

Responses to Medicaid Transformation Waiver Comments Received During State Public Comment Period

Comment	AL TSA Response
Is AL TSA looking at developing Home and Community based settings that can address clients with co-occurring conditions such as Developmental Disabilities and Mental Health...current settings/providers can't serve these clients.	This is out of scope for the Demonstration waiver.
New LTSS - #2 Will there be Estate Recovery? Current FCSP clients stay "off" Medicaid to avoid recovery. Don't want to decrease current Family Caregiver Support Program funding with expectation clients will go on...	WA is seeking authority through the waiver to exempt Initiative 2 services from the application of estate recovery.
How will services be provided?	Clients access the broad array of Medicaid and Older Americans Act/State Funded services in a variety of ways and WA intends to use the same types of service providers used in current LTSS programs.
Though I agree we need to de-link nursing facility level of care from home and community based eligibility, I do have some concerns. Will there be an exception to rule process in case there are not readily available supports to stabilize a client in the community? We use nursing facilities on occasion when housing is unstable and no providers are available to serve people at home.	It is expected that those who need nursing facility services will meet the revised NFLOC criteria. Resource development is an ongoing activity the state undertakes to identify and develop providers.
Will the new services for LTSS be available for other Medicaid beneficiaries?	The new services will be available only to those beneficiaries enrolled in either the MAC or TSOA programs. Both programs will have functional eligibility criteria.
How will expansion of Medicaid-funded caregiver support services affect SFCSP and III E Services?	Older American Act funding for NFCSP (Title III E) is determined by a federal funding formula and would not be affected. DSHS is not proposing changes in the state family caregiver program. These programs are able to serve individuals who will not qualify for services available under the 1115 waiver.
If the transformation is successful, I expect an increase in lifespan of persons with serious mental illness. Have you modeled this in the "age wave" chart?	The age wave charts are based on average life expectancy of today's population including the known bulge of Baby Boomers.
Initiative 2: Will adult day health services be available/covered?	The benefit chart submitted with the application includes Adult Day Health as a service option.
We continuously have issues with who assists clients: RSN or HCS. Several cases (HCA) involved clients with severe mental health problems and very limited physical health issues and Home and Community Services must address the case.	An aim of the waiver is to integrate service delivery to ensure the person is well served according to their needs. Unmet need for Home and Community Services is based upon functional impairment whether that is due to physical, cognitive, mental health, or developmental disability.

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Are there any projections as to how this transformation project may impact providers of Medicaid-COPES Assisted Living?	The MAC and TSOA benefit packages are designed to help individuals remain in their own homes. Services will not be available to individuals residing in Assisted Living facilities. Potentially AL facilities may be providers of respite services under the 1115 waiver.
Can you expand on how current eligibility for LTC will be modified and has this been modeled? Do we have some idea of just how much we hope to bend the forecasted caseloads in traditional LTC services over the next five years?	Current functional eligibility for home and community based long-term services and supports will not be modified. Functional criteria for nursing facility eligibility is under development and stakeholder feedback will be requested.
What will be done with Medicaid savings from the new MAC and TSOA programs?	Reinvestment of savings from LTSS initiatives will ultimately be determined by the legislature. It is the intent of DSHS to reinvest savings in serving the increased population coming with the "age wave".
The waiver application should make clear that Medicare Advantage members are not excluded from participation in Initiative 2 activities.	All dual eligible clients who are eligible for the LTSS benefits will be eligible to participate.
The state excluded Medicare Advantage members in the past from participation in the planned duals demonstration. We believe that the initiatives described in the waiver for LTSS to individuals at risk of utilizing more intensive care would be beneficial to our Medicare Advantage members and want to ensure that they are considered in the discussions with CMS.	Medicare Advantage members were excluded from participation in the duals demonstration because they would have had to disenroll from the Advantage plan to enroll in a Medicare/Medicaid managed care plan. Eligible Medicare Advantage members are eligible to participate in Fee-for-Service Home and Community Based Services offered through Long Term Services and Supports.
Please confirm that MAC will not be applied to individuals enrolled in HCBS/nursing home at the time of implementation.	The intent of the MAC program is to offer another option to eligible clients/families. Although the expectation is that individuals currently receiving LTSS will remain in their current program, if there were a request for enrollment in MAC, the client would be able to make that choice.
What will be the default program?	There will be no 'default' program. The Demonstration waiver will broaden the array of services available to older adults and enable participants to select the program that best meets their needs.
Will someone enrolled in MAC be able to transfer to MPC, CFC, or nursing home status if eligible?	Yes. Anyone who meets eligibility for other programs may choose to be served in another program.

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<p>We are concerned about the posture of “choice” within the context of enrolling in MAC or full HCBS both when an individual is a new enrollee and when circumstances change. This choice must be functionalized to not be passive – i.e., an individual remains on MAC unless she indicates she wants HCBS.</p>	<p>As part of person-centered planning, all participants receive information about all services they may be eligible to receive and about their choices of providers. Participants may freely choose between services they are eligible to receive and the providers of those services; there will be no auto or passive enrollment.</p>
<p>What protections will HCA be implementing to ensure the enrollee’s choice is safeguarded? Will written guaranties spell out MAC participants’ right to move to other programs? Will case managers obtain informed consent in writing from MAC participants spelling out that the participant understands the right to obtain full HCBS or nursing home care and chooses MAC instead?</p>	<p>The state will ensure protections and implement a process that outlines the options and eligibility for HCBS services and clients will consent to services.</p>
<p>How often and how does someone in MAC get reviewed for HCBS eligibility? We recommend regular review of eligibility and upon review, if an individual is determined eligible, default into HCBS.</p>	<p>Assessments occur at least every 12 months, when the participant or unpaid caregiver’s circumstances or needs change significantly, or at the request of the participant. At each assessment, as part of person-centered planning, all participants receive information about services they may be eligible to receive and about their choices of providers. Participants may freely choose between services they are eligible to receive and the providers of those services.</p>
<p>At this time, there are simply too many unknowns about MAC that must be revealed, discussed, and fleshed out before CMS approves a waiver that includes this proposed benefit.</p>	<p>There will be opportunities for stakeholder engagement and input as the programs are developed.</p>
<p>What happens when a TSOA enrollee becomes eligible for some other benefit program?</p>	<p>At each assessment, as part of person centered planning, all participants receive information about all services they may be eligible to receive and about their choices of providers. Participants may freely choose between services they are eligible to receive and the providers of those services. The client would be disenrolled from TSOA if he or she become eligible for another benefit and no longer met the eligibility criteria.</p>
<p>How often will TSOA enrollees be reviewed? If there is a choice between receiving TSOA and another scope of benefits, HCA should default the individual out of TSOA and into the more robust coverage.</p>	<p>Financial/functional eligibility is redetermined annually or when circumstances change. If the individual receives Medicaid under existing programs, they are not eligible for TSOA.</p>
<p>Does HCA propose that TSOA will be a choice for enrollees in the same manner as MAC/HCBS? If so, we oppose this proposal. However, if there will be a choice, there must be protections in place to ensure that individuals enroll in less robust coverage options only when there is fully informed decision making.</p>	<p>TSOA enrollees are not financially eligible for Medicaid funded LTSS services. The TSOA program will allow this population, which meets functional eligibility for LTSS but not financial eligibility for Medicaid, to receive community-based LTSS.</p>

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<p>As with MAC, we recommend HCA more clearly explain how this program will be implemented in relation to the existing LTSS and other Medicaid program eligibility processes.</p>	<p>TSOA enrollees are not financially eligible for Medicaid funded LTSS services. The TSOA program will allow this population, which meets functional eligibility for LTSS but not financial eligibility for Medicaid, to receive community-based LTSS.</p>
<p>The state should explain why these possible inequities with respect to married couples in the two programs are acceptable or, more preferably, devise a system where eligibility for MAC or TSOA services is not determined by the randomness of the needy spouse's income. Eligibility for taxpayer-funded services should never be driven by the luck-of-the-draw.</p>	<p>This follows the existing methodologies for 1915 (c) waivers used today where only the income of the applicant is counted. Allocations to spouses only happen in the post-eligibility treatment of income process which would not be applicable to TSOA recipients.</p>
<p>The draft application says that HCA intends to change the functional eligibility standards for nursing home eligibility, but does not say what the new standard will be. Which clients does HCA wish to exclude from nursing home services?</p>	<p>The intent is to exclude clients who have the lowest level of need for activities of daily living support. The eligibility criteria will be developed with stakeholder input.</p>
<p>Please clarify the details of the cost-sharing amounts and the methodology used to determine said amounts.</p>	<p>The state is considering cost-sharing based upon state median income criteria or federal benefit levels. American Indian/Alaska Natives would not be required to cost-share.</p>
<p>HCA should provide information about the person-centered services and any financial management services that will be part of personal care and/or LTSS. HCA should clearly explain how the new benefits in these areas will be provided.</p>	<p>Participants will receive in-home case management through the AAA case management system. Services will be authorized through existing authorization and payment systems.</p>
<p>Both MAC and TSOA benefits will not be subject to estate recovery or post-eligibility treatment of income. We anticipate the state will use this as a selling point with prospective clients and/or their families to entice enrollment. But, MAC and TSOA, as the waiver application notes, are "limited benefit packages." We cannot support MAC or TSOA unless the state is required, as a condition of waiver approval, to provide neutral, easy-to-understand information about the pros and cons of MAC and TSOA in reference to other programs for which a prospective client may be eligible. This information must be written by a neutral, third party such as the Washington State Bar Association Elder Law Section or legal services advocates, with input from DSHS as to accuracy only. Legal services advocates are experts in the field whose publications for long-term care clients are already in use.</p>	<p>The State routinely works with legal advocate organizations to review materials developed that describe state benefits and programs and is committed to do so in this instance.</p>
<p>Please clarify whether this new package of benefits would be considered minimum essential coverage (MEC) for the purposes of qualifying for premium tax credits when purchasing qualified health plans (QHPs) on the state-based exchange, Washington Healthplanfinder, and for imposition of the individual mandate tax penalties for failure to maintain MEC throughout the year.</p>	<p>The TSOA benefit would not be considered Minimum Essential Coverage since the TSOA benefit package does not provide Required Essential Benefits. Someone eligible for TSOA who meets the eligibility criteria for enrollment in a QHP would be eligible to enroll and would be subject to individual mandate tax penalties for failure to maintain MEC throughout the year, if applicable.</p>

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<p>With regard to TSOA, it is unclear who would be providing personal care, respite, and housework and errand services under this new eligibility category. We recommend that HCA ensure that provider qualifications are the same for these programs as for the Medicaid Personal Care program.</p>	<p>The State will use existing provider types and qualifications for TSOA and MAC services.</p>
<p>We are concerned about individuals served in nursing facilities at the time of waiver approval. HCA should clarify that people who leave a nursing facility in the aforementioned scenarios are still considered grandfathered (i.e., they will be able to return to a nursing facility under the currently existing admission criteria) and not treated essentially as new applicants for nursing home level care subject to the new, more restrictive criteria. We strongly urge you to adopt this approach.</p>	<p>This issue will be reviewed in workgroups during the development of policies.</p>
<p>Stakeholder/Consumer Participation: The above-suggested stakeholder oversight/advisory body should be given a clear mandate to address all areas of waiver-related activities, and not just those related to developing and approving those activities in which ACHs are expected to play a major role.</p>	<p>As indicated in the application submitted to CMS, there are a number of opportunities planned to engage stakeholders in the development of LTSS activities.</p>
<p>A truly effective outreach plan can only be developed and implemented using the resources and expertise of providers, consumers, and other stakeholders who already provide similar LTSS services and who best understand their own and their families' needs for LTSS services. The application should state explicitly that the outreach plan will be developed in concert with stakeholders.</p> <p>The application should state more explicitly how MAC will be provided, including provisions for independent counseling organizations to be funded/utilized for this purpose.</p>	<p>The state intends to involve stakeholders, clients, and providers in the development of outreach strategies. All providers who meet the provider qualifications will be eligible to enroll.</p>
<p>Specifically related to nursing homes, assisted living, and long-term services and supports, Plymouth is interested in exploring alternative models for providing this level of care to the aging and medically frail people we serve, while also helping them to remain in their homes whenever possible. We continue to struggle to find ways to serve our residents who experience significant health challenges toward the end of their lives, and it is nearly impossible to find long-term care settings with a harm reduction philosophy who are able to address the unique needs of our population – many of whom exhibit co-occurring disorders alongside significant medical issues.</p>	<p>There will be opportunity for stakeholder engagement and input as the programs are developed.</p>
<p>In 1995 ALTC relocated people into homes from skilled nursing facilities. What is needed is more investment for unpaid family care givers. Health homes and care coordination first rolled out for dual-eligibles and the program has been successful. ALTC is the only agency that has bent the cost curve successfully. We are concerned that this program might go away.</p>	<p>There are no changes to the existing programs. The new benefit packages being considered in this application are in addition to the LTSS program and Medicaid services that already exist.</p>

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<p>The last paragraph on page 3 refers to: “more closely tying 80% of the health determinants that exist outside the clinical healthcare system to the 20% of delivery system outputs that impact overall health” I suggest strengthening that to: “more closely tying, and increasing investment in the 80% of the health determinants that exist outside the clinical healthcare system to the 20% of delivery system outputs that impact overall health” The success in developing Washington’s LTSS system taught us that it is critical to make investments in community supports in addition to philosophical statements. The statements alone are not enough.</p>	<p>This comment is related most specifically to Initiative 1. The MAC and TSOA benefits in Initiative 2 are targeted to community based services designed to keep individuals in their own homes.</p>
<p>Page 30 includes a number of important measures to be included in MCO and BHO contracts. To facilitate MCOs and BHOs working in concert with the LTSS system the key LTSS measure HB 1519 list of measures needs to be added: Home and Community-Based Service (HCBS) Use per 100 Member Months of Use of Long-term Supports and Services (LTSS)</p>	<p>Language was added to the waiver to better incorporate the HCBS performance measure.</p>
<p>We also recommend that outcome measures in the MCO and BHO contracts include a measure of utilization of community LTSS supports. This is addressed in the HB 1519 list of measures as Home and Community-Based Service (HCBS) Use per 100 Member Months of Use of Long-term Supports and Services (LTSS).</p>	<p>Language was added to the waiver to better incorporate the HCBS performance measure.</p>
<p>The Program for All-Inclusive Care for the Elderly (PACE) is a comprehensive, cost effective program providing wrap-around medical and social services to certain frail, community-dwelling elderly individuals, enabling them to remain in the community rather than receive care in a nursing home. While PACE has been implemented in a small scale in Kent and Seattle, this innovative and proven program achieves much of what is described in the LTSS portion of the waiver and has not been adequately funded to meet the true need in communities across the state for such services. We believe the waiver is a great opportunity to allow the program to expand and urge HCA to include PACE in the state’s menu of approved transformation projects.</p>	<p>The state is supportive of expansion of PACE sites in Washington State. PACE is a fully capitated program that includes all medical services, long term services and supports, mental health and chemical dependency services. It is a Medicaid State Plan service and therefore is outside the scope of the 1115 waiver.</p>
<p>Integration of palliative care strategies to improve health and quality of life and reduce costs: Providence would like to work with HCA to proactively identify areas where palliative care can be woven into strategies and investments throughout the waiver – including, but not limited to, the proposed LTSS benefit packages.</p>	<p>Hospice and palliative care is a benefit under Medicare and Medicaid and there will be stakeholder opportunities to assist in determining the transformation project toolkit for Initiative 1. Under the LTSS benefit individuals will be referred to use existing benefits under Medicaid and Medicare.</p>

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<p>Will DSHS contractors such as Home and Community Based Services (HCBS) and Area Agencies on Aging (AAA), be required to participate in transformation projects and required to meet performance and outcome measures similar to those applicable to HCA MCO and BHO contractors? (See page 6 of draft application.)</p>	<p>Transformation projects are specific to Initiative 1. Some transformation projects will be required by the state and others will be chosen locally based upon community needs assessment. It is anticipated that, if projects are targeted to older adults or individuals receiving LTSS, the state's aging and disability network is likely to participate. Pursuant to state statute, the state is working to incorporate shared performance measures across service coordination entities which include MCOs, BHOs, and AAAs.</p>
<p>Access to Care for Patients Post-Discharge: WSHA supports the state's goal to reduce nursing home costs. We would like to better understand the proposed changes to reduce nursing home benefits in Medicaid and how they may or may not intersect with current managed care contracts. Adequate capacity to serve patients in non-skilled nursing settings is critical to ensuring patients are discharged from the hospital appropriately when they no longer need this level of care.</p>	<p>This issue will be reviewed in workgroups during the development of policies. The intent is to serve individuals with the lowest needs in community settings. It is anticipated that individuals who have a need for skilled nursing care will meet revised nursing facility eligibility criteria.</p>
<p>The model of providing long-term services and supports in lieu of nursing homes may be challenging to implement in some rural areas. It needs to take account of areas of the state where alternative resources such as home health and other services simply do not exist. Not having access to nursing home services for patients in rural areas where there are no alternative resources may then add additional burdens to rural providers.</p>	<p>It is anticipated that individuals who have the need for skilled nursing services will meet revised nursing facility eligibility criteria.</p>
<p>Need for detail on mechanisms and safeguards to achieve the goal of quality and cost-effective care. While the construct of using long-term services in the most clinically appropriate and cost-effective manner is sensible, the WSMA recommends that HCA articulate in some detail the mechanisms it envisions that will ensure that patients' quality of care needs will be met under these new models. For example, if a cohort of patients will not qualify for nursing home services, it is unclear as to what manner of care giving skills will be required by other individuals and organizations to absorb that load.</p>	<p>The change in nursing facility eligibility would only impact those individuals with the lowest needs. These needs are most frequently met in the community today and there is training and certification of long term care workers to ensure quality of care in these community settings.</p>
<p>Furthermore, it is also unclear whether HCA has assessed the size of the workforce – including family members of the patients – that would be needed.</p>	<p>Clients will be able to choose the Medicaid service package that best meet their needs. The change in nursing facility eligibility would only impact those individuals with the lowest needs. These needs are most frequently met in the community today. Development and training of caregivers (both paid and unpaid) is an important part of ensuring an adequate and quality workforce and is an activity the state is actively engaged in.</p>

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<p>We have experienced the effects of a strategy of ending the institutionalization of mental health patients, which decreased those associated expenditures incurred by selected state agencies but also, in many cases, merely released those patients into the streets with little or no continuity of care. A similar undesirable outcome could potentially occur by limiting access to long-term services. Therefore HCA should articulate what safeguards will be in place in order to avoid a failure of this proposal.</p>	<p>Washington has a 30 year history of developing community based alternatives to nursing home care and resource development continues to be a high priority for the state. The change in nursing facility eligibility would only impact those individuals with the lowest needs. These needs are most frequently met in the community today for the medicaid population. Nursing facilities will continue to be a vital part of the long term services and supports continuum.</p>
<p>The Department of Services for the Blind Older Blind Independent Living Program serves senior adults with significant vision loss. We provide training, counseling, and low cost technology to assist in adapting to vision loss and remaining independent in the community. None of these services are currently covered by Medicaid. All of these services are influential in reducing the need for in-home supports and keeping these individuals out of long term care facilities until other health factors, other than vision, necessitate provision of long term supports...We further believe that vision rehabilitation services should be included as part of the initiative on Tailored Supports for Older Adults.</p>	<p>There will be opportunity for stakeholder engagement as these programs are developed.</p>
<p>Our concerns are focused upon how this two-tiered system will be managed. Currently, it is extremely difficult to involuntarily discharge a resident from a nursing home. The involuntary discharge process requires an administrative hearing and administrative appeal process that can take over a year to complete.</p>	<p>This issue will be reviewed in workgroups during the development of policies.</p>
<p>Implementation of the proposed draft waiver has the goal of reducing admissions to nursing homes. However, it is not clear how implementation would work and how reimbursement rates would be affected. Facilities with a less acute population may see a significant deterioration in census, while those facilities with a higher post-acute care census may find support in transitioning low acuity residents to lower levels of care.</p>	<p>This issue will be reviewed in workgroups during the development of policies.</p>
<p>The bigger questions we face concern how the Department intends to implement this program, given the complexity of relevant regulations, and what rate the Department intends to pay facilities for clients who do not meet the new stricter admission criteria.</p>	<p>This issue will be reviewed in workgroups during the development of policies.</p>
<p>The draft waiver request is silent as to what course of action should be taken if a Medicaid resident enters a nursing home under the stricter new criteria but shortly thereafter improves.</p>	<p>This issue will be reviewed in workgroups during the development of policies. This is an issue that occurs today.</p>
<p>The draft waiver does not consider instances when a resident enters a facility as a Medicare resident and converts to Medicaid, but does not meet the stricter admission criteria.</p>	<p>This issue will be reviewed in workgroups during the development of policies.</p>

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If the resident refuses to move to a lower level of care, what would be the payment process for the resident?	This issue will be reviewed in workgroups during the development of policies.
In addition, would residents with low level care needs that hover near the Medicaid eligibility criteria cutoff always be at risk for transfer to a different level of care?	These individuals would only be at risk if they no longer met the eligibility criteria for nursing facilities. This is an issue that happens in today's Medicaid system. This issue will be reviewed in workgroups during the development of policies.
Who would be responsible for facilitating the transfer to the lower level care setting? Would this burden fall on the facility?	This issue will be reviewed in workgroups during the development of policies.
If the resident refused to move and took advantage of his/her administrative appeal rights, would the facility be expected to bear the expense (in both time and resources) of defending the need to discharge the resident without DSHS support?	This issue will be reviewed in workgroups during the development of policies.
It is our position that the Department, in the waiver application, should commit to two propositions. First, that there will be no reduction in reimbursement rates while the facility attempts to relocate the resident. Second, the Department should commit to employing additional resources to assist providers when they attempt to discharge Medicaid residents who do not meet the stricter admission criteria.	These issues will be reviewed in workgroups during the development of policies.
While the waiver addresses the needs of unpaid family caregivers, it does little to explicitly address or invest in the formal caregiving workforce.....We suggest that HCA insert language on page 27 in the Health Systems Capacity Building section stating, "Additionally, telemedicine programs which extend limited resources and workforce development projects that increase the care skills of long-term services and supports individual providers will be considered."	There will be opportunities for stakeholder engagement in the development of the Transformation Project Toolkit.
SEIU 775 is concerned about the potential inadvertent exclusion or limiting of LTSS as an important part of ACH work. MCOs and BHOs, the drivers of ACHs, identification of community needs, and selection of regional transformation projects, have relatively little expertise in or coordination with LTSS systems. We ask that explicit language is inserted into transformation project RFPs to encourage ACHs to target LTSS in integration projects.	LTSS providers are participating in the two pilot ACHs and in many developing ACHs statewide. It is anticipated that LTSS providers will be engaged in transformation projects that target older adults, individuals with disabilities, or long term care participants.
With regards to the MAC program, more clarity is needed on both how individuals are presented the MAC and traditional LTSS programs, and the enrollment process.	The intent of the MAC program is to offer an additional option to eligible clients/families. Although the expectation is that individuals currently receiving LTSS will remain in their current program, if there were a request for enrollment in MAC, the client would be able to make that choice.

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<p>It is unclear how the “consumer directed budget” of the MAC program is defined. For both the MAC and TSOA plans, if consumers are able to hire individuals informally for personal care, respite, housework, and errand services and set their own wages, it brings up serious questions around worker protections and benefits, such as worker’s compensation and health insurance. We would like to see clarity in the MAC and TSOA benefit charts on pages 22 and 23 that the State does intend to use individual and agency providers to fulfill this work.</p>	<p>The State will use existing provider types and qualifications for TSOA and MAC services.</p>
<p>SEIU is also interested in whether the State has identified an entity that has the capacity and expertise to provide the caregiver training, support, and consultation benefits listed in the MAC and TSOA plans, and believes that the Training Partnership may be the ideal choice to provide such training.</p>	<p>The State will use existing infrastructure and qualifications for TSOA and MAC services.</p>
<p>SEIU 775 would like to see savings be reinvested in the system and asks that the next draft insert a fourth bullet on page 7 stating, “Anticipated savings from the MAC and TSOA programs will be reinvested in the LTSS system, specifically through capacity-building grants.”</p>	<p>Reinvestment of savings from LTSS initiatives will ultimately be determined by the legislature. It is the intent of DSHS to reinvest savings in serving the increased population coming with the "age wave".</p>
<p>Skilled Nursing Facility Eligibility The waiver will increase the functional eligibility requirement for SNF services, but more info is needed as to what the new threshold is, how it will be determined, and how this will be de-linked from HCBS eligibility. In addition, what assurances are being provided that HCBS eligibility will remain the same in the future and not reduced to later meet the NFLOC threshold?</p>	<p>The intent of the waiver is to sustain access to long term services and supports as the number of individuals eligible to receive care grows significantly as a result of the age wave. The state intends to keep the functional eligibility criteria for community based services where it is today to provide the opportunity to divert individuals with lower needs from the need to access services in nursing facilities. There will be opportunity for stakeholder comment on drafts of revised nursing facility eligibility criteria.</p>
<p>Public Awareness of Saving for Long-Term Care If the State is seeking to help people avoid accessing Medicaid services, it should consider using demonstration funds to support a public awareness campaign to help families better understand and plan for long-term care expenses. This would result in more Washingtonians saving for long-term care needs and/or purchasing long-term care insurance plans, and help them avoid spending down to qualify for Medicaid.</p>	<p>The state will consider the feasibility of this suggestion in its negotiations with CMS. The state is launching a new website, Community Living Connections, which is designed to provide information and education about long term services and supports as well as a resource directory to help individuals find available resources. This website was developed through federal grant and Older Americans' Act funding.</p>
<p>Beyond getting supportive housing and supported employment benefits included in MCO contracts (Initiative 3), how do you specifically envision MCOs being involved in Initiatives 1 & 2?</p>	<p>MCOs will not directly provide the benefits in initiative 2 but will continue to have the same responsibilities for assisting in coordination of care across systems.</p>
<p>Even though the majority of Long-term Services and Supports will remain outside of managed care, are there pieces of the proposed benefits that will affect how MCOs manage the health of their members?</p>	<p>MCOs will not directly provide the benefit but will continue to have the same responsibilities for assisting in coordination of care across systems.</p>