Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

An Analysis of Expenditures for Medicaid Clients Served in Adult Family Homes and Assisted Living Facilities by Acuity Level

Second Engrossed Substitute House Bill 2376
Chapter 36, Laws of 2016
Section 206 (21)

January 10, 2017

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Table of Contents

Executive Summary

Home and community services in long-term care offers choices to clients and savings to taxpayers over more expensive nursing home care. Some providers of community residential services have expressed concerns about payment equity between facilities. Payment rates are set based on Legislative appropriation levels and direction.

The 2016 Legislature required the Department of Social and Health Services (DSHS) to analyze expenditures for clients supported in community residential facilities, by acuity level. These facilities include facilities licensed as Adult Family Homes (AFHs) and Assisted Living Facilities (ALFs, which have contracts for Assisted Living or AL[1], Adult Residential Care or ARC, and Enhanced Adult Residential Care or EARC).

This report is the first comprehensive analysis to compare expenditures for clients living in community residential facilities that include *all* long-term services and supports funded by the DSHS Aging and Long-Term Support Administration (ALTSA)[2]. The analysis uses Fiscal Year (FY) 2016 actual expenditures, the most recent full year of data available and includes:

- Personal care delivered by residential facilities.
- Services for the client performed by other providers, for example, nurse delegation, adult day health, and transition services. (See Appendix A for full list of "other provider" services.)
- Client responsibility (expenditures for room and board and participation; previous reviews did not include this data).

Caveats on How to Use this Report

This analysis is neither a "cost study" nor a review of how much of providers' costs are covered by Medicaid payment rates. Rather, this analysis provides a broad view of how per capita expenditures compare for clients of similar acuity level (as measured by the need for personal care assistance), including services from non-facility providers. This provides a guide for future study, as well as data to use when considering changes in rates or policy.

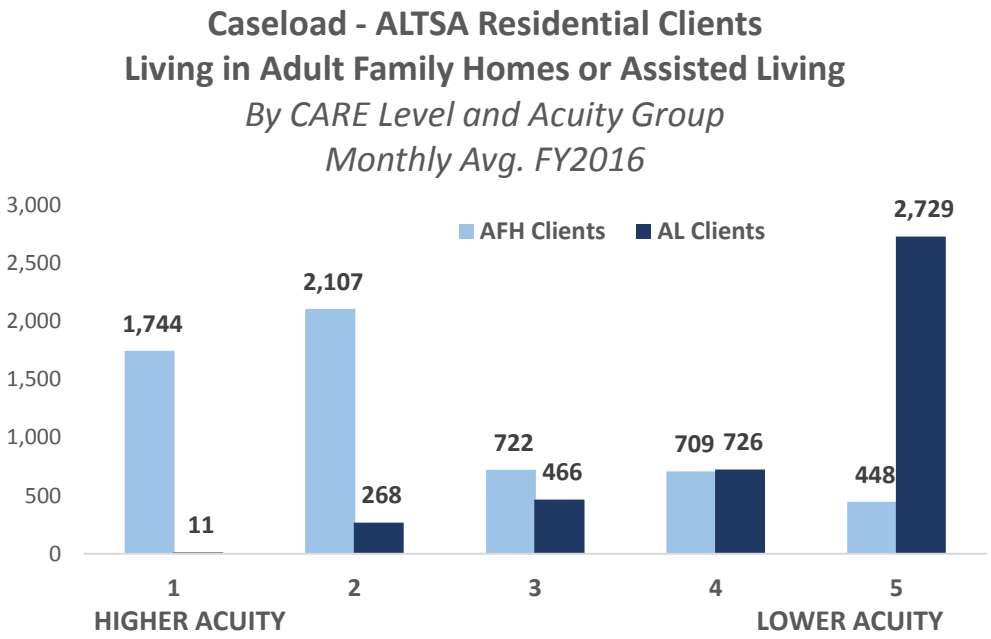
Also, this analysis does not reflect differences in client needs that are not easily communicated by personal care acuity groupings, such as different needs for nursing tasks. In addition, there are differences in facilities as required by their license or contract, such as private rooms vs. shared rooms, which complicate comparisons on a per person basis.

Major Findings: Client Acuity and Caseload

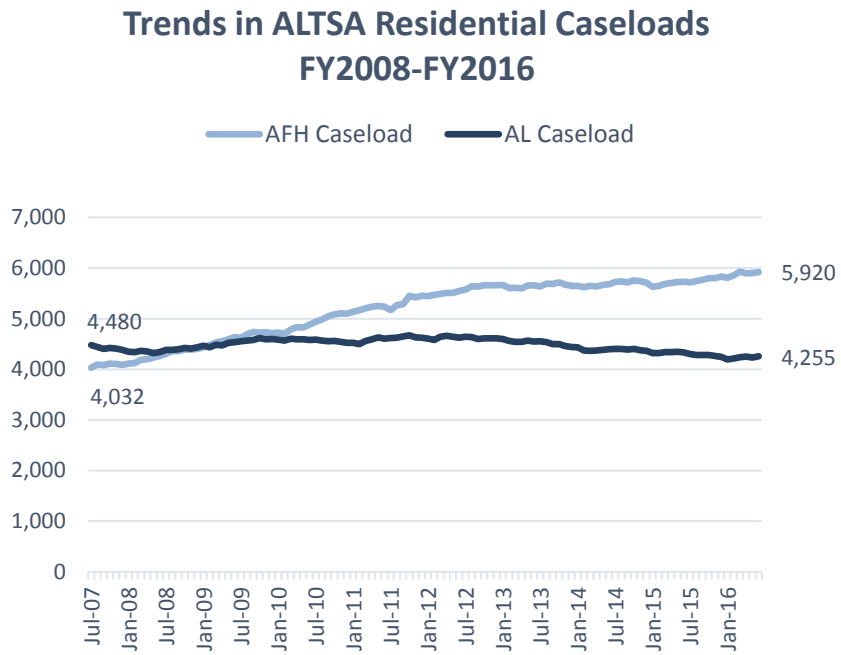
1. See chart below. AFHs primarily serve higher acuity clients, and AL and ARC primarily serve clients with lower acuity. EARC serves a broader

array of client acuity. Both AL and EARC can contract to serve clients needing specialty dementia care.

- AFHs provide the majority of ALTSA's capacity to serve the highest acuity clients in home and community facilities (50 percent of all home and community clients in Group 1 are served in AFHs, another 46 percent are served at home.) By doing so, AFHs serve a caseload of over 1,700 clients who would likely otherwise reside in nursing homes.
- AL serves 43 percent of ALTSA's home and community clients at the very lowest acuity level (lowest level within Group 5) who are still eligible for nursing home care[3] (in-home serves another 50 percent, and other ALFs, including ARC and EARC, 5 percent). In this way, AL provides another residential option for a caseload of over 1,400 people (over half of Group 1 in AL) who cannot or do not want to live at home any longer[4].



- Caseload and acuity trends are going in different directions for AFHs and AL. *AFH caseloads have increased 47 percent* between July 2007 and June 2016,, primarily at the very highest acuity group.[5] In that same period, *AL caseloads have declined five percent*, almost all in the lower acuity group. (The middle and upper groups in AL are small, but stable.) See chart below.

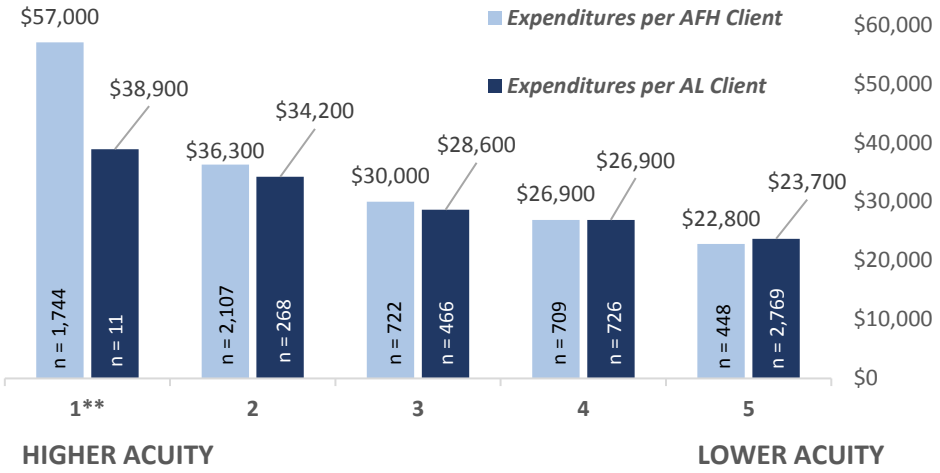


Major Findings: Per Capita Expenditures

2. For FY2016, as would be expected, the higher the client acuity (need for personal care assistance) the higher the per capita expenditures, including residential and all ALTSA services. This is true across all residential facility types.

3. See chart below. For FY2016, for Groups 2 and 3, the *second highest and middle acuity* groups, per capita expenditures for clients living in AFHs were greater than those living in AL.
    - In total, expenditures for AFH clients are about six percent higher than AL in Group 2 and five percent higher in Group 3.
    - These higher per capita expenditures for clients served in AFHs are due primarily to additional services for the client that are performed by providers other than the AFH, such as nurse delegation, skilled nursing, and adult day health.
    - For Group 4, the average expenditures per client are the same when rounded to an annual level.

FY2016 Annual Per Capita Expenditures
for All ALTSA Services*
for Clients Living in AFHs and AL
Rounded, by Acuity Group



*Includes residential expenditures, other providers, client responsibility. Expenditures for enhanced rates for additional levels of service are removed to increase comparability.
**Conclusions cannot be drawn from the Group 1 comparison as there are too few clients in AL at this acuity level (n = 11).

4. For FY2016, at the *lowest acuity group (Group 5)*, per capita expenditures for clients living in AL are about 4 percent higher than those for clients in AFHs. In FY2017 this is expected to change, see below.

5. Conclusions cannot be drawn for the highest acuity level (Group 1) due to the very low utilization of AL by clients in Group 1. (While 1,744 Group 1 clients lived in AFHs, only 11 clients of similar acuity lived in AL.)

6. The differential between ALTSA per capita expenditures for clients living in AFH and AL is increasing in FY2017, the current fiscal year.

    - Higher AFH rates of 5 percent were approved by the Legislature and went into effect as of July 1, 2017; there is no change to ALF rates. If all other costs stay similar to FY2016, ALTSA per capita expenditures will be higher for clients living in AFHs than for AL for Groups 1, 2, 3, and 4, and equivalent for Group 5.

Implications

Any changes to our system of long-term services and supports should consider the simultaneous challenge of serving an increasing client population with dementia or behavioral health needs, as well as the general demographic shift of the “age wave”.

Both AFHs and AL are an important component of the long-term services and supports provider network. AFH serve many clients with high acuity, and AL offers an alternative to nursing homes for lower acuity clients who no longer wish to or can remain at home. AL is also the only option for people who would like the privacy of having their own bedroom. While AFHs are growing as part of our Medicaid long-term services and supports, AL is shrinking as an option available to Medicaid clients.

Decision-makers may want to consider rate and/or policy changes that strengthen the AL system. This would enable more AL clients to “age in place” in their current AL residence if their needs increase, or if they are a private pay client converting to Medicaid.

Background

The mission of DSHS Aging and Long-Term Support Administration (ALTSA) is to *transform lives by promoting choice, independence, and safety through innovative services*.

ALTSA is a national leader in promoting home and community based long-term services and supports (LTSS), including supports for people with high needs. Today, the AARP ranks Washington state second highest in the nation for promoting LTSS in home and community-based settings. These are the settings most people choose, and are also the most cost-effective.

What are home and community-based services?

In the context of long-term care, home and community-based services include those that are an alternative to nursing home care. These services are not a continuum of care, rather, most acuity levels and clients can be served in a variety of home and community-based settings.

In FY2016, over 64 percent of all of ALTSA's clients were served at home, 16 percent in nursing homes, and another 20 percent in community residential facilities, including:

- Adult Family Homes (9 percent of all ALTSA clients)
- Assisted Living Facilities which have contracts for
    - Assisted Living) (7 percent of ALTSA clients)
    - Adult Residential Care or Enhanced Adult Residential Care (4 percent of ALTSA clients)

Home care and community residential services are supplemented by many other ALTSA services such as skilled nursing, nurse delegation, meal delivery, home modifications, behavior supports, assistive technology, etc.

What is personal care and what are Activities of Daily Living?

Long-term care is not a medical service. Long-term care's primary service is *personal care* provided by home care workers and community residential facilities. Clients' nursing and other needs are also addressed as part of their care plan.

Personal care helps people accomplish Activities of Daily Living, or ADLs, which are tasks a person would normally do for themselves if they did not have a disability. ADLs include assistance with bathing, bed mobility, body care, dressing, eating, locomotion, walking, medication management, toileting, transfer, and personal hygiene. Personal care also includes Incidental Activities of Daily Living (IADLs), but the need for IADLs alone does not make an individual eligible for service. IADLs include meal preparation, ordinary housework, essential shopping, and travel to medical

services. Personal care may take the form of hands-on assistance, cuing and/or supervision to prompt the person to perform a task.

What is the legislative requirement for this report?

The 2016 Legislature required this report in its legislation for the Supplemental Operating budget. Chapter 36, Laws of 2016, section 206 (21) states:

> *The department of social and health services shall provide to the legislature an analysis of expenditures for Medicaid[6] clients served in adult family homes and assisted living facilities by acuity level. The analysis shall include all services provided to Medicaid clients in each care setting, including all services covered by the daily rate and services provided in addition to the daily rate. The department shall submit the report to the legislature by November 15, 2016.*

The focus on this report will primarily be on comparing expenditures for clients in Adult Family Homes (AFHs) to those of clients residing in Assisted Living Facilities (ALFs) contracted as "Assisted Living", or AL.

How is client acuity measured, and how is it used in this report?

In order to become a client and receive services, a person must be both financially eligible for services and functionally eligible. People who meet this criteria are assigned an ALTSA case manager. The case manager performs an in-person assessment (using the Comprehensive Assessment and Reporting Evaluation Tool, or CARE) and develops a plan of care with the client.

In CARE, clients and their caregivers are asked a series of questions about the client's abilities, needs, and preferences. Clients are then assigned one of 17 classification groups based on the assessment. Those groups take into consideration clinical characteristics of the client that impact the *provision of personal care services* including

- Activities of Daily Living (ADLs)
- Cognitive performance
- Clinical complexity and
- Mood/behavioral symptoms.

The primary framework for discussing client acuity for this report is the 17 CARE level rating scale. However, there are elements of client needs that are captured during the assessment but are independent of the CARE levels, such as a client's need for some type of nursing care, for example, assistance with insulin injection (this need can be met with nurse delegation).

In addition, the 17 CARE levels can be further grouped into Groups 1 through 5, representing a broad look at client acuity in terms of need for assistance with activities of daily living and other areas. See table below. This report will look at both the broad groups and the 17 CARE levels.

ACUITY GROUPINGS

HIGHER ACUITY	GROUP	CARE LEVEL
	Group 1 - Extremely limited ADL, often immobile	E High, E Med, D High
	Group 2 – Very limited ADL, plus cognitive problems	D Med-High, D Med, C High, C Med-High
	Group 3 – Moderately limited ADL, plus clinically complex	D Low, C Med, B High
	Group 4 – Moderately limited ADL and/or behavior challenge	C Low, B Med-High, B med, A High
	Group 5 – Moderately limited ADL	B Low, A Med, A Low

ADL = Activities of Daily Living, including eating, dressing, bathing, toileting, moving around, etc.

How do clients decide where to live?

Clients and their caregivers participate in an in-person assessment of acuity and needs, and agree to a plan of care with their ALTSA case manager. The setting for a client will depend on client choice, matching clients' needs with appropriate providers, and the overall availability of various providers in a preferred geographic area. Again, the facilities or settings are not a continuum of care. Clients are not "placed" based on case manager preference, rather the client's care plan is a collaborative process.

The primary factors that clients, their families, and case managers use to determine where a client will live and receive services are diverse, and include, but are not limited to:

- Whether the client wants to remain in their own home
- The type of preferred residential facility based on the client's preferences (i.e. based on size of facility, whether a private room is desired)
- The ability of the residential provider to meet the client's needs, preferably over the long-term as the client's needs change
- The availability of such a provider (i.e. a client may prefer a specific facility or type of facility, but there may not be one with openings at that time)
- The location of the residential facility in terms of proximity to family, friends, and access to preferred activities and
- The reputation of the quality of the residential facility and/or the impression of the quality of the facility during a visit by the client and family.

What are the main differences between community residential facilities for ALTSA clients?

Residential facilities have many similarities, although they each have their own licensing and contract requirements. There are two types of licensed community residential facilities:

1. Adult Family Homes (AFHs) and
2. Assisted Living Facilities (ALFs) (once known as "boarding homes") which have contracts for either
    - Assisted Living (AL)
    - Adult Residential Care (ARC) or
    - Enhanced Adult Residential Care (EARC).

All residential facility types, including AFHs and ALFs of all contract types:

- Are licensed to serve both private pay residents and publicly-funded clients of varying acuity levels
- Must provide room and board, personal care, supervision, and activities
- Have a statutory minimum requirement for 75 hours of training for their workers and
- Have a statutory requirement for an in-person health, safety, and quality inspection at least every eighteen months, plus an initial inspection prior to taking any residents.

Some residential facilities have *specialty contracts* to serve individuals with mental health needs, developmental disabilities, or to provide specialty dementia care. These have additional training and staffing requirements and enhanced payment rates.

Major Distinguishing Characteristics of Residential Facilities

- ALFs (AL, EARC, and ARC contract types) are typically larger facilities, with an average of 60 residents.
- Only AL requires private "apartments" (bed, bath, and kitchens); these are usually shared in other facilities.
- Only AL and EARC are required to have intermittent nursing available at the facility (vs. available through another provider, like a nurse delegator, that a client in an AFH may use.)

See Appendix B, which further delineates between facility types. One location/company could have multiple licenses, i.e. a portion of a site may be contracted as AL and another portion with shared bedrooms contracted as an EARC.

Other Noticeable Differences

- ARCs (not EARCs) are now the least common facility type, and they are typically older facilities. Clients tend to have lower overall acuity with some behavioral health needs.
- AL overwhelmingly serves private pay residents as a share of its beds statewide (74 percent compared to 43 percent for AFHs.)[7] Even though the number of AL facilities is increasing, fewer AL facilities have Medicaid contracts, making this a shrinking option for Medicaid clients, and the ALTSA AL caseload is declining.

Lastly, even within facility types, specific AFHs and ALFs may be noticeably different from each other in a way that influences whether clients choose to reside there, for example – whether pets are allowed, whether specific languages are spoken by caregivers, and where there are cultural or religious affiliations.

What are the differences between expenditures, costs, and rates?

Each of these terms has a specific meaning in this report and are not interchangeable.

- "Expenditures" represent funds *actually spent* by the state or client for a service. Expenditures reflect a rate multiplied by the units used (i.e. days) for a variety of services, and also reflect multiple payers, including state and federal sources, client contribution, and third party payers such as private insurance. This report focuses on expenditures.
- "Rates" are equivalent to a price per unit (i.e. rate per day). Rates are published by DSHS and are based on Legislative appropriation and direction and Washington Administrative Code. Rates influence expenditures, but so do the amount and types of services used. See more about rates below.
- "Costs" mean the actual financial effort to accomplish a service (may differ from an expenditure). Costs *are not the subject* of this report.

How are payment rates set for residential services?

Funding Level

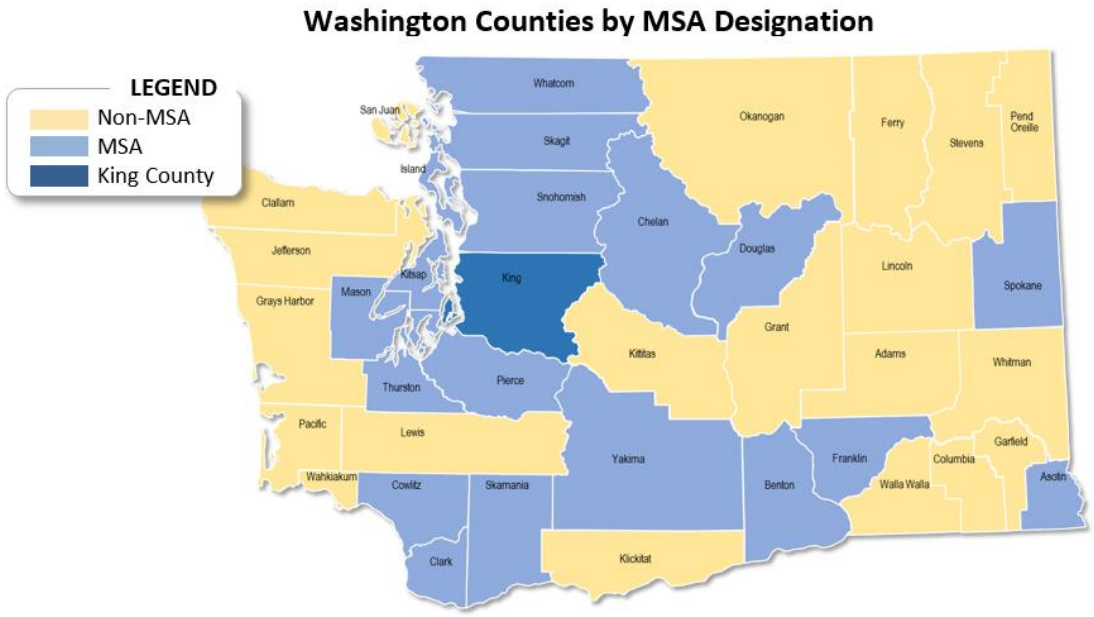
Within the funding available, payments for residential facilities are paid as daily rates, published in an annual schedule by DSHS (See Appendices C and D). DSHS has very limited ability to impact rates through its own actions. There are no automatic increases each year, rather, the level of funding available to support the rates comes solely from Legislative decisions and appropriations. The current amount of the rates is a legacy of compounded funding changes over time. When establishing the rates, DSHS follows the federal guidelines found in 42 U.S.C. § 1396a (a)(30)(A) ("Section 30(A)").

State law also requires collective bargaining with the state over Medicaid rates for AFH providers (owners). AFH owners are currently represented by the Adult Family Home Council (AFHC). The AFHC bargains with the Governor's Labor Relations Office each biennium over potential rate changes and other factors. Bargaining agreements or arbitration awards are subject to funding by the Legislature, and when funded, have resulted in rate increases. (No such bargaining requirement exists for ALFs.)

Rate Determinants within the Overall Funding Level

The main determinants of which rate a residential facility receives for standard (non-enhanced) services are:

- *Acuity of the client:* Higher CARE levels (the main measure of acuity) have higher rates.
- *Facility type:*
  - AL contracted ALFs have higher rates for lower and middle acuity levels.
  - AFHs have higher rates at the highest acuity levels.
  - ARC and EARC rates are lower than other ALF rates for most acuity levels.
- *Geographic area:* Areas that generally have higher costs of living are assigned higher rates. (Urban areas designated as Metropolitan Statistical Areas or MSAs by the U.S. Census Bureau have the highest rates and more rural areas, or "Non-MSAs" have the lowest. King County is an MSA to which an additional rate increment is added.) See map below.



Other Factors Reflecting Additional Service Levels
"Add-ons" or enhancements to the base rates in the schedule are paid for additional services that require specialized training and staffing. This can include specialty dementia care contracts, or services designed to support clients leaving state or local psychiatric hospitals (Expanded Community Services). Because these rate enhancements actually reflect a different level of service not provided by most AFHs or ALFs, these expenditures must be excluded if the desire is to look at similar levels of service.

What other services do clients receive besides residential services?

A client's needs and preferences are determined in their assessment and are part of their care plan. In addition to the type of personal care or "main" personal care service the client will utilize (like in-home care, or community residential care in an AFH or ALF), the plan will also specify the client's use of other services such as Adult Day Health, nursing, or transition services, behavioral supports, etc. These expenditures are only 4 percent of the total ALTSA expenditures for residential clients, but they are critical to support the client in the community vs. a nursing home. (See Appendix A for a full list of the services included in this analysis.)

In most cases, these services are delivered by another provider, not the residential facility. In some cases, such as intermittent nursing at an AL or EARC, these services are done by facility staff, as required by licensing and contract requirements. See table below for which services are considered part of a residential facility's contract, or are done separately by another provider.

The client may also receive non-duplicative supports through other agencies or parts of DSHS (i.e. Medicaid medical care paid by the State Health Care Authority, food assistance through DSHS Economic Services Administration, and federal housing assistance). These other expenditures are not part of this analysis, as data was not complete. Further, focusing on ALTSA expenditures alone, including "other providers" allows an effective comparison of the value of a total ALTSA service package between facility type.

Rates for these other providers are set in a similar way to those for community residential facilities. The base level of funding is a result of historical decisions, increases are subject to authorization and funding by the Legislature, and as with ALFs, there is no collective bargaining.

CLIENT-SPECIFIC SERVICES PAID TO PROVIDERS OTHER THAN RESIDENTIAL FACILITIES MEDICAID FUNDED WAIVER or GRANT SERVICES				
Service Available through Other Provider	**Adult Family Home (AFH) License**	**Assisted Living Facility (ALF) License**		
	AFH Contract	**ARC Contract**	**EARC Contract**	**AL Contract**
Adult Day Health	X		X	X
Specialized Medical Equipment and Supplies	X	X (as allowed by the State Plan)	X	X
Nurse Delegation	X		(no, intermittent nursing is required by EARC contract, so provided by facility RN)	(no, intermittent nursing is required by AL contract, so provided by facility RN)
State Plan Home Health	X	X	X (if not duplicative*)	X (if not duplicative*)
Waiver Skilled Nursing	X	(no, ARCs are not covered as a waiver service)		
Private Duty Nursing	X			
Residential Caregiver/Recipient Training	X		X	X
Residential Caregiver/Recipient Training – Enhanced Community Services	X		X	
Community Transition Service	X	X	X	X
Professional Support Services (available only to RCL clients)	X	X	X	X
Residential Environmental Modifications (available only to RCL clients)	X	X	X	X
Transportation Services (for therapeutic goal, if not covered by brokered transportation or transit)	X	X (if not replacing what is required under contract)	X (if not replacing what is required under contract)	X (if not replacing what is required under contract)
Specialized Psychiatric Services (available only to DDA waiver clients)	X	X	X	X

Why is there interest in comparing residential expenditures?

Washington State faces a growing caseload of long-term clients (as the baby boom ages) requiring a focus on cost effective services. On average, home and community services are more cost effective than nursing home care, in addition to being vastly preferred by clients.

Within home and community services, different providers have had varying success with vendor rate increases with the Legislature, leading to concerns from some providers about equity. While it is easy to compare rates, which are published annually in a schedule, it is more complex to compare expenditures for similar services.

Some residential providers have expressed concerns about how the "cost" of their service is perceived when compared to others. Some stakeholders have suggested looking at average per capita expenditures, considering other service costs outside the residential facility, as part of an overall "client service package".

Analytical Approach and Methodology

This report attempts to compare the *average per capita expenditures* of clients living in residential services by acuity level, including all of a client's ALTSA services. (Note that using average per capita expenditures allows for ease in making comparisons, and that individual clients have higher or lower service expenditures than the average.)

The average per capita expenditures were calculated by determining the amount of total expenditure in FY2016 by residential facility and by acuity level, and dividing this by the average monthly number of clients in each residential facility, by acuity level. FY2016 data is most recent, complete annual expenditure information from the ProviderOne information system. If a client had any residential service in FY2016, their expenditures for both residential services and any other ALTSA services in that month were captured. Totals for residential services by facility type were cross-checked with both the ALTSA budget forecast and Agency Financial Reporting System (AFRS) data.

Acuity level information was obtained from both CARE assessment data and the ProviderOne information systems.

What is Client Responsibility and how is it Used in this Analysis?

Except for rare cases, publicly funded long-term care services are not "free" for clients. The client retains responsibility for covering the cost of their monthly *room and board* (which federal Medicaid funds are not

allowed to cover), typically through their Social Security income. If their (relatively low) income exceeds a certain level, then they also contribute to the cost of their care (this is called *participation*) each month. Under law, clients in residential services are allowed to retain $63 of their monthly income, called the Personal Needs Allowance, to purchase items not included in their room and board, such as postage, beauty/barber services, gifts, etc.

When looking at the *appropriation levels* needed for the state budget, client responsibility can be set aside. However, when studying total expenditures between facilities, it is important to factor it in. If client responsibility is not included, this "under prices" the total expenditure for a client's long-term care and can create false comparisons. (A comparable concept would be a "co-pay" or "premium", without it, the service is not provided.)

In this analysis, we found that client responsibility is much higher for clients living in ALFs, particularly those with Assisted Living (AL) contracts. For AL, 50 percent of the total expenditure was covered by the client; for other ALFs, 43 percent; and for AFHs, 29 percent. However, this is not because of the services, but because of the client's income.

Historically, ALFs have served clients with slightly greater incomes who had income to pay participation as well as room and board. Many ALFs with AL contracts do not accept "new" Medicaid clients, only those who pay privately for a certain period and then become Medicaid eligible later. If AL accepted more Medicaid clients with similar incomes to those with AFH, the pattern of client responsibility would also look more similar.

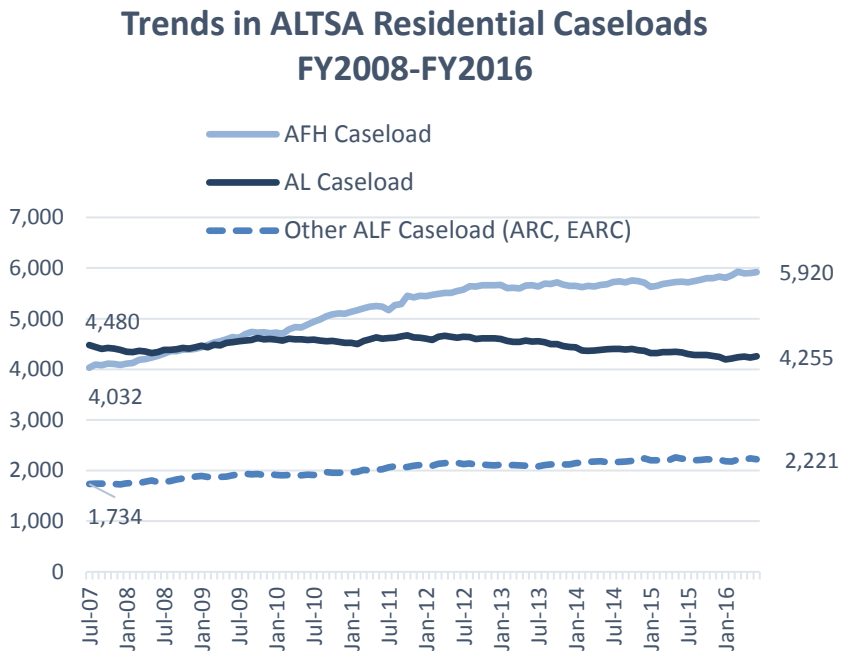
Analysis and Findings

Client Caseloads

Caseloads for ALTSA programs are forecasted by the Caseload Forecast Council. Trends between July 2007 and June 2016 show:

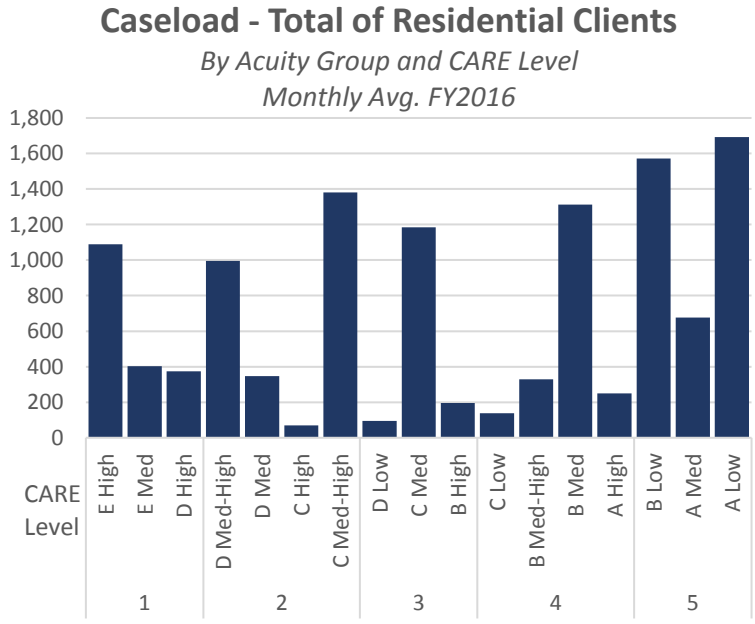
- A 47 percent increase in the AFH caseload (23 percent since FY2010)
- A five percent *decline* in AL caseload (7 percent less since FY2010)
- A 28 percent increase in other ALF caseload (due to more EARCs).

The fact that the AL caseload is declining makes it unique in all of home and community services. AL also has fewer Medicaid contracts, down from a maximum of 356 in FY2008 to 257 in 2016, a 31 percent decline.



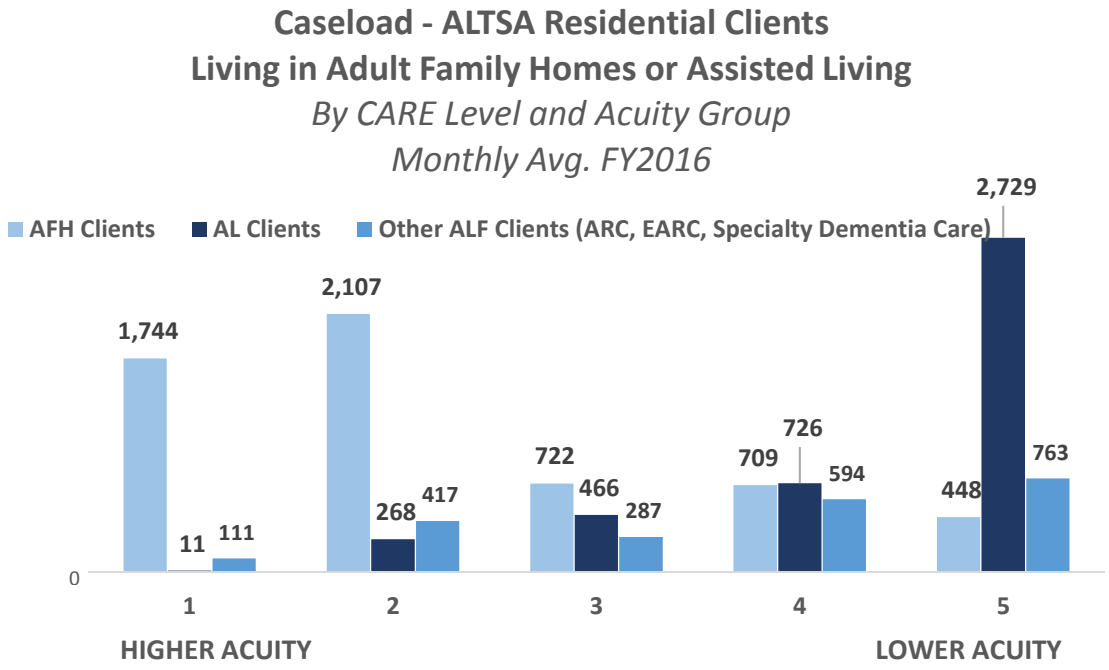
Client Acuity in Community Residential Facilities

As can be seen below, the full range of clients at different CARE acuity levels are served in community residential facilities.



Although most of the facilities (except ARC) should theoretically be able to serve proportionally similar numbers of clients at all acuity levels, we do see distinct patterns by facility type.

- AFHs serve more clients at the highest acuity levels, particularly at the very highest levels, and relatively few at the lower levels.
- AL primarily serves clients at the lowest acuity levels.
- Other ALFs total (ARC, EARC) serve many fewer clients, but in a broader range of acuity levels.

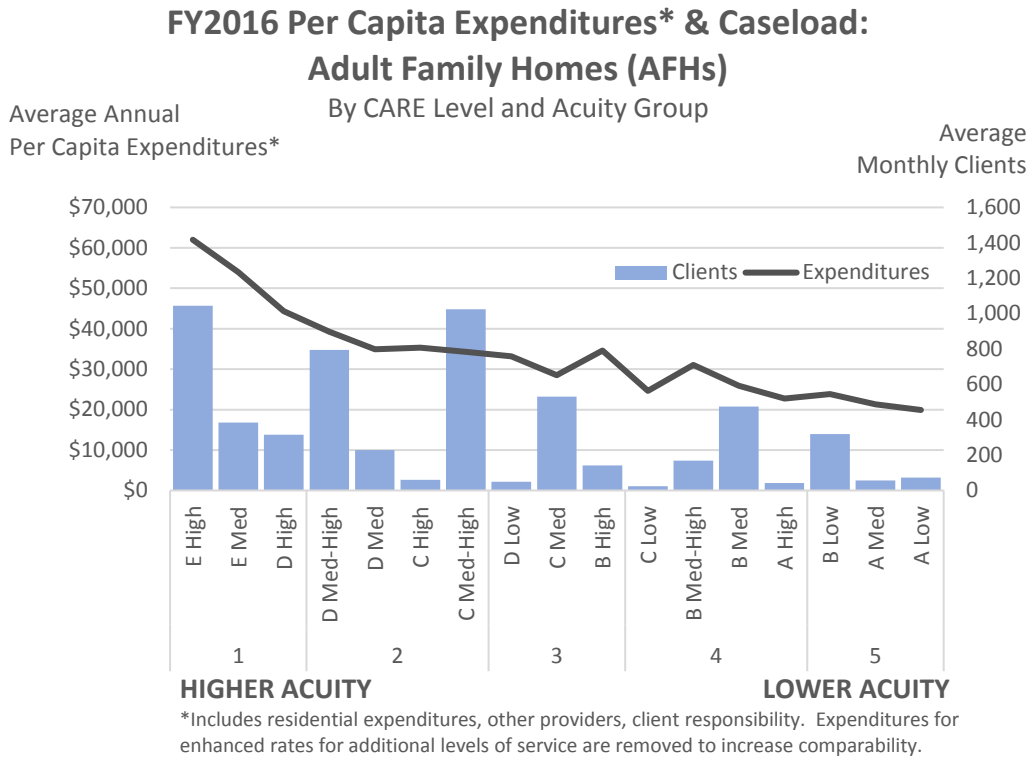


Below is another view of how the facilities compare, further grouping the two highest acuity groups. The proportion of highest to lowest acuity clients for AFH and AL are nearly inverse of each other.

Residential Service	Percent Highest Acuity (Groups 1 and 2)	Percent Lowest Acuity (Group 5)
Adult Family Homes	67%	8%
Assisted Living	7%	65%
ARC	2%	70%
EARC	20%	39%
EARC – Specialty Dementia Care	46%	5%

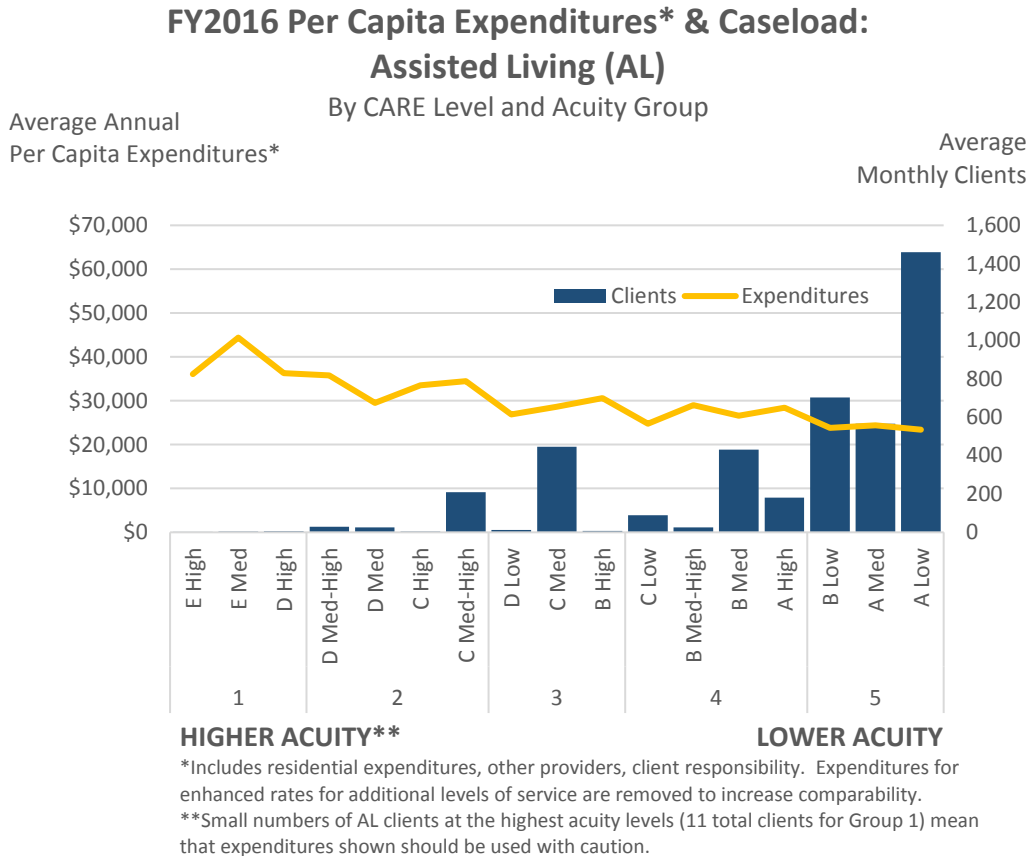
Is there an apparent relationship between caseload by acuity group and per capita expenditures[8]?

See chart below, which includes "other provider" expenditures. AFHs have a high population of high acuity clients, where per capita expenditures for all ALTSA services (and AFH rates) are also the highest.



*Includes residential expenditures, other providers, client responsibility. Expenditures for enhanced rates for additional levels of service are removed to increase comparability.

On the other hand, AL has the most clients at the lowest acuity levels, where per capita expenditures are also the lowest. This suggests that other factors besides expenditures are at work in why there are fewer medium and higher acuity clients living in AL. See chart below.



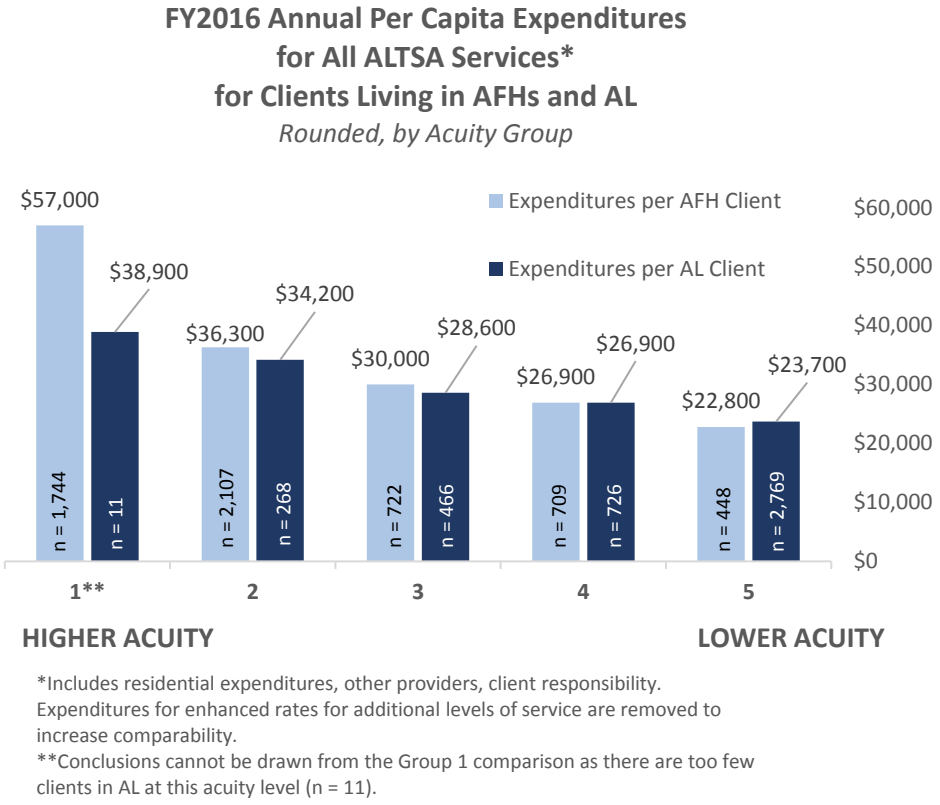
*Includes residential expenditures, other providers, client responsibility. Expenditures for enhanced rates for additional levels of service are removed to increase comparability.
**Small numbers of AL clients at the highest acuity levels (11 total clients for Group 1) mean that expenditures shown should be used with caution.

How do per capita expenditures compare for clients living in different residential facilities?

See chart below. To simplify, rounded annual per capita expenditures by the five larger acuity groups are shown, rather than monthly per capita expenditure and all CARE levels. As above, all ALTSA "other provider" expenditures are included.

- Expenditures per capita for clients living in AFHs are higher than for those living in AL for Groups 1-3, the higher and medium acuity groups. However, conclusions cannot be made about the Group 1 comparison as there are so few clients living in AL in Group 1.
- Group 4 is effectively equivalent (rounding eliminates slight difference).
- For Group 5, lowest acuity, per capita expenditures for clients living in AL are higher than for AFH.

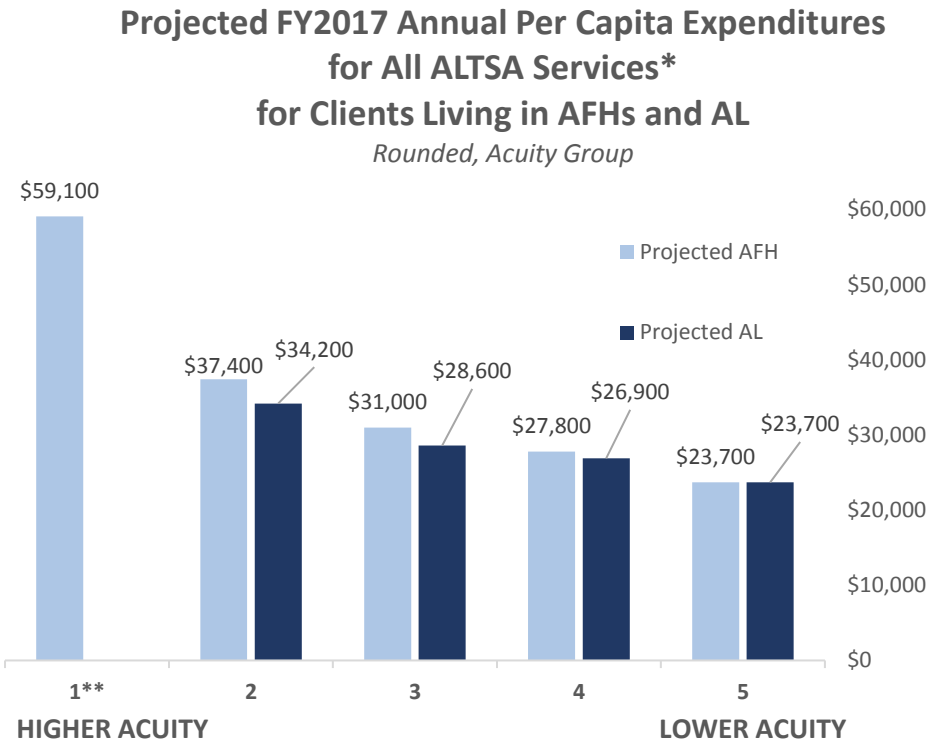
- Without “other provider” expenditures, this chart would look quite different; the differential between AFH and AL would be somewhat less for Groups 1 and 2, and AL would actually appear greater than AFH for Groups 3 and 4 as well.



*Includes residential expenditures, other providers, client responsibility. Expenditures for enhanced rates for additional levels of service are removed to increase comparability.
**Conclusions cannot be drawn from the Group 1 comparison as there are too few clients in AL at this acuity level (n = 11).

How will per capita expenditures look for FY 2017, the current fiscal year?

See chart below. FY2017 rates are already in effect as of July 1, 2016. AFHs received a 5 percent vendor rate increase under the terms of their current collective bargaining agreement. (Other providers did not have increases.) This is projected to increase expenditures for AFH clients by a slightly lower percentage than 5 percent, as other providers also make up total expenditures. With this change, we project that per capita expenditures for clients living in AFH will continue to be greater for Groups 2 and 3, and will also now be greater for Group 4 and effectively equivalent for Group 5. See chart below.



*Includes residential expenditures, other providers, client responsibility. Expenditures for enhanced rates for additional levels of service are removed to increase comparability.
**Insufficient information to make a projection for AL for FY2017, as there are so few AL clients with this level of acuity (11 in FY2016).

Summary and Conclusions

Without making judgements about the appropriate levels of rates or expenditures themselves, the data shows that expenditure levels for clients of similar CARE acuity levels do differ whether the client is served in an AFH or an ALF, and these differences are growing.

At the very highest acuity levels, the difference is difficult to tease out, because there are very few clients living in AL at these levels.

For the second highest and medium acuity levels, the use of "other provider" services such as adult day health, nurse delegation, and skilled nursing result in a higher per capita expenditure for clients in AFHs vs. those living in AL.

For the lowest acuity levels, although FY2016 data shows that per capita expenditures for AL are higher than those for clients in AFH, we also project that rate changes in FY2017 will equalize these expenditures.

More clients will need to be served by ALTSA residential services in the future. AFH caseloads continue to grow and will presumably help meet that need. The combination of a decline in AL contracts, a reduction in AL caseloads, and overall flattening of AL per capita expenditures is concerning.

AL represents an alternative to nursing homes for lower acuity clients who cannot or do not wish to live at home with supports, and also offers an option for clients who would like more privacy than is available in an AFH, or wish to live in a bigger facility. Further, strengthening the AL system may enable more AL clients to "age in place" if their needs increase, or if they are a private pay client in AL converting to Medicaid.

AL are an important component of the long-term services and supports provider network, and in order to have that continue for Medicaid clients, decision-makers may want to consider payment or policy changes.

Appendix A – List of Other Provider Services (FY2016)

Adult Day Health
- Adult Day Health - Day
- Adult Day Health - Intake

Behavior supports and client training
- ECS Behavior Support
- Client Training, non-medical
- Behavior Support - Individual
- Client Training, medical
- Substance Abuse Services
- Psychological Testing

Nursing, Nurse Delegation (no PDN)
- Nurse Delegation
- Skilled Nursing - RN
- Skilled Nursing - Special Circumstances

Transition/discharge support
- Community Choice Guide
- Transition Items
- Transition Services
- Discharge Items
- Residential Care Discharge Services (LTC Manual - Ch 10 Discharge Resources)
- RCL Demonstration Transition Items
- Transition Services: Shopping/paying

Private Duty Nursing
- Private Duty Nursing

Other
- Wellness Education
- Client Reimbursement
- Transportation Expense Reimbursement
- Specialized Goods Purchase Card-State
- Specialized Goods Purchase Card-RCL
- Housing Subsidy
- CFC Client Responsibility Reimbursement
- Adult Day Care - Day
- Specialized Goods Purchase Card-Federal
- Financial Management Services
- Adult Day Care - 15min
- Emergency Rental Assistance
- Nutritional Services

Equipment, assistive technology, supplies, environmental modifications
- Environmental Adaptations Residential
- Non-Medical Equipment & Supplies
- Furniture portion of lift chair
- DME: Bathroom and toileting

DME Miscellaneous
Assistive Technology-CFC
Installation/Maintenance of Non-Medical Equipment
DME: Hospital beds and supplies
Non-Medical Supplies
PERS Service-GPS
DME: Wheelchairs and access
DME: Urinary/incontinence equipment
DME: Mobility aids and supplies
Assistive Technology

Appendix B – Services For ALTSA Clients in Residential Facilities

SERVICES <u>REQUIRED</u> BY RESIDENTIAL FACILITY LICENSE and/or CONTRACT *(Facilities can and do choose to provide services not required by license or contract)*				
Services Required	**Adult Family Home (AFH) License**	**Assisted Living Facility (ALF) License**		
	AFH Contract	**ARC Contract**	**EARC Contract**	**AL Contract**
Personal Care and Supervision[9]	X	X	X	X
Facility Assessment[10]	X	X	X	X
Room & Board[11] (client responsibility must cover)	X	X	X	X
Negotiated Service Agreement (NSA) or Negotiated Care Plan (NCP)[12]	X	X	X	X
Activities[13]	X	X	X	X
Staff training[14]	X	X	X	X
Quality Improvement Committee[15]		X	X	X
Medication Administration[16]	X (by Nurse Delegation)		X	X
Medication Assistance	X	X	X	X
Intermittent Nursing [17]			X	X
Personal care supplies[18]			X	X
Private apartment-like unit[19]				X
Private bathroom				X
Private kitchen area				X
Awake staff 24 hours a day[20]			X w/specialty dementia contract	X w/specialty dementia contract
Secured accessible outdoor area w/ environmental & safety requirement[21]			X w/specialty dementia contract	X w/specialty dementia contract

Appendix C – FY2016 Community Residential Rates

Community Residential Daily Rates Effective July 1, 2015

King County

	AL	AL w Cap Add-On	ARC	EARC	AFH
Classification	Daily Rate	Daily Rate	Daily Rate	Daily Rate	Daily Rate
A Low (1)	$67.22	$72.64	$47.67	$47.67	$49.37
A Med (2)	$72.74	$78.16	$54.03	$54.03	$56.53
A High (3)	$81.57	$86.99	$59.30	$59.30	$63.11
B Low (4)	$67.22	$72.64	$47.67	$47.67	$50.21
B Med (5)	$74.96	$80.38	$60.39	$60.39	$63.41
B Med H (6)	$84.83	$90.25	$64.19	$64.19	$67.85
B High (7)	$89.28	$94.70	$73.31	$73.31	$77.40
C Low (8)	$72.74	$78.16	$54.03	$54.03	$56.53
C Med (9)	$81.57	$86.99	$67.70	$67.70	$71.84
C Med H (10)	$101.43	$106.85	$90.09	$90.09	$93.72
C High (11)	$102.44	$107.86	$90.95	$90.95	$95.01
D Low (12)	$74.96	$80.38	$72.87	$72.87	$73.21
D Med (13)	$83.23	$88.65	$84.35	$84.35	$89.32
D Med H (14)	$107.49	$112.91	$107.13	$107.13	$107.23
D High (15)	$115.79	$121.21	$115.79	$115.79	$121.91
E Med (16)	$139.84	$145.26	$139.84	$139.84	$147.04
E High (17)	$163.89	$169.31	$163.89	$163.89	$172.19

"Metropolitan Counties

	AL	AL w Cap Add-On	ARC	EARC	AFH
Classification	Daily Rate	Daily Rate	Daily Rate	Daily Rate	Daily Rate
A Low (1)	$61.69	$66.61	$47.67	$47.67	$49.37
A Med (2)	$65.02	$69.94	$51.91	$51.91	$54.34
A High (3)	$79.37	$84.29	$56.56	$56.56	$59.81
B Low (4)	$61.69	$66.61	$47.67	$47.67	$50.21
B Med (5)	$70.52	$75.44	$57.22	$57.22	$60.10
B Med H (6)	$79.83	$84.75	$60.81	$60.81	$64.37
B High (7)	$87.07	$91.99	$71.25	$71.25	$75.24
C Low (8)	$65.02	$69.94	$52.12	$52.12	$54.74
C Med (9)	$79.37	$84.29	$66.84	$66.84	$70.12
C Med H (10)	$98.10	$103.02	$83.73	$83.73	$87.17
C High (11)	$99.09	$104.01	$89.04	$89.04	$92.41
D Low (12)	$70.52	$75.44	$71.87	$71.87	$71.62
D Med (13)	$80.98	$85.90	$82.67	$82.67	$86.95
D Med H (14)	$103.98	$108.90	$104.50	$104.50	$103.99
D High (15)	$112.63	$117.55	$112.63	$112.63	$117.98
E Med (16)	$135.52	$140.44	$135.52	$135.52	$141.91
E High (17)	$158.40	$163.32	$158.40	$158.40	$165.84

"Non-Metropolitan Counties

	AL	AL w Cap Add-On	ARC	EARC	AFH
Classification	Daily Rate	Daily Rate	Daily Rate	Daily Rate	Daily Rate
A Low (1)	$60.61	$65.85	$47.67	$47.67	$49.37
A Med (2)	$65.02	$70.26	$50.86	$50.86	$53.26
A High (3)	$79.37	$84.61	$55.66	$55.66	$58.73
B Low (4)	$60.61	$65.85	$47.67	$47.67	$50.21
B Med (5)	$70.52	$75.76	$56.16	$56.16	$59.01
B Med H (6)	$79.83	$85.07	$59.68	$59.68	$63.13
B High (7)	$87.07	$92.31	$67.41	$67.41	$71.23
C Low (8)	$65.02	$70.26	$50.86	$50.86	$53.26
C Med (9)	$79.37	$84.61	$63.20	$63.20	$67.48
C Med H (10)	$98.10	$103.34	$80.54	$80.54	$83.90
C High (11)	$99.09	$104.33	$84.18	$84.18	$87.47
D Low (12)	$70.52	$75.76	$67.96	$67.96	$67.80
D Med (13)	$80.98	$86.22	$78.17	$78.17	$82.29
D Med H (14)	$103.98	$109.22	$98.79	$98.79	$98.41
D High (15)	$106.48	$111.72	$106.48	$106.48	$111.62
E Med (16)	$128.11	$133.35	$128.11	$128.11	$134.23
E High (17)	$149.75	$154.99	$149.75	$149.75	$156.86

** Metropolitan Counties (Urban) Benton, Clark, Franklin, Island, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, and Yakima Counties.

*** Non-Metropolitan Counties: Adams, Asotin, Chelan, Clallam, Columbia, Cowlitz, Douglas, Ferry, Kittitas, Garfield, Grant, Grays Harbor, Jefferson, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, San Juan, Skagit, Skamania, Stevens, Wahkiakum, Walla Walla, and Whitman.

Appendix D – FY2017 Community Residential Rates

Community Residential Daily Rates Effective July 1, 2016

King County

Classification	AL Daily Rate	AL w Cap Add-On Daily Rate	ARC Daily Rate	EARC Daily Rate	AFH Daily Rate
A Low (1)	$67.22	$72.64	$47.67	$47.67	$52.47
A Med (2)	$72.74	$78.16	$54.03	$54.03	$59.36
A High (3)	$81.57	$86.99	$59.30	$59.30	$66.27
B Low (4)	$67.22	$72.64	$47.67	$47.67	$52.72
B Med (5)	$74.96	$80.38	$60.39	$60.39	$66.58
B Med H (6)	$84.83	$90.25	$64.19	$64.19	$71.24
B High (7)	$89.28	$94.70	$73.31	$73.31	$81.27
C Low (8)	$72.74	$78.16	$54.03	$54.03	$59.36
C Med (9)	$81.57	$86.99	$67.70	$67.70	$75.43
C Med H (10)	$101.43	$106.85	$90.09	$90.09	$98.41
C High (11)	$102.44	$107.86	$90.35	$90.35	$99.76
D Low (12)	$74.96	$80.38	$72.87	$72.87	$76.87
D Med (13)	$83.23	$88.65	$84.35	$84.35	$93.79
D Med H (14)	$107.49	$112.91	$107.13	$107.13	$112.59
D High (15)	$115.79	$121.21	$115.79	$115.79	$128.01
E Med (16)	$139.84	$145.26	$139.84	$139.84	$154.39
E High (17)	$163.89	$169.31	$163.89	$163.89	$180.80

"Metropolitan Counties

Classification	AL Daily Rate	AL w Cap Add-On Daily Rate	ARC Daily Rate	EARC Daily Rate	AFH Daily Rate
A Low (1)	$61.69	$66.61	$47.67	$47.67	$52.47
A Med (2)	$65.02	$69.94	$51.91	$51.91	$57.06
A High (3)	$79.37	$84.29	$56.56	$56.56	$62.80
B Low (4)	$61.69	$66.61	$47.67	$47.67	$52.72
B Med (5)	$70.52	$75.44	$57.22	$57.22	$63.11
B Med H (6)	$79.83	$84.75	$60.81	$60.81	$67.59
B High (7)	$87.07	$91.99	$71.25	$71.25	$79.00
C Low (8)	$65.02	$69.94	$52.12	$52.12	$57.48
C Med (9)	$79.37	$84.29	$66.84	$66.84	$73.63
C Med H (10)	$98.10	$103.02	$83.73	$83.73	$91.53
C High (11)	$99.09	$104.01	$89.04	$89.04	$97.03
D Low (12)	$70.52	$75.44	$71.87	$71.87	$75.20
D Med (13)	$80.38	$85.30	$82.67	$82.67	$91.30
D Med H (14)	$103.98	$108.90	$104.50	$104.50	$109.19
D High (15)	$112.63	$117.55	$112.63	$112.63	$123.88
E Med (16)	$135.52	$140.44	$135.52	$135.52	$149.01
E High (17)	$158.40	$163.32	$158.40	$158.40	$174.13

""Non-Metropolitan Counties

Classification	AL Daily Rate	AL w Cap Add-On Daily Rate	ARC Daily Rate	EARC Daily Rate	AFH Daily Rate
A Low (1)	$60.61	$65.85	$47.67	$47.67	$52.47
A Med (2)	$65.02	$70.26	$50.86	$50.86	$55.92
A High (3)	$79.37	$84.61	$55.66	$55.66	$61.67
B Low (4)	$60.61	$65.85	$47.67	$47.67	$52.72
B Med (5)	$70.52	$75.76	$56.16	$56.16	$61.96
B Med H (6)	$79.83	$85.07	$59.68	$59.68	$66.29
B High (7)	$87.07	$92.31	$67.41	$67.41	$74.79
C Low (8)	$65.02	$70.26	$50.86	$50.86	$55.92
C Med (9)	$79.37	$84.61	$63.20	$63.20	$70.85
C Med H (10)	$98.10	$103.34	$80.54	$80.54	$88.10
C High (11)	$99.09	$104.33	$84.18	$84.18	$91.84
D Low (12)	$70.52	$75.76	$67.96	$67.96	$71.19
D Med (13)	$80.38	$86.22	$78.17	$78.17	$86.40
D Med H (14)	$103.98	$109.22	$98.79	$98.79	$103.33
D High (15)	$106.48	$111.72	$106.48	$106.48	$117.20
E Med (16)	$128.11	$133.35	$128.11	$128.11	$140.94
E High (17)	$149.75	$154.99	$149.75	$149.75	$164.70

** Metropolitan Counties (Urban) Benton, Clark, Franklin, Island, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, and Yakima Counties.

*** Non-Metropolitan Counties: Adams, Asotin, Chelan, Clallam, Columbia, Cowlitz, Douglas, Ferry, Garfield, Grant, Grays Harbor, Jefferson, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, San Juan, Skagit, Skamania, Stevens, Wahkiakum, Walla Walla, and Whitman.

Endnotes

[1] This report will focus primarily on ALF with Assisted Living contracts, denoted AL, as it is the bulk of this service sector. References to ALF means all contract types (AL, ARC, or EARC).

[2]This analysis focuses on clients of ALTSA, and does not include clients receiving services from the Division of Developmental Disabilities (DDA), which would need a separate analysis with a different approach. A very low percentage of DDA clients receive services from Assisted Living Facilities (ALFs), and almost none receive services from ALFs with an Assisted Living contract. The most common residential option for clients of DDA, Supported Living, was not included in the Legislative requirement, but would be the most suitable for comparison to AFHs for DDA clients. Further, waiver services for DDA clients and ALTSA clients differ and would make comparisons that blend the two client groups less informative.

[3] Defined as CARE level A-Low, the lowest part of Group 5.

[4] Even if clients in Assisted Living have a CARE level of A-low, they would still need to meet Nursing Facility Level of Care (NFLOC) to be eligible for services in Assisted Living, which means that they could also access care in a nursing home, if they chose.

[5] Defined as CARE level E-High, the highest part of Group 1.

[6] The legislative language requiring the report specifically refers to "Medicaid" clients. This analysis broadly interprets this to mean any client served by ALTSA in community residential services (publicly-funded clients), so that if the payment source is for example, Roads to Community Living (Money Follows the Person federal grant), and not Medicaid, the client and the service expenditures are still included (Medicaid is the vast majority).

[7] FY2016 data from Office of Rates Management, based on the percent of licensed beds that are estimated to be occupied, less average Medicaid residents.

[8] This and the next chart include all ALTSA per capita expenditures except for additional services for enhanced rates.

[9] Personal Care and Supervision: Personal care is available in all residential facilities and defined as assistance to accomplish tasks that residents would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance or cuing and/or supervision to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Personal care includes assistance with bathing, bed mobility, body care, dressing, eating, locomotion, walking, medication management, toileting, transfer and personal hygiene. Personal care also includes incidental activities of daily living, but the need for IADL's alone does not make an individual eligible for service. IADLs include: meal preparation, ordinary housework, essential shopping, travel to medical services, (WAC 388-106-0010 and 388-845-1300).

[10] Facility Assessment: Assisted Living Facilities (ALF) are required by WAC 388-78A-2060 to complete their own preadmission assessment using a Qualified Assessor (WAC 388-78A-2080) prior to admitting any resident and complete a full assessment (WAC 388-78A-2090) at least annually or when the NSA no longer meets the resident's needs. Adult Family Homes (AFH) are required to obtain a written assessment that contains accurate information about the prospective resident's current needs and preferences before admitting a resident to the home (WAC 388-76-10330). The AFH assessment must be completed by a qualified assessor (WAC 388-76-10150) or the department case manager for Medicaid residents, (WAC 388-76-10345). All residential facilities are required to update the assessment when there is a significant change, when the NSA/NCP no longer reflects the current status of the resident, at the resident's request or at least annually (WAC 388-78A-2100 and 388-76-10345).

[11] Room & Board is defined as lodging, food and utilities for a set price. This item is the client's responsibility to pay.

[12] Negotiated Service Agreement (NSA) or Negotiated Care Plan (NCP): The NSA for ALFs or NCP for AFHs are created and used by the provider to determine the service

and care needs of individual residents. The NSA/NCP should detail how services will be delivered to meet resident's choice and needs (WAC 388-78A-2140 and 388-76-10355). The NSA/NCP must be reviewed and revised at least annually, or any time it no longer addresses the needs and preferences of the client (WAC 388-78A-2150 and 388-76-10380). Facilities contracted to provide ECS services must create an individual crisis prevention plan in addition to the NSA or NCP as required by contract.

[13] Activities are defined in WAC 388-78A-2180 for ALF's. This includes a space as well as supplies, equipment and staff support necessary for residents to engage in independent, self-directed or group activities that are appropriate to the setting, consistent with the resident's assessed interests, functional abilities, preferences, and negotiated service agreement. Group activities must be offered at least three times per week by caregivers. The Specialized Dementia Care contract (SDCP) and the Expanded Community Services Contract (ECS) require daily group activities. AFHs are required to provide the same assistance with activities as addressed in Chapters 70.128 70.128.130 RCW and WAC 388-76-10335, 388-76-10510 and 388-76-10620.

[14] Staff training: All long term care workers are required to complete 75 hours of training, specialty training when caring for persons with developmental disabilities, dementia or mental health issues and 12 hours of continuing education (388-112).

[15] Quality Improvement Committee ALFs are required to maintain a quality assurance committee with specific staff involvement in order to maintain and improve the quality of care (388-78A-2460).

[16] Medication Assistance and Administration: All residential facilities should only admit residents who need assistance with medication when there is a system in place to ensure the medication needs of each resident are met related to medications, can ensure medications are received as prescribed and the NSA or NCP documents that the facility is providing medication assistance (WAC 388-106-0010). Medication administration can only be performed by a practitioner or by nurse delegation unless done by a family member or legally appointed representative. (WAC 388-78A-2210 and 388-76-10455).

[17] Intermittent Nursing: (WAC 388-78A-2310), are required by contract in an AL and EARC to provide nursing care to meet the needs of the residents, AFHs who care for a resident in need of nursing services are required to contract with a nurse or nurse delegator if the provider is not licensed under Washington State to provide nursing services (WAC 388-76-10405). Intermittent Nursing Services may include, but is not limited to: medication administration, administration of health treatments, diabetes management, non-routine ostomy care, tube feeding and nurse delegation.

[18] Personal care supplies Personal care supplies are required by AL and EARC contract only (WAC 388-110-150). At no additional cost to the resident, the provider must provide generic personal care items needed by the client such as: soap, shampoo, toilet paper, toothbrush, deodorant, sanitary napkins, and disposable razors. This does not include items covered by medical coupons. It does not preclude clients from choosing to purchase their own personal care items.

[19] Private apartment-like unit, bathroom & kitchen: Assisted Living contracts (AL) are required (WAC 388-110-140) to provide a private apartment-like unit that is a minimum of two hundred twenty square feet, a private bathroom, and a lockable entry door and kitchen area. AFHs are required to have single bedrooms with a minimum of eighty square feet or double occupancy with at least one-hundred twenty square feet, common use areas and shared kitchens (WAC 388-76-106 & 107).

[20] Awake staff 24 hours a day**:** the Specialty Dementia Care contract (WAC 388-110-220(3) requires awake staff 24 hours a day to care persons with dementia. Some Individual client CARE assessments and service plans require awake 24 hour staffing based on client need.

[21] Secured accessible outdoor area w/environmental & safety requirement: the Specialty Dementia Care contract (WAC 388-110-220(3) requires the SDCP contracted facility to provide a secured accessible outdoor area w/environmental & safety requirement to allow for safe wandering.