Little Hoover Commission
Testimony by
Charles Reed
August 26, 2010

Twenty Five years ago Washington State's Long-Term Care System looked pretty much like the rest of the United States. Those in need of long-term care services were served primarily in nursing homes at a cost that was straining the state budget. Many of those served in nursing homes would have preferred some other some less structured setting to have their long-term care needs met but these setting were not accessible or simply just not available. Unfortunately this is still the state of long-term care services in most places around the country. It is not the case in Washington State.

The Washington State Long-Term Care System is now recognized as one of the most "balanced" long-term care systems in the county. What brought this change about was the decision made in Washington State to focus on consumer choice to drive the long-term care system. A set of core values was developed to drive the planning, development and operation of the Washington State Long-Term Care System.

We have found in Washington State that if you give long-term care consumers what they want, you will probably save money. If Washington State had not reformed its' long-term care system it is projected there would be over 24,000 Medicaid eligible people living in Nursing Homes, instead there are less than 13,000.

Core Values for a Good Long-Term System

1. Persons with disabilities and their families are entitled to maximum feasible choice/participation in selecting care settings and providers.

2. Persons with disabilities have the right to expect "quality of life" personal dignity, maximum feasible independence, health security and quality of care.

3. Persons with disabilities have the right to choose and /direct a care plan involving "managed risk" in exchange for the advantages of personal freedom.

4. The array of public services options and individual client choices may be bonded by reasonable considerations of cost effectiveness.

These values were important in working toward a balanced long-term care system to meet consumer's needs. However, it was also important to operationalize the values and develop the functions that allowed for the balancing of the long-term care system.

What it takes to have a good State Long-Term Care System

Beliefs

A clear vision that consumer choice should drive the long-term care system.

A belief that quality of life is as important as quality of care.

A belief that no one service is more important than another. The most important service is the one the consumer wants and needs.

Functions

A single organizational unit in state government to plan, develop, and operate the long-term care system.

A single budget with flexibility and authority to spend on a varied array of long-term care services to meet consumer needs and preferences.

A single point of entry with a fast, timely and standardized way to assess financial and functional eligibility, authorize needed services and collect data to manage the long-term care system.

A case management system with capacity to provide assistance and oversight for consumers.

A fair rate setting and contracting process for providers.

A process for assuring quality oversight throughout the system.

A well organized, articulate, sophisticated group of consumers/families and providers who advocate for the long-term care system.

A process for resource development that meets consumer demand.

In Washington State these functions are located in one single place in State Government. This is the place that is held accountable by the Governor, the legislature and the public for the planning, development and operation of the state's long-term care system. Having all of these functions in one place in state government is perhaps the key factor that has allowed the State of Washington to have one of the most balanced long-term care systems in the country.

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Core Values For a Good Long Term Care System

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- Persons with disabilities have the right to expect “quality of life”, personal dignity, maximum feasible independence, health, security and quality of care.

- Persons with disabilities have the right to choose and/direct a care plan involving “managed risk”, in exchange for the advantages of personal freedom.

- The array of public service options and individual client choices may be bonded by reasonable considerations of cost-effectiveness.

Three Tenets of a Balanced LTC System

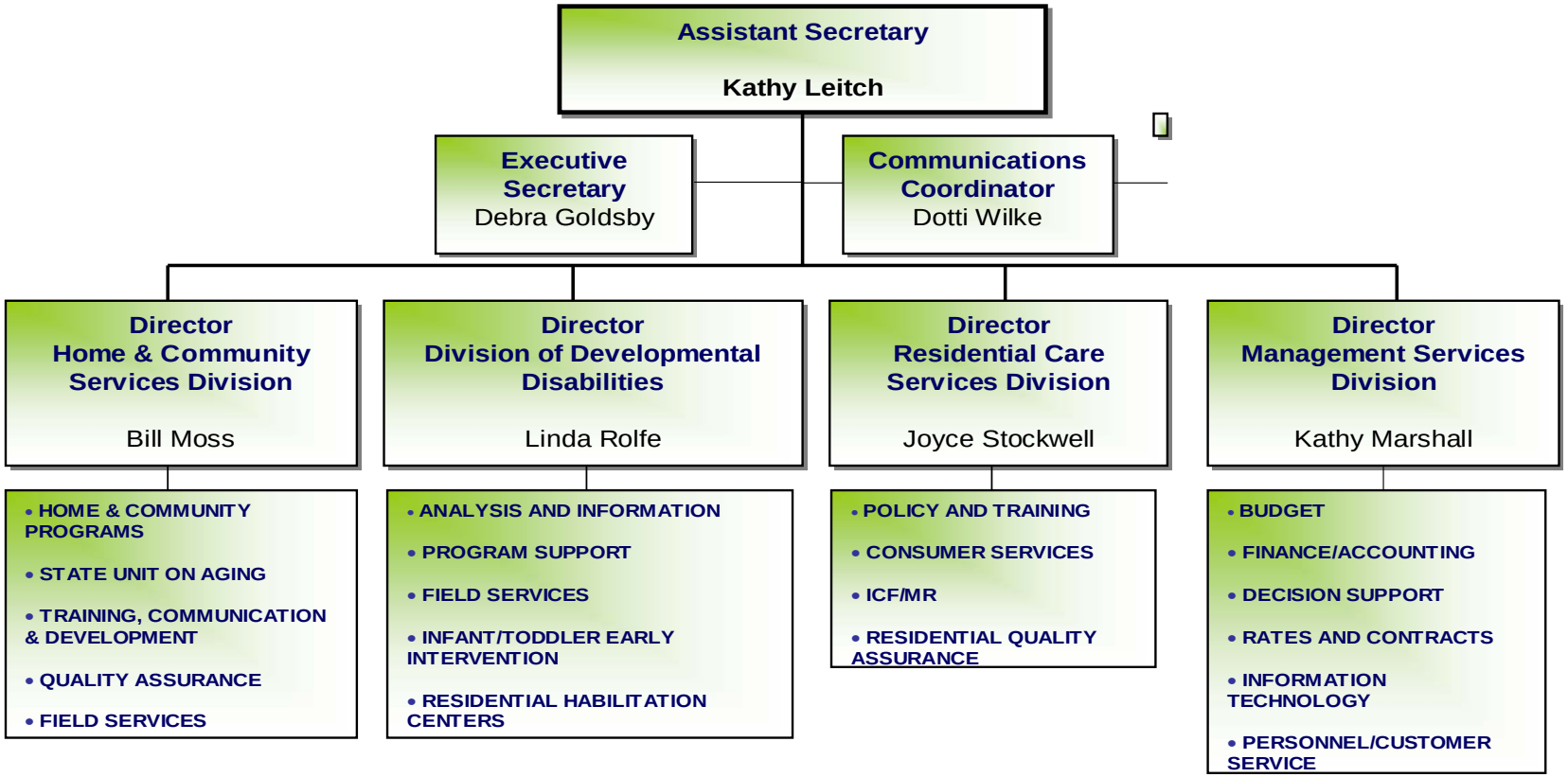
No One Service is Most Important

- Washington provides an array of services– the most important service is the one the client needs .
  - Nursing home
  - Adult family home
  - Boarding home
  - Assisted Living
  - Personal care in-home
  - Supportive services such as adult day health, respite, client training, skilled nursing, home delivered meals, etc.

Washington's LTC system

- Supports family caregivers as primary resource for long term care
- Consolidates a full array of options: in-home, community residential, nursing home
- Controls & coordinates entire LTC budget (nursing home, home & community, AOA/AAA funding)
- Controls and coordinates residential care QA and regulatory compliance

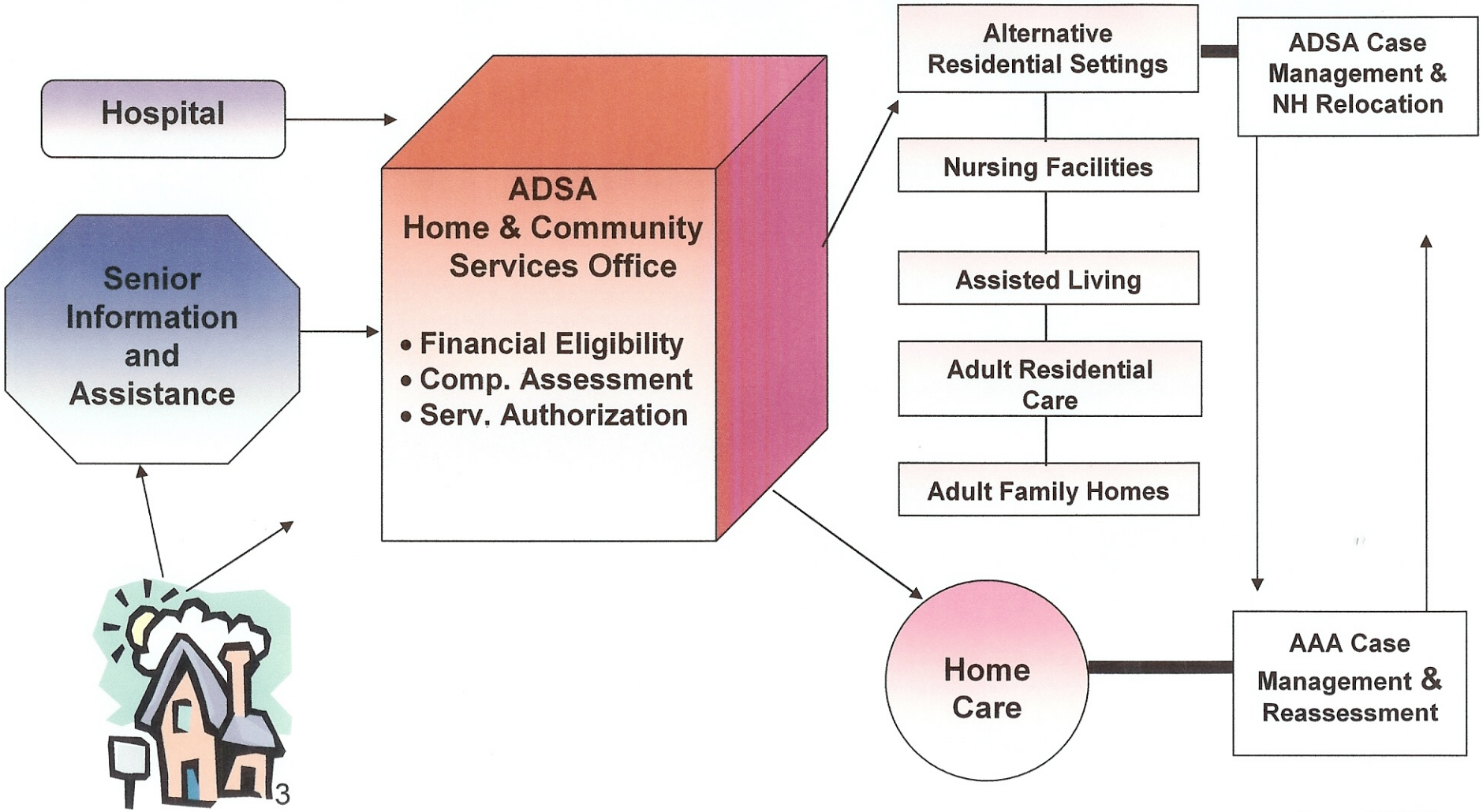
The ADSA Organization



ADSA

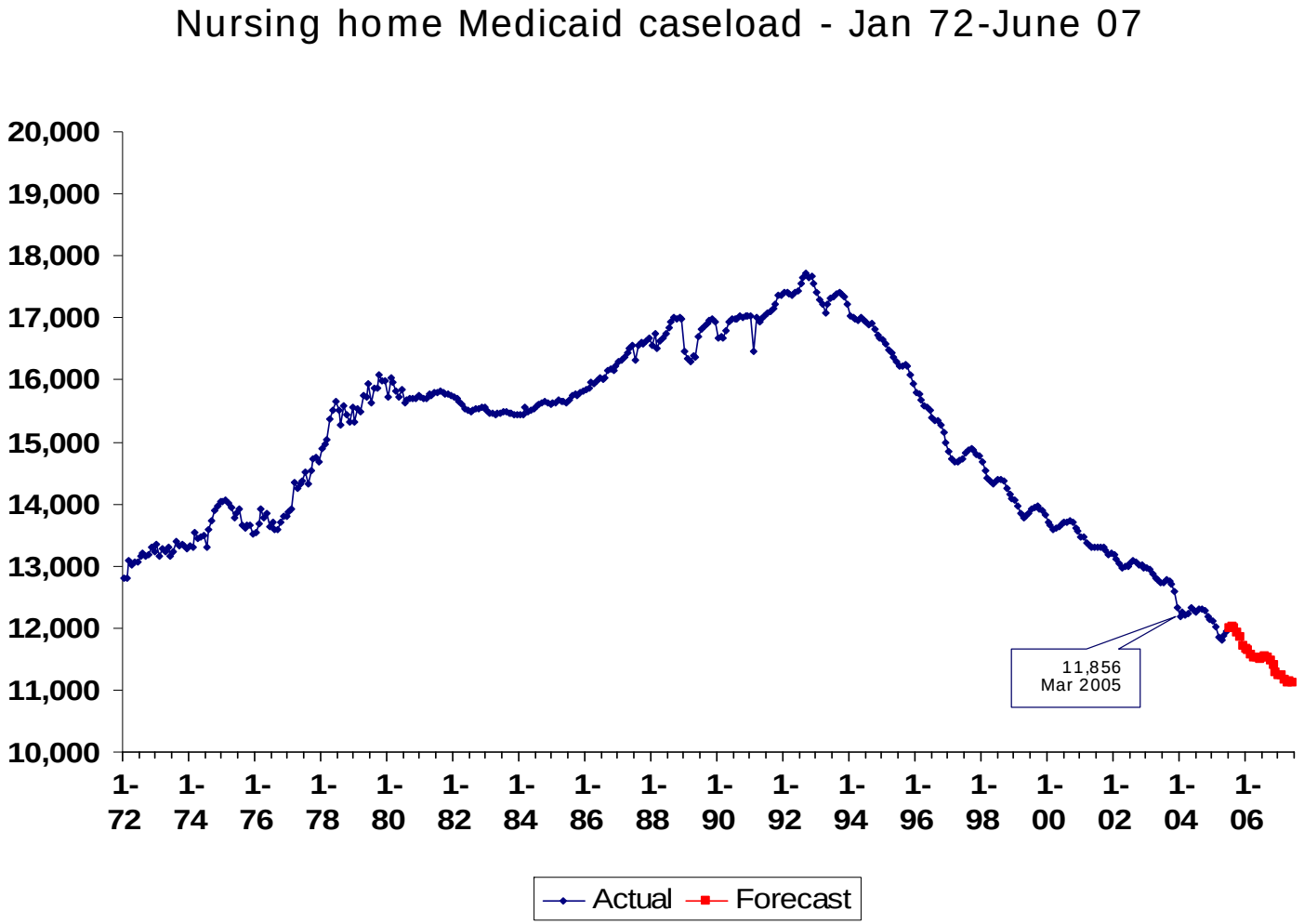
Washington State
Department of Social and Health Services
Aging & Disability Services Administration

The LTC Delivery System



August 2003

The Medicaid nursing home caseload continues to reduce as a result of efforts to offer home and community services



SOURCES: Actuals - MMIS; Forecast – CASELOAD FORECAST COUNCIL

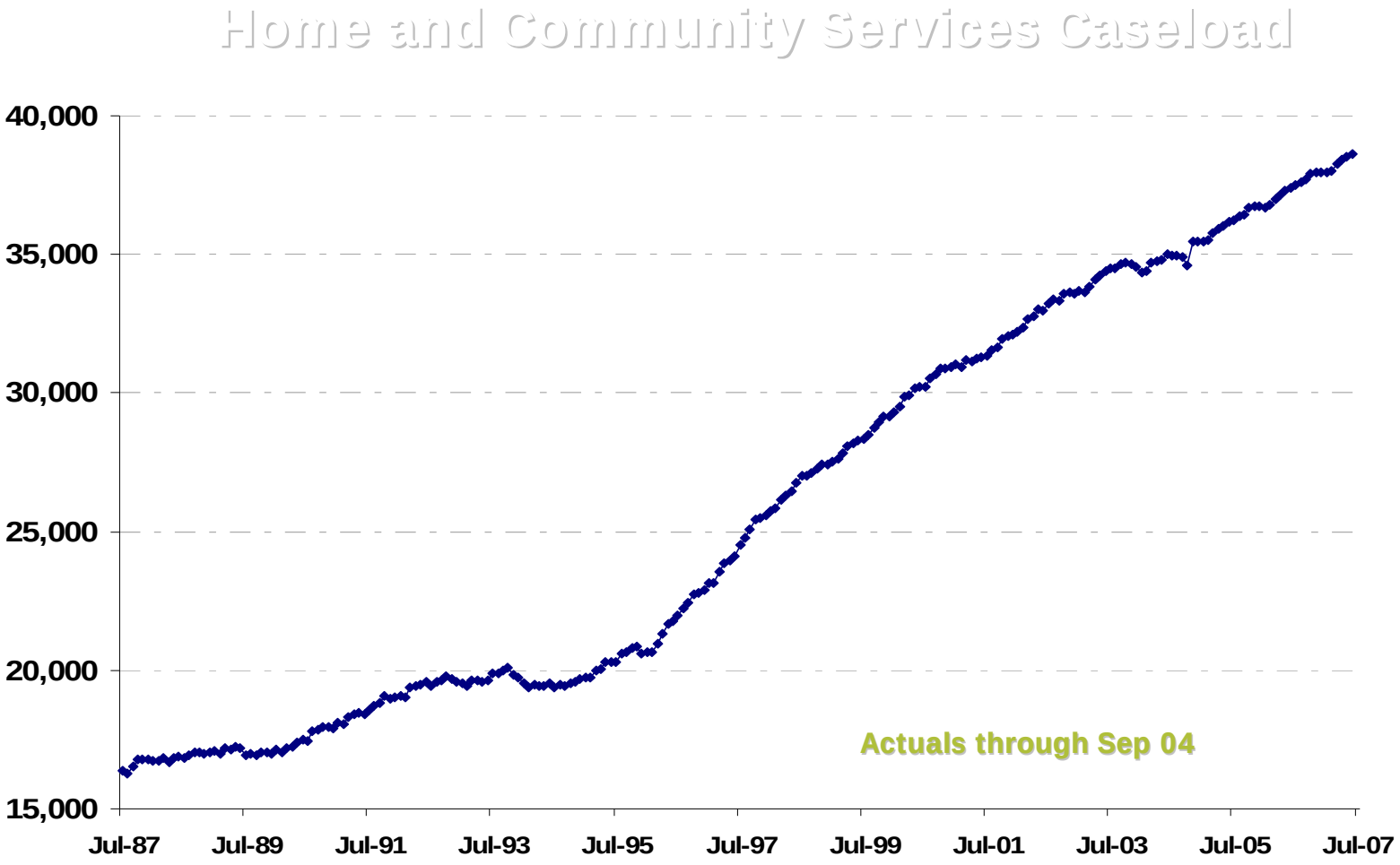
- Avg monthly cost per case for nursing homes is $3,505
- Avg monthly cost per case for community services is $1,155
- March 2006 caseload 11,649

SOURCE: EMIS Sep 2005

GOAL:

- Goal for nursing home caseload is 11,505 for June 06, 11,127 for June 07

Washington's LTC System



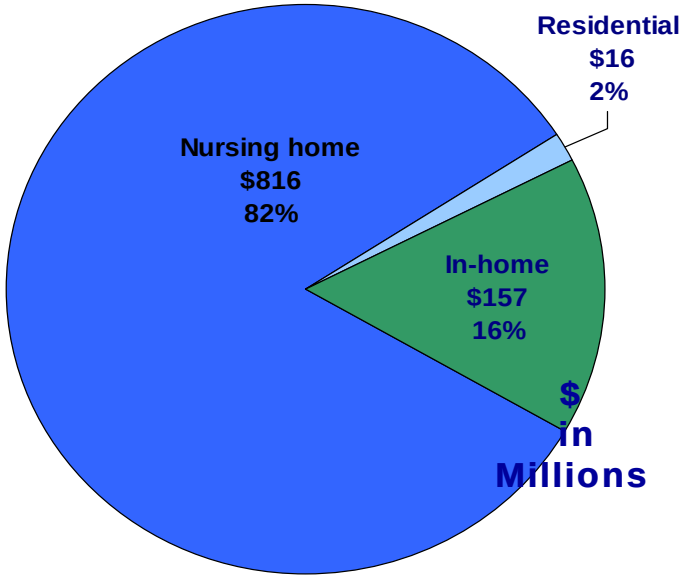
Give Consumers what they want and it will probably save money.

- Over the past 12 years, Washington LTC reform policy encouraging development of client-preferred home and community based options has resulted in an annual reduction of 401 clients per year in nursing homes and allowed community placements to increase by an annualized caseload of 1,309 clients.
- If Washington had not reformed its' LTC system it is projected that the NF caseload today would be over 24,000 instead it is less than 13,000

- An additional 14,000 consumers have been served in HCBS settings.
- The cost to serve this increased HCBS population has been paid in large part with savings from the nursing home budget.

Medicaid long term care expenditure shift resulting from efforts to expand home and community services

1991-1993 biennium

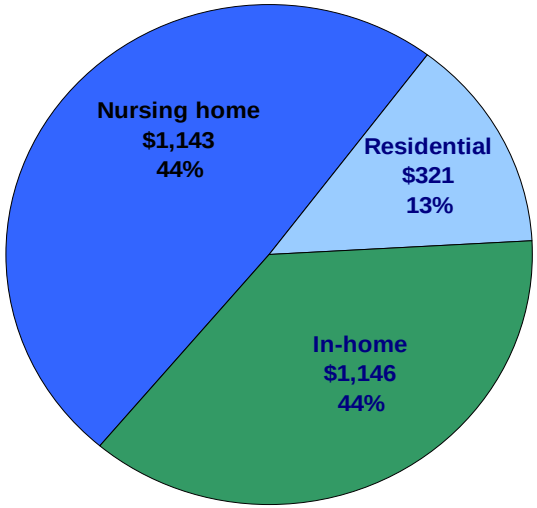


$ in Millions

Total = $989,000,000

Caseload of all services approx 38,000

2005-2007 biennium



Total = $2,517,000,000

Caseload of all services approx. 47,000

SOURCE: ADSA BUDGET OFFICE Aug 2005

What it takes to have a good State Long-Term Care System.

- A clear State Vision that consumer choice should drive the long-term care system.
- A belief that quality of life is as important as quality of care.
- A belief that no one service is more important than another. The most important service is the one the consumer wants and needs.

The Ideal State Long-Term Care System

- A single organizational unit in State Government to plan, develop and operate the long-term care system.
- A single budget with flexibility and authority to spend on a varied array of long-term care services to meet consumer needs and preferences.

- A fast, timely and standardized way to assess financial and functional eligibility.
- A case management system with capacity to provide assistance and oversight for consumers.
- Fair rate setting and contracting process for providers.

- A process for assuring quality oversight throughout the system.
- A well organized articulate, sophisticated group of consumers/families and providers who advocate for the long-term system.
- ***A process for resource development that meets consumer demand***

The History of Long Term Care Balancing in Washington State 1981-2005

For more information contact:
Kathy Leitch, Assistant Secretary,
Aging and Disability Services Administration
Department of Social and Health Services (360) 902-7797

1981 Long-Term Care System Development Project

Funded by a federal DHHS grant, DSHS established a long-term care task force of all the departmental offices involved in long-term care. The task force was organized in response to

(1) a rapidly growing demand for publicly funded long-term care services,
(2) fragmented and inadequate community alternative services, and
(3) the growing costs of providing institutional care which were increasing disproportionately to the overall economy.

Results of the project included the CARES pre-admission screening model of Medicaid community-option waivers, expanded case management services, and a better-coordinated delivery system based on individualized assessment and care planning.

The Chore Program was restructured to eliminate non-essential services and tighten income eligibility levels. As a result, over 4,000 clients were dropped from the program. In lieu of the full Chore Program, funding was made available for a Volunteer Chore program administered by the AAAs.

1982-1983 Pre-admission Screening and Assessment Model Adopted

Washington adopts the Comprehensive Adult Resources Evaluation System (CARES), a pre-admission screening and assessment model. CARES provides a multidisciplinary assessment of the strengths and needs of persons at risk of entering a nursing home or other residential setting. The goal of the assessment is to develop a recommended service plan which best matches the clients' needs with available services.

1983 Public Hearings on Long-Term Care

Public hearings co-sponsored by the House Social and Health Services Committee and the State Council on Aging. The hearings were intended to provide state policy-makers with local perspective on perceived problems and potential improvements in the state's long-term care service system. Public testimony provided substantial support for respite care, resulting in a legislative initiative for a respite care demonstration. Results also provided evidence of growing understanding and support for case management as a crucial element in the long-term care system.

1983 COPES Waiver

DSHS granted a home and community-based care Medicaid waiver from the federal Department of Health and Human Services. The waiver program, dubbed COPES (Community Options Program Entry System), offers in-home personal care, congregate care, adult family home care, and case management services to persons who would otherwise require care in a skilled or intermediate nursing care facility.

1984 Respite Care

Legislature authorized three respite care demonstration projects. Respite services provide temporary care of disabled adults, and give caregivers a break from the physical, psychological and financial demands of continuous care.

1984 Long-Term Care Planning Group

DSHS transforms Long-Term Care Systems Development Project Task Force (see 1981) into on-going Long-Term Care Planning Group (LTCPG).

1984 DSHS Long–Term Care Policy

DSHS adopts Long-Term Care Policy recommended by the LTCPG. Policy calls for expansion of home and community-based care in conjunction with reduced emphasis on nursing homes.

1984 Nursing Home Bed Need Target Revised

The State Health Coordinating Council amended the State Health Plan to revise the nursing home bed need target downward from 60.2 beds/1000 persons age 65+ to 53.7 beds/1000. The revision was intended to promote development and funding for home/community care programs. Nevertheless, 900 new beds were allowed from 1984-1987.

1985 Public Hearings on Long-Term Care

Public hearings on long-term care were co-sponsored by the Senate Human Services and Corrections Committee, House Social and Health Services Committee, and the State Council on Aging. Results of the hearings underscored the need:

- For a statutory base for long-term care providing a clear policy direction for the implementation of a comprehensive and cost-effective system of services;
- To support family caregivers in order to prevent burn-out and also counter the potential for elder abuse;
- To expand case management services to keep pace with the growing need for long-term care;
- For maximizing independence and utilizing community-based services

1986 Statewide Adoption of Case Management Standards

These standards describe case management provided by state field staff and aging network staff and how these entities will work together. Statewide standards and implementation established a foundation on which to build a comprehensive and coordinated service delivery system.

1986 Creation of Aging & Adult Services Administration (AASA)

Activities formerly performed by the Bureau of Aging and Adult Services and Bureau of Nursing Home Affairs are combined into the Aging and Adult Services Administration. This significant change in administrative structure meant that, for the first time, one administrative entity was responsible for the full array of services available to meet long-term care needs including in-home services, community residential services, and nursing homes.

1989 Significant Legislative Developments

- Title XIX Personal Care approved
- Statewide Respite Program enacted
- Mental Health decentralization mandated (RSN system)

1989 Nursing Home Bed Need Target Revised

The State Health Coordinating Council proposed and the Governor approved an amendment revising the nursing home bed target downward from 53.7 beds/1,000 persons age 65+ to 45 beds/1000. The revision is intended to promote development and funding for home/community care.

1989 DSHS Strategic Plan for Long-Term Care

The DSHS Long-Term Care Policy Group conducted a strategic planning process and prepared a report, Long-Term Care in Washington State: Critical Issues and Strategies.

1992 Assisted Living Emerges as Major New LTC Option

Both the private sector and AASA promote development of Assisted Living as cost-effective alternative to nursing home care. A national association is formed to assist in developing standards that emphasize personal dignity and autonomy associated with individual living space.

1992 State Budget Crisis Threatens LTC Progress

Faced with the need for major human services budget cuts, Governor Gardner supports AASA proposal to offer relocation assistance to nursing home residents who would prefer to receive services at home or in community-based residential settings. Part of the resulting nursing home budget savings would be used to offset the budget shortfall. The remainder would enhance home and community-based LTC options.

1993 Legislature Enacts Community Options Program

New state law articulated state policy favoring the development of home/community care for the functionally disabled, strengthened the nursing home certificate-of-need process, expanded the number of authorized Assisted Living units and provided modest enhancements for priority LTC service options.

1994 Legislature Calls for LTC Report

State statute required AASA to prepare recommendations on how long-term care programs could be restructured to better comply with cost growth limitations established under State Voter Initiative 601. The report, issued in Fall 1994 became the basis for the LTC Options Program enacted by the Legislature the following year.

1995 AASA LTC Options Program Enacted

State statute was passed limiting unnecessary nursing home utilization by diversion and voluntary relocation. Budget savings were targeted to satisfy I-601 spending limits and for investment to expand and improve home/community care. Case management was expanded and nurse delegation authorized in non-medical residential settings.

1996 AASA LTC Options Program Strategic Plan

AASA prepared a six-year strategic plan and related budget proposals premised on further expansion and quality improvement in home/community services. Planning assumptions include reducing Medicaid nursing home caseload from the 15,000 level in 1996 to the 12,000 level in 2003.

1997 Caseload Forecasting Council established

The legislature passed a final budget for AASA/LTC that was $38 million short of the Governor's budget. Controversy surrounded the caseload projections. AASA was forced to launch a regulatory process to raise the threshold of eligibility as a hedge against the odds of losing a bid for supplemental budget. In the end no eligibility changes were necessary and the legislature established a Caseload Forecasting Council that included executive representatives. The Council ushered in a new era of rational caseload projections and related budget planning.

1998 Oversight for boarding homes transferred to AASA/DSHS

Oversight responsibility for boarding homes was transferred from Department of Health to DSHS following three consecutive years of bad quality reports from the Ombudsman. The transfer was controversial. The Governor took the initiative following cases of client abuse surfacing during the tail end of the session.

1998 Washington moves to case-mix payment system for nursing homes

The 15,000-word statute codifying the cost-reimbursement nursing home payment system was amended to include a case-mix payment system.

1999 Self-directed care becomes an option

Legislation authorized the Self-Directed Care program allowing a person with a functional disability to choose to direct his or her own health related tasks through a non-licensed, paid personal aide.

2001 Expansion of Home/Community Care

Medically Needy waiver is authorized to expand Medicaid home/community care eligibility for clients with income above the SSI categorically needy standard. This expands access and controls costs for clients who otherwise have no alternative to nursing home placement.

AASA begins project to establish a rate structure for community residential rates based on the assessed needs of clients.

2001 Home Care Quality Initiative

Initiative 775 (Quality Home Care) was passed indicating strong public support for in-home care as an alternative to nursing home placement. Major issues include setting up the board of the new Home Care Authority, conducting an election for the workers, bargaining for wages and benefits and securing necessary funding.

2001 Quality Assurance for Home & Community-Based Care

AASA created a specialized QA unit to oversee LTC eligibility, client assessment, care planning and case management by HCS and AAA staff.

2002 DDD+AASA = Aging & Disability Services Administration (ADSA)

The DSHS Secretary mandated the merger of Aging & Adult Services Administration and the Division of Developmental Disabilities. The new organization, ADSA was expected to improve the planning, coordination and accountability of DD services.

2003 Revised LTC Client Assessment (CARE) is Implemented

The new CARE system, with revised content and improved automation features, passed through the pilot and training phase and statewide implementation was underway.

Start of project providing specialized dementia care in boarding homes for individuals who have been discharged from a nursing home.

As directed by the Legislature, ADSA changed functional eligibility for Medicaid Personal Care program and put steps in place to limit caseload growth for COPES waiver program to 1.1%.

ADSA begins development of Expanded Community Services program to more appropriately serve elderly and disabled individuals with mental health needs in less restrictive community settings. The state budget set a target for reduced state hospital usage for these individuals.

2003 Budget Constraints Drive Eligibility Cuts, New Program

As directed by the Legislature, ADSA changed functional eligibility for Medicaid Personal Care program and put steps in place to limit caseload growth for COPES waiver program to 1.1%.

ADSA begins development of Expanded Community Services program to more appropriately serve elderly and disabled individuals with mental health needs in less restrictive community settings. The state budget set a target for reduced state hospital usage for these individuals.

2004 Further expansion of home and community services

COPES waiver clients began to be authorized for nurse delegation in-home. By state law, nurse delegation had previously been allowed only in residential settings.

Waivers serving Medically Needy clients in-home and in residential settings opened during 2003-04

ADSA begins “Coming Home Program”, a collaboration with the Robert Wood Johnson Foundation and NCB Development Corporation to demonstrate the viability of creating modest assisted living facilities in small communities.

2005 Expansion of Chemical Dependency Treatment options for LTC clients

Budget moves $6.9 million from LTC budget to the budget for the division of alcohol and substance abuse, doubling the numbers of aged and disabled clients expected to receive chemical dependency treatment services. The additional services are expected to reduce medical assistance and LTC expenditures sufficient to offset at least 80% of the short-term cost of the service expansion.

2005 LTC Financing Task Force Established

State law establishes a joint legislative and executive task to review public and private mechanisms for financing long-term care.

Rebalancing Long-Term Care Systems in Washington: Experience up to July 31, 2005

Abbreviated Report

submitted to the

Centers for Medicare & Medicaid Services (CMS),
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CMS Project Officer, 4/15/2006 to present, Dina Elani

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The overall project 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. The 3-year study calls for case studies of the experience of 8 states—other states in the study are: Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, and Vermont. The baseline case study covers a period through July 31, 2005. Updates will be prepared for the period ending July 31, 2006 and 2007.

A slightly earlier version of this Abbreviated Report was presented for discussion at a CMS Open Door Forum, February 22, 2006. 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, Director of the Aging and Disability Services Administration (ADSA) in the Department of Social and Health Services, and Penny Black, who at the time this report was prepared was the Director of ADSA's Home and Community Based Services Division.

Rebalancing Long-Term Care Systems in Washington: Abbreviated Report

Highlights

The State of Washington has made outstanding progress towards a system of long-term care that maximizes choice and promotes community integration.[1] It has exhibited a steady commitment towards expanding HCBS services, dating back to the establishment of the state-funded CHORE services program in 1981. Among the highlights:

- A consolidated management structure where policy, implementation, and budget control are combined in a single governmental entity, the Aging and Disability Services Administration (ADSA). Initially, the ADSA focused on older people and people with physical disabilities, but recently services for consumers with mental retardation and developmental disability were integrated within ADSA. Funding for LTC is designated and managed in a single appropriation, giving ADSA the flexibility to adjust budgets according to programmatic needs (for example, expanding waiver services without seeking a supplemental appropriation).

- Credibility with executive branch and legislative officials by establishing a track record for reducing the nursing home census and producing regular reports that track caseloads and spending.

- Strong and consistent leadership at state and regional levels over decades of program development, and by a well-articulated vision for long-term care that is embedded in legislation and is widely understood and promulgated.

- A unique assessment and information system, which combines data about consumers and information on the service they receive. It is built on a modularized assessment that is entered electronically by case managers, and permits ready supervision and training of personnel, quality assurance, forecasting, and planning. This system, known as CARE (Comprehensive Assessment and Reporting Evaluation) has built-in algorithms for equitable care planning within and across consumer populations. CARE assessments are used to access not only waiver services but also Medicaid state plan personal care services and state funded services.

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[1] This abbreviated report is a synopsis of a much longer report on rebalancing long-term care systems in Washington, performed under contract between the University of Minnesota and CNAC Corporation through a Master Contract between CMS and CNAC. The full-length report, which contains organizational charts, timelines, references, and much more detail, appears on the website HCBS.org and on the University of Minnesota Principal Investigator's Website http://www.hsr.umn.edu/LTCResourceCenter/. Similar abbreviated and full case studies have been prepared for the States of Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, and Vermont. The case study covers a period up to July 31, 2005; subsequent reports will update the information as of July 2006 and July 2007.

- A well-developed capacity for personal care delivered by independent providers (IP). As a result of a ballot initiative in 2001, the state created a Home Care Authority, which is appointed by the Governor, is largely comprised of people with disabilities, and is a resource for both providers and consumers in the IP system. IP providers are vigorously represented by the Service Employees International Union (SEIU), and the workers, including those who are family members of the consumer, enjoy competitive wages and benefits.

- An array of residentially based services that are integrated into the HCBS programs, and has established innovative quality monitoring approaches for all residentially based services, ranging from nursing homes to small family homes.

- A fast-track system to facilitate access to HCBS services for all applicants, including potential consumers in hospitals.

At this point, the state's primary challenge is to maintain its relatively advanced stage of development and to make improvements in targeted areas, such as assisting people with DD to receive care in more integrated settings, managing the growth of the Independent Provider (IP) model of home care, investing in Information Technology, and better meeting the needs of consumers with mental illness.

Context

- The state legislature is well informed about long-term care. Numerous nurses and other health professionals have been elected to the legislature and serve on the Health Committee.

- The state has a tradition of bringing public policy issues directly to the voters through ballot initiatives. This has a mixed impact on LTC reform. For example, passage of Initiative 601 in 1993, limiting state spending to a three year rolling average of inflation and population growth, has hampered innovation. On the other hand, in 2001, the successful Initiative 775 approved formation of a Home Care Quality Authority and a union contract and wage levels for Independent Providers of home care services.

- In a rapid time period, the union representing Independent Providers has become an influential political force, rivaling the nursing home lobby in its power.

- Parents of consumers living in state institutions for mental retardation and developmental disabilities, combined with unions of state employees working in this sector, have slowed progress in transitions to the community for this population.

Real Choice Systems Change (RCSC) Grants

Washington received three RSCS change grants between 2001 and 2004, totaling 2,763,008.[2] The design of the projects all fit within Washington's larger scheme for enhancing consumer-direction, and bringing all populations needing service into a unified service system. Collectively, the grants explored cash and voucher options, adapted the assessment and care-planning tools used for seniors and people with physical disabilities so that they would be more appropriate for people with developmental disabilities, permitted work on a Quality Assurance/Quality Improvement Outcome Tool, and assisted in transitions both from nursing homes and State psychiatric hospitals. Collaboration with the State housing authorities was built into two of the projects. The Aging and Disability Resource Center, in the planning stages during our baseline case study and funded in October 2005, will be piloted in the Tacoma area, apply to all disability groups, involve independent living centers, expand the Comprehensive Assessment and Reporting Evaluation System to include state funded services, Benefit Checkups, and AOA funded services, and entail vigorous "social service marketing" to expand awareness of services in the State of Washington. Washington's own data systems will be utilized to examine the effectiveness of these measures.

Programs and Services

The bulk of services are authorized under 2 large HCBS waivers: the (COPES) waiver, established in 1983 for seniors and adults with physical disabilities; and the Community Alternatives Waiver, established in the same year for the MR/DD population, but eliminated in 2004 and replaced by 4 MR/DD waivers. The COPES waiver is managed by the Home and Community Services Division and DD waivers by the Developmental Disabilities Division.

Noteworthy Medicaid state plan and state-funded community LTC services include:

- The Medicaid State Plan Personal Care program, available for consumers who have an unmet or partially met need with at least three activities of daily living. A single entry point is used for state plan services and COPES services, which are managed in tandem. About 40% of personal care consumers under the state plan are under age 65.

- The CHORE program is a small personal care program funded by state general revenues and serving consumers not eligible for Medicaid personal care or the COPES waiver program. Enrollment in the CHORE program has declined recently and appropriations remain at FY 2001 levels.

[2] Awards included a Nursing Facility Transition Grant (Supported Transitions) in 2001, used to assist people under age 65 to leave nursing homes; a Real Choice System Change Grant ("Community Living Initiative") in 2002, which was used to design and implement a variety of systemic approaches across state agencies for Community Living Initiative, including enhancing training for community-direction, developing payment mechanisms, and developing a quality outcome tool; and Money Follows the Person Grant in 2003, which was used to develop assessment tools and interactive service plans for adults and children with developmental disability. In 2005, after the period covered in this baseline case study, Washington received an Aging and Disability Resource Center.

- The New Freedom Waiver, a 3-year pilot program (through September 2007) in King County (Seattle) and Clark County (Vancouver) is funded through a 'Cash and Counseling' infrastructure grant from the Robert Wood Johnson Foundation (with CMS match). Services began in 2005 and targets were for 100 enrollees by September 2005, 400 by September 2006 and 750 by September 2007. The program will offer consumers the opportunity to manage the full array of services purchased within their care plan and to purchase equipment and other goods related to their service needs.

Featured Management Approaches

CARE System for Assessment and Case Management

The Comprehensive Assessment and Reporting Evaluation (CARE) System, an exemplar of an investment in Information Technology to guide a long-term care system, illustrates how a good assessment and information system and investment in training field personnel in its use can inform every element of a state's LTC system. Motivated originally by a legislative directive to develop a new classification and payment methodology that bases payment for services to the consumer's needs, CARE has transformed the delivery and management of LTC services throughout the state and has resulted in a paperless, modular state-of-the-art assessment process. The CARE assessment tool includes all elements in the nursing home Minimum Data Set (MDS), along with other direct consumer assessments with the goal of permitting comparisons of client characteristics across programs and settings, including nursing homes.

After the assessment tool was tested for reliability and linked to a payment algorithm, CARE was implemented in 2003 with intensive training for assessors and case managers to accustom them to the use of laptops and pull-down menus. This approach forces case managers to take all relevant information into account during the assessment and prevents assessors to proceed if fields that should be complete are blank. A time study was performed that connected hours of service use and client characteristics and Resource Allocation algorithms that allow for an automated assignment of a base number of hours. Separate Resource Allocation algorithms are used for residential settings, such as adult family homes, enhanced adult residential care, and assisted living. The CARE tool is currently also used with individuals with DD who are receiving Medicaid state plan personal care services and is being modified for consumers with DD who receive waiver services. When that process is complete, all care planning and allocation of resources will be incorporated into CARE.

Access Management

Access to services is managed through a large network of state regional field offices where financial and functional assessments are consolidated. The CARE tool determines functional eligibility and the decision-making built into the tool prepares a care plan and assigns the individual to one of 14 tiers based on the number, type and scope of unmet needs. Although case managers may over-ride those allocations, the intent of the computer algorithm is to promote equity in resource allocations and remove unconscious human bias. If eligible, applicants choose the setting and services that are appropriate based on the findings from the assessment. The case manager prepares the authorization and arranges services. Consumers who receive care in a residential setting or a nursing home continue to receive case management from an ADSA social

worker or registered nurse. Ongoing case management for in-home consumers, apart from the MR/DD waiver system, is the responsibility of the Area Agencies on Aging (AAAs). The ADSA allocated $36 million in 2005 to AAAs for ongoing case management for in-home COPES and Medicaid Personal Care State plan clients. AAAs receive $1,100 a year per consumer for case management services. ADSA reviews payment system data to enumerate the consumers who received an authorized service and determine the monthly payment for case management. Presently, ADSA is working to modify algorithms and incorporate MR/DD waivers into the CARE system.

Fast Track Eligibility

The Aging and Disability Services Administration (ADSA) developed procedures to expedite financial eligibility determinations. Care managers are permitted to "presume" Medicaid eligibility for in-home and residential services for adults with disabilities and elders who are being discharged from hospitals. If financially eligible, the case manager completes an assessment and service plan and authorizes services for 90 days. Moreover, because Federal Financial Participation is not available for services delivered to applicants who are not eligible for Medicaid, state funds are used to pay for services in the few instances in which the applicant is found ineligible. State officials believe that the financial risk due to errors is limited compared to the savings realized by serving a person in the community. The state believes that it has achieved substantial savings because of these policies. Applications from individuals living in the community (as opposed to those in hospital) may also be expedited. Applications are taken over the phone, by mail or during a home visit by the eligibility worker. The expedited process has reduced the average time required to make decisions from 37 days to 17 days. ADSA does not receive federal reimbursement for services that are delivered to beneficiaries who are falsely presumed to be eligible, but the error rate in this fast track system has been less than 1%.

Nursing Home Transition

In 1995, the ADSA re-assigned case managers from hospitals to each nursing home in the state to work with residents who are interested in relocating; recognizing that most people discharged from a hospital needed a short-term rehabilitation stay before they could return home. Each transition case manager is responsible for working with about 100 residents in 2-3 facilities during the relocation process.

Case managers contact all nursing home residents who have been admitted from a hospital within seven days of admission to the nursing facility to inform them of their right to decide where they will live and discuss their preferences, likely care needs, and service options. Individuals admitted from a community setting who are Medicaid beneficiaries, or are likely to become a Medicaid beneficiary within 180 days, receive a preadmission assessment and options counseling. A full comprehensive assessment is completed when the resident expresses an interest in moving to the community. The case manager then develops a transition plan with the consumer.

Lack of funds for housing and transition services is a recurring barrier for nursing home residents to maintain an existing independent living arrangement during a temporary nursing facility stay, to relocate from a nursing home to a less restrictive residential setting, or to establish an independent residence. In response, Washington now covers such services under the

waivers, tapping several sources of funds, including the Medical Institution Income Exemption Fund (MIIE), Community Transition Services (CTS), the Residential Care Discharge Allowance, the Civil Penalty Fund, the Assistive Technology Fund, and a Real Choice Systems Change Transitions Services grant.

Independent Providers and Home Care Quality Authority

By 2004, over half of all consumers of in-home LTC received services from independent providers. Individual providers in Washington are represented by the Service Employees International Union (SEIU) as a result of the passage of a referendum that also established the Home Care Quality Authority and bargaining rights for individual providers.

The Home Care Quality Authority (HCQA) was created by Initiative 775 in 2001 and state legislation in 2002 to improve the quality of long-term in-home care services by recruiting, training, and developing a worker registry and by stabilizing the work force of individual providers through collective bargaining. HCQA has a nine member board and an executive director. In its first two years, HCQA helped improve the wages and benefits of the independent providers and developed a Registry to help match potential workers with consumers.

HCQA contracts with local organizations to operate and maintain Referral and Workforce Resource Centers to help consumers find individual providers. The Centers maintain a database of individual providers who have passed a background check. Consumers can search for workers based on their needs, preferences, geographic location, language, and worker qualifications.

The HCQA also developed an application form and interview guidelines to help consumers find prospective workers. For IPs, the HCQA developed training manual and a safety manual as well as information about peer mentoring, professional development, responsibilities to the consumer "employer," and providing personal assistance. Independent providers must have a signed contract with ADSA and meet with the case manager to review the service plan before they can be reimbursed for providing services.

Quality Assurance and Improvement

ADSA utilizes innovative quality assurance and quality improvement approaches in nursing home, residential and in-home settings. The parameters of its quality assurance program are described in statute, which mandates the system be client-centered and promote privacy, independence, dignity, choice, and a home or home-like environment for consumers and establishes the goal of continuous quality improvement.

The CARE system is integral to the quality assurance program. CARE data are used to generate a wide range of reports on the quality of in-home LTC services that allow supervisory and management staff to review and compare care plans, validate authorizations against care plans, monitor assessment and reassessment dates, maintain an accurate list of the number of consumers in each setting and ensure that case managers are making referrals for nursing services and responding to high risk consumers. Managers can compare the clinical and other characteristics of consumers across in-home and residential settings. Data can be sorted by case manager, supervisory unit, field offices, region, and statewide. The data allows ADSA managers to examine consistency in and completeness of the assessment and ensure compliance with the

assurances contained in the waiver. Managers reported that they use the data to identify and quantify costs savings, cost avoidance and issues that may indicate a need for further training.

ADSA is also responsible for oversight and quality in residential settings. Responsibility for licensing and oversight of boarding homes was transferred from the Department of Health to ADSA in 1998. The Residential Care Services Division (RCS) was established to promote and protect the rights, security and well-being of individuals living in licensed or certified residential care facilities (boarding homes, adult family homes, nursing facilities, supported living services programs, and ICF-MRs).

RCS uses separate regional staff for nursing home and boarding home/ALF inspections to allow more specialization. However, field managers cover all three settings to improve an understanding of regulatory framework. RCS has authority to impose a range of intermediate sanctions. However, the ban on admissions has been the most effective. RCS issues a press release to publicize the survey findings and remedies. Similar remedies are used for AFHs. Placing conditions on the license is the most often used remedy for AFHs.

RCS provides consultation to nursing homes to improve compliance and quality. Quality Assurance Nurses visit nursing homes quarterly to review quality indicators e.g., the frequency of pressure sores. The nurse meets with the provider if they identify a problem area, discuss the problem area and suggest steps to address the problem, including a referral to the facility's quality assurance committee. A similar process was available to boarding homes but had to be dropped in 2003 because of a lack of funding.

Caseload Forecasting

Budgets for long term care services in Washington are based on caseload forecasts prepared by an independent Caseload Forecasting Council. The Council projects and adjusts the expected caseloads for nursing home and home and community based service programs for elders and adults with physical disabilities. The council consists of two individuals appointed by the governor and four individuals who are appointed by the House and Senate leadership. A member of the legislature chairs the Council. The forecast is submitted to the legislature and becomes the basis for determining the Governor's budget for nursing home spending, home and community services programs and case managers and is used by the legislature to develop the budget. Projections are based on historical trends and changes in policy that affect eligibility or the amount of services that may be authorized. Caseloads are projected for each month of the biennium.

Quantitative Markers of Rebalancing

Changing Patterns in Nursing Home Use as Marker of Rebalancing

To assess the potential effect of HCBS on nursing home use, we examined the MDS data on all Washington nursing homes for the years 2002, 2003, and 2004. We reasoned that if HCBS was having an effect, the case mix in nursing homes should become higher, i.e., the level of disability (both functional and cognitive) should increase. Because nursing homes serve at least two streams of clients, one requiring post-acute care (PAC) after discharge from hospitals and

the more traditional long-term resident, we examined the case mix at two points in time: admission and three months after admission. The former would include the PAC population, but the latter should be a more direct reflection of long-term care that HCBS was intended to defray.

Table 1 shows the changes in the NH case mix on admission and 3 months after admission for 2002, 2003, and 2004. The latter is a better test of the long-term care population. Between 2002 and 2004, the functioning level of elders admitted to NHs in WA deteriorated slightly from the average ADL score of 14.67 in 2002 to an average ADL score of 15.26 in 2004 (the possible score of the ADL variable is between 0 and 24: a higher score means higher ADL dependence). During the same period of time, the cognitive functioning of elders admitted into NHs improved slightly. The average CPS score went down from 1.87 in 2002 to 1.76 in 2004 (the possible score for CPS is between 0 and 6: a higher CPS score means lower cognitive functioning). Moreover, the rate of persons with no cognitive impairment or mild impairment increased.

Table 1: Change in Nursing Home Acuity at Admission and 3 Months Post Admission in Washington, 2002-2004

	2002	2003	2004
At Admission			
Mean ADL	14.67	15.05	15.26
Mean CPS	1.87	1.81	1.76
3 Months Post Admission			
Mean ADL	13.99	14.05	14.32
Mean CPS	2.63	2.58	2.52

The ADL functioning at 3 months after admission deteriorated slightly between 2002 and 2004. The average ADL scores in 2002, 2003, and 2004 were 13.99, 14.05, and 14.32 respectively. However, the proportion of persons with no ADL dependencies did not change appreciably, although the rate for few dependencies did go down. For cognitive functioning, the CPS scores improved slightly between 2002 and 2004. The CPS score in 2002 is 2.63, dropped slightly to 2.58 in 2003 and further dropped to 2.52 in 2004. Moreover the proportion with no cognitive impairment increased.

Balance Between Institutional and Community Care

Figure 1 shows the average monthly enrollment of clients for each of 5 years, 2000 to 2004. (This presentation is different from that used for most of the state reports in this series. The numbers of clients tracked here are reported as client-years, i.e., they are converted to full year equivalents. Because it counts fewer beneficiaries, it raises the average cost per beneficiary. Care should thus be taken in comparing this measure across states.) The Senior and Disabled Waivers, which include the COPES waiver, the Medically needy Residential Waiver (begun in 2003) and the Medically Needy In-Home Waiver (begun in 2004), serve the largest numbers of persons, more than twice as many people as are in nursing facilities, a number which is declining. The number of persons served under the personal care program of the State Medicaid Plan is also growing rapidly; this program includes both aging and disabled participants and consumers with MR/DD. The MR/DD institutions are comprised of both the state habilitation centers (which house about 1000 people) and a small number of people in ICF/MRs.

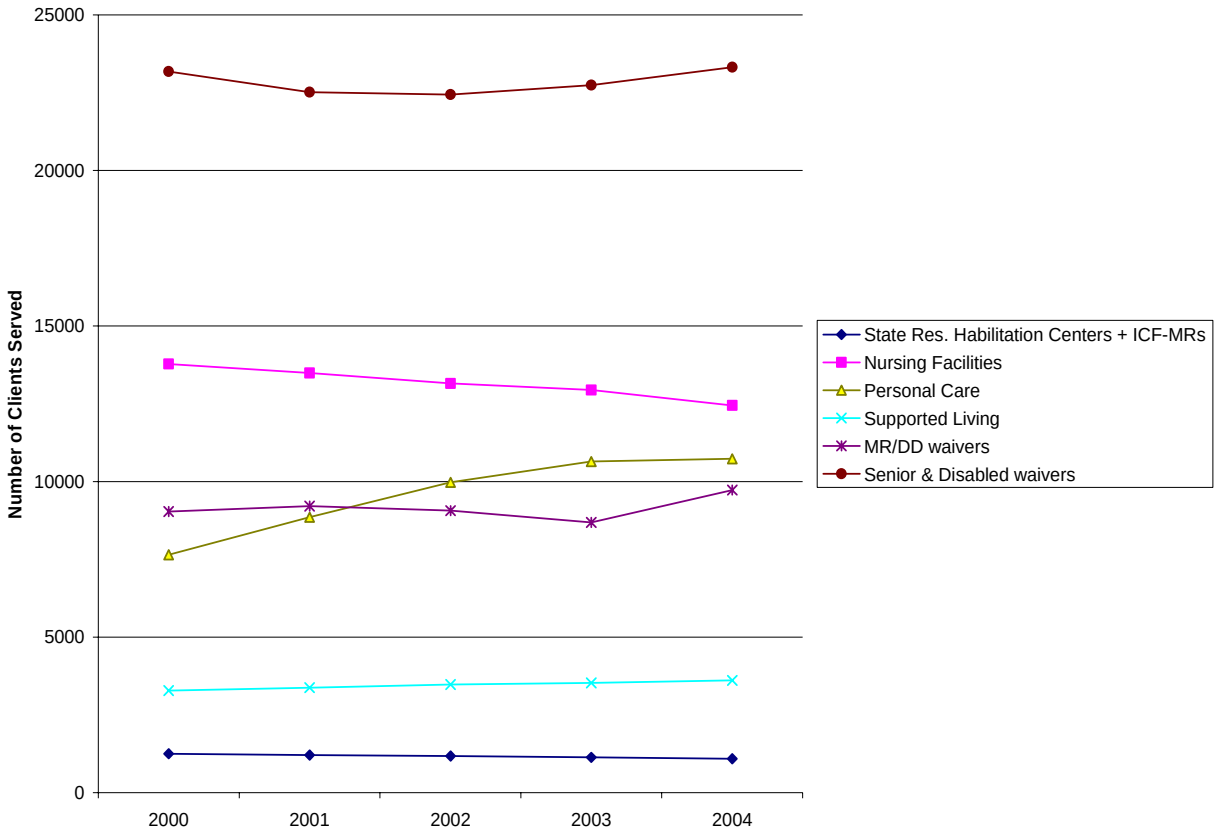

Figure 1. Clients Served in Selected Washington Programs, 2000-2004.

Figure 2 shows the annual Medicaid expenditures for these same programs. MR-DD waivers, supportive living, and personal care under the State Medicaid Plan show the greatest growth. Senior and Disabled waivers (the COPES Waiver and the 2 Medically Needy Waivers) show growth in 2004, but the nursing home expenditures also grew. State Residential Rehabilitation Centers and MR/ICFs combined were stable.

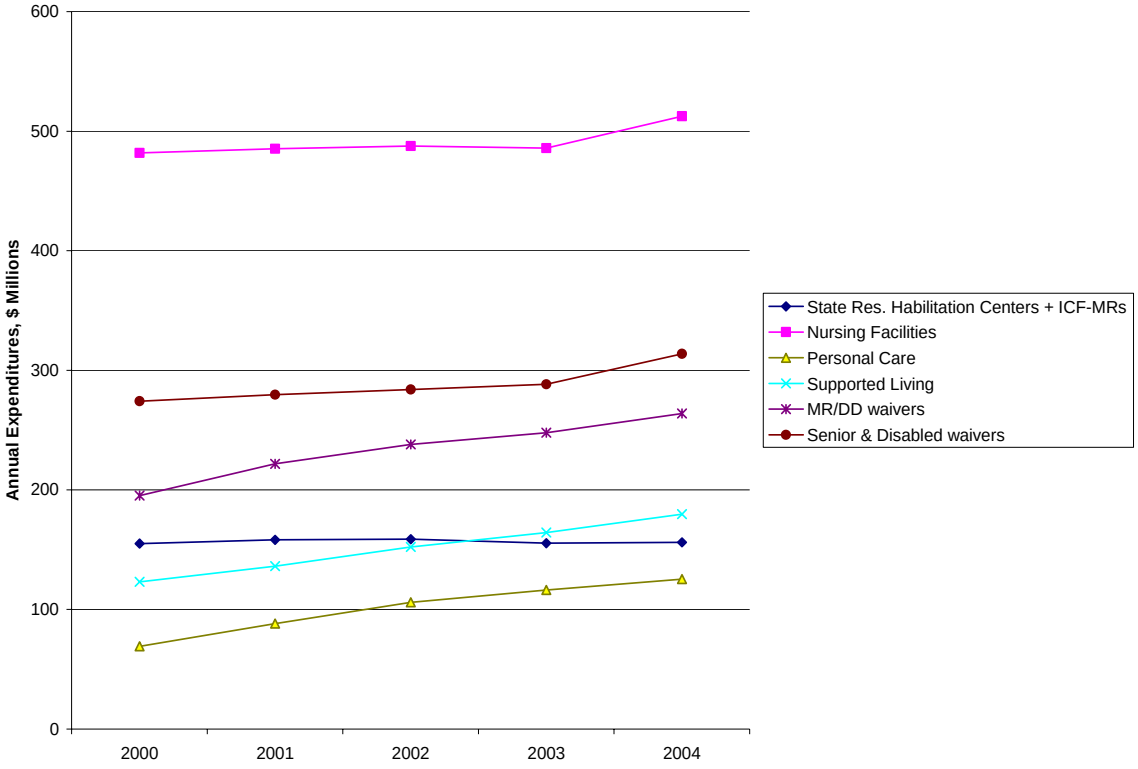

Figure 2. Expenditures for Selected Washington Programs, 2000-2004.

Figure 3 shows the Medicaid expenditures per client served by major programs over the five year period from 2000 to 2004. The small numbers of persons served in the remaining MR/DD institutions (largely the state rehabilitation centers) generated high and growing costs per client. Supportive living also showed substantial growth. MR-DD waiver costs per client costs grew until 2003 and then fell slightly. Costs per consumer in the MR/DD waivers still remained way above costs per consumer in the Senior and Disabled waivers.

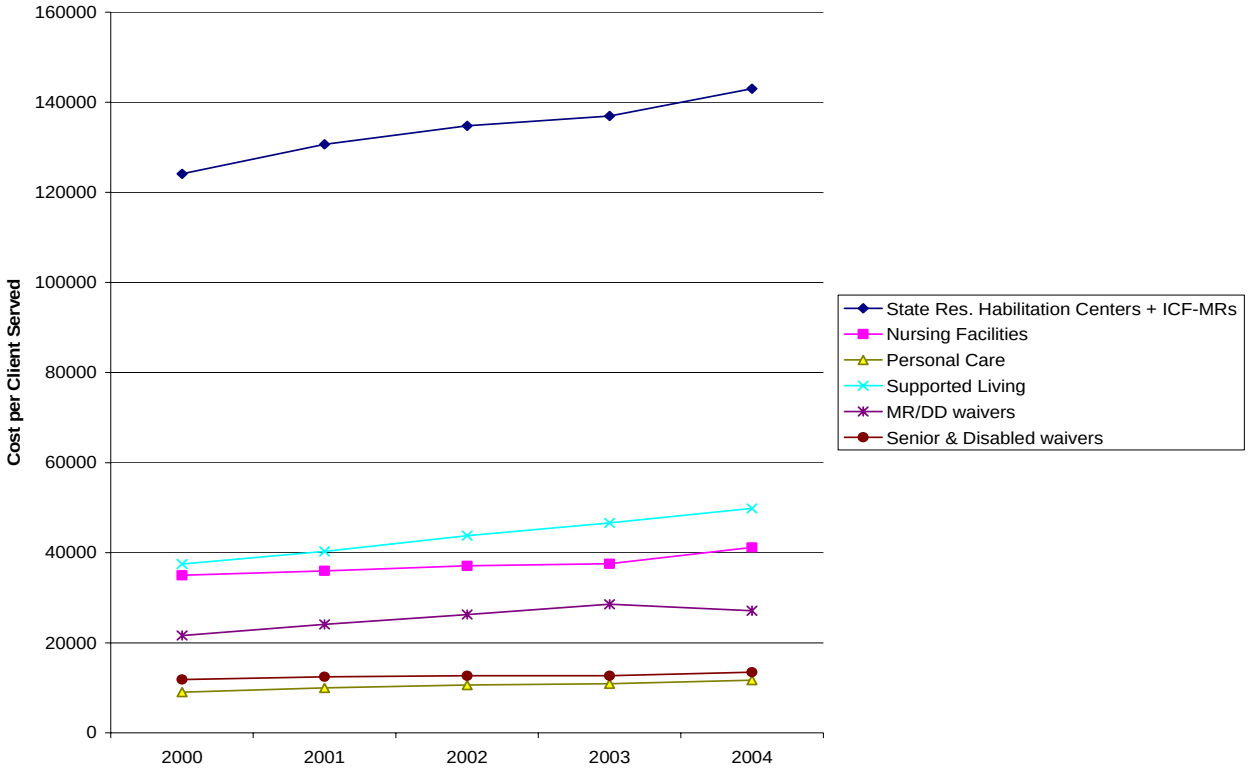

Figure 3. Per Capita Expenditures for Selected Washington Programs, 2000-2004.

The three figures together show Washington's substantial progress in rebalancing community care and point to further targets in reducing institutional services or making community care more efficient.

Conclusion

Recent developments have put the state of Washington at the forefront of long-term care system reform. A unionized independent provider sector has developed and expanded rapidly, fueled by state support to both the independent providers and consumers through the State's Home Care Quality Authority. As a consequence, independent providers are well paid and receive good benefits relative to such providers in other states. The CARE assessment tool allows case managers, supervisors and central office managers to oversee their programs proactively, providing unusual opportunities to identify and plan for a full range of consumer needs, including health care needs and mental health needs. State officials are in a position to identify and reach out to hard-to-serve groups, such as persons with mental health and chemical dependency problems. The innovative home and community service quality assurance systems allows managers to target practices that do not comply with the eligibility, care planning, payment, and case management standards.

Washington has particularly endeavored to make the financial and functional eligibility user friendly and quick, and it has organized its system so all services are accessed through a single computerized assessment system. Access to community care is enhanced through a vigorous effort to divert consumers from nursing homes by assigning case managers to work with consumers in hospitals and in post-hospital nursing home placements. Washington has an extraordinary capability to generate information about its own system, able to track providers or programs and link information about consumers, quality and costs.

Issues for Future Observation

- Further efforts to downsize or eliminate the remaining state institutions for individuals with developmental disabilities.

- The further development of the CARE system to apply better to individuals with developmental disabilities.

- The growth and rising costs per capita for the Independent Provider sector, which is expected to soon equal or exceed that of home care agency services or community residential care settings.

- The evolution of the Home Care Quality Authority, a unique entity that is attempting to develop Referral Centers statewide. Its progress should be of national interest.

- The continued development and expansion of consumer direction within a strong case managed system.

- The development of innovative initiatives to increasing affordable housing and developing a data-driven collaboration between housing authorities and ADSA. Current exploration of reverse mortgages and specialized community residential care settings for specific target populations are of interest.

- The evolution of the Washington Medicaid Integration Partnership in providing an effective program for the most difficult to serve individuals who have a combination of mental health problems, chemical dependency problems, physical health problems, and need for long-term care.

Long-Term Care Information from States

1. Organizational Structure.

   List State organizational units which have primary responsibility for the following.

   A. Medicaid budget and policy for Long-Term Care.
   B. Medicaid waivers.
   C. Medicaid eligibility determination for Long-Term Care.
   D. Functional eligibility for Long-Term Care.
   E. Nursing Facility survey and certification.
   F. Nursing Facility rate setting.
   G. Residential care survey and certification,(includes assisted living, adult family homes, boarding homes, group homes, etc)
   H. Older American Act budget and policy.
   I. Budget and Policy for in-home care services.
   J. Case management for long-term care services.
   K. Adult Protective Services.
   L. Quality Assurance for in-home care services.

   Are all of these components located in the same umbrella agency, different umbrella agencies, or separate agencies reporting directly to Governor?

2. Budget

   A. Nursing Home Budget now and ten years ago.
   B. Residential care budget now and ten years ago. (Includes assisted living, adult family homes, boarding homes, group homes, etc.)
   C. In-home services now and ten years ago.
   D. Budget and staff for nursing home and residual care survey and certification now and ten years ago.
   E. Rates for each service now and ten years ago.
   F. Are Rates fair and adequate for all levels of care to keep providers participating?
   G. Does the legislature appropriate the long-term care budget by “budget item or category of service”? Do state agencies have authority to move money from one budget item or category without permission of the legislature? Is there a certain percent of the budget that is flexible?

3. Assessment, eligibility determination, case management and services.

    A. Is there a single entry point that assesses functional and financial need for long-term care services, in-home, community residential, and nursing homes?
    B. How long does eligibility determination take? Functional? Financial? Who does it? Can presumptive eligibility be done for financial eligibility determination?
    C. Is the assessment done utilizing a standardized tool? Is the tool automated to collect data to assist in program management? (Determine levels of care by setting, length of stay, cost of care, etc.)
    D. Is assessment and case management done by the same agency and people? Do these agencies or people provide any direct care services?
    E. How does the consumer find the "front door" of the point of entry for needed services?
    F. Are long-term care functional and financial assessments done in hospital settings for those needing long-term care at hospital discharge?
    G. Do people residing in nursing homes wanting to be discharged to another setting have assistance from anyone in the long-term care system to do so.?
    H. Is anyone in the long-term care system assigned the responsibility of helping those who want to be discharged from a nursing home to find needed care options?
    I. Do people in nursing homes know about and have access to other types of long-term care services?
    J. Is there a standardized method to do reassessments of current consumers in a timely fashion? Who does reassessment? Do they have authority to increase or decrease service levels?
    K. How do those wanting in-home services find a provider?
    L. Is there a waiting list for any long-term care service? Which services? How long is the waiting list?
    M. Will the state pay for family caregivers?
    N. Are all services options available in all communities?

4. Quality and oversight.

    A. Is there a fully functional and fully staffed system of quality oversight for long-term care services that enforce all regulations and standards and apply sanctions when necessary?
    B. Are surveys done unannounced and done on time?
    C. Is there a way for consumers and families to voice complaints regarding service and are complaints investigated in a timely fashion?

D. Are those employed in the long-term care system subject to “background checks” before employment?
E. Are there training requirement for those working in the long-term care system? Are the training standards enforced?
F. Is there a well functioning ombudsman system in place for institutional services? For community and in-home services?

5. Philosophy and advocacy

A. Does the executive and legislative branch of government have a clear vision that consumer choice should drive the long term care system and no one long-term care service is more important that another.
B. Is there a philosophy in state government that believes that persons with disability have the right to expect “quality of life,” personal dignity, maximum feasible independence, health security and quality of care? And that the array of public service choices may be bonded by reasonable considerations of cost effectiveness.
C. Is there a well informed, articulate group of consumers that are organized to advocate for improvements in the long-term care system that have a “presence” with decision makers in the executive and legislative branches of government.