

**Rebalancing Long-Term Care Systems in Washington:
State Case Study as of December 2007**

**Submitted to the
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The overall Rebalancing Research is being conducted through a Task Order under a CMS Master Contract between CMS and the CNA Corporation, Arlington, VA, and subcontracts and consultant agreements between CNAC and the various researchers. Rosalie A. Kane is the principal investigator from the University of Minnesota and Elizabeth Williams is the CNAC project director. This final case study for the State of Washington covers a period through December 2007. The statements and opinions in the report are those of the writers and do not necessarily reflect the views of CMS or any of its staff, or the State liaisons to the project, or any other state staff or persons who spoke to us from participating states. We thank the Washington Liaison to the study, Kathy Leitch, Assistant Secretary, Aging and Disability Services Administration, Washington Department of Social and Health Services.

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Preface

In 2003, Congress directed the Centers for Medicare & Medicaid Services (CMS) to commission a study in up to 8 States to explore the various management techniques and programmatic features that States have put in place to rebalance their Medicaid long-term care (LTC) systems and their investments in long-term support services towards community care. The States of Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington are participating in this 3-year Rebalancing Study. For the study, CMS defined rebalancing as reaching “a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional services (i.e., Nursing Facilities [NF] and Intermediate Care Facilities for the Mentally Retarded [ICFs-MR]) and those used for community-based supports under its State Plan and waiver options.” CMS further clarified that a balanced LTC system “offers individuals a reasonable array of balanced options, particularly adequate choices of community and institutional options.”

The products for the study include 3 iterations of State-specific case studies that qualitatively and quantitatively examine each State’s management approaches to rebalance its long-term care systems, six crosscutting topic papers on issues in rebalancing, and a series of 5 Chartbooks presenting quantitative analyses of Medicaid expenditures for consumers in HCBS versus nursing homes, as well as Medicare expenditures for individuals dually eligible for Medicaid and Medicare. A list of these products with web links for completed documents is provided in the Appendix.

For the final case studies—in this instance for the State of Washington, we concentrated on the perspective of State officials on accomplishments in rebalancing their long-term support systems for all clientele, and the future directions for the State. We also updated particular strategies that we had highlighted in the 2005 case study and the 2006 Updates. The report is based on comprehensive review of web and print materials, a site visit by Robert Mollica, Jake Priester, and Rosalie Kane on December 6 and 7, 2008 and telephone interviews as needed before and after the site visits.

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Executive Summary

Washington ranks among the top states for Medicaid spending on home and community based services. Stable leadership, a vision and strong commitment to respect individual preferences, the consolidation of all responsibility for long term licensing, oversight, policy, program management and funding contribute the state's success. Like other states, Washington faces continuing pressure to obtain the staff and financial resources to sustain its progress. The Aging and Disability Services Administration (ADSA) has a strong track record for managing spending within available resources and the ability to explore and address challenges posed by individuals with complex health and functional needs. The State also is a pioneer in the development of a working relationship with unions for independently employed in-home workers, including family members employed as providers for their relatives.

This case study highlights the following:

- a state organizational structure that houses all functions (budgeting and planning, service delivery, and quality assurance) for all populations in the same state governmental unit;
- the continued use of the Comprehensive Assessment Review and Evaluation (CARE) tool to guide the allocation and quality monitoring and the added assessment capacity in the CARE system;
- recent developments for the Home Care Quality Authority and the unionized independent provider system at the heart of Washington's delivery system;
- forecasting approaches to budget allocation;
- ongoing quality initiatives in residential care;
- improved access through the ADRC;
- the addition of new elements in the array of services (including a cash option called New Freedom);
- new managed care pilots;
- new approaches to residential settings and supportive housing;
- implementation of the Money Follows the Person demonstration through which the state intends to help effect transitions for the participants in all target groups;
- anticipated future initiatives relating to housing, manpower issues, and strategies to help those with severe mental illness and behavioral challenges to make transitions to the community.

General lessons derived from Washington's experience include the following:

- the importance of a well articulated and consistently promulgated vision, which in Washington includes a strong commitment to respect individual preferences, to make choices available for community care, and to work closely with consumer stakeholders.
- the importance of consolidating all responsibility for long term support licensing, oversight, policy, program management and funding contribute the state's success, and organizing the units within ADSA by function—e.g. individual supports, residential services—rather than by age or disability group and the control over budgets for both the HCBS and institutional services are integral to its successes.
- the importance of data driven programs and a comprehensive data base that combines assessment and service data and is used for tracking utilization and quality and in forecasting. This data capacity allowed the state to develop independent provider models while maintaining oversight and accountability; allowed it to manage within resources in a way that inspired confidence among legislators; and permitted identifying individuals with complex functional and psychological needs. Washington officials believe that the initial three million dollar investment in its automated modular CARES data base was money well spent, as were the upgrades to the system to incorporate all populations.
- the value of an investment in case management, largely through state-funded case managers. The Washington programs combine an active data-driven care planning process with a system where in-home services are largely delivered by independent providers.
- the importance of a wide range of community residential options, including small adult family homes, and the crucial roles that delegation of nursing services in these settings, as well as in home care, plays in rendering the system responsive and affordable. The value-driven vision for consumer choice and quality of life applies to participants in group residential settings as well as those at home and undergirds quality improvement activity.
- the importance of developing an internal State capability to negotiate union contracts in a system that relies heavily on Independent Providers (IPs), and the need to develop structures to mediate the relationship between independent providers and consumer-employers, and resources to help both the IPs and those employing them.

Rebalancing Long-Term Care Systems in Washington: State Case Study as of December 2007

Introduction

Background

Washington was invited to participate in the Rebalancing Research Project as an example of a state that had made substantial progress in moving towards community care prior to the beginning of our quantitative tracking in the Year 2000. The State is characterized by a unified budgeting and planning process across all target populations, movement towards independent provider models for home and community based services, and a strong emphasis on information systems and quality monitoring keyed to a computerized participant assessment system.

Summary of Earlier Rebalancing Case Studies

Management strategies in Washington that have been tracked in the Rebalancing Project included: a state organizational structure that houses all functions (budgeting and planning, service delivery, and quality assurance) for all populations in the same state governmental unit; the Comprehensive Assessment Review and Evaluation (CARE) tool used to guide the allocation and quality monitoring; the Home Care Quality Authority and the unionized Independent Provider system that is at the heart of Washington's delivery system; forecasting approaches to budget allocation; and quality initiatives in residential care. A short and long baseline case study on rebalancing in Washington was released in 2005 and an update of activities in Washington between July 2006 and July 2007 was part of a report released in April 2007.¹ All these directions have continued and been expanded.

¹ Links to the short case study *Rebalancing Long-Term Care Systems in Washington: Experience up to July 31st, 2005* and to the update report, *A Year in State Management Practice for Rebalancing Long-Term Care Systems: Update of Activities in 8 States*, July 2005 to July 2006 are on the CMS New Freedom website, last visited on April 8, 2008 at http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp#TopOfPage. A long baseline case

State Initiatives

Update on Previously Identified State Initiatives

Home Care Quality Authority and independent providers.

The Home Care Quality Authority (HCQA) was established by a ballot initiative in November 2001 to improve the quality of long term In-Home services delivered by In-Home providers through improved regulations, higher standards, increased accountability, and the enhanced ability of consumers to obtain services.² It is governed by a nine-member board. In 2007, HCQA established the Home Care Referral Registry to improve the quality of long term in-home care services for people receiving under the Community Options Program Entry System (COPES) HCBS waiver and the Medicaid personal care state plan option.. The referral registry is a web based search tool that supports matching individual providers and clients. The registry web site offers tools such as frequently asked questions, resource information about a series of health topics, a guide for consumers about interviewing potential workers, a job description, tips for hiring workers, and manuals on effective communication, supervision and how to hire and keep good staff.³

HCQA conducts periodic provider surveys. A provider survey conducted in 2006 found that 76% of independent providers served a family member and 56% of family providers lived with the consumer/employer.⁴ Sixty two percent of the respondents disagreed with the statement that it is likely that I will actively look for a different type of job in the next year and 8% agreed with

study on Washington is on the website of the Long-Term Care Resource Center at University of Minnesota, at http://www.hpm.umn.edu/lrcresourcecenter/on_going_research/Rebalancing_state_ltc_systems_case_studies.htm.

² More information about the Authority is available at <http://www.hcqa.wa.gov/default.html>.

³ These developments were supported by a 2004 CMS grant for a Direct Service Worker Demonstration project.

⁴ Candiya Mann and Dave Pavelcehk. Individual Provider Mail Survey. Washington State University. May 2007. Available at:

http://www.hcqa.wa.gov/Surveys/survey_docs/HCQA%20Provider%20Mail%20Survey%20FINAL.pdf and http://www.hcqa.wa.gov/Surveys/survey_docs/HCQA%20IP%20Phone%20Survey%20Report%20FINAL.pdf

the statement. Respondents were asked to name two things that would cause them to stay in this line of work, the most frequent reply was higher wages and more paid hours. While many respondents were aware of the worker registry, only 5% were listed on the registry. Employee benefits were considered important to the workers and 72% were receiving health benefits but just 33% were receiving health benefits through their employment as an independent provider. Half the respondents who did not have health insurance were not aware that were eligible to receive coverage and others were not aware it was available.

State officials reported that legislation passed in 2006 allows the Service Employees International Union, which represents independent home care workers, to negotiate policy issues that affect the number of hours worked. Chapter 106 of the Acts of 2006 requires, “as a mandatory subject of bargaining, negotiations over any Department of Social and Health Services rule or policy that applies generally to a significant group of individual providers or consumers and, by its application, may result in a significant change in the number of hours worked by a significant number of individual providers.” The bill passed after implementation of a so-called "shared living" rule under which ADSA determined that case managers could not authorize hours of paid care for services such as shopping, housework, laundry, or meal preparation if the individual provider lives in the same household with the consumer. The Act explicitly states that the individual plan of care and rules or policies that implement legislative changes to the program or services are not subject to collective bargaining.

Key informants reported that individuals using Independent Providers tend to have more ADL impairments than agency clients however, after several years of decline the number of individuals choosing to receive services from a home care agency is increasing. Applicants with family members tend to prefer the Independent Provider model. Applicants who are reluctant to

recruit their own worker and prefer to rely on an agency to provide back up support tend to select the agency model. Despite the change, 55 percent of all in-home clients choose the Independent Provider model.

CARE system and modifications for MR/DD.

ADSA's Division of Developmental Disabilities completed a three-phase project to create modules in the CARE tool to be used for older adults and for individuals with disabilities. The first phase a Children's Medicaid Personal Care (MPC) Assessment standardized the assessment process and authorization of MPC services for children with developmental disabilities. The adult assessment was modified with developmental age guidelines to assess the specific needs of children with developmental disabilities. The assessment generates standardized care plans for MPC, which outline authorized paid care tasks and additional informal supports.

The assessment more consistently determines the number of paid care hours based upon a child's functional need for assistance and the amount of informal support available. During phase II, DDD developed an interim "Mini Assessment" to determine clients' needs. Intake and eligibility determination sections were added to the CARE assessment that centralized the medical and financial information to help determine eligibility. The final phase was completed in June 2007 with a comprehensive adult assessment that is used for home and community based waiver services and state plan personal care services. Rules implementing the new assessment process were issued.

Other activities

The State organization along functional lines in the Aging and Disability Services Administration continued along the lines described in the baseline report with some changes of personnel due to retirements. The structure continues to work well and key informants attribute

much of Washington's success to an organizational structure that consolidates all activities (planning, budgeting, service management, quality assurance) for participants of all ages and disabilities in the community and in institutions within a single agency organized along function lines. The quality initiatives developed for residential care that were described in the earlier report also continue, with a continued emphasis on providing technical assistance and monitoring as well as on enforcement.

New Initiatives

Financing and chronic care management.

In 2007, a legislatively-created task force on long term care financing and chronic care management issued its preliminary report (a final report was due in December 2007 but has not been released). The task force was charged with the following: Reviewing public and private mechanisms for financing long term care to ensure that the system that is adequate to meet the needs of persons of all ages with functional limitations:

- that efficient payment models that will effectively sustain public funding and maximize the use of financial resources to directly meet the needs of persons of all ages with functional limitations;
- To identify state laws and regulations that should be revised and/or eliminated in order to reduce or contain costs to individuals and the state;
- The feasibility of private options for realistically enabling individuals to pay for long-term care and the most effective tools for implementing these options; and
- Options that will support long-term care needs of rural communities.

The task force (comprised of members of the legislature and state agencies) was also asked to recommend chronic care management and disability prevention interventions that will reduce health care and long-term care costs to individuals and the state, improve the health of individuals over their life span, and encourage patient self-management of chronic care needs. .

The preliminary report contained long term recommendations to incorporate self self-management as a core component of care; to increase utilization of the chronic care model or other models that integrate medical and social care management; to increase access to linguistically and culturally appropriate services and supports; to promote access to information needed to plan for future long term care service needs through a searchable data base and other means; to expand support for informal caregivers; to develop specialized housing options for specific populations; and to improve services in Tribal areas. The preliminary report also made recommendations on the financing of services. These recommendations included designing a reimbursement system that links payments to quality; continue to fund residential options to offset the institutional bias; and integrate financing with care delivery to align incentives for quality and prevention.⁵

Money Follows the Person demonstration.

Washington received a Money Follows the Person award from the Centers for Medicare & Medicaid Services for a “Roads to Community Living” project which will investigate and test what services and support will successfully help people with complex, long term care needs transition from institutional to community settings. Successful interventions will form the basis for changes that will result in more people with complex long term care needs being able to remain independent or transition into community settings. ADSA plans to support the relocation of 660 individuals – older adults, individuals with physical disabilities and individuals with mental illness – to community settings such as a home or apartment, or a group setting with four or fewer residents.⁶

⁵ Interim Report to the Governor and Legislature. Joint Task Force on Long Term Care Financing and Chronic Care Management. Available at: http://www.governor.wa.gov/lctf/reports/lctf_interim_report_200701.pdf

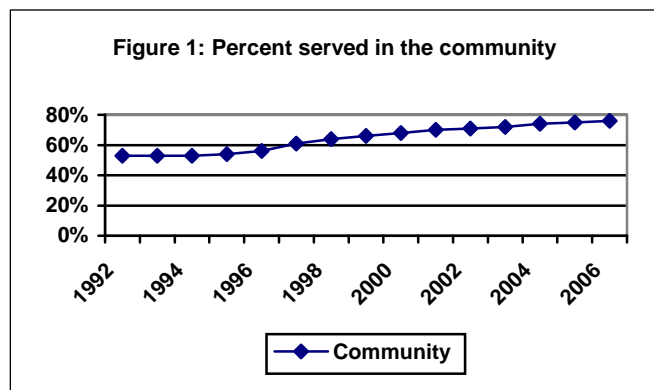
⁶ Washington’s Operational Plan for its Money Follows the Person Demonstration, Roads to Community Living, is now posted on the ADSA website. It offers a good summary of LTSS programs in Washington and of current goals.

Other current activities.

In addition to the Money Follows the Person project, the Aging and Disability Services Administration (ADSA) implemented in the calendar year 2007, several new projects to expand and target services to people with disabilities. An Aging and Disability Resource Center pilot provides expanded information, assistance and referral to individuals seeking information about and access to services. The Cash and Counseling pilot program that has been planned since 2005 began offering participants in King County (i.e. Seattle area) broader flexibility to use funds to purchase goods and services that support their independence. Two managed care programs also began operating. One serves dual eligibles and the second serves Medicaid beneficiaries with health, mental health and chemical dependency needs.

Goals, Objectives and Accomplishments

Washington operates a mature long term supports system that offers consumers a choice of settings and a wide array of services. State officials consider a long term care system to be “balanced” if it allows consumers to



choose where they want to live and to receive an array of services that support their choice. Since 1992, the percentage of individuals receiving long term supports in residential and in-home settings increased from 53 percent to 76 percent (see Figure 1).⁷ Washington spends 75% of its Medicaid long term funds for home and community based services for individuals with

On web, last visited, June 10, 2008 at <http://www.aasa.dshs.wa.gov/Professional/roads/documents/Operational%20Protocol.pdf>.

⁷ Brian Burwell, Kate Sredl and Steve Eiken. Medicaid Long Term Care Expenditures in FY 2006. Memorandum. Thomson Healthcare. August 10, 2007.

developmental disabilities and 54.6%, second in the nation, on services for older adults and individuals with disabilities. These trends suggest that Washington operates a system that is now well balanced towards community care. ADSA is now focusing on the special populations who have difficulty living or moving to the community with existing services and programs. Despite a rich array of community services, Washington still has 4 state-operated Residential Habilitation Centers serving about 1100 adults with developmental disability and faces political obstacles in dramatically downsizing or closing them.

The Aging and Disability Services Administration (ADSA) has enjoyed stable and long term leadership that sets specific caseload and spending goals and uses sophisticated data system that allows managers to track progress and inform state policy. Integration of the all the key components of the long term care system in one agency was viewed by state officials and managers as the primary reason for their success and it “embeds one philosophy” across an entire system.

In July 2006, ADSA issued a five year strategic plan that recognizes the increasing complexity of the needs of the individuals served by ADSA and pressure to meet these changing needs without new public funding. The Plan⁸ describes five goals:

- Maintaining an appropriate balance between institutional services and home and community services to ensure that individuals are able to receive services in the most appropriate, preferred setting possible.
- Supporting informal care for persons with disabilities and older persons who need long term support.
- Expanding our vision to include helping Washington’s citizens to plan for future care needs such as doing financial planning, engaging in health promoting behaviors, and benefiting from early intervention.

⁸ Aging and Disability Services Administration. Strategic Plan 2007-2011. July 1, 2006. Department of Social and Health Services. Olympia. WA. Available at: <http://www1.dshs.wa.gov/strategic/currentplan.htm>

- Improving upon the already strong performance of programs that monitor the quality of care, quality of life, safety of vulnerable children and adults, and accountability of programs.
- Continuing to develop programs to respond holistically to individual needs.

The Plan would continue to promote home and community based services options that will reduce the Medicaid nursing facility caseload to 10,500 by FY 2011. The plan also includes new monitoring activities for nursing facility case managers. Steps will be taken to ensure that payment rates are fair and consistent and create incentives to serve beneficiaries in appropriate settings. Strategies are also described that will expand the types of home and community based services that are available to eligible beneficiaries that include assisting rural communities to expand services, help tribes develop residential resources, and expand the number of individuals using in-home nurse delegation.

The plan addresses the increasing number of people with dementia by incorporating strategies that improve brain health, improve outreach to caregivers to encourage long term care planning, partnering with physicians and health plan to improve coordination of services and encourage family caregivers to use respite and support services earlier in the disease process.

State Organization

The Department of Social and Health Services (DSHS) is an umbrella agency for five programmatic administrations – the Aging and Disability Services Administration, Children’s Administration, Economic Services Administration, Juvenile Rehabilitation Administration, and the Health and Recovery Services Administration. ADSA is responsible for long term services and supports for elders, adults with physical disabilities and people with developmental disabilities including licensing institutional and residential settings and Medicaid financial

eligibility functions. The Health and Recovery Services Administration manages Medicaid acute care services.

ADSA, the key organization for long term care, is organized into four Divisions: Home and Community Care Services, Developmental Disabilities, Residential Care Services (which includes nursing homes), and Management Services. The Assistant Secretary heading ADSA serves as the director of the State Unit on Aging and has also been delegated responsibility as Medicaid director for Long-Term Care, in conjunction with the Assistant Secretary for the Medical Services Division, the designated Medicaid agency.

ADSA's mission statement defines its role – to assist adults with disabling conditions due to aging, disease or accident and children and adults with developmental disabilities to gain access the high quality, cost effective supports they need. The vision statement states:

ADSA helps individuals and their families improve quality of life, develop and maintain self-sufficiency, and remain contributing members of their community. We guide a system of services that are high quality, responsive to individual needs and preferences, and cost effective. We achieve success by supporting individuals, families and caregivers; expanding service options; and continuously improving quality of care and support in all settings. The supports and services we deliver are based on each individual's unique strengths and needs.

We contain overall costs by promoting prevention and self-reliance, reducing unnecessary use of more expensive services, and preventing or reducing the need for future services or resources. Within Medicaid programs we are developing an increasingly integrated social and health care program. Our objective is a system that delivers seamless medical, habilitative, mental health, long-term care, employment and supportive services in the person's own community.⁹

One of the important tools available to ADSA is the unified budget or single line appropriation. Funding for all long term care Medicaid state plan and waiver services for elders and adults with physical disabilities – community, residential, and nursing facility – are appropriated in a single line item based on a caseload forecast prepared by the Caseload Forecasting Council. While the single budget includes different categories for nursing facility, state plan personal care services and home and community based waiver services, ADSA

⁹ Strategic plan, See Reference 6.

manages spending against the total appropriation rather than the amount budgeted for each category. Spending is tracked monthly and shifts can be made within categories without further action by the legislature. Legislative approval of a transfer from the nursing facility category to the home and community based services category is not required. This flexibility allows ADSA to support consumer choice, avoid delays in accessing community services and use of waiting lists while managing spending with a unified or global budget.

Governor Gregoire's 2009 budget contains two expansions that indicate continued commitment and priorities in the Governor's office. The budget re-affirms the goal of care in the least restrictive alternative and recommended specific funding for: a) respite and training for 500 more unpaid caregivers working with long-term care and developmentally disabled adults so they may remain with their families, and b) a 4.8 percent rate increase effective July 1, 2008, (in lieu of the 2 percent increase currently in the budget) and an 8 percent rate increase for adult family homes.

Access

Since release of the 2005 report Washington case study, ADSA implemented several initiatives to improve access to services. The state received an Aging and Disability Resource Center (ADRC) grant from the Administration on Aging in 2005. The grant, which is being piloted in one area, builds on the existing senior information and assistance in the state's 13 Area Agencies on Aging. The ADRC offers consumers and family members information about the available choices for long term supports; options and benefits counseling; crisis intervention; referrals to appropriate programs; and planning for future needs.

Prior to the grant, the pilot site, the Pierce County Human Services Aging and Long Term Care Department, provided information and assistance to elderly persons and their families,

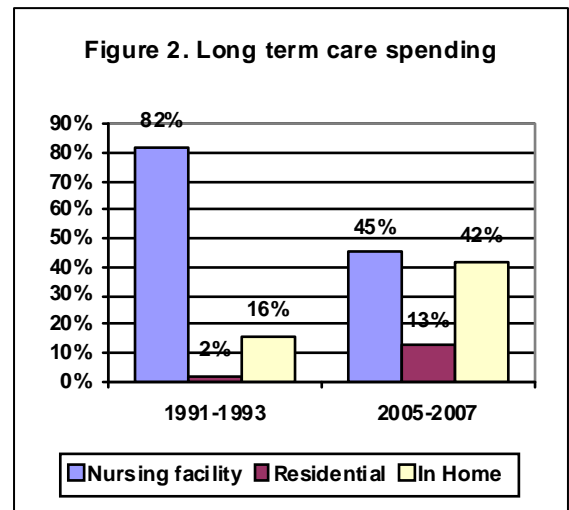
primarily by telephone. The grant expanded information and assistance services to individuals with disabilities of all ages and income levels and allowed the AAA to upgrade its website, send staff to the person’s home when necessary, and serve individuals who came to the site. Staff also provides information about long term care services at community events. The web site offers long term support options counseling, benefits counseling, employment options counseling, referral, crisis intervention and future planning.

The grant summary describes the objectives of this project:

- Develop a model Aging & Disability Resource Center;
- Implement a fully functional aging and disability I&R/A resource database/client management system;
- Create seamless coordinate between the pilot ADRC and specialized entry points that require financial eligibility determination, needs assessment and/or individualized service authorization; and
- Expand “Benefits Check Up” to serve the full spectrum of people, regardless of age or particular disability.

The ADRCs will streamline access to local resources by holding community forums that include Independent Living Centers, libraries, senior centers, developmental disability and other providers to increase communication and understanding of what each organization offers to improve referrals to other organizations.

A Memorandum of Understanding is signed by ADRC partners that specify their willingness to participate in community forums and to provide or attend training sessions to share information. Partners report that the process has improved coordination and



;working relationships among them. ADSA planned to seek funding from the state legislature to expand the program to other AAAs.

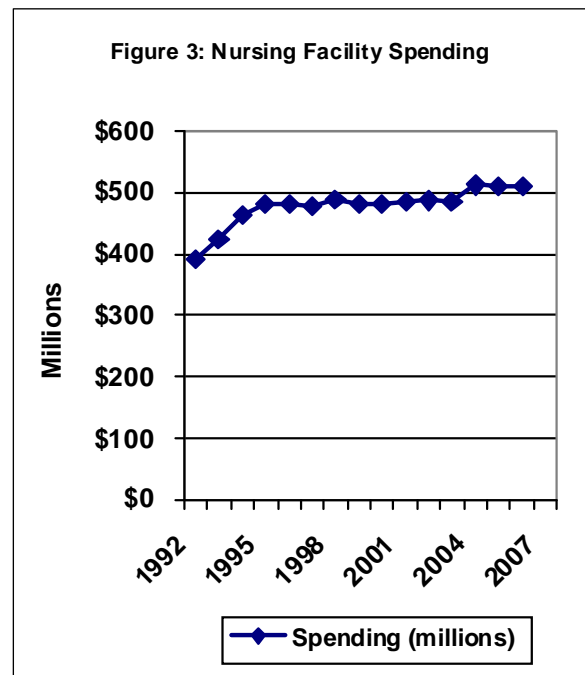
Service Array

ADSA continues to offer a full array of in-home, residential and institutional services for elders and adults with disabilities. Washington has significantly increased expenditures for individuals receiving services in residential and community settings. During the 1991-1993 bienniums, 82% of long term care spending for elders and individuals with disability was paid to nursing facilities. By the 2005-2007 bienniums, spending for nursing facility care dropped to 45%.¹⁰ (See figure 2).

In the mid-1990s, the Washington legislature directed the Aging and Disability Services Administration to reduce the nursing home census by 750 individuals. Over 12 years, the Medicaid nursing home census dropped from 16,642 to 11,900. The savings allowed the home and community based services caseload to grow from 19,772 to 37,008 consumers. The average cost of serving one person in a community setting is one-third the cost of a nursing home.

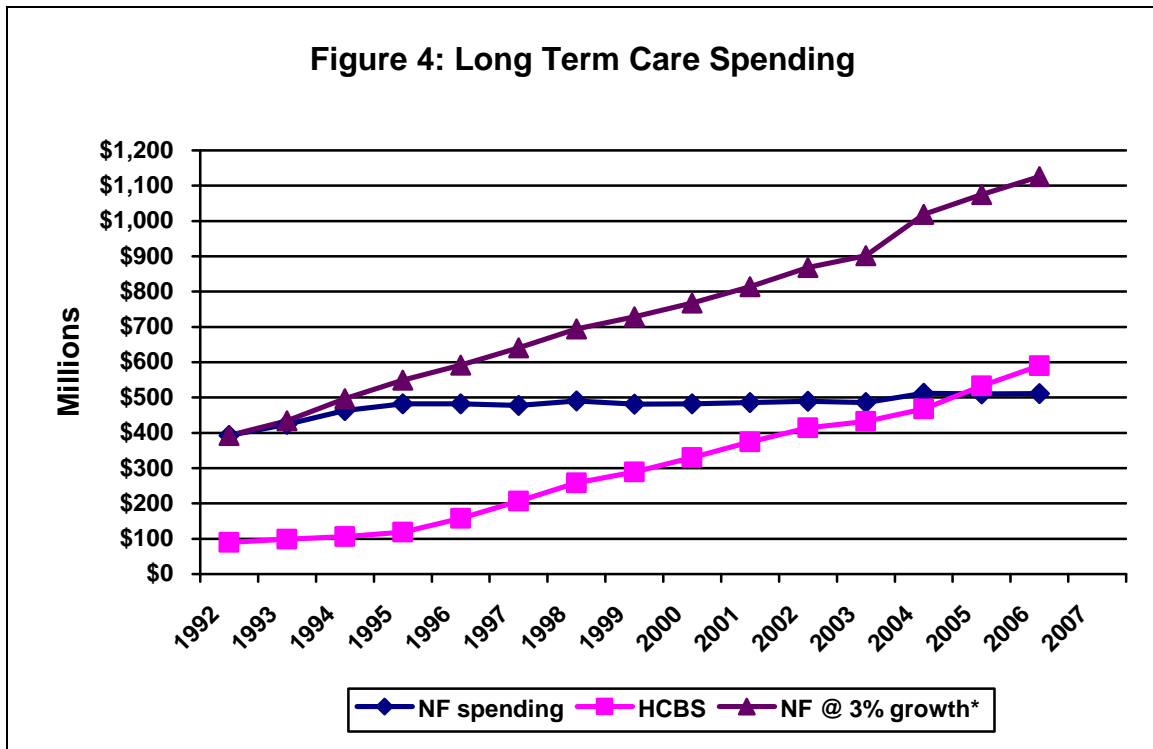
Nursing facility spending was essentially flat from 1995 through 2003, rose from \$486 million to \$512 million in 2004 and held steady through 2006. (See figure 3).

State officials estimate that if home and community based services had not expanded, the Medicaid nursing home census would have risen



¹⁰ Interim Report to the Governor and Legislature. Ibid.

3% a year. Spending for nursing home care alone would have exceeded \$1.1 billion a year in SFY 2006, which is greater than the combined cost of nursing home and community spending. See figure 4. State officials believe that 5-10% of the remaining nursing home residents could be served in the community.



See Table 1 for another way of viewing trends in Washington and their effect on rebalancing. The average number of consumers served in the community rose from 19,772 a month in FY 1995 to 34,639 a month in FY 2004 and 37,008 in FY 2006. Spending for community services increased from \$119 million in FY 1995 to \$467 million in FY 2004 and \$589.7 in FY 2006. The number of Medicaid beneficiaries served in nursing homes dropped from 16,642 a month in FY 95 to 12,447 in FY 2004 and 11,900 in FY 2006. Spending was \$482 million in FY 1995, \$513 million in FY 2004 and dropped to \$510.5 million in FY 2006. State officials estimated the number of people served in nursing homes would have been 18,962 a month in FY 1995 and

26,249 in FY 2006 if community services had not expanded and the nursing home caseload grew at a rate of 2.3% year.

Table 1. Caseload and Spending Trends for Elders & Adults with Physical Disabilities

Fiscal year	Community services		Nursing home		Projected nursing home	
	Ave # consumers	Spending (Millions)	Ave # consumers	Spending (Millions)	Ave # consumers	Spending (Millions)
1995	19,772	\$118.9	16,642	\$481.6	18,962	\$548.7
1996	20,887	\$158.5	15,904	\$482.1	19,531	\$592.0
1997	23,116	\$206.8	14,992	\$477.7	20,117	\$640.9
1998	25,675	\$257.6	14,643	\$490.4	20,721	\$693.9
1999	27,576	\$289.5	14,080	\$480.9	21,343	\$728.9
2000	29,319	\$329.9	13,782	\$481.8	21,983	\$768.5
2001	30,913	\$374.2	13,529	\$486.3	22,642	\$813.9
2002	32,213	\$414.4	13,152	\$487.5	23,331	\$864.4
2003	33,729	\$432.4	12,943	\$485.8	24,021	\$901.6
2004	34,636	\$467.8	12,447	\$512.6	24,742	\$1,018.9
2005	35,516	\$533.2	12,084	\$509.8	25,484	\$1,075.2
2006	37,008	\$589.7	11,900	\$510.5	26,249	\$1,126.1

Adding to the array of services, in February 2007, after considerable planning, a “Cash and Counseling” pilot program, called New Freedom, was implemented in the Seattle area (King County) under a §1915 (c) waiver to offer provides consumers the option to control their own waiver services. Participants receive a monthly budget based on their assessed needs. The budget may be used to hire individuals to provider personal assistance, treatment and health maintenance, individual directed goods, services and supports, environmental or vehicle modifications, and training and educational supports. Budgets are based on the assigned classification generated by completion of the comprehensive assessment reporting and evaluation tool. The calculation will be based on the published hourly rate for individual provider personal care paid by the department multiplied by the number of hours generated by the assessment, multiplied by a factor of .95, plus an amount equal to the average per participant expenditures for non-personal care supports purchased in the COPES waiver. The average is recalculated in July

of each year.¹¹ Up to \$3,000 of funds that are not used may be held in reserve for future purchases that are identified in the spending plan. Counselors work with consumers to develop and periodically revise spending plans as needs and preferences change.

The pilot planned to serve 100 participants by December 2007, 400 by December 2008 and 750 by December 2009. As of December 2007, however, only 40 consumers were enrolled and only 33 were receiving services under their own budget. The enrollment date was later than expected because of initial union opposition to the concept, and enrollment has been slower than expected because the state already offers consumers the option to use Independent Providers to deliver personal care services. In 2007, ADSA launched a marketing initiative that explained the additional flexibility available through individual budgets that helped to boost participation. Participants are choosing to pay for assistive devices and services that are beneficial to their health such as smoking cessation, weight loss, and activities. Seventy five percent of the individual budgets are spent on personal care. The average age of participants in New Freedom is 55 but the participants range from the mid-20s to over 80 years of age.

Quality Initiatives

ADSA is responsible for monitoring the quality, safety and accountability of the services provided to all citizens. ADSA has quality assurance units in the Home and Community Services and Developmental Disabilities Divisions to oversee provider and staff compliance with policy and statutory requirements. Nursing homes are inspected at least every 15 months and adult family homes and boarding homes are inspected at least every 18 months. Supported Living programs are certified every two years. Inspections are unannounced and they are scheduled so that facilities that have had problems in the past are inspected more frequently.

¹¹ Washington Administrative Code 388-106-1445. Available at: <http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-1445>.

ADSA's strategic plan noted that, because they are small, adult family homes tend to have fewer contacts with people outside the facilities than larger facilities. ADSA plans to add staff to visit newly licensed adult family homes within 90 days to ensure that providers understand and are meeting requirements. ADSA would like to expand the scope of Quality Assurance Nurses (QANs) who provide technical assistance to nursing homes to also assist boarding homes and adult family homes.

The Division of Developmental Disabilities issued a report on the quality of care in 2006. The report presents information using the Quality Framework developed by the Centers for Medicare & Medicaid Services and the National Core Indicators. The report provides data on each of the seven components of the quality framework: participant access; participant-centered service planning and delivery; provider capacity; participant safeguards; rights and responsibilities; participant outcomes and satisfaction; and system performance.¹²

The report indicated that 73% of the children served through the §1915 (c) waiver and 86% of the adults said they received the services and supports they need. Eighty four percent of the participants surveyed felt the plan of care helped them plan to meet their goals and needs. A review of case records found that 89% of the plans of care addressed health and safety items in 2006 compared to 73% in 2005. Eighty five percent of the children served responded that their plan of care included things that are important to them. The report also presents data on case management training, incident report, mortality reviews and other topics. The report lists focus areas for improvement and actions taken in 2006 and the plan of action for 2007.

In 2007, the legislature passed HB 2284 which created a long term care workforce development work group under the Joint Long Term Care Task Force. The workgroup was

¹² Quality Is Everyone's Business. ADSA. September, 2007. Available at: <http://www1.dshs.wa.gov/ddd/qassurance.shtml>

charged with evaluating current training requirements for long term care workers concerning the quality of care provided to vulnerable people across all home and community based long term care settings. The workgroup was asked to make recommendations about the appropriate number of basic training hours, the content of basic training curricula, and the development of criteria associated with certification of new long term care workers. The law states that the recommendations are intended to apply uniformly to all long term care workers; take into consideration the training standards for workers providing similar care in nursing homes; be evidence-based and informed by existing research; be based on the care needs of clients; be developed with input from worker representatives; be structured in a manner to articulate with certification and apprenticeship programs; and be informed by broader workforce development and long term care delivery needs.

ADSA currently requires 34 hours of training for agency and independent providers. However, parents of children with developmental disabilities are required to receive six hours of training. The final report recommended a combination of core training requirements and population or setting specific requirements. Core training would cover competencies in 24 topics and an additional 15 topics would be covered for population or setting specific training.¹³ The core training topics are covered by the existing training curriculum. Workers would be exempted from the training if they successfully passed a competency test. Training could be delivered through several learning methodologies – classroom, skill slab, clients/caregiver experience, client and/or health professional training, on-the-job training, mentoring/supervision, competencies development classes, case studies or scenarios, adult learning methods and job shadowing. The workgroup did not reach agreement on the number of hours of training but

¹³ Long Term Care Worker Training Workgroup. Final Report. Available at: http://www.governor.wa.gov/lctcf/workgroup/2007report/LTCWkrTrng_FINAL_120607.pdf

discussed requiring as much as 120 hours of training. The final report states that more than half of the workgroup members supported at least 85 hours of training.

Housing

ADSA is preparing to expand a supportive housing program that was developed in 1999 in one elderly housing building. The model offers consumers a choice of agency services, independent provider or clustered services. Under the traditional model, multiple case managers and providers serve consumers in one building. Cluster care assigns and coordinates a team of care providers to provide support for scheduled and unscheduled tasks. Access to services is increased over one-to-one models of care for extended periods of the day that can include evenings and weekends.

Under the traditional model, home care clients are authorized a number of hours a month based on their functional impairments and unmet needs. Home care agencies convert the monthly hours into a weekly schedule and workers are assigned to provide support. Once the worker completes the tasks, the client has limited if any access to assistance for needs that cannot be scheduled. The traditional delivery model has several limitations. Schedule changes can be difficult to accommodate. Clients may have an appointment with their physician when the worker cannot assist or the appointment has to be planned around the worker's schedule rather than the client's schedule. Services may not be delivered due to worker turnover, illness or vacation if a replacement cannot be located. Clients may prefer to go without services rather than allow the home care agency to assign a substitute

By clustering workers, consumers received services when they are needed rather than in hourly blocks of time because care providers are on-site and do not have to travel to the persons.

Providers are able to offer tenants who are not eligible for Medicaid to purchase services in 30 minute units which lowers the cost to the tenant.

State officials described several advantages over traditional delivery practices:

- Client access to services is improved by making service available 7 days a week;
- The number of days per month and times per day clients receive services increased without an increase in costs;
- Client satisfaction increased;
- Client safety and service oversight improved because of the increase in the number of times clients receive services;
- The ability to age in place for clients is increased. Clients are able to remain independent in their homes longer and return home from hospital stays more quickly due to the availability of care seven days a week;
- Worker availability improve and turnover declined;
- Workers report higher job satisfaction;
- Maintain or reduce costs while improving service delivery;

State officials indicated that several challenges have to be addressed to implement a cluster care model. Multiple home care agencies often deliver services to tenants in larger elderly housing sites which means one agency may not have a sufficient aggregate number of service hours to make it feasible unless clients select a single agency or agencies agree to allow one agency to serve the building which, if the provider were willing, may conflict with freedom of choice requirements under §1915 (c) waivers. Between 1,000 and 1,500 total service hours are required to provide services seven days a week for extended periods of time. Based on the average service authorization, an agency would need between 10 and 16 clients to be viable.

Expanding the program has been hampered by resistance from providers who may not be designated to serve the building and consumers who do not want to lose their current care

provider. ADSA addresses the consumer's concern by allowing a choice of models. However, as new tenants enrolled in the program, they chose the cluster model.

The Division of Developmental Disabilities (DDS) offers a supportive housing service in which service providers serve individuals in community residential placements. The participants rent or sometimes own the home. ADSA certifies and contracts with 125 supportive living agencies that offer an array of services from few hours a day to intensive 24 hour supports. Some agencies also offer therapies, financial services and adult family home options. Participants may decide to share the home with 3 or 4 others who each have their own bed rooms.

DDS also offer a companion home option which provides 24 hour care to a single participant. The care provider has no other employment outside home. Forty five consumers participate in this option.

The state's Money Follows the Person Grant identified housing as one barrier to transitioning. Project staff plans to work with the Department of Social and Health Services Housing Coordinator to cultivate existing networks and housing connections for accessible and affordable community housing for participants. ADSA staff will also work with providers to develop community housing and assisted and supportive living opportunities throughout the state including in rural areas and tribal lands which have been historically difficult to reach. Staff will work with local public housing authorities and providers to identify appropriate units of housing for eligible individuals as they are preparing for discharge. This will include identifying options for accessibility and affordability on an individual basis. For example, when an eligible individual is planning to discharge to a specific community and utilizes an electric wheelchair, staff will work with the housing provider to ensure that the available unit is completely

accessible to that specific person's needs, including subsidized rental voucher assistance when needed.

Future of Nursing Homes

The number of nursing facilities in Washington has remained fairly stable after a spate of closures in the mid-1990s. One certificate of need was approved recently and two additional requests have been made. Recent floods caused extensive damage to some nursing facilities that may be forced to close. State officials have adopted a market approach to the existing supply by supporting a full array of options.

A legislative task force discussed options for a pay for performance model for nursing facilities to provide exceptional care. The task force contracted with researchers from Brown and Harvard University to recommend ways to simplify the payment system and make it transparent to legislators.

ADSA's Residential Services Division designed a survey to assure that nursing facilities create and sustain environments that support quality of life for residents. Quality of life is "based on personal values, life styles and experiences. The experience of quality of life includes physical health and functioning, social engagement and emotional well-being, cognitive performance, work productivity and role performance, sexual functioning and life satisfaction." The survey process includes observations, potential issues and individual residents whose quality of life may be inadequate. Interviews are conducted with 5-8 residents using a quality of life tool. Prior to the interview, information is gathered from medical records, MDS information, and staff.

The survey includes general opening questions and questions that address relationships and interactions, privacy, autonomy and choice, food, pleasure and enjoyment and spiritual issues.

The survey tool and process was piloted tested. Surveys results from 100 residents found that increased awareness by residents led to changes in staff behavior such as control over schedules, dietary preferences, activities. Residents were not aware that they could exercise control over their life in a nursing facility.

Integration of Acute and Long Term Services

The Medicaid Integration Partnership is a voluntary managed care pilot program in one county that combines medical, mental health and chemical dependency services and was designed to moderate the progress of illness and disability and to better manage Medicaid expenditures. WMIP serves SSI and SSI-related Medicaid beneficiaries in Snohomish County through a contract with Molina Healthcare of Washington. Consulting nurses are available by phone 24/7. Long term care services were added to the program in October 2006. The program serves about 2800 beneficiaries. Emergency room visits declined from 128.6 per 1,000 enrollee months to 125.9 per 1,000 enrollee months and inpatient hospitalization rates have increased at a slower rate than for beneficiaries who receive services through the fee for service.

A Medicare-Medicaid Integration Project (MMIP) began in June 2005 in two counties. The program is voluntary and serves dual eligible elders age 65 and older. The contractor, Evercare, was designated as a Special Needs Plan to receive Medicare payments. By February 2007, the program served 77 members. Goals for 2007 include expanding enrollment to 500 and expanding Evercare's provider network to include 30 adult family homes. However, enrollment has not yet met expectations and future of this pilot project is under discussion.. Other models are also being explored.

Conclusions

Washington ranks among the top states for Medicaid spending on home and community based services. Although each State has its unique history and circumstances, some lessons can be extrapolated from Washington to other states working on rebalancing. Washington enjoys stable leadership, which has helped in the coherent and deliberate implementation of its vision and goals. Having leaders who worked for decades within the Aging and Disability Services Administration (ADSA) is a luxury that a State cannot plan for and that is extraordinarily helpful. Other lessons from Washington are more in the control of State officials.

- Washington articulated and promulgated a vision, which includes a strong commitment to respect individual preferences, to make choices available for community care, and to work closely with consumer stakeholders.
- Washington consolidated all responsibility for long term support licensing, oversight, policy, program management and funding contribute the state's success. State informants believe that the organization of the units within ADSA by function—e.g. individual supports, residential services—rather than by age or disability group and the control over budgets for both the HCBS and institutional services are integral to its successes.
- Washington programs are data driven. The State developed a comprehensive data base that combines assessment and service data and is used for tracking utilization and quality and in forecasting. This data capacity serves the State in many ways: it allows it to confidently move ahead with independent provider models while maintaining oversight and accountability; and it inspires confidence among legislators. Washington officials believe that the initial three million dollar investment in its automated modular CARES data base was money well spent, as were the upgrades to the system to incorporate all populations. The Aging and Disability Services Administration has a strong track record for managing spending within available resources and the ability to explore and address challenges posed by individuals with complex health and functional needs. The data system allowed the State to identify challenges, particularly in serving consumers with serious mental health problems.
- Washington maintains a commitment to investing in case management, largely through state-funded case managers. While trying to avoid intrusive roles for case managers in the lives of the participants, Washington officials value the infrastructure created for an auditable case management function that drives quality control. The Washington programs combine an active data-driven care planning process with a system where in-home services are largely delivered by independent providers.

- A wide range of community residential options, including small adult family homes, has helped Washington develop its current balance towards HCBS. State officials also strongly believe that a clear policy permitting the delegation of nursing services in these settings, as well as in home care, has rendered the system responsive and affordable. A strong commitment to participant choice, community integration, and quality of life undergirds all the quality assurance activities, including those for residents of community residential settings.
- Washington offers some lessons for any State that is working with an independent provider system. First, the State found it extremely important to develop its Home Care Quality Authority as a mechanism to mediate the relationship between independent providers and consumer-employers. The Home Care Quality Authority has particular credibility because it is almost completely comprised of users of personal care. Washington learned that labor unions would be important actors in the system, and would have the skills and influence to be able to approach legislators directly. Although the union (in Washington's case the Service Employees International Union, SEIU) and the State largely share goals for the system, the State learned the importance of developing a strong internal capability in labor relations and union contracting. With union leadership, the wages and benefits for Independent Providers increased more rapidly than the State had expected and various rulings (for example, about live-in workers) led to overall cost increases, which needed to be incorporated in the budget. The State was also interested in upgrading the wages of workers, but the State has a strong interest in not having the conditions of work dictated by the union in a way that would interfere with consumer control over choice of workers, schedules, tasks performed, and the like. To work effectively in this milieu State agencies needed to develop new capabilities and knowledge. Washington has also demonstrated that a system can function well and be accountable even when a large proportion of the unionized Independent Providers are family members of the participants.