
*Washington Complex Discharge Pilot:
Outcomes and Analysis*

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

TO
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SENATE WAYS AND MEANS COMMITTEE
SENATE HEALTH AND LONG-TERM CARE COMMITTEE
SENATE LAW & JUSTICE COMMITTEE
HOUSE APPROPRIATIONS COMMITTEE
HOUSE HEALTH CARE AND WELLNESS COMMITTEE
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FROM
THE COMPLEX DISCHARGE TASK FORCE

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Executive Summary

In 2023, the Washington State Legislature established the Complex Discharge Task Force and Pilot to address a persistent challenge in the state’s healthcare system: hundreds of individuals remain in acute care hospitals for extended periods—weeks, months, or years—despite being medically ready for discharge. Driving these prolonged stays are fragmented systems, resource limitations, and the complex medical, behavioral, social, and long-term care needs of patients. The resulting delays place a significant burden on patients and families, restrict access for others needing acute care, and add system costs reaching millions of dollars annually for hospitals and other providers.

On July 1, 2025, the Task Force submitted the report, [Complex Discharge Task Force and Pilot: Recommendations](#), which outlines a clear path forward for the Task Force, state agencies, and the legislature to address systemic barriers to discharge for individuals with complex needs. This addendum, *Complex Discharge Pilot: Outcomes & Analysis*, summarizes key pilot outcomes and reinforces the Task Force’s recommendations.

Complex Discharge Pilot and Key Outcomes

The Complex Discharge Pilot tested a new model of care designed to reduce delays in transitions of care for individuals with complex needs by providing Enhanced Care Management (ECM) with lower caseloads; cross-system care coordination; dedicated long-term care eligibility and enrollment staffing; flexible Supportive Services; and strengthened partnerships with skilled nursing facilities and community providers. From April 2024 to June 2025, five hospital systems across the state implemented the model, supported by the Health Care Authority (HCA), the Department of Social and Health Services (DSHS), and the Complex Discharge Task Force. An analysis of pilot data identified the following key outcomes:

❖ Significant Reductions in Length of Stay

The pilot achieved dramatic reductions in both hospital and skilled nursing facility (SNF) length of stay (LOS) for patients with complex discharge needs. **Median hospital LOS decreased from 28 days to 11 days, and SNF LOS dropped from 77 days to 19 days between Quarter 2 (Q2) 2024 and Q2 2025.** The decreasing trend in LOS was consistent across all pilot sites and barrier types, except for legal barriers (primarily guardianship), which showed varied lengths of stay throughout the pilot, underscoring the underlying systemic nature of these barriers that are outside the control of the care team and require further policy action, as highlighted in the Task Force July 1, 2025, recommendations.

❖ Lower Inpatient Readmission Rates

Pilot participants had **37 percent lower odds of inpatient readmission within 30 days compared to similar Medicaid populations**, based on the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) All-Cause Readmission criteria. This finding suggests that the ECM model’s comprehensive, patient-

The pilot demonstrated substantial reductions in hospital and skilled nursing facility length of stay and hospital readmission rates, as well as improved care coordination efficiency and patient satisfaction.

These results demonstrate the effectiveness of the Complex Discharge Model of Care in overcoming discharge barriers and connecting patients to a more appropriate level of care to meet their needs.

centered approach not only facilitated timely discharges, but also ensured better support in post-acute settings.

❖ Increased Access and Utilization of LTSS

In addition to alleviating hospital discharge bottlenecks, the pilot significantly expanded access to long-term services and supports (LTSS) and connected people to post-acute and community care settings that could more effectively address their needs. Compared with similarly situated Medicaid populations, pilot participants had a significant increase in the use of LTSS settings. Therefore, while SNF LOS decreased for pilot participants at the pilot SNF sites, there was an overall increase in the access and utilization of LTSS nursing facility, residential and community services. These trends reflect the effectiveness of the pilot's strategy in supporting individuals to transition more quickly out of higher cost hospital and SNF settings and into longer-term settings that can better address their needs.

❖ High Patient Satisfaction

Survey results showed that **79 percent of patients who responded to the survey rated their care as good to excellent, and 70 percent agreed or strongly agreed that the program improved their health and well-being.** Patients reported improved access to services, better communication, and more meaningful support in achieving their care goals. Pilot sites also noted improvements in staff morale and engagement when patients were able to move to a more appropriate care setting.

❖ Improved Care Coordination and Efficiency

During the course of the pilot, the **average length of enrollment in ECM services decreased from 275 days to 110 days, reflecting more efficient collaboration among ECM staff, DSHS case managers, managed care organizations, and post-acute partners.** Weekly multidisciplinary team meetings and strong partnerships enabled cross-system problem-solving, smoother transitions, and increased access to services and effective care to meet patient needs.

❖ Flexible Use of Supportive Services

Pilot programs had access to flexible Supportive Service dollars to address patient-specific barriers to care transitions, such as transportation, 1:1 caregivers, and home health support. Over 90 percent of Supportive Services provided were not otherwise Medicaid billable because of the setting in which the service was provided or other service eligibility criteria. Pilot sites also used Supportive Services funds for Medicaid-covered services (9.3%) in cases that helped to expedite access and reduce delays in care transitions. **This flexibility allowed sites to address patient-specific barriers quickly, reducing delays that would otherwise prolong hospital stays.**

❖ Cost Impacts

A key goal of the pilot was to support patients to transition out of high-cost, high-acuity settings when medically appropriate and into post-acute and community care settings that could more effectively address their needs. This shift in settings generated substantial hospital cost savings by significantly reducing inpatient LOS and lowering readmission rates for individuals facing complex discharge barriers. Using a standard hospital day rate and subtracting pilot costs, the LOS reduction translated into an estimated **hospital direct care net savings of nearly \$28,000 per patient, amounting to almost \$14 million in net savings across all patients served by the pilot.**

Beyond the savings in hospital costs highlighted in this report, the Task Force recognizes broader systemwide cost impacts likely to result from supporting timely transitions of care into more effective

settings. The pilot's success in facilitating timely transitions into long-term care settings, for example, should be expected to increase Medicaid LTSS utilization and costs. At the same time, several other system effects may reduce costs over time. These include decreases in avoidable emergency department use and preventable hospital stays, improved workforce satisfaction and reduced burnout, and more efficient care coordination across the health system. While this review does not include a system-level cost analysis, the Task Force underscores the need for the legislature to consider these broader system cost impacts when evaluating future investments needed to strengthen transitions of care for this population.

Task Force Recommendations & Path Forward

The Complex Discharge Pilot demonstrates that a coordinated, patient-centered model, supported by dedicated staffing, flexible funding, and cross-system collaboration, can significantly reduce avoidable hospital and SNF LOS and improve transitions of care for individuals with a range of medical, behavioral, social, and long-term care needs. As outlined in its July 1, 2025, report, **the Task Force recommends statewide expansion of the model, sustained funding, state agency actions to support cross-system alignment, and targeted policy changes to address persistent structural barriers.** These recommendations include collaboration with Tribal partners to ensure care transitions for American Indian and Alaska Native populations and member of Tribal communities. Together these actions will improve care transitions, align system investments, and strengthen the state's healthcare system for all Washingtonians.

Background

On any given day, nearly 850 patients in Washington State are medically ready for discharge from acute care settings but remain hospitalized because of a range of systemic barriers that prevent timely discharge of patients with complex clinical, behavioral, social, and long-term care needs. These delays place a significant burden on patients and families, restrict access for other people in need of acute care, and result in millions of dollars in system costs annually for hospitals and other providers.

To address this persistent challenge, the Washington State Legislature created the Complex Discharge Task Force and Pilot in 2023 to move the state toward a comprehensive approach to addressing discharge barriers. Over the course of two years, the Task Force engaged more than 150 stakeholders and launched five pilot sites to test an innovative model of care and to develop recommendations that address system-level barriers to discharge.

On July 1, 2025, the Task Force submitted its report, [Complex Discharge Task Force and Pilot: Recommendations](#), which outlines a clear **path forward for the Task Force, state agencies, and the legislature to address systemic barriers to discharge for individuals with complex needs**. This addendum, *Complex Discharge Pilot: Outcomes & Analysis*, summarizes key pilot outcomes and reinforces the Task Force's recommendations and path forward for continued work to address discharge barriers.

Complex Discharge Pilot

From July 2023 to June 2025, the Complex Discharge Pilot program designed and tested a complex discharge model of care to support Medicaid patient transitions from hospitals to post-acute care and home and community-based settings, including skill nursing facilities (SNFs), assisted living, adult family homes, other community settings, or patient homes. The pilot included five sites across Washington, with the first site launching in April 2024 and a fifth site in January 2025.

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

Complex Discharge Model of Care

The model focused on a patient-centered approach to coordination of social, behavioral, medical, and long-term care services, beginning in the hospital and following the patient to a lower level of care setting. Key components of the Complex Discharge model of care include:

- **Enhanced Care Management (ECM) Team:** Two hospital-based ECM staff with a capped caseload (1:15 ECM staff-patient ratio) supported patients to develop care plans and navigate access to care across settings.

- **Partnerships with Post-Discharge Providers:** Hospitals participating in the pilot contracted with dedicated SNFs and partnered with other community providers to provide resources to support individuals with complex needs, including additional payments for skilled nursing facilities to support more complex patients.
- **Supportive Services:** Pilot sites had access to funding for Supportive Services to address patient-level barriers to discharge, allowing flexibility in addressing barriers through services either not covered or not quickly available through Medicaid.
- **Long-Term Care Eligibility and Enrollment Staff:** A Department of Social and Health Services (DSHS) case manager was dedicated to each pilot site with a capped caseload (1:30 case manager-client ratio vs. standard caseloads of 1:83) to support completion of Home and Community Services (HCS) assessments, person-centered care planning and access to community based long-term services and supports.
- **Multidisciplinary care team:** To implement the care plan, a multidisciplinary care team of cross-system partners convened weekly to coordinate care. This team included ECM staff, DSHS staff, managed care organizations (MCOs), SNF partners, and other parties involved in patient care.

Pilot Payment Model

Pilot sites received funding to sustain the pilot model of care across fiscal years (FYs) 2024 and 2025 through the following funding streams:

1. **Administrative payments** for contracted SNF partners to build capacity to support care for patients with more complex needs.
2. **ECM payments** in support of hospital pilot sites efforts to increase capacity to deliver ECM, including hiring staff.
3. **Supportive service payments** that cover services that were either not covered or not readily available through Medicaid.

See **Appendix A** for details regarding the pilot payment model structure and amounts for each funding stream.

Pilot Patient Eligibility and Demographics

Each pilot site was allocated 30 slots for patients. Eligible patients included adults who were medically ready for discharge from acute care but were unable to transition to post-acute or community settings due to a range of system barriers related to their medical, behavioral, long-term care, and social needs. All participants were covered by Medicaid—managed care, fee-for-service, or dual Medicare-Medicaid coverage. The Washington Health Care Authority (HCA) reviewed Medicaid eligibility for individuals with pending coverage on a case-by-case basis. A total of 492 patients participated in the Complex Discharge Pilot between April 2024 and June 2025. Following is a summary of key demographic characteristics.

Age Distribution

The pilot population ranged from 19 to 94 years old.

- Over half of the participants were adults between 45 and 64 years of age (51%).
- 21 percent of participants were younger than 44 years old.
- 28 percent were ages 65 and older.

Race/Ethnicity

The racial and ethnic breakdown reflects the diversity of similarly aged individuals in Washington State as follows:

- White: 75 percent
- Black or African American: 13 percent
- Asian: 4.5 percent
- Native American or Alaska Native: 3.3 percent
- Smaller percentages identified as Native Hawaiian, other, or did not provide race

Payer Type

All participants were covered by Medicaid and enrolled in managed care, fee-for-service (FFS), and dual-eligible plans. Percentages were as follows:

- Managed care: 66 percent
- FFS: 2 percent
- Dually covered by Medicare and Medicaid: 32 percent

Pilot Evaluation Methodology

The Complex Discharge Pilot was designed to evaluate a new model of care for Medicaid patients experiencing barriers to transitions from acute care hospitals to post-acute and community settings. The pilot was implemented across five hospital sites between April 2024 and June 2025, with each site partnering with SNFs and community providers to support patient transitions.

Data Collection and Reporting

Each hospital and SNF partner submitted regular reports to HCA on patient enrollment, use of administrative payments, and Supportive Services expenditures (see **Appendix B**). After the pilot concluded, UW (University of Washington) Medicine performed a comprehensive quality analysis using Health Insurance Portability and Accountability Act (HIPAA)-compliant data transformations to protect patient privacy. Hospital identities were anonymized, patient identifiers were replaced with unique codes, and dates were standardized for trend analysis. All data and reports were stored securely within UW Medicine's network.

Comparative Analysis

The DSHS Research and Data Analysis Division (RDA) supported evaluation by linking pilot participant data to integrated client databases. RDA developed a comparison population of Medicaid patients with similar risk factors and lengths of stay. Regression models were used to measure impacts on 30-day all-cause inpatient readmission rates and transitions to Medicaid-paid LTSS, controlling for an extensive set of baseline attributes and risk factors. Analyses focused on people in inpatient settings (as distinct from nursing facility settings) when they were assigned an ECM case manager.

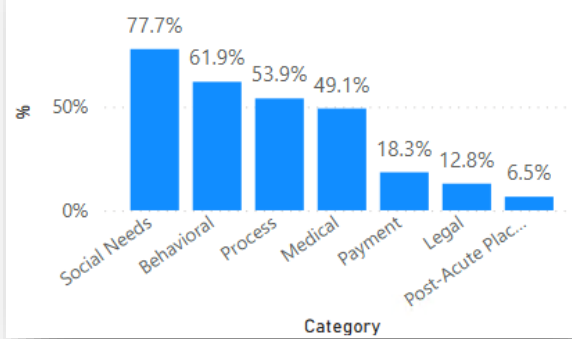
Patient Experience Surveys

Hospital ECM staff administered a patient experience survey to pilot participants and their families. Surveys included Likert scale and free-text questions to capture patient perspectives on care experience and program impact. Responses were collected anonymously and analyzed for common themes. These results are summarized in the *Complex Discharge Task Force Final Report* (July 1, 2025) and highlighted in this analysis to offer a patient and family perspective on care received.

Pilot Patient Barriers to Discharge

Complex discharge patients have multiple medical, behavioral, social, and long-term care needs that can create barriers to transitions of care stemming from system complexity, siloed delivery systems, gaps in care, and underlying regulatory barriers. The pilot’s findings underscore that most patients experience several barriers simultaneously. For example, a patient with behavioral health needs and a lack of housing may also face delays in Medicaid eligibility and require a legal guardian. Some barriers, such as guardianship issues or dialysis services, may also occur less frequently but create much longer delays in care transitions than others. The complexity and intersection of these transition barriers highlight the need for flexible, cross-system, and patient-centered care models as reflected in the care model used in the pilot. Following is a summary of key types of barriers experienced by individuals who participated in the pilot.¹

Figure 1. Complex Discharge Barriers by Category Experienced by Pilot Participants

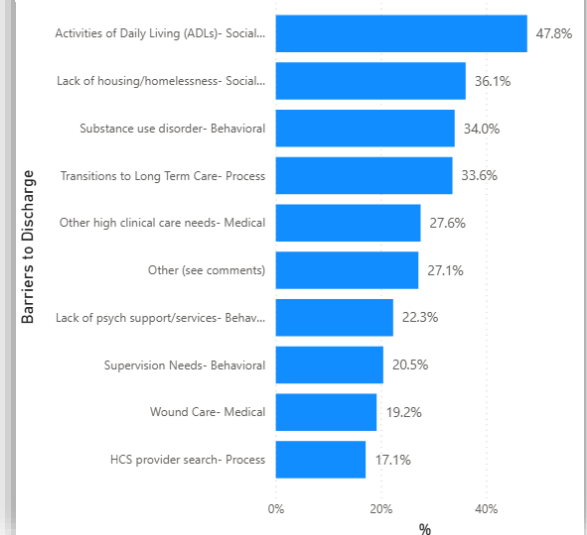


Social Needs

The most common barrier was social needs (77.7%), including homelessness, unstable housing, absence of family or community support, and unmet basic needs. Key barriers in this category include:

- Activities of daily living (ADLs): 47.8 percent
- Lack of housing/homelessness: 36.1 percent
- Lack of family support: 10.9 percent
- Client or family refusal/preference: 8.1 percent
- Lack of transportation: 7.9 percent

Figure 2. Top 10 Complex Discharge Barrier Subgroups



Behavioral Health

Behavioral health challenges (61.9%) include untreated mental illness, substance use disorders (SUD), or cognitive impairment (e.g., dementia).

- SUD: 34.0 percent
- Lack of psychiatric support/services: 22.3 percent
- Supervision needs: 20.5 percent
- Other complex behavioral needs: 15.7 percent
- Aggressive or inappropriate behavior: 11.7 percent
- High potential for harm to self/others: 4.0 percent
- Restraints: 1.9%

¹ Pilot sites reported discharge barriers based on the Standard Discharge Barrier List developed by the Bree Collaborative and published in the Complex Patient Discharge Report and Guidelines (January 24, 2024), accessed at [Bree-Complex-Discharge-Recommendations-FINAL-0124.pdf](https://www.bree.org/Complex-Discharge-Recommendations-FINAL-0124.pdf)

Process Barriers

Process barriers (53.9%) refer to processes such as:

- Transitions to long-term care: 33.6 percent
- HCS provider search: 17.1 percent
- Unable to return to previous setting: 16.5 percent
- Medicaid financial eligibility timeframe: 3.5 percent
- Waiting on referral response: 2.5 percent
- Development Disabilities Administration (DDA) provider search: 2.1 percent
- DDA assessment timeframe: 2.1 percent

Medical Barriers

Patients (49.1%) may have ongoing medical needs that require specialized support outside the hospital, such as complex wound care, dialysis, or neurological impairments.

- High clinical care needs: 27.6 percent
- Wound care: 19.2 percent
- Neurological (e.g., dementia, traumatic brain injury): 6.7 percent
- Bariatric status: 6.5 percent
- Hemodialysis/dialysis availability: 3.8 percent

Payment Barriers

Financial and payment issues, such as coverage authorization processes or reimbursement rates, can prevent patients (18.3%) from accessing the care they need after discharge.

- Durable medical equipment (DME): 7.1 percent
- Lack of payment options: 4.6 percent
- Insurance authorization process: 3.8 percent
- Medicaid reimbursement rates: 3.5 percent
- Delays in Medicaid determination: 3.3 percent
- MCO-funded rates: 2.5 percent

Legal Barriers

Legal barriers, primarily related to guardianship or decision-making capacity, can significantly delay discharge (12.8%). Patients who are unable to consent to care or transition setting may require court-appointed guardians. Securing guardianship is a process that can take months.

- Guardianship/conservatorship: 10.2 percent
- Prior felony conviction (e.g., sex offense/arson/violence): 1.5 percent
- DSHS-Adult Protective Services (APS): 1.3 percent
- Engagement with legal system related to behavioral health, SUD: 0.8 percent

Post-Acute Capacity Barriers

Delays in post-acute transitions because of a shortage of available beds in SNFs, adult family homes, or other community settings can prevent individuals (6.5%) from transitioning out of hospitals.

- Bed type unavailable: 5.0 percent
- Delay in response or communication: 1.9 percent

Pilot Outcomes and Analysis

The pilot demonstrated substantial reductions in hospital and SNF length of stay (LOS), lower hospital readmission rates, increased access and utilization of LTSS, improved care coordination efficiency, reduced hospital costs, and offered high patient satisfaction. Each of these key outcomes is reviewed below.

❖ Significant Reductions in Length of Stay

The pilot achieved dramatic reductions in both hospital and SNF LOS for patients with complex discharge needs. Median hospital LOS decreased from 28 days to 11 days, and SNF LOS dropped from 77 days to 19 days between Quarter Two (Q2) 2024 and Q2 2025. The decreasing trend in LOS was consistent across all pilot sites and barrier types, except for legal barriers (primarily guardianship). Individuals experiencing legal barriers to discharge experienced varied LOS throughout the pilot, underscoring the underlying systemic nature of these barriers that are outside of the control of the care team. (See Figures 3–5)

Figure 3. Median Hospital LOS, by Quarter

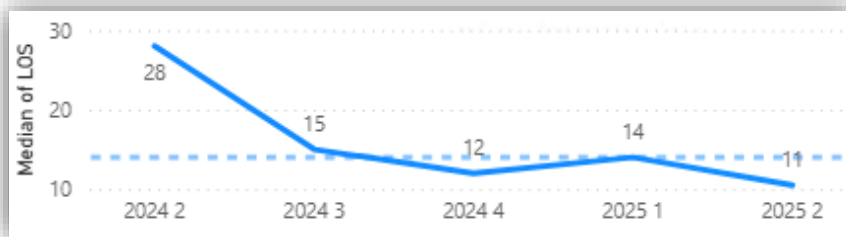


Figure 4. Median SNF LOS, by Quarter

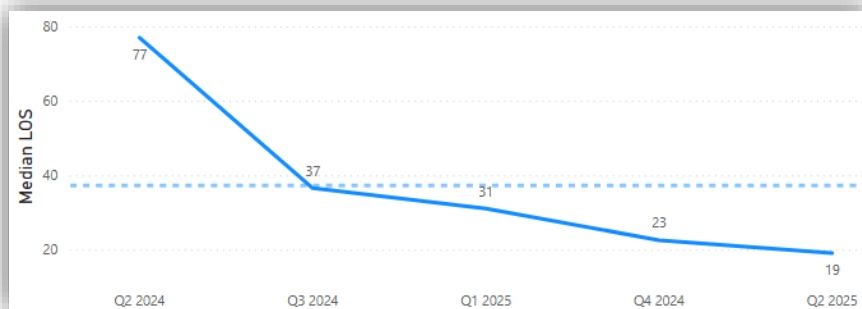
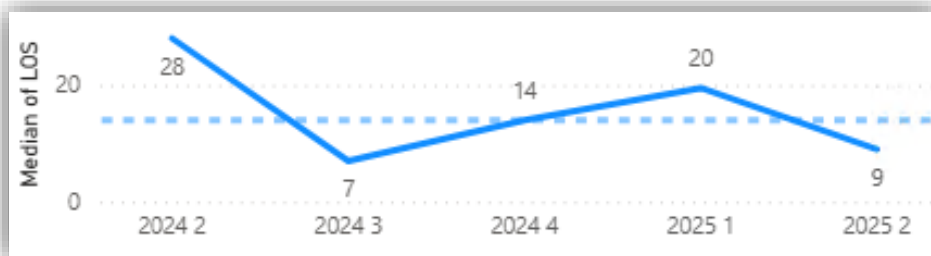


Figure 5. Median Hospital LOS by Quarter—Legal Barriers



❖ **Lower Inpatient Readmission Rates**

Pilot participants had 37 percent lower odds of inpatient readmission within 30 days than similar Medicaid populations, based on National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) All-Cause Readmission criteria. This finding suggests that the ECM model’s comprehensive, patient-centered approach not only facilitated timely discharges, but also ensured better support in post-acute settings.

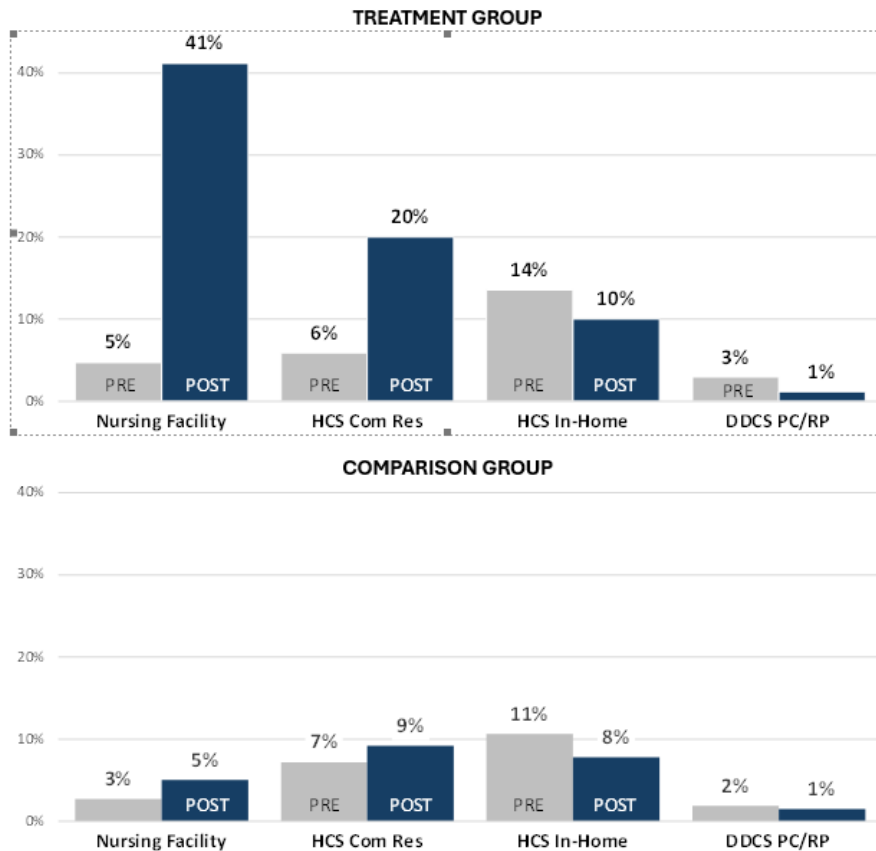
❖ **Increased Access and Utilization of LTSS**

In addition to alleviating hospital discharge bottlenecks, the pilot significantly expanded access to LTSS services and connected people to post-acute and community care settings that could more effectively address their needs. Compared with similarly situated Medicaid populations, pilot participants had a significant increase in the use of non-SNF LTSS settings (See Figure 6). Therefore, while SNF LOS decreased for pilot participants at the pilot SNF sites, there was an overall increase in the access and utilization of LTSS nursing facility, residential and community services. These trends reflect the effectiveness of the pilot’s strategy in supporting individuals to transition more quickly out of higher cost hospital and SNF settings and into longer-term settings that can better address their needs. With this model, individuals were supported to access LTSS services and move into more stable post-acute environments that better support their recovery and long-term well-being.

Figure 6. Medicaid LTSS Utilization for Pilot Participants and Medicaid Comparison Group

Unadjusted Pre-Admission and Post-Discharge Medicaid LTSS Service Utilization²

LOS in reference inpatient episode > 10 days



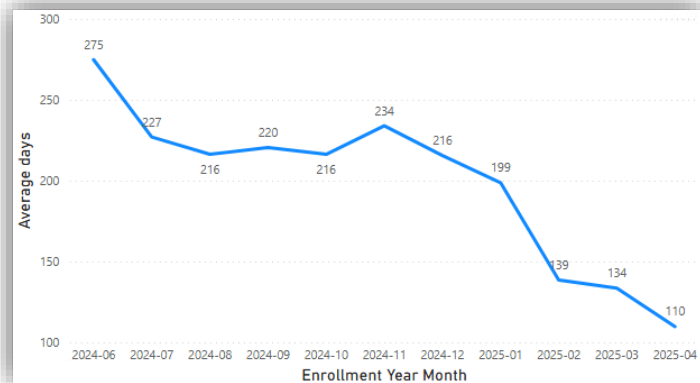
❖ **High Patient Satisfaction**

Survey results showed that 79 percent of patients responding to the survey rated their care as good to excellent, and 70 percent agreed or strongly agreed that the program improved their health and well-being. Patients reported improved access to services, better communication, and meaningful support in achieving care goals. See the July 1, 2025, Task Force [report](#) for a detailed summary of patient and family experience of the pilot.

❖ **Improved Care Coordination and Efficiency**

Throughout pilot, the average ECM period showed a sustained decrease, from 275 days at the beginning of the program to 110 days at the end, reflecting continued improvement and more efficient collaboration among ECM staff, DSHS case managers, managed care organizations (MCOs), and post-acute partners. Weekly multidisciplinary team meetings and strong partnerships enabled cross-system problem-solving and smoother transitions. The most frequent ECM interventions included coordination with HCS, MCOs, and families, as well as care conferences and outreach to SNFs or adult family homes, behavioral health supports, referral follow-up, and DME arrangements.

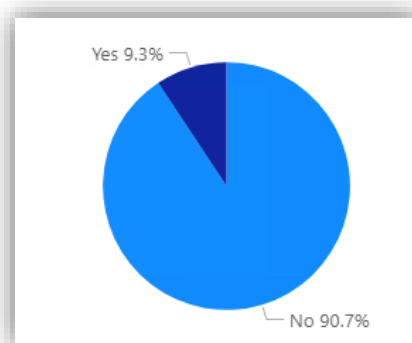
Figure 7. ECM Enrollment Period



❖ **Flexible Use of Supportive Services**

Pilot patients received Supportive Services needed for their transitions of care, including 1:1 caregivers, DME, transportation, and medications. Over 90 percent of Supportive Services provided were not otherwise Medicaid billable because of the setting in which they were provided or other service eligibility criteria. Pilot sites also used Supportive Services funds for Medicaid-covered services (9.3%) in cases that helped to expedite access and reduce delays in care transitions. This flexibility allowed sites to address patient-specific barriers quickly, reducing delays that would otherwise prolong hospital stays.

Figure 8. Supportive Services: Percent Medicaid Billable vs. Not Billable



❖ **Cost Impacts**

A key goal of the pilot was to support patients to transition out of high-cost, high-acuity settings when medically appropriate, and into post-acute and community care settings that could more effectively address their needs. This shift in settings generated substantial hospital cost savings by significantly reducing inpatient LOS and lowering readmission rates for individuals facing complex discharge barriers. Using a standard hospital day rate and subtracting pilot

costs, the LOS reduction translated into an estimated **hospital direct care net savings of nearly \$28,000 per patient, amounting to almost \$14 million in net savings across all patients served by the pilot.**

Beyond the savings in hospital costs highlighted in this report, the Task Force recognizes that care for individuals with complex needs involves multiple partners across the health system, each with distinct roles and budget implications. As a result, supporting timely transitions of care can generate both cost reductions and cost increases in different parts of the system. The pilot's success in facilitating timely transitions into long-term care settings, for example, should be expected to increase Medicaid LTSS utilization and costs. At the same time, several other system effects may reduce costs over time. These include decreases in avoidable emergency department use and preventable hospital stays, improved workforce satisfaction and reduced burnout, and more efficient care coordination across the health system. Together these impacts highlight broader system considerations that factor into the cost impacts resulting from connecting individuals with complex needs to a more appropriate level of care. While this review does not include a system-level cost analysis, the Task Force underscores the need for the legislature to consider these broader system cost considerations when evaluating future system investments needed to strengthen transitions of care for this population.

Task Force Recommendations & Path Forward

The Complex Discharge Pilot demonstrated that a coordinated, patient-centered model supported by dedicated staffing, flexible funding, and cross-system collaboration can significantly reduce hospital and SNF stays and improve transitions of care for individuals with a range of medical, behavioral, social, and long-term care needs. As outlined in its July 1, 2025 [report](#), **the Task Force recommends strategic actions by the Task Force itself, state agencies and the legislature** to support statewide expansion of the model, sustained funding, cross-system alignment, and targeted policy changes to address persistent structural barriers. These recommendations include collaboration with Tribal partners to ensure care transitions for American Indian and Alaska Native populations and member of Tribal communities.

The path forward to advance the Task Force recommendations includes the following key actions:

- The **Task Force** will continue in 2026 to develop a *Sustainable Funding Plan* to secure permanent funding for the Complex Discharge Model of Care. This plan will outline a path for using existing authorities, such as the Health Homes model, and incorporate lessons from the pilot and further evaluation to refine payment models, address service gaps, and strengthen system capacity.
- **State agencies**, with direction of the governor, should establish a leadership structure that oversees and directs agency cross-system initiatives related to transitions of care. Changes in agency leadership provide an opportunity to evaluate current structures, develop resources navigate services and streamline system complexity, improve processes and better align efforts across the continuum of care. This work should also include opportunities available through the upcoming 2028 Medicaid MCO re-procurement to implement contracting changes that incentivize and strengthen MCO accountability for care transitions.
- We call on the **legislature** for action on a range of policy options identified in the Task Force report to address delays in care transitions resulting from guardianship and conservatorship processes and the lack of available guardians and conservators to take low-income clients. As

demonstrated through the pilot outcomes, the care model alone cannot address the delays created by processes relating to patient decision-making and, hence, will require further policy action and funding.

The Complex Discharge Pilot offers a compelling blueprint for transforming care transitions in Washington State. Continued focus on this path forward will be essential to build on this progress, reduce avoidable extended hospital stays, and strengthen the state's healthcare system for the future. Although the current state budget constraints and the anticipated impacts of federal Medicaid policies may limit the scope of efforts in the near term, the Task Force emphasizes the imperative of meaningful steps that can be taken now to align Washington healthcare to support care transitions for individuals with a range of medical, behavioral, social, and long-term care needs.

Appendix A. Pilot Payment Model

The Washington State Office of Financial Management, with support from the state agencies and the Task Force, led the effort to establish three funding streams to sustain the pilot across fiscal years (FY) 2024 and 2025. Each of the funding streams was designed with flexibility in mind, not only to provide the pilot sites with options that best suit their operations, but also to test their efficacy in supporting Enhanced Care Management (ECM).

| Funding Stream | Purpose | Payment Methodology |
|-------------------------------------|---|--|
| Administrative Payments | Funding to support services provided by the contracted pilot skilled nursing facility (SNF) partners. This funding is provided on top of existing Medicaid payment rates and is meant to help participating SNFs develop capacity to care for patients with more complex needs. | Pilot hospitals and SNFs had the flexibility to contract using one of three daily payment model options: <ul style="list-style-type: none"> ● \$200 per bed ● \$280 per patient ● \$50/\$200 bed/patient hybrid model (\$50 per bed per day, with an additional \$200 daily payment for each patient within a bed) |
| ECM Payments | Funding to support the hospital pilot sites in increasing capacity, including hiring staff to support ECM and administering ECM services to pilot patients with a 15:1 caseload ratio. | Each pilot site received a lump sum of \$41,500 monthly through the end of FY 2024. Beginning FY 2025, ECM payments were paid by the Health Care Authority (HCA) based on utilization at \$1,500 per patient per month. The maximum amount a pilot site could receive was \$45,000 per month, or \$1,500 for each of the 30 filled ECM slots. |
| Supportive Services Payments | Funding to support pilot sites and post-acute partners in addressing patients’ barriers to discharge. Funding was limited to use for the following services, unless an exception was approved by HCA: <ul style="list-style-type: none"> ● Medical transportation ● Durable medical equipment ● 1:1 Sitters ● Behavioral health support ● Medical supplies ● Caregiver support ● Home health support | For FY 2024, each pilot site was allocated \$250,000. For FY 2025, each pilot site was allocated \$1.2 million. Pilot sites had the option to bill HCA for services after they are rendered or receive a lump sum amount. If a pilot site chose to receive a lump sum, they were expected to return excess funds that are not used to HCA prior to the end of the fiscal year. |

Appendix B. Pilot Reporting and Data

To support oversight and monitoring of the pilot program, HCA developed reporting tools to track patients enrolled in the pilot program, each SNF's use of administrative payments, and services paid for using Supportive Services funds. The table below describes each report.

| Report Title | Submission Cadence | Summary of Data Fields |
|------------------------------------|--------------------|--|
| Complex Discharge Report | Weekly | <ul style="list-style-type: none"> • Patient Demographics • Hospital Admission Information • ECM Enrollment and ECM Discharge Information • Discharge Plan and Disposition • Barriers to Discharge • ECM Interventions |
| Administrative Payments Log | Monthly | <ul style="list-style-type: none"> • Patient Demographics • Allocation of Administrative Payments • Description of Services Provided • Barriers to Billing Services to Medicaid if Service Is Medicaid Billable • Discharge Plan Post-SNF |
| Supportive Services Log | Monthly | <ul style="list-style-type: none"> • Patient Demographics • Description of Services Provided • Barriers to Billing Services to Medicaid if Service Is Medicaid Billable |