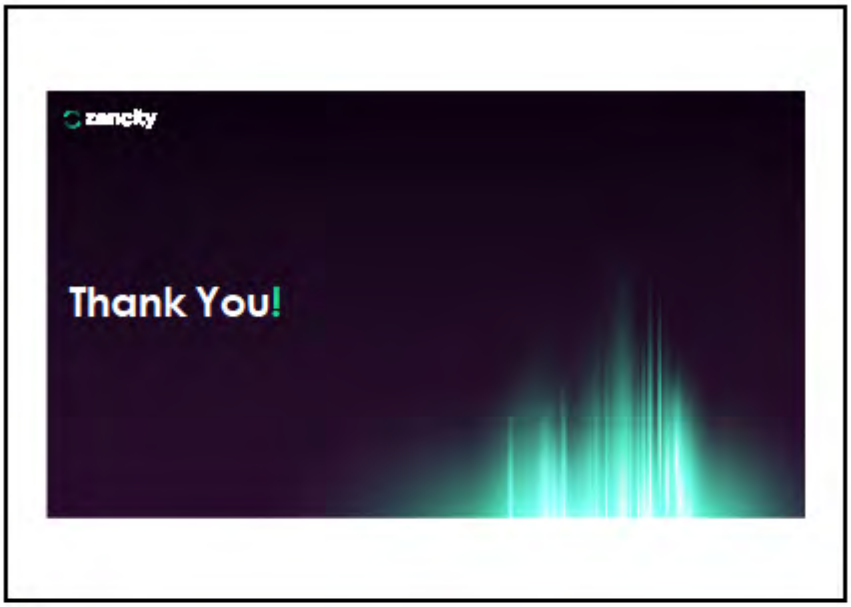

Summary - Individual Health
Physical health
Mental health
Dental health
Physical health
Mental health
Dental health
28%
38%
21%
17%
51%
33%
54%

27


Summary - Community Health
What is a healthy community?
What is most important for improving community health?
Suggestions for improvement
5.7%
56%
5.7%
40%

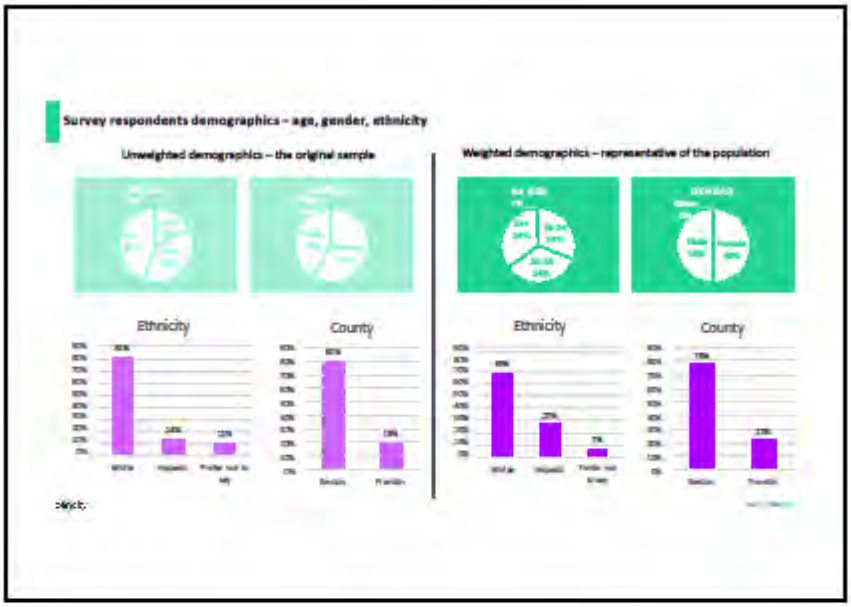
28

14

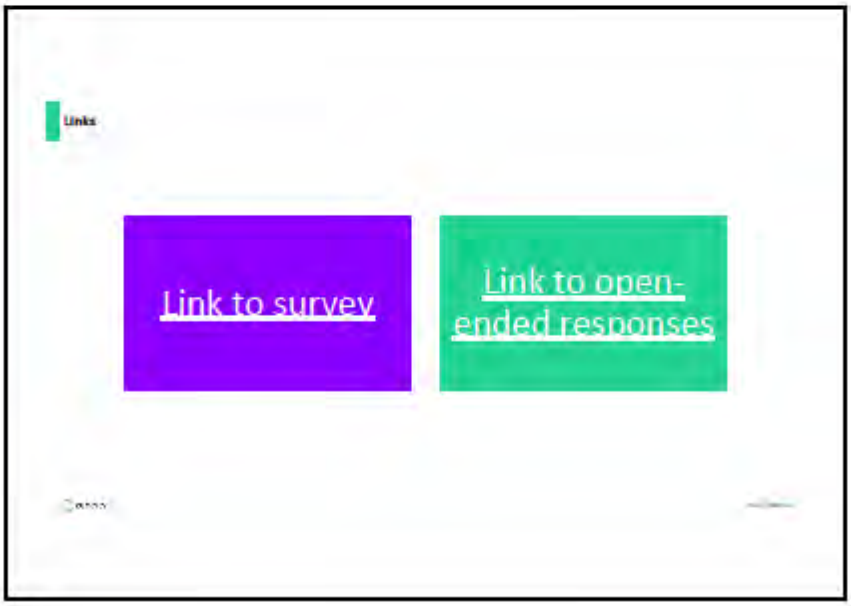


29

30


Survey respondents demographics – age, gender, ethnicity
Unweighted demographics – the original sample
Weighted demographics – representative of the population
Ethnicity
County
Ethnicity
County

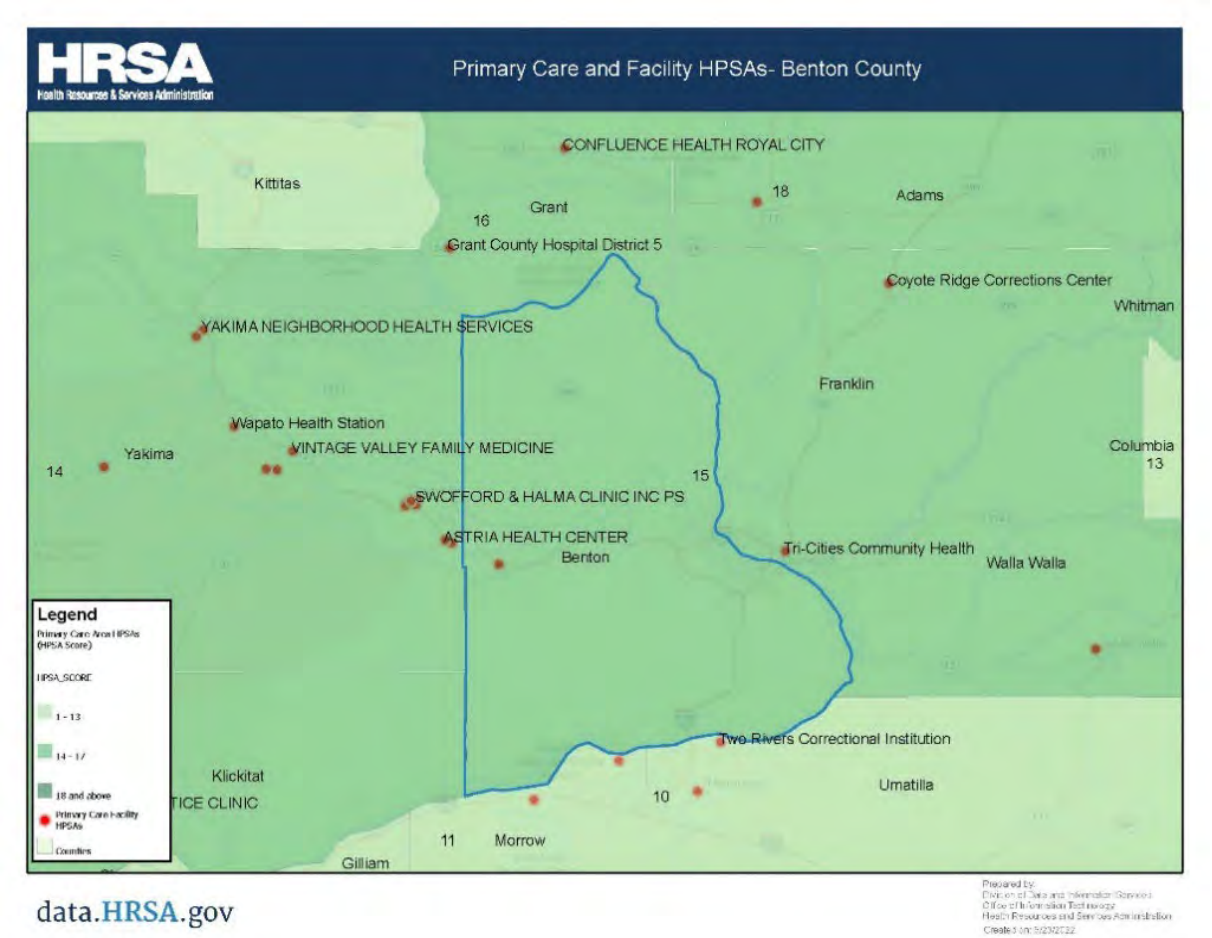
31

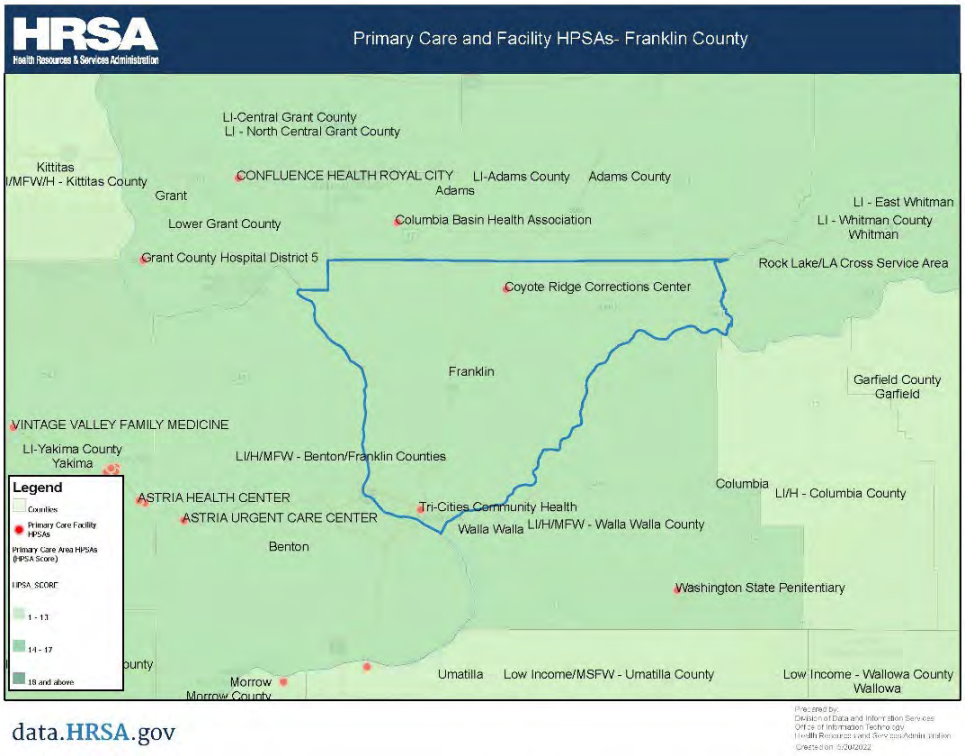

Links
Link to survey
Link to open-ended responses

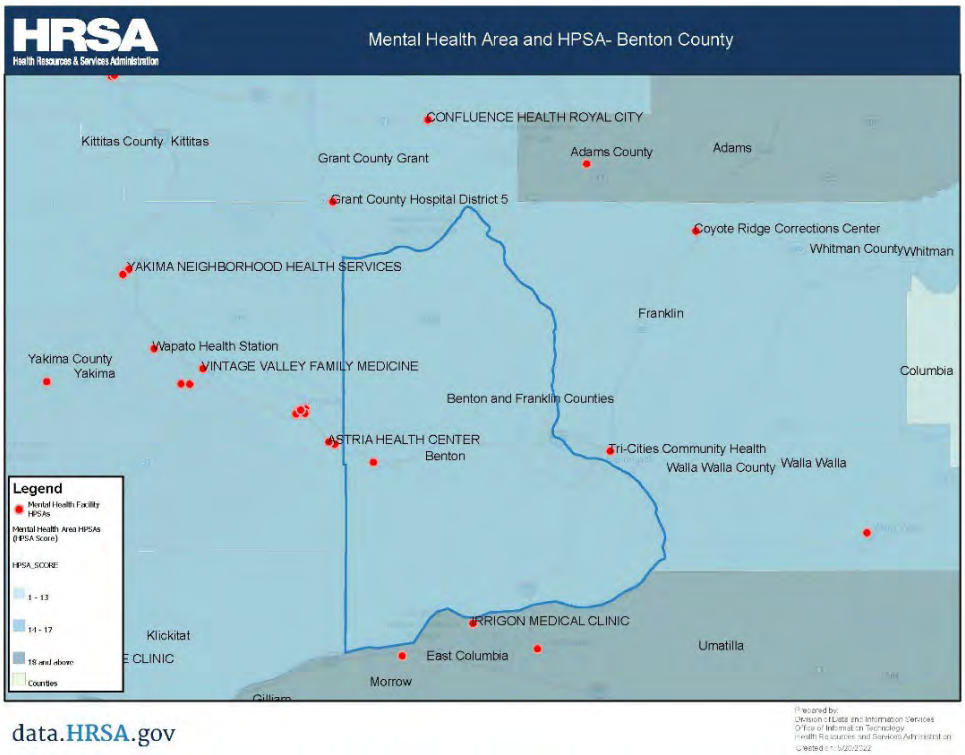
32

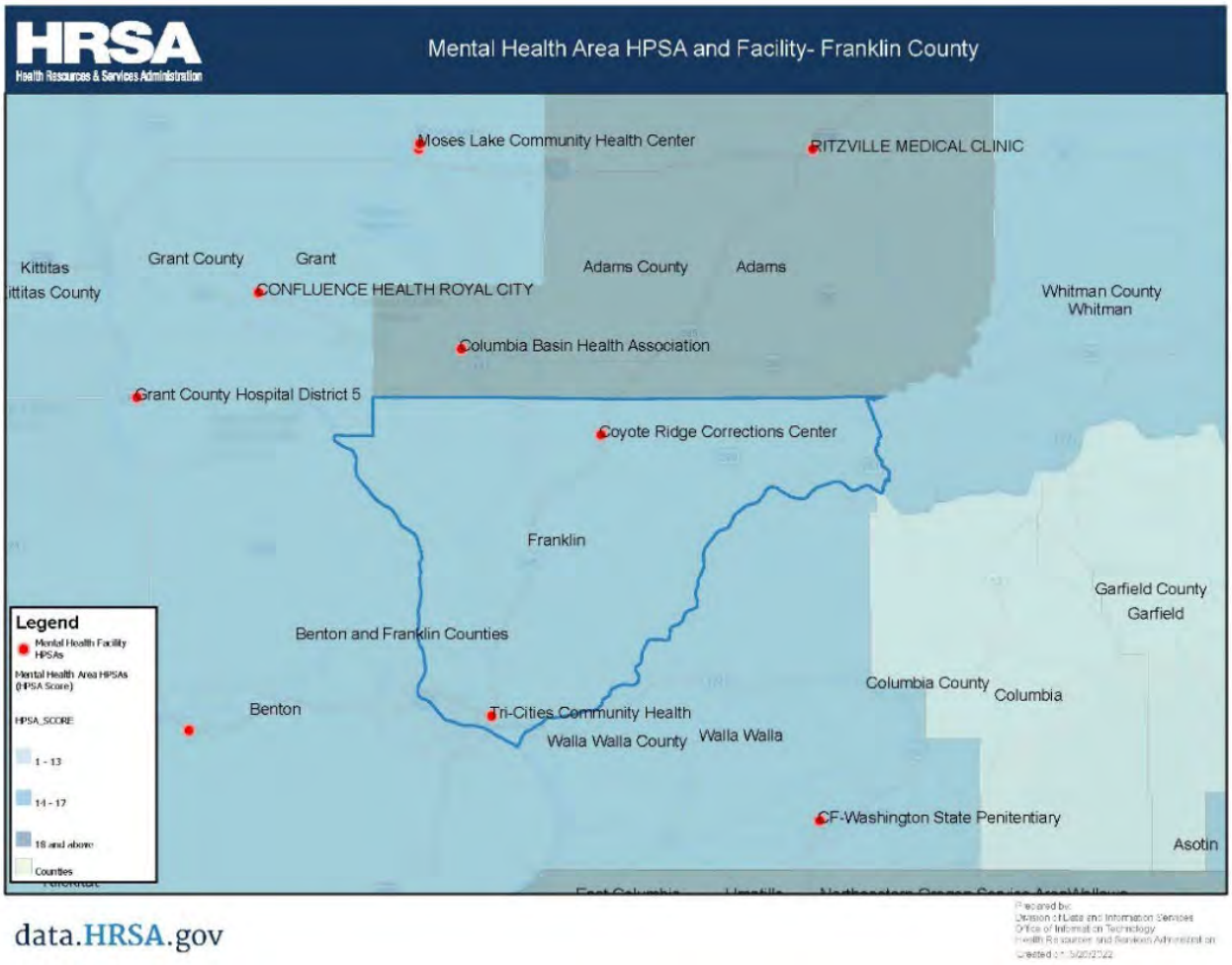
HEALTH PROFESSIONAL SHORTAGE AREA

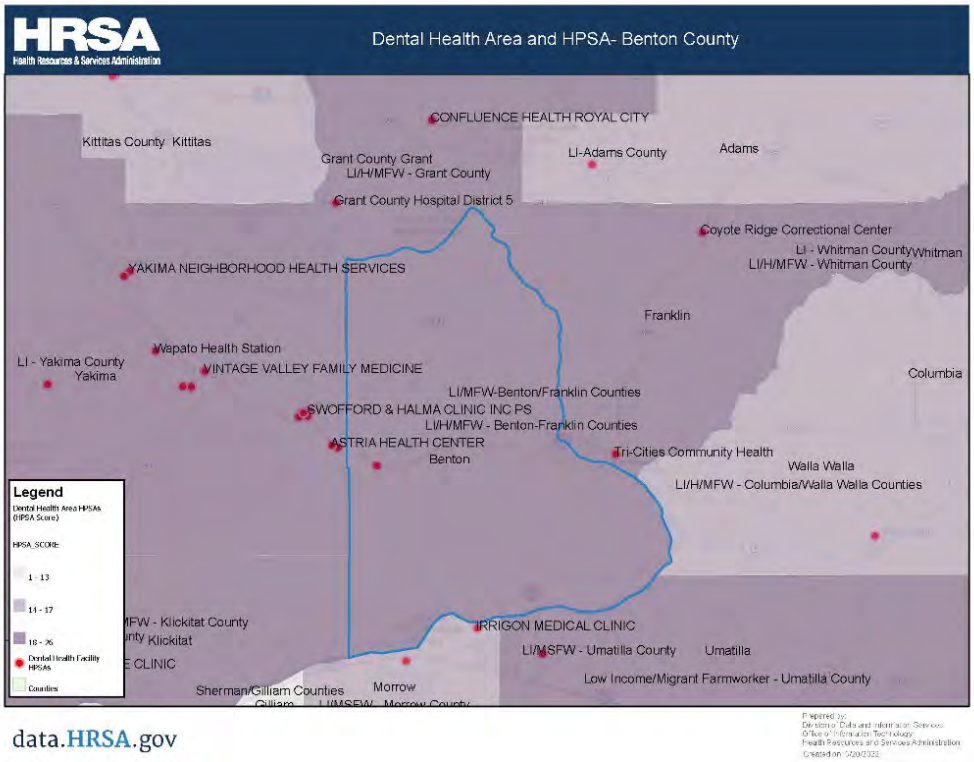
The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas HPSAs) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Benton and Franklin Counties are HPSAs as depicted on the maps below.

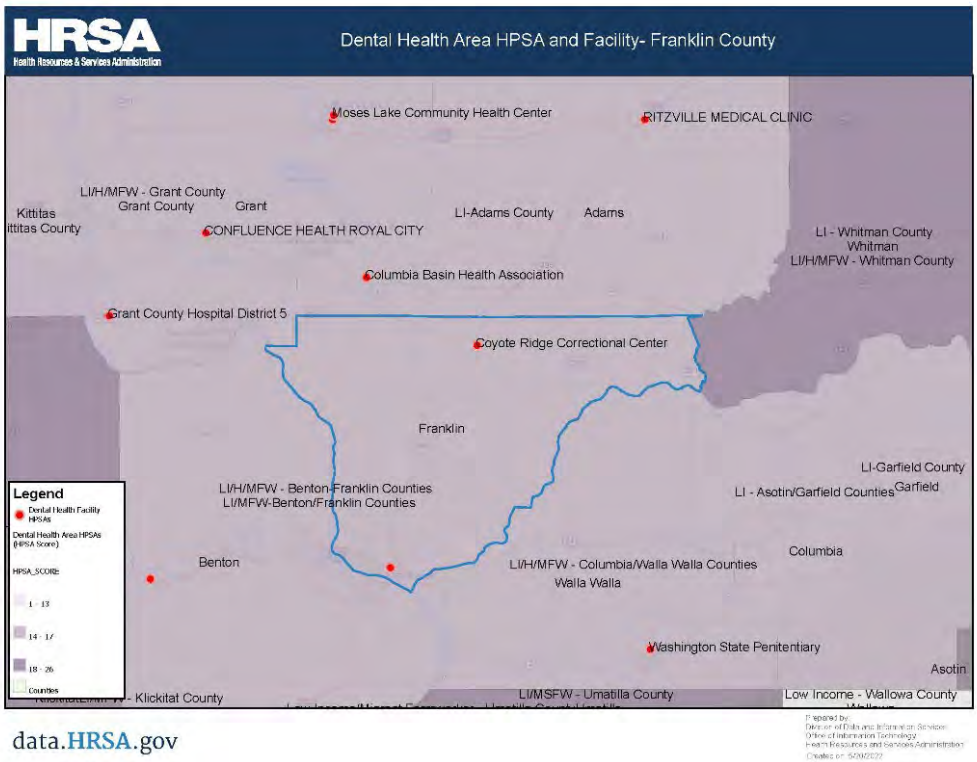



HRSA
Health Resources & Services Administration
Primary Care and Facility HPSAs- Franklin County
LI-Central Grant County
LI - North Central Grant County
Kittitas
I/MFW/H - Kittitas County
CONFLUENCE HEALTH ROYAL CITY
LI-Adams County
Adams County
Adams
Grant
Lower Grant County
Columbia Basin Health Association
LI - East Whitman
LI - Whitman County
Whitman
Grant County Hospital District 5
Rock Lake/LA Cross Service Area
Coyote Ridge Corrections Center
Franklin
Garfield County
Garfield
VINTAGE VALLEY FAMILY MEDICINE
LI-Yakima County
Yakima
LI/H/MFW - Benton/Franklin Counties
Columbia
LI/H - Columbia County
ASTRIA HEALTH CENTER
ASTRIA URGENT CARE CENTER
Tri-Cities Community Health
Walla Walla
LI/H/MFW - Walla Walla County
Benton
Washington State Penitentiary
Legend
Counties
Primary Care Facility HPSAs
Primary Care Area HPSAs (HPSA Score)
HPSA SCORE
1 - 13
14 - 17
18 and above
Morrow
Morrow County
Umatilla
Low Income/MSFW - Umatilla County
Low Income - Wallowa County
Wallowa
data.HRSA.gov


HRSA
Health Resources & Services Administration
Mental Health Area and HPSA- Benton County
CONFLUENCE HEALTH ROYAL CITY
Kittitas County
Kittitas
Grant County
Grant
Adams County
Adams
Grant County Hospital District 5
Coyote Ridge Corrections Center
Whitman County
Whitman
YAKIMA NEIGHBORHOOD HEALTH SERVICES
Franklin
Wapato Health Station
Yakima County
Yakima
VINTAGE VALLEY FAMILY MEDICINE
Columbia
Benton and Franklin Counties
ASTRIA HEALTH CENTER
Benton
Tri-Cities Community Health
Walla Walla County
Walla Walla
Legend
Mental Health Facility HPSAs
Mental Health Area HPSAs (HPSA Score)
HPSA SCORE
1 - 13
14 - 17
18 and above
Counties
Klickitat
IRRIGON MEDICAL CLINIC
Umatilla
East Columbia
Morrow
data.HRSA.gov

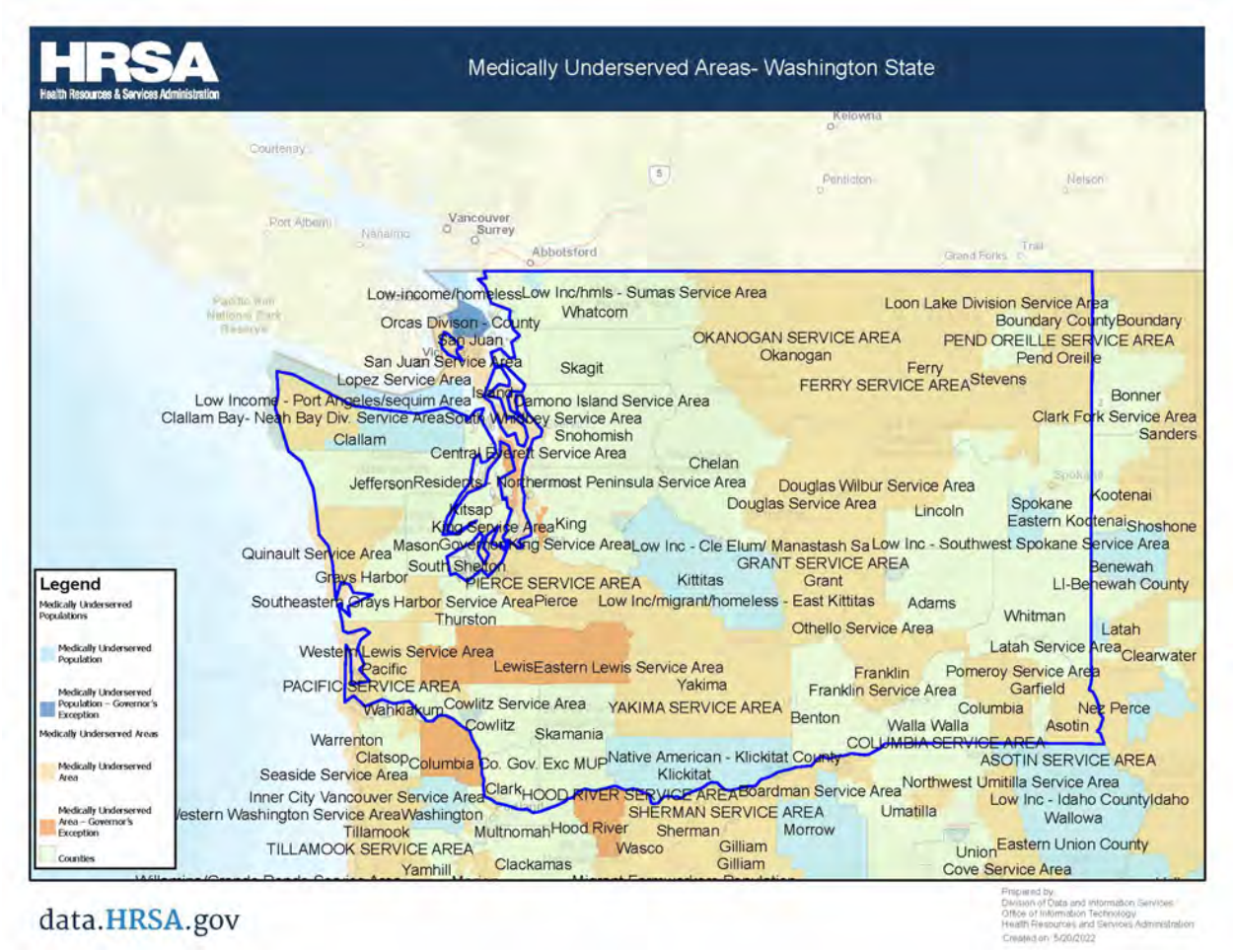

HRSA
Health Resources & Services Administration
Mental Health Area HPSA and Facility- Franklin County
Moses Lake Community Health Center
RITZVILLE MEDICAL CLINIC
Kittitas
ittitas County
Grant County
Grant
CONFLUENCE HEALTH ROYAL CITY
Adams County
Adams
Whitman County
Whitman
Columbia Basin Health Association
Grant County Hospital District 5
Coyote Ridge Corrections Center
Franklin
Garfield County
Garfield
Legend
Mental Health Facility HPSAs
Mental Health Area HPSAs (HPSA Score)
HPSA_SCORE
1 - 13
14 - 17
18 and above
Counties
Benton and Franklin Counties
Columbia County
Columbia
Benton
Tri-Cities Community Health
Walla Walla County
Walla Walla
CF-Washington State Penitentiary
Asotin
data.HRSA.gov


HRSA
Health Resources & Services Administration
Dental Health Area and HPSA- Benton County
CONFLUENCE HEALTH ROYAL CITY
Kittitas County Kittitas
Grant County Grant
LI/H/MFW - Grant County
LI-Adams County
Adams
Grant County Hospital District 5
Coyote Ridge Correctional Center
LI - Whitman County
LI/H/MFW - Whitman County
YAKIMA NEIGHBORHOOD HEALTH SERVICES
Franklin
Wapato Health Station
LI - Yakima County
Yakima
VINTAGE VALLEY FAMILY MEDICINE
Columbia
LI/MFW-Benton/Franklin Counties
SWOFFORD & HALMA CLINIC INC PS
LI/H/MFW - Benton-Franklin Counties
ASTRIA HEALTH CENTER
Benton
Tri-Cities Community Health
Walla Walla
LI/H/MFW - Columbia/Walla Walla Counties
Legend
Dental Health Area HPSAs (HPSA Score)
HPSA_SCORE
1 - 13
14 - 17
18 - 26
Dental Health Facility HPSAs
Counties
IRRIGON MEDICAL CLINIC
LI/MSFW - Umatilla County
Umatilla
Low Income/Migrant Farmworker - Umatilla County
Sherman/Gilliam Counties
Morrow
data.HRSA.gov


HRSA
Health Resources & Services Administration
Dental Health Area HPSA and Facility- Franklin County
Moses Lake Community Health Center
RITZVILLE MEDICAL CLINIC
LI/H/MFW - Grant County
Grant County
Grant
Kittitas
Kittitas County
LI-Adams County
Adams
CONFLUENCE HEALTH ROYAL CITY
LI - Whitman County
Whitman
LI/H/MFW - Whitman County
Columbia Basin Health Association
Grant County Hospital District 5
Coyote Ridge Correctional Center
Franklin
LI-Garfield County
Garfield
LI - Asotin/Garfield Counties
LI/H/MFW - Benton-Franklin Counties
LI/MFW-Benton/Franklin Counties
Legend
Dental Health Facility HPSAs
Dental Health Area HPSAs (HPSA Score)
HPSA_SCORE
1 - 13
14 - 17
18 - 26
Counties
Benton
Columbia
LI/H/MFW - Columbia/Walla Walla Counties
Walla Walla
Washington State Penitentiary
Asotin
LI/MSFW - Umatilla County
Low Income - Wallowa County
Klickitat County
data.HRSA.gov

MEDICALLY UNDERSERVED AREA/ MEDICAL PROFESSIONAL SHORTAGE AREA

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of health care services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled and with national averages to determine an area's level of medical "under service." MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set and no renewal process is necessary. The following map depicts Franklin County as a MUA. Benton County and Franklin County are not identified as having MUPs.



Appendix 2: Community Input

INTRODUCTION

Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, as these individuals have firsthand knowledge of the needs and strengths of the community. The Benton-Franklin CHNA Collaborative conducted 21 interviews with working partners and community collaborators (partners), including 33 participants. Partners are defined as people who are invested in the well-being of the community and have first-hand knowledge of community needs and strengths. They also conducted 10 listening sessions with 67 community members. The goal of the interviews and listening sessions was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs.

METHODOLOGY

Selection

The Benton-Franklin CHNA Collaborative completed 10 listening sessions that included a total of 67 participants. The sessions took place between March 30 and May 26, 2022.

Table_Apx 1: Community Input

Community Input Type and Population	Location of Session	Date	Language
Listening session with older adults	Senior Life Resources/ Meal on Wheels	5/11/2022	English
Listening session with college students	Virtual	5/4/2022	English
Listening session with youth experiencing homelessness	Virtual with My Friends' Place	4/6/2022	English
Listening session with men experiencing homelessness	Tri-City Union Gospel Mission	3/30/2022	English
Listening session with Spanish-speaking men experiencing homelessness	Tri-City Union Gospel Mission	3/30/2022	Spanish
Listening session with women experiencing homelessness	Women's Shelter of the Tri-City Union Gospel Mission	3/30/2022	English
Listening session with veterans	Virtual	5/5/2022	English
Listening session with people whose family members are or were living with mental illness and SUD as well as people living with mental illness	Virtual with NAMI	5/26/2022	English
Listening session with parents of students in the Migrant Program	Kennewick School District Admin Building	5/12/2022	Spanish
Listening session with parents of children and adults with developmental disabilities	The Arc of Tri-Cities	5/19/2022	English

The collaborative conducted 21 partner interviews including 33 participants overall between March and April 2022. Partners were selected based on their knowledge of the community and engagement in work that directly serves people experiencing health disparities and social inequities. The Benton-Franklin CHNA Collaborative aimed to engage partners from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives.

Table_Apx 2. Key Community Partner Participants

#	Organization	Name	Title	Sector
1	Arc of Tri-Cities	Donna Tracy	Program Manager	Intellectual and developmental disabilities
	Arc of Tri-Cities	Melissa Brooks, RN	Parent to Parent Coordinator	
2	Benton County Department of Human Services	Kyle Sullivan	Manager	Developmental disabilities, community resources, emergency services, housing, veteran's resources
3	Boys and Girls Clubs of Benton and Franklin Counties	Brian Ace	Executive Director	Education, preschool, childcare
4	Columbia Basin College	Dr. Rebekah Woods, JD, PhD	President	Education, college, health care workforce development
	Columbia Basin College	Douglas Hughes, MAE-CI, CSFA, CST, CRCST	Dean: School of Health Sciences	
5	Community Health Plan of Washington City of Pasco	Blanche Barajas	Outreach Specialist Mayor	Health insurance City government
	Pasco Fire Department/ EMS	Ben Shearer	Community Risk Reduction Specialist	Emergency services
6	Family Learning Center	Teresa Roosendaal	Executive Director	Education, ESL, refugee services
7	Greater Columbia Behavioral Health Youth Suicide Prevention Coalition	Cameron Fordmeir	Regional Administrator for the Substance Use Disorder Recovery Navigator Program Chair	Mental health, substance use/misuse
8	HPMC Occupational Medical Services	Karen Phillips, MD	Site Occupational Medical Director	Occupational medicine, environmental safety, Hanford workers
	HPMC Occupational Medical Services	Audrey Wright	Health Education Specialist	

9	Kennewick Police Department	Chris Guerrero	Kennewick Police Chief	Law enforcement, emergency services
10	Kennewick School District	Brian Leavitt	K-12 Student Services Director	Education
	Kennewick School District	Alyssa St. Hilaire	Director of Federal Programs	
	Kennewick School District	Traci Pierce	Superintendent	
	Kennewick School District	Robyn Chastain	Executive Director, Communications and Public Relations	
11	Kiona-Benton City School District	Pete Peterson	Superintendent	Education
12	Lourdes Health	Joan White-Wagoner	CEO	Health care
	Trios Health	John Solheim	CEO	
13	North Franklin School District	Jim Jacobs	Superintendent	Education
14	Prosser Memorial Health	Craig Marks	CEO	Health care
	Prosser Memorial Health	Kristi Mellema	Chief Safety Officer	
15	Senior Life Resources Northwest	Grant Baynes	Executive Director	Senior supportive care services, older adults
16	Tri-Cities Hispanic Chamber of Commerce Heritage University	Martin Valadez	Executive Director Regional Director Tri-Cities Campus	Commerce, Latino/a community Education, university
17	Tri-City Development Council (TRIDEC)	Karl Dye	CEO	Economic development, business, tourism
	Visit Tri-Cities	Michael Novakovich	CEO	
18	Tri-City Union Gospel Mission	Susan Campbell, RN	Tri-City Union Gospel Mission Volunteer	Homelessness
19	Two Rivers Health District, Kennewick Public Hospital District	Gary Long	President	Health care
	Two Rivers Health District, Kennewick Public Hospital District	Wanda Briggs	Commissioner	
20	United Way of Benton and Franklin Counties	Dr. LoAnn Ayers	President and CEO	Community resources, food security, education
	United Way of Benton and Franklin Counties	Paul Klein	Director of Community Impact	
21	Yakima Valley Farm Workers Clinics (locally known as Miramar)	Micheal Young	Vice President of Operations East	Community health center, health care

Facilitation Guides

For the listening sessions, participants were asked an icebreaker and three questions (see Listening Session Questions for the full list of questions):

- Community members' definitions of health and well-being
- The community needs
- The community strengths

For the partner interviews, Providence developed a facilitation guide that was used across all hospitals completing their 2022 CHNAs (see Partner Interview Questions for the full list of questions):

- The community served by the partner's organization
- The community strengths
- Prioritization of unmet health related needs in the community, including social determinants of health
- The COVID-19 pandemic's effects on community needs
- Suggestions for how to leverage community strengths to address community needs
- Successful community health initiatives and programs
- Opportunities for collaboration between organizations

Training

The facilitation guides provided instructions on how to conduct a partner interview and listening session, including basic language on framing the purpose of the sessions. Facilitators participated in trainings on how to successfully facilitate a partner interview and listening session and were provided question guides.

Data Collection

Partner interviews were conducted virtually and recorded with the participant's permission. Two note takers documented the listening session conversations.

Analysis

Qualitative data analysis was conducted by Providence using Atlas.ti, a qualitative data analysis software. The data were coded into themes, which allows the grouping of similar ideas across the interviews, while preserving the individual voice.

The recorded interviews were sent to a third party for transcription. The analyst listened to all audio files to ensure accurate transcription. The partner names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti. The analyst read through the notes and developed a preliminary list of codes, or common topics that were mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded eight domains relating to the topics of the questions: 1) name, title, and organization of partner, 2) population served by organization, 3) greatest community strength and opportunities to leverage these strengths 4)

unmet health-related needs, 5) disproportionately affected population, 6) effects of COVID-19, 7) successful programs and initiatives, and 8) opportunities to work together.

The analyst then coded the information line by line. All information was coded, and new codes were created as necessary. All quotations, or other discrete information from the notes, were coded with a domain and a theme. Codes were then refined to better represent the information. Codes with only one or two quotations were coded as "other," and similar codes were groups together into the same category. The analyst reviewed the code definitions and revised as necessary to best represent the information included in the code.

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. The analyst used the query tool and the co-occurrence table to better understand which codes were used frequently together. For example, the code "food insecurity" can occur often with the code "obesity." Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

This process was repeated for the listening sessions, although rather than recordings, notes were used. The analyst coded three domains related to the topics of the questions: 1) vision, 2) needs, and 3) strengths.

FINDINGS FROM COMMUNITY LISTENING SESSIONS

Vision of a Health Community

Listening session participants were asked to share their vision of a health community. The following themes emerged:

- **Community engagement and connection:** In a healthy community there is a sense of engagement and willingness to work together to help one another. People are working together towards common goals, having meaningful conversations, and volunteering. They work to build community and put in the effort to care for one another, including keeping one another safe from COVID-19.
- **Easy access to health care, including mental health services, for everyone**: Community members shared that in a healthy community everyone has access to health care services, including mental health care. No one is turned away and people are treated with compassion. They shared people should be able to get the care they need in a timely manner and care should be patient centered.
- **Safety**: Many community members spoke to the importance of feeling safe in their community. Part of feeling safe is addressing crime and substance use on the streets. Some members also thought having a good police presence indicates a healthy community.
- **Diversity, inclusion, and respect**: Community members spoke to the importance of all people being accepted and having a united community. They shared that a healthy community is diverse and welcoming of people. Specifically people with disabilities are able to engage meaningfully and safely in the community.

- **Opportunities for recreation and a healthy lifestyle**: Community members shared people should have opportunities for recreation and a physically, spiritually, and emotionally healthy lifestyle. They can exercise and eat healthy food, as well as care for their spirituality. Their physical environment, including the water and air, also promotes health.
- **Economic security, including affordable housing and employment:** In a healthy community everyone has access to affordable housing, employment opportunities, and education.

Community Needs

High priority community needs identified from listening sessions

- **Mental health:** Mental health was the most frequently discussed need by community members. Their primary concern was how challenging it can be to find a mental health provider accepting new patients and covered by one's insurance. Long wait times, potentially caused by staffing shortages, means many people have unmet mental health needs. There is also a need for improved services for people in crisis, such as mobile outreach—a service which has been discontinued. The following populations were identified as having unmet needs:
    - Veterans: There are a lack of local providers who take VA patients. It can be challenging for veterans to get mental health services until in crisis.
    - Spanish-speaking people: There is a need for more mental health services in Spanish, including group therapy in Spanish.
    - Young people: It can be very challenging for young people to access mental health appointments. There is a lack of inpatient facilities for young people, meaning they often have to travel to other parts of the state far from their families. Participants spoke to the importance of more screening for mental health needs and teaching coping skills in schools.
    - Older adults: To address social isolation, there is a need for more prosocial activities for older adults. It is also important the community foster opportunities to demonstrate that older adults matter and belong.
- **Homelessness and housing instability:** Participants shared housing is expensive and there is a lack of affordable and low-income housing. Applying to rent an apartment is time intensive and requires resources. Participants noted additional challenges for the following populations:
    - Young people: Young people often need a cosigner to rent an apartment, which is challenging for those without support. There is a need for more resources for young people looking for housing.
    - People with developmental disabilities: There is a need for more independent housing for people with developmental disabilities. It is currently a crisis-driven housing system.
    - Older adults: To remain in their homes, older adults often need support, including help with upkeep and safety checks. The rising cost of housing can be challenging for older adults, noting a need for discounts.
- **Access to health care services:** Participants were particularly concerned about challenges accessing timely and affordable primary and specialty care because of long wait times and

provider turnover. Patients with Medicaid or those uninsured have fewer options for care. Everyone should have access to health care insurance. They discussed the need for more culturally responsive health care services, and providers with empathy for patients' situations. They shared there are specific challenges in accessing responsive and timely care for the following groups:

  - Young people, including those estranged from guardians, experiencing houselessness, and/or identifying as LGBTQIA+: Young people estranged from a guardian cannot access crucial health care services due to lack of parental consent. There is a need for providers to be more aware of the "Mature Minor" law. Young people, particularly those experiencing homelessness or identifying as LGBTQIA+, spoke to not always receiving respectful care and feeling judged by providers. There is a need for LGBTQIA+ specific health resources, including Hormone Replacement Therapy, and for providers to be better educated on how to provide respectful and competent care to this group.
  - People with developmental disabilities: Participants spoke to the need for more local providers with training in treating people with developmental disabilities. There is a need for more accommodations at hospitals and healthcare facilities to support these families.
  - Veterans: There is a need for improved continuity of care for veterans being discharged from the VA. The nearest permanent VA medical facilities are in Walla Walla, Yakima, and Spokane.

- **Substance use/misuse:** Participants were particularly concerned about the lack of detox services in the community, noting the need for a detox center locally. They were also concerned about their perception of increased substance use/misuse by people on the street and living unhoused.

Medium priority community needs identified from listening sessions

- **Community resources:** Participants shared there needs to be more communication about available programs and resources in the community, through a variety of channels. They mentioned the importance of not only sharing information online but through additional methods. This may require more intentional outreach.
- **Safety:** Community members spoke to concerns about an increase in crime and concerns about safety. In particular, they were worried about theft, people carrying weapons close to schools, substance use in public, and gangs. They noted wanting to see faster response times from first responders and some participants shared wanting to see better police engagement in the community.
- **Transportation:** Participants shared transportation can be especially challenging for older adults and people with disabilities. They shared the current process for accessing transportation services is invasive and time intensive, with long wait times. They noted transportation is a barrier to getting to health care appointments and other resources. They shared wanting to see free bus passes and transportation services that do not require long applications.

- **Economic security, including job training and educational opportunities:** Participants discussed wanting more investment in educational opportunities for adults, as well as college resources for high school students. They noted a need for job training, particularly for Spanish-speaking adults, and more temporary job placement for veterans being discharged.

While less frequently discussed, participants also talked about needs related to **parenting and family support**, including affordable childcare and before/after school care, as well as help purchasing necessities for children, like diapers. Participants also discussed **racism, discrimination, and lack of inclusion.** Participants shared they experience racism when seeking job opportunities and discrimination contributed to people being turned away from care. They want to see more inclusion for people with developmental disabilities and marginalized groups, including people experiencing homelessness.

Community Assets

The following table includes programs, initiatives, or other resources that participants noted are working well for them.

Area of Need	**Program, Initiative, or Other Resource**
Access to health care	Grace Clinic
Community resources and information	2-1-1 Department of Social & Health Services iMPACT! Compassion Center JustServe Local churches providing food, clothing, and other resources
Disability services and inclusion	Benton Franklin Parent Coalition Children's Developmental Center Down Syndrome Association of the Mid-Columbia, particularly playdates for all ages The Arc of Tri-Cities, particularly the Spanish program for parents and resource list on website Special Olympics
Domestic violence, assault, and trafficking	Mirror Ministries Support, Advocacy & Resource Center (SARC)
Education	Migrant Education Program
Economic	Goodwill Industries employment services Grace Kitchen WorkSource
Food security	Food banks Meals on Wheels

Housing and homelessness	Housing Resource Center Safe Harbor's My Friends' Place Tri-City Union Gospel Mission
LGBTQIA+ resources	The Q Card Project
Mental health	Clubhouse International Mental Health Court Parents and Children Together (PACT) Practice the Pause program
Recreation	Fitness center and walking paths at the Columbia Basin College Parks and green spaces
Substance use/misuse	Oxford House Tri-Cities—Transitional Housing
Transportation	Dial-a-Ride Free public transportation and bus passes
Veterans	Columbia Basin Veterans Center Benton County Veterans Therapeutic Court Sport therapy programs and recreational therapy programs for veterans (social situation with free activities)

FINDINGS FROM PARTNER INTERVIEWS

Community Strengths

The interviewer asked partners to share one of the strengths they see in the community and discuss how we can leverage these community strengths to address community needs. This is an important question because all communities have strengths. While a CHNA is primarily used to identify gaps in services and challenges, we also want to ensure that we highlight and leverage the community strengths that already exist. The following strengths emerged as themes:

Community engagement and willingness to help

Partners identified the greatest strength of Benton and Franklin Counties as the community engagement and people's willingness to show up to help one another. They shared that people care for one another, support one another, welcome new folks to the community, and volunteer to meet the needs of others. People care deeply about the community and many people have remained in the community for many years and are giving back. For example, at the start of COVID-19, community members donated soap and cleaning supplies to health care facilities. Another example is the active, grassroots network of parents coming together to help children with developmental disabilities. The passage of the one-tenth of 1% sales tax for behavioral health needs demonstrates the community's commitment to ensuring people can access the services needed.

> *"We have a community that cares and wants to improve the conditions and the lives of the children, youth, and their families in our community. I see a lot of things, a lot of great things going on. This is not a community that stands by and watches passively, this is a community that rolls up its sleeves and gets to work."—Community Partner*

> *"It's a community that rises up to help one another."—Community Partner*

To leverage this strength, partners recommended reaching out to community members to share what the community needs are and how they can get involved in solutions. Another example is to create a model that ensures volunteers provide support where it is needed most to create collective impact. This would involve community agencies working together to identify how to leverage volunteers to make the greatest impact.

> *"The biggest asset anybody have (sic) isn't money, it's their time. How they could get engaged with different things would be huge, because that's why it's called a community and people getting involved in things."—Community Partner*

A spirit of collaboration and partnership

Partners spoke to a strong spirit of collaboration and partnership in Benton and Franklin Counties. There is a lot of commitment to working together to make meaningful change and working towards shared goals. They shared examples of collaborations between law enforcement agencies, nonprofits, faith-based organizations, health care, government, emergency response teams, and community members. The COVID-19 pandemic has been an example of organizations coming together to respond to a crisis.

> *"I think the willingness to collaborate and to really talk about what's going on in the community, that is a strength of this community, but I see it in the nature of my job in talking to a lot of people. I see it over and over again that the will is there, but there are often gaps in communication. Even though people are really trying, it's not for lack of trying or for a lack of goodwill, but people don't know what other people are doing or other organizations are doing."—Community Partner*

Partners emphasized this strength can be leveraged to align priorities and goals between organizations, creating shared efforts and avoiding territorialism. Partners recommended leveraging this strength by focusing on local organizations to meet community needs, rather than outside sources. They also recommended bringing in community members to participate in collaboratives and continuing to create opportunities for more communication. This communication can help identify available capacity to address challenges and services that can meet needs.

> *"I'll start by saying I think the greatest strength in the Tri-Cities is the collaborative nature of all the different entities that put their specific agendas aside and they absolutely want to work together with partners to do what's best for the community as a whole."—Community Partner*

Strong network of community organizations to meet needs

Partners shared there are many local organizations to meet people's health and social determinant of health needs. There are multiple hospitals, clinics, urgent care centers, and specialists in the community to give patients options. There are strong school districts which are connected to many of the families and serve as a trusted partner. The Hanford site employs many people.

To leverage this network of organizations partners suggest facilitating more coordinated responses to ensure they are not operating in silos. They also suggested more communication between health care systems and collaborating on creative ways to recruit health care professionals to the community. The schools and many community-based organizations have trust built with community members and can

help share information, particularly during challenging times like the COVID-19 pandemic. Services can also be co-located at schools which can serve as a trusted site for families.

Diversity of cultures and community knowledge

Partners shared the people of Benton and Franklin Counties are a strength. There are many cultures represented in the communities and opportunities to build relationships with people of different backgrounds. This strength can be leveraged by ensuring community-building events celebrate the diversity in the community. In conversations about how to address needs, community members affected by those needs should be included in the decision making.

> *"Are we paying attention to those community events that can highlight some of the diversity in our community? Are there such things? Very few. Celebrate the different cultures."—Community Partner*

High Priority Unmet Health-Related Needs

Partners were asked to identify their top five health-related needs in the community. Four needs were prioritized by most partners and with high priority. Four additional needs were categorized as medium priority. The effects of the COVID-19 pandemic will be woven throughout the following sections on health-related needs.

Partners were most concerned about the following health-related needs:

1. Mental health
2. Substance use/misuse
3. Access to health care services
4. Homelessness and housing instability

Mental health

Mental health was overwhelmingly identified as the most pressing community need. Partners frequently spoke to mental health as a foundational need connected to many other needs and important for well-being. They noted mental health needs to be addressed in conjunction with substance use/misuse challenges. They also see mental health challenges as connected to community violence, with anger and stress manifesting in the form of violence. Racism and discrimination also affect people's mental health and feeling of belonging.

> *"How are we making people know and understand that they are welcome here that this is a place that wants them to be part of the community and that cares about them?"—Community Stakeholder*

Community partners spoke to the following needs related to mental health services:

- **More mental health treatment services:** This includes mental health counselors and facilities at all clinical levels. They noted it can be challenging to find providers locally.

"Of course, mental health is on everybody's mind. Just isn't enough [services] available."—Community Stakeholder

- **Improved crisis services:** Partners shared crisis response is often overwhelmed. They would like more crisis response professionals who can go to schools or other locations in the community when there is a crisis.
- **Pediatric inpatient services:** There is a need for more pediatric psychiatry facilities and inpatient services.
- **A focus on early identification and early intervention**: Partners shared they want to see a new model of responding to mental health challenges that focuses on early identification and intervention of needs in response to early signs of emotional and mental health challenges.

"We just don't seem to have the resources as a nation and as a community to address mental health, both in its most tragic outcomes, meaning those that really need to find some sort of residency to help deal with that, but I think, also, in trying to understand the mental health precursors. How someone may start on this end of the spectrum."—Community Stakeholder

Contributing to the community needs are system challenges and access barriers including the following:

- **Workforce challenges:** Recruiting and retaining qualified mental health professionals is difficult. The challenging nature of the work and low wages for entry level roles contribute to burnout. This work can be draining, particularly without good support and supervision. The testing and supervision requirements for licensure can also be a barrier for professionals. There is a need to build up the workforce by opening up pathways for existing health care professionals to become mental health professionals. Partners also suggested mental health organizations work together to meet community needs by each providing one piece of the needed services, rather than competing to provide the same services and recruit the same people.

"You're working with the most vulnerable people, situations, and scenarios, and when you help somebody they go off living productive lives and you don't hear from them. Individuals that don't have a good outcome, whether it's perceived or actual, you'll hear a lot about it. When you do good it's not really emphasized unless you have good leadership who reminds you and does those supervisions and debriefings and remind you of the purpose and why you're there. Otherwise, you're just hearing the bad all day long and you're seeing the bad and it's reinforced. It can be draining and there can be high burnout in that field." – Community stakeholder

- **Transportation**: Transportation to services can be especially difficult for people living in more rural areas, including North Franklin County. Other areas, such as Benton City have no mental health services locally. Within the Tri-Cities, people may have to travel quite a distance between different services and appointments, meaning people may have to prioritize some services over others.

- **Language and culture:** There are limited mental health services in Spanish, Russian, and other primary languages spoken in the area.

Partners names the following populations as having additional mental health needs:

- **Young people**: Mental health needs for young people have only increased due to the COVID-19 pandemic. Partners noted seeing an increase in anxiety, depression, and social isolation. They were also concerned about youth suicide. They were concerned about bullying and social media negatively affecting youth mental health. They noted seeing an increase in behavioral issues with students, potentially connected to a lack of stability during the pandemic.
- **Young people in foster care**: Accessing quality mental health treatment and having treatment options can be more challenging for young people in foster care.
- **People with developmental disabilities:** Partners shared people with developmental disabilities have few options for accessing behavior support specific to their needs locally, noting a need to provide more intentional support for this group and their caregivers. Some of these support needs include building social skills, support for families in crisis, and providers with knowledge and training to support people with developmental disabilities. Washington State mandates insurance cover behavioral services for individuals with autism, but it is challenging to find providers. There is a need for more provider education and improved disability inclusion.

  "[People with developmental disabilities] require more of a behavior mechanisms and new structure, we just don't have the services here in the Tri-Cities."—Community Partner

- **Older adults:** Ensuring older adults feel cared for and valued in the community is important. There is a need for improved social connections for older adults experiencing social isolation.
- **Hanford workforce:** Accessing mental health services may be challenging for some of the workforce at Hanford.

Partners spoke to the COVID-19 pandemic as exacerbating mental health needs for everyone and contributing to a lot of stress for families, and a lack of connection for many people, including older adults. While there has been more stress for people, it has been more socially acceptable to talk about that stress.

> *"People talking more about their stress because it was something that more people felt comfortable because more people were openly discussing it. It might have always been something but now, it was in your face and okay to talk about. The mental health really took an upswing in need and verbalized need during the pandemic."—Community Partner*

The pandemic has contributed to a lack of connection for many people, including older adults, making it more difficult for people to feel connected and build relationships.

> *"If I was looking for a glaring gap, mental health services for students, parents, families, the community as a whole, that's probably our number one issue right now and along with that, almost those clinical-level mental health services but also just counseling in general."—Community Partner*

The pandemic has negatively affected the mental health of young people. A lack of stability and access to caring adults for some children during the pandemic contributed to increased behavioral needs. Partners spoke to schools experiencing challenges with students re-adjusting to being in person and dealing with the resulting mental health and behavioral needs.

> *"The youth that most needed stability during the last two years and access to caring adults to advocate for them, probably had the least access as we dealt with isolation in school shutdown. I think that's been for sure negatively impact due to COVID."—Community Partner*

Partners have seen increased anxiety in young people and exacerbated mental health needs for school-age children, particularly in areas where there may not be the resources in schools to address the needs.

> *"I honestly believe in and can attest with my job and the kids we serve and staff we serve, because of COVID, there's been an increase in anxiety. There's been a clear shift in need from physical to mental health and maybe seeking some stability around that becomes quite a priority."—Community Partner*

> *"I think what it has done is it's exacerbated the need for mental health, especially among our school-aged kids, and we do not have the same level of resources given our rural atmosphere that some of the other school districts may have access to. There's no doubt that the pandemic has exacerbated that, though, in a big way."—Community Partner*

Health care providers also experienced increased stress and mental health needs during the pandemic. Some of the mental health workforce moved to telehealth positions where they can be compensated at a higher rate.

Telehealth services improved access for some people but created challenges for others, particularly people with a developmental disability or people lacking access to or comfort with technology.

Substance use/misuse

Partners highly prioritized substance use/misuse because of how it affects whole families and communities. They shared substance use/misuse is a huge issue in the community. They emphasized the importance of addressing mental health and substance use/misuse together, as these issues can be co-occurring.

> *"[A] substance use disorder always affects the children. It creates a feeling of uncertainty and unsafety in the home, there's a desire to find stability elsewhere. There also comes with that a sense of dependence and being able to take care of the parents and others in the home."—Community Partner*

They shared there are not enough substance use disorder (SUD) treatment services in the community, although there are many great efforts underway, including the Recovery Center, to meet the need. Partners were especially excited about these efforts although shared the following needs:

- **A detox center for withdrawal management:** Partners emphasized how critical it is to have a detox center within the community. Without these services, people who need medically

supervised detox either end up in jail or have to seek services in Yakima or Spokane. Traveling outside the area is challenging for the individual and their support system. Patients ready for treatment need to have immediate access to an assessment to ensure they have timely access to treatment when they are engaged.

- **Inpatient SUD treatment services**: The Recovery Center should help address this need.

> *"It's I think a shame, a crime and shame that you have somebody in the community as big as ours, that if they need inpatient drug or alcohol treatment, that they can't have access to that locally, that they have to go out of the community for that. That will be something that we address with [the recovery center]."—Community Partner*

Addressing the substance use/misuse needs in the community is a huge challenge without the appropriate treatment options locally. They shared there needs to be a unified approach with warm handoffs between services.

> *"The mental health and substance use disorders issues that we're dealing with right now are huge and I strongly believe we're not going to rest our way out of this problem."—Community Partner*

There is insufficient behavioral health workforce to meet the need, potentially due to low wages for people without advanced degrees and burnout in the field. There can also be high burnout in the field considering negative outcomes are often most emphasized. Good support and quality supervision are crucial to supporting this workforce.

> *"You're working with the most vulnerable people, situations, and scenarios, and when you help somebody they go off living productive lives and you don't hear from them. Individuals that don't have a good outcome, whether it's perceived or actual, you'll hear a lot about it. When you do good it's not really emphasized unless you have good leadership who reminds you and does those supervisions and debriefings and remind you of the purpose and why you're there. Otherwise, you're just hearing the bad all day long and you're seeing the bad and it's reinforced. It can be draining and there can be high burnout in that field." – Community Partner*

Partners identified the following groups that may not receive the support needed in accessing support for substance use/misuse issues:

- **Young people:** Partners were concerned about substance use/misuse starting in middle and high school.
- **Older adults:** Their needs may be overlooked or ignored because of their age.
- **People experiencing homelessness:** Partners were concerned about substance use/misuse on the streets, potentially affecting community safety.

During the COVID-19 pandemic, partners have seen substance use/misuse increase for both adults and young people.

Access to health care services

Partners shared that while there are many health care services in the two counties, there is still a need for more primary care providers and specialists to reduce wait times. Partners report patients can wait months to see a primary care provider. People without one may be forced to use their ED for health care needs. Partners also reports it can be challenging finding enough primary care physicians for all the Hanford staff.

> *"Not having enough primary care providers in the area or having long waits for individuals who need basic healthcare needs. Then it would be also the transportation to where unfortunately there's some communities that wait to see a doctor until are actually in pain or they wait it out. Usually at that point, you may need to call an ambulance, the ER. — Community Partner*

There are also long wait times to see specialists, including for endocrinology, gastroenterology, oncology, etc. People travel from other areas to receive specialty care locally, which can increase demand. Partners report a desperate shortage of specialists, meaning patients wait three or four months to get an appointment and many specialists are overwhelmed with demand.

> *"Most specialty care just cannot wait three, four, or five months to get in, and that's where we end up a lot. We have patients who are able, that often go outside the community to larger markets like Seattle or Portland or Spokane, but it's often problematic there as well."—Community Partner*

In addition to more primary care providers and specialty providers, partners spoke to the following needs to improve access to care:

- **Improved training and recruitment:** Partners shared it can be challenging to recruit health care professionals from outside of the area, particularly with the high cost of housing. It is also important to ensure people within the community stay and provide services. Local training programs, like Columbia Basin College, are limited by a finite number of clinical placements. Training programs cannot grow without new practices or expanded hospitals. The COVID-19 vaccine mandate has also meant some providers have left.
- **Discharge planning and medication management:** Improved discharge planning to ensure patients can fill their prescriptions is important for all patients, but especially people experiencing homelessness.
- **Post-acute care:** For people needing a skilled nursing facility or hospice, there are also limited options in the community.
- **Health education, including family planning support:** Health education should be provided in a culturally sensitive way.

Access to preventive care is especially important for ensuring people receive timely and appropriate care, avoiding unnecessary calls to EMS or avoidable ED visits. Because of policies, EMS and the Fire Department are only reimbursed if they transport a patient to the hospital, but sometimes treating and not transporting is the best option. Another challenge is that EMS and the Fire Department have to bring

patients to the Emergency Department for jail booking clearance. This can be unnecessary from a medical perspective and potentially not the best use of resources. There is opportunity for better collaboration and policy change to address some of these systems.

> *"Trying to encourage our lawmakers, Congress, and legislation to think about those things that we need to redesign those systems to take care of people."—Community Partner*

The health care system can be challenging for people to navigate due to the following barriers:

- **Technology and health literacy:** Technology and online forms may be difficult for people to navigate if they lack a computer or comfort with technology. Technology can create additional barriers for older adults, people whose primary language is not English, and people with a disability. There is a need for more support for people experiencing barriers to care, rather than leaving people to figure it out on their own.

  "I think the world of electronics is alienating a lot of people… I personally love it, but if you have a language barrier, a disability, your hearing, your vision, bottom line, it's not accessible to you."—Community Partner

- **Transportation**: This was highlighted as a primary barrier for people, particularly if they live in a rural area or have mobility issues. Public transportation can be difficult for people needing to take multiple buses to get to appointments. Tri-Cities is very spread out, meaning patients may have to travel between different providers and appointments. Reliable transportation can be crucial for ensuring people with chronic conditions and people experiencing homelessness receive preventive and timely care.

  "We're so spread out, nobody can just go one place and be served. You have to bounce all over the different appointments in three cities, and we don't have the transportation structure that I think other cities may have."—Community Partner

- **Cost of care**: People with low incomes or lacking insurance may not be able to afford the cost of care.

  "There's a broad population of people who, for whatever reason, don't have the ability to pay for their medical care and are not on some sort of state supplemental plan."—Community Partner

- **Language**: Ensuring all materials are translated into Spanish, Russian, and other primary languages of patients is important for improving access.
- **Childcare**: A lack of childcare can make it more difficult for parents to go to their appointments.
- **Appointment times during work hours: T**here is a need for extended clinic hours and weekend hours to ensure people can see their provider without missing work. This is also relevant for Hanford site workers.

Partners highlighted the following populations as experiencing additional barriers to care:

- **People with developmental disabilities:** Care needs to be adapted to meet the needs of people with developmental disabilities. Partners suggested finding creative solutions to working with patients is important.

  "I think that's one thing too is our providers are pretty stretched in our community and so the ability to be creative tends to get diminished. I don't know if we just don't have enough providers."—Community Partner

- **Older adults:** Technology and transportation can be barriers to care for older adults and they may need support in navigating the health care system. Health care workers that provide home visits may be able to support discharge planning and ensure older adults are safe in their home.

  "[Older adults] either don't get on, or if they're able to get on Zoom somehow, they don't interact to the same degree with that. I think we've just got to broaden out our communication styles and simplify them for those groups that need that done for them."—Community Partner

- **Young people**: School have identified a need for improved home hygiene related to things like lice, bed bugs, etc. Accessing appointments with pediatricians is difficult.

  "As a parent, it's been really difficult even in my own personal life and then also having and seeing this echoed broadly in the community and hearing stories from our students, how difficult it is to get kids into the doctor, or to do so in a way that's timely or to get feedback about just the care that they're receiving because the clinics are so inundated."—Community Partner

- **The Latino/a community:** Partners were concerned about the Latino/a community having access to preventive care if patients lack a primary care provider and insurance. Due to social inequities and disinformation about the COVID-19 vaccine, the Latino/a community was disproportionately affected by COVID-19. This underscores the importance of building trust with this community.
- **People experiencing homelessness:** This population may need additional resources to support accessing care, including transportation resources.

Due to the COVID-19 pandemic, some people delayed preventive health care services or were not able to access the health care services they needed. As people return to care, there are long-wait times for appointments and delays, leading to unmet health needs. Some patients had surgeries delayed or canceled and others had medications lapse.

"I think this last year and particularly this year since January, we've seen a lot of unmet health things where, what, maybe a diabetic hadn't come in as regularly as they were because we couldn't get them in or they were scared to come out or they had just declined to get service during that time. The amount of unmet needs went up during COVID because

so much of our healthcare capacity was directed and siloed toward COVID care."—Community Partner

Partners agreed telehealth improved access for some patients but is challenging for those without access to or comfort with technology. They shared it should not fully replace in-person care considering the importance of those face-to-face interactions. Families without internet access or technology were isolated at the start of the pandemic.

COVID-19 vaccine disinformation and the politicization of public health practices put additional strain on the health care system and providers. Partners emphasized the lessons learned about the importance of building trust with the community, particularly specific populations that have been historically marginalized. While health care providers are generally seen as experts, some experienced distrust by patients related to COVID-19 vaccine information.

"As a general rule, patients have a high respect for providers and nurses and medical staff and tend to look for them for expertise and direction, and I think that the pandemic, because of [vaccine disinformation and the politicizing of COVID], has really influenced patients into rejecting or questioning things that they would have typically just naturally accepted."—Community Partner

Positively, the pandemic created more opportunities for education and outreach with communities, and increased awareness of the role of health care and public health in the community.

"I guess it just goes back to my previous statement about awareness and let's say education. Because it's really more awareness and to get people to buy in and understand why public health and its role within healthcare, in general, is important to us."—Community Partner

Through vaccine outreach and engagement with Community Health Workers, partners learned the importance of providing vaccine clinics outside of work hours and ensuring they are offered at places where people already go, like grocery stores. Having bilingual folks working and being very consistent with timing helps build trust.

"Consistency, finding out what works for them, making it easy. How do you lower the barriers [to the COVID-19 vaccine]? How do you make it easier for them and comfortable for them?"—Community Partner

Partners also saw that providing isolation and quarantine space at local motels for people living unsheltered worked well.

Homelessness and housing instability

Partners prioritized homelessness and housing instability because of its connection to so many other needs and because of the importance of people first being stably housed before addressing their other needs.

"Yes, food in their stomach, those essential needs truly are essential because it starts there. It starts with a good night's sleep, it starts with being warm in the winter, it starts with having access to appropriate meals, and then the rest of that stuff can work itself out."—Community Partner

They described homelessness as a symptom of other issues, including mental health, substance use/misuse, access to health care, economic security, and more.

"I guess, circling back around to my main theme is that homelessness is a symptom. It's a symptom of issues that have occurred probably over time that we really need to keep focusing in my view on the upstream, which is mental health, substance use disorder, healthcare. Even financial planning when it comes to major medical needs because that's, healthcare is one of the big issues in bankruptcy, and bankruptcy then leading to loss of a home." – Community Partner

Partners shared homelessness and housing instability is growing and it includes people in a variety of living situations, including folks not just living unsheltered, but also those living in their cars or RVs, couch surfing, and moving frequently.

"We're seeing folks who are living out of their cars and not just the typical, what people associate homelessness with, someone living in a tent or living under an overpass type of scenario. We have people living in their cars, living in motor homes, moving from spot to spot."—Community Partner

This means people in different situations may need different levels of support and different types of services.

"When I looked at the homeless as a population, it truly is not a homogenous group, there are many reasons why people become homeless and the needs of the homeless as we addressed them, really we need strategies that meet their specific needs."—Community Partner

They spoke to needing more housing in general and more services including the following:

- **Homelessness services:** More hygiene services for students, care coordination and navigation for folks experiencing chronic homelessness, and more street-based care to meet folks where they are needed to improve the health and well-being of folks experiencing homelessness.
- **Low-barrier permanent supportive housing:** This type of housing with on-site services is particularly important for ensuring folks in recovery or with a substance use disorder remain stably housed. Partners emphasized the importance of taking a Housing First approach.

"In Benton County, we need to develop permanent supportive housing options. It works. Again, it's an initial investment, but in the long run from a quality of life, from a humanistic standpoint, and from the people that don't care about that, they just care about where their taxpayer dollars goes, it saves taxpayer dollars in the end too, with these ancillary services."—Community Partner

- **Transitional housing:** Providing housing for 6-12 months with supportive staff will help people re-engage in the community and build skills to live independently.
- **Workforce housing**: There needs to be housing available for folks who are recruited for jobs in the community. A lack of affordable housing units in the community makes it challenging to attract workforce to the area and some workers find themselves living in RVs because they cannot find housing.

The high cost of housing and low housing stock have made finding affordable housing a challenge for many people in the community, both wanting to buy and rent homes. Partners were concerned about young people and young families being able to find an affordable home. The market is competitive and expensive, meaning young people are priced out of buying their first home and building equity.

> *"I sit there and I think when a young family, they're both working but not making a huge salary and they maybe have a kid or two, I don't know how they're going to be able to purchase a home or even in a lot of situations, rent. When we start talking about affordable housing, affordable for young families, but then again, we just simply don't have enough units for people that are at the poverty level too."—Community Partner*

People are willing to pay above fair market rent, meaning landlords are able to charge high prices for apartments. Partners are seeing landlords increase rent by $400 or $600 a month, burdening people and leading to spending tradeoffs. This high cost of rent also contributes to overcrowding as families double up in apartments.

> *"They have to spend too much money on their housing to be able to afford some of the other things that they need in life."—Community Partner*

They spoke to very low vacancy rates, leading to competition for rentals and increases in rental prices. This can make it more challenging for people with any criminal history or a poor credit score to find housing. While there are efforts to develop new housing locally, it tends to be for people with higher incomes and therefore, is not meeting the unmet need.

> *"Our vacancy rate in Benton and Franklin Counties is below 1%. There just aren't units to put [people] in."—Community Partner*

> *"I never thought that we'd be in this situation where our housing stock, availability, whatever you want to call it is in such bad shape."—Community Partner*

For people with low incomes, a behavioral health condition, or any negative rental history, finding affordable, stable housing can be more challenging. People's incomes have not increased at the same rate as the cost of housing, meaning those who work in seasonal roles may have more difficulty finding affordable, stable housing.

> *"I think the overarching concern we hear from people is affordable housing. If we're trying to attract the young workforce to our community, there's certainly challenges related to that. When we look at a lot of the hospitality workers, particularly the people that haven't worked their way into managerial roles, the incomes that they make, housing becomes a challenge."—Community Partner*

There are no skilled nursing facilities locally and older adults living on a fixed income may be more likely to be unstably housed. Families with children with special needs may also have difficulty finding housing that accommodates and meets their needs.

The COVID-19 eviction moratoriums benefited some renters, but also created frustration for landlords falling behind on their mortgage. There is a strong need for rental assistance for people unable to pay back the rent they owe.

Medium Priority Unmet Health-Related Needs

Four additional needs were often prioritized by partners:

5. Economic insecurity, education, and job skills
6. Affordable childcare and preschools
7. Food insecurity
8. Community safety

Economic insecurity, education, and job skills

Partners discussed the need for more financial stability for many families, ensuring there are living wage jobs, job skill trainings, and investments in education. Economic security is connected to a lot of other needs, including housing and access to other resources.

With the high cost of housing, families may spend a substantial portion of their income on rent, especially for seasonal and agricultural workers. To address these needs, partners advocated for the following:

- **More equitable funding of public education and support for higher education:** The way public education is currently funded contributes to the opportunity gap. Higher-income schools receive more funding than lower-incomes schools, which creates economic inequities later.
- **Increased job skill training, particularly for students in more rural districts:** There are fewer opportunities for high school students to access business internships, apprenticeships, etc. than there used to be. Transportation can be a barrier for some students.
- **Support for skilled work training**: Some high schools are cutting classes related to skilled work, such as metalworking and mechanics. Partners noted the importance of having programs to train plumbers, electricians, construction workers, etc. which are in demand.

> *"We need skilled workers. We don't need everyone to go to a four-year college, I'm sorry. We need plumbers, we need electricians, we need construction people and those are all really good-paying jobs."—Community Partner*

They emphasized the importance of supporting educational opportunities so that people can do work that is meaningful to them and something they feel good about accomplishing.

> *"I think it would be nice if we look at how do we help people evolve or improve the stability of that socio-economic situation over the course of their lives and, at a minimum, generationally."—Community Partner*

High inflation and challenges with workforce employment were identified as challenges for the local economy. Business owners are having difficulty filling positions, affecting their ability to meet demands and stay open.

Partners identified the following populations as being disproportionately affected by economic insecurity:

- **People with developmental disabilities and their caregivers:** Finding childcare for children with special needs is very challenging, meaning these parents are often unable to work full time jobs. This is especially difficult for single parents of a child with a developmental disability or other special need. There are also limited opportunities for people with developmental disabilities to develop job-related skills.

"Most kids with developmental disabilities are staying [in school] until 21 because the world looks pretty bleak for them in a lot of opportunities."—Community Partner

- **Seasonal workers:** Due to the nature of the work, seasonal workers may receive variable income throughout the year.
- **The Latino/a community:** Partners spoke to the importance of supporting the Latino/a community in accessing educational opportunities and addressing inequities in access to education. For some, there may be a lack of understanding about the return on investment for higher education.

"I don't think there's enough individuals from the Latino community that are going on to higher education. There's more and more… There's still so many people that don't go on and really educating them and their parents about the importance of higher education."—Community Partner

The COVID-19 pandemic affected businesses and workers, particularly in the service and hospitality industries. Some small businesses and restaurants closed when people were staying home, leading to workers in the service sector losing their jobs. Schools are also facing many challenges meeting the needs of their students and can benefit from additional resources.

Affordable childcare and preschools

Partners emphasized affordable and flexible childcare as crucial for stable families and a strong workforce. Without addressing this need, people will not be able to participate fully in the workforce and there will continue to be staffing challenges. Many employers are reporting that childcare is a factor in their difficulty recruiting workers.

"That's affordable childcare and preschools. It's having a dramatic effect on our workforce and our ability for meeting the needs of our clients because we just can't, we could hire 100 people today and still be short. It's that bad. I think a lot of it is because of that inability to have their kids look after in an affordable place. We don't get to use their talent."—Community Partner

Childcare is also crucial for allowing caregivers to access other services, including health care.

There is very little affordable childcare in the community and limited free preschool spots, meaning the cost is a barrier for many families. The Early Childhood Education and Assistance Program (ECEAP), or Washington's free pre-kindergarten program, gets full quickly.

> *"I've heard multiple times that it's almost impossible to find affordable childcare in this community."—Community Partner*

For families working non-traditional hours, finding flexible childcare can be very difficult. Some parents may only need childcare on certain days or specific hours, particularly if they work an early or late shift. It also needs to be easily accessible for people living in rural areas.

> *"Is childcare available for nontraditional work shifts? What does it look like if you work Tuesday, Wednesdays, and Thursdays, but not any other days? The way the model is structured, you have to pay for your slot. That becomes really problematic."—Community Partner*

For families with a child with a disability, there is very little childcare that can meet the child's needs. Even children eligible for benefits through the Developmental Disability Administration (DDA) experience challenge finding childcare providers with the capacity and knowledge to support the child. Children with a disability but who are unable to qualify for the DDA will have even more difficulty. This prevents parents from working and can be especially challenging for single parents who may have no choice but to care for their child instead of working. This puts families in very challenging positions where they are not able to meet their basic needs because the parent(s) cannot work without safe childcare.

The pandemic highlighted how important childcare is for keeping people staffed and for businesses being able to recruit and retain employees.

> *"Affordable childcare and preschools, just from a workforce development standpoint, this pandemic brought a lot of interesting things to the forefront and the care of children and the flexibility that we have to provide to our teams so that we can continue to keep them employed and doing the great work that they do, but also taking care of their families. This has really found itself on the map in a pretty significant way."—Community Partner*

While challenging before the COVID-19 pandemic, staffing for childcare centers only became more difficult. Some staff had to resign to care for their own children and there is generally high turnover.

> *"Oh, and whether it's pandemic-related or not, I couldn't tell you, but staffing for us has been a challenge, just like everybody. I haven't been able to find qualified [childcare] staff that'll stay the course and be there long enough to make a meaningful difference. It's a challenge."—Community Partner*

Childcare centers had to drastically reduce enrollment based on COVID-19 guidelines, meaning they could serve fewer children. Some centers changed how they provide services and are not returning to their pre-pandemic enrollment numbers.

Food insecurity

Many partners shared that the community is working to ensure people have access to food, although the food options may not always be the healthiest and programs may not address what is causing food insecurity. People may not be able to access these food resources if they lack transportation.

They shared that food pantries often provide non-perishable foods, which are often not as nutritional as fresh foods. School lunches provided by the districts may not always be the healthiest either. Cost may be a factor.

> *"Once again, because you're dealing with a lot of donated food especially non-perishables, it's not necessarily going to be the healthiest choice, and so I think there's real disconnect between healthy options for families and what is easily and readily available. I think that's problematic in the long run."—Community Partner*

Fresh and healthy foods can be challenging for families with low incomes to afford. Families new to the United States may not be familiar with reading the food labels and identifying healthy foods for their children. For example, families may assume a lot of the foods like breakfast cereals are healthy options, but they can have a lot of sugar.

> *"At Christmas time, a lot of schools think it's a good thing to send kids home with a box or a number of boxes of cereal to eat over Christmas break. If those kids didn't have that cereal, they think that that's going to promote their health. You know what? They're used to eating rice and beans or something equivalent to that for breakfast or rice and vegetables. I think that's a healthier choice than sugar cereal."—Community Partner*

Workers on the Hanford site have little access to food on-site besides what they bring.

The pandemic exacerbated food insecurity for many people. While there have been additional supports to provide food to families, partners noted there are often a lot of cars lined up waiting to receive food assistance at events, underscoring the need. Partners emphasized the importance of ensuring all families that need help are receiving it, since the need only seems to have worsened in the past few years.

> *"It's a challenge we face in our nation, we subsidize the least healthy food. It makes it very difficult to be able to afford healthy fruits, vegetables, appropriate proteins, so on so forth."—Community partner*

Community safety

Partners shared that while they do not think Benton and Franklin Counties overall are unsafe, they are concerned about increased community violence and neighborhoods where residents do not feel safe. This might contribute to people not feeling comfortable accessing parks or recreation, which affects chronic conditions, mental health, and overall wellness.

> *"I think I will actually say community violence, lack of feeling of safety. I want to be clear to articulate that I don't think this is a broad community issue. I do think they're isolated neighborhoods within our community where this is a real challenge and does not get the focus that it should based on who does or does not live in those neighborhoods."—Community Partner*

In neighborhoods with higher crime rates, residents feel more insecurity. Not all neighborhoods get the same level of attention to ensure safety.

Partners spoke to seeing a large increase in gun violence in 2021. The increase in gun violence is measured by an increase in shots fired for a variety of reasons.

> *"When I talk about gun violence, I'm talking shots-fired calls, whether it was directed at somebody or shots-fired in the air that we responded to, so that whole gamut. We saw a huge increase in that, and to pin it down to something specific, it's happening nationwide. There's huge increase across the nation."—Community Partner*

Gun violence needs to be addressed locally as a community, as well as a country.

> *"I personally think that as a country, we need to do something about gun violence."—Community Partner*

Partners are also seeing people manifesting anger and stress into violence, potentially due to the effects of the pandemic.

> *"There just seems to be, again, I don't know if it's COVID related, but anger and stress that's manifesting itself into ways that we're seeing in the community that are unusual."—Community Partner*

They emphasized that addressing community safety needs to be a collaboration between law enforcement and the community. This requires building relationships between law enforcement and the community and also having the resources to move people into safe situations if they are affecting public safety.

> *"Public safety isn't about police or fire doing something specific. It is that collaboration when somebody feels safe to leave their doors unlocked like we used to. All of that. It can't be done alone. We tell our folks, every contact matters. Every single contact, when you're dealing with somebody, you can make a difference, because the majority of the time, you're dealing with really good people who are having a really bad day."—Community Partner*

Community Partner Identified Assets

Partners were asked to identify one or two community initiatives or programs that they believe are currently meeting community needs.

Table_Apx 3. Organizations and Initiatives Addressing Community Needs in Benton and Franklin Counties

Community Need	Community Organization/Initiative
Access to Health Care	• Benton Franklin Community Health Alliance: Brings together representation from various groups in the health care community to promote conversation and collective problem-solving. • Camp Trios for children with Type 1 diabetes • Columbia Basin Health Association • Community Health Worker/ Promotores programs: They have the ability to go into people's homes to understand their specific needs and situation and provide more in-depth case management. • Free vaccinations for children in schools • Grace Clinic: Provides free medical, dental, and mental health services to people without insurance. Many partners emphasized how crucial this clinic is for ensuring everyone has access to health care services. • Nurse-Family Partnership at the Health Department: Brings health care services to people who need it most, rather than expecting people to seek out or travel to services. It is a good example of a community-based intervention. • Tri-Cities Community Health: In partnership with the National Alliance for Hispanic Health, provides the Diabetes Prevention Program for Latino/a individuals in Pasco. • Yakima Farmworkers Clinic: Provides health care services to communities with barriers accessing health care services.
Behavioral Health	• One-tenth of one percent sales tax for mental health that passed in Benton and Franklin Counties: Invests in an inpatient and outpatient treatment program. • Benton Franklin Behavioral Health Advisory Committee: This committee is currently in progress and will make recommendations on programs or services that will be funded by the one-tenth of one percent sales tax for mental health. • The Recovery Coalition: Brings a lot of awareness to behavioral health needs in the community and current gaps in services. • Wraparound with Intensive Services (WISe) Program: Wraparound services to help children, youth, and their families with intensive mental health care. • The Recovery Center: The current efforts underway to establish a drug and alcohol treatment center with mental health services is seen as great progress to meet a dire need. • Comprehensive Healthcare: Embedded therapists in Kennewick School District provides on-site mental health support in schools. This ensures there is no need to wait for outside referrals and minimizes a lot of barriers to care.
Education	• Communities in Schools: Provides resources to families and students, building trust and support to help students be successful.

Food Insecurity	• Churches providing food • Meals on Wheels: Partnering with Pasco Fire so that they can provide food baskets or frozen meals if a family has an urgent need for food. During the pandemic Meals on Wheels has adapted to meet people's needs, providing drive-through pick-up options and more flexibility with combinations of hot and frozen meals. • Salvation Army Food Bank: Provides food distribution twice a week. • Second Harvest: Works to ensure food is distributed at community events and is easily accessible. Food distributions at schools are also helpful.
Health and Social Services	• Coalition for a Healthy Benton City: Works with school districts to increase community connectedness and address substance use/misuse. • Mustangs for Mustangs: Provides emergency assistance for anyone in Prosser, along with their immediate families. Their services are related to personal safety, utility assistance, food security, transportation, housing, and medical needs. • Safe Kids Benton-Franklin: Evidence-based programs to help parents and caregivers prevent childhood injuries.
Housing and Homelessness	• Elijah Family Homes: Provides stable housing for families seeking recovery and safety from substance use/misuse, abuse, and poverty. The program invests in families long-term to help them gain self-sufficiency. • Pasco Haven: A 60-unit housing project in Pasco that provides mental health support and health care services.
Senior Services	• Prosser Senior Community Center
Services for People with Developmental Disabilities	• The Arc: Provides a space where children with developmental disabilities can feel included and part of a community through programs like the summer camp and Special Olympics. These programs create spaces for friendship and belonging. • Tri-Cities Community Health: Includes providers who have completed the Center of Excellence Training to be able to diagnose children with autism.

Community Partners: Opportunities to Work Together

Participants were asked, "What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?" Partners shared the following opportunities:

Engage in partnership opportunities based on shared community priorities

Community based organizations in Benton and Franklin Counties are working towards addressing similar needs. Partners emphasized rallying around these needs, acknowledging the primary issues in the community, and partnering to solve them. Partnering allows for more creative solutions to addressing challenging problems and opportunity for sharing resources. They described a need for strategic collaboration.

"Collaboration is wonderful. I think that strategic collaboration is even more useful. Collaboration can lead to outcomes or it can lead to conversations that don't lead to much else."—Community Partner

Partners recommended measuring progress towards goals and communicating frequently to keep everyone aligned.

"Those are the suggestions that I always have. Stay local, keep the facts in mind, get the emotions or all of your biases out of the way and let's speak to what needs to be done and how to do that appropriately."—Community Partner

Partners identified the following shared priorities where sectors could better align to address complex challenges:

- Addressing behavioral health staffing challenges: Partners shared organizations may compete to recruit the same people or provide the same services. They advocated for a system that works together to collectively meet the needs of the community, with different organizations each providing a sub-set of services. Together, multiple organizations will meet the full needs of the community, layering different services, rather than competing for the same services. This means all organizations do not need to try to do everything but can be strategic with how they leverage resources.

  "There are so many things that we could layer that don't have to be done by one agency or have to be done by all agencies. We can start layering the services that we don't have rather than competing for the same resources."—Community Partner

- Homelessness and health care: There is opportunity for more communication about post-discharge care and supporting the needs of patients experiencing homelessness. Finding solutions to barriers to care, including transportation, requires partnership. One opportunity is to create volunteer opportunities for nurses to work with people living unsheltered to give nurses a better understanding of community health work and the specific needs of this population.

De-siloed and whole person care

Patients have multiple needs and should have their needs addressed holistically. When people seek services in a health care setting, providers need to be considering what other services they need and how they can be connected. Unfortunately, patients can be passed between services without a lot of follow up or support. Warm hand offs may ensure people have support in those transitions. The COVID-19 pandemic made some communication and care coordination between organizations more difficult. Case conferencing on shared patients may help improve linkages.

"I just feel that in general, organizations just really need to collaborate to be more open and not so jealous of the services that they offer, but really look at it in the aspect of we're helping one person. What do they need? Do they need clothing? Do they need

transportation? Do they need health insurance? Just really be the connector of all the service."—Community Partner

Provide community-based services to ease access

Partners emphasized the benefits of bringing needed services to people. They shared home visits can be especially helpful for older adults who may have difficulty getting to care. Providing care in the home can be a preventive measure rather than waiting until people have emergent needs. Community Health Workers or Promotores can provide case management and personalized care in the community. Co-located services in schools or places where families already go can also reduce barriers. These services aim to reach out to people and meet them where they are, not expecting them to overcome barriers on their own.

"I think healthcare as a whole needs to be redesigned, if we're going to reach out to those disadvantaged people, we need to quit expecting them to overcome those barriers and do that."—Community Partner

Leverage convenors to promote action

Partners would like to see more effective collaboration that moves beyond conversations and leads to community improvement. This requires dedicated funding and leadership to keep work moving. Neutral convenors can pull together competing systems to foster dialogue and promote community solutions. They can also support including community members and patients to gain insight. This can also reduce competition and help the community think strategically about how to leverage resources.

"Whatever the issue is, youth mental health or access to healthy food, or neighborhood safety, whatever the case is, you can pick the issue, but how do we find a way to convene people that care, but also to have action associated with it so you're not just spending time talking about the problem, but instead, you're trying to implement a solution. I think that would be the big suggestion I would have is to find conveners that are willing to bring together resources and people to try to solve bigger issues across boundaries and across scope."—Community Partner

Build trust and relationships between organizations

Trust between organizations is the foundation for making progress towards community goals. Particularly in times of challenge and crisis, there has to be strong trust and communication. Opportunities for relationship building are between the police departments and the Emergency Departments at local hospitals. Additionally, the local health systems could continue to communicate to ensure they are collectively meeting the health needs of residents. Building relationships allows organizations to learn about others' strengths and opportunities to learn from one another.

LIMITATIONS

While partners and listening sessions participants were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a partner. Multiple interviewers conducted the session, which may affect the consistency in how the questions were asked. Multiple note-takers affected the consistency and quality of notes across the different listening sessions.

Some listening sessions were conducted virtually, which may have created barriers for some people to participate. Virtual sessions can also make facilitating conversation between participants more challenging.

The analysis was completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

PARTNER INTERVIEW QUESTIONS

1. Please state your name, title, and organization as you would like them included in the report.
2. How would you define the community that your organization serves?
3. While a Community Health Needs Assessment is primarily used to identify gaps in services and challenges in the community, we want to ensure that we highlight and leverage the community strengths that already exist. Please briefly share the greatest strength you see in the community your organization serves.
4. Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health.
5. Using the table, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). [see table below]
6. Has the COVID-19 pandemic influenced or changed the unmet health-related needs in your community? If yes, in what ways?
7. What suggestions do you have for how we can leverage community strengths to address these community needs?
8. Please identify one or two community health initiatives or programs that you see currently meeting the needs of the community.
9. What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?
10. Is there anything else you would like to share?

Question 5: Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). Please note, these needs are listed in alphabetical order.			
	Access to health care services		Gun violence
	Access to dental care		HIV/AIDS

	Access to safe, reliable, affordable transportation		Homelessness/lack of safe, affordable housing
	Affordable childcare and preschools		Job skills training
	Aging problems		Lack of community involvement and engagement
	Bullying in schools		Mental health concerns and treatment access
	Community violence; lack of feeling of safety		Obesity and chronic conditions
	Disability inclusion		Opportunity gap in education (e.g. funding, staffing, support systems, etc. in schools)
	Domestic violence, child abuse/neglect		Racism and discrimination
	Economic insecurity (lack of living wage jobs and unemployment)		Safe and accessible parks/recreation
	Environmental concerns (e.g. climate change, fires/smoke, pollution)		Safe streets for all users (e.g. crosswalks, bike lanes, lighting, speed limits)
	Few community-building events (e.g. arts and cultural events)		Substance Use Disorders and treatment access
	Food insecurity		Other:

LISTENING SESSION QUESTIONS

1. What makes a health community? How can you tell when your community is healthy?
2. What's needed? What more could be done to help your community be healthy?
3. What's working? What are the resources that currently help your community be healthy?
4. Is there anything else related to the topics we discussed today that you think I should know that I haven't asked or that you haven't shared?

Click here for "An Analysis of Trends in Behavioral Health of Residents in Benton & Franklin Counties."

Click here for "An Analysis of Trends in the Continuum of Housing for Homeless & Low-Income Residents in Benton & Franklin Counties."

Appendix 3: Community Health Improvement Plan Guiding Concepts

Community Health Improvement Plan (CHIP) Guiding Concepts

Equity: As defined by the U.S. Department of Health and Human Services, health equity is the attainment of the highest level of health for all people. Population-level factors, such as the physical, built, social, and policy environments, can have a greater impact on health outcomes than individual-level factors. The root causes of health inequity can be directly linked to a failure to address these population-level factors. In addition, linkages between science, policy, and practice are critical to achieving health equity.
https://www.cdc.gov/minorityhealth/publications/health_equity/index.html#:~:text=As%20defined%20by%20the%20U.S.,outcomes%20than%20individual%2Dlevel%20factors.

Life-course wellness: Reducing health disparities requires an understanding of the mechanisms that generate disparities. Life course approaches to health disparities leverage theories that explain how socially patterned physical, environmental, and socioeconomic exposures at different stages of human development shape health within and across generations and can therefore offer substantial insight into the etiology of health disparities.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6356123/

Health in All Policies (HiAP): is a collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people. HiAP recognizes that health is created by a multitude of factors beyond healthcare and, in many cases, beyond the scope of traditional public health activities. https://www.cdc.gov/policy/hiap/index.html

Evidence-based: The interventions, policies, and community supports listed in the CHIP will be evidence-based. They will be disease prevention approaches that have the potential to impact public health. Resources from the National Institutes of Health list agencies and organizations with their own process to identify what is evidence-based but often a systematic review or a meta-analysis is used to evaluate the body of evidence in a given field.
https://prevention.nih.gov/research-priorities/dissemination-implementation/evidence-based-practices-programs

Collective Impact: Collective Impact is a framework to tackle deeply entrenched and complex social problems. It is an innovative and structured approach to making collaboration work across government, business, philanthropy, non-profit organizations and citizens to achieve significant and lasting social change. The Collective Impact approach is premised on the belief that no single policy, government department, organization or program can tackle or solve the increasingly complex social problems we face as a society. https://www.chathamcountync.gov/Home/ShowDocument?id=38860

Appendix 4: Community Health Needs Assessment Steering Committee

Table_Apx 4. Community Health Needs Assessment Committee Members

Name	Title	Organization	Sector
Sean Domagalski, RN, BSN, MHA	Performance Manager	Benton-Franklin Health District	Public Health
Kelly Harnish, MPH, MCHES	Public Health Educator, Community Health Improvement Plan Coordinator	Benton-Franklin Health District	Public Health
Karen Hayes, MA	Community Health Investment Manager	Kadlec Regional Medical Center/Providence	Hospital
Pernell Hodges	Epidemiologist	Benton-Franklin Health District	Public Health
Hazel Kwak, BHSC, NCMA	Community Health Investment Coordinator	Kadlec Regional Medical Center/Providence	Hospital
Kristi Mellema, BSN, RN	Chief Quality and Compliance Officer	Prosser Memorial Health	Hospital
Amy Person, MD	Health Officer	Benton-Franklin Health District	Public Health
Carla Prock, RN, BSN	Senior Manager, Healthy People & Communities	Benton-Franklin Health District	Public Health
Christy Wang, BSN, RN, MPH	Epidemiologist	Benton-Franklin Health District	Public Health
Kirk Williamson	Program Manager	Benton-Franklin Health Alliance	Public Health

RESEARCH INSTITUTE for HOME CARE

ADVANCING HOME CARE THROUGH RESEARCH.

Home Care Chartbook 2023

Prepared by KNG Health Consulting, LLC

Sponsored by HOMECARE & HOSPICE National Association for Home Care & Hospice

The **Research Institute for Home Care** is a non-profit, national consortium of home care providers and organizations. The Institute invests in research and education about home health care and its ability to deliver quality, cost-effective, patient-centered care across the care continuum. The Institute is committed to conducting and sponsoring research and initiatives that demonstrate and enhance the value proposition that home care has to offer patients and the entire U.S. health care system.

Previously the Alliance for Home Health Quality & Innovation, the Institute has been providing critical research and data on home care for over a decade.

The Home Care Chartbook, published annually by the Institute, provides a broad overview of home health patients, the home health workforce, organizational trends, and the economic contribution of home health agencies. The Chartbook also provides data on 30-day rehospitalization rates among traditional Medicare beneficiaries.

It summarizes and analyzes statistics on home health from a range of government sources, including the Medicare Current Beneficiary Survey, Bureau of Labor Statistics, Medicare Cost Reports, Home Health Compare, and Medicare fee-for-service claims.

Table of Contents

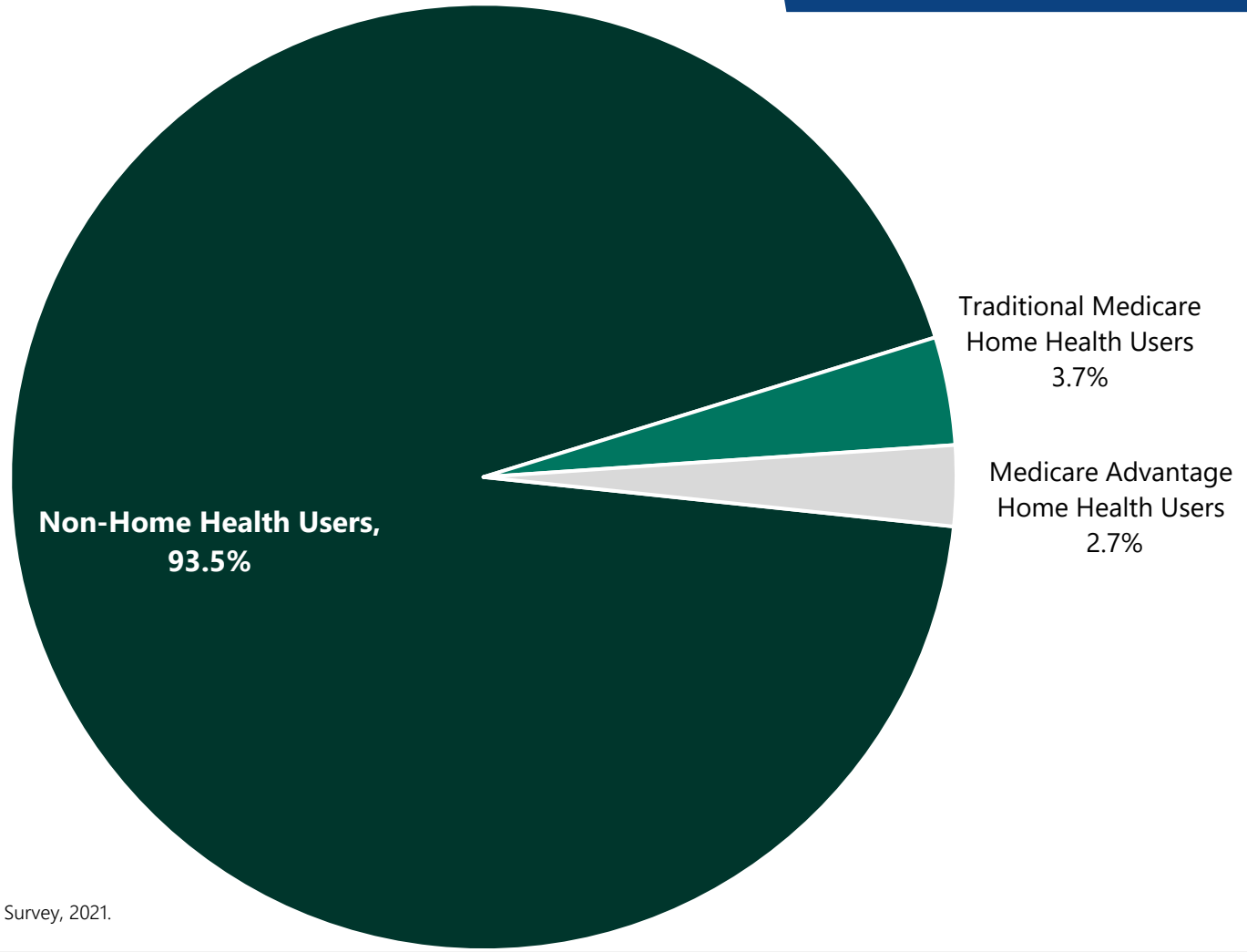
RESEARCH INSTITUTE for HOME CARE

ADVANCING HOME CARE THROUGH RESEARCH.

Demographics of Home Health Users

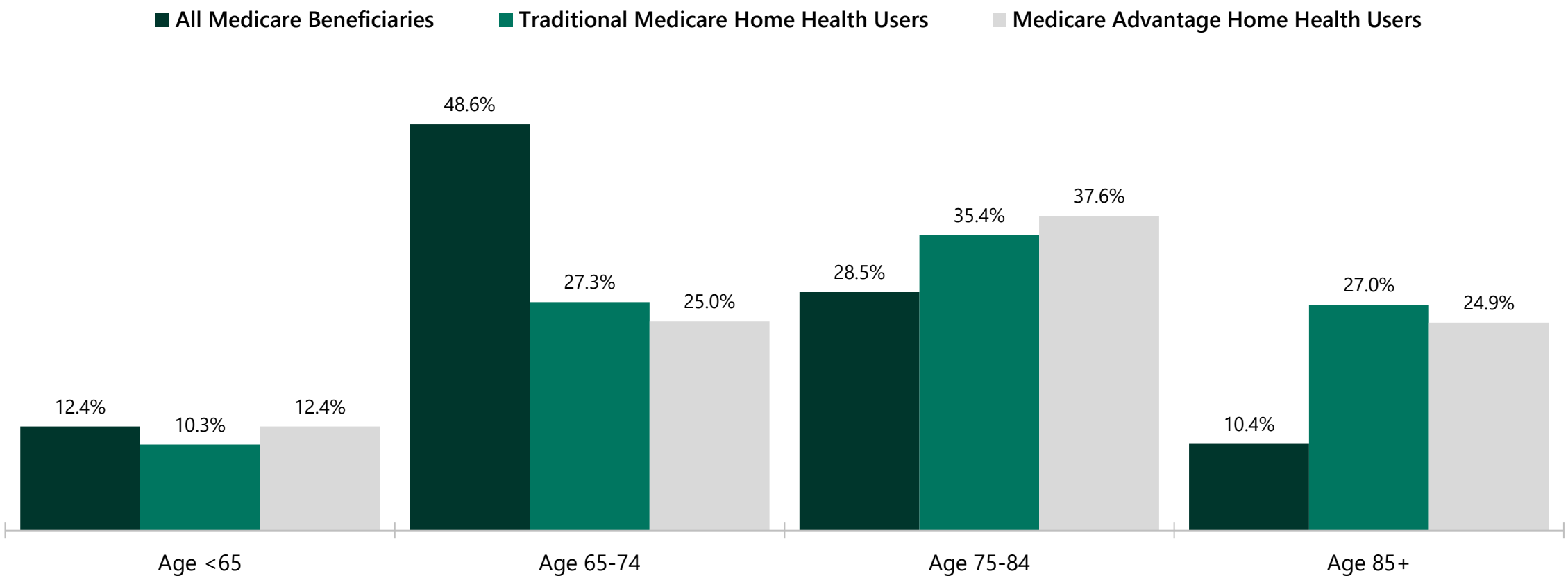
Sponsored by HOMECARE & HOSPICE National Association for Home Care & Hospice

Chart 1.1: Distribution of Home Health Users in Traditional Medicare and Medicare Advantage, 2021



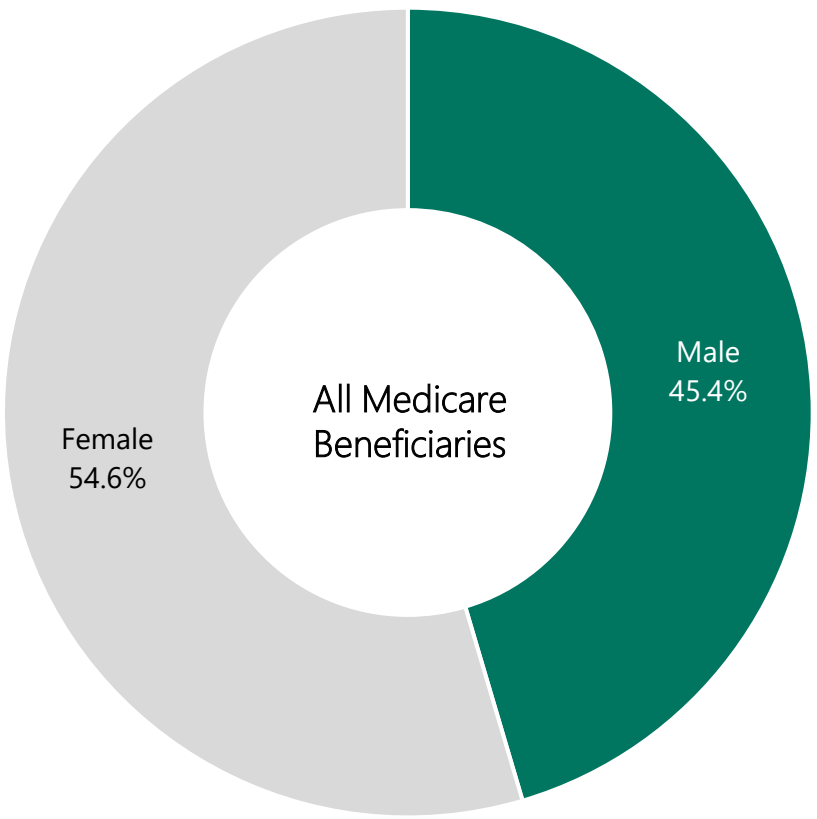
Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.

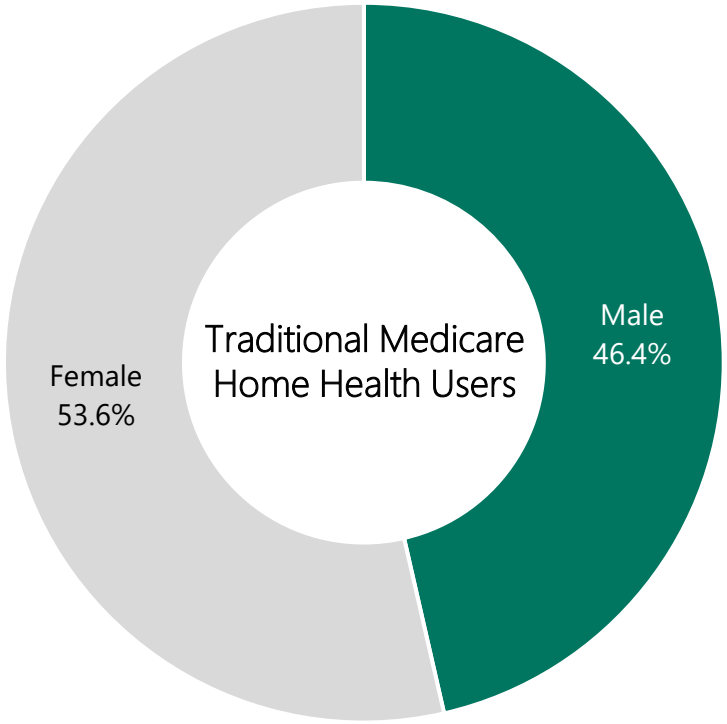
Chart 1.2: Age Distribution of Medicare Beneficiaries, Traditional Medicare Home Health Users, and Home Health Users in Medicare Advantage, 2021

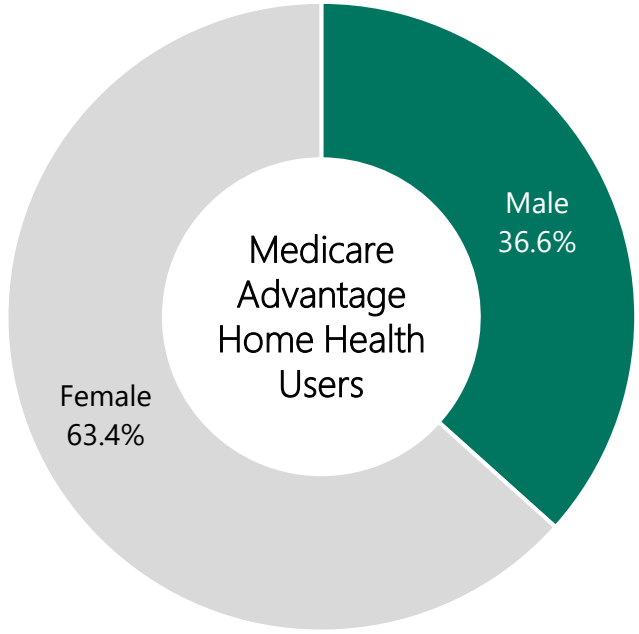


Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.

Chart 1.3: Gender Distribution of Medicare Beneficiaries, Traditional Medicare Home Health Users, and Home Health Users in Medicare Advantage, 2021

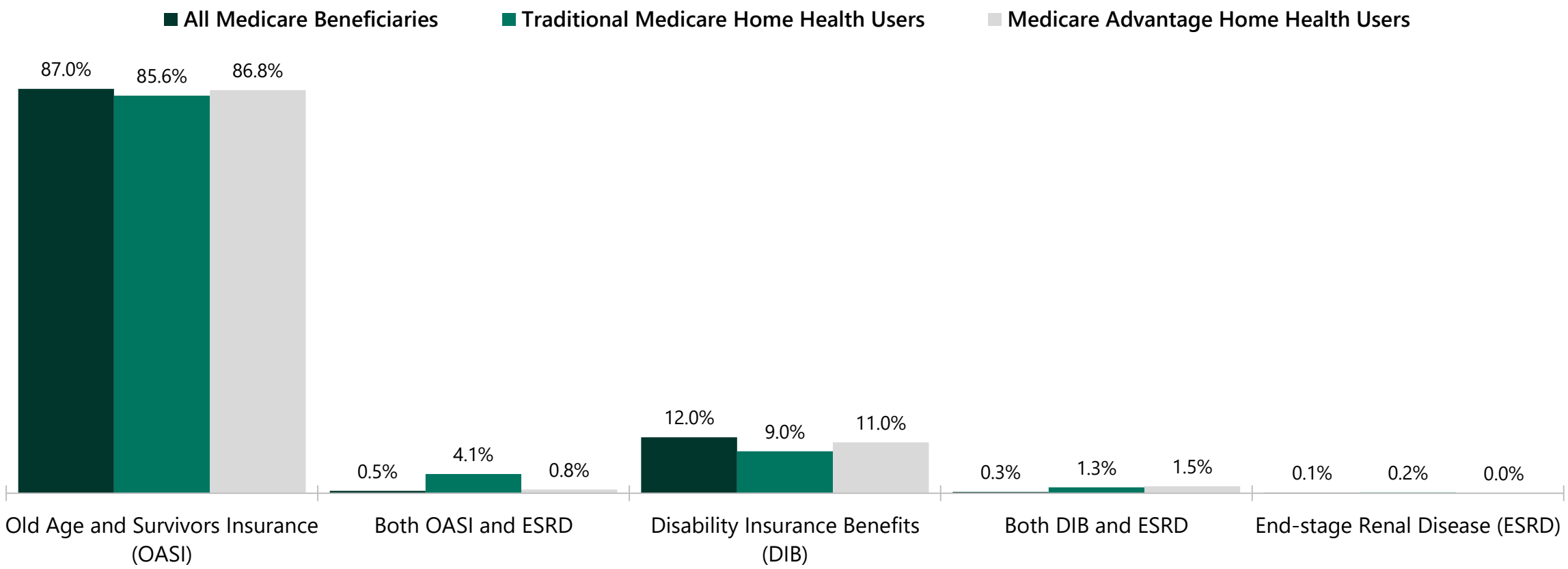






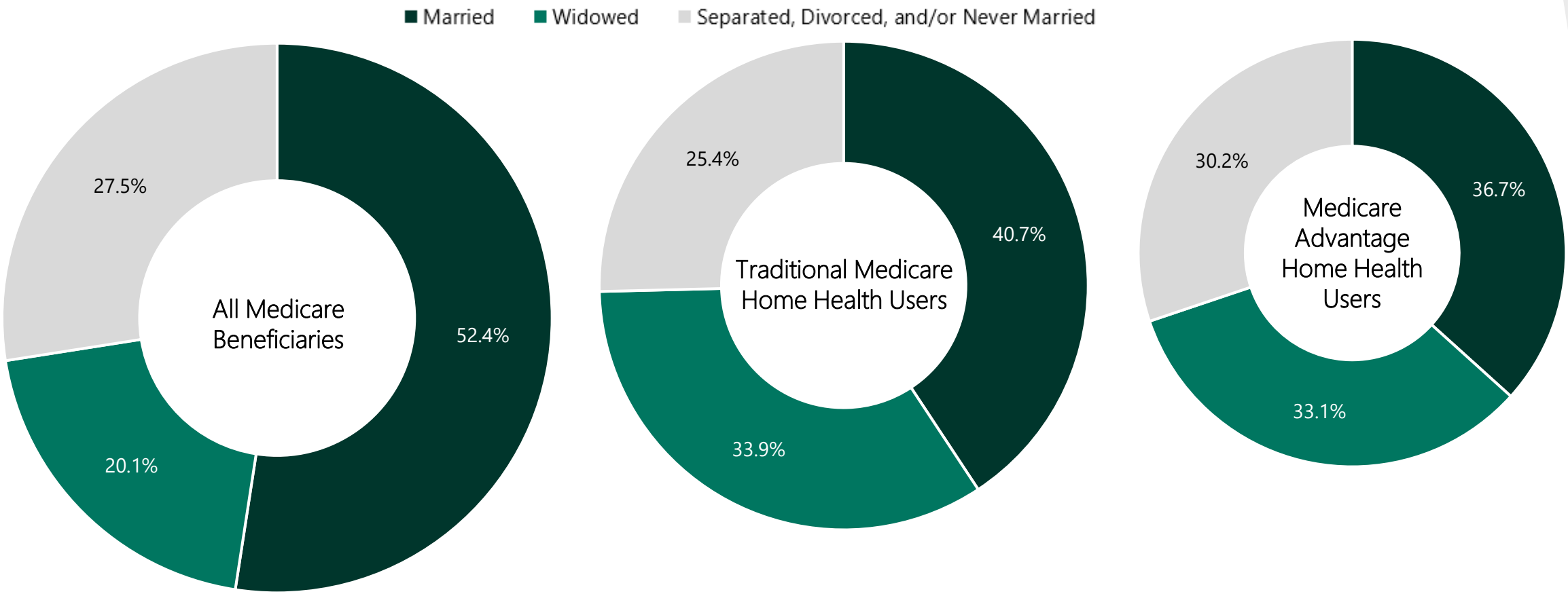
Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.

Chart 1.4: Reason for Medicare Enrollment of Medicare Beneficiaries, Traditional Medicare Home Health Users, and Home Health Users in Medicare Advantage, 2021



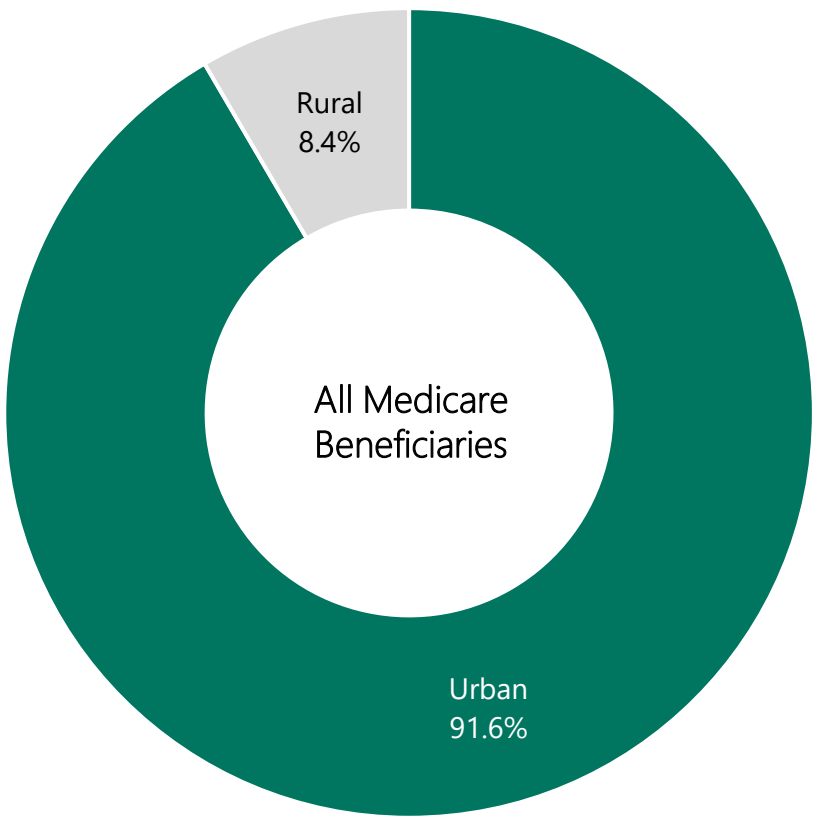
Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.

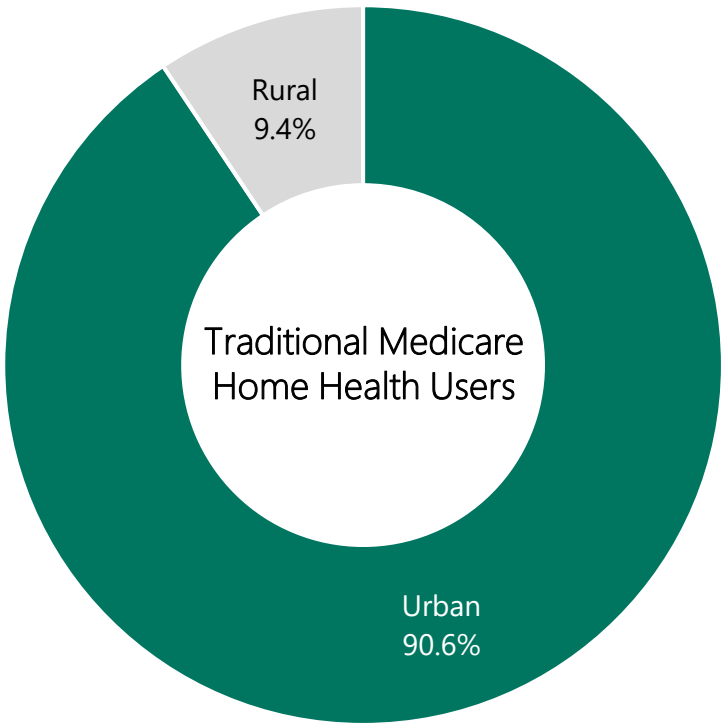
Chart 1.5: Marital Status of Medicare Beneficiaries, Traditional Medicare Home Health Users, and Home Health Users in Medicare Advantage, 2021

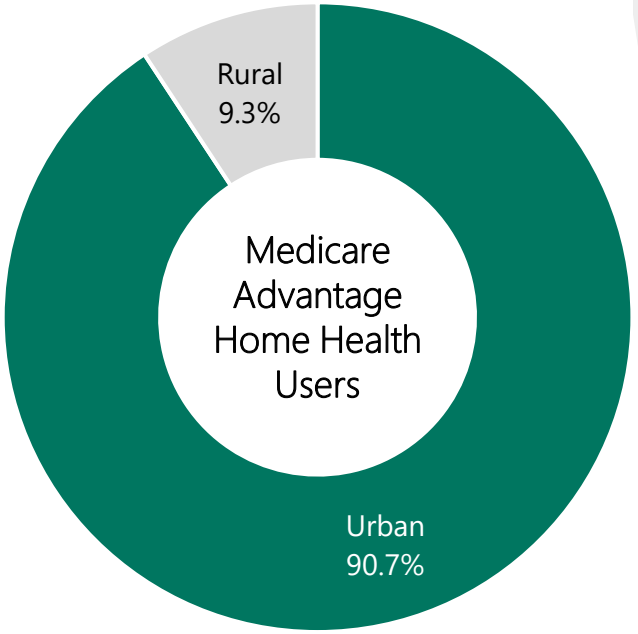


Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.

Chart 1.6: Rural Status of Medicare Beneficiaries, Traditional Medicare Home Health Users, and Home Health Users in Medicare Advantage, 2021

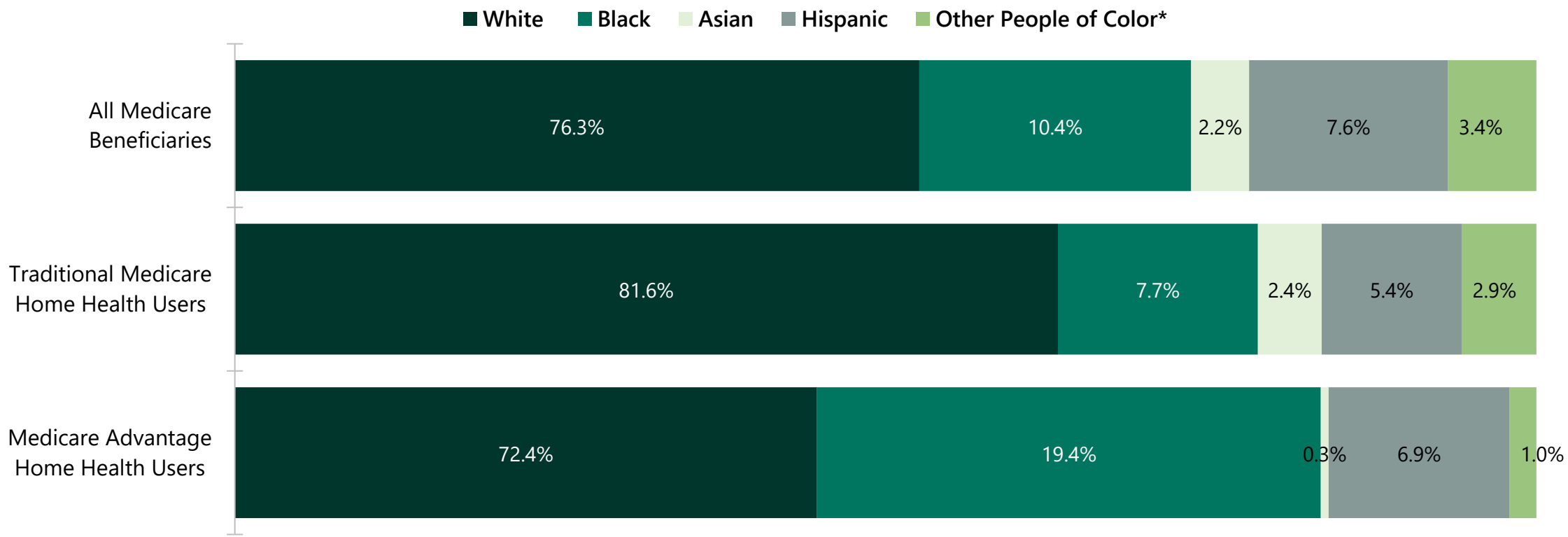






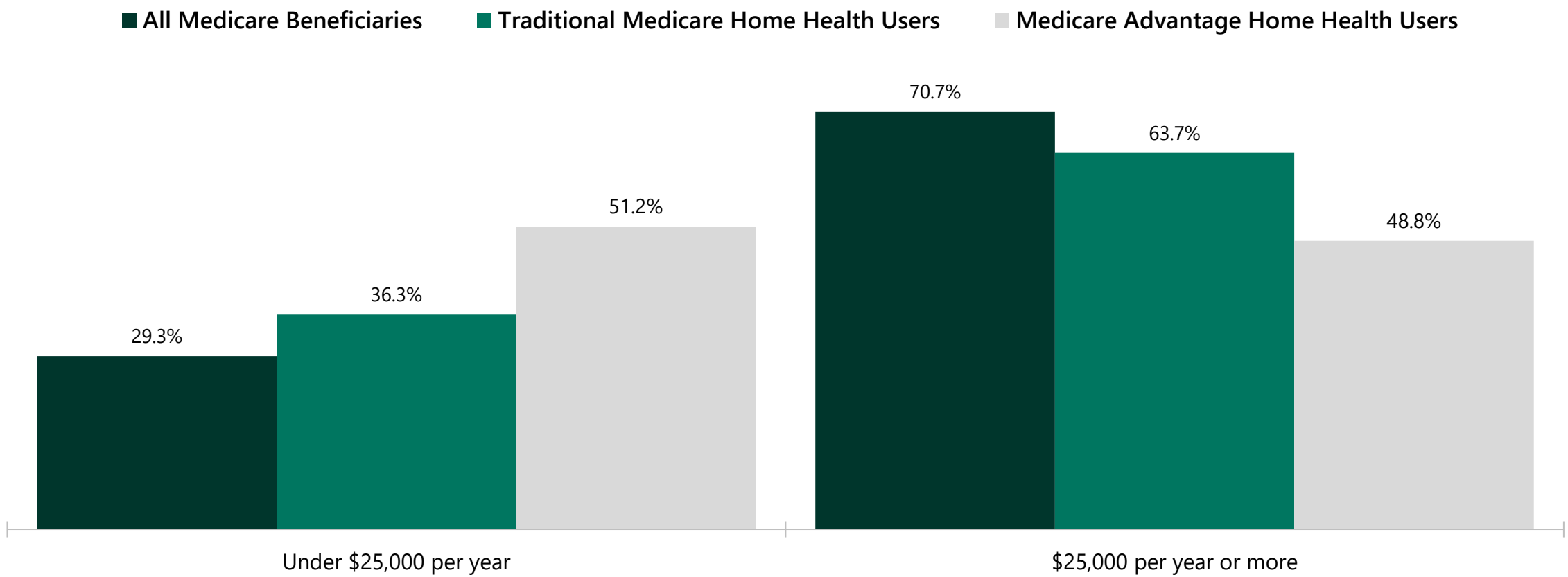
Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.
Rural is defined as a "small town" or "rural" area.

Chart 1.7: Race of Medicare Beneficiaries, Traditional Medicare Home Health Users, and Home Health Users in Medicare Advantage, 2021



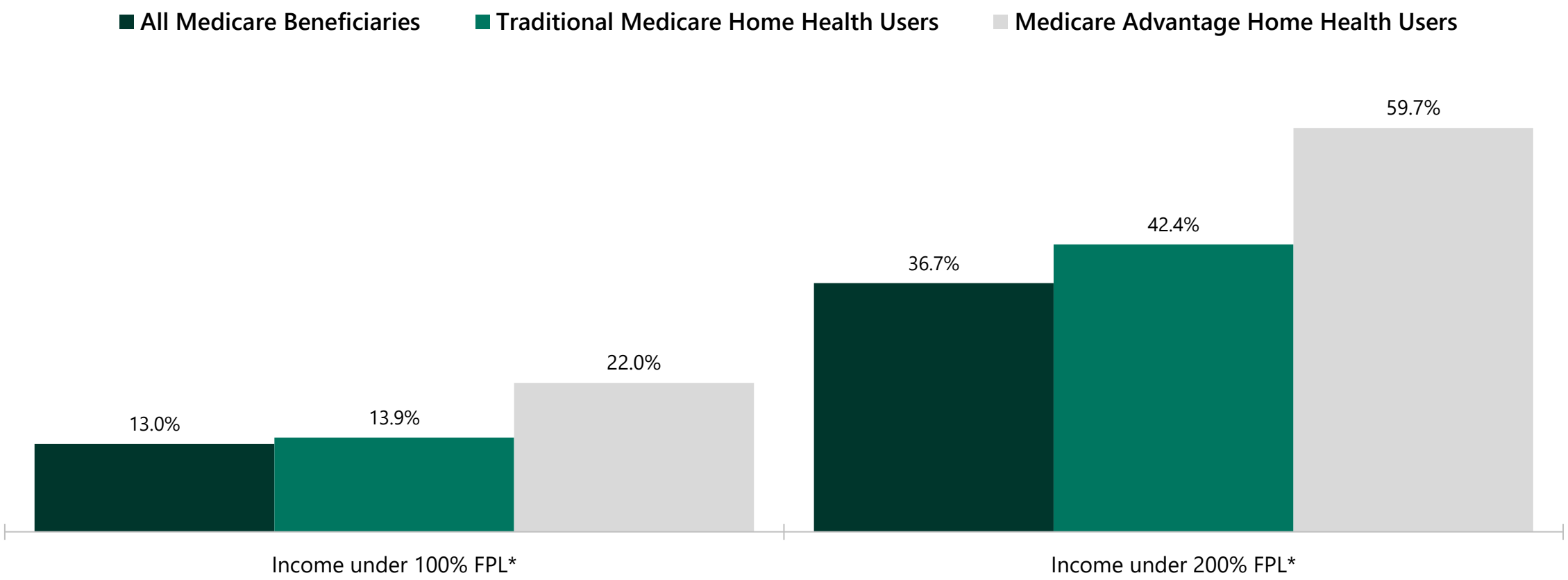
Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
*Other People of Color includes American Indian, Alaska Native, Pacific Islander, Other, and More than one race.
Totals may not sum to 100 percent due to rounding.

Chart 1.8: Income Distribution of Medicare Beneficiaries, Traditional Medicare Home Health Users, and Home Health Users in Medicare Advantage, 2021



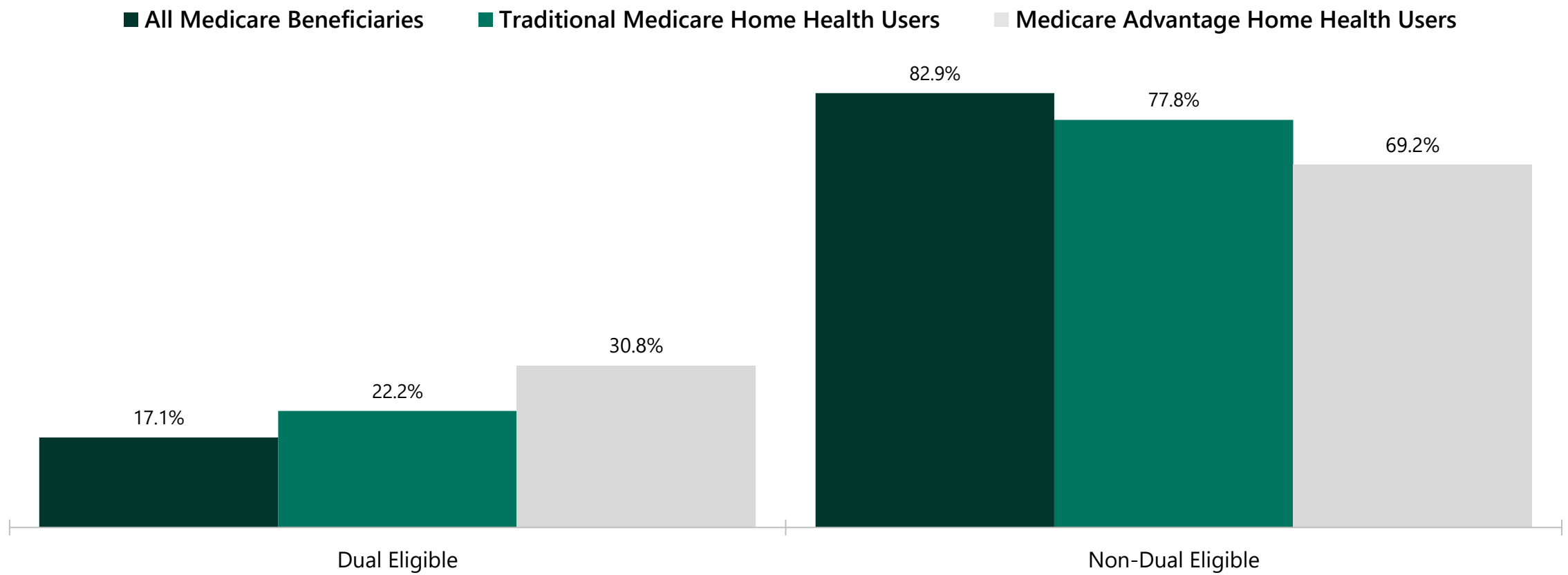
Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.

Chart 1.9: Income Distribution by Federal Poverty Level (FPL) of Medicare Beneficiaries, Traditional Medicare Home Health Users, and Home Health Users in Medicare Advantage, 2021



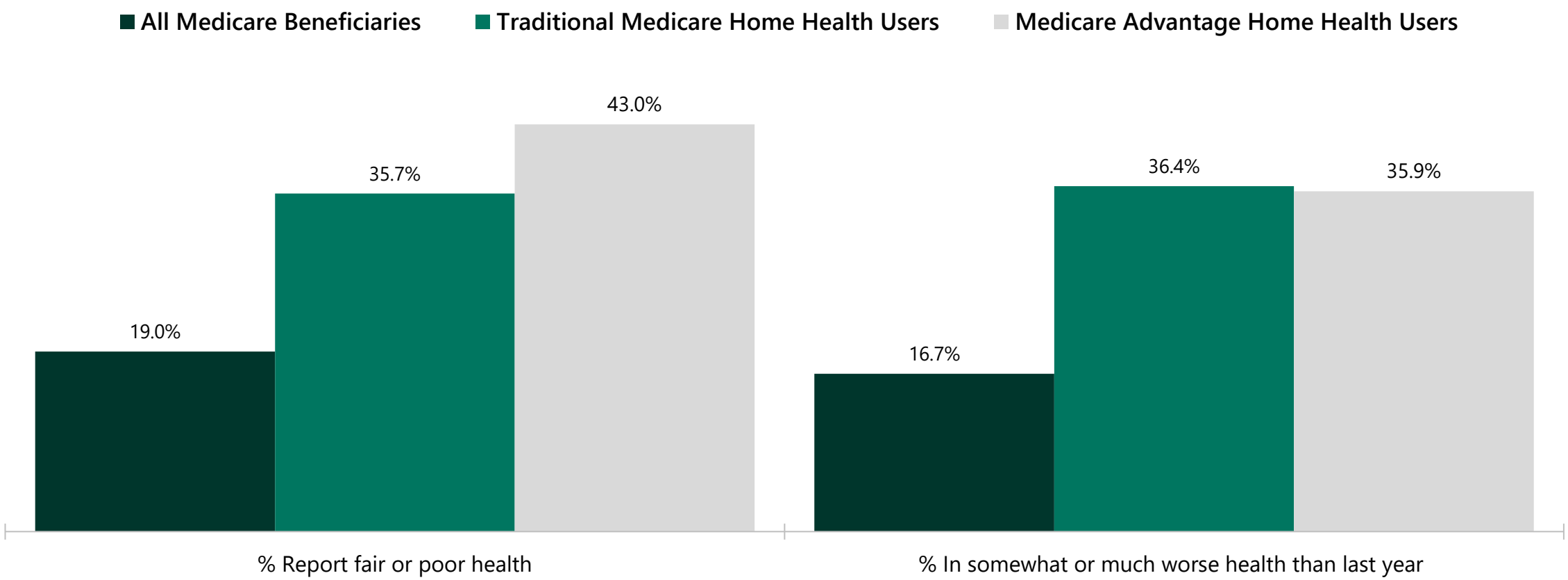
Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
*In 2021, 100% of FPL for a household of 1 was $12,880, a household of 2 was $17,420, a household of 3 was $21,960, and a household of 4 was $26,500. As a result, 200% of FPL was double each amount.

Chart 1.10: Dual Eligibility Status of Medicare Beneficiaries, Traditional Medicare Home Health Users, and Home Health Users in Medicare Advantage, 2021



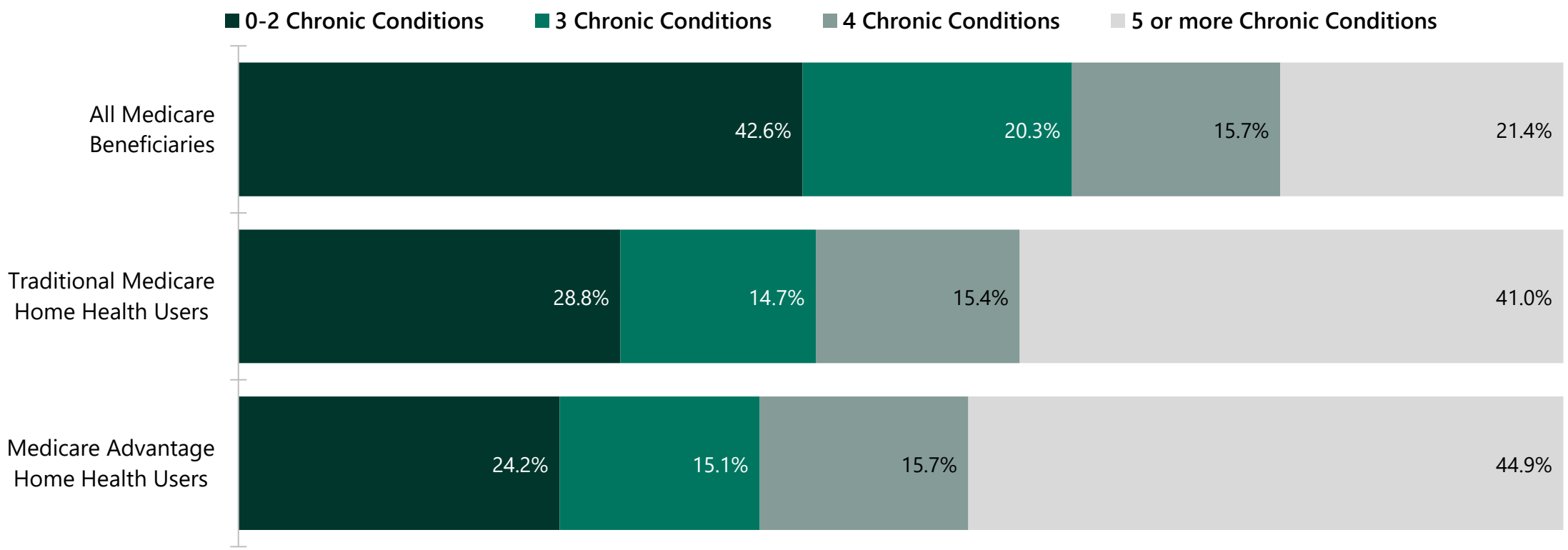
Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.
Dual Eligibles are defined as individuals with any state buy-in at any point during the year.

Chart 1.11: Share of Medicare Beneficiaries, Traditional Medicare Home Health Users, and Home Health Users in Medicare Advantage, by Measures of General Health Status, 2021



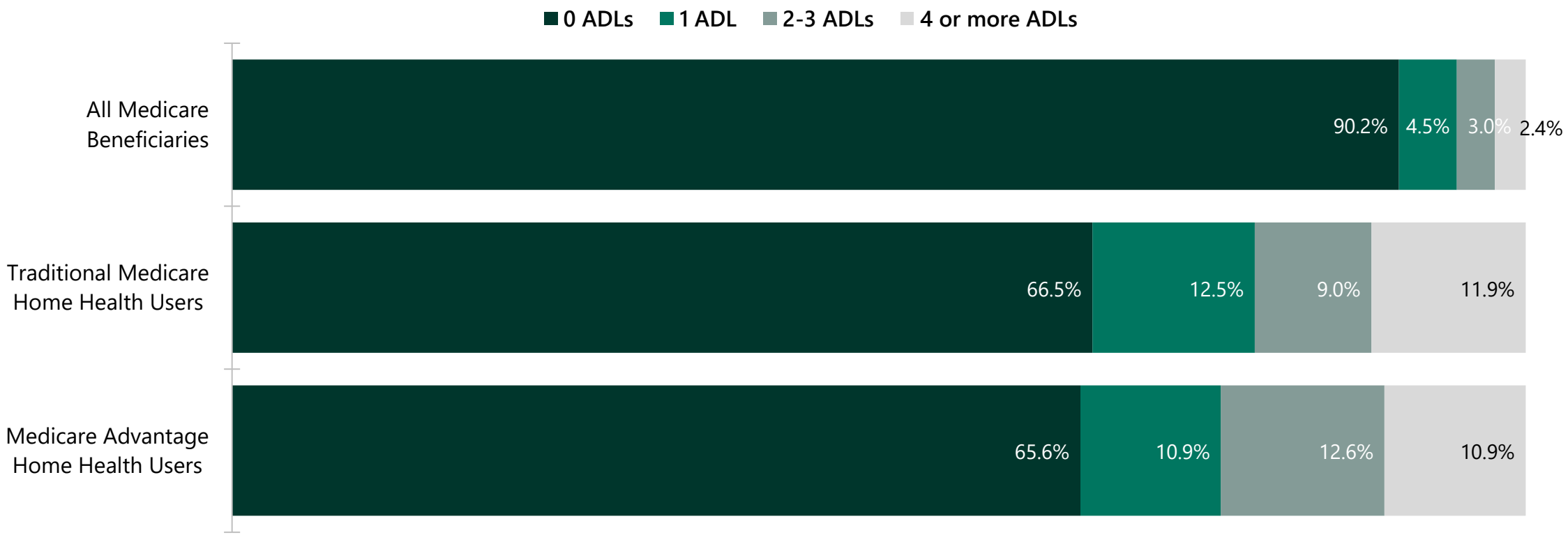
Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.

Chart 1.12: Share of Medicare Beneficiaries, Traditional Medicare Home Health Users, and Home Health Users in Medicare Advantage, by Number of Chronic Conditions, 2021



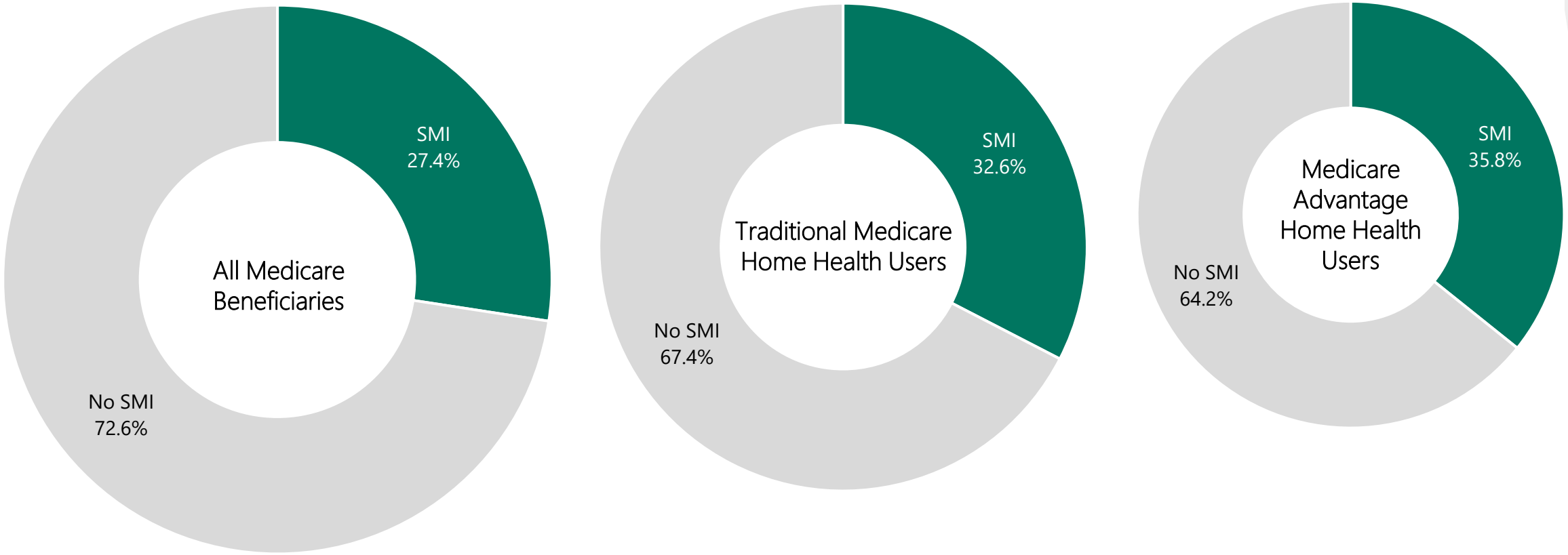
Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.

Chart 1.13: Share of Medicare Beneficiaries, Traditional Medicare Home Health Users, and Home Health Users in Medicare Advantage, by Number of Activities of Daily Living (ADLs), 2021



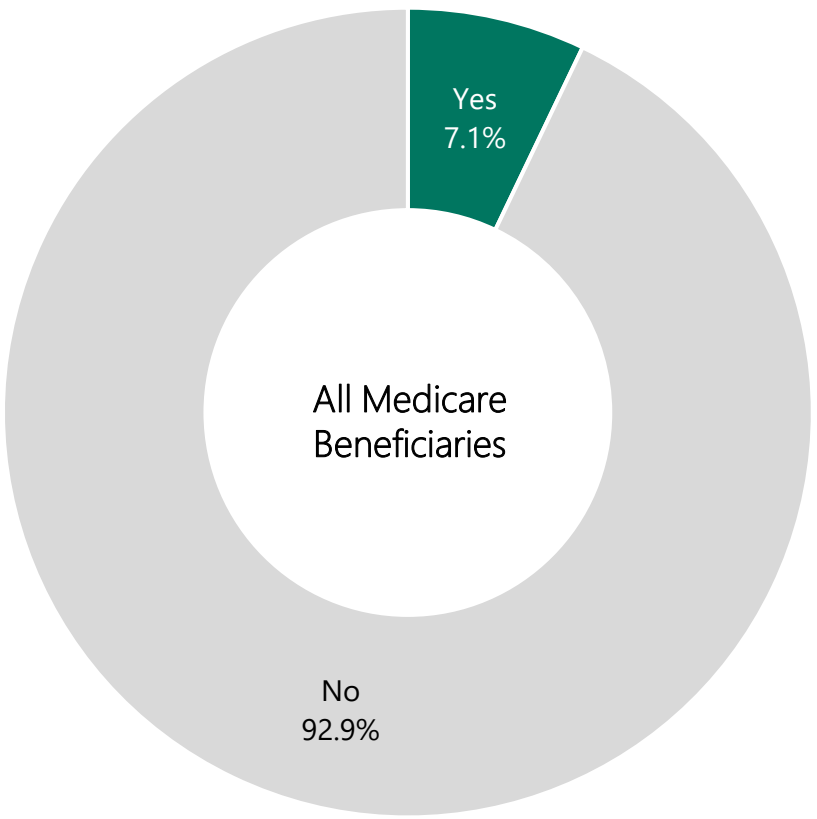
Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.
ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.

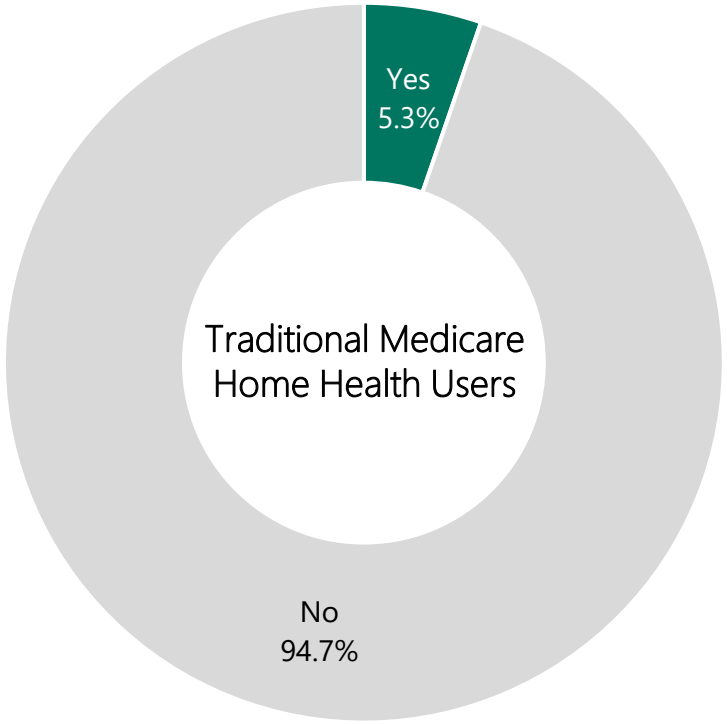
Chart 1.14: Share of Medicare Beneficiaries, Traditional Medicare Home Health Users, and Home Health Users in Medicare Advantage, with Severe Mental Illness (SMI), 2021

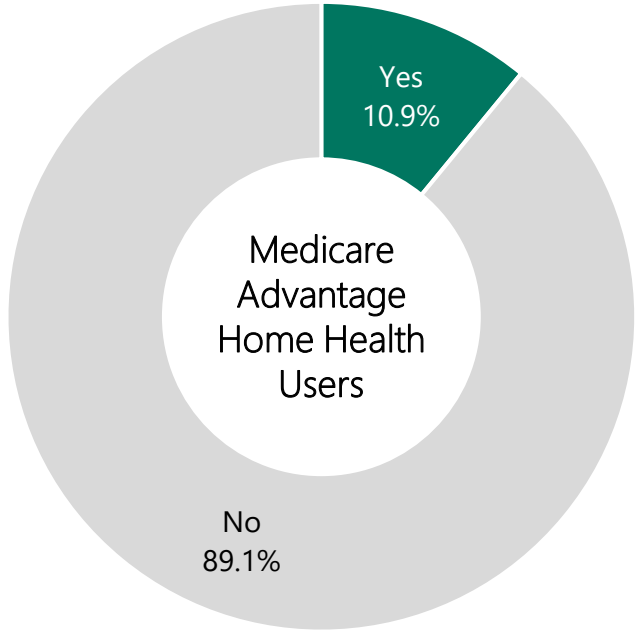


Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.
Severe mental illness (SMI) is defined as having depression or other mental disorder, including bipolar disorder, schizophrenia, and other psychoses.

Chart 1.15: Share of Medicare Beneficiaries, Traditional Medicare Home Health Users, and Home Health Users in Medicare Advantage who had Trouble Accessing Needed Care, 2021

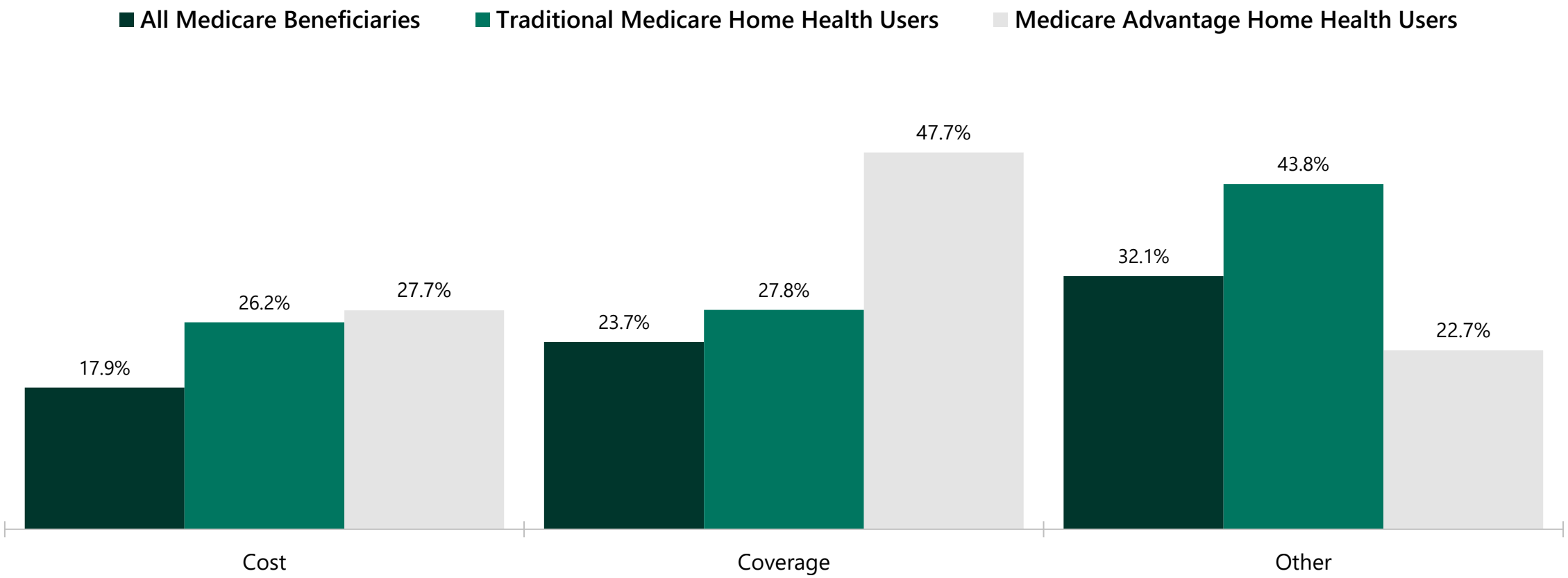






Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Access to care includes information about the respondents' use of all types of medical services.

Chart 1.16: Top Reasons Medicare Beneficiaries, Traditional Medicare Home Health Users, and Home Health Users in Medicare Advantage had Trouble Accessing Needed Care, 2021



Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.
Access to care includes information about the respondents' use of all types of medical services.
Respondent can select multiple reasons; the percentages are calculated as the number of respondents who selected the reason over all respondents that indicated having trouble getting needed care.

Table 1.1: Selected Characteristics of Medicare Beneficiaries, Traditional Medicare Home Health Users, and Home Health Users in Medicare Advantage, 2021

Demographics of Home Health Users

	All Medicare Beneficiaries	Traditional Medicare Home Health Users	Medicare Advantage Home Health Users
Beneficiary Characteristics			
% People of Color	24.5%	20.1%	29.9%
% Female	54.6%	53.6%	63.4%
% Age 85+	10.4%	27.0%	24.9%
% Income 200% or less than FPL	36.7%	42.4%	59.7%
% Living alone	29.9%	34.3%	40.9%
% Dual Eligible	17.1%	22.2%	30.8%
Health Characteristics			
% 3+ Chronic conditions	57.4%	71.1%	75.9%
% 2+ ADL limitations*	5.3%	21.0%	23.6%
% Report fair or poor health	19.0%	35.7%	43.0%
% Are in somewhat worse health than last year	16.7%	36.4%	35.9%
% Severe Mental Illness	27.4%	32.6%	35.8%

Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
In 2021, 100% of FPL for a household of 1 was $12,880, a household of 2 was $17,420, a household of 3 was $21,960, and a household of 4 was $26,500. As a result, 200% of FPL was double each amount.
Dual Eligibles are defined as individuals with any state buy-in at any point during the year.
ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.
Severe mental illness (SMI) is defined as having depression or other mental disorder, including bipolar disorder, schizophrenia, and other psychoses.

Table 1.2: Selected Beneficiary Characteristics of All Medicare Home Health Users by Age, 2021

	Age <65	Age 65-74	Age 75-84	Age 85+
Gender				
% Male	46.4%	55.1%	37.1%	34.7%
% Female	53.6%	44.9%	62.9%	65.3%
Race				
% White	59.5%	73.3%	80.7%	85.6%
% Black	22.2%	15.6%	10.9%	8.1%
% Other	18.3%	11.1%	8.4%	6.3%
Marital Status				
% Married	18.2%	55.8%	46.7%	20.1%
% Widowed	8.2%	14.0%	32.9%	65.2%
% Separated, Divorced, Never Married	73.5%	30.2%	20.4%	14.7%
Income Distribution				
% Under $25,000 per year	81.1%	36.1%	37.2%	40.4%
% $25,000 per year or more	18.9%	63.9%	62.8%	59.6%
Living Alone				
% Living Alone	36.8%	31.3%	34.1%	47.2%
Dual Eligibility				
% Dual Eligible	68.4%	25.4%	20.3%	15.9%
% Non-Dual Eligible	31.6%	74.6%	79.7%	84.1%

Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.
Dual Eligibles are defined as individuals with any state buy-in at any point during the year.

Table 1.3: Selected Health Characteristics of All Medicare Home Health Users by Age, 2021

	Age <65	Age 65-74	Age 75-84	Age 85+
Measures of General Health Status				
% Report Fair or Poor Health	60.3%	42.0%	38.6%	26.5%
% In Somewhat or Much Worse Health than Last Year	41.7%	36.4%	33.7%	37.1%
Chronic Conditions				
% Have 3 or More Chronic Conditions	62.3%	77.5%	76.5%	68.9%
Disability				
% Have 2 or More ADLs	31.5%	20.9%	15.5%	28.3%
Cognitive Function				
% with Presence of SMI	53.5%	38.5%	32.0%	23.6%

Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.
Severe mental illness (SMI) is defined as having depression or other mental disorder, including bipolar disorder, schizophrenia, and other psychoses.

Table 1.4: Selected Beneficiary Characteristics of All Medicare Home Health Users by Gender, 2021

	Male	Female
Age		
% Age <65	12.3%	10.4%
% Age 65-74	34.4%	20.5%
% Age 75-84	31.9%	39.6%
% Age 85+	21.4%	29.5%
Race		
% White	79.0%	76.7%
% Black	10.5%	14.2%
% Other	10.4%	9.1%
Marital Status		
% Married	56.5%	26.1%
% Widowed	17.5%	45.4%
% Separated, Divorced, Never Married	26.0%	28.5%
Income Distribution		
% Under $25,000 per year	31.7%	50.7%
% $25,000 per year or more	68.3%	49.3%
Living Alone		
% Living Alone	29.4%	42.7%
Dual Eligibility		
% Dual Eligible	22.7%	28.2%
% Non-Dual Eligible	77.3%	71.8%

Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.
Dual Eligibles are defined as individuals with any state buy-in at any point during the year.

Table 1.5: Selected Health Characteristics of All Medicare Home Health Users by Gender, 2021

	Male	Female
Measures of General Health Status		
% Report Fair or Poor Health	42.2%	36.3%
% In Somewhat or Much Worse Health than Last Year	39.3%	34.0%
Chronic Conditions		
% Have 3 or More Chronic Conditions	72.0%	74.0%
Disability		
% Have 2 or More ADLs	22.2%	21.9%
Cognitive Function		
% with Presence of SMI	27.5%	38.7%

Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.
Severe mental illness (SMI) is defined as having depression or other mental disorder, including bipolar disorder, schizophrenia, and other psychoses.

Table 1.6: Selected Beneficiary Characteristics of All Medicare Home Health Users by Race, 2021

	All Beneficiaries	Black Beneficiaries	Hispanic Beneficiaries
Gender			
% Male	42.2%	35.1%	47.1%
% Female	57.8%	64.9%	52.9%
Age			
% Age <65	11.2%	19.7%	21.0%
% Age 65-74	26.4%	32.5%	23.8%
% Age 75-84	36.3%	31.2%	34.0%
% Age 85+	26.1%	16.6%	21.2%
Marital Status			
% Married	39.0%	24.2%	28.6%
% Widowed	33.6%	29.7%	28.7%
% Separated, Divorced, Never Married	27.4%	46.1%	42.7%
Income Distribution			
% Under $25,000 per year	42.7%	64.7%	80.0%
% $25,000 per year or more	57.3%	35.3%	20.0%
Living Alone			
% Living Alone	37.1%	37.7%	33.0%
Dual Eligibility			
% Dual Eligible	25.9%	48.8%	71.9%
% Non-Dual Eligible	74.1%	51.2%	28.1%

Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.
Dual Eligibles are defined as individuals with any state buy-in at any point during the year.

Table 1.7: Selected Health Characteristics of All Medicare Home Health Users by Race, 2021

	All Beneficiaries	Black Beneficiaries	Hispanic Beneficiaries
Measures of General Health Status			
% Report Fair or Poor Health	38.8%	42.7%	55.9%
% In Somewhat or Much Worse Health than Last Year	36.2%	35.4%	30.0%
Chronic Conditions			
% Have 3 or More Chronic Conditions	73.2%	81.4%	77.6%
Disability			
% Have 2 or More ADLs	22.1%	24.6%	34.3%
Cognitive Function			
% with Presence of SMI	33.9%	30.6%	45.0%

Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.
Severe mental illness (SMI) is defined as having depression or other mental disorder, including bipolar disorder, schizophrenia, and other psychoses.

Table 1.8: Selected Beneficiary Characteristics of All Medicare Home Health Users by Dual Eligibility Status, 2021

	Dual Eligible	Non-Dual Eligible
Gender		
% Male	37.1%	44.0%
% Female	62.9%	56.0%
Age		
% Age <65	29.6%	4.8%
% Age 65-74	25.9%	26.5%
% Age 75-84	28.5%	39.1%
% Age 85+	16.0%	29.6%
Race		
% White	54.8%	85.6%
% Black	23.9%	8.7%
% Other	21.3%	5.6%
Marital Status		
% Married	15.1%	47.3%
% Widowed	31.6%	34.3%
% Separated, Divorced, Never Married	53.4%	18.5%
Income Distribution		
% Under $25,000 per year	90.6%	25.9%
% $25,000 per year or more	9.4%	74.1%
Living Alone		
% Living Alone	42.2%	35.3%

Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.
Dual Eligibles are defined as individuals with any state buy-in at any point during the year.

Table 1.9: Selected Health Characteristics of All Medicare Home Health Users by Dual Eligibility Status, 2021

	Dual Eligible	Non-Dual Eligible
Measures of General Health Status		
% Report Fair or Poor Health	53.6%	33.6%
% In Somewhat or Much Worse Health than Last Year	34.9%	36.7%
Chronic Conditions		
% Have 3 or More Chronic Conditions	74.7%	72.6%
Disability		
% Have 2 or More ADLs	36.3%	17.1%
Cognitive Function		
% with Presence of SMI	46.1%	29.7%

Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.
Severe mental illness (SMI) is defined as having depression or other mental disorder, including bipolar disorder, schizophrenia, and other psychoses.

Table 1.10: Selected Beneficiary Characteristics of All Medicare Home Health Users by Severe Mental Illness (SMI), 2021

	Any SMI	Depression	Mental Disorder
Gender			
% Male	34.2%	33.2%	43.2%
% Female	65.8%	66.8%	56.8%
Age			
% Age <65	17.7%	17.4%	25.0%
% Age 65-74	29.9%	29.8%	40.5%
% Age 75-84	34.3%	34.2%	25.2%
% Age 85+	18.1%	18.6%	9.3%
Race			
% White	76.7%	76.8%	73.5%
% Black	11.4%	11.6%	4.2%
% Other	11.9%	11.5%	22.3%
Marital Status			
% Married	32.6%	32.9%	32.9%
% Widowed	33.9%	33.4%	33.2%
% Separated, Divorced, Never Married	33.5%	33.7%	33.9%
Income Distribution			
% Under $25,000 per year	52.1%	52.4%	49.5%
% $25,000 per year or more	47.9%	47.6%	50.5%
Living Alone			
% Living Alone	44.2%	44.8%	37.5%
Dual Eligibility			
% Dual Eligible	35.2%	34.8%	42.9%
% Non-Dual Eligible	64.8%	65.2%	57.1%

Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.
Dual Eligibles are defined as individuals with any state buy-in at any point during the year.
Severe mental illness (SMI) is defined as having depression or other mental disorder, including bipolar disorder, schizophrenia, and other psychoses.

Table 1.11: Selected Health Characteristics of All Medicare Home Health Users by Severe Mental Illness (SMI), 2021

	Any SMI	Depression	Mental Disorder
Measures of General Health Status			
% Report Fair or Poor Health	51.6%	51.2%	53.8%
% In Somewhat or Much Worse Health than Last Year	42.5%	43.6%	32.5%
Chronic Conditions			
% Have 3 or More Chronic Conditions	90.4%	90.9%	92.5%
Disability			
% Have 2 or More ADLs	29.0%	28.8%	39.2%

Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.
Severe mental illness (SMI) is defined as having depression or other mental disorder, including bipolar disorder, schizophrenia, and other psychoses.

Table 1.12: Selected Beneficiary Characteristics of All Medicare Home Health Users Compared to Skilled Nursing Facility Users, 2021

	Home Health Users	Skilled Nursing Facility Users
Gender		
% Male	42.2%	40.3%
% Female	57.8%	59.7%
Age		
% Age <65	11.2%	13.0%
% Age 65-74	26.4%	21.6%
% Age 75-84	36.3%	28.4%
% Age 85+	26.1%	36.9%
Race		
% White	77.7%	81.2%
% Black	12.7%	7.8%
% Other	9.7%	11.0%
Marital Status		
% Married	39.0%	30.0%
% Widowed	33.6%	27.2%
% Separated, Divorced, Never Married	27.4%	42.8%
Income Distribution		
% Under $25,000 per year	42.7%	56.9%
% $25,000 per year or more	57.3%	43.1%
Living Alone		
% Living Alone	37.1%	17.8%
Dual Eligibility		
% Dual Eligible	25.9%	47.8%
% Non-Dual Eligible	74.1%	52.2%

Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.
Dual Eligibles are defined as individuals with any state buy-in at any point during the year.

Table 1.13: Selected Health Characteristics of All Medicare Home Health Users Compared to Skilled Nursing Facility Users, 2021

	Home Health Users	Skilled Nursing Facility Users
Measures of General Health Status		
% Report Fair or Poor Health	38.8%	17.8%
% In Somewhat or Much Worse Health than Last Year	36.2%	18.0%
Chronic Conditions		
% Have 3 or More Chronic Conditions	73.2%	29.5%
Disability		
% Have 2 or More ADLs	22.1%	11.9%

Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.

Table 1.14: Selected Health Characteristics of All Medicare Home Health Users over Time (2017-2021)

	2017	2018	2019	2020	2021
Socioeconomic Characteristics					
% Have Incomes under 100% of the Federal Poverty Level (FPL)	26.5%	20.5%	22.3%	23.1%	17.4%
% Have Incomes under 200% of the Federal Poverty Level (FPL)	57.1%	54.4%	55.9%	57.3%	49.8%
% Dual Eligible	32.4%	28.6%	29.4%	30.6%	25.9%
Chronic Conditions					
% Have 3 or More Chronic Conditions	82.3%	75.0%	76.0%	76.1%	73.2%
Disability					
% Have 2 or More ADLs	27.8%	20.2%	22.9%	23.8%	22.1%
Cognitive Function					
% with Presence of SMI	38.3%	34.0%	34.8%	37.8%	33.9%

Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2017-2021.
In 2021, 100% of FPL for a household of 1 was $12,880, a household of 2 was $17,420, a household of 3 was $21,960, and a household of 4 was $26,500. As a result, 200% of FPL was double each amount.
Dual Eligibles are defined as individuals with any state buy-in at any point during the year.
ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.
Severe mental illness (SMI) is defined as having depression or other mental disorder, including bipolar disorder, schizophrenia, and other psychoses.
Note: Analyses on data prior to 2018 were not conducted by KNG Health Consulting. As a result, there may be slight methodological differences in results.

RESEARCH INSTITUTE for HOME CARE

ADVANCING HOME CARE THROUGH RESEARCH.

Clinical Profile of Home Health Users

Sponsored by HOMECARE & HOSPICE National Association for Home Care & Hospice

Table 2.1: Top 20 Medicare Severity Diagnosis Related Groups (MS-DRGs) for Beneficiaries Discharged from Hospital to Part A Home Health Episodes, 2022

MS-DRGs	Number of Home Health Part A Claims	Percent of Total Home Health Part A Claims
SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC	78,683	6.6%
HEART FAILURE AND SHOCK WITH MCC	62,402	5.2%
RESPIRATORY INFECTIONS AND INFLAMMATIONS WITH MCC	54,543	4.5%
MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITHOUT MCC	52,626	4.4%
SIMPLE PNEUMONIA AND PLEURISY WITH MCC	21,290	1.8%
SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITHOUT MCC	18,205	1.5%
KIDNEY AND URINARY TRACT INFECTIONS WITHOUT MCC	15,416	1.3%
INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION WITH CC OR TPA IN 24 HOURS	15,137	1.3%
INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITH MCC	14,048	1.2%
PULMONARY EDEMA AND RESPIRATORY FAILURE	13,923	1.2%
ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE WITH MCC	13,859	1.2%
RENAL FAILURE WITH CC	12,838	1.1%
KIDNEY AND URINARY TRACT INFECTIONS WITH MCC	12,763	1.1%
RENAL FAILURE WITH MCC	12,491	1.0%
HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH CC	11,881	1.0%
MAJOR SMALL AND LARGE BOWEL PROCEDURES WITH CC	11,408	1.0%
CELLULITIS WITHOUT MCC	11,405	1.0%
CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH MCC	11,184	0.9%
HIP REPLACEMENT WITH PRINCIPAL DIAGNOSIS OF HIP FRACTURE WITHOUT MCC	10,934	0.9%
SYNCOPE AND COLLAPSE	10,653	0.9%
Total for Top 20 MS-DRGs	**465,689**	**38.8%**

Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
Note: Data is limited to beneficiaries with a Part A home health episode and a short-term acute care hospital stay within 14 days of home health admission discharged in 2022. Prior short term-acute care stays are limited to 2021 and 2022.
CC – Complication or Comorbidity; MCC – Major Complication or Comorbidity All Medicare

Table 2.2: Comparison of Top 20 MS-DRGs for Beneficiaries Discharged from Hospital to Part A Home Health Episodes, 2018-2022

MS-DRGs	2018	2019	2020	2021	2022
SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC	78,911	77,883	84,183	85,472	78,683
HEART FAILURE AND SHOCK WITH MCC	65,603	68,242	62,540	63,498	62,402
RESPIRATORY INFECTIONS AND INFLAMMATIONS WITH MCC	9,782	10,116	39,281	80,334	54,543
MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITHOUT MCC	206,011	189,379	109,933	68,748	52,626
SIMPLE PNEUMONIA AND PLEURISY WITH MCC	26,556	24,504	21,800	16,018	21,290
SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITHOUT MCC	24,295	23,584	22,108	20,654	18,205
KIDNEY AND URINARY TRACT INFECTIONS WITHOUT MCC	20,669	20,344	17,751	16,929	15,416
INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION WITH CC OR TPA IN 24 HOURS	18,159	18,387	19,475	18,546	15,137
INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITH MCC	13,248	13,309	16,280	16,552	14,048
PULMONARY EDEMA AND RESPIRATORY FAILURE	22,310	21,244	17,059	14,463	13,923
ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE WITH MCC	13,354	13,413	13,820	14,612	13,859
RENAL FAILURE WITH CC	19,005	17,840	16,598	14,962	12,838
KIDNEY AND URINARY TRACT INFECTIONS WITH MCC	12,673	11,936	12,312	12,717	12,763
RENAL FAILURE WITH MCC	13,742	12,876	13,050	13,388	12,491
HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH CC	9,693	10,061	14,316	14,050	11,881
MAJOR SMALL AND LARGE BOWEL PROCEDURES WITH CC	15,155	13,995	13,420	13,077	11,408
CELLULITIS WITHOUT MCC	18,471	16,989	13,764	12,819	11,405
CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH MCC	24,233	21,636	14,872	11,830	11,184
HIP REPLACEMENT WITH PRINCIPAL DIAGNOSIS OF HIP FRACTURE WITHOUT MCC*	0	0	2,419	12,338	10,934
SYNCOPE AND COLLAPSE	12,420	11,904	11,129	11,205	10,653
Total for Top 20 MS-DRGs	**624,290**	**597,642**	**536,110**	**532,212**	**465,689**

Source: KNG Health analysis of the Medicare Standard Analytic Files, 2018-2022.
*MS-DRG: "HIP REPLACEMENT WITH PRINCIPAL DIAGNOSIS OF HIP FRACTURE WITHOUT MCC" was added to the list of MS-DRGs in October 2020.
Note: Data is limited to beneficiaries with a Part A home health episode and a short-term acute care hospital stay within 14 days of home health admission discharged in each year. Prior short term-acute care stays are limited to the year of interest and the prior year.

Table 2.3: Top 20 Primary International Classification of Diseases, Version 10 (ICD-10) Diagnoses for All Home Health Claims, 2022

Primary ICD-10 Diagnoses	Number of Home Health Claims	Percent of Total Home Health Claims
TYPE 2 DIABETES MELLITUS	668,712	7.7%
ENCOUNTER FOR OTHER POSTPROCEDURAL AFTERCARE	469,948	5.4%
ORTHOPEDIC AFTERCARE	456,811	5.2%
HYPERTENSIVE HEART DISEASE	355,737	4.1%
PRESSURE ULCER	332,964	3.8%
ESSENTIAL (PRIMARY) HYPERTENSION	316,158	3.6%
SEQUELAE OF CEREBROVASCULAR DISEASE	291,818	3.3%
HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE	280,469	3.2%
OTHER CHRONIC OBSTRUCTIVE PULMONARY DISEASE	242,296	2.8%
FRACTURE OF FEMUR	188,179	2.2%
ATRIAL FIBRILLATION AND FLUTTER	163,691	1.9%
PARKINSON'S DISEASE	163,617	1.9%
EMERGENCY USE OF COVID-19 DIAGNOSIS	162,771	1.9%
ENCOUNTER FOR FITTING AND ADJUSTMENT OF OTHER DEVICES	140,036	1.6%
OTHER DISORDERS OF URINARY SYSTEM	133,279	1.5%
OSTEOARTHRITIS OF KNEE	133,181	1.5%
HYPERTENSIVE CHRONIC KIDNEY DISEASE	122,469	1.4%
OTHER DISORDERS OF VEINS	122,429	1.4%
UNSPECIFIED DEMENTIA	111,316	1.3%
ALZHEIMER'S DISEASE	107,225	1.2%
Total for Top 20 Primary ICD-10 Diagnoses	**4,963,106**	**56.8%**

Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
Note: Cohort includes all Home Health claims in 2022 Standard Analytic File.

Table 2.4: Comparison of Top 20 Primary International Classification of Diseases, Version 10 (ICD-10) Diagnoses for All Home Health Claims, 2018-2022

Primary ICD-10 Diagnoses	2018	2019	2020	2021	2022
TYPE 2 DIABETES MELLITUS	436,263	425,619	775,054	807,110	668,712
ENCOUNTER FOR OTHER POSTPROCEDURAL AFTERCARE	276,956	272,620	462,147	573,055	469,948
ORTHOPEDIC AFTERCARE	414,993	411,774	439,492	517,912	456,811
HYPERTENSIVE HEART DISEASE	231,060	232,623	363,700	378,128	355,737
PRESSURE ULCER	225,077	215,875	372,701	393,513	332,964
ESSENTIAL (PRIMARY) HYPERTENSION	217,154	215,293	334,211	460,622	316,158
SEQUELAE OF CEREBROVASCULAR DISEASE	204,483	205,440	333,802	354,209	291,818
HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE	158,925	173,266	276,595	280,710	280,469
OTHER CHRONIC OBSTRUCTIVE PULMONARY DISEASE	287,759	267,145	348,732	306,593	242,296
FRACTURE OF FEMUR	119,290	123,531	195,695	218,313	188,179
ATRIAL FIBRILLATION AND FLUTTER	106,724	101,984	171,740	193,088	163,691
PARKINSON'S DISEASE	95,180	100,182	163,586	191,194	163,617
EMERGENCY USE OF COVID-19 DIAGNOSIS	0	0	87,376	253,709	162,771
ENCOUNTER FOR FITTING AND ADJUSTMENT OF OTHER DEVICES	73,083	69,840	151,942	161,752	140,036
OTHER DISORDERS OF URINARY SYSTEM	87,942	91,224	144,164	155,747	133,279
OSTEOARTHRITIS OF KNEE	77,312	80,256	131,084	166,480	133,181
HYPERTENSIVE CHRONIC KIDNEY DISEASE	73,393	80,053	131,868	137,109	122,469
OTHER DISORDERS OF VEINS	92,845	93,381	146,123	146,581	122,429
UNSPECIFIED DEMENTIA	53,948	60,621	104,034	130,011	111,316
ALZHEIMER'S DISEASE	51,814	59,672	111,326	130,541	107,225
Total for Top 20 Primary ICD-10 Diagnoses	**3,284,201**	**3,280,399**	**5,245,372**	**5,956,377**	**4,963,106**

Source: KNG Health analysis of the Medicare Standard Analytic Files, 2018-2022.
Note: Cohorts include all Home Health claims in 2018-2022 Standard Analytic Files.

Table 2.5: Percent of Medicare Home Health Users with 3 or More Chronic Conditions Compared to All Medicare Beneficiaries, by State, 2022

State	% of Beneficiaries with 3+ CC	% of HH Users with 3+ CC
Alabama	7.39%	85.54%
Alaska	9.00%	85.05%
Arizona	5.75%	84.48%
Arkansas	9.23%	84.72%
California	7.11%	83.83%
Colorado	5.30%	81.11%
Connecticut	7.52%	86.78%
Washington, D.C.	9.59%	85.51%
Delaware	9.34%	87.01%
Florida	7.88%	83.20%
Georgia	6.83%	86.10%
Hawaii	3.94%	89.61%
Idaho	6.04%	80.38%
Illinois	9.66%	88.16%
Indiana	8.46%	88.36%
Iowa	8.47%	89.22%
Kansas	10.07%	88.05%
Kentucky	7.88%	85.07%
Louisiana	7.97%	84.65%
Maine	5.71%	87.31%
Maryland	10.56%	87.68%
Massachusetts	10.17%	85.14%
Michigan	6.74%	86.96%
Minnesota	6.25%	89.03%
Mississippi	10.95%	83.50%
Missouri	7.66%	86.69%
Montana	6.86%	83.98%
Nebraska	9.32%	89.40%
Nevada	7.30%	83.74%
New Hampshire	8.41%	82.60%
New Jersey	8.66%	87.29%
New Mexico	5.85%	82.32%
New York	7.40%	87.04%
North Carolina	6.95%	87.73%
North Dakota	11.18%	92.07%
Ohio	7.06%	87.82%
Oklahoma	10.86%	86.79%
Oregon	4.93%	86.23%
Pennsylvania	7.17%	86.44%
Rhode Island	6.11%	85.97%
South Carolina	8.33%	86.01%
South Dakota	10.26%	87.06%
Tennessee	7.44%	87.62%
Texas	7.75%	86.00%
Utah	6.57%	79.61%
Vermont	8.75%	84.60%
Virginia	8.96%	86.61%
Washington	6.12%	87.60%
West Virginia	9.04%	88.35%
Wisconsin	6.33%	88.89%
Wyoming	9.62%	81.29%

Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
Note: Beneficiaries with 3+ chronic conditions are defined as traditional Medicare beneficiaries with at least 3 chronic condition diagnoses based on inpatient, skilled nursing facility, and/or home health agency Medicare claims. Home health users with 3+ chronic conditions are defined as traditional Medicare beneficiaries with at least 3 chronic condition diagnoses based on home health agency Medicare claims.
Having a chronic condition is defined as having a Medicare claim with a chronic condition listed by the Centers for Medicare and Medicaid Services' Chronic Conditions Data Warehouse.

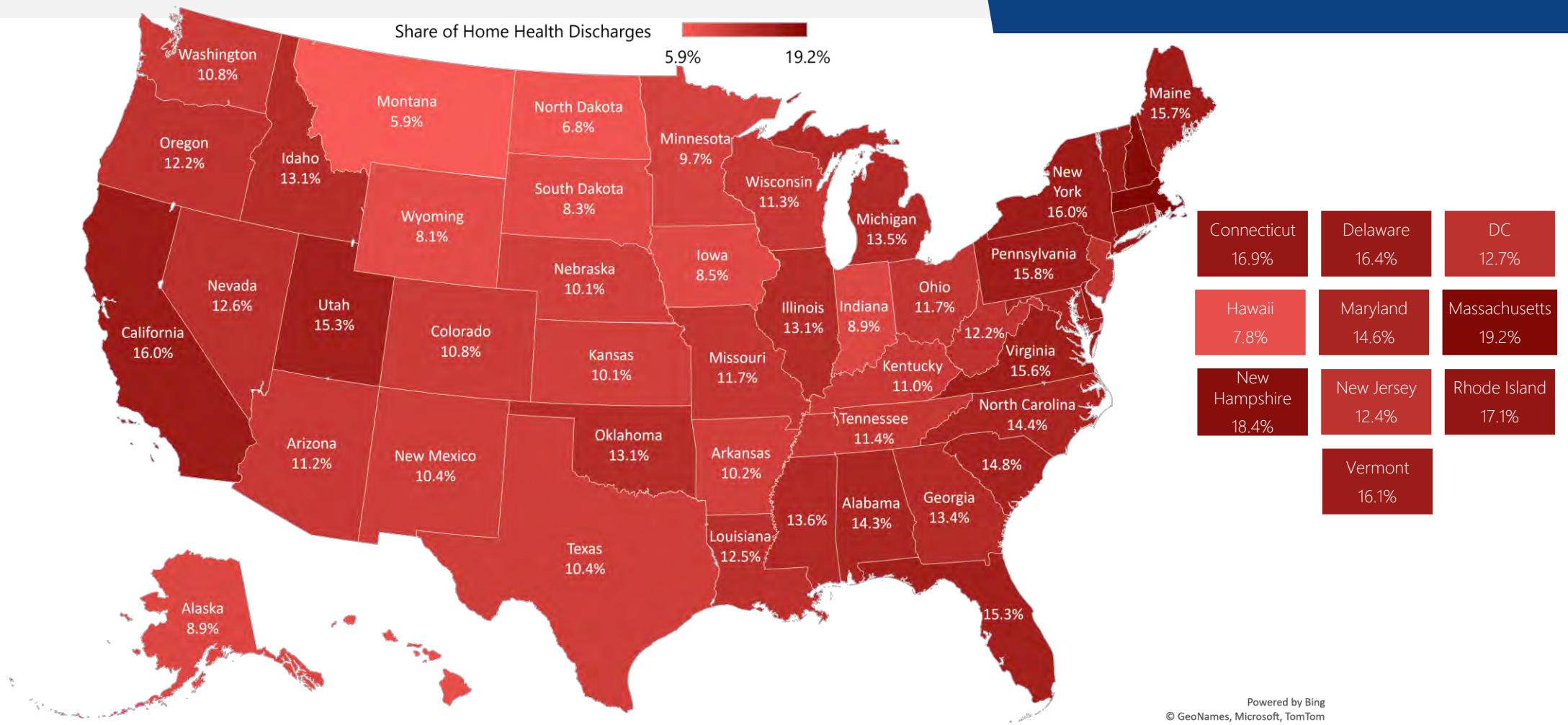
RESEARCH INSTITUTE for HOME CARE

ADVANCING HOME CARE THROUGH RESEARCH.

Role of Home Health in Post-Acute Care Market

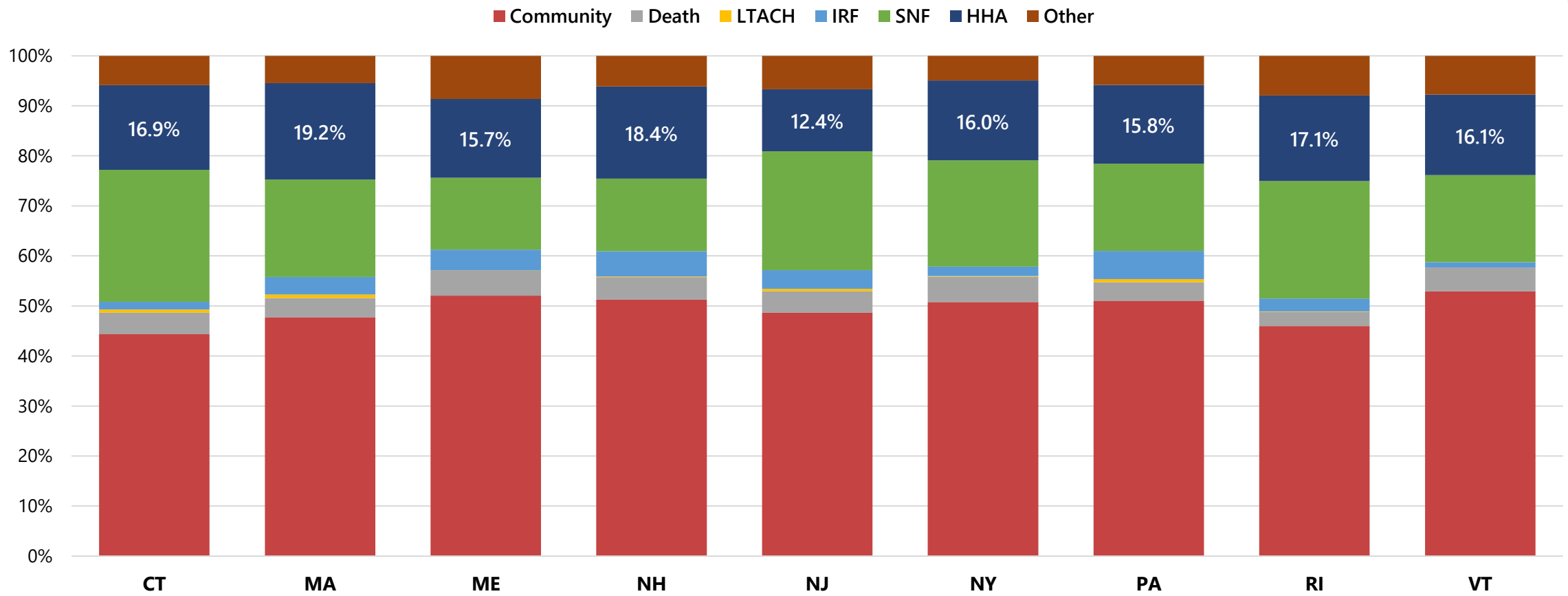
Sponsored by HOMECARE & HOSPICE National Association for Home Care & Hospice

Chart 3.1: Share of Home Health Discharges following an Inpatient Stay by State, 2022



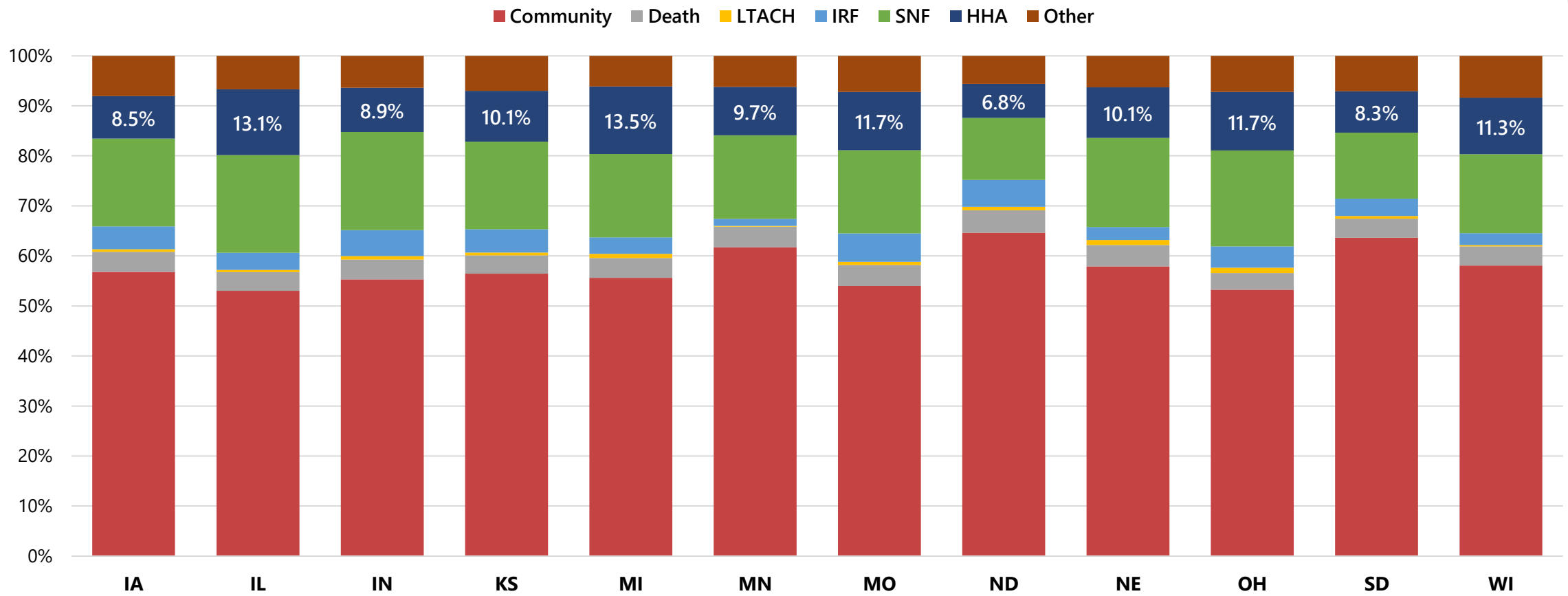
Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
Note: Home health discharges are defined as a home health admission within 14 days of discharge from a short-term acute care hospital.

Chart 3.2a: Initial Patient Destinations Following an Inpatient Hospital Stay for Medicare Beneficiaries in 2022, for States in Northeastern Region



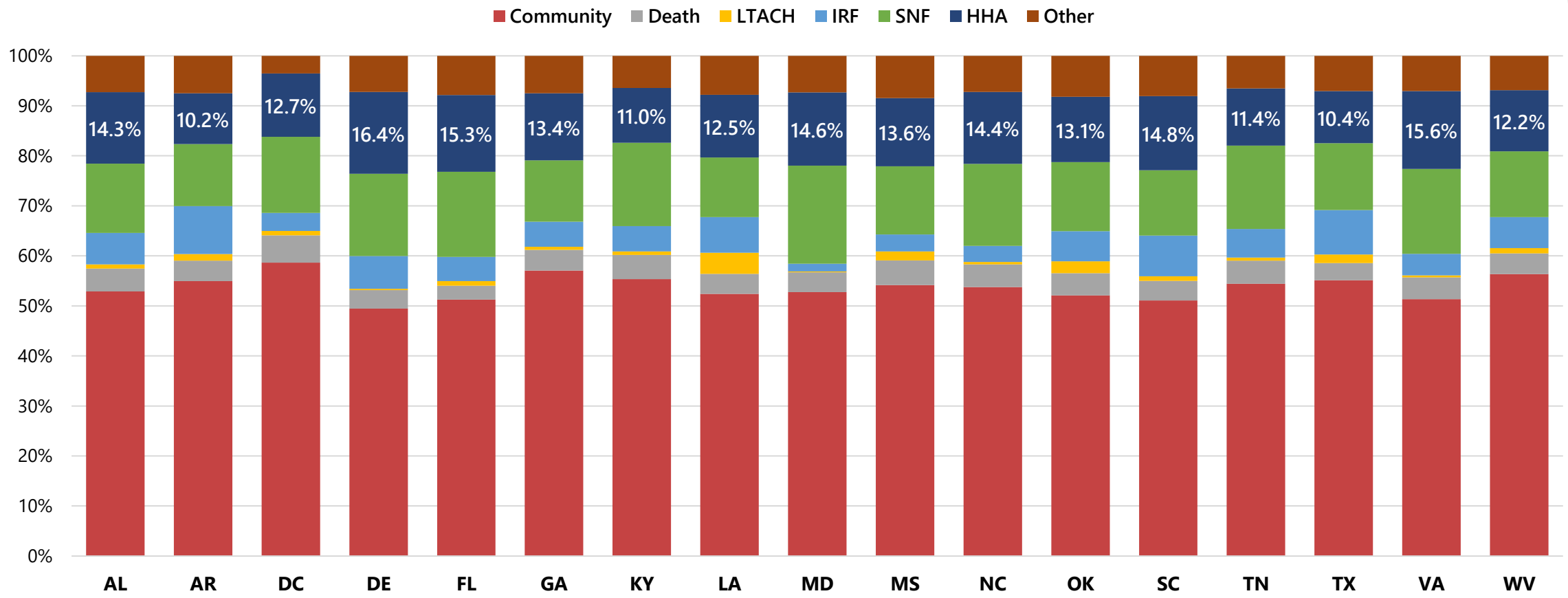
Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
Community: Discharges to the community without skilled home health care; includes individuals living at home, assisted living facilities, and retirement communities.
SNF = skilled nursing facility, HHA = home health agency, IRF = inpatient rehabilitation facility, and LTACH = long-term acute care hospital
Other: Hospice, a different inpatient hospital, or other inpatient hospitals such as inpatient psychiatric facilities.

Chart 3.2b: Initial Patient Destinations Following an Inpatient Hospital Stay for Medicare Beneficiaries in 2022, for States in Midwestern Region



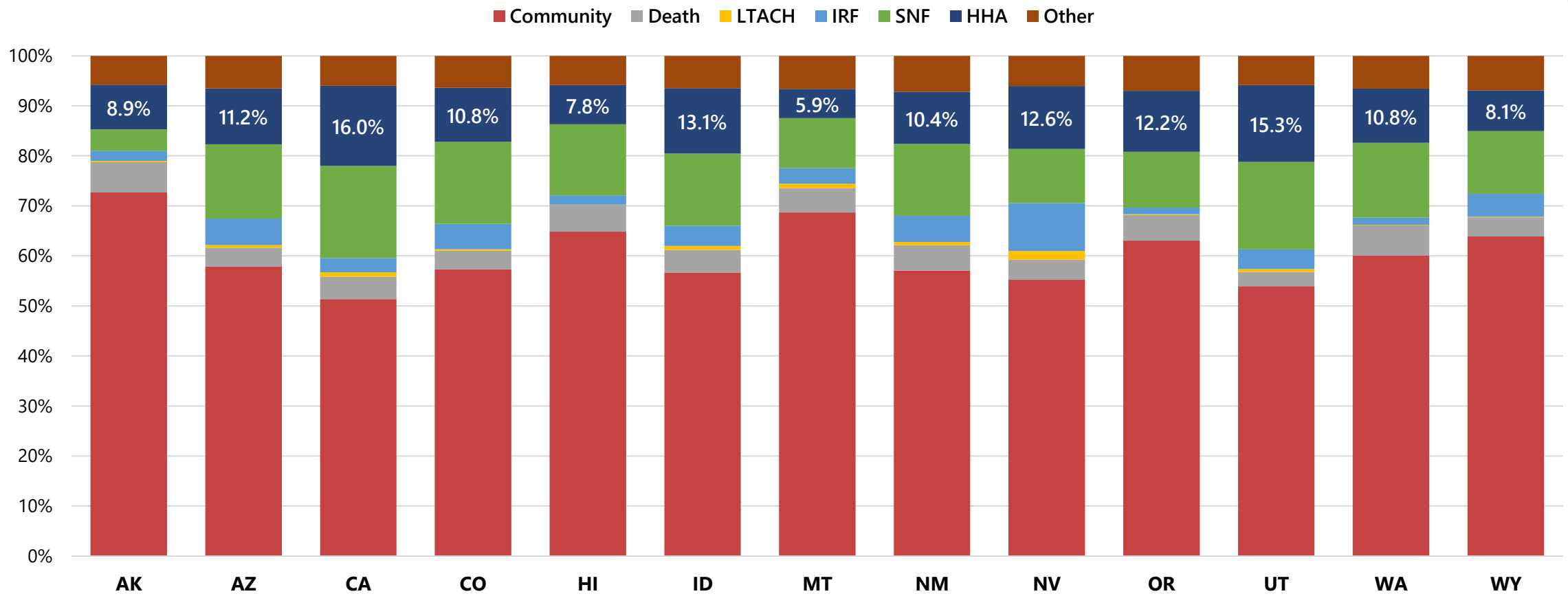
Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
Community: Discharges to the community without skilled home health care; includes individuals living at home, assisted living facilities, and retirement communities.
SNF = skilled nursing facility, HHA = home health agency, IRF = inpatient rehabilitation facility, and LTACH = long-term acute care hospital
Other: Hospice, a different inpatient hospital, or other inpatient hospitals such as inpatient psychiatric facilities.

Chart 3.2c: Initial Patient Destinations Following an Inpatient Hospital Stay for Medicare Beneficiaries in 2022, for States in Southern Region



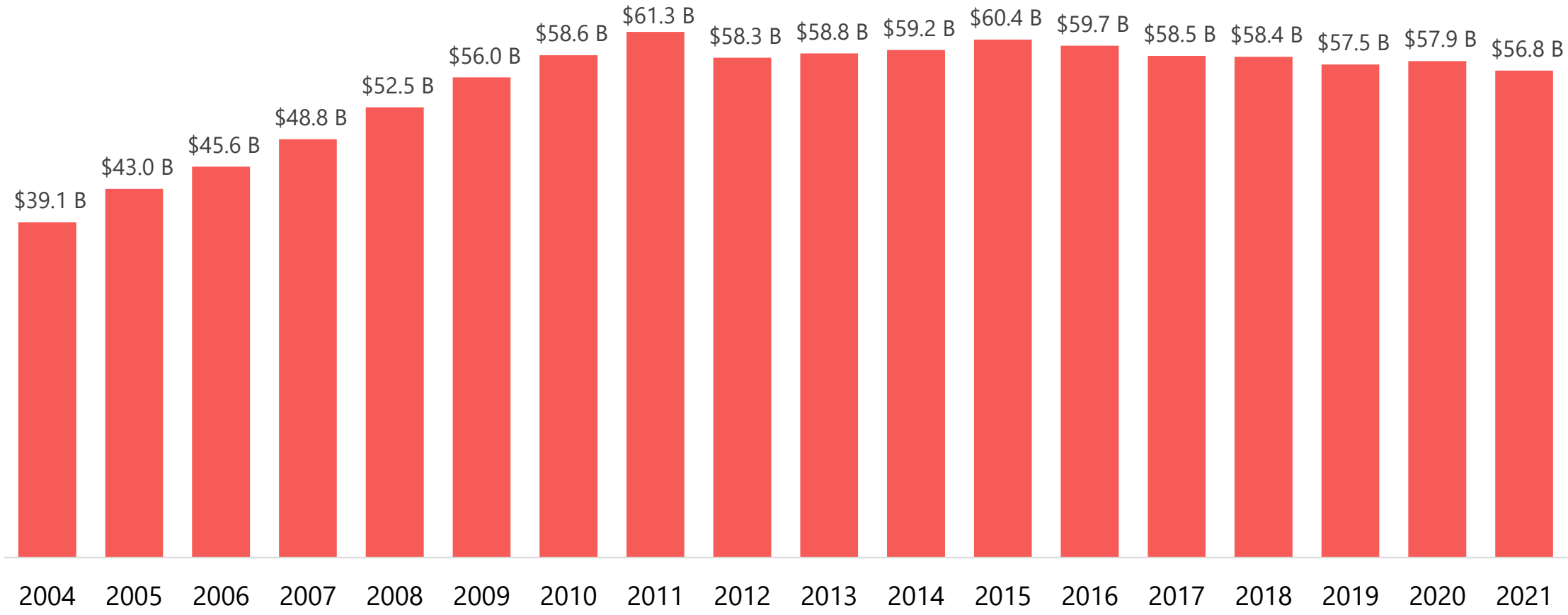
Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
Community: Discharges to the community without skilled home health care; includes individuals living at home, assisted living facilities, and retirement communities.
SNF = skilled nursing facility, HHA = home health agency, IRF = inpatient rehabilitation facility, and LTACH = long-term acute care hospital
Other: Hospice, a different inpatient hospital, or other inpatient hospitals such as inpatient psychiatric facilities.

Chart 3.2d: Initial Patient Destinations Following an Inpatient Hospital Stay for Medicare Beneficiaries in 2022, for States in Western Region



Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
Community: Discharges to the community without skilled home health care; includes individuals living at home, assisted living facilities, and retirement communities.
SNF = skilled nursing facility, HHA = home health agency, IRF = inpatient rehabilitation facility, and LTACH = long-term acute care hospital
Other: Hospice, a different inpatient hospital, or other inpatient hospitals such as inpatient psychiatric facilities.

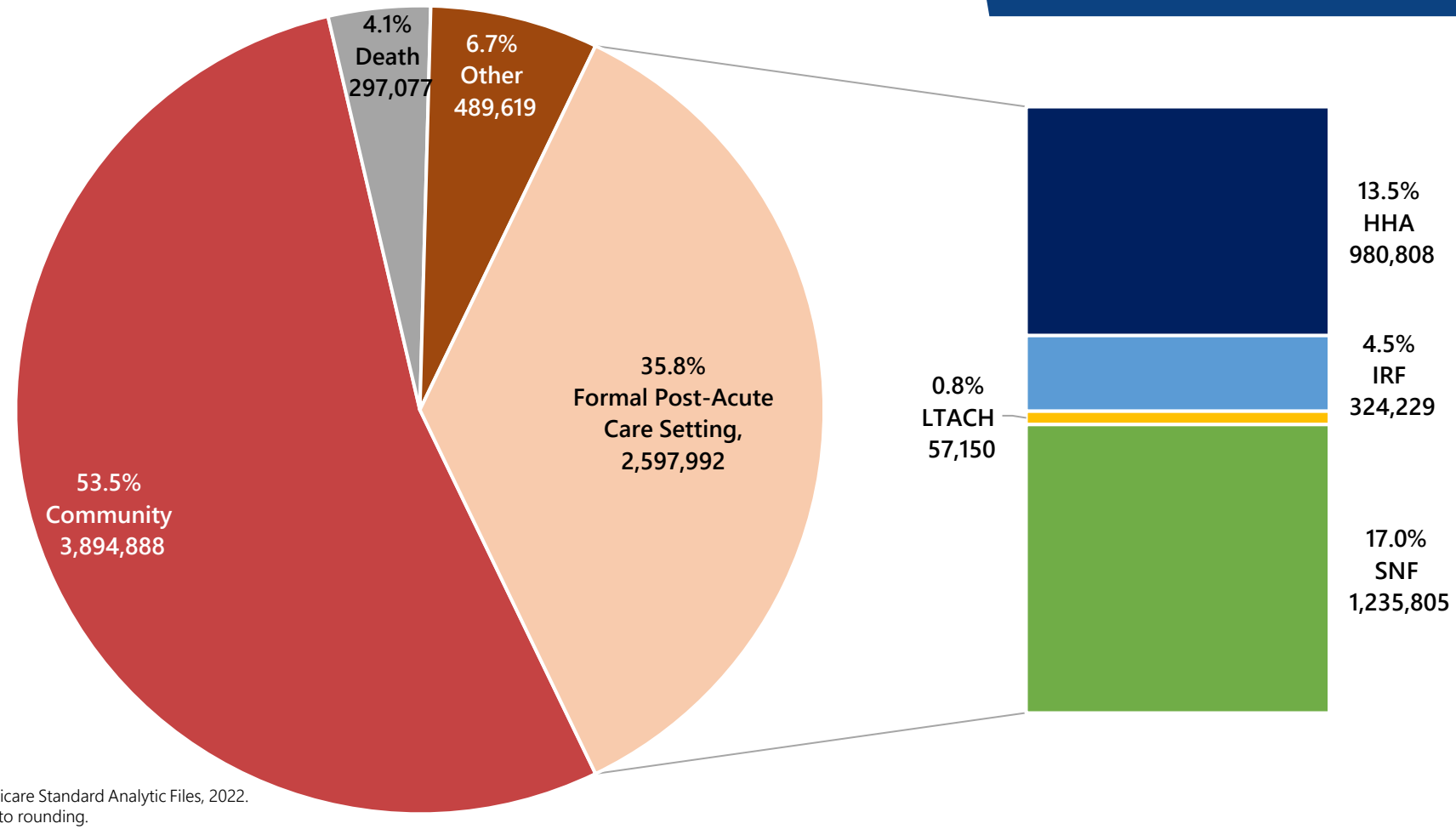
Chart 3.3: Total Medicare Post-Acute Care Expenditures, Billions of Dollars, 2004-2021



Source: Medicare Payment Advisory Commission. A Data Book: Health Care Spending and the Medicare Program, July 2023.

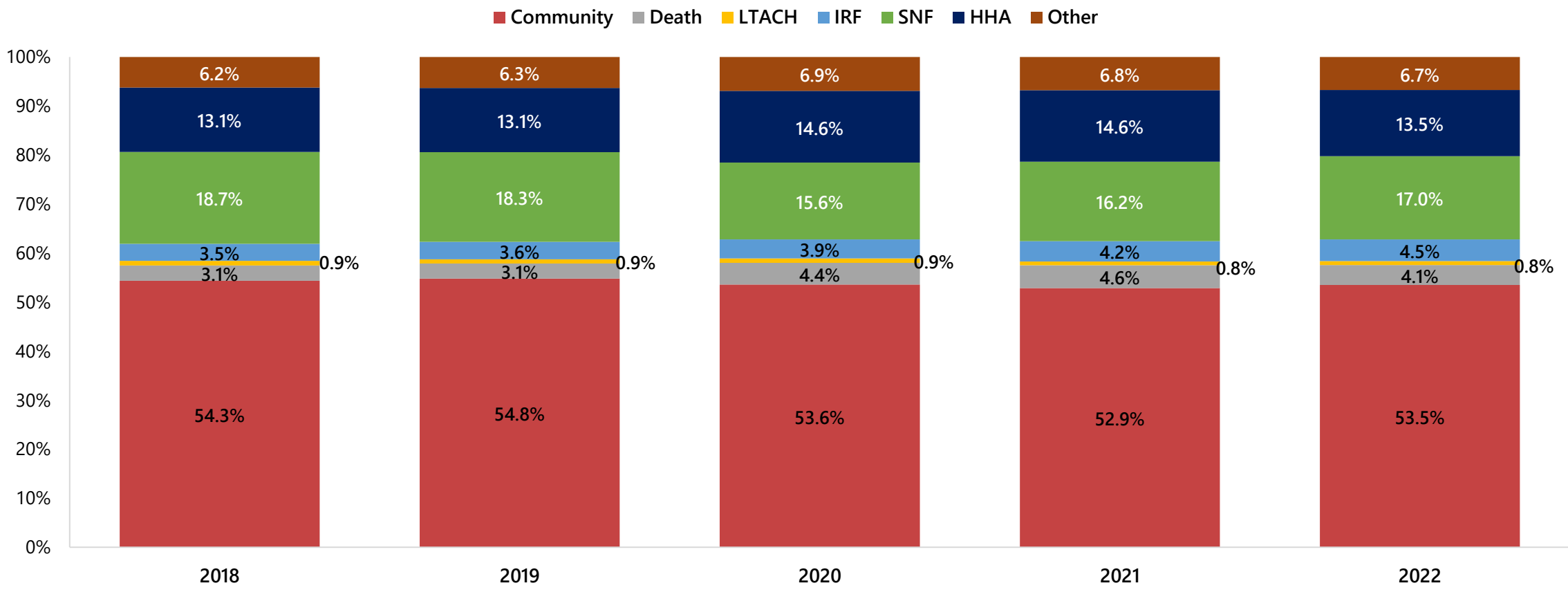
Chart 3.4: Initial Patient Destinations Following an Inpatient Hospital Stay for Medicare Beneficiaries, 2022

Role of Home Health in Post-Acute Care Market



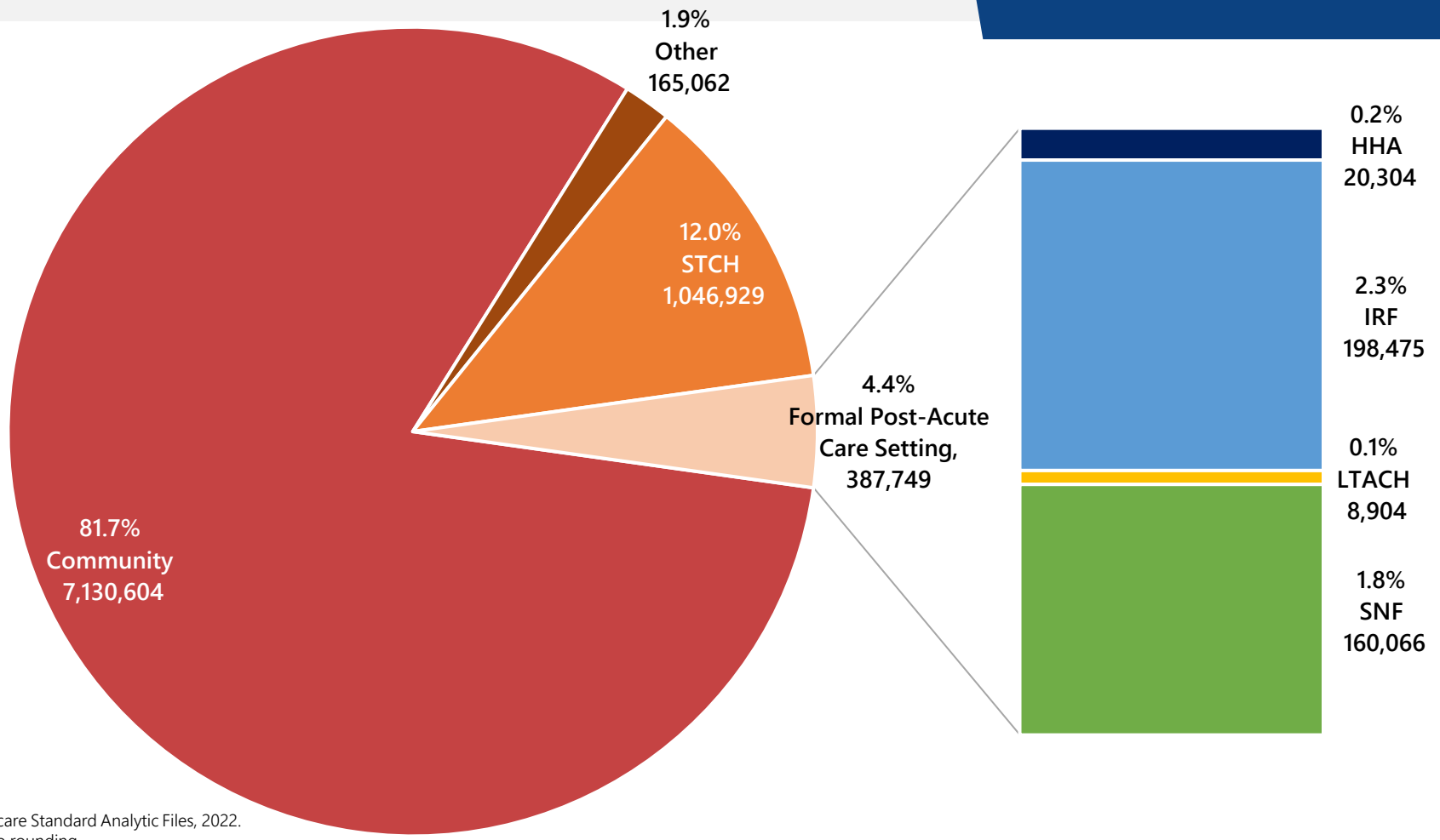
Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
Totals may not sum to 100 percent due to rounding.
Community: Discharges to the community without skilled home health care; includes individuals living at home, assisted living facilities, and retirement communities.
Formal Post-Acute Care Settings: Settings designated as post-acute care by Medicare. Includes skilled nursing facilities (SNF), home health agencies (HHA), inpatient rehabilitation facilities (IRF), and long-term acute care hospitals (LTACH).
Other: Hospice, a different inpatient hospital, or other inpatient hospitals such as inpatient psychiatric facilities.

Chart 3.5: Initial Patient Destinations Following an Inpatient Hospital Stay for Medicare Beneficiaries, 2018-2022



Source: KNG Health analysis of the Medicare Standard Analytic Files, 2018-2022.
Totals may not sum to 100 percent due to rounding.
Community: Discharges to the community without skilled home health care; includes individuals living at home, assisted living facilities, and retirement communities.
SNF = skilled nursing facility, HHA = home health agency, IRF = inpatient rehabilitation facility, and LTACH = long-term acute care hospital
Other: Hospice, a different inpatient hospital, or other inpatient hospitals such as inpatient psychiatric facilities.

Chart 3.6: Distribution of Care Settings Prior to Home Health Episodes, 2022



Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
Totals may not sum to 100 percent due to rounding.
Community: Discharges to the community without skilled home health care; includes individuals living at home, assisted living facilities, and retirement communities.
SNF = skilled nursing facility, HHA = home health agency, IRF = inpatient rehabilitation facility, LTACH = long-term acute care hospital, and STCH = short-term acute care hospital
Other: Hospice, a different inpatient hospital, or other inpatient hospitals such as inpatient psychiatric facilities.

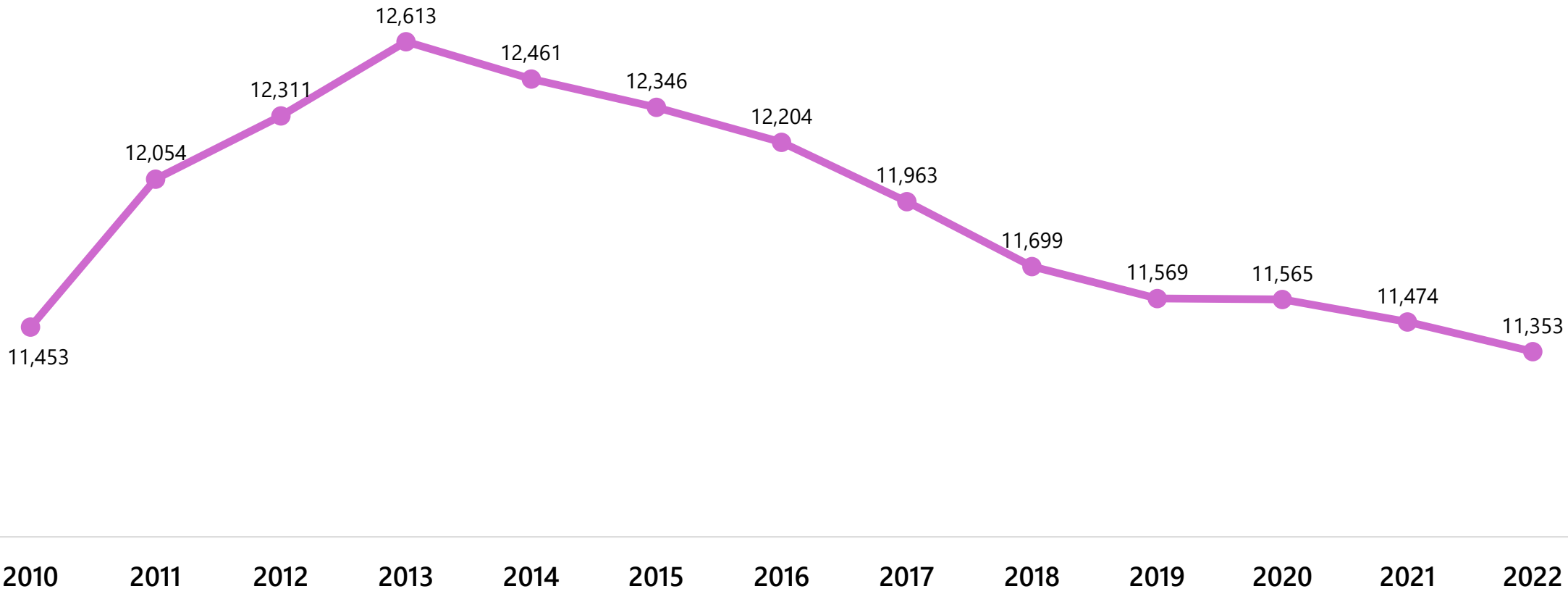
RESEARCH INSTITUTE for HOME CARE

ADVANCING HOME CARE THROUGH RESEARCH.

Organizational Trends in Home Health

Sponsored by HOMECARE & HOSPICE National Association for Home Care & Hospice

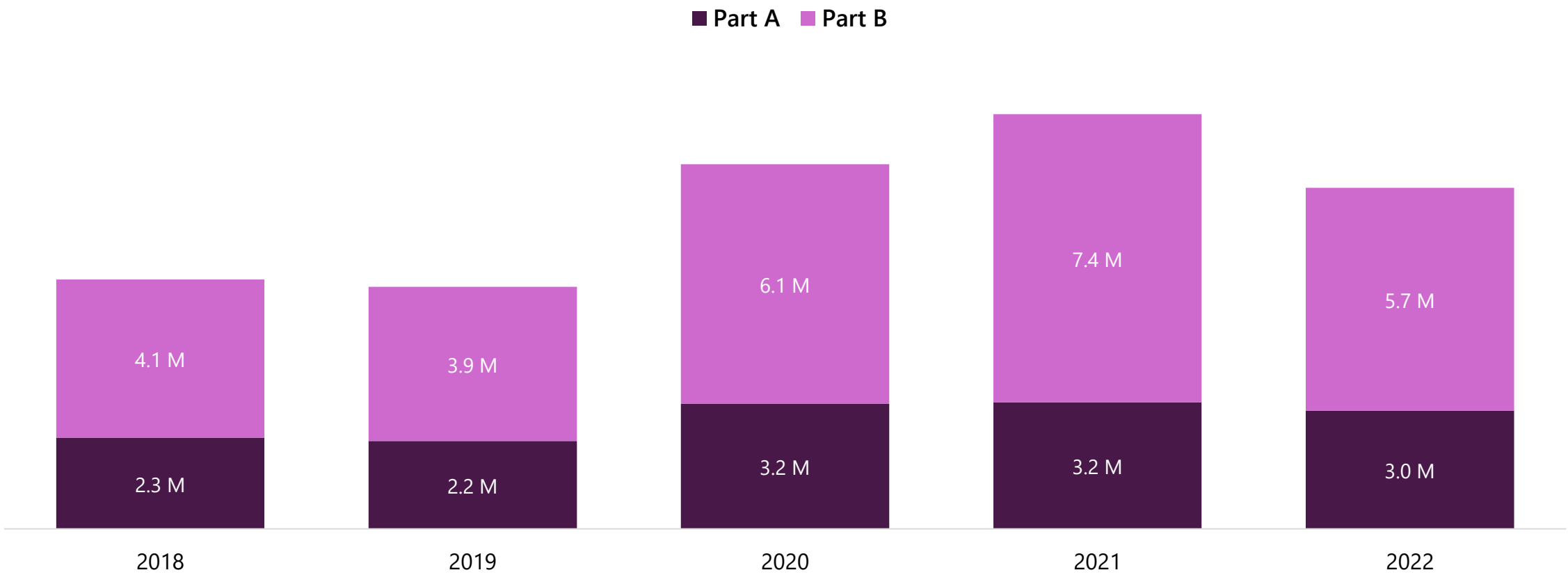
Chart 4.1: Number of Active Home Health Agencies, 2010-2022



Source: Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy, March 2014 -2019;
Medicare Payment Advisory Commission. A Data Book: Health Care Spending and the Medicare Program, July 2023.

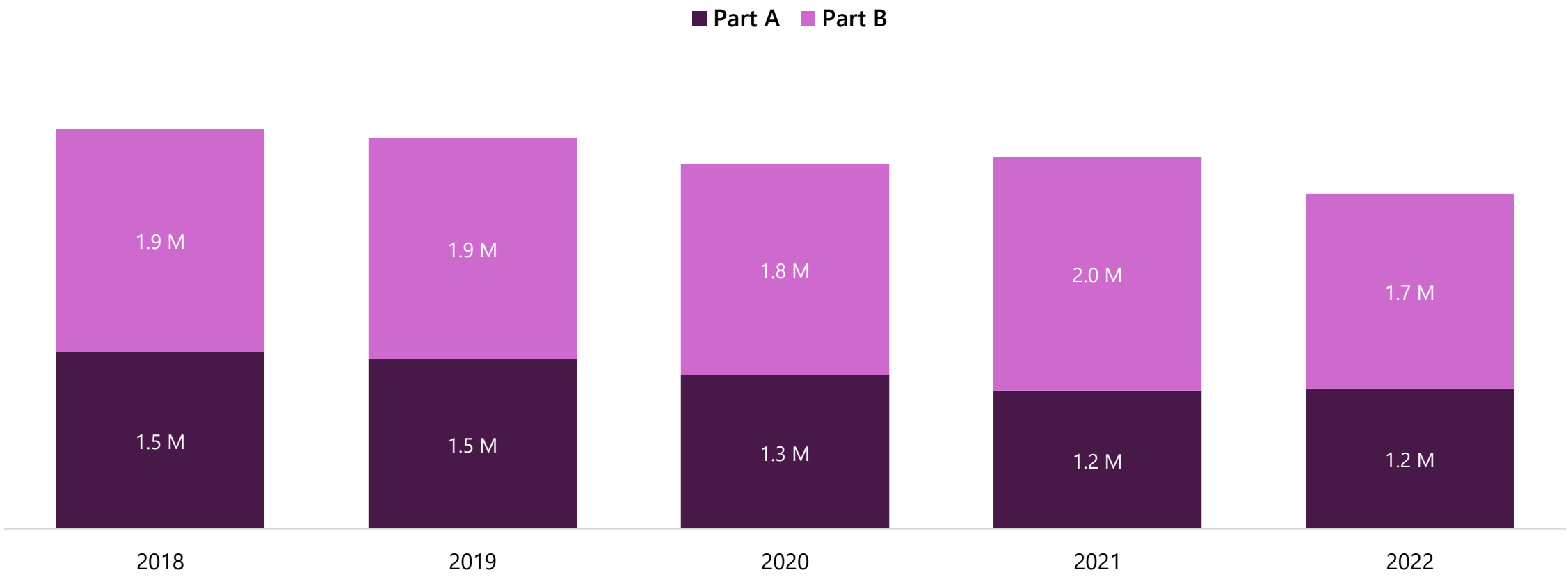
Note: "Active home health agencies" includes all agencies operating during a year, including agencies that closed or opened at some point during the year. The number of home health agencies between 2010 and 2016, are based on the Medicare Payment Advisory Commission's analysis of Provider of Service files. The number of home health agencies between 2017 and 2022 are based on Medicare Payment Advisory Commission's analysis of CMS's Quality, Certification, and Oversight files.

Chart 4.2: Number of Medicare Part A and Part B Home Health Episodes, in Millions, 2018-2022



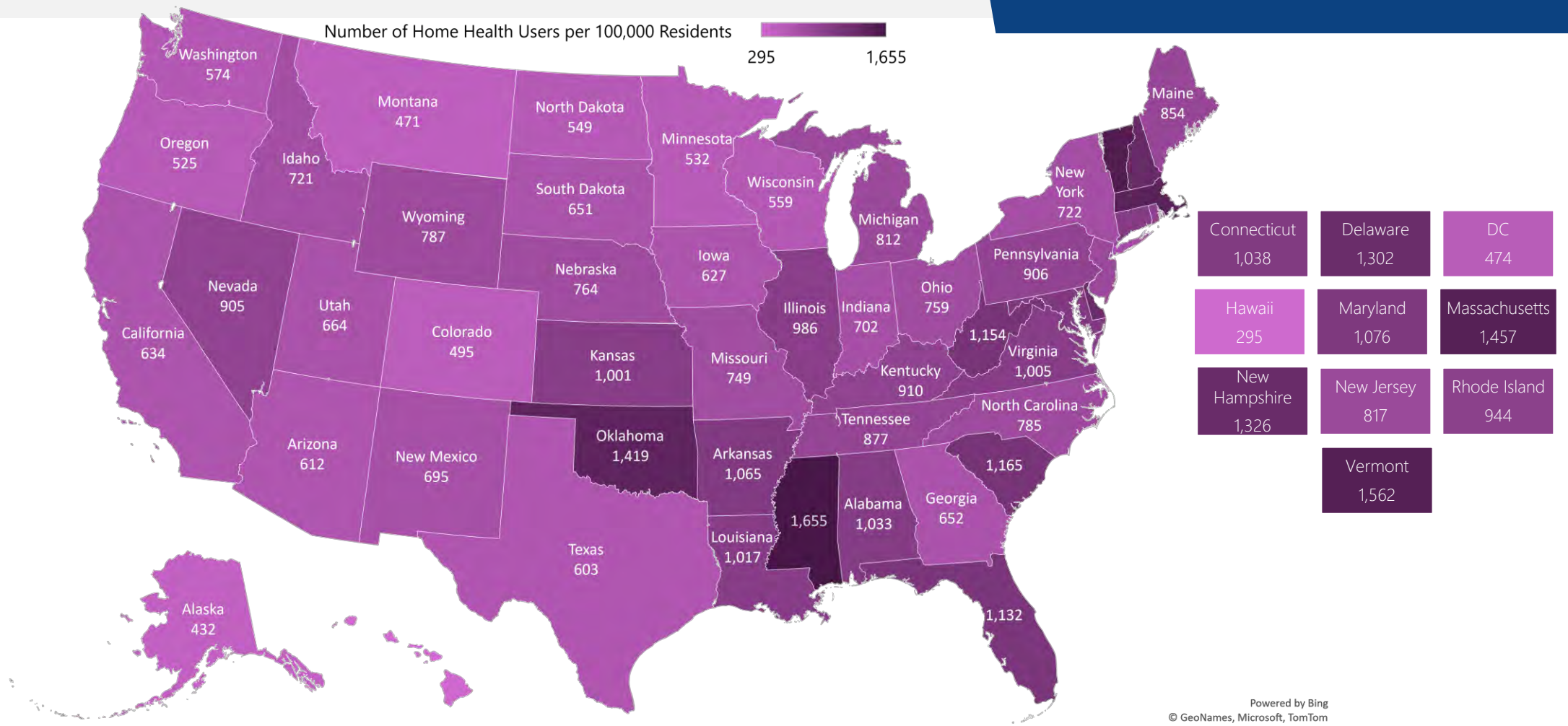
Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
In 2020, due to changes outlined in the Patient-Driven Groupings Model (PDGM), the definition of home health episodes changed from 60 days to 30 days.
Note: Part A home health episode is defined as a home health claim with a claim value code of "62." Part B home health episodes are defined as a home health claim without a claim value code of "62."

Chart 4.3: Number of Medicare Beneficiaries with Part A and Part B Home Health Episodes, in Millions, 2018-2022



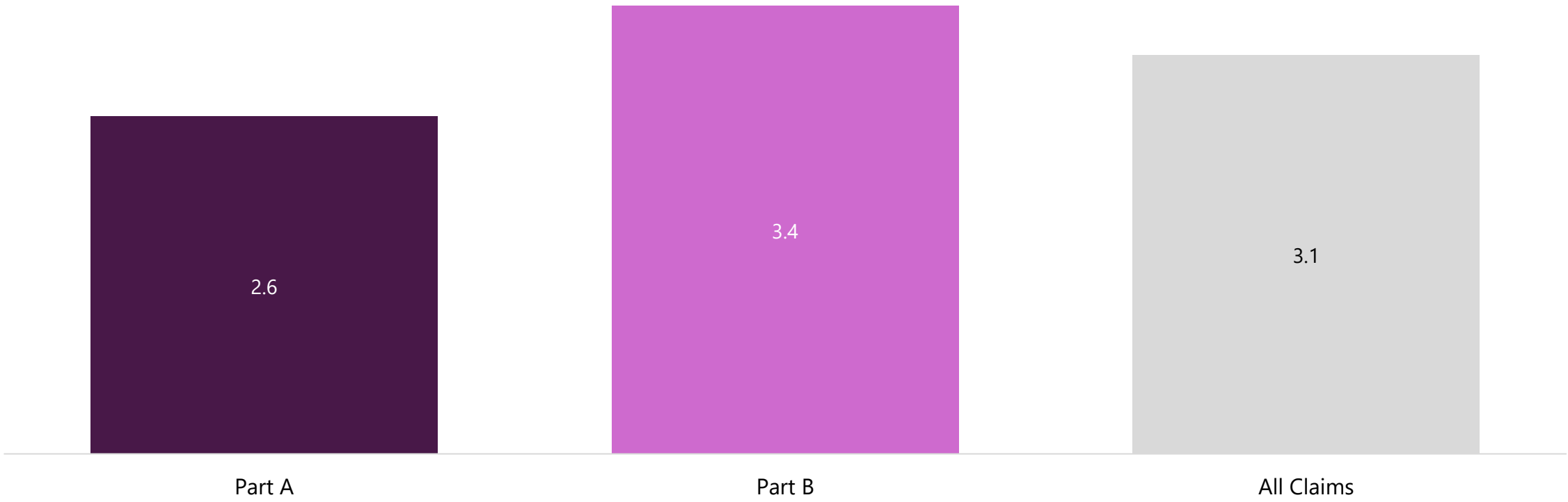
Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
In 2020, due to changes outlined in the Patient-Driven Groupings Model (PDGM), the definition of home health episodes changed from 60 days to 30 days.
Note: Part A home health episode is defined as a home health claim with a claim value code of "62." Part B home health episodes are defined as a home health claim without a claim value code of "62."
Part A and Part B categories are not mutually exclusive. Medicare Beneficiaries can have both a Part A and Part B episode.

Chart 4.4: Number of Medicare Beneficiaries with a Home Health Episode per 100,000 Residents by State, 2022



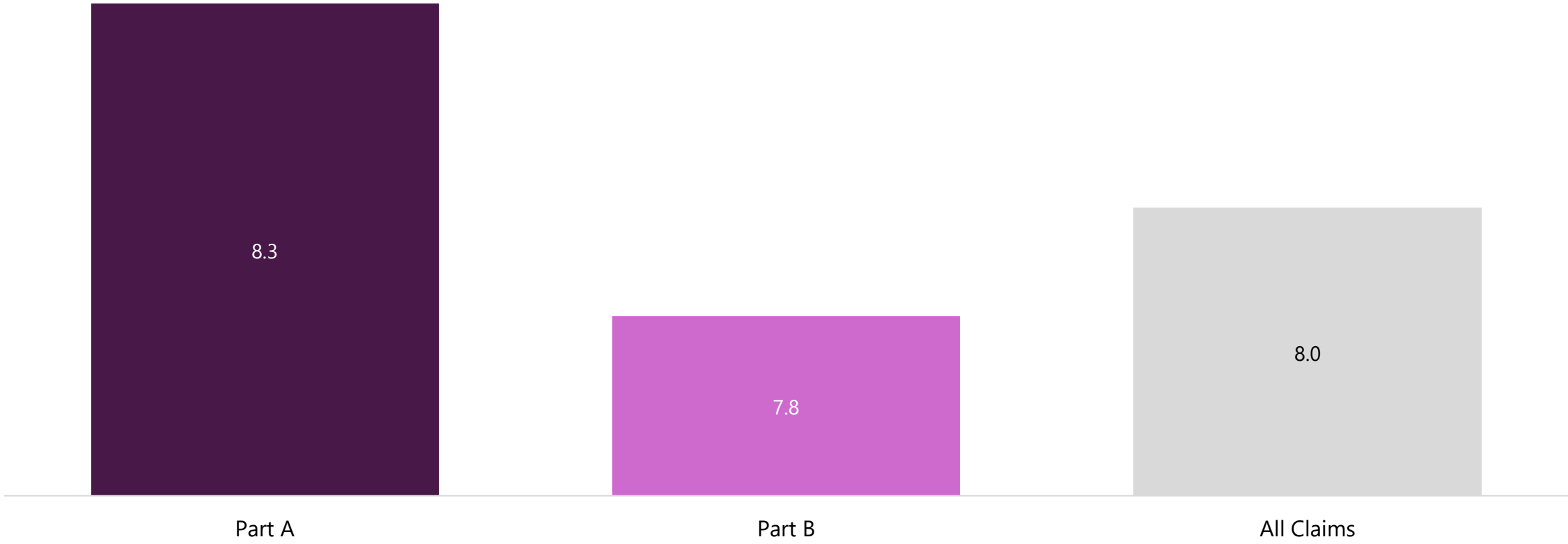
Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
Note: State resident counts are based on state population estimates produced by the United States Census Bureau.

Chart 4.5: Average Number of Home Health Episodes per Medicare Home Health User by Part A, Part B, and all Claims, 2022



Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
In 2020, due to changes outlined in the Patient-Driven Groupings Model (PDGM), the definition of home health episodes changed from 60 days to 30 days.
Note: Part A home health episode is defined as a home health claim with a claim value code of "62." Part B home health episodes are defined as a home health claim without a claim value code of "62."

Chart 4.6: Average Number of Home Health Visits per Episode by Part A, Part B, and all Claims, 2022



Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
In 2020, due to changes outlined in the Patient-Driven Groupings Model (PDGM), the definition of home health episodes changed from 60 days to 30 days.
Note: Part A home health episode is defined as a home health claim with a claim value code of "62." Part B home health episodes are defined as a home health claim without a claim value code of "62."

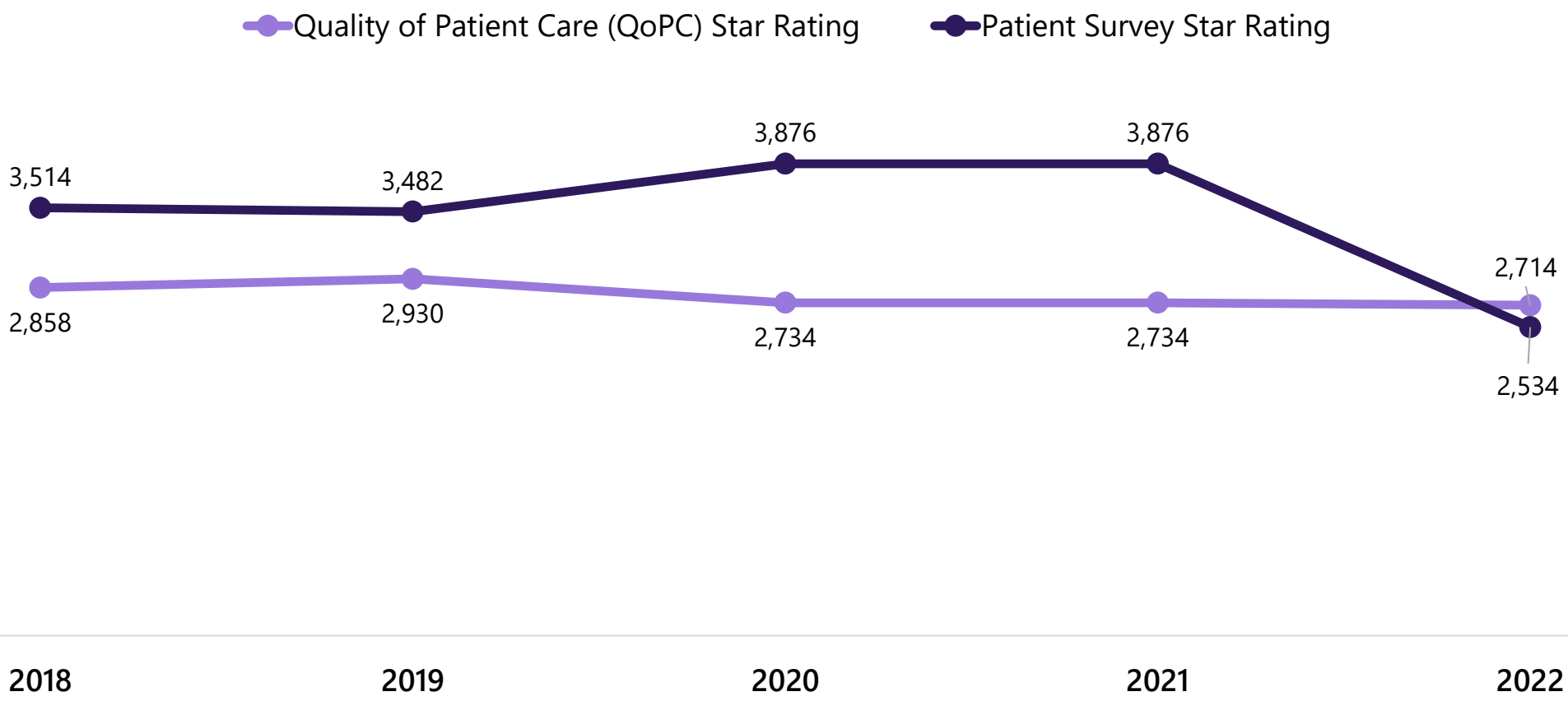
RESEARCH INSTITUTE for HOME CARE

ADVANCING HOME CARE THROUGH RESEARCH.

Quality of Home Health Care

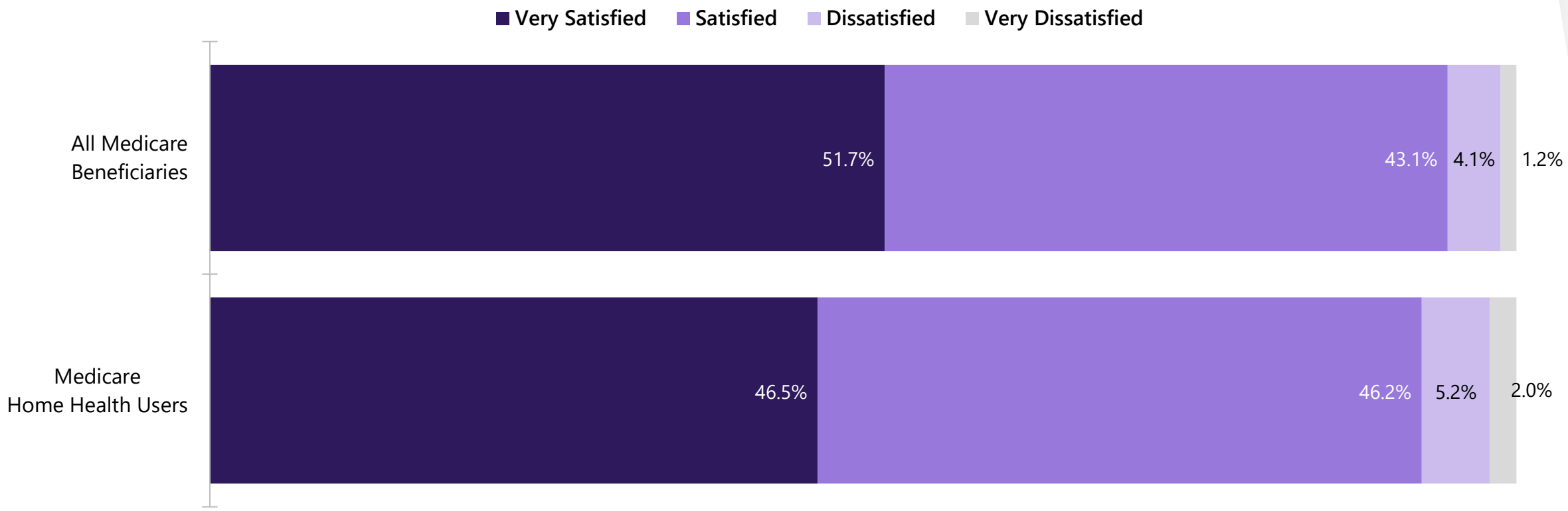
Sponsored by HOMECARE & HOSPICE National Association for Home Care & Hospice

Chart 5.1: Number of High-Quality* Medicare Certified Home Health Agencies by Type of Home Health star ratings, 2018-2022



Source: KNG Health analysis of Home Health Care Compare Data, 2018-2022.
* Home Health Agencies are defined as high-quality if they have a QoPC star rating or Patient Survey Star Rating of 4 or higher.
Note: The Quality of Patient Care (QoPC) Star Rating is based on OASIS assessments and Medicare claims data. Collection for this measure began in 2015. The Patient Survey Star Ratings are based on the Home Health CAHPS Survey. Collection for this measure began in 2016.
Note: Home Health Care Compare data and Home Health CAHPS Survey data are based on annual October refresh.

Chart 5.2: "Satisfaction: Quality of Care" Measure in Home Health Users and All Medicare Beneficiaries, 2021



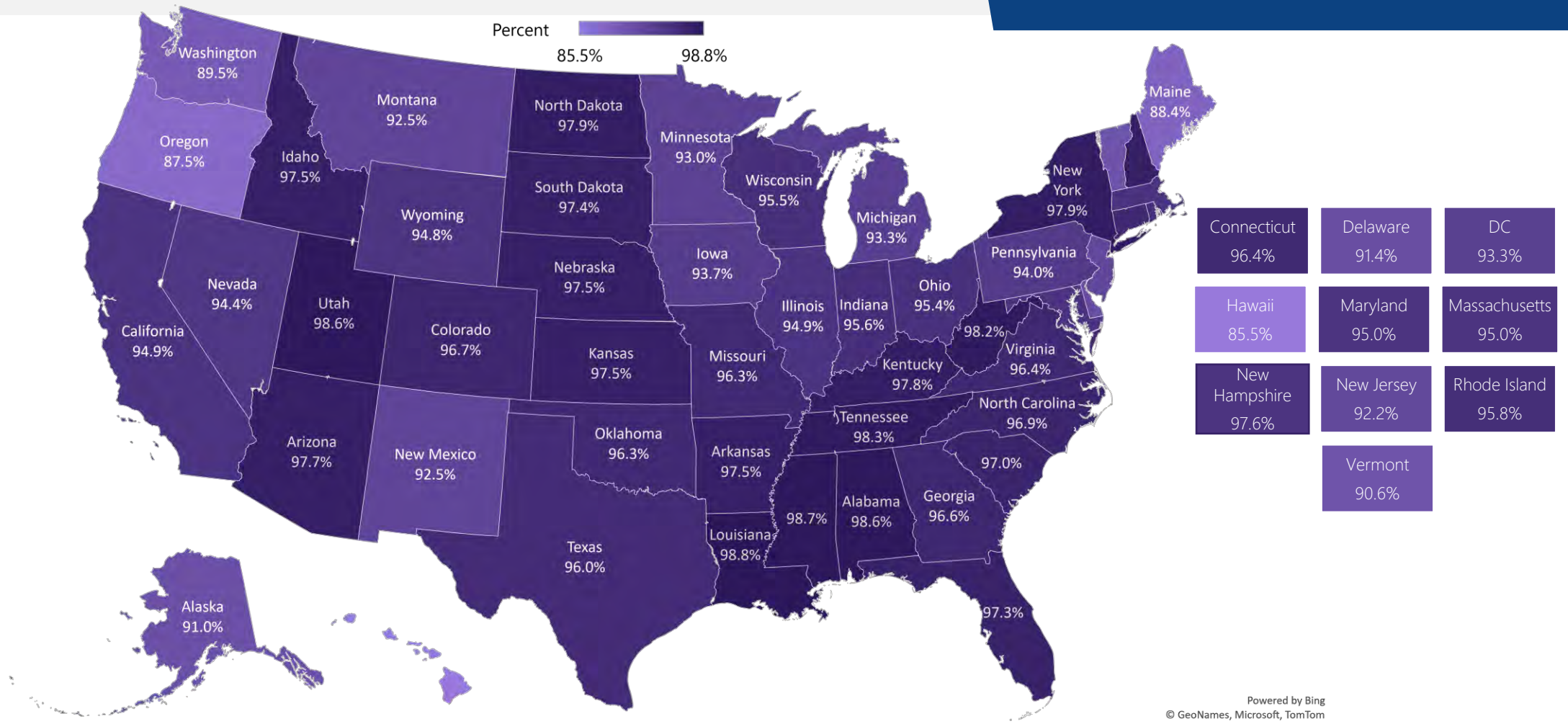
Source: KNG Health analysis of the Medicare Current Beneficiary Survey, 2021.
Totals may not sum to 100 percent due to rounding.
Satisfaction with Care includes all medical services received.

Table 5.1: National Average for How Often Home Health Team Met Quality Measures Related to Patient Care, 2018-2022

Measure of Patient Care	2018	2019	2020	2021*	2022
Checked patients for depression	97.8%	97.5%	97.4%	N/A	N/A
Checked patients' risk of falling	99.5%	99.6%	99.6%	N/A	N/A
For diabetic patients, got doctor's orders, gave and educated about foot care	97.4%	97.9%	96.4%	N/A	N/A
Taught patients (or their family caregivers) about their drugs	98.0%	98.5%	98.6%	N/A	98.5%
Began care in timely manner	93.9%	95.1%	95.7%	N/A	95.7%
Determined whether patients received a flu shot for the current flu season	77.8%	78.6%	78.7%	N/A	75.4%
Determined whether patients received a pneumococcal vaccine (pneumonia shot)	80.9%	81.8%	82.2%	N/A	N/A

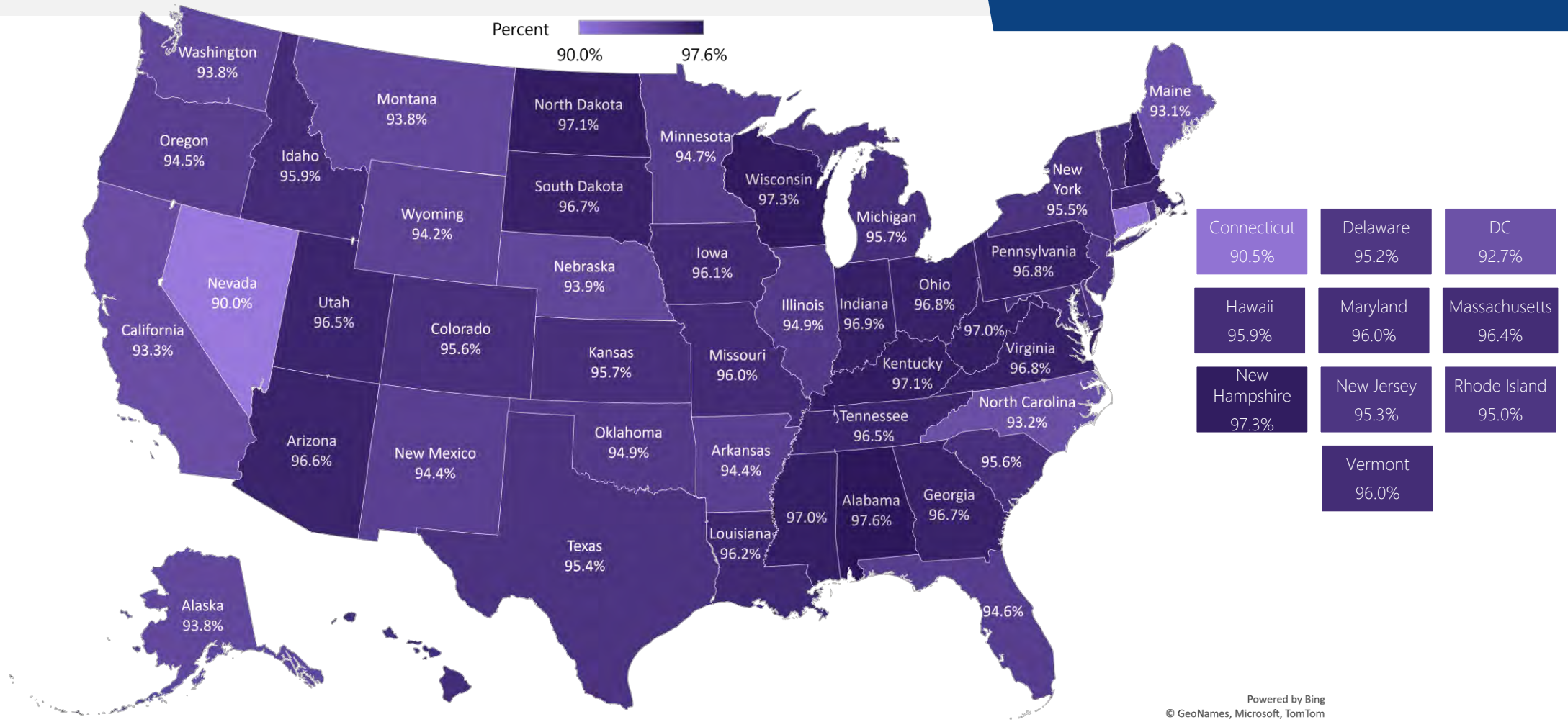
Source: KNG Health analysis of Home Health Care Compare Data, 2018-2022.
Note: Home Health Care Compare data is based on annual October refresh.
*The Centers for Medicare & Medicaid Services did not collect new data in 2021. As a result, data reported on Home Health Care Compare for 2021 is the same data reported in 2020.

Chart 5.3: Performance on "How Often the Home Health Team Began Their Patients' Care in a Timely Manner" by State, 2022



Source: KNG Health analysis of Home Health Care Compare Data, 2022.
Note: Home Health Care Compare data is based on annual October refresh.

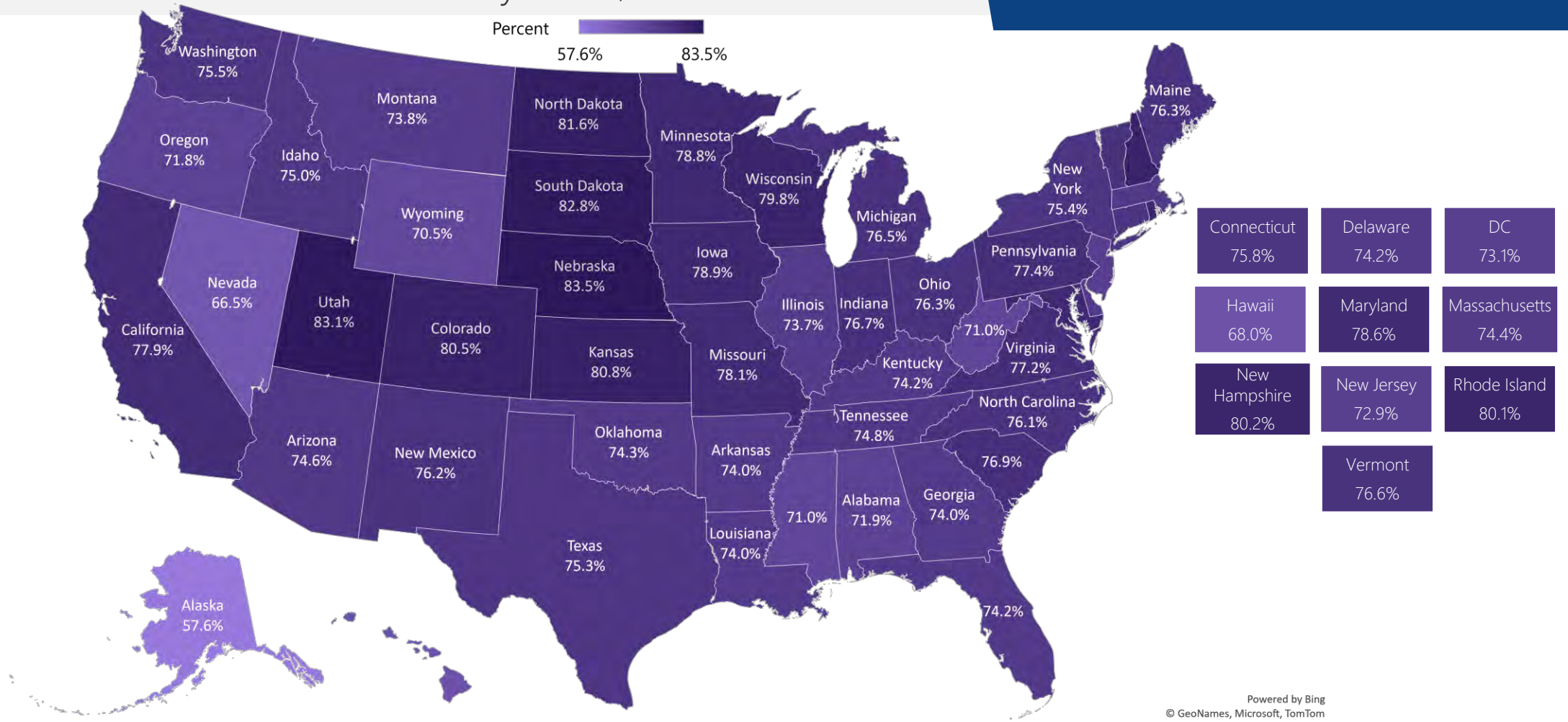
Chart 5.4: Performance on "How Often Physician-Recommended Actions to Address Medication Issues were Completely Timely" by State, 2022



Connecticut 90.5%	Delaware 95.2%	DC 92.7%
Hawaii 95.9%	Maryland 96.0%	Massachusetts 96.4%
New Hampshire 97.3%	New Jersey 95.3%	Rhode Island 95.0%
	Vermont 96.0%	

Source: KNG Health analysis of Home Health Care Compare Data, 2022.
Note: Home Health Care Compare data is based on annual October refresh.

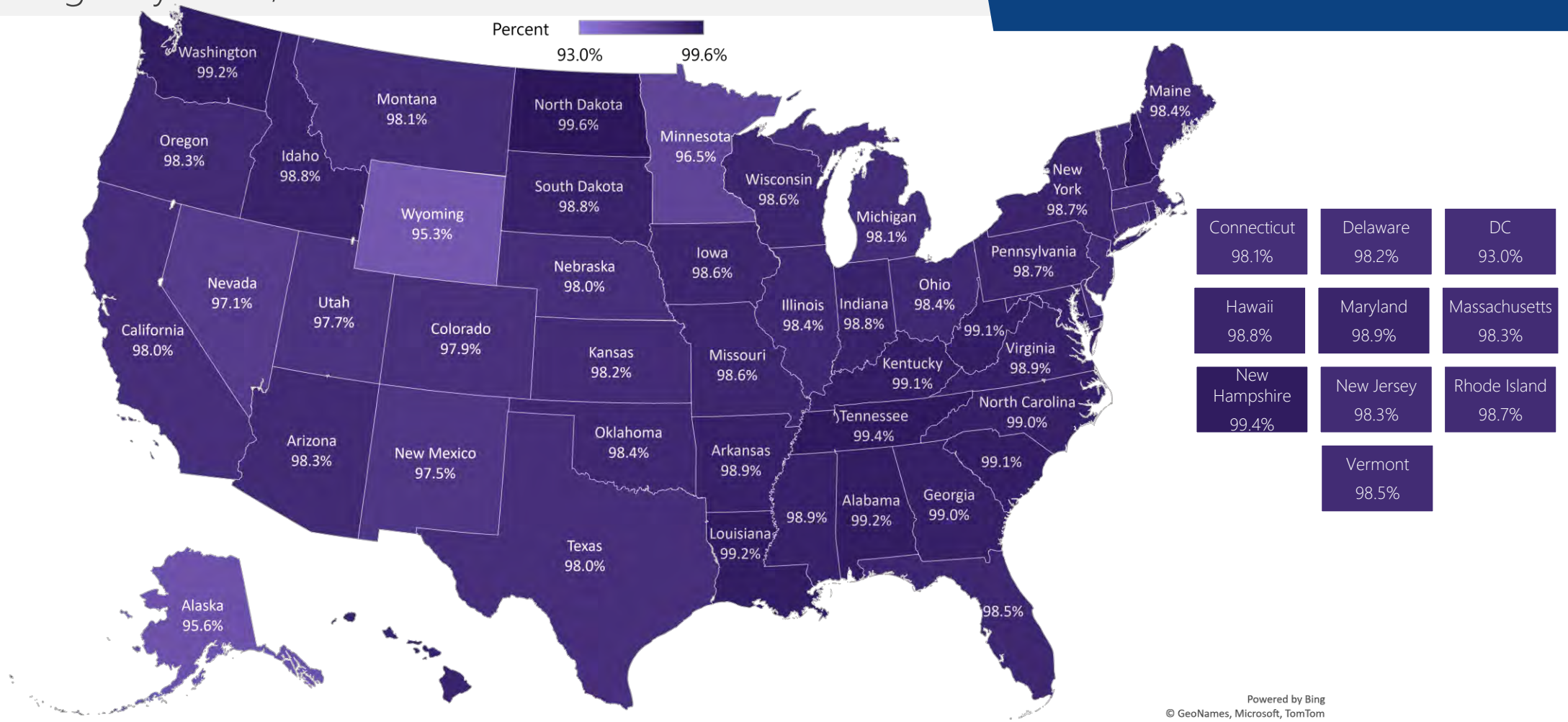
Chart 5.5: Performance on "How Often the Home Health Team Made Sure that Their Patients Have Received a Flu Shot for the Current Flu Season" by State, 2022



Connecticut 75.8%	Delaware 74.2%	DC 73.1%
Hawaii 68.0%	Maryland 78.6%	Massachusetts 74.4%
New Hampshire 80.2%	New Jersey 72.9%	Rhode Island 80.1%
	Vermont 76.6%	

Source: KNG Health analysis of Home Health Care Compare Data, 2022.
Note: Home Health Care Compare data is based on annual October refresh.

Chart 5.6: Performance on "How Often the Home Health Team Taught Patients (or Their Family Caregivers) About Their Drugs" by State, 2022



Source: KNG Health analysis of Home Health Care Compare Data, 2022.
Note: Home Health Care Compare data is based on annual October refresh.

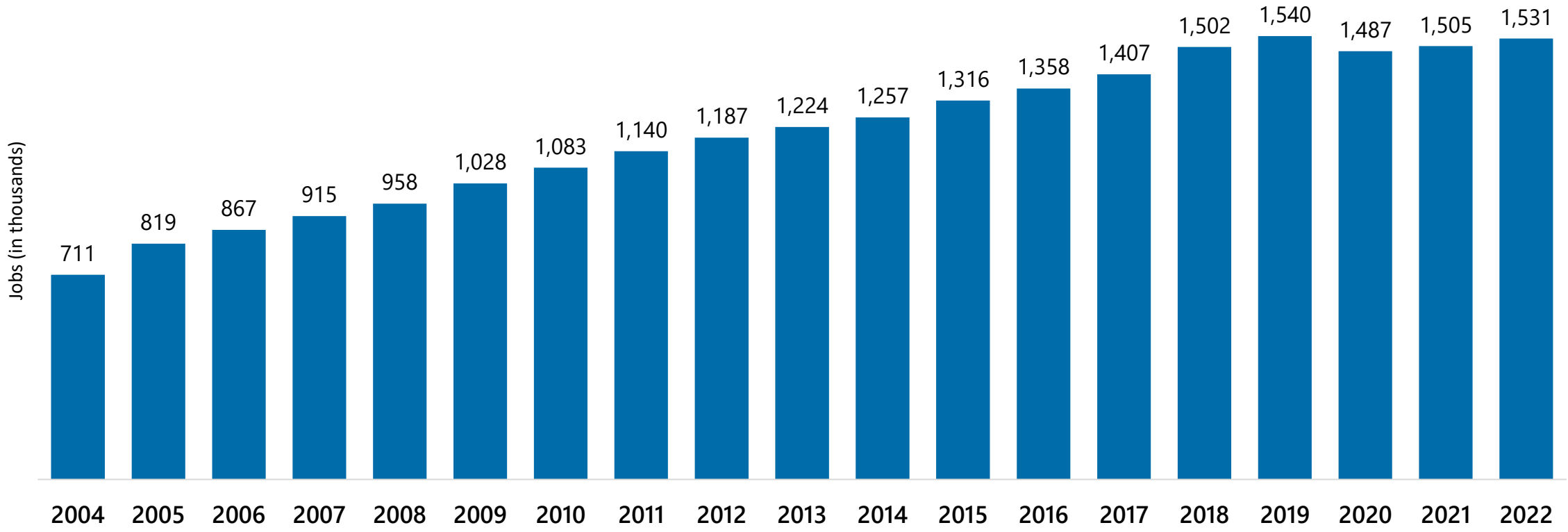
RESEARCH INSTITUTE for HOME CARE

ADVANCING HOME CARE THROUGH RESEARCH.

Economic Contributions of Home Health Agencies

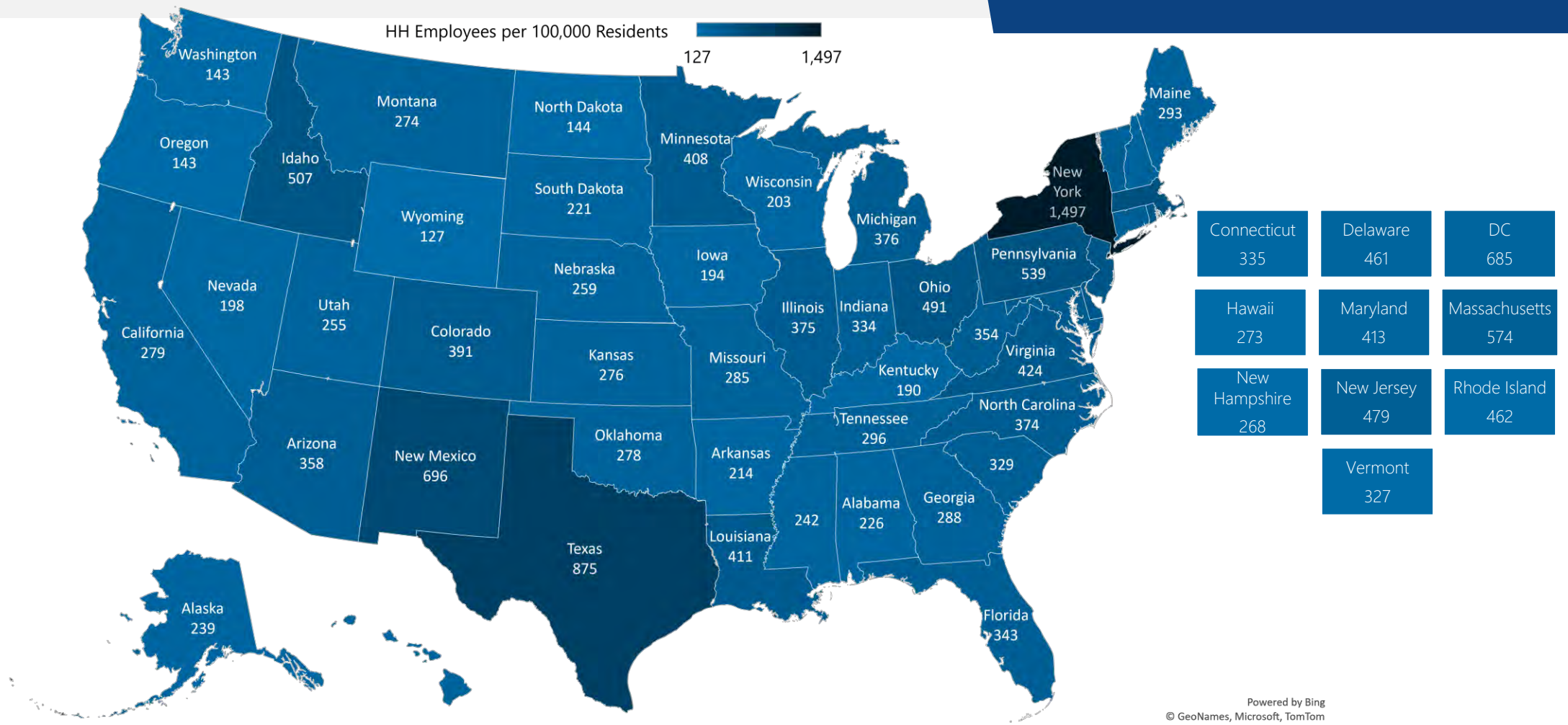
Sponsored by HOMECARE & HOSPICE National Association for Home Care & Hospice

Chart 6.1: Impact of Home Health on Jobs, Nationally, 2004 - 2022



Source: Quarterly Census of Employment and Wages (QCEW) collected by the U.S. Bureau of Labor Statistics. Private, NAICS 6216 Home health care services. Annual Averages, All establishment sizes.
Note: This chart reports employment data for privately-owned facilities only, including for-profit and non-profit organizations, and does not include employment from government-owned facilities. Output is not adjusted by U.S. Bureau of Economic Analysis multipliers.

Chart 6.2: Estimated Number of Home Health (HH) Employees by State per 100,000 Residents, 2022



Source: Quarterly Census of Employment and Wages (QCEW) collected by the U.S. Bureau of Labor Statistics. Private, NAICS 6216 Home health care services. Annual Averages, All establishment sizes.
Note: This chart reports employment data for privately-owned facilities only, including for-profit and non-profit organizations, and does not include employment from government-owned facilities. Output is not adjusted by U.S. Bureau of Economic Analysis multipliers.

Table 6.1: Impact of Home Health (HH) on Employment by State, 2022

State	Estimated Number of HH Employees[1]	Multiplier for Employment[2]	Estimated Jobs Created by HH Industry[3]
Alabama	11,478	1.5487	17,776
Alaska	1,751	1.2562	2,200
Arizona	26,310	1.4433	37,973
Arkansas	6,516	1.3968	9,102
California	108,843	1.4710	160,108
Colorado	22,857	1.4980	34,240
Connecticut	12,132	1.4284	17,329
Delaware	4,690	1.3834	6,488
District of Columbia	4,603	1.1330	5,215
Florida	76,387	1.5371	117,414
Georgia	31,443	1.5316	48,158
Hawaii	3,926	1.3825	5,428
Idaho	9,822	1.3921	13,673
Illinois	47,182	1.4622	68,990
Indiana	22,803	1.4731	33,591
Iowa	6,223	1.4268	8,879
Kansas	8,092	1.4469	11,708
Kentucky	8,559	1.5098	12,922
Louisiana	18,869	1.4431	27,230
Maine	4,054	1.4625	5,929
Maryland	25,442	1.3901	35,367
Massachusetts	40,076	1.4303	57,321
Michigan	37,688	1.4659	55,247
Minnesota	23,309	1.3866	32,320
Mississippi	7,110	1.4804	10,526
Missouri	17,628	1.4316	25,236
Montana	3,072	1.3397	4,116
Nebraska	5,099	1.3866	7,070
Nevada	6,289	1.4921	9,384
New Hampshire	3,744	1.4150	5,298
New Jersey	44,393	1.4794	65,675
New Mexico	14,703	1.3342	19,617
New York	294,620	1.3132	386,895
North Carolina	40,050	1.4610	58,513
North Dakota	1,120	1.3638	1,527
Ohio	57,777	1.4515	83,863
Oklahoma	11,191	1.4502	16,229
Oregon	6,065	1.4516	8,804
Pennsylvania	69,916	1.4843	103,776
Rhode Island	5,057	1.3898	7,028
South Carolina	17,375	1.4872	25,840
South Dakota	2,008	1.3293	2,669
Tennessee	20,880	1.6181	33,786
Texas	262,638	1.5379	403,911
Utah	8,620	1.5978	13,773
Vermont	2,115	1.4054	2,972
Virginia	36,780	1.4116	51,919
Washington	11,150	1.4203	15,836
West Virginia	6,285	1.3352	8,392
Wisconsin	11,986	1.4491	17,369
Wyoming	736	1.3198	971
Total U.S.	**1,531,462**		**2,215,604**

1. QCEW collected by the U.S. Bureau of Labor Statistics, 2022.
2. U.S. Bureau of Economic Analysis multipliers, 2021.
3. KNG Health Analysis.

Note: The QCEW collects wage data quarterly. All states report employment figures on privately owned home health agencies, including for-profit and non-profit organizations.

Table 6.2: Impact of Home Health (HH) on Labor Income by State, 2022

State	Estimated Home Health Total Wages[1]	Multiplier for Earnings[2]	Estimated Impact of HH Payroll on Labor Income[3]
Alabama	$644,908,281	1.5015	$968,329,792
Alaska	$50,617,845	1.3563	$68,652,984
Arizona	$1,016,594,508	1.5941	$1,620,553,344
Arkansas	$277,981,178	1.4497	$402,989,312
California	$5,407,428,800	1.5794	$8,540,492,800
Colorado	$1,069,144,073	1.6241	$1,736,396,800
Connecticut	$675,914,740	1.4836	$1,002,787,136
Delaware	$221,660,610	1.3904	$308,196,928
District of Columbia	$188,043,381	1.1720	$220,386,848
Florida	$3,688,378,872	1.5997	$5,900,299,776
Georgia	$1,257,261,228	1.6399	$2,061,782,656
Hawaii	$170,715,863	1.4681	$250,627,952
Idaho	$296,342,115	1.4751	$437,134,272
Illinois	$1,849,424,375	1.6690	$3,086,689,280
Indiana	$907,524,950	1.5478	$1,404,667,008
Iowa	$303,688,252	1.4164	$430,144,032
Kansas	$340,556,485	1.4797	$503,921,408
Kentucky	$479,617,729	1.4904	$714,822,272
Louisiana	$728,126,508	1.4830	$1,079,811,584
Maine	$200,474,020	1.4790	$296,501,056
Maryland	$1,101,100,603	1.5164	$1,669,708,928
Massachusetts	$1,974,317,903	1.5204	$3,001,753,088
Michigan	$1,552,021,769	1.5725	$2,440,554,240
Minnesota	$826,354,922	1.5495	$1,280,436,992
Mississippi	$359,357,088	1.4320	$514,599,360
Missouri	$680,277,578	1.5557	$1,058,307,776
Montana	$108,498,572	1.4184	$153,894,384
Nebraska	$207,223,949	1.4471	$299,873,792
Nevada	$363,770,780	1.4547	$529,177,344
New Hampshire	$210,595,127	1.4863	$313,007,520
New Jersey	$1,942,603,270	1.5910	$3,090,681,600
New Mexico	$385,667,348	1.4075	$542,826,816
New York	$9,782,510,174	1.4491	$14,175,836,160
North Carolina	$1,556,524,250	1.6153	$2,514,253,824
North Dakota	$52,381,193	1.3689	$71,704,616
Ohio	$2,094,003,238	1.5898	$3,329,046,272
Oklahoma	$439,518,342	1.5213	$668,639,232
Oregon	$291,446,500	1.5059	$438,889,280
Pennsylvania	$3,323,841,608	1.5715	$5,223,416,832
Rhode Island	$227,137,572	1.4524	$329,894,592
South Carolina	$635,605,610	1.5709	$998,472,832
South Dakota	$82,176,232	1.3936	$114,520,792
Tennessee	$1,084,586,826	1.6503	$1,789,893,632
Texas	$6,866,018,295	1.7143	$11,770,415,104
Utah	$397,109,814	1.5873	$630,332,416
Vermont	$122,737,692	1.4074	$172,741,024
Virginia	$1,363,601,714	1.5328	$2,090,128,640
Washington	$592,204,567	1.4817	$877,469,504
West Virginia	$258,439,845	1.3752	$355,406,496
Wisconsin	$554,375,279	1.5047	$834,168,448
Wyoming	$30,962,738	1.3395	$41,474,588
Total U.S.	**$59,241,374,211**		**$92,356,713,364**

1. QCEW collected by the U.S. Bureau of Labor Statistics, 2022.
2. U.S. Bureau of Economic Analysis multipliers, 2021.
3. KNG Health Analysis.

Note: The QCEW collects wage data quarterly. All states report employment figures on privately owned home health agencies, including for-profit and non-profit organizations

Table 6.3: Impact of Home Health (HH) on Output by State, 2021

State	Estimated Home Health Expenditures[1]	Multiplier for Output[2]	Estimated Impact of HH Spending on Output[3]
Alabama	$515,595,008	1.9972	$1,029,746,356
Alaska	$41,562,348	1.7036	$70,805,618
Arizona	$472,246,848	2.1624	$1,021,186,588
Arkansas	$299,989,120	1.8874	$566,199,474
California	$4,497,503,232	2.1518	$9,677,727,082
Colorado	$448,333,792	2.2374	$1,003,102,051
Connecticut	$619,548,928	1.9523	$1,209,545,343
Delaware	$152,314,928	1.7676	$269,231,876
District of Columbia	$88,823,632	1.2987	$115,355,249
Florida	$2,621,190,400	2.1617	$5,666,227,315
Georgia	$650,141,184	2.2648	$1,472,439,800
Hawaii	$61,310,856	1.9401	$118,949,189
Idaho	$167,147,424	1.9218	$321,223,922
Illinois	$2,733,633,280	2.3641	$6,462,582,381
Indiana	$514,217,632	2.0970	$1,078,314,314
Iowa	$306,478,752	1.8248	$559,262,431
Kansas	$398,210,240	1.9751	$786,505,061
Kentucky	$376,647,232	1.9919	$750,243,609
Louisiana	$462,769,312	1.9351	$895,504,877
Maine	$218,973,280	1.9113	$418,523,618
Maryland	$397,578,112	2.0208	$803,425,894
Massachusetts	$1,294,352,000	2.0258	$2,622,098,268
Michigan	$1,574,087,424	2.1296	$3,352,176,654
Minnesota	$577,204,608	2.0905	$1,206,646,300
Mississippi	$334,799,840	1.8410	$616,366,492
Missouri	$669,668,608	2.1160	$1,417,018,732
Montana	$76,690,976	1.8139	$139,109,761
Nebraska	$159,881,760	1.8630	$297,859,725
Nevada	$274,713,952	1.9053	$523,412,499
New Hampshire	$282,542,336	1.8841	$532,338,004
New Jersey	$747,385,536	2.1956	$1,640,959,707
New Mexico	$3,460,987,648	1.7802	$6,161,250,227
New York	$1,813,762,176	1.9322	$3,504,551,195
North Carolina	$968,903,552	2.2317	$2,162,302,002
North Dakota	$34,285,232	1.7330	$59,416,308
Ohio	$1,226,502,528	2.1827	$2,677,086,968
Oklahoma	$536,065,056	1.9946	$1,069,235,392
Oregon	$323,923,648	1.9967	$646,778,364
Pennsylvania	$1,706,583,808	2.1375	$3,647,822,971
Rhode Island	$186,886,816	1.8682	$349,141,939
South Carolina	$439,196,480	2.1642	$950,509,052
South Dakota	$141,022,864	1.7657	$249,004,069
Tennessee	$820,166,144	2.2966	$1,883,593,651
Texas	$3,061,358,592	2.4486	$7,496,042,813
Utah	$310,190,624	2.1923	$680,030,930
Vermont	$181,988,288	1.7655	$321,300,313
Virginia	$792,984,896	2.0663	$1,638,544,623
Washington	$495,819,360	1.9788	$981,127,379
West Virginia	$235,659,152	1.7061	$402,058,076
Wisconsin	$475,852,704	1.9875	$945,757,227
Wyoming	$46,056,860	1.6846	$77,587,386
Total U.S.	**$39,293,739,008**		**$82,547,229,075**

1. CMS Medicare Cost Reports for Home Health Agencies, 2021.
2. U.S. Bureau of Economic Analysis multipliers, 2021.
3. KNG Health Analysis.

Note: All Medicare-certified home health agencies are required to submit an annual cost report, which includes cost and charges by cost center in total and for Medicare. Cost report data do not include expenditures from HHA contractors, but the multiplier is intended to account for such figures.

RESEARCH INSTITUTE for HOME CARE

ADVANCING HOME CARE THROUGH RESEARCH.

Health Outcomes of Home Health Users

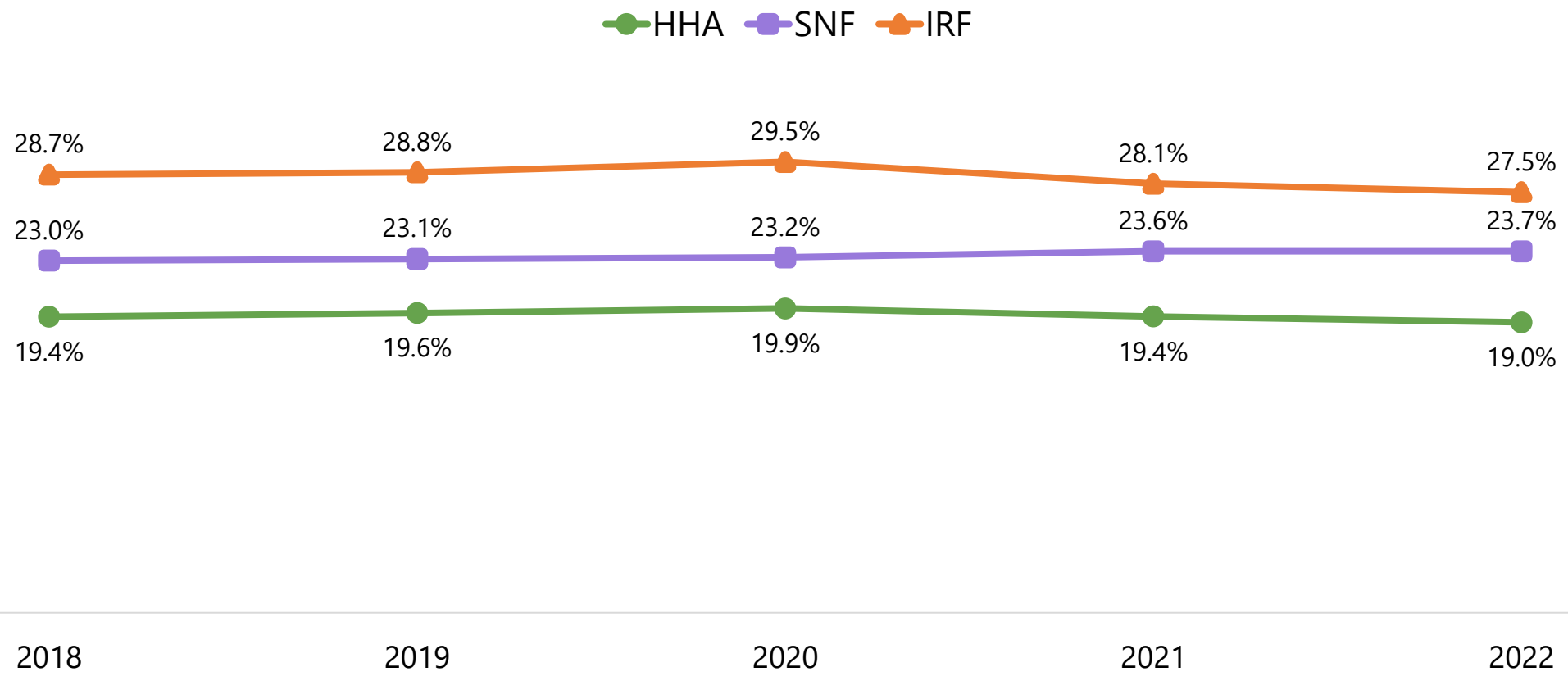
Sponsored by HOMECARE & HOSPICE National Association for Home Care & Hospice

Table 7.1: 30-day Readmission Rates for Top 20 MS-DRGs Discharged from Hospital to Selected Post-Acute Care Settings, by Setting, 2022

MS-DRGs	% of Home Health Users Readmitted Within 30 Days	% of Skilled Nursing Facility Users Readmitted Within 30 Days
SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC	19.0%	23.7%
HEART FAILURE AND SHOCK WITH MCC	20.3%	25.6%
RESPIRATORY INFECTIONS AND INFLAMMATIONS WITH MCC	16.9%	22.0%
MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITHOUT MCC	4.0%	8.4%
SIMPLE PNEUMONIA AND PLEURISY WITH MCC	16.7%	21.9%
SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITHOUT MCC	16.2%	19.0%
KIDNEY AND URINARY TRACT INFECTIONS WITHOUT MCC	14.6%	15.8%
INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION WITH CC OR TPA IN 24 HOURS	11.4%	16.6%
INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITH MCC	19.8%	26.7%
PULMONARY EDEMA AND RESPIRATORY FAILURE	19.0%	24.9%
ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE WITH MCC	26.9%	29.4%
RENAL FAILURE WITH CC	19.1%	21.1%
KIDNEY AND URINARY TRACT INFECTIONS WITH MCC	16.0%	18.0%
RENAL FAILURE WITH MCC	21.1%	23.6%
HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH CC	6.4%	10.3%
MAJOR SMALL AND LARGE BOWEL PROCEDURES WITH CC	15.1%	19.9%
CELLULITIS WITHOUT MCC	12.7%	15.8%
CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH MCC	18.5%	24.5%
HIP REPLACEMENT WITH PRINCIPAL DIAGNOSIS OF HIP FRACTURE WITHOUT MCC	6.5%	11.4%
SYNCOPE AND COLLAPSE	12.5%	17.2%
Total for Top 20 MS-DRGs*	**17.6%**	**21.9%**

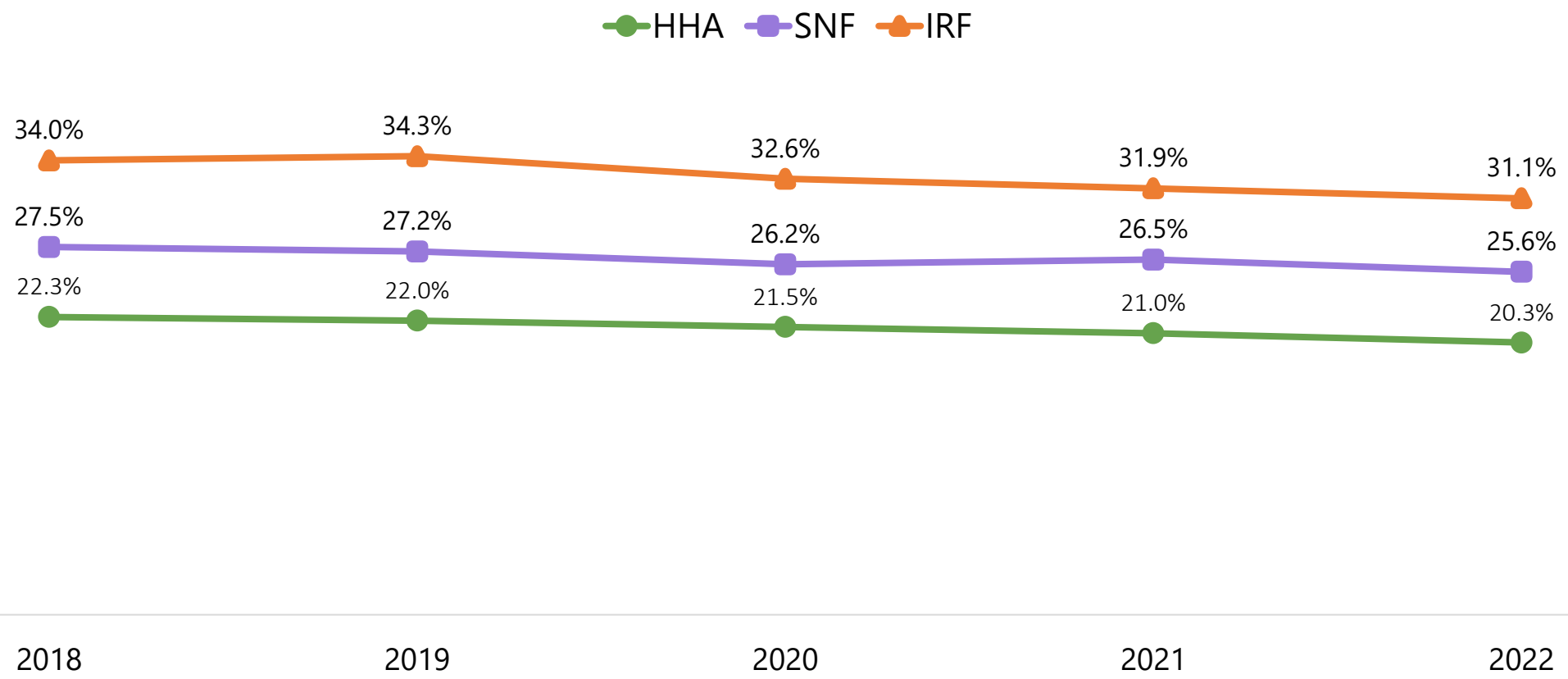
Source: KNG Health analysis of the Medicare Standard Analytic Files, 2022.
*Includes all MS-DRGs, not just those listed.
Note: Data for beneficiaries with a Part A home health episode and a prior short-term acute care hospital stay in 2016-2021. CC = Complication or Comorbidity; MCC = Major Complication or Comorbidity All Medicare

Chart 7.1a: 30-day Readmission Rates for MS-DRG 871 Discharged from Hospital to Selected Post-Acute Care Settings, 2018-2022



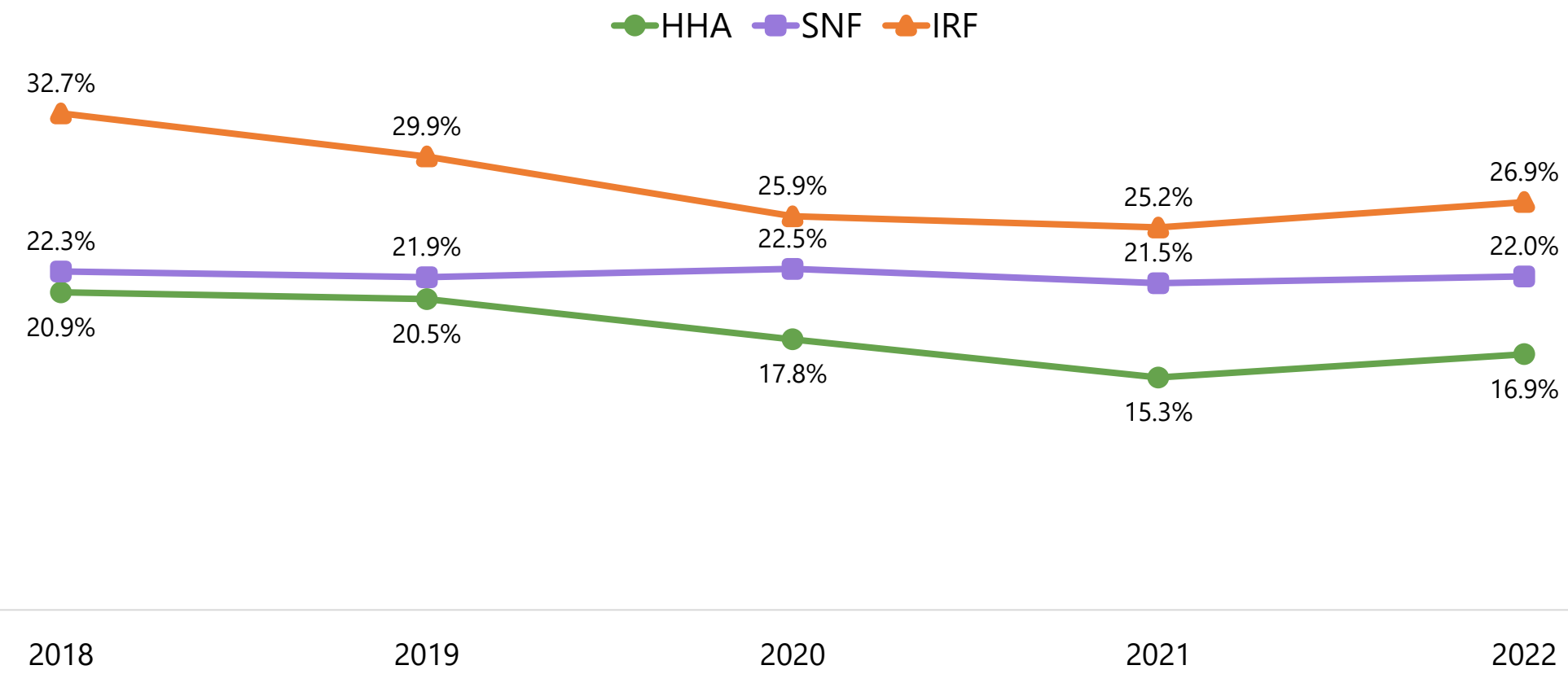
Source: KNG Health analysis of the Medicare Standard Analytic Files, 2018-2023.
HHA = home health agency, SNF = skilled nursing facility, and IRF = inpatient rehabilitation facility
Note: Analysis includes Part A home health claims only.
MS-DRG 871 - SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC

Chart 7.1b: 30-day Readmission Rates for MS-DRG 291 Discharged from Hospital to Selected Post-Acute Care Settings, 2018-2022



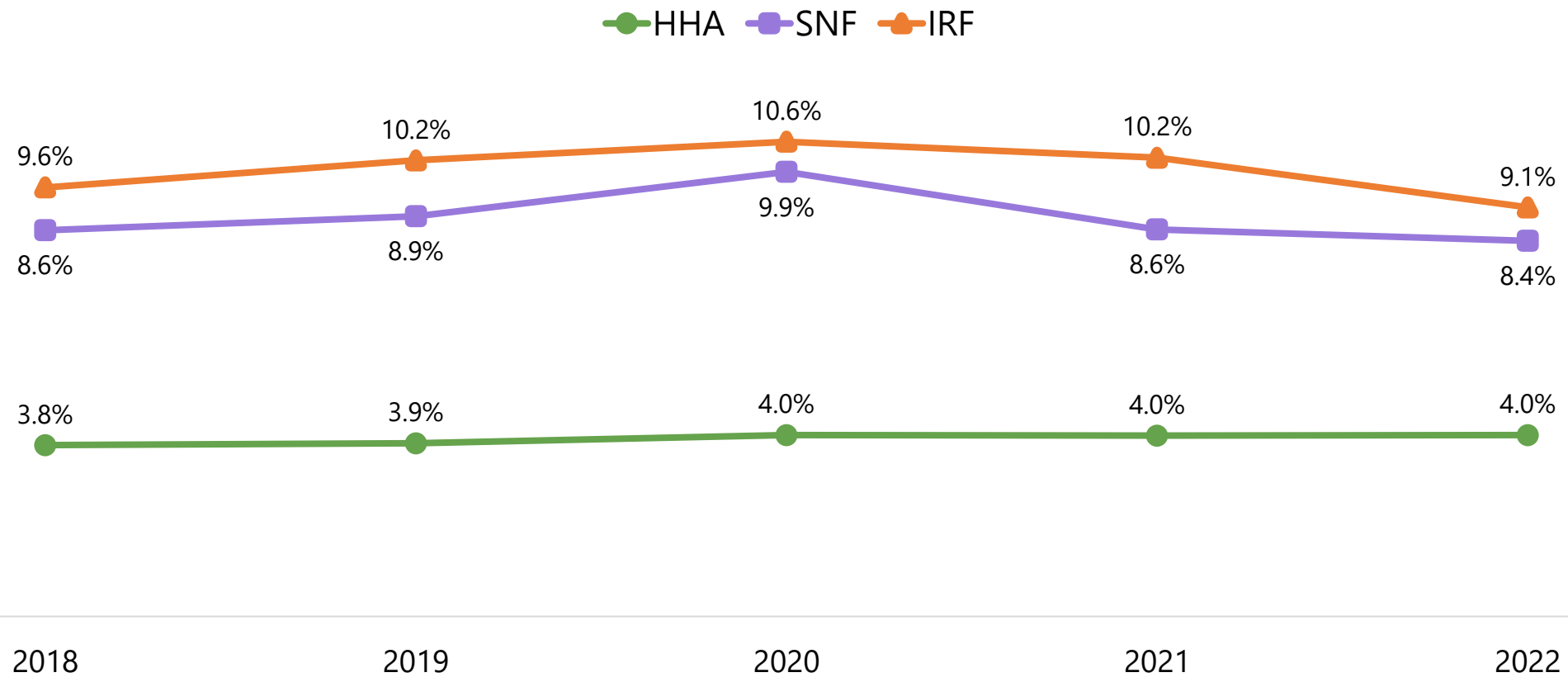
Source: KNG Health analysis of the Medicare Standard Analytic Files, 2018-2023.
HHA = home health agency, SNF = skilled nursing facility, and IRF = inpatient rehabilitation facility
Note: Analysis includes Part A home health claims only.
MS-DRG 291 - HEART FAILURE AND SHOCK WITH MCC

Chart 7.1c: 30-day Readmission Rates for MS-DRG 177 Discharged from Hospital to Selected Post-Acute Care Settings, 2018-2022



Source: KNG Health analysis of the Medicare Standard Analytic Files, 2018-2023.
HHA = home health agency, SNF = skilled nursing facility, and IRF = inpatient rehabilitation facility
Note: Analysis includes Part A home health claims only.
MS-DRG 177 - RESPIRATORY INFECTIONS AND INFLAMMATIONS WITH MCC

Chart 7.1d: 30-day Readmission Rates for MS-DRG 470 Discharged from Hospital to Selected Post-Acute Care Settings, 2018-2022



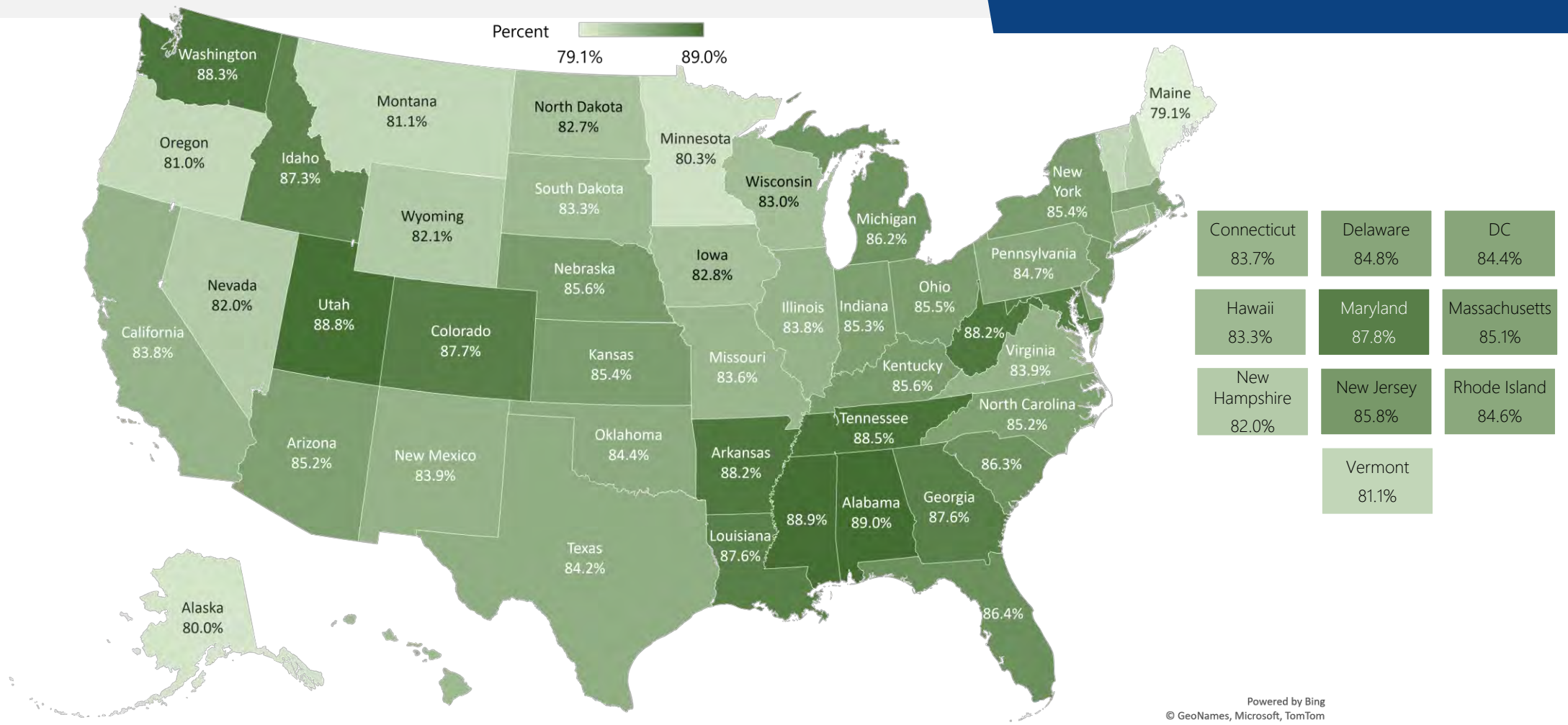
Source: KNG Health analysis of the Medicare Standard Analytic Files, 2018-2023.
HHA = home health agency, SNF = skilled nursing facility, and IRF = inpatient rehabilitation facility
Note: Analysis includes Part A home health claims only.
MS-DRG 470 - MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITHOUT MCC

Table 7.2: National Averages for Patient Outcomes while in Home Health Care, 2018 – 2022

Measure of Patient Outcomes	2018	2019	2020	2021*	2022
Wounds improved or healed after operation	90.9%	91.5%	92.3%	N/A	N/A
Got better at bathing	76.6%	79.7%	82.3%	N/A	85.3%
Had less pain when moving around	77.2%	80.6%	N/A	N/A	N/A
Breathing improved	76.2%	79.8%	82.8%	N/A	85.6%
Got better at walking or moving around	74.1%	77.7%	79.6%	N/A	83.1%
Got better at getting in and out of bed	72.3%	77.5%	81.1%	N/A	84.3%
Got better at taking drugs correctly by mouth	64.6%	69.4%	75.0%	N/A	80.5%
Had to be admitted to hospital	15.8%	15.6%	15.4%	N/A	14.2%
Needed any urgent, unplanned care in the hospital emergency room – without being admitted to the hospital	12.9%	12.8%	13.0%	N/A	11.6%

Source: KNG Health analysis of Home Health Care Compare Data, 2018-2022.
Note: Home Health Care Compare data is based on annual October refresh.
*The Centers for Medicare & Medicaid Services did not collect new data in 2021. As a result, data reported on Home Health Care Compare for 2021 is the same data reported in 2020.

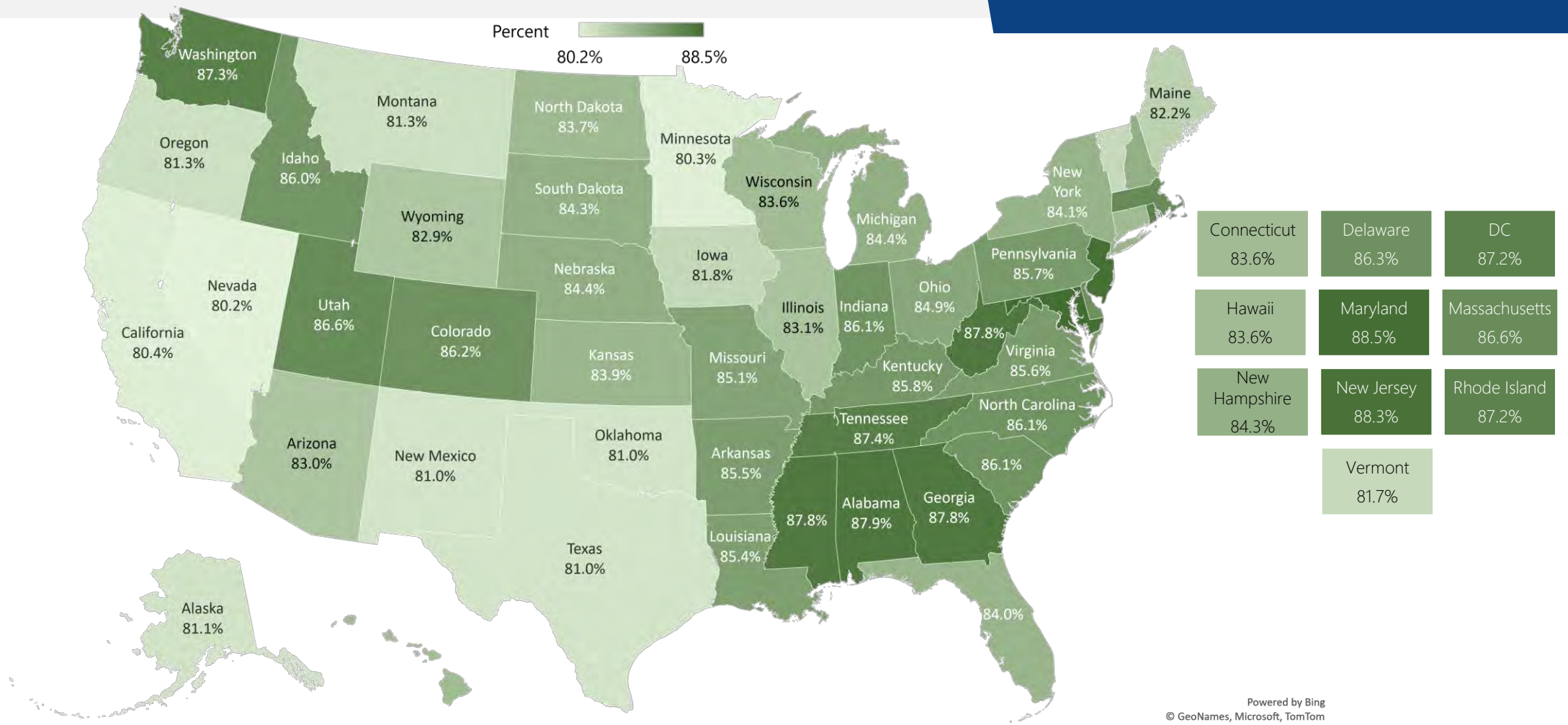
Chart 7.2: Performance on "How Often Patients Got Better at Bathing" by State, 2022



Connecticut 83.7%	Delaware 84.8%	DC 84.4%
Hawaii 83.3%	Maryland 87.8%	Massachusetts 85.1%
New Hampshire 82.0%	New Jersey 85.8%	Rhode Island 84.6%
	Vermont 81.1%	

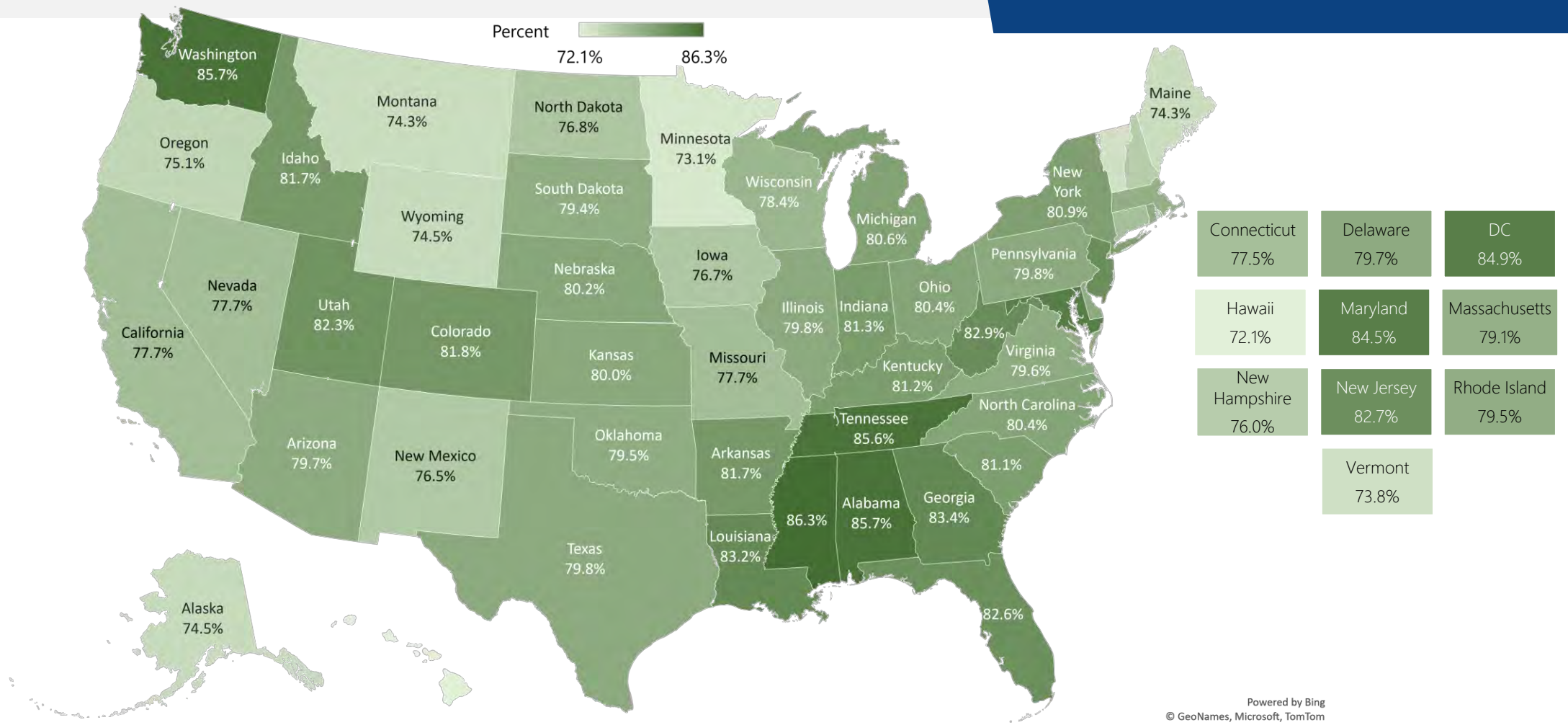
Source: KNG Health analysis of Home Health Care Compare Data, 2022.
Note: Home Health Care Compare data is based on annual October refresh.
*The Centers for Medicare & Medicaid Services did not collect new data in 2021. As a result, data reported on Home Health Care Compare for 2021 is the same data reported in 2020.

Chart 7.3: Performance on "How Often Patients Got Better at Getting In and Out of Bed" by State, 2022



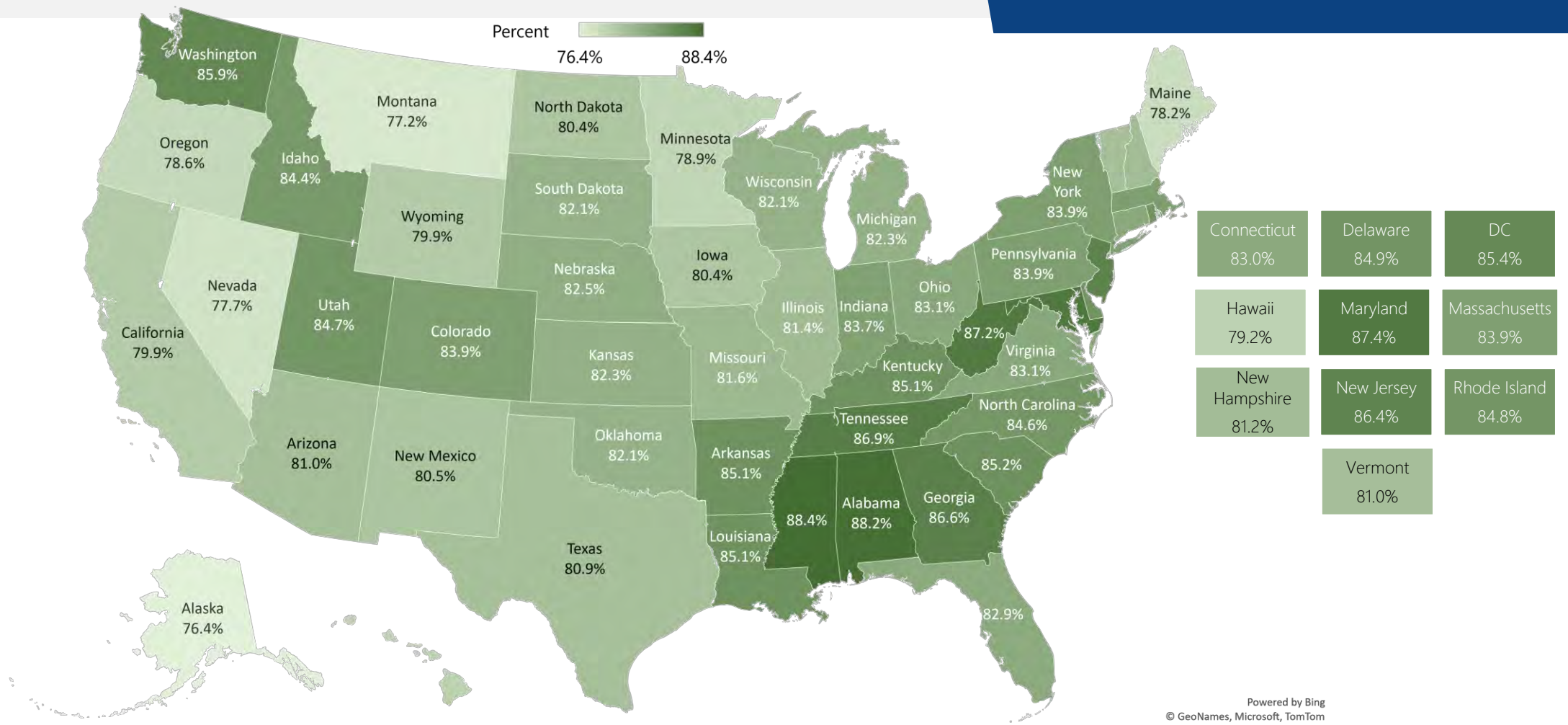
Source: KNG Health analysis of Home Health Care Compare Data, 2022.
Note: Home Health Care Compare data is based on annual October refresh.

Chart 7.4: Performance on "How Often Patients Got Better at Taking Their Drugs Correctly by Mouth" by State, 2022



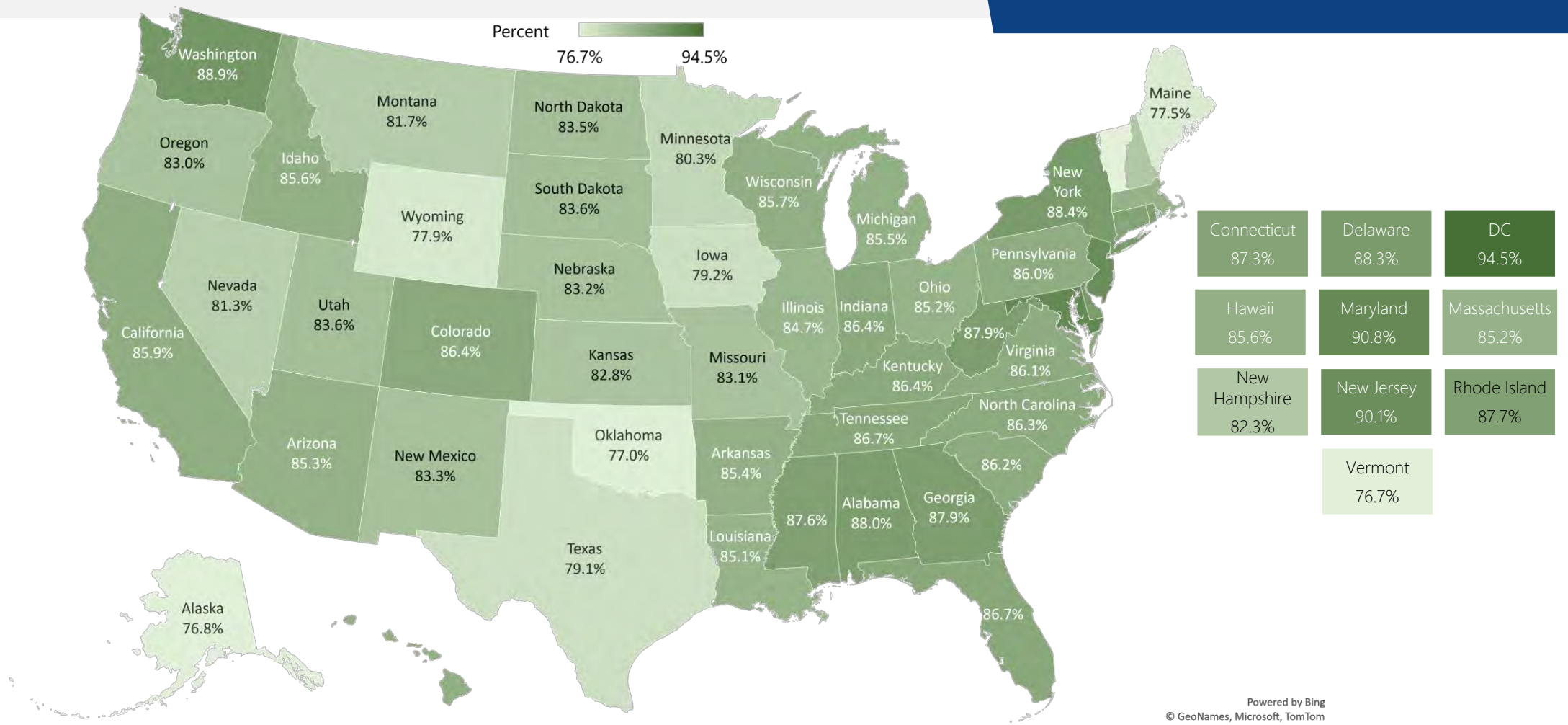
Source: KNG Health analysis of Home Health Care Compare Data, 2022.
Note: Home Health Care Compare data is based on annual October refresh.

Chart 7.5: Performance on "How Often Patients Got Better at Walking or Moving Around" by State, 2022



Source: KNG Health analysis of Home Health Care Compare Data, 2022.
Note: Home Health Care Compare data is based on annual October refresh.

Chart 7.6: Performance on "How Often Patients' Breathing Improved" by State, 2022



Source: KNG Health analysis of Home Health Care Compare Data, 2022.
Note: Home Health Care Compare data is based on annual October refresh.

RESEARCH INSTITUTE for HOME CARE

ADVANCING HOME CARE THROUGH RESEARCH.

Appendix

Sponsored by HOMECARE & HOSPICE National Association for Home Care & Hospice

Methodology: Medicare Current Beneficiary Survey

Data and Study Population

- The Medicare Current Beneficiary Survey is a nationally representative sample that contains information on beneficiary demographics, health status, household characteristics, access, satisfaction, and usual source of care, as well as insurance coverage. This data includes statistics on both Traditional Medicare beneficiaries and Medicare Advantage beneficiaries.
- To examine the demographic, socioeconomic, and clinical characteristics of Medicare Beneficiaries and Medicare Home Health users, we conducted analyses using data from the 2021 Medicare Current Beneficiary Survey.
- The patient population included in our analysis consists of Medicare beneficiaries who fulfill the following criteria:
  - Both traditional and Medicare Advantage Beneficiaries must be continuously enrolled in their respective Medicare plan for either a full year or be only enrolled in traditional or Medicare Advantage during the year. Beneficiaries that switch between traditional Medicare and Medicare Advantage are excluded from the analysis.
  - Medicare Home Health Users must receive home health services at least one time during the year.

Methodology: Medicare Current Beneficiary Survey (continued)

Identification of Study Cohorts

- All Medicare Beneficiaries are identified as survey respondents living both in the community and facilities.
- Traditional Medicare Home Health Users are identified as traditional Medicare beneficiaries who receive home health services that were captured in the Outcome and Assessment Information segment of the Medicare Current Beneficiary Survey.
- Medicare Advantage Home Health Users are identified as survey respondents who were coded as Medicare Advantage beneficiaries in the Health Insurance Summary segment in Medicare Current Beneficiary Survey every month of the year.

Descriptive Analysis

- Demographic characteristics: Obtained from the following Medicare Current Beneficiary Survey segments:
  - Demographics
- Socioeconomic characteristics: Obtained from the following Medicare Current Beneficiary Survey segments:
  - Demographics
  - Health Insurance Summary
  - Household Characteristics
- Clinical characteristics: Obtained from the following Medicare Current Beneficiary Survey segments:
  - General Health
  - Chronic Conditions
  - Nagi Disability
  - Access to Care
  - Outcome and Assessment Information
  - Satisfaction with Care

Methodology: U.S. Bureau of Labor Statistics and Bureau of Economic Analysis Data and Home Health Care Compare Data

U.S. Bureau of Labor Statistics and Bureau of Economic Analysis Data

- To examine the economic contributions of home health agencies to the U.S. economy, we conducted analyses using 2022 data from the U.S. Bureau of Labor Statistics and 2021 multipliers from the Bureau of Economic Analysis, which are "estimates of regional input-output multipliers for any state, county, or combination of states or counties," limited to the industry of home healthcare services (NAICS 6216).

Home Health Care Compare Data

- To examine the organizational trends of home health agencies, quality of home health agencies and home care, and the patient outcomes of home health users, we conducted analyses using 2018-2022 Home Health Care Compare data. Due to data collection pauses in 2020, the 2021 Home Health Care Compare data is a duplicate of 2020 data and was not referenced in this report.

Methodology: Medicare Cost Report Data

- Medicare Cost Report data is a collection of facility characteristics, utilization, costs and charges, Medicare settlement, and financial statement data reported to the Healthcare Cost Report Information System. Cost Report data is reported annually by all Medicare-certified institutional providers, including home health agencies.

- Medicare Cost Reports were used to calculate the total home health agency expenditures for economic impact analysis.
  - The total expenditures for individual home health agencies correspond to the total operating expenditures listed on the home health agency's statement of Revenues and Expenses (Worksheet F-1) accounting for additions and subtractions in the FY 2020 HHA NMRC File and then aggregated up to a state level. Hospital-based home health agency costs (Worksheet H) are aggregated up to a state level and then added to the freestanding home health agency expenses.

Methodology: Medicare Claims Data

Appendix

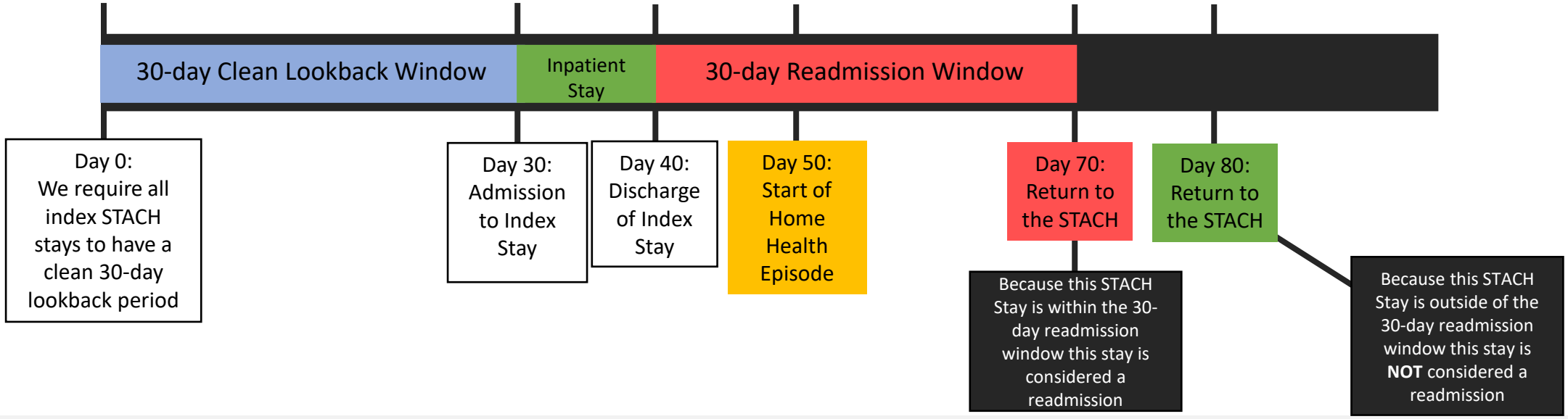
- The 2015-2023 Q1 100% Home Health Agency Standard Analytic LDS, 2015-2023 Q1 100% Inpatient Standard Analytic File, and 2015-2023 Q1 100% Skilled Nursing Standard Analytic LDS (SNF SAF) were used to examine:
  - the clinical profile of traditional Medicare home health users.
  - the role of Home Health Agencies (HHAs) in the post-acute care industry;
  - the organizational trends of home health agencies; and
  - the health outcomes of traditional Medicare home health users.

- We used 2 methodologies to define Part A home health care episodes/visits.
  - When assessing Part A home health episodes with a preceding hospitalization, we required the home health claims to have a short-term acute care hospital stay within 14 days of admission.
  - When assessing all Part A home health episodes, we required the home health claims to have a claim value code of "62," which indicated Medicare Part A was the source of payment.[1]

1. Morefield, B., & Tomai, L. (2021). Distinguishing frontloading: an Examination of Medicare Home Health Claims. *Health Services and Outcomes Research Methodology*, *21*(4), 477-485.

Methodology: Calculating Readmission Rates for Traditional Medicare Beneficiaries

- In this analysis, we define a readmission as an admission to a short-term acute care hospital (STACH) within 30 days of an initial, or 'index', admission to a STACH. To be considered an index admission, there must be no other STACH admission in the prior 30 days.
- Using the Medicare claims data, we identified readmission rates based on the following methodology.



October 2023

Report for Washington Managed Fee-for-Service (MFFS)

Final Demonstration Year 7 and Preliminary Demonstration Year 8 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative

Prepared for

Susannah Woodman, MSW, MPH
Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
Mail Stop WB-06-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted by

Angela M. Greene, MS, MBA
Zhanlian Feng, PhD
RTI International
3040 East Cornwallis Road
P.O. Box 12194
Research Triangle Park, NC 27707-2194

RTI Project Number 0212790.003.002.007/008

REPORT FOR WASHINGTON MANAGED FEE-FOR-SERVICE (MFFS)

MEDICARE SAVINGS ESTIMATES
FINAL DEMONSTRATION YEAR 7 AND PRELIMINARY DEMONSTRATION YEAR 8
MEDICARE-MEDICAID FINANCIAL ALIGNMENT INITIATIVE

by

Actuarial Research Corporation
Michael Sandler, ASA, MAAA
Lan Zhao, PhD
Anthony Simms, ASA, MAAA
Todd Trapnell, MPP
Alicia Nussbaum

RTI International
Giuseppina Chiri, PhD

Project Directors: Angela M. Greene, MS, MBA, and Zhanlian Feng, PhD

Federal Project Officer: Susannah Woodman, MSW, MPH

RTI International

CMS Contract No. HHSM-500-2014-00037i TO#7 / #8

October 2023

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.

CONTENTS

LIST OF TABLES

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), 6 (DY6), 7 (DY7) and 8 (DY8) include beneficiaries from all counties.

This report includes an analysis of Medicare Parts A & B savings during the 24-month period from January 1, 2020 through December 31, 2021: final Medicare savings estimates for DY7 (January 1, 2020 through December 31, 2020) and preliminary Medicare savings estimates for DY8 (January 1, 2021 through December 31, 2021). Final Medicare savings estimates for DY1 through DY6 and preliminary Medicare savings estimates for DY7 appeared in previously released Washington Medicare savings reports.

An actuarial analysis was used to perform the Medicare saving calculations in this report, to distinguish it from the multivariate regression-based method that has been used to estimate the impact of the demonstration on quality and cost of care 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 or fell outside of it. 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 shown in Table 7 and summarized below.

- Total Medicare savings in Demonstration Year 7 were calculated as $33.7 million or 6.8 percent of target expenditures. An additional $4.1 million in attributed savings (savings attributed to eligible months prior to the start of the most recent cohort) sums to a total final calculated Demonstration Year 7 Medicare savings amount of $37.8 million.

- Preliminary total Medicare savings (without attributed savings) in Demonstration Year 8 were calculated as $17.2 million or 3.8 percent. Including preliminary attributed Medicare savings estimates of $8.1 million results in a grand total preliminary Demonstration Year 8 Medicare savings estimate of $25.3 million.

- Medicare savings declined from DY7 to DY8, from $33.7 million (final result) to $17.2 million (preliminary estimate without attributed savings.) Over this time period, the number of applicable member months for the intervention period declined from 282,924 to 256,677, and the PMPM savings declined from $119.03 (final estimate) to $66.98 (preliminary estimate).

- Per the previously published Washington Medicare Savings reports, total Medicare savings were calculated as:

  – Demonstration Year 1: $34.9 million

  – Demonstration Year 2: $30.2 million

  – Demonstration Year 3: $46.6 million

  – Demonstration Year 4: $56.0 million

  – Demonstration Year 5: $66.2 million

  – Demonstration Year 6: $59.1 million.

- The current estimate of cumulative grand total Demonstration Medicare savings for all cohorts, including preliminary estimate of Cohorts 10A and 10B attributed savings, through Demonstration Year 8 is $356.0 million.

1. Introduction

The Washington Health Homes MFFS demonstration leverages Medicaid health homes, established under Section 2703 of the Affordable Care Act, to integrate care for full-benefit Medicare-Medicaid beneficiaries. Washington has targeted the demonstration to high-cost, high-risk Medicare-Medicaid enrollees based on the principle that focusing intensive care coordination on those with the greatest need also provides the greatest potential for improved health outcomes and cost savings.

The demonstration is organized around the principles of patient activation, 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 four 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). Additionally, 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, 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 and assignment of demonstration eligible beneficiaries into health homes and began planning for termination. In late October 2015, new information became available about projected savings for

the demonstration.[1] 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 7 (January 1, 2020 through December 31, 2020), and a preliminary analysis of Medicare data for Demonstration Year 8 (January 1, 2021 through December 31, 2021) under the Medicare-Medicaid Financial Alignment Initiative. CMS previously released six Medicare savings reports[2] by RTI.

This report provides *final* Medicare savings estimates for Demonstration Year 7 and *preliminary* Medicare savings estimates for Demonstration Year 8, the additional 12-month period spanning from January 1, 2021 through December 31, 2021. With this report, Demonstration Years 1 through 7 experience and Medicare savings calculations are considered complete.[3]

We use an actuarial analysis to perform the Medicare savings calculations in this report, 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 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 7, but preliminary for Demonstration Year 8. Under the MFFS financial alignment model, only Medicare Parts A and B are included. 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 7 has been updated to include any retroactive adjustments to

---

1 See more details in Appendix A of an earlier report, at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalResults.pdf

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, 4, 5 and 6 experience and savings included in this report is pulled directly from the previous report and does not incorporate any new information or calculations.

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.

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. In other words, for any given period, did the beneficiary meet the requirements related to necessary Medicare coverage and enrollment and geographic location. Similarly did they die and/or receive hospice care during the report timeline. ARC used beneficiary eligibility information extracted from the appropriate tables on the Integrated Data Repository (IDR) on October 19, 2022, 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 7 and preliminary Medicare savings estimates for Demonstration Year 8.

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 8 will include updated values for all months in Demonstration Year 8.

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, 2021 and processed by CMS through September 2022. 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 September 2022. We have assumed the claims runout is effectively 100 percent complete for Demonstration Year 7.

Medicare payments were separated into the seven standard claim categories: Inpatient, Skilled Nursing Facility (SNF), Hospice, Outpatient, Home Health, Professional, and 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: Age (65+) or Disability (<65)

2. Level of Long-Term Services and Supports (LTSS): Institution, Home and Community-Based Services (HCBS), or Community

3. Presence of Severe and Persistent Mental Illness (SPMI): Yes or 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 based on those who met eligibility requirements at the following points in time:

Cohort	Eligibility Requirement Date	Counties	Exclusions
Cohort 1A-1F	July 1 to Dec 1, 2013	NOT King and Snohomish	Rolled out by county over the course of 6 months
Cohort 2	January 1, 2014	NOT King and Snohomish	Not in Cohort 1
Cohort 3	January 1, 2015	NOT King and Snohomish	Not in Cohort 1 or 2
Cohort 4	January 1, 2016	NOT King and Snohomish	Not in Cohorts 1, 2 or 3
Cohort 5A	January 1, 2017	NOT King and Snohomish	Not in Cohorts 1, 2, 3 or 4
Cohort 5B	April 1, 2017	King and Snohomish	Not in Cohorts 1, 2, 3, 4 or 5A
Cohort 6A	January 1, 2018	NOT King and Snohomish	Not in Cohorts 1, 2, 3, 4, 5A or 5B
Cohort 6B	January 1, 2018	King and Snohomish	Not in Cohort 1, 2, 3, 4, 5A or 5B
Cohort 7A	January 1, 2019	NOT King and Snohomish	Not in Cohorts 1, 2, 3, 4, 5A, 5B,6A or 6B
Cohort 7B	January 1, 2019	King and Snohomish	Not in Cohorts 1, 2, 3, 4, 5A, 5B, 6A, or 6B
Cohort 8A	January 1, 2020	NOT King and Snohomish	Not in Cohorts 1, 2, 3, 4, 5A, 5B, 6A, 6B, 7A or 7B
Cohort 8B	January 1, 2020	King and Snohomish	Not in Cohorts 1, 2, 3, 4, 5A, 5B, 6A, 6B, 7A or 7B
Cohort 9A	January 1, 2021	NOT King and Snohomish	Not in Cohorts 1, 2, 3, 4, 5A, 5B, 6A, 6B, 7A, 7B,8A or 8B
Cohort 9B	January 1, 2021	King and Snohomish	Not in Cohorts 1, 2, 3, 4, 5A, 5B, 6A, 6B, 7A, 7B,8A or 8B

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 the following 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[5].

For beneficiaries in the comparison group, we applied the same checks, except that residence was checked for the appropriate counties in the comparison states.

Comparison group identification used a Metropolitan Statistical Area (MSA) level analysis where counties were grouped by MSA, with a single non-MSA area constructed for counties that do not belong to an MSA in each state. 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 eligibility for each respective cohort.

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.[6] The use of a separate comparison group for these two counties reflects how they are notably different in composition from other regions of Washington. Therefore, the two comparison groups used are mutually exclusive.

---

4 The PRISM score is based on a proprietary algorithm developed by the state of Washington.

5 SSP, CEC, ESRD-CEC, IAH, PCF, VTAPM, CJR, PCM, ETC, BPCIA, TCOC, MDPCP, CPC+, DC, KCC, etc.

6 A description of the comparison group selection methodology was included in previous Washington annual evaluation reports (available at: https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/financialalignmentinitiative/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. Later in this section we describe the relative distribution of the intervention and comparison group beneficiaries after the updates.

Special Note 3: During Demonstration Year 7, the COVID-19 pandemic emerged and affected healthcare delivery systems nationwide. We note that the first confirmed case in the United States occurred in Washington state, and the state endured one of the earliest outbreaks of the pandemic. The savings calculations for Demonstration Years 7 and 8 do not include any adjustments or changes to the methodology to specifically account for any potentially disproportionate effects of COVID-19 on either the intervention or comparison groups that would not be reflected in the geographic and outlier adjustments in the analysis.

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 40 percent prevalence of SPMI compared with 47 percent in the comparison group. In the intervention group, 40 percent of members used HCBS, and 11 percent used facility-based LTSS, whereas the prevalence in the comparison group was 15 percent HCBS and 30 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-through 8, the savings percentage experienced by all Cohorts 2 through 4, 5A through 8A and 5B through 8B were attributed to these few months for Cohorts 3, 4, 5A through 9A and 6B through 9B, respectively. Cohorts 10A and 10B will consist of those who were eligible for the demonstration in January 2022 in the original demonstration area and who were not in Cohorts 1, through 9B and those who were eligible for the demonstration in January 2022 in King and Snohomish counties who were not in Cohorts 1 through 9B.

For this report, we have tabulated the eligible member months in Demonstration Year 8 (January 2021 through December 2021) of preliminary Cohorts 10A and 10B and attributed the PMPM savings achieved for Cohorts 9A and 9B, respectively, to these first few months of eligibility of Cohorts 10A and 10B. 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.
- Cohort 8A: January through December 2019.

- Cohort 8B: January through December 2019.
- Cohort 9A: January through December 2020.
- Cohort 9B: January through December 2020.

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, 2022.
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 through 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 through 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.

14. For Cohorts 1 through 7B, January 1, 2020 if the beneficiary was part of a Medicare shared savings program in 2020, but had not been part of a shared savings program prior to 2020.

15. For Cohorts 1 through 8B, January 1, 2021 if the beneficiary was part of a Medicare shared savings program in 2021, but had not been part of a shared savings program prior to 2021.

When one of the above 15 events occurs during a month, a pro-rated number of member months are calculated, so that the number of member months contains fractions of whole months. For Cohorts 2 through 9B, the member months are calculated beginning on January 1, 2014 through 2021 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, their experience would once again be included. Note that a beneficiary is not dropped from the analysis if their 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 of the 7 types of service, and for each month of the Demonstration Year for a total of 168 PMPM expenditure groups for each cohort in each demonstration year. For the intervention group, when aggregating across months, cells, types of service, or cohorts, expenditures are tabulated and divided by member months 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. PMPMs obtained in this way are referred to as "re-weighted" 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 period and (2) the comparison group PMPM in the baseline period:

Target PMPM = Baseline Intervention PMPM * (Demo Comparison PMPM /

Baseline Comparison PMPM)

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.[7] 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 re-calculated by excluding the amounts above the threshold.

[7] 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 a total of 14,020 Medicare-Medicaid enrollees in the intervention group and 23,228 Medicare-Medicaid enrollees in the comparison group. After 8.5 years of operations, there were 2,528 eligible intervention group members and 2,172 eligible comparison group members as of December 31, 2021. The monthly attrition rates for the intervention and comparison groups were 1.67 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 1.01 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 (0.41 percent vs. 0.17 percent[8]) 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. Table 1, below, 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	2,217	0.97%	1.81%
1B	3,859	0.64%	1.61%
1C	393	0.76%	1.95%
1D	6,032	0.81%	1.66%
1E	727	0.67%	1.63%
1F	792	0.58%	1.65%
Total	14,020		

[8] 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.

Appendix Tables A.A–A.O detail and summarize the attrition for all cohorts during the course of the demonstration. Reasons for ineligibility are summarized in Appendix Tables A.A–A.N. Appendix Table A.A summarizes the reasons for ineligibility for members of Cohort 1 who became ineligible during the first 8.5 years of demonstration operations. Appendix Table A.B summarizes the reasons for ineligibility for members of Cohort 2 who became ineligible during their 8 years of demonstration operations. Appendix Tables A.C–A.N summarize the reasons for ineligibility for members of Cohorts 3, 4, 5A, 5B, 6A/B, 7A/B, 8A/B and 9A/B who became ineligible during their time in the demonstration. Appendix Table A.O summarizes the monthly attrition rates for all cohorts. Monthly attrition rates were relatively stable across time and across cohorts. Comparison group attrition was slightly higher overall than intervention group attrition for all cohorts and as the demonstration progressed, attrition rates trended slightly higher for more recently added cohorts. Participation in an SSP was significantly higher for the comparison groups, loss of eligibility was slightly higher for the intervention groups, and all other categories were about the same between comparison and intervention groups within a given cohort.

5. Results of PMPM Cost Analysis

5.1 Medicare Savings before Adjustments

The Medicare 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 detailed in Appendix Tables B.A–B.N. These tables show the incurred claims, member months, and per member per month (PMPM) costs for all Cohorts for the baseline period and for Demonstration Years 7 and 8 by category of beneficiary.

One significant difference between Cohorts 1 and 5B as compared to all other cohorts is that Cohorts 1 and 5B represent a cross-section of demonstration-eligible beneficiaries, whereas all other cohorts 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 all other cohorts' 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 re-weighted 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 beneficiary-level annual costs of total paid claims (Washington and comparison states combined).

Appendix Tables B.A-1 through B.L-2 show pairs of eligible months, PMPMs, and trends for cohorts 1 through 8B in Demonstration years 7 and 8 for the comparison group. Appendix Tables B.M and B.N show eligible months, PMPMs, and trends for cohorts 9A and 9B, respectively, in Demonstration year 8 for the comparison group. These tables, as listed below, are organized by 6 beneficiary categories and additionally present the overall trend which is the ratio of Demonstration Period PMPM divided by Baseline Period PMPM. Trends with a value > 1 indicate that demonstration period PMPM were greater than baseline PMPM. There is substantial fluctuation in the trends both across cells and across cohorts, but they do stabilize in more recent cohorts as there is less total attrition and larger relative population size in the demonstration periods. Overall, the trends to demonstration year 8 tend to be a little lower than the trends to demonstration year 7.

Appendix Table	Cohort	Demo Year	Appendix Table	Cohort	Demo Year
Table B.A.1	Cohort 1	DY7	Table B.B.1	Cohort 2	DY7
Table B.A.2		DY8	Table B.B.2		DY8
Table B.C.1	Cohort 3	DY7	Table B.D.1	Cohort 4	DY7
Table B.C.2		DY8	Table B.D.2		DY8
Table B.E.1	Cohort 5A	DY7	Table B.F.1	Cohort 5B	DY7
Table B.E.2		DY8	Table B.F.2		DY8
Table B.G.1	Cohort 6A	DY7	Table B.H.1	Cohort 6B	DY7
Table B.G.2		DY8	Table B.H.2		DY8
Table B.I.1	Cohort 7A	DY7	Table B.J.1	Cohort 7B	DY7
Table B.I.2		DY8	Table B.J.2		DY8
Table B.K.1	Cohort 8A	DY7	Table B.L.1	Cohort 8B	DY7
Table B.K.2		DY8	Table B.L.2		DY8
Table B.M	Cohort 9A	DY8	Table B.N	Cohort 9B	DY8

Table 2 below summarizes the comparison group cost trends for each cohort in total.

Table 2
Comparison group summary (all cohorts)

	Baseline period			Demonstration Year 7				Demonstration Year 8			
Cohort	Number of eligible months	Medicare incurred claims	PMPM	Number of eligible months	Medicare incurred claims	PMPM	Cost trend (demo year 7/baseline period)	Number of eligible months	Medicare incurred claims	PMPM	Cost trend (demo year 8/baseline period)
Cohort 1	495,181.0	$792,439,622	$1,600.30	40,209.8	$80,129,190	$1,992.78	1.24525	29,949.4	$57,362,194	$1,915.30	1.19684
Cohort 2	42,008.3	$67,515,192	$1,607.19	8,390.8	$15,113,500	$1,801.19	1.12071	6,293.5	$10,671,342	$1,695.60	1.05501
Cohort 3	65,614.5	$109,816,298	$1,673.66	14,752.3	$23,092,214	$1,565.33	0.93527	11,330.9	$18,316,788	$1,616.54	0.96587
Cohort 4	74,886.5	$130,154,124	$1,738.02	19,942.6	$33,360,676	$1,672.83	0.96249	14,164.8	$23,958,162	$1,691.39	0.97317
Cohort 5A	55,234.5	$100,113,666	$1,812.52	17,520.7	$34,040,848	$1,942.89	1.07193	12,074.3	$21,215,382	$1,757.07	0.96941
Cohort 5B	210,281.7	$332,690,142	$1,582.12	56,554.5	$104,086,237	$1,840.46	1.16329	43,631.0	$79,007,017	$1,810.80	1.14454
Cohort 6A	48,146.2	$96,337,228	$2,000.93	19,020.7	$36,791,264	$1,934.27	0.96669	13,725.4	$24,921,199	$1,815.69	0.90742
Cohort 6B	54,424.9	$96,838,525	$1,779.31	18,445.1	$30,890,407	$1,674.72	0.94122	14,211.8	$24,191,509	$1,702.22	0.95667
Cohort 7A	34,245.1	$73,787,223	$2,154.68	19,452.3	$37,303,252	$1,917.68	0.89000	12,500.9	$22,487,438	$1,798.87	0.83486
Cohort 7B	39,801.9	$76,341,094	$1,918.03	20,427.6	$36,535,128	$1,788.52	0.93248	14,718.9	$25,263,855	$1,716.43	0.89489
Cohort 8A	28,489.1	$69,197,528	$2,428.91	28,034.5	$65,391,158	$2,332.53	0.96032	16,372.8	$33,224,527	$2,029.25	0.83546
Cohort 8B	29,657.0	$63,007,366	$2,124.54	28,877.5	$56,450,515	$1,954.83	0.92012	15,738.0	$29,076,041	$1,847.50	0.86960
Cohort 9A	24,132.3	$64,452,017	$2,670.77					23,618.8	$52,781,015	$2,234.71	0.83673
Cohort 9B	24,226.4	$57,824,603	$2,386.84					23,195.6	$47,907,967	$2,065.39	0.86533

Appendix Tables C.A–C.T 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 Appendix Tables C.A–C.T 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 Appendix Tables C.A–C.T 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 (as shown Appendix Table B.A), but in Appendix Table C.A it is $2,057.93. This is because in Appendix Tables C.A–C.T, 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.

Appendix Tables C.A-1 and C.A-2 show the results for the entire Cohort 1 for Demonstration Years 7 and 8, respectively. For example, Appendix Table C.A-1 shows that, for Demonstration Year 7, the PMPM for the comparison group increased by 30.6 percent from the baseline period, whereas that of the intervention group increased by only 19.9 percent, a difference of 10.7 percentage points. Similarly, Appendix Table C.A-2 shows that, for Demonstration Year 8, the PMPM for the comparison group increased by 28.2 percent from the baseline period, whereas that of the intervention group increased by 31.6 percent, a difference of 3.4 percentage points.

Tables 3.A and 3.B below summarize the results of Appendix Tables C.A–C.T 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. Cohort 1D showed savings in Demonstration Year 7 and negative savings (increased expenditures) in Demonstration Year 8. Cohorts 1B, 1C, 1E, and 1F all show negative Medicare savings in both demonstration years. Cohort 2 shows slight Medicare savings in Demonstration Year 7 and slight negative savings in Demonstration Year 8, but the small size of the cohort means the savings is less substantial. Cohort 3 shows slightly negative savings in Demonstration Year 7 and moderate Medicare savings in Demonstration Year 8. Cohorts 4, 5A, 5B, 6A, 6B, 7B, 8A and 8B all show Medicare savings in Demonstration Year 7, with Cohort 7A showing moderately negative savings. In Demonstration Year 8, level of savings shrinks for most cohorts and cohorts 5A, 7A and 8B all show negative 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
Summary by cohort of per member per month (PMPM), baseline versus Demonstration Year 7

Cohort	Group (comparison/ Intervention)	Baseline period			Demonstration Year 7			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	6,312.0	$13,566,702	$2,149.36	1.323
	I	48,488.0	$128,622,626	$2,652.67	6,312.0	$16,100,704	$2,550.81	0.962
1B	C	83,567.1	$131,605,106	$1,574.84	12,573.7	$26,040,550	$2,071.04	1.315
	I	83,567.1	$108,476,913	$1,298.08	12,573.7	$22,253,570	$1,769.86	1.363
1C	C	7,946.8	$12,115,020	$1,524.51	969.2	$1,966,093	$2,028.50	1.331
	I	7,946.8	$7,898,710	$993.94	969.2	$1,612,730	$1,663.92	1.674
1D	C	129,399.2	$207,882,769	$1,606.52	19,395.0	$40,321,445	$2,078.96	1.294
	I	129,399.2	$219,493,469	$1,696.25	19,395.0	$39,492,807	$2,036.23	1.200
1E	C	15,153.3	$23,465,894	$1,548.56	2,361.3	$4,736,181	$2,005.71	1.295
	I	15,153.3	$10,288,068	$678.93	2,361.3	$3,030,212	$1,283.25	1.890
1F	C	15,986.6	$24,688,247	$1,544.31	2,621.7	$5,334,212	$2,034.63	1.318
	I	15,986.6	$9,731,043	$608.70	2,621.7	$3,029,282	$1,155.46	1.898
1 total	C	300,541.1	$478,511,235	$1,592.17	44,233.0	$91,965,182	$2,079.11	1.306
	I	300,541.1	$484,510,829	$1,612.13	44,233.0	$85,519,305	$1,933.38	1.199
2	C	4,220.4	$7,342,975	$1,739.88	2,080.7	$3,884,764	$1,867.03	1.073
	I	4,220.4	$9,945,769	$2,356.60	2,080.7	$4,698,292	$2,258.01	0.958
3	C	61,200.6	$93,045,998	$1,520.35	19,626.8	$31,740,171	$1,617.19	1.064
	I	61,200.6	$103,440,434	$1,690.19	19,626.8	$35,689,148	$1,818.39	1.076
4	C	62,395.6	$96,865,182	$1,552.44	21,178.4	$35,131,034	$1,658.82	1.069
	I	62,395.6	$108,719,430	$1,742.42	21,178.4	$38,330,744	$1,809.90	1.039

(continued)

Table 3.A (continued)
Summary by cohort of per member per month (PMPM), baseline versus Demonstration Year 7

Cohort	Group (comparison/ Intervention)	Baseline period			Demonstration Year 7			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	
5A	C	65,796.4	$107,612,835	$1,635.54	27,183.8	$49,051,217	$1,804.43	1.103
	I	65,796.4	$110,831,462	$1,684.46	27,183.8	$45,282,908	$1,665.80	0.989
5B	C	65,414.5	$107,080,977	$1,636.96	28,585.4	$55,332,601	$1,935.70	1.182
	I	65,414.5	$113,207,213	$1,730.61	28,585.4	$53,915,562	$1,886.13	1.090
6A	C	51,245.5	$100,075,043	$1,952.86	25,620.5	$50,751,548	$1,980.90	1.014
	I	51,245.5	$102,206,255	$1,994.44	25,620.5	$43,775,692	$1,708.62	0.857
6B	C	36,877.4	$64,261,823	$1,742.58	17,901.2	$29,727,534	$1,660.65	0.953
	I	36,877.4	$69,409,748	$1,882.18	17,901.2	$31,586,811	$1,764.51	0.937
7A	C	46,757.6	$93,789,158	$2,005.86	30,000.8	$54,465,704	$1,815.48	0.905
	I	46,757.6	$87,735,987	$1,876.40	30,000.8	$53,186,770	$1,772.85	0.945
7B	C	22,665.5	$42,348,648	$1,868.42	13,800.7	$22,475,076	$1,628.55	0.872
	I	22,665.5	$45,179,933	$1,993.34	13,800.7	$22,290,308	$1,615.16	0.810
8A	C	36,696.5	$76,684,514	$2,089.70	36,291.3	$73,826,297	$2,034.27	0.973
	I	36,696.5	$75,138,004	$2,047.55	36,291.3	$65,621,143	$1,808.18	0.883
8B	C	17,043.2	$33,246,266	$1,950.70	16,421.5	$28,732,978	$1,749.72	0.897
	I	17,043.2	$33,145,837	$1,944.81	16,421.5	$28,424,461	$1,730.93	0.890

Table 3.B
Summary by cohort of per member per month (PMPM), baseline versus Demonstration Year 8

		Baseline period			Demonstration Year 8			
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	4,120.8	$8,728,066	$2,118.07	1.304
	I	48,488.0	$128,622,626	$2,652.67	4,120.8	$9,883,388	$2,398.44	0.904
1B	C	83,567.1	$131,605,106	$1,574.84	8,903.3	$18,058,292	$2,028.28	1.288
	I	83,567.1	$108,476,913	$1,298.08	8,903.3	$16,575,067	$1,861.68	1.434
1C	C	7,946.8	$12,115,020	$1,524.51	667.3	$1,330,602	$1,994.01	1.308
	I	7,946.8	$7,898,710	$993.94	667.3	$1,196,820	$1,793.52	1.804
1D	C	129,399.2	$207,882,769	$1,606.52	15,679.6	$32,017,466	$2,041.98	1.271
	I	129,399.2	$219,493,469	$1,696.25	15,679.6	$37,041,674	$2,362.41	1.393
1E	C	15,153.3	$23,465,894	$1,548.56	1,891.7	$3,748,511	$1,981.53	1.280
	I	15,153.3	$10,288,068	$678.93	1,891.7	$3,182,060	$1,682.09	2.478
1F	C	15,986.6	$24,688,247	$1,544.31	2,100.0	$4,202,405	$2,001.12	1.296
	I	15,986.6	$9,731,043	$608.70	2,100.0	$2,891,075	$1,376.69	2.262
1 total	C	300,541.1	$478,511,235	$1,592.17	33,362.7	$68,085,342	$2,040.76	1.282
	I	300,541.1	$484,510,829	$1,612.13	33,362.7	$70,770,085	$2,121.24	1.316
2	C	4,220.4	$7,342,975	$1,739.88	1,489.3	$2,491,198	$1,672.72	0.961
	I	4,220.4	$9,945,769	$2,356.60	1,489.3	$3,485,272	$2,340.20	0.993
3	C	61,200.6	$93,045,998	$1,520.35	15,285.4	$25,207,296	$1,649.11	1.085
	I	61,200.6	$103,440,434	$1,690.19	15,285.4	$27,337,771	$1,788.49	1.058
4	C	62,395.6	$96,865,182	$1,552.44	15,601.3	$28,818,924	$1,847.21	1.190
	I	62,395.6	$108,719,430	$1,742.42	15,601.3	$27,900,042	$1,788.31	1.026

(continued)

Table 3.B (continued)
Summary by cohort of per member per month (PMPM), baseline versus Demonstration Year 8

		Baseline period			Demonstration Year 8			
Cohort	Group	Number of eligible months (intervention group)	Medicare incurred claims	PMPM	Number of eligible months (intervention group)	Medicare incurred claims	PMPM	Cost trend (Demonstration Year/baseline period)
5A	C	65,796.4	$107,612,835	$1,635.54	19,857.0	$31,645,896	$1,593.69	0.974
	I	65,796.4	$110,831,462	$1,684.46	19,857.0	$35,560,883	$1,790.85	1.063
5B	C	65,414.5	$107,080,977	$1,636.96	22,211.0	$42,629,284	$1,919.29	1.172
	I	65,414.5	$113,207,213	$1,730.61	22,211.0	$44,068,348	$1,984.08	1.146
6A	C	51,245.5	$100,075,043	$1,952.86	18,846.1	$32,752,216	$1,737.88	0.890
	I	51,245.5	$102,206,255	$1,994.44	18,846.1	$33,141,657	$1,758.54	0.882
6B	C	36,877.4	$64,261,823	$1,742.58	13,581.5	$25,286,154	$1,861.81	1.068
	I	36,877.4	$69,409,748	$1,882.18	13,581.5	$22,916,704	$1,687.35	0.896
7A	C	46,757.6	$93,789,158	$2,005.86	20,131.8	$37,948,389	$1,885.00	0.940
	I	46,757.6	$87,735,987	$1,876.40	20,131.8	$36,068,006	$1,791.60	0.955
7B	C	22,665.5	$42,348,648	$1,868.42	9,644.2	$15,026,230	$1,558.05	0.834
	I	22,665.5	$45,179,933	$1,993.34	9,644.2	$15,780,506	$1,636.26	0.821
8A	C	36,696.5	$76,684,514	$2,089.70	23,270.8	$45,844,068	$1,970.02	0.943
	I	36,696.5	$75,138,004	$2,047.55	23,270.8	$44,388,305	$1,907.47	0.932
8B	C	17,043.2	$33,246,266	$1,950.70	10,811.3	$18,348,592	$1,697.17	0.870
	I	17,043.2	$33,145,837	$1,944.81	10,811.3	$18,608,070	$1,721.17	0.885
9A	C	36,543.7	$78,755,081	$2,155.10	36,783.5	$80,876,454	$2,198.72	1.020
	I	36,543.7	$77,445,770	$2,119.27	36,783.5	$70,197,676	$1,908.40	0.901
9B	C	16,436.9	$36,322,230	$2,209.80	15,801.5	$32,516,258	$2,057.80	0.931
	I	16,436.9	$36,960,759	$2,248.65	15,801.5	$31,187,264	$1,973.69	0.878

5.2 Medicare AGA Adjustments

The trend in health care costs is not uniform across the United States and varies by geographic area. CMS measures these variations for each calendar year by county with the calculation of the Average Geographic Adjustment (AGA) factors. The purpose of this adjustment is to control for geographic variation in secular cost trends. 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).[9] Tables 4.A and 4.B show the results of the calculations for Demonstration Years 7 and 8, 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 7, the AGA factor increased by 1.35 percent (a factor of 1.0135) for the comparison group and increased by 4.57 percent (a factor of 1.0457) for the intervention group. If the AGA had increased by the same 4.57 percent in the comparison area as it did in the intervention area, instead of increasing by 1.35 percent, then the trend of the comparison group would have increased by an additional 3.17 percent (1.0457/1.0135 = 1.0317), which is the AGA adjustment factor that we apply to the comparison group trend.

[9] 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 4.A
Average AGA factor by group for baseline period and Demonstration Year 7

Cohort	Group comparison intervention	Baseline period	Demonstration Year 7	Trend in AGA factor	Adjustment to comparison group trend
1 total	C	0.89646	0.90860	1.01354	1.03169
	I	0.88374	0.92409	1.04566	
2	C	0.89647	0.91252	1.01791	1.03786
	I	0.89107	0.94137	1.05645	
3	C	0.88723	0.90893	1.02445	0.99434
	I	0.90748	0.92441	1.01866	
4	C	0.88806	0.90822	1.02271	0.99309
	I	0.90803	0.92224	1.01565	
5A	C	0.89184	0.90849	1.01867	0.98108
	I	0.92374	0.92319	0.99940	
6B	C	0.90539	0.90875	1.00371	1.00397
	I	0.89743	0.90434	1.00770	
7A	C	0.90671	0.91575	1.00997	0.98672
	I	0.93094	0.92773	0.99656	
7B	C	0.90474	0.90544	1.00078	1.01665
	I	0.89073	0.90626	1.01744	
8A	C	0.91232	0.91270	1.00042	0.99395
	I	0.93079	0.92554	0.99437	
8B	C	0.90518	0.90625	1.00118	1.00576
	I	0.89628	0.90251	1.00695	

Table 4.B
Average AGA factor by group for baseline period and Demonstration Year 8

Cohort	Group Comparison Intervention	Baseline period	Demonstration Year 8	Trend in AGA factor	Adjustment to comparison group trend
1 total	C	0.89646	0.90971	1.01478	1.02907
	I	0.88374	0.92287	1.04428	
2	C	0.89647	0.91165	1.01693	1.04075
	I	0.89107	0.94309	1.05837	
3	C	0.88723	0.90565	1.02075	1.00039
	I	0.90748	0.92667	1.02115	
4	C	0.88806	0.91014	1.02487	0.98607
	I	0.90803	0.91765	1.01059	
5A	C	0.89184	0.91180	1.02238	0.97873
	I	0.92374	0.92433	1.00064	
5B	C	0.90563	0.91745	1.01305	0.99378
	I	0.89981	0.90588	1.00675	
6A	C	0.90383	0.91893	1.01671	0.97628
	I	0.93245	0.92554	0.99259	
6B	C	0.90539	0.91362	1.00910	0.99896
	I	0.89743	0.90465	1.00805	
7A	C	0.90671	0.91889	1.01343	0.98064
	I	0.93094	0.92518	0.99381	
7B	C	0.90474	0.91624	1.01271	1.00495
	I	0.89073	0.90652	1.01773	
8A	C	0.91232	0.92115	1.00968	0.98789
	I	0.93079	0.92841	0.99745	
8B	C	0.90518	0.91445	1.01024	0.99722
	I	0.89628	0.90294	1.00743	
9A	C	0.91280	0.91718	1.00480	0.98933
	I	0.93089	0.92537	0.99407	
9B	C	0.91152	0.91471	1.00349	0.99796
	I	0.90190	0.90320	1.00144	

Appendix Tables D.A–D.T show the detailed Medicare savings calculations for each cohort and Demonstration Year, taking into account the AGA adjustment factors (but still excluding the outlier adjustment). These tables are organized thus:

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).

Column (g) show total dollar savings by multiplying the number of eligible months in column (a) by the PMPM savings.

Finally, column (h) shows the corresponding percentage savings, which is the PMPM savings divided by the target PMPM.

Tables 5.A–5.C below summarize the savings calculation (before the attributed savings and the outlier adjustment) by cohort for the entire Demonstration (Years 1, 2, 3, 4, 5, 6, 7 and 8 combined) and Demonstration Years 7 and 8 separately. Table 5.A shows that for all eight Demonstration Years so far combined, the total savings before the outlier adjustment are $304.2 million or 8.0 percent.

Table 5.B shows the Demonstration Year 7 savings by cohort. The saving percentages range from 12.2% for cohort 6A to negative 5.1% for cohort 7A, which was the first full cohort in the history of the demonstration to show negative savings for an entire demonstration year by this savings analysis before the outlier adjustment. Overall, all cohorts combined experienced savings of 5.6% in demonstration year 7 which was the lowest savings percentage for any demonstration year previously calculated in this analysis. Prior to demonstration year 7, overall savings before outlier adjustment had been relatively stable between 9 and 10 percent.

Table 5.C shows the Demonstration Year 8 savings by cohort. Demonstration Year 8 continued the trend that had started in Demonstration Year 7 and saw an even sharper drop in overall savings before outlier adjustment. The savings percentages ranged from 13.4% for cohort 4 to negative 13.4% for Cohort 5A. There were seven cohorts (1, 2, 5A, 5B, 6A, 6B, 7A and 8B) with negative savings and the overall savings for all cohorts combined was 1.8% before outlier adjustment.

Table 5.A
Summary of Demonstration Years 1, 2, 3, 4, 5, 6, 7 and 8
Medicare 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	105,679.2	$2,652.67	1.245	$3,301.51	$2,568.79	$732.72	$77,433,320	22.2%
1B	197,672.6	$1,298.08	1.222	$1,586.33	$1,542.30	$44.03	$8,703,849	2.8%
1C	17,729.1	$993.94	1.273	$1,264.99	$1,367.10	-$102.10	-$1,810,214	-8.1%
1D	292,097.8	$1,696.25	1.209	$2,051.35	$1,838.07	$213.29	$62,300,746	10.4%
1E	35,584.0	$678.93	1.203	$816.52	$1,216.02	-$399.50	-$14,215,818	-48.9%
1F	38,504.1	$608.70	1.189	$723.96	$1,142.16	-$418.20	-$16,102,367	-57.8%
1 total	687,288.1	$1,612.13	1.211	$1,951.52	$1,781.72	$169.79	$116,697,731	8.7%
2	28,740.7	$2,356.60	0.872	$2,055.66	$1,969.51	$86.15	$2,475,971	4.2%
3	232,687.7	$1,690.19	0.983	$1,660.70	$1,569.16	$91.54	$21,299,291	5.5%
4	203,943.0	$1,742.42	1.043	$1,817.72	$1,612.77	$204.95	$41,797,679	11.3%
5A	191,971.0	$1,684.46	1.020	$1,718.48	$1,570.22	$148.26	$28,460,854	8.6%
5B	185,077.4	$1,730.61	1.106	$1,913.48	$1,808.54	$104.94	$19,422,411	5.5%
6A	129,706.2	$1,994.44	0.965	$1,924.77	$1,665.33	$259.44	$33,651,504	13.5%
6B	91,126.6	$1,882.18	0.980	$1,844.27	$1,701.01	$143.26	$13,054,716	7.8%
7A	93,829.0	$1,876.40	0.947	$1,777.62	$1,743.28	$34.34	$3,222,317	1.9%
7B	44,440.8	$1,993.34	0.910	$1,813.40	$1,662.82	$150.58	$6,691,744	8.3%
8A	59,562.1	$2,047.55	0.962	$1,969.08	$1,846.97	$122.11	$7,272,904	6.2%
8B	27,232.8	$1,944.81	0.884	$1,718.76	$1,727.06	-$8.30	-$226,030	-0.5%
9A	36,783.5	$2,119.27	1.016	$2,153.50	$1,908.40	$245.10	$9,015,680	11.4%
9B	15,801.5	$2,248.65	0.916	$2,059.62	$1,973.69	$85.93	$1,357,826	4.2%
ALL Cohorts	**2,028,190.4**	**$1,750.97**			**$1,714.96**	**$149.98**	**$304,194,599**	**8.0%**

Table 5.B
Summary of Demonstration Year 7
Medicare 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	6,312.0	$2,652.67	1.378	$3,656.14	$2,550.81	$1,105.32	$6,976,783	30.2%
1B	12,573.7	$1,298.08	1.341	$1,740.46	$1,769.86	-$29.40	-$369,672	-1.7%
1C	969.2	$993.94	1.508	$1,498.78	$1,663.92	-$165.13	-$160,054	-11.0%
1D	19,395.0	$1,696.25	1.295	$2,195.94	$2,036.23	$159.71	$3,097,488	7.3%
1E	2,361.3	$678.93	1.251	$849.68	$1,283.25	-$433.57	-$1,023,818	-51.0%
1F	2,621.7	$608.70	1.232	$749.67	$1,155.46	-$405.79	-$1,063,857	-54.1%
1 total	44,233.0	$1,612.13	1.304	$2,101.97	$1,933.38	$168.58	$7,456,870	8.0%
2	2,080.7	$2,356.60	1.056	$2,489.17	$2,258.01	$231.16	$480,978	9.3%
3	19,626.8	$1,690.19	1.091	$1,844.33	$1,818.39	$25.94	$509,126	1.4%
4	21,178.4	$1,742.42	1.065	$1,856.00	$1,809.90	$46.10	$976,347	2.5%
5A	27,183.8	$1,684.46	1.079	$1,817.92	$1,665.80	$152.12	$4,135,240	8.4%
5B	28,585.4	$1,730.61	1.157	$2,001.62	$1,886.13	$115.49	$3,301,449	5.8%
6A	25,620.5	$1,994.44	0.976	$1,945.85	$1,708.62	$237.23	$6,078,030	12.2%
6B	17,901.2	$1,882.18	0.957	$1,801.41	$1,764.51	$36.90	$660,511	2.0%
7A	30,000.8	$1,876.40	0.899	$1,686.18	$1,772.85	-$86.67	-$2,600,038	-5.1%
7B	13,800.7	$1,993.34	0.878	$1,749.88	$1,615.16	$134.72	$1,859,220	7.7%
8A	36,291.3	$2,047.55	0.974	$1,993.97	$1,808.18	$185.79	$6,742,704	9.3%
8B	16,421.5	$1,944.81	0.908	$1,765.55	$1,730.93	$34.62	$568,518	2.0%
ALL Cohorts	**282,924.0**	**$1,769.62**	**1.076**	**$1,904.24**	**$1,796.67**	**$107.57**	**$30,435,320**	**5.6%**

Table 5.C
Summary of Demonstration Year 8
Medicare 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	4,120.8	$2,652.67	1.338	$3,548.00	$2,398.44	$1,149.56	$4,737,058	32.4%
1B	8,903.3	$1,298.08	1.313	$1,704.32	$1,861.68	-$157.36	-$1,401,060	-9.2%
1C	667.3	$993.94	1.464	$1,455.62	$1,793.52	-$337.91	-$225,486	-23.2%
1D	15,679.6	$1,696.25	1.259	$2,135.19	$2,362.41	-$227.22	-$3,562,700	-10.6%
1E	1,891.7	$678.93	1.203	$816.88	$1,682.09	-$865.21	-$1,636,743	-105.9%
1F	2,100.0	$608.70	1.213	$738.27	$1,376.69	-$638.42	-$1,340,695	-86.5%
1 total	33,362.7	$1,612.13	1.252	$2,018.44	$2,121.24	-$102.80	-$3,429,627	-5.1%
2	1,489.3	$2,356.60	0.941	$2,216.65	$2,340.20	-$123.55	-$184,005	-5.6%
3	15,285.4	$1,690.19	1.103	$1,864.45	$1,788.49	$75.95	$1,160,996	4.1%
4	15,601.3	$1,742.42	1.185	$2,065.24	$1,788.31	$276.93	$4,320,448	13.4%
5A	19,857.0	$1,684.46	0.938	$1,579.55	$1,790.85	-$211.29	-$4,195,674	-13.4%
5B	22,211.0	$1,730.61	1.131	$1,957.70	$1,984.08	-$26.38	-$585,822	-1.3%
6A	18,846.1	$1,994.44	0.856	$1,706.82	$1,758.54	-$51.72	-$974,787	-3.0%
6B	13,581.5	$1,882.18	1.027	$1,933.64	$1,687.35	$246.29	$3,344,918	12.7%
7A	20,131.8	$1,876.40	0.945	$1,772.29	$1,791.60	-$19.31	-$388,687	-1.1%
7B	9,644.2	$1,993.34	0.828	$1,650.18	$1,636.26	$13.92	$134,248	0.8%
8A	23,270.8	$2,047.55	0.934	$1,911.85	$1,907.47	$4.39	$102,108	0.2%
8B	10,811.3	$1,944.81	0.855	$1,662.64	$1,721.17	-$58.53	-$632,821	-3.5%
9A	36,783.5	$2,119.27	1.016	$2,153.50	$1,908.40	$245.10	$9,015,680	11.4%
9B	15,801.5	$2,248.65	0.916	$2,059.62	$1,973.69	$85.93	$1,357,826	4.2%
ALL Cohorts	**256,677.4**	**$1,887.63**	**$1.02**	**$1,910.79**	**$1,875.55**	**$35.24**	**$9,044,802**	**1.8%**

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. Appendix Table E shows the results of this tabulation. These results are used to make the outlier adjustment as shown in Table 6 below, which has the same column headings as Tables 5A–5C. Table 6 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 in Appendix Table E, 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 example, for Cohort 1, the trend factor calculated from the comparison group from the baseline period to Demonstration Year 7 is 1.2453 (= $1,992.78 / $1,600.30) for the untruncated PMPMs, and it is 1.1216 (= $1,756.59 / $1,566.21) for the truncated PMPMs. The ratio of these trend factors is the outlier adjustment factor 0.9007 (= 1.1216 / 1.2453) that is to be applied to the comparison group trend. For Demonstration Year 8, the resulting outlier adjustment factor is 0.8729.

Table 6, shown below, contains totals savings and savings percent, including outlier adjustment but excluding attributed savings, for all demonstration years combined, followed by demonstration years 7 and 8 separately. The outlier adjustment increases overall calculated savings for demonstration year 7 from 5.6% to 6.8% and for demonstration year 8 from 1.8% to 3.8%. Both of these figures are still well below historical norms calculated by this analysis for prior demonstration years.

Table 6
Summary through Demonstration Year 8
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 1-8 combined								
Cohort 1 – total	687,266.8	$1,612.13	1.210	$1,951.25	$1,782.01	$169.23	$116,309,450	8.7%
Outlier adjusted	687,266.8	$1,568.69	1.167	$1,830.45	$1,677.12	$153.33	$105,376,632	8.4%
Cohort 2	28,734.7	$2,356.60	0.872	$2,055.89	$1,969.90	$85.99	$2,470,869	4.2%
Outlier adjusted	28,734.7	$2,283.99	0.835	$1,907.71	$1,818.47	$89.24	$2,564,288	4.7%
Cohort 3	232,699.7	$1,690.19	0.983	$1,660.81	$1,569.38	$91.44	$21,277,503	5.5%
Outlier adjusted	232,699.7	$1,628.57	0.950	$1,547.15	$1,469.97	$77.18	$17,959,955	5.0%
Cohort 4	203,942.2	1,742.40	1.043	$1,817.57	$1,613.16	$204.41	$41,688,285	11.2%
Outlier adjusted	203,942.2	$1,688.50	1.017	$1,717.74	$1,517.33	$200.40	$40,870,791	11.7%
Cohort 5A	191,937.4	1,684.50	1.020	$1,718.20	$1,570.60	$147.61	$28,331,157	8.6%
Outlier adjusted	191,937.4	$1,627.86	0.996	$1,621.87	$1,471.79	$150.08	$28,806,650	9.3%
Cohort 5B	185,038.0	1,730.60	1.106	1,914.4	$1,808.60	$105.87	$19,589,749	5.5%
Outlier adjusted	185,038.0	$1,663.65	1.089	$1,811.48	$1,659.14	$152.34	$28,188,582	8.4%
Cohort 6A	129,736.0	$1,994.44	0.965	$1,925.35	$1,665.87	$259.48	$33,663,809	13.5%
Outlier adjusted	129,736.0	$1,923.45	0.946	$1,818.64	$1,547.31	$271.34	$35,202,237	14.9%
Cohort 6B	91,070.7	$1,882.18	0.981	$1,846.00	$1,702.30	$143.70	$13,087,126	7.8%
Outlier adjusted	91,070.7	$1,816.26	0.960	$1,744.35	$1,566.04	$178.31	$16,239,227	10.2%
Cohort 7A	93,890.6	$1,876.40	0.947	$1,777.46	$1,747.15	$30.31	$2,845,732	1.7%
Outlier adjusted	93,890.6	$1,831.12	0.933	$1,708.78	$1,651.38	$57.39	$5,388,584	3.4%
Cohort 7B	44,411.1	$1,993.34	0.910	$1,813.58	$1,663.96	$149.62	$6,644,746	8.2%
Outlier adjusted	44,411.1	$1,868.77	0.889	$1,661.70	$1,547.51	$114.19	$5,071,511	6.9%

(continued)

Table 6 (continued)
Summary through Demonstration Year 8
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
Cohort 8A	59,562.1	$2,047.55	0.962	$1,969.08	$1,846.97	$122.11	$7,272,904	6.2%
Outlier adjusted	59,562.1	$1,980.01	0.960	$1,900.39	$1,760.80	$139.59	$8,313,988	7.3%
Cohort 8B	27,232.8	$1,944.81	0.884	$1,718.76	$1,727.06	-$8.30	-$226,030	-0.5%
Outlier adjusted	27,232.8	$1,856.91	0.880	$1,633.32	$1,606.45	$26.88	$731,892	1.6%
Cohort 9A	36,783.5	$2,119.27	1.016	$2,153.50	$1,908.40	$245.10	$9,015,680	11.4%
Outlier adjusted	36,783.5	$2,053.50	1.016	$2,085.62	$1,819.37	$266.25	$9,793,707	12.8%
Cohort 9B	15,801.5	$2,248.65	0.916	$2,059.62	$1,973.69	$85.93	$1,357,826	4.2%
Outlier adjusted	15,801.5	2086.78	0.933	$1,946.64	1799.42	$147.22	$2,326,270	7.6%
ALL Cohorts	**2,028,190.4**	**1750.97**	**1.07**	**1864.94**	**1714.96**	**$149.98**	**$304,194,599**	**8.0%**
Outlier adjusted	**2,028,190.4**	**1693.25**	**1.04**	**1757.15**	**1605.87**	**$151.28**	**$306,834,314**	**8.6%**
				Demonstration Year 7				
Cohort 1 – total	44,233.0	$1,612.10	1.304	2,102.0	1,933.4	$168.58	$7,456,870	8.0%
Outlier adjusted	44,233.0	$1,570.53	1.174	$1,844.31	$1,724.11	$120.21	$5,317,035	6.5%
Cohort 2	2,080.7	$2,356.60	1.056	2,489.2	2,258.0	$231.16	$480,978	9.3%
Outlier adjusted	2,080.7	$2,280.88	0.929	$2,118.17	$1,897.72	$220.45	$458,702	10.4%
Cohort 3	19,626.8	$1,690.20	1.091	1,844.3	1,818.4	$25.94	$509,126	1.4%
Outlier adjusted	19,626.8	$1,628.93	1.015	$1,653.12	$1,615.55	$37.57	$737,401	2.3%
Cohort 4	21,178.4	$1,742.40	1.065	1,856.0	1,809.9	$46.10	$976,347	2.5%
Outlier adjusted	21,178.4	$1,688.50	1.005	$1,696.93	$1,609.61	$87.31	$1,849,177	5.1%
Cohort 5A	27,183.8	$1,684.50	1.079	1,817.9	1,665.8	$152.12	$4,135,240	8.4%
Outlier adjusted	27,183.8	$1,627.86	1.028	$1,672.65	$1,523.51	$149.13	$4,054,042	8.9%

(continued)

Table 6 (continued)
Medicare Summary Through Demonstration Year 8
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
Cohort 5B	28,585.4	$1,730.60	1.157	2,001.6	1,886.1	$115.49	$3,301,449	5.8%
Outlier adjusted	28,585.4	$1,663.65	1.117	$1,858.17	$1,687.17	$171.00	$4,888,065	9.2%
Cohort 6A	25,620.5	$1,994.40	0.976	1,945.9	1,708.6	$237.23	$6,078,030	12.2%
Outlier adjusted	25,620.5	$1,923.45	0.944	$1,815.32	$1,577.75	$237.56	$6,086,522	13.1%
Cohort 6B	17,901.2	$1,882.20	0.957	1,801.4	1,764.5	$36.90	$660,511	2.0%
Outlier adjusted	17,901.2	$1,816.26	0.924	$1,678.26	$1,560.52	$117.74	$2,107,636	7.0%
Cohort 7A	30,000.8	$1,876.40	0.899	1,686.2	1,772.8	-$86.67	-$2,600,038	-5.1%
Outlier adjusted	30,000.8	$1,831.12	0.883	$1,617.53	$1,675.00	-$57.46	-$1,723,990	-3.6%
Cohort 7B	13,800.7	$1,993.30	0.878	1,749.9	1,615.2	$134.72	$1,859,220	7.7%
Outlier adjusted	13,800.7	$1,868.77	0.851	$1,589.49	$1,492.19	$97.30	$1,342,851	6.1%
Cohort 8A	36,291.3	2,047.6	0.974	1,994.0	1,808.2	$185.79	$6,742,704	9.3%
Outlier adjusted	36,291.3	$1,980.01	0.983	$1,946.95	$1,738.50	$208.45	$7,564,871	10.7%
Cohort 8B	16,421.5	1,944.8	0.908	1,765.6	1,730.9	$34.62	$568,518	2.0%
Outlier adjusted	16,421.5	$1,856.91	0.911	$1,691.18	$1,630.57	$60.61	$995,371	3.6%
ALL Cohorts	**282,924.0**	**$1,825.18**	**$1.05**	**$1,903.30**	**$1,796.67**	**$106.63**	**$30,168,955**	**5.6%**
Outlier adjusted	**282,924.0**	**$1,762.39**	**$1.01**	**$1,761.61**	**$1,642.57**	**$119.03**	**$33,677,683**	**6.8%**
				Demonstration Year 8				
Cohort 1 – total	33,362.7	1,612.1	1.252	2,018.4	2,121.2	-$102.80	-$3,429,627	-5.1%
Outlier adjusted	33,362.7	$1,570.53	1.093	$1,716.48	$1,792.47	-$75.99	-$2,535,207	-4.4%
Cohort 2	1,489.3	2,356.6	0.941	2,216.6	2,340.2	-$123.55	-$184,005	-5.6%
Outlier adjusted	1,489.3	$2,280.88	0.800	$1,823.84	$1,861.66	-$37.82	-$56,325	-2.1%

(continued)

Table 6 (continued)
Summary through Demonstration Year 8
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
Cohort 3	15,285.4	1,690.2	1.103	1,864.4	1,788.5	$75.95	$1,160,996	4.1%
Outlier adjusted	15,285.4	$1,628.93	1.005	$1,637.80	$1,553.53	$84.26	$1,287,978	5.1%
Cohort 4	15,601.3	1,742.4	1.185	2,065.2	1,788.3	$276.93	$4,320,448	13.4%
Outlier adjusted	15,601.3	$1,688.50	1.042	$1,759.92	$1,565.36	$194.56	$3,035,361	11.1%
Cohort 5A	19,857.0	1,684.5	0.938	1,579.6	1,790.8	-$211.29	-$4,195,674	-13.4%
Outlier adjusted	19,857.0	$1,627.86	0.876	$1,425.65	$1,557.19	-$131.54	-$2,612,020	-9.2%
Cohort 5B	22,211.0	1,730.6	1.131	1,957.7	1,984.1	-$26.38	-$585,822	-1.3%
Outlier adjusted	22,211.0	$1,663.65	1.070	$1,779.91	$1,710.48	$69.42	$1,541,937	3.9%
Cohort 6A	18,846.1	1,994.4	0.856	1,706.8	1,758.5	-$51.72	-$974,787	-3.0%
Outlier adjusted	18,846.1	$1,923.45	0.813	$1,563.31	$1,566.80	-$3.49	-$65,733	-0.2%
Cohort 6B	13,581.5	1,882.2	1.027	1,933.6	1,687.4	$246.29	$3,344,918	12.7%
Outlier adjusted	13,581.5	$1,816.26	0.977	$1,775.13	$1,509.35	$265.77	$3,609,590	15.0%
Cohort 7A	20,131.8	1,876.4	0.945	1,772.3	1,791.6	-$19.31	-$388,687	-1.1%
Outlier adjusted	20,131.8	$1,831.12	0.906	$1,659.20	$1,635.41	$23.79	$478,877	1.4%
Cohort 7B	9,644.2	1,993.3	0.828	1,650.2	1,636.3	$13.92	$134,248	0.8%
Outlier adjusted	9,644.2	$1,868.77	0.786	$1,469.51	$1,479.66	-$10.14	-$97,824	-0.7%
Cohort 8A	23,270.8	2,047.6	0.934	1,911.9	1,907.5	$4.39	$102,108	0.2%
Outlier adjusted	23,270.8	$1,980.01	0.923	$1,827.77	$1,795.58	$32.19	$749,117	1.8%
Cohort 8B	10,811.3	1,944.8	0.855	1,662.6	1,721.2	-$58.53	-$632,821	-3.5%
Outlier adjusted	10,811.3	$1,856.91	0.832	$1,545.44	$1,569.81	-$24.37	-$263,479	-1.6%

(continued)

Table 6 (continued)
Summary through Demonstration Year 8
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
Cohort 9A	36,783.5	2,119.3	1.016	2,153.5	1,908.4	$245.10	$9,015,680	11.4%
Outlier adjusted	36,783.5	$2,053.50	1.016	$2,085.62	$1,819.37	$266.25	$9,793,707	12.8%
Cohort 9B	15,801.5	2,248.7	0.916	2,059.6	1,973.7	$85.93	$1,357,826	4.2%
Outlier adjusted	15,801.5	$2,086.78	0.933	$1,946.64	$1,799.42	$147.22	$2,326,270	7.6%
ALL Cohorts	**256,677.4**	**$1,887.63**	**$1.02**	**$1,910.79**	**$1,875.55**	**$35.24**	**$9,044,802**	**1.8%**
Outlier adjusted	**256,677.4**	**$1,818.53**	**$0.96**	**$1,746.09**	**$1,679.11**	**$66.98**	**$17,192,249**	**3.8%**

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. The table below shows the applicable eligibility months for attributed savings for each cohort:

Cohort	First month	Last month
2	July 2013	December 2013
3	January 2014	December 2014
4	January 2015	December 2015
5A	January 2016	December 2016
6A	January 2017	December 2017
6B	April 2017	December 2017
7A	January 2018	December 2018
7B	January 2018	December 2018
8A	January 2019	December 2019
8B	January 2019	December 2019
9A	January 2020	December 2020
9B	January 2020	December 2020
10A	January 2021	December 2021
10B	January 2021	December 2021

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 Washington also flagged demonstration eligibility are included in the attributed savings calculation for newly eligible cohorts.

Table 7 shows a summary of the amount of attributed Medicare savings for Cohorts 2 through 9B (and preliminary estimates for Cohorts 10A and 10B) for all demonstration years combined, and for Demonstration Years 7 and 8. For example, 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. Results for each of Demonstration Years 1 through 6 are found in Appendix Table F.

Table 7
Summary of ALL Demonstration Years
Medicare 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 1-8 combined (outlier adjusted)								
Cohort 1	687,266.8	$1,568.69	1.167	$1,830.45	$1,677.12	$153.33	$105,376,632	8.38%
Cohort 2	28,734.70	$2,283.99	0.835	$1,907.71	$1,818.47	$89.24	$2,564,288	4.68%
Cohort 3	232,699.73	$1,628.57	0.950	$1,547.15	$1,469.97	$77.18	$17,959,955	4.99%
Cohort 4	203,942.21	$1,688.50	1.017	$1,717.74	$1,517.33	$200.40	$40,870,791	11.67%
Cohort 5A	191,937.40	$1,627.86	0.996	$1,621.87	$1,471.79	$150.08	$28,806,650	9.25%
Cohort 5B	185,037.99	$1,663.65	1.089	$1,811.48	$1,659.14	$152.34	$28,188,582	8.41%
Cohort 6A	129,735.98	$1,923.45	0.946	$1,818.64	$1,547.31	$271.34	$35,202,237	14.92%
Cohort 6B	91,070.72	$1,816.26	0.960	$1,744.35	$1,566.04	$178.31	$16,239,227	10.22%
Cohort 7A	93,890.59	$1,831.12	0.933	$1,708.78	$1,651.38	$57.39	$5,388,584	3.36%
Cohort 7B	44,411.07	$1,868.77	0.889	$1,661.70	$1,547.51	$114.19	$5,071,511	6.87%
Cohort 8A	59,562.13	$1,980.01	0.960	$1,900.39	$1,760.80	$139.59	$8,313,988	7.35%
Cohort 8B	27,232.75	$1,856.91	0.880	$1,633.32	$1,606.45	$26.88	$731,892	1.65%
Cohort 9A	36,783.48	$2,053.50	1.016	$2,085.62	$1,819.37	$266.25	$9,793,707	12.77%
Cohort 9B	15,801.50	$2,086.78	0.933	$1,946.64	$1,799.42	$147.22	$2,326,270	7.56%
Cohorts 1 to 9A/B	2,028,190.42			$1,757.15	$1,605.87	$151.28	$306,834,314	8.61%
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%

(continued)

Table 7 (continued)
Summary of ALL Demonstration Years
Medicare 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
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	22,332.93	$1,682.08				$142.13	$3,174,191	8.45%
Cohort 8B	10,075.37	$1,545.00				$156.86	$1,580,402	10.15%
Cohort 9A	18,728.23	$1,777.24				$190.28	$3,563,579	10.28%
Cohort 9B	8,532.38	$1,850.31				$66.32	$565,844	4.16%
Cohort 10A estimate	24,465.13					$266.25	$6,513,912	
Cohort 10B estimate	10,986.45					$147.22	$1,617,407	
Cohorts 1 to 10A/B	2,319,671.92						**$355,951,220**	
Demonstration Year 7 (outlier adjusted)								
Cohort 1	44,232.98	$1,570.53	1.174	$1,844.31	$1,724.11	$120.21	$5,317,035	6.52%
Cohort 2	2,080.72	$2,280.88	0.929	$2,118.17	$1,897.72	$220.45	$458,702	10.41%
Cohort 3	19,626.78	$1,628.93	1.015	$1,653.12	$1,615.55	$37.57	$737,401	2.27%
Cohort 4	21,178.39	$1,688.50	1.005	$1,696.93	$1,609.61	$87.31	$1,849,177	5.15%

(continued)

Table 7 (continued)
Summary of ALL Demonstration Years
Medicare 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
Cohort 5A	27,183.85	$1,627.86	1.028	$1,672.65	$1,523.51	$149.13	$4,054,042	8.92%
Cohort 5B	28,585.36	$1,663.65	1.117	$1,858.17	$1,687.17	$171.00	$4,888,065	9.20%
Cohort 6A	25,620.50	$1,923.45	0.944	$1,815.32	$1,577.75	$237.56	$6,086,522	13.09%
Cohort 6B	17,901.19	$1,816.26	0.924	$1,678.26	$1,560.52	$117.74	$2,107,636	7.02%
Cohort 7A	30,000.79	$1,831.12	0.883	$1,617.53	$1,675.00	($57.46)	($1,723,990)	-3.55%
Cohort 7B	13,800.70	$1,868.77	0.851	$1,589.49	$1,492.19	$97.30	$1,342,851	6.12%
Cohort 8A	36,291.31	$1,980.01	0.983	$1,946.95	$1,738.50	$208.45	$7,564,871	10.71%
Cohort 8B	16,421.47	$1,856.91	0.911	$1,691.18	$1,630.57	$60.61	$995,371	3.58%
Cohorts 1 to 8A/B	282,924.04			$1,761.61	$1,642.57	$119.03	$33,677,683	6.76%
Attributed savings								
Cohort 9A	18,728.23	$1,777.24				$190.28	$3,563,579	10.28%
Cohort 9B	8,532.38	$1,850.31				$66.32	$565,844	4.16%
Cohorts 1 to 9A/B	310,184.64					$121.89	**$37,807,106**	
Demonstration Year 8 (outlier adjusted)								
Cohort 1	33,362.66	$1,570.53	1.093	$1,716.48	$1,792.47	($75.99)	($2,535,207)	-4.43%
Cohort 2	1,489.31	$2,280.88	0.800	$1,823.84	$1,861.66	($37.82)	($56,325)	-2.07%
Cohort 3	15,285.38	$1,628.93	1.005	$1,637.80	$1,553.53	$84.26	$1,287,978	5.14%
Cohort 4	15,601.33	$1,688.50	1.042	$1,759.92	$1,565.36	$194.56	$3,035,361	11.05%
Cohort 5A	19,857.03	$1,627.86	0.876	$1,425.65	$1,557.19	($131.54)	($2,612,020)	-9.23%

(continued)

Table 7 (continued)
Summary of ALL Demonstration Years
Medicare 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
Cohort 5B	22,211.02	$1,663.65	1.070	$1,779.91	$1,710.48	$69.42	$1,541,937	3.90%
Cohort 6A	18,846.12	$1,923.45	0.813	$1,563.31	$1,566.80	($3.49)	($65,733)	-0.22%
Cohort 6B	13,581.46	$1,816.26	0.977	$1,775.13	$1,509.35	$265.77	$3,609,590	14.97%
Cohort 7A	20,131.77	$1,831.12	0.906	$1,659.20	$1,635.41	$23.79	$478,877	1.43%
Cohort 7B	9,644.24	$1,868.77	0.786	$1,469.51	$1,479.66	($10.14)	($97,824)	-0.69%
Cohort 8A	23,270.82	$1,980.01	0.923	$1,827.77	$1,795.58	$32.19	$749,117	1.76%
Cohort 8B	10,811.28	$1,856.91	0.832	$1,545.44	$1,569.81	($24.37)	($263,479)	-1.58%
Cohort 9A	36,783.48	$2,053.50	1.016	$2,085.62	$1,819.37	$266.25	$9,793,707	12.77%
Cohort 9B	15,801.50	$2,086.78	0.933	$1,946.64	$1,799.42	$147.22	$2,326,270	7.56%
Cohorts 1 to 9A/B	256,677.40			$1,746.09	$1,679.11	$66.98	$17,192,249	3.84%
Attributed savings								
Cohort 10A estimate	24,465.13					$266.25	$6,513,912	
Cohort 10B estimate	10,986.45					$147.22	$1,617,407	
Cohorts 1 to 10A/B	292,128.99					$86.69	**$25,323,568**	

We should note that 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.

5.6 Summary of Total Gross Medicare Savings

Table 6 summarizes the savings calculation by cohort including the outlier adjustment. For the eight Demonstration Years to date combined, the outlier adjustment increased the total Medicare savings by about $2.6 million. Medicare savings were reduced for Cohorts 1, 3, 4 and 7B, but increased for Cohorts 2, 5A, 5B, 6A, 6B, 7A, 8A, 8B, 9A and 9B. The total increase in calculated savings across all cohorts 1 to 9A/B in Table 6 was $1.7 million ($304.2 million to $306.8 million). Across all ten cohorts and all eight Demonstration Years, total Medicare savings after the outlier adjustment was $306.8 million, or 8.6 percent.

Table 7 summarizes total gross Medicare savings calculations, including the attributed savings from Cohorts 2, 3, 4, 5A, 6A, 6B, 7A, 7B, 8A, 8B, 9A, 9B, 10A and 10B. Including attributed savings brings the total Medicare savings for all nine cohorts to $356.0 million.

The Medicare savings for Demonstration Year 7, $37,807,106 (Table 7), is now considered to be final. The Medicare savings of $25,323,568 for Demonstration Year 8 is considered to be preliminary. In future analysis (if planned), Demonstration Year 8 savings can be updated to include any retroactive adjustments to claims and eligibility for beneficiaries in both the intervention and comparison groups.

5.7 Additional Analysis

Appendix Tables G.A through G.N show additional analysis of the savings by month for Demonstration Years 7 and 8 for each cohort. This set of tables show, for each month of the Demonstration Year, the target PMPM, the actual intervention PMPM, and the ratio of the demonstration PMPM to the target PMPM (or, the D/T ratio). A ratio less than 1.00 shows savings, whereas a ratio greater than 1.00 shows negative savings.

Tables 8.A and 8.B show additional results of the savings by type of service for all cohorts combined for Demonstration Years 7 and 8, respectively. 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 8.A and 8.B show the D/T ratio by type of service. For all cohorts and both Demonstration Years 7 and 8, the lowest D/T ratio is for hospice services. However, in dollar terms, significant savings were also achieved for home health agency costs, professional services and skilled nursing facility services. Inpatient services experienced savings in Demonstration Year 7 and slightly increased costs in Demonstration Year 8. Increased costs were experienced for DME and outpatient hospital services.

Tables 9.A and 9.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 7 (Table 9.A) and Demonstration Year 8 (Table 9.B), and in line with what was previously seen in Demonstration Years 1, 2, 3, 4, 5 and 6.

Table 8.A
PMPM costs for Demonstration Year 7 based on incurred Medicare claims for Cohorts 1–8A/B

	Intervention		PMPM					
Type of service	Incurred claims	Member months	Intervention (D)	Comparison	Target (T)	Ratio (D/T)	PMPM savings	Dollar savings
Baseline	$1,457,877,430	823,834.7			$1,769.62	1.00		
Durable medical equipment	$20,669,284	282,924.0	$73.06	$69.85	$70.59	1.03	-$2.47	-$698,820
Home health agency	$23,849,583	282,924.0	$84.30	$102.43	$103.20	0.82	$18.91	$5,349,315
Hospice	$6,243,607	282,924.0	$22.07	$94.23	$96.87	0.23	$74.80	$21,161,869
Inpatient	$183,613,372	282,924.0	$648.98	$653.17	$667.92	0.97	$18.94	$5,358,054
Outpatient	$125,095,374	282,924.0	$442.15	$380.01	$384.23	1.15	-$57.92	-$16,387,151
Professional	$90,707,585	282,924.0	$320.61	$359.86	$368.39	0.87	$47.78	$13,518,130
SNF	$58,142,339	282,924.0	$205.51	$203.43	$213.05	0.96	$7.54	$2,133,923
Total	**$508,321,144**	**282,924.0**	**$1,796.67**	**$1,862.99**	**$1,904.24**	**0.94**	**$107.57**	**$30,435,320**

Table 8.B
PMPM costs for Demonstration Year 8 based on incurred Medicare claims for Cohorts 1–9A/B

Type of service	Intervention		PMPM			Ratio		
	Incurred claims	Member months	Intervention (D)	Comparison	Target (T)	(D/T)	PMPM savings	Dollar savings
Baseline	$1,457,877,430	823,834.7			$1,769.62	1.00		
Durable medical equipment	$19,974,216	256,677.4	$77.82	$71.15	$71.09	1.09	-$6.73	-$1,727,134
Home health agency	$24,384,471	256,677.4	$95.00	$107.75	$106.88	0.89	$11.88	$3,048,299
Hospice	$6,241,933	256,677.4	$24.32	$97.32	$98.73	0.25	$74.41	$19,100,441
Inpatient	$176,751,878	256,677.4	$688.61	$679.67	$682.11	1.01	-$6.50	-$1,669,404
Outpatient	$114,821,162	256,677.4	$447.34	$348.81	$346.38	1.29	-$100.96	-$25,913,888
Professional	$92,190,736	256,677.4	$359.17	$386.32	$391.15	0.92	$31.98	$8,209,505
SNF	$47,046,193	256,677.4	$183.29	$208.16	$214.44	0.85	$31.16	$7,996,984
Total	**$481,410,589**	**256,677.4**	**$1,875.55**	**$1,899.18**	**$1,910.79**	**0.98**	**$35.24**	**$9,044,802**

Table 9.A
PMPM costs by category of beneficiary for Demonstration Year 7 based on incurred Medicare claims for Cohorts 1–8A/B

Category of beneficiary	Total		Durable medical equipment		Home health agency		Hospice		Inpatient		Outpatient		Professional		SNF	
	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	**$106.63**	**$30,168,955**	**-$2.51**	**-$710,413**	**$18.86**	**$5,335,333**	**$74.80**	**$21,161,869**	**$18.60**	**$5,262,026**	**-$58.13**	**-$16,447,318**	**$47.57**	**$13,458,842**	**$7.45**	**$2,108,616**
Fac 65+ SPMI	$544.53	$5,433,393	-$10.67	-$106,456	-$28.49	-$284,240	$215.11	$2,146,415	$95.86	$956,526	$155.95	$1,556,128	$109.70	$1,094,580	$7.06	$70,440
Fac 65+ no SPMI	$544.37	$3,900,674	-$12.22	-$87,575	-$14.00	-$100,345	$162.14	$1,161,798	$147.07	$1,053,790	$157.14	$1,125,966	$112.43	$805,579	-$8.17	-$58,539
HCBS 65+ SPMI	$518.35	$14,406,567	$12.08	$335,806	$41.92	$1,165,035	$150.29	$4,176,932	$130.41	$3,624,358	$62.22	$1,729,142	$75.30	$2,092,805	$46.14	$1,282,489
HCBS 65+ no SPMI	$307.30	$11,416,993	-$0.91	-$33,957	$46.03	$1,709,949	$141.31	$5,250,042	$68.71	$2,552,809	-$7.15	-$265,492	$68.17	$2,532,805	-$8.86	-$329,161
Com 65+ SPMI	$192.06	$3,611,469	$9.50	$178,704	$36.94	$694,595	$101.07	$1,900,519	-$21.33	-$401,111	-$48.44	-$910,787	$64.34	$1,209,803	$49.98	$939,746
Com 65+ no SPMI	-$101.42	-$5,133,319	$5.00	$253,121	$9.54	$482,977	$64.57	$3,268,265	-$69.72	-$3,528,876	-$138.25	-$6,997,614	$1.35	$68,307	$26.09	$1,320,500
Fac <65 SPMI	$831.52	$3,678,795	-$14.64	-$64,753	-$17.40	-$76,990	$83.51	$369,479	$10.35	$45,782	$188.38	$833,413	$250.52	$1,108,368	$330.79	$1,463,496
Fac <65 no SPMI	$527.94	$1,809,885	-$69.23	-$237,318	-$8.51	-$29,166	$83.34	$285,711	$186.20	$638,316	$52.94	$181,482	$159.83	$547,921	$123.37	$422,939
HCBS <65 SPMI	-$76.03	-$2,258,665	-$19.53	-$580,311	$6.83	$202,935	$39.70	$1,179,554	-$0.86	-$25,457	-$103.98	-$3,088,989	$18.54	$550,943	-$16.74	-$497,339
HCBS <65 no SPMI	$40.04	$1,230,383	-$2.70	-$83,050	$39.56	$1,215,827	$20.76	$638,138	$15.92	$489,389	-$95.14	-$2,923,818	$91.95	$2,825,968	-$30.33	-$932,071
Com <65 SPMI	-$131.06	-$4,321,264	-$0.47	-$15,501	$11.65	$384,124	$16.17	$533,240	-$28.20	-$929,662	-$123.13	-$4,059,829	$9.03	$297,730	-$16.12	-$531,366
Com <65 no SPMI	-$119.59	-$3,605,958	-$8.93	-$269,122	-$0.97	-$29,368	$8.35	$251,776	$26.07	$786,161	-$120.28	-$3,626,919	$10.75	$324,033	-$34.57	-$1,042,519

Table 9.B
PMPM costs by category of beneficiary for Demonstration Year 8 based on incurred Medicare claims for Cohorts 1–9A/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	**$35.24**	**$9,044,802**	**-$6.73**	**-$1,727,134**	**$11.88**	**$3,048,299**	**$74.41**	**$19,100,441**	**-$6.50**	**-$1,669,404**	**-$100.96**	**-$25,913,888**	**$31.98**	**$8,209,505**	**$31.16**	**$7,996,984**
Fac 65+ SPMI	$405.61	$3,614,117	-$15.57	-$138,711	-$34.51	-$307,476	$188.79	$1,682,187	$73.68	$656,543	$137.96	$1,229,274	$98.98	$881,957	-$43.73	-$389,656
Fac 65+ no SPMI	$401.59	$2,286,902	-$4.94	-$28,117	-$17.59	-$100,182	$157.46	$896,657	$23.49	$133,775	$102.58	$584,168	$103.58	$589,830	$37.01	$210,771
HCBS 65+ SPMI	$596.97	$15,148,833	-$2.84	-$71,942	$6.13	$155,560	$132.73	$3,368,202	$280.24	$7,111,363	-$10.22	-$259,453	$85.15	$2,160,727	$105.78	$2,684,377
HCBS 65+ no SPMI	$135.82	$4,192,325	$1.66	$51,276	$10.26	$316,663	$180.04	$5,557,220	-$47.47	-$1,465,121	-$57.99	-$1,790,033	$17.28	$533,486	$32.04	$988,833
Com 65+ SPMI	$499.56	$8,714,703	$12.41	$216,556	$54.43	$949,547	$105.48	$1,840,038	$144.43	$2,519,496	-$50.26	-$876,797	$123.43	$2,153,201	$109.64	$1,912,664
Com 65+ no SPMI	-$104.54	-$4,793,024	$2.47	$113,289	$12.06	$552,785	$58.25	$2,670,467	-$55.63	-$2,550,672	-$147.68	-$6,771,111	$8.03	$368,062	$17.98	$824,157
Fac <65 SPMI	$541.58	$2,149,025	-$28.73	-$113,997	-$61.98	-$245,947	$72.78	$288,783	-$86.46	-$343,094	$182.97	$726,054	$214.66	$851,803	$248.34	$985,423
Fac <65 no SPMI	$343.63	$1,078,282	-$71.13	-$223,198	-$29.41	-$92,288	$50.56	$158,647	$18.31	$57,465	$25.95	$81,422	$158.30	$496,733	$191.05	$599,501
HCBS <65 SPMI	-$3.91	-$107,717	-$13.44	-$369,943	$31.62	$870,547	$50.72	$1,396,325	$28.54	$785,651	-$106.78	-$2,939,658	-$2.22	-$61,034	$7.64	$210,396
HCBS <65 no SPMI	-$191.74	-$5,249,603	-$18.10	-$495,447	$14.10	$385,919	$23.32	$638,498	-$100.64	-$2,755,354	-$133.35	-$3,651,042	$15.68	$429,312	$7.25	$198,512
Com <65 SPMI	-$269.08	-$8,579,413	-$6.09	-$194,272	$11.74	$374,256	$10.03	$319,795	-$84.70	-$2,700,469	-$174.80	-$5,573,188	-$35.39	-$1,128,291	$10.12	$322,757
Com <65 no SPMI	-$328.58	-$9,409,629	-$16.50	-$472,628	$6.60	$188,915	$9.90	$283,624	-$108.91	-$3,118,986	-$233.03	-$6,673,522	$32.60	$933,719	-$19.23	-$550,750

6. Summary

This report details the results of the actuarial savings analysis for demonstration years 7 and 8 for the Washington Managed Fee-for-Service demonstration. These two most recent demonstration years, covering the 24-month period from January 1, 2020 to December 31, 2021, experienced lower levels of calculated savings than the prior demonstration years. The COVID-19 pandemic emerged early in Demonstration Year 7 and affected healthcare delivery systems nationwide, with a significant adverse impact on morbidity and mortality, particularly among older and frailer populations. As noted in the report, the savings calculations for Demonstration Years 7 and 8 do not include any explicit adjustments or changes to the methodology to specifically account for any potentially disproportionate effects of COVID-19 on either the intervention or comparison group that would not be reflected in the geographic and outlier adjustments already included in the analysis. Additionally, there could be other factors related to the longevity of the demonstration and the overall attrition of the earlier cohorts that could lead to reduced calculated savings as we near a decade past the initial start of the demonstration.

Appendix A
Reasons for Ineligibility

Appendix Table A.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	5,222	0.76%	9,470	1.01%
Loss of Part A or B	55	0.01%	87	0.01%
GHO enrollment	2,166	0.32%	3,398	0.36%
Medicare secondary payer	258	0.04%	384	0.04%
Moved out of service area	458	0.07%	970	0.10%
Participation in SSP	527	0.08%	5,130	0.55%
Loss of eligibility	2,806	0.41%	1,617	0.17%
All ineligibles[10]	**11,492**	**1.67%**	**21,056**	**2.25%**
Beneficiaries as of 7/1/2013	14,020		23,228	
Beneficiaries as of 12/31/2021	2,528		2,172	
Total member months	686,315.58		933,805.47	

GHO = Group Health Organization.

[10] For Cohorts 1, 2, 3, 4, 5A/B, 6A/B and 7A/B we included attrition experience from Demonstration Years 1, 2, 3, 4, 5 and 6 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, 4, 5 and 6 experience was finalized, it was not re-run, but the total beneficiary counts for first day eligible and eligible as of 12/31/2021 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.

Appendix Table A.B
Reasons for ineligibility for Cohort 2

	Intervention group		Comparison group	
Final ineligibility reason	**Number of events**	**Monthly attrition rate**	**Number of events**	**Monthly attrition rate**
Death	201	0.70%	1,501	0.92%
Loss of Part A or B	9	0.03%	17	0.01%
GHO enrollment	108	0.38%	655	0.40%
Medicare secondary payer	15	0.05%	70	0.04%
Moved out of service area	38	0.13%	224	0.14%
Participation in SSP	35	0.12%	973	0.59%
Loss of eligibility	185	0.65%	432	0.26%
All ineligibles	**591**	**2.06%**	**3,872**	**2.37%**
Beneficiaries as of 1/1/2014	704		4,332	
Beneficiaries as of 12/31/2021	113		460	
Total member months	28,638.57		163,616.47	

Appendix Table A.C
Reasons for ineligibility for Cohort 3

	Intervention group		Comparison group	
Final ineligibility reason	**Number of events**	**Monthly attrition rate**	**Number of events**	**Monthly attrition rate**
Death	1,559	0.67%	2,188	0.98%
Loss of Part A or B	14	0.01%	31	0.01%
GHO enrollment	955	0.41%	901	0.40%
Medicare secondary payer	103	0.04%	94	0.04%
Moved out of service area	191	0.08%	287	0.13%
Participation in SSP	201	0.09%	1,543	0.69%
Loss of eligibility	1,529	0.66%	578	0.26%
All ineligibles	**4,552**	**1.96%**	**5,622**	**2.52%**
Beneficiaries as of 1/1/2015	5,707		6,453	
Beneficiaries as of 12/31/2021	1,155		831	
Total member months	232,381.79		223,529.78	

Appendix Table A.D
Reasons for ineligibility for Cohort 4

	Intervention group		Comparison group	
Final ineligibility reason	**Number of events**	**Monthly attrition rate**	**Number of events**	**Monthly attrition rate**
Death	1,454	0.71%	2,331	1.02%
Loss of Part A or B	30	0.01%	27	0.01%
GHO enrollment	1,120	0.55%	1,237	0.54%
Medicare secondary payer	102	0.05%	95	0.04%
Moved out of service area	221	0.11%	282	0.12%
Participation in SSP	256	0.13%	1,595	0.69%
Loss of eligibility	1,550	0.76%	646	0.28%
All ineligibles	**4,733**	**2.32%**	**6,213**	**2.71%**
Beneficiaries as of 1/1/2016	5,921		7,241	
Beneficiaries as of 12/31/2021	1,188		1,028	
Total member months	203,734.40		229,642.24	

Appendix Table A.E
Reasons for ineligibility for Cohort 5A

	Intervention group		Comparison group	
Final ineligibility reason	**Number of events**	**Monthly attrition rate**	**Number of events**	**Monthly attrition rate**
Death	1,280	0.67%	1,692	1.15%
Loss of Part A or B	23	0.01%	25	0.02%
GHO enrollment	1,185	0.62%	1,075	0.73%
Medicare secondary payer	93	0.05%	43	0.03%
Moved out of service area	183	0.10%	146	0.10%
Participation in SSP	252	0.13%	1,130	0.77%
Loss of eligibility	1,745	0.91%	479	0.33%
All ineligibles	**4,761**	**2.48%**	**4,590**	**3.12%**
Beneficiaries as of 1/1/2017	6,236		5,472	
Beneficiaries as of 12/31/2021	1,475		882	
Total member months	191,659.15		146,965.26	

Appendix Table A.F
Reasons for ineligibility for Cohort 5B

	Intervention group		Comparison group	
Final ineligibility reason	**Number of events**	**Monthly attrition rate**	**Number of events**	**Monthly attrition rate**
Death	1,436	0.78%	4,688	0.99%
Loss of Part A or B	24	0.01%	71	0.01%
GHO enrollment	1,397	0.76%	4,070	0.86%
Medicare secondary payer	67	0.04%	246	0.05%
Moved out of service area	241	0.13%	709	0.15%
Participation in SSP	72	0.04%	6,131	1.29%
Loss of eligibility	1,048	0.57%	1,429	0.30%
All ineligibles	**4,285**	**2.32%**	**17,344**	**3.65%**
Beneficiaries as of 4/1/2017	5,961		20,505	
Beneficiaries as of 12/31/2021	1,676		3,161	
Total member months	184,895.57		475,810.28	

Appendix Table A.G
Reasons for ineligibility for Cohort 6A

	Intervention group		Comparison group	
Final ineligibility reason	**Number of events**	**Monthly attrition rate**	**Number of events**	**Monthly attrition rate**
Death	960	0.74%	1,303	1.23%
Loss of Part A or B	14	0.01%	19	0.02%
GHO enrollment	897	0.69%	930	0.88%
Medicare secondary payer	65	0.05%	35	0.03%
Moved out of service area	186	0.14%	130	0.12%
Participation in SSP	175	0.13%	925	0.87%
Loss of eligibility	1,266	0.98%	462	0.44%
All ineligibles	**3,563**	**2.75%**	**3,804**	**3.60%**
Beneficiaries as of 1/1/2018	4,956		4,795	
Beneficiaries as of 12/31/2021	1,393		991	
Total member months	129,765.69		105,773.40	

Appendix Table A.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	675	0.74%	1,289	1.15%
Loss of Part A or B	12	0.01%	23	0.02%
GHO enrollment	725	0.80%	1,220	1.09%
Medicare secondary payer	43	0.05%	46	0.04%
Moved out of service area	141	0.16%	192	0.17%
Participation in SSP	26	0.03%	1,110	0.99%
Loss of eligibility	682	0.75%	470	0.42%
All ineligibles	**2,304**	**2.53%**	**4,350**	**3.88%**
Beneficiaries as of 1/1/2018	3,342		5,392	
Beneficiaries as of 12/31/2021	1,038		1,042	
Total member months	90,954.72		112,058.63	

Appendix Table A.I
Reasons for ineligibility for Cohort 7A

Final ineligibility reason	Intervention group		Comparison group	
	Number of events	Monthly attrition rate	Number of events	Monthly attrition rate
Death	910	0.97%	946	1.45%
Loss of Part A or B	13	0.01%	15	0.02%
GHO enrollment	704	0.75%	828	1.27%
Medicare secondary payer	31	0.03%	29	0.04%
Moved out of service area	110	0.12%	110	0.17%
Participation in SSP	167	0.18%	345	0.53%
Loss of eligibility	1,100	1.17%	275	0.42%
All ineligibles	**3,035**	**3.23%**	**2,548**	**3.91%**
Beneficiaries as of 1/1/2019	4,484		3,452	
Beneficiaries as of 12/31/2021	1,449		904	
Total member months	93,968.59		65,230.92	

Appendix Table A.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	344	0.77%	945	1.31%
Loss of Part A or B	6	0.01%	20	0.03%
GHO enrollment	445	1.00%	831	1.15%
Medicare secondary payer	15	0.03%	30	0.04%
Moved out of service area	93	0.21%	158	0.22%
Participation in SSP	17	0.04%	535	0.74%
Loss of eligibility	521	1.17%	224	0.31%
All ineligibles	**1,441**	**3.24%**	**2,743**	**3.79%**
Beneficiaries as of 1/1/2019	2,139		3,821	
Beneficiaries as of 12/31/2021	698		1,078	
Total member months	44,408.07		72,332.94	

Appendix Table A.K
Reasons for ineligibility for Cohort 8A

	Intervention group		Comparison group	
Final ineligibility reason	**Number of events**	**Monthly attrition rate**	**Number of events**	**Monthly attrition rate**
Death	561	0.94%	699	1.57%
Loss of Part A or B	5	0.01%	2	0.00%
GHO enrollment	525	0.88%	571	1.29%
Medicare secondary payer	23	0.04%	14	0.03%
Moved out of service area	69	0.12%	75	0.17%
Participation in SSP	143	0.24%	196	0.44%
Loss of eligibility	673	1.13%	202	0.45%
All ineligibles	**1,999**	**3.35%**	**1,759**	**3.96%**
Beneficiaries as of 1/1/2020	3,612		2,942	
Beneficiaries as of 12/31/2021	1,613		1,183	
Total member months	59,680.13		44,431.28	

Appendix Table A.L
Reasons for ineligibility for Cohort 8B

Final ineligibility reason	Intervention group		Comparison group	
	Number of events	Monthly attrition rate	Number of events	Monthly attrition rate
Death	203	0.74%	638	1.43%
Loss of Part A or B	5	0.02%	7	0.02%
GHO enrollment	314	1.15%	565	1.27%
Medicare secondary payer	7	0.03%	8	0.02%
Moved out of service area	47	0.17%	113	0.25%
Participation in SSP	10	0.04%	381	0.85%
Loss of eligibility	315	1.16%	69	0.15%
All ineligibles	**901**	**3.30%**	**1,781**	**3.99%**
Beneficiaries as of 1/1/2020	1,650		2,925	
Beneficiaries as of 12/31/2021	749		1,144	
Total member months	27,265.75		44,645.52	

Appendix Table A.M
Reasons for ineligibility for Cohort 9A[11]

Final ineligibility reason	Intervention group		Comparison group	
	Number of events	Monthly attrition rate	Number of events	Monthly attrition rate
Death	352	0.96%	334	1.41%
Loss of Part A or B	8	0.02%	4	0.02%
GHO enrollment	327	0.89%	330	1.40%
Medicare secondary payer	13	0.04%	7	0.03%
Moved out of service area	69	0.19%	51	0.22%
Loss of eligibility	427	1.16%	41	0.17%
All ineligibles	**1,196**	**3.25%**	**767**	**3.25%**
Beneficiaries as of 1/1/2021	3,742		2,409	
Beneficiaries as of 12/31/2021	2,546		1,642	
Total member months	36,783.48		23,618.76	

[11] 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 and participation in an SSP during first demonstration period excludes a beneficiary from even being assigned to a cohort.

Appendix Table A.N
Reasons for ineligibility for Cohort 9B

Final ineligibility reason	Intervention group		Comparison group	
	Number of events	Monthly attrition rate	Number of events	Monthly attrition rate
Death	138	0.87%	327	1.41%
Loss of Part A or B	8	0.05%	8	0.03%
GHO enrollment	182	1.15%	299	1.29%
Medicare secondary payer	2	0.01%	10	0.04%
Moved out of service area	33	0.21%	69	0.30%
Loss of eligibility	170	1.08%	22	0.09%
All ineligibles	**533**	**3.37%**	**735**	**3.17%**
Beneficiaries as of 1/1/2021	1,630		2,362	
Beneficiaries as of 12/31/2021	1,097		1,627	
Total member months	15,801.50		23,195.56	

Appendix Table A.O
Monthly attrition rates by Cohort

Cohort	Monthly Attrition Rates	
	Intervention Group	Comparison Group
1	1.67%	2.25%
2	2.06%	2.37%
3	1.96%	2.52%
4	2.32%	2.71%
5A	2.48%	3.12%
5B	2.32%	3.65%
6A	2.75%	3.60%
6B	2.53%	3.88%
7A	3.23%	3.91%
7B	3.24%	3.79%
8A	3.35%	3.96%
8B	3.30%	3.99%
9A	3.25%	3.25%
9B	3.37%	3.17%

Appendix B
Eligible Months, Incurred Claims, and PMPM for the Comparison Group, Baseline Period, DY7 and DY8

Appendix Table B.A-1
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 1

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Total	**495,181.0**	**$792,439,622**	**$1,600.30**	**40,209.8**	**$80,129,190**	**$1,992.78**	**1.24525**
Facility, age 65+, with SPMI	32,115.2	$66,311,502	$2,064.80	1,512.0	$3,918,632	$2,591.73	1.25520
Facility, age 65+, no SPMI	80,858.8	$139,945,392	$1,730.74	2,213.9	$3,924,121	$1,772.46	1.02411
HCBS, age 65+, with SPMI	10,838.8	$20,539,243	$1,894.97	853.4	$2,088,925	$2,447.87	1.29177
HCBS, age 65+, no SPMI	51,925.0	$84,282,667	$1,623.16	2,704.2	$7,067,786	$2,613.62	1.61021
Community, age 65+, with SPMI	12,587.9	$16,488,055	$1,309.84	1,302.1	$2,354,566	$1,808.31	1.38056
Community, age 65+, no SPMI	92,332.0	$108,551,869	$1,175.67	7,335.6	$12,699,731	$1,731.25	1.47256
Facility, age <65, with SPMI	10,531.3	$26,564,713	$2,522.45	1,347.4	$3,146,958	$2,335.66	0.92595
Facility, age <65, no SPMI	12,082.5	$28,804,414	$2,383.97	1,225.2	$3,415,448	$2,787.72	1.16936
HCBS, age <65, with SPMI	18,074.4	$30,515,893	$1,688.35	1,981.5	$3,430,881	$1,731.42	1.02551
HCBS, age <65, no SPMI	28,593.8	$55,535,580	$1,942.22	2,945.7	$7,112,183	$2,414.42	1.24312
Community, age <65, with SPMI	58,269.0	$76,748,751	$1,317.15	6,838.3	$9,701,437	$1,418.70	1.07710
Community, age <65, no SPMI	86,972.3	$138,151,543	$1,588.45	9,950.6	$21,268,523	$2,137.42	1.34560

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.A-2
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 1

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Total	**495,181.0**	**$792,439,622**	**$1,600.30**	**29,949.4**	**$57,362,194**	**$1,915.30**	**1.19684**
Facility, age 65+, with SPMI	32,115.2	$66,311,502	$2,064.80	989.4	$1,818,020	$1,837.55	0.88994
Facility, age 65+, no SPMI	80,858.8	$139,945,392	$1,730.74	1,329.0	$2,325,696	$1,749.91	1.01108
HCBS, age 65+, with SPMI	10,838.8	$20,539,243	$1,894.97	653.4	$1,764,942	$2,701.09	1.42540
HCBS, age 65+, no SPMI	51,925.0	$84,282,667	$1,623.16	1,845.9	$4,196,533	$2,273.38	1.40059
Community, age 65+, with SPMI	12,587.9	$16,488,055	$1,309.84	909.3	$1,604,653	$1,764.67	1.34724
Community, age 65+, no SPMI	92,332.0	$108,551,869	$1,175.67	5,275.3	$9,729,225	$1,844.31	1.56874
Facility, age <65, with SPMI	10,531.3	$26,564,713	$2,522.45	1,027.5	$2,452,067	$2,386.33	0.94604
Facility, age <65, no SPMI	12,082.5	$28,804,414	$2,383.97	1,079.3	$2,079,086	$1,926.32	0.80803
HCBS, age <65, with SPMI	18,074.4	$30,515,893	$1,688.35	1,788.3	$3,510,648	$1,963.13	1.16275
HCBS, age <65, no SPMI	28,593.8	$55,535,580	$1,942.22	2,315.1	$5,645,746	$2,438.71	1.25563
Community, age <65, with SPMI	58,269.0	$76,748,751	$1,317.15	5,338.4	$8,253,297	$1,546.02	1.17377
Community, age <65, no SPMI	86,972.3	$138,151,543	$1,588.45	7,398.5	$13,982,280	$1,889.88	1.18976

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.B-1
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 2

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Total	**42,008.3**	**$67,515,192**	**$1,607.19**	**8,390.8**	**$15,113,500**	**$1,801.19**	**1.12071**
Facility, age 65+, with SPMI	2,059.8	$5,419,492	$2,631.14	292.7	$517,421	$1,767.76	0.67186
Facility, age 65+, no SPMI	6,716.7	$14,724,625	$2,192.23	438.7	$926,469	$2,112.09	0.96344
HCBS, age 65+, with SPMI	613.4	$1,053,551	$1,717.67	154.8	$214,536	$1,386.12	0.80698
HCBS, age 65+, no SPMI	3,544.0	$5,267,521	$1,486.32	515.0	$1,420,220	$2,757.70	1.85538
Community, age 65+, with SPMI	1,074.8	$1,446,270	$1,345.67	203.0	$263,602	$1,298.33	0.96482
Community, age 65+, no SPMI	9,976.7	$13,004,722	$1,303.52	1,849.2	$3,606,587	$1,950.33	1.49621
Facility, age <65, with SPMI	668.8	$2,180,795	$3,260.87	129.2	$362,468	$2,805.69	0.86041
Facility, age <65, no SPMI	794.5	$2,553,958	$3,214.35	296.5	$906,143	$3,055.63	0.95062
HCBS, age <65, with SPMI	1,076.6	$1,473,625	$1,368.80	354.0	$384,314	$1,085.63	0.79313
HCBS, age <65, no SPMI	1,902.1	$2,801,867	$1,473.05	524.5	$1,078,178	$2,055.82	1.39562
Community, age <65, with SPMI	5,313.9	$6,380,978	$1,200.82	1,546.4	$1,866,206	$1,206.84	1.00502
Community, age <65, no SPMI	8,267.2	$11,207,788	$1,355.69	2,086.9	$3,567,356	$1,709.39	1.26091

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.B-2
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 2

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Total	**42,008.3**	**$67,515,192**	**$1,607.19**	**6,293.5**	**$10,671,342**	**$1,695.60**	**1.05501**
Facility, age 65+, with SPMI	2,059.8	$5,419,492	$2,631.14	226.1	$445,561	$1,970.39	0.74887
Facility, age 65+, no SPMI	6,716.7	$14,724,625	$2,192.23	270.2	$406,516	$1,504.40	0.68624
HCBS, age 65+, with SPMI	613.4	$1,053,551	$1,717.67	115.9	$173,552	$1,497.18	0.87163
HCBS, age 65+, no SPMI	3,544.0	$5,267,521	$1,486.32	373.3	$1,072,950	$2,873.98	1.93362
Community, age 65+, with SPMI	1,074.8	$1,446,270	$1,345.67	139.5	$286,476	$2,053.23	1.52580
Community, age 65+, no SPMI	9,976.7	$13,004,722	$1,303.52	1,292.5	$1,784,893	$1,380.98	1.05943
Facility, age <65, with SPMI	668.8	$2,180,795	$3,260.87	144.3	$666,943	$4,621.46	1.41725
Facility, age <65, no SPMI	794.5	$2,553,958	$3,214.35	232.6	$505,251	$2,171.78	0.67565
HCBS, age <65, with SPMI	1,076.6	$1,473,625	$1,368.80	254.1	$625,572	$2,461.89	1.79858
HCBS, age <65, no SPMI	1,902.1	$2,801,867	$1,473.05	467.0	$558,426	$1,195.69	0.81171
Community, age <65, with SPMI	5,313.9	$6,380,978	$1,200.82	1,250.5	$1,702,253	$1,361.21	1.13357
Community, age <65, no SPMI	8,267.2	$11,207,788	$1,355.69	1,527.3	$2,442,951	$1,599.52	1.17986

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.C-1
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 3

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Total	**65,614.5**	**$109,816,298**	**$1,673.66**	**14,752.3**	**$23,092,214**	**$1,565.33**	**0.93527**
Facility, age 65+, with SPMI	4,878.2	$11,042,653	$2,263.65	776.4	$1,735,403	$2,235.11	0.98739
Facility, age 65+, no SPMI	12,137.4	$26,728,998	$2,202.20	1,353.6	$2,822,565	$2,085.26	0.94690
HCBS, age 65+, with SPMI	1,111.6	$1,593,577	$1,433.58	401.2	$753,557	$1,878.07	1.31005
HCBS, age 65+, no SPMI	4,599.1	$7,305,283	$1,588.42	775.4	$1,545,193	$1,992.71	1.25452
Community, age 65+, with SPMI	2,510.0	$3,725,198	$1,484.15	613.7	$791,300	$1,289.35	0.86875
Community, age 65+, no SPMI	12,485.8	$16,640,967	$1,332.79	2,573.6	$3,350,732	$1,301.97	0.97688
Facility, age <65, with SPMI	1,125.0	$3,949,081	$3,510.30	247.3	$598,422	$2,419.92	0.68938
Facility, age <65, no SPMI	1,435.9	$4,985,720	$3,472.12	348.8	$880,284	$2,523.99	0.72693
HCBS, age <65, with SPMI	2,068.1	$2,424,892	$1,172.54	809.2	$645,257	$797.43	0.68009
HCBS, age <65, no SPMI	2,938.7	$3,982,170	$1,355.08	970.1	$1,952,901	$2,013.10	1.48560
Community, age <65, with SPMI	10,202.2	$11,555,501	$1,132.64	3,176.9	$2,985,464	$939.75	0.82969
Community, age <65, no SPMI	10,122.4	$15,882,259	$1,569.02	2,706.1	$5,031,135	$1,859.15	1.18491

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.C-2
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 3

Category of beneficiary	Baseline period			Demonstration Year 8			Trend (D/B)[a]
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**65,614.5**	**$109,816,298**	**$1,673.66**	**11,330.9**	**$18,316,788**	**$1,616.54**	**0.96587**
Facility, age 65+, with SPMI	4,878.2	$11,042,653	$2,263.65	518.6	$695,467	$1,341.15	0.59247
Facility, age 65+, no SPMI	12,137.4	$26,728,998	$2,202.20	852.4	$1,459,026	$1,711.60	0.77722
HCBS, age 65+, with SPMI	1,111.6	$1,593,577	$1,433.58	231.4	$546,875	$2,363.81	1.64889
HCBS, age 65+, no SPMI	4,599.1	$7,305,283	$1,588.42	626.1	$1,176,813	$1,879.49	1.18324
Community, age 65+, with SPMI	2,510.0	$3,725,198	$1,484.15	484.7	$806,039	$1,662.91	1.12045
Community, age 65+, no SPMI	12,485.8	$16,640,967	$1,332.79	1,781.4	$3,477,202	$1,951.98	1.46458
Facility, age <65, with SPMI	1,125.0	$3,949,081	$3,510.30	252.5	$422,436	$1,673.32	0.47669
Facility, age <65, no SPMI	1,435.9	$4,985,720	$3,472.12	308.4	$689,838	$2,237.19	0.64433
HCBS, age <65, with SPMI	2,068.1	$2,424,892	$1,172.54	701.1	$627,186	$894.63	0.76299
HCBS, age <65, no SPMI	2,938.7	$3,982,170	$1,355.08	749.2	$1,116,398	$1,490.21	1.09972
Community, age <65, with SPMI	10,202.2	$11,555,501	$1,132.64	2,736.8	$3,176,133	$1,160.54	1.02463
Community, age <65, no SPMI	10,122.4	$15,882,259	$1,569.02	2,088.5	$4,123,375	$1,974.29	1.25829

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.D-1
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 4

Category of beneficiary	Baseline period			Demonstration Year 7			Trend (D/B)[a]
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**74,886.5**	**$130,154,124**	**$1,738.02**	**19,942.6**	**$33,360,676**	**$1,672.83**	**0.96249**
Facility, age 65+, with SPMI	8,799.9	$23,177,043	$2,633.77	1,666.6	$3,766,950	$2,260.27	0.85819
Facility, age 65+, no SPMI	10,464.5	$21,506,946	$2,055.23	1,610.0	$3,567,861	$2,216.06	1.07825
HCBS, age 65+, with SPMI	2,013.0	$3,798,610	$1,887.04	572.7	$1,050,843	$1,834.90	0.97237
HCBS, age 65+, no SPMI	4,656.9	$6,769,043	$1,453.55	1,095.6	$2,573,288	$2,348.68	1.61582
Community, age 65+, with SPMI	3,872.4	$6,423,922	$1,658.90	1,184.4	$2,002,839	$1,690.98	1.01934
Community, age 65+, no SPMI	13,747.0	$17,606,796	$1,280.78	3,735.5	$5,159,705	$1,381.26	1.07846
Facility, age <65, with SPMI	2,039.5	$7,820,424	$3,834.53	494.9	$1,268,295	$2,562.97	0.66839
Facility, age <65, no SPMI	1,184.9	$4,054,838	$3,422.18	394.3	$1,048,440	$2,658.84	0.77694
HCBS, age <65, with SPMI	2,214.7	$2,946,358	$1,330.34	704.8	$686,256	$973.73	0.73194
HCBS, age <65, no SPMI	2,526.6	$3,932,951	$1,556.63	937.9	$1,807,159	$1,926.82	1.23781
Community, age <65, with SPMI	11,399.1	$13,242,226	$1,161.69	3,855.5	$4,045,017	$1,049.14	0.90312
Community, age <65, no SPMI	11,968.0	$18,874,966	$1,577.12	3,690.4	$6,384,024	$1,729.91	1.09688

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.D-2
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 4

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Total	**74,886.5**	**$130,154,124**	**$1,738.02**	**14,164.8**	**$23,958,162**	**$1,691.39**	**0.97317**
Facility, age 65+, with SPMI	8,799.9	$23,177,043	$2,633.77	1,148.1	$2,525,746	$2,199.88	0.83526
Facility, age 65+, no SPMI	10,464.5	$21,506,946	$2,055.23	941.6	$2,224,236	$2,362.22	1.14937
HCBS, age 65+, with SPMI	2,013.0	$3,798,610	$1,887.04	384.9	$967,628	$2,514.21	1.33236
HCBS, age 65+, no SPMI	4,656.9	$6,769,043	$1,453.55	637.8	$2,222,378	$3,484.37	2.39715
Community, age 65+, with SPMI	3,872.4	$6,423,922	$1,658.90	796.9	$1,862,765	$2,337.51	1.40907
Community, age 65+, no SPMI	13,747.0	$17,606,796	$1,280.78	2,564.4	$3,917,253	$1,527.53	1.19266
Facility, age <65, with SPMI	2,039.5	$7,820,424	$3,834.53	397.7	$788,942	$1,983.96	0.51739
Facility, age <65, no SPMI	1,184.9	$4,054,838	$3,422.18	287.7	$486,237	$1,690.20	0.49390
HCBS, age <65, with SPMI	2,214.7	$2,946,358	$1,330.34	595.5	$580,247	$974.42	0.73246
HCBS, age <65, no SPMI	2,526.6	$3,932,951	$1,556.63	779.3	$1,593,483	$2,044.64	1.31350
Community, age <65, with SPMI	11,399.1	$13,242,226	$1,161.69	2,931.9	$2,606,742	$889.10	0.76535
Community, age <65, no SPMI	11,968.0	$18,874,966	$1,577.12	2,699.0	$4,182,504	$1,549.66	0.98259

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.E-1
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 5A

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Total	**55,234.5**	**$100,113,666**	**$1,812.52**	**17,520.7**	**$34,040,848**	**$1,942.89**	**1.07193**
Facility, age 65+, with SPMI	9,699.9	$22,110,254	$2,279.44	2,599.1	$6,141,350	$2,362.88	1.03661
Facility, age 65+, no SPMI	5,768.6	$12,028,564	$2,085.19	1,263.6	$3,820,531	$3,023.47	1.44997
HCBS, age 65+, with SPMI	1,794.4	$3,717,937	$2,071.96	698.7	$2,179,845	$3,120.02	1.50583
HCBS, age 65+, no SPMI	2,470.4	$3,972,554	$1,608.09	765.1	$1,405,150	$1,836.54	1.14206
Community, age 65+, with SPMI	4,508.5	$7,350,151	$1,630.30	1,577.7	$2,081,937	$1,319.62	0.80944
Community, age 65+, no SPMI	8,094.0	$9,210,465	$1,137.94	2,607.8	$3,677,439	$1,410.17	1.23923
Facility, age <65, with SPMI	2,106.1	$7,470,590	$3,547.09	685.9	$2,495,235	$3,638.14	1.02567
Facility, age <65, no SPMI	957.5	$3,328,035	$3,475.88	433.5	$1,230,989	$2,839.88	0.81703
HCBS, age <65, with SPMI	2,203.2	$3,920,524	$1,779.45	816.0	$1,262,671	$1,547.33	0.86955
HCBS, age <65, no SPMI	1,620.6	$2,444,637	$1,508.51	719.3	$1,095,744	$1,523.36	1.00984
Community, age <65, with SPMI	9,316.4	$12,525,536	$1,344.46	3,000.1	$3,535,526	$1,178.48	0.87654
Community, age <65, no SPMI	6,695.1	$12,034,419	$1,797.49	2,354.1	$5,114,430	$2,172.61	1.20869

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.E-2
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 5A

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Total	**55,234.5**	**$100,113,666**	**$1,812.52**	**12,074.3**	**$21,215,382**	**$1,757.07**	**0.96941**
Facility, age 65+, with SPMI	9,699.9	$22,110,254	$2,279.44	1,594.7	$3,187,002	$1,998.45	0.87673
Facility, age 65+, no SPMI	5,768.6	$12,028,564	$2,085.19	761.3	$1,516,758	$1,992.44	0.95552
HCBS, age 65+, with SPMI	1,794.4	$3,717,937	$2,071.96	398.8	$663,470	$1,663.47	0.80285
HCBS, age 65+, no SPMI	2,470.4	$3,972,554	$1,608.09	435.7	$1,070,182	$2,456.46	1.52756
Community, age 65+, with SPMI	4,508.5	$7,350,151	$1,630.30	1,167.2	$2,658,891	$2,278.02	1.39731
Community, age 65+, no SPMI	8,094.0	$9,210,465	$1,137.94	1,853.5	$2,226,304	$1,201.15	1.05555
Facility, age <65, with SPMI	2,106.1	$7,470,590	$3,547.09	584.3	$1,577,344	$2,699.52	0.76105
Facility, age <65, no SPMI	957.5	$3,328,035	$3,475.88	338.8	$1,495,939	$4,414.77	1.27012
HCBS, age <65, with SPMI	2,203.2	$3,920,524	$1,779.45	577.3	$553,360	$958.53	0.53867
HCBS, age <65, no SPMI	1,620.6	$2,444,637	$1,508.51	563.5	$1,094,304	$1,942.08	1.28741
Community, age <65, with SPMI	9,316.4	$12,525,536	$1,344.46	2,326.6	$2,503,318	$1,075.98	0.80030
Community, age <65, no SPMI	6,695.1	$12,034,419	$1,797.49	1,472.6	$2,668,510	$1,812.05	1.00810

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.F-1
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 5B

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Total	**210,281.7**	**$332,690,142**	**$1,582.12**	**56,554.5**	**$104,086,237**	**$1,840.46**	**1.16329**
Facility, age 65+, with SPMI	24,578.5	$46,576,524	$1,895.01	4,662.5	$12,169,981	$2,610.19	1.37740
Facility, age 65+, no SPMI	10,335.3	$17,577,714	$1,700.74	2,059.8	$4,454,212	$2,162.41	1.27145
HCBS, age 65+, with SPMI	5,802.8	$12,529,769	$2,159.27	1,487.7	$3,969,238	$2,667.96	1.23558
HCBS, age 65+, no SPMI	6,670.5	$11,370,351	$1,704.57	1,628.1	$3,810,443	$2,340.45	1.37304
Community, age 65+, with SPMI	26,146.3	$42,479,059	$1,624.67	6,493.9	$13,419,031	$2,066.41	1.27190
Community, age 65+, no SPMI	34,850.4	$41,713,161	$1,196.92	8,243.6	$13,826,574	$1,677.26	1.40131
Facility, age <65, with SPMI	5,902.3	$15,354,462	$2,601.42	2,552.7	$6,200,721	$2,429.07	0.93374
Facility, age <65, no SPMI	2,785.0	$4,054,836	$1,455.96	1,294.1	$1,727,926	$1,335.20	0.91706
HCBS, age <65, with SPMI	7,250.9	$12,543,076	$1,729.86	2,440.5	$3,387,427	$1,388.02	0.80239
HCBS, age <65, no SPMI	4,331.2	$7,234,071	$1,670.21	1,526.9	$2,667,616	$1,747.14	1.04605
Community, age <65, with SPMI	57,206.1	$81,825,914	$1,430.37	17,525.8	$25,362,699	$1,447.17	1.01174
Community, age <65, no SPMI	24,422.3	$39,431,205	$1,614.56	6,638.9	$13,090,369	$1,971.75	1.22124

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.F-2
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 5B

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Total	**210,281.7**	**$332,690,142**	**$1,582.12**	**43,631.0**	**$79,007,017**	**$1,810.80**	**1.14454**
Facility, age 65+, with SPMI	24,578.5	$46,576,524	$1,895.01	3,376.1	$8,150,858	$2,414.26	1.27401
Facility, age 65+, no SPMI	10,335.3	$17,577,714	$1,700.74	1,509.2	$3,100,431	$2,054.35	1.20792
HCBS, age 65+, with SPMI	5,802.8	$12,529,769	$2,159.27	1,102.9	$2,966,144	$2,689.32	1.24547
HCBS, age 65+, no SPMI	6,670.5	$11,370,351	$1,704.57	977.5	$2,269,532	$2,321.75	1.36207
Community, age 65+, with SPMI	26,146.3	$42,479,059	$1,624.67	5,578.3	$12,013,345	$2,153.60	1.32557
Community, age 65+, no SPMI	34,850.4	$41,713,161	$1,196.92	5,706.6	$9,698,730	$1,699.58	1.41995
Facility, age <65, with SPMI	5,902.3	$15,354,462	$2,601.42	2,221.3	$4,315,571	$1,942.83	0.74683
Facility, age <65, no SPMI	2,785.0	$4,054,836	$1,455.96	1,334.8	$1,822,934	$1,365.71	0.93802
HCBS, age <65, with SPMI	7,250.9	$12,543,076	$1,729.86	2,088.6	$3,115,868	$1,491.86	0.86242
HCBS, age <65, no SPMI	4,331.2	$7,234,071	$1,670.21	1,165.5	$2,172,019	$1,863.52	1.11574
Community, age <65, with SPMI	57,206.1	$81,825,914	$1,430.37	14,076.4	$21,137,056	$1,501.59	1.04979
Community, age <65, no SPMI	24,422.3	$39,431,205	$1,614.56	4,493.8	$8,244,530	$1,834.63	1.13631

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.G-1
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 6A

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Total	**48,146.2**	**$96,337,228**	**$2,000.93**	**19,020.7**	**$36,791,264**	**$1,934.27**	**0.96669**
Facility, age 65+, with SPMI	9,767.7	$23,702,945	$2,426.66	3,533.5	$8,942,690	$2,530.80	1.04291
Facility, age 65+, no SPMI	4,958.5	$9,755,842	$1,967.49	1,793.9	$4,309,007	$2,401.99	1.22084
HCBS, age 65+, with SPMI	1,685.3	$3,551,857	$2,107.56	552.2	$1,345,150	$2,435.97	1.15582
HCBS, age 65+, no SPMI	1,716.9	$3,400,100	$1,980.33	545.4	$1,572,145	$2,882.80	1.45572
Community, age 65+, with SPMI	4,220.9	$8,520,127	$2,018.58	1,629.5	$2,754,137	$1,690.21	0.83733
Community, age 65+, no SPMI	7,106.5	$10,648,158	$1,498.38	3,108.4	$3,699,855	$1,190.28	0.79438
Facility, age <65, with SPMI	2,027.2	$6,011,790	$2,965.53	883.2	$3,111,727	$3,523.10	1.18801
Facility, age <65, no SPMI	611.2	$1,798,045	$2,941.86	237.1	$729,081	$3,075.36	1.04538
HCBS, age <65, with SPMI	1,302.7	$2,856,009	$2,192.44	543.8	$1,160,734	$2,134.64	0.97364
HCBS, age <65, no SPMI	1,275.8	$2,021,794	$1,584.75	667.9	$967,587	$1,448.63	0.91411
Community, age <65, with SPMI	7,915.5	$14,247,500	$1,799.94	3,286.1	$4,113,303	$1,251.74	0.69543
Community, age <65, no SPMI	5,558.0	$9,823,061	$1,767.36	2,239.8	$4,085,850	$1,824.22	1.03217

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.G-2
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 6A

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Total	**48,146.2**	**$96,337,228**	**$2,000.93**	**13,725.4**	**$24,921,199**	**$1,815.69**	**0.90742**
Facility, age 65+, with SPMI	9,767.7	$23,702,945	$2,426.66	2,342.1	$5,822,878	$2,486.19	1.02453
Facility, age 65+, no SPMI	4,958.5	$9,755,842	$1,967.49	1,072.1	$2,456,498	$2,291.33	1.16459
HCBS, age 65+, with SPMI	1,685.3	$3,551,857	$2,107.56	366.0	$861,507	$2,353.75	1.11681
HCBS, age 65+, no SPMI	1,716.9	$3,400,100	$1,980.33	350.3	$666,486	$1,902.82	0.96086
Community, age 65+, with SPMI	4,220.9	$8,520,127	$2,018.58	1,274.8	$2,275,679	$1,785.18	0.88437
Community, age 65+, no SPMI	7,106.5	$10,648,158	$1,498.38	2,222.5	$3,484,259	$1,567.69	1.04626
Facility, age <65, with SPMI	2,027.2	$6,011,790	$2,965.53	626.7	$1,538,969	$2,455.83	0.82812
Facility, age <65, no SPMI	611.2	$1,798,045	$2,941.86	171.4	$298,132	$1,739.88	0.59142
HCBS, age <65, with SPMI	1,302.7	$2,856,009	$2,192.44	430.6	$686,959	$1,595.53	0.72774
HCBS, age <65, no SPMI	1,275.8	$2,021,794	$1,584.75	516.6	$700,800	$1,356.52	0.85598
Community, age <65, with SPMI	7,915.5	$14,247,500	$1,799.94	2,606.9	$3,310,477	$1,269.89	0.70552
Community, age <65, no SPMI	5,558.0	$9,823,061	$1,767.36	1,745.6	$2,818,555	$1,614.66	0.91360

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.H-1
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 6B

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Total	**54,424.9**	**$96,838,525**	**$1,779.31**	**18,445.1**	**$30,890,407**	**$1,674.72**	**0.94122**
Facility, age 65+, with SPMI	7,406.7	$17,936,369	$2,421.63	2,202.1	$5,473,752	$2,485.70	1.02645
Facility, age 65+, no SPMI	3,502.1	$7,628,312	$2,178.22	1,015.4	$2,663,230	$2,622.84	1.20412
HCBS, age 65+, with SPMI	1,523.2	$3,546,533	$2,328.39	494.4	$1,144,931	$2,315.66	0.99453
HCBS, age 65+, no SPMI	1,913.0	$3,585,759	$1,874.42	602.4	$1,135,462	$1,884.76	1.00552
Community, age 65+, with SPMI	6,899.0	$12,403,562	$1,797.87	2,198.4	$4,162,425	$1,893.36	1.05311
Community, age 65+, no SPMI	9,172.2	$11,800,787	$1,286.59	2,862.8	$3,250,075	$1,135.27	0.88239
Facility, age <65, with SPMI	1,437.1	$5,049,052	$3,513.48	678.0	$2,324,936	$3,428.93	0.97594
Facility, age <65, no SPMI	717.0	$1,285,178	$1,792.44	512.4	$547,749	$1,069.06	0.59643
HCBS, age <65, with SPMI	1,514.3	$2,766,356	$1,826.87	582.3	$1,109,603	$1,905.46	1.04302
HCBS, age <65, no SPMI	1,151.1	$1,445,239	$1,255.57	533.0	$580,886	$1,089.77	0.86795
Community, age <65, with SPMI	12,960.2	$19,697,076	$1,519.81	4,705.7	$5,431,990	$1,154.35	0.75953
Community, age <65, no SPMI	6,229.1	$9,694,302	$1,556.29	2,058.0	$3,065,368	$1,489.49	0.95708

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.H-2
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 6B

Category of beneficiary	Baseline period			Demonstration Year 8			Trend (D/B)[a]
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**54,424.9**	**$96,838,525**	**$1,779.31**	**14,211.8**	**$24,191,509**	**$1,702.22**	**0.95667**
Facility, age 65+, with SPMI	7,406.7	$17,936,369	$2,421.63	1,676.2	$3,947,407	$2,354.90	0.97244
Facility, age 65+, no SPMI	3,502.1	$7,628,312	$2,178.22	718.8	$1,218,478	$1,695.09	0.77820
HCBS, age 65+, with SPMI	1,523.2	$3,546,533	$2,328.39	303.6	$957,321	$3,153.28	1.35427
HCBS, age 65+, no SPMI	1,913.0	$3,585,759	$1,874.42	358.6	$882,908	$2,462.11	1.31354
Community, age 65+, with SPMI	6,899.0	$12,403,562	$1,797.87	1,929.3	$3,535,856	$1,832.70	1.01937
Community, age 65+, no SPMI	9,172.2	$11,800,787	$1,286.59	2,287.4	$3,319,398	$1,451.18	1.12793
Facility, age <65, with SPMI	1,437.1	$5,049,052	$3,513.48	594.4	$1,697,398	$2,855.62	0.81276
Facility, age <65, no SPMI	717.0	$1,285,178	$1,792.44	395.3	$669,159	$1,692.83	0.94443
HCBS, age <65, with SPMI	1,514.3	$2,766,356	$1,826.87	442.2	$713,913	$1,614.36	0.88368
HCBS, age <65, no SPMI	1,151.1	$1,445,239	$1,255.57	383.3	$368,814	$962.31	0.76644
Community, age <65, with SPMI	12,960.2	$19,697,076	$1,519.81	3,726.7	$4,837,830	$1,298.16	0.85416
Community, age <65, no SPMI	6,229.1	$9,694,302	$1,556.29	1,395.9	$2,043,027	$1,463.57	0.94043

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.I-1
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 7A

Category of beneficiary	Baseline period			Demonstration Year 7			Trend (D/B)[a]
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**34,245.1**	**$73,787,223**	**$2,154.68**	**19,452.3**	**$37,303,252**	**$1,917.68**	**0.89000**
Facility, age 65+, with SPMI	6,953.9	$18,019,761	$2,591.33	4,134.8	$10,073,354	$2,436.22	0.94014
Facility, age 65+, no SPMI	4,042.1	$10,608,375	$2,624.49	2,486.1	$6,441,914	$2,591.15	0.98730
HCBS, age 65+, with SPMI	1,377.9	$2,856,622	$2,073.21	711.4	$1,470,907	$2,067.52	0.99725
HCBS, age 65+, no SPMI	1,434.0	$2,114,941	$1,474.85	851.4	$1,514,088	$1,778.29	1.20574
Community, age 65+, with SPMI	2,748.4	$4,602,266	$1,674.53	1,523.0	$2,018,221	$1,325.14	0.79135
Community, age 65+, no SPMI	5,028.4	$7,829,938	$1,557.15	2,743.0	$3,786,741	$1,380.51	0.88656
Facility, age <65, with SPMI	1,085.2	$4,612,561	$4,250.32	561.9	$2,033,685	$3,619.16	0.85150
Facility, age <65, no SPMI	524.2	$1,950,666	$3,721.04	298.1	$778,421	$2,611.22	0.70174
HCBS, age <65, with SPMI	1,227.1	$3,314,576	$2,701.09	746.3	$1,603,776	$2,149.08	0.79563
HCBS, age <65, no SPMI	877.8	$1,819,294	$2,072.65	681.0	$1,300,141	$1,909.09	0.92109
Community, age <65, with SPMI	5,082.8	$8,237,940	$1,620.74	2,590.2	$3,035,331	$1,171.85	0.72304
Community, age <65, no SPMI	3,863.3	$7,820,284	$2,024.26	2,125.0	$3,246,674	$1,527.88	0.75479

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.I-2
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 7A

Category of beneficiary	Baseline period			Demonstration Year 8			Trend (D/B)[a]
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**34,245.1**	**$73,787,223**	**$2,154.68**	**12,500.9**	**$22,487,438**	**$1,798.87**	**0.83486**
Facility, age 65+, with SPMI	6,953.9	$18,019,761	$2,591.33	2,536.7	$5,630,401	$2,219.56	0.85653
Facility, age 65+, no SPMI	4,042.1	$10,608,375	$2,624.49	1,359.9	$2,457,740	$1,807.23	0.68860
HCBS, age 65+, with SPMI	1,377.9	$2,856,622	$2,073.21	477.7	$1,373,587	$2,875.19	1.38683
HCBS, age 65+, no SPMI	1,434.0	$2,114,941	$1,474.85	508.8	$854,456	$1,679.33	1.13864
Community, age 65+, with SPMI	2,748.4	$4,602,266	$1,674.53	1,004.2	$1,708,086	$1,700.92	1.01576
Community, age 65+, no SPMI	5,028.4	$7,829,938	$1,557.15	1,911.5	$2,714,961	$1,420.36	0.91215
Facility, age <65, with SPMI	1,085.2	$4,612,561	$4,250.32	295.5	$566,799	$1,918.35	0.45134
Facility, age <65, no SPMI	524.2	$1,950,666	$3,721.04	243.0	$766,203	$3,153.52	0.84748
HCBS, age <65, with SPMI	1,227.1	$3,314,576	$2,701.09	525.0	$1,173,568	$2,235.55	0.82765
HCBS, age <65, no SPMI	877.8	$1,819,294	$2,072.65	496.5	$869,397	$1,751.22	0.84492
Community, age <65, with SPMI	5,082.8	$8,237,940	$1,620.74	1,801.2	$2,586,009	$1,435.75	0.88586
Community, age <65, no SPMI	3,863.3	$7,820,284	$2,024.26	1,341.0	$1,786,232	$1,332.01	0.65803

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.J-1
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 7B

Category of beneficiary	Baseline period			Demonstration Year 7			Trend (D/B)[a]
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**39,801.9**	**$76,341,094**	**$1,918.03**	**20,427.6**	**$36,535,128**	**$1,788.52**	**0.93248**
Facility, age 65+, with SPMI	6,593.0	$14,980,794	$2,272.24	3,137.0	$8,147,949	$2,597.35	1.14308
Facility, age 65+, no SPMI	2,920.3	$7,269,394	$2,489.23	1,177.5	$2,661,581	$2,260.39	0.90807
HCBS, age 65+, with SPMI	1,132.7	$2,589,544	$2,286.22	553.5	$1,237,648	$2,235.84	0.97797
HCBS, age 65+, no SPMI	1,161.8	$2,281,127	$1,963.41	536.5	$779,489	$1,452.96	0.74002
Community, age 65+, with SPMI	5,614.3	$10,526,717	$1,874.99	2,998.8	$6,300,344	$2,100.97	1.12053
Community, age 65+, no SPMI	5,982.2	$9,082,698	$1,518.29	3,158.2	$4,064,758	$1,287.06	0.84770
Facility, age <65, with SPMI	1,360.7	$4,805,722	$3,531.93	719.9	$1,798,495	$2,498.12	0.70730
Facility, age <65, no SPMI	573.0	$1,008,315	$1,759.71	410.6	$531,393	$1,294.05	0.73538
HCBS, age <65, with SPMI	806.7	$1,648,239	$2,043.19	450.5	$759,976	$1,687.02	0.82568
HCBS, age <65, no SPMI	820.0	$904,370	$1,102.93	464.8	$341,141	$733.91	0.66542
Community, age <65, with SPMI	8,865.1	$14,711,981	$1,659.54	4,697.7	$6,695,375	$1,425.23	0.85881
Community, age <65, no SPMI	3,972.2	$6,532,195	$1,644.48	2,122.4	$3,216,978	$1,515.70	0.92169

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.J-2
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 7B

Category of beneficiary	Baseline period			Demonstration Year 8			Trend (D/B)[a]
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**39,801.9**	**$76,341,094**	**$1,918.03**	**14,718.9**	**$25,263,855**	**$1,716.43**	**0.89489**
Facility, age 65+, with SPMI	6,593.0	$14,980,794	$2,272.24	2,108.4	$4,733,823	$2,245.24	0.98812
Facility, age 65+, no SPMI	2,920.3	$7,269,394	$2,489.23	870.5	$1,782,355	$2,047.59	0.82258
HCBS, age 65+, with SPMI	1,132.7	$2,589,544	$2,286.22	334.1	$467,885	$1,400.52	0.61259
HCBS, age 65+, no SPMI	1,161.8	$2,281,127	$1,963.41	369.1	$524,820	$1,421.98	0.72424
Community, age 65+, with SPMI	5,614.3	$10,526,717	$1,874.99	2,094.6	$4,005,405	$1,912.23	1.01986
Community, age 65+, no SPMI	5,982.2	$9,082,698	$1,518.29	2,398.3	$3,722,529	$1,552.15	1.02230
Facility, age <65, with SPMI	1,360.7	$4,805,722	$3,531.93	535.7	$1,356,110	$2,531.35	0.71670
Facility, age <65, no SPMI	573.0	$1,008,315	$1,759.71	342.8	$540,165	$1,575.55	0.89535
HCBS, age <65, with SPMI	806.7	$1,648,239	$2,043.19	388.9	$726,425	$1,867.99	0.91425
HCBS, age <65, no SPMI	820.0	$904,370	$1,102.93	280.4	$195,269	$696.39	0.63139
Community, age <65, with SPMI	8,865.1	$14,711,981	$1,659.54	3,539.0	$4,948,578	$1,398.28	0.84257
Community, age <65, no SPMI	3,972.2	$6,532,195	$1,644.48	1,457.0	$2,260,491	$1,551.42	0.94341

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.K-1
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 8A

Category of beneficiary	Baseline period			Demonstration Year 7			Trend (D/B)[a]
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**28,489.1**	**$69,197,528**	**$2,428.91**	**28,034.5**	**$65,391,158**	**$2,332.53**	**0.96032**
Facility, age 65+, with SPMI	6,363.1	$19,470,755	$3,059.96	6,708.4	$19,454,113	$2,899.96	0.94771
Facility, age 65+, no SPMI	3,451.5	$9,669,835	$2,801.60	3,547.6	$9,791,288	$2,759.99	0.98515
HCBS, age 65+, with SPMI	1,169.0	$2,779,853	$2,377.97	1,250.6	$3,004,088	$2,402.06	1.01013
HCBS, age 65+, no SPMI	1,471.0	$2,224,008	$1,511.90	1,501.5	$3,087,946	$2,056.57	1.36025
Community, age 65+, with SPMI	2,024.3	$4,224,102	$2,086.69	1,806.7	$3,289,352	$1,820.61	0.87248
Community, age 65+, no SPMI	3,545.0	$4,816,610	$1,358.72	3,287.7	$3,582,838	$1,089.77	0.80206
Facility, age <65, with SPMI	1,336.0	$6,377,719	$4,773.90	1,463.3	$5,614,610	$3,837.01	0.80375
Facility, age <65, no SPMI	488.0	$1,702,858	$3,489.69	482.4	$1,877,690	$3,892.33	1.11538
HCBS, age <65, with SPMI	943.6	$2,201,321	$2,332.83	897.1	$1,804,500	$2,011.45	0.86223
HCBS, age <65, no SPMI	853.0	$1,550,938	$1,818.15	870.1	$2,204,665	$2,533.73	1.39358
Community, age <65, with SPMI	3,939.6	$8,445,894	$2,143.87	3,516.5	$6,501,265	$1,848.81	0.86237
Community, age <65, no SPMI	2,905.1	$5,733,635	$1,973.67	2,702.5	$5,178,803	$1,916.28	0.97092

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.K-2
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 8A

Category of beneficiary	Baseline period			Demonstration Year 8			Trend (D/B)[a]
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**28,489.1**	**$69,197,528**	**$2,428.91**	**16,372.8**	**$33,224,527**	**$2,029.25**	**0.83546**
Facility, age 65+, with SPMI	6,363.1	$19,470,755	$3,059.96	3,588.4	$7,559,852	$2,106.76	0.68849
Facility, age 65+, no SPMI	3,451.5	$9,669,835	$2,801.60	1,989.4	$4,999,509	$2,513.01	0.89699
HCBS, age 65+, with SPMI	1,169.0	$2,779,853	$2,377.97	801.1	$1,992,512	$2,487.24	1.04595
HCBS, age 65+, no SPMI	1,471.0	$2,224,008	$1,511.90	857.5	$2,081,644	$2,427.53	1.60562
Community, age 65+, with SPMI	2,024.3	$4,224,102	$2,086.69	1,024.4	$1,314,038	$1,282.69	0.61470
Community, age 65+, no SPMI	3,545.0	$4,816,610	$1,358.72	1,934.8	$3,330,725	$1,721.48	1.26699
Facility, age <65, with SPMI	1,336.0	$6,377,719	$4,773.90	902.4	$2,683,366	$2,973.50	0.62287
Facility, age <65, no SPMI	488.0	$1,702,858	$3,489.69	269.2	$1,400,061	$5,201.51	1.49053
HCBS, age <65, with SPMI	943.6	$2,201,321	$2,332.83	642.0	$1,457,279	$2,269.82	0.97299
HCBS, age <65, no SPMI	853.0	$1,550,938	$1,818.15	601.8	$877,087	$1,457.50	0.80164
Community, age <65, with SPMI	3,939.6	$8,445,894	$2,143.87	2,115.3	$2,841,791	$1,343.46	0.62665
Community, age <65, no SPMI	2,905.1	$5,733,635	$1,973.67	1,646.5	$2,686,663	$1,631.78	0.82677

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.L-1
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 8B

Category of beneficiary	Baseline period			Demonstration Year 7			Trend (D/B)[a]
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**29,657.0**	**$63,007,366**	**$2,124.54**	**28,877.5**	**$56,450,515**	**$1,954.83**	**0.92012**
Facility, age 65+, with SPMI	4,988.0	$13,959,085	$2,798.53	5,176.3	$13,770,309	$2,660.26	0.95059
Facility, age 65+, no SPMI	2,021.8	$4,508,217	$2,229.81	2,007.9	$4,871,195	$2,426.05	1.08800
HCBS, age 65+, with SPMI	713.5	$1,565,908	$2,194.59	692.7	$1,438,162	$2,076.22	0.94606
HCBS, age 65+, no SPMI	770.0	$1,534,169	$1,992.44	704.4	$1,332,881	$1,892.33	0.94975
Community, age 65+, with SPMI	3,825.8	$8,193,628	$2,141.69	3,503.2	$6,661,984	$1,901.66	0.88793
Community, age 65+, no SPMI	4,242.7	$6,176,993	$1,455.93	3,992.2	$5,140,750	$1,287.69	0.88445
Facility, age <65, with SPMI	850.8	$3,845,400	$4,519.92	859.5	$3,244,247	$3,774.53	0.83509
Facility, age <65, no SPMI	548.7	$2,306,894	$4,204.55	524.3	$1,220,564	$2,327.95	0.55368
HCBS, age <65, with SPMI	808.7	$2,010,658	$2,486.28	815.1	$1,280,790	$1,571.41	0.63203
HCBS, age <65, no SPMI	713.8	$996,461	$1,396.04	685.3	$927,249	$1,353.14	0.96926
Community, age <65, with SPMI	6,940.6	$11,015,021	$1,587.04	6,631.1	$9,380,384	$1,414.61	0.89135
Community, age <65, no SPMI	3,232.7	$6,894,930	$2,132.87	3,285.6	$7,181,999	$2,185.88	1.02485

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.L-2
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 8B

Category of beneficiary	Baseline period			Demonstration Year 8			Trend (D/B)[a]
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**29,657.0**	**$63,007,366**	**$2,124.54**	**15,738.0**	**$29,076,041**	**$1,847.50**	**0.86960**
Facility, age 65+, with SPMI	4,988.0	$13,959,085	$2,798.53	2,492.3	$7,253,120	$2,910.26	1.03992
Facility, age 65+, no SPMI	2,021.8	$4,508,217	$2,229.81	964.4	$1,739,739	$1,803.92	0.80900
HCBS, age 65+, with SPMI	713.5	$1,565,908	$2,194.59	333.6	$784,624	$2,351.84	1.07165
HCBS, age 65+, no SPMI	770.0	$1,534,169	$1,992.44	369.3	$687,869	$1,862.41	0.93474
Community, age 65+, with SPMI	3,825.8	$8,193,628	$2,141.69	2,036.2	$3,510,724	$1,724.16	0.80505
Community, age 65+, no SPMI	4,242.7	$6,176,993	$1,455.93	2,147.7	$3,124,937	$1,455.01	0.99937
Facility, age <65, with SPMI	850.8	$3,845,400	$4,519.92	520.1	$1,314,463	$2,527.18	0.55912
Facility, age <65, no SPMI	548.7	$2,306,894	$4,204.55	406.3	$693,317	$1,706.42	0.40585
HCBS, age <65, with SPMI	808.7	$2,010,658	$2,486.28	461.2	$761,819	$1,651.97	0.66444
HCBS, age <65, no SPMI	713.8	$996,461	$1,396.04	397.9	$271,479	$682.34	0.48876
Community, age <65, with SPMI	6,940.6	$11,015,021	$1,587.04	3,860.7	$5,415,108	$1,402.63	0.88380
Community, age <65, no SPMI	3,232.7	$6,894,930	$2,132.87	1,748.3	$3,518,844	$2,012.68	0.94365

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.M
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 9A

Category of beneficiary	Baseline period			Demonstration Year 8			Trend (D/B)[a]
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**24,132.3**	**$64,452,017**	**$2,670.77**	**23,618.8**	**$52,781,015**	**$2,234.71**	**0.83673**
Facility, age 65+, with SPMI	5,685.6	$20,271,981	$3,565.52	5,705.5	$12,748,748	$2,234.45	0.62668
Facility, age 65+, no SPMI	3,006.1	$10,991,232	$3,656.31	3,018.3	$7,263,954	$2,406.67	0.65822
HCBS, age 65+, with SPMI	1,308.4	$3,354,762	$2,564.11	1,228.7	$4,364,932	$3,552.45	1.38545
HCBS, age 65+, no SPMI	1,062.6	$2,177,516	$2,049.15	1,111.0	$2,250,230	$2,025.45	0.98843
Community, age 65+, with SPMI	1,610.0	$2,540,416	$1,577.89	1,567.4	$3,413,837	$2,178.02	1.38034
Community, age 65+, no SPMI	2,698.5	$3,814,970	$1,413.72	2,510.4	$3,859,603	$1,537.46	1.08753
Facility, age <65, with SPMI	1,046.2	$4,378,083	$4,184.77	1,086.9	$3,421,275	$3,147.74	0.75219
Facility, age <65, no SPMI	480.4	$1,974,955	$4,110.66	489.7	$984,537	$2,010.44	0.48908
HCBS, age <65, with SPMI	922.9	$1,691,201	$1,832.40	932.8	$2,141,736	$2,296.08	1.25305
HCBS, age <65, no SPMI	767.3	$1,406,187	$1,832.73	787.7	$1,402,534	$1,780.61	0.97157
Community, age <65, with SPMI	3,127.8	$6,722,202	$2,149.16	2,832.2	$4,813,093	$1,699.40	0.79073
Community, age <65, no SPMI	2,416.5	$5,128,512	$2,122.31	2,348.2	$6,116,535	$2,604.77	1.22733

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table B.N
Eligible months, incurred claims, and PMPM for the comparison group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 9B

Category of beneficiary	Baseline period			Demonstration Year 8			Trend (D/B)[a]
	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	
Total	**24,226.4**	**$57,824,603**	**$2,386.84**	**23,195.6**	**$47,907,967**	**$2,065.39**	**0.86533**
Facility, age 65+, with SPMI	4,025.3	$13,759,900	$3,418.34	3,850.6	$8,956,076	$2,325.91	0.68042
Facility, age 65+, no SPMI	1,464.2	$4,073,199	$2,781.84	1,511.7	$3,371,658	$2,230.39	0.80177
HCBS, age 65+, with SPMI	739.0	$1,990,809	$2,693.92	716.7	$2,364,184	$3,298.85	1.22455
HCBS, age 65+, no SPMI	675.8	$1,141,910	$1,689.80	644.0	$1,332,925	$2,069.67	1.22480
Community, age 65+, with SPMI	3,366.3	$6,237,040	$1,852.77	3,140.0	$6,228,514	$1,983.61	1.07062
Community, age 65+, no SPMI	3,456.3	$5,547,484	$1,605.05	3,304.9	$4,778,189	$1,445.81	0.90079
Facility, age <65, with SPMI	697.2	$3,106,435	$4,455.36	745.3	$2,996,161	$4,019.87	0.90225
Facility, age <65, no SPMI	424.0	$1,058,325	$2,496.05	414.1	$552,626	$1,334.52	0.53465
HCBS, age <65, with SPMI	813.6	$2,319,548	$2,851.02	747.2	$1,788,071	$2,393.19	0.83942
HCBS, age <65, no SPMI	531.4	$1,465,266	$2,757.60	515.9	$702,624	$1,361.99	0.49390
Community, age <65, with SPMI	5,360.8	$10,191,839	$1,901.19	5,013.9	$8,973,326	$1,789.70	0.94136
Community, age <65, no SPMI	2,672.6	$6,932,849	$2,594.04	2,591.4	$5,863,613	$2,262.70	0.87227

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix C
Eligible Months, Incurred Claims, and PMPM for the Re-weighted Comparison Group and the Intervention Group, Baseline Period, DY7 and DY8

Appendix Table C.A-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 1 Total

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**300,541.1**	**$478,511,235**	**$1,592.17**	**44,233.0**	**$91,965,182**	**$2,079.11**	**1.306**
Facility, age 65+, with SPMI	8,034.5	$16,534,542	$2,057.93	385.9	$1,001,961	$2,596.62	1.262
Facility, age 65+, no SPMI	20,695.7	$35,690,181	$1,724.52	669.2	$1,186,369	$1,772.87	1.028
HCBS, age 65+, with SPMI	12,692.4	$24,055,314	$1,895.25	1,603.3	$3,921,834	$2,446.08	1.291
HCBS, age 65+, no SPMI	57,590.4	$93,564,252	$1,624.65	6,028.0	$15,710,597	$2,606.27	1.604
Community, age 65+, with SPMI	7,196.4	$9,442,825	$1,312.15	958.9	$1,728,143	$1,802.25	1.374
Community, age 65+, no SPMI	54,777.7	$64,461,342	$1,176.78	6,774.8	$11,739,659	$1,732.83	1.473
Facility, age <65, with SPMI	2,328.6	$5,874,283	$2,522.69	382.2	$898,129	$2,350.03	0.932
Facility, age <65, no SPMI	2,819.8	$6,751,321	$2,394.22	432.6	$1,210,278	$2,797.94	1.169
HCBS, age <65, with SPMI	21,022.7	$35,496,599	$1,688.49	4,798.2	$8,306,567	$1,731.19	1.025
HCBS, age <65, no SPMI	40,606.4	$78,915,525	$1,943.43	8,852.6	$21,428,341	$2,420.57	1.246
Community, age <65, with SPMI	29,285.3	$38,589,730	$1,317.72	5,220.0	$7,410,449	$1,419.63	1.077
Community, age <65, no SPMI	43,491.1	$69,135,320	$1,589.64	8,127.4	$17,422,854	$2,143.73	1.349
Intervention group	**300,541.1**	**$484,510,829**	**$1,612.13**	**44,233.0**	**$85,519,305**	**$1,933.38**	**1.199**
Facility, age 65+, with SPMI	8,034.5	$17,576,967	$2,187.68	385.9	$499,975	$1,295.71	0.592
Facility, age 65+, no SPMI	20,695.7	$39,145,639	$1,891.49	669.2	$1,474,303	$2,203.15	1.165
HCBS, age 65+, with SPMI	12,692.4	$24,018,817	$1,892.37	1,603.3	$3,335,372	$2,080.30	1.099
HCBS, age 65+, no SPMI	57,590.4	$90,235,491	$1,566.85	6,028.0	$12,471,899	$2,068.99	1.320
Community, age 65+, with SPMI	7,196.4	$9,895,987	$1,375.13	958.9	$1,474,644	$1,537.88	1.118
Community, age 65+, no SPMI	54,777.7	$66,727,404	$1,218.15	6,774.8	$12,575,900	$1,856.27	1.524
Facility, age <65, with SPMI	2,328.6	$7,974,151	$3,424.47	382.2	$581,810	$1,522.35	0.445
Facility, age <65, no SPMI	2,819.8	$11,926,346	$4,229.44	432.6	$1,134,158	$2,621.97	0.620
HCBS, age <65, with SPMI	21,022.7	$35,119,181	$1,670.54	4,798.2	$7,396,354	$1,541.49	0.923
HCBS, age <65, no SPMI	40,606.4	$72,535,248	$1,786.30	8,852.6	$17,929,731	$2,025.36	1.134
Community, age <65, with SPMI	29,285.3	$37,682,667	$1,286.74	5,220.0	$8,717,849	$1,670.09	1.298
Community, age <65, no SPMI	43,491.1	$71,672,932	$1,647.99	8,127.4	$17,927,309	$2,205.80	1.338

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.A-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 1 Total

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**300,541.1**	**$478,511,235**	**$1,592.17**	**33,362.7**	**$68,085,342**	**$2,040.76**	**1.282**
Facility, age 65+, with SPMI	8,034.5	$16,534,542	$2,057.93	314.4	$573,055	$1,822.90	0.886
Facility, age 65+, no SPMI	20,695.7	$35,690,181	$1,724.52	335.2	$585,734	$1,747.25	1.013
HCBS, age 65+, with SPMI	12,692.4	$24,055,314	$1,895.25	1,115.7	$3,008,202	$2,696.35	1.423
HCBS, age 65+, no SPMI	57,590.4	$93,564,252	$1,624.65	4,128.8	$9,349,908	$2,264.54	1.394
Community, age 65+, with SPMI	7,196.4	$9,442,825	$1,312.15	675.3	$1,187,334	$1,758.36	1.340
Community, age 65+, no SPMI	54,777.7	$64,461,342	$1,176.78	4,691.7	$8,639,130	$1,841.37	1.565
Facility, age <65, with SPMI	2,328.6	$5,874,283	$2,522.69	318.4	$760,447	$2,388.43	0.947
Facility, age <65, no SPMI	2,819.8	$6,751,321	$2,394.22	317.7	$612,214	$1,927.16	0.805
HCBS, age <65, with SPMI	21,022.7	$35,496,599	$1,688.49	3,816.5	$7,470,513	$1,957.44	1.159
HCBS, age <65, no SPMI	40,606.4	$78,915,525	$1,943.43	7,188.6	$17,574,707	$2,444.80	1.258
Community, age <65, with SPMI	29,285.3	$38,589,730	$1,317.72	4,159.6	$6,430,076	$1,545.84	1.173
Community, age <65, no SPMI	43,491.1	$69,135,320	$1,589.64	6,300.9	$11,894,023	$1,887.67	1.187
Intervention group	**300,541.1**	**$484,510,829**	**$1,612.13**	**33,362.7**	**$70,770,085**	**$2,121.24**	**1.316**
Facility, age 65+, with SPMI	8,034.5	$17,576,967	$2,187.68	314.4	$1,124,179	$3,576.03	1.635
Facility, age 65+, no SPMI	20,695.7	$39,145,639	$1,891.49	335.2	$458,224	$1,366.89	0.723
HCBS, age 65+, with SPMI	12,692.4	$24,018,817	$1,892.37	1,115.7	$2,782,442	$2,494.00	1.318
HCBS, age 65+, no SPMI	57,590.4	$90,235,491	$1,566.85	4,128.8	$10,532,372	$2,550.94	1.628
Community, age 65+, with SPMI	7,196.4	$9,895,987	$1,375.13	675.3	$952,906	$1,411.19	1.026
Community, age 65+, no SPMI	54,777.7	$66,727,404	$1,218.15	4,691.7	$10,640,492	$2,267.95	1.862
Facility, age <65, with SPMI	2,328.6	$7,974,151	$3,424.47	318.4	$467,126	$1,467.16	0.428
Facility, age <65, no SPMI	2,819.8	$11,926,346	$4,229.44	317.7	$457,897	$1,441.39	0.341
HCBS, age <65, with SPMI	21,022.7	$35,119,181	$1,670.54	3,816.5	$6,328,547	$1,658.22	0.993
HCBS, age <65, no SPMI	40,606.4	$72,535,248	$1,786.30	7,188.6	$16,597,907	$2,308.91	1.293
Community, age <65, with SPMI	29,285.3	$37,682,667	$1,286.74	4,159.6	$6,890,779	$1,656.59	1.287
Community, age <65, no SPMI	43,491.1	$71,672,932	$1,647.99	6,300.9	$13,537,212	$2,148.46	1.304

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.B-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 1A

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**48,488.0**	**$78,754,198**	**$1,624.20**	**6,312.0**	**$13,566,702**	**$2,149.36**	**1.323**
Facility, age 65+, with SPMI	1,352.5	$2,783,905	$2,058.35	34.0	$88,428	$2,600.82	1.264
Facility, age 65+, no SPMI	2,903.2	$4,986,268	$1,717.53	43.8	$77,770	$1,776.61	1.034
HCBS, age 65+, with SPMI	2,269.5	$4,300,359	$1,894.85	262.2	$638,647	$2,435.29	1.285
HCBS, age 65+, no SPMI	10,415.6	$16,922,467	$1,624.72	939.7	$2,448,081	$2,605.20	1.603
Community, age 65+, with SPMI	1,044.6	$1,366,976	$1,308.56	169.5	$305,386	$1,802.04	1.377
Community, age 65+, no SPMI	8,618.5	$10,152,870	$1,178.03	822.5	$1,423,999	$1,731.30	1.470
Facility, age <65, with SPMI	479.0	$1,208,097	$2,521.97	46.5	$109,139	$2,345.40	0.930
Facility, age <65, no SPMI	596.9	$1,420,117	$2,379.14	104.0	$291,935	$2,806.80	1.180
HCBS, age <65, with SPMI	3,601.9	$6,081,141	$1,688.33	645.5	$1,117,667	$1,731.39	1.026
HCBS, age <65, no SPMI	8,245.1	$16,023,110	$1,943.35	1,622.2	$3,923,872	$2,418.87	1.245
Community, age <65, with SPMI	2,682.4	$3,530,797	$1,316.26	465.8	$661,058	$1,419.06	1.078
Community, age <65, no SPMI	6,278.7	$9,978,092	$1,589.20	1,156.2	$2,480,721	$2,145.59	1.350
Intervention group	**48,488.0**	**$128,622,626**	**$2,652.67**	**6,312.0**	**$16,100,704**	**$2,550.81**	**0.962**
Facility, age 65+, with SPMI	1,352.5	$4,491,706	$3,321.06	34.0	$47,302	$1,391.25	0.419
Facility, age 65+, no SPMI	2,903.2	$7,189,174	$2,476.33	43.8	$46,304	$1,057.79	0.427
HCBS, age 65+, with SPMI	2,269.5	$6,589,879	$2,903.67	262.2	$414,377	$1,580.11	0.544
HCBS, age 65+, no SPMI	10,415.6	$24,885,794	$2,389.27	939.7	$2,513,043	$2,674.33	1.119
Community, age 65+, with SPMI	1,044.6	$2,160,270	$2,067.95	169.5	$152,234	$898.31	0.434
Community, age 65+, no SPMI	8,618.5	$18,306,257	$2,124.06	822.5	$1,838,907	$2,235.75	1.053
Facility, age <65, with SPMI	479.0	$2,542,110	$5,306.80	46.5	$83,135	$1,786.56	0.337
Facility, age <65, no SPMI	596.9	$2,844,227	$4,764.97	104.0	$163,278	$1,569.84	0.329
HCBS, age <65, with SPMI	3,601.9	$10,014,768	$2,780.44	645.5	$1,471,513	$2,279.54	0.820
HCBS, age <65, no SPMI	8,245.1	$22,193,360	$2,691.70	1,622.2	$4,617,372	$2,846.38	1.057
Community, age <65, with SPMI	2,682.4	$6,561,637	$2,446.14	465.8	$1,240,523	$2,662.97	1.089
Community, age <65, no SPMI	6,278.7	$20,843,442	$3,319.71	1,156.2	$3,512,715	$3,038.17	0.915

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.B-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 1A

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**48,488.0**	**$78,754,198**	**$1,624.20**	**4,120.8**	**$8,728,066**	**$2,118.07**	**1.304**
Facility, age 65+, with SPMI	1,352.5	$2,783,905	$2,058.35	16.3	$29,913	$1,832.60	0.890
Facility, age 65+, no SPMI	2,903.2	$4,986,268	$1,717.53	12.0	$20,958	$1,746.50	1.017
HCBS, age 65+, with SPMI	2,269.5	$4,300,359	$1,894.85	147.4	$395,246	$2,682.23	1.416
HCBS, age 65+, no SPMI	10,415.6	$16,922,467	$1,624.72	587.1	$1,327,889	$2,261.70	1.392
Community, age 65+, with SPMI	1,044.6	$1,366,976	$1,308.56	104.6	$187,629	$1,793.81	1.371
Community, age 65+, no SPMI	8,618.5	$10,152,870	$1,178.03	488.5	$900,509	$1,843.34	1.565
Facility, age <65, with SPMI	479.0	$1,208,097	$2,521.97	25.0	$58,674	$2,346.96	0.931
Facility, age <65, no SPMI	596.9	$1,420,117	$2,379.14	67.6	$129,513	$1,914.59	0.805
HCBS, age <65, with SPMI	3,601.9	$6,081,141	$1,688.33	448.5	$878,895	$1,959.84	1.161
HCBS, age <65, no SPMI	8,245.1	$16,023,110	$1,943.35	1,224.0	$2,994,129	$2,446.12	1.259
Community, age <65, with SPMI	2,682.4	$3,530,797	$1,316.26	247.0	$381,547	$1,544.72	1.174
Community, age <65, no SPMI	6,278.7	$9,978,092	$1,589.20	752.7	$1,423,164	$1,890.72	1.190
Intervention group	**48,488.0**	**$128,622,626**	**$2,652.67**	**4,120.8**	**$9,883,388**	**$2,398.44**	**0.904**
Facility, age 65+, with SPMI	1,352.5	$4,491,706	$3,321.06	16.3	$11,579	$709.40	0.214
Facility, age 65+, no SPMI	2,903.2	$7,189,174	$2,476.33	12.0	$5,681	$473.40	0.191
HCBS, age 65+, with SPMI	2,269.5	$6,589,879	$2,903.67	147.4	$318,059	$2,158.42	0.743
HCBS, age 65+, no SPMI	10,415.6	$24,885,794	$2,389.27	587.1	$1,694,078	$2,885.40	1.208
Community, age 65+, with SPMI	1,044.6	$2,160,270	$2,067.95	104.6	$213,167	$2,037.97	0.986
Community, age 65+, no SPMI	8,618.5	$18,306,257	$2,124.06	488.5	$1,209,129	$2,475.08	1.165
Facility, age <65, with SPMI	479.0	$2,542,110	$5,306.80	25.0	$49,817	$1,992.70	0.375
Facility, age <65, no SPMI	596.9	$2,844,227	$4,764.97	67.6	$166,245	$2,457.60	0.516
HCBS, age <65, with SPMI	3,601.9	$10,014,768	$2,780.44	448.5	$813,935	$1,814.99	0.653
HCBS, age <65, no SPMI	8,245.1	$22,193,360	$2,691.70	1,224.0	$3,118,993	$2,548.13	0.947
Community, age <65, with SPMI	2,682.4	$6,561,637	$2,446.14	247.0	$270,880	$1,096.68	0.448
Community, age <65, no SPMI	6,278.7	$20,843,442	$3,319.71	752.7	$2,011,823	$2,672.77	0.805

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.C-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 1B

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**83,567.1**	**$131,605,106**	**$1,574.84**	**12,573.7**	**$26,040,550**	**$2,071.04**	**1.315**
Facility, age 65+, with SPMI	2,625.5	$5,399,392	$2,056.49	209.0	$541,889	$2,592.77	1.261
Facility, age 65+, no SPMI	5,728.2	$9,863,362	$1,721.89	202.3	$359,401	$1,776.24	1.032
HCBS, age 65+, with SPMI	3,563.5	$6,749,830	$1,894.18	472.8	$1,154,469	$2,441.55	1.289
HCBS, age 65+, no SPMI	15,666.1	$25,409,746	$1,621.96	1,971.2	$5,138,669	$2,606.85	1.607
Community, age 65+, with SPMI	2,079.3	$2,725,280	$1,310.68	251.1	$451,632	$1,798.32	1.372
Community, age 65+, no SPMI	16,756.0	$19,691,126	$1,175.17	2,275.5	$3,942,266	$1,732.51	1.474
Facility, age <65, with SPMI	707.2	$1,783,893	$2,522.57	159.6	$372,179	$2,331.29	0.924
Facility, age <65, no SPMI	436.0	$1,056,112	$2,422.27	91.8	$254,983	$2,777.80	1.147
HCBS, age <65, with SPMI	6,710.7	$11,329,713	$1,688.31	1,614.2	$2,792,237	$1,729.75	1.025
HCBS, age <65, no SPMI	9,528.3	$18,510,143	$1,942.64	2,068.5	$5,007,021	$2,420.55	1.246
Community, age <65, with SPMI	8,555.1	$11,262,998	$1,316.53	1,324.6	$1,880,120	$1,419.39	1.078
Community, age <65, no SPMI	11,211.2	$17,823,513	$1,589.79	1,932.8	$4,145,684	$2,144.89	1.349
Intervention group	**83,567.1**	**$108,476,913**	**$1,298.08**	**12,573.7**	**$22,253,570**	**$1,769.86**	**1.363**
Facility, age 65+, with SPMI	2,625.5	$4,153,377	$1,581.91	209.0	$189,963	$908.91	0.575
Facility, age 65+, no SPMI	5,728.2	$9,679,939	$1,689.87	202.3	$468,413	$2,315.00	1.370
HCBS, age 65+, with SPMI	3,563.5	$5,032,372	$1,412.22	472.8	$969,912	$2,051.24	1.452
HCBS, age 65+, no SPMI	15,666.1	$18,456,030	$1,178.09	1,971.2	$3,463,060	$1,756.81	1.491
Community, age 65+, with SPMI	2,079.3	$2,370,627	$1,140.11	251.1	$342,802	$1,364.98	1.197
Community, age 65+, no SPMI	16,756.0	$16,271,631	$971.09	2,275.5	$4,237,401	$1,862.21	1.918
Facility, age <65, with SPMI	707.2	$2,294,483	$3,244.58	159.6	$195,782	$1,226.36	0.378
Facility, age <65, no SPMI	436.0	$1,627,921	$3,733.76	91.8	$149,743	$1,631.31	0.437
HCBS, age <65, with SPMI	6,710.7	$9,300,631	$1,385.95	1,614.2	$2,110,054	$1,307.15	0.943
HCBS, age <65, no SPMI	9,528.3	$14,182,694	$1,488.47	2,068.5	$3,891,024	$1,881.04	1.264
Community, age <65, with SPMI	8,555.1	$9,515,214	$1,112.23	1,324.6	$2,156,685	$1,628.18	1.464
Community, age <65, no SPMI	11,211.2	$15,591,994	$1,390.75	1,932.8	$4,078,733	$2,110.25	1.517

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.C-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 1B

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**83,567.1**	**$131,605,106**	**$1,574.84**	**8,903.3**	**$18,058,292**	**$2,028.28**	**1.288**
Facility, age 65+, with SPMI	2,625.5	$5,399,392	$2,056.49	195.2	$356,429	$1,825.52	0.888
Facility, age 65+, no SPMI	5,728.2	$9,863,362	$1,721.89	117.2	$206,675	$1,764.02	1.024
HCBS, age 65+, with SPMI	3,563.5	$6,749,830	$1,894.18	248.0	$669,205	$2,698.65	1.425
HCBS, age 65+, no SPMI	15,666.1	$25,409,746	$1,621.96	1,259.6	$2,848,493	$2,261.41	1.394
Community, age 65+, with SPMI	2,079.3	$2,725,280	$1,310.68	163.7	$284,448	$1,737.51	1.326
Community, age 65+, no SPMI	16,756.0	$19,691,126	$1,175.17	1,564.5	$2,880,007	$1,840.85	1.566
Facility, age <65, with SPMI	707.2	$1,783,893	$2,522.57	130.3	$311,525	$2,390.42	0.948
Facility, age <65, no SPMI	436.0	$1,056,112	$2,422.27	65.0	$125,568	$1,931.82	0.798
HCBS, age <65, with SPMI	6,710.7	$11,329,713	$1,688.31	1,213.8	$2,375,425	$1,956.94	1.159
HCBS, age <65, no SPMI	9,528.3	$18,510,143	$1,942.64	1,565.9	$3,830,794	$2,446.33	1.259
Community, age <65, with SPMI	8,555.1	$11,262,998	$1,316.53	932.9	$1,441,863	$1,545.62	1.174
Community, age <65, no SPMI	11,211.2	$17,823,513	$1,589.79	1,447.1	$2,727,860	$1,885.07	1.186
Intervention group	**83,567.1**	**$108,476,913**	**$1,298.08**	**8,903.3**	**$16,575,067**	**$1,861.68**	**1.434**
Facility, age 65+, with SPMI	2,625.5	$4,153,377	$1,581.91	195.2	$783,246	$4,011.55	2.536
Facility, age 65+, no SPMI	5,728.2	$9,679,939	$1,689.87	117.2	$145,473	$1,241.65	0.735
HCBS, age 65+, with SPMI	3,563.5	$5,032,372	$1,412.22	248.0	$453,136	$1,827.33	1.294
HCBS, age 65+, no SPMI	15,666.1	$18,456,030	$1,178.09	1,259.6	$2,955,687	$2,346.51	1.992
Community, age 65+, with SPMI	2,079.3	$2,370,627	$1,140.11	163.7	$302,034	$1,844.94	1.618
Community, age 65+, no SPMI	16,756.0	$16,271,631	$971.09	1,564.5	$3,130,956	$2,001.26	2.061
Facility, age <65, with SPMI	707.2	$2,294,483	$3,244.58	130.3	$170,282	$1,306.62	0.403
Facility, age <65, no SPMI	436.0	$1,627,921	$3,733.76	65.0	$37,197	$572.25	0.153
HCBS, age <65, with SPMI	6,710.7	$9,300,631	$1,385.95	1,213.8	$1,647,008	$1,356.85	0.979
HCBS, age <65, no SPMI	9,528.3	$14,182,694	$1,488.47	1,565.9	$3,168,936	$2,023.67	1.360
Community, age <65, with SPMI	8,555.1	$9,515,214	$1,112.23	932.9	$1,419,867	$1,522.04	1.368
Community, age <65, no SPMI	11,211.2	$15,591,994	$1,390.75	1,447.1	$2,361,245	$1,631.72	1.173

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.D-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 1C

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**7,946.8**	**$12,115,020**	**$1,524.51**	**969.2**	**$1,966,093**	**$2,028.50**	**1.331**
Facility, age 65+, with SPMI	78.0	$162,290	$2,080.64	5.9	$14,417	$2,442.17	1.174
Facility, age 65+, no SPMI	509.6	$883,213	$1,733.25	12.0	$21,389	$1,782.38	1.028
HCBS, age 65+, with SPMI	415.4	$787,714	$1,896.19	59.0	$145,625	$2,468.23	1.302
HCBS, age 65+, no SPMI	1,567.7	$2,541,768	$1,621.34	151.3	$395,290	$2,611.92	1.611
Community, age 65+, with SPMI	286.6	$380,569	$1,327.67	73.2	$133,016	$1,818.12	1.369
Community, age 65+, no SPMI	2,225.3	$2,627,533	$1,180.74	142.8	$246,662	$1,727.59	1.463
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	$66,590	$2,774.58	1.043
HCBS, age <65, with SPMI	422.7	$715,949	$1,693.58	101.0	$173,806	$1,720.85	1.016
HCBS, age <65, no SPMI	710.1	$1,381,750	$1,945.94	110.5	$264,926	$2,397.52	1.232
Community, age <65, with SPMI	731.4	$963,007	$1,316.70	156.3	$222,501	$1,423.64	1.081
Community, age <65, no SPMI	924.0	$1,476,169	$1,597.59	133.3	$281,871	$2,115.16	1.324
Intervention group	**7,946.8**	**$7,898,710**	**$993.94**	**969.2**	**$1,612,730**	**$1,663.92**	**1.674**
Facility, age 65+, with SPMI	78.0	$190,149	$2,437.80	5.9	$7,282	$1,233.50	0.506
Facility, age 65+, no SPMI	509.6	$823,008	$1,615.10	12.0	$8,846	$737.19	0.456
HCBS, age 65+, with SPMI	415.4	$406,330	$978.12	59.0	$126,082	$2,136.98	2.185
HCBS, age 65+, no SPMI	1,567.7	$1,419,597	$905.53	151.3	$234,959	$1,552.52	1.714
Community, age 65+, with SPMI	286.6	$432,595	$1,509.16	73.2	$84,754	$1,158.45	0.768
Community, age 65+, no SPMI	2,225.3	$1,691,547	$760.14	142.8	$275,978	$1,932.91	2.543
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	$64,331	$2,680.48	0.267
HCBS, age <65, with SPMI	422.7	$312,759	$739.84	101.0	$51,286	$507.79	0.686
HCBS, age <65, no SPMI	710.1	$625,225	$880.51	110.5	$242,848	$2,197.72	2.496
Community, age <65, with SPMI	731.4	$608,832	$832.44	156.3	$230,508	$1,474.87	1.772
Community, age <65, no SPMI	924.0	$936,659	$1,013.70	133.3	$285,855	$2,145.06	2.116

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.D-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 1C

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**7,946.8**	**$12,115,020**	**$1,524.51**	**667.3**	**$1,330,602**	**$1,994.01**	**1.308**
Facility, age 65+, with SPMI	78.0	$162,290	$2,080.64	0.0	$0	$0.00	0.000
Facility, age 65+, no SPMI	509.6	$883,213	$1,733.25	12.0	$20,958	$1,746.50	1.008
HCBS, age 65+, with SPMI	415.4	$787,714	$1,896.19	47.6	$128,043	$2,689.26	1.418
HCBS, age 65+, no SPMI	1,567.7	$2,541,768	$1,621.34	116.4	$263,888	$2,266.70	1.398
Community, age 65+, with SPMI	286.6	$380,569	$1,327.67	39.0	$69,578	$1,784.04	1.344
Community, age 65+, no SPMI	2,225.3	$2,627,533	$1,180.74	105.5	$194,775	$1,845.63	1.563
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	$46,472	$1,936.35	0.728
HCBS, age <65, with SPMI	422.7	$715,949	$1,693.58	62.0	$120,475	$1,943.15	1.147
HCBS, age <65, no SPMI	710.1	$1,381,750	$1,945.94	65.0	$159,000	$2,446.16	1.257
Community, age <65, with SPMI	731.4	$963,007	$1,316.70	119.8	$184,509	$1,540.06	1.170
Community, age <65, no SPMI	924.0	$1,476,169	$1,597.59	75.9	$142,903	$1,882.07	1.178
Intervention group	**7,946.8**	**$7,898,710**	**$993.94**	**667.3**	**$1,196,820**	**$1,793.52**	**1.804**
Facility, age 65+, with SPMI	78.0	$190,149	$2,437.80	0.0	$0	$0.00	0.000
Facility, age 65+, no SPMI	509.6	$823,008	$1,615.10	12.0	$33,048	$2,754.00	1.705
HCBS, age 65+, with SPMI	415.4	$406,330	$978.12	47.6	$54,989	$1,154.92	1.181
HCBS, age 65+, no SPMI	1,567.7	$1,419,597	$905.53	116.4	$244,324	$2,098.65	2.318
Community, age 65+, with SPMI	286.6	$432,595	$1,509.16	39.0	$50,443	$1,293.41	0.857
Community, age 65+, no SPMI	2,225.3	$1,691,547	$760.14	105.5	$215,869	$2,045.51	2.691
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	$25,407	$1,058.61	0.105
HCBS, age <65, with SPMI	422.7	$312,759	$739.84	62.0	$62,657	$1,010.60	1.366
HCBS, age <65, no SPMI	710.1	$625,225	$880.51	65.0	$239,831	$3,689.71	4.190
Community, age <65, with SPMI	731.4	$608,832	$832.44	119.8	$130,810	$1,091.84	1.312
Community, age <65, no SPMI	924.0	$936,659	$1,013.70	75.9	$139,443	$1,836.50	1.812

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.E-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 1D

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**129,399.2**	**$207,882,769**	**$1,606.52**	**19,395.0**	**$40,321,445**	**$2,078.96**	**1.294**
Facility, age 65+, with SPMI	3,449.1	$7,099,156	$2,058.27	129.8	$338,365	$2,607.34	1.267
Facility, age 65+, no SPMI	9,573.0	$16,530,797	$1,726.81	358.8	$635,324	$1,770.66	1.025
HCBS, age 65+, with SPMI	5,666.9	$10,738,746	$1,895.01	738.5	$1,811,937	$2,453.40	1.295
HCBS, age 65+, no SPMI	24,215.1	$39,358,354	$1,625.36	2,437.8	$6,350,362	$2,605.00	1.603
Community, age 65+, with SPMI	2,995.7	$3,929,249	$1,311.61	345.1	$621,144	$1,799.84	1.372
Community, age 65+, no SPMI	19,735.0	$23,217,237	$1,176.45	2,452.2	$4,248,242	$1,732.40	1.473
Facility, age <65, with SPMI	850.9	$2,145,788	$2,521.68	107.0	$252,045	$2,355.56	0.934
Facility, age <65, no SPMI	1,455.9	$3,482,455	$2,391.90	153.3	$429,460	$2,801.62	1.171
HCBS, age <65, with SPMI	8,850.4	$14,942,652	$1,688.37	1,984.0	$3,437,549	$1,732.63	1.026
HCBS, age <65, no SPMI	18,671.7	$36,297,579	$1,943.99	4,186.6	$10,134,514	$2,420.71	1.245
Community, age <65, with SPMI	13,939.8	$18,378,011	$1,318.39	2,596.3	$3,686,644	$1,419.99	1.077
Community, age <65, no SPMI	19,995.6	$31,762,746	$1,588.48	3,905.7	$8,375,859	$2,144.53	1.350
Intervention group	**129,399.2**	**$219,493,469**	**$1,696.25**	**19,395.0**	**$39,492,807**	**$2,036.23**	**1.200**
Facility, age 65+, with SPMI	3,449.1	$8,089,951	$2,345.53	129.8	$255,018	$1,965.09	0.838
Facility, age 65+, no SPMI	9,573.0	$19,529,844	$2,040.09	358.8	$807,482	$2,250.47	1.103
HCBS, age 65+, with SPMI	5,666.9	$11,401,735	$2,012.00	738.5	$1,652,948	$2,238.13	1.112
HCBS, age 65+, no SPMI	24,215.1	$41,155,717	$1,699.59	2,437.8	$5,590,653	$2,293.36	1.349
Community, age 65+, with SPMI	2,995.7	$4,345,812	$1,450.66	345.1	$808,789	$2,343.57	1.616
Community, age 65+, no SPMI	19,735.0	$26,698,339	$1,352.84	2,452.2	$4,797,432	$1,956.35	1.446
Facility, age <65, with SPMI	850.9	$2,783,711	$3,271.35	107.0	$215,692	$2,015.82	0.616
Facility, age <65, no SPMI	1,455.9	$6,939,015	$4,766.02	153.3	$641,196	$4,182.89	0.878
HCBS, age <65, with SPMI	8,850.4	$14,556,363	$1,644.72	1,984.0	$3,341,972	$1,684.46	1.024
HCBS, age <65, no SPMI	18,671.7	$33,932,964	$1,817.35	4,186.6	$8,278,986	$1,977.50	1.088
Community, age <65, with SPMI	13,939.8	$18,504,005	$1,327.43	2,596.3	$4,231,073	$1,629.69	1.228
Community, age <65, no SPMI	19,995.6	$31,556,013	$1,578.14	3,905.7	$8,871,565	$2,271.45	1.439

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.E-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 1D

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**129,399.2**	**$207,882,769**	**$1,606.52**	**15,679.6**	**$32,017,466**	**$2,041.98**	**1.271**
Facility, age 65+, with SPMI	3,449.1	$7,099,156	$2,058.27	102.8	$186,713	$1,816.37	0.882
Facility, age 65+, no SPMI	9,573.0	$16,530,797	$1,726.81	170.1	$295,227	$1,735.91	1.005
HCBS, age 65+, with SPMI	5,666.9	$10,738,746	$1,895.01	624.7	$1,687,088	$2,700.60	1.425
HCBS, age 65+, no SPMI	24,215.1	$39,358,354	$1,625.36	1,805.9	$4,092,272	$2,266.02	1.394
Community, age 65+, with SPMI	2,995.7	$3,929,249	$1,311.61	273.3	$478,229	$1,749.64	1.334
Community, age 65+, no SPMI	19,735.0	$23,217,237	$1,176.45	1,798.4	$3,312,255	$1,841.76	1.566
Facility, age <65, with SPMI	850.9	$2,145,788	$2,521.68	98.0	$234,354	$2,391.37	0.948
Facility, age <65, no SPMI	1,455.9	$3,482,455	$2,391.90	114.0	$219,683	$1,927.04	0.806
HCBS, age <65, with SPMI	8,850.4	$14,942,652	$1,688.37	1,685.0	$3,297,337	$1,956.87	1.159
HCBS, age <65, no SPMI	18,671.7	$36,297,579	$1,943.99	3,571.4	$8,724,705	$2,442.96	1.257
Community, age <65, with SPMI	13,939.8	$18,378,011	$1,318.39	2,259.9	$3,494,063	$1,546.13	1.173
Community, age <65, no SPMI	19,995.6	$31,762,746	$1,588.48	3,176.1	$5,995,540	$1,887.72	1.188
Intervention group	**129,399.2**	**$219,493,469**	**$1,696.25**	**15,679.6**	**$37,041,674**	**$2,362.41**	**1.393**
Facility, age 65+, with SPMI	3,449.1	$8,089,951	$2,345.53	102.8	$329,354	$3,204.00	1.366
Facility, age 65+, no SPMI	9,573.0	$19,529,844	$2,040.09	170.1	$261,171	$1,535.66	0.753
HCBS, age 65+, with SPMI	5,666.9	$11,401,735	$2,012.00	624.7	$1,936,849	$3,100.40	1.541
HCBS, age 65+, no SPMI	24,215.1	$41,155,717	$1,699.59	1,805.9	$5,109,757	$2,829.43	1.665
Community, age 65+, with SPMI	2,995.7	$4,345,812	$1,450.66	273.3	$267,893	$980.11	0.676
Community, age 65+, no SPMI	19,735.0	$26,698,339	$1,352.84	1,798.4	$4,771,915	$2,653.39	1.961
Facility, age <65, with SPMI	850.9	$2,783,711	$3,271.35	98.0	$107,895	$1,100.97	0.337
Facility, age <65, no SPMI	1,455.9	$6,939,015	$4,766.02	114.0	$185,358	$1,625.95	0.341
HCBS, age <65, with SPMI	8,850.4	$14,556,363	$1,644.72	1,685.0	$3,389,242	$2,011.41	1.223
HCBS, age <65, no SPMI	18,671.7	$33,932,964	$1,817.35	3,571.4	$8,291,434	$2,321.64	1.277
Community, age <65, with SPMI	13,939.8	$18,504,005	$1,327.43	2,259.9	$4,328,703	$1,915.47	1.443
Community, age <65, no SPMI	19,995.6	$31,556,013	$1,578.14	3,176.1	$8,062,102	$2,538.38	1.608

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.F-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 1E

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**15,153.3**	**$23,465,894**	**$1,548.56**	**2,361.3**	**$4,736,181**	**$2,005.71**	**1.295**
Facility, age 65+, with SPMI	279.0	$573,525	$2,055.64	0.0	$0	$0.00	0.000
Facility, age 65+, no SPMI	1,143.7	$1,980,257	$1,731.43	38.9	$68,579	$1,761.19	1.017
HCBS, age 65+, with SPMI	297.0	$563,184	$1,896.24	17.3	$41,288	$2,386.60	1.259
HCBS, age 65+, no SPMI	3,090.8	$5,031,005	$1,627.75	258.8	$676,192	$2,613.01	1.605
Community, age 65+, with SPMI	352.0	$462,917	$1,315.11	49.0	$88,452	$1,805.14	1.373
Community, age 65+, no SPMI	3,588.7	$4,220,750	$1,176.13	491.0	$853,680	$1,738.54	1.478
Facility, age <65, with SPMI	137.2	$347,384	$2,531.06	34.0	$82,067	$2,413.73	0.954
Facility, age <65, no SPMI	211.0	$502,282	$2,380.48	36.0	$99,885	$2,774.58	1.166
HCBS, age <65, with SPMI	755.0	$1,273,188	$1,686.34	240.0	$416,051	$1,733.55	1.028
HCBS, age <65, no SPMI	1,481.9	$2,878,416	$1,942.35	397.3	$964,402	$2,427.39	1.250
Community, age <65, with SPMI	1,654.5	$2,183,008	$1,319.43	372.0	$527,826	$1,418.89	1.075
Community, age <65, no SPMI	2,162.5	$3,449,978	$1,595.37	427.0	$917,760	$2,149.32	1.347
Intervention group	**15,153.3**	**$10,288,068**	**$678.93**	**2,361.3**	**$3,030,212**	**$1,283.25**	**1.890**
Facility, age 65+, with SPMI	279.0	$340,940	$1,222.01	0.0	$0	$0.00	0.000
Facility, age 65+, no SPMI	1,143.7	$983,611	$860.02	38.9	$102,305	$2,627.34	3.055
HCBS, age 65+, with SPMI	297.0	$202,815	$682.88	17.3	$27,217	$1,573.25	2.304
HCBS, age 65+, no SPMI	3,090.8	$2,497,709	$808.12	258.8	$335,979	$1,298.33	1.607
Community, age 65+, with SPMI	352.0	$271,496	$771.30	49.0	$10,460	$213.47	0.277
Community, age 65+, no SPMI	3,588.7	$1,918,612	$534.63	491.0	$686,783	$1,398.65	2.616
Facility, age <65, with SPMI	137.2	$57,996	$422.56	34.0	$47,553	$1,398.63	3.310
Facility, age <65, no SPMI	211.0	$260,623	$1,235.18	36.0	$55,616	$1,544.89	1.251
HCBS, age <65, with SPMI	755.0	$439,693	$582.37	240.0	$137,243	$571.84	0.982
HCBS, age <65, no SPMI	1,481.9	$849,446	$573.21	397.3	$530,173	$1,334.44	2.328
Community, age <65, with SPMI	1,654.5	$1,149,973	$695.05	372.0	$467,678	$1,257.20	1.809
Community, age <65, no SPMI	2,162.5	$1,315,153	$608.17	427.0	$629,204	$1,473.55	2.423

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.F-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 1E

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**15,153.3**	**$23,465,894**	**$1,548.56**	**1,891.7**	**$3,748,511**	**$1,981.53**	**1.280**
Facility, age 65+, with SPMI	279.0	$573,525	$2,055.64	0.0	$0	$0.00	0.000
Facility, age 65+, no SPMI	1,143.7	$1,980,257	$1,731.43	12.0	$20,958	$1,746.50	1.009
HCBS, age 65+, with SPMI	297.0	$563,184	$1,896.24	12.0	$32,155	$2,679.58	1.413
HCBS, age 65+, no SPMI	3,090.8	$5,031,005	$1,627.75	167.5	$380,846	$2,273.25	1.397
Community, age 65+, with SPMI	352.0	$462,917	$1,315.11	42.1	$74,713	$1,773.42	1.349
Community, age 65+, no SPMI	3,588.7	$4,220,750	$1,176.13	322.0	$592,133	$1,838.67	1.563
Facility, age <65, with SPMI	137.2	$347,384	$2,531.06	31.9	$76,757	$2,405.93	0.951
Facility, age <65, no SPMI	211.0	$502,282	$2,380.48	26.0	$49,936	$1,918.25	0.806
HCBS, age <65, with SPMI	755.0	$1,273,188	$1,686.34	221.9	$434,147	$1,956.20	1.160
HCBS, age <65, no SPMI	1,481.9	$2,878,416	$1,942.35	349.5	$855,442	$2,447.73	1.260
Community, age <65, with SPMI	1,654.5	$2,183,008	$1,319.43	302.1	$467,473	$1,547.59	1.173
Community, age <65, no SPMI	2,162.5	$3,449,978	$1,595.37	404.6	$763,952	$1,888.17	1.184
Intervention group	**15,153.3**	**$10,288,068**	**$678.93**	**1,891.7**	**$3,182,060**	**$1,682.09**	**2.478**
Facility, age 65+, with SPMI	279.0	$340,940	$1,222.01	0.0	$0	$0.00	0.000
Facility, age 65+, no SPMI	1,143.7	$983,611	$860.02	12.0	$6,959	$579.95	0.674
HCBS, age 65+, with SPMI	297.0	$202,815	$682.88	12.0	$4,607	$383.88	0.562
HCBS, age 65+, no SPMI	3,090.8	$2,497,709	$808.12	167.5	$377,370	$2,252.51	2.787
Community, age 65+, with SPMI	352.0	$271,496	$771.30	42.1	$10,638	$252.51	0.327
Community, age 65+, no SPMI	3,588.7	$1,918,612	$534.63	322.0	$523,731	$1,626.26	3.042
Facility, age <65, with SPMI	137.2	$57,996	$422.56	31.9	$67,616	$2,119.41	5.016
Facility, age <65, no SPMI	211.0	$260,623	$1,235.18	26.0	$6,815	$261.79	0.212
HCBS, age <65, with SPMI	755.0	$439,693	$582.37	221.9	$203,957	$919.00	1.578
HCBS, age <65, no SPMI	1,481.9	$849,446	$573.21	349.5	$1,044,422	$2,988.47	5.214
Community, age <65, with SPMI	1,654.5	$1,149,973	$695.05	302.1	$339,092	$1,122.58	1.615
Community, age <65, no SPMI	2,162.5	$1,315,153	$608.17	404.6	$596,853	$1,475.17	2.426

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.G-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 1F

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**15,986.6**	**$24,688,247**	**$1,544.31**	**2,621.7**	**$5,334,212**	**$2,034.63**	**1.318**
Facility, age 65+, with SPMI	250.4	$516,275	$2,061.64	7.2	$18,862	$2,622.13	1.272
Facility, age 65+, no SPMI	838.0	$1,446,285	$1,725.88	13.3	$23,907	$1,794.46	1.040
HCBS, age 65+, with SPMI	480.2	$915,481	$1,906.48	53.4	$129,867	$2,432.56	1.276
HCBS, age 65+, no SPMI	2,635.0	$4,300,912	$1,632.22	269.2	$702,004	$2,607.58	1.598
Community, age 65+, with SPMI	438.1	$577,833	$1,318.94	71.0	$128,514	$1,810.05	1.372
Community, age 65+, no SPMI	3,854.1	$4,551,826	$1,181.02	590.8	$1,024,809	$1,734.56	1.469
Facility, age <65, with SPMI	99.2	$249,940	$2,519.72	35.0	$82,699	$2,362.83	0.938
Facility, age <65, no SPMI	99.0	$234,480	$2,368.48	23.5	$67,425	$2,873.24	1.213
HCBS, age <65, with SPMI	682.0	$1,153,956	$1,691.97	213.4	$369,258	$1,730.22	1.023
HCBS, age <65, no SPMI	1,969.2	$3,824,528	$1,942.14	467.5	$1,133,606	$2,424.91	1.249
Community, age <65, with SPMI	1,722.2	$2,271,910	$1,319.22	305.0	$432,301	$1,417.38	1.074
Community, age <65, no SPMI	2,919.1	$4,644,822	$1,591.19	572.4	$1,220,959	$2,133.04	1.341
Intervention group	**15,986.6**	**$9,731,043**	**$608.70**	**2,621.7**	**$3,029,282**	**$1,155.46**	**1.898**
Facility, age 65+, with SPMI	250.4	$310,844	$1,241.30	7.2	$410	$57.02	0.046
Facility, age 65+, no SPMI	838.0	$940,063	$1,121.79	13.3	$40,953	$3,073.94	2.740
HCBS, age 65+, with SPMI	480.2	$385,684	$803.19	53.4	$144,837	$2,712.95	3.378
HCBS, age 65+, no SPMI	2,635.0	$1,820,644	$690.94	269.2	$334,205	$1,241.39	1.797
Community, age 65+, with SPMI	438.1	$315,186	$719.43	71.0	$75,604	$1,064.85	1.480
Community, age 65+, no SPMI	3,854.1	$1,841,018	$477.67	590.8	$739,398	$1,251.48	2.620
Facility, age <65, with SPMI	99.2	$54,697	$551.42	35.0	$39,647	$1,132.78	2.054
Facility, age <65, no SPMI	99.0	$43,706	$441.48	23.5	$59,994	$2,556.57	5.791
HCBS, age <65, with SPMI	682.0	$494,966	$725.74	213.4	$284,285	$1,332.06	1.835
HCBS, age <65, no SPMI	1,969.2	$751,558	$381.65	467.5	$369,328	$790.04	2.070
Community, age <65, with SPMI	1,722.2	$1,343,004	$779.84	305.0	$391,383	$1,283.22	1.646
Community, age <65, no SPMI	2,919.1	$1,429,671	$489.77	572.4	$549,237	$959.53	1.959

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.G-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 1F

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**15,986.6**	**$24,688,247**	**$1,544.31**	**2,100.0**	**$4,202,405**	**$2,001.12**	**1.296**
Facility, age 65+, with SPMI	250.4	$516,275	$2,061.64	0.0	$0	$0.00	0.000
Facility, age 65+, no SPMI	838.0	$1,446,285	$1,725.88	12.0	$20,958	$1,746.50	1.012
HCBS, age 65+, with SPMI	480.2	$915,481	$1,906.48	36.0	$96,465	$2,679.58	1.406
HCBS, age 65+, no SPMI	2,635.0	$4,300,912	$1,632.22	192.2	$436,521	$2,271.05	1.391
Community, age 65+, with SPMI	438.1	$577,833	$1,318.94	52.5	$92,738	$1,766.99	1.340
Community, age 65+, no SPMI	3,854.1	$4,551,826	$1,181.02	412.7	$759,450	$1,840.38	1.558
Facility, age <65, with SPMI	99.2	$249,940	$2,519.72	33.2	$79,136	$2,386.40	0.947
Facility, age <65, no SPMI	99.0	$234,480	$2,368.48	21.0	$41,042	$1,954.36	0.825
HCBS, age <65, with SPMI	682.0	$1,153,956	$1,691.97	185.2	$364,234	$1,966.43	1.162
HCBS, age <65, no SPMI	1,969.2	$3,824,528	$1,942.14	412.8	$1,010,637	$2,448.26	1.261
Community, age <65, with SPMI	1,722.2	$2,271,910	$1,319.22	298.0	$460,622	$1,545.71	1.172
Community, age <65, no SPMI	2,919.1	$4,644,822	$1,591.19	444.5	$840,603	$1,891.18	1.189
Intervention group	**15,986.6**	**$9,731,043**	**$608.70**	**2,100.0**	**$2,891,075**	**$1,376.69**	**2.262**
Facility, age 65+, with SPMI	250.4	$310,844	$1,241.30	0.0	$0	$0.00	0.000
Facility, age 65+, no SPMI	838.0	$940,063	$1,121.79	12.0	$5,892	$490.96	0.438
HCBS, age 65+, with SPMI	480.2	$385,684	$803.19	36.0	$14,803	$411.20	0.512
HCBS, age 65+, no SPMI	2,635.0	$1,820,644	$690.94	192.2	$151,156	$786.41	1.138
Community, age 65+, with SPMI	438.1	$315,186	$719.43	52.5	$108,730	$2,071.68	2.880
Community, age 65+, no SPMI	3,854.1	$1,841,018	$477.67	412.7	$788,891	$1,911.72	4.002
Facility, age <65, with SPMI	99.2	$54,697	$551.42	33.2	$71,516	$2,156.60	3.911
Facility, age <65, no SPMI	99.0	$43,706	$441.48	21.0	$36,876	$1,756.00	3.978
HCBS, age <65, with SPMI	682.0	$494,966	$725.74	185.2	$211,748	$1,143.19	1.575
HCBS, age <65, no SPMI	1,969.2	$751,558	$381.65	412.8	$734,290	$1,778.81	4.661
Community, age <65, with SPMI	1,722.2	$1,343,004	$779.84	298.0	$401,426	$1,347.07	1.727
Community, age <65, no SPMI	2,919.1	$1,429,671	$489.77	444.5	$365,746	$822.85	1.680

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.H-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 2

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**4,220.4**	**$7,342,975**	**$1,739.88**	**2,080.7**	**$3,884,764**	**$1,867.03**	**1.073**
Facility, age 65+, with SPMI	69.3	$194,922	$2,811.37	14.7	$26,672	$1,809.29	0.644
Facility, age 65+, no SPMI	224.1	$559,070	$2,494.36	49.1	$103,754	$2,115.20	0.848
HCBS, age 65+, with SPMI	143.3	$268,777	$1,875.10	77.2	$105,562	$1,368.07	0.730
HCBS, age 65+, no SPMI	667.3	$1,128,010	$1,690.47	245.5	$675,119	$2,750.52	1.627
Community, age 65+, with SPMI	112.9	$181,213	$1,605.69	63.0	$81,531	$1,294.15	0.806
Community, age 65+, no SPMI	715.1	$1,136,725	$1,589.61	356.4	$695,109	$1,950.56	1.227
Facility, age <65, with SPMI	48.6	$188,821	$3,883.32	34.0	$89,982	$2,646.52	0.682
Facility, age <65, no SPMI	49.0	$186,028	$3,796.49	11.5	$33,525	$2,911.16	0.767
HCBS, age <65, with SPMI	258.8	$412,435	$1,593.54	119.9	$127,815	$1,066.13	0.669
HCBS, age <65, no SPMI	572.9	$962,097	$1,679.28	444.2	$915,118	$2,060.11	1.227
Community, age <65, with SPMI	329.2	$441,888	$1,342.48	210.7	$252,583	$1,198.72	0.893
Community, age <65, no SPMI	1,029.8	$1,682,991	$1,634.24	454.6	$777,993	$1,711.27	1.047
Intervention group	**4,220.4**	**$9,945,769**	**$2,356.60**	**2,080.7**	**$4,698,292**	**$2,258.01**	**0.958**
Facility, age 65+, with SPMI	69.3	$438,707	$6,327.51	14.7	$85,948	$5,830.16	0.921
Facility, age 65+, no SPMI	224.1	$1,196,636	$5,338.95	49.1	$65,763	$1,340.69	0.251
HCBS, age 65+, with SPMI	143.3	$256,776	$1,791.38	77.2	$147,376	$1,909.98	1.066
HCBS, age 65+, no SPMI	667.3	$1,545,012	$2,315.40	245.5	$713,217	$2,905.73	1.255
Community, age 65+, with SPMI	112.9	$289,402	$2,564.32	63.0	$171,210	$2,717.61	1.060
Community, age 65+, no SPMI	715.1	$1,450,968	$2,029.05	356.4	$448,149	$1,257.56	0.620
Facility, age <65, with SPMI	48.6	$110,141	$2,265.17	34.0	$37,698	$1,108.78	0.489
Facility, age <65, no SPMI	49.0	$450,522	$9,194.32	11.5	$131,453	$11,414.69	1.241
HCBS, age <65, with SPMI	258.8	$748,549	$2,892.19	119.9	$243,571	$2,031.67	0.702
HCBS, age <65, no SPMI	572.9	$1,300,020	$2,269.10	444.2	$787,931	$1,773.78	0.782
Community, age <65, with SPMI	329.2	$674,242	$2,048.38	210.7	$644,077	$3,056.70	1.492
Community, age <65, no SPMI	1,029.8	$1,484,795	$1,441.79	454.6	$1,221,899	$2,687.68	1.864

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.H-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 2

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**4,220.4**	**$7,342,975**	**$1,739.88**	**1,489.3**	**$2,491,198**	**$1,672.72**	**0.961**
Facility, age 65+, with SPMI	69.3	$194,922	$2,811.37	0.0	$0	$0.00	0.000
Facility, age 65+, no SPMI	224.1	$559,070	$2,494.36	24.0	$35,908	$1,496.15	0.600
HCBS, age 65+, with SPMI	143.3	$268,777	$1,875.10	31.2	$46,853	$1,500.45	0.800
HCBS, age 65+, no SPMI	667.3	$1,128,010	$1,690.47	130.9	$379,356	$2,899.01	1.715
Community, age 65+, with SPMI	112.9	$181,213	$1,605.69	64.0	$124,832	$1,950.50	1.215
Community, age 65+, no SPMI	715.1	$1,136,725	$1,589.61	261.2	$359,088	$1,374.99	0.865
Facility, age <65, with SPMI	48.6	$188,821	$3,883.32	24.0	$108,883	$4,536.77	1.168
Facility, age <65, no SPMI	49.0	$186,028	$3,796.49	0.0	$0	$0.00	0.000
HCBS, age <65, with SPMI	258.8	$412,435	$1,593.54	96.1	$232,942	$2,423.96	1.521
HCBS, age <65, no SPMI	572.9	$962,097	$1,679.28	328.0	$391,433	$1,193.36	0.711
Community, age <65, with SPMI	329.2	$441,888	$1,342.48	166.6	$228,699	$1,372.47	1.022
Community, age <65, no SPMI	1,029.8	$1,682,991	$1,634.24	363.3	$583,204	$1,605.20	0.982
Intervention group	**4,220.4**	**$9,945,769**	**$2,356.60**	**1,489.3**	**$3,485,272**	**$2,340.20**	**0.993**
Facility, age 65+, with SPMI	69.3	$438,707	$6,327.51	0.0	$0	$0.00	0.000
Facility, age 65+, no SPMI	224.1	$1,196,636	$5,338.95	24.0	$75,700	$3,154.15	0.591
HCBS, age 65+, with SPMI	143.3	$256,776	$1,791.38	31.2	$93,248	$2,986.25	1.667
HCBS, age 65+, no SPMI	667.3	$1,545,012	$2,315.40	130.9	$454,122	$3,470.37	1.499
Community, age 65+, with SPMI	112.9	$289,402	$2,564.32	64.0	$152,449	$2,382.02	0.929
Community, age 65+, no SPMI	715.1	$1,450,968	$2,029.05	261.2	$320,327	$1,226.56	0.605
Facility, age <65, with SPMI	48.6	$110,141	$2,265.17	24.0	$22,729	$947.05	0.418
Facility, age <65, no SPMI	49.0	$450,522	$9,194.32	0.0	$0	$0.00	0.000
HCBS, age <65, with SPMI	258.8	$748,549	$2,892.19	96.1	$403,015	$4,193.70	1.450
HCBS, age <65, no SPMI	572.9	$1,300,020	$2,269.10	328.0	$538,863	$1,642.83	0.724
Community, age <65, with SPMI	329.2	$674,242	$2,048.38	166.6	$209,749	$1,258.74	0.615
Community, age <65, no SPMI	1,029.8	$1,484,795	$1,441.79	363.3	$1,215,070	$3,344.33	2.320

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.I-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 3

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**61,200.6**	**$93,045,998**	**$1,520.35**	**19,626.8**	**$31,740,171**	**$1,617.19**	**1.064**
Facility, age 65+, with SPMI	1,249.3	$2,839,727	$2,273.12	266.3	$602,127	$2,261.14	0.995
Facility, age 65+, no SPMI	4,252.8	$9,447,994	$2,221.61	483.8	$1,007,044	$2,081.58	0.937
HCBS, age 65+, with SPMI	2,628.5	$3,772,984	$1,435.39	660.4	$1,255,616	$1,901.44	1.325
HCBS, age 65+, no SPMI	11,866.5	$18,638,532	$1,570.68	2,880.6	$5,786,243	$2,008.68	1.279
Community, age 65+, with SPMI	1,951.3	$2,888,862	$1,480.46	742.7	$945,975	$1,273.62	0.860
Community, age 65+, no SPMI	11,506.7	$15,358,114	$1,334.72	3,571.7	$4,659,704	$1,304.60	0.977
Facility, age <65, with SPMI	423.5	$1,488,014	$3,513.99	158.5	$390,112	$2,460.52	0.700
Facility, age <65, no SPMI	696.3	$2,415,969	$3,469.81	330.9	$836,162	$2,526.88	0.728
HCBS, age <65, with SPMI	3,460.0	$4,039,095	$1,167.38	1,790.9	$1,430,205	$798.61	0.684
HCBS, age <65, no SPMI	6,699.9	$9,106,677	$1,359.22	3,220.8	$6,557,333	$2,035.91	1.498
Community, age <65, with SPMI	6,565.4	$7,436,908	$1,132.75	2,191.9	$2,066,648	$942.86	0.832
Community, age <65, no SPMI	9,900.5	$15,613,122	$1,577.00	3,328.2	$6,203,002	$1,863.78	1.182
Intervention group	**61,200.6**	**$103,440,434**	**$1,690.19**	**19,626.8**	**$35,689,148**	**$1,818.39**	**1.076**
Facility, age 65+, with SPMI	1,249.3	$3,181,407	$2,546.62	266.3	$719,639	$2,702.43	1.061
Facility, age 65+, no SPMI	4,252.8	$9,034,621	$2,124.41	483.8	$838,166	$1,732.51	0.816
HCBS, age 65+, with SPMI	2,628.5	$5,191,095	$1,974.89	660.4	$1,349,941	$2,044.28	1.035
HCBS, age 65+, no SPMI	11,866.5	$21,031,541	$1,772.34	2,880.6	$5,718,323	$1,985.10	1.120
Community, age 65+, with SPMI	1,951.3	$2,712,797	$1,390.23	742.7	$1,253,257	$1,687.33	1.214
Community, age 65+, no SPMI	11,506.7	$14,881,472	$1,293.29	3,571.7	$6,042,584	$1,691.78	1.308
Facility, age <65, with SPMI	423.5	$1,956,037	$4,619.24	158.5	$352,570	$2,223.74	0.481
Facility, age <65, no SPMI	696.3	$3,042,252	$4,369.28	330.9	$631,743	$1,909.12	0.437
HCBS, age <65, with SPMI	3,460.0	$6,775,101	$1,958.15	1,790.9	$3,193,765	$1,783.36	0.911
HCBS, age <65, no SPMI	6,699.9	$12,516,956	$1,868.23	3,220.8	$6,914,575	$2,146.83	1.149
Community, age <65, with SPMI	6,565.4	$8,598,440	$1,309.66	2,191.9	$3,493,024	$1,593.60	1.217
Community, age <65, no SPMI	9,900.5	$14,518,716	$1,466.46	3,328.2	$5,181,561	$1,556.87	1.062

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.I-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 3

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**61,200.6**	**$93,045,998**	**$1,520.35**	**15,285.4**	**$25,207,296**	**$1,649.11**	**1.085**
Facility, age 65+, with SPMI	1,249.3	$2,839,727	$2,273.12	222.7	$299,451	$1,344.78	0.592
Facility, age 65+, no SPMI	4,252.8	$9,447,994	$2,221.61	311.3	$532,134	$1,709.20	0.769
HCBS, age 65+, with SPMI	2,628.5	$3,772,984	$1,435.39	495.6	$1,151,330	$2,323.20	1.619
HCBS, age 65+, no SPMI	11,866.5	$18,638,532	$1,570.68	1,938.2	$3,639,458	$1,877.77	1.196
Community, age 65+, with SPMI	1,951.3	$2,888,862	$1,480.46	536.3	$893,490	$1,665.94	1.125
Community, age 65+, no SPMI	11,506.7	$15,358,114	$1,334.72	2,584.1	$5,018,344	$1,942.00	1.455
Facility, age <65, with SPMI	423.5	$1,488,014	$3,513.99	131.4	$219,248	$1,668.31	0.475
Facility, age <65, no SPMI	696.3	$2,415,969	$3,469.81	271.9	$608,003	$2,236.26	0.644
HCBS, age <65, with SPMI	3,460.0	$4,039,095	$1,167.38	1,507.8	$1,338,476	$887.72	0.760
HCBS, age <65, no SPMI	6,699.9	$9,106,677	$1,359.22	2,707.4	$4,022,909	$1,485.90	1.093
Community, age <65, with SPMI	6,565.4	$7,436,908	$1,132.75	1,935.3	$2,247,402	$1,161.29	1.025
Community, age <65, no SPMI	9,900.5	$15,613,122	$1,577.00	2,643.4	$5,237,051	$1,981.16	1.256
Intervention group	**61,200.6**	**$103,440,434**	**$1,690.19**	**15,285.4**	**$27,337,771**	**$1,788.49**	**1.058**
Facility, age 65+, with SPMI	1,249.3	$3,181,407	$2,546.62	222.7	$368,039	$1,652.79	0.649
Facility, age 65+, no SPMI	4,252.8	$9,034,621	$2,124.41	311.3	$710,009	$2,280.54	1.073
HCBS, age 65+, with SPMI	2,628.5	$5,191,095	$1,974.89	495.6	$1,183,799	$2,388.72	1.210
HCBS, age 65+, no SPMI	11,866.5	$21,031,541	$1,772.34	1,938.2	$3,044,253	$1,570.67	0.886
Community, age 65+, with SPMI	1,951.3	$2,712,797	$1,390.23	536.3	$714,282	$1,331.80	0.958
Community, age 65+, no SPMI	11,506.7	$14,881,472	$1,293.29	2,584.1	$5,365,373	$2,076.29	1.605
Facility, age <65, with SPMI	423.5	$1,956,037	$4,619.24	131.4	$454,912	$3,461.53	0.749
Facility, age <65, no SPMI	696.3	$3,042,252	$4,369.28	271.9	$401,207	$1,475.66	0.338
HCBS, age <65, with SPMI	3,460.0	$6,775,101	$1,958.15	1,507.8	$2,583,583	$1,713.51	0.875
HCBS, age <65, no SPMI	6,699.9	$12,516,956	$1,868.23	2,707.4	$5,410,119	$1,998.28	1.070
Community, age <65, with SPMI	6,565.4	$8,598,440	$1,309.66	1,935.3	$2,922,150	$1,509.95	1.153
Community, age <65, no SPMI	9,900.5	$14,518,716	$1,466.46	2,643.4	$4,180,044	$1,581.30	1.078

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.J-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 4

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**62,395.6**	**$96,865,182**	**$1,552.44**	**21,178.4**	**$35,131,034**	**$1,658.82**	**1.069**
Facility, age 65+, with SPMI	2,453.0	$6,453,449	$2,630.84	553.1	$1,252,576	$2,264.66	0.861
Facility, age 65+, no SPMI	2,527.9	$5,282,819	$2,089.78	436.5	$991,612	$2,271.72	1.087
HCBS, age 65+, with SPMI	4,306.6	$8,037,334	$1,866.30	1,349.1	$2,470,958	$1,831.51	0.981
HCBS, age 65+, no SPMI	9,921.7	$14,424,152	$1,453.79	2,970.9	$6,986,357	$2,351.59	1.618
Community, age 65+, with SPMI	2,937.0	$4,882,376	$1,662.39	1,022.0	$1,734,834	$1,697.55	1.021
Community, age 65+, no SPMI	13,051.3	$16,756,974	$1,283.93	3,975.9	$5,499,677	$1,383.26	1.077
Facility, age <65, with SPMI	701.0	$2,687,764	$3,834.18	176.4	$444,964	$2,521.77	0.658
Facility, age <65, no SPMI	435.0	$1,496,911	$3,441.17	165.2	$441,411	$2,672.45	0.777
HCBS, age <65, with SPMI	4,420.2	$5,880,332	$1,330.34	2,305.7	$2,251,860	$976.63	0.734
HCBS, age <65, no SPMI	5,763.7	$9,009,151	$1,563.09	3,055.7	$5,887,390	$1,926.68	1.233
Community, age <65, with SPMI	7,698.0	$8,968,160	$1,165.00	2,613.6	$2,740,486	$1,048.55	0.900
Community, age <65, no SPMI	8,180.2	$12,985,760	$1,587.47	2,554.2	$4,428,908	$1,733.95	1.092
Intervention group	**62,395.6**	**$108,719,430**	**$1,742.42**	**21,178.4**	**$38,330,744**	**$1,809.90**	**1.039**
Facility, age 65+, with SPMI	2,453.0	$8,183,909	$3,336.29	553.1	$1,074,709	$1,943.08	0.582
Facility, age 65+, no SPMI	2,527.9	$5,640,529	$2,231.28	436.5	$758,979	$1,738.77	0.779
HCBS, age 65+, with SPMI	4,306.6	$10,380,911	$2,410.48	1,349.1	$2,754,078	$2,041.36	0.847
HCBS, age 65+, no SPMI	9,921.7	$16,659,970	$1,679.14	2,970.9	$5,655,643	$1,903.68	1.134
Community, age 65+, with SPMI	2,937.0	$5,604,559	$1,908.28	1,022.0	$1,530,434	$1,497.54	0.785
Community, age 65+, no SPMI	13,051.3	$15,923,824	$1,220.09	3,975.9	$6,695,630	$1,684.06	1.380
Facility, age <65, with SPMI	701.0	$3,135,378	$4,472.72	176.4	$264,379	$1,498.33	0.335
Facility, age <65, no SPMI	435.0	$1,415,092	$3,253.09	165.2	$514,863	$3,117.15	0.958
HCBS, age <65, with SPMI	4,420.2	$7,918,350	$1,791.41	2,305.7	$4,143,800	$1,797.17	1.003
HCBS, age <65, no SPMI	5,763.7	$10,787,145	$1,871.58	3,055.7	$6,264,494	$2,050.09	1.095
Community, age <65, with SPMI	7,698.0	$11,310,650	$1,469.29	2,613.6	$3,603,656	$1,378.81	0.938
Community, age <65, no SPMI	8,180.2	$11,759,112	$1,437.51	2,554.2	$5,070,080	$1,984.97	1.381

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.J-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 4

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**62,395.6**	**$96,865,182**	**$1,552.44**	**15,601.3**	**$28,818,924**	**$1,847.21**	**1.190**
Facility, age 65+, with SPMI	2,453.0	$6,453,449	$2,630.84	387.7	$851,019	$2,195.06	0.834
Facility, age 65+, no SPMI	2,527.9	$5,282,819	$2,089.78	289.5	$685,349	$2,367.43	1.133
HCBS, age 65+, with SPMI	4,306.6	$8,037,334	$1,866.30	864.1	$2,164,659	$2,504.96	1.342
HCBS, age 65+, no SPMI	9,921.7	$14,424,152	$1,453.79	2,039.2	$7,033,624	$3,449.24	2.373
Community, age 65+, with SPMI	2,937.0	$4,882,376	$1,662.39	696.3	$1,635,781	$2,349.18	1.413
Community, age 65+, no SPMI	13,051.3	$16,756,974	$1,283.93	2,740.7	$4,185,641	$1,527.23	1.189
Facility, age <65, with SPMI	701.0	$2,687,764	$3,834.18	164.0	$323,568	$1,972.97	0.515
Facility, age <65, no SPMI	435.0	$1,496,911	$3,441.17	131.3	$222,395	$1,694.22	0.492
HCBS, age <65, with SPMI	4,420.2	$5,880,332	$1,330.34	1,908.9	$1,885,201	$987.61	0.742
HCBS, age <65, no SPMI	5,763.7	$9,009,151	$1,563.09	2,492.8	$5,090,518	$2,042.12	1.306
Community, age <65, with SPMI	7,698.0	$8,968,160	$1,165.00	1,866.2	$1,660,572	$889.83	0.764
Community, age <65, no SPMI	8,180.2	$12,985,760	$1,587.47	2,020.8	$3,080,599	$1,524.48	0.960
Intervention group	**62,395.6**	**$108,719,430**	**$1,742.42**	**15,601.3**	**$27,900,042**	**$1,788.31**	**1.026**
Facility, age 65+, with SPMI	2,453.0	$8,183,909	$3,336.29	387.7	$765,539	$1,974.58	0.592
Facility, age 65+, no SPMI	2,527.9	$5,640,529	$2,231.28	289.5	$626,319	$2,163.52	0.970
HCBS, age 65+, with SPMI	4,306.6	$10,380,911	$2,410.48	864.1	$2,170,655	$2,511.90	1.042
HCBS, age 65+, no SPMI	9,921.7	$16,659,970	$1,679.14	2,039.2	$4,524,415	$2,218.74	1.321
Community, age 65+, with SPMI	2,937.0	$5,604,559	$1,908.28	696.3	$998,600	$1,434.11	0.752
Community, age 65+, no SPMI	13,051.3	$15,923,824	$1,220.09	2,740.7	$4,731,954	$1,726.56	1.415
Facility, age <65, with SPMI	701.0	$3,135,378	$4,472.72	164.0	$346,693	$2,113.98	0.473
Facility, age <65, no SPMI	435.0	$1,415,092	$3,253.09	131.3	$296,201	$2,256.48	0.694
HCBS, age <65, with SPMI	4,420.2	$7,918,350	$1,791.41	1,908.9	$3,006,505	$1,575.03	0.879
HCBS, age <65, no SPMI	5,763.7	$10,787,145	$1,871.58	2,492.8	$4,606,780	$1,848.06	0.987
Community, age <65, with SPMI	7,698.0	$11,310,650	$1,469.29	1,866.2	$3,020,069	$1,618.32	1.101
Community, age <65, no SPMI	8,180.2	$11,759,112	$1,437.51	2,020.8	$2,806,314	$1,388.74	0.966

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.K-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 5A

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**65,796.4**	**$107,612,835**	**$1,635.54**	**27,183.8**	**$49,051,217**	**$1,804.43**	**1.103**
Facility, age 65+, with SPMI	2,862.0	$6,538,294	$2,284.49	826.2	$1,959,841	$2,372.03	1.038
Facility, age 65+, no SPMI	2,190.1	$4,588,613	$2,095.20	486.4	$1,472,148	$3,026.46	1.444
HCBS, age 65+, with SPMI	6,603.4	$13,633,279	$2,064.59	2,799.6	$8,741,574	$3,122.44	1.512
HCBS, age 65+, no SPMI	8,400.5	$13,349,568	$1,589.14	3,167.6	$5,823,446	$1,838.45	1.157
Community, age 65+, with SPMI	5,113.6	$8,331,575	$1,629.28	1,966.3	$2,592,209	$1,318.35	0.809
Community, age 65+, no SPMI	11,806.2	$13,441,078	$1,138.48	4,381.7	$6,211,867	$1,417.67	1.245
Facility, age <65, with SPMI	768.5	$2,724,718	$3,545.43	390.8	$1,424,048	$3,643.97	1.028
Facility, age <65, no SPMI	321.0	$1,106,626	$3,447.43	172.0	$490,750	$2,852.66	0.827
HCBS, age <65, with SPMI	5,810.6	$10,301,608	$1,772.91	3,448.4	$5,334,150	$1,546.84	0.872
HCBS, age <65, no SPMI	4,143.8	$6,256,237	$1,509.79	2,503.2	$3,833,540	$1,531.46	1.014
Community, age <65, with SPMI	10,167.6	$13,655,351	$1,343.02	4,165.4	$4,897,747	$1,175.83	0.876
Community, age <65, no SPMI	7,609.1	$13,685,889	$1,798.62	2,876.2	$6,269,897	$2,179.92	1.212
Intervention group	**65,796.4**	**$110,831,462**	**$1,684.46**	**27,183.8**	**$45,282,908**	**$1,665.80**	**0.989**
Facility, age 65+, with SPMI	2,862.0	$9,052,081	$3,162.82	826.2	$1,779,291	$2,153.51	0.681
Facility, age 65+, no SPMI	2,190.1	$4,385,773	$2,002.58	486.4	$743,242	$1,527.96	0.763
HCBS, age 65+, with SPMI	6,603.4	$15,018,129	$2,274.31	2,799.6	$5,684,976	$2,030.64	0.893
HCBS, age 65+, no SPMI	8,400.5	$14,823,067	$1,764.55	3,167.6	$6,314,573	$1,993.50	1.130
Community, age 65+, with SPMI	5,113.6	$8,819,180	$1,724.64	1,966.3	$2,921,005	$1,485.57	0.861
Community, age 65+, no SPMI	11,806.2	$12,552,136	$1,063.18	4,381.7	$6,172,337	$1,408.65	1.325
Facility, age <65, with SPMI	768.5	$4,002,047	$5,207.50	390.8	$1,326,188	$3,393.56	0.652
Facility, age <65, no SPMI	321.0	$1,146,659	$3,572.15	172.0	$470,134	$2,732.82	0.765
HCBS, age <65, with SPMI	5,810.6	$12,307,623	$2,118.15	3,448.4	$5,808,907	$1,684.51	0.795
HCBS, age <65, no SPMI	4,143.8	$5,751,726	$1,388.04	2,503.2	$4,644,614	$1,855.47	1.337
Community, age <65, with SPMI	10,167.6	$13,782,730	$1,355.55	4,165.4	$5,039,608	$1,209.88	0.893
Community, age <65, no SPMI	7,609.1	$9,190,309	$1,207.80	2,876.2	$4,378,033	$1,522.16	1.260

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.K-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 5A

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**65,796.4**	**$107,612,835**	**$1,635.54**	**19,857.0**	**$31,645,896**	**$1,593.69**	**0.974**
Facility, age 65+, with SPMI	2,862.0	$6,538,294	$2,284.49	593.2	$1,183,751	$1,995.53	0.874
Facility, age 65+, no SPMI	2,190.1	$4,588,613	$2,095.20	310.9	$620,382	$1,995.61	0.952
HCBS, age 65+, with SPMI	6,603.4	$13,633,279	$2,064.59	1,965.9	$3,220,333	$1,638.12	0.793
HCBS, age 65+, no SPMI	8,400.5	$13,349,568	$1,589.14	1,940.5	$4,741,521	$2,443.49	1.538
Community, age 65+, with SPMI	5,113.6	$8,331,575	$1,629.28	1,305.7	$2,979,074	$2,281.52	1.400
Community, age 65+, no SPMI	11,806.2	$13,441,078	$1,138.48	3,210.5	$3,837,451	$1,195.28	1.050
Facility, age <65, with SPMI	768.5	$2,724,718	$3,545.43	235.9	$636,962	$2,700.48	0.762
Facility, age <65, no SPMI	321.0	$1,106,626	$3,447.43	124.7	$530,182	$4,251.77	1.233
HCBS, age <65, with SPMI	5,810.6	$10,301,608	$1,772.91	2,691.4	$2,580,867	$958.93	0.541
HCBS, age <65, no SPMI	4,143.8	$6,256,237	$1,509.79	1,852.4	$3,598,660	$1,942.67	1.287
Community, age <65, with SPMI	10,167.6	$13,655,351	$1,343.02	3,359.2	$3,630,808	$1,080.87	0.805
Community, age <65, no SPMI	7,609.1	$13,685,889	$1,798.62	2,266.8	$4,085,905	$1,802.49	1.002
Intervention group	**65,796.4**	**$110,831,462**	**$1,684.46**	**19,857.0**	**$35,560,883**	**$1,790.85**	**1.063**
Facility, age 65+, with SPMI	2,862.0	$9,052,081	$3,162.82	593.2	$1,437,966	$2,424.07	0.766
Facility, age 65+, no SPMI	2,190.1	$4,385,773	$2,002.58	310.9	$443,973	$1,428.15	0.713
HCBS, age 65+, with SPMI	6,603.4	$15,018,129	$2,274.31	1,965.9	$4,425,389	$2,251.11	0.990
HCBS, age 65+, no SPMI	8,400.5	$14,823,067	$1,764.55	1,940.5	$4,360,693	$2,247.24	1.274
Community, age 65+, with SPMI	5,113.6	$8,819,180	$1,724.64	1,305.7	$2,539,211	$1,944.65	1.128
Community, age 65+, no SPMI	11,806.2	$12,552,136	$1,063.18	3,210.5	$5,116,008	$1,593.52	1.499
Facility, age <65, with SPMI	768.5	$4,002,047	$5,207.50	235.9	$360,555	$1,528.62	0.294
Facility, age <65, no SPMI	321.0	$1,146,659	$3,572.15	124.7	$242,818	$1,947.27	0.545
HCBS, age <65, with SPMI	5,810.6	$12,307,623	$2,118.15	2,691.4	$4,042,992	$1,502.19	0.709
HCBS, age <65, no SPMI	4,143.8	$5,751,726	$1,388.04	1,852.4	$3,304,505	$1,783.88	1.285
Community, age <65, with SPMI	10,167.6	$13,782,730	$1,355.55	3,359.2	$5,393,960	$1,605.75	1.185
Community, age <65, no SPMI	7,609.1	$9,190,309	$1,207.80	2,266.8	$3,892,813	$1,717.31	1.422

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.L-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 5B

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**65,414.5**	**$107,080,977**	**$1,636.96**	**28,585.4**	**$55,332,601**	**$1,935.70**	**1.182**
Facility, age 65+, with SPMI	4,136.0	$7,818,931	$1,890.46	1,033.0	$2,693,762	$2,607.59	1.379
Facility, age 65+, no SPMI	2,322.6	$3,940,959	$1,696.81	606.1	$1,306,068	$2,154.86	1.270
HCBS, age 65+, with SPMI	8,071.3	$17,537,844	$2,172.88	3,527.7	$9,409,490	$2,667.35	1.228
HCBS, age 65+, no SPMI	9,022.6	$15,430,790	$1,710.23	3,634.3	$8,503,004	$2,339.67	1.368
Community, age 65+, with SPMI	6,083.6	$9,863,360	$1,621.31	2,553.4	$5,284,191	$2,069.51	1.276
Community, age 65+, no SPMI	14,579.5	$17,434,468	$1,195.82	5,997.0	$10,078,745	$1,680.64	1.405
Facility, age <65, with SPMI	1,284.5	$3,347,273	$2,605.80	510.4	$1,237,729	$2,424.95	0.931
Facility, age <65, no SPMI	579.0	$843,478	$1,456.78	294.3	$389,216	$1,322.52	0.908
HCBS, age <65, with SPMI	5,481.1	$9,483,022	$1,730.13	3,455.7	$4,792,734	$1,386.92	0.802
HCBS, age <65, no SPMI	3,758.0	$6,270,810	$1,668.64	2,266.9	$3,959,919	$1,746.85	1.047
Community, age <65, with SPMI	6,450.3	$9,221,719	$1,429.66	3,073.5	$4,451,315	$1,448.30	1.013
Community, age <65, no SPMI	3,646.1	$5,888,326	$1,614.98	1,633.2	$3,226,427	$1,975.47	1.223
Intervention group	**65,414.5**	**$113,207,213**	**$1,730.61**	**28,585.4**	**$53,915,562**	**$1,886.13**	**1.090**
Facility, age 65+, with SPMI	4,136.0	$11,235,848	$2,716.60	1,033.0	$2,999,308	$2,903.36	1.069
Facility, age 65+, no SPMI	2,322.6	$4,959,944	$2,135.54	606.1	$1,386,958	$2,288.32	1.072
HCBS, age 65+, with SPMI	8,071.3	$15,592,008	$1,931.80	3,527.7	$6,512,313	$1,846.08	0.956
HCBS, age 65+, no SPMI	9,022.6	$12,101,533	$1,341.24	3,634.3	$6,511,316	$1,791.64	1.336
Community, age 65+, with SPMI	6,083.6	$10,289,715	$1,691.40	2,553.4	$4,663,851	$1,826.56	1.080
Community, age 65+, no SPMI	14,579.5	$17,589,282	$1,206.44	5,997.0	$8,402,761	$1,401.17	1.161
Facility, age <65, with SPMI	1,284.5	$5,382,129	$4,189.90	510.4	$1,895,910	$3,714.46	0.887
Facility, age <65, no SPMI	579.0	$1,328,071	$2,293.73	294.3	$930,879	$3,163.03	1.379
HCBS, age <65, with SPMI	5,481.1	$11,153,684	$2,034.93	3,455.7	$6,438,795	$1,863.26	0.916
HCBS, age <65, no SPMI	3,758.0	$5,231,307	$1,392.03	2,266.9	$5,552,501	$2,449.39	1.760
Community, age <65, with SPMI	6,450.3	$11,304,842	$1,752.61	3,073.5	$4,308,602	$1,401.87	0.800
Community, age <65, no SPMI	3,646.1	$7,038,850	$1,930.53	1,633.2	$4,312,368	$2,640.37	1.368

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.L-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 5B

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**65,414.5**	**$107,080,977**	**$1,636.96**	**22,211.0**	**$42,629,284**	**$1,919.29**	**1.172**
Facility, age 65+, with SPMI	4,136.0	$7,818,931	$1,890.46	590.1	$1,419,679	$2,405.85	1.273
Facility, age 65+, no SPMI	2,322.6	$3,940,959	$1,696.81	361.0	$735,155	$2,036.67	1.200
HCBS, age 65+, with SPMI	8,071.3	$17,537,844	$2,172.88	2,651.2	$7,014,853	$2,645.89	1.218
HCBS, age 65+, no SPMI	9,022.6	$15,430,790	$1,710.23	2,703.8	$6,222,976	$2,301.55	1.346
Community, age 65+, with SPMI	6,083.6	$9,863,360	$1,621.31	1,884.1	$4,050,833	$2,149.98	1.326
Community, age 65+, no SPMI	14,579.5	$17,434,468	$1,195.82	4,595.6	$7,770,105	$1,690.76	1.414
Facility, age <65, with SPMI	1,284.5	$3,347,273	$2,605.80	398.5	$777,185	$1,950.29	0.748
Facility, age <65, no SPMI	579.0	$843,478	$1,456.78	205.4	$280,484	$1,365.85	0.938
HCBS, age <65, with SPMI	5,481.1	$9,483,022	$1,730.13	2,969.5	$4,434,856	$1,493.47	0.863
HCBS, age <65, no SPMI	3,758.0	$6,270,810	$1,668.64	1,958.4	$3,645,949	$1,861.73	1.116
Community, age <65, with SPMI	6,450.3	$9,221,719	$1,429.66	2,601.2	$3,897,181	$1,498.23	1.048
Community, age <65, no SPMI	3,646.1	$5,888,326	$1,614.98	1,292.3	$2,380,027	$1,841.76	1.140
Intervention group	**65,414.5**	**$113,207,213**	**$1,730.61**	**22,211.0**	**$44,068,348**	**$1,984.08**	**1.146**
Facility, age 65+, with SPMI	4,136.0	$11,235,848	$2,716.60	590.1	$1,114,853	$1,889.28	0.695
Facility, age 65+, no SPMI	2,322.6	$4,959,944	$2,135.54	361.0	$882,785	$2,445.66	1.145
HCBS, age 65+, with SPMI	8,071.3	$15,592,008	$1,931.80	2,651.2	$5,215,663	$1,967.26	1.018
HCBS, age 65+, no SPMI	9,022.6	$12,101,533	$1,341.24	2,703.8	$5,341,416	$1,975.51	1.473
Community, age 65+, with SPMI	6,083.6	$10,289,715	$1,691.40	1,884.1	$3,112,989	$1,652.22	0.977
Community, age 65+, no SPMI	14,579.5	$17,589,282	$1,206.44	4,595.6	$7,825,518	$1,702.82	1.411
Facility, age <65, with SPMI	1,284.5	$5,382,129	$4,189.90	398.5	$1,107,358	$2,778.84	0.663
Facility, age <65, no SPMI	579.0	$1,328,071	$2,293.73	205.4	$638,334	$3,108.44	1.355
HCBS, age <65, with SPMI	5,481.1	$11,153,684	$2,034.93	2,969.5	$5,952,089	$2,004.40	0.985
HCBS, age <65, no SPMI	3,758.0	$5,231,307	$1,392.03	1,958.4	$4,029,765	$2,057.71	1.478
Community, age <65, with SPMI	6,450.3	$11,304,842	$1,752.61	2,601.2	$4,971,268	$1,911.15	1.090
Community, age <65, no SPMI	3,646.1	$7,038,850	$1,930.53	1,292.3	$3,876,311	$2,999.65	1.554

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.M-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 6A

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**51,245.5**	**$100,075,043**	**$1,952.86**	**25,620.5**	**$50,751,548**	**$1,980.90**	**1.014**
Facility, age 65+, with SPMI	2,983.4	$7,275,051	$2,438.54	1,043.5	$2,640,529	$2,530.53	1.038
Facility, age 65+, no SPMI	1,780.9	$3,501,971	$1,966.38	571.0	$1,371,439	$2,401.86	1.221
HCBS, age 65+, with SPMI	5,934.9	$12,433,792	$2,095.03	2,760.0	$6,723,068	$2,435.86	1.163
HCBS, age 65+, no SPMI	6,235.3	$12,364,008	$1,982.90	2,804.0	$8,058,513	$2,873.98	1.449
Community, age 65+, with SPMI	3,535.9	$7,176,174	$2,029.49	1,892.7	$3,204,602	$1,693.17	0.834
Community, age 65+, no SPMI	7,629.4	$11,448,086	$1,500.51	3,708.6	$4,413,707	$1,190.14	0.793
Facility, age <65, with SPMI	1,446.6	$4,284,949	$2,962.09	914.0	$3,207,950	$3,509.81	1.185
Facility, age <65, no SPMI	1,110.7	$3,308,099	$2,978.45	844.5	$2,619,879	$3,102.46	1.042
HCBS, age <65, with SPMI	5,162.9	$11,356,161	$2,199.59	3,247.3	$6,927,037	$2,133.17	0.970
HCBS, age <65, no SPMI	3,228.4	$5,124,319	$1,587.25	2,189.1	$3,171,039	$1,448.54	0.913
Community, age <65, with SPMI	7,216.3	$12,968,802	$1,797.17	3,284.0	$4,107,964	$1,250.91	0.696
Community, age <65, no SPMI	4,980.8	$8,833,631	$1,773.54	2,362.0	$4,305,820	$1,822.98	1.028
Intervention group	**51,245.5**	**$102,206,255**	**$1,994.44**	**25,620.5**	**$43,775,692**	**$1,708.62**	**0.857**
Facility, age 65+, with SPMI	2,983.4	$10,028,144	$3,361.36	1,043.5	$2,856,083	$2,737.10	0.814
Facility, age 65+, no SPMI	1,780.9	$4,091,617	$2,297.47	571.0	$734,790	$1,286.87	0.560
HCBS, age 65+, with SPMI	5,934.9	$15,182,148	$2,558.12	2,760.0	$5,983,150	$2,167.78	0.847
HCBS, age 65+, no SPMI	6,235.3	$11,287,100	$1,810.19	2,804.0	$4,536,268	$1,617.81	0.894
Community, age 65+, with SPMI	3,535.9	$7,139,268	$2,019.05	1,892.7	$3,178,152	$1,679.20	0.832
Community, age 65+, no SPMI	7,629.4	$10,590,533	$1,388.11	3,708.6	$5,292,412	$1,427.08	1.028
Facility, age <65, with SPMI	1,446.6	$4,054,834	$2,803.02	914.0	$2,389,654	$2,614.51	0.933
Facility, age <65, no SPMI	1,110.7	$1,264,106	$1,138.14	844.5	$900,595	$1,066.48	0.937
HCBS, age <65, with SPMI	5,162.9	$12,719,808	$2,463.72	3,247.3	$6,042,847	$1,860.89	0.755
HCBS, age <65, no SPMI	3,228.4	$4,799,057	$1,486.50	2,189.1	$3,365,096	$1,537.18	1.034
Community, age <65, with SPMI	7,216.3	$13,988,314	$1,938.45	3,284.0	$4,591,589	$1,398.18	0.721
Community, age <65, no SPMI	4,980.8	$7,061,327	$1,417.71	2,362.0	$3,905,056	$1,653.30	1.166

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.M-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 6A

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**51,245.5**	**$100,075,043**	**$1,952.86**	**18,846.1**	**$32,752,216**	**$1,737.88**	**0.890**
Facility, age 65+, with SPMI	2,983.4	$7,275,051	$2,438.54	634.0	$1,573,934	$2,482.39	1.018
Facility, age 65+, no SPMI	1,780.9	$3,501,971	$1,966.38	392.5	$894,940	$2,280.19	1.160
HCBS, age 65+, with SPMI	5,934.9	$12,433,792	$2,095.03	1,944.9	$4,549,854	$2,339.32	1.117
HCBS, age 65+, no SPMI	6,235.3	$12,364,008	$1,982.90	1,974.2	$3,805,136	$1,927.39	0.972
Community, age 65+, with SPMI	3,535.9	$7,176,174	$2,029.49	1,427.7	$2,541,106	$1,779.83	0.877
Community, age 65+, no SPMI	7,629.4	$11,448,086	$1,500.51	2,775.2	$4,361,386	$1,571.58	1.047
Facility, age <65, with SPMI	1,446.6	$4,284,949	$2,962.09	677.9	$1,668,835	$2,461.87	0.831
Facility, age <65, no SPMI	1,110.7	$3,308,099	$2,978.45	753.1	$1,306,434	$1,734.71	0.582
HCBS, age <65, with SPMI	5,162.9	$11,356,161	$2,199.59	2,502.4	$3,991,070	$1,594.88	0.725
HCBS, age <65, no SPMI	3,228.4	$5,124,319	$1,587.25	1,657.5	$2,263,516	$1,365.62	0.860
Community, age <65, with SPMI	7,216.3	$12,968,802	$1,797.17	2,401.0	$3,041,013	$1,266.59	0.705
Community, age <65, no SPMI	4,980.8	$8,833,631	$1,773.54	1,705.7	$2,754,993	$1,615.20	0.911
Intervention group	**51,245.5**	**$102,206,255**	**$1,994.44**	**18,846.1**	**$33,141,657**	**$1,758.54**	**0.882**
Facility, age 65+, with SPMI	2,983.4	$10,028,144	$3,361.36	634.0	$952,312	$1,501.98	0.447
Facility, age 65+, no SPMI	1,780.9	$4,091,617	$2,297.47	392.5	$778,404	$1,983.27	0.863
HCBS, age 65+, with SPMI	5,934.9	$15,182,148	$2,558.12	1,944.9	$3,874,088	$1,991.87	0.779
HCBS, age 65+, no SPMI	6,235.3	$11,287,100	$1,810.19	1,974.2	$4,233,884	$2,144.57	1.185
Community, age 65+, with SPMI	3,535.9	$7,139,268	$2,019.05	1,427.7	$2,703,853	$1,893.82	0.938
Community, age 65+, no SPMI	7,629.4	$10,590,533	$1,388.11	2,775.2	$3,784,037	$1,363.54	0.982
Facility, age <65, with SPMI	1,446.6	$4,054,834	$2,803.02	677.9	$1,014,517	$1,496.62	0.534
Facility, age <65, no SPMI	1,110.7	$1,264,106	$1,138.14	753.1	$1,045,885	$1,388.75	1.220
HCBS, age <65, with SPMI	5,162.9	$12,719,808	$2,463.72	2,502.4	$4,485,405	$1,792.42	0.728
HCBS, age <65, no SPMI	3,228.4	$4,799,057	$1,486.50	1,657.5	$3,071,908	$1,853.34	1.247
Community, age <65, with SPMI	7,216.3	$13,988,314	$1,938.45	2,401.0	$4,489,973	$1,870.08	0.965
Community, age <65, no SPMI	4,980.8	$7,061,327	$1,417.71	1,705.7	$2,707,392	$1,587.29	1.120

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.N-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 6B

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**36,877.4**	**$64,261,823**	**$1,742.58**	**17,901.2**	**$29,727,534**	**$1,660.65**	**0.953**
Facility, age 65+, with SPMI	1,661.3	$4,014,399	$2,416.43	462.4	$1,134,848	$2,454.50	1.016
Facility, age 65+, no SPMI	1,114.5	$2,401,017	$2,154.35	315.9	$830,701	$2,629.59	1.221
HCBS, age 65+, with SPMI	4,645.1	$10,776,546	$2,319.98	2,360.6	$5,419,039	$2,295.59	0.989
HCBS, age 65+, no SPMI	5,075.5	$9,483,790	$1,868.54	2,399.2	$4,500,335	$1,875.73	1.004
Community, age 65+, with SPMI	3,969.4	$7,044,648	$1,774.76	2,029.2	$3,833,317	$1,889.04	1.064
Community, age 65+, no SPMI	8,806.0	$11,292,981	$1,282.42	3,978.8	$4,508,941	$1,133.24	0.884
Facility, age <65, with SPMI	618.0	$2,135,696	$3,455.66	326.9	$1,126,888	$3,446.87	0.997
Facility, age <65, no SPMI	497.5	$883,628	$1,776.19	293.5	$314,704	$1,072.30	0.604
HCBS, age <65, with SPMI	2,770.0	$5,053,178	$1,824.25	1,605.6	$3,042,080	$1,894.66	1.039
HCBS, age <65, no SPMI	2,222.3	$2,780,808	$1,251.33	1,443.5	$1,568,261	$1,086.43	0.868
Community, age <65, with SPMI	3,449.6	$5,209,670	$1,510.24	1,646.6	$1,899,915	$1,153.87	0.764
Community, age <65, no SPMI	2,048.2	$3,185,461	$1,555.21	1,038.9	$1,548,505	$1,490.48	0.958
Intervention group	**36,877.4**	**$69,409,748**	**$1,882.18**	**17,901.2**	**$31,586,811**	**$1,764.51**	**0.937**
Facility, age 65+, with SPMI	1,661.3	$5,090,470	$3,064.17	462.4	$1,047,748	$2,266.12	0.740
Facility, age 65+, no SPMI	1,114.5	$3,548,559	$3,184.00	315.9	$944,520	$2,989.88	0.939
HCBS, age 65+, with SPMI	4,645.1	$9,859,451	$2,122.54	2,360.6	$4,221,683	$1,788.37	0.843
HCBS, age 65+, no SPMI	5,075.5	$7,956,973	$1,567.72	2,399.2	$3,661,482	$1,526.10	0.973
Community, age 65+, with SPMI	3,969.4	$6,757,915	$1,702.52	2,029.2	$2,986,586	$1,471.78	0.864
Community, age 65+, no SPMI	8,806.0	$10,622,370	$1,206.27	3,978.8	$4,275,547	$1,074.58	0.891
Facility, age <65, with SPMI	618.0	$3,152,460	$5,100.83	326.9	$1,165,446	$3,564.81	0.699
Facility, age <65, no SPMI	497.5	$526,891	$1,059.11	293.5	$203,745	$694.23	0.655
HCBS, age <65, with SPMI	2,770.0	$6,815,495	$2,460.47	1,605.6	$2,886,951	$1,798.05	0.731
HCBS, age <65, no SPMI	2,222.3	$3,955,957	$1,780.13	1,443.5	$3,605,913	$2,498.03	1.403
Community, age <65, with SPMI	3,449.6	$6,575,663	$1,906.23	1,646.6	$4,172,014	$2,533.78	1.329
Community, age <65, no SPMI	2,048.2	$4,547,544	$2,220.21	1,038.9	$2,415,176	$2,324.68	1.047

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.N-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 6B

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**36,877.4**	**$64,261,823**	**$1,742.58**	**13,581.5**	**$25,286,154**	**$1,861.81**	**1.068**
Facility, age 65+, with SPMI	1,661.3	$4,014,399	$2,416.43	293.3	$683,858	$2,331.59	0.965
Facility, age 65+, no SPMI	1,114.5	$2,401,017	$2,154.35	239.7	$405,498	$1,691.85	0.785
HCBS, age 65+, with SPMI	4,645.1	$10,776,546	$2,319.98	1,734.0	$5,466,481	$3,152.54	1.359
HCBS, age 65+, no SPMI	5,075.5	$9,483,790	$1,868.54	1,769.6	$4,356,818	$2,461.97	1.318
Community, age 65+, with SPMI	3,969.4	$7,044,648	$1,774.76	1,653.0	$3,035,522	$1,836.35	1.035
Community, age 65+, no SPMI	8,806.0	$11,292,981	$1,282.42	3,042.6	$4,432,033	$1,456.66	1.136
Facility, age <65, with SPMI	618.0	$2,135,696	$3,455.66	232.0	$658,786	$2,839.41	0.822
Facility, age <65, no SPMI	497.5	$883,628	$1,776.19	288.5	$481,047	$1,667.13	0.939
HCBS, age <65, with SPMI	2,770.0	$5,053,178	$1,824.25	1,226.8	$1,985,442	$1,618.33	0.887
HCBS, age <65, no SPMI	2,222.3	$2,780,808	$1,251.33	1,132.2	$1,088,650	$961.50	0.768
Community, age <65, with SPMI	3,449.6	$5,209,670	$1,510.24	1,182.0	$1,535,999	$1,299.54	0.860
Community, age <65, no SPMI	2,048.2	$3,185,461	$1,555.21	787.6	$1,156,021	$1,467.73	0.944
Intervention group	**36,877.4**	**$69,409,748**	**$1,882.18**	**13,581.5**	**$22,916,704**	**$1,687.35**	**0.896**
Facility, age 65+, with SPMI	1,661.3	$5,090,470	$3,064.17	293.3	$554,464	$1,890.43	0.617
Facility, age 65+, no SPMI	1,114.5	$3,548,559	$3,184.00	239.7	$455,048	$1,898.59	0.596
HCBS, age 65+, with SPMI	4,645.1	$9,859,451	$2,122.54	1,734.0	$2,984,612	$1,721.24	0.811
HCBS, age 65+, no SPMI	5,075.5	$7,956,973	$1,567.72	1,769.6	$2,964,279	$1,675.07	1.068
Community, age 65+, with SPMI	3,969.4	$6,757,915	$1,702.52	1,653.0	$1,991,303	$1,204.65	0.708
Community, age 65+, no SPMI	8,806.0	$10,622,370	$1,206.27	3,042.6	$4,211,918	$1,384.32	1.148
Facility, age <65, with SPMI	618.0	$3,152,460	$5,100.83	232.0	$426,939	$1,840.14	0.361
Facility, age <65, no SPMI	497.5	$526,891	$1,059.11	288.5	$407,035	$1,410.63	1.332
HCBS, age <65, with SPMI	2,770.0	$6,815,495	$2,460.47	1,226.8	$2,506,880	$2,043.35	0.830
HCBS, age <65, no SPMI	2,222.3	$3,955,957	$1,780.13	1,132.2	$1,860,657	$1,643.34	0.923
Community, age <65, with SPMI	3,449.6	$6,575,663	$1,906.23	1,182.0	$2,632,933	$2,227.60	1.169
Community, age <65, no SPMI	2,048.2	$4,547,544	$2,220.21	787.6	$1,920,637	$2,438.52	1.098

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.O-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 7A

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**46,757.6**	**$93,789,158**	**$2,005.86**	**30,000.8**	**$54,465,704**	**$1,815.48**	**0.905**
Facility, age 65+, with SPMI	3,809.6	$9,922,666	$2,604.68	1,918.1	$4,677,629	$2,438.62	0.936
Facility, age 65+, no SPMI	2,203.8	$5,865,589	$2,661.58	1,357.1	$3,519,166	$2,593.08	0.974
HCBS, age 65+, with SPMI	6,978.0	$14,292,060	$2,048.16	4,345.1	$8,968,690	$2,064.07	1.008
HCBS, age 65+, no SPMI	6,832.0	$9,999,269	$1,463.59	4,256.5	$7,552,967	$1,774.47	1.212
Community, age 65+, with SPMI	3,031.8	$5,081,153	$1,675.93	1,841.1	$2,436,303	$1,323.31	0.790
Community, age 65+, no SPMI	6,550.5	$10,276,117	$1,568.75	4,021.4	$5,538,766	$1,377.32	0.878
Facility, age <65, with SPMI	838.1	$3,647,011	$4,351.55	573.6	$2,069,074	$3,607.32	0.829
Facility, age <65, no SPMI	408.1	$1,535,898	$3,763.39	272.4	$709,606	$2,605.04	0.692
HCBS, age <65, with SPMI	3,681.0	$9,937,913	$2,699.77	3,158.0	$6,771,660	$2,144.31	0.794
HCBS, age <65, no SPMI	2,743.4	$5,707,149	$2,080.35	2,334.8	$4,441,955	$1,902.53	0.915
Community, age <65, with SPMI	5,663.0	$9,234,036	$1,630.59	3,508.6	$4,096,046	$1,167.44	0.716
Community, age <65, no SPMI	4,018.3	$8,290,298	$2,063.13	2,414.2	$3,683,842	$1,525.92	0.740
Intervention group	**46,757.6**	**$87,735,987**	**$1,876.40**	**30,000.8**	**$53,186,770**	**$1,772.85**	**0.945**
Facility, age 65+, with SPMI	3,809.6	$8,358,661	$2,194.13	1,918.1	$4,719,312	$2,460.35	1.121
Facility, age 65+, no SPMI	2,203.8	$5,228,923	$2,372.69	1,357.1	$2,061,770	$1,519.21	0.640
HCBS, age 65+, with SPMI	6,978.0	$15,684,642	$2,247.72	4,345.1	$8,506,067	$1,957.60	0.871
HCBS, age 65+, no SPMI	6,832.0	$11,115,152	$1,626.92	4,256.5	$8,345,236	$1,960.61	1.205
Community, age 65+, with SPMI	3,031.8	$5,038,294	$1,661.79	1,841.1	$2,317,718	$1,258.90	0.758
Community, age 65+, no SPMI	6,550.5	$9,290,753	$1,418.33	4,021.4	$6,163,755	$1,532.74	1.081
Facility, age <65, with SPMI	838.1	$2,746,817	$3,277.45	573.6	$1,255,652	$2,189.16	0.668
Facility, age <65, no SPMI	408.1	$1,308,200	$3,205.47	272.4	$272,255	$999.48	0.312
HCBS, age <65, with SPMI	3,681.0	$9,150,705	$2,485.91	3,158.0	$6,403,327	$2,027.67	0.816
HCBS, age <65, no SPMI	2,743.4	$4,104,114	$1,496.02	2,334.8	$3,788,078	$1,622.47	1.085
Community, age <65, with SPMI	5,663.0	$9,339,771	$1,649.26	3,508.6	$5,082,291	$1,448.53	0.878
Community, age <65, no SPMI	4,018.3	$6,369,955	$1,585.23	2,414.2	$4,271,311	$1,769.27	1.116

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.O-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 7A

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**46,757.6**	**$93,789,158**	**$2,005.86**	**20,131.8**	**$37,948,389**	**$1,885.00**	**0.940**
Facility, age 65+, with SPMI	3,809.6	$9,922,666	$2,604.68	1,090.8	$2,425,567	$2,223.66	0.854
Facility, age 65+, no SPMI	2,203.8	$5,865,589	$2,661.58	801.0	$1,445,673	$1,804.91	0.678
HCBS, age 65+, with SPMI	6,978.0	$14,292,060	$2,048.16	2,922.1	$8,447,775	$2,891.02	1.412
HCBS, age 65+, no SPMI	6,832.0	$9,999,269	$1,463.59	2,724.5	$4,562,945	$1,674.79	1.144
Community, age 65+, with SPMI	3,031.8	$5,081,153	$1,675.93	1,290.3	$2,195,935	$1,701.84	1.015
Community, age 65+, no SPMI	6,550.5	$10,276,117	$1,568.75	2,608.6	$3,707,619	$1,421.28	0.906
Facility, age <65, with SPMI	838.1	$3,647,011	$4,351.55	465.4	$861,124	$1,850.47	0.425
Facility, age <65, no SPMI	408.1	$1,535,898	$3,763.39	192.6	$614,965	$3,193.29	0.849
HCBS, age <65, with SPMI	3,681.0	$9,937,913	$2,699.77	2,239.3	$4,975,930	$2,222.12	0.823
HCBS, age <65, no SPMI	2,743.4	$5,707,149	$2,080.35	1,729.6	$3,024,869	$1,748.88	0.841
Community, age <65, with SPMI	5,663.0	$9,234,036	$1,630.59	2,548.7	$3,664,386	$1,437.76	0.882
Community, age <65, no SPMI	4,018.3	$8,290,298	$2,063.13	1,519.0	$2,021,600	$1,330.90	0.645
Intervention group	**46,757.6**	**$87,735,987**	**$1,876.40**	**20,131.8**	**$36,068,006**	**$1,791.60**	**0.955**
Facility, age 65+, with SPMI	3,809.6	$8,358,661	$2,194.13	1,090.8	$2,078,799	$1,905.76	0.869
Facility, age 65+, no SPMI	2,203.8	$5,228,923	$2,372.69	801.0	$1,362,325	$1,700.85	0.717
HCBS, age 65+, with SPMI	6,978.0	$15,684,642	$2,247.72	2,922.1	$5,640,935	$1,930.45	0.859
HCBS, age 65+, no SPMI	6,832.0	$11,115,152	$1,626.92	2,724.5	$5,577,701	$2,047.24	1.258
Community, age 65+, with SPMI	3,031.8	$5,038,294	$1,661.79	1,290.3	$1,623,492	$1,258.20	0.757
Community, age 65+, no SPMI	6,550.5	$9,290,753	$1,418.33	2,608.6	$4,359,804	$1,671.29	1.178
Facility, age <65, with SPMI	838.1	$2,746,817	$3,277.45	465.4	$1,118,887	$2,404.37	0.734
Facility, age <65, no SPMI	408.1	$1,308,200	$3,205.47	192.6	$333,588	$1,732.20	0.540
HCBS, age <65, with SPMI	3,681.0	$9,150,705	$2,485.91	2,239.3	$4,761,719	$2,126.46	0.855
HCBS, age <65, no SPMI	2,743.4	$4,104,114	$1,496.02	1,729.6	$2,732,658	$1,579.93	1.056
Community, age <65, with SPMI	5,663.0	$9,339,771	$1,649.26	2,548.7	$3,840,231	$1,506.76	0.914
Community, age <65, no SPMI	4,018.3	$6,369,955	$1,585.23	1,519.0	$2,637,867	$1,736.61	1.095

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.P-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 7B

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**22,665.5**	**$42,348,648**	**$1,868.42**	**13,800.7**	**$22,475,076**	**$1,628.55**	**0.872**
Facility, age 65+, with SPMI	1,456.3	$3,318,688	$2,278.85	671.9	$1,741,868	$2,592.34	1.138
Facility, age 65+, no SPMI	919.5	$2,291,624	$2,492.14	469.6	$1,065,273	$2,268.62	0.910
HCBS, age 65+, with SPMI	2,825.6	$6,483,869	$2,294.70	1,757.6	$3,903,484	$2,220.89	0.968
HCBS, age 65+, no SPMI	3,081.5	$6,080,738	$1,973.32	1,911.7	$2,769,747	$1,448.86	0.734
Community, age 65+, with SPMI	2,238.3	$4,200,018	$1,876.43	1,187.9	$2,486,335	$2,093.08	1.115
Community, age 65+, no SPMI	5,466.4	$8,308,989	$1,520.01	3,450.3	$4,399,601	$1,275.12	0.839
Facility, age <65, with SPMI	290.9	$1,033,571	$3,552.58	110.4	$273,675	$2,479.23	0.698
Facility, age <65, no SPMI	179.5	$323,120	$1,800.27	123.0	$160,480	$1,304.71	0.725
HCBS, age <65, with SPMI	1,672.6	$3,398,664	$2,032.02	1,260.6	$2,126,663	$1,687.05	0.830
HCBS, age <65, no SPMI	1,114.3	$1,232,394	$1,105.98	818.4	$596,988	$729.50	0.660
Community, age <65, with SPMI	2,271.4	$3,770,553	$1,660.02	1,364.1	$1,923,726	$1,410.22	0.850
Community, age <65, no SPMI	1,149.2	$1,906,421	$1,658.86	675.2	$1,027,236	$1,521.28	0.917
Intervention group	**22,665.5**	**$45,179,933**	**$1,993.34**	**13,800.7**	**$22,290,308**	**$1,615.16**	**0.810**
Facility, age 65+, with SPMI	1,456.3	$5,206,040	$3,574.85	671.9	$1,444,061	$2,149.12	0.601
Facility, age 65+, no SPMI	919.5	$2,433,945	$2,646.91	469.6	$1,214,512	$2,586.44	0.977
HCBS, age 65+, with SPMI	2,825.6	$6,105,055	$2,160.63	1,757.6	$2,696,334	$1,534.08	0.710
HCBS, age 65+, no SPMI	3,081.5	$5,868,760	$1,904.53	1,911.7	$3,278,494	$1,714.99	0.900
Community, age 65+, with SPMI	2,238.3	$4,237,579	$1,893.21	1,187.9	$1,983,847	$1,670.07	0.882
Community, age 65+, no SPMI	5,466.4	$7,401,720	$1,354.04	3,450.3	$4,256,269	$1,233.58	0.911
Facility, age <65, with SPMI	290.9	$1,527,833	$5,251.45	110.4	$209,810	$1,900.68	0.362
Facility, age <65, no SPMI	179.5	$1,146,709	$6,388.92	123.0	$138,024	$1,122.14	0.176
HCBS, age <65, with SPMI	1,672.6	$3,240,923	$1,937.71	1,260.6	$2,048,973	$1,625.42	0.839
HCBS, age <65, no SPMI	1,114.3	$1,646,553	$1,477.66	818.4	$1,512,533	$1,848.26	1.251
Community, age <65, with SPMI	2,271.4	$3,902,422	$1,718.08	1,364.1	$2,033,674	$1,490.82	0.868
Community, age <65, no SPMI	1,149.2	$2,462,393	$2,142.64	675.2	$1,473,776	$2,182.58	1.019

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.P-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 7B

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**22,665.5**	**$42,348,648**	**$1,868.42**	**9,644.2**	**$15,026,230**	**$1,558.05**	**0.834**
Facility, age 65+, with SPMI	1,456.3	$3,318,688	$2,278.85	361.7	$814,681	$2,252.07	0.988
Facility, age 65+, no SPMI	919.5	$2,291,624	$2,492.14	232.6	$484,344	$2,082.34	0.836
HCBS, age 65+, with SPMI	2,825.6	$6,483,869	$2,294.70	1,271.2	$1,786,005	$1,404.96	0.612
HCBS, age 65+, no SPMI	3,081.5	$6,080,738	$1,973.32	1,345.5	$1,916,231	$1,424.23	0.722
Community, age 65+, with SPMI	2,238.3	$4,200,018	$1,876.43	762.1	$1,460,711	$1,916.70	1.021
Community, age 65+, no SPMI	5,466.4	$8,308,989	$1,520.01	2,454.9	$3,814,764	$1,553.94	1.022
Facility, age <65, with SPMI	290.9	$1,033,571	$3,552.58	84.3	$210,823	$2,500.87	0.704
Facility, age <65, no SPMI	179.5	$323,120	$1,800.27	116.1	$183,255	$1,578.03	0.877
HCBS, age <65, with SPMI	1,672.6	$3,398,664	$2,032.02	980.3	$1,839,258	$1,876.23	0.923
HCBS, age <65, no SPMI	1,114.3	$1,232,394	$1,105.98	566.6	$394,358	$696.03	0.629
Community, age <65, with SPMI	2,271.4	$3,770,553	$1,660.02	988.9	$1,384,270	$1,399.85	0.843
Community, age <65, no SPMI	1,149.2	$1,906,421	$1,658.86	480.1	$737,531	$1,536.32	0.926
Intervention group	**22,665.5**	**$45,179,933**	**$1,993.34**	**9,644.2**	**$15,780,506**	**$1,636.26**	**0.821**
Facility, age 65+, with SPMI	1,456.3	$5,206,040	$3,574.85	361.7	$743,932	$2,056.49	0.575
Facility, age 65+, no SPMI	919.5	$2,433,945	$2,646.91	232.6	$560,721	$2,410.71	0.911
HCBS, age 65+, with SPMI	2,825.6	$6,105,055	$2,160.63	1,271.2	$2,195,288	$1,726.92	0.799
HCBS, age 65+, no SPMI	3,081.5	$5,868,760	$1,904.53	1,345.5	$2,326,175	$1,728.91	0.908
Community, age 65+, with SPMI	2,238.3	$4,237,579	$1,893.21	762.1	$1,025,846	$1,346.08	0.711
Community, age 65+, no SPMI	5,466.4	$7,401,720	$1,354.04	2,454.9	$3,299,779	$1,344.16	0.993
Facility, age <65, with SPMI	290.9	$1,527,833	$5,251.45	84.3	$208,295	$2,470.87	0.471
Facility, age <65, no SPMI	179.5	$1,146,709	$6,388.92	116.1	$93,376	$804.07	0.126
HCBS, age <65, with SPMI	1,672.6	$3,240,923	$1,937.71	980.3	$1,461,638	$1,491.02	0.769
HCBS, age <65, no SPMI	1,114.3	$1,646,553	$1,477.66	566.6	$1,236,766	$2,182.87	1.477
Community, age <65, with SPMI	2,271.4	$3,902,422	$1,718.08	988.9	$1,864,622	$1,885.61	1.098
Community, age <65, no SPMI	1,149.2	$2,462,393	$2,142.64	480.1	$764,068	$1,591.59	0.743

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.Q-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 8A

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**36,696.5**	**$76,684,514**	**$2,089.70**	**36,291.3**	**$73,826,297**	**$2,034.27**	**0.973**
Facility, age 65+, with SPMI	2,281.2	$7,089,903	$3,107.93	2,038.9	$5,914,622	$2,900.89	0.933
Facility, age 65+, no SPMI	1,285.5	$3,586,312	$2,789.81	1,125.8	$3,100,212	$2,753.78	0.987
HCBS, age 65+, with SPMI	5,063.4	$12,089,202	$2,387.57	4,881.5	$11,717,332	$2,400.33	1.005
HCBS, age 65+, no SPMI	4,985.7	$7,565,106	$1,517.36	4,844.5	$9,983,267	$2,060.75	1.358
Community, age 65+, with SPMI	3,069.8	$6,420,086	$2,091.34	2,990.6	$5,434,554	$1,817.20	0.869
Community, age 65+, no SPMI	5,689.7	$7,713,217	$1,355.65	5,767.8	$6,280,340	$1,088.87	0.803
Facility, age <65, with SPMI	601.7	$2,858,350	$4,750.41	582.4	$2,234,500	$3,836.93	0.808
Facility, age <65, no SPMI	368.1	$1,278,314	$3,472.84	364.0	$1,417,822	$3,895.27	1.122
HCBS, age <65, with SPMI	3,341.9	$7,804,403	$2,335.31	3,472.3	$6,909,408	$1,989.85	0.852
HCBS, age <65, no SPMI	2,298.1	$4,201,683	$1,828.36	2,508.7	$6,364,647	$2,537.00	1.388
Community, age <65, with SPMI	4,288.1	$9,215,779	$2,149.15	4,141.1	$7,624,740	$1,841.25	0.857
Community, age <65, no SPMI	3,423.3	$6,862,157	$2,004.56	3,573.7	$6,844,855	$1,915.34	0.955
Intervention group	**36,696.5**	**$75,138,004**	**$2,047.55**	**36,291.3**	**$65,621,143**	**$1,808.18**	**0.883**
Facility, age 65+, with SPMI	2,281.2	$7,194,679	$3,153.86	2,038.9	$5,014,173	$2,459.25	0.780
Facility, age 65+, no SPMI	1,285.5	$3,742,466	$2,911.28	1,125.8	$2,747,921	$2,440.86	0.838
HCBS, age 65+, with SPMI	5,063.4	$11,550,288	$2,281.13	4,881.5	$9,014,629	$1,846.68	0.810
HCBS, age 65+, no SPMI	4,985.7	$9,020,906	$1,809.36	4,844.5	$8,641,848	$1,783.85	0.986
Community, age 65+, with SPMI	3,069.8	$6,794,334	$2,213.25	2,990.6	$5,047,303	$1,687.71	0.763
Community, age 65+, no SPMI	5,689.7	$8,316,343	$1,461.65	5,767.8	$8,081,072	$1,401.07	0.959
Facility, age <65, with SPMI	601.7	$3,239,207	$5,383.38	582.4	$2,381,592	$4,089.51	0.760
Facility, age <65, no SPMI	368.1	$529,358	$1,438.12	364.0	$511,050	$1,404.04	0.976
HCBS, age <65, with SPMI	3,341.9	$6,388,174	$1,911.53	3,472.3	$7,784,988	$2,242.01	1.173
HCBS, age <65, no SPMI	2,298.1	$4,400,107	$1,914.71	2,508.7	$4,714,662	$1,879.30	0.982
Community, age <65, with SPMI	4,288.1	$8,206,963	$1,913.89	4,141.1	$6,163,587	$1,488.40	0.778
Community, age <65, no SPMI	3,423.3	$5,755,180	$1,681.20	3,573.7	$5,518,318	$1,544.14	0.918

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.Q-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 8A

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**36,696.5**	**$76,684,514**	**$2,089.70**	**23,270.8**	**$45,844,068**	**$1,970.02**	**0.943**
Facility, age 65+, with SPMI	2,281.2	$7,089,903	$3,107.93	1,133.2	$2,387,110	$2,106.57	0.678
Facility, age 65+, no SPMI	1,285.5	$3,586,312	$2,789.81	643.0	$1,616,073	$2,513.46	0.901
HCBS, age 65+, with SPMI	5,063.4	$12,089,202	$2,387.57	3,248.7	$8,090,430	$2,490.38	1.043
HCBS, age 65+, no SPMI	4,985.7	$7,565,106	$1,517.36	3,089.7	$7,478,687	$2,420.54	1.595
Community, age 65+, with SPMI	3,069.8	$6,420,086	$2,091.34	1,994.7	$2,567,386	$1,287.08	0.615
Community, age 65+, no SPMI	5,689.7	$7,713,217	$1,355.65	3,364.7	$5,738,847	$1,705.61	1.258
Facility, age <65, with SPMI	601.7	$2,858,350	$4,750.41	366.5	$1,092,666	$2,980.95	0.628
Facility, age <65, no SPMI	368.1	$1,278,314	$3,472.84	268.7	$1,395,103	$5,191.84	1.495
HCBS, age <65, with SPMI	3,341.9	$7,804,403	$2,335.31	2,548.8	$5,769,089	$2,263.45	0.969
HCBS, age <65, no SPMI	2,298.1	$4,201,683	$1,828.36	1,735.6	$2,513,806	$1,448.42	0.792
Community, age <65, with SPMI	4,288.1	$9,215,779	$2,149.15	2,710.4	$3,644,736	$1,344.74	0.626
Community, age <65, no SPMI	3,423.3	$6,862,157	$2,004.56	2,166.9	$3,550,136	$1,638.32	0.817
Intervention group	**36,696.5**	**$75,138,004**	**$2,047.55**	**23,270.8**	**$44,388,305**	**$1,907.47**	**0.932**
Facility, age 65+, with SPMI	2,281.2	$7,194,679	$3,153.86	1,133.2	$2,345,657	$2,069.99	0.656
Facility, age 65+, no SPMI	1,285.5	$3,742,466	$2,911.28	643.0	$1,107,231	$1,722.06	0.592
HCBS, age 65+, with SPMI	5,063.4	$11,550,288	$2,281.13	3,248.7	$7,015,514	$2,159.50	0.947
HCBS, age 65+, no SPMI	4,985.7	$9,020,906	$1,809.36	3,089.7	$6,031,277	$1,952.08	1.079
Community, age 65+, with SPMI	3,069.8	$6,794,334	$2,213.25	1,994.7	$3,841,239	$1,925.69	0.870
Community, age 65+, no SPMI	5,689.7	$8,316,343	$1,461.65	3,364.7	$5,202,310	$1,546.15	1.058
Facility, age <65, with SPMI	601.7	$3,239,207	$5,383.38	366.5	$1,624,792	$4,432.67	0.823
Facility, age <65, no SPMI	368.1	$529,358	$1,438.12	268.7	$299,170	$1,113.35	0.774
HCBS, age <65, with SPMI	3,341.9	$6,388,174	$1,911.53	2,548.8	$5,165,779	$2,026.74	1.060
HCBS, age <65, no SPMI	2,298.1	$4,400,107	$1,914.71	1,735.6	$3,271,921	$1,885.23	0.985
Community, age <65, with SPMI	4,288.1	$8,206,963	$1,913.89	2,710.4	$3,995,855	$1,474.29	0.770
Community, age <65, no SPMI	3,423.3	$5,755,180	$1,681.20	2,166.9	$4,487,560	$2,070.92	1.232

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.R-1
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 7, by category of beneficiary: Cohort 8B

	Baseline period			Demonstration Year 7			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**17,043.2**	**$33,246,266**	**$1,950.70**	**16,421.5**	**$28,732,978**	**$1,749.72**	**0.897**
Facility, age 65+, with SPMI	903.2	$2,529,934	$2,801.00	764.0	$2,015,474	$2,638.10	0.942
Facility, age 65+, no SPMI	654.6	$1,468,149	$2,242.66	595.0	$1,439,290	$2,418.95	1.079
HCBS, age 65+, with SPMI	1,825.3	$3,956,809	$2,167.73	1,670.8	$3,479,220	$2,082.36	0.961
HCBS, age 65+, no SPMI	2,061.0	$4,107,716	$1,993.06	2,009.6	$3,818,443	$1,900.11	0.953
Community, age 65+, with SPMI	1,715.6	$3,670,252	$2,139.30	1,555.9	$2,963,526	$1,904.73	0.890
Community, age 65+, no SPMI	4,754.6	$6,940,246	$1,459.70	4,630.3	$5,976,315	$1,290.70	0.884
Facility, age <65, with SPMI	266.0	$1,204,187	$4,527.02	264.6	$1,000,553	$3,782.07	0.835
Facility, age <65, no SPMI	118.0	$500,666	$4,242.94	124.4	$286,045	$2,299.39	0.542
HCBS, age <65, with SPMI	989.9	$2,444,382	$2,469.44	1,046.2	$1,647,345	$1,574.64	0.638
HCBS, age <65, no SPMI	982.8	$1,384,558	$1,408.83	1,094.6	$1,470,226	$1,343.19	0.953
Community, age <65, with SPMI	1,662.0	$2,645,514	$1,591.77	1,551.3	$2,198,267	$1,417.03	0.890
Community, age <65, no SPMI	1,110.2	$2,393,853	$2,156.21	1,114.9	$2,438,274	$2,187.05	1.014
Intervention group	**17,043.2**	**$33,145,837**	**$1,944.81**	**16,421.5**	**$28,424,461**	**$1,730.93**	**0.890**
Facility, age 65+, with SPMI	903.2	$2,665,852	$2,951.48	764.0	$1,954,616	$2,558.44	0.867
Facility, age 65+, no SPMI	654.6	$1,988,936	$3,038.19	595.0	$1,940,936	$3,262.04	1.074
HCBS, age 65+, with SPMI	1,825.3	$3,536,576	$1,937.51	1,670.8	$2,947,655	$1,764.21	0.911
HCBS, age 65+, no SPMI	2,061.0	$2,628,342	$1,275.27	2,009.6	$2,762,395	$1,374.60	1.078
Community, age 65+, with SPMI	1,715.6	$3,202,588	$1,866.71	1,555.9	$2,035,597	$1,308.33	0.701
Community, age 65+, no SPMI	4,754.6	$6,418,271	$1,349.91	4,630.3	$4,707,014	$1,016.57	0.753
Facility, age <65, with SPMI	266.0	$1,404,239	$5,279.10	264.6	$978,641	$3,699.24	0.701
Facility, age <65, no SPMI	118.0	$158,965	$1,347.16	124.4	$246,755	$1,983.56	1.472
HCBS, age <65, with SPMI	989.9	$2,786,336	$2,814.90	1,046.2	$2,971,302	$2,840.17	1.009
HCBS, age <65, no SPMI	982.8	$2,142,705	$2,180.27	1,094.6	$1,712,556	$1,564.58	0.718
Community, age <65, with SPMI	1,662.0	$3,485,494	$2,097.18	1,551.3	$2,962,057	$1,909.38	0.910
Community, age <65, no SPMI	1,110.2	$2,727,532	$2,456.76	1,114.9	$3,204,936	$2,874.72	1.170

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.R-2
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 8B

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**17,043.2**	**$33,246,266**	**$1,950.70**	**10,811.3**	**$18,348,592**	**$1,697.17**	**0.870**
Facility, age 65+, with SPMI	903.2	$2,529,934	$2,801.00	431.9	$1,251,204	$2,896.71	1.034
Facility, age 65+, no SPMI	654.6	$1,468,149	$2,242.66	322.7	$583,803	$1,809.11	0.807
HCBS, age 65+, with SPMI	1,825.3	$3,956,809	$2,167.73	1,150.2	$2,694,280	$2,342.50	1.081
HCBS, age 65+, no SPMI	2,061.0	$4,107,716	$1,993.06	1,264.9	$2,340,182	$1,850.12	0.928
Community, age 65+, with SPMI	1,715.6	$3,670,252	$2,139.30	1,022.7	$1,760,133	$1,721.03	0.804
Community, age 65+, no SPMI	4,754.6	$6,940,246	$1,459.70	3,127.2	$4,574,666	$1,462.85	1.002
Facility, age <65, with SPMI	266.0	$1,204,187	$4,527.02	181.1	$462,625	$2,554.36	0.564
Facility, age <65, no SPMI	118.0	$500,666	$4,242.94	86.0	$147,149	$1,711.03	0.403
HCBS, age <65, with SPMI	989.9	$2,444,382	$2,469.44	722.3	$1,190,889	$1,648.84	0.668
HCBS, age <65, no SPMI	982.8	$1,384,558	$1,408.83	762.5	$504,722	$661.91	0.470
Community, age <65, with SPMI	1,662.0	$2,645,514	$1,591.77	1,093.0	$1,536,974	$1,406.14	0.883
Community, age <65, no SPMI	1,110.2	$2,393,853	$2,156.21	646.7	$1,301,965	$2,013.25	0.934
Intervention group	**17,043.2**	**$33,145,837**	**$1,944.81**	**10,811.3**	**$18,608,070**	**$1,721.17**	**0.885**
Facility, age 65+, with SPMI	903.2	$2,665,852	$2,951.48	431.9	$930,554	$2,154.36	0.730
Facility, age 65+, no SPMI	654.6	$1,988,936	$3,038.19	322.7	$545,448	$1,690.26	0.556
HCBS, age 65+, with SPMI	1,825.3	$3,536,576	$1,937.51	1,150.2	$2,548,587	$2,215.83	1.144
HCBS, age 65+, no SPMI	2,061.0	$2,628,342	$1,275.27	1,264.9	$1,710,126	$1,352.00	1.060
Community, age 65+, with SPMI	1,715.6	$3,202,588	$1,866.71	1,022.7	$978,364	$956.63	0.512
Community, age 65+, no SPMI	4,754.6	$6,418,271	$1,349.91	3,127.2	$3,778,684	$1,208.31	0.895
Facility, age <65, with SPMI	266.0	$1,404,239	$5,279.10	181.1	$434,651	$2,399.90	0.455
Facility, age <65, no SPMI	118.0	$158,965	$1,347.16	86.0	$45,536	$529.49	0.393
HCBS, age <65, with SPMI	989.9	$2,786,336	$2,814.90	722.3	$2,109,969	$2,921.35	1.038
HCBS, age <65, no SPMI	982.8	$2,142,705	$2,180.27	762.5	$1,210,768	$1,587.85	0.728
Community, age <65, with SPMI	1,662.0	$3,485,494	$2,097.18	1,093.0	$2,038,230	$1,864.73	0.889
Community, age <65, no SPMI	1,110.2	$2,727,532	$2,456.76	646.7	$2,277,152	$3,521.20	1.433

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.S
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 9A

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**36,543.7**	**$78,755,081**	**$2,155.10**	**36,783.5**	**$80,876,454**	**$2,198.72**	**1.020**
Facility, age 65+, with SPMI	2,137.3	$7,625,162	$3,567.71	1,905.3	$4,274,441	$2,243.42	0.629
Facility, age 65+, no SPMI	1,104.6	$4,060,163	$3,675.79	1,000.5	$2,416,710	$2,415.46	0.657
HCBS, age 65+, with SPMI	4,508.8	$11,553,752	$2,562.51	4,177.7	$14,808,103	$3,544.53	1.383
HCBS, age 65+, no SPMI	4,201.1	$8,547,691	$2,034.64	3,977.0	$8,008,477	$2,013.71	0.990
Community, age 65+, with SPMI	2,770.5	$4,420,970	$1,595.71	2,687.7	$5,858,525	$2,179.74	1.366
Community, age 65+, no SPMI	6,396.0	$9,180,343	$1,435.32	6,720.7	$10,329,446	$1,536.97	1.071
Facility, age <65, with SPMI	532.4	$2,214,850	$4,159.97	525.7	$1,657,874	$3,153.78	0.758
Facility, age <65, no SPMI	205.0	$846,472	$4,129.78	237.0	$468,998	$1,979.15	0.479
HCBS, age <65, with SPMI	3,030.8	$5,573,180	$1,838.83	3,128.3	$7,179,571	$2,295.01	1.248
HCBS, age <65, no SPMI	2,219.2	$4,109,543	$1,851.79	2,356.6	$4,200,978	$1,782.66	0.963
Community, age <65, with SPMI	5,024.6	$10,867,589	$2,162.87	5,012.3	$8,516,648	$1,699.16	0.786
Community, age <65, no SPMI	4,413.4	$9,755,365	$2,210.41	5,054.7	$13,156,682	$2,602.85	1.178
Intervention group	**36,543.7**	**$77,445,770**	**$2,119.27**	**36,783.5**	**$70,197,676**	**$1,908.40**	**0.901**
Facility, age 65+, with SPMI	2,137.3	$8,823,137	$4,128.23	1,905.3	$4,762,913	$2,499.80	0.606
Facility, age 65+, no SPMI	1,104.6	$3,753,576	$3,398.22	1,000.5	$1,749,480	$1,748.57	0.515
HCBS, age 65+, with SPMI	4,508.8	$12,028,265	$2,667.75	4,177.7	$9,969,072	$2,386.24	0.894
HCBS, age 65+, no SPMI	4,201.1	$7,003,302	$1,667.02	3,977.0	$7,379,331	$1,855.51	1.113
Community, age 65+, with SPMI	2,770.5	$7,205,320	$2,600.70	2,687.7	$5,648,649	$2,101.65	0.808
Community, age 65+, no SPMI	6,396.0	$9,598,470	$1,500.69	6,720.7	$10,444,216	$1,554.04	1.036
Facility, age <65, with SPMI	532.4	$2,457,652	$4,616.01	525.7	$1,468,785	$2,794.08	0.605
Facility, age <65, no SPMI	205.0	$621,227	$3,030.85	237.0	$484,372	$2,044.03	0.674
HCBS, age <65, with SPMI	3,030.8	$6,330,661	$2,088.76	3,128.3	$5,240,827	$1,675.28	0.802
HCBS, age <65, no SPMI	2,219.2	$3,295,130	$1,484.81	2,356.6	$3,658,080	$1,552.28	1.045
Community, age <65, with SPMI	5,024.6	$9,115,041	$1,814.08	5,012.3	$8,205,263	$1,637.04	0.902
Community, age <65, no SPMI	4,413.4	$7,213,987	$1,634.58	5,054.7	$11,186,688	$2,213.11	1.354

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix Table C.T
Eligible months, incurred claims, and PMPM for the re-weighted comparison group and the intervention group, baseline period, and the Demonstration Year 8, by category of beneficiary: Cohort 9B

	Baseline period			Demonstration Year 8			
Category of beneficiary	Number of eligible months	Incurred claims	PMPM	Number of eligible months	Incurred claims	PMPM	Trend (D/B)[a]
Re-weighted comparison group	**16,436.9**	**$36,322,230**	**$2,209.80**	**15,801.5**	**$32,516,258**	**$2,057.80**	**0.931**
Facility, age 65+, with SPMI	928.2	$3,177,189	$3,423.09	951.9	$2,198,767	$2,309.88	0.675
Facility, age 65+, no SPMI	448.2	$1,246,073	$2,780.34	430.8	$961,168	$2,230.97	0.802
HCBS, age 65+, with SPMI	1,977.6	$5,291,253	$2,675.63	1,803.6	$5,955,134	$3,301.88	1.234
HCBS, age 65+, no SPMI	2,023.4	$3,402,942	$1,681.77	1,840.0	$3,776,067	$2,052.21	1.220
Community, age 65+, with SPMI	1,583.2	$2,939,895	$1,856.96	1,444.7	$2,867,504	$1,984.89	1.069
Community, age 65+, no SPMI	3,843.0	$6,189,107	$1,610.47	3,671.2	$5,313,147	$1,447.25	0.899
Facility, age <65, with SPMI	152.2	$661,461	$4,346.18	163.0	$648,585	$3,978.26	0.915
Facility, age <65, no SPMI	137.0	$339,751	$2,479.94	145.0	$194,237	$1,339.56	0.540
HCBS, age <65, with SPMI	1,251.7	$3,579,355	$2,859.69	1,191.6	$2,860,913	$2,400.89	0.840
HCBS, age <65, no SPMI	841.1	$2,332,104	$2,772.69	910.7	$1,236,395	$1,357.57	0.490
Community, age <65, with SPMI	2,038.4	$3,890,745	$1,908.70	1,859.5	$3,330,724	$1,791.15	0.938
Community, age <65, no SPMI	1,212.9	$3,272,354	$2,697.92	1,389.4	$3,173,616	$2,284.11	0.847
Intervention group	**16,436.9**	**$36,960,759**	**$2,248.65**	**15,801.5**	**$31,187,264**	**$1,973.69**	**0.878**
Facility, age 65+, with SPMI	928.2	$3,685,005	$3,970.21	951.9	$2,203,919	$2,315.29	0.583
Facility, age 65+, no SPMI	448.2	$1,922,562	$4,289.78	430.8	$951,970	$2,209.62	0.515
HCBS, age 65+, with SPMI	1,977.6	$4,411,972	$2,231.00	1,803.6	$3,346,320	$1,855.40	0.832
HCBS, age 65+, no SPMI	2,023.4	$2,802,205	$1,384.88	1,840.0	$2,787,285	$1,514.83	1.094
Community, age 65+, with SPMI	1,583.2	$3,658,256	$2,310.70	1,444.7	$2,686,931	$1,859.89	0.805
Community, age 65+, no SPMI	3,843.0	$5,007,346	$1,302.96	3,671.2	$5,140,751	$1,400.29	1.075
Facility, age <65, with SPMI	152.2	$794,776	$5,222.14	163.0	$382,156	$2,344.05	0.449
Facility, age <65, no SPMI	137.0	$385,632	$2,814.83	145.0	$375,243	$2,587.89	0.919
HCBS, age <65, with SPMI	1,251.7	$3,000,342	$2,397.10	1,191.6	$2,385,728	$2,002.11	0.835
HCBS, age <65, no SPMI	841.1	$2,386,481	$2,837.34	910.7	$2,538,436	$2,787.22	0.982
Community, age <65, with SPMI	2,038.4	$5,949,273	$2,918.56	1,859.5	$5,310,155	$2,855.62	0.978
Community, age <65, no SPMI	1,212.9	$2,956,908	$2,437.85	1,389.4	$3,078,370	$2,215.56	0.909

[a] Demonstration Period PMPM divided by Baseline Period PMPM.

Appendix D
Medicare Savings Calculation: Intervention and Target PMPM, by Cohort and Category of Beneficiary

Appendix Table D.A-1
Medicare Demonstration Year 7 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	**6,312.0**	**$2,652.67**	**1.378**	**$3,656.14**	**$2,550.81**	**$1,105.32**	**$6,976,783**	**30.2%**
Facility, age 65+, with SPMI	34.0	$3,321.06	1.302	$4,322.52	$1,391.25	$2,931.27	$99,663	67.8%
Facility, age 65+, no SPMI	43.8	$2,476.33	1.065	$2,637.05	$1,057.79	$1,579.26	$69,131	59.9%
HCBS, age 65+, with SPMI	262.2	$2,903.67	1.325	$3,848.67	$1,580.11	$2,268.57	$594,923	58.9%
HCBS, age 65+, no SPMI	939.7	$2,389.27	1.652	$3,947.08	$2,674.33	$1,272.75	$1,195,993	32.2%
Community, age 65+, with SPMI	169.5	$2,067.95	1.418	$2,933.38	$898.31	$2,035.07	$344,876	69.4%
Community, age 65+, no SPMI	822.5	$2,124.06	1.514	$3,216.61	$2,235.75	$980.86	$806,761	30.5%
Facility, age <65, with SPMI	46.5	$5,306.80	0.959	$5,088.62	$1,786.56	$3,302.05	$153,656	64.9%
Facility, age <65, no SPMI	104.0	$4,764.97	1.216	$5,793.92	$1,569.84	$4,224.09	$439,346	72.9%
HCBS, age <65, with SPMI	645.5	$2,780.44	1.057	$2,938.88	$2,279.54	$659.34	$425,626	22.4%
HCBS, age <65, no SPMI	1,622.2	$2,691.70	1.284	$3,455.16	$2,846.38	$608.79	$987,567	17.6%
Community, age <65, with SPMI	465.8	$2,446.14	1.112	$2,720.19	$2,662.97	$57.22	$26,657	2.1%
Community, age <65, no SPMI	1,156.2	$3,319.71	1.393	$4,623.18	$3,038.17	$1,585.01	$1,832,583	34.3%

Appendix Table D.A-2
Medicare Demonstration Year 8 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	**4,120.8**	**$2,652.67**	**1.338**	**$3,548.00**	**$2,398.44**	**$1,149.56**	**$4,737,058**	**32.4%**
Facility, age 65+, with SPMI	16.3	$3,321.06	0.915	$3,037.33	$709.40	$2,327.93	$37,998	76.6%
Facility, age 65+, no SPMI	12.0	$2,476.33	1.044	$2,584.25	$473.40	$2,110.85	$25,330	81.7%
HCBS, age 65+, with SPMI	147.4	$2,903.67	1.455	$4,224.16	$2,158.42	$2,065.74	$304,402	48.9%
HCBS, age 65+, no SPMI	587.1	$2,389.27	1.430	$3,417.33	$2,885.40	$531.93	$312,307	15.6%
Community, age 65+, with SPMI	104.6	$2,067.95	1.409	$2,912.95	$2,037.97	$874.98	$91,521	30.0%
Community, age 65+, no SPMI	488.5	$2,124.06	1.608	$3,416.50	$2,475.08	$941.42	$459,903	27.6%
Facility, age <65, with SPMI	25.0	$5,306.80	0.957	$5,078.56	$1,992.70	$3,085.86	$77,146	60.8%
Facility, age <65, no SPMI	67.6	$4,764.97	0.828	$3,943.82	$2,457.60	$1,486.22	$100,536	37.7%
HCBS, age <65, with SPMI	448.5	$2,780.44	1.194	$3,319.15	$1,814.99	$1,504.16	$674,542	45.3%
HCBS, age <65, no SPMI	1,224.0	$2,691.70	1.295	$3,485.64	$2,548.13	$937.51	$1,147,547	26.9%
Community, age <65, with SPMI	247.0	$2,446.14	1.207	$2,953.60	$1,096.68	$1,856.92	$458,660	62.9%
Community, age <65, no SPMI	752.7	$3,319.71	1.224	$4,063.97	$2,672.77	$1,391.19	$1,047,166	34.2%

Appendix Table D.B-1
Medicare Demonstration Year 7 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	**12,573.7**	**$1,298.08**	**1.341**	**$1,740.46**	**$1,769.86**	**-$29.40**	**-$369,672**	**-1.7%**
Facility, age 65+, with SPMI	209.0	$1,581.91	1.299	$2,054.39	$908.91	$1,145.48	$239,405	55.8%
Facility, age 65+, no SPMI	202.3	$1,689.87	1.062	$1,794.56	$2,315.00	-$520.44	-$105,305	-29.0%
HCBS, age 65+, with SPMI	472.8	$1,412.22	1.329	$1,877.30	$2,051.24	-$173.94	-$82,248	-9.3%
HCBS, age 65+, no SPMI	1,971.2	$1,178.09	1.656	$1,950.76	$1,756.81	$193.95	$382,308	9.9%
Community, age 65+, with SPMI	251.1	$1,140.11	1.413	$1,611.29	$1,364.98	$246.31	$61,858	15.3%
Community, age 65+, no SPMI	2,275.5	$971.09	1.519	$1,475.20	$1,862.21	-$387.01	-$880,627	-26.2%
Facility, age <65, with SPMI	159.6	$3,244.58	0.953	$3,091.81	$1,226.36	$1,865.46	$297,812	60.3%
Facility, age <65, no SPMI	91.8	$3,733.76	1.182	$4,413.19	$1,631.31	$2,781.88	$255,358	63.0%
HCBS, age <65, with SPMI	1,614.2	$1,385.95	1.056	$1,463.55	$1,307.15	$156.40	$252,471	10.7%
HCBS, age <65, no SPMI	2,068.5	$1,488.47	1.285	$1,912.68	$1,881.04	$31.64	$65,449	1.7%
Community, age <65, with SPMI	1,324.6	$1,112.23	1.112	$1,236.88	$1,628.18	-$391.31	-$518,324	-31.6%
Community, age <65, no SPMI	1,932.8	$1,390.75	1.392	$1,935.46	$2,110.25	-$174.79	-$337,828	-9.0%

Appendix Table D.B-2
Medicare Demonstration Year 8 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	**8,903.3**	**$1,298.08**	**1.313**	**$1,704.32**	**$1,861.68**	**-$157.36**	**-$1,401,060**	**-9.2%**
Facility, age 65+, with SPMI	195.2	$1,581.91	0.912	$1,442.64	$4,011.55	-$2,568.92	-$501,575	-178.1%
Facility, age 65+, no SPMI	117.2	$1,689.87	1.051	$1,776.77	$1,241.65	$535.12	$62,695	30.1%
HCBS, age 65+, with SPMI	248.0	$1,412.22	1.464	$2,067.84	$1,827.33	$240.52	$59,643	11.6%
HCBS, age 65+, no SPMI	1,259.6	$1,178.09	1.433	$1,687.67	$2,346.51	-$658.84	-$829,886	-39.0%
Community, age 65+, with SPMI	163.7	$1,140.11	1.362	$1,553.13	$1,844.94	-$291.80	-$47,771	-18.8%
Community, age 65+, no SPMI	1,564.5	$971.09	1.610	$1,563.67	$2,001.26	-$437.59	-$684,601	-28.0%
Facility, age <65, with SPMI	130.3	$3,244.58	0.975	$3,162.34	$1,306.62	$1,855.71	$241,841	58.7%
Facility, age <65, no SPMI	65.0	$3,733.76	0.820	$3,062.63	$572.25	$2,490.37	$161,874	81.3%
HCBS, age <65, with SPMI	1,213.8	$1,385.95	1.192	$1,652.04	$1,356.85	$295.19	$358,313	17.9%
HCBS, age <65, no SPMI	1,565.9	$1,488.47	1.296	$1,928.38	$2,023.67	-$95.29	-$149,217	-4.9%
Community, age <65, with SPMI	932.9	$1,112.23	1.208	$1,343.47	$1,522.04	-$178.57	-$166,581	-13.3%
Community, age <65, no SPMI	1,447.1	$1,390.75	1.220	$1,696.82	$1,631.72	$65.10	$94,205	3.8%

Appendix Table D.C-1
Medicare Demonstration Year 7 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	**969.2**	**$993.94**	**1.508**	**$1,498.78**	**$1,663.92**	**-$165.13**	**-$160,054**	**-11.0%**
Facility, age 65+, with SPMI	5.9	$2,437.80	1.209	$2,947.29	$1,233.50	$1,713.79	$10,117	58.1%
Facility, age 65+, no SPMI	12.0	$1,615.10	1.059	$1,709.78	$737.19	$972.59	$11,671	56.9%
HCBS, age 65+, with SPMI	59.0	$978.12	1.342	$1,313.08	$2,136.98	-$823.90	-$48,610	-62.7%
HCBS, age 65+, no SPMI	151.3	$905.53	1.660	$1,502.92	$1,552.52	-$49.60	-$7,506	-3.3%
Community, age 65+, with SPMI	73.2	$1,509.16	1.411	$2,128.81	$1,158.45	$970.36	$70,993	45.6%
Community, age 65+, no SPMI	142.8	$760.14	1.508	$1,146.02	$1,932.91	-$786.90	-$112,352	-68.7%
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	1.075	$10,791.46	$2,680.48	$8,110.98	$194,664	75.2%
HCBS, age <65, with SPMI	101.0	$739.84	1.047	$774.81	$507.79	$267.03	$26,970	34.5%
HCBS, age <65, no SPMI	110.5	$880.51	1.271	$1,118.79	$2,197.72	-$1,078.92	-$119,221	-96.4%
Community, age <65, with SPMI	156.3	$832.44	1.115	$928.38	$1,474.87	-$546.49	-$85,411	-58.9%
Community, age <65, no SPMI	133.3	$1,013.70	1.366	$1,384.38	$2,145.06	-$760.67	-$101,369	-54.9%

Appendix Table D.C-2
Medicare Demonstration Year 8 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	**667.3**	**$993.94**	**1.464**	**$1,455.62**	**$1,793.52**	**-$337.91**	**-$225,486**	**-23.2%**
Facility, age 65+, with SPMI	0.0	$2,437.80	0.000	$0.00	$0.00	$0.00	$0	0.0%
Facility, age 65+, no SPMI	12.0	$1,615.10	1.034	$1,670.21	$2,754.00	-$1,083.79	-$13,006	-64.9%
HCBS, age 65+, with SPMI	47.6	$978.12	1.458	$1,425.67	$1,154.92	$270.76	$12,892	19.0%
HCBS, age 65+, no SPMI	116.4	$905.53	1.436	$1,300.74	$2,098.65	-$797.91	-$92,893	-61.3%
Community, age 65+, with SPMI	39.0	$1,509.16	1.381	$2,083.72	$1,293.41	$790.31	$30,822	37.9%
Community, age 65+, no SPMI	105.5	$760.14	1.607	$1,221.36	$2,045.51	-$824.15	-$86,975	-67.5%
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	0.748	$7,515.11	$1,058.61	$6,456.50	$154,956	85.9%
HCBS, age <65, with SPMI	62.0	$739.84	1.180	$872.93	$1,010.60	-$137.66	-$8,535	-15.8%
HCBS, age <65, no SPMI	65.0	$880.51	1.293	$1,138.73	$3,689.71	-$2,550.99	-$165,814	-224.0%
Community, age <65, with SPMI	119.8	$832.44	1.203	$1,001.77	$1,091.84	-$90.07	-$10,792	-9.0%
Community, age <65, no SPMI	75.9	$1,013.70	1.212	$1,228.80	$1,836.50	-$607.70	-$46,142	-49.5%

Appendix Table D.D-1
Medicare Demonstration Year 7 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	**19,395.0**	**$1,696.25**	**1.295**	**$2,195.94**	**$2,036.23**	**$159.71**	**$3,097,488**	**7.3%**
Facility, age 65+, with SPMI	129.8	$2,345.53	1.305	$3,060.59	$1,965.09	$1,095.50	$142,168	35.8%
Facility, age 65+, no SPMI	358.8	$2,040.09	1.056	$2,153.56	$2,250.47	-$96.91	-$34,773	-4.5%
HCBS, age 65+, with SPMI	738.5	$2,012.00	1.335	$2,686.44	$2,238.13	$448.31	$331,095	16.7%
HCBS, age 65+, no SPMI	2,437.8	$1,699.59	1.651	$2,806.39	$2,293.36	$513.03	$1,250,649	18.3%
Community, age 65+, with SPMI	345.1	$1,450.66	1.413	$2,050.47	$2,343.57	-$293.10	-$101,151	-14.3%
Community, age 65+, no SPMI	2,452.2	$1,352.84	1.517	$2,052.75	$1,956.35	$96.40	$236,397	4.7%
Facility, age <65, with SPMI	107.0	$3,271.35	0.963	$3,150.80	$2,015.82	$1,134.98	$121,443	36.0%
Facility, age <65, no SPMI	153.3	$4,766.02	1.207	$5,753.64	$4,182.89	$1,570.75	$240,781	27.3%
HCBS, age <65, with SPMI	1,984.0	$1,644.72	1.058	$1,739.65	$1,684.46	$55.20	$109,508	3.2%
HCBS, age <65, no SPMI	4,186.6	$1,817.35	1.284	$2,333.82	$1,977.50	$356.31	$1,491,743	15.3%
Community, age <65, with SPMI	2,596.3	$1,327.43	1.111	$1,474.72	$1,629.69	-$154.96	-$402,320	-10.5%
Community, age <65, no SPMI	3,905.7	$1,578.14	1.393	$2,197.70	$2,271.45	-$73.75	-$288,051	-3.4%

Appendix Table D.D-2
Medicare Demonstration Year 8 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	**15,679.6**	**$1,696.25**	**1.259**	**$2,135.19**	**$2,362.41**	**-$227.22**	**-$3,562,700**	**-10.6%**
Facility, age 65+, with SPMI	102.8	$2,345.53	0.907	$2,126.37	$3,204.00	-$1,077.62	-$110,774	-50.7%
Facility, age 65+, no SPMI	170.1	$2,040.09	1.032	$2,104.66	$1,535.66	$569.00	$96,771	27.0%
HCBS, age 65+, with SPMI	624.7	$2,012.00	1.465	$2,946.92	$3,100.40	-$153.48	-$95,881	-5.2%
HCBS, age 65+, no SPMI	1,805.9	$1,699.59	1.432	$2,434.60	$2,829.43	-$394.83	-$713,044	-16.2%
Community, age 65+, with SPMI	273.3	$1,450.66	1.371	$1,988.54	$980.11	$1,008.43	$275,634	50.7%
Community, age 65+, no SPMI	1,798.4	$1,352.84	1.609	$2,177.06	$2,653.39	-$476.33	-$856,634	-21.9%
Facility, age <65, with SPMI	98.0	$3,271.35	0.975	$3,190.78	$1,100.97	$2,089.81	$204,801	65.5%
Facility, age <65, no SPMI	114.0	$4,766.02	0.829	$3,949.18	$1,625.95	$2,323.23	$264,848	58.8%
HCBS, age <65, with SPMI	1,685.0	$1,644.72	1.192	$1,960.36	$2,011.41	-$51.05	-$86,019	-2.6%
HCBS, age <65, no SPMI	3,571.4	$1,817.35	1.293	$2,349.57	$2,321.64	$27.93	$99,752	1.2%
Community, age <65, with SPMI	2,259.9	$1,327.43	1.207	$1,601.69	$1,915.47	-$313.78	-$709,102	-19.6%
Community, age <65, no SPMI	3,176.1	$1,578.14	1.223	$1,929.75	$2,538.38	-$608.63	-$1,933,053	-31.5%

Appendix Table D.E-1
Medicare Demonstration Year 7 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	**2,361.3**	**$678.93**	**1.251**	**$849.68**	**$1,283.25**	**-$433.57**	**-$1,023,818**	**-51.0%**
Facility, age 65+, with SPMI	0.0	$1,222.01	0.000	$0.00	$0.00	$0.00	$0	0.0%
Facility, age 65+, no SPMI	38.9	$860.02	1.047	$900.66	$2,627.34	-$1,726.67	-$67,234	-191.7%
HCBS, age 65+, with SPMI	17.3	$682.88	1.298	$886.32	$1,573.25	-$686.93	-$11,884	-77.5%
HCBS, age 65+, no SPMI	258.8	$808.12	1.654	$1,336.53	$1,298.33	$38.21	$9,887	2.9%
Community, age 65+, with SPMI	49.0	$771.30	1.414	$1,090.49	$213.47	$877.02	$42,974	80.4%
Community, age 65+, no SPMI	491.0	$534.63	1.523	$814.33	$1,398.65	-$584.32	-$286,922	-71.8%
Facility, age <65, with SPMI	34.0	$422.56	0.983	$415.50	$1,398.63	-$983.13	-$33,426	-236.6%
Facility, age <65, no SPMI	36.0	$1,235.18	1.201	$1,483.87	$1,544.89	-$61.01	-$2,196	-4.1%
HCBS, age <65, with SPMI	240.0	$582.37	1.060	$617.06	$571.84	$45.21	$10,851	7.3%
HCBS, age <65, no SPMI	397.3	$573.21	1.289	$738.76	$1,334.44	-$595.68	-$236,665	-80.6%
Community, age <65, with SPMI	372.0	$695.05	1.109	$770.97	$1,257.20	-$486.23	-$180,876	-63.1%
Community, age <65, no SPMI	427.0	$608.17	1.390	$845.15	$1,473.55	-$628.40	-$268,325	-74.4%

Appendix Table D.E-2
Medicare Demonstration Year 8 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	**1,891.7**	**$678.93**	**1.203**	**$816.88**	**$1,682.09**	**-$865.21**	**-$1,636,743**	**-105.9%**
Facility, age 65+, with SPMI	0.0	$1,222.01	0.000	$0.00	$0.00	$0.00	$0	0.0%
Facility, age 65+, no SPMI	12.0	$860.02	1.035	$890.29	$579.95	$310.34	$3,724	34.9%
HCBS, age 65+, with SPMI	12.0	$682.88	1.452	$991.72	$383.88	$607.84	$7,294	61.3%
HCBS, age 65+, no SPMI	167.5	$808.12	1.435	$1,159.57	$2,252.51	-$1,092.94	-$183,104	-94.3%
Community, age 65+, with SPMI	42.1	$771.30	1.386	$1,068.78	$252.51	$816.26	$34,388	76.4%
Community, age 65+, no SPMI	322.0	$534.63	1.607	$859.14	$1,626.26	-$767.12	-$247,048	-89.3%
Facility, age <65, with SPMI	31.9	$422.56	0.978	$413.11	$2,119.41	-$1,706.30	-$54,436	-413.0%
Facility, age <65, no SPMI	26.0	$1,235.18	0.829	$1,023.69	$261.79	$761.91	$19,834	74.4%
HCBS, age <65, with SPMI	221.9	$582.37	1.193	$694.74	$919.00	-$224.27	-$49,772	-32.3%
HCBS, age <65, no SPMI	349.5	$573.21	1.296	$743.15	$2,988.47	-$2,245.33	-$784,705	-302.1%
Community, age <65, with SPMI	302.1	$695.05	1.207	$838.79	$1,122.58	-$283.79	-$85,724	-33.8%
Community, age <65, no SPMI	404.6	$608.17	1.218	$740.63	$1,475.17	-$734.54	-$297,194	-99.2%

Appendix Table D.F-1
Medicare Demonstration Year 7 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	**2,621.7**	**$608.70**	**1.232**	**$749.67**	**$1,155.46**	**-$405.79**	**-$1,063,857**	**-54.1%**
Facility, age 65+, with SPMI	7.2	$1,241.30	1.310	$1,626.37	$57.02	$1,569.36	$11,289	96.5%
Facility, age 65+, no SPMI	13.3	$1,121.79	1.070	$1,200.75	$3,073.94	-$1,873.19	-$24,956	-156.0%
HCBS, age 65+, with SPMI	53.4	$803.19	1.316	$1,056.89	$2,712.95	-$1,656.06	-$88,412	-156.7%
HCBS, age 65+, no SPMI	269.2	$690.94	1.646	$1,137.24	$1,241.39	-$104.16	-$28,041	-9.2%
Community, age 65+, with SPMI	71.0	$719.43	1.414	$1,016.95	$1,064.85	-$47.89	-$3,400	-4.7%
Community, age 65+, no SPMI	590.8	$477.67	1.513	$722.90	$1,251.48	-$528.58	-$312,297	-73.1%
Facility, age <65, with SPMI	35.0	$551.42	0.967	$533.17	$1,132.78	-$599.61	-$20,986	-112.5%
Facility, age <65, no SPMI	23.5	$441.48	1.250	$551.94	$2,556.57	-$2,004.63	-$47,042	-363.2%
HCBS, age <65, with SPMI	213.4	$725.74	1.054	$764.92	$1,332.06	-$567.14	-$121,038	-74.1%
HCBS, age <65, no SPMI	467.5	$381.65	1.288	$491.43	$790.04	-$298.61	-$139,594	-60.8%
Community, age <65, with SPMI	305.0	$779.84	1.108	$864.23	$1,283.22	-$418.99	-$127,792	-48.5%
Community, age <65, no SPMI	572.4	$489.77	1.383	$677.23	$959.53	-$282.30	-$161,588	-41.7%

Appendix Table D.F-2
Medicare Demonstration Year 8 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	**2,100.0**	**$608.70**	**1.213**	**$738.27**	**$1,376.69**	**-$638.42**	**-$1,340,695**	**-86.5%**
Facility, age 65+, with SPMI	0.0	$1,241.30	0.000	$0.00	$0.00	$0.00	$0	0.0%
Facility, age 65+, no SPMI	12.0	$1,121.79	1.039	$1,165.02	$490.96	$674.06	$8,089	57.9%
HCBS, age 65+, with SPMI	36.0	$803.19	1.444	$1,160.17	$411.20	$748.97	$26,963	64.6%
HCBS, age 65+, no SPMI	192.2	$690.94	1.430	$987.79	$786.41	$201.38	$38,707	20.4%
Community, age 65+, with SPMI	52.5	$719.43	1.377	$990.41	$2,071.68	-$1,081.27	-$56,749	-109.2%
Community, age 65+, no SPMI	412.7	$477.67	1.602	$765.15	$1,911.72	-$1,146.58	-$473,146	-149.9%
Facility, age <65, with SPMI	33.2	$551.42	0.974	$537.13	$2,156.60	-$1,619.47	-$53,704	-301.5%
Facility, age <65, no SPMI	21.0	$441.48	0.849	$374.67	$1,756.00	-$1,381.33	-$29,008	-368.7%
HCBS, age <65, with SPMI	185.2	$725.74	1.195	$867.39	$1,143.19	-$275.80	-$51,085	-31.8%
HCBS, age <65, no SPMI	412.8	$381.65	1.297	$494.96	$1,778.81	-$1,283.85	-$529,971	-259.4%
Community, age <65, with SPMI	298.0	$779.84	1.206	$940.11	$1,347.07	-$406.96	-$121,275	-43.3%
Community, age <65, no SPMI	444.5	$489.77	1.223	$598.96	$822.85	-$223.89	-$99,515	-37.4%

Appendix Table D.G-1
Medicare Demonstration Year 7 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	**44,233.0**	**$1,612.13**	**1.304**	**$2,101.97**	**$1,933.38**	**$168.58**	**$7,456,870**	**8.0%**
Facility, age 65+, with SPMI	385.9	$2,187.68	1.188	$2,598.32	$1,295.71	$1,302.62	$502,642	50.1%
Facility, age 65+, no SPMI	669.2	$1,891.49	1.045	$1,976.80	$2,203.15	-$226.35	-$151,466	-11.5%
HCBS, age 65+, with SPMI	1,603.3	$1,892.37	1.328	$2,513.69	$2,080.30	$433.39	$694,864	17.2%
HCBS, age 65+, no SPMI	6,028.0	$1,566.85	1.617	$2,534.04	$2,068.99	$465.04	$2,803,291	18.4%
Community, age 65+, with SPMI	958.9	$1,375.13	1.434	$1,971.88	$1,537.88	$434.00	$416,149	22.0%
Community, age 65+, no SPMI	6,774.8	$1,218.15	1.457	$1,775.23	$1,856.27	-$81.04	-$549,040	-4.6%
Facility, age <65, with SPMI	382.2	$3,424.47	0.841	$2,879.04	$1,522.35	$1,356.69	$518,497	47.1%
Facility, age <65, no SPMI	432.6	$4,229.44	1.211	$5,120.84	$2,621.97	$2,498.87	$1,080,910	48.8%
HCBS, age <65, with SPMI	4,798.2	$1,670.54	1.011	$1,688.29	$1,541.49	$146.80	$704,389	8.7%
HCBS, age <65, no SPMI	8,852.6	$1,786.30	1.263	$2,256.85	$2,025.36	$231.49	$2,049,279	10.3%
Community, age <65, with SPMI	5,220.0	$1,286.74	1.106	$1,423.34	$1,670.09	-$246.76	-$1,288,066	-17.3%
Community, age <65, no SPMI	8,127.4	$1,647.99	1.389	$2,288.90	$2,205.80	$83.10	$675,422	3.6%

Appendix Table D.G-2
Medicare Demonstration Year 8 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	**33,362.7**	**$1,612.13**	**1.252**	**$2,018.44**	**$2,121.24**	**-$102.80**	**-$3,429,627**	**-5.1%**
Facility, age 65+, with SPMI	314.4	$2,187.68	0.799	$1,749.01	$3,576.03	-$1,827.02	-$574,351	-104.5%
Facility, age 65+, no SPMI	335.2	$1,891.49	1.012	$1,914.58	$1,366.89	$547.69	$183,603	28.6%
HCBS, age 65+, with SPMI	1,115.7	$1,892.37	1.467	$2,776.62	$2,494.00	$282.62	$315,312	10.2%
HCBS, age 65+, no SPMI	4,128.8	$1,566.85	1.401	$2,195.41	$2,550.94	-$355.53	-$1,467,913	-16.2%
Community, age 65+, with SPMI	675.3	$1,375.13	1.379	$1,896.71	$1,411.19	$485.52	$327,845	25.6%
Community, age 65+, no SPMI	4,691.7	$1,218.15	1.531	$1,865.43	$2,267.95	-$402.52	-$1,888,502	-21.6%
Facility, age <65, with SPMI	318.4	$3,424.47	0.810	$2,772.65	$1,467.16	$1,305.48	$415,649	47.1%
Facility, age <65, no SPMI	317.7	$4,229.44	0.842	$3,560.02	$1,441.39	$2,118.63	$673,040	59.5%
HCBS, age <65, with SPMI	3,816.5	$1,670.54	1.124	$1,877.65	$1,658.22	$219.43	$837,444	11.7%
HCBS, age <65, no SPMI	7,188.6	$1,786.30	1.263	$2,255.72	$2,308.91	-$53.20	-$382,408	-2.4%
Community, age <65, with SPMI	4,159.6	$1,286.74	1.169	$1,503.98	$1,656.59	-$152.61	-$634,813	-10.1%
Community, age <65, no SPMI	6,300.9	$1,647.99	1.185	$1,952.53	$2,148.46	-$195.93	-$1,234,532	-10.0%

Appendix Table D.H-1
Medicare Demonstration Year 7 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	**2,080.7**	**$2,356.60**	**1.056**	**$2,489.17**	**$2,258.01**	**$231.16**	**$480,978**	**9.3%**
Facility, age 65+, with SPMI	14.7	$6,327.51	0.666	$4,213.98	$5,830.16	-$1,616.19	-$23,826	-38.4%
Facility, age 65+, no SPMI	49.1	$5,338.95	0.876	$4,676.39	$1,340.69	$3,335.69	$163,621	71.3%
HCBS, age 65+, with SPMI	77.2	$1,791.38	0.757	$1,356.47	$1,909.98	-$553.50	-$42,709	-40.8%
HCBS, age 65+, no SPMI	245.5	$2,315.40	1.683	$3,897.67	$2,905.73	$991.94	$243,473	25.4%
Community, age 65+, with SPMI	63.0	$2,564.32	0.831	$2,130.35	$2,717.61	-$587.27	-$36,998	-27.6%
Community, age 65+, no SPMI	356.4	$2,029.05	1.271	$2,579.03	$1,257.56	$1,321.47	$470,923	51.2%
Facility, age <65, with SPMI	34.0	$2,265.17	0.706	$1,600.29	$1,108.78	$491.51	$16,711	30.7%
Facility, age <65, no SPMI	11.5	$9,194.32	0.796	$7,314.98	$11,414.69	-$4,099.72	-$47,213	-56.0%
HCBS, age <65, with SPMI	119.9	$2,892.19	0.694	$2,008.22	$2,031.67	-$23.45	-$2,811	-1.2%
HCBS, age <65, no SPMI	444.2	$2,269.10	1.272	$2,885.92	$1,773.78	$1,112.13	$494,020	38.5%
Community, age <65, with SPMI	210.7	$2,048.38	0.926	$1,897.21	$3,056.70	-$1,159.49	-$244,316	-61.1%
Community, age <65, no SPMI	454.6	$1,441.79	1.086	$1,566.11	$2,687.68	-$1,121.57	-$509,897	-71.6%

Appendix Table D.H-2
Medicare Demonstration Year 8 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	**1,489.3**	**$2,356.60**	**0.941**	**$2,216.65**	**$2,340.20**	**-$123.55**	**-$184,005**	**-5.6%**
Facility, age 65+, with SPMI	0.0	$6,327.51	0.000	$0.00	$0.00	$0.00	$0	0.0%
Facility, age 65+, no SPMI	24.0	$5,338.95	0.623	$3,325.82	$3,154.15	$171.67	$4,120	5.2%
HCBS, age 65+, with SPMI	31.2	$1,791.38	0.833	$1,491.86	$2,986.25	-$1,494.39	-$46,663	-100.2%
HCBS, age 65+, no SPMI	130.9	$2,315.40	1.776	$4,113.01	$3,470.37	$642.64	$84,094	15.6%
Community, age 65+, with SPMI	64.0	$2,564.32	1.257	$3,224.12	$2,382.02	$842.11	$53,895	26.1%
Community, age 65+, no SPMI	261.2	$2,029.05	0.899	$1,823.87	$1,226.56	$597.31	$155,992	32.7%
Facility, age <65, with SPMI	24.0	$2,265.17	1.216	$2,754.11	$947.05	$1,807.06	$43,369	65.6%
Facility, age <65, no SPMI	0.0	$9,194.32	0.000	$0.00	$0.00	$0.00	$0	0.0%
HCBS, age <65, with SPMI	96.1	$2,892.19	1.583	$4,578.62	$4,193.70	$384.92	$36,991	8.4%
HCBS, age <65, no SPMI	328.0	$2,269.10	0.740	$1,678.19	$1,642.83	$35.36	$11,598	2.1%
Community, age <65, with SPMI	166.6	$2,048.38	1.062	$2,175.53	$1,258.74	$916.78	$152,766	42.1%
Community, age <65, no SPMI	363.3	$1,441.79	1.021	$1,472.25	$3,344.33	-$1,872.07	-$680,167	-127.2%

Appendix Table D.I-1
Medicare Demonstration Year 7 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	**19,626.8**	**$1,690.19**	**1.091**	**$1,844.33**	**$1,818.39**	**$25.94**	**$509,126**	**1.4%**
Facility, age 65+, with SPMI	266.3	$2,546.62	0.987	$2,513.44	$2,702.43	-$188.99	-$50,327	-7.5%
Facility, age 65+, no SPMI	483.8	$2,124.41	0.930	$1,974.75	$1,732.51	$242.25	$117,195	12.3%
HCBS, age 65+, with SPMI	660.4	$1,974.89	1.317	$2,600.69	$2,044.28	$556.41	$367,423	21.4%
HCBS, age 65+, no SPMI	2,880.6	$1,772.34	1.269	$2,249.61	$1,985.10	$264.51	$761,940	11.8%
Community, age 65+, with SPMI	742.7	$1,390.23	0.854	$1,187.95	$1,687.33	-$499.38	-$370,914	-42.0%
Community, age 65+, no SPMI	3,571.7	$1,293.29	0.971	$1,255.35	$1,691.78	-$436.42	-$1,558,788	-34.8%
Facility, age <65, with SPMI	158.5	$4,619.24	0.696	$3,213.94	$2,223.74	$990.20	$156,995	30.8%
Facility, age <65, no SPMI	330.9	$4,369.28	0.723	$3,159.26	$1,909.12	$1,250.13	$413,679	39.6%
HCBS, age <65, with SPMI	1,790.9	$1,958.15	0.679	$1,330.37	$1,783.36	-$452.99	-$811,239	-34.0%
HCBS, age <65, no SPMI	3,220.8	$1,868.23	1.489	$2,782.28	$2,146.83	$635.45	$2,046,665	22.8%
Community, age <65, with SPMI	2,191.9	$1,309.66	0.827	$1,083.74	$1,593.60	-$509.86	-$1,117,573	-47.0%
Community, age <65, no SPMI	3,328.2	$1,466.46	1.175	$1,723.35	$1,556.87	$166.48	$554,069	9.7%

Appendix Table D.I-2
Medicare Demonstration Year 8 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	**15,285.4**	**$1,690.19**	**1.103**	**$1,864.45**	**$1,788.49**	**$75.95**	**$1,160,996**	**4.1%**
Facility, age 65+, with SPMI	222.7	$2,546.62	0.591	$1,503.93	$1,652.79	-$148.86	-$33,149	-9.9%
Facility, age 65+, no SPMI	311.3	$2,124.41	0.768	$1,631.69	$2,280.54	-$648.84	-$202,007	-39.8%
HCBS, age 65+, with SPMI	495.6	$1,974.89	1.619	$3,197.81	$2,388.72	$809.10	$400,973	25.3%
HCBS, age 65+, no SPMI	1,938.2	$1,772.34	1.187	$2,103.58	$1,570.67	$532.91	$1,032,875	25.3%
Community, age 65+, with SPMI	536.3	$1,390.23	1.125	$1,564.27	$1,331.80	$232.47	$124,682	14.9%
Community, age 65+, no SPMI	2,584.1	$1,293.29	1.453	$1,879.19	$2,076.29	-$197.10	-$509,335	-10.5%
Facility, age <65, with SPMI	131.4	$4,619.24	0.475	$2,194.33	$3,461.53	-$1,267.20	-$166,535	-57.7%
Facility, age <65, no SPMI	271.9	$4,369.28	0.643	$2,810.15	$1,475.66	$1,334.49	$362,826	47.5%
HCBS, age <65, with SPMI	1,507.8	$1,958.15	0.761	$1,489.56	$1,713.51	-$223.95	-$337,670	-15.0%
HCBS, age <65, no SPMI	2,707.4	$1,868.23	1.094	$2,043.23	$1,998.28	$44.95	$121,706	2.2%
Community, age <65, with SPMI	1,935.3	$1,309.66	1.025	$1,343.01	$1,509.95	-$166.94	-$323,069	-12.4%
Community, age <65, no SPMI	2,643.4	$1,466.46	1.256	$1,842.21	$1,581.30	$260.91	$689,700	14.2%

Appendix Table D.J-1
Medicare Demonstration Year 7 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	**21,178.4**	**$1,742.42**	**1.065**	**$1,856.00**	**$1,809.90**	**$46.10**	**$976,347**	**2.5%**
Facility, age 65+, with SPMI	553.1	$3,336.29	0.853	$2,847.42	$1,943.08	$904.34	$500,189	31.8%
Facility, age 65+, no SPMI	436.5	$2,231.28	1.077	$2,403.28	$1,738.77	$664.51	$290,062	27.7%
HCBS, age 65+, with SPMI	1,349.1	$2,410.48	0.972	$2,344.17	$2,041.36	$302.81	$408,531	12.9%
HCBS, age 65+, no SPMI	2,970.9	$1,679.14	1.604	$2,694.04	$1,903.68	$790.37	$2,348,100	29.3%
Community, age 65+, with SPMI	1,022.0	$1,908.28	1.013	$1,932.91	$1,497.54	$435.37	$444,928	22.5%
Community, age 65+, no SPMI	3,975.9	$1,220.09	1.069	$1,304.39	$1,684.06	-$379.67	-$1,509,521	-29.1%
Facility, age <65, with SPMI	176.4	$4,472.72	0.653	$2,919.74	$1,498.33	$1,421.41	$250,806	48.7%
Facility, age <65, no SPMI	165.2	$3,253.09	0.771	$2,507.90	$3,117.15	-$609.26	-$100,632	-24.3%
HCBS, age <65, with SPMI	2,305.7	$1,791.41	0.729	$1,306.09	$1,797.17	-$491.08	-$1,132,297	-37.6%
HCBS, age <65, no SPMI	3,055.7	$1,871.58	1.224	$2,290.96	$2,050.09	$240.86	$736,012	10.5%
Community, age <65, with SPMI	2,613.6	$1,469.29	0.894	$1,312.93	$1,378.81	-$65.88	-$172,194	-5.0%
Community, age <65, no SPMI	2,554.2	$1,437.51	1.085	$1,559.15	$1,984.97	-$425.82	-$1,087,636	-27.3%

Appendix Table D.J-2
Medicare Demonstration Year 8 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	**15,601.3**	**$1,742.42**	**1.185**	**$2,065.24**	**$1,788.31**	**$276.93**	**$4,320,448**	**13.4%**
Facility, age 65+, with SPMI	387.7	$3,336.29	0.822	$2,741.73	$1,974.58	$767.15	$297,420	28.0%
Facility, age 65+, no SPMI	289.5	$2,231.28	1.115	$2,488.24	$2,163.52	$324.73	$94,006	13.1%
HCBS, age 65+, with SPMI	864.1	$2,410.48	1.322	$3,187.27	$2,511.90	$675.37	$583,616	21.2%
HCBS, age 65+, no SPMI	2,039.2	$1,679.14	2.337	$3,924.73	$2,218.74	$1,705.99	$3,478,827	43.5%
Community, age 65+, with SPMI	696.3	$1,908.28	1.393	$2,657.80	$1,434.11	$1,223.69	$852,082	46.0%
Community, age 65+, no SPMI	2,740.7	$1,220.09	1.173	$1,430.57	$1,726.56	-$295.99	-$811,220	-20.7%
Facility, age <65, with SPMI	164.0	$4,472.72	0.507	$2,268.40	$2,113.98	$154.42	$25,324	6.8%
Facility, age <65, no SPMI	131.3	$3,253.09	0.485	$1,579.30	$2,256.48	-$677.18	-$88,891	-42.9%
HCBS, age <65, with SPMI	1,908.9	$1,791.41	0.732	$1,311.42	$1,575.03	-$263.61	-$503,194	-20.1%
HCBS, age <65, no SPMI	2,492.8	$1,871.58	1.288	$2,410.98	$1,848.06	$562.92	$1,403,239	23.3%
Community, age <65, with SPMI	1,866.2	$1,469.29	0.753	$1,106.55	$1,618.32	-$511.77	-$955,056	-46.2%
Community, age <65, no SPMI	2,020.8	$1,437.51	0.947	$1,361.18	$1,388.74	-$27.57	-$55,705	-2.0%

Appendix Table D.K-1
Medicare Demonstration Year 7 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	**27,183.8**	**$1,684.46**	**1.079**	**$1,817.92**	**$1,665.80**	**$152.12**	**$4,135,240**	**8.4%**
Facility, age 65+, with SPMI	826.2	$3,162.82	1.017	$3,215.56	$2,153.51	$1,062.05	$877,498	33.0%
Facility, age 65+, no SPMI	486.4	$2,002.58	1.416	$2,834.85	$1,527.96	$1,306.88	$635,701	46.1%
HCBS, age 65+, with SPMI	2,799.6	$2,274.31	1.482	$3,370.61	$2,030.64	$1,339.97	$3,751,390	39.8%
HCBS, age 65+, no SPMI	3,167.6	$1,764.55	1.133	$1,999.94	$1,993.50	$6.44	$20,413	0.3%
Community, age 65+, with SPMI	1,966.3	$1,724.64	0.793	$1,368.30	$1,485.57	-$117.27	-$230,591	-8.6%
Community, age 65+, no SPMI	4,381.7	$1,063.18	1.221	$1,297.70	$1,408.65	-$110.95	-$486,145	-8.5%
Facility, age <65, with SPMI	390.8	$5,207.50	1.008	$5,247.11	$3,393.56	$1,853.55	$724,360	35.3%
Facility, age <65, no SPMI	172.0	$3,572.15	0.812	$2,900.16	$2,732.82	$167.34	$28,787	5.8%
HCBS, age <65, with SPMI	3,448.4	$2,118.15	0.856	$1,812.63	$1,684.51	$128.12	$441,800	7.1%
HCBS, age <65, no SPMI	2,503.2	$1,388.04	0.995	$1,380.90	$1,855.47	-$474.57	-$1,187,935	-34.4%
Community, age <65, with SPMI	4,165.4	$1,355.55	0.859	$1,163.93	$1,209.88	-$45.95	-$191,397	-3.9%
Community, age <65, no SPMI	2,876.2	$1,207.80	1.189	$1,435.71	$1,522.16	-$86.45	-$248,643	-6.0%

Appendix Table D.K-2
Medicare Demonstration Year 8 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	**19,857.0**	**$1,684.46**	**0.938**	**$1,579.55**	**$1,790.85**	**-$211.29**	**-$4,195,674**	**-13.4%**
Facility, age 65+, with SPMI	593.2	$3,162.82	0.853	$2,698.40	$2,424.07	$274.33	$162,732	10.2%
Facility, age 65+, no SPMI	310.9	$2,002.58	0.931	$1,863.63	$1,428.15	$435.48	$135,379	23.4%
HCBS, age 65+, with SPMI	1,965.9	$2,274.31	0.776	$1,765.18	$2,251.11	-$485.93	-$955,282	-27.5%
HCBS, age 65+, no SPMI	1,940.5	$1,764.55	1.504	$2,653.72	$2,247.24	$406.48	$788,772	15.3%
Community, age 65+, with SPMI	1,305.7	$1,724.64	1.369	$2,361.68	$1,944.65	$417.03	$544,537	17.7%
Community, age 65+, no SPMI	3,210.5	$1,063.18	1.027	$1,091.95	$1,593.52	-$501.57	-$1,610,284	-45.9%
Facility, age <65, with SPMI	235.9	$5,207.50	0.744	$3,875.72	$1,528.62	$2,347.10	$553,610	60.6%
Facility, age <65, no SPMI	124.7	$3,572.15	1.208	$4,313.46	$1,947.27	$2,366.19	$295,057	54.9%
HCBS, age <65, with SPMI	2,691.4	$2,118.15	0.529	$1,120.88	$1,502.19	-$381.30	-$1,026,241	-34.0%
HCBS, age <65, no SPMI	1,852.4	$1,388.04	1.259	$1,747.06	$1,783.88	-$36.82	-$68,213	-2.1%
Community, age <65, with SPMI	3,359.2	$1,355.55	0.787	$1,067.48	$1,605.75	-$538.27	-$1,808,137	-50.4%
Community, age <65, no SPMI	2,266.8	$1,207.80	0.981	$1,184.58	$1,717.31	-$532.73	-$1,207,605	-45.0%

Appendix Table D.L-1
Medicare Demonstration Year 7 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	**28,585.4**	**$1,730.61**	**1.157**	**$2,001.62**	**$1,886.13**	**$115.49**	**$3,301,449**	**5.8%**
Facility, age 65+, with SPMI	1,033.0	$2,716.60	1.383	$3,756.10	$2,903.36	$852.74	$880,923	22.7%
Facility, age 65+, no SPMI	606.1	$2,135.54	1.273	$2,718.97	$2,288.32	$430.64	$261,014	15.8%
HCBS, age 65+, with SPMI	3,527.7	$1,931.80	1.231	$2,377.08	$1,846.08	$531.00	$1,873,198	22.3%
HCBS, age 65+, no SPMI	3,634.3	$1,341.24	1.371	$1,839.31	$1,791.64	$47.67	$173,257	2.6%
Community, age 65+, with SPMI	2,553.4	$1,691.40	1.279	$2,164.07	$1,826.56	$337.51	$861,788	15.6%
Community, age 65+, no SPMI	5,997.0	$1,206.44	1.409	$1,699.63	$1,401.17	$298.46	$1,789,863	17.6%
Facility, age <65, with SPMI	510.4	$4,189.90	0.933	$3,907.28	$3,714.46	$192.83	$98,421	4.9%
Facility, age <65, no SPMI	294.3	$2,293.73	0.910	$2,086.67	$3,163.03	-$1,076.36	-$316,773	-51.6%
HCBS, age <65, with SPMI	3,455.7	$2,034.93	0.803	$1,634.62	$1,863.26	-$228.64	-$790,115	-14.0%
HCBS, age <65, no SPMI	2,266.9	$1,392.03	1.049	$1,460.39	$2,449.39	-$989.01	-$2,241,969	-67.7%
Community, age <65, with SPMI	3,073.5	$1,752.61	1.015	$1,779.10	$1,401.87	$377.23	$1,159,403	21.2%
Community, age <65, no SPMI	1,633.2	$1,930.53	1.226	$2,366.34	$2,640.37	-$274.03	-$447,562	-11.6%

Appendix Table D.L-2
Medicare Demonstration Year 8 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	**22,211.0**	**$1,730.61**	**1.131**	**$1,957.70**	**$1,984.08**	**-$26.38**	**-$585,822**	**-1.3%**
Facility, age 65+, with SPMI	590.1	$2,716.60	1.267	$3,441.16	$1,889.28	$1,551.88	$915,758	45.1%
Facility, age 65+, no SPMI	361.0	$2,135.54	1.194	$2,549.36	$2,445.66	$103.70	$37,433	4.1%
HCBS, age 65+, with SPMI	2,651.2	$1,931.80	1.212	$2,340.45	$1,967.26	$373.19	$989,409	15.9%
HCBS, age 65+, no SPMI	2,703.8	$1,341.24	1.340	$1,796.67	$1,975.51	-$178.84	-$483,545	-10.0%
Community, age 65+, with SPMI	1,884.1	$1,691.40	1.319	$2,231.12	$1,652.22	$578.90	$1,090,721	25.9%
Community, age 65+, no SPMI	4,595.6	$1,206.44	1.407	$1,697.12	$1,702.82	-$5.70	-$26,211	-0.3%
Facility, age <65, with SPMI	398.5	$4,189.90	0.744	$3,117.31	$2,778.84	$338.47	$134,879	10.9%
Facility, age <65, no SPMI	205.4	$2,293.73	0.932	$2,137.34	$3,108.44	-$971.10	-$199,421	-45.4%
HCBS, age <65, with SPMI	2,969.5	$2,034.93	0.858	$1,745.82	$2,004.40	-$258.59	-$767,878	-14.8%
HCBS, age <65, no SPMI	1,958.4	$1,392.03	1.109	$1,544.02	$2,057.71	-$513.69	-$1,006,004	-33.3%
Community, age <65, with SPMI	2,601.2	$1,752.61	1.042	$1,825.63	$1,911.15	-$85.51	-$222,439	-4.7%
Community, age <65, no SPMI	1,292.3	$1,930.53	1.134	$2,188.26	$2,999.65	-$811.39	-$1,048,523	-37.1%

Appendix Table D.M-1
Medicare Demonstration Year 7 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	**25,620.5**	**$1,994.44**	**0.976**	**$1,945.85**	**$1,708.62**	**$237.23**	**$6,078,030**	**12.2%**
Facility, age 65+, with SPMI	1,043.5	$3,361.36	1.019	$3,426.39	$2,737.10	$689.29	$719,257	20.1%
Facility, age 65+, no SPMI	571.0	$2,297.47	1.201	$2,759.44	$1,286.87	$1,472.57	$840,820	53.4%
HCBS, age 65+, with SPMI	2,760.0	$2,558.12	1.142	$2,920.15	$2,167.78	$752.37	$2,076,570	25.8%
HCBS, age 65+, no SPMI	2,804.0	$1,810.19	1.425	$2,578.78	$1,617.81	$960.97	$2,694,509	37.3%
Community, age 65+, with SPMI	1,892.7	$2,019.05	0.820	$1,656.31	$1,679.20	-$22.89	-$43,315	-1.4%
Community, age 65+, no SPMI	3,708.6	$1,388.11	0.780	$1,082.31	$1,427.08	-$344.77	-$1,278,599	-31.9%
Facility, age <65, with SPMI	914.0	$2,803.02	1.165	$3,265.70	$2,614.51	$651.18	$595,179	19.9%
Facility, age <65, no SPMI	844.5	$1,138.14	1.024	$1,165.96	$1,066.48	$99.48	$84,003	8.5%
HCBS, age <65, with SPMI	3,247.3	$2,463.72	0.954	$2,349.96	$1,860.89	$489.07	$1,588,149	20.8%
HCBS, age <65, no SPMI	2,189.1	$1,486.50	0.897	$1,334.07	$1,537.18	-$203.11	-$444,639	-15.2%
Community, age <65, with SPMI	3,284.0	$1,938.45	0.684	$1,326.84	$1,398.18	-$71.34	-$234,283	-5.4%
Community, age <65, no SPMI	2,362.0	$1,417.71	1.011	$1,433.31	$1,653.30	-$220.00	-$519,623	-15.3%

Appendix Table D.M-2
Medicare Demonstration Year 8 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	**18,846.1**	**$1,994.44**	**0.856**	**$1,706.82**	**$1,758.54**	**-$51.72**	**-$974,787**	**-3.0%**
Facility, age 65+, with SPMI	634.0	$3,361.36	0.993	$3,339.33	$1,501.98	$1,837.35	$1,164,952	55.0%
Facility, age 65+, no SPMI	392.5	$2,297.47	1.131	$2,599.08	$1,983.27	$615.81	$241,696	23.7%
HCBS, age 65+, with SPMI	1,944.9	$2,558.12	1.090	$2,787.53	$1,991.87	$795.65	$1,547,499	28.5%
HCBS, age 65+, no SPMI	1,974.2	$1,810.19	0.948	$1,716.47	$2,144.57	-$428.10	-$845,162	-24.9%
Community, age 65+, with SPMI	1,427.7	$2,019.05	0.856	$1,728.09	$1,893.82	-$165.73	-$236,612	-9.6%
Community, age 65+, no SPMI	2,775.2	$1,388.11	1.022	$1,419.08	$1,363.54	$55.54	$154,125	3.9%
Facility, age <65, with SPMI	677.9	$2,803.02	0.811	$2,274.56	$1,496.62	$777.94	$527,345	34.2%
Facility, age <65, no SPMI	753.1	$1,138.14	0.569	$647.30	$1,388.75	-$741.45	-$558,397	-114.5%
HCBS, age <65, with SPMI	2,502.4	$2,463.72	0.708	$1,743.65	$1,792.42	-$48.77	-$122,033	-2.8%
HCBS, age <65, no SPMI	1,657.5	$1,486.50	0.840	$1,248.44	$1,853.34	-$604.90	-$1,002,623	-48.5%
Community, age <65, with SPMI	2,401.0	$1,938.45	0.688	$1,333.62	$1,870.08	-$536.46	-$1,288,023	-40.2%
Community, age <65, no SPMI	1,705.7	$1,417.71	0.889	$1,260.41	$1,587.29	-$326.88	-$557,554	-25.9%

Appendix Table D.N-1
Medicare Demonstration Year 7 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	**17,901.2**	**$1,882.18**	**0.957**	**$1,801.41**	**$1,764.51**	**$36.90**	**$660,511**	**2.0%**
Facility, age 65+, with SPMI	462.4	$3,064.17	1.020	$3,125.91	$2,266.12	$859.79	$397,528	27.5%
Facility, age 65+, no SPMI	315.9	$3,184.00	1.226	$3,902.74	$2,989.88	$912.86	$288,378	23.4%
HCBS, age 65+, with SPMI	2,360.6	$2,122.54	0.994	$2,108.86	$1,788.37	$320.49	$756,552	15.2%
HCBS, age 65+, no SPMI	2,399.2	$1,567.72	1.008	$1,580.60	$1,526.10	$54.50	$130,767	3.4%
Community, age 65+, with SPMI	2,029.2	$1,702.52	1.069	$1,820.47	$1,471.78	$348.70	$707,588	19.2%
Community, age 65+, no SPMI	3,978.8	$1,206.27	0.888	$1,070.69	$1,074.58	-$3.89	-$15,468	-0.4%
Facility, age <65, with SPMI	326.9	$5,100.83	1.001	$5,107.91	$3,564.81	$1,543.10	$504,488	30.2%
Facility, age <65, no SPMI	293.5	$1,059.11	0.606	$642.14	$694.23	-$52.09	-$15,287	-8.1%
HCBS, age <65, with SPMI	1,605.6	$2,460.47	1.043	$2,565.60	$1,798.05	$767.56	$1,232,393	29.9%
HCBS, age <65, no SPMI	1,443.5	$1,780.13	0.871	$1,551.32	$2,498.03	-$946.71	-$1,366,575	-61.0%
Community, age <65, with SPMI	1,646.6	$1,906.23	0.767	$1,462.33	$2,533.78	-$1,071.44	-$1,764,195	-73.3%
Community, age <65, no SPMI	1,038.9	$2,220.21	0.962	$2,136.35	$2,324.68	-$188.33	-$195,657	-8.8%

Appendix Table D.N-2
Medicare Demonstration Year 8 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	**13,581.5**	**$1,882.18**	**1.027**	**$1,933.64**	**$1,687.35**	**$246.29**	**$3,344,918**	**12.7%**
Facility, age 65+, with SPMI	293.3	$3,064.17	0.965	$2,956.42	$1,890.43	$1,066.00	$312,659	36.1%
Facility, age 65+, no SPMI	239.7	$3,184.00	0.785	$2,498.50	$1,898.59	$599.92	$143,786	24.0%
HCBS, age 65+, with SPMI	1,734.0	$2,122.54	1.357	$2,881.14	$1,721.24	$1,159.91	$2,011,269	40.3%
HCBS, age 65+, no SPMI	1,769.6	$1,567.72	1.317	$2,064.71	$1,675.07	$389.64	$689,528	18.9%
Community, age 65+, with SPMI	1,653.0	$1,702.52	1.035	$1,761.80	$1,204.65	$557.16	$920,991	31.6%
Community, age 65+, no SPMI	3,042.6	$1,206.27	1.136	$1,369.79	$1,384.32	-$14.53	-$44,204	-1.1%
Facility, age <65, with SPMI	232.0	$5,100.83	0.821	$4,187.92	$1,840.14	$2,347.79	$544,722	56.1%
Facility, age <65, no SPMI	288.5	$1,059.11	0.938	$993.69	$1,410.63	-$416.94	-$120,306	-42.0%
HCBS, age <65, with SPMI	1,226.8	$2,460.47	0.886	$2,180.51	$2,043.35	$137.15	$168,267	6.3%
HCBS, age <65, no SPMI	1,132.2	$1,780.13	0.767	$1,366.08	$1,643.34	-$277.26	-$313,920	-20.3%
Community, age <65, with SPMI	1,182.0	$1,906.23	0.860	$1,638.67	$2,227.60	-$588.93	-$696,088	-35.9%
Community, age <65, no SPMI	787.6	$2,220.21	0.943	$2,093.45	$2,438.52	-$345.07	-$271,785	-16.5%

Appendix Table D.O-1
Medicare Demonstration Year 7 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	**30,000.8**	**$1,876.40**	**0.899**	**$1,686.18**	**$1,772.85**	**-$86.67**	**-$2,600,038**	**-5.1%**
Facility, age 65+, with SPMI	1,918.1	$2,194.13	0.923	$2,025.55	$2,460.35	-$434.80	-$834,010	-21.5%
Facility, age 65+, no SPMI	1,357.1	$2,372.69	0.961	$2,280.11	$1,519.21	$760.90	$1,032,641	33.4%
HCBS, age 65+, with SPMI	4,345.1	$2,247.72	0.993	$2,232.37	$1,957.60	$274.77	$1,193,914	12.3%
HCBS, age 65+, no SPMI	4,256.5	$1,626.92	1.194	$1,942.97	$1,960.61	-$17.64	-$75,078	-0.9%
Community, age 65+, with SPMI	1,841.1	$1,661.79	0.779	$1,294.37	$1,258.90	$35.47	$65,310	2.7%
Community, age 65+, no SPMI	4,021.4	$1,418.33	0.866	$1,228.39	$1,532.74	-$304.34	-$1,223,888	-24.8%
Facility, age <65, with SPMI	573.6	$3,277.45	0.818	$2,680.52	$2,189.16	$491.36	$281,831	18.3%
Facility, age <65, no SPMI	272.4	$3,205.47	0.683	$2,189.17	$999.48	$1,189.69	$324,068	54.3%
HCBS, age <65, with SPMI	3,158.0	$2,485.91	0.783	$1,946.96	$2,027.67	-$80.71	-$254,879	-4.1%
HCBS, age <65, no SPMI	2,334.8	$1,496.02	0.902	$1,349.82	$1,622.47	-$272.65	-$636,569	-20.2%
Community, age <65, with SPMI	3,508.6	$1,649.26	0.706	$1,164.93	$1,448.53	-$283.61	-$995,060	-24.3%
Community, age <65, no SPMI	2,414.2	$1,585.23	0.730	$1,156.92	$1,769.27	-$612.35	-$1,478,318	-52.9%

Appendix Table D.O-2
Medicare Demonstration Year 8 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	**20,131.8**	**$1,876.40**	**0.945**	**$1,772.29**	**$1,791.60**	**-$19.31**	**-$388,687**	**-1.1%**
Facility, age 65+, with SPMI	1,090.8	$2,194.13	0.837	$1,836.72	$1,905.76	-$69.04	-$75,308	-3.8%
Facility, age 65+, no SPMI	801.0	$2,372.69	0.665	$1,577.40	$1,700.85	-$123.45	-$98,879	-7.8%
HCBS, age 65+, with SPMI	2,922.1	$2,247.72	1.383	$3,109.67	$1,930.45	$1,179.22	$3,445,769	37.9%
HCBS, age 65+, no SPMI	2,724.5	$1,626.92	1.122	$1,825.02	$2,047.24	-$222.22	-$605,435	-12.2%
Community, age 65+, with SPMI	1,290.3	$1,661.79	0.996	$1,654.51	$1,258.20	$396.31	$511,373	24.0%
Community, age 65+, no SPMI	2,608.6	$1,418.33	0.888	$1,259.89	$1,671.29	-$411.40	-$1,073,206	-32.7%
Facility, age <65, with SPMI	465.4	$3,277.45	0.417	$1,366.71	$2,404.37	-$1,037.66	-$482,882	-75.9%
Facility, age <65, no SPMI	192.6	$3,205.47	0.832	$2,667.95	$1,732.20	$935.75	$180,208	35.1%
HCBS, age <65, with SPMI	2,239.3	$2,485.91	0.807	$2,005.82	$2,126.46	-$120.64	-$270,148	-6.0%
HCBS, age <65, no SPMI	1,729.6	$1,496.02	0.824	$1,233.20	$1,579.93	-$346.74	-$599,715	-28.1%
Community, age <65, with SPMI	2,548.7	$1,649.26	0.865	$1,426.00	$1,506.76	-$80.76	-$205,831	-5.7%
Community, age <65, no SPMI	1,519.0	$1,585.23	0.633	$1,002.80	$1,736.61	-$733.81	-$1,114,633	-73.2%

Appendix Table D.P-1
Medicare Demonstration Year 7 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	**13,800.7**	**$1,993.34**	**0.878**	**$1,749.88**	**$1,615.16**	**$134.72**	**$1,859,220**	**7.7%**
Facility, age 65+, with SPMI	671.9	$3,574.85	1.156	$4,132.77	$2,149.12	$1,983.64	$1,332,871	48.0%
Facility, age 65+, no SPMI	469.6	$2,646.91	0.925	$2,448.83	$2,586.44	-$137.61	-$64,619	-5.6%
HCBS, age 65+, with SPMI	1,757.6	$2,160.63	0.984	$2,125.48	$1,534.08	$591.41	$1,039,469	27.8%
HCBS, age 65+, no SPMI	1,911.7	$1,904.53	0.746	$1,421.63	$1,714.99	-$293.36	-$560,815	-20.6%
Community, age 65+, with SPMI	1,187.9	$1,893.21	1.134	$2,146.41	$1,670.07	$476.33	$565,827	22.2%
Community, age 65+, no SPMI	3,450.3	$1,354.04	0.853	$1,154.61	$1,233.58	-$78.98	-$272,498	-6.8%
Facility, age <65, with SPMI	110.4	$5,251.45	0.709	$3,725.63	$1,900.68	$1,824.95	$201,451	49.0%
Facility, age <65, no SPMI	123.0	$6,388.92	0.737	$4,707.34	$1,122.14	$3,585.20	$440,979	76.2%
HCBS, age <65, with SPMI	1,260.6	$1,937.71	0.844	$1,635.50	$1,625.42	$10.07	$12,700	0.6%
HCBS, age <65, no SPMI	818.4	$1,477.66	0.671	$990.88	$1,848.26	-$857.38	-$701,640	-86.5%
Community, age <65, with SPMI	1,364.1	$1,718.08	0.864	$1,483.77	$1,490.82	-$7.04	-$9,608	-0.5%
Community, age <65, no SPMI	675.2	$2,142.64	0.932	$1,997.61	$2,182.58	-$184.97	-$124,898	-9.3%

Appendix Table D.P-2
Medicare Demonstration Year 8 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	**9,644.2**	**$1,993.34**	**0.828**	**$1,650.18**	**$1,636.26**	**$13.92**	**$134,248**	**0.8%**
Facility, age 65+, with SPMI	361.7	$3,574.85	0.994	$3,553.71	$2,056.49	$1,497.22	$541,616	42.1%
Facility, age 65+, no SPMI	232.6	$2,646.91	0.841	$2,224.87	$2,410.71	-$185.84	-$43,226	-8.4%
HCBS, age 65+, with SPMI	1,271.2	$2,160.63	0.616	$1,331.54	$1,726.92	-$395.38	-$502,617	-29.7%
HCBS, age 65+, no SPMI	1,345.5	$1,904.53	0.726	$1,383.00	$1,728.91	-$345.91	-$465,413	-25.0%
Community, age 65+, with SPMI	762.1	$1,893.21	1.028	$1,946.10	$1,346.08	$600.02	$457,270	30.8%
Community, age 65+, no SPMI	2,454.9	$1,354.04	1.028	$1,391.79	$1,344.16	$47.63	$116,922	3.4%
Facility, age <65, with SPMI	84.3	$5,251.45	0.707	$3,715.28	$2,470.87	$1,244.40	$104,903	33.5%
Facility, age <65, no SPMI	116.1	$6,388.92	0.881	$5,628.17	$804.07	$4,824.10	$560,218	85.7%
HCBS, age <65, with SPMI	980.3	$1,937.71	0.929	$1,799.70	$1,491.02	$308.69	$302,603	17.2%
HCBS, age <65, no SPMI	566.6	$1,477.66	0.633	$934.78	$2,182.87	-$1,248.08	-$707,138	-133.5%
Community, age <65, with SPMI	988.9	$1,718.08	0.848	$1,456.60	$1,885.61	-$429.01	-$424,234	-29.5%
Community, age <65, no SPMI	480.1	$2,142.64	0.931	$1,994.34	$1,591.59	$402.74	$193,343	20.2%

Appendix Table D.Q-1
Medicare Demonstration Year 7 savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 8A

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	**36,291.3**	**$2,047.55**	**0.974**	**$1,993.97**	**$1,808.18**	**$185.79**	**$6,742,704**	**9.3%**
Facility, age 65+, with SPMI	2,038.9	$3,153.86	0.927	$2,924.67	$2,459.25	$465.42	$948,950	15.9%
Facility, age 65+, no SPMI	1,125.8	$2,911.28	0.981	$2,855.69	$2,440.86	$414.83	$467,016	14.5%
HCBS, age 65+, with SPMI	4,881.5	$2,281.13	0.999	$2,278.31	$1,846.68	$431.64	$2,107,056	18.9%
HCBS, age 65+, no SPMI	4,844.5	$1,809.36	1.349	$2,440.68	$1,783.85	$656.83	$3,181,987	26.9%
Community, age 65+, with SPMI	2,990.6	$2,213.25	0.863	$1,910.50	$1,687.71	$222.79	$666,279	11.7%
Community, age 65+, no SPMI	5,767.8	$1,461.65	0.798	$1,166.56	$1,401.07	-$234.52	-$1,352,652	-20.1%
Facility, age <65, with SPMI	582.4	$5,383.38	0.803	$4,321.44	$4,089.51	$231.94	$135,072	5.4%
Facility, age <65, no SPMI	364.0	$1,438.12	1.115	$1,603.97	$1,404.04	$199.93	$72,773	12.5%
HCBS, age <65, with SPMI	3,472.3	$1,911.53	0.847	$1,618.72	$2,242.01	-$623.28	-$2,164,249	-38.5%
HCBS, age <65, no SPMI	2,508.7	$1,914.71	1.379	$2,639.79	$1,879.30	$760.49	$1,907,857	28.8%
Community, age <65, with SPMI	4,141.1	$1,913.89	0.852	$1,629.69	$1,488.40	$141.28	$585,057	8.7%
Community, age <65, no SPMI	3,573.7	$1,681.20	0.950	$1,596.63	$1,544.14	$52.48	$187,556	3.3%

Appendix Table D.Q-2
Medicare Demonstration Year 8 savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 8A

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	**23,270.8**	**$2,047.55**	**0.934**	**$1,911.85**	**$1,907.47**	**$4.39**	**$102,108**	**0.2%**
Facility, age 65+, with SPMI	1,133.2	$3,153.86	0.669	$2,109.95	$2,069.99	$39.96	$45,284	1.9%
Facility, age 65+, no SPMI	643.0	$2,911.28	0.890	$2,590.06	$1,722.06	$868.00	$558,097	33.5%
HCBS, age 65+, with SPMI	3,248.7	$2,281.13	1.030	$2,349.02	$2,159.50	$189.51	$615,664	8.1%
HCBS, age 65+, no SPMI	3,089.7	$1,809.36	1.575	$2,849.87	$1,952.08	$897.79	$2,773,885	31.5%
Community, age 65+, with SPMI	1,994.7	$2,213.25	0.608	$1,344.77	$1,925.69	-$580.92	-$1,158,780	-43.2%
Community, age 65+, no SPMI	3,364.7	$1,461.65	1.243	$1,816.21	$1,546.15	$270.06	$908,651	14.9%
Facility, age <65, with SPMI	366.5	$5,383.38	0.620	$3,336.18	$4,432.67	-$1,096.49	-$401,919	-32.9%
Facility, age <65, no SPMI	268.7	$1,438.12	1.478	$2,125.16	$1,113.35	$1,011.81	$271,884	47.6%
HCBS, age <65, with SPMI	2,548.8	$1,911.53	0.957	$1,830.09	$2,026.74	-$196.66	-$501,235	-10.7%
HCBS, age <65, no SPMI	1,735.6	$1,914.71	0.782	$1,497.52	$1,885.23	-$387.71	-$672,892	-25.9%
Community, age <65, with SPMI	2,710.4	$1,913.89	0.618	$1,182.90	$1,474.29	-$291.39	-$789,784	-24.6%
Community, age <65, no SPMI	2,166.9	$1,681.20	0.807	$1,357.13	$2,070.92	-$713.79	-$1,546,747	-52.6%

Appendix Table D.R-1
Medicare Demonstration Year 7 savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 8B

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	**16,421.5**	**$1,944.81**	**0.908**	**$1,765.55**	**$1,730.93**	**$34.62**	**$568,518**	**2.0%**
Facility, age 65+, with SPMI	764.0	$2,951.48	0.947	$2,796.27	$2,558.44	$237.83	$181,699	8.5%
Facility, age 65+, no SPMI	595.0	$3,038.19	1.085	$3,296.17	$3,262.04	$34.13	$20,309	1.0%
HCBS, age 65+, with SPMI	1,670.8	$1,937.51	0.966	$1,872.13	$1,764.21	$107.92	$180,309	5.8%
HCBS, age 65+, no SPMI	2,009.6	$1,275.27	0.959	$1,222.90	$1,374.60	-$151.70	-$304,850	-12.4%
Community, age 65+, with SPMI	1,555.9	$1,866.71	0.896	$1,671.73	$1,308.33	$363.41	$565,417	21.7%
Community, age 65+, no SPMI	4,630.3	$1,349.91	0.889	$1,200.68	$1,016.57	$184.11	$852,495	15.3%
Facility, age <65, with SPMI	264.6	$5,279.10	0.840	$4,436.27	$3,699.24	$737.03	$194,983	16.6%
Facility, age <65, no SPMI	124.4	$1,347.16	0.545	$734.29	$1,983.56	-$1,249.27	-$155,410	-170.1%
HCBS, age <65, with SPMI	1,046.2	$2,814.90	0.641	$1,805.44	$2,840.17	-$1,034.73	-$1,082,507	-57.3%
HCBS, age <65, no SPMI	1,094.6	$2,180.27	0.959	$2,090.70	$1,564.58	$526.12	$575,876	25.2%
Community, age <65, with SPMI	1,551.3	$2,097.18	0.895	$1,877.77	$1,909.38	-$31.61	-$49,032	-1.7%
Community, age <65, no SPMI	1,114.9	$2,456.76	1.020	$2,506.27	$2,874.72	-$368.45	-$410,772	-14.7%

Appendix Table D.R-2
Medicare Demonstration Year 8 savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 8B

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	**10,811.3**	**$1,944.81**	**0.855**	**$1,662.64**	**$1,721.17**	**-$58.53**	**-$632,821**	**-3.5%**
Facility, age 65+, with SPMI	431.9	$2,951.48	1.032	$3,047.03	$2,154.36	$892.67	$385,579	29.3%
Facility, age 65+, no SPMI	322.7	$3,038.19	0.805	$2,446.42	$1,690.26	$756.17	$244,017	30.9%
HCBS, age 65+, with SPMI	1,150.2	$1,937.51	1.079	$2,089.64	$2,215.83	-$126.18	-$145,135	-6.0%
HCBS, age 65+, no SPMI	1,264.9	$1,275.27	0.927	$1,181.74	$1,352.00	-$170.27	-$215,368	-14.4%
Community, age 65+, with SPMI	1,022.7	$1,866.71	0.803	$1,498.11	$956.63	$541.48	$553,783	36.1%
Community, age 65+, no SPMI	3,127.2	$1,349.91	1.000	$1,350.02	$1,208.31	$141.71	$443,145	10.5%
Facility, age <65, with SPMI	181.1	$5,279.10	0.563	$2,973.67	$2,399.90	$573.76	$103,915	19.3%
Facility, age <65, no SPMI	86.0	$1,347.16	0.402	$541.67	$529.49	$12.18	$1,048	2.2%
HCBS, age <65, with SPMI	722.3	$2,814.90	0.666	$1,874.71	$2,921.35	-$1,046.65	-$755,948	-55.8%
HCBS, age <65, no SPMI	762.5	$2,180.27	0.469	$1,021.51	$1,587.85	-$566.34	-$431,847	-55.4%
Community, age <65, with SPMI	1,093.0	$2,097.18	0.881	$1,847.73	$1,864.73	-$17.01	-$18,589	-0.9%
Community, age <65, no SPMI	646.7	$2,456.76	0.931	$2,288.14	$3,521.20	-$1,233.07	-$797,421	-53.9%

Appendix Table D.S
Medicare Demonstration Year 8 savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 9A

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	**36,783.5**	**$2,119.27**	**1.016**	**$2,153.50**	**$1,908.40**	**$245.10**	**$9,015,680**	**11.4%**
Facility, age 65+, with SPMI	1,905.3	$4,128.23	0.622	$2,567.20	$2,499.80	$67.40	$128,426	2.6%
Facility, age 65+, no SPMI	1,000.5	$3,398.22	0.650	$2,208.36	$1,748.57	$459.79	$460,029	20.8%
HCBS, age 65+, with SPMI	4,177.7	$2,667.75	1.368	$3,649.29	$2,386.24	$1,263.05	$5,276,691	34.6%
HCBS, age 65+, no SPMI	3,977.0	$1,667.02	0.979	$1,631.75	$1,855.51	-$223.77	-$889,912	-13.7%
Community, age 65+, with SPMI	2,687.7	$2,600.70	1.351	$3,514.11	$2,101.65	$1,412.46	$3,796,282	40.2%
Community, age 65+, no SPMI	6,720.7	$1,500.69	1.059	$1,589.61	$1,554.04	$35.56	$239,014	2.2%
Facility, age <65, with SPMI	525.7	$4,616.01	0.750	$3,461.95	$2,794.08	$667.87	$351,085	19.3%
Facility, age <65, no SPMI	237.0	$3,030.85	0.474	$1,437.00	$2,044.03	-$607.03	-$143,847	-42.2%
HCBS, age <65, with SPMI	3,128.3	$2,088.76	1.234	$2,577.91	$1,675.28	$902.63	$2,823,740	35.0%
HCBS, age <65, no SPMI	2,356.6	$1,484.81	0.952	$1,414.12	$1,552.28	-$138.16	-$325,588	-9.8%
Community, age <65, with SPMI	5,012.3	$1,814.08	0.777	$1,409.87	$1,637.04	-$227.17	-$1,138,636	-16.1%
Community, age <65, no SPMI	5,054.7	$1,634.58	1.165	$1,904.18	$2,213.11	-$308.94	-$1,561,604	-16.2%

Appendix Table D.T
Medicare Demonstration Year 8 savings calculation: Intervention and target PMPM, by category of beneficiary: Cohort 9B

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	**15,801.5**	**$2,248.65**	**0.916**	**$2,059.62**	**$1,973.69**	**$85.93**	**$1,357,826**	**4.2%**
Facility, age 65+, with SPMI	951.9	$3,970.21	0.674	$2,675.10	$2,315.29	$359.81	$342,498	13.5%
Facility, age 65+, no SPMI	430.8	$4,289.78	0.801	$3,437.14	$2,209.62	$1,227.51	$528,849	35.7%
HCBS, age 65+, with SPMI	1,803.6	$2,231.00	1.232	$2,749.37	$1,855.40	$893.97	$1,612,329	32.5%
HCBS, age 65+, no SPMI	1,840.0	$1,384.88	1.218	$1,687.16	$1,514.83	$172.33	$317,092	10.2%
Community, age 65+, with SPMI	1,444.7	$2,310.70	1.068	$2,466.70	$1,859.89	$606.81	$876,635	24.6%
Community, age 65+, no SPMI	3,671.2	$1,302.96	0.897	$1,169.33	$1,400.29	-$230.96	-$847,913	-19.8%
Facility, age <65, with SPMI	163.0	$5,222.14	0.913	$4,770.31	$2,344.05	$2,426.26	$395,559	50.9%
Facility, age <65, no SPMI	145.0	$2,814.83	0.539	$1,517.98	$2,587.89	-$1,069.91	-$155,136	-70.5%
HCBS, age <65, with SPMI	1,191.6	$2,397.10	0.838	$2,008.48	$2,002.11	$6.37	$7,586	0.3%
HCBS, age <65, no SPMI	910.7	$2,837.34	0.489	$1,386.39	$2,787.22	-$1,400.83	-$1,275,796	-101.0%
Community, age <65, with SPMI	1,859.5	$2,918.56	0.937	$2,733.29	$2,855.62	-$122.33	-$227,480	-4.5%
Community, age <65, no SPMI	1,389.4	$2,437.85	0.845	$2,059.82	$2,215.56	-$155.74	-$216,396	-7.6%

Appendix E
Outlier Adjustment Data

Appendix Table E
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	14,020	153	$1,612.13	$1,570.53	97.42%
Comparison – Baseline	23,228	219	$1,600.30	$1,566.21	97.87%
Intervention – Demo Year 7	14,020	197	$1,933.38	$1,724.11	89.18%
Comparison – Demo Year 7	23,228	176	$1,992.78	$1,756.59	88.15%
Comparison group trend factor DY7[12]			1.2453	1.1216	0.9007
Intervention – Demo Year 8	14,020	231	$2,121.24	$1,792.47	84.50%
Comparison – Demo Year 8	23,228	142	$1,915.30	$1,636.29	85.43%
Comparison group trend factor DY8			1.1968	1.0447	0.8729
Cohort 2					
Intervention – Baseline	704	10	$2,356.60	$2,280.88	96.79%
Comparison – Baseline	4,332	41	$2,258.01	$1,897.72	84.04%
Intervention – Demo Year 7	704	11	$1,801.19	$1,542.35	85.63%
Comparison – Demo Year 7	4,332	41	$1,801.19	$1,542.35	88.71%
Comparison group trend factor DY7			1.1207	0.9853	0.8792
Intervention – Demo Year 8	704	16	$2,340.20	$1,861.66	79.55%
Comparison – Demo Year 8	4,332	35	$1,695.60	$1,403.88	82.80%
Comparison group trend factor DY8			1.0550	0.8969	0.8501
Cohort 3					
Intervention – Baseline	5,707	75	$1,690.19	$1,628.93	96.38%
Comparison – Baseline	6,453	46	$1,673.66	$1,643.68	98.21%

(continued)

[12] Note: the comparison group trend factors here in the outlier adjustment are prior to the reweighting of the comparison group member months.

Appendix Table E (continued)
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
Intervention – Demo Year 7	5,707	77	$1,818.39	$1,615.55	88.85%
Comparison – Demo Year 7	6,453	45	$1,565.33	$1,429.73	91.34%
Comparison group trend factor DY7			0.9353	0.8698	0.9300
Intervention – Demo Year 8	5,707	73	$1,788.49	$1,553.53	86.86%
Comparison – Demo Year 8	6,453	49	$1,616.54	$1,447.03	89.51%
Comparison group trend factor DY8			0.9659	0.8804	0.9115
Cohort 4					
Intervention – Baseline	5,921	65	$1,742.42	$1,688.50	96.91%
Comparison – Baseline	7,241	66	$1,738.02	$1,696.19	97.59%
Intervention – Demo Year 7	5,921	78	$1,809.90	$1,609.61	88.93%
Comparison – Demo Year 7	7,241	54	$1,672.83	$1,540.32	92.08%
Comparison group trend factor DY7			0.9625	0.9081	0.9435
Intervention – Demo Year 8	5,921	72	$1,788.31	$1,565.36	87.53%
Comparison – Demo Year 8	7,241	60	$1,691.39	$1,451.57	85.82%
Comparison group trend factor DY8			0.9732	0.8558	0.8794
Cohort 5A					
Intervention – Baseline	6,236	70	$1,684.46	$1,627.86	96.64%
Comparison – Baseline	5,472	47	$1,812.52	$1,765.67	97.41%
Intervention – Demo Year 7	6,236	70	$1,665.80	$1,523.51	91.46%
Comparison – Demo Year 7	5,472	48	$1,942.89	$1,801.97	92.75%
Comparison group trend factor DY7			1.0719	1.0206	0.9521
Intervention – Demo Year 8	6,236	77	$1,790.85	$1,557.19	86.95%

(continued)

Appendix Table E (continued)
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
Comparison – Demo Year 8	5,472	41	$1,757.07	$1,598.60	90.98%
Comparison group trend factor DY8			0.9694	0.9054	0.9340
Cohort 5B					
Intervention – Baseline	5,961	98	$1,730.61	$1,663.65	96.13%
Comparison – Baseline	20,505	166	$1,582.12	$1,529.13	96.65%
Intervention – Demo Year 7	5,961	97	$1,886.13	$1,687.17	89.45%
Comparison – Demo Year 7	20,505	168	$1,840.46	$1,717.81	93.34%
Comparison group trend factor DY7			1.1633	1.1234	0.9657
Intervention – Demo Year 8	5,961	118	$1,984.08	$1,710.48	86.21%
Comparison – Demo Year 8	20,505	147	$1,810.80	$1,655.25	91.41%
Comparison group trend factor DY8			1.1445	1.0825	0.9458
Cohort 6A					
Intervention – Baseline	4,956	56	$1,994.44	$1,923.45	96.44%
Comparison – Baseline	4,795	41	$2,000.93	$1,951.03	97.51%
Intervention – Demo Year 7	4,956	52	$1,708.62	$1,577.75	92.34%
Comparison – Demo Year 7	4,795	46	$1,934.27	$1,824.45	94.32%
Comparison group trend factor DY7			0.9667	0.9351	0.9673
Intervention – Demo Year 8	4,956	61	$1,758.54	$1,566.80	89.10%
Comparison – Demo Year 8	4,795	37	$1,815.69	$1,681.41	92.60%
Comparison group trend factor DY8			0.9074	0.8618	0.9497
Cohort 6B					
Intervention – Baseline	3,342	51	$1,882.18	$1,816.26	96.50%
Comparison – Baseline	5,392	37	$1,779.31	$1,739.74	97.78%

Appendix Table E (continued)
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
Intervention – Demo Year 7	3,342	57	$1,764.51	$1,560.52	88.44%
Comparison – Demo Year 7	5,392	31	$1,674.72	$1,580.91	94.40%
Comparison group trend factor DY7			0.9412	0.9087	0.9654
Intervention – Demo Year 8	3,342	51	$1,687.35	$1,509.35	89.45%
Comparison – Demo Year 8	5,392	37	$1,702.22	$1,583.39	93.02%
Comparison group trend factor DY8			0.9567	0.9101	0.9513
Cohort 7A					
Intervention – Baseline	4,884	47	$1,876.40	$1,831.12	97.59%
Comparison – Baseline	3,452	33	$2,154.68	$2,109.68	97.91%
Intervention – Demo Year 7	4,884	48	$1,772.85	$1,675.00	94.48%
Comparison – Demo Year 7	3,452	32	$1,917.68	$1,845.72	96.25%
Comparison group trend factor DY7			0.8900	0.8749	0.9830
Intervention – Demo Year 8	4,884	48	$1,791.60	$1,635.41	91.28%
Comparison – Demo Year 8	3,452	32	$1,798.87	$1,689.68	93.93%
Comparison group trend factor DY8			0.8349	0.8009	0.9593
Cohort 7B					
Intervention – Baseline	2,139	29	$1,993.34	$1,868.77	93.75%
Comparison – Baseline	3,821	31	$1,918.03	$1,877.65	97.90%
Intervention – Demo Year 7	2,139	29	$1,615.16	$1,492.19	92.39%
Comparison – Demo Year 7	3,821	31	$1,788.52	$1,696.40	94.85%
Comparison group trend factor DY7			0.9325	0.9035	0.9689
Intervention – Demo Year 8	2,139	27	$1,636.26	$1,479.66	90.43%

(continued)

Appendix Table E (continued)
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
Comparison – Demo Year 8	3,821	33	$1,716.43	$1,596.07	92.99%
Comparison group trend factor DY8			0.8949	0.8500	0.9499
Cohort 8A					
Intervention – Baseline	3,612	42	$2,047.55	$1,980.01	96.70%
Comparison – Baseline	2,942	24	$2,428.91	$2,360.03	97.16%
Intervention – Demo Year 7	3,612	41	$1,808.18	$1,738.50	96.15%
Comparison – Demo Year 7	2,942	25	$2,332.53	$2,288.41	98.11%
Comparison group trend factor DY7			0.9603	0.9697	1.0097
Intervention – Demo Year 8	3,612	36	$1,907.47	$1,795.58	94.13%
Comparison – Demo Year 8	2,942	30	$2,029.25	$1,949.29	96.06%
Comparison group trend factor DY8			0.8355	0.8260	0.9886
Cohort 8B					
Intervention – Baseline	1,650	18	$1,944.81	$1,856.91	95.48%
Comparison – Baseline	2,925	28	$2,124.54	$2,069.74	97.42%
Intervention – Demo Year 7	1,650	21	$1,730.93	$1,630.57	94.20%
Comparison – Demo Year 7	2,925	25	$1,954.83	$1,910.54	97.73%
Comparison group trend factor DY7			0.9201	0.9231	1.0032
Intervention – Demo Year 8	1,650	26	$1,721.17	$1,569.81	91.21%
Comparison – Demo Year 8	2,925	20	$1,847.50	$1,752.18	94.84%
Comparison group trend factor DY8			0.8696	0.8466	0.9735

(continued)

Appendix Table E (continued)
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 9A					
Intervention – Baseline	3,742	39	$2,119.27	$2,053.50	96.90%
Comparison – Baseline	2,409	23	$2,670.77	$2,611.44	97.78%
Intervention – Demo Year 8	3,742	41	$1,908.40	$1,819.37	95.33%
Comparison – Demo Year 8	2,409	21	$2,234.71	$2,183.96	97.73%
Comparison group trend factor DY8			0.8367	0.8363	0.9995
Cohort 9B					
Intervention – Baseline	1,630	17	$2,248.65	$2,086.78	92.80%
Comparison – Baseline	2,362	23	$2,386.84	$2,289.97	95.94%
Intervention – Demo Year 8	1,630	20	$1,973.69	$1,799.42	91.17%
Comparison – Demo Year 8	2,362	20	$2,065.39	$2,018.14	97.71%
Comparison group trend factor DY8			0.8653	0.8813	1.0185

Appendix F
Savings by Cohort for Demonstration Years 1–6, After All Adjustments Including the Outlier Adjustment and Attributed Savings

Appendix Table F
Demonstration Years 1–6 Medicare 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 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%
Attributed savings								
Cohort 2	1,809.40	$1,817.45				$161.78	$292,723	8.90%
Cohort 3	36,294.60	$1,365.18				$75.52	$2,740,977	5.50%
Cohorts 1+2+3	235,686.10					$148.04	**$34,891,668**	
Demonstration Year 2 (outlier adjusted)								
Cohort 1	116,440.81	$1,566.42	1.155	$1,809.13	$1,597.70	$211.42	$24,618,168	11.69%
Cohort 2	5,247.88	$2,288.30	0.796	$1,821.17	$1,769.81	$51.36	$269,530	2.82%
Cohort 3	59,323.07	$1,627.53	0.914	$1,487.69	$1,431.82	$55.86	$3,313,972	3.76%
Cohorts 1+2+3	181,011.76			$1,704.13	$1,548.33	$155.80	$28,201,670	9.14%
Attributed savings								
Cohort 4	35,488.55	$1,478.37				$55.51	$1,970,085	3.76%
Cohorts 1+2+3+4	216,500.31					$139.36	**$30,171,755**	
Demonstration Year 3 (outlier adjusted)								
Cohort 1	99,473.87	$1,570.53	1.146	$1,799.76	$1,585.47	$214.29	$21,316,089	11.91%
Cohort 2	4,312.07	$2,280.88	0.771	$1,759.23	$1,748.62	$10.61	$45,754	0.60%
Cohort 3	47,319.84	$1,628.93	0.868	$1,413.15	$1,370.64	$42.52	$2,011,822	3.01%

(continued)

Appendix Table F (continued)
Demonstration Years 1–6 Medicare 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
Cohort 4	60,468.49	$1,688.50	1.014	$1,712.85	$1,457.21	$255.64	$15,457,893	14.92%
Cohorts 1+2+3+4	211,574.27			$1,687.63	$1,504.09	$183.54	$38,831,557	10.88%
Attributed savings								
Cohort 5A	35,843.05	$1,442.97				$215.36	$7,719,063	14.92%
Cohorts 1+2+3+4+5	247,417.32					$188.15	**$46,550,620**	
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%
Attributed savings								
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%
Cohorts 1 to 6A/B	327,905.66					$170.67	**$55,963,993**	
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%

(continued)

Appendix Table F (continued)
Demonstration Years 1–6 Medicare 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
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%
Attributed savings								
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%
Cohorts 1 to 7A/B	351,722.55					$188.13	**$66,169,591**	
Demonstration Year 6 (outlier adjusted)								
Cohort 1	54,612.00	$1,570.53	1.226	$1,925.97	$1,780.96	$145.00	$7,918,936	7.53%
Cohort 2	2,478.23	$2,280.88	0.846	$1,928.98	$1,681.88	$247.10	$612,366	12.81%
Cohort 3	24,068.85	$1,628.93	1.067	$1,738.13	$1,583.99	$154.15	$3,710,100	8.87%
Cohort 4	26,758.64	$1,688.50	1.037	$1,750.87	$1,552.16	$198.71	$5,317,174	11.35%
Cohort 5A	35,426.65	$1,627.86	1.039	$1,691.48	$1,501.15	$190.34	$6,743,069	11.25%
Cohort 5B	36,910.56	$1,663.65	1.121	$1,864.50	$1,707.48	$157.01	$5,795,459	8.42%
Cohort 6A	35,570.79	$1,923.45	0.946	$1,818.88	$1,518.49	$300.39	$10,685,017	16.51%
Cohort 6B	25,084.85	$1,816.26	0.960	$1,743.54	$1,620.91	$122.62	$3,076,023	7.03%
Cohort 7A	43,758.02	$1,831.12	0.980	$1,794.14	$1,642.54	$151.60	$6,633,697	8.45%

(continued)

Appendix Table F (continued)
Demonstration Years 1–6 Medicare 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
Cohort 7B	20,966.13	$1,868.77	0.962	$1,797.64	$1,615.13	$182.51	$3,826,484	10.15%
Cohorts 1 to 7A/B	305,634.72			$1,806.15	$1,628.43	$177.72	$54,318,325	9.84%
Attributed savings								
Cohort 8A	22,332.93	$1,682.08				$142.13	$3,174,191	8.45%
Cohort 8B	10,075.37	$1,545.00				$156.86	$1,580,402	10.15%
Cohorts 1 to 8A/B	338,043.02					$174.75	**$59,072,918**	

Appendix G
Medicare PMPM Costs for Intervention and Comparison Groups, by Month

Appendix Table G.A
Medicare PMPM costs for intervention and comparison groups, by month: Cohort 1

	Intervention group		PMPM			
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	Ratio (D/T)
Baseline	$484,510,829	300,541.1	$1,612	$1,592	$1,612	1.00
Jan-20	$7,545,770	3,996.5	$1,888	$2,063	$2,096	0.90
Feb-20	$7,143,928	3,927.3	$1,819	$2,105	$2,131	0.85
Mar-20	$7,339,736	3,856.8	$1,903	$2,208	$2,233	0.85
Apr-20	$6,190,360	3,790.8	$1,633	$1,690	$1,718	0.95
May-20	$6,427,041	3,734.8	$1,721	$1,623	$1,648	1.04
Jun-20	$6,680,398	3,713.5	$1,799	$2,041	$2,062	0.87
Jul-20	$7,591,874	3,659.1	$2,075	$2,198	$2,223	0.93
Aug-20	$7,619,464	3,600.3	$2,116	$2,298	$2,313	0.92
Sep-20	$7,245,699	3,556.6	$2,037	$2,281	$2,309	0.88
Oct-20	$7,109,669	3,519.8	$2,020	$2,217	$2,238	0.90
Nov-20	$6,979,400	3,448.8	$2,024	$2,082	$2,092	0.97
Dec-20	$7,645,965	3,428.6	$2,230	$2,181	$2,197	1.02
Jan-21	$6,117,655	3,024.9	$2,022	$2,118	$2,101	0.96
Feb-21	$5,912,455	2,993.9	$1,975	$1,908	$1,891	1.04
Mar-21	$6,432,603	2,930.5	$2,195	$2,247	$2,233	0.98
Apr-21	$6,275,311	2,887.7	$2,173	$2,145	$2,127	1.02
May-21	$6,056,130	2,834.9	$2,136	$2,154	$2,126	1.00
Jun-21	$6,617,647	2,789.6	$2,372	$2,145	$2,119	1.12
Jul-21	$5,764,767	2,751.6	$2,095	$1,886	$1,863	1.12
Aug-21	$5,194,220	2,713.7	$1,914	$1,857	$1,857	1.03
Sep-21	$5,560,360	2,662.5	$2,088	$1,974	$1,954	1.07
Oct-21	$5,558,908	2,628.0	$2,115	$2,230	$2,182	0.97
Nov-21	$5,601,869	2,601.1	$2,154	$1,818	$1,796	1.20
Dec-21	$5,678,160	2,544.4	$2,232	$1,974	$1,937	1.15
Total	$156,289,390	77,595.6	$2,014	$2,063	$2,066	0.97

Appendix Table G.B
Medicare PMPM costs for intervention and comparison groups, by month: Cohort 2

	Intervention group		PMPM			
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	Ratio (D/T)
Baseline	$9,945,769	4,220.4	$2,357	$1,740	$2,357	1.00
Jan-20	$423,453	184.6	2,293.3	2,150.0	$2,937	0.78
Feb-20	$315,188	181.7	1,734.4	1,580.9	$2,083	0.83
Mar-20	$393,380	179.5	2,190.9	1,717.6	$2,248	0.97
Apr-20	$384,171	182.4	2,106.6	1,296.0	$1,732	1.22
May-20	$369,856	180.4	2,050.3	1,859.8	$2,425	0.85
Jun-20	$351,878	171.8	2,047.8	2,192.9	$2,926	0.70
Jul-20	$349,667	173.0	2,021.2	1,971.7	$2,642	0.76
Aug-20	$406,579	170.1	2,390.7	2,199.2	$2,998	0.80
Sep-20	$400,579	166.0	2,413.1	1,787.1	$2,398	1.01
Oct-20	$406,551	167.0	2,434.4	1,627.4	$2,216	1.10
Nov-20	$503,356	163.7	3,074.2	1,513.3	$1,972	1.56
Dec-20	$393,634	160.4	2,453.8	2,569.1	$3,370	0.73
Jan-21	$352,979	135.6	2,602.8	1,718.3	$2,311	1.13
Feb-21	$454,094	135.4	3,353.0	1,253.0	$1,716	1.95
Mar-21	$466,633	133.0	3,508.5	1,926.1	$2,572	1.36
Apr-21	$451,975	131.1	3,447.6	2,011.0	$2,595	1.33
May-21	$307,475	128.4	2,395.5	2,185.3	$3,074	0.78
Jun-21	$165,674	124.6	1,329.6	1,761.7	$2,394	0.56
Jul-21	$278,756	120.1	$2,320	$1,423	$1,723	1.35
Aug-21	$183,839	118.3	$1,554	$1,519	$1,884	0.82
Sep-21	$161,720	119.0	$1,359	$1,403	$1,919	0.71
Oct-21	$146,402	115.3	$1,270	$1,771	$2,374	0.53
Nov-21	$240,090	115.5	$2,079	$1,518	$1,968	1.06
Dec-21	$275,633	113.0	$2,439	$1,519	$1,955	1.25
Total	$8,183,564	3,570.0	$2,292	$1,786	$2,375	0.96

Appendix Table G.C
Medicare PMPM costs for intervention and comparison groups, by month: Cohort 3

	Intervention group		PMPM			
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	Ratio (D/T)
Baseline	$103,440,434	61,200.6	$1,690	$1,520	$1,690	1.00
Jan-20	$3,041,784	1,754.8	1,733.4	1,439.9	$1,617	1.07
Feb-20	$3,151,397	1,729.4	1,822.2	1,585.2	$1,793	1.02
Mar-20	$2,441,021	1,682.8	1,450.6	1,510.1	$1,749	0.83
Apr-20	$2,694,532	1,666.1	1,617.2	1,322.6	$1,498	1.08
May-20	$3,281,291	1,648.8	1,990.1	1,455.7	$1,617	1.23
Jun-20	$2,947,035	1,659.3	1,776.0	1,475.4	$1,694	1.05
Jul-20	$3,289,120	1,640.1	2,005.4	1,836.1	$2,073	0.97
Aug-20	$2,707,288	1,613.5	1,677.9	1,934.4	$2,187	0.77
Sep-20	$2,772,885	1,588.5	1,745.6	1,241.8	$1,399	1.25
Oct-20	$3,204,613	1,568.3	2,043.4	1,674.9	$1,933	1.06
Nov-20	$2,853,817	1,532.3	1,862.5	1,945.6	$2,205	0.84
Dec-20	$3,304,367	1,542.9	2,141.7	2,052.1	$2,452	0.87
Jan-21	$2,690,524	1,394.8	1,929.0	1,651.4	$1,835	1.05
Feb-21	$2,172,213	1,374.5	1,580.4	1,496.3	$1,811	0.87
Mar-21	$2,135,559	1,341.1	1,592.4	2,107.6	$2,405	0.66
Apr-21	$2,117,086	1,332.4	1,589.0	1,620.6	$1,806	0.88
May-21	$2,112,146	1,313.5	1,608.0	1,579.7	$1,755	0.92
Jun-21	$2,130,016	1,280.6	1,663.3	1,350.0	$1,531	1.09
Jul-21	$2,207,216	1,261.9	$1,749	$1,696	$1,848	0.95
Aug-21	$2,430,470	1,243.8	$1,954	$1,757	$1,963	1.00
Sep-21	$2,401,842	1,208.9	$1,987	$1,512	$1,752	1.13
Oct-21	$2,581,199	1,193.1	$2,163	$1,584	$1,750	1.24
Nov-21	$1,874,478	1,182.5	$1,585	$1,455	$1,644	0.96
Dec-21	$2,485,021	1,158.3	$2,145	$1,981	$2,271	0.94
Total	$63,026,919	34,912.2	$1,805	$1,631	$1,853	0.97

Appendix Table G.D
Medicare PMPM costs for intervention and comparison groups, by month: Cohort 4

	Intervention group		PMPM			
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	Ratio (D/T)
Baseline	$108,719,430	62,395.6	$1,742	$1,552	$1,742	1.00
Jan-20	$3,170,851	1,957.7	1,619.7	1,502.7	$1,688	0.96
Feb-20	$3,101,558	1,916.3	1,618.5	1,878.3	$2,139	0.76
Mar-20	$3,501,275	1,852.3	1,890.2	1,487.0	$1,648	1.15
Apr-20	$2,883,530	1,816.8	1,587.2	1,418.6	$1,592	1.00
May-20	$2,989,536	1,781.8	1,677.8	1,660.6	$1,843	0.91
Jun-20	$3,552,063	1,788.1	1,986.5	1,785.7	$2,013	0.99
Jul-20	$3,069,607	1,756.8	1,747.3	1,924.3	$2,177	0.80
Aug-20	$2,873,771	1,717.9	1,672.9	1,932.9	$2,171	0.77
Sep-20	$3,183,661	1,691.2	1,882.5	1,522.2	$1,693	1.11
Oct-20	$3,201,329	1,663.2	1,924.8	1,480.9	$1,611	1.19
Nov-20	$3,228,744	1,616.2	1,997.7	1,629.0	$1,807	1.11
Dec-20	$3,574,819	1,620.0	2,206.7	1,688.0	$1,888	1.17
Jan-21	$2,450,031	1,432.6	1,710.2	1,860.4	$2,019	0.85
Feb-21	$2,197,647	1,405.3	1,563.9	1,592.3	$1,782	0.88
Mar-21	$2,416,864	1,364.9	1,770.7	2,151.0	$2,441	0.73
Apr-21	$2,396,994	1,366.2	1,754.5	1,871.1	$2,113	0.83
May-21	$2,370,300	1,339.3	1,769.9	1,581.1	$1,746	1.01
Jun-21	$2,410,317	1,304.7	1,847.4	2,097.1	$2,344	0.79
Jul-21	$2,491,950	1,279.9	$1,947	$1,724	$1,926	1.01
Aug-21	$2,206,914	1,255.2	$1,758	$1,362	$1,516	1.16
Sep-21	$2,425,275	1,231.1	$1,970	$1,864	$2,062	0.96
Oct-21	$2,407,877	1,219.0	$1,975	$2,618	$2,974	0.66
Nov-21	$2,087,286	1,210.6	$1,724	$1,432	$1,601	1.08
Dec-21	$2,038,588	1,192.6	$1,709	$2,041	$2,298	0.74
Total	$66,230,786	36,779.7	$1,801	$1,739	$1,945	0.93

Appendix Table G.E
Medicare PMPM costs for intervention and comparison groups, by month: Cohort 5A

	Intervention group		PMPM			
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	Ratio (D/T)
Baseline	$110,831,462	65,796.4	$1,684	$1,636	$1,684	1.00
Jan-20	$4,204,887	2,538.9	1,656.2	1,860.0	$1,870	0.89
Feb-20	$3,632,532	2,475.6	1,467.4	1,718.5	$1,746	0.84
Mar-20	$3,464,211	2,402.7	1,441.8	1,785.3	$1,805	0.80
Apr-20	$3,039,402	2,339.5	1,299.2	1,685.1	$1,735	0.75
May-20	$3,441,200	2,283.4	1,507.0	1,601.3	$1,622	0.93
Jun-20	$3,737,238	2,273.8	1,643.6	1,419.1	$1,442	1.14
Jul-20	$4,736,624	2,242.2	2,112.5	1,952.3	$1,964	1.08
Aug-20	$3,429,686	2,173.2	1,578.2	1,950.4	$1,955	0.81
Sep-20	$3,997,479	2,162.6	1,848.4	2,013.1	$2,039	0.91
Oct-20	$4,117,316	2,128.5	1,934.4	1,997.2	$2,013	0.96
Nov-20	$3,463,032	2,078.3	1,666.3	1,771.5	$1,763	0.95
Dec-20	$4,019,301	2,085.2	1,927.6	1,945.6	$1,899	1.02
Jan-21	$3,286,386	1,837.4	1,788.6	2,164.8	$2,192	0.82
Feb-21	$2,841,109	1,794.6	1,583.1	1,653.8	$1,545	1.02
Mar-21	$3,406,921	1,756.8	1,939.3	1,733.7	$1,748	1.11
Apr-21	$2,912,426	1,736.4	1,677.3	1,590.6	$1,613	1.04
May-21	$2,698,670	1,702.3	1,585.3	1,641.5	$1,618	0.98
Jun-21	$2,994,593	1,667.5	1,795.9	1,206.5	$1,184	1.52
Jul-21	$3,056,712	1,652.4	$1,850	$1,569	$1,580	1.17
Aug-21	$3,013,289	1,613.0	$1,868	$1,378	$1,365	1.37
Sep-21	$2,911,034	1,556.5	$1,870	$1,499	$1,470	1.27
Oct-21	$2,976,945	1,534.1	$1,941	$1,395	$1,398	1.39
Nov-21	$2,682,223	1,525.6	$1,758	$1,326	$1,276	1.38
Dec-21	$2,780,575	1,480.6	$1,878	$1,875	$1,873	1.00
Total	$80,843,791	47,040.9	$1,719	$1,715	$1,717	1.00

Appendix Table G.F
Medicare PMPM costs for intervention and comparison groups, by month: Cohort 5B

	Intervention group		PMPM			
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	Ratio (D/T)
Baseline	$113,207,213	65,414.5	$1,731	$1,637	$1,731	1.00
Jan-20	$4,369,680	2,628.5	1,662.4	1,852.1	$1,897	0.88
Feb-20	$4,870,580	2,574.0	1,892.2	1,973.2	$2,035	0.93
Mar-20	$5,485,846	2,531.6	2,166.9	1,975.8	$2,014	1.08
Apr-20	$3,771,540	2,482.9	1,519.0	1,480.0	$1,566	0.97
May-20	$4,229,157	2,441.7	1,732.1	1,836.6	$1,912	0.91
Jun-20	$4,351,867	2,406.6	1,808.3	1,823.5	$1,906	0.95
Jul-20	$4,430,479	2,363.6	1,874.5	1,984.2	$2,050	0.91
Aug-20	$4,480,868	2,303.0	1,945.7	2,072.3	$2,120	0.92
Sep-20	$4,452,182	2,272.9	1,958.8	2,108.5	$2,138	0.92
Oct-20	$4,302,316	2,234.3	1,925.6	2,001.2	$2,076	0.93
Nov-20	$4,176,364	2,181.7	1,914.2	2,030.2	$2,121	0.90
Dec-20	$4,994,682	2,164.6	2,307.5	2,162.4	$2,263	1.02
Jan-21	$4,045,391	2,038.7	1,984.3	2,300.8	$2,355	0.84
Feb-21	$3,519,149	1,995.6	1,763.4	2,179.3	$2,168	0.81
Mar-21	$3,893,962	1,953.0	1,993.9	2,129.4	$2,161	0.92
Apr-21	$4,328,806	1,937.7	2,234.0	1,825.3	$1,872	1.19
May-21	$4,270,677	1,907.7	2,238.7	2,005.2	$2,041	1.10
Jun-21	$4,181,099	1,864.0	2,243.1	1,937.1	$1,950	1.15
Jul-21	$3,634,694	1,836.1	$1,980	$1,770	$1,820	1.09
Aug-21	$3,242,927	1,800.3	$1,801	$1,767	$1,809	1.00
Sep-21	$3,105,802	1,748.8	$1,776	$1,767	$1,800	0.99
Oct-21	$3,160,022	1,731.8	$1,825	$1,681	$1,744	1.05
Nov-21	$3,370,010	1,715.1	$1,965	$1,744	$1,798	1.09
Dec-21	$3,315,809	1,682.2	$1,971	$1,803	$1,862	1.06
Total	$97,983,910	50,796.4	$1,929	$1,929	$1,982	0.97

Appendix Table G.G
Medicare PMPM costs for intervention and comparison groups, by month: Cohort 6A

	Intervention group		PMPM			
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	Ratio (D/T)
Baseline	$102,206,255	51,245.5	$1,994	$1,953	$1,994	1.00
Jan-20	$4,194,289	2,398.9	1,748.4	1,919.9	$1,929	0.91
Feb-20	$3,419,139	2,343.8	1,458.8	1,880.8	$1,847	0.79
Mar-20	$3,773,459	2,261.1	1,668.9	1,512.1	$1,484	1.12
Apr-20	$3,299,093	2,212.4	1,491.2	2,146.1	$2,121	0.70
May-20	$3,263,320	2,164.5	1,507.6	1,944.8	$1,903	0.79
Jun-20	$3,294,903	2,152.8	1,530.5	1,725.4	$1,681	0.91
Jul-20	$3,320,768	2,117.1	1,568.6	2,100.5	$2,080	0.75
Aug-20	$4,328,642	2,066.5	2,094.7	2,728.6	$2,704	0.77
Sep-20	$3,642,634	2,023.3	1,800.3	2,118.8	$2,059	0.87
Oct-20	$3,905,263	2,000.8	1,951.9	2,042.4	$1,989	0.98
Nov-20	$3,416,818	1,946.3	1,755.5	1,577.3	$1,478	1.19
Dec-20	$3,917,364	1,933.0	2,026.6	2,130.3	$2,118	0.96
Jan-21	$2,639,367	1,739.9	1,517.0	1,520.1	$1,535	0.99
Feb-21	$2,621,486	1,701.7	1,540.5	1,520.4	$1,535	1.00
Mar-21	$3,226,800	1,662.2	1,941.3	1,832.0	$1,829	1.06
Apr-21	$3,117,026	1,647.8	1,891.7	1,677.6	$1,641	1.15
May-21	$2,469,900	1,630.4	1,514.9	1,801.1	$1,723	0.88
Jun-21	$2,620,983	1,592.3	1,646.0	1,561.5	$1,529	1.08
Jul-21	$2,517,146	1,558.4	$1,615	$2,036	$2,024	0.80
Aug-21	$2,699,071	1,527.7	$1,767	$1,774	$1,777	0.99
Sep-21	$3,466,958	1,486.2	$2,333	$1,789	$1,720	1.36
Oct-21	$2,895,693	1,456.1	$1,989	$1,781	$1,793	1.11
Nov-21	$2,163,965	1,440.3	$1,502	$1,631	$1,554	0.97
Dec-21	$2,703,262	1,403.1	$1,927	$1,997	$1,868	1.03
Total	$76,917,349	44,466.6	$1,730	$1,878	$1,845	0.94

Appendix Table G.H
Medicare PMPM costs for intervention and comparison groups, by month: Cohort 6B

	Intervention group		PMPM			
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	Ratio (D/T)
Baseline	$69,409,748	36,877.4	$1,882	$1,743	$1,882	1.00
Jan-20	$2,602,103	1,698.4	1,532.1	1,739.8	$1,974	0.78
Feb-20	$3,060,240	1,663.6	1,839.5	1,711.6	$1,838	1.00
Mar-20	$2,893,904	1,613.9	1,793.1	1,727.5	$1,823	0.98
Apr-20	$2,385,493	1,564.7	1,524.6	1,214.3	$1,307	1.17
May-20	$2,787,486	1,530.6	1,821.2	1,807.6	$1,992	0.91
Jun-20	$2,848,700	1,517.3	1,877.5	1,697.5	$1,898	0.99
Jul-20	$2,993,480	1,485.8	2,014.7	1,654.7	$1,797	1.12
Aug-20	$2,363,383	1,429.2	1,653.7	1,540.0	$1,670	0.99
Sep-20	$2,065,506	1,396.5	1,479.0	1,833.7	$1,913	0.77
Oct-20	$2,401,849	1,370.3	1,752.8	1,725.2	$1,827	0.96
Nov-20	$2,119,859	1,322.1	1,603.4	1,528.7	$1,626	0.99
Dec-20	$3,064,806	1,308.8	2,341.6	1,749.1	$1,941	1.21
Jan-21	$1,954,611	1,245.2	1,569.8	1,892.5	$1,967	0.80
Feb-21	$1,525,783	1,214.9	1,255.9	1,424.3	$1,493	0.84
Mar-21	$1,923,291	1,181.5	1,627.9	1,494.6	$1,578	1.03
Apr-21	$1,960,462	1,179.9	1,661.6	1,635.4	$1,705	0.97
May-21	$1,706,339	1,156.4	1,475.6	2,886.0	$2,889	0.51
Jun-21	$2,124,542	1,131.1	1,878.3	1,909.2	$2,003	0.94
Jul-21	$1,649,700	1,112.4	$1,483	$1,395	$1,479	1.00
Aug-21	$1,673,374	1,103.0	$1,517	$2,136	$2,178	0.70
Sep-21	$1,848,582	1,086.5	$1,701	$1,899	$2,010	0.85
Oct-21	$1,985,495	1,068.7	$1,858	$2,079	$2,133	0.87
Nov-21	$1,878,695	1,060.1	$1,772	$1,919	$2,050	0.86
Dec-21	$2,685,830	1,042.0	$2,578	$1,709	$1,758	1.47
Total	$54,503,515	31,482.6	$1,731	$1,747	$1,858	0.93

Appendix Table G.I
Medicare PMPM costs for intervention and comparison groups, by month: Cohort 7A

	Intervention group		PMPM			
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	Ratio (D/T)
Baseline	$87,735,987	46,757.6	$1,876	$2,006	$1,876	1.00
Jan-20	$5,360,413	2,925.5	1,832.3	1,960.2	$1,833	1.00
Feb-20	$5,125,360	2,847.3	1,800.0	2,071.5	$1,975	0.91
Mar-20	$3,906,637	2,723.2	1,434.6	1,571.0	$1,451	0.99
Apr-20	$3,608,517	2,637.1	1,368.4	1,335.6	$1,249	1.10
May-20	$4,191,623	2,571.4	1,630.1	1,486.5	$1,331	1.22
Jun-20	$4,402,647	2,515.3	1,750.3	1,566.0	$1,453	1.20
Jul-20	$4,443,645	2,448.9	1,814.5	1,927.6	$1,790	1.01
Aug-20	$4,633,838	2,375.0	1,951.1	2,090.8	$1,913	1.02
Sep-20	$4,195,945	2,338.9	1,794.0	2,122.4	$1,992	0.90
Oct-20	$4,518,811	2,281.8	1,980.4	1,897.7	$1,736	1.14
Nov-20	$4,389,898	2,180.7	2,013.1	1,760.3	$1,645	1.22
Dec-20	$4,409,436	2,155.7	2,045.5	2,065.2	$1,922	1.06
Jan-21	$3,035,738	1,896.2	1,601.0	1,788.9	$1,647	0.97
Feb-21	$2,873,855	1,843.5	1,558.9	1,878.9	$1,714	0.91
Mar-21	$3,241,162	1,816.3	1,784.5	2,020.4	$1,871	0.95
Apr-21	$3,791,118	1,779.4	2,130.5	1,966.9	$1,871	1.14
May-21	$2,884,328	1,739.6	1,658.0	1,781.1	$1,671	0.99
Jun-21	$2,871,602	1,687.1	1,702.1	1,893.8	$1,804	0.94
Jul-21	$2,616,915	1,660.6	$1,576	$2,214	$2,136	0.74
Aug-21	$2,868,065	1,623.0	$1,767	$1,758	$1,675	1.06
Sep-21	$3,333,346	1,574.5	$2,117	$1,840	$1,759	1.20
Oct-21	$3,090,820	1,540.6	$2,006	$2,136	$2,010	1.00
Nov-21	$2,646,305	1,510.3	$1,752	$1,707	$1,590	1.10
Dec-21	$2,814,753	1,460.5	$1,927	$1,598	$1,498	1.29
Total	$89,254,777	50,132.6	$1,780	$1,843	$1,721	1.03

Appendix Table G.J
Medicare PMPM costs for intervention and comparison groups, by month: Cohort 7B

	Intervention group		PMPM			
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	Ratio (D/T)
Baseline	$45,179,933	22,665.5	$1,993	$1,868	$1,993	1.00
Jan-20	$2,173,298	1,357.8	1,600.6	1,648.1	$1,757	0.91
Feb-20	$1,824,453	1,329.1	1,372.7	1,465.5	$1,548	0.89
Mar-20	$2,128,822	1,278.5	1,665.1	1,408.3	$1,496	1.11
Apr-20	$1,698,257	1,221.7	1,390.0	1,254.2	$1,353	1.03
May-20	$1,833,714	1,196.9	1,532.1	1,853.8	$1,984	0.77
Jun-20	$1,614,496	1,155.9	1,396.8	1,753.2	$1,889	0.74
Jul-20	$1,507,838	1,125.7	1,339.4	1,603.6	$1,721	0.78
Aug-20	$1,802,003	1,089.9	1,653.4	1,548.2	$1,654	1.00
Sep-20	$1,996,608	1,064.4	1,875.8	1,577.5	$1,713	1.10
Oct-20	$1,769,354	1,031.6	1,715.2	1,594.3	$1,793	0.96
Nov-20	$1,811,449	980.6	1,847.2	1,781.4	$1,898	0.97
Dec-20	$2,130,016	968.6	2,199.1	2,217.8	$2,383	0.92
Jan-21	$1,386,272	914.6	1,515.7	1,662.5	$1,878	0.81
Feb-21	$1,375,394	893.4	1,539.5	1,533.8	$1,649	0.93
Mar-21	$1,447,860	871.7	1,660.9	1,529.3	$1,629	1.02
Apr-21	$1,863,970	858.5	2,171.2	1,916.8	$1,965	1.10
May-21	$1,354,375	833.7	1,624.6	1,569.4	$1,679	0.97
Jun-21	$1,215,224	809.2	1,501.7	1,882.2	$1,903	0.79
Jul-21	$1,324,658	795.5	$1,665	$1,277	$1,412	1.18
Aug-21	$1,258,692	772.3	$1,630	$1,225	$1,294	1.26
Sep-21	$1,063,673	743.8	$1,430	$1,336	$1,436	1.00
Oct-21	$997,256	727.2	$1,371	$1,519	$1,591	0.86
Nov-21	$1,085,854	721.7	$1,505	$1,379	$1,422	1.06
Dec-21	$1,407,279	702.6	$2,003	$1,807	$1,855	1.08
Total	$38,070,814	23,444.9	$1,624	$1,600	$1,709	0.95

Appendix Table G.K
Medicare PMPM costs for intervention and comparison groups, by month: Cohort 8A

	Intervention group		PMPM			
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	Ratio (D/T)
Baseline	$75,138,004	36,696.5	$2,048	$2,090	$2,048	1.00
Jan-20	$6,708,650	3,590.4	1,868.5	2,133.1	$2,076	0.90
Feb-20	$6,396,451	3,442.4	1,858.1	1,980.4	$1,922	0.97
Mar-20	$5,637,621	3,319.9	1,698.1	2,016.3	$1,981	0.86
Apr-20	$4,995,142	3,198.5	1,561.7	1,612.2	$1,591	0.98
May-20	$5,173,804	3,096.3	1,671.0	2,084.4	$2,057	0.81
Jun-20	$5,109,678	3,018.7	1,692.7	2,291.2	$2,276	0.74
Jul-20	$5,661,456	2,969.6	1,906.5	2,240.9	$2,238	0.85
Aug-20	$5,961,021	2,873.5	2,074.5	2,032.9	$2,002	1.04
Sep-20	$5,013,666	2,802.7	1,788.8	2,051.0	$2,031	0.88
Oct-20	$4,562,162	2,733.1	1,669.2	1,977.8	$1,973	0.85
Nov-20	$4,664,999	2,644.8	1,763.9	1,821.3	$1,796	0.98
Dec-20	$5,736,493	2,601.5	2,205.1	2,176.5	$2,148	1.03
Jan-21	$3,523,785	2,299.4	1,532.5	1,739.5	$1,714	0.89
Feb-21	$3,601,326	2,212.2	1,627.9	1,561.8	$1,514	1.08
Mar-21	$4,133,459	2,153.6	1,919.3	2,500.4	$2,415	0.79
Apr-21	$4,327,226	2,109.0	2,051.8	2,238.8	$2,101	0.98
May-21	$3,928,274	2,029.9	1,935.2	1,829.1	$1,738	1.11
Jun-21	$3,824,915	1,955.5	1,956.0	1,809.6	$1,772	1.10
Jul-21	$3,284,417	1,889.1	$1,739	$1,918	$1,888	0.92
Aug-21	$4,187,536	1,829.0	$2,289	$2,049	$2,028	1.13
Sep-21	$3,315,075	1,762.6	$1,881	$1,779	$1,705	1.10
Oct-21	$3,557,282	1,713.7	$2,076	$1,820	$1,765	1.18
Nov-21	$3,557,200	1,687.7	$2,108	$1,831	$1,807	1.17
Dec-21	$3,147,810	1,629.0	$1,932	$2,649	$2,592	0.75
Total	$110,009,448	59,562.1	$1,847	$2,009	$1,969	0.94

Appendix Table G.L
Medicare PMPM costs for intervention and comparison groups, by month: Cohort 8B

	Intervention group		PMPM			
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	Ratio (D/T)
Baseline	$33,145,837	17,043.2	$1,945	$1,951	$1,945	1.00
Jan-20	$3,211,767	1,639.0	1,959.6	1,964.2	$1,986	0.99
Feb-20	$2,460,253	1,557.3	1,579.8	1,660.2	$1,670	0.95
Mar-20	$2,542,976	1,484.6	1,712.9	1,730.0	$1,784	0.96
Apr-20	$2,297,282	1,433.3	1,602.8	1,277.9	$1,312	1.22
May-20	$2,089,441	1,400.9	1,491.5	1,527.8	$1,582	0.94
Jun-20	$2,430,266	1,366.9	1,777.9	1,665.7	$1,643	1.08
Jul-20	$2,490,010	1,342.9	1,854.2	1,699.3	$1,773	1.05
Aug-20	$2,252,225	1,307.0	1,723.2	1,780.0	$1,790	0.96
Sep-20	$2,064,567	1,269.0	1,626.9	1,929.8	$1,908	0.85
Oct-20	$2,239,535	1,239.8	1,806.4	2,133.2	$2,007	0.90
Nov-20	$2,117,671	1,197.8	1,767.9	1,770.0	$1,753	1.01
Dec-20	$2,228,467	1,182.9	1,883.8	1,935.0	$1,906	0.99
Jan-21	$1,516,256	1,084.8	1,397.7	2,001.7	$1,946	0.72
Feb-21	$1,353,169	1,048.2	1,290.9	1,608.2	$1,627	0.79
Mar-21	$2,008,567	1,003.2	2,002.2	1,830.7	$1,820	1.10
Apr-21	$1,689,500	969.2	1,743.2	1,384.4	$1,385	1.26
May-21	$1,686,904	937.3	1,799.8	1,446.8	$1,432	1.26
Jun-21	$1,969,335	901.2	2,185.3	1,984.5	$1,786	1.22
Jul-21	$1,318,653	880.4	$1,498	$1,459	$1,479	1.01
Aug-21	$1,637,568	856.5	$1,912	$1,607	$1,505	1.27
Sep-21	$1,283,243	820.1	$1,565	$1,764	$1,716	0.91
Oct-21	$1,626,421	785.1	$2,072	$1,710	$1,708	1.21
Nov-21	$1,347,224	773.4	$1,742	$1,810	$1,802	0.97
Dec-21	$1,171,230	751.9	$1,558	$1,752	$1,738	0.90
Total	$47,032,531	27,232.8	$1,727	$1,729	$1,719	1.00

Appendix Table G.M
Medicare PMPM costs for intervention and comparison groups, by month: Cohort 9A

	Intervention group		PMPM			
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	Ratio (D/T)
Baseline	$77,445,770	36,543.7	$2,119	$2,155	$2,119	1.00
Jan-21	$7,333,597	3,722.5	1,970.1	2,019.4	$1,952	1.01
Feb-21	$6,032,754	3,545.2	1,701.6	2,181.8	$2,116	0.80
Mar-21	$7,188,325	3,429.2	2,096.2	2,326.7	$2,313	0.91
Apr-21	$6,387,998	3,324.9	1,921.2	1,918.1	$1,911	1.01
May-21	$5,910,441	3,188.6	1,853.6	2,340.2	$2,287	0.81
Jun-21	$5,988,039	3,073.3	1,948.4	2,648.0	$2,606	0.75
Jul-21	$5,445,235	2,960.8	1,839.1	2,365.1	$2,276	0.81
Aug-21	$5,684,605	2,871.0	1,980.0	2,349.5	$2,284	0.87
Sep-21	$5,990,581	2,765.5	2,166.2	2,036.3	$2,015	1.08
Oct-21	$4,565,764	2,692.2	1,695.9	2,125.2	$2,060	0.82
Nov-21	$4,857,269	2,650.5	1,832.6	2,144.1	$2,144	0.85
Dec-21	$4,813,069	2,559.7	1,880.3	1,908.0	$1,862	1.01
Total	$70,197,676	36,783.5	$1,908	$2,199	$2,154	0.89

Appendix Table G.N
Medicare PMPM costs for intervention and comparison groups, by month: Cohort 9B

	Intervention group		PMPM			
Month/Year	Incurred claims	Eligible months	Intervention	Comparison	Target	Ratio (D/T)
Baseline	$36,960,759	16,436.9	$2,249	$2,210	$2,249	1.00
Jan-21	$3,014,812	1,620.7	1,860.2	2,555.1	$2,571	0.72
Feb-21	$2,944,513	1,548.8	1,901.2	1,989.8	$1,989	0.96
Mar-21	$2,932,942	1,475.7	1,987.5	2,072.0	$2,087	0.95
Apr-21	$2,533,966	1,408.0	1,799.7	2,062.1	$2,080	0.87
May-21	$2,960,673	1,363.2	2,171.9	1,948.2	$1,951	1.11
Jun-21	$2,672,536	1,312.8	2,035.8	2,047.2	$2,023	1.01
Jul-21	$2,375,117	1,264.5	1,878.4	2,120.0	$2,059	0.91
Aug-21	$2,261,645	1,224.8	1,846.6	2,314.4	$2,309	0.80
Sep-21	$2,483,493	1,188.8	2,089.0	1,518.5	$1,577	1.32
Oct-21	$2,211,635	1,153.3	1,917.6	2,195.2	$2,176	0.88
Nov-21	$2,672,018	1,135.5	2,353.1	1,771.7	$1,790	1.31
Dec-21	$2,123,913	1,105.5	1,921.3	1,922.3	$1,923	1.00
Total	$31,187,264	15,801.5	$1,974	$2,058	$2,060	0.96

Benton County Acute Care Provider

Name	Type	Address	City	ZipCode
Kadlec Regional Medical Center	Hospital	888 Swift Boulevard	Richland	99352
Lourdes Counseling Center	Hospital	1175 Carondelet Drive	Richland	99354
Prosser Memorial Health	Hospital	723 MEMORIAL ST	Prosser	99350
Trios Southridge Hospital	Hospital	3810 Plaza Way	Kennewick	99338

Benton County Post-Acute Care Providers

Includes Assisted Living Facilities (ALF) and Nursing Homes (NH)

Name	Type	Address	City	ZipCode
Amber Hills Assisted Living	ALF	125 N Wamba Rd	Prosser	99350
BONAVENTURE OF THE TRI-CITIES	ALF	1800 BELLERIVE DRIVE	RICHLAND	99352
Brookdale Canyon Lakes	ALF	2802 W 35TH AVE	KENNEWICK	99337
Brookdale Meadow Springs	ALF	770 Gage Blvd	Richland	99352
Brookdale Richland	ALF	1629 George Washington Way	Richland	99354
Brookdale Torbett	ALF	221 Torbett St	Richland	99354
Callaway Gardens Alzheimers Special Care Center	ALF	5505 W Skagit Ct	Kennewick	99336
CIELS SENIOR LIVING OF TRI CITIES	ALF	7255 W Grandridge Blvd	Kennewick	99336
CIELS SENIOR LIVING MEMORY CARE	ALF	575 N Young St	Kennewick	99336
GUARDIAN ANGEL HOMES (THE COTTAGE)	ALF	245 Van Giesen St	Richland	99354
HAWTHORNE COURT	ALF	524 N Ely St	Kennewick	99336
Parkview Estates	ALF	7820 W 6th Ave	Kennewick	99336
Prestige Assisted Living at Richland	ALF	1745 Pike Ave	Richland	99354
NORTHCARE ASSISTED LIVING, FISHER	ALF	520 N FISHER STREET	KENNEWICK	99336
NORTHCARE ASSISTED LIVING, HOXIE	ALF	1939 Hoxie Ave	Richland	99354
NORTHCARE ASSISTED LIVING, OLYMPIA	ALF	1208 W 11TH PL	KENNEWICK	99337
NORTHCARE ASSISTED LIVING 110TH	ALF	3321 110TH AVENUE	KENNEWICK	99336
NORTHCARE PASCO	ALF	5921 ROAD 60 DRIVE	PASCO	99301
Royal Columbian Senior Living	ALF	5615 W Umatilla Ave	Kennewick	99336
Ruan's Garden	ALF	3502 W 4th Ave	Kennewick	99336
SUN TERRACE PROSSER	ALF	2131 WINE COUNTRY ROAD	PROSSER	99350
Three Rivers Place Senior Living	ALF	1108 W 5th Ave	Kennewick	99336
Windsong at Southridge	ALF	4000 W 24th Avenue	Kennewick	99338
LIFE CARE CENTER OF KENNEWICK	NH	1508 W 7TH AVE	KENNEWICK	99336
LIFE CARE CENTER OF RICHLAND	NH	44 GOETHALS DR	RICHLAND	99352
Regency Canyon Lakes Rehabilitation and Nursing Center	NH	2702 S Ely St	Kennewick	99337
RICHLAND REHABILITATION CENTER	NH	1745 PIKE AVE	RICHLAND	99354


BENTON COUNTY MAP
WASHINGTON, USA
LEGEND
Major City/Town
County Seat
Golf Course
Mountain Peak/Hill
Airport Type
Small
Heliport
Highway Class
Interstate
Federal
State
Other
Railroad
River/Stream
River/Lake/Reservoir
County Subdivision
County Boundary
State Boundary
Grant
Franklin
Yakima
Klickitat
Walla Walla
Oregon
Columbia R.
Yakima R.
Hanford Site
Lookout (1106 mtr.)
Rattlesnake Mountain (1076 mtr.)
Wnp-2 Plant Support Facility Heliport
Hammer Evoc Skid Pad Heliport
Mc Whorter Ranch Airport
Northwest Benton
Benton City
Horn Rapids Golf Club
West Richland
Richland Airport
Richland
Kadlec Medical Center Heliport
Benton
Prosser Hospital Heliport
Chandler Butte (623 mtr.)
Prosser Airport
Prosser
Meadow Springs Country Club
Vista Field
Tri City Country Club
Kennewick
Kennewick General Hospital Heliport
Richland-Kennewick
Canyon Lakes Golf Course
Finley
Jump Off Joe (670 mtr.)
Woodfield Airport
Johnson Butte (621 mtr.)
South Benton
Columbia Crest Winery Airport
Copyright © 2016 www.mapsofworld.com