home care
association of washington
REPRESENTING HOME HEALTH, HOSPICE, & HOME CARE AGENCIES

HCAW
BOARD PACKET

August 16, 2019

https://global.gotomeeting.com/join/249235357
Phone: (571) 317-3112
Access Code: 249-235-357

HCAW August 2019 Board Meeting Agenda

Our Vision: We are inspired to position homecare services as a leader in healthcare in Washington State.

Our Mission: To promote the long-term growth and sustainability of in-home services in Washington State. HCAW provides leadership for consumers by unifying in-home services providers through public outreach, education, legislative advocacy and supporting practice standards.

Date: 8/16/19		**Time:** 9:30 a.m. – 12:00 p.m.	**Location:** https://global.gotomeeting.com/join/249235357 (571) 317-3112 / 249-235-357	
TIME	**TOPIC**	**DISCUSSION**	**PLAN OF ACTION**	**RESPONSIBLE**
9:30 a.m.	Call to Order	Welcome/Updates	Review	Marilou
9:35 a.m	Legislative Updates	• Region X Report • Public Policy Report • HCA Stakeholder Meeting • Sick Leave Legislation	Discussion Review Discussion/Approval Discussion	Brent Leslie Leslie/Donna/All Christine/All
10:10 a.m.	Approval of Minutes	• June 2019	Approval	All
10:15 a.m.	Financial Report	• Review and approval of June & July 2019 financials	Review/Approval	Amber/all
10:25 a.m.	Executive Director Report	• Highlights • D&O Insurance Renewal	Review Approval	Christine All
10:35 a.m.	Education Updates	• NAHC Fall Meeting • Education Calendar	Discussion	Rachel/Gretchen/Brent/Christine
11:00 a.m.	Membership Committee	• HCAW's Position on Preceptorships	Discussion	Kyle/Nate
11:15 a.m.	Strategic Plan	• Review of accomplishments • Tabled Items • Planning for 2019 Retreat	Review Discussion Discussion	All
12:00 p.m.	Adjournment	Review of key deliverables/action items/decisions		Marilou
	Next Meeting	September 20th at Memorial Home Care Services, Yakima		

Board Meeting Minutes
Friday, June 21, 2019
Teleconference
9:30AM – 12:00PM

Our Vision: We are inspired to position homecare services as a leader in healthcare in Washington State.

Our Mission: To promote the long-term growth and sustainability of in-home services in Washington State. HCAW provides leadership for consumers by unifying in-home services providers through public outreach, education, legislative advocacy and supporting practice standards.

ATTENDANCE

Board: Marilou Church, President; Rachel Manchester, President-Elect; Amber Hahn-Keenan, Secretary/Treasurer; Directors Kyle Long, Geoff Meinken, Tammi Reeser, Nate Smith, Alisa Van Sickle; Brent Korte, Ex-Officio;
Staff: Leslie Emerick, Public Policy Director; Donna Goodwin, Clinical Director; Christine Opiela, Executive Director
Not in Attendance: Director Gretchen Anderson

CALL TO ORDER

Marilou welcomed everyone and called the meeting to order at 9:34AM.

It was moved and seconded to approve the minutes from the May 31, 2019 Board meeting. Motion carried.

I. FINANCIAL REPORT

Amber reviewed the May 2019 financials:

- The Annual Conference income and expenses will show in the May 2019 reports. This is best practices as the conference overlapped both April and May.
- Under budget for dues renewal income, which may be a trend in the industry with the new and upcoming regulations and changes.

It was moved and seconded to place the May 2019 financials on file. Motion carried.

Christine presented the draft 2019-2020 budget:

- Membership is a large revenue stream for the Association, but it has not met budgeted dues income in recent years. The amount for Provider dues has been reduced as the Board is anticipating a drop in renewals dues.
- HCAW also receives a large portion of income from educational programs. To offset the reduced budgeted dues income, workshop income has increased. Members may be interested in a recruiting event at the conference or as a separate workshop. HCAW may be able to sell the Blueprint for OASIS books for next year's workshop to offset printing costs.

- The career board has growth potential, so the budgeted amount has been increased.
- The Clinical Director budgeted expense has been reduced to better reflect actual costs.
- The budgeted expenses for the website have also been reduced as the Association will most likely stay with the same AMS this fiscal year.

It was moved and seconded to approve the next fiscal year's budget. Motion carried.

II. EXECUTIVE DIRECTOR'S REPORT

Christine reviewed highlights from her report:

- Committee assignments were reviewed. Melinda will join the AME Committee and Tammi will join the Membership Committee.
- All Board members are to review and sign the Policy Acknowledgement Agreement.
- Wild Apricot is charging a 20% fee to customers using a third-party processor. HCAW uses PayPal, which has the same rates as Wild Apricot's service. Christine recommended staying with PayPal and incurring the fee. If HCAW moves to another AMS, it may need to change processors again to escape similar fees.

It was moved and seconded to stay with PayPal for another year and incur additional Wild Apricot charges. Motion carried.

- NAHC's Fall Conference is in October in Seattle. HCAW will reach out to provide support and possibly connect on educational offerings.

III. LEGISLATIVE REPORTS

Leslie presented her Public Policy report:

- 2020 is a short legislative session (60 days).
- Leslie is tracking HB 2158 and the LTC Trust Act as more information becomes available on their impact.
- The Governor signed HB 1175 but progress has slowed down. Physicians are concerned authorizing hospice orders may be a conflict of interest.
- The Operating Budget was signed in May and allows HCA to begin structuring the HH workgroup. Leslie is communicating with HCA to ensure HCAW has a place at the table to provide data and input. HCAW will meet internally first to establish a position and detail members' concerns.
- Private Duty Nursing funding begins January 2020. Leslie has asked PD members to keep her informed on how the rate increase has impacted their agencies and patients.
- A general fund has been provided for the development of a Palliative Care Roadmap. Hard copies are expected to be available September 30, 2020.
- Leslie will attend a public meeting on the Clark County CON issue. Like HCAW, WSHPCO is neutral on the issue and supportive of the process.
- The Nursing Assistant fees have changed

  <u>Registration Credentials</u>

  - Application – Registration: was $65, now $85
  - Renewal of registration: was $70, now $95

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Certification Credentials

- Application for certification: was $65, now $85
- Certification renewal: was $70, now $95

Brent reviewed the Region X report:

- NAHC committees are now at work and are focusing on many issues.
- Brent has joined NAHC's legislative council as a regional representative. He will advise NAHC staff as to which policy positions to take, etc.
- The Executive Committee is providing goals for President Bill Dombi and succession planning. It is important to consider the future landscape and prepare for what it may be after he retires.
- NHPCO is against the hospice proposed rule and NAHC prefers a 50% phase in the first year (a slower, then faster phase but not all at once). HCAW position is to not undercut routine care, but Brent will share NAHC's position in more detail before a final decision is made.

IV. STRATEGIC PLAN

The Board reviewed the current strategic plan:

Membership:

- Kyle and Nate asked for more Membership Committee volunteers to accomplish goals.
- Conduct after full strategic planning session; Hire marketing firm to develop – *tabled*

Advocacy:

- All goals have been accomplished.

Community:

- Virtual brown bag events with relevant topics
  - Clinical, mid-level, and case managers would be the primary demographic.
  - The calls will be structured in a round-robin style with a moderator and loose agenda.
  - There is a concern members may not have the time to join the calls. If successful, it is another opportunity to show value to prospective members.
  - A "regulatory roundup" topic was recommended. The call would focus on the most sited problems, what changes have agencies made to be compliant, etc.?
- Provide strong clinical track content at Annual Conference
  - The fall program is an opportunity to offer more clinical tracks.
- Community blog/chat room on website - *tabled*
- Networking opportunities at regional events - *tabled*

Education:

- Speaker pool
  - A database has been created to include previous HCAW speakers and those submitted by the community. Board members to send recommendations to the AME Committee.
- Create a virtual resource library

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- Content is needed (i.e. patient experience, VBP) to provide online resources with the option to package for sale. HCAW will reach out to members to share resources.
- HCAW can host webinars with members as presenters. It is important these do not conflict with the Association's Online University.

- Enhance, enrich, broaden conference offerings
  - Annual conference evaluations report stronger education tracks and keynotes than in previous years. This will be an ongoing goal for the Association.
- Create and distribute Member Directory - *tabled*

V. OTHER BUSINESS

The next Board meeting will be held Friday, August 16th at 9:30am.

There being no other business, the meeting was adjourned at 12:15pm.

It was motioned and seconded to end the board meeting. Motion carried.

SUMMARY OF ACTION ITEMS

- Christine to invite Tammi to the Membership Committee and Melinda to the AME Committee.
- Board members to sign the Policy Acknowledgement Agreement and send to Christine.
- Rachel, Brent, Donna, and Greg will be invited to the HCA workgroup.
- Christine to send 2019 Rural Palliative Care Education Series information to members.
- Brent to send NAHC's official response on the hospice proposed rule to Marilou, Amber, Donna, and Melinda.
- Board members to encourage staff to join the Membership Committee.
- Rachel to send Melinda brown bag topic ideas.
- Board members to recommend speakers and topics to Rachel and Gretchen.
- Board members to share resources that can be made available to members.
- Board members to send webinar topics they or a staff person can present to Rachel and Gretchen.
- Christine to update the strategic plan.

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Home Care Association of Washington
Actual vs. Budget Performance
For the Month and Twelve Months Ended June 30, 2019

	June 19	Budget	$ Over Budget	% of Budget	Jul '18 - Jun 19	Annual Budget	$ Over Budget
Ordinary Income/Expense							
Income							
4000 · Provider Dues	16,601.46	17,916.66	-1,315.20	92.66%	198,800.51	215,000.00	-16,199.49
4010 · Affiliate Dues	249.68	333.34	-83.66	74.9%	3,053.08	4,000.00	-946.92
4100 · Annual Meeting/Conv - Spring	6,200.00	0.00	6,200.00	100.0%	42,510.00	48,000.00	-5,490.00
4110 · Conf Trade Show Booth	0.00	0.00	0.00	0.0%	6,665.00	25,000.00	-18,335.00
4200 · Workshops/Seminars	18,575.00	3,750.00	14,825.00	495.33%	40,317.70	45,000.00	-4,682.30
4240 · Job Target/Career Board	0.00	125.00	-125.00	0.0%	476.06	1,500.00	-1,023.94
4250 · Newsletter Ads/Subscriptions	0.00	54.16	-54.16	0.0%	75.00	650.00	-575.00
4280 · Sponsorships/Endorsements/Rebat	0.00	0.00	0.00	0.0%	3,000.00	2,500.00	500.00
4285 · Affiliate Sponsor	0.00	0.00	0.00	0.0%	0.00	7,500.00	-7,500.00
4310 · OCS OASIS Partnership	0.00	125.00	-125.00	0.0%	0.00	1,500.00	-1,500.00
4385 · Website Advertising	0.00	83.34	-83.34	0.0%	0.00	1,000.00	-1,000.00
5000 · Interest & Dividends	20.52	0.00	20.52	100.0%	255.21	0.00	255.21
Total Income	41,646.66	22,387.50	19,259.16	186.03%	295,152.56	351,650.00	-56,497.44
Expense							
7000 · Management/Facilities/Staff/Equ	12,083.33	12,083.34	-0.01	100.0%	146,699.96	145,000.00	1,699.96
7010 · Service Charge Expense	167.11	416.66	-249.55	40.11%	2,941.65	5,000.00	-2,058.35
7020 · Staff Travel	9.04	416.66	-407.62	2.17%	1,466.69	5,000.00	-3,533.31
7130 · Lobbyist/Legislative Consultant	3,700.00	3,700.00	0.00	100.0%	41,900.00	41,900.00	0.00
7150 · Lobbyist Expenses	0.00	125.00	-125.00	0.0%	1,144.87	1,500.00	-355.13
7180 · Clinical Director	637.50	4,166.66	-3,529.16	15.3%	9,665.25	50,000.00	-40,334.75
7190 · Clinical Director Expenses	0.00	250.00	-250.00	0.0%	0.00	3,000.00	-3,000.00
7195 · Policy & Advocacy	125.00	208.34	-83.34	60.0%	1,308.67	2,500.00	-1,191.33
7230 · Insurance	108.33	166.66	-58.33	65.0%	1,284.71	2,000.00	-715.29
7240 · Office Supplies/Equipment	0.00	41.66	-41.66	0.0%	587.21	500.00	87.21
7250 · Printing/Stationery	0.80	125.00	-124.20	0.64%	290.32	1,500.00	-1,209.68
7260 · Photocopies	0.00	83.34	-83.34	0.0%	8.90	1,000.00	-991.10
7270 · Telephone	60.00	0.00	60.00	100.0%	660.00	0.00	660.00
7290 · Tech. Dev/Maint/Website	210.61	222.50	-11.89	94.66%	2,408.30	2,670.00	-261.70
7310 · Postage	0.00	54.16	-54.16	0.0%	615.72	650.00	-34.28
7370 · NAHC Dues/Other Memberships	0.00	125.00	-125.00	0.0%	1,250.00	1,500.00	-250.00
7400 · Membership Certificates	0.00	20.84	-20.84	0.0%	0.00	250.00	-250.00
7520 · Board Meetings Expense	0.00	208.34	-208.34	0.0%	36.46	2,500.00	-2,463.54
7530 · President's Travel Expense	0.00	166.66	-166.66	0.0%	0.00	2,000.00	-2,000.00
7540 · Strategic Planning	0.00	125.00	-125.00	0.0%	1,380.35	1,500.00	-119.65
7560 · Taxes	0.00	0.00	0.00	0.0%	0.00	100.00	-100.00
7580 · Miscellaneous	0.00	0.00	0.00	0.0%	53.51	0.00	53.51
7600 · Unallocated Contingency	0.00	41.66	-41.66	0.0%	0.00	500.00	-500.00
7700 · Annual Mtg/Convention Spring							
7710 · Speaker	0.00	0.00	0.00	0.0%	8,839.47	6,000.00	2,839.47
7715 · Food and Beverage	0.00	0.00	0.00	0.0%	16,259.76	35,000.00	-18,740.24
7720 · Technology	0.00	0.00	0.00	0.0%	4,876.53	5,500.00	-623.47
7725 · Hand Outs	0.00	0.00	0.00	0.0%	0.00	1,500.00	-1,500.00
7730 · Lodging	951.58	0.00	951.58	100.0%	3,149.96	2,700.00	449.96
7740 · Travel	0.00	0.00	0.00	0.0%	566.02	2,000.00	-1,433.98
7700 · Annual Mtg/Convention Spring - Other	1,125.00	0.00	1,125.00	100.0%	2,169.41	0.00	2,169.41
Total 7700 · Annual Mtg/Convention Spring	2,076.58	0.00	2,076.58	100.0%	35,861.15	52,700.00	-16,838.85
7900 · Workshops/Seminar Expense							
7910 · Speaker	10,000.00	1,250.00	8,750.00	800.0%	15,937.23	15,000.00	937.23
7915 · Food and Beverage	162.15	366.66	-204.51	44.22%	1,291.85	4,400.00	-3,108.15
7920 · Technology	360.00	250.00	110.00	144.0%	4,320.00	3,000.00	1,320.00
7925 · Hand Outs	0.00	208.34	-208.34	0.0%	1,922.06	2,500.00	-577.94
7930 · Lodging & Transportation	965.31				1,781.74	0.00	1,781.74
7900 · Workshops/Seminar Expense - Other	0.00	125.00	-125.00	0.0%	3,149.00	1,500.00	1,649.00
Total 7900 · Workshops/Seminar Expense	11,487.46	2,200.00	9,287.46	522.16%	28,401.88	26,400.00	2,001.88
Total Expense	30,665.76	24,947.48	5,718.28	122.92%	277,965.60	349,670.00	-71,704.40
Net Ordinary Income	10,980.90	-2,559.98	13,540.88	-428.95%	17,186.96	1,980.00	15,206.96
Other Income/Expense							
Other Income							
9000 · Baird Change in Market Value	5,454.71				-1,051.67		
9100 · Baird Income and Distributions	735.95				4,417.95		
Total Other Income	6,190.66				3,366.28		
Net Other Income	6,190.66				3,366.28		
Net Income	**17,171.56**	**-2,559.98**	**19,731.54**	**-670.77%**	**20,553.24**	**1,980.00**	**18,573.24**

Home Care Association of Washington
Statement of Activities
For the Month Ended June 30, 2019 and 2018

	June 2019	June 2018
Ordinary Income/Expense		
Income		
4000 · Provider Dues	16,601.46	17,352.12
4010 · Affiliate Dues	249.68	141.86
4100 · Annual Meeting/Conv - Spring	6,200.00	975.00
4200 · Workshops/Seminars	18,575.00	15,880.00
5000 · Interest & Dividends	20.52	18.76
Total Income	41,646.66	34,367.74
Expense		
7000 · Management/Facilities/Staff/Equ	12,083.33	18,750.00
7010 · Service Charge Expense	167.11	1,849.48
7020 · Staff Travel	9.04	0.00
7100 · Executive Director	0.00	6,400.00
7110 · Executive Director Expenses	0.00	85.78
7130 · Lobbyist/Legislative Consultant	3,700.00	3,200.00
7180 · Clinical Director	637.50	0.00
7195 · Policy & Advocacy	125.00	0.00
7230 · Insurance	108.33	103.14
7240 · Office Supplies/Equipment	0.00	19.99
7250 · Printing/Stationery	0.80	0.00
7270 · Telephone	60.00	0.00
7290 · Tech. Dev/Maint/Website	210.61	0.00
7700 · Annual Mtg/Convention Spring		
7715 · Food and Beverage	0.00	115.49
7730 · Lodging	951.58	0.00
7740 · Travel	0.00	408.75
7700 · Annual Mtg/Convention Spring - Other	1,125.00	0.00
Total 7700 · Annual Mtg/Convention Spring	2,076.58	524.24
7900 · Workshops/Seminar Expense		
7910 · Speaker	10,000.00	5,000.00
7915 · Food and Beverage	162.15	1,476.24
7920 · Technology	360.00	477.00
7930 · Lodging & Transportation	965.31	0.00
Total 7900 · Workshops/Seminar Expense	11,487.46	6,953.24
Total Expense	30,665.76	37,885.87
Net Ordinary Income	10,980.90	-3,518.13
Other Income/Expense		
Other Income		
9000 · Baird Change in Market Value	5,454.71	-1,278.92
9100 · Baird Income and Distributions	735.95	715.33
Total Other Income	6,190.66	-563.59
Net Other Income	6,190.66	-563.59
Net Income	**17,171.56**	**-4,081.72**

Home Care Association of Washington
Statement of Financial Position
As of June 30, 2019 and June 30, 2018

	June 30, 2019	June 30, 2018
ASSETS		
Current Assets		
Checking/Savings		
1000 · PCB Checking 0944	106,606.90	43,604.12
1010 · PCB Money Mkt	95,578.33	139,329.71
1020 · Baird Cash and Equivalents	30,417.76	31,394.07
1030 · Bairds Investment Assets	102,067.39	97,724.80
1050 · Paypal	1,242.45	5,629.78
Total Checking/Savings	335,912.83	317,682.48
Accounts Receivable		
1200 · Accounts Receivable	13,982.00	250.00
Total Accounts Receivable	13,982.00	250.00
Other Current Assets		
1300 · Prepaid Expenses	16,533.33	3,200.00
1310 · Prepaid Insurance	325.03	309.74
1375 · Prepaid Workshop Expenses	1,800.00	1,800.00
Total Other Current Assets	18,658.36	5,309.74
Total Current Assets	368,553.19	323,242.22
TOTAL ASSETS	**368,553.19**	**323,242.22**
LIABILITIES & NET ASSETS		
Liabilities		
Current Liabilities		
Accounts Payable		
2000 · Accounts Payable	26,067.82	0.00
Total Accounts Payable	26,067.82	0.00
Other Current Liabilities		
2110 · Deferred Dues		
2115 · Provider Dues	99,608.76	104,112.77
2120 · Affiliate Dues	1,498.11	851.19
Total 2110 · Deferred Dues	101,106.87	104,963.96
2360 · Payable to HCAW PAC	2,727.00	180.00
Total Other Current Liabilities	103,833.87	105,143.96
Total Current Liabilities	129,901.69	105,143.96
Total Liabilities	129,901.69	105,143.96
Net Assets		
3000 · Unrestricted Net Assets	202,129.25	202,129.25
32000 · Retained Earnings	15,969.01	22,805.77
Net Income	20,553.24	-6,836.76
Total Net Assets	238,651.50	218,098.26
TOTAL LIABILITIES & NET ASSETS	**368,553.19**	**323,242.22**

Home Care Association of Washington
Statement of Activities
For the Month Ended July 31, 2019 and 2018

	July 2019	July 2018
Ordinary Income/Expense		
Income		
4000 · Provider Dues	16,601.46	19,354.25
4010 · Affiliate Dues	249.68	287.80
4100 · Annual Meeting/Conv - Spring	0.00	2,020.00
4200 · Workshops/Seminars	0.00	7,346.00
5000 · Interest & Dividends	21.04	20.74
Total Income	16,872.18	29,028.79
Expense		
7000 · Management/Facilities/Staff/Equ	12,083.33	12,083.33
7010 · Service Charge Expense	21.50	280.67
7130 · Lobbyist/Legislative Consultant	3,700.00	3,200.00
7195 · Policy & Advocacy	125.00	0.00
7230 · Insurance	108.33	103.14
7240 · Office Supplies/Equipment	0.00	478.25
7250 · Printing/Stationery	0.00	98.86
7310 · Postage	0.00	71.39
7900 · Workshops/Seminar Expense		
7910 · Speaker	0.00	5,000.00
7915 · Food and Beverage	0.00	84.64
7920 · Technology	360.00	360.00
7925 · Hand Outs	0.00	1,922.06
7930 · Lodging & Transportation	0.00	816.43
Total 7900 · Workshops/Seminar Expense	360.00	8,183.13
Total Expense	16,398.16	24,498.77
Net Ordinary Income	474.02	4,530.02
Other Income/Expense		
Other Income		
9000 · Baird Change in Market Value	3,109.47	1,016.77
9100 · Baird Income and Distributions	128.98	203.56
Total Other Income	3,238.45	1,220.33
Net Other Income	3,238.45	1,220.33
Net Income	**3,712.47**	**5,750.35**

Home Care Association of Washington
Statement of Financial Position
As of July 31, 2019 and July 31, 2018

	July 31, 2019	July 31, 2018
ASSETS		
Current Assets		
Checking/Savings		
1000 · PCB Checking 0944	76,818.33	61,421.78
1010 · PCB Money Mkt	95,598.62	139,350.02
1020 · Baird Cash and Equivalents	30,546.74	31,584.60
1030 · Bairds Investment Assets	105,176.86	98,754.60
1050 · Paypal	1,242.45	1,582.00
Total Checking/Savings	309,383.00	332,693.00
Accounts Receivable		
1200 · Accounts Receivable	13,982.00	3,207.00
Total Accounts Receivable	13,982.00	3,207.00
Other Current Assets		
1300 · Prepaid Expenses	4,325.00	0.00
1310 · Prepaid Insurance	216.70	206.60
1375 · Prepaid Workshop Expenses	1,440.00	1,440.00
Total Other Current Assets	5,981.70	1,646.60
Total Current Assets	329,346.70	337,546.60
TOTAL ASSETS	**329,346.70**	**337,546.60**
LIABILITIES & NET ASSETS		
Liabilities		
Current Liabilities		
Accounts Payable		
2000 · Accounts Payable	0.00	12,083.33
Total Accounts Payable	0.00	12,083.33
Other Current Liabilities		
2110 · Deferred Dues		
2115 · Provider Dues	83,007.30	96,771.27
2120 · Affiliate Dues	1,248.43	1,413.39
Total 2110 · Deferred Dues	84,255.73	98,184.66
2175 · Deferred Workshop Income	0.00	3,000.00
2360 · Payable to HCAW PAC	2,727.00	430.00
Total Other Current Liabilities	86,982.73	101,614.66
Total Current Liabilities	86,982.73	113,697.99
Total Liabilities	86,982.73	113,697.99
Net Assets		
3000 · Unrestricted Net Assets	202,129.25	202,129.25
32000 · Retained Earnings	36,522.25	15,969.01
Net Income	3,712.47	5,750.35
Total Net Assets	242,363.97	223,848.61
TOTAL LIABILITIES & NET ASSETS	**329,346.70**	**337,546.60**

August 7, 2019

HCAW August 2019 Public Policy Report

Prepared by Leslie Emerick, Director of Public Policy

Legislative Overview

Rep. Laurie Jinkins was elected to serve as the new speaker-elect of the state House of Representatives. Jinkins' election makes her the first female and openly gay speaker in Washington state history. Rep Frank Chopp has stepped down from the speakership but will continue to be a representative in the state legislature until which time he decides not to run again. Rep Cody announced that he will be serving on the House Health Care Committee! Chopp was the longest serving Speaker of the House in WA State. I have known Laurie for over 10 years, and it will be interesting to see what changes this might bring to the state legislature. She is a big supporter of in-home services and her mother-in-law was recently in hospice care….

State agencies have started implementing bills that were passed by the state legislature in the 2019 session. Most laws went into effect 90 days after the last day of the legislative session, which was July 28, 2019. The state budget went into effect immediately, so many budget proviso requirements have started to be implemented.

2020 is the short 60-day session of the biennial legislature starting on the second Monday in January. During the short session legislators work on the Supplemental Budget for the states 2-year Operating Budget to fix or address issues that were not predicted in the original budget. In theory they do not add new issues, but there are still around 2,000 bills typically introduced in a short session so time flies by quickly in a short session.

Our In-Home Services Day is January 28th in Olympia… Mark your calendars!! I will be sending out additional information as we get closer, but you will need to start making appointments with your legislators in late December or very early January to assure you get a meeting with them.

Here are some bills that passed this session we will be following for implementation impacts:

Bill Signing of HB 1175 with Governor Inslee, the bill sponsor Rep Kilduff and others! Rep Laurie Jinkins, House Speaker elect, is standing behind me to the right!

(PS: I promise never to wear that blouse to a bill signing again!)

HB 1175 Concerning authorization of health care decisions by an individual or designated person, went into effect on July 28th . The newly enacted law has two elements that will help patients when they are unable to make their own medical decisions. First, the law expands the type of people who can be a surrogate health care decision-maker to include extended family members

and close friends. Second, the law allows a notary to finalize a health care directive (commonly known as an advance directive for health care or a living will). Previously, two witnesses were required to finalize a health care directive, which presented a barrier for some patients wishing to complete this form.

I spoke with Bonnie Bizzell (Bonnie.Bizzell@honoringchoicespnw.org) at WSHA in the Honoring Choice program and she has offered us some additional resources. She is also available as a resource if you have any questions regarding the new bill. WSHA was the proponent of the legislation. WSHA has updated their website as well, including adding a revised Honoring Choices PNW advance directive and an updated decision-making hierarchy poster.

- You can find the WSHA Bulletin on HB 1175 here; it has more details and implications (including action needed) about the law;
- The WSHA sample health care decision declaration for close friends is linked in the bulletin above or you can click here (*note: automatic Word document download*)

E2SHB 2158 **Creating a workforce education investment to train Washington students for Washington**. The bill had a 20% health professions B & O tax increase, from 1.5% to 1.8%, which WAHCA opposed. WAHCA has sent an email specifically to DOR asking for a determination for home health and hospice.

I received a call from Brian O'Sullivan, DOR Tax Information Specialist responding to my email saying that the department is still working on identifying the impacted professions from the legislation. I gave him information on the RCWs and WACs for In-Home Services, so they had a better idea of how these services are offered. He did state that the department would offer the opportunity to appeal a decision if our impacted business felt that the increased tax was not correctly applied or not subject to this legislative mandate.

2SHB 1087 Long-Term Care Trust Act : provide benefits for long-term services and supports to qualified individuals who need assistance with at least three activities of daily living. Establishes eligibility requirements for the Trust Program for persons who pay a premium of 0.58 percent of a person's wages for a specific amount of time. According to Bea Rector at DSHS, they are beginning the important work of statute implementation. The first activities are working with the Office of Financial Management to recruit and appoint the LTC Trust Commission and the hiring key staff.

The Governor's Office is currently recruiting for the Long-Term Care Trust Commission. The purpose of the Commission is to propose recommendations to the appropriate executive agency or legislature regarding:

- Criteria for determining that an individual has met the requirements to be a qualified individual;

- Criteria for determining that an individual has met the requirements to be an eligible beneficiary;
- Criteria for minimum qualifications for the registration of long-term services and supports providers;
- Establishment of payment maximums for approved services;
- Changes to rules or policies to improve the operation of the program;
- Recommendations for the annual adjustment of the benefit unit;
- Refunding premiums for a deceased qualified individuals with a dependent who is an individual with a developmental disability and dependent for support from a qualified individual;
- Assisting the state actuary with the preparation of regular actuarial reports on the solvency and financial status of the program and advising the legislature on actions necessary to maintain trust solvency;
- Recommendations on whether and how to extend coverage to individuals who became disabled before the age of eighteen; and
- Recommendations on a method of calculating agency administrative expenses to limit expenses while providing sufficient funds to adequately operate the program.

The Commission's recommendations and decisions must be guided by the joint goals of maintaining benefit adequacy and maintaining fund solvency and sustainability.

The Governor's office has opened the recruitment period for people interested in being considered for appointment to this Commission. Any individual interested in being appointed will need to apply online via the link below. Additional information on this Commission can be found on the Governor's boards and commissions profile page.

- *Application for Appointment:* https://www.governor.wa.gov/boards-commissions/boards-commissions/apply-serve-board-or-commission
- *Commission Profile:* https://www.governor.wa.gov/boards-commissions/board-and-commissions/profile/Long-Term%20Services%20and%20Supports%20Trust%20Commission

Department of Health Issues

Palliative Care Roadmap: I participated in a very preliminary meeting with Pat Justis at DOH to discuss how the workgroup will be structured. I am looking forward to the workgroup starting sometime in September!

(24) $25,000 of the general fund provided solely for the development of a palliative care road map to provide information and guidance to providers, patients, families, and caregivers of individuals living with a serious or life-threatening illness. The department must work in consultation with appropriate stakeholders, including but not limited to, the health care authority, the department of social and

health services, and hospital-based, outpatient, and community-based palliative care providers. Hard copies must be available for distribution no later than September 30, 2020.

Palliative Care-Rural Health Integration Advisory Team (PC-RHIAT): I am still participating on the advisory team for the Community Engagement Workgroup. I frequently bring up how home care can have a role in palliative care. To learn more about the Washington Rural Palliative Care Initiative please visit : https://waportal.org/partners/home/washington-rural-palliative-care-initiative

Safe Medicine Return Program: Here is the final rulemaking for the Safe Medicine Return Program. These rules will become effective August 1, 2019. From reading the concise explanatory statement, it sounds like the program for pre-paid mailers is not in place yet…so more to come on that issue! The enabling legislation (chapter 69.48 RCW) is very prescriptive in how the drug take-back program is to be established and executed, including the functions that the department must perform. The rules only touch on parts of the law in need of more clarity. The rules primarily address administrative and oversight details and include:

- A process to identify covered manufacturers who must pay into the drug take-back program.
- The type of budget information required in the program operator's proposal submitted to the program for approval, as well as budget information submitted by the program operator with each annual report.
- The process to appeal department decisions.
- How to determine areas in the state underserved by the drug take-back program.
- Setting department fees.

The adopted rules were filed on 7/1/2019. Copies of the adopted rules and program proposal application form are attached.

Adoption_Notice.pdf

Safe_Medication_Return_Concise_Explanat

- SMR_Rule_Final.pdf
- Safe_Medication_Return_Program_Proposal_Application.pdf

Certified Nursing Assistant Fee Increase: Despite our opposition, the CR-103 has been filed on for CNA Fees which proposes increasing application and active renewal fees, as well as adjustments to the late renewal penalty, for all nursing assistants. The fees go into effect on 10/1/2019.

In-Home Services Roundtable July 23, 2019: I was unable to attend, but Donna can give an update!

LTC Workforce Development Steering Workgroup: I have been invited to participate in this workgroup, but they have not had their first meeting yet so more to come! The kick-off meeting is on September 19….

Clark County CON Issue: I spoke with Kristin Pederson, DOH Assistant Secretary about this issue to relay our concerns about the accuracy of data being used in this particular CON review. I was clear that there were "red flags" that the department didn't address, like a 0 count for one year, when doing their analysis. I was clear that we depend on their data to make assessments for CON and it damages the credibility of the agency when the data is inaccurately assessed. She assured me that they would do better in the future, but were not going to do anything about it at this point as they were too far down the path to establishing a new CON in the Vancouver area.

I attended the meeting in Vancouver on June 26th with Greg Pang and MaryKay Morelli, Community Home Health and Hospice and Hospice. The concern by HCAW and WSHPCO has been the issue of an inaccurate assessment for Hospice CON with the DOH. At no point in the meeting did they address the issue of inaccurate data that was submitted to DOH. The public hearing was only to determine which new hospice would be allowed to operate in Clark County. There were 5 applicants for the CON. The majority of testimony came from Providence.

The DOH currently uses historical 2015-2017 agency-specific admissions data to establish 2020 projections. This data has been requested by the DOH and for many years has been reported by all hospice agencies annually. Clark County is currently served by three hospice agencies: Community Home Health & Hospice, Kaiser Permanente, and PeaceHealth Southwest. The DOH recently reported Clark County needs an additional 1.27 hospice agencies by 2020. This was based off the 2015-2017 data provided by these three agencies. In reviewing their submitted data, PeaceHealth Southwest noticed they under-reported their 2015 reporting data by error. This issue has not been addressed by DOH not corrected and they have proceeded with the CON application hearing.

Health Care Authority (HCA) Issues

Home Health Rate Increase and Methodology Workgroup: The first meeting was held on July 10th at the Health Care Authority headquarters. There were 25 people on the phone so lots of interest! Unfortunately, the sound for the call was not working.

We had an in-person meeting set up for August 7th with a facilitator in Lacey, WA and with around 12 members from our association participating. The attendance was pretty good from the hospital association, other state agencies and the managed care organizations. We discussed varying models of care such as bundled payment, per diem, a Medicare type model and even updating fee for service. HCA staff collected lots of input and we will have another discussion around the beginning of September. I will send out the notices as soon as I get a date.

Here is the language from the budget proviso for the workgroup:

(33) The authority shall facilitate a home health work group consisting of home health provider associations, hospital associations, managed care organizations, the department of social and health services, and the department of health to develop a new medicaid payment methodology for home health services. The authority must submit a report with final recommendations and a proposed implementation timeline to the legislature by November 30, 2019.

Adult Palliative Care Rules: HCA had their first stakeholder workgroup meeting for establishing a draft for the rules and has invited a team of palliative care providers for development of the proposal on July 26, 2019. The HCA staff interviewed all forms of palliative care providers in the state and discussed what a broad-based palliative care benefit would look like. The department is going back to the "drawing board" and will come up with a draft to review.

Labor and Industries Issues

Executive, Administrative, and Professional ("EAP" or "white collar") exemptions from the Minimum Wage Act: The department has initiated rulemaking and will be holding stakeholder meetings around the state for feedback. This will have a very negative impact on home care agencies. I attended the hearing in Tumwater on July 15th. Public hearings are scheduled for several dates in July and August, and the department is accepting comments through September 6th. https://www.lni.wa.gov/WorkplaceRights/Wages/Overtime/OvertimeRules/default.asp

DSHS Issues

WAC 388-76-10250 as it applies to Adult Family Homes: Barb and I recently received a concern shared by a Hospice physician about WAC 388-76-10250. We contacted DSHS about this issue and they said that they might do rulemaking in the future. I asked if this might be speeded up if we submit an official request for rulemaking! This is not the first time a Hospice physician has asked about this issue. Here was Barb's response that I think is worth sharing. The physician shared the following:

- A hospice patient who resides in an Adult Family Home has improved. He now has a prognosis of greater than six months and thus no longer meets the eligibility criterion to be on Hospice.
- The Adult Foster Home care provider would like the resident to remain on Hospice, because this would allow the care provider to honor the patient's POLST and Advance Directive wishes to *not* have to call 911 and have EMS arrive to perform resuscitation.
- The hospice physician cannot certify the resident qualifies for continuing on hospice if eligibility criteria are not met.
- The hospice physician said this is not the first time an Adult Foster Home provider has made the request to keep a patient on hospice just for this reason (i.e. to be able to honor

Public Policy Updates

Bree Collaborative Palliative Care Workgroup: I will be attended the July 12th meeting in Seattle for this workgroup. The next meeting is August 16th. I requested that they consider adding in-home services to part of the care model for palliative care. The group is creating and reviewing recommendations for providing palliative care in the state. They are focusing on a funding mechanism for reimbursement for palliative care. Here is a link to the meeting materials: http://www.breecollaborative.org/topic-areas/current-topics/palliative-care/

WA State Dementia Collaborative: I am still on the Health and Medical Subcommittee and am a member of the Dementia Collaborative for the state. Here is a link to the website outlining the activities of the collaborative: https://www.dshs.wa.gov/altsa/dementia-action-collaborative
If anyone wants to order some more Dementia Roadmaps for your agency, please go to: www.dshs.wa.go/altsa/dementa-action-collaborative

Home Health Stakeholder Workgroup 8.7.19

Apple Health Managed Care Organizations	Provider Organizations	State Organizations
Amerigroup Washington: • Elizabeth Johnson • Erika Lang **Community Health Plan of Washington:** • Cathy Neiman **Coordinated Care of Washington:** • Edie Dibble • Jessi Giulio • Melissa Knopp **Molina:** • June Smith **United Healthcare:** • Julie Newman	**Community Home Health and Hospice:** • Alisa Van Sickle • Greg Pang • Randy Dalton **Home Care Association of Washington:** • Christine Opiele • Donna Goodwin • Leslie Emerick **Other:** • Amber Hahn-Keenan, Virginia Mason Memorial • Brent Korte, EvergreenHealth • Geoff Meinken, Careforce • Gretchen Anderson, Sunshine Health Facilities • Kyle Long, Aveanna Healthcare • Marc Berg, Berg Data Solutions • Mike Pugsley, Ashley House • Sheena Tomar, Service Employees International Union (SEIU) 775 Benefits Group • Zosia Stanley, Washington State Hospital Association	**Health Care Authority (HCA):** • Cynde Rivers, Clinical Quality and Care Transformation (CQCT) • Dean Runolfson, CQCT • Gail Kreiger, Medicaid Programs and Operational Integrity (MPOI) • Gary Hanson, Planning and Performance Division (PPD) • Joan Chappell, CQCT • Josh Morse, CQCT • Robin Brake, Financial Services Division (FSD) • Sarah Pearson, CQCT **Department of Social and Health Services (DSHS):** • Doris Barret, Developmental Disabilities Administration (DDA) • Jerome Spearman, Aging and Long-Term Services Administration (ALTSA) **Other:** • Pat Justis, Department of Health (DOH) • Sandy Stith, Senate Ways and Means (Senate)

Ground Rules

- Respect everyone's opinion
- Challenge ideas, not people
- Data driven
- Take non-related business outside
- Take things like they are now – current state
- Have fun

Success Factors

- improve Clinical outcomes for members
- Improve access for patients
- Reimbursement rate equals or exceeds cost
- Reimbursement rate adjusted for rural areas
- Understand roles moving forward
- Fiscal note – project out hospital savings (quantify reduced readmissions; cost differential between increased home health vs. hospital visits)
    - Previous fiscal note for SB 5828 (2019-20) discussed Medicare rates, but not Medicare methodology
- Home health agencies competing for patients
- Legislative funding
    - Legislature needs options
- Keeping patients out of the ED/hospital
- Home health agencies are fighting to get Medicaid patients
    - Example: Per Brent Korte, only about 2 percent of EvergreenHealth clients are on Medicaid
- Best providers get paid more, and worst providers get paid less

Scope

- Proviso language (need to determine whether this includes both HCA *and* DSHS Home Health programs)
- Report out on the new payment methodologies (considering "a" through "f" of the budget proviso)
- Need to include information about Medicare bundled rate (average $250) includes both professional fee and supplies/equipment
    - WA is one of 9 states participating in the Medicare value-based, bundled payment method (based on care outcomes)

Role of Home Health

- Key in delivery model

- Value partners
- Reduce hospital stays, emergency department (ED) visits, and hospital readmissions
- Strengthen role of home health
- Strong recommendation to legislature, building upon the goals in the proviso
- Potential / opportunity
- Patient satisfaction / engagement
- Keep people in their homes
- Court case indicated that home health can focus on preventing deterioration (within the constraints of Medicaid), not just improving health
- Provide services at least restrictive setting; that is why Medicaid does not use the homebound rule
- Maintenance on home health; Medicare requirement includes "homebound status"; Medicaid needs to figure out what to do about the homebound status requirement
- Interaction with discharge planners (social workers)
    - Hard to find facilities (e.g., adult family homes, assisted living facilities, skilled nursing facilities, etc.) that will take Medicaid/Medicare patients; social worker at the hospital is typically the one who identifies the appropriate level of care; reach out to the plan/agency to make those arrangements; primary care providers make their own decisions; about 60 percent of referrals come from the community; another attendee indicated about 40 percent come from the community (and 60 percent from facility)
- Provide supplies (issues)
    - Medicaid's $99 only includes professional fee; struggle to get supplies/equipment covered by Medicaid; facilities eat the cost of supplies/equipment; difficult to order the supplies also; Medicaid patients have a bag of supplies/equipment when they enter care, but difficulty getting more

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Difference between services provided by HCA and DSHS

HCA

- Acute needs
- Release from hospital
- Receives home health benefit in lieu of going to a skilled nursing facility
- Physical therapy (PT), occupational therapy (OT), speech therapy
- Example: myocardial infarction (MI / heart attack), chronic obstructive pulmonary disease (COPD)

Once it escalates to chronic (e.g., daily or long-term but intermittent), transfers to DSHS. (Example: diabetic in rural area needing someone to administer daily insulin shots.) The budget proviso needs to consider both acute and chronic care. Need to keep HCA and DSHS policies in sync. Funding streams must stay separate.

DSHS

- Limited access in rural areas
- Need in home (daily) care and possibly lacking other support
- Reduce hospital readmissions
- Daily chronic nursing care

Definitions

Telemedicine

- Telemedicine in Home Health WAC = Telemonitoring (see WAC 182-551-2125)
- Other HCA RCW and WAC includes the definition of telemedicine (see RCW 74.09.325 and WAC 182-531-1730)
- It does not include telephone calls
- The group discussed telemedicine as telehealth and wants to include telephone calls
- Insight could be gathered from the Telemedicine Collaborative
- Telemedicine must use HIPAA compliant face-to-face systems, such as HIPAA compliant Skype
- Pat Justis at DOH can speak to the "telehealth case consultation model"
- Telehealth requires a visit, per definition
- Medicare bundle includes telemedicine visits, and HCA pays for face-to-face visits
- Kaiser found that there were barriers with the cost of equipment and technology knowledge (i.e., user error)
- Kaiser uses high-touch phone calls which are called telehealth encounters ($10)
- May need to change the RCW and WAC to include telephone for home health, as an exception to the rule

Social Workers

- Provide resources to behavioral health and mental health interventions / connections
- Help with completing DSHS eligibility forms
- Community Options Program Entry System (COPES)
- Addressing financial issues
- Care coordination
- Assessment of psycho-social issues
- Advanced care planning
- In Medicaid, social workers are not currently reimbursed as part of the home health benefit; we pay for social work as a behavioral health provider
- Independent or advanced social workers: some requirements specify that the social worker be an LICSW, but Medicare only requires MSW
- Number of social worker visits would vary by needs of patient
- Sheena Tomar (SEIU 775, representing long-term care workers)- Home Care Aides – Opportunity to incorporate into home health team
- Home care aides perform some tele-monitoring

- Colorado state leans heavily on home care aides
- HCA does not pay Home Care Aides outside of the Home Health Agency; home health aides are part of the home health benefit
- Nationally, for home health services, group health is the highest (one visit per episode; incentive to have those visits); in Yakima, use 1.6 visits (high Medicaid population)

Rural / Underserved

- How far out is rural? Reviewed page 15 of There's No Place Like Home report (DOH, January 2019): urban core, sub-urban, large rural town, small town / isolated rural
- A definition needs to be established for the legislative report that is at the sub-county level
- Also discussed cost of living based on the wage index

Home Health Utilization and Network Adequacy / Workforce Issues:

- WA is significantly below the national average for home health utilization; we don't know why we are much lower than the national average; Spokane and Southwest WA tend to be higher (closer to the national average); it does not reflect the payer's reimbursement rates; if low rates are due to insufficient workforce, then we might need to ask how many patients we turn away due to insufficient capacity; it creates a disincentive to providers to refer to home health services, which drives utilization down generally; quality of care varies significantly at different providers (e.g., Evergreen vs. University of Washington); if go into hospice at Evergreen, about 75 percent will die on hospice; however, only about 30 percent of UW patients on hospice die on hospice – they tend to die in the ICU and receive expensive procedures at end-of-life
- Network adequacy problem with providing services in rural areas; need to be careful about what we assume / assert; workforce issue; very few nurses in WA that are licensed that are not already working; need more nurses; get them from somewhere else? Worker reinvestment might begin to increase workforce after 2020
- Discussion about whether increasing reimbursement rate would overcome the workforce shortages; pull from other states? What about the lag? Divert from other healthcare fields (i.e., to be attractive to incoming nursing students); every change will take time (e.g., two years), but we shouldn't be worried about it; this is a huge problem that might be outside the scope of this workgroup; will provide a constraint to implementing reimbursement change (relevant to the two-year state budget)
- Home health services workforce differs significantly by agency; mixed between RNs and PTs, some have LPNs or PTAs; question about what paraprofessionals can do; while workforce is an issue, making home health services more attractive in rural areas is relevant to this workgroup;
- If home health is more attractive, then patients that had worse health will not need to be in the hospital, which means RNs in the hospital will have less incentive to move to home health; however, there likely is not excess capacity in the hospitals; most nurses are trained to work in acute care settings and might not move to home health

Service Cost and Payment Methodology:

Service Costs:

- Data – Cost. Reduce hospital readmissions vs providing services in rural areas (total cost of care). This is an opportunity for savings.
- Example: $300 plus per day for hospital stay vs. $99 for a home health visit. Approximately $250 Medicare rate (bundled, includes supplies).
- Burden – cost of supplies. Supplies are bundled in Medicare payment model.
- Costs are $150 plus for the home health visit. Home health agencies are starting to drop out, not providing the services due to the cost and low reimbursement rate from Medicaid.

Payment methods and considerations:

- Medicare bundled payment system with or without value-based purchasing
    - Bundled payment method groups patients and provider types (e.g., OB, hospice, etc.)
- Medicare bundled payment with value-based purchasing;
- FFS model (current model),
- Per diem (like the hospice model);
- Episodic payment (e.g., number of visits, or length of time);
- Capitated;
- Consider using episodic payment with three tiers, based on the severity of the patient's needs – similar to the results of the Continuity Assessment Record and Evaluation (CARE) tool:
    1. General population
    2. Population with fewer resources, social determinates of health
    3. Population with multiple co-morbidities, social determinates of health
- The continuum of care goes from HCA (acute) to DSHS (chronic);
- Agencies using episodic payments can manage their population however they want;
- Base rate multiplied by some risk-based or value-based or geography-based factors:
    - Do not want to dis-incentivize taking more extreme / difficult cases, those with higher risk. Avoid cherry-picking patients, but account for outliers.
- Need to consider the pros and cons of various models
- Appetite for creating something new vs. tweaking something already existing
    - HCA is expert in Medicaid, but need info about Medicare; HCA pays a consultant to pay our diagnosis-related groups (DRGs); HCA does not have that skillset; we might need consultants to help us with the methods; administrative burden of Medicare's Outcome and Assessment Information Set (OASIS) system is high; consider using a common system (OASIS) to avoid adding administrative burden; we want to know what Medicare is doing
    - OASIS is our master document; probably shouldn't move too far away from that

- Outcomes must be measureable;
- Incentivize efficiency
- How are other states managing their home health? Are others using FFS or other methods? Oregon uses FFS, based on cost, independent of Medicare reimbursement methodology;

Outcome and Assessment Information Set (OASIS) System

OASIS assesses patients' function, etc. – similar to the Minimum Data Set (MDS) for skilled nursing facilities; administered at start of care, resumption of care, discharge, etc.

- OASIS has been around since 2000; home health services has been built around OASIS and Medicare HIPPS; outcome measures are in it; examples are ER use and hospital readmissions;
- OASIS determines the HIPPS (Health Insurance Prospective Payment System) code, which translates into a dollar amount; on claim form, enter G codes and HIPPS codes; uses a separate revenue code; covers 60 days of care; on 1/1/2020, the new Patient-Driven Groupings Model (PDGM) goes into effect, changes to 30 days of care; there are 480 HIPPS codes now, will be reduced to fewer codes (100-or something) in 2020;
- Homebound status is part of this, otherwise would not be eligible for Medicare; if a patient is not homebound, OASIS might allow us to complete the form, but acuity score might reduce the payment amount; it's similar to a diagnosis-related group (DRG);
- The clinician fills out the OASIS form, which produces the HIPPS code; and the agency's software uses that code to produce a rate; Medicare often performs adjustments; in 2020, institutions will have different HIPPS codes than for community claims; also codes and reimbursements will differ by the length of the care;
- The system has a table that gives reimbursement based on geographical area (like hospice) – wage index, to calculate the base rate; we need a list of reimbursement rates by codes; need data around the codes, by county, to model it out for a fiscal note; compare Medicare reimbursement to FFS reimbursement.

There are 29 measures in the Oasis system which includes patient satisfaction, hospital readmissions, ED use, employees getting flu vaccinations, etc. The reimbursement base changes once a year and varies by geographical area. DOH collects the HIPPS data; DOH also has claims data for Medicare, Medicare managed care, and Medicaid. The contact at DOH is Jane Hawk, who runs the Medicare program at DOH (Health Systems Oversight).

Performance Measures

- Decrease ED
- Decrease Hospital Readmissions
- Increase Timely Access
- Increase Access

- Medication Reconciliation
- Pain

What would increase the level of social work needed?

- Social determinates of health
- Mental health diagnosis
- Multiple co-morbid conditions

Methodologies – Discussion of Options

Fee for Service (FFS)	
Definition	Current State Home Health Services
Services	Skilled Nursing, OT, PT, Speech, Home Health Aid, Supplies, Telehealth. Include the services to fill in the gap: Telemedicine, social worker, and rural add-on.
Method to Create the Rate	Rates are paid at the service level.
Fiscal Analysis Creation	HCA created a fiscal note previously based on the Medicare Low Utilization Payment Adjustment (LUPA) rate. The fiscal note included a 3% increase to the base rate for rural areas.
Notes	Could offer a capitated FFS model with limitation extension. PF/OT/Speech were all capped at 6 units, but all subject to limitation extensions. We might want to increase the number of therapies to match the higher cap. Do we use the Medicare episodic or the LUPA rate? The LUPA rate differentiates between the specific service/professional involved. Leslie Emerick to facilitate a conference call with Marc Berg and Robin Brake about the financial analysis. LUPA rates might be too low; regular Medicare rate is higher. Perhaps there needs to be a number of visits within a certain time after discharge, and fewer periods after that time (which might be difficult for providers to manage). FFS does not have an acuity consideration. Some think that FFS is dead nationally; does not hold providers accountable; consider the rural element, that success is not the same for a DSHS patient as for a hip-replacement patient. All MCOs' reimbursement methodology is the same as the state methodology (FFS); need to check nationally; in the 9 states piloting the value-based purchasing demonstration with Medicare, need to find out what methods they use in managed care; if state changed their methodology, it would flow to the MCOs;

Medicare Bundling	
Definition	Medicare prospective payment system (including the PDGM – patient-driven groupings model – starting on 1/1/2020).
Services	Skilled Nursing, OT, PT, Speech, Home Health Aide, Supplies, Telehealth. Include the services to fill in the gap: Telemedicine, social worker, and rural add-on. 30-day payment periods for 60-day episodes. 60-day recertification.
Method to Create the Rate	Use Health Insurance Prospective Payment System (HIPPS) codes from the Outcome and Assessment Information Set (OASIS) system. Continuation of funding based on CMS annual rule.
Fiscal Analysis Creation	Use HIPPS codes. DOH receives the current Medicaid claims. HCA would need a data share agreement (DSA) with DOH to receive the data. HCA would run the model based off of the data.

Notes	Bundling offers the opportunity to provide additional services such as the telephone calls, advance care planning and the palliative care assessment (checklist/screening tool). Projected utilization based on past clients' utilization and Medicare rates; need to consider a statewide average; currently there is established information we could use; however, PDGM is coming 1/1/2020, which changes things (e.g., 30-day episodes); claims data lag over a year; Medicare assumes same level of care (at agency level) under new payment system; can roll up to the state level; CMS has total payments under the old and total (reduced) payments under the new; Marc Berg to help with this.

Medicare VBP	
Definition	Medicare bundling with reimbursement changes (increase or decrease) based on performance outcome from previous two years (i.e., baseline year vs. performance year). Varies up or down based on the previous two years.
Services	Skilled Nursing, OT, PT, Speech, Home Health Aide, Supplies, Telehealth. Include the services to fill in the gap: Telemedicine, social worker, and rural add-on. Opportunity to include services for which we could not reimburse at a line-item level: tele-monitoring (telephone calls), advanced care planning, and palliative care assessment/checklist (standardized screening tool) – in addition to Oasis; concern about adding administrative burden to agencies;
Method to Create the Rate	Receive a percent of total billable amount. This could be budget neutral with upside and downside risk. Performance measures would be based on previous two years success or lack of success.
Fiscal Analysis Creation	Based on bundle using HIPPS codes, but includes VBP component. Unsure whether we can use Medicare's data in the analysis; much like the Medicare bundled model, but need more information about performance; assume an unweighted average of roughly $2,347 - $4,263 per 60-day episode (i.e., in the current system – not after 1/1/2020)
Notes	Two years ago, Doris Barret (DSHS-DDA) and Leslie Emerick-Bloom met with Susan Birch; discussed decision package; Medicaid reimbursement ($99) is less than the cost to provide the service ($150); home health agencies are dropping out; determined that we will not look at rate increases, because there is plenty of money in the system to use value-based purchasing. Value-based method should consider both improvement and stabilization; not necessarily mirroring the OASIS form, create a set of metrics that makes sense for the Medicaid population; need to consider outliers carefully; regarding tele-monitoring, population receiving home health services do not have the technology, so it will be expensive to implement.

	Medicare value-based purchasing baseline year in 2016; reset every 4 years; providers need to meet benchmarks or show percentage improvement; graded on a curve; if all providers improve, it becomes harder to excel; about 9 measures, weighted by importance. Correlation between home health visits occurring vs. outcomes; some visits do not produce outcomes, so would not be cost-effective; maybe have fewer, more effective visits, but pay more for them. Would need to lead to improved outcomes and improved access. Would the measure be improvement or maintaining the level? How could you incentivize access? Maybe give points for rural clients? Would there be an opt-out option (example: rural or smaller providers without the resources)? If so, how would this work? Are all considered equal or would there be adjustment for rural or higher risk populations? Case mix adjustment for agency or type of patient. VBP takes lots of effort to perform well, and the reward is not realized by most; could be budget neutral across state by grading on the curve (top 25 percent gets money from other providers) – unless everyone improves, and the state has to pay everyone; begin with a positive payment incentive, and then gradually incorporate negative incentives (payment reductions); need to be careful that providers do not cherry-pick clients to improve their performance; discussed the possibility of giving certain providers certain measures, based on what is attainable; perhaps rural providers could opt in/out might work for some; would need to determine which providers would be required to participate (e.g., some serve both urban and rural areas); how many rural agencies are there? How do we incentivize access? Perhaps set a threshold – percent of clients served on their caseloads; try to increase actual numbers of Medicaid clients served; need to case-mix adjust for each agency or type of agency, based on what kind of patients they serve (e.g., orthopedic differs from cancer); HIPPS codes consider this, and will be more case-mix adjusted (by diagnosis codes instead of discharge codes) in 2020; decrease ER use; decrease readmissions; increase timeliness; increase access; incentivize percentage of panel of admissions be Medicaid; medication reconciliation and pain; also consider payment model adjustment that considers mental health diagnosis and comorbid diagnoses; need to consider how to treat rural providers differently; don't want to penalize rural provides (i.e., too rural to fail).

Per Diem	
Definition	Per day rate (like the hospice model; Medicare bundling by 60 days; everything else is the same; volume helps agencies manage their bottom lines) – not per visit

Services	Skilled Nursing, OT, PT, Speech, Home Health Aide, Supplies, Telehealth. Include the services to fill in the gap: Telemedicine, social worker, and rural add-on. Opportunity to include services for which we could not reimburse at a line-item level: tele-monitoring (telephone calls), advanced care planning, and palliative care assessment/checklist (standardized screening tool) – in addition to Oasis; concern about adding administrative burden to agencies;
Method to Create the Rate	Distribute the total amount for the episode to pay more at the first part of the episode and less at the end of the episode, because few patients are on the caseload for the whole time; hospice calls it a "service intensity add-on"; hospice has a failsafe (patients die or graduate to other services); what is the average length of treatment for the patients; how to operationalize (actuarially complicated); what is the base rate ($3,000 as an example);
Fiscal Analysis Creation	Use the same method as for Medicare bundled payment (i.e., develop model from $3,000 base and average length of treatment. The Medicare average payment per episode is $2,347-$4,263.); need to look at our Medicaid claims/encounter data to determine what proportion of clients experience worse health after their home health services end – tie the data together; will involve an actuarial analysis and forecasting data;
Notes	Would beginning days or initial episode be reimbursed at a higher rate than the subsequent days or subsequent episodes? How would this be operationalized? In hospice this is called a service intensity add-on. Consider how the per diem rate would change if the patient went from acute to chronic care. More services could also be provided in the first 1-2 weeks in order to avoid ED/hospital readmissions (danger zone); consider reconciling three times per week.

Next Steps and Action Items:

- In the next meeting, we need to focus on what we need to do for the fiscal analysis / note; get access to the data we need to perform the analysis; determine how to incorporate DSHS data in the model
- Leslie Emerick to facilitate a conference call with Marc Berg and Robin Brake about the financial analysis (i.e., LUPA vs regular Medicare rates)
- Marc Berg to help with Medicare bundling fiscal analysis
- MCOs to check with their national organizations about home health reimbursement for Medicaid managed care (i.e., FFS or other) – especially in the 9 states piloting the value-based purchasing demonstration with Medicare

Executive Director Report
August 2019

Board

Attendance Sheet

Reminder an attendance tracking sheet is included in the board packet. As per your governing documents, board members are allowed 2 absences before a vacancy may be declared. We realize there are times where you are unable to join due to prior commitments (i.e. work travel, etc.) so we'll mark "E" for these excused absences.

Policy Acknowledgement Agreement – ***please return to Christine***

All board members are required to fill out the Policy Acknowledgement Agreement included in the board packet. This is a confirmation you have received copies of the Antitrust Guidelines and the Whistleblower, Document Retention, and Conflict of Interest Policies. These are all included in HCAW's Policies & Procedures Manual which has been sent out with the packet and is held on the Board Members Only page (login required).

I'm missing forms from: Marilou, Kyle, Melinda, Tammi, Nate

Insurance Renewal

HCAW's D&O Insurance is up for renewal. The quoted fee has increased $65 and is still within budget. Last year, Greg audited the insurance policy and confirmed coverage is acceptable. We have not made any additional changes to our policy and I don't have any to recommend. You can view the full policy on the enclosed letter. Please let me know if you would like us to add additional coverage.

Membership

Renewals

Special thanks to Tammi for assisting with Kindred at Home's renewals! We received payment this week and are looking forward to getting them more involved.

Advocacy

Consultant – *approval needed*

HCA hosted a stakeholder meeting last week to discuss the Medicaid HH reimbursement. The group came up with four potential models and the HCA is compiling data to find the most viable one. The turnaround time for the final report is rapidly approaching and there is a strong chance we will run out of time. HCA is very receptive to receiving data and assistance. Marc Berg has offered to serve as a consultant for HCAW to help make the process move faster. We don't have an official proposal from Marc, but below are the tasks that are/are not included:

Total: $2,500*

**Includes travel to Olympia*

- Provide HCA with Medicare data sets for the FFS model;
- Assist HCA in outlining the six different disciplines and clarify where data can be found;
- Assist HCA in combining the Medicare prospective payment and VBP;
- Generally advise where data can be found and how to review it;
- Participate in stakeholder meetings with HCAW representatives (Leslie, Donna, etc.)
- Work with HCA/HCAW through the completion of any report/analysis to the legislature.
- Attend all meetings both in-person and via phone as required.

Not in scope:

- Analysis of Medicaid claims data to model new payment proposals (he will work with HCA to help define the work needed but they will need to do the actual work)
- Assistance during the legislative session to present and explain the analysis (he's happy to do this but we just need to discuss HCAW expectations/needs).

This is not part of the budgeted expenses so the Board will need to approve this expense. I've asked Marc to create a more formal proposal that goes into a bit more detail about the work involved. I'll forward any questions from the Board so he can address them. If the Board prefers to wait on voting until seeing the proposal (recommended) we can conduct the vote over email next week.

Education

2019 NAHC Conference – *October 13-15, 2019 | Seattle, WA –* ***please fill out form***

NAHC's fall conference is an opportunity for HCAW to build on the relationship and help boost attendance. HCAW usually hosts a fall program around this time, but the Annual Meeting/Education (AME) Committee is concerned about competing for attendees The Committee decided to reach out to NAHC to discuss how HCAW can be involved and help boost attendance.

Rachel, Gretchen, Brent, and I recently met with NAHC's team and they are supportive of HCAW hosting our fall program in conjunction with their conference. They are confirming space for approx. 50 people on Saturday, October 12th. If there is room, they are willing to offer it at no additional charge. They are hosting their H3IT Conference at this time, but it is a smaller event and won't conflict with HCAW's program. The AME Committee is considering presentations on motivational interviewing and regulatory update but needs your input on what is valuable. For reference, here is NAHC's schedule at a glance: http://seattle2019.nahc.org/attendees/schedule-at-a-glance/

NAHC would like to have several HCAW members act as a welcoming committee to visiting attendees. If you are planning on attending the conference, please let me know so I can coordinate with NAHC.

Those reserving rooms in NAHC's room block will receive a $200 discount. HCAW members will receive an additional $100 discount when they register. NAHC created a special landing page for our members to register. We had a small technical error they're fixing – once working, I'll share with membership.

Three of their presenters are from Washington State:

- Ginny Kenyon (& Shelly Barrett) – "Care Planning in a PDGM World: Evolving Clinical Staff Effectively to Produce Successes for Both Patients and Agencies"
- Brent Korte (& Nick Seabrook) – "PDGM: Early lessons in planning and preparation from three experts"
- Christine Lang, ABILITY, an Inovalon Company *(not a member)* – "A Strategic Approach to Market Development For Home Health"

NAHC has asked the Board to fill out their favorite spots in Seattle. They're looking for a local's guide they can share with attendees. Please fill out the following survey and share with your team: https://www.surveymonkey.com/r/nahcseattlesbest

2020 Blueprint for OASIS Workshop – *June 3-5, 2020 | Tukwila, WA*
Save the date! Next year's Blueprint for OASIS workshop and exam will be held once again at Providence (thank you Rachel!). The workshop will be June 3-4th and the exam will be June 5th. More information will be available as the event nears.

Mercer Consumer, a service of
Mercer Health & Benefits Administration LLC
540 W. Madison Street
Chicago, IL 60661

August 8, 2019

HOME CARE ASSOCIATION OF WASHINGTON
2311 N 45TH ST, #337
SEATTLE, WA 98103

RE: Association Professional Liability Insurance
Client #: 9768329

Dear Policyholder:

Thank you for your interest in the Association Professional Liability Insurance. For your review we are pleased to present the following personalized premium quotation underwritten by the Great American Ins. Co.

The enclosed premium quotation details the coverage terms and conditions. Please also review the "Quotation Subject To" section for any additional information or material required.

In this transaction, Mercer Consumer is acting as the insurance agent and program manager for Great American Ins Co ("Insurer") for this type of coverage, and not as your insurance broker. Comparable insurance products may be available in the insurance market place. Mercer Consumer is only offering this selected carrier quote proposal.

In accordance with industry custom, we are compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. We may also receive additional monetary and nonmonetary compensation from insurers, or from other insurance intermediaries, which may be contingent upon volume, profitability, or other factors. This compensation may include payment from insurers for marketing related expenses or investments in technology. Our compensation may vary depending on the type of insurance purchased and the insurer selected. We will provide you additional information about our compensation upon your request.

You may obtain this information by referring to https://www.personal-plans.com/disclosure and enter in the security code O5035371 or call us at 1-888-206-5088 for specific details.

If you choose to accept our premium quotation terms, please return the completed material by the "Quotation Expiration" date indicated. Should you have any questions, please contact our office.

I appreciate the opportunity to assist you with this important coverage and look forward to your response

Sincerely,

Luz Maysonet
Mercer Consumer
Phone: 877-451-4003
Fax: 312-627-6172

Enclosures: Premium Quotation
CA License #0G39709, In CA d/b/a Mercer Health & Benefits Insurance Services LLC
Mercer is part of family of the MMC companies, including Guy Carpenter, Marsh, and the Oliver Wyman Group (including Lippincott and NERA Economic Consulting)

TALENT • HEALTH • RETIREMENT • INVESTMENTS

PREMIUM QUOTATION

PROFESSIONAL LIABILITY INSURANCE

Offered by Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
Underwritten by Underwriters at Great American Ins Co

Quotation prepared for: HOME CARE ASSOCIATION OF WASHINGTON

Submitted by: Mercer Consumer

Date of Quotation: August 8, 2019

Quote Expiration Date: September 14, 2019

Policy Description	Association Professional Liability Plan	Policy Number	EPP4025692
Policy Effective Date	09/14/2019	Policy Expiration Date	09/14/2020

Limit of Liability	**$1,000,000** per claim **$1,000,000** aggregate
Deductible	**$2,500** Each claim
Premium	**$1,365.00**
Total Premium	**$1,365.00**

Endorsements/Exclusions
D16100 D16505 DTCOV2015 (02/15) DTDIS2015 (02/15) IL7324 D16337

This quotation is subject to the following conditions:

- **All other terms, conditions and provisions of the policy.**
- **Signing and dating the Authorization to Bind (below)**

In order to activate this coverage, please return a copy of this signed Premium Quotation with your payment for **the total premium due by the Quotation Expiration Date indicated above**. Your check should be made payable to Mercer Consumer.

PLEASE REMIT TO: Mercer Consumer
PO Box 310222
Des Moines, IA 50331-0222

Authorization to Bind:

You are authorized to place insurance on our behalf as shown above. I / We certify that the application remains unchanged since its original completion, including any amendments attached prior to the date of this statement.

X_____ _____
Signature Date

CA License #0G39709, In CA d/b/a Mercer Health & Benefits Insurance Services LLC

home care association of washington
REPRESENTING HOME HEALTH, HOSPICE, & HOME CARE AGENCIES

2019-2020 Board Meeting Attendance

Board Member	Meeting Dates									
	May	June	Aug	Sept	Oct	Nov	Jan	Feb	March	April
Marilou Church	Y									
Rachel Manchester	Y									
Amber Hahn-Keenan	Y									
Gretchen Anderson	N									
Brent Korte	Y									
Kyle Long	Y									
Geoff Meinken	Y									
Melinda Moore	Y									
Tammi Reeser	Y									
Nate Smith	Y									
Alisa Van Sickle	Y									

E = excused
R = retired

Per HCAW's Bylaws (Article VIII; Section 5):
Attendance: To enable maximum efficiency of the Board of Directors, meeting attendance is expected. After two (2) absences within a year, a vacancy may be declared.

Therefore with ten (10) meetings set for the year board members must attend 8, unless excused.