PERFORMANCE AUDIT

Office of the Washington State Auditor
Pat McCarthy

Assessing Extended Family Exemptions for Individual Providers

February 21, 2019

Report Number: 1023358

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Executive Summary

Background (page 6)

This audit examined how exemptions from some statutory training requirements and certification for Medicaid-funded in-home care workers, called "individual providers," might affect the availability of those workers, and the risks and benefits of broadening those exemptions. The 2008 voter-approved Initiative 1029 required long-term care workers to be certified by the Washington State Department of Health as "home care aides" after completing specific training and passing an examination. Budget concerns delayed its implementation. Initiative 1163, passed in 2011, hastened the effective date and required biennial audits on long-term in-home care. This audit is the fifth of those mandated audits.

What is the extent of unmet need for individual providers in Washington? (page 8)

The state has insufficient data to determine the extent of Washington's unmet need for individual providers, because the demand for providers can only be loosely estimated from population data. Though the extent of unmet need is difficult to quantify, Washington's policy decisions and national studies point to a significant and growing shortage of long-term care workers, as growth in the population of elderly people is outpacing growth in the labor force. In addition, Washington is experiencing a shift in long-term care from institutions to in-home and community-based care.

What are the benefits and risks of broadening exemptions from full training and certification for individual providers who are extended family members? (page 13)

One policy option for addressing the unmet need for individual providers is to expand the training and certification exemptions for extended family members. Exempted family members must complete some training, but less than non-exempt home care aides, and are not required to become certified. Expanding exemptions to extended family members could increase the amount of long-term

care available to people in home settings, though the impact is difficult to quantify. Broadening the exemptions would likely increase some state program costs, though it is difficult to know how much. The impact expanding exemptions would have on the quality of care would depend on the experience and training of family members who become individual providers. Finally, expanding exemptions would place exempt individual providers outside the Department of Health's licensing and disciplinary umbrella.

State Auditor's Conclusions (page 18)

Broad demographic trends and various studies suggest a growing need for long-term care, though it is difficult to quantify. Those trends and studies also suggest there will be an insufficient number of caregivers to meet that need. Potential caregivers come from a variety of sources, including informal personal arrangements, charitable organizations, private companies and government programs. Consistent with the voters' mandate in Initiative 1163, this audit focused on one specific source of caregivers: home care aides working as individual providers and paid through the Medicaid program, and the training requirements that apply to them.

One option stakeholders have suggested as a way of getting more people to serve as caregivers is to broaden the family exemption from full training requirements for extended family members. Broadening the exemption would make it easier for extended family members to qualify as individual providers and be paid through Medicaid. Relaxing the requirements has the potential to make more family care available in situations where full training requirements keep family members from being paid and the lack of payment limits the care a family member can provide.

While broadening the training exemption could potentially make more care available, there is no good way of quantifying the potential impact. It depends on how many extended family members would be willing to provide more care if the training requirements were reduced, and that is not easily known. Though broadening the exemptions might prove helpful in attracting more caregivers, we stop short of recommending this option given our inability to reasonably estimate the potential impact.

Recommendations

This audit did not produce recommendations.

Next steps

Our performance audits of state programs and services are reviewed by the Joint Legislative Audit and Review Committee (JLARC) and/or by other legislative committees whose members wish to consider findings and recommendations on specific topics. Representatives of the Office of the State Auditor will review this audit with JLARC's Initiative 900 Subcommittee in Olympia. The public will have the opportunity to comment at this hearing. Please check the JLARC website for the exact date, time, and location (www.leg.wa.gov/JLARC). The Office conducts periodic follow-up evaluations to assess the status of recommendations and may conduct follow-up audits at its discretion. See **Appendix A**, which addresses the I-900 areas covered in the audit. **Appendix B** contains information about our methodology.

Background

For people who lack the ability to care for themselves due to a disabling condition or chronic illness, long-term care can help them preserve their independence, avoid institutional care and sustain the best possible level of functioning. Caregivers help their clients perform activities of daily living, such as dressing, bathing, preparing meals and other household chores; they may also assist with some basic healthcare needs, such as administering medication. However, long-term care workers do not provide the same level of medical care as nurses or other medical professionals.

Voters in Washington twice approved initiatives that increased the training and certification requirements for long-term care workers

Washington's training and certification requirements for long-term care workers are set in statute and have been revised several times, twice following voter approval of two related initiatives. In 2000, the Legislature broadened existing training requirements to cover healthcare workers who care for elderly or disabled clients in assisted living, adult family homes, the clients' own homes and other settings. The legislation set out the hours of training, continuing education and other requirements, and directed the Department of Social and Health Services (DSHS) to craft the rules governing their implementation. The Legislature also defined long-term care workers as people who work in state-licensed assisted living facilities or adult family homes, as employees of home care agencies, or who contract directly with the state to provide in-home care to Medicaid-eligible clients. The latter are defined in Washington's law as individual providers.

Twice, in 2008 and 2011, voters approved initiatives intended to enhance existing requirements and to establish a new category of care workers that are certified, to be called "home care aides." ***Initiative 1029 (I-1029)***, approved in 2008, increased the training requirements for some workers, and required long-term care workers to complete an examination and be certified by the Department of Health (DOH) as home care aides. The initiative also required long-term care workers to undergo both state and federal background checks. Among those exempted from the full home care aide training requirements and certification were individual providers caring for a biological, step or adoptive child or parent, although they were still required to receive some training.

Funding issues the state faced at that time prompted a delay of the initiative's implementation. As direct contractors with the state, individual providers are represented by the Service Employees International Union (SEIU) Local 775, which negotiates their contracts. The 2008 collective bargaining agreement that followed I-1029 was found not financially feasible by the director of Washington's Office

of Financial Management. As a result, then-Governor Gregoire excluded those pay increases in her budget to the Legislature, and delayed implementation of the initiative.

In 2011, voters responded to the delayed implementation by approving ***Initiative 1163 (I-1163)***, which hastened the date by which I-1029's additional training, certification and background checks requirements took effect. **Appendix C** provides a table showing the certification requirements of long-term care workers following the adoption of I-1163.

Initiative 1163 also requires biennial performance audits

In addition to speeding up the implementation of the home care aide training requirements, Initiative 1163 also required the Office of the State Auditor to conduct performance audits of the in-home long-term care program it created. The first audit was to be completed by early January 2013, and on a biennial basis thereafter. Consistent with that requirement, the Office has since published four performance audits.

The first two performance audits found that not all long-term care providers met certification requirements within required timeframes, and that many applicants did not complete the training and certification process. The third audit examined progress on these issues and found that the number of applicants increased, but the completion rates remained the same. The fourth followed up on these issues by identifying barriers to certification, such as training and exam scheduling. The audit recommended that DSHS and DOH continue to address barriers faced by applicants. Suggestions included expanding available languages and emphasizing flexible training schedules. **Appendix D** includes links to the previous required performance audits, and a bibliography of the studies referred to in this report.

In both oral and written testimony to the Legislature following previous audit presentations, some stakeholders asked for expanded individual provider training and certification exemptions to help make in-home care easier to find. Some stakeholders also told legislators that family members did not need to complete the full spectrum of training meant for career caregivers assisting disabled clients with a broad array of needs.

Based on the stakeholder testimony following the earlier I-1163 performance audits, this audit examines the potential for expanding the exemptions to extended family members. Specifically, it sought to answer the following questions:

1. **What is the extent of unmet need for individual providers in Washington?**
2. **What are the benefits and risks of broadening exemptions from full training and certification for individual providers who are extended family members?**

Audit Results

What is the extent of unmet need for individual providers in Washington?

Answer in brief

The state has insufficient data to determine the extent of Washington's unmet need for individual providers, because the demand for providers can only be loosely estimated from population data. Though the extent of unmet need is difficult to quantify, Washington's policy decisions and national studies point to a significant and growing shortage of long-term care workers, as growth in the population of elderly people is outpacing growth in the labor force. In addition, Washington is experiencing a shift in long-term care from institutions to in-home and community-based care.

The state has insufficient data to determine the extent of Washington's unmet need for individual providers

Understanding the extent of need for individual providers – those who care for people who meet Medicaid criteria – starts with an understanding of the unmet need for long-term care workers overall. To calculate the state's unmet need for total long-term care workers, or any subset of those workers, requires known values or estimates of both the demand for and supply of workers. In the case of long-term care workers, neither the demand nor total supply can be calculated with absolute precision. The sections below describe in more detail why Washington's unmet need cannot be quantified.

The calculations are similarly problematic for national policymakers. In 2016, the Government Accountability Office published an audit on the long-term care workforce that stated:

> **"Reported difficulties recruiting and retaining direct care workers and the anticipated growth in the elderly population have fueled concerns about the capacity of the paid direct care workforce to meet the demand for long term services and supports. Despite these concerns, policymakers lack data to help assess the size of the problem."**

The demand for in-home long-term care can be only loosely estimated from population data

The population in the United States is clearly aging. The U.S. Census Bureau estimates that by 2035, Americans 65 and older will outnumber those below 18 for the first time in history, making the potential need for long-term care unprecedented. Here in Washington, the Office of Financial Management projects the proportion of people 65 and older to increase from 15 percent in 2017 to 21 percent by 2030.

As the population ages, the number of older people who need long-term care services will also likely rise. Research from the U.S. Department of Health and Human Services' Office of Disability, Aging and Long-Term Care Policy estimates that more than half the population over 65 nationwide will develop a disability that will require some type of long-term care. Placing this estimate alongside state demographic numbers developed by the Office of Financial Management and the federal Administration on Intellectual and Developmental Disabilities, it seems likely that more than 700,000 of the state's residents who are now over the age of 65 or developmentally disabled may need some type of long-term care at some point in their lives. The proportion of citizens over 65 is the overwhelming majority (around 86 percent) of those likely to need care, and growth in the elderly population will drive the growth in demand for care workers in the future.

The degree of need for long-term care by that portion of the population, however, is not known. While population estimates by age group are available, those estimates do not attempt to predict how many people in any age group will be disabled enough to require such care. Further, for those who need long-term care, the number of caregivers each person will need is also difficult to predict. Some might need care from only one caregiver for a few hours a day, while others may need around-the-clock shifts of multiple caregivers.

The total supply of long-term care workers who are currently available in Washington is also unknown

Both state and federal agencies, including the federal Bureau of Labor Statistics, keep a count of various categories of health care workers, but neither are able to determine with precision the number of all long-term care workers.

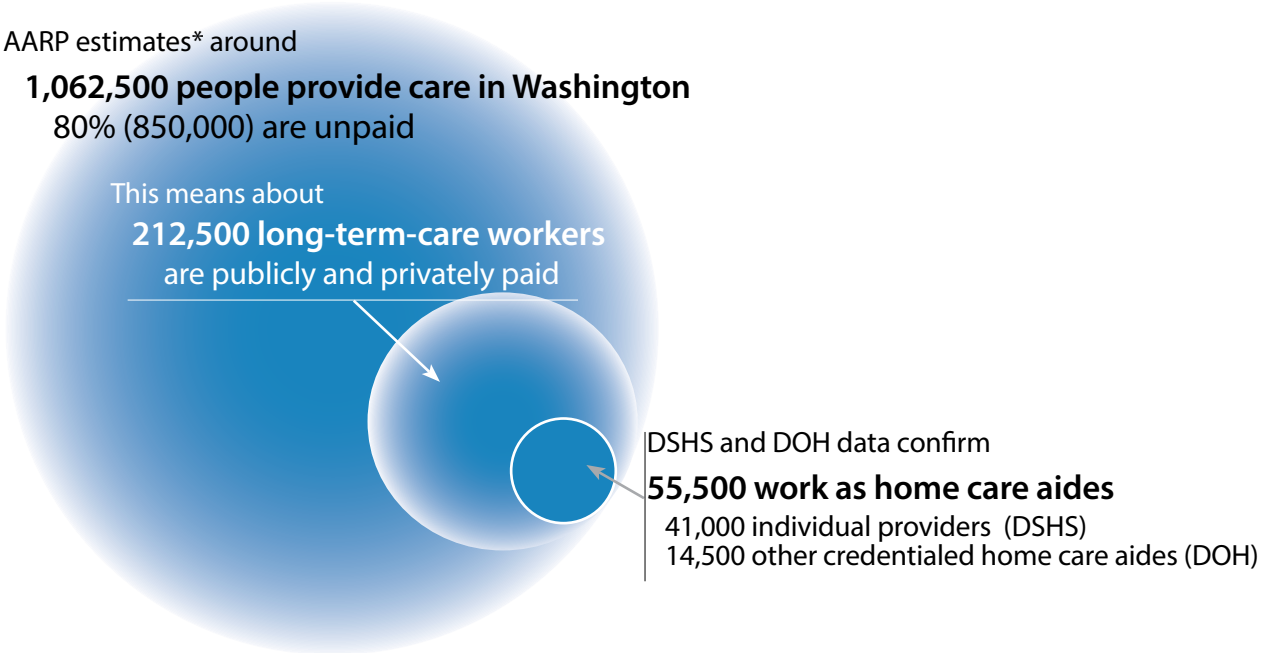
The federal Bureau of Labor Statistics publishes employment statistics for various categories of health care workers at the state level, but the definitions of workers within those categories do not align with Washington's statutory definition of long-term care workers. Bureau statistics include worker categories of home health aides, personal care aides and nursing aides. Each of these categories have duties that overlap with Washington's definitions of long-term care workers, but some also have duties outside the state's definitions.

DOH and DSHS each maintain counts of some categories of paid long-term care workers, but not all of them. DOH maintains records for all workers with current home care aide certificates, including individual providers, but does not track long-term care workers who were exempt from certification. DSHS maintains records of individual providers, including those who have attained other medical credentials, but does not – indeed could not – maintain a count of records for paid long-term care workers with other credentials working for private companies.

The number of people acting as unpaid caregivers is even more difficult to quantify. The best estimate of unpaid caregivers in Washington comes from the American Association of Retired Persons (AARP), a nonprofit, nonpartisan association providing information and services to people aged 50 and older. The AARP approximated the number of unpaid long-term care workers by state based on calculations that used a weighted average of data from various sources. AARP's estimate for Washington in 2015 was 828,000 unpaid caregivers. AARP also estimates that unpaid caregivers represent about 80 percent of the long-term care workforce, and DSHS confirmed that this is a nationally accepted standard. DSHS staff refer frequently to the AARP estimates in presentations and publications, and have updated the estimate of unpaid caregivers to 850,000 to reflect agency data and known population growth. If unpaid caregivers represent 80 percent of all workers, the number of paid workers, including those employed by private businesses, would therefore total around 213,000.

Exhibit 1 shows the total number of long-term care workers in Washington, and includes both AARP's estimates of unpaid workers and the resulting estimate of paid workers, validated by DSHS.

Exhibit 1 – Of the estimated total number of Washington's long-term care workers, only a small portion can be quantified with data



Source: DOH licensee counts, DSHS individual provider counts, AARP long-term care worker estimates.
** Note: AARP defines caregivers as someone who provides a broad range of assistance for an older person or an adult with a chronic, disabling or serious health condition.*

Though the extent of unmet need is difficult to quantify, Washington's policy decisions and national studies point to a significant and growing shortage of long-term care workers

Washington is experiencing a shift in long-term care from institutions to in-home and community-based care

As the population ages, increasing emphasis is placed on "aging in place." The Centers for Disease Control and Prevention (CDC), the nation's lead public health agency, defines aging in place as "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level."

In 2015, Washington State University's William D. Ruckelshaus Center and the University of Washington's Health Policy Center published a joint study titled "Aging in Place: A Policy Approach for Aging Well in Washington State." The authors cited aging in place as a key policy focus in Washington for several reasons. First, the report points to analyses conducted by private- and public-sector researchers showing that the costs of health-care related services can be significantly lower in a home or community-based setting than in a nursing home or assisted living facility. Second, Medicaid increasingly emphasizes providing home and community-based services instead of institutional care. As a result of this emphasis, the report states, Washington's Medicaid program is seeing both cost savings and an increased capacity to serve older adult clients. Finally, the report points to the desire by older adults to remain in their homes as they age, in large part because of the benefits they enjoy, including life satisfaction, good health and self-esteem.

Caseload data from DSHS validates the shift from institutional care to in-home aging. Its data show a 14 percent increase in in-home care over the last five years, and a 5 percent decrease in institutional care over the same period.

National studies indicate a significant and growing shortage of care workers

A growing shortage of healthcare workers overall is also well documented in media reports and published studies, although the extent of the shortage is not quantified. The reports and studies warn about increasing difficulty in finding qualified care as growth in the aging population is expected to greatly outpace the growth in working-age adults, suggesting insufficient care workers may be available to serve the growing need. This was also corroborated by testimony before Washington's

Legislature during previous audits of the home care aide program.

The Professional Healthcare Institute, a policy and research group providing services for direct care workers and frequently cited in publications by the Centers for Medicare and Medicaid Services, estimates that by 2050, the number of working-age adults for every senior over 85 will fall from 32 to 12, based on data from the U.S. Census and the Bureau of Labor Statistics.

Similarly, a 2012 report by the Leadership Council of Aging Organizations, a coalition of non-profit organizations serving older Americans, estimates that between 2000 and 2040, the number of older people needing home care will increase from 2.2 million to 5.3 million, and the number living in nursing homes will increase from 1.2 million to 2.7 million. This report estimates that to meet the increased need for care in these years, the number of direct care workers would need to increase by 2 percent annually, yet the overall working-age population is expected to increase by only 0.5 percent annually.

Chris Farrell, senior economics contributor for American Public Media's Marketplace, wrote in a 2018 Forbes article that the demand for home care workers is expected to increase dramatically in coming years. He asserts that government statisticians rank home care as one of the nation's fastest growing occupations, with an additional 1 million workers needed by 2026.

The United States is "heading towards a severe shortage of caregivers, both paid and unpaid," wrote Paul Osterman in his 2017 book, *Who Will Care For Us? Long-Term Care and the Long-Term Workforce*. Osterman also is a professor of human resources and management at the Massachusetts Institute of Technology's Sloan School of Management.

These forecasted shortages in long-term care workers based on demographic trends more broadly suggest families may experience greater difficulty finding qualified caregivers in the future.

What are the benefits and risks of broadening exemptions from full training and certification for individual providers who are extended family members?

Answer in brief

One policy option for addressing the unmet need for individual providers is to expand the training and certification exemptions for extended family members. Expanding exemptions to extended family members could increase the amount of long-term care available to people in home settings, though the impact is difficult to quantify. Broadening the exemptions would likely increase some state program costs, though it is difficult to know how much. The impact expanding exemptions would have on the quality of care would depend on the experience and training of family members who become individual providers. Finally, expanding exemptions would place exempt individual providers outside the Department of Health's licensing and disciplinary umbrella.

One policy option for addressing the anticipated unmet need for individual providers is to expand the training and certification exemptions for extended family members

As already noted, a number of demographic trends suggest that the United States will experience a dramatic increase in the number of people needing long-term care in the coming decades, and the need will likely outpace the number of workers available to provide that care.

The expected shortages in long-term care workers mean that families of people with disabilities, including those who are eligible for Medicaid, will likely face challenges in finding qualified caregivers. One possible way to address future unmet need is to expand training and certification exemptions beyond those currently afforded to parents and adult children. Expanding exemptions means allowing extended family members, such as grandparents, siblings or cousins, to become individual providers with limited training and no certification. These family members may have personal understanding of the client's needs.

Expanding exemptions could increase the amount of long-term care available to people in home settings, though the impact is difficult to quantify

A 2013 study funded by the federal Centers for Medicare and Medicaid Services (CMS) identified training requirements as a potential hurdle to recruiting family caregivers

CMS has devoted substantial resources to helping states ensure adequate recruitment and retention of quality Medicaid providers, and in particular qualified direct service workers such as individual providers. In that effort, CMS has recognized that "building and promoting an adequate, well-qualified, and competent direct service workforce is a particularly challenging task."

In a 2010 CMS leadership summit to develop common goals and recommendations for the direct service workforce and family caregivers, summit participants identified training as critically important for both groups of care workers. These long-term care researchers and administrators also identified key differences in what training should include and how it should be approached for paid/professional workers versus family caregivers. One recommendation that resulted from work at the summit was to develop career path opportunities for direct service workers. As part of that discussion, however, participants noted that "paid caregivers who are family members and friends of the person receiving services may not want to attend classes or receive certification and any training requirements could reduce the pool of participant-directed service workers."

In its 2013 study designed to give state Medicaid agencies a toolkit for continuing education and training, CMS identified *Guiding Principles* addressing training programs for in-home care. It recommended, among other things, that training should recognize that people "frequently hire family and friends who already have significant experience" in caring for them. It also noted that relatives often have "prior knowledge of the [client's] condition and care needs, and have received some informal training from various health-care professionals," such as family physicians and home-health nurses. Further, the study suggests that both potential relative and non-relative care workers not be unduly burdened by training requirements, possibly reducing "the availability of this non-traditional direct service workforce."

Consistent with these CMS sources, stakeholders testifying both orally and in writing at previous audit hearings pointed to the need for solutions to ease their difficulty in finding in-home care, such as expanding family exemptions for individual providers. The extended family relationships mentioned include grandparents, siblings, cousins, nieces and nephews.

Relaxing the training requirements could make it easier to recruit family members to serve as individual providers

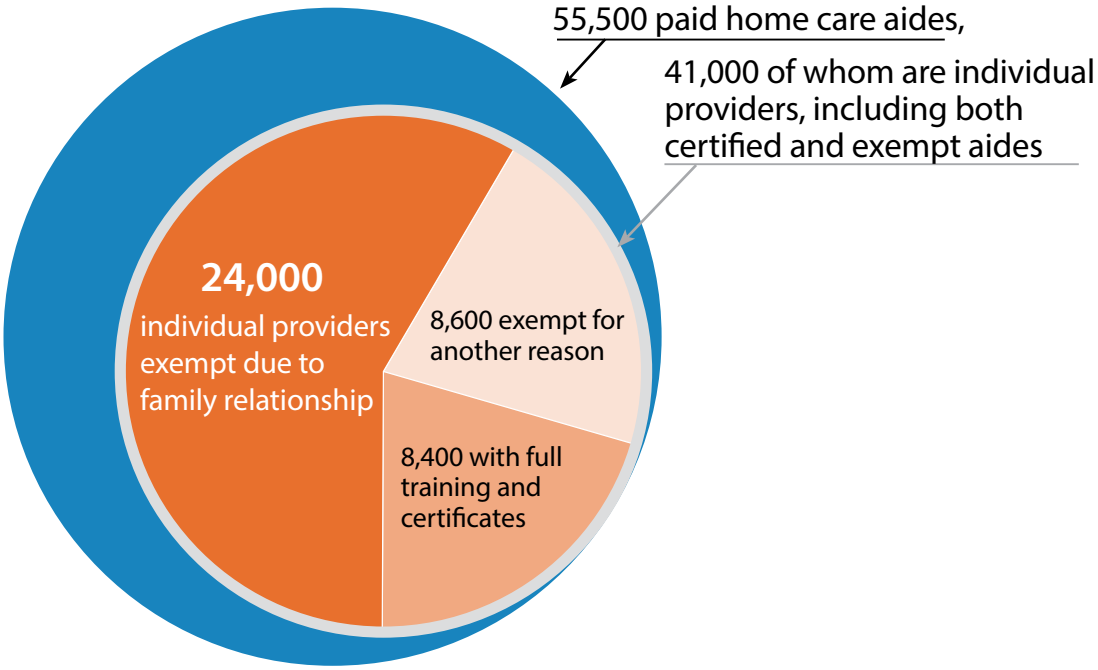
Under current law, the training requirement for family-exempt individual providers is reduced from 75 hours to either 35 or 14 hours, depending on the type of client (see Figure 2 in Appendix C), and no certification is required. Most training for these family-exempt individual providers is offered online, with only six hours of classroom training required.

By reducing the training requirements and offering the flexibility of online training, extended family members may be more inclined to become individual providers and be paid for their services. In some cases, this may mean that family members currently providing some unpaid, or informal, care could either provide the same level of care or potentially more care once they are paid. In other cases, family members who currently provide no care may be enticed to become paid caregivers.

However, there are too many unknown factors to reliably quantify the impact on amount of care that would be made available

The effect on the supply of care by expanding family exemptions beyond parents and adult children cannot be easily quantified. Currently, family-exempt individual providers make up almost 60 percent of the state's roughly 41,000 individual providers, shown in **Exhibit 2**. The estimated number of unpaid caregivers (seen in Exhibit 1) is significantly greater than the number of paid caregivers, and more specifically, individual providers.

Exhibit 2 – About 80 percent of all individual providers are exempt from home care aide certification and full training requirements



The impact on the amount of care that would become available depends upon two unknowns: whether currently unpaid family caregivers will provide more care once they are paid, and the number of family members not currently providing care who will become paid caregivers. When currently unpaid caregivers provide the same level of care for pay, the number of hours of care available does not change.

The effect on quality of care depends on the experience and training of family members who become individual providers

Some extended family members already provide long-term care without pay but do so with no previous training. The importance of an adequately trained long-term care workforce is well documented, and some studies equate the quality of care with the level of training. For example, the Leadership Council of Aging Organizations recently reported that national and state research and policy analyses consistently suggest that "inadequate basic training contributes to high turnover among direct care workers." A joint study by Washington State University and the University of Washington on aging in place states "...without an adequately trained workforce, keeping older adults healthy and independent will be a challenge."

Full training for individual providers involves instruction about a broad range of care issues that may arise. SEIU Local 775 said it has concerns that expanding family training exemptions would reduce the quality of care. An extended family member who has not previously provided any care, or provides it but has never received any training, would likely benefit from the full spectrum of care training. However, following our Office's earlier I-1163 audit hearings, other stakeholders testified to legislators that one-size-fits-all training requirements often exceed the family's need, while not allowing for unique training that would most benefit them.

Currently, family-exempt individual providers select specific training topics online based on the client's needs. Parents and adult children are typically more familiar with their client, and it is reasonable they do not necessarily require the broad knowledge of care provided in the standardized 75 hours of training. These close-family exemptions recognize the likelihood that the caregiver has first-hand familiarity with the client's specific needs and the training that best services those needs. Likewise, the 2013 CMS study and the 2010 CMS Leadership Summit concluded family caregivers should receive training that is tailored to each family's needs. The 2013 study noted one might argue that alternative training requirements which allow for such customization could preserve or even enhance the overall quality of care.

However, if individual provider exemptions extend to more remote family members, a grandchild or nephew may not be as readily familiar with the needs of their elderly relative as parents are with their disabled child. The more remote

family member may not immediately know the specific training that best serves the client's needs. Nonetheless, it is important to recognize that unpaid, extended-family caregivers currently receive no formal training whatsoever. Any training would likely be an improvement to no training.

Broadening the exemptions would likely increase some program costs, though it is difficult to know by how much

Program costs to the state would increase if a reduction in training requirements for extended family members resulted in an increase in the number of individual providers and an increase in the overall number of hours that individual providers work. However, there are no data or studies that estimate the magnitude of such an increase.

Expanding exemptions would also place exempt individual providers outside DOH's licensing and disciplinary umbrella

When workers attain licenses or certifications through DOH, those workers become subject to disciplinary action by the agency. Certified home care aides fall under that regulatory umbrella. By expanding training exemptions for family individual providers, these new providers would deliver services unregulated by DOH.

DSHS data suggest that many existing individual providers are family members who completed full training and received a credential. If exemptions were expanded to include these people, more caregivers would be entering the workforce without a credential and therefore outside the state's disciplinary umbrella. This would create some additional risk. For example, DOH reports that its roughly 22,900 certified home care aides had a 5 percent complaint rate between July 1, 2017, and June 30, 2018. DOH reviews each of these complaints, investigates compelling cases and disciplines aides as necessary. Disciplinary actions may include fines or the loss or suspension of one's license to practice. Although the potential for substandard care may differ, these DOH safeguards would not exist for extended family individual providers.

State Auditor's Conclusions

Broad demographic trends and various studies suggest a growing need for long-term care, though it is difficult to quantify. Those trends and studies also suggest there will be an insufficient number of caregivers to meet that need. Potential caregivers come from a variety of sources, including informal personal arrangements, charitable organizations, private companies and government programs. Consistent with the voters' mandate in Initiative 1163, this audit focused on one specific source of caregivers: home care aides paid through the Medicaid program and the training requirements that apply to them.

One option stakeholders have suggested as a way of getting more people to serve as caregivers is to broaden the family exemption from full training requirements for extended family members. Broadening the exemption would make it easier for extended family members to qualify as individual providers and be paid through Medicaid. Relaxing the requirements has the potential to make more family care available in situations where full training requirements keep family members from being paid and the lack of payment limits the care a family member can provide.

While broadening the training exemption could potentially make more care available, there is no good way of quantifying the potential impact. It depends on how many extended family members would be willing to provide more care if the training requirements were reduced, and that is not easily known. Though broadening the exemptions might prove helpful in attracting more caregivers, we stop short of recommending this option given our inability to reasonably estimate the potential impact.

Recommendations

This audit makes no recommendations.

Agency Response

STATE OF WASHINGTON

February 14, 2019

The Honorable Pat McCarthy
Washington State Auditor
P.O. Box 40021
Olympia, WA 98504-0021

Dear Auditor McCarthy:

Thank you for the opportunity to review the State Auditor's Office performance audit report, "Assessing Extended Family Exemptions for Individual Providers." The Office of Financial Management worked with the Department of Health and the Department of Social and Health Services to provide this response.

We appreciate your team looking into the extent of unmet need for individual providers for some of our state's most vulnerable people and recognize the challenges in quantifying the growing need for long-term care.

We add that the state covers the costs of 75 hours of training, including wages while completing training, testing and certification for those extended family members who are required to take these hours. The report points out that administrative costs may increase if exemptions were allowed for extended family members. However, due to these other costs borne by the state, the overall costs may decrease or remain the same.

Expanding exemptions would allow more Washingtonians to stay in their homes and enable extended family members to care for their loved ones. This would be beneficial and have a positive impact.

We will continue to work together and with stakeholders to address the need for qualified individual providers.

Sincerely,

David Schumacher
Director
Office of Financial Management

Cheryl Strange
Secretary
Department of Social and Health Services

John Wiesman
Secretary
Department of Health

cc: David Postman, Chief of Staff, Office of the Governor
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Appendix A: Initiative 900 and Auditing Standards

Initiative 900 requirements

Initiative 900, approved by Washington voters in 2005 and enacted into state law in 2006, authorized the State Auditor's Office to conduct independent, comprehensive performance audits of state and local governments.

Specifically, the law directs the Auditor's Office to "review and analyze the economy, efficiency, and effectiveness of the policies, management, fiscal affairs, and operations of state and local governments, agencies, programs, and accounts." Performance audits are to be conducted according to U.S. Government Accountability Office government auditing standards.

In addition, the law identifies nine elements that are to be considered within the scope of each performance audit. The State Auditor's Office evaluates the relevance of all nine elements to each audit. The table below indicates which elements are addressed in the audit. Specific issues are discussed in the Results and Recommendations sections of this report.

I-900 element	Addressed in the audit
1. Identify cost savings	**No.** The audit determined that expanded training exemptions would likely increase (not decrease) the state's payments for Medicaid funded home care workers. Consequently, the audit did not identify any cost savings.
2. Identify services that can be reduced or eliminated	**Yes.** The audit considered potential reduction of the training requirements for people who would fall under expanded exemptions.
3. Identify programs or services that can be transferred to the private sector	**No.** The audit considered the pros and cons of reduced training requirements for certain individual providers. It did not consider transferring anything to the private sector.
4. Analyze gaps or overlaps in programs or services and provide recommendations to correct them	**Yes.** The audit looked at the potential gap between the need for and supply of individual providers.
5. Assess feasibility of pooling information technology systems within the department	**No.** It did not address IT systems in any way.

I-900 element	Addressed in the audit
6. Analyze departmental roles and functions, and provide recommendations to change or eliminate them	**No.** The audit did not evaluate changing or eliminating any roles or functions.
7. Provide recommendations for statutory or regulatory changes that may be necessary for the department to properly carry out its functions	**No.** The audit looked at the benefits and risks of expanding training exemptions for Medicaid-funded home care workers. It makes no recommendations.
8. Analyze departmental performance data, performance measures and self-assessment systems	**No.** It did not evaluate the agencies' performance or performance measures.
9. Identify relevant best practices	**No.** It did not consider best practices.

Compliance with generally accepted government auditing standards

We conducted this performance audit under the authority of state law (RCW 43.09.470), approved as Initiative 900 by Washington voters in 2005, and in accordance with generally accepted government auditing standards as published in Government Auditing Standards (December 2011 revision) issued by the U.S. Government Accountability Office. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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Appendix B: Scope, Objectives and Methodology

Scope

This audit examined training and certification exemptions afforded to individual providers who are the adult children and parents of Medicaid-eligible disabled people in Washington. The audit did not determine whether the state should or should not broaden the exemptions, nor did the audit address the quality of training that individual providers are required to complete.

Objectives

The purpose of this audit is to examine how exemptions from some statutory training requirements and certification for Medicaid-funded in-home care workers, called "individual providers," potentially affect the availability of those workers, and the risks and benefits of broadening those exemptions. The audit sought to answer the following questions:

1. What is the extent of unmet need for individual providers in Washington?
2. What are the benefits and risks of broadening exemptions from full training and certification for individual providers who are extended family members?

Methodology

To complete this audit, we conducted three primary activities:

1. **Collected available state and federal data.** To assess the extent of unmet need for both long-term care (LTC) workers overall and Individual Providers (IP), we sought to estimate both the demand for and supply of workers in the state. We examined Bureau of Labor Statistics (BLS) employment data, and requested and reviewed existing data from both the Department of Social and Health Services (DSHS) and the Department of Licensing (DOL). We also compiled and analyzed demographic data from the U.S. Census Bureau and the state's Office of Financial Management.
2. **Reviewed literature and relevant studies.** Because not all supply and demand data were available, we reviewed literature that addressed estimates of those portions of supply and demand. In addition we reviewed literature that discussed trends in the overall supply of and demand for LTC workers. The literature also provided us with an understanding of the impact of training on long-term care.

3. **Interviewed stakeholders and reviewed previous legislative testimony.** We interviewed stakeholders that play a key role in the system for in-home long-term care services, including both DOH and DSHS staff, and representatives of the Service Employees International Union (SEIU) 775. We also interviewed representatives from two organizations that provided public testimony on our 2016 I-1163 performance audit – the Freedom Foundation and the Developmental Disabilities' Council – to understand their perspectives on the benefits and risks of expanding exemptions for individual providers. In addition, we reviewed written testimony sent to the Legislature following previous audits on the topic of in-home long-term care issues.

Appendix C: Certification Requirements Following I-1163

Figure 1 shows the certification requirements following adoption of I-1163.

Figure 1 – Certification and training requirements for Individual Providers and other types of home care workers

Type of LTC Worker	Where they work, how employed	Training required	Exemptions from standard training or certification
Long-term care workers requiring a Home Care Aide certificate			
Individual Providers This group is the audit's primary focus.	In clients' homes; Contracted through DSHS, paid by Medicaid	Standard 75 hours; Pass exam administered by DOH	Certain family relationships to client; Respite; Limited hours; Holds another certification; Past employment history
Home care agency workers ("agency providers")	In clients' homes; Employed by a care agency	Standard 75 hours; Pass exam administered by DOH	Holds another certification; Past employment history
Assisted living facility workers	In assisted living facilities; Employed by facility		
Adult family home workers	In adult family homes; Employed by home		
Long-term care workers not requiring a Home Care Aide certificate until January 1, 2016			
Community residential business employees	At businesses contracted by DSHS as supported living providers or group homes; Employed by business	Standard training but exam and certificate not required	Holds another certification; Past employment history
Not considered long-term care workers in Washington			
Nursing home workers	In nursing homes; Employed by facility	Subject to other professional training requirements not examined as part of this audit	
Hospital or hospice workers	In hospitals or hospices; Employed by facility		

Figure 2 shows the differences in certification requirements and how they vary depending upon the setting and the caregiver's relationship to the client.

Figure 2 – Training and certification requirements for home care aides vary by client and setting

Type of LTC Worker	Training		HCA certification	Continuing education required
	Hours	Training provider		
All other home care aides				
All home care aides *other than* Individual Providers.	5 hours orientation, 70 hours basic training	DSHS approved training by qualified instructor	Yes	12 hours a year
Individual Providers (IP)				
IP caring for elderly, developmentally or functionally disabled person (*other than* those listed below)	5 hours orientation, 70 hours basic training	Training Partnership	Yes	12 hours a year
Parent or adult child IP caring for elderly or functionally disabled child or adult	5 hours orientation, 30 hours basic training	Training Partnership	No	None
Parent IP caring for developmentally disabled child	12 hours of training relevant to the needs of developmentally disabled persons	Training Partnership	No	None
IP providing respite care for developmentally disabled person, working 300 hours or less annually	2 hours orientation, 12 hours training	Training Partnership	No	None

Appendix D: Earlier Audit Work and Bibliography

Earlier performance audits in the I-1163 series, conducted by our Office, are available on our website.

Report title	Report number	Publication date
Barriers to Home Care Aide Certification	1018059	November 28, 2016
I-1163: Long-term Care Worker Certification Requirements 2016	1017262	August 4, 2016
Initiative 1163 Long Term Care Workers	1012952	December 18, 2014
Initiative 1163: Long-Term Care Worker Certification Requirements	1008965	January 8, 2013

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