Analysis of the Washington Supported Living Medicaid Payment Methodology

Final Report – for Winter 2019 Legislative Session

Prepared for:

Washington State Department of Social and Health Services (DSHS)

***Submitted by:***

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**Introduction**

Navigant Consulting, Inc. was engaged by the Washington State Department of Social and Health Services (DSHS, or the Department) to conduct an analysis of the current Medicaid payment methodology and rates paid for Supported Living (SL) services relative to federal requirements. In addition, this payment methodology includes group homes and group training homes, which have slightly different requirements and similar client assessments, but are not a part of this report. This report only addresses supported living services.

In Washington, SL services are primarily funded by Medicaid through two 1915(c) waivers – the Core Services waiver and the Community Protection waiver, as well as some funding from “state only” funds. The federal provisions related to 1915(c) waivers are described in U.S.C. 1936, and specify that states are allowed to target waivers to particular populations, and consequently, unlike state plan benefits, they do not require that services be made available to all categorically or medically needy groups. States must also specify, for each waiver, a limit on the number of individuals who may receive benefits. Such limits are commonly referred to as caseload capacity.

In Washington, the Developmental Disabilities Administration (DDA) manages the caseload size of the SL program, limiting the number of individuals that can receive services under the waivers based on those that fall into higher acuity levels of assessed needs. In January of 2019, there were 3,982 individuals receiving SL program benefits.

The number of individuals receiving SL services is limited to the legislatively appropriated capacity of the program. Our analysis of the Medicaid payment methodology and rates is primarily focused on determining that resulting payments are sufficient to enlist an adequate pool of providers to serve the individuals who are authorized to receive SL services, and that the services provided to those served are of adequate quality.

This report does not address the overall adequacy of services that are made available to individuals with developmental disabilities nor the overall funding levels associated with the State’s broader array of home and community based services.

# Section I: Overview of New Tiered Payment Methodology

Tiered rate methodology adopted as of January 1, 2019 is the method used to assign the client’s daily rate; there are nine tiers. The process to arrive at the daily rate of pay includes:

* The client’s assessed residential needs through Comprehensive Assessment Reporting Evaluation (CARE) using the Supports Intensity Scale (SIS) generates the client’s residential support level;
* The application of the residential rate assessment which takes into consideration sharing of supports with household members generates the tier rate; and
* The tier rate varies by county designation.

This description is intended to provide a high-level overview of how payment rates are set for individuals receiving SL services. To evaluate Washington’s Supported Living program, Navigant reviewed program policy rules and guidelines. It also included, rate, caseload, expenditure data, and staffing surveys completed by the service providers.

**Overview of the Supported Living Program**

Washington’s SL program provides habilitative instruction and supports to persons with developmental disabilities ages 18 and older who live in their own homes in the community. Supports vary based on the individual’s needs, and include support with activities of daily living, instrumental activities of daily living (e.g., shopping, cooking, cleaning, transportation), community engagement and integration, and other assistance as needed. Clients must pay for their own housing, food and other living expenses. DDA contracts with private agencies to provide SL services. Some SL services are provided directly by DDA through the state-operated living alternative (SOLA) program (approximately 140 clients). The combined total number of clients serviced by contracted providers and SOLA equals 4,122. Per DDA policy, clients receiving SL services may share the home with up to three other clients.

After program eligibility is determined, SL client needs are assessed by DDA employees—Case Managers (CM)—using an assessment tool to determine client specific needs and the level of residential support. The assessment tool assigns each client a residential support level (1 through 6), which are separate from a tier. Clients in Support Need Level 1 need weekly or less support, while clients in Levels 5 and 6 require 24-hour daily support. [[1]](#footnote-1) The majority of SL clients fall into levels 4, 5 and 6. Figure 1 provides an overview of the Residential Support Need Levels and a description of the Level.

**Figure 1: Supported Living Enrollment by Support Need Level**

| **Residential Support Need Level** | **Characteristics** |
| --- | --- |
| Level 1: Weekly or Less | Client only requires supervision, training, or physical assistance in areas that typically occur weekly or less often, such as shopping, paying bills, or medical appointments. Client is generally independent in support areas that typically occur daily or every couple of days. |
| Level 2: Multiple Times Per Week | Client can maintain daily health and safety but needs supervision, training, or physical assistance with tasks that typically occur every few days, such as light housekeeping, menu planning, or guidance and support with relationships. Client is generally independent in support areas that must occur daily. |
| Level 3a: Intermittent Daily – Low | Client is able to maintain health and safety for short periods of time (i.e., hours, but not days) OR needs supervision, training, or physical assistance with activities that typically occur daily, such as bathing, dressing, or taking medications. |
| Level 3b: Intermittent Daily - Moderate | Client requires supervision, training, or physical assistance with multiple tasks that typically occur daily OR requires frequent checks for health and safety or due to disruptions in routines. |
| Level 4: Continuous Day and Nighttime Intermittent Check | Client requires support with a large number of activities that typically occur daily OR is only able to maintain health and safety for less than 2 hours, if at all. Client also requires occasional health and safety checks or support during overnight hours. |
| Level 5: Continuous Day + Continuous Night | Client is only able to maintain health and safety for less than 2 hours, if at all, OR requires support with a large number of activities that occur daily or almost every day AND requires nighttime staff within the home. |
| Level 6: Community Protection Program (Continuous Day + Continuous Night) | The client is part of the Community Protection Program and requires constant supervision support to ensure community and client safety. |

*Source: Data from the WA Developmental Disabilities Administration WAC and the Resource Manager Guidebook*

**Supported Living Assessment Process**

Since 2007, the Washington SL program has used an evidence-based assessment instrument called the Supports Intensity Scale (SIS) to evaluate a client’s support needs. The SIS measures an individual’s support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports the individual requires. [[2]](#footnote-2) In Washington, the results of the SIS are used to calculate the amount of daily direct support, called Instruction and Support Services (ISS). ISS also includes the following:

1. Night time needs for clients who require overnight support and/or supervision
2. Transportation time to assist clients access community engagement and integration activities
3. Program manager or supervision time
4. An administrator’s time worked on ISS (only for agencies that meet the requirements of DDA Policy 6.04)
5. Leave time and other benefits offered to employees
6. Time spent in required training

The support assessment predicts ISS needs for a client as if the client lived alone. The results of each assessment are then reviewed by DDA employed Resource Managers (RM) who conducts a residential rate assessment. The RM is responsible for considering additional factors that may affect a client’s rate, such as: employment provided by a different entity, consistent time spent with family outside of the client’s home, and support refused by the client. In addition, the RM looks for opportunities where supports that occur within households or clusters of households are shared with other clients. The shared supports create economies within each household.

While developing each client’s individual rate, RMs meet with representatives from the SL provider to learn of all possible economies of scale and support provided by others that will evaluate clients supports provided in the most time and cost efficient manner possible.

A residential rate assessment is completed by the resource manager prior to a client beginning supported living services, when a significant change in the client’s condition occurs, when there is a change in the client’s household composition, when requested by the provider, or if a new client’s anticipated shared supports are found to be inaccurate once the client has moved. A temporary increase in a client’s condition can be addressed through the “staff add-on,” which allows for a temporary change in the client’s ISS needs. Longer-term or permanent changes require a reassessment to determine a new rate. In some cases, a “cost of care adjustment” can be made when a client temporarily leaves the program and it affects the economies of scale for other clients. If that client lives with other clients, a cost of care adjustment may be applied to increase the housemates’ rates who remain in the home to account for the loss of certain economies of scale and other fixed administrative costs.

**Tier Reimbursement Methodology**

The Department implemented a new payment methodology for supported living, group home, and group home training services that went into effect on January 1, 2019. Reimbursement for ISS hours covered staff salaries, wages, benefits, payroll taxes, and related training time. The main goals of establishing the new payment methodology were to:

* Focus on client support and outcomes
* Increase flexibility for providers
* Reduce administrative complexity

In designing the new payment methodology, the Department formed a workgroup that included both Department and provider representatives. Through a series of six meetings, the workgroup developed a recommendation for the new rate methodology. The new reimbursement rates include the same rate components as the prior methodology. Under the new rate structure, providers are reimbursed a daily reimbursement rate that varies by nine different tiers. Additionally, hours and benchmarks will no longer be used to calculate reimbursement through the new tiered rate methodology. The intent of this change is to reduce the administrative complexity of the system as rates will be limited to nine tiers. Clients are assessed and then assigned to the appropriate rate tier. Providers are then reimbursed at the reimbursement rate associated with the tier. The Department sets rates prospectively in accordance with State legislative appropriation.

Tiers one through eight use a standardized rate methodology. Each tier is linked to a daily rate. The daily rate associated with each tier is based on the weighted average cost of services. A client with higher acuity and complex support needs require a higher level of service and fewer shared supports. As the support need increases the tier increases.

Tier level nine is a uniform exception to the standardized formula. Each client in this tier has a personalized daily rate designed to address the unique client needs that are more than tier eight.

Counties are designated into one of three geographical categories (MSA, Non-MSA, and King County), each category has a unique set of daily rates for each tier.[[3]](#footnote-3) The rate for each tier is all-inclusive, which includes direct and indirect costs of service delivery, administration, transportation, community residential services training (CRST), and residential professional services.

The daily rate is electronically calculated using the Residential Rates for Developmental Disabilities (RRDD) and consists of the following rate components:

* Instruction and Support Services (ISS)
* Administrative/Non-Staff
* Transportation
* Residential Professional Services

Figure 2 includes the SL rate components and utilization by tier. As previously mentioned, tier 9 is an exception to the funding formula and is calculated based upon the individual’s unique needs.

**Figure 2: Supported Living Tier Utilization and Daily Rates (ISS and Administrative Components) at initial implementation, January 2019**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  | **Daily Rate (Including ISS and Administrative/Non-Staff Components) \* Community Protection (CP) and Non-Community Protection (Non-CP)** | | | | | |
| **Tier** | **SL Count** | **Percent of SL Clients per Tier** | **Non-MSA (Non-CP)** | **Non-MSA (CP)** | **MSA (Non-CP)** | **MSA (CP)** | **King (Non-CP)** | **King (CP)** |
| 1 | 357 | 8.97% | $76.34 | $78.74 | $77.68 | $80.13 | $80.99 | $83.61 |
| 2 | 355 | 8.92% | $179.09 | $183.09 | $182.20 | $186.28 | $189.37 | $193.76 |
| 3 | 661 | 16.60% | $260.11 | $265.30 | $264.57 | $268.86 | $274.43 | $279.06 |
| 4 | 1,141 | 28.65% | $330.00 | $334.31 | $335.64 | $347.05 | $247.85 | $252.61 |
| 5 | 864 | 21.70% | $406.84 | $411.63 | $313.77 | $318.65 | $428.64 | $433.90 |
| 6 | 236 | 5.93% | $489.16 | $494.48 | $497.52 | $502.95 | $515.23 | $521.04 |
| 7 | 296 | 7.43% | $349.33 | $355.17 | $558.68 | $564.64 | $578.53 | $584.95 |
| 8 | 19 | 0.48% | $653.63 | $660.13 | $664.77 | $671.39 | $688.23 | $695.37 |
| 9 | 53 | 1.33% | Individual ISS Rate + Administrative Component | | | | | |

\* *Other client specific unique services are not part of the ISS or Administrative tier components. The total community residential payment rate for SL services are the ISS, Administrative, and other service components.*

DDA will also provide payment for other covered components as add-ons to the daily rate, such as:

* Cost of Care Adjustment (COCA) – DDA will cover the necessary costs to maintain uninterrupted services due to the loss of economies of scale to clients remaining in the home when there is a temporary absence of a household member.
* Staff add-on for client specific need - a staff add-on to account for short-term additional support to protect a client’s safety or well-being. A provider may request a staff add-on if the client has a short-term need for an increase in staffing beyond the assessed tier and daily rate.

The resource manager completes a rate assessment prior to a client beginning Supported Living services and:

1. When a significant change in the client’s condition occurs;
2. There is a change in client’s household composition;
3. If a new client’s anticipated shared supports are found to be inaccurate once the client has moved; or
4. Upon request from the service provider.

During the transition to this new reimbursement methodology, the Department is implementing a hold harmless provision for SFYs 2019 and 2020. During this period, the Department will hold providers harmless for the ISS and administrative non-staff components of the rates. If the ISS reimbursement component or the administrative non-staff component is less under the new reimbursement methodology, the hold harmless adjustment will be applied up to the appropriation amount set by the state legislature. The Department has an appropriation of $1.2 million dollars for both SFY 2019 and 2020 to cover the hold harmless costs.

As discussed previously, the SL program is primarily funded by Medicaid, using two 1915(c) waivers – the Core Services waiver and the Community Protection waiver, as well as funding from the Money Follows the Person (MFP) federal grant through the Roads to Community Living. As displayed in Figure 3 below, total Medicaid expenditures (state and federal) in fiscal year 2018 were approximately $475 million. With the implementation of the tiered methodology in 2019, future analyses will examine whether the tiers appropriately control costs.

**Figure 3: Annual Supported Living Enrollment and Expenditures for FY 2009-FY2018**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Fiscal Year** | **Enrollment** | **Expenditures**  **(in 000’s)** | **Average Expenditures per Client** | **Average Expenditures per Resident Day** |
| 2009 | 3,479 | $275,900 | $79,304 | $219 |
| 2010 | 3,496 | $275,500 | $78,804 | $218 |
| 2011 | 3,539 | $285,900 | $80,786 | $225 |
| 2012 | 3,701 | $293,500 | $79,303 | $227 |
| 2013 | 3,695 | $314,100 | $85,007 | $234 |
| 2014 | 3,824 | $335,506 | $87,737 | $246 |
| 2015 | 3,906 | $364,754 | $93,393 | $261 |
| 2016 | 3,946 | $428,006 | $108,466 | $297 |
| 2017 | 3,941 | $466,877 | $118,466 | $325 |
| 2018 | 3,948 | $474,744 | $120,249 | $327 |

*Source: Navigant analysis based on data from the WA Developmental Disabilities Administration*

Implementation of the tier rate methodology occurred January 1, 2019, so the chart above does not reflect current expenditures under the new methodology. There is no data to predict what the future expenditures will be; however, the new methodology leverages the SIS assessment tool that CMs are familiar with and integrates that into the tiered rate methodology. By using tiered rates based on needs, providers are able to focus on the unique needs of the individual, instead of the administrative burden that accompanies rates based upon time. Washington is an early adopter of tiered rates for SL services and the Department will need to monitor the impact on individuals, providers, and service delivery. Navigant works directly with CMS providing technical assistance to states to make sure they are in alignment with HCBS rules. With Washington’s new tiered methodology, CMS will be looking for validation of the outcomes related to the new rates based on needs.

# Section II: Access and Service Delivery

The DDA manages the number of individuals served in the SL program based on the appropriated program capacity for these services by the Legislature. The clients added to this capacity must have critical community support needs. Critical community support is defined in the legislative budget language (biennial budget). There are more individuals that request these services than the allotted capacity, and DDA determines which individuals receive SL services based on the critical need identified. Generally, those individuals whose needs fall in levels 4 through 6 are referred for services. In 2018, 79.7 percent of the total individuals served were assessed in levels 4 through 6.

The Department indicated that more recently providers of supported living services have shared with the Department a difficulty with acquiring and retaining staff that provide direct support services to clients. According to the providers, this can be attributed to the increase in the average wage and benefits of Home Care staff. The wage and benefit levels for Home Care staff are negotiated through collective bargaining and the Department has no influence over the outcomes of those negotiations. The resulting higher wages and benefits are more attractive to individuals providing those types of direct support services. Additionally, the minimum wage has increased general competition, resulting in staff leaving supported living work for jobs with similar wages in other industries.

We reviewed wage and staffing information tied to the SL program between 2016 and 2017, as reported by providers through the DDA Residential Programs Cost Report. During calendar year 2017, 76 percent of the SL providers in Washington reported that their recruiting challenges had gotten worse since calendar year 2016. Additionally, SL providers reported close to 50 percent turnover for entry level and supervisor staff during calendar year 2017, and those positions account for over 95 percent of all staff vacancies. As previously mentioned, this may be a result of low wages, especially when compared to competing positions. Figure 4 shows the provider-reported SL wages, by staff type, and compares them to similar occupational classifications from the Bureau of Labor and Statistics (BLS).

**Figure 4: 2017 Supported Living Wages in Year 1 of Employment Compared to Comparable Occupations as Reported by the BLS (May 2017 Wages)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Staff Type from DDA Cost Report** | **Reported SL Staff Wages (2017)** | **BLS WA Statewide Wages (Average)** | **Percent Difference Between Reported SL Wages and BLS** |
| Entry Level | $12.24 | $13.76 | 11.7% |
| Supervisor | $15.37 | $24.14 | 44.4% |
| Program Managers | $19.59 | $30.31 | 43.0% |
| Specialists | $19.33 | $19.01 | 1.7% |
| Residential Chronic Nursing Services | $26.75 | $31.97 | 17.8% |

*Source: Staff wage data provided by the Management Services Division, Office of Rates Management. Bureau of Labor and Statistics occupational classifications used for the analysis are: Home Health Aides, First-Line Supervisors of Protective Service Workers, All Other, Social and Community Service Managers, Community and Social Service Specialists, All Other, and a 50 percent Registered Nurses blended with 50 percent Licensed Practical and Licensed Vocational Nurses.*

As demonstrated in Figure 4, the provider reported wages are mostly lower than similar positions in Washington, as reported through the BLS. It is important to note that SL supervisors and program manager wages are close to half of the statewide average for First-Line Supervisors of Protective Service Workers and Social and Community Service Managers. It is reasonable to assume that high turnover for SL providers is due to higher paying competing jobs.

The statewide minimum wage on January 1, 2016 was $9.47 per hour, which increased to $11.00 per hour on January 1, 2017, an increase of 16 percent. While the wages of SL staff increased between CY 2016 and 2017, they did not increase at the same rate as the minimum wage, especially in the entry level and supervisor positions, which have significant shortages. The Department’s cost report does not capture the reason for staff turnover; however, they should consider adding potential reasons for turnover to the cost report to identify the most common reasons. In addition, the Department will need to prepare for provider rate increases to keep current with minimum wage, as the minimum wage in Washington will reach $13.50 in 2020. Some cities in Washington already have wage requirements above the Washington state minimum wage for 2020. SL providers operating in these cities must be responsive to the city minimum wage requirements.

According to data provided by the State, as of November 2018, there were 120 contracted provider locations serving 4,196 clients. Figure 5 shows the number of clients served in the Supported Living program as well as the number of provider locations from 2009 through 2018. The number of individuals receiving Supported Living services has fluctuated slightly but overall steadily increased since 2009. Enrollment has increased by 20.6 percent since 2009. The number of provider locations has fluctuated slightly between 2009 and 2018, however, has overall remained relatively stable.

**Figure 5: Supported Living Number of Clients and Provider Locations in Washington 2009 – 2018**

|  |  |  |
| --- | --- | --- |
| **Fiscal Year** | **Number of Clients Served** | **Number of Contracted Provider Locations** |
| 2009 | 3,479 | 117 |
| 2010 | 3,496 | 116 |
| 2011 | 3,539 | 115 |
| 2012 | 3,701 | 119 |
| 2013 | 3,796 | 115 |
| 2014 | 3,881 | 116 |
| 2015 | 4,003 | 119 |
| 2016 | 4,196 | 115 |
| 2017 | 3,949 | 116 |
| 2018 | 4,196 | 120 |

*Source: Data provided by the Developmental Disabilities Administration*

Note that Figure 5 represents the number of contracted provider locations to provide SL services. Some providers have more than one location, so the actual number of agencies would be less than the number of locations shown above.

# Section III: Quality of Support Services

In the previous section we analyzed the service delivery for supported living services and access to support services for Washington’s Medicaid beneficiaries. In this section, we analyze whether Washington’s Medicaid payment methodology supports provision of services at an acceptable level of quality.

**Certification and Complaint Inspections**

The Department has both certification evaluation and complaint investigation protocols for Certified Community Residential Services Agencies (SL providers). Certification evaluations and complaint inspections are conducted by Residential Care Services (RCS) within the Aging and Long Term Care Administration. The purpose of both processes is to identify and document violations of regulatory requirements by providers.  Regulatory violations include potential and actual abuse, neglect, abandonment, financial exploitation, and other harm to clients or circumstances which compromise client’s safety and/or services. Providers are presented with the violations in writing and required to correct each identified citation. The Department conducts follow up verification to assure correction. The purpose of these processes is to bring providers into regulatory compliance to assure appropriate safety and services for clients. The outcome of regulatory work conducted by RCS is shared with DDA to ensure necessary case management and resource management follow up.

SL providers are subject to a certification evaluation at a minimum of every two years. In some instances, inspections may occur more frequently. Complaints Investigations are conducted when a report of abuse, neglect, financial exploitation or a regulatory violation is received by the complaint hotline from the public, case managers, mandated reporters, SL agencies, law enforcement or others. Both evaluations and investigations may include on-site observations; interviews with clients, interviews with provider staff, guardians and others; as well as record review.

Whether discovered by virtue of a complaint or while on a certification evaluation, when there is an indication a crime has been committed, the supported living provider is required to immediately report this to law enforcement. Referrals are also made to the State Department of Health when individuals may have violated state licensing regulations and Medicaid Fraud Control Unit (MFCU) in the case of fraudulent activity on the part of the provider or others. Both contracted providers and Department employees are mandatory reporters.

The Department monitors regulatory compliance identified in both certification evaluations and complaint investigations for significant and/or patterns of violations. When RCS sees a pattern of concern, they can issue fines or require specific conditional corrections be made. They can also issue a stop to new referrals which would limit expansion of a supported living provider. Provisional certification determined by RCS when serious recurrent deficiencies jeopardize one or more client’s health, safety, and/or welfare. Providers with a provisional certification are subject to a higher frequency of inspections, at least one every 90 days, by the Department. A provisional certification can be extended for a total of 180 days. When the provider does not come into substantial compliance within that timeframe, the provider will lose their certification. A provider must be certified in order to contract with DDA, so when a provider loses certification the provider can no longer deliver supported living services under that contract.

Figure 6 shows the total number of citations between 2009 and 2018 based on data provided by the Department. This data indicates that between 2009 and 2015, the number of inspection citations decreased by 33.3 percent. During the same period, the number of complaint citations increased, and the total number of citations increased significantly. Between 2015 and 2018 the total inspection citations increased by 49.8 percent while the total complaint citations increased by approximately 4.0 percent. Overall, the total citations have increased by 31.7 percent between 2015 and 2018. Citation data for 2018 was available through September 14th at the time this report was completed.

Based on discussions with the Department, it is our understanding that there was a backlog of complaints the Department was not able to investigate due to limited staff resources. In 2016, the Department had more staffing resources available and was able to review the outstanding complaints. This resulted in an increase in the number of citations in 2016. The number of inspection citations also increased from 2016 to 2017. It is our understanding that this increase is related to an increase in provisional certifications. Provisional certifications require a visit at least once every 90 days. The increased visits requirement results in more intense scrutiny and often results in additional citations.

**Figure 6: Citations in Supported Living Agencies 2009 – 2018**

|  |  |  |  |
| --- | --- | --- | --- |
| **Calendar Year** | **Certification Evaluation Citations** | **Complaint Investigation Citations** | **Total Citations** |
| 2009 | 463 | 18 | 481 |
| 2010 | 316 | 69 | 385 |
| 2011 | 335 | 140 | 475 |
| 2012 | 100 | 139 | 239 |
| 2013 | 129 | 138 | 267 |
| 2014 | 145 | 181 | 326 |
| 2015 | 309 | 202 | 511 |
| 2016 | 482 | 324 | 806 |
| 2017 | 704 | 214 | 918 |
| 2018 | 463 | 210 | 673 |

The number of provisional certifications issued and the number of instances of decertification from 2009 through 2018 is fairly minimal and it does not appear there is an increasing trend in these instances. It appears the number of provisional certifications issued were at the highest in 2017 while the number of decertification instances were highest in 2011. Figure 7 below shows the number of provisional certifications issued and the number of decertification instances between 2009 and 2018. Certification data for 2018 was available through September 14th at the time this table was completed.

**Figure 7: Provisional Certification and Decertification Instances 2009 – 2018**

|  |  |  |
| --- | --- | --- |
| **Calendar Year** | **Provisional Certification** | **Decertification** |
| 2009 | 0 | 0 |
| 2010 | 0 | 0 |
| 2011 | 4 | 4 |
| 2012 | 3 | 0 |
| 2013 | 3 | 0 |
| 2014 | 0 | 0 |
| 2015 | 3 | 1 |
| 2016 | 2 | 0 |
| 2017 | 5 | 1 |
| 2018 | 2 | 2 |

*Source: Data provided by the Department*

DDA’s Residential Quality Assurance Unit provides monitoring, training and technical assistance to Supported Living & Group Home Providers contracted through the Developmental Disabilities Administration.  DDA’s Residential QA’s work is informed by qualitative and quantitative measures derived primarily from: statement of deficiency trends and patterns; routine client, guardian and provider surveys; and rule and policy changes.  All SODs or Statements of Deficiency issued by RCS are tracked and trended by DDA Residential QA for patterns and violations affecting client health and welfare.  Residential QA’s routine surveys include: in-person individual interviews using a statistically significant sample of SL/GH clients, guardian satisfaction surveys, Individual Instruction & Support Plan (IISP) sampling, and community integration surveys.  Targeted training and technical assistance is also driven by Residential QA’s specific areas of subject matter expertise, including: IISPs, Background Checks, Functional Assessment/Positive Behavior Support Planning & Client Funds Management.

# Section IV: Payment-To-Cost Analysis

The SL program is unique to other programs in Washington State. The majority of clients in SL programs are Medicaid clients and therefore providers rely on Medicaid reimbursement for most of the revenue needed to cover the costs of providing services to clients.

In this section, we describe our analysis of the payments under the current Medicaid payment methodology in relation to the costs incurred by SL providers for serving Medicaid-eligible clients.

**Cost Reporting**

All SL providers are required to submit annual cost reports to DDA.[[4]](#footnote-4) Providers must provide and sign, under penalty of perjury, details of actual ISS and professional service hours provided, staff salaries and benefits, direct support purchased services, training costs, transportation costs, and other administrative and operating expenses. The cost reports are used by DDA in the settlement process to recoup any overpayments due to underprovided services. If DDA determines that some portion of the funds paid to a provider were not used for service provision, they will recoup the excess amount from the provider.

Under the current system, and ending in calendar year 2018, providers must repay DDA for any undelivered ISS hours or dollars, whichever is greater. The settlement process will continue under the new tiered payment system; however, only total dollars expended will be factored into the settlement. The recoupment no longer includes ISS hours. Historically, DDA recouped approximately $1 and $2 million annually through settlement. It is unclear what the amount of any future recoupments may be.

**Payment-to-Cost Comparison**

We first evaluated the total costs reported by providers and the total Medicaid reimbursement received by providers using calendar year (CY) 2017 Cost Report data provided by the Department. We combined total reported ISS reimbursement and non-staff reimbursement, and compared that sum to the total costs reported by the providers. For the purposes of this analysis, we analyzed the reported costs and reimbursements at the agency level rather than for individual provider locations. We also excluded any closed providers from the analysis.

Our analysis indicated there were 82 Supported Living agencies still in operation with 2017 Cost Report data. Of these 82 agencies, 50 were determined to have a pay-to-cost ratio exceeding 100 percent.

Figure 8 below also indicates 23 agencies have a pay-to-cost ratio between 95 percent and 100 percent and five agencies have a pay-to-cost ratio between 90 percent and 95 percent. A total of 3 agencies have a pay-to-cost ratio below 90 percent. The lowest pay-to-cost ratio was determined to be 84.1 percent.

About 89 percent of the agencies are reimbursed at levels of above 95 percent of costs. Proper reimbursement is crucial in the supported living program as agencies do not have private pay clients and rely on Medicaid reimbursement to support their programs. It should be noted that for agencies reimbursed at over 100 percent of costs, some of the funds paid out may be recouped through the settlement process.

**Figure 8: Pay-to-Cost Ratio Summary – CY 2017**

|  |  |
| --- | --- |
| **Pay-to-Cost Ratio Range** | **Number of Agencies** |
| Greater than 100% | 50 |
| Between 100% - 95% | 23 |
| Between 95% - 90% | 6 |
| Under 90% | 3 |
| **Total** | **82** |

*Calculated based on data provided by the Department*

In addition, we conducted an analysis of the pay-to-cost ratios in CY 2020 based on the 2017 Cost Report data provided by the Department. To conduct this analysis, we first inflated the 2017 Cost Report data to CY 2019 using Consumer Price Index (CPI) data for the Western Region of the US and for the Seattle Metropolitan Area as published by the U.S. Bureau of Labor Statistics.[[5]](#footnote-5)

To calculate the inflation factor necessary to inflate CY 2017 costs to CY 2020 levels, we first determined the annual percentage change in the two CPI indices mentioned above between the midpoint of CY 2017 and CY 2018. Since CPI data is only available through August of 2018, we then applied this percentage change to the index at the midpoint of CY 2018 to estimate the index at the midpoint of CY 2019 and out to CY 2020. The percentage change determined was used to inflate the costs reported in 2017 by providers.

Since the new payment methodology went into effect in January of 2019, the Department provided Navigant with the estimated weighted average reimbursement rates for each facility in 2019. Navigant calculated an estimated reimbursement amount for each facility by multiplying the weighted average reimbursement rate by the total number of resident days reported in the Cost Report for each facility. The resulting payments were compared to the inflated costs for each facility.

It should be noted the payment-to-cost analysis under the new reimbursement system is an estimate. Once cost and payment information under the new system is available, the actual payment-to-cost levels should be closely evaluated. Figure 9 below summarizes the estimated payment-to-cost levels based on the estimated CY 2020 weighted average reimbursement rates for each facility.

**Figure 9: Pay-to-Cost Ratio Summary – CY 2020**

|  |  |  |
| --- | --- | --- |
| **Pay-to-Cost Ratio Range** | **Number of Agencies Based on Seattle Area Inflation Index** | **Number of Agencies Based on Western Region Inflation Index** |
| Greater than 100% | 50 | 46 |
| Between 100% - 95% | 18 | 22 |
| Between 95% - 90% | 4 | 3 |
| Under 90% | 10 | 11 |
| **Total** | **82** | **82** |

For CY 2017 we calculated that the majority of providers are reimbursed at least at 95 percent of the reported costs incurred for providing SL services. Similarly, when inflating those CY 2017 costs to CY 2020, and accounting for the estimated weighted average reimbursement rates for providers in CY 2020, it appears that the majority of providers will be reimbursed at 95 percent or more of costs. It is important to note that the minimum wage in 2017 was $11.00 per hour and will be to $13.50 per hour in 2020, which could lower the projected pay-to-cost ratios. With the change in reimbursement methodology it is reasonable to assume that providers will continue to have most of their costs covered in CY 2020.

**Comparison to Other Payer Rates**

In December of 2016, Navigant completed a report for the Department comparing Washington’s average Medicaid reimbursement rate for supported living services to the average Medicaid reimbursement rates for these services in several other states. In that report, we compared Washington’s rates to the reimbursement rates of Oregon, Minnesota, Colorado, and Illinois. In addition to examining the payment-to-cost ratios for Washington’s Medicaid reimbursement rates, we also attempted to compare the Medicaid rates to the reimbursement rates of other public and private payers. The report looked at the old payment methodology and not the new tiered rates. That report concluded that Washington’s previous rates appeared appropriate when compared to other states.

For this comparison, we first conducted research for publicly available information on reimbursement rate levels for supported living services paid by private payers, through both commercial insurance and self-pay arrangements. We were not able to find any comprehensive and publicly available information on the reimbursement rates paid by private payers. We also confirmed with the Department that there was no information collected in the cost reports, such as commercial payer revenues and hours, which would allow us to estimate the average non-Medicaid rates received by providers for purposes of this comparison. The Department also indicated that approximately 99 percent of all SL services in Washington are reimbursed through Medicaid, which adds context to understanding how difficult it is to find non-Medicaid comparative data.

Since we did not find any published information on commercial or self-pay reimbursement rates, and since providers in Washington do not report other sources of revenue that would allow us to calculate proxy reimbursement rates for other payers, we alternatively reviewed Medicaid reimbursement rates for similar services paid in several other states. When the Department explored moving to an alternate rate structure, DDA sent a letter to all Developmental Disability Director’s asking for their experiences with other rate methodologies, including tiered rates, and received limited responses. This reinforces one the biggest challenges with comparing Washington’s rate methodology to other states, there are not a lot of states with a similar rate structure for their SL rates. However, we identified Colorado as a state that uses tiered rates for Residential Habilitation Services and Supports (RHSS), a similar service to Washington’s SL.[[6]](#footnote-6) Colorado’s RHSS services are provided in either an individual setting, three or fewer persons receiving services residing in a single residential setting, or group setting, where four to eight persons receiving services reside. Figure 10 summarizes the payment rates and utilization of each tier, effective January 2019.

**Figure 10 Colorado RHSS Reimbursement Rates and Utilization, by Individual and Group Setting (Effective January 1, 2019)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Tier** | **Individual Setting** | | **Group Setting** | |
| **Payment Rate** | **Individuals Using Services** | **Payment Rate** | **Individuals Using Services** |
| Supports Level 1 | $66.46 | 424 | $90.41 | 72 |
| Supports Level 2 | $107.39 | 434 | $118.99 | 190 |
| Supports Level 3 | $131.22 | 262 | $140.18 | 133 |
| Supports Level 4 | $159.76 | 249 | $165.60 | 147 |
| Supports Level 5 | $183.58 | 361 | $182.93 | 196 |
| Supports Level 6 | $230.71 | 270 | $216.46 | 143 |
| Supports Level 7 | Indiv. Rate | 25 | Indiv. Rate | 153 |

*Source: CO DD Fee Schedule and Appendix J-2 of CO DD Waiver Application*

When reviewing Colorado’s RHSS rates it is important to note that they implemented statewide rates, there are no MSA adjustments, and the exact rate components are not known. In addition, Washington has more tiers than Colorado, adding an additional layer of complexity to this rate comparison. Colorado has both a lower rate floor and ceiling than Washington, when comparing the highest and lowest rate tiers. In addition, Colorado has a lower minimum wage ($12 per hour in January 2020) than Washington, which may be a reason why Colorado has lower residential rates when compared to Washington.

Overall, it is important to note that, even when comparing Medicaid rates in other states, there can be significant differences in the rate setting methodologies as well as variations in the service definitions for the SL services offered. In addition, there are disparities in the minimum wage levels across states for the services offered. Although it is unclear that minimum wages are a direct input in the rate methodologies of these other states, we assume the states consider minimum wage levels as they set the rates. Furthermore, if services are provided primarily in an environment with many individuals there could be economies of scale and lower costs for services, or higher costs for smaller residential services.

Again, it is difficult to simply compare reimbursement rates across states. The rate methodologies and services vary across states, and tiers are not widely used by other states. The intensity of the services and the use of the services may vary across states, and with limited information available it is difficult to know how similar services are used in other states or the intensity of the services required by clients. As such, it is important to evaluate provider payment-to-cost levels, as Washington does, on an annual basis. In CY 2017, the payment-to-cost analysis based on provider reported data indicates that about two thirds of providers were reimbursed at least 95 percent of cost.

# Section V: Conclusion

Our analysis of the Medicaid payment methodology for SL services in Washington State focused on determining whether the payments to providers are sufficient to enlist enough providers to serve the individuals who are enrolled in the SL program, and that the services provided to those enrolled are of adequate quality.

As described earlier in this report, the Department has indicated that more recently providers of supported living services have shared with the Department difficulty with acquiring and retaining staff that provide direct support services to clients. This can be attributed, according to the providers, to the increase in the average wage and benefits of Home Care staff which are more attractive to individuals providing these types of direct support services. In addition, the minimum wage has increased competition for wage earners with other industries. Despite this, enrollment of individuals in the SL program has increased in recent years along with the average daily reimbursement rate. Furthermore, it should be noted that SFY 2019 rates have increased by approximately 13 percent from SFY 2017 levels across all counties. Factors for the rising rates, include, increasing acuity of individuals receiving SL services, and legislatively approved increases to the staffing benchmarks.

The total number of citations between 2009 and 2015 has varied, increasing overall by 6.2 percent, while the number of providers has increased slightly over the same period. Between 2015 and 2016, the number of citations increased more significantly, with total citations increasing by approximately 58 percent. According to the Department, however, this increase was due to reviewing a backlog of complaints as more staffing resources were available. Total citations also increased between 2016 and 2017. It is our understanding that this increase was a result of an increase in provisional certifications. More frequent inspections are required for providers with a provisional certification status, and this results in the opportunity for more citations.

In addition, we reviewed information on the number of provisional certifications and decertifications issued by the Department between 2009 and 2018. The number of provisional certifications were at their highest levels in 2017 while the number of decertifications were at their highest levels in 2011. Despite the increase of provisional certifications in 2017, there does not appear to be an increasing trend in provisional certifications over the years. However, the Department should continue to monitor this. The number of decertifications has decreased from 4 cases in 2011 to 2 cases in 2018.

Based on the analyses described in this report, it appears that the average daily reimbursement rate for supported living services along with the average expenditure per client have steadily increased since 2009 along with enrollment. In addition, for CY 2017, which is the most recent year for which cost report data is available, it appears that the majority of providers are reimbursed at least at 95 percent of the reported costs incurred for providing SL services. When inflating those CY 2017 costs to CY 2020, and accounting for the estimated weighted average reimbursement rates for providers in CY 2020, it appears that the majority of providers will be reimbursed at 95 percent or more of costs. However, with minimum wage increasing in 2020, Washington will need to make sure the SL rates continue to be competitive within the industry of care giving and industries outside of caregiving that compete directly for this labor pool. As Washington looks to the future, the reimbursement rates will need to reflect the increased costs that providers will incur.

Ultimately, we understand that it is difficult to directly attribute trends in utilization, capacity, quality, and other factors described in this report to the rates paid for services, and to know with certainty how these trends might be affected by rates established by the Department. As such, we recommend that the Department continue to monitor changes in access and quality over time so that any issues that might arise can be investigated and addressed in a timely manner.

# Appendix A: List of Acronyms

* CM: Case Manager
* CP: Community Protection
* CPI: Consumer Price Index
* CY: Calendar Year
* DDA: Developmental Disabilities Administration
* DSHS: Washington State Department of Social and Health Services
* IISP: Individual Instruction & Support Plan
* ISS: Instruction and Support Services
* MFCU: Medicaid Fraud Control Unit
* MFP: Money Follows the Person
* MSA: Metropolitan Statistical Area
* RM: Resource Manager
* SFY: State Fiscal Year
* SIS: Supports Intensity Scale
* SL: Supported Living
* SOD: Statement of Deficiency

1. Level 6 is reserved for clients with a criminal history in the Community Protection (CP) program who are considered to pose a potential threat to society. These clients require 24-hour supervision. [↑](#footnote-ref-1)
2. The SIS has been shown to be a valid and reliable assessment tool, and 17 states are currently using it statewide to assess their developmentally/intellectually disabled populations. See American Association of Intellectual Disabilities. Available online: <http://aaidd.org/sis/sisonline/states-using-sis> [↑](#footnote-ref-2)
3. King County is recognized as having unique characteristics relative to other metropolitan statistical area counties for purposes of determining reimbursement rates as stated in this policy. DSHS currently recognizes the following counties as metropolitan statistical area counties in Washington: Asotin, Benton, Chelan, Clark, Cowlitz, Douglas, Franklin, Island, Kitsap, Mason, Pierce, Skagit, Snohomish, Spokane, Thurston, Whatcom, and Yakima. Final determination for metropolitan statistical area designations are made by DSHS. All other counties are considered non-metropolitan statistical areas. [↑](#footnote-ref-3)
4. Cost reports are due on or before March 31 and cover the preceding calendar year. [↑](#footnote-ref-4)
5. Consumer Price Index – All Urban Consumers, All items and CPI – All Urban Consumers, Seattle-Tacoma-Bremerton, All items. [↑](#footnote-ref-5)
6. Per Colorado’s 1915(c) DD waiver application, RHSS services are defined as, “designed to ensure the health, safety and welfare of the participant, and to assist in the acquisition, retention and/or improvement in skills necessary to support the participant to live and participate successfully in their community.” These services may include a combination of lifelong - or extended duration - supervision, training, and/or support (i.e. support is any task performed for the participant, where learning is secondary or incidental to the task itself, or an adaptation is provided) which are essential to daily community living, including assessment and evaluation, the cost of training materials, transportation, fees, and supplies. [↑](#footnote-ref-6)