Washington State Department of Social and Health Services

Transforming Lives

Aging and Long-Term Support Administration FY2020 Preliminary Budget Reduction Proposal Questions and Answers

Introduction: This document was developed in response to questions asked during a preliminary budget reduction stakeholder webinar on June 25, 2020. The answers contained within this document are based on preliminary budget reduction modeling completed in June at the direction of the Office of Financial Management (OFM). These are preliminary exercises and are subject to change.

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1. **What is the next step in this process? How do proposed reductions become final? Is there a link where all of this is posted?** DSHS is already implementing some reductions, such as freezes on hiring, travel and purchasing, furlough days and other administrative controls. Reductions that mean an impact to client services are pending direction from the Governor (Office of Financial Management) and passage by the Legislature. Any official budget reduction information will be available at www.ofm.wa.gov.

2. **For any reductions in FY21, what would be the earliest possible implementation date? Is eligibility being cut retroactively to July 1, 2020? If so, what if providers serve clients after July 1? Will they be reimbursed?** The modeling assumed an implementation date of October 1, 2020 for provider rate cuts in order to allow time for direction from the Governor and the Legislature, give notice to providers, and enact the rate changes in the payment system. However, given that there has not yet been a call for a special session, any rate cut seems unlikely in the near future. The eligibility reductions in the model are assumed to occur January 1, 2021. Similarly, these reductions cannot occur without federal Centers for Medicare and Medicaid (CMS) approval or notifications to providers, and that process will not begin without further direction from the Legislature.

3. **It sounds like the out years will require a 25% reduction in service for a 15% budget cut; is this accurate?** More than 15% of the clients are impacted because eligibility reductions will target the lower acuity clients, therefore more people will lose services to meet a 15% reduction funding target. If enacted, the eligibility reduction combined with program eliminations, would result in more than 15% of ALTSA clients losing services.

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4. **Are the enhanced FMAP add-ons being pulled back effective July 1 for Assisted Living and Skilled Nursing Facilities? We have also heard that a portion of the add-ons may continue and be retroactively adjusted; is that true?** The legislature and OFM authorized a continuation of enhanced rates for July through September. In most cases, such as Nursing Homes and Assisted Living Facilities, the rates will be adjusted retroactively to July 1, while in other cases, such as DDA community residential, the rates will be implemented in August. The enhanced rates were calculated based on the authorized funding provided. In the case of nursing homes, that means a $13 per day add-on for July, and a $5 per day add-on for August and September to stay within the amount authorized after the cost of the inflation factor effective July 1 was less than had been predicted.

5. **To the extent that the reduction would be isolated to COVID-19 Enhanced Match, what does this look like and is that considered one-time?** The temporary enhanced rate add-ons for the months of July – Sept are not necessarily related to the enhanced rates in January through June, but are targeted based on direction from OFM and the Legislature. The amount is also subject to caseload changes and the actual costs that are submitted as Medicaid service costs.

6. **Given the population utilizing long-term care has had the worst COVID-19 outcomes, is the state considering the risk of cutting services and what it could mean for COVID exposure to this population?** We are not able to provide services to the extent they exceed our budget appropriations and in order to meet the budget reduction target we were given, eligibility cuts and program eliminations are unavoidable. In an attempt to mitigate this in the least impactful way, eligibility cuts would be to the clients with the lowest level of need.

7. **In the June 5th budget reduction stakeholder letter, the provider rates reduction proposal amounted to $60.6M GF-S; $9.4M total funds. Is that a typo in the total funds?** Yes, it should have been $94.4M.

8. **For the proposed provider rate reduction, what is the estimated dollar breakdown by setting (Skilled Nursing Facility (SNF), Assisted Living Facility (ALF), Adult Family Home (AFH), Other)?** The chart below includes both ALTSA and DDA. For the sake of expediency, a few setting/provider types were not included in the chart because they are not included Medicaid forecast. These figures assume the enacted 2020 session forecast for caseload and per capita expenditures.

Area	FY21	21-23 Biennium
Adult Day Health	$ 189,000	$ 504,000
Adult Family Homes	$ 8,892,000	$ 23,712,000
Assisted Living	$ 3,483,000	$ 9,288,000
In-Home Agency	$ 11,268,000	$ 30,048,000
In-Home Indiv Providers	$ 33,389,000	$ 89,037,000
Managed Care	$ 873,000	$ 2,328,000
Nursing Homes	$ 17,037,000	$ 45,432,000
Private Duty Nursing	$ 594,000	$ 1,584,000
DDA Respite Other Out Home	118,000	315,000
Total	**$ 75,843,000**	**$ 202,248,000**

9. **Does DSHS believe rate reductions for SNF, ALF, AFH, etc. can be taken without legislative action?** No, there would need to be legislative action.

10. **Are the 3% reductions taken from the FY21 appropriated rates or is the base today's rates (FY20)?** The 3% reduction was based upon the FY21 appropriation in the Winter 2020 forecast prior to any changes passed by the legislature in the 2020 supplemental.

11. **For ALFs, has any thought been given to how this would be implemented, if approved? Would it reduce every classification by 3% or only classifications that received new funding in the 19-21 biennium (several classifications received no new funding from FY19 rates)?** No, that level of detail in implementing a potential reduction has not been decided.

12. **For SNFs, what changes, if any, would there need to be in this scenario to the statutory methodology in order to meet the 3% across the board?** We assume that the reduction would come in the form of a lowered budget dial, where we have existing statutory authority and guidance from RCW 74.46.421(4)(b).

13. **What percentage of total clients would lose eligibility if this level of eligibility cut were taken?** Estimated Number of Clients by CARE Classification Group (this is taken from June 6 modeling. Actual impacts would vary.):

NFLOC Level Reduction - Scenario 5

Acuity Order	Classification Group	Total HCBS % Client reduction	Assisted Living Client	ARC/EARC/ Dementia Client	ESF Client	PACE Client	AFH Client	Agency Provider Client	IP Client	Subtract Duplicate client w/ both IP/AP Client	Total Reduction Client
1	A Low	80%	1,186	178		128	84	654	456	4	2,682
2	B Low	76%	485	680	31	73	650	1,200	782	7	3,894
3	A Med	73%	356	57		48	43	1,138	1,253	12	2,883
4	B Med	52%	196	237	3	71	366	1,838	2,187	63	4,835
5	C Low	76%	71	32	1	6	28	173	139	4	446
6	A High	54%	63	16		20	20	511	776	10	1,396
7	D Low	9%	3	8		-	13	3	31	-	58
8	B Med-High	17%	9	97	7	8	96	40	74	1	330
9	B High	6%	3	28		1	66	15	68	2	179
10	C Med	28%	50	33		33	101	1,408	2,186	91	3,720
11	D Med	0%	1			2	1	1	5	-	10
12	C Med-High	1%					1	56	86	4	139
TOTAL			**2,423**	**1,366**	**42**	**390**	**1,469**	**7,037**	**8,043**	**198**	**20,572**

14. How would this level of eligibility cut translate to impact on the provider network?

Estimated Number of Clients by Provider Type:

Modeling of MPC Elimination and NFLOC Eligibility Change By Setting	Total client population served May snapshot	Estimated number of clients losing service if modeled level of eligibility change occurred	Estimated % client reduction
AFH	7,472	1,469	19.6%
ARC/EARC	2,925	1,366	46.7%
Assisted Living	3,854	2,423	62.8%
In-home Home Care Agency	15,853	7,037	44.3%
In-home Individual Provider	30,331	8,043	26.5%
Ancillary Services*	N/A	N/A	N/A
ESF	52	42	80.7%
PACE	933	390	41.8%
HCBS TOTALS:	**61,420**	**20,572**	
Nursing Home	9,410	684	7.3%

*Ancillary Services such as nurse delegation, personal emergency response systems, behavior supports, etc. are authorized based upon assessment and these services for client no longer functionally eligible would be ended. The client counts are already reflected in the primary personal care settings/providers.

15. **Eliminating Medicaid Personal Care (MPC) was discussed but will we eliminate N05 eligibility?** No, N05 is the ACES medical code used to identify individuals who became eligible for Medicaid as a result of Medicaid expansion in 2014. There is no change anticipated to this medical coverage group. Individuals who are eligible for N05 coverage may also receive Medicaid Personal Care services. If the decision is made to eliminate MPC, the client will remain eligible for their medical coverage.

16. **Can you discuss how your cuts at ALTSA may specifically affect people with developmental disabilities?** We are currently looking at data to see if we can provide more specific numbers related to individuals with developmental disabilities.

17. **How do these proposed reductions compare to the 2009-2011 Biennial and Supplemental Reductions?** In the 2009-2011 biennia there was not an eligibility cut where clients who were previously eligible for services were determined ineligible. Adult Day Health was transitioned from a state plan service to a 1915 waiver service which meant that some individuals lost eligibility, but the service remained available. There were provider rate cuts in the 2009-11 biennia and some of them were later partially restored. There was a reduction made to the hours clients were authorized to receive in the in-home setting and that reduction was not restored.

18. **When will clients be notified of these cuts?** Clients would be notified when there is a final decision that a change in eligibility will occur.

19. **What does the new eligibility look like?** There are currently three ways a person becomes functionally eligible for Nursing Facility Level of Care (NFLOC). A daily need for a specific treatment under the supervision of a nurse; an unmet need with a minimum number of seven qualifying Activities of Daily Living (ADLs) or an unmet need with one qualifying ADL in addition to a cognitive impairment. ; Qualifying ADLs include: Bed Mobility, Eating, Transfer, Toileting, Bathing, Ambulation, and Medication Management.

    To become eligible for the Medicaid Personal Care (MPC) program, an individual must not be NFLOC eligible and have an unmet need with at last three of ten qualifying ADLs. The qualifying ADLs include, Ambulation, Bathing, Dressing, Eating, Personal Hygiene, Bed Mobility, Medication Management, Toileting, Transfer, and Body Care.

The eligibility reduction that was modeled for this budget exercise would:

- Eliminate the MPC program.
- Change the NFLOC eligibility model to increase the functional impairment level required for eligibility in the following ways:
    - Previously, where one method required a specific treatment need under the supervision of a nurse, the types of treatments and provider types are reduced.
    - The method that previously required an unmet need with at least three ADLs is removed.
    - The method that previously required an unmet need with at least two ADLs is increased to at least four ADLs. When Medication Management is one of the ADLs identified, it has changed from requiring assistance at any frequency to needing daily assistance.
    - The method that previously required an unmet need with at least one ADL in addition to a cognitive impairment is increased to at least two ADLs in addition to a cognitive impairment. When Medication Management is one of the ADLs identified, it has changed from requiring assistance at any frequency to needing daily assistance. The data elements that compose identification of "cognitive impairment" have also changed.
    - Removes the ability for a client to decline assistance and become eligible.
    - Narrows the situations where a client can become eligible because an activity didn't occur because they didn't have a caregiver but would have accepted assistance if they had a caregiver.

20. **For those who currently reside in Assisted Living and receive assistance with less than 5 ADLs, will they still be eligible when changes are made? Or will they be taken off services?** In our proposed modeling, clients must meet the eligibility criteria outlined in question 19, above, to be eligible for long-term services and supports.

21. **What about the Meaningful Day program? Will it be cut and what other programs will be cut for Adult Family Homes?** The Meaningful Day program will remain. Ancillary services would be ended for clients no longer eligible.

22. **Where will all the clients go when these cuts happen that force Adult Family Homes to close?** Unfortunately, there may be providers that are not able to remain in business due to this overwhelming economic downturn. This is not something anyone wants to see happen. Adult Family Homes are a critical resource in our long-term services and supports continuum and closing a home will mean that residents will have to transition. Because cuts are based on eligibility, some clients will lose publicly-funded long-term care services. Other clients will be displaced with limited publicly-funded service options available.

23. **What are the potential impacts on acute care hospital transitions?**
Acute care hospital transitions will be significantly impacted should the proposed budget cuts move forward. We already see an impact to acute hospital transition work due to the furloughs that have been put in place. HCS was able to significantly improve time from HCS referral to assessment in an acute care hospital with the additional resources provided during the acute hospital surge (with COVID-specific funding provided) and will quickly lose the ground gained due to reduced staff time to conduct assessments, determine financial eligibility and facilitate transitions. Changes in eligibility will impact the number of clients who are eligible for services, leaving more people in acute hospitals with no access to ALTSA community services. This will significantly impact the group of clients who are already challenging to transition to the community due to their complex, often behavioral health, needs. Provider rate reductions will further limit the capacity of HCS to transition clients into the community, especially those individuals who experience barriers to discharge and where there are already limited providers who can meet complex needs.

24. **What are the potential impacts on state hospital transitions?** Since July 1, 2017 ALTSA has been involved in a significant number of state hospital transitions. Due to the changes in eligibility, it is likely that the majority of individuals transitioning from state hospitals would no longer be eligible for ALTSA services and would need services through another system. There are also potential cuts that could be made to behavioral health services funded through the Health Care Authority that impact state hospital transitions.

25. **Will cuts impact the Residential Support Waiver?** This level of cut would impact contracted providers and individuals served in Medicaid state plans and all of the ALTSA waivers, to include RSW.

26. **Will this also reduce mental health supplemental payments?** The mental health supplemental payments are administered through the Health Care Authority and Managed Care Organizations and are not part of ALTSA's budget and therefore not part of our reduction proposals.

27. **Are you planning the elimination of the Area Agency on Aging (AAA) model in your OFM ALTSA budget to fold them into the Home and Community Service employee workload?** No, this is not planned in any of our reduction exercises.

28. **How many ALTSA case managers serve clients eligible for in-home services? How many AAA and HCS employees may be impacted by these reductions?** The decreases in FTE are due to the assumed reductions in caseloads based upon loss of functional eligibility for personal care services under the State Plan and waivers:

Staffing Reductions due to potential functional eligibility changes: Assuming roughly 20,500 client lose services	**FTE Equivalents**	**GF-S**	**Total Funds**
AAA	280	10,967,000	21,130,000
HCS	124.5	7,275,000	14,550,000
TOTALS		**18,242,000**	**35,680,000**

29. **Why are you considering furloughs versus a reduction in force? A reduction in force should provide more real time reductions in expenses. Re-filling those positions should only happen as revenues recover in order to support the cost.** At this point ALTSA has been able to continue all of our services and we added an extreme amount of work addressing all of the impacts of COVID-19. Furloughing staff across the state agencies is a way to gain some savings and keep a very necessary workforce in place as we continue to serve clients and address COVID-19.

30. **Can reductions in leases and properties be achieved if the experience of "work from home" has been successful?** Yes, however it would be quite some time before we realized any savings. New leases are on a 10-year commitment and renewals are on 5-year terms. Facilities with leases about to expire would be prime candidates to terminate, but just moving out of a facility can cost hundreds of thousands of dollars. Many of our facilities are shared with other programs that would need to be in a position to move/consolidate too. We also do not have cancellation clauses in many of our leases, so if we cancel and move out, we would still pay the full term amount. If we add cancellation clauses to a lease, the rent increases substantially.

31. **Are you considering cuts related to unnecessary paperwork/clerical items? Like translating documents? Translations cost the state millions of dollars when we could utilize free translation services through Google, rather than paying the high costs of a vendor.** Translation of documents into the languages that individuals with limited English proficiency can understand is required under:
    - Federal law – Title VI of the Civil Rights Act of 1964.
    - RCW 74-04-025
    - WAC 388-271-0030
    - DSHS Administrative Policy 7-21
    - Legal agreement and consent decrees the Department entered into.

    Violating any of these provisions can put the Department at risk of litigations that can result in reduction or loss of federal financial assistance.

    Due to the risk of possible distortion of the meaning and intent of the documents by machine translation, the Department utilizes DES Master Contract for Translation Services 04218. The contract requires the use of certified or recognized translators and reviewers when providing translation services to DSHS.

    Most of DSHS' official documents and their translations are not stored in paper, but rather are available for downloading from the DSHS Forms website and the DSHS Publications Library.

32. **Can ALTSA send out a poll to stakeholders for ideas on alternative cuts?**
    We welcome your suggestions for alternatives to meet our target. Please email your suggestions to our inbox at: ALTSAcomms@dshs.wa.gov between now and August 7th to coincide with budget proposal timelines.