LTSS Trust Commission Recommendations Report

RCW 50B.04.030 (4)

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Long-Term Services and Supports Trust Commission

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Executive Summary

Enacted in 2019, the Long-Term Services and Supports (LTSS) Trust Program (Chapter 50B.04 RCW), now called WA Cares Fund, is a contributory long-term service and supports insurance program that provides a maximum lifetime benefit of $36,500 (adjusted annually up to inflation) for all qualified, eligible Washingtonians.

It is financed by an employee premium of 0.58% of wages, the maximum rate which can be assessed according to the statute. Individuals who have met work and contribution requirements of 10 years with no more than a 5-year interruption (or 3 out of the last 6 years at the time of application) and who need assistance with three or more activities of daily living may claim full WA Cares Fund benefits from approved providers. Individuals born before 1968 also have the opportunity to earn partial WA Cares Fund benefits, namely 10 percent of the maximum lifetime benefit for each year they contribute.

WA Cares Fund is a multi-agency program administered collaboratively by the Department of Social and Health Services (DSHS), the Employment Security Department (ESD), and the Health Care Authority (HCA). The Office of the State Actuary performs actuarial valuations and makes recommendations to maintain trust solvency. The WA Cares Fund is overseen by the 21-member LTSS Trust Commission (see Appendix A for a list of Commission Members).

On July 1, 2023, premium assessments began for covered workers and self-employed individuals began electing coverage. On July 1, 2026, DSHS will begin paying benefits on behalf of eligible beneficiaries.

Based on actuarial analysis updated in October 2022, under most scenarios evaluated, including the base plan scenario, the program's premium assessment of 0.58% ($0.58 per $100 of wages, or about $24/month for the median covered earner making $50,100/year) was projected to keep the WA Cares Fund solvent over the entire 75-year projection period (through June 30, 2098). There were scenarios identified that, without corrective action, could lead the program to have insufficient revenue to provide for full program benefits over the entire projection period. (For more information on program solvency, see Appendix B; for the Commission's WA Cares Fund Risk Management Framework, see Appendix C). WA Cares Fund is projected to result in Medicaid cost avoidance for both the state general fund and the federal government as a result of delaying or diverting people from Medicaid long-term services and supports (see Appendix D). This also means that fewer Washingtonians will need to spend down their life savings to qualify for Medicaid long-term care due to WA Cares Fund. WA Cares Fund is also projected to result in a reduction in Medicare utilization and expenditure.

Per RCW 50B.04.030, the LTSS Trust Commission is charged with proposing recommendations to the Legislature or the appropriate Executive Agency on specific aspects of the program. The Commission's recommendations and decisions are guided by the joint goals of maintaining benefit adequacy and maintaining solvency and sustainability.

The Commission considered three main policy issues this year:

1. Portability cost offsets
2. Eligible beneficiary criteria
3. Minimum provider qualifications

For each of the topics above, the LTSS Trust Commission researched policy options, impacts, and administrative feasibility and developed policy recommendations. When a particular policy option had the potential to impact the long-term solvency of the program, actuarial analysis was conducted. Please note that the estimated actuarial impact of enacting multiple policy options may not equal the sum of the individual policy impacts. Detailed actuarial analysis can be found in Appendix D.

January 1, 2024, Commission Recommendations

1) Portability Cost Offsets

LEGISLATIVE REQUIREMENT

Under current statute, those who vest and leave the state cannot claim benefits outside of Washington. Making benefits portable without any policy adjustments to manage the cost of doing so would increase the premium required to fund the program significantly.

During the 2022 legislative session, Operating Budget Bill ESSB 5693 required the Commission to recommend options for extending benefits to out-of-state eligible beneficiaries. In its 2023 report to the legislature (submitted January 1, 2023, based on work conducted throughout 2022), the Commission made the following recommendation on managing the cost of expanding benefits to people who leave the state (one of four portability challenges addressed in its 2023 report):

> *Allow anyone with at least one year of qualifying contributions who leaves the state to elect portable benefits coverage by choosing to continue contributing premiums to WA Cares until the Normal Retirement Age under Social Security (currently age 67 for those born in 1960 or later). The premium would be equal to the last "in-state" premium assessed, adjusted for wage inflation. Workers who leave the state at age 67 or later would not be required to pay in further. This recommendation is contingent on finding ways to offset the cost of making benefits portable.*

During its work over the course of 2023, the Commission refined this recommendation by considering, supported by actuarial analysis, a number of ways to offset the cost of making benefits portable.

POLICY ISSUE

Per RCW 50B.04.010(6), "eligible beneficiary" means a qualified individual who is age eighteen or older, **resides in the state of Washington**, has been determined to meet the minimum level of assistance with activities of daily living necessary to receive benefits through the trust program (as established in this chapter) and has not exhausted the lifetime limit of benefit units. Many workers leave the state either during their working years or after retirement. Some may have paid in less than 10 years and left before they could permanently qualify, while others will have qualified and be unable to claim benefits when they need long-term care. Per the current statute, only people who reside in Washington can access WA Cares Fund benefits. In order to fund portability, the Commission weighed a range of potential cost offsets, including modifications to both program structure and to the portability recommendation made in 2022.

COMMISSION RECOMMENDATION ON PORTABILITY COST OFFSETS

The 2024 Commission recommendation on managing the cost of portability supersedes the 2023 report recommendation referenced above. The 2024 portability cost offset recommendation (Option 1 below) modifies the 2023 recommendation and makes modest changes to program structure.

Option 1 - Recommended by the Commission: The following set of measures are recommended to offset the expected cost of portability. By adopting these, the state would make it possible for most Washington workers who leave the state and have a care need to still receive their earned WA Cares benefits, without having to increase the premium on the basis of expected costs. The recommendation includes the following set of measures:

- Allow anyone who leaves the state after making at least three years of in-state qualifying contributions to elect portable benefits coverage by agreeing to continue contributing premiums as long as they continue working.
- Require workers who elect portable coverage upon leaving the state to contribute to WA Cares as long as they continue to work based on their actual wages (or in the case of self-employment, net profit). Require workers to report their wages, pay premiums regularly, and provide documentation of their wages at the time of payment of premium. If an individual who elects portable coverage reports no wages, the lack of wages earned through employment or self-employment must be verified. ESD will research what documentation could be provided to verify wages at time of payment of premium and any exceptions that should apply. ESD will consider user experience and develop ways to support individuals accurately reporting their wages at time of payment. Failure to remit assessed premiums after electing portable coverage will have consequences, including cancellation of coverage, or payment of back premiums and interest, or a combination of those. The Commission recommends ESD and DSHS research viable options to include in statute.[1]
- Once a worker turns 67, they are no longer required to provide documentation of their wages or lack thereof, although they are still required to contribute on any wages earned through employment or self-employment.
- Increase the number of hours worked required to earn a qualifying year from 500 to 1000. This recommendation applies to all workers, both in and out of state.
- Use Washington's Medicaid-style long-term care threshold and incorporate a 90-day forward certification of need into the eligibility criteria. The intent of this certification is to determine that a person's need for assistance with activities of daily living is expected to last for at least 90 days. If a person's need for assistance with activities of daily living is not expected to last for at least 90 days, they would not be deemed an eligible beneficiary. This is neither an elimination period nor a waiting period. This threshold would apply to all individuals who live in Washington when they need care.
- Adopt a HIPAA-style benefit eligibility threshold for out-of-state residents. This is the standard benefit eligibility threshold required for tax-qualified private long-term care insurance policies nationwide. This standard would apply to all beneficiaries who live out-of-state when they need care, reducing administrative costs by leveraging the benefit eligibility threshold which the vast majority of assessors outside of Washington are already experienced administering.
- Give the State Investment Board (SIB) authority to invest Trust assets in a diversified portfolio, including equities**.** This would require a ballot initiative to amend the state constitution.
- Continue to leverage the Risk Management Framework to regularly monitor emerging experience and its impacts on actuarial status of the program.

Actuarial analysis: According to analysis prepared by the independent actuarial firm Milliman, this package of recommendations would require an estimated total program premium assessment of 0.54% if the recommended ballot initiative allowing investment in equities passes (an estimated reduction of the current total program premium

[1] Workgroup recommendation is pending a full vote of the LTSS Trust Commission and may be revised.

assessment of 0.04%), or 0.58% if it does not (no change to the estimated current total program premium assessment). See Appendix D for supporting information.

Pros:

- Would offset portability expected costs without any significant negative effects on program participants.
- Would preserve benefits for longer-term care needs, whether during working years or old age. This aligns with the benefit eligibility workgroup recommendation.

Cons:

- Would eliminate the ability for beneficiaries to use their benefit for short-term care needs (lasting fewer than 90 days).
- Some part-time workers in the transition cohort (born before 1968) might not currently work 1000 hours per year and therefore not earn qualifying years. These workers would have to increase their hours to nearly half-time in a given year to earn a qualifying year. (Over the long-term, most workers will meet the qualifying years requirement by working at least 1000 hours per year in 10 different years over the course of their career.)

Additional portability cost offsets options considered by the workgroup but rejected (all options include 90-day forward certification, HIPAA out of state, and investing in equities):

Option 2: Similar to option 2, but this removes the pathway for beneficiaries to be eligible after 3 years of contributions in the past six years. This option limits the number of beneficiaries who would be eligible to receive benefits before 2033. This option was rejected because working age people with disabilities would have pay in for 10 years to earn benefits and not just 3. This option limits being able to show metrics or gain experience during the first decade of the program.

Option 3: Similar to the option 2 but reduces benefits to 50% for 3 of the last 6 years pathway. This option limits working-aged people with disabilities to only be able to receive half of their lifetime benefit after 3 years of contribution. This option was rejected due to the similar implications as option 2 but with less impact.

Option 4: Similar to option 2, but this option pauses on making a decision on the 3 out of the 6 years pathway and re-evaluating in 2026 once we a better understanding of program finances. This option could potentially limit the option for beneficiaries to be eligible after 3 years of contributions. This option was rejected because it would not take action on this pathway for three years and doesn't give beneficiaries clarity on whether this pathway would be available to them. This option could have impacts on working aged people with disabilities who may be counting on being able to utilize the benefit after 3 years.

Option 5: This option requires periodic recertification of Private Long-Term Care Insurance coverage. This option would ensure those that purchased Private Long-Term Care Insurance have coverage and are maintaining it. This option was rejected because it would require skilled staff to review complex long-term care policies and would require authority to cancel previously permanent exemptions.

Option 6: Similar to option 5, but this allows individuals who dropped their Private Long-Term Care Insurance coverage to repurchase it in order to pass recertifications. This option was rejected due to similar implication as option 5.

2) Benefit Eligibility

LEGISLATIVE REQUIREMENT

The WA Cares Fund Statute (Chapter 50B.04 RCW) requires the LTSS Trust Commission to propose recommendations to the appropriate executive agency or the legislature regarding the establishment of criteria for determining that an individual has met the requirements to be an eligible beneficiary as established in RCW 50B.04.060

POLICY ISSUE

The Commission began considering eligibility criteria in 2022 and reconvened in 2023. Per RCW 50.04.010(6), "Eligible beneficiary" means a qualified individual who is age eighteen or older, residing in the state of Washington, has been determined to meet the minimum level of assistance with activities of daily living necessary to receive benefits through the trust program, as established in this chapter, and has not exhausted the lifetime limit of benefit units.
Per RCW 50B.04.060(2), Beginning July 1, 2026, a qualified individual may become an eligible beneficiary by filing an application with the department of social and health services and undergoing an eligibility determination which includes an evaluation that the individual requires assistance with at least three activities of daily living.

In 2023, the Benefit Eligibility workgroup reviewed the components of two benefit eligibility threshold options: A Washington Medicaid-style threshold or a national private insurance HIPAA-style threshold, and the impacts and challenges of each.

The Medicaid style threshold evaluates self-performance, meaning what a person was able to do for themselves and/or how much assistance was required by a caregiver. Under this threshold, a person could qualify depending on how an activity of daily living (ADL) occurred three or more times in the last seven days and if the person needs assistance with at least three out of seven ADLs. It also considers cognitive impairment when some ADL assistance is also required.

The HIPAA style threshold evaluates if a person is chronically ill and requires substantial assistance with at least two out of six ADLs. A person is considered chronically ill when it is certified that the person is unable to perform at least two ADLs without substantial assistance from another person for a period of at least 90 days. There is no ADL requirement if a person has a severe cognitive impairment or requires substantial supervision.

COMMISSION RECOMMENDATION ON BENEFIT ELIGIBILITY

Option 1 - Recommended by the Commission:

Adopt the Medicaid-style benefit threshold which aligns with Washington state Medicaid standard that is currently used.

Incorporate a 90-day forward certification of need into eligibility. This is not an elimination period nor a waiting period, which are typically used in private long-term care insurance where individuals pay out of pocket.

Adopt the HIPAA benefit eligibility threshold for out-of-state residents, same as the private long- term care insurance standard. This would allow DSHS to simplify administration of conducting assessments nationwide.

Actuarial analysis: According to analysis prepared by the independent actuarial firm Milliman, these recommendations, taken together with the portability recommendations discussed above, would require an estimated total program premium assessment of 0.54% if the recommended ballot initiative allowing investment

in equities passes (an estimated reduction of the current total program premium assessment of 0.04%), or 0.58% if it does not (no change to the estimated current total program premium assessment). See Appendix D for supporting information.

Pros:

- Would preserve benefits for longer-term care needs, whether during an individual's working years or old age. This would eliminate the risk of benefits being used for short-term care needs, many of which are partially addressed through other policies like paid family and medical leave.
- Under this threshold, individuals in state who are in earlier stages of cognitive impairment could be considered eligible. This could help get support to individuals earlier in their care trajectory and potentially slow or mitigate degeneration of functional or cognitive capacity.

Cons:

- Would eliminate the ability for beneficiaries to use their benefit for very short-term care needs, such as a ski accident.

Additional eligibility threshold options considered by the workgroup but rejected:

Option 2: HIPAA-style benefit threshold for all
This option could help preserve benefits for long-term care needs that can be used later in life. The HIPAA benefit threshold is used across the private long-term care insurance industry. Therefore, assessments, ADLs, and definitions would be consistent nationwide. It could help support a more seamless transition to private long-term care insurance policies. This option creates less opportunities for beneficiaries to quality as less ADLs are assessed. Individuals would need to have a severe cognitive impairment to be eligible. This creates less opportunities for individuals with mild to moderate cognitive impairment to qualify. This option could reduce program costs.

Option 3: Medicaid-style benefit threshold for all
Similar to Option 1, but this would not include the 90-day forward certification of need and it does not include the HIPAA-style threshold for those that move out of state. This option would allow individuals who have short term care needs to become eligible sooner. This could be an incentive for beneficiaries to use their benefit earlier in life, which could cause them to not have enough funds to use later. Although this creates more opportunities to be eligible, this could drive up the cost of the program long-term.

Option 4: Medicaid-style benefit threshold and 90-day forward certification of need
Similar to Option 3, but this does not include the HIPAA-style threshold for those that move out of state. This option would allow people access to care during a critical period of need but would only provide care to people whose conditions are not expected to resolve within three months.

3) Minimum Provider Qualifications

LEGISLATIVE REQUIREMENT

Under RCW 50B.040.020(3)(c), the Department of Social and Health Services (DSHS) is required to "register long-term services and supports providers that meet minimum qualifications." The definition of "long-term services and supports provider" under RCW 50B.04.010(11) establishes provider minimum qualifications as those "qualifications applicable in law to the approved service they provide".

POLICY ISSUE

For many WA Cares Fund providers, the applicable qualification is a license or certification issued by a state agency to provide a specific service. For others, the only applicable qualification is a business license. The Commission considered whether the minimum qualifications defined in the statute are adequate to effectively provide the "approved services" established in the statute.

COMMISSION RECOMMENDATIONS ON MINIMUM PROVIDER QUALIFICATIONS

Group 1: Providers offer direct assistance with Activities of Daily Living

Adult Family Home: An Adult Family Home is a residential home in which a person or persons provide personal care, special care, room, and board for two (2) to eight (8) adults who are unrelated by blood or marriage to the person or persons providing the services as licensed under chapter 70.128 RCW.

Recommended by the Commission: Establish the minimum qualification as an Adult Family Home operating under a valid license issued by DSHS or comparable credential issued by a Tribal government

- **Pros**: Offers the widest provider pool creating more choice for beneficiaries
- **Cons:** Individuals who exhaust their benefit may no longer be able to reside at the home if/when they transition to using Medicaid benefits unless the provider has or is willing to execute a Medicaid contract to continue serving the individual

Additional options considered by the workgroup, but rejected:

- Establish minimum qualification as an Adult Family Home operating under a valid license issued by DSHS or comparable credential issued by a Tribal government *and contracted by DSHS to provide Medicaid services*

Assisted Living Facility: An Assisted Living Facility is a home or other institution that is advertised, announced, or maintained for the express or implied purpose of providing housing, basic services, and assuming general responsibility for the safety and well-being of the residents, and may also provide domiciliary care, consistent with chapter 18.20 RCW to seven or more residents after July 1, 2000. However, an Assisted Living Facility that is licensed for three to six residents prior to or on July 1, 2000, may maintain its Assisted Living Facility license under chapter 18.21 RCW if it is continually licensed as an Assisted Living Facility.

Recommended by the Commission: Establish the minimum qualification as an Assisted

Living Facility operating under a valid license issued by DSHS or comparable credential issued by a Tribal government

- **Pros**: This recommendation offers the widest provider pool creating more choice for beneficiaries

- **Cons:** Individuals who exhaust their benefit may no longer be able to reside at the facility if/when they transition to using Medicaid benefits unless the provider has or is willing to execute a Medicaid contract to continue serving the individual

Additional options considered by the workgroup, but rejected:

- Establish minimum qualification as an Assisted Living Facility operating under a valid license issued by DSHS or comparable credential issued by a Tribal government *and contracted by DSHS to provide Medicaid services*

Nursing Home: A Nursing Home is any home, place or institution which operates or maintains facilities providing convalescent or chronic care, or both, for a period more than twenty-four consecutive hours for three or more patients not related by blood or marriage to the operator, who by reason of illness or infirmity, are unable properly to care for themselves, as licensed under chapter 18.51 RCW.

Recommended by the Commission: Establish the minimum qualification as a Nursing Home operating under a valid Nursing Home license issued by DSHS.

- **Pros**: Offers the widest provider pool creating more choice for beneficiaries

- **Cons:** For a very small number of Nursing Homes that hold only a state issued license and are not certified by the Centers for Medicare and Medicaid Services, individuals who exhaust their benefit may no longer be able to reside at the facility if/when they transition to using Medicaid benefits

Additional options considered by the workgroup, but rejected:

- No other options were considered

In-home personal care: Personal care means physical or verbal assistance with activities of daily living and instrumental activities of daily living provided because of a person's functional disability. There are two types of in-home service agencies that provide in-home personal care in Washington state: The DSHS contracted Consumer Directed Employer under requirements of Chapter 74.39A RCW, and Department of Health licensed Home Care Agencies under Chapter 70.127 RCW.

A Consumer Directed Employer is a private entity that contracts with the department to be the legal employer of Individual Providers for purposes of performing administrative functions. The entity's responsibilities are described in Chapter 74.39A RCW. The currently contracted Consumer Directed Employer is Consumer Direct Care Washington (CDWA).

An Individual Provider is a person, including a personal aide, who is employed by the Consumer Directed Employer. They have met the background check, basic training,

continuing education, and other requirements established under Chapter 74.39A RCW to provide personal care or respite care services.

A Home Care Agency is a person administering or providing home care services directly or through a contract arrangement to individuals in places of temporary or permanent residence under Chapter 70.127 RCW. In-home care services are nonmedical services and assistance provided to ill, disabled, or vulnerable individuals that enable them to remain in their residences.

Recommended by the Commission: Establish the minimum qualification as:
An Individual Provider employed by Consumer Direct Care Washington (CDWA) and qualified to provide personal care

An agency with a valid Home Care Agency license issued by the Department of Health with three years of experience as a licensed Home Care Agency and currently contracted by DSHS to provide Medicaid services. *The Commission also recommends DSHS research the components of a home care agency Medicaid contract along with other industry standards to ensure quality of care. This may be considered a substitute for the aforementioned requirement to hold a Medicaid contract.*[2] In places where there is a capacity issue, recommend adopting an exception process for the Medicaid contract requirement.

- **Pros**: Quality of care issues for new providers have been addressed by the Department of Health; proven record of workers' protection policies; experience coordinating and leveraging existing systems; experience billing public agencies

- **Cons**: If a Medicaid contract is required, beneficiaries will have limited choices for in-home care agencies. Approximately 50 of 260 licensed agencies are currently contracted with Medicaid and the existing Medicaid provider network has waitlists for care.

Additional options considered by the workgroup, but rejected:

- An agency with a valid Home Care Agency license issued by the Department of Health
- An agency with a valid Home Care Agency license issued by the Department of Health with three years of experience as a licensed home care agency and providing services to paying clients within Washington State.

Group 2: Core Services to In-home Care

Adaptive Equipment and Technology: Adaptive Equipment and Technology are assistive devices and items that would increase, maintain, or improve a beneficiary's ability to perform activities of daily living (ADL) or to perceive control or communicate within their living environment.

Recommended by the Commission: Any retail vendor with a Washington state business license and NPI number *(Medical provider only),* the contractor must be a legal business entity and legitimately engaged.

[2] Workgroup recommendation is pending a full vote of the LTSS Trust Commission and may be revised.

For purchases under a certain dollar threshold, a beneficiary may be able to purchase an item from a retail or online store of their choice and be reimbursed by a Financial Management Services (FMS) vendor contracted by DSHS if beneficiary submits receipt to FMS vendor for covered purchased item.

- **Pros**: This recommendation offers the widest provider pool creating more choice for beneficiaries. More choice, control, and accessibility for beneficiaries to obtain needed items in a timely manner.

- **Cons**: Beneficiary may not have adequate balance to cover purchased item, additional admin cost paid to FMS vendor; may be cost prohibitive to monitor adequately; items purchased may be returned after payment to beneficiary which increases risk of fraud up to a certain dollar threshold per purchase; extensive training required to learn ProviderOne system; limited oversight for retail vendors with no assistive technology experience.

Additional options considered by the workgroup but rejected:

- Any retail vendor with a Washington State business license, NPI number (Medical provider only) and a Core Provider Agreement with Health Care authority.

Environmental Modifications: Environmental Modification services provide needed changes such as ramps, stair lift, and widened doorways for a wheelchair in the home to increase, improve or maintain a beneficiary's health, welfare, safety, and independence.

Recommended by the Commission: Any General Contractor and/or Specialty contractor registered with L&I, licensed, bonded, and insured and meets the requirements of Chapter 18.27 RCW and contractor owner must pass a DSHS criminal background check.

Any non-profit 501(c)(3) organization that is bonded and insured that offers environmental modifications or minor home repairs.

- **Pros**: Offers the widest provider pool creating more choice for beneficiaries.

- **Cons:** Vendors may not have experience in ADA requirements resulting in modifications that are ultimately ineffective for the user; no experience using ProviderOne.

Additional options considered by the workgroup but rejected:

- Any General Contractor and/or Specialty contractor registered with L&I, licensed, bonded, and insured and meets the requirements of Chapter 18.27 RCW and contractor owner must pass a DSHS criminal background check and *contractor must have one year experience in ADA accessible modifications.*

Home Delivered Meals: Home delivered meals provide nutritionally balanced meals delivered to the beneficiary's home

Recommended by the Commission: Any vendor that has a business license with the state of Washington and meets the standards of chapter 246-215 WAC

- **Pros**: Offers the widest provider pool creating more choice for beneficiaries; could be beneficial for rural communities with limited access to services.

- **Cons:** Quality or standard of care may be a concern; meals may not be nutritious; no experience using ProviderOne

Additional options considered by the workgroup but rejected:

- Must meet the Washington State Senior Nutrition program standards along with meeting the standards in chapter 246-215 WAC

Personal Emergency Response Systems: Personal Emergency Response System (PERS) is a service to secure help in an emergency through an electronic device that is either connected to the beneficiary's phone or operates using GSM cellular signals and is programmed to signal a response center and that is staffed by trained professionals who will immediately summon help for the beneficiary.

Recommended by the Commission: Current Washington business license and the equipment is approved by the Federal Communications Commission and meets the Underwriters Laboratories, Inc. (UL) or ETL (Intertek) standard for home health care signaling equipment and pass a DSHS background check for owner/contract signer.

- **Pros**: Offers the widest provider pool creating more choice for beneficiaries.

- **Cons:** No experience in ProviderOne.

Additional options considered by the workgroup but rejected:

- Current Washington business license and the equipment is approved by the Federal Communications Commission and meets the Underwriters Laboratories, Inc. (UL) or ETL (Intertek) standard for home health care signaling equipment and completed DSHS background check for owner/contract signer and *must have one year of experience to provide service.*

Group 3: Core Services to In-home Care, Community Access, and Family Support

Adult Day Services:

Adult Day Health (ADH) centers provide supervised daytime programs including skilled nursing and rehabilitative therapy services to beneficiaries who need assistance throughout the day.

Adult Day Care (ADC) centers provide supervised daytime programs to support families by providing care and meaningful activities to beneficiaries who need assistance or supervision throughout the day.

Recommended by the Commission: Any Adult Day contractor that meets requirements of WAC 388-71-0702 through 388-71-0776

- **Pros**: Individuals who exhaust their benefit are likely able to use Medicaid funds to cover ongoing care need.

- **Cons:** Limits choice of providers for beneficiaries; could disincentivize new providers from participating in WA Cares.

Additional options considered by the workgroup but rejected:

- Any Adult Day contractor that meets requirements of WAC 388-71-0702 through 388-71-0776 and *has one year experience of providing Adult Day services*

Eligible Relative Care: An eligible relative may be paid to provide in-home personal care without becoming a fully trained and certified Home Care Aide. Eligible relatives still have background check and training requirements to support the health and safety of their family member per RCW 74.39A.076. An eligible relative may also work for a home care agency, however, home care aide training and certification will apply. Qualified family members may be paid for approved personal care services through a third option if recommended by the Commission and adopted by DSHS. The Commission may consider whether to adopt a third option in a subsequent report.

A family member may also be eligible to provide respite care (see definition below). Additional policy recommendations may also be made by the Commission related to assistance with instrumental activities of daily living.

Recommended by the Commission: Any relative Individual Provider employed by CDWA and qualified to provide personal care and that relative provider meets requirements in Chapter 388-71 WAC.

- **Pros**: Aligns with existing requirements, provides some assurance of quality and safety for the beneficiary

Additional options considered by the workgroup but rejected:

- None

Respite for Family Caregivers: Respite care gives the primary caregiver a break from their caregiving duties by paying a trained caregiver to provide short-term support ranging from a couple of hours for self-care to a couple of weeks to take a much-needed vacation.

Recommended by the Commission: An Individual Provider employed by CDWA and qualified to provide personal care and provider meets requirements in Chapter 388-71 WAC.

An agency with a valid Home Care Agency license with WA DOH per Chapter 246-335 WAC:

An Adult Day site, Adult Family Home that meets licensing and respite requirements of Chapter 388-76 WAC: Assisted Living Facility that meets licensing and respite

requirements of Chapter 388-78A WAC:, or Nursing Home that meets licensing and respite requirements of Chapter 388-97 WAC: (does not include CMS Certification requirements).

- **Pros**: Offers the widest provider pool creating more choice for beneficiaries.

Additional options considered by the workgroup but rejected:

- Any Adult Day site, Adult Family Home, Assisted Living Facility or Nursing Home that meets licensing and respite requirements and has a Medicaid contract in place and at least one year experience.

Transportation: Transportation services are to support beneficiaries who have no other means of transferring to and from the grocery store, medical appointments, social services, and recreational activities.

Recommended by the Commission: Any Transportation provider that meets the requirements described in the Washington Utilities and Transportation Commission (WUTC) of WAC 480-30 or WAC 480-31

For Transportation purchases under a certain dollar threshold, a beneficiary may turn in receipts for an approved transportation purchase and be reimbursed by a Financial Management Services (FMS) vendor contracted by DSHS if beneficiary submits receipt to FMS vendor for covered purchase.

- **Pros**: Opens potential provider options for transportation services that are not connected to Medicaid brokerage; will provide beneficiary more choice in who they want to provide their transportation; Medicaid brokerage currently does not allow transportation to social activities or grocery shopping.

- **Cons:** Provider may not be experienced in transporting vulnerable adults; beneficiary could pay for transportation out of pocket but not have funds in WA Cares account to cover cost; could be an add-on cost to cover administrative fee for FMS vendor to reimburse.

Additional options considered by the workgroup but rejected:

- Any Transportation provider that meets the requirements described in the Washington Utilities and Transportation Commission (WUTC) of WAC 480-30 or WAC 480-31 is part of the Medicaid Brokerage and has at least one year of experience as a transportation provider

Group 4: Wrap Around Services

Care Transition Coordination: Care Transition Coordination is a time-limited service that complements primary care. It is designed to ensure coordination and health care continuity with the goal of avoiding preventable poor outcomes as beneficiaries return home from an acute care setting like a hospital or skilled nursing facility. Care Transition Coordination is not case management.

Recommended by the Commission: Any contractor with applicable license, credential and/or

certification applicable to care transition coordination that is in good standing, including, but not limited to:

Solo practitioners or sole proprietors.

Agencies, including governmental agencies and non-profit 501(c)(3) organizations.

Contracted Health Home Care Coordination Organizations (CCO) associated with a Health Home Lead Entity that employs individuals with the applicable license, credential, or certification.

Any evidence-based program (EBP) provider that is licensed and credentialed. Fidelity to EBP must be verified at the time of contracting.

- **Pros**: Likely includes the greatest number of providers with fewest barriers to participation

Additional option considered by the workgroup but rejected:

- Same as the option recommended, but the contractor must also have at least one year of experience.

Dementia Supports: Dementia Supports offers community-based services to beneficiaries and their caregivers to improve care for the beneficiary.

Recommended by the Commission: Any contractor with license, credential, and/or certification applicable to dementia supports that is in good standing, including, but not limited to:

Solo practitioners or sole proprietors.

Agencies, including governmental agencies and non-profit 501(c)(3) organizations.
Contracted Health Home Care Coordination Organizations (CCO) associated with a Health Home Lead Entity that employs individuals with the applicable license, credential, or certification.

Any evidence-based program (EBP) provider that is licensed and credentialed. Fidelity to EBP must be verified at the time of contracting.

- **Pros:** Likely includes the greatest number of providers with fewest barriers to participation

Additional option considered by the workgroup but rejected:

- Same as the option recommended, but the contractor must also have at least one year of experience.

Memory Care: Memory Care Services are received in a residential setting which: 1) meets requirements to provide care for individuals with dementia; and 2) are staffed by individuals who have received dementia specialty training to help a beneficiary with dementia maintain the

highest possible quality of life and physical health while living with the losses typical of dementia.

Recommended by the Commission: *See previously determined minimum qualifications for Nursing Home, Assisted Living Facilities, and Adult Family Homes.*

In addition, facilities must comply with all requirements for serving residents with dementia, including specialty training requirements for Assisted Living Facilities and Adult Family Homes detailed in Chapter 388-112A-0490.

- **Pros:** Offers the widest provider pool creating more choice for beneficiaries.

Additional options considered by the workgroup but rejected:

- No other options considered

Education and Consultation: Through this service beneficiaries receive education and training regarding the beneficiary's diagnoses and chronic health issues aimed at supporting the beneficiary to better manage their health.

Recommended by the Commission: Any contractor with applicable license, credential and/or certification applicable to education and consultation that is in good standing, including, but not limited to:

Solo practitioners or sole proprietors.
Agencies, including governmental agencies and non-profit 501(c)(3) organizations.

Contracted Health Home Care Coordination Organizations (CCO) associated with a Health Home Lead Entity that employs individuals with the applicable license, credential, or certification.

Any evidence-based program (EBP) provider that is licensed and credentialed. Fidelity to EBP must be verified at the time of contracting.

- **Pros**: Likely includes the greatest number of providers with fewest barriers to participation

Additional options considered by the workgroup but rejected:

- Same as the option recommended, but the contractor must also have at least one year of experience.

Services that assist paid and unpaid family caregivers: Through this service, beneficiary's paid and unpaid caregivers receive supports, education and training regarding the beneficiary's diagnoses and chronic health issues aimed at supporting the beneficiaries, their families, and caregivers, including maintaining their own health and wellness.

Recommended by the Commission: Any contractor with applicable license, credential and/or certification applicable to service that assist caregivers that is in good standing, including, but

not limited to:

Solo practitioners or sole proprietors.

Agencies, including governmental agencies and non-profit 501(c)(3) organizations.

Contracted Health Home Care Coordination Organizations (CCO) associated with a Health Home Lead Entity that employs individuals with the applicable license, credential, or certification.

Any evidence-based program (EBP) provider that is licensed and credentialed. Fidelity to EBP must be verified at the time of contracting.

- **Pros**: Likely includes the greatest number of providers with fewest barriers to participation

Additional options considered by the workgroup but rejected:

- Same as the option recommended, but the contractor must also have at least one year of experience.

Home Safety Evaluation: This service offers the assessment of a beneficiary's home by a professional therapist to identify and reduce or eliminate potential hazards to help minimize injury while in the home.

Recommended by the Commission: Any contractor meeting the following:
A licensed Home Health Agency that meets the requirements of Chapter 246-335 WAC and Chapter 70.127 RCW.

A licensed occupational therapist meeting the requirements of Chapter 18.59 RCW and Chapter 246-847 WAC (solo practitioner or agency).

Any licensed physical therapist meeting the requirements of Chapter 18.74 RCW and Chapter 246-915 WAC (solo practitioner or agency).

- **Pros:** Likely includes the greatest number of providers with fewest barriers to participation

Additional options considered by the workgroup but rejected:

- Same as the option recommended, but the contractor must also have at least one year of experience.

Professional Services: Professional services include assessment and evaluation, counseling, and therapies that are aimed to improve, maintain, and maximize beneficiaries' abilities toward independent functioning and health maintenance.

Recommended by the Commission: Any contractor with applicable license, credential and/or certification applicable to professional services that is in good standing, including, but not limited to:
Solo practitioners or sole proprietors.
Agencies, including governmental agencies and non-profit 501(c)(3) organizations.

Contracted Health Home Care Coordination Organizations (CCO) associated with a Health Home Lead Entity that employs individuals with the applicable license, credential, or certification.

Any evidence-based program (EBP) provider that is licensed and credentialed. Fidelity to EBP must be verified at the time of contracting.

- **Pros**: Likely includes the greatest number of providers with fewest barriers to participation

Additional options considered by the workgroup but rejected:

- Same as the option recommended, but the contractor must also have at least one year of experience.

Appendix A: Long-Term Services and Supports Trust Commission Members

Senator Karen Keiser (D)
Representative Paul Harris (R)
Senator Judy Warnick (R)
Representative Frank Chopp (D)
Representative Nicole Macri (D)
Senator Steve Conway (D)
Senator Curtis King (R)
Representative Bryan Sandlin (R)
Secretary Jilma Meneses Department of Social and Health Services
Commissioner Cami Feek Employment Security Department
Taylor Linke Health Care Authority
Madeleine Foutch Representative of a union representing long-term care workers
Ruth Egger Individual receiving LTSS (or designee or representative of consumers receiving LTSS)
Andrew Nicholas Worker who is paying the premium (or will likely be paying the premium)
Rachel Smith Representative of an organization of employers whose members collect the premium (or will likely be collecting)
John Ficker Adult Family Home providers representative
Laura Cepoi Area Agencies on Aging representative
Peter Nazzal Home Care Association representative
Michael Tucker Representative of an organization representing retired persons
Lauri St. Ours Representative of an association representing skilled nursing facilities and assisted living providers
Mark Stensager Recipient of LTSS (or designee or representative of consumers under the program)

Appendix B: Office of the State Actuary Report on WA Cares Fund Solvency

See The Office of the State Actuary report on WA Cares Fund solvency

Appendix C: WA Cares Fund Risk Management Framework

See WA Cares Fund Risk Management Framework

Appendix D: Milliman Actuarial Analysis & Plan Design Change Analyses

Milliman's Plan Design Change Analysis can be found at: https://leg.wa.gov/osa/additionalservices/Pages/WACaresFund.aspx

1. "**2022 WA Cares Fund Actuarial Study**": Milliman's update to the 2020 study to refresh underlying modeling assumptions and reflect more up-to-date program parameters

   https://leg.wa.gov/osa/additionalservices/Documents/Report01-2022WACaresFundActuarialStudy.pdf

2. "**Potential Program Changes with Portability of Benefits**": Milliman's modeling of alternative program packages to assess feasibility of adjusting the program to feature portability of benefits.

   https://leg.wa.gov/osa/additionalservices/Documents/Masselink16-2023PortabilityPackagedModelingRequests.pdf