Analysis of the Washington Supported Living Medicaid Payment Methodology

Final Report – for Winter 2018 Legislative Session

Prepared for:

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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 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 the State Supplemental Program[[1]](#footnote-1) and other state 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 optional 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 program capacity.

In Washington, the Developmental Disabilities Administration (DDA) manages the size of the SL program, limiting the number of individuals that can receive services under the waivers based on those that fall into higher levels of assessed needs. In October of 2017, there were 3,949 individuals supported in the SL program.

The number of individuals that are supported in the SL program is limited to the 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 enough 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 Current Payment Methodology

This section describes the current Medicaid payment methodology for SL services in Washington. 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 manuals and guidelines, rate and expenditure data, and survey and caseload data.

**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 participation, and other assistance as needed. Clients must pay for their own housing, food and other expenses. DDA contracts with private agencies to provide SL services. SL services are provided to 3,949 clients, however, some SL services are also provided directly by DDA through the state-operated living alternative (SOLA) program (approximately 130 clients). Clients receiving SL services share the home with up to three other clients.

SL clients are assessed by DDA employees—Case Managers (CM)—using an assessment tool to determine the level of support they will need. The assessment tool assigns each client a support needs level (1 through 6). Clients in Support Need Level 1 need weekly or less support, while clients in Levels 5 and 6 require 24-hour daily support. [[2]](#footnote-2) The majority of SL clients fall into levels 4, 5 and 6, as indicated in Figure 1.

**Figure 1: Supported Living Enrollment by Support Need Level, as of October 2017**

| **Support Need Level** | **Characteristics** | **2017 Enrollment** | **Percentage of Total Enrollment** |
| --- | --- | --- | --- |
| 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.  | 16 | 0.4% |
| 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.  | 137 | 3.5% |
| 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. | 288 | 7.3% |
| 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. | 381 | 9.6% |
| 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. | 467 | 11.8% |
| 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. | 2,268 | 57.4% |
| Level 6: Community Protection Program | The client is part of the Community Protection Program and requires constant supervision support to ensure community and client safety. | 392 | 9.9% |

 *Source: Data from the WA Developmental Disabilities Administration 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, which was developed in 2004 by the American Association on Intellectual and Developmental Disabilities, 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. [[3]](#footnote-3) The state-employed CMs conduct a structured interview with each client or the client’s guardian to identify the type and frequency of supports needed to participate in daily activities. In Washington, the results of the SIS are used to calculate the number of daily direct support hours, called Instruction and Support Services (ISS) hours, a client will need.[[4]](#footnote-4) In addition to direct support time, ISS hours also include the following:

1. Staff night time hours for clients who require overnight support and/or supervision
2. Staff transportation time to travel between clients’ homes
3. Administrator’s hours worked on ISS (only for agencies that meet the requirements of DDA Policy 6.04)
4. Staff training hours

The assessment predicts ISS hours for a client as if the client lived alone. The results of each assessment are then reviewed by DDA-employed Resource Managers (RM) who are responsible for considering additional factors that may affect a client’s support needs, such as family assistance or shared hours with other clients. For example, if a client’s family is able to support him or her two days per week, the client’s weekly ISS total will be reduced accordingly. In addition, the RM will look for “economies of scale” opportunities to share hours that occur within households or clusters that share ISS hours with other clients. For example, if three clients live together and they all require meal support, one SL employee could spend one hour at the home supporting all three clients with meal preparation.

While developing each client’s individual rate, RMs meet with representatives from the SL provider to learn of all possible economies of scale that will help provide support for clients in the most time and cost-efficient manner possible. Typically, nighttime support is shared by clients in a household, as is unscheduled protective supervision. Medical hours are typically utilized as individual hours.

Each client’s ISS hours are reassessed annually or more frequently if a client’s needs or living arrangements change. In 2017, SL clients received an average of 15.0 ISS hours per day. A temporary increase in a client’s condition that is expected to last 90 days or less can be addressed through the “temporary staff add-on,” which allows for a temporary change in the client’s ISS hours. 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 (up to 90 days) and it affects the economies of scale for other clients. For example, if a client is hospitalized, the provider must notify DDA through an incident reporting system and DDA will suspend payments for that client while they are out of the home. If that client lives with other clients, a cost of care adjustment may be applied to increase the housemates’ rates to account for the loss of certain economies of scale and other fixed administrative costs.

**Provider Reimbursement**

SL providers are reimbursed a daily rate that is composed of five cost centers: ISS costs (required under RCW 74.39A), transportation, administrative costs, residential professional services costs, and other costs. Since 2007, SL providers have been reimbursed based on each client’s daily authorized ISS hours. Prior to 2007, rates were negotiated individually for each client based on the provider’s assessment of the client’s needs. The current methodology allows the state more control over assessing client needs and determining reimbursement rates and to standardize rates across providers. Authorized rates are set prospectively after accounting for clients’ support needs, family/unpaid assistance, and economies of scale/shared hours. Reimbursements for ISS hours cover staff salaries, wages, benefits, payroll taxes, and related training time. In rare situations, costs related to staff lodging where the SL program is approved to provide the temporary residence for staff are reflected in the other costs component.

ISS rates vary based on whether the client lives in (1) King County, (2) a Metropolitan Statistical Area (MSA), or (3) a Non-MSA. In state fiscal year (SFY) 2019, ISS Rates for each county type are:

* King County: $19.53 per ISS hour
* MSA county: $18.93 per ISS hour
* Non-MSA county: $18.62 per ISS hour

Hourly ISS rates are established by the state legislative direction, and have fluctuated over the past several years, based on budgetary appropriations, as displayed in Figure 2 below. Since SFY 2009, ISS acuity per capita has increased by approximately 20 percent in all counties due to higher acuity clients served.

**Figure 2: Hourly ISS Rates, by County, SFY 2009-2019**

*Source: Navigant analysis based on data provided by WA Department of Developmental Disabilities*

In addition to the hourly ISS rate, SL providers are also reimbursed a daily administrative rate to cover administrative, residential professional services costs, and transportation costs. Examples of administrative costs include building leases, utilities, liability insurance, depreciation, accounting, staff transportation, maintenance, housekeeping supplies, and other purchased services. Residential professional services costs include professional services provided by licensed nurses, language translators, and other professional services.

The administrative/non-staff component varies based on incremental daily ISS hours and county type (MSA, non-MSA, or King County) of the client’s residence.[[5]](#footnote-5) For example, in King County, the standard administrative/non-staff rate for a client who needs four (4) ISS hours per day is $28.64 per day, and the rate for a client who needs twenty-four (24) ISS hours per day is $49.95.[[6]](#footnote-6) In 2005, DDA officials and a committee of providers and stakeholders conducted an analysis of providers’ administrative costs to establish new standard administrative/non-staff rates based on averages of these costs. At that time, administrative/non-staff rates varied widely across providers, based largely on previously negotiated rates. However, funding was not available to immediately adjust all providers to the standard levels. The state and providers agreed to adjust rates incrementally over time to eventually bring all providers to the standard.[[7]](#footnote-7) Effective July 1, 2015 the Department has brought all providers up to the standard administrative/non-staff rate. It should be noted, however, that the standard rates have not been updated since they were established in 2005; thus, they are still based on administrative costs from 2004. The same is also true for transportation costs.

As noted, the RM determines the client’s daily rate as the sum of the ISS costs (benchmark rate multiplied by daily ISS hours), administrative/non-staff rate, and allowances for indirect client support costs (professional services, the assessed transportation rate, and any unique negotiated rate components).[[8]](#footnote-8) According to DDA officials, the 2017 statewide average daily rate is about $325 — approximately $270 for ISS and $55 for administrative/non-staff costs and other indirect client support costs. In Figure 3, we provide a summary of average daily rates from 2009 to 2017. The ISS component increased slightly more than the administrative/non-staff component since 2009— 49 percent versus 41 percent, respectively. Within that span of time, the most significant increases in the daily rates occurred between 2015 and 2016.

**Figure 3: Average Daily Supported Living Rates, 2009-2017**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Fiscal Year** | **Average Daily ISS Rate** | **Percent Change** | **Average Daily Administrative and Indirect Client Support Rate** | **Percent Change** | **Average Daily Total Rate** | **Percent Change** |
| 2009 | $181.23 | NA | $38.61 | NA | $219.83 | NA |
| 2010 | $181.27 | 0.0% | $38.58 | -0.1% | $219.85 | 0.0% |
| 2011 | $185.30 | 2.2% | $39.35 | 2.0% | $224.65 | 2.2% |
| 2012 | $187.72 | 1.3% | $39.84 | 1.2% | $227.56 | 1.3% |
| 2013 | $194.41 | 3.6% | $40.91 | 2.7% | $235.32 | 3.4% |
| 2014 | $208.14 | 7.1% | $42.66 | 4.3% | $250.81 | 6.6% |
| 2015 | $220.99 | 6.2% | $43.73 | 2.5% | $264.72 | 5.5% |
| 2016 | $246.18 | 11.4% | $50.91 | 16.4% | $297.09 | 12.2% |
| 2017 | $270.14 | 9.7% | $54.61 | 7.3% | $324.75 | 9.3% |

*Source: Navigant analysis of Washington Developmental Disabilities Administration data*

Average annual costs per client have increased from approximately $79,000 in 2009 to nearly $118,000 in 2017, in part due to this increasing acuity. While program enrollment grew approximately 13.3 percent during this time period, total program expenditures grew by approximately 49 percent. The discrepancy between the enrollment growth and expenditure growth may be explained by the increasing acuity (i.e., more clients in support levels 5 and 6), further impacted by the aging of the existing client population and the higher behavior and medical complexity of clients entering this service.

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 4 below, total Medicaid expenditures (state and federal) in fiscal year 2017 were approximately $467 million.

**Figure 4: Annual Supported Living Enrollment and Expenditures, FY 2009-FY2017**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 |

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

# 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 meet 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 2017, 79.2 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 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 competition resulting in staff leaving for jobs with similar wages in other industries.

According to data provided by the State, as of December 2016, there were 116 contracted provider locations serving 3,949 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 2017. The number of individuals receiving Supported Living services has fluctuated slightly but overall steadily increased since 2009. Enrollment has increased by 13.5 percent since 2009.

The number of provider locations has fluctuated slightly between 2009 and 2017, however, has overall remained relatively stable.

**Figure 5: Supported Living Number of Clients and Provider Locations in Washington 2009 – 2017**

|  |  |  |
| --- | --- | --- |
| **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 |

*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 and complaint investigation protocols for Certified Community Residential Services Agencies, AKA SL providers. 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, 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. 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. In addition, the outcome of all regulatory work is shared with DDA to ensure necessary case management and resource management follow up.

SL providers are subject to a certification evaluation at 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 inspections and investigations include on-site observations; interviews with clients, provider staff, guardians and others; as well as record review.

Whether discovered by virtue of a complaint or while on inspection, when there is an indication a crime has been committed, the Department immediately reports 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.

The Department monitors regulatory compliance identified in both certification review and investigations for significant and/or patterns of violations. A provider is provisionally certified or decertified if it is determined 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 by the Department prior to a decision to grant additional certification. When decertified, a provider can no longer operate an SL agency.

Figure 6 shows the total number of citations between 2009 and 2017 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 complaint citations increased, and the total number of citations increased significantly. Between 2015 and 2017 the total inspection citations increased by 19.4 percent while the total complaint citations decreased by approximately 8.4 percent. Overall, the total citations have increased by 8.4 percent between 2015 and 2017. Citation data for 2017 was available through August 31st 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.

**Figure 6: Citations in Supported Living Agencies 2009 – 2017**

|  |  |  |  |
| --- | --- | --- | --- |
| **Calendar Year** | **Inspection Citations** | **Complaint 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 | 369 | 185 | 554 |

The number of provisional certifications issued and the number of instances of decertification from 2009 through 2017 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 2017. Certification data for 2017 was available through October 9th at the time this report was completed.

**Figure 7: Provisional Certification and Decertification Instances 2009 – 2017**

|  |  |  |
| --- | --- | --- |
| **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 |

*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 issued by RCS are tracked and trended by DDA Residential QA for disconcerting patterns and egregious 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.[[9]](#footnote-9) 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 ISS hours—that is, cases where the provider provided fewer ISS hours than the total for which they were contracted. For example, if DDA determines that a provider in King County was paid for 100 ISS hours that it did not deliver; the provider would repay DDA $1,953 for the total ISS rate component related to those hours. This amount is calculated based on 100 hours multiplied by the SFY 2019 ISS hourly rate for King County of $19.53. DDA also performs a reconciliation of the cost of the services provided. 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.

Providers must repay DDA for any undelivered ISS hours. Through the settlement process, DDA typically recoups approximately $1 to $2 million annually.

**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) 2016 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.

Our analysis indicated there were 87 Supported Living agencies with 2015 Cost Report data. Of these 87 agencies, 50 were determined to have a pay-to-cost ratio exceeding 100 percent. For these 50 agencies, pay-to-cost ratios ranged from 100.1 percent to 117.2 percent.

Figure 8 below also indicates 23 agencies have a pay-to-cost ratio between 95 percent and 100 percent and seven agencies have a pay-to-cost ratio between 90 percent and 95 percent. A total of seven agencies have a pay-to-cost ratio below 90 percent. The lowest pay-to-cost ratio was determined to be 49.7 percent. Of the 7 agencies reimbursed below 90 percent of cost, 5 have a pay-to-cost ratio greater than 70 percent.

Over two thirds 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 2016**

|  |  |
| --- | --- |
| **Pay-to-Cost Ratio Range** | **Number of Agencies** |
| Greater than 100% | 50 |
| Between 100% - 95% | 23 |
| Between 95% - 90% | 7 |
| Under 90%  | 7 |
| **Total** | **87** |

*Calculated based on data provided by the Department*

In addition, we conducted an analysis of the pay-to-cost ratios in CY 2019 based on the 2016 Cost Report data provided by the Department. To conduct this analysis, we first inflated the 2016 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.[[10]](#footnote-10)

To calculate the inflation factor necessary to inflate CY 2016 costs to CY 2019 levels, we first determined the annual percentage change in the two CPI indices mentioned above between the midpoint of CY 2016 and CY 2017. Since CPI data is only available through August of 2017, we then applied this percentage change to the index at the midpoint of CY 2017 to estimate the index at the midpoint of CY 2018. Using the same approach, we applied the same calculated percentage change to calculate the index at the midpoint of CY 2018 and CY 2019. We then determined the percentage change in the indices between CY 2016 to CY 2019. The percentage change determined was used to inflate the costs reported in 2016 by providers.

To appropriately match payments to our estimate of costs for CY 2019, we estimated payments using the actual payments from CY 2016. To do this, we adjusted the total ISS reimbursements and non-staff reimbursements from 2016 to reflect the rate increases that were given through SFY 2019. Since the SL reimbursement rates for SFY 2020 have not been determined yet, for the purposes of this analysis we assume that the ISS rates effective as of SFY 2019 will remain in effect through the end of CY 2019. The 2016 ISS and non-staff reimbursements were increased by 15.87 percent for agencies in Non-MSA counties, 15.57 percent for agencies in MSA counties, and 15.02 percent for agencies in King County. This represents the rate increase that occurred between rates effective in CY 2016 and the most recently available rates. Figure 9 below provides a summary of the estimated pay-to-cost ratios based on the inflated costs and estimated adjusted payments for CY 2019.

**Figure 9: Pay-to-Cost Ratio Summary – CY 2019**

|  |  |  |
| --- | --- | --- |
| **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% | 73 | 77 |
| Between 100% - 95% | 7 | 3 |
| Between 95% - 90% | 1 | 2 |
| Under 90%  | 6 | 5 |
| **Total** | **87** | **87** |

**Comparison to Other Payer Rates**

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. This section of the report describes our findings.

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.

An additional challenge in comparing Washington’s hourly ISS rates to the rates of other payers is that the hourly ISS rates represent a bundle of various services individuals may receive through the program. As discussed in Section I of this report, the service needs of clients are assessed to determine the types of support services they require as well as the total number of service hours they require. The total authorized service hours for a client therefore reflect the total hours related to the variety of support services they require. Providers are then reimbursed based on the effective ISS rate and the number of service hours after applying the economies of scale for each person served. In addition, providers are reimbursed an administrative/non-staff rate for each client, the amount of which varies based on both the number of authorized service hours authorized, and the county. Due to these reasons, it is difficult to draw conclusions from a comparison of these rates to other published rates for individual or “unbundled” services.

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. The services we used for comparison were determined as part of an additional study completed in December of 2016 for the Department. 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. These differences make a simple comparison of reimbursement rates across the states difficult.

For the purpose of comparing Washington’s Medicaid reimbursement rates to the rates other states pay, we first attempted to identify services across several other states that are similar in nature to the supported living services offered in Washington. We then identified the most recently published hourly equivalent rates for each of the states. Figure 10 below compares the available Medicaid reimbursement rates for similar services across four other states for one hour of SL services.

**Figure 10: Medicaid Reimbursement Rates by State**

|  |  |
| --- | --- |
| **State** | **Reimbursement Rate** |
| Oregon | $22.26 |
| Minnesota | $37.67 |
| Colorado | $24.52 |
| Illinois | $12.34 |

As noted earlier in the report, Washington’s reimbursement rates include an administrative/non-staff component, which varies based on the number of authorized ISS hours. In other words, the administrative/non-staff rate component increases at a decreasing rate as the total ISS hours per day increase. Understanding that the average number of authorized ISS hours per day was 15 hours in 2017 (as described previously in this report), we determined what the administrative/non-staff component of the rate would have been for an individual with 15 authorized ISS hours. We then added the calculated hourly administrative/non-staff component rate amount to the ISS hourly rate amount to determine that average hourly SL rate for this comparison.

The SFY 2019 ISS rate for King County is $19.53. Assuming 15 authorized ISS hours, the ISS daily rate component is $292.95. The total administrative/non-staff rate for King County for 15 authorized ISS hours is $39.80, which brings the total daily rate to $332.75. The reimbursement rate per ISS hour for an individual with 15 authorized ISS hours is therefore $22.18. Compared to the available information for other states reviewed in the study, Washington’s reimbursement rate is similar in level to Oregon’s hourly reimbursement rate, however, is lower than the Colorado’s and Minnesota’s reimbursement rates.

As mentioned above, due to the differences in both the rate-setting and payment methods in these states, as well as the potential differences in the intensity of the services provided in these states, it is difficult to do a simple comparison of Medicaid reimbursement rates. It is not possible to discern from our research exactly how each of these other states is using these services or how intensive these services are. However, we do know that in Washington, SL services are very intensive. As demonstrated earlier in the report, approximately 80 percent of clients are classified in levels 4 through 6, which require continuous supports, and on average clients receive 15 hours of ISS services per day.

If for example, the rates for one of these states were for services that required, on average, an equivalent of five ISS hours, the Washington rate for comparison purposes would be higher; the rate would be calculated by adding a total ISS rate of $97.65 and a total administrative/non-staff component of $30.40. The effective hourly reimbursement rate under this scenario would be $25.61. Both Oregon’s and Minnesota’s rate methodologies calculate the administrative costs based on a flat percentage. Therefore, as the direct care costs increase, the administrative costs increase proportionately whereas in Washington, this is based on a regression formula.

The reimbursement rates across states may also be affected by the minimum wage. While the minimum wage may not be a direct input in calculating reimbursement rates, states likely consider minimum wage levels when setting reimbursement rates. Across all of these states, Washington has one of the higher minimum wages. In 2016, Washington’s minimum wage was $9.47. The minimum wage at the time was similar to the minimum wage for Oregon’s Portland metro area of $9.74 and to Minnesota’s minimum wage for large employers of $9.50. In 2016, the minimum wage in Colorado was $8.31 and in Illinois was $8.27.

Again, it is difficult to simply compare reimbursement rates across states. The rate methodologies and services vary across 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 2016, the payment-to-cost analysis based on provider reported data indicates that over 80 percent 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. Further, it should be noted that while the hourly ISS benchmarks remained the same for SFY 2012 through SFY 2014, in SFY 2015 through SFY 2019 the ISS benchmarks have increased. SFY 2019 rates have increased by approximately 13 percent from SFY 2017 levels across all counties.

Based on the trend in citation data provided by the Department, it appears that the quality of services provided by SL providers is adequate. 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. This resulted in an increase in the number of citations. In 2017, the total citations declined from 2016 levels and are slightly higher than 2015 levels.

In addition, we reviewed information on the number of provisional certifications and decertifications issued by the Department between 2009 and 2016. The number of provisional certifications were at their highest levels in 2017 while the number of decerticiations 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 but the Department should continue to monitor this. The number of decertifications has decreased from 4 cases in 2011 to 1 cases in 2017.

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 2016, 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 2016 costs to CY 2019, and accounting for the percent adjustments to the hourly reimbursement rates that occurred between CY 2016 and SFY 2019, it appears that the majority of providers will be reimbursed at 95 percent or more of costs.

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
1. The State Supplemental Program is a state-funded cash assistance program for certain clients who the U.S. Social Security Administration determined to be eligible for Supplemental Security Income. [↑](#footnote-ref-1)
2. 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-2)
3. 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-3)
4. DDA uses a statistical model to predict the amount of support time necessary to meet the health and welfare needs of the client. The statistical model uses data obtained from 271 test cases to predict typical support time needs based on answers to selected questions in the SIS assessment. This statistical approach resulted in a correlation of greater than 90 percent between responses to these questions and the number of actual individual support hours the client required. [↑](#footnote-ref-4)
5. Administrative/non-staff rates are slightly higher for clients in the Community Protection (CP) program. For example, a CP client who lives in King County with 24 ISS hours would garner $55.87 per day. [↑](#footnote-ref-5)
6. The administrative/non-staff component is based on a logarithmic scale—the reimbursement rate increases at a decreasing rate as the daily ISS hours increase. [↑](#footnote-ref-6)
7. As part of the effort to bring providers closer to the administrative standard, DDA administrators do not apply legislatively mandated rate reductions or increases uniformly across all SL providers. For example, in 2011, the Washington legislature imposed a three percent reduction in administrative/non-staff rates; providers farthest below the standard did not receive any reductions, while those above standard may have received as much as a five percent rate reduction. [↑](#footnote-ref-7)
8. In rare cases, DDA will negotiate reimbursement for rent and utilities expenses of Supported Living staff to live with clients in their home. [↑](#footnote-ref-8)
9. Cost reports are due on or before March 31 and cover the preceding calendar year. [↑](#footnote-ref-9)
10. Consumer Price Index – All Urban Consumers, All items and CPI – All Urban Consumers, Seattle-Tacoma-Bremerton, All items. [↑](#footnote-ref-10)