I. The Joint Legislative Executive Committee on Aging and Disability Issues

Enacting Legislation and Membership

The Joint Legislative Executive Committee on Aging and Disability Issues (Committee) was established in the 2013-15 operating budget. The Committee was charged with the responsibility to identify strategic actions to prepare for the aging of Washington's population by:

1. Establishing a profile of Washington's older population and population with disabilities and a projection of those populations through 2030;

2. Establishing an inventory of services and supports from health care and long-term services and supports;

3. Identifying budget and policy options to effectively use public resources to reduce the growth rate in state expenditures compared to current policies;

4. Identifying strategies to better serve the health care needs of the aging population and people with disabilities and promote healthy living;

5. Identifying options for financing mechanisms for long-term care services and supports to promote additional private responsibility to meet needs for services;

6. Identifying options to promote financial security in retirement, support people staying in the workforce, and expand the availability of workplace retirement savings plans; and

7. Identifying options to help communities adapt to the aging demographic in planning for housing, land use, and transportation.

The Committee is comprised of four members of the Senate, four members of the House of Representatives, and four members of the Executive Branch. The following persons have been appointed to the Committee:

Senate:

- Sen. Barbara Bailey
- Sen. Bruce Dammeier
- Sen. Jeannie Darneille
- Sen. Karen Keiser

House of Representatives:

- Rep. Paul Harris
- Rep. Laurie Jinkins
- Rep. Norm Johnson
- Rep. Steve Tharinger

Executive Branch:

- Marcie Frost, Director of the Department of Retirement Systems
- Jason McGill, Representing the Office of the Governor
- Kevin Quigley, Secretary of the Department of Social and Health Services
- Dorothy Teeter, Director of the Health Care Authority

2013 Activities

The Committee held two meetings in the fall of 2013: one on September 25 and the second on November 4.

September 25 meeting

At the first meeting, Senator Bailey and Representative Tharinger were selected as co-chairs and members were reminded of their statutory duties. At this meeting, the Committee received background information relating to the aging population and long-term care to provide the members with a broad view of the demographic trends facing Washington, the fiscal implications for the state, and a preliminary look at state programs that serve seniors and those with disabilities. Topics discussed included:

- Information regarding state services for the aging population, including funding and demographic data; and
- Department of Social and Health Services and Health Care Authority initiatives to inventory long-term care resources and demographic data.

November 4 meeting

At the November 4 meeting, members received background information on aging issues and participated in a roundtable discussion on those issues. Topics discussed included:

- A review of the Governor's Aging Summit recommendations;
- Adult Protective Services, including information from the Department of Social and Health Services, the King County Prosecutor's Office, and Disability Rights Washington;
- Options for promoting financial security, including information from the Department of Retirement Services and a presentation on life settlements (converting life insurance to income to pay for long-term care needs); and
- Long-term services and supports, including information from the Olympia Area Agency on Aging, the Department of Social and Health Services, and the Office of the Insurance Commissioner.

Both meetings provided opportunities for the public to provide their testimony and their suggestions for Committee consideration.

In December 2013, the Committee finished its Interim Report to the Legislature. Included in the Interim Report was a summary of the Demographic Trends in Washington and a Budget Overview. Also part of the Interim Report was a Committee Work Plan for 2014. The Work Plan detailed a plan of 5 meetings to address substantive issues such as healthy aging, workforce quality and protection from elder abuse and exploitation, and financial security. The Work Plan also included time for the Committee members to discuss the work completed during its two-year existence with an opportunity to develop recommendations for the Final Report due in December 2014.

The 2013 Interim Report and materials from the 2013 meetings are available at the Committee's website: http://www.leg.wa.gov/jointcommittees/ADJLEC/Pages/default.aspx.

2014 Legislation

During the 2014 legislative session, the Legislature passed two bills that affected the activities of the Committee.

ESHB 2746

ESHB 2746 directs the Department of Social and Health Services to refinance Medicaid personal care through use of the Community First Choice Option (CFCO). The CFCO is an optional entitlement program offered under the federal Affordable Care Act which provides Medicaid matching funds that cover 56 percent of the cost of services, rather than the usual 50 percent.

Under ESHB 2746, savings from refinancing existing services may be used to offset the cost of implementation and any savings remaining must be reserved for additional investment in home and community-based services for individuals with developmental disabilities and individuals with long-term care needs.

ESHB 2746 directs the Committee to provide recommendations for investments in home and community-based services. The Committee's final report to the Legislature must explore the cost and benefit of rate enhancements for providers of long-term services and supports, restoration of hours for in-home clients, additional investment in the family caregiver support program, and additional investment in the Individual and Family Services Program or other Medicaid services that support individuals with developmental disabilities.

SSB 6124

The Interim Report of the Committee listed consideration of developing a state Alzheimer's plan as one of the goals to be discussed at the Committee's first meeting in 2014. However, before this discussion occurred, legislation was introduced during the 2014 legislative session to begin development of such a plan. SSB 6124 directs the Department of Social and Health Services to develop an Alzheimer's plan for the state of Washington, using a group of stakeholders detailed in the bill. These stakeholders include representatives of state agencies, health care providers, adult family home providers, people with Alzheimer's disease and their families and caregivers, health care policy advocates, and researchers.

Two members of the Committee, Senator Keiser and Representative Tharinger, serve on the workgroup. At the September 2014 meeting of the Committee, continuation of the work towards development of an Alzheimer's plan has been listed among the suggestions for future discussion.

2014 Activities

May 19 meeting

The May 19 meeting focused on issues relating to healthy aging. The Committee reviewed the options for seniors and the disabled along the continuum of care and considered the program options for the range of needs that they face. This review included overviews on:

- The Older Americans Act;
- Financing, services, and access of the Area Agencies on Aging;
- Healthy communities and transportation issues, with a focus on the activities of Clark County;
- The Family Caregiver Support Program; and
- The state Alzheimer's plan development.

June 18 meeting

The June 18 meeting focused on issues relating to workforce quality and protection from elder abuse and exploitation. The Committee reviewed the current workforce and potential workforce development issues that need to be addressed to ensure sufficient resources will be available to provide quality care during the upcoming demographic shift. This review included overviews on:

- Health care and home care workforce needs for the elderly;
- Workforce quality, with discussions on the future of the long-term care workforce; and
- Elder abuse and exploitation.

July 14 meeting

The July 14 meeting focused on ways to enable Washington residents to become more financially independent and self-sufficient. This review included overviews on:

- Retirement planning available through the Department of Retirement Systems;
- Long-term care funding, with both public and private sector options being discussed; and
- Long-term care options and Medicaid avoidance.

September 15 meeting

The September 15 meeting was reserved for the Committee to receive any remaining information it needed to develop recommendations to the Legislature and to begin considering what the recommendations should address. The Committee heard from the public and heard presentations on:

- The Community First Choice Option Work Group;
- Use of technology to help people maintain independence; and
- The Training Partnership and workforce quality.

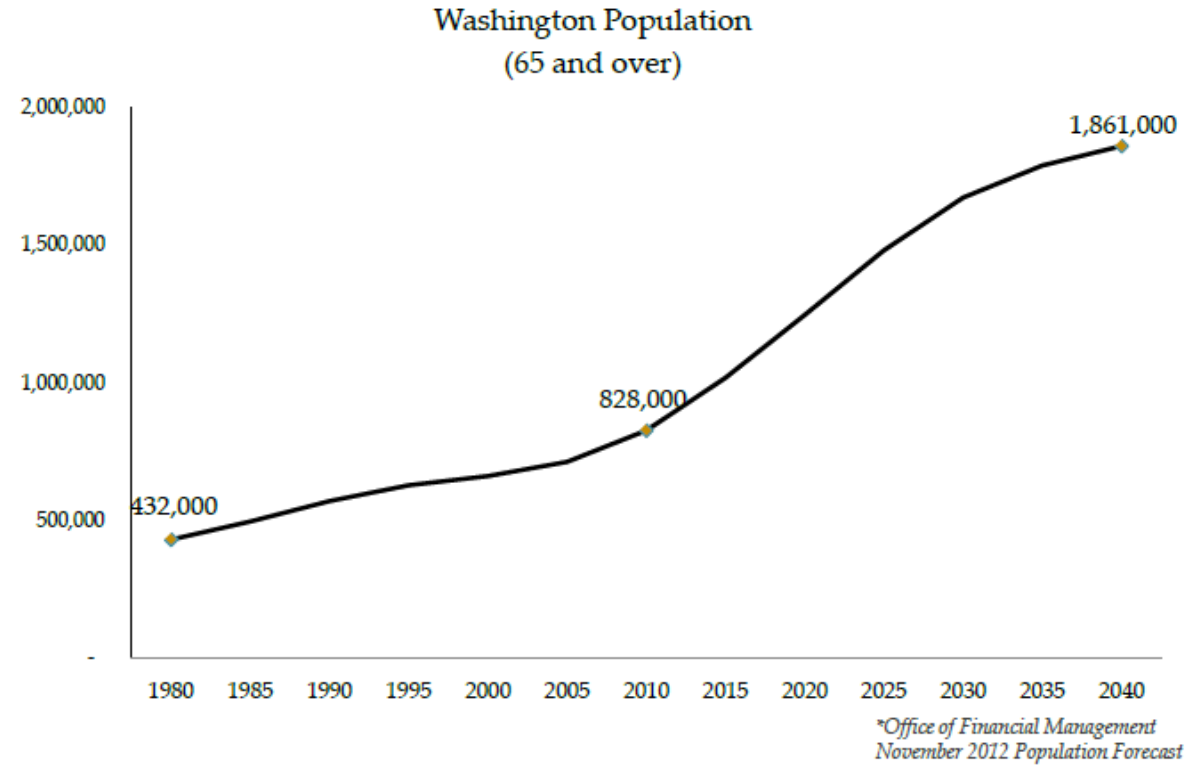
The recommendations of individual Committee members were placed into a table and provided to all Committee members after the September meeting. The table represents all the ideas of the Committee but are not necessarily items that all Committee members agree upon. The original table is available on the Committee's website and the table, as adopted by the Committee in December, is in section IV of this report.

December 15 meeting

The December 15 meeting discussed the Final Report of the Committee. Policy options offered by individual Committee members and the table developed after the September 15 meeting were discussed and voted on by the Committee. Members discussed each option and recommended that they be addressed in the short term (2015 legislative session), mid-term (2016 legislative session), or in the long-term (2017 legislative session and beyond). The table in section IV of this report is the result of this discussion.

II. Population Forecast

Since 1980 Washington's population over age 65 has doubled and is projected to more than double again by 2040. According to the Office of Financial Management's November 2012 Population Forecast, there are currently approximately 830,000 people in Washington who are age 65 and over, or almost 14 percent of the population. By 2040 that number is estimated to reach 1,860,000 people, or 21 percent of the project population.



A 2011 report released by DSHS found that, of the 1.2 million people in Washington age 60 or older in 2011, approximately 91,000, or seven percent, were below the Federal Poverty Level. Almost 47,000 of these people had limited English proficiency. About 261,000 of these people were disabled. In addition, almost 81,000 people in Washington who were age 70 or above had dementia. For the full report, see Appendix A.

The Aging and Long-Term Services Administration at DSHS provides services to low-income seniors in need of long-term services and supports. In fiscal year 2011, DSHS had just over 45,000 senior clients receiving services. About 36 percent of these clients were between age 75 and 84 years old and another 36 percent were age 85 or older. The total cost to Medicaid and Medicare for providing long-term services and supports to these client was $1.042 billion with most of that covered by Medicaid.

Compounding these demographic challenges is the fact that many of those nearing retirement age are not financially prepared to retire. A 2014 Gallup survey found that the top financial concern for Americans between 50 and 64 years old was not having enough money for retirement. Despite that concern, a 2014 report of the Board of Governors of the Federal Reserve System cited results of a survey that found that barely 40 percent of people 60 years old and over had given "a lot of thought" or "a fair amount of thought" to financial planning for retirement, while almost the same number of people responded that they had given such planning "a little thought" or "none at all." For those between 45 and 59 years old, the figures were nearly the same. The survey also found that almost a quarter of those between 45 and 59 have no retirement savings or pension.

III. Service Inventory

One of the responsibilities of the Committee is to establish an inventory of long-term services and supports that are available to Washington residents. The service inventory describes the population that receives long-term services and supports and highlights the array of programs and providers that are available. The Department of Social and Health Services assembled the service inventory and it can be found in its entirety in Appendix B.

The service inventory depicts the population in Washington that receives long-term services and supports through state and local programs. Nearly two-thirds of those receiving services through the Department's Aging and Long-Term Support Administration are over 65 years old. The Medicaid program supports about 60 percent of the nursing home residents in the state and is the primary public payer of long-term supports and services provided in community-based settings. The service inventory also highlights the fact that in Washington 80 percent of all long-term services and supports are provided by unpaid family caregivers. This amounts to over 850,000 people providing services valued at $10.6 billion.

The service inventory details the types of existing services and programs, the intended population to benefit from the services and programs, a description of the programs, and the extent of the availability. Through the Area Agencies on Aging there are programs to support family caregivers, people with chronic conditions, veterans with significant cognitive impairment, lower-income seniors, and adults receiving public assistance. Through the state's Medicaid program there are various program options available to people in need of nursing facility levels of care to allow them to receive specifically tailored services in different types of settings. The state offers services to protect vulnerable adults from abuse, neglect, and financial exploitation through Adult Protective Services, the Long-Term Care Ombuds, and the Office of Public Guardianship. There are also various resources for individuals to receive information about how to access programs to meet their needs. Lastly, the service inventory provides a description of all of the settings and types of providers that are available in Washington, including the number of available providers in the state.

IV. Policy Options

The Committee is responsible for identifying key strategic actions to prepare for the aging of Washington's population. The issues presented by the state's demographic shift will require a sustained effort over the coming years. For that reason, the Committee has framed the following policy options in terms of timing for implementation (short-term is the 2015 session, mid-term is the 2016 session, and long-term is 2017 and beyond). Ten members of the Committee attended the final Committee meeting of 2014 and determined when these policy options should be addressed. How those members voted is reflected in the table below.

	Group	Suggestion	Priority Level		
			Short-Term	Mid-Term	Long-Term
1	Insurance	Long Term Care Insurance Study. Contracted actuarial insurance industry study of options to finance long term care insurance for the citizens of Washington State, including options for public financing and public-private partnerships. ($400,000 total funds; $200,000 GF-State - contingent on $200,000 in private contribution)	10		
2	CFCO	Use Savings from the Community First Choice Option (CFCO): Federal matching funds cover 56% of the cost of services under the CFCO, which is 6% higher than the current rate. Implementing the CFCO is projected to save roughly $80 million GF-State in 2015-17. The Legislature authorized DSHS to utilize *roughly half* the savings to provide services to clients with developmental disabilities: (1) 4,000 additional clients on the Individual & Family Services waiver (to primarily receive respite), and (2) 1,000 additional clients on the Basic Plus waiver (to primarily receive personal care and therapies). The Legislature also directed the JLEC on Aging/Disability to explore options for further investment in home and community based services. The following reinvestment options have been identified by the JLEC as equally important:	10		
		a Family Caregiver Support Program (FCSP). FCSP helps caregivers sustain caregiving activities, and ensure their own mental and physical health. Stress, depression, and caregiving burden are assessed by the Tailored Caregiver Assessment and Referral (TCARE) intervention. TCARE recommends evidence-based strategies, and the Committee supports such strategies, to help caregivers who are most burdened with caregiving responsibilities. In FY13, about 8,000 caregivers received services - such as respite, counseling, support groups, information, and assistance - through FCSP. As an example, DSHS estimates that increasing the annual FCSP budget by $4.5 million GF-State could serve 3,750 additional caregivers. *This option is scalable*.			
		b Medicaid rate enhancements for providers of long-term services and supports. Wages and benefits for Individual Providers (IP) and Adult Family Homes are collectively bargained. Homecare agencies receive rate adjustments based on incremental changes to the IP			

Group	Suggestion		Priority Level		
			Short-Term	Mid-Term	Long-Term
		contract. By statute, rate components for nursing homes are either rebased every two years (non-capital components), or every year (capital components). Medicaid rates for all other providers are adjusted through legislative direction. *This option is scalable*. For reference, the major providers are the following: (1) Individual Providers (2) Adult Family Homes (3) Agency Providers (4) Nursing Homes (5) Assisted Living (6) Adult Residential Care (7) DD Community Residential (8) DD Employment Programs (9) Adult Day Health (10) Managed Care (PACE)			
	c	Restoration of hours for home care clients. Hours of personal care for clients living in their own homes were reduced, on average, by 4% in Fiscal Year 2010 and 10% in Fiscal Year 2011, for a combined savings of roughly $65 million GF-State per year. Savings from the CFCO are insufficient to restore the full reduction, but DSHS has stated that a partial restoration, including a targeted approach, could be possible. For reference, a 1% increase in annual homecare hours would cost roughly $10 million GF-State. *This option is scalable*.			
	d	Pre-Medicaid Services. DSHS has identified items in the agency request 2015-17 Biennial Budget to delay, or divert, individuals from entering the more expensive Medicaid long-term care system, including: (1) $5 million GF-State per year for counseling services to help clients/caregivers understand options, plan for outcomes, and access resources, (2) $500,000 GF-State per year to expand Memory Care & Wellness beyond current programs in limited geographic areas, and (3) $20,000 GF-State per year for an evidence-based program for people caring for someone with Alzheimer's disease, called Star-Caregiver (Star-C). *This option is scalable*.			
	e	Area Agencies on Aging Case Management Funding. AAAs are currently not funded for the 1:62 case manager to client ratio that is spelled out in their contract. Lack of adequate funding creates risk to federal funding, poor client outcomes and failure to fully address clinical needs of clients as well as the ability to fully comply with new federal rules that went into effect March 2014. ($28 million total funds; $14 million GF-State)			

	Group	Suggestion	Priority Level		
			Short-Term	Mid-Term	Long-Term
3	Retirement planning	START Proposal. Create a Save Toward a Retirement Today state retirement savings plan. Permits private employers and employees to participate in retirement plans administered by the Washington State Department of Retirement Systems. Empowers the Washington State Investment Board to invest the funds contributed by participating employers and employees to the Start Plan.		9[1]	
4	Retirement planning	Encourage residents to plan for their retirement using tools available to them in the private market. Encourage planning before retirement with an emphasis on what residents can do for themselves to achieve their own planned retirement, without relying on state action (e.g., through education campaigns).		9	
5	Long-term Care Planning	Similar to the private market retirement planning suggestion, develop strategies and policies that will incentivize individuals to plan ahead and get more involved with their own future long-term care needs. This could be through insurance, savings programs, or other planning tools.		9	
6	Client Safety	Elder Abuse Omnibus Bill. Criminal codes should be updated to include a crime of financial exploitation of an adult and a reduction in the intent standard for the felony criminal mistreatment statute. Law enforcement agencies should be incentivized to use specialized elder abuse detectives and prosecutors as well as multidisciplinary teams There should be additional resources, as identified by DSHS, made available to support Adult Protective Services staffing for financial exploitation and self-neglect cases so that cases may be closed in a timely manner (6 FTE for financial exploitation; 3 FTE for self-neglect cases - $2 million total funds; $1.5 million GF-S)	10		
7	Client Safety	Timely response to complaints must occur within the Residential Care Services Complaint Investigations and Complaint Resolution Unit Intake Staffing.	10		
8	Client Safety	The regulation of CCRCs should be given attention by the Committee in 2015 interim.		10	
9	System Change	End of life care planning, patient counseling, system improvement (like Oregon's) See Bree Collaborative recommendations	10		
10	System Change	Duals pilot and health homes. These programs provide comprehensive services in one place for the highest cost, highest risk populations and should continue. If these service models are proven effective through improved outcomes, additional federal funds may be leveraged	10		

[1] For item 3, one member requested that it be noted for the record that she was recommending no action on these items.

	Group	Suggestion	Priority Level		
			Short-Term	Mid-Term	Long-Term
		through shared savings with Medicare. (13.6 FTEs, $10.1 million total funds; $4.6 million GF-S) Workforce needs associated with the aging population (e.g. primary care, geriatrics, nurse chronic care management, LTC workers supports, community health worker supports). Specialty training particularly around dementia, cognitive impairments, mental health, and executive functioning (decision making capacity) is needed in all areas of the workforce to include health care, long term care, community partners, and informal caregivers. Some solutions include: 1) Implementing a screening tool that will help caregivers and medical professionals understand client capability including executive functioning. This tool will help both professionals and family members know whether or not an individual understands the consequences of their decisions and will increase knowledge about the level of vulnerability for fraud, neglect, and abuse; 2) More in depth training to help family and professional caregivers understand special needs of older adults (For example, how do you help someone who is not taking their medications or how can you allow the client to have maximum independence and choice in their particular situation?); and 3) A social media campaign to address bias and stereotypes about the capabilities and decision making abilities of older adults. 4) The effects of homelessness on the availability of long-term supports and services should be considered. *This option is scalable*.			
11	Committee	The work of the Committee needs to be continued in a forum that includes state-level policy makers to consider long-term care policies. This could be continuing the committee in its current format and specifying a number of meetings yearly with or without an end date in the statute. Other items to consider are whether the committee should submit a report to the Legislature, whether membership should be modified, and the amount of stakeholder involvement.	10		
12	Healthy Living	Comprehensive community-based solutions to issues facing the aging population must be considered, including transportation options, housing options, and the use of community health workers. The state must encourage community efforts to plan for the needs of aging		10	10

	Group	Suggestion	Priority Level		
			Short-Term	Mid-Term	Long-Term
		populations by supporting local initiatives that promote independence or by removing barriers that inhibit local solutions. The state should support opportunities to promote the use of community health workers to assist the independence of residents.			
13	Technology	Policy needs to consider ways that technology can complement or substitute for human caregivers to reduce costs while maintaining or improving the quality of care. Technology can help target the limited supply of caregivers and health care providers to more effectively serve clients. Restrictions on telehealth reimbursement must be removed. The state should increase flexibility in reimbursing for technologies that support independence and home telehealth for those with chronic health conditions where fiscally feasible. A long-term strategy for the cost-effective use of technology to prolong independence and improve quality of life must be established to provide guidance for policymakers to use as new technologies become available.		10	
14	System Change	Look for ways to partner with the Federal Government to redesign Medicaid programs to allow for different eligibility criteria with a goal of obtaining services earlier and delaying enrollment in the full Medicaid program. (Potentially create a Family Caregiver Program that will allow federal match on services that prevent or delay individuals from becoming Medicaid clients.)	10		
15	Workforce	Respite services and other supports for unpaid caregivers. The needs of unpaid caregivers must be met through respite services and other supports, including the exploration of using Residential Habilitation Centers (RHCs) where available. Currently respite and supports are provided to unpaid LTC caregivers through the Family Caregiver Support Program (See item number 2a above). Through this program, planned respite may be provided in the client's own home, or with a short stay in an adult family home or nursing home. Funding for FCSP may be targeted towards respite, supplemental services (such as equipment), training, and/or counseling. Caregivers of clients with DD can receive respite services through the Individual and Family Support (IFS) program. Respite is currently offered at Yakima Valley School. Other RHCs offer short term emergency admissions for crisis, but not planned respite. *This option is scalable*.		10	
16	Workforce	In-home Respite Providers. Remove barriers for part time respite providers and address the workforce needs (how to address the shortage of qualified workers). Most often, a family feels most comfortable with someone they know providing care in their home to their loved one while the primary caregiver is receiving respite. The respite may be as	10		

	Group	Suggestion	Priority Level		
			Short-Term	Mid-Term	Long-Term
		little as a few hours a week. However provisions of the mandatory training law that require 35 hours of training before that individual can be hired by the client to provide respite care. Beginning July 1, 2016, this requirement increases and the passing of a certification exam will also be required. This is becoming a barrier for part-time respite providers. The law does not take into account any actual previous experience of an individual who the client would like to provide respite. *This option is a policy option and may not require additional funding.*			
17	System Change	Continue the work of the Alzheimer's Plan Work Group which was established through SSB 6124. DSHS is the agency coordinating the efforts of the Work Group which consists of a variety of stakeholders as well as two legislative members (who also serve on the JLEC). The Work Group report is due to the Governor by January 1, 2016 and stakeholder meetings are currently under way.	10		
18	System Change	As Washington's population ages, the number of people who will need guardianship and information about assisted decision making options will grow significantly. The state needs to understand how the formal guardianship system, both public and private, can respond to this need in a way that maintains high standards and public confidence. The state also needs to review how families, seniors, and people with disabilities can access effective decision making options short of full guardianship.		10	

Appendices

Appendix A.....Age Wave Technical Notes
Appendix B.....Inventory of Long-Term Supports and Services
Appendix C.....Community First Choice Option

APPENDIX C. Community First Choice Option

The Community First Choice Option (CFCO) is an optional entitlement program offered under the Affordable Care Act (ACA). To be eligible, clients must be assessed as needing nursing facility level of care, and must have income that falls below 150 percent of the federal poverty level. States may also choose to include individuals who have higher incomes if those individuals receive medical assistance under certain waiver eligibility groups.

Services offered under the CFCO must include (1) assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health related tasks, (2) acquisition, maintenance, and enhancement of skills to complete ADLs, IADLs, and health related tasks, (3) back-up systems that ensure the continuity of care and support, and (4) voluntary training on how to select, manage, and dismiss attendant care providers. Other services, such as transition assistance and employer training, may be included under the CFCO at the discretion of each state. Federal Medicaid matching funds would cover 56 percent of the cost for services provided under the CFCO, instead of the current 50 percent matching rate.

The 2014 Legislature passed SHB 2746 and SSB 6387. SHB 2746 directed the Department of Social & Health Services (DSHS) to refinance personal care services through the CFCO. SSB 6387 reinvested some of the savings from CFCO into paid services for individuals with a developmental disability. SHB 2746 further directed the Joint Legislative Executive Committee on Aging and Disability to explore the costs and benefits for additional investment in home and community based services.

Item Description	2015-17 GF-State	2017-19 GF-State
SHB 2746 savings	-$79 million	-$80 million
SSB 6387 investments	$22 million	$36 million
Available for further investment	***-$57 million***	***-$44 million***
Potential Investment Options:		
1. LTC Insurance Study	$0.2 million	-
2. Family Caregiver Support Program	$9.0 million	$9.0 million
3. 1% wage increase (Individual Providers)	$5.0 million	$5.0 million
4. 1% rate increase (Agency Provider)	$2.0 million	$2.0 million
5. 1% rate increase (Adult Family Homes)	$2.0 million	$2.0 million
6. 1% rate increase (Nursing Homes)	$6.6 million	$6.6 million
7. 1% rate increase (Assisted Living)	$1.0 million	$1.0 million
8. 1% rate increase (Adult Residential Care)	$0.4 million	$0.4 million
9. 1% rate increase (DD Community Residential)	$3.8 million	$3.8 million
10. 1% rate increase (DD Employment Programs)	$0.6 million	$0.6 million
11. 1% rate increase (Adult Day Health)	$0.1 million	$0.1 million
12. 1% rate increase (PACE)	$0.1 million	$0.1 million
13. Hours restoration for home care clients (1%)	$10 million	$10 million
14. Pre-Medicaid Services (i.e. counseling, memory care)	$11 million	$11 million
15. APS – financial exploitation and self-neglect (9 FTE)	$1.5 million	$1.5 million
16. RCS – complaint investigations and intake (23 FTE)	$3.9 million	$3.9 million
17. Lower staffing ratio for Area Agencies on Aging	$14 million	$14 million
18. Strategy 2 of the dual eligible project	$4.6 million	$4.6 million
TOTAL	**$75.8 million**	**$75.6 million**

Personal care refers to support with routine activities that people tend to complete without needing assistance, called activities of daily living (ADL). Common ADL needs include dressing, bathing, eating, toileting, transferring, and continence. Personal care may also refer to support with activities performed by a person living independently

in a community setting, called instrumental activities of daily living (IADL). Common IADL needs include shopping, cooking, laundry, meal preparation, and housework.
Clients may receive personal care in their own home from a contracted individual provider, or from an employee working for a licensed home care agency. Clients may also receive personal care within a residential setting, such as an Adult Family Home or an Assisted Living facility. In Fiscal Year 2013, approximately 60,000 clients within the Department of Social and Health Services (DSHS) received personal care services.

Currently, clients may access personal care through an optional state plan service, called Medicaid Personal Care (MPC), or through programs that provide home and community based services to individuals who would otherwise require institutionalization, called Medicaid waivers. Medicaid state plan services are an entitlement. Medicaid waivers are not an entitlement. Federal Medicaid matching funds cover 50 percent of the cost for personal care services under MPC, or a Medicaid waiver.

Over the past several years there have been variations in state payments to providers of different long-term services and supports. The following chart shows the recent history of state payment rates.

Rate Adjustments	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15
a. Individual Provider (1)	-	-	-	-	-	-	-	-
b. Agency Provider (2)	-	-	-	-	-	-	-	-
c. Adult Family Home	3.2%	2%	-4%	-	-	-	-	-
d. Nursing Home (3)	-	-	-	-	-	-	-	-
e. Assisted Living	6%	2%	-4%	-	-	-2%	-	-
f. Adult Residential Care	6%	2%	-4%	-	-	-2%	-	-
g. DD Community Residential	5%	2%	-3%	-	-1%	-	-	1.8%
h. DD Employment Programs	1.6%	1%	-3%	-	-	-	-	-
i. Adult Day Health (4)	2%	2%	-	-	-	-	-	-
j. PACE	2%	2%	-	-	-	-	-5%	-

Notes:

(1) Wages and benefits for individual providers are collectively bargained. The cost of contract changes have varied. For example, the biennial cost of contract changes in 2013-15 was approximately $110 million GF-State. Individual providers have not received reductions in wages and benefits, but hours of care for in-home clients were reduced (on average) by 4% in FY10 and 10% in FY11.

(2) The hourly rate for agency providers is adjusted to match contract changes for individual providers. The cost of "agency parity" has varied. For example, the biennial cost in 2013-15 was approximately $30 million GF-State. Homecare agencies received a $0.13/hr reduction in the 2010 Supplemental budget. Also, hours of care for in-home clients were reduced (on average) by 4% in FY10 and 10% in FY11.

(3) Nursing home rates were last rebased in FY10. However, revenue generated from the nursing home Safety Net Assessment has allowed for investment in nursing home rates. For example, new rate add-ons were established in FY15, which raised the statewide average rate from $187/day to $199/day in FY15.

(4) Adult Day Health was eliminated as an available service for clients living in residential settings in FY10. Due to litigation, ADH was restored for both in-home and residential clients. However, in FY12, the legislature prohibited clients from receiving both employment services and ADH, which resulted in roughly 40% drop in the ADH caseload.