Analysis of the Washington Supported Living Medicaid Payment Methodology

Final Report

Prepared for:

Washington State Department of Social and Health Services (DSHS)

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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 individual 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 December of 2015, there were 4,003 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, and rate and expenditure 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. 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 December 2015**

| **Support Need Level** | **Characteristics** | **2015 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.  | 7 | 0.2% |
| 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.  | 153 | 3.8% |
| 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. | 298 | 7.4% |
| 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. | 378 | 9.4% |
| 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. | 458 | 11.4% |
| 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. | 2,293 | 57.3% |
| 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. | 416 | 10.4% |

*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 with fewer than 20 employees)
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 the 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 2015, SL clients receive an average of 14.2 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 roommates’ 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, 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. Costs related to staff lodging in cases where the SL program provides the primary 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) 2016, ISS Rates for each county type are:

* King County: $16.68 per ISS hour
* MSA county: $16.08 per ISS hour
* Non-MSA county: $15.77 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 rates have increased by approximately 1.5 percent in all counties. In addition, the Department indicated that ISS rates effective SFY 2017 will increase by $0.60 across the geographic areas.

**Figure 2: Hourly ISS Rates, by County, SFY 2007-2016**

*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 and therapists, language translators, and Dialectical Behavioral Therapists.

The administrative 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 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 rates based on averages of these costs. At that time, administrative 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)

As of April 2015, 13 percent of providers (15 out of 115 providers) received administrative reimbursements that were below the standard rate, while 85 percent (98 providers) were equal to the standard. Of providers below the standard in April 2015, most received administrative reimbursements that were, on average, about 1.6 percent below the standard. As of April 2015, there were two providers that received administrative reimbursements above the standard rate.[[8]](#footnote-8) In comparison, as of October 2014, 37 percent of providers (43 out of 117 providers) received administrative reimbursements that were below the standard rate 63 percent (74 providers) were equal to the standard, and there were no providers above the standard rate. In addition, of the providers below the standard, in 2013, most received administrative reimbursements that were, on average, about 1.5 percent below standard. Effective July 1, 2015 the Department has brought all providers up to the standard administrative 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.

As noted, the RM determines the client’s daily rate as the sum of the ISS costs (wage rate multiplied by daily ISS hours), administrative rate, and allowances for indirect client support costs (professional services, the assessed transportation rate, and any unique negotiated rate components).[[9]](#footnote-9) According to DDA officials, the 2015 statewide average daily rate is about $265—approximately $221 for ISS and $44 for administrative costs and other indirect client support costs. In Figure 3, we provide a summary of average daily rates from 2007 to 2015. The ISS component increased significantly more than the administrative component since 2007—47 percent versus 23 percent, respectively. Within that span of time, the most significant increases in the daily rates occurred between 2007 and 2008, and between 2014 and 2015.

**Figure 3: Average Daily Supported Living Rates, 2007-2015**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Fiscal Year** | **Average Daily ISS Rate** | **Percent Change** | **Average Daily Administrative and Indirect Client Support Rate** | **Percent Change** | **Average Daily Total Rate** | **Percent Change** |
| 2007 | $150.04 | NA | $35.49 | NA | $185.53 | NA |
| 2008 | $170.97 | 13.9% | $37.53 | 5.7% | $208.50 | 12.4% |
| 2009 | $181.23 | 6.0% | $38.61 | 2.9% | $219.83 | 5.4% |
| 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 | 13.7% | $43.73 | 6.9% | $264.72 | 12.5% |

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

The average daily rate varies across providers based on client acuity mix, incidental client service costs, and differences in administrative rates relative to the standard. In an effort to adjust for these differences, we determined and compared the average *hourly* rates (including the administrative component) reimbursed across providers to detect any variance. Based on current 2015 rates, we observed that most providers—76 percent—have hourly rates of between $18 and $20 (excluding professional services costs). When we compared just the hourly administrative component of the rates, we observed that 91 percent of providers’ average hourly administrative rates are between $2 and $4.

Because a client’s total rate is based on several components that vary based on direct support needs and shared hours with other clients, each client has a unique rate. While this process is highly responsive to even small changes in a client’s needs or environment, the frequency of rate changes and reassessments creates a burden both for DDA staff and providers. According to DDA, there were typically about 300 rate changes per month for a total of over 6,000 rate changes in 2012.

On January 1, 2014, DDA implemented rounding to the nearest hour rather than half hour when determining if a rate change is necessary upon reassessment. According to DDA, this was expected to significantly reduce the number of rates and rate changes overall[[10]](#footnote-10). However, since the implementation, DDA has not observed a reduction in the number of rate changes that occur. According to the Department, this is attributed to the shifts in the administrative component of the rates related to the effort of bringing all providers to the standard administrative rates.

Average annual costs per client have increased from approximately $67,000 in 2007 to nearly $93,000 in 2015, in part due to this increasing acuity. While program enrollment grew approximately 13 percent during this time period, total program expenditures grew by over 40 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.

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 some funding from the State Supplemental Program and other state funds.[[11]](#footnote-11) As displayed in Figure 4 below, total Medicaid expenditures (state and federal) in fiscal year 2015 were approximately $364.8 million.

**Figure 4: Annual Supported Living Enrollment and Expenditures, FY 2007-FY2015**

|  |  |  |  |
| --- | --- | --- | --- |
| **Fiscal Year** | **Enrollment** | **Expenditures** | **Average Expenditures per Client** |
| 2007 | 3,444 | $229,900,000 | $66,753.77 |
| 2008 | 3,498 | $255,000,000 | $72,898.80 |
| 2009 | 3,479 | $275,900,000 | $79,304.40 |
| 2010 | 3,496 | $275,500,000 | $78,804.35 |
| 2011 | 3,539 | $285,900,000 | $80,785.53 |
| 2012 | 3,701 | $293,500,000 | $79,302.89 |
| 2013 | 3,796 | $314,100,000  | $82,744.99  |
| 2014 | 3,824 | $335,505,505 | $87,736.80 |
| 2015 | 3,906 | $364,754,200 | $93,393.05 |

*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 2015, 79.1 percent of the total individuals served, were assessed in levels 4 through 6.

Based on discussions with the Department, DDA has not had any difficulty in the past with finding SL services for the clients who are authorized to receive support. However, the Department indicated that more recently providers of supported living services have voiced concerns with acquiring and retaining staff that provide direct support services to clients.

According to the Department, this can be attributed to the increase in the average wage and benefits of Home Care staff. Additionally, the minimum wage has increased competition resulting in staff leaving for jobs with similar wages in other industries. The wage and benefit levels for Home Care staff are negotiated through collective bargaining and the Department has no influence over these rates. Since these higher wages and benefits in other settings are more attractive to individuals providing these types of direct support services, Supported Living agencies have voiced concerns regarding attracting and retaining staff. As of December 2015, there were 115 contracted provider locations serving 4,003 clients. Figure 5 below shows the number of clients served in the Supported Living program as well as the number of provider locations from 2008 through 2015. The number of individuals receiving Supported Living services has been steadily increasing since 2008. Enrollment has increased by 14.4 percent since 2008.

The number of provider locations appears to be relatively stable and since 2008 has increased slightly. The number of provider locations since 2008 has increased by approximately 5.3 percent.

**Figure 5: Supported Living Number of Clients and Provider Locations in Washington 2008 – 2015**

|  |  |  |
| --- | --- | --- |
| **Fiscal Year** | **Number of Clients Served** | **Number of Contracted Provider Locations** |
| 2008 | 3,498 | 113 |
| 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 |

*Source: Data provided by the Developmental Disabilities Administration*

Note 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 providers 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.

**Inspections**

The Department has both inspection and complaint 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, 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 (MFCU) in the case of fraudulent activity on the part of the provider or others.

The Department monitors regulatory compliance identified in both inspections 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 inspections by the Department prior to a decision to grant additional certification. When decertified, a provider can no longer operate an SL agency.

Data provided by the Department indicates since 2009 the number of inspection citations has decreased. Between 2009 and 2015, the number of inspection citations have decreased by 49.8 percent. During the same period, the number complaint citations increased during this period, and the total number of citations increased by 6.2 percent. Figure 6 below shows the total number of citations between 2009 and 2015. Based on discussions with the Department, it is our understanding that the increase in the number of citations between 2014 and 2015 is primarily due to policy changes for the program regarding how follow-ups on citations are conducted. The new policy increased the number of follow-ups identified in 2015.

**Figure 6: Citations in Supported Living Agencies 2009 – 2015**

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

The number of provisional certifications issued and the number of instances of decertification from 2009 through 2015 is fairly minimal and it does not appear there is an increasing trend in these instances. It appears, the number of provisional certifications issued and 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 2015.

**Figure 7: Provisional Certification and Decertification Instances 2009 – 2015**

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

*Source: Data provided by the Department*

**Client Safety**

In an auditor’s report published in July of 2013 by the State Auditor’s Office entitled Improving payment systems and monitoring necessary to prevent errors and improve safety, it was reported that 23 out of approximately 1,500 SL staff were found to have disqualifying criminal background checks. The report does not conclude whether these SL staff had unsupervised access to clients and states the information regarding these situations was provided so the administration can conduct a review and follow-up with agencies. The auditor’s report does conclude, however, that findings from prior investigations have found cases where support providers with a disqualifying criminal background had unsupervised access to clients and points to a 2011 DSHS internal audit which found 11 of the 55 SL staff identified the report had unsupervised access to clients.

The auditor’s report also concludes that from a sample of SL staff, the SL providers employing those staff were unable to provide certifications related to important safety training for at least 12 percent of the SL staff. The report points out that the Administration relies on each provider to ensure SL staff have the proper training and certifications and that this is properly documented.

In November of 2011, Initiative 1163 was passed in Washington State which expands the background check, training, and certification of requirements for staff providing services in home and community based settings. The auditor’s report notes staff providing supported living services, beginning in 2016, will also be included under the Initiative’s requirements. The auditor’s report states this will likely increase compliance with training.

# 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.[[12]](#footnote-12) 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 $1,668 for the total ISS rate component related to those hours. This amount is calculated based on 100 hours multiplied by the SFY 2016 ISS hourly rate for King County of $16.68.

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) 2014 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 provider level rather than for individual provider locations.

Our analysis indicated there were 103 Supported Living providers with 2014 Cost Report data. Of these 103 providers, 65 were determined to have a pay-to-cost ratio exceeding 100 percent. For these 65 providers, pay-to-cost ratios ranged from 100.0 percent to 111.4 percent.

Figure 8 below also indicates 22 providers have a pay-to-cost ratio between 95 percent and 100 percent and 10 providers have a pay-to-cost ratio between 90 percent and 95 percent. Only 5 providers have a pay-to-cost ratio below 90 percent. The lowest pay-to-cost ratio was determined to be 60.2 percent. Of the 5 providers reimbursed below 90 percent of cost, 3 have a pay-to-cost ratio greater than 70 percent.

The vast majority of providers are reimbursed at levels of above 95 percent of costs. Proper reimbursement is crucial in the supported living program as providers do not have of private pay clients and rely on Medicaid reimbursement to support their programs. It should be noted, that for providers 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 2014**

|  |  |
| --- | --- |
| **Pay-to-Cost Ratio Range** | **Number of Providers** |
| Greater than 100% | 65 |
| Between 100% - 95% | 23 |
| Between 95% - 90% | 10 |
| Under 90%  | 5 |
| **Total** | **103** |

*Calculated based on data provided by the Department*

In addition, we conducted an analysis of the pay-to-cost ratios in CY 2017 based on the 2014 Cost Report data provided by the Department. To conduct this analysis, we first inflated the 2014 Cost Report data to CY 2017 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.[[13]](#footnote-13)

To calculate the inflation factor necessary to inflate CY 2014 costs to CY 2017 levels, we first determined the annual percentage change in the two CPI indices mentioned above between the midpoint of CY 2014 and CY 2015. Since CPI data is only available through August of 2015, we then applied this percentage change to the index at the midpoint of CY 2015 to estimate the index at the midpoint of CY 2016. Using the same approach, we applied the same calculated percentage change to calculate the index at the midpoint of CY 2016 and CY 2017. We then determined the percentage change in the indices between CY 2014 to CY 2017. The percentage change determined was used to inflate the costs reported in 2014 by providers.

The total ISS reimbursements and non-staff reimbursements in 2014 were also adjusted to reflect the rate increases through SFY 2017. The 2014 ISS and non-staff reimbursements were increased by 8.99 percent for providers in Non-MSA counties, 8.81 percent for providers in MSA counties, and 8.47 percent for providers in King County. This represents the rate increase that occurred between SFY 2014 and SFY 2017. Figure 9 below provides a summary of the estimated pay-to-cost ratios based on the inflated costs and estimated adjusted payments for CY 2017.

**Figure 9: Pay-to-Cost Ratio Summary – CY 2017**

|  |  |  |
| --- | --- | --- |
| **Pay-to-Cost Ratio Range** | **Number of Providers Based on Seattle Area Inflation Index** | **Number of Providers Based on Western Region Inflation Index** |
| Greater than 100% | 82 | 86 |
| Between 100% - 95% | 14 | 10 |
| Between 95% - 90% | 0 | 0 |
| Under 90%  | 7 | 7 |
| **Total** | **103** | **103** |

Based upon the estimated costs and payments for CY 2017 using both indices, there will be an increase in the number of providers to be reimbursed at more than 95 percent of cost compared to 2014 levels, and it appears the majority of providers will now be at that level.

# 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.

Based on discussions with the Department, in the past there has been no difficulty enlisting sufficient numbers of providers to serve those clients authorized to receive support in the SL program. However, as indicated earlier in this report, the Department has indicated that more recently providers of supported living services have voiced concerns to the Department regarding difficulty with acquiring and retaining staff that provide direct support services to clients. This can be attributed, according to the Department, 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. Despite this, enrollment of individuals in the SL program has continued to increase along with the average daily reimbursement rate. Further, it should be noted that while the hourly ISS rates remained the same for SFY 2012 through SFY 2014, in SFY 2015 and in SFY 2016 the ISS have increased. SFY 2016 rates have increased by approximately 4 percent from SFY 2015 levels across all counties. The ISS rates will also increase in SFY 2017 by $0.60, approximately 3.7 percent, from the SFY 2016 levels.

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 since 2009 has increased by 6.2 percent, while the number of agencies has increased slightly over the same period. The increase in the most current period is primarily due to policy changes that have increased the number of follow-ups identified. In addition, since 2011, the number of provisional certifications issued has decreased slightly from 4 cases to 3 cases in 2015. The number of decertifications has decreased from 4 cases in 2011 to 1 case in 2015.

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 2007 along with enrollment. In addition, for CY 2014, 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 costs incurred for providing SL services. When inflating those 2014 costs to 2017, and accounting for the percent adjustments to the hourly reimbursement rates that occurred between SFY 2014 and SFY 2016, it appears that the majority of providers will be reimbursed at 95 percent or more of costs.

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 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 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 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 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. The provider with the lowest rate was 6.7 percent below standard. [↑](#footnote-ref-8)
9. 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-9)
10. The methodology of rounding to nearest hour rather than half hour has been implemented for all clients except single households. There are relatively few clients in a single household setting. [↑](#footnote-ref-10)
11. The State Supplemental Program is a state funded cash assistance program for certain clients who the Social Security Administration determines are eligible for Supplemental Security Income (SSI). [↑](#footnote-ref-11)
12. Cost reports are due on or before March 31 and cover the preceding calendar year. [↑](#footnote-ref-12)
13. Consumer Price Index – All Urban Consumers, All items and CPI – All Urban Consumers, Seattle-Tacoma-Bremerton, All items. [↑](#footnote-ref-13)