SENATE BILL REPORT

ESHB 1569

AS OF MARCH 22, 1991

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

SPONSORS: House Committee on Health Care (originally sponsored by 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).

HOUSE COMMITTEE ON HEALTH CARE

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Staff: Don Sloma (786-7414)

Hearing Dates: March 25, 1991

BACKGROUND:

The Long-term Care Commission was created in 1989 and issued its final report to the Legislature in January 1991.

The commission found that more than 200,000 people in Washington have chronic physical or mental disabilities that prevent them from managing at least one task of daily life. The population needing long-term care includes those who are elderly, developmentally disabled, mentally ill, head injured, suffering from AIDS, and others who do not qualify for any state or federal assistance. By the year 2010, the number is projected to grow by more than 50 percent, almost twice as fast as the state's total population.

Expenditures for state-administered long-term care services increased from about $635 million during 1981-83 to $1.6 billion in 1989-91. If current programs, policies and funding patterns continue, state expenditures on long-term care will almost triple over the next 20 years, assuming no increases in the percentage of the eligible population served.

Despite these expenditure increases, many long-term care programs continue to report waiting lists and demands for expanded services which outstrip available resources.

The piecemeal fashion in which the long-term care system has developed has resulted in a complicated patchwork of programs, eligibility standards and administrative arrangements. As a result, needed services are often difficult to access and administer. Individuals who have similar needs and resources often qualify for very different levels of care.

Medicaid funds are currently used to finance many types of long-term care services. However, eligibility could be expanded to increase the number of persons who qualify and the types of services delivered.

SUMMARY:

The Legislature intends to organize the foundation for financing and providing community based long-term care services for all functionally disabled persons. The Legislature intends to provide secured benefit assurance in perpetuity without requiring family or program beneficiary impoverishment.

A five member secured benefit program board is established and must be appointed by the Governor. Members must represent public payers, private payers, and functionally disabled persons. The board is authorized to make rules, plan, design and administer a regional system of community-based long-term care and support services, establish a uniform assessment tool to measure clients' functional disability, manage the secured benefits expense and reserve accounts, identify statutory waivers to allow federal funds to be used in the program, establish a sliding fee scale, develop payment and cost control mechanisms, develop and enforce program performance standards, establish an office of the inspector general, contract with and monitor model administrative projects, develop and administer a long-term care information system, and employ a staff for the program.

A 13-member secured benefit policy advisory committee is established.

The Legislature intends that community based long-term care services allow beneficiaries to live as independently as possible. To this end, the Legislature intends that all services commonly considered to be community based services be provided by the secured benefit board, and to allow flexibility in defining new or additional services that will contribute to the intent of the law.

In addition, the Legislature recognizes that the availability of services does not guarantee their use, and that aggressive targeting and outreach are necessary to assure service availability to the most dispossessed.

Community-based long-term care and support services must be provided based upon the results of a functional assessment. Minimum required 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.

The Legislature intends that a series of pilot projects be funded to test various administrative models. Lessons learned through the pilot projects are intended to be applied to the development of the statewide system.

The secured benefit board must establish a competitive bidding process and criteria 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. Coordination must be established with existing regional mental health administrative entities.

In contracting for regional administrative projects several case management models will be considered. At least one 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 must 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 must recommend an administrative structure to be applied statewide and a schedule for the transition of categorical programs into the program.

During the pilot project period, pilot project funds will be administered by the secured benefit board. These funds must include the share of state and federal funds which would have been spent for community based long-term care services in the pilot project counties under the existing system. Upon enactment of legislation establishing a statewide administrative structure for the program, all community based long-term care funds shall be deposited into the secured benefit account and be administered by the secured benefit board.

Areas of the state not covered by model projects may maintain their current long-term care administrative and delivery systems during the pilot project period or may make changes consistent with the benefit program.

The board must design and administer a long-term care information system which: (1) seeks to use a common client identifier for each person using long-term care services; (2) tracks use of long-term care services; (3) protects confidentiality; and (4) allows access to information regarding the cost, availability and use of long-term care services.

A secured benefit fund is created in the state treasury. The benefit fund must consist 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 must 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 the calendar years beginning on or after January 1, 1996.

The maximum amount of wages subject to the insurance contribution is $53,400 per year. Individuals earning less than $8,000 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 state general funds 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 charged to program beneficiaries must generate up to 20 percent of the total operating cost of the program. The amount of cost-sharing a person must pay must be related to 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.

A private Long-Term Care Insurance Commission is established to determine the role of private insurance in the new system. The Insurance Commissioner must appoint the seven-member board. The commission must report its recommendations to the board, the Insurance Commissioner, and the Legislature before December 2, 1992.

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.

The current Medicaid system will be expanded in four 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) to include respite care, home delivered meals, adult day care, and electronic emergency response systems and to increase cost lids in the Community Options Program Entry System (COPES) program.

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.

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.

Appropriation: none

Revenue: yes

Fiscal Note: available

Effective Date: The bill contains an emergency clause and takes effect immediately.