HOUSE BILL REPORT

HB 1569

As Reported By House Committee on:
Health Care

Title: An act relating to establishment and financing of a community-based long-term care and support services system for functionally disabled persons.

Brief Description: Providing for community-based long-term care and support services for functionally disabled persons.

Sponsor(s): Representatives Braddock, Prentice, Franklin, Locke, Morris, Sprenkle, Anderson, Nelson, Jacobsen, Belcher, Rasmussen, Wineberry, Brekke, Cole, Peery, R. Fisher, Spanel, Cantwell, Valle, Riley, Phillips and Paris.

Brief History:
Reported by House Committee on:
Health Care, February 25, 1991, DPS.

HOUSE COMMITTEE ON HEALTH CARE

Majority Report: *That Substitute House Bill No. 1569 be substituted therefor, and the substitute bill do pass.* Signed by 10 members: Representatives Braddock, Chair; Day, Vice Chair; Moyer, Ranking Minority Member; Casada, Assistant Ranking Minority Member; Cantwell; Edmondson; Franklin; Morris; Paris; and Prentice.

Staff: Antonio Sanchez (786-7383).

Background: Concerns about the lack of availability and access to long-term care and the high cost and poor quality of services, led to the 1989 Legislature's creation of the Long-term Care Commission. The 18-member commission and approximately 150 technical advisory members addressed these and other problems by developing specific long-term care policy recommendations. The commission issued its final report to the Legislature in January 1991.

The number of Washingtonians who need long-term care is growing dramatically. The Long-term care Commission found that currently more than 200,000 people in Washington have chronic physical or mental disabilities that prevent them from managing the tasks of daily life. By the year 2010,

the number will grow by more than 50 percent, almost twice as fast as that of the state's total population.

Expenditures on state-administered long-term care services have also grown substantially. Expenditures have increased from about $635 million during 1981-83 to $1.6 billion in 1989-91. If current trends continue, state expenditures on long-term care will almost triple over the next 20 years, even if there is no increase in the percentage of the eligible population served.

Despite these expenditure increases, there are substantial gaps in the availability of publicly-funded services. Most families do not qualify for any publicly-funded programs and yet do not have the resources to purchase care privately. Those who do qualify for them do not receive enough assistance to continue living in their home, and are forced to enter an institution, such as a nursing home.

The rules and administrative structures governing publicly-funded long-term care programs are complex, fragmented, and often inequitable. The desire to control public caseloads and expenditures, and the piecemeal fashion in which the long-term care system has developed, have resulted in a complicated patchwork of programs, eligibility standards and administrative arrangements that are difficult to access and administer and that can result in individuals who have similar needs and resources qualifying for very different levels of care.

Currently there are two systems for providing long-term care in Washington state: the informal system, made up of family and friends; and the formal system made up of local, state, and federally funded services. Due to demographic, economic, and social factors, family members are less available to provide long-term care at home. Washington state provides an array of formal long-term care assistance to the functionally disabled.

Medicaid long term care services also have significant eligibility gaps. Medicaid long-term care programs currently provide a range of services to persons with functional disabilities, however, eligibility for program services could be expanded in a variety of ways to increase the numbers of persons who qualify and the types of services that are currently delivered.

Summary of Substitute Bill:

ADMINISTRATION OF THE PROGRAM

SECURED BENEFIT PROGRAM BOARD - A secured benefit program board is established consisting of five members, appointed by the governor. Members will represent public payers, private payers, and functionally disabled persons. Terms of the board are specified. The first board members can be appointed to staggered terms of up to eight years. Three of the initial board members must serve at least four years. The board has a range of powers and duties that include: rule making authority; responsibility for planning, designing, and administering a regional system of community-based long-term care and support services; establishing a non age specific uniform assessment tool for measuring the clients' level of functional disability; managing the secured benefits expense and reserve accounts; identifying statutory waivers to allow federal funds to be used in the program; establishing the sliding fee scale; developing payment and cost control mechanisms for services provided; developing and enforcing program performance standards; establishing an office of the inspector general; contracting with and monitoring model administrative projects; developing and administering a long-term care information system; and employing a staff for the program.

POLICY ADVISORY COMMITTEE - A secured benefit policy advisory committee is established. The committee will be composed of 13 members.

COMMUNITY BASED LONG-TERM CARE AND SUPPORT SERVICES - Community-based long-term care and support services will be provided based upon the results of functional assessment of a person's functional abilities. Basic services in the benefit program include: public education; telephone information and assistance, screening and referral; outreach; case management services; personal care and household services; respite care; nursing services; day care and day health care; mental health day treatment and other mental health counseling; habilitation services; and transportation services.

Services not covered in the program include services provided in: nursing homes; state institutions for developmentally disabled persons; and state institutions for the mentally ill. Exceptions can be granted by the board to pay for community based services provided in nursing homes and other health care facilities.

IMPLEMENTATION OF THE PROGRAM

REGIONAL ADMINISTRATIVE MODEL PROJECTS - The secured benefit board will establish a competitive bidding process and the specific criteria used to select, measure, monitor, and evaluate the regional administrative model projects.

Regional model projects will be limited to one or more counties with a total population of at least 40,000. The model projects will be contracted in two phases. The first phase will be a one year planning grant and the next phase will be a three year contract to operate the model project for three years. The geographical parameters for the model regional administrative projects are defined in five specific locations. Coordination must be established with existing regional mental health administrative entities.

In contracting for regional administrative projects a diversity of case management models will be considered. At least one of the models will allow the case manager to authorize and manage the services received by each program beneficiary within budgeted funds.

The board must contract with an independent entity to evaluate the projects. An evaluation report will be submitted to the Legislature no later than three years after the model projects begin operation. Based on the results of the evaluation, the board will recommend to the Legislature an administrative structure to be applied statewide and a schedule for the transition of categorical programs into the program.

All other areas of the State not covered by model projects can maintain their current long-term care administrative and delivery systems or make changes consistent with the benefit program.

PROGRAM FINANCING

SECURED BENEFIT FUND - A secured benefit fund is created in the state treasury. The benefit fund will be made up of employee contributions, state and federal funds, and client contributions. Employees, employers, and self employed individuals must contribute to the insurance fund a percentage of their wages. The amount taken from employees wages will be divided equally between employer and the employee according to the following staggered schedule: 0.1 percent for calendar year 1992; 0.2 percent for calendar year 1993; 0.3 percent for calendar year 1994; 0.4 percent for calendar year 1995; and 0.5 percent for calendar years beginning on or after January 1, 1996. The maximum amount of wages subject to the insurance contribution is $40,000 per year. Individuals earning less than $6,000 annually will not have to pay an insurance contribution. The public insurance funds will be collected annually by the Employment Security Department. Other sources of program funds in the secured benefit fund include: general fund state spending for community based long-term care services; federal funds received by the State as payments for community-based long-

term care and support services; and program beneficiary cost-sharing such as sliding fees and deductibles. Sliding fees must generate up to 20 percent of the total operating cost of the program. The amount of cost-sharing a person must pay depends upon family size and income of the applicant's spouse or a minor applicant's parents if allowable by the federal government. Cost-sharing for households below 150 percent of the federal poverty level will be nominal.

A secured benefit trust account is established to hold program funds. For calendar years 1992, 1993, and 1994, all the insurance contributions are allocated to the current expenditure account in the trust fund. For calendar years beginning on January 1, 1995, 50 percent of the annual public insurance revenues must be held in the trust account until the year 2010 to be invested by the state investment board.

PRIVATE LONG-TERM CARE INSURANCE - A private long-term care insurance commission is established. The insurance commissioner must appoint the seven member board. The commission makes its recommendations to the board, insurance commissioner, and the Legislature before December 2, 1992.

IN-MIGRATION - Persons who have applied for program benefits but have not lived in Washington state for 12 months prior to their application must pay a monthly premium for program benefits. The premium will be based on the level and type of benefits available through the program.

MEDICAID EXPANSION - The current Medicaid system will be expanded in four different areas: 1) to include children 18 years old or younger who would otherwise require institutional assistance; 2) to include developmentally disabled persons living in community-supported living arrangements such as tenant support programs and developmentally disabled group homes; 3) to include personal care services and Hospice care to cover the medical needy; and 4) the COPES program (Community Options Program Entry System) is modified to provide greater flexibility.

COMMUNITY BASED SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES - For every developmentally disabled person taken out of an institution a sum of money equivalent to the amount of state funds that it would have cost to care for that individual in an institution, plus the annual inflation rate, will be deposited into the secured benefit fund every two years.

SOCIAL HEALTH MAINTENANCE ORGANIZATIONS - The Department of Social and Health Services must work with existing health

maintenance organizations to seek a federal waiver to establish a social health maintenance organization.

Substitute Bill Compared to Original Bill: The definition of administrative entity is expanded to include reference to regional government agencies and further specifies that the community-based long-term care system will be regionally operated at the local level.

The selection criteria for the policy advisory committee members is expanded.

The Department of Health retains its licensing and regulatory authority over community-based long-term care and support services providers and their employees. For new services established through the program, the board may request that the Legislature or the Department of Health develop and implement licensing standards.

Reference is added to the list of quality assurance activities conducted by the board at the regional or local level. Contracts with administrative entities must specify the quality assurance activities that will be undertaken at the regional or local level.

The board is authorized to develop criteria for paying for community-based long-term care and support services provided in nursing homes or other health care facilities if the use of such facilities is cost-effective and offers high quality services.

Prior to statewide implementation of the program, program beneficiary cost-sharing will be required only in regional administrative model project sites and only if such cost-sharing would not be prohibited by federal law.

Criteria for administrative model projects is expanded. Administrative model projects will be regionally-operated. Regional administrative model projects will plan, coordinate and administer community-based long-term care services for regions composed of one or more counties with a total population of at least 40,000 and must have the support of the county authority in the county or counties included in the project proposal. The projects are required to identify mechanisms to coordinate with regional support networks, including at least the use of interagency agreements to specify responsibilities for services to persons functionally disabled in whole or in part by mental illness.

Case management services must be provided by the administrative projects to functionally disabled persons either directly or by contract with other agencies.

Contracting procedures are specified for planning and operation of regional administrative model projects. Contracting would be in two phases: one year planning grants for the second year of the 1991-1993 biennium; and three year contracts to operate the projects, beginning on or after July 1, 1993. Based upon the quality of applications received, the board is directed to locate project sites in specific geographic locations.

The amount of employee and employer contributions to the fund is modified. The amount will increase from 0.1 percent in 1992 and increase 0.1 percent every year until it reaches 0.5 percent in 1996. For calendar years 1992, 1993 and 1994, all of the insurance contributions would be allocated to the current expenditure account. For calendar years beginning on or after January 1, 1995, 50 percent goes to the trust account and 50 percent to the current expenditures account.

The current Medicaid system is expanded in four different areas: 1) to include children 18 years old or younger who would otherwise require institutional assistance; 2) to include developmentally disabled persons living in community-supported living arrangements such as tenant support programs and developmental disabled group homes; 3) to include personal care services and Hospice care for the medical needy. Under this expansion persons could qualify for services based on means tested eligibility criteria that also includes consideration of out of pocket medical expenses incurred by the individual requesting the service; and 4) the COPES program is modified to provide greater flexibility.

For every developmentally disabled person taken out of an institution a sum of money equivalent to the amount of state funds that it would have cost to care for that individual in an institution, plus the annual inflation rate, be deposited into a secured benefit fund every two years.

The Department of Social and Health Services must work with existing health maintenance organizations to seek a federal waiver to establish a social health maintenance organization.

Pending state-wide implementation of the program, existing executive branch agencies will administer all community-based long-term care and support services funds, except those relating to regional model administrative projects. Upon state-wide implementation of the program, all community-based long-term care funds will be administered by the board and deposited in the secured benefit fund.

Any funds remaining after the planning grants for regional administrative model projects have been allocated will be taken from the insurance contributions for the period of January 1, 1992 through June 29, 1993. Funds are appropriated for the second year of the 1991-1993 biennium for specific service expansions in Medicaid, and appropriation of remaining funds for community-based long-term care and support services as determined in the biennial budget is provided for.

The effective date for community-based long-term care and support service expansions is July 1, 1992.

Fiscal Note: Requested February 26, 1991.

Appropriation: Yes.

Effective Date of Substitute Bill: Sections 1 through 22, 24 and 31 take effect July 1, 1991. Sections 23, and 25 through 30 take effect July 1, 1992.

Testimony For: The need for a comprehensive and coordinated long-term care system is one of the most serious issues facing our State and our country. This measure would assist persons of all ages and with different disabilities. Families will be able to support the ones they love in their own homes if more community services are made available. Establishing a sliding fee scale so that everyone who needs it can get care and help even when their income is above the poverty level is very essential. This measure would eliminate the fragmentation of funding sources and lack of funding for support services that currently leaves families and providers without predictable, consistent services. The bill's focus on functional disabilities, its community-based care emphasis, its concept of included services, its approach to administrative models, and its innovative funding mechanisms represent bold and need reforms of long-term care concerns.

Testimony Against: The Department of Social and Health Services cannot support the bill because it is not in the governor's 1991-93 biennial budget.

Witnesses: Blanche Jones, House Care Association of Washington (pro); Dorothy Yager (pro); Nick Beamer and Norm Winington, Eastern Washington Area Agency on Aging (pro); Helen Sohlberg, American Association of Retired Persons (pro); Evan Iverson, Senior Citizens' Lobby (pro); Dan Evans, Washington Chore and Home Care Coalition (pro); Mike Whitley and Margaret Casey, Washington State Catholic Conference (pro); William McCandles (pro); Paul Trause, Department of Social and Health Services (con); Pat

Thibaudeau, Washington Community Mental Health Council; Irene Robbins, Alzhiemers Association (pro); Mary Lynn Short, Washington State Nurses Association (pro); John Weber, Developmental Disabilities Planning Council (pro); Ruben Mehl, Washington State Council of Senior Citizens; Frank Winslow, Alzhiemers Society of Washington (pro); Luther Smith (pro); James Anderson; and Jeff Larson, Washington Assembly for Citizens with Disabilities (pro).