Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Engrossed 2nd Substitute House Bill 1694, Sec 10

Addressing Home Care Workforce Shortages:
Allowing a spouse or registered domestic partner to receive payment for providing home care services to the spouse or domestic partner

December 31, 2023

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Executive Summary

Engrossed 2nd Substitute House Bill 1694 was passed during the 2023 legislative session addressing homecare workforce shortages. Section 10 directs the Department of Social and Health Services to consider an option to help mitigate this shortage by designing a pilot for legislative consideration that would permit the paying of spouses [1] to provide personal care services for their spouse who is eligible for long-term services and supports and has complex medical needs.

Allowing spouses to become paid caregivers in Washington state supports workforce development and is responsive to preferences expressed by clients, Tribal Governments, and advocates. The goal of completing a pilot program report is to lay out a roadmap to implementation that includes best practices from other states, identifies considerations to implementation, identifies statutes and or Washington Administrative Codes that will need to change, and impact on budget appropriations.

The pilot program report shall consider:

- Appropriate acuity level of the care-receiving spouse[1].
- Projected number of individuals to be served.
- Payment parameters for the pilot project.
- Fiscal considerations and use of Medicaid matching funds.
- Geographic locations for implementing the pilot project.
- Ways to design the project to aid in future statewide implementation.
- Cost estimates for implementing the pilot project and cost estimates for implementing expansion of the pilot project.

Additionally, the report shall address a proposed timeline for implementation of the pilot project and the training needs of the care-providing spouse or domestic partner.

Recommendations

DSHS recommends that the Legislature appropriate funding to allow the Aging and Long-Term Support Administration for a limited pilot program to pay spouses and state registered domestic partners to provide personal care services to their spouse who has extraordinary complex care needs identified in their individualized CARE assessment.

This would be accomplished through use of a 1915(c) home and community-based waiver approved by Centers for Medicare and Medicaid Services. Using this wavier authority allows the state to define the clinical characteristics of a person who has extraordinary complex care needs as well as the qualifications of the spouse. It also allows the state to manage enrollment

[1] Throughout the report the term “spouse” includes married spouse and state registered domestic partner

consistent with budget appropriations of the legislature. Federal approval of a waiver allows the state to utilize Medicaid match to help fund the increase in appropriations that would be necessary to fund the pilot.

There are two provider employer options to operationalize paying spouses to provide personal care for their spouse. Either option would increase the appropriation needed in the program that allow them as a qualified provider. They include the following:

- Consumer Directed Employer to allow clients to self-direct their spouse as an Individual Provider as defined in RCW 74.39A.240.
- Home care agency long-term care worker as defined in WAC 388-71-0503. Use of this option would require a change to RCW 74.39A.326.

The reasons for these recommendations will be further explained in this report.

Background

Since the late 1980s, the Department of Social and Health Services has offered personal care services to eligible individuals as an optional Medicaid State Plan service. The federal rules that govern the Medicaid Personal Care program prohibit states from receiving federal matching funds if payments are made to individuals who are legally responsible for the Medicaid beneficiary. Spouses and parents of minor children are examples of legally responsible individuals included in the Medicaid definition. For more information regarding parents being paid providers for their minor children, see Feasibility Study from DSHS's Developmental Disabilities Administration. To ensure 50% matching funds from the federal government, available in Medicaid personal care programs, DSHS wrote program rules in WAC Chapter 388-106 prohibiting spouses from being paid to provide personal care services to their spouse. The state applied the same rules and Medicaid authority language in 1915(c) waivers to maintain consistency in the types of qualified providers across Medicaid programs as it was common for individuals to move between Medicaid authorities based upon needs and preferences for long-term services and supports as well as changes in functional and financial eligibility status.

In 2014, the Washington State Legislature passed Engrossed Substitute House Bill 2746 directing DSHS to implement a Community First Choice option available under section 1915(k) of the Social Security Act to take advantage of an additional 6% federal match of funding to expand the types of services clients could receive in the personal care programs. In July 2015, DSHS implemented the Community First Choice (CFC) program which serves nearly all clients receiving personal care services under Aging and Long-Term Support Administration. For clients whose income is too high to meet financial eligibility criteria for CFC, ALTSA can use the 1915(c) waiver eligibility rules which allows clients to access CFC personal care in addition to the waiver supplemental services. When the 1915(k) option was implemented, the state continued the same list of qualified providers of personal care.

Washington's contracted Long-Term Services and Supports providers have been experiencing workforce shortages. These shortages have been exacerbated by the Public Health Emergency over the last few years. The result is longer waits to access care for clients who need long-term care services in all settings, and we anticipate this trend will only worsen over the next 20 years based on the aging demographic. In addition, there have been occasions when clients were not well served by the current system of qualified Medicaid providers due to the complexity of the level of acuity of the person needing care. This results in people having to leave employment to care for their spouse without the ability to be paid for the care provided. This creates financial strain on those families.

This pilot design report to the legislature provides data about the considerations of allowing spouses to become paid caregivers in Washington state as well as implications for making this change.

Extraordinary Care and Target Population Size

Key to a successful pilot will be ensuring that Washington can leverage state-funded investment with federal Medicaid matching dollars. At the same time, Washington will need to prepare for people who are having their needs met by their spouse without Medicaid and are not interested in having another type of paid caregiver in their home. This will increase the number of individuals accessing Medicaid funded long-term services and supports. The surest way to best understand the impact of allowing spouses to qualify as paid providers on budget and programs would be to use a waiver authority where the number in the program can be capped, geographic limits can be set, and client attributes can be defined. The recommended target for the pilot will initially be 150 to 200, with allowance for growth up to 500. This would allow sufficient experience to estimate impacts should the legislature want to expand the waiver in the future.

The initial target population will be working-age caregivers (ages 18 to 69) where the caregiver is, or could be, contributing to the family income by working and whose spouse has complex medical and personal care needs. Over the past decade, we've heard from constituents that younger people were leaving the workforce to care for their spouse whose needs were not well met by Individual Providers (IP) or Home Care Agency providers. These were often situations where the care receiver had skilled RN needs that couldn't be delegated through nurse delegation and no other family was available to be an IP. However, the family suffered economically without the spouse's outside earning potential.

The Centers for Medicare and Medicaid Services allows states to pay spouses as caregivers when the client requires a "medically extraordinary" level of care. It is up to states to determine the eligibility level of care for their programs. DSHS researched how other states interpret medically extraordinary care and found a wide variance including:

- Oregon, with a strategy most in line with Washington's proposal, defines very specific exceptional criteria, which includes:
    - Full assistance with at least four of the six activities of daily living, and
    - A debilitating medical condition such as cachexia, severe neuropathy, coma, persistent stage three or four wounds, late-stage cancer, frequent and unpredictable seizures, or
    - A spinal cord injury or similar disability with permanent impairment.
- Arizona and Utah use a broader interpretation and define extraordinary care as any support for ADLs and IADLs that exceed care typically provided by a spouse of an individual without a disability or chronic condition.
- Wisconsin allows spouse providers when the amount of personal care supports exceed the normal spousal caregiving responsibilities for a spouse without a disability or finds it necessary to forego paid employment to provide the service.
- Oklahoma's eligibility is based on there being no available worker in the area or complex needs with medical documentation from a health care professional that the spouse would be best caregiver.

The Washington long-term care eligibility and assessment tool, known as CARE, assigns one of 17 classification levels to determine individual level of benefit. Data was analyzed for eligibility criteria that aligned with the existing Exceptional Care or "E-group" with a few changes. Criteria for this group is outlined in WAC 388-106-0110 and includes components of:

- a turning/repositioning program
- range of motion
- an Activities of Daily Living (ADL) score of 22 or more, plus:
    - Either total bowel/catheter care or
    - Tube feeding and dialysis or
    - Ventilator/respirator (tasks that require nurse delegation)

We feel confident that these criteria in a new classification group, specific to spouses being cared for by their spouse, would meet CMS' medically extraordinary care requirement.

For our pilot group, we propose for clients (ages 18-69) that the ADL score requirement to be lowered from 22 or more to 18 and to target working age spouses. We could learn more about the needs of this population by considering other clients, with medically complex needs through an Exception to Rule (ETR) process, who want their spouses to provide paid care.

Based on the above new classification group criteria, DSHS Research and Data Analysis was able to identify 212 married/partnered in-home clients statewide who meet the lower ADL score and client age requirements. In addition, there are another 118 clients who meet these criteria

living in residential settings (Adult Family Homes and Assisted Living facilities) who may want to consider returning home if they could employ their spouse as their paid provider. If 100 of the 330-client pool opt in, we could also serve another 100 individuals with paid spouses as more people become aware of the program and through potential ETRs. If the size of the population participating in the pilot is too narrow, impacting the number of people eligible to participate, the qualifying criteria for spousal providers could be broadened to increase the size of the pilot population.

Because we can determine classification group eligibility through administrative data, we could implement as soon as funding appropriations and CMS approval are obtained. We could adjust as needed to stay within budget appropriation/waiver cap goals. Other challenges, such as WAC and/or RCW changes and risk mitigation for adverse outcomes, are described in later sections of this report.

ALTSA anticipates that acuity requirements in the new classification group will lead to frustration among those clients who wish to participate in the pilot but are not eligible. Applying effective communication and engagement tactics will help mitigate this frustration.

Another option to mitigate the frustration of clients not functionally eligible to participate in the spousal provider waiver would be to use the current CARE classification groups (described in WAC 388-106-0125) instead of the new modified E group. If this option was chosen, a larger number of clients would meet the eligibility criteria to have their spouse as a paid provider resulting in the need for a statewide wait list if funding was appropriated to only serve up to 500 clients. Managing a statewide wait list would also create an administrative burden for which additional staff would be needed.

Best Practices in Other States

ALTSA contacted 10 states to learn about their programs that pay spouses as paid caregivers. Seven states (Kentucky, Arizona, Oklahoma, North Dakota, Oregon, Utah, and Wisconsin) provided valuable information for Washington to consider. This section outlines the best practices from these seven states.

Authority

All seven states use a CMS waiver authority to pay spouses to be caregivers. Oregon does not specifically call out the option for spouses to be paid caregivers but instead include spouses in the definition of a qualified provider for in-home services.

Age Requirements

All states responding to ALTSA's inquiry require that spouses be at least 18 years of age (note that one state does allow for exceptions to this age limit) and most states require that the spouse demonstrate their ability to perform the personal care tasks safely.

Health and Welfare

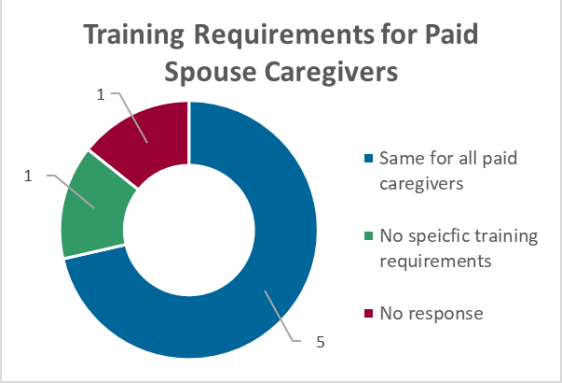
The health and welfare of both the client and spouse is very important to all states. Arizona reports that spouses who choose to be a paid caregiver must be employed by a home care agency to provide for additional oversight and the case manager must conduct in-home visits every 90 days. Most other states require case managers or support coordinators to complete increased in-home visits to the client, some as often as monthly. Wisconsin required both scheduled and unannounced home visits. All states required spouse providers to complete background checks like other paid providers.

Many states shared that there is a need for respite and burnout prevention options for the spouses completing paid caregiver tasks. Utah reported they are working to develop resources which may be tailored to each family's need. Examples include resources on proper lifting techniques, appropriate referrals to home health/nursing supports and caregiver support networks for social/emotional support, etc. Washington has developed robust services to support unpaid family caregivers through general fund state and Medicaid funds through an 1115 waiver. Current policy limits the use of these services to unpaid caregivers. That policy could be revisited to support paid spouses with these types of services which would increase the funding needed in these programs and potentially create expectations and or need to expand the availability of those services to other paid family caregivers.

Arizona, Kentucky, and Oklahoma all limit spouse providers to no more than 40 hours of paid care per week. Oregon only allows spouses to provide up to half of the hours allocated for instrumental activities of daily living. North Dakota pays spouses a monthly rate based upon the client's assessed need for assistance with activities of daily living. In Utah, there are daily and weekly maximum hour limits based upon the client's extraordinary care needs and prior authorization from Financial Management Service for the number of hours that can be served by the spouse provider.

Training Requirements

Six states require spouse providers to meet the same training requirements as other qualified providers including continuing education annually. Another state's requirement is for the caregiver to have demonstrated the ability to perform necessary tasks because they acknowledge uncompensated care may have been rendered for extended periods prior to this flexibility being allowed. One state did not indicate their training requirements.



Effectively communicating the pilot requirements to current and prospective participants, through a variety of channels, will increase the likelihood of their success in navigating it.

Statutes, Regulations and Federal Authorities

DSHS explored the population to be served and researched how other states operated their programs that allow spouses to be paid providers. Based upon this research, it was determined that a 1915(c) waiver would be the most appropriate CMS authority for Washington to use for the spousal pilot project. This authority will allow the state to target the specific type of clients, allow the state to limit the number of clients to be served based upon appropriation authority, choose the specific set of services to be provided, outline the provider qualifications, and limit the geographic location of the pilot, if necessary. Use of the 1915(c) waiver will also provide the state with 50% federal matching funds for services delivered under the waiver. It is important to note that use of a federal authority would also require the spouse, as a paid provider, to be eligible for employment in the United States. Other state laws that apply to paid caregivers, such as background checks, would also apply.

Regarding timelines, it would take approximately 12-18 months to draft and submit a 1915(c) waiver request and receive approval from CMS. State rulemaking, changes to CARE, if needed, drafting policy and training staff could occur concurrently with the waiver application/approval process.

Consideration was given for using both the Consumer Directed Employer of Individual Providers and DSHS contracted Home Care Agencies as potential employers of this provider group. It is important to note that to allow spouse and registered domestic partners to be providers employed by home care agencies, the following RCWs would need to be changed:

- RCW 74.39A.326: In-home personal care or respite services to family members—Department not authorized to pay—Exceptions—Enforcement—Rules.
  (Note: As this RCW applies to all relatives, changing it could impact all relative types. Unless the change is applied in a fashion targeted only to spouses)
- RCW 18.88B.041: Defines which LTC providers are not required to become credentialed home care aides.

- RCW 74.39A.076: Defines which LTC providers require 35 hours of Basic Training.
- RCW 74.39A.341: Defines which providers require continuing education.

The RCW changes described above will need to be understood and integrated into training and processes of CDWA, home care agencies as well as the entities that provide training which will require time and effort.

Similarly, depending on the employer option chosen, several WACs related to provider training and certification would also need to be changed through the formal rule-making process.

Provider Training, Supports and Benefits

Training for individual providers employed by CDWA is dictated by statute RCW.74.39A.076. The training requirements for home care agency workers are outlined in RCW.74.39A.074.

As part of this pilot design, ALTSA recommends that the same training rules and requirements be adopted that were put in place by HB1694 which allows long-term care workers to provide approved services for a spouse through the United States Department of Veterans' Affairs, Veteran Directed Home Services program. These training requirements are the best fit at this time, as the curriculum is already in place, and modification to the current training category would not entail the creation of new rules or training categories by either the Training Partnership or CDWA. This would allow a quick and relatively seamless transition when these providers begin caring for their spouse. The timeframe for implementation of these training requirements would be minimal.

HB1694 sets the training and certification parameters for the Veteran Directed Home Services spouses as below:

- RCW 18.88B.041 exempts a long-term care worker providing approved services only for a spouse or registered domestic partner and funded through the United States department of veterans' affairs home and community-based programs from being required to become a credentialed Home Care Aide. This RCW would need to be amended to include spouses or registered domestic partners providing services to their spouse as an employee of a home care agency through this new program.
- RCW 74.39.076 requires that these providers must complete 35 hours of training within the first 120 days after becoming an individual provider. Five of the 35 hours must be completed before becoming eligible to provide care. Two of these five hours shall be devoted to an orientation training regarding an individual provider's role as caregiver and the applicable terms of employment, and three hours shall be devoted to safety training, including basic safety precautions, emergency procedures, and infection control.
    - Providers in this training category do not have to complete basic training if they are:
        - Registered nurses, licensed practical nurses, certified nursing assistants or

persons who are in an approved training program for certified nursing assistants under Chapter 18.88A RCW.
    - Medicare certified home health aides, or other persons who hold a similar health credential, as determined by the secretary, or
    - Persons with special education training and an endorsement granted by the superintendent of public instruction, as described in RCW 228A.300.010, if the secretary determines that the circumstances do not require certification.
    - Persons who were initially hired as long-term care workers prior to January 7, 2012, and who completes all the training requirements in effect as of the date the person was hired.
  - These providers must complete 12 hours of continuing education by their birthdate each year after the completion of Basic Training.

For a list of other Law and Rule Changes (RCW and WAC) see Appendix A.

It will be incumbent on ALTSA and/or the employer of spouses/domestic partners to provide this new category of providers with the information, knowledge, tools, and skills they will need to successfully navigate the resources, and laws/rules that apply to them.

Payment Mechanisms and Impacts

The payment mechanisms for allowing spouses to be paid providers are relatively straightforward and will leverage existing infrastructure and functionality. The services that will be provided to the demographic group already exist, and the clients are also eligible for the services, so the work would focus on expanding existing practices and system configurations to include and identify this new group of providers (spouses). Listed below are the considerations that will need to be addressed, as well as anticipated impacts to the payment system based on what is known at this time.

The expected changes to DSHS systems utilized for implementation of the pilot could potentially be implemented within three months but it is unknown what timeline the contracted CDE vendor would need to implement DSHS changes.

Payment Process

- Service authorizations would be created in ProviderOne through the CARE interface based on the outcome of the client's functional eligibility determination (CARE Assessment) and client's choice of provider.
- Spouses would be an employee/Individual Provider with the Consumer Directed Employer or Home Care Agency depending upon how the legislature chooses to implement the pilot.
- Servicing provider would provide service based on authorization and submit timesheet to billing provider.
- The authorized provider would submit claim(s) in ProviderOne for service days based on the times worked by IP(s).

- Rates paid would be derived on the social service authorization and configured per any relevant employer policies.

Options for identifying claim lines for providers who are covered by HB 1694		
	Benefits	Risks/cost
Configure a new Claim Modifier: The billing provider would include an additional modifier on their claim lines that would indicate that the 1694 relationship between client and social service servicing only provider. This option follows the existing process used to bypass Electronic Visit Verification rules in ProviderOne for live-in providers.	Existing process that is demonstrated to be effective. Does not require additional effort from authorizing worker. Keeps DSHS staff out of managing individual client/provider shift management. Allows for reporting and monitoring ProviderOne claims data thus eliminating the need for new reporting tools to identify these claims.	New claim modifier will need to be configured in ProviderOne. Provider will need to update their billing processes.
Billing Provider Self-Report: The responsibility of tracking and reporting client/provider relationships is with the billing provider who must prepare the information in a way that meets DSHS's requirements and remit those details in a to-be-determined workflow.	No special system configuration needed. Does not require input from authorizing worker. Does not require management of servicing provider scheduling.	Will require specific monitoring by DSHS staff. No direct link in MMIS between relationship type and payment data. May need to be added to contracts. Need to establish workflow/system to ingest and store information provided.

There may be a cost associated with changes made to either CARE or ProviderOne systems. Changes made to CARE and ProviderOne are typically in scope for normal business functions, but larger changes may require a change request for either system due to the size, difficulty, or complexity of the change.

Payment for services rendered as a part of this pilot will be remitted per current system functionality and policy. If a unique funding source/account coding needs to be attributed to these services that are distinct from other in-home personal care DSHS will need to configure that for the implementation.

Financial Eligibility Implications

To qualify for long-term services and supports, the client must be both functionally and financially eligible for the program. In many cases there may be an obligation on the part of the client to also pay towards the cost of the services they receive. CMS has prescriptive regulations that govern the calculation of how much a client must pay which includes allocations of income between the client and their spouse to protect the spouse not receiving LTSS from becoming impoverished as a result of their spouse's needs for LTSS. The following section makes some assumptions and recommendations relating to ways to structure eligibility to ensure there is minimum impact to our clients and their spouse.

The following is assumed:

If the state included the option to pay spouse providers under the state plan program, Community First Choice (CFC), it would need to be available to all Medicaid eligible clients in Washington that meet categorically needy or Alternate Benefit Plan scope of care and are also functionally eligible. Per federal law, paying spouse providers would not be allowed under the Medicaid Personal Care (MPC) state plan program. To limit the scope and size of the pilot, the state would need to use a 1915(c) Home and Community Based Services (HCBS) waiver to define the extraordinary care needs of the eligible clients who choose their spouse to be their paid caregiver. This would assist the state to manage the associated costs and allow the legislature the ability to determine the extent of expansion based upon budget appropriation levels. In a state plan, there is not an ability to cap enrollment.

Financial Eligibility Impacts

- An individual's earned income is counted toward basic food, cash, and non-institutional medical programs. This may affect eligibility for, and benefit amounts for the client and their household.
- Very low-income clients who are eligible for non-institutional healthcare coverage under a categorically needy (CN) or Alternate Benefit Program may access CFC, MPC or Medicaid Alternate Care (MAC) under that coverage. If the family has an increase in earned income, they may lose financial eligibility for these programs when counting a spouse's income. This may affect the entire household's medical for the non-institutional Medicaid group they are currently receiving. This is one of the reasons DSHS is recommending to only permit spouses to provide care under a 1915(c) waiver where income amounts can be higher.
- Spousal income doesn't count in HCBS 1915(c) waiver eligibility. Only the client's income is used in determining the initial financial eligibility. However, the spouse's income is taken into consideration when determining the amount that the client must pay toward their cost of care. To avoid a situation where the more the care provider spouse earns taking care of their spouse, the more the care recipient spouse has to pay toward that care, it will be important to work with CMS to structure the new waiver in such a way to avoid unintended impacts to our clients.

- Spousal income does apply to Modified Adjusted Gross Income eligibility through the Health Plan Finder, as income is based on the household tax filer's income (see 2nd bullet as this affects CFC only, MAC and state plan type services).
- All HCBS waivers in Washington use the same financial eligibility rules across each per Chapter 182-515 WAC. This streamlines eligibility when a client changes from one HCBS waiver to another.
- Most individuals on HCBS waivers access personal care through CFC for the department to receive the additional 6% enhanced federal match.

ALTSA implications

Community First Choice (CFC) and Medicaid Alternative Care (MAC) individuals may have multiple agency involvement. Those under age 65 and not on Medicare may be on Modified Adjusted Gross Income (MAGI) healthcare coverage which is accessed through the Healthplanfinder website and managed by the Health Benefit Exchange. ALTSA Public Benefit Specialists have limited access to information on MAGI cases and other CN cases managed by the Health Care Authority (Foster Care, Breast and Cervical Cancer program).

Clients on the CFC or MAC programs who receive their healthcare coverage under MAGI based programs who also receive cash and food benefits are managed through the Economic Services Administration, Community Services Division.

It would be imperative to ensure the spouse is aware of reporting requirements to HCA and ESA for Basic Food and/or cash benefits. Earnings may affect the household's eligibility for these programs and the spouse's earnings may affect the client's eligibility for CN non-institutional program and if that is the case, public benefit specialists (PBS) would need to look at eligibility under HCBS waiver rules. This would include a resource evaluation.

When an individual is enrolled in CFC and has wrap around services under the COPES waiver, an ALTSA public benefit specialist is assigned to manage financial eligibility. That results in improved quality assurance with eligibility for basic food and spouse's medical as it is assumed social worker/case manager would report when the spouse is getting paid for caregiving. If an individual on MAGI and receiving CFC needs to access the COPES waiver for a spouse to be paid, or any other HCBS waiver service, a disability determination would need to be completed if a current disability determination does not exist. This can take the Division of Disability Determination Services up to 90 days to adjudicate.

Spousal caregiving earnings would have no effect on the client's initial eligibility for HCBS waiver eligibility but may affect the current spousal allocation from the client's income and may affect the household's basic food.

Eligibility Recommendation

Since spousal income is not counted in a client's HCBS eligibility it is recommended to limit the eligibility for the spouse to a specific 1915(c) HCBS waiver. It gives the state the ability to:

- Cap enrollment to stay within appropriated budget amounts.
- Streamline eligibility by using the same financial eligibility rules as current HCBS waivers.
- Limit eligibility system programming.
- Not count the caregiver income when determining HCBS waiver eligibility for the client.

Additional Considerations

The paid caregiver income counts toward other benefits such as:

- HUD housing.
- Supplemental Security Income. SSI recipients do have options when receiving earned income through Ticket to Work.
- If the spouse has a disability and is receiving earnings subject to taxes, they may be able to access Apple Health for Workers with Disabilities which has no income, resource, or age limit. Disability and receiving earnings are requirements for the HWD program. The SW/CM would need to inform the spouse that earned income may affect low-income families who receive needs-based programs such as SSI, food benefits, housing benefits and their own Apple Health Benefits. There may be potential tax implications as well.

Cost and Budget Estimates

Assumptions:

- Services are assumed at average per capita costs of $8,505. This is based upon existing clients and FY23 expenditures which include personal care and other related costs such as assistive technology, non-medical equipment, home delivered prepared meal, etc. Data source: ProviderOne claims data.
- Existing clients (204) shift to new waiver resulting in loss of CFC match of 6%. Total cost impact is zero, but GFS impact is $1.2M due to loss of federal matching funds.
- New clients added (296). We phase in 60 in FY25 and then continue to phase in the remaining 236 over the next four years. By July 2029 we reach 500 clients. Annual costs start out at $1.7M and at full implementation reach $30.2M for the new client population.
- HCS Staffing = phase in over same period as clients, with cost at $1.3 M ($651,000 GFS) in the first year and $3.6M ($1.8M GFS) at full implementation. Calculation is based upon existing ratio of 362 to 1 changing to 50 to 1. Resulting in an additional 13.8 FTE after full implementation. This cost also includes the following:
    - Organizational Change Manager (projected at 20 hours a week for a 12-month contract) to apply the structured processes that will support effective awareness, engagement, and adoption of this change by all impacted groups.
    - HCS HQ Regional Trainer (2-year project position) for development and implementation period.
    - Workforce Navigator (in the ALTSA Workforce Development Unit) to support spouse providers.
- AAA Staffing = phase in over same period as clients first year cost is $164,000 ($82,000 GFS) and at full implementation $1,2M ($598,00 GFS). Calculation is based upon existing

ratio of 75 to 1 changing to 50 to 1 resulting in an additional 7.3 FTE after full implementation. The lower caseload ratio is needed to perform the additional oversight, health and safety visits that are best practice in other states.

- No inflation or cost increases are assumed in the modeling. If per caps increase or additional funding is provided by the legislature, these would be applied like other services and staffing costs.

Biennium	Cost	Average Number of Clients
23-25	$1.8M ($900,000 GFS)	120
25-27	$28.9M ($14.4M GFS)	346
27-29	$56.4M ($28.4M GFS)	482

Technical Impacts

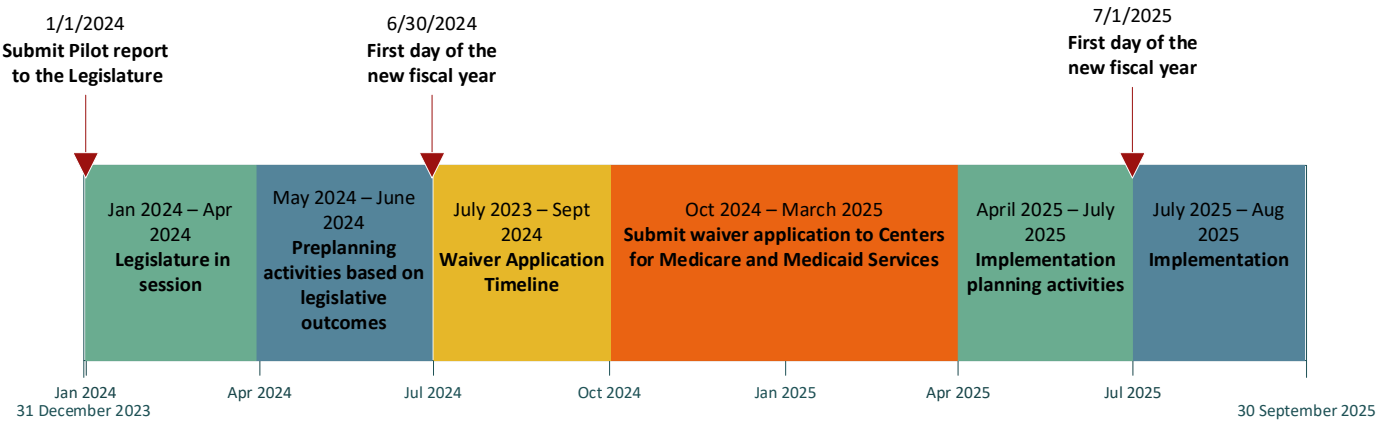
The technical and system changes needed in CARE will be small and completed with existing resources and will require approximately 200 hours of development time and 30 hours of testing time. Changes to CDWA are also small and can be made within the existing budget and no additional funding required because system changes are built into the administration payment DSHS makes to CDWA.

Modifying existing reports to capture changes in programs and services requires approximately 250 hours of development and testing time combined. Changes to the payment mechanisms include configuration changes to track and manage the new associated claims in the payment system would take approx. 100 hours. (See Payment Mechanism)

Implementation Timeline

Once the waiver has been approved by CMS, ALTSA will use a phased-in approach to implement the pilot across the entire state to the targeted population rather than a geographical area. The exact date of implementation depends on how quickly CMS approves the amendments. It can take a minimum of six months for approval but is often longer (up to 18 months).

Timeline: 18 months total including submitting waiver application, system configuration, rulemaking, drafting policy, meeting with stakeholders and partners, and staff training.



Date	Detailed Description
12/31/23	**Submit Pilot report to the Legislature**
1/1/24 – 4/30/24	**Legislature in session**
5/1/24 – 6/30/24	**Preplanning activities based on legislative outcomes**
7/1/24	**First Date of the new fiscal year** -If Legislature approves, this is the earliest to get funding to start the project -Once Legislature approves, the program can begin the implementation process
7/1/24 – 9/30/24	**Waiver application timeline** -Draft the waiver application -Complete Tribal Roundtables and Consultation -Conduct stakeholder meetings -Implementation planning
10/1/24 – 3/31/25	**Submit waiver application to Centers for Medicare and Medicaid Services** -Allow at least 90 days for CMS to review and approve (this process could take up to an additional two to three months if there are questions submitted to ALTSA from CMS) -During this CMS review time, the ALTSA program staff concurrently work on rulemaking, system configuration, drafting policy and developing staff training -Implementation planning
4/1/25 – 6/30/25	**Implementation planning activities**
Summer 2025	**Implementation**

If it is determined after implementation that changes are needed to change the training requirements of the spousal caregivers, the eligibility criteria of the target population or to increase the number of individuals to be served, ALTSA would need to submit a waiver amendment to CMS. As noted above, this process could take between six and 18 months to complete.

Barriers and Challenges to Implementation

ALTSA recognizes that barriers to implementation exist and will need to be addressed to the extent possible if implementation is requested by legislation. The following is a list of identified barriers, some of which are not unique to spouse providers. For purposes of this pilot, we will focus on spouse provider specific ones.

- The recommendation is to begin with a pilot and utilize a definition of extraordinary that targets the ability to pay a spouse as a paid provider to a subset of eligible clients. We expect that there will be individuals who believe the state should have broader policy.
- Concerns voiced by constituents that the state is paying spouses to care for their spouse using taxpayer dollars.
- A lack of infrastructure or technology, such as broadband, may impact the ability of rural communities to support receiving access to long-term services and supports and to access any virtual training options. Potential lack of oversight from others in the client's life creating a higher risk of abuse and neglect.
    - One potential mitigation could be to increase the number of required home visits by the case manager to quarterly per RCW 71A.12.320. This would require reduced caseload size and more FTEs to accomplish.
- For families receiving Temporary Assistance to Needy Families, Supplemental Nutrition Assistance Program/Basic food, HUD housing, or other income-based program benefit, the earnings may negatively affect their benefit.
- Spousal burnout due to being both paid and informal caregiver for their spouse.
- Social isolation for both client and spousal caregiver.
- Statutes and policies exist that paid providers must meet to be qualified. These include background checks and required training. There will be some spouses who may not be able to meet these requirements and that will be a frustration.
- ALTSA met with tribal partners who shared feedback about barriers particular to their communities Appendix B.

Positive Factors to Implement

- There may be an increased utilization of client's assessed hours.
- Increased caregiver pool. If spouses are now providing all or part of the care for a client, this may allow an already assigned IP to serve other clients in need.
- Continuity of care: spouses are already familiar with the spouse care needs.

- Clients are more at ease with having a loved one care for them – no disruption of routines, no stranger coming into the home, etc.

Next Steps and Follow-up Items if Funded

- Recommendation to offer consultation to our tribal partners. To ensure full tribal participation the duration for this activity could take up to three months.
- Recommendation for contracted change management resource to:
    - Gather additional collaborator input (re: implementation, how will we define this process, design what the program looks like, parameters).
    - Managing transition and resistance during and after implementation will require a structured process and data that allows ALTSA to monitor the readiness trajectory of impacted groups. Tactics that support these outcomes are included in the Change Management/Readiness Factors section of this report.
- Input from CDWA: Address questions from Benefits Group regarding reporting needs and associated elements, requirements to implement, ensure these are clearly defined so CDWA can prepare.
- Execute the implementation plan.
- Identify additional FTEs needed to implement the program.
- Risk management after deployment needs to be defined and implemented.
    - Support and operationalizing /sustainment of program after deployment.
    - Meeting the needs of the clients post deployment.
    - Understanding the resources in the geographic areas.
    - Program management, processes built in for checks and balances, mitigate.
    - Support decision making when things are not working.
    - Risk management at the client level and all levels.

Collaborator Impact and Engagement

ALTSA engaged the services of Vivid Company to perform Organizational Change Management, impact analysis, risk assessment, and collaborator analysis and engagement related to implementing the pilot program described in this report. Certified Change Management Professionals™ staff met with representatives from 13 external collaborator groups to discuss their perspectives on the potential benefits and challenges of implementing this change. In addition, ALTSA surveyed 121 internal collaborators to capture their perspectives. Overwhelmingly, external and internal collaborators see a need for this change. There is a recognized need for clear program eligibility requirements and program success parameters that are rooted in established best practices.

Meetings were also held with ALTSA leaders and subject matter experts to perform an initial assessment of the change envisioned by this pilot. Prosci® tools, professional experience, and a deep historical knowledge of the ALTSA impacted Collaborator Groups were used to conduct

the assessment and develop findings and recommendations.

Conclusion

DSHS recommends that the Legislature appropriate funding to allow the Aging and Long-Term Support Administration for a limited pilot program to pay spouses and state registered domestic partners to provide personal care services to their spouse who has extraordinary complex care needs identified in their individualized CARE assessment. This would be accomplished through use of a 1915(c) home and community-based waiver approved by Centers for Medicare and Medicaid Services. ALTSA proposes to include the following services in the spousal waiver:

- Personal care services with a limited number of hours available for the spouse provider and the remaining assessed hours be provided by the client's other choice of provider(s).
- Specialized equipment and supplies including assistive/adaptive technology.
- Client Support Training and Wellness Education.
- Home Delivered Meals.
- Skilled Nursing.
- Environmental modifications necessary for health and safety.

Additionally, it is recommended that spouses be employed by either the Consumer Directed Employer as Individual Providers as defined in RCW 74.39A.240 or a contracted home care agency as defined in WAC 388-71-0503. If funded, this new 1915(c) waiver will allow ALTSA to continue our vital work toward fulfilling the mission to transform lives by promoting choice, independence, and safety through innovative services.

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The Department would like to recognize the generous contributions of time and expertise from staff representing several entities:

- Area Agencies on Aging
- Washington Tribes
- Developmental Disabilities Administration
- Organizational Change Management and Workgroup Facilitation from Vivid Co.
- Community Collaborators
- Numerous staff from within ALTSA's divisions

Appendices

Appendix A – Training and Benefits WACs and RCWs

Law and Rule Changes (RCW and WAC)

To allow this provider group to provide personal care services, the following RCW and WAC sections would need to be modified:

- RCW 18.88B.041: Defines which LTC providers are not required to become credentialed home care aides.
- RCW 74.39A.076: Defines which LTC providers require 35 hours of Basic Training.
- RCW 74.39A.341: Defines which providers require continuing education.
    - This would require modification if at the time of any future pilot, to continue aligning training requirements, the Continuing Education requirements for the spouses providing care through the VDHC program are removed by that provider groups inclusion in this RCW.
- WAC 388-71-0523: What are the training and certification requirements for individual providers and home care agency long-term care workers?
- WAC 388-71-0880: Who must take the 30-hour basic training and by when must it be completed?
- WAC 388-71-0888: When do the 70-hour basic training and certification requirements apply to an individual whose required basic training was previously less than seventy hours?
- WAC 388-71-0977: Once an individual is required to obtain certification as a home care aide, may that individual revert to exempt status?
- WAC 388-71-1001: Which long-term care workers are exempt from the continuing education requirement?
    - This would be dependent on what the requirements of the other spouses are at the time of any future pilot. We recommend that CE requirements be removed to align with other “relative” caregivers.
- WAC 388-115-0540: When will the consumer directed employer reject your selected individual provider?
- WAC 388-115-0523: What are the training and certification requirements for individual providers?

Appendix B – Tribal Forum document

The Washington Department of Social and Health Services Aging and Long-Term Support Administration, and Developmental of Disabilities Administration collaborated to hold open forums between 7/20/2023-8/18/2023. The objective was to hear from tribes and Urban Indian Health Organizations to discuss barriers to the implementation of HB 1694 within Indian Country.

In all forums, tribes stressed the need to honor, acknowledge and respect Tribal Sovereignty and Self Determination, recognizing tribes are self-governed Nations and that what would work for one government may not work for another. Tribes stressed the importance of not doing something like this fast but doing it right, as well as considering what works for communities and tribes themselves.

Tribes stated that often, appropriate governance structures to support implementation are not considered or not put in place. For example, tribes in this forum spoke that they feel they are an afterthought after the implementation.

Tribes requested that the department understand the traditional values that are held when providing care for their elder or a loved one. Tribes stated that although other communities may feel an institution is an option for their loved ones, it is not an option for them. Tribes care for their elders and loved ones with respect and give back to them as they gave to the community. Tribes want their elders and loved ones to be in their home and want them to have dignity and honor. It is important that tribal members, especially elders, be honored in having their own self-directed care; having someone they are familiar and comfortable with in providing the care, and not opening their home to a stranger.

During the discussion, DSHS and tribes strategized together to identify some barriers to implementation of such a pilot. The first identified characteristics of a barrier was the use of an outside agency for individual providers that involves SEIU775. Tribes stated, while they understand that SEIU775 works to recognize and treat everyone equally, they fail to recognize tribes are self-governed nations and should be treated as such. Tribes prefer to have their own autonomy of membership and be treated through an equitable lens. One tribe mentioned that because of SEIU775 and the agency it works with for individual providers, they have opted to provide their own home care agency for individual providers.
Other barriers include:

- Training, in geographically rural tribal communities, may be challenging to travel to locations that offer training. In addition, there may be a lack of public transportation or gaining access to transportation that may prevent tribes from accessing the training that is needed to become an individual provider.
- During the discussion of training, tribes spoke of the how the training is provided and that trainings like the one provided for individual providers, often fails to look at:
    - Individual learning styles.

    - The literacy level of provider as compared to the written test.
    - The eligibility requirements to be a provider and what they must do.
    - The relevance of the written test.
    - What is being lectured and what caretakers are having to go through.
- A lack of infrastructure or technology, such as broadband, may impact the ability of rural communities to support receiving access to long-term services and supports. In addition, access to any trainings that may be virtual.
- Lack of awareness of the program should this be implemented.
    - How would tribes know this program exist or the policy has changed to support spouse and/or parent to be a paid caretaker?
- Background checks for crimes that may disqualify them from being a caretaker. Individuals can be disqualified because of a crime that was committed 10-20 years ago and the tribal member may have not committed any crimes since.
- Policies and requirements that make it hard for tribes to engage with services and resources for caregivers.
- Completing an assessment to identify support needs has been a barrier to access services. It can be almost a month long wait to schedule the assessment.
    - It was suggested to explore options for tribes to perform the assessment themselves.
- There was an inquiry that tribes would like to consider for the feasibility and cost of paying the parents of children under 18 years old who are medically complex or have complex support needs related to their behaviors; tribes are interested in knowing if this would apply to some of the placements caring for children who fit the criteria.

In conclusion, one tribe stated lack of clarity, existing policies, and lack of political will is ultimately the barrier to implementation.