Contracted Community Residential Services Rate Study Report

SB 5693 Sec. 203 (1)(z)(i)(C)(I-III)

October 25, 2023

Prepared by Milliman for the Washington State Department of Social and Health Services Developmental Disabilities Administration

MILLIMAN REPORT

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Commissioned by the Washington State Department of Social and Health Services

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Table of Contents

Executive Summary

Milliman, Inc. was engaged by the Washington State Department of Social and Health Services Developmental Disabilities Administration to conduct a legislatively-mandated study of Medicaid payment rates for contracted community residential service providers and provide recommendations for alternate and enhanced rate structures for legislative consideration. These providers currently support the ability of approximately 4,100 individuals with developmental disabilities across Washington to live in home and community-based settings.

SB 5693 Sec. 203 (1)(z)(i)(C)(I-III)

Contract with a private vendor for a study of Medicaid rates for contracted community residential service providers. The study must be submitted to the governor and the appropriate committees of the legislature no later than December 1, 2023, and must include:

(I) A recommendation of rates needed for facilities to cover their costs and adequately recruit, train, and retain direct care professionals;

(II) Recommendations for an enhanced rate structure, including when and for whom this rate structure would be appropriate; and

(III) An assessment of options for an alternative, opt-in rate structure for contracted supported living providers who voluntarily serve individuals with complex behaviors, complete additional training, and submit to additional monitoring.

This study included an intensive review of the current payment methodology, analysis of provider costs and wages, interviews with national associations, a review of five other states' approaches and gathering Washington-specific stakeholder feedback via interviews with providers, state associations and individuals receiving services ("client interviews"). Milliman's subcontractor, the University of Washington, conducted the client interviews.

Individuals receiving community residential services vary widely in the amount and type of support needs, and interactions with staff shape much of how each client experiences daily life. Some individuals have complex behavioral support needs, which may involve completing a Functional Assessment, developing a Positive Behavior Support Plan, additional direct support professional training and coaching, use of behavioral technician or enhanced DSP instead of general DSP for some portion of a client's care, and the use of behavioral support specialists for overall oversight, coaching, training and supervision of behavioral support services.

Payment rates for Medicaid services, according to Section 1902 (a)(30)(A) of the Social Security Act, must be "consistent with efficiency, economy, and quality of care". States have significant flexibility within those requirements regarding how payment rates are developed and structured. Washington's current payment system contains "rate tiers" that are structured on a per client day basis and vary based on the level of instruction and support service needs of the individual. Under this system, additional staffing involved with behavioral supports (e.g., 2:1 staffing in some cases) may result in a higher rate tier and providers have the option of negotiating payment rates for individuals with particularly complex behavioral support needs.

Providers have indicated, however, that negotiating payment rates for each individual with complex behavioral support needs is time-intensive and particularly challenging for smaller providers. Additionally, there is a need for the current payment system to explicitly recognize additional recruiting and training for DSP staff to support the PBSP, additional DSP time spent developing a PBSP, wage differentials related to the use of behavioral technician or enhanced DSP to provide direct client support, and the use of behavioral support specialists for overall oversight, coaching, training and supervision of behavioral support services. More broadly, the current payment system also does not tie payments to specific outcomes (e.g., using value-based payment structure such as pay for performance).

Washington's community residential service providers are experiencing notable workforce challenges, in particular in recruiting and retaining DSPs who perform the vast majority of direct care. Providers face increased competition from other market sectors for these employees (e.g., retail and restaurants) which has led to rapidly increasing wages. These challenges are mirrored in the national direct care workforce and have been exacerbated by the COVID-19 public health emergency.

Washington's community residential service providers have experienced significant increases in DSP wages, most notably a cumulative 40% increase in the average DSP wage from $14.38 in 2019 to $20.12 in the second half of 2022. Total program cost growth has outpaced recent payment increases, even with a 23% instruction and support services rate increase effective mid-year 2022. Funding tied to the public health emergency has helped providers cover their costs and increase ISS worker compensation, however, this funding will be phased out by June 2024. In 2022, the ISS and non-ISS payment to expense ratio was 98.6% including COVID-related temporary revenue (used to increase ISS worker compensation). In the absence of this funding, the ISS and non-ISS payment to expense ratio would have been 90.1%.

ISS expenses refer to expenses for direct and indirect services related to providing the assessed level of support and instruction to clients.

Non-ISS expenses are administrative, operating and other non-ISS costs (excluding transportation).

The recommendations resulting from this study, summarized below, are designed to enhance the ability of the tiered rate structure to reflect changes in the costs of service delivery and enhance the ability of providers to serve individuals with complex behavioral support needs. These recommendations also reflect the need to tie payments to value and support DSHS' ability to analyze provider costs and staffing to assess the extent to which changes in payment levels and payment structures are supporting high quality, effective and efficient service delivery.

Legislative Requirement #1: A recommendation of rates needed for facilities to cover their costs and adequately recruit, train and retain direct care professionals.

Primary Recommendations

- **Update current tiered payment rates** to fully reflect increases in ISS and non-ISS expenses, specifically based on calendar year 2022 provider experience and anticipating the continuation of ISS staff compensation increases implemented by providers through the temporary COVID rate increases. This rate update in conjunction with additional funding for behavioral supports described in the next set of recommendations is intended to support the ability of providers to serve existing and new clients.
    - The estimated fiscal impact (including non-federal and federal share) of this recommendation would be approximately $81 million (10.0% of total 2022 payments), based on calendar year 2022 utilization. This rate update would allow providers to continue the enhanced compensation implemented during the pandemic period which providers have indicated has been critical in stabilizing DSP recruitment and retention. For context, the estimated fiscal impact would decrease to approximately $38 million (4.6% of total 2022 payments) if it excludes the portion of the rate updates for providers to continue the expenses for ISS staff compensation increases currently covered by temporary COVID revenue. Legislative action would be required to implement any updates to payment rates.

- The recommendation for updating current tiered payment rates does not include an estimate of cost increases beyond 2022 given the significant amount of uncertainties related to the current inflation environment, workforce shortage and the unwinding impact of public health emergency related to Medicaid financing. We recommend DSHS consider use of a package of key community residential service program metrics to inform future funding changes as described in the recommendation below.
- The timing of the phase-out of the current temporary COVID revenue should be considered when evaluating the timing for this recommendation, if adopted. Temporary COVID revenue is in the process of being phased out, with full phase-out occurring by July 1, 2024.

- **Establish a package of key community residential service program metrics to inform future funding decisions.** This data-driven package of metrics would provide all stakeholders with a commonly understood, standardized summary of key program experience indicators such as client counts (total and for individuals with complex behavioral support needs), client day counts (total and for individuals with complex behavioral support needs), ISS staff full time equivalent counts (total and by ISS staff type), ISS staff turnover rate (total and by ISS staff type), average hourly wages by ISS staff type, ISS staff full time equivalent counts per client day (total and by ISS staff type) and ISS and non-ISS costs and revenues per client day. This package would rely on the existing cost report data collection process and administrative data.
- **Simplify rating regions,** for example, by consolidating Non-King Metropolitan Statistical Area and Non-Metropolitan Statistical Areas into one rating region to simplify the existing regional rate variations.

Secondary Recommendations

- **Refine Schedule E in the current cost report template to collect the full-time equivalent counts and average hourly wage by each ISS staff type, including by type of specialist staff.** This refinement would support development and analysis of key community residential service program metrics specific to staffing and hourly wages.
  - While the current template collects the number of positions, providers employ full and part-time employees. Obtaining the total number of full-time equivalents represented by all positions would support analyses of overall staffing capacity in a consistent manner.
  - Obtaining the average hourly wage by ISS staff type across all staff including new hires and existing hires would provide consistent analysis of overall wage levels by ISS staff type. Currently the cost report collects the average starting wage and the average wage after two years. While these two metrics are supportive of understanding hourly wage dynamics, it is also necessary to consider the overall average hourly wage by staff type.
  - Expanding the existing broad “specialist” staff type included in Schedule E to report data by specialist staff type would support analysis of staffing capacity and wages related to providing behavioral supports.
- **Partner with educational and training institutions to support DSP workforce development.** Encourage high school, community college and university students to become DSPs by partnering with educational and training institutions to offer tailored

courses to individuals seeking to enter the health care field and/or advance their health care careers.

Legislative Requirement #2: Recommendations for an enhanced rate structure, including when and for whom this rate structure would be appropriate.

Legislative Requirement #3: Assessment of options for an alternative, opt-in rate structure for contracted supported living providers who voluntarily serve individuals with complex behaviors, complete additional training and submit to additional monitoring.

The following set of recommendations is responsive to Legislative Requirements #2 and #3 together.

Primary Recommendations

- **Establish a standard set of mutually exclusive add-on per diem payments** available to all providers that reflect the range of approaches (and related costs) involved in supporting individuals with complex behavioral support needs. This recommendation would significantly reduce the need for providers to negotiate payment rates for individuals with complex support needs, which is administratively burdensome.
    - Add-on payments would be available to existing and new clients, with approval tied to individual client characteristics and needs as identified during the assessment process. It is expected that the existing tier 9 payments which providers have individually negotiated with DSHS for clients with complex behavioral support needs will be phased out over time after the implementation of the standardized add-on payments.
    - The fiscal impact of this recommendation is estimated to range from $54 million to $80 million (6.6% - 9.8% of total 2022 payments) and would vary based on specific program and policy decisions and depend on legislative approvals. This estimated fiscal impact is in addition to the estimated fiscal impact of updating tiered rates described above. Note that this estimated fiscal impact does not include new clients outside the existing clients in 2022 nor any potential savings from the anticipated phase-out of the existing payments under payment tier 9 that the providers currently receive from DSHS to support clients with complex behavioral support needs.
- **Develop an incentive-based optional value-based payment structure,** with a long-term goal of requiring all providers to participate. Tying incentive payments to outcomes will support accountability and place the focus of the payment system on the desired outcomes of community residential services. Funding would rely on legislative approval. It would be necessary to develop a framework for this approach, including selecting included outcomes, to determine a fiscal impact. DSHS could consider, for example, outcomes related to:
    - DSP credentialing/training, for example, credentialing offered by National Association for the Dually Diagnosed or by the National Association of Direct Support Professionals.

- Supports for individuals with complex behavioral support needs (e.g., the extent to which clients successfully transition to a lower payment tier based on effective interventions resulting in lower staffing resources)

Secondary Recommendations

- Collect staffing and wage data on behavioral support specialists and other staff with specialized training in behavioral supports. This recommendation will support monitoring of staffing used by providers that receive behavioral support add-on payments and potentially inform analyses related to future value-based payment strategies. The recommendation for Legislative Requirement #1 regarding refining Schedule E in the current cost report template provides additional detail regarding this data collection.

This report is organized into the following sections:

I. Purpose of rate study
II. Key Background, including a summary of the client perspective, prior rate increases, current payment methodology, provider feedback and national trends
III. High level observations
IV. Recommendations
V. Approach to conducting study, including data sources and methodology
VI. Limitations

Additional analyses and research can be found in the following appendices.

Appendix A: Client Interview Report

Appendix B: Summary of Targeted State Research

Appendix C: Provider Financial Performance

Appendix D: Instruction and Support Services Staff Wages and Staffing

Appendix E: Fiscal Impact Analysis

I. Purpose

The Washington State Legislature mandated that DSHS perform a study of Medicaid rates for contracted community residential service providers. This study must provide the following for consideration:[1]

- A recommendation of rates needed for community residential service providers to cover their costs and adequately recruit, train and retain direct support professionals.
- Recommendations for an enhanced rate structure, including when (circumstances) and for whom (type of client) this rate structure would be appropriate.
- An assessment of options for an alternative, opt-in rate structure for contracted supported living providers who voluntarily serve individuals with complex behaviors, complete additional training and submit to additional monitoring.

The study is due to the governor and the appropriate committees of the State Legislature no later than Dec. 1, 2023.

II. Key Background

Community residential service providers support the ability of individuals with developmental disabilities to live in home and community-based settings by delivering a wide range of instruction and support services. Most of this support is provided via supported living services (provided in homes that are owned, rented, or leased by the individual receiving services or their legal representative), with some support also occurring in group homes.[2]

Staff Types Providing Care

- Direct support professionals, also referred to as direct care workers or "entry level" staff, perform the majority of direct care.
- Other key staff positions include 1st line supervisors, program managers, specialists and nurses (Registered Nurses and Licensed Practical Nurses).
- Behavioral support specialists including Board Certified Behavior Analysts.

Some individuals receiving community residential services have complex behavioral support needs, which may involve additional recruiting and training for DSP staff to support the PBSP, additional DSP time spent developing a PBSP, wage differentials related to the use of behavioral technician or enhanced DSP to provide direct client support and the use of behavioral support specialists for overall oversight, coaching, training and supervision of behavioral support services. A high-level analysis of the assessment data provided by DSHS indicates that approximately one third of the clients might have complex behavioral support needs.[3]

Some individuals receiving community residential services may be eligible for a Medicaid behavioral health service called community behavioral health support services.[4] Community behavioral health support service is limited to clients eligible for Home and Community Services only, with a primary diagnosis of mental illness. As most Developmental Disabilities Administration clients have intellectual or developmental disabilities (or related diagnosis) as their primary diagnosis, this service will likely primarily benefit a very small portion of individuals who are in the highest payment tier for residential services. As part of the payment approach,

[1] SB 5693 Sec. 203 (1)(z)(i)(C)(I-III)
[2] Washington Administrative Code 388-101-3000
[3] Based on a high-level analysis of 2022 member level assessment data provided by DSHS using the presence of behavioral score "2" for one or more of the six complex behavioral support indicators which include: emotional outburst, suicide attempt, sexual aggression, property destruction, self-injury, and assaults or injuries to others.
[4] CBHS is a new 1915i service and will replace the current Behavioral Health Personal Care (BHPC) service effective July 1, 2024.

the Washington State Health Care Authority pays a portion of the rate, with DSHS paying the remainder.

CLIENT PERSPECTIVE

The 25 client interviews conducted by the University of Washington team for this study provided insights into community integration and desirable staff qualities for residential services. Interactions with staff shape much of how each client experiences daily life. The relationship between DSPs and the clients they work with is extremely intimate and at times can be complex to navigate for client and staff. Overall, interviews with clients revealed that positive staff interactions were largely characterized by clear communication, patience, shared understanding and care. In contrast, negative interactions were tied to clients feeling a lack of control or autonomy over their daily activities and feeling disrespected by staff. These findings are reflected in clients' clear message that honesty and trust are intertwined with the quantity and quality of communication staff engage in; that being ignored, dismissed, or simply told what to do are experienced as disrespect; and that notions of safety, empowerment and feeling cared for are embedded in particularized treatment. These observations suggest that **specialized expertise among DSPs, whether acquired through training or experience, are a critical component to the quality of life for clients who receive Medicaid-funded residential services**. Appendix A provides the University of Washington's detailed summary of these interviews.

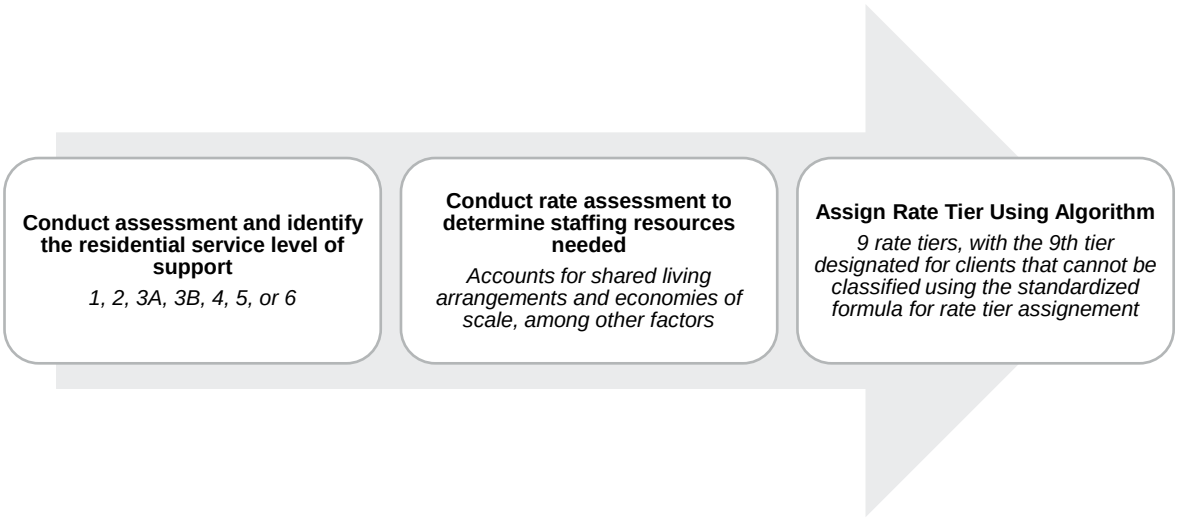
CURRENT RESIDENTIAL SERVICES PAYMENT METHODOLOGY

Payment rates for Medicaid services, according to Section 1902 (a)(30)(A) of the Social Security Act, must be "consistent with efficiency, economy, and quality of care." States have significant flexibility within those requirements regarding how payment rates are developed and structured. Washington's Medicaid reimbursement methodology for community residential services has been in place since January 2019 and include two major payment rate components that vary by rate tier (1-9) and geographic location (King, Metropolitan Statistical Area and Non-Metropolitan Statistical Area):

- **ISS payment rate** – 98% of this rate is comprised of the base rate, with the remainder reflecting the Community Residential Service Training rate. ISS payments are subject to an annual one-sided retrospective settlement process where providers are required to refund the full amount of surplus to DSHS if the eligible ISS costs are less than payments.
- **Non-ISS payment rate** – The base rate also varies by four combinations of service and client types (supported living services for Community Protection Program clients, supported living services for non-Community Protection Program clients, group home services for wheelchair clients, group home services for non-wheelchair clients). Similar to the ISS rate, there is a small component for the Admin/Non-Staff Community Residential Service Training rate.

The rate tier assignment process is illustrated in Exhibit 1 on the following page.

EXHIBIT 1: PAYMENT RATE TIER ASSIGNMENT



Approximately half of all clients fall into rate tiers 4 and 5, and a very small proportion fall into the two highest levels (Exhibit 2 provides additional detail based on the Developmental Disabilities Administration July 2023 Rate Capacity Report). Rate tiers 1-8 correspond to a standardized ISS base rate, with rate tier 9 reflecting exceptional care that requires a negotiated rate based on the unique needs of the individual.

EXHIBIT 2: NUMBER OF CLIENTS BY PAYMENT TIER – JULY 2023

PAYMENT TIER LEVEL	NUMBER OF CLIENTS	PERCENT OF TOTAL
1	245	6%
2	322	8%
3	412	10%
4	866	21%
5	1,246	30%
6	369	9%
7	476	12%
8	68	2%
9	114	3%
Total	**4,118**	

In addition to the daily ISS tiered rate and non-ISS tiered rate as the dominant payment rate components, the final daily rate also includes other rate components as applicable. These additional components include the transportation rate, professional service adjustments, and various miscellaneous client-specific service payments.

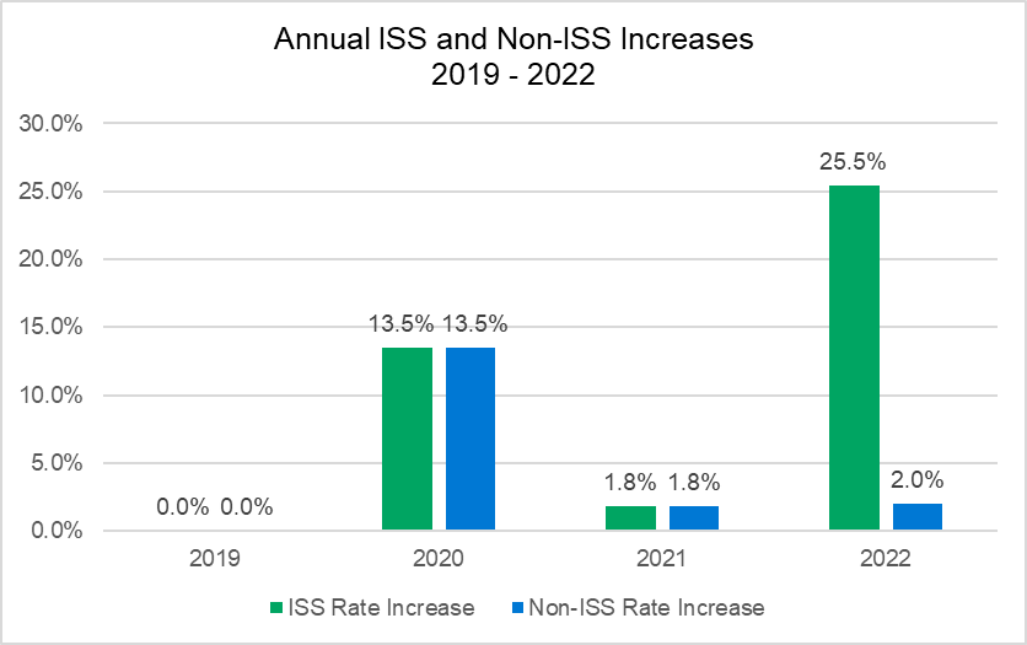
Providers delivering care to individuals with complex behavioral health needs may submit requests for rates that exceed the tier level for consideration by Developmental Disabilities Administration. DSHS is also in the process of developing a legislatively-mandated pilot program for individuals requiring additional staffing due to complex behavioral health needs. This program is still under development but may present an opportunity to explore implementation of some of the recommendations found in this report.

RATE INCREASES

Payment rate increases are separately determined for the ISS and non-ISS rate component. Percentage increases have varied notably from year to year, and the ISS rate increase in 2022 was substantially higher than the non-ISS rate increase. The COVID-19-related temporary rate increase amounts provided prior to 2022 are scheduled to be phased out by June 2024 via a

20% reduction occurring every two quarters in SFYs 2023 and 2024. Exhibit 3 summarizes the rate increases provided by DSHS since January 2019.[5]

EXHIBIT 3: RATE INCREASES SINCE 2019 (NON-COVID RELATED)



PROVIDER FEEDBACK ON CURRENT PAYMENT RATE STRUCTURE

Provider feedback on the current payment approach was collected via interviews with Washington provider associations and the provider group interviews. **Interviewees consistently indicated that the move to a rate tier payment methodology in 2019 was positive overall, although some providers experience the tiering / rate assignment process as opaque.** Interviewees also expressed the following:

- Preference for billing on the current per diem basis as compared to legacy billing method using 15-minute or hourly increments. According to provider feedback, the per diem approach allows for increased flexibility and reduces administrative burden.
- Request for a standardized rate methodology for behavioral supports. Providers indicated that negotiating rates for individuals requiring behavioral supports takes a long time and is inefficient.
- Advocacy for standardized rate updates at predetermined intervals, with specific feedback that such an approach would support provider planning and keep payments current with inflation and related provider cost increases.

NATIONAL TRENDS IN APPROACHES TO PAYING FOR COMMUNITY RESIDENTIAL SERVICES.

Tiered payment structures are a common approach used by states and have included variation in payment rates by provider type, number of individuals served and geographic area. Some states such as Minnesota use customizable rates models that enable significant tailoring of

[5] Summary of rate history increases provided by DSHS on March 3, 2023.

rates by individual need. Specialized negotiated payment rates and “exceptional” rate bands may also be employed to account for particular intensive support needs.

The provider associations that we interviewed advocated for **standardized rate updates at predetermined intervals,** indicating that such an approach would support provider planning and keep payments current with provider costs increases.

Specialized payments for individuals with behavioral support needs vary across states, including separately billed behavior supports services, cost-based rates, negotiated rates and the inclusion of hourly supports in a per diem rate for needs specific to mental health management. For example, Minnesota’s interactive rate model allows for tailoring specific to behavioral health needs, Georgia uses a behavioral support service that is independent of residential and community living supports and paid in 15-minute intervals and California uses customizable rate models for specialized Adult Residential Facilities.

Value-based payment approaches for home and community-based services are still evolving, and the states reviewed for purposes of this rate study primarily focused on quality measure reporting. Some associations indicated that moving to alternative payment models would support an overall focus on value. Association feedback also included the need to move from process measures towards outcomes measures to ensure that people are meeting their personal goals.

Various strategies are being used by states and providers to support professionalizing the DSP workforce, with a specific focus on credentialing, establishing clear career paths and advocating for a standard Bureau of Labor Statistics occupation code for DSPs. While credentialing efforts are often occurring at the provider level, there are state level efforts to require credentialing. For example, New York is implementing a pilot program for DSP and frontline supervisor credentialing, funded by American Rescue Plan Act.[6] Participating DSPs will be able to advance through the three levels of National Association of Direct Support Professionals Certification and, upon completion, will qualify for up to $2,250 in total bonuses through a tiered bonus structure. Frontline supervisors that achieve frontline supervisor certification are eligible to receive a bonus of $1,000.

Medicaid state agencies and providers may also need to comply with new federal requirements regarding DSP compensation as a percentage of Medicaid payments. The Centers for Medicare and Medicaid Services’ proposed Access Rule includes a broad set of new state Medicaid requirements intended to improve access to high-quality home and community-based services. A notable provision in the proposed Access Rule is the requirement that direct care worker compensation represents at least 80% of the Medicaid payment for homemaker, home health aide and personal care services. The Centers for Medicare and Medicaid Services further indicated in the proposed Access Rule that it is possible that a similar percentage threshold could be established for other home and community-based services, including residential services. If a federal direct care worker compensation threshold percentage is established for community residential services, it will be necessary for DSHS to collect and report data to show compliance with this threshold and determine how to address situations where this threshold is not met. Currently, ISS costs represent approximately 87% of total ISS and non-ISS payments (excluding transportation revenue).

Appendix B provides a summary of other state research conducted for this study.

[6] National Association of Direct Support Professionals. August 15, 2022. News: New York State Partners with NADSP to Provide NADSP Certification to 2,400 Direct Support Professionals. Available online: https://nadsp.org/nadsp-news-nadsp-certification-in-nys/#:~:text=The%20pilot%20project%2C%20funded%20through%20the%20American%20Rescue,their%20staff%20the%20opportunity%20to%20achieve%20NADSP%20Certification.

III. High Level Observations

The Milliman team's review of the current payment methodology and Washington stakeholder feedback, analysis of provider costs and wages and interviews with national associations and a review of five other states' approaches has yielded the following key observations.

Overall payment structure. The use of rate tiers under the current Washington Medicaid payment approach allows for variation in payment based on level of need and is consistent with approaches used by other states to tailor payment to client needs. There are limitations under the current approach, however, in that these rate tiers do not explicitly recognize the range of costs related to behavioral supports. The current payment system also does not tie payments to specific outcomes (e.g., using value-based payment structures such as pay for performance).

Geographic variation in provider costs. DSHS currently employs separate rate cohorts for King County, Non-King County Metropolitan Statistical Area and Non-Metropolitan Statistical Area ISS and non-ISS payment rate components. Our analysis indicates that there is an opportunity to streamline the rating regions given the relatively small cost and payment differences observed between the Non-King Metropolitan Statistical Areas and Non-Metropolitan Statistical Areas.

Workforce challenges. The DSP role is physically and mentally demanding as compared to other industries with similar wages, and requires skilled, well-trained workers to effectively support individuals with a wide range of physical and behavior support needs. Providers report experiencing significant workforce challenges, specifically related to recruiting and retaining DSPs, behavioral support specialists and other staff with specialized training in behavioral supports. These challenges – exacerbated by the COVID-19 public health emergency – are mirrored nationwide, driven by relatively low DSP wages, competition from other industries, lack of advancement opportunities, the physical and mental demands of caregiving, among other reasons.

Turnover in 2022 remained high for DSPs working in community residential services as illustrated in Exhibit 4, with providers reporting an increased reliance on overtime and supervisor time to fill staffing needs.

EXHIBIT 4: DEVELOPMENTAL DISABILITIES ADMINISTRATION STAFFING SURVEY AVERAGE TURNOVER RATE BY STAFF TYPE (2022)

	ENTRY LEVEL	1ST LINE SUPERVISORS	PROGRAM MANAGERS	SPECIALISTS	NURSES (RN, LPN)	ALL COMBINED
Supported Living	50%	34%	17%	11%	32%	43%
Group Home	57%	25%	22%	10%	10%	51%

Providers face increased competition from other market sectors (e.g., retail and restaurants) and Washington's community residential service providers have experienced significant increases in ISS worker wages, resulting a cumulative 40% increase in the average DSP wage from $14.38 in 2019 to $20.12 in 2022. The impact of the mid-year payment increase in 2022 can be seen in the increase of DSP wages from $17.89 in the first half of 2022 to $20.12 in the second half of the year. DSP wages in 2022 were higher than home health and personal care aides, and higher or similar to competing occupations in the state. Exhibits 5 and 6 on the following page provide additional detail regarding wage trends and comparison to competing

occupations, with Appendix D providing additional detail on analyses of provider wages and retention.

EXHIBIT 5: DEVELOPMENTAL DISABILITIES ADMINISTRATION STAFFING SURVEY AVERAGE HOURLY WAGES BY YEAR

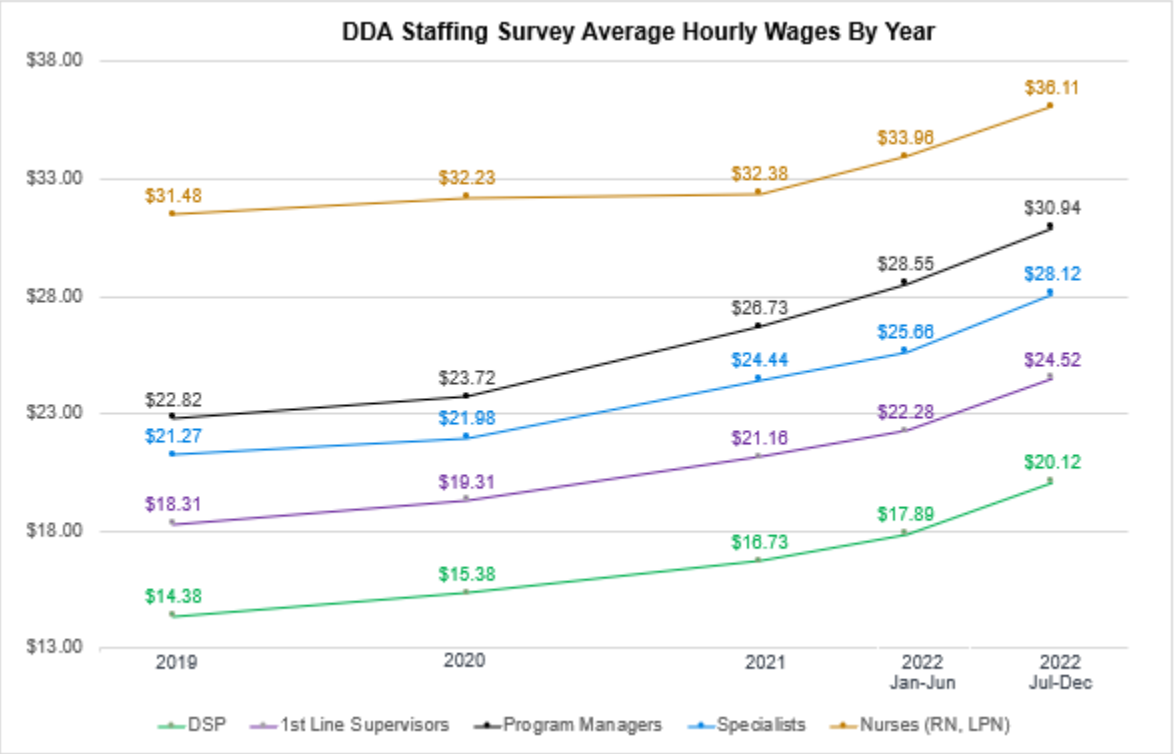


EXHIBIT 6: 2022 AVERAGE HOURLY WAGES BY OCCUPATION – WASHINGTON STATE

Sources: The average DSP wage is from the 2022 Developmental Disabilities Administration Community Residential Staffing Survey (reflecting wages from the second half of 2022), and the remaining hourly wage amounts were from 2022 BLS data from Washington state or state minimum wage data sources. Note that there are two different Seattle minimum wages ($17.27 and $15.75) and we have included the higher one in the exhibit above.

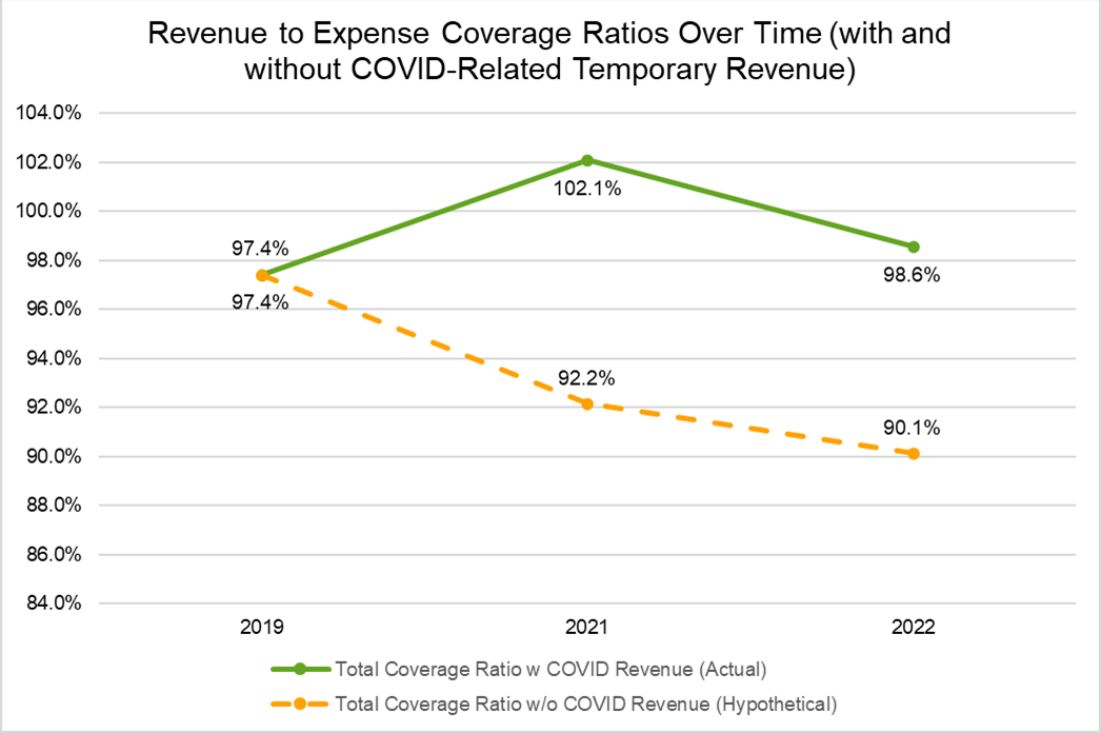
Provider financial performance. COVID payments have had a notable impact on the overall provider revenue to expense ratio (ISS and non-ISS). As illustrated in Exhibit 7 below, total ISS and non-ISS revenues including COVID revenues were 97% of expenses in 2019 as compared to 99% in 2022. In the absence of the COVID revenues, the provider revenue to expense ratio would have decreased from 97% in 2019 to 90% in 2022. The full impact of the recent off-cycle 23% ISS rate increase remains to be seen, however, as this increase was only in effect for the 2nd half of calendar year 2022. Providers have reported that they will need to incur workforce expenses that have been covered to date by COVID revenues (e.g., retention bonuses and ISS wages).

Instruction and support services expenses refer to expenses for direct and indirect services related to providing the assessed level of support and instruction to clients.

Non-ISS expenses are administrative, operating and other costs not specific to ISS (excluding transportation).

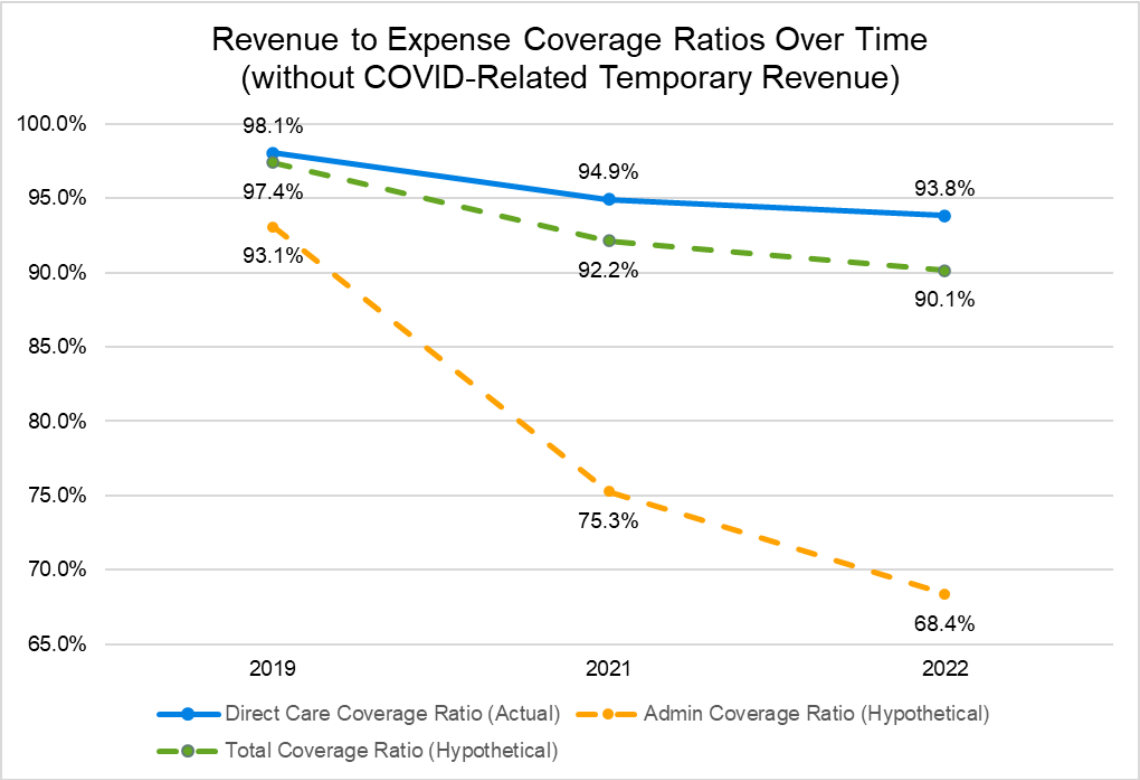
An analysis of the revenue to expense ratio by ISS and non-ISS rate components illustrates how excluding COVID funding would have resulted in a notable difference over time between revenues and expenses for the non-ISS rate component in particular (Exhibit 8). Providers have also reported challenges in recognizing non-ISS costs under the current system, such as costs related to inflation/cost of supplies and liability insurance. Staff interviewed from the Community Protection Provider Association indicated that liability insurance coverage requirements are notably higher for their providers. Appendix C provides additional detail on provider financial performance.

EXHIBIT 7: REVENUE TO EXPENSE COVERAGE RATIOS OVER TIME (WITH AND WITHOUT COVID-RELATED TEMPORARY REVENUE)



Notes: Chart reflects 2019, 2021 and 2022 Developmental Disabilities Administration Residential Support Program Cost Report data. Data from 2020 was not analyzed due to the uniqueness of experience that year. Transportation revenues and expenses are excluded from the calculations as transportation is separately funded outside of the ISS and non-ISS component.

EXHIBIT 8: REVENUE TO EXPENSE COVERAGE RATIOS OVER TIME (WITHOUT COVID-RELATED TEMPORARY REVENUE)



Notes: Chart reflects 2019, 2021 and 2022 Developmental Disabilities Administration Residential Support Program Cost Report data. Data from 2020 was not analyzed due to the uniqueness of experience that year. Transportation revenues and expenses are excluded from the calculations as transportation is separately funded outside of the ISS and non-ISS component.

Importance of ISS staff expertise. Client interviews suggest that specialized expertise among DSPs, whether acquired through training or experience, is a critical component to the quality of life for clients who receive Medicaid-funded community residential services.

Importance of behavioral supports and existing limitations. The intensity of behavioral supports varies widely, and individuals in need of those supports may fall into any of the existing nine payment tiers based on the intensity of their needs and their specific living arrangement (e.g., sharing staff with a housemate). There is a wide range of approaches to supporting clients with complex behavioral support needs (no "one size fits all").

- In some cases, clients can be supported through the development of a PBSP for use by all ISS staff.
- In other cases, one or more of the following may also be needed: Additional training for DSPs, use of behavioral support staff and specialists for some portion of the client's care, or overall increased staffing.

DSHS and providers have reported overall limitations on provider capacity to support individuals with complex behavioral support needs, including:

- Limited ability to recruit and retain behavioral support staff and specialists. Providers interviewed for this study indicated that having these staff types in-agency is key to supporting existing clients with complex behavioral support needs and taking on new clients.

- Difficulty in supporting individuals with behavioral support needs.
- Training and career growth opportunities for DSPs related to behavioral support needs.

Under the current payment approach, providers must negotiate individualized payment rates for individuals with highly complex behavioral support needs, which is time consuming and can be particularly challenging for smaller providers. The current assessment process captures costs related to increased DSP staffing for behavioral support (e.g., 2:1 staffing in some cases). However, the current payment system does not explicitly recognize additional recruiting and training for DSP staff to support the PBSP, additional DSP time spent developing a PBSP, wage differentials related to the use of behavioral technician or enhanced DSP to provide direct client support, and the use of behavioral support specialists for overall oversight, coaching, training and supervision of behavioral support services.

IV. Recommendations

The recommendations resulting from this study are designed to enhance the ability of the tiered rate structure to reflect changes in the costs of service delivery and enhance the ability of providers to serve individuals with behavioral support needs. These recommendations also reflect the need to tie payments to value and allow for ongoing rigorous analysis of provider costs and staffing so that all stakeholders can assess the extent to which changes in payment levels and payment structures are supporting high quality, effective and efficient service delivery. We have organized these recommendations by the applicable legislative requirements and included both primary and secondary recommendations.

Legislative Requirement #1: A recommendation of rates needed for facilities to cover their costs and adequately recruit, train and retain direct care professionals.

Primary Recommendations

- **Update current tiered payment rates** to fully reflect increases in ISS and non-ISS expenses, specifically based on calendar year 2022 provider experience and anticipating the continuation of ISS staff compensation increases implemented by providers through the temporary COVID rate increases. This rate update in conjunction with additional funding for behavioral supports described in the next set of recommendations is intended to support the ability of providers to serve existing and new clients.
    - The estimated fiscal impact (including non-federal and federal share) of this recommendation would be approximately $81 million (10.0% of total 2022 payments), based on calendar year 2022 utilization. This rate update would allow providers to continue the enhanced compensation implemented during the pandemic period which providers have indicated has been critical in stabilizing DSP recruitment and retention. For context, the estimated fiscal impact would decrease to approximately $38 million (4.6% of total 2022 payments) if it excludes the portion of the rate updates for providers to continue the expenses for ISS staff compensation increases currently covered by temporary COVID revenue. Legislative action would be required to implement any updates to payment rates.
    - The recommendation for updating current tiered payment rates does not include an estimate of cost increases beyond 2022 given the significant amount of

uncertainties related to the current inflation environment, workforce shortage and the unwinding impact of public health emergency related to Medicaid financing. We recommend DSHS consider use of a package of key community residential service program metrics to inform funding changes beyond 2022 as described in the recommendation below.

    - The timing of the phase-out of the current temporary COVID revenue should be considered when evaluating the timing for this recommendation, if adopted. Temporary COVID revenue is in the process of being phased out, with full phase-out occurring by July 1, 2024.

- **Establish a package of key community residential service program metrics to inform future funding decisions.** This data-driven package of metrics would provide all stakeholders with a commonly understood, standardized summary of key program experience indicators such as client counts (total and for individuals with complex behavioral support needs), client day counts (total and for individuals with complex behavioral support needs), ISS staff full time equivalent counts (total and by ISS staff type), ISS staff turnover rate (total and by ISS staff type), average hourly wages by ISS staff type, ISS staff full time equivalent counts per client day (total and by ISS staff type) and ISS and non-ISS costs and revenues per client day. This package would rely on the existing cost report data collection process and administrative data.
- **Simplify rating regions, for example, by consolidating Non-King Metropolitan Statistical Areas and Non-Metropolitan Statistical Areas into one rating region to simplify the existing regional rate variations.** This consolidation could help simplify the payment rate methodology while maintaining an equitable payment rate system that recognizes notable cost variations between King County and other areas. Although Non-Metropolitan Statistical Areas represent a geographically significant portion of the state, the client days paid for this region only accounts for approximately 7% of total client days based on calendar year 2022 cost report data, as compared to approximately 68% for Non-King Metropolitan Statistical Areas. Additionally, the reported DSP wage differences are less than 1% between Metropolitan Statistical Areas and Non-Metropolitan Statistical Areas based on 2022 Washington Community Residential staffing survey data. On the payment side, the rate differences between Non-King Metropolitan Statistical Areas and Non-Metropolitan Statistical Areas are generally less than 2.0% based on the most current payment rates effective January 1, 2023. This relatively small difference presents an opportunity to simplify the current rating regions through consolidation and refinement.

Secondary Recommendations

- **Refine Schedule E in the current cost report template to collect the full-time equivalent counts and average hourly wage by each ISS staff type, including by type of specialist staff.** This refinement would support development and analysis of key community residential service program metrics specific to staffing and hourly wages.
    - While the current template collects the number of positions, providers employ full and part-time employees. Obtaining the total number of full-time equivalents represented by all positions would support analyses of overall staffing capacity in a consistent manner.
    - Obtaining the average hourly wage by ISS staff type across all staff including new hires and existing hires would provide consistent analysis of overall wage

levels by ISS staff type. Currently the cost report collects the average starting wage and the average wage after two years. While these two metrics are supportive of understanding hourly wage dynamics, it is also necessary to consider the overall average hourly wage by staff type.

  - Expanding the existing broad "specialist" staff type included in Schedule E to report data by specialist staff type would support analysis of staffing capacity and wages related to providing behavioral supports.

- **Partner with educational and training institutions to support DSP workforce development.** Encourage high school, community college and university students to seek a career path as a DSP by partnering with educational and training institutions to offer tailored courses to individuals seeking to enter the health care field and/or advance their health care careers. Consider use of a credentialing program that could be connected to specific wage levels or wage increases funded through the Medicaid program. DSHS could also expand on its current efforts to encourage individuals to join the home and community-based services workforce (e.g., YouTube video, brochure and frequently asked questions on the DSHS webpage) via a formal public marketing campaign.

Legislative Requirement #2: Recommendations for an enhanced rate structure, including when and for whom this rate structure would be appropriate.

Legislative Requirement #3: Assessment of options for an alternative, opt-in rate structure for contracted supported living providers who voluntarily serve individuals with complex behaviors, complete additional training and submit to additional monitoring.

The following set of recommendations is responsive to Legislative Requirements #2 and #3 together.

Primary Recommendations

- **Establish a standard set of mutually exclusive add-on per diem payments** available to all providers that reflect the range of approaches (and related costs) involved in supporting individuals with complex behavioral support needs. This recommendation would significantly reduce the need for providers to negotiate payment rates for individuals with complex support needs, which is administratively burdensome.
  - Add-on payments would be available to existing and new clients, with approval tied to individual client characteristics and needs as identified during the assessment process. It is expected that the existing tier 9 payments which providers have individually negotiated with DSHS for clients with complex behavioral support needs will be phased out over time after the implementation of the standardized add-on payments.
  - Exhibit 9 provides an example of how these add-on payments could be structured with a final structure and related eligibility and staffing qualifications dependent on DSHS program and policy decisions. The example in Exhibit 9 includes the use of an "enhanced DSP" staff type, defined as a behavioral technician or a DSP that completes a DSHS-approved credentialing program

related to behavioral supports. The enhanced DSP is assumed to receive a higher wage than DSPs, per feedback received from providers.

- The fiscal impact of this recommendation (based on the structure identified in Exhibit 9) is estimated to range from $54 million to $80 million (6.6% - 9.8% of total 2022 payments) and would vary based on specific program and policy decisions and depend on legislative approvals. This estimated fiscal impact is in addition to the estimated fiscal impact of updating tiered rates described above. Note that this estimated fiscal impact does not include new clients outside the existing clients in 2022 nor any potential savings from the anticipated phase-out of the existing payments under payment tier 9 that the providers currently receive from DSHS to support clients with complex behavioral support needs.

EXHIBIT 9: EXAMPLE OF AN POTENTIAL APPROACH TO ADD-ONS FOR BEHAVIORAL SUPPORTS

	LEVEL A	LEVEL B	LEVEL C
Eligibility	Individuals with a PBSP, with the need for the additional indirect care hours documented in the respective Person-Centered Service Plan.	Individuals with a PBSP and in need of behavioral supports due to one or more of the below: • Frequent crisis contacts for possible mental health detention. • Frequent and negative interactions with community members. • Frequent use of emergency services. • Persistent contact or risk of contact with law enforcement. • Documented behavior of frequency or intensity that puts them or the community at risk.	Individuals with a PBSP and in need of direct support from a behavioral analytic/technician, and behavioral support specialist (e.g., Board Certified Behavior Analyst level) due to one or more of the below: • Frequent crisis contacts for possible mental health detention. • Frequent and negative interactions with community members. • Frequent use of emergency services. • Persistent contact or risk of contact with law enforcement. • Documented behavior of frequency or intensity that puts them or the community at risk.
Additional hours to support enhanced coordination and documentation related to behavioral support needs, i.e., development of a PBSP	DSP time with oversight from a behavioral support specialist (e.g., Board Certified Behavior Analyst level)	DSP time with oversight from a behavioral support specialist (e.g., Board Certified Behavior Analyst level)	Behavioral support specialist (e.g., Board Certified Behavior Analyst level)
Enhanced staffing		Partial replacement of DSP hours with hours from an enhanced DSP	Full replacement of DSP hours with hours from an enhanced DSP
Supervision, training and coaching of DSP regarding behavioral support needs. Includes hands-on training, modeling and skill development		Provided by behavioral support specialist (e.g., Board Certified Behavior Analyst level)	Provided by behavioral support specialist (e.g., Board Certified Behavior Analyst level)

- **Develop an incentive-based optional value-based payment structure,** with a long-term goal of requiring all providers to participate. Tying incentive payments to outcomes will support accountability and place the focus of the payment system on the desired outcomes of community residential services. Funding would rely on legislative approval. It would be necessary to develop a framework for this approach, including selecting included outcomes, to determine a fiscal impact. DSHS could consider, for example, outcomes related to:
    - DSP credentialing/training, for example credentialing offered by the National Association for the Dually Diagnosed or by the National Association of Direct Support Professionals.
    - Supports for individuals with complex behavioral support needs (e.g., the extent to which clients successfully transition to a lower payment tier based on effective interventions resulting in lower staffing resources).

Secondary Recommendation

- **Collect staffing and wage data on behavioral support specialists and other staff with specialized training in behavioral supports.** This recommendation will support monitoring of staffing used by providers that receive behavioral support add-on payments and potentially inform analyses related to future value-based payment strategies. The recommendation for Legislative Requirement #1 regarding refining Schedule E in the current cost report template provides additional detail regarding this data collection.

V. Approach to Conducting Study

The approach to conducting this study includes reviewing the current reimbursement methodology, gathering Washington-specific stakeholder feedback, conducting analyses of provider costs and staffing and reviewing other state payment methodologies for these important services. We describe this approach in more detail below.

REVIEW OF CURRENT REIMBURSEMENT METHODOLOGY

We based on our review of the current community residential services reimbursement methodology on relevant sections of the Washington Administrative Code and DSHS Developmental Disabilities Administration policies and payment rate-related communications.

WASHINGTON-SPECIFIC STAKEHOLDER FEEDBACK

We obtained a wide range of stakeholder feedback via interviews including providers, Washington state associations and individuals receiving services, as described below.

Provider Interviews (April and September 2023)

Community residential service providers were asked to participate in two rounds of group interviews to share their perspectives on DSHS' payment methodology and the related challenges and costs of service delivery.

For the first round of interviews in April 2023, we held separate group interviews based on provider type, size and support of individuals with complex behavioral support needs, specifically:

- Group homes.
- Large supported living providers (60+ clients).
- Medium/small supported living providers (less than 60 clients).
- Providers supporting individuals with complex behavioral support needs.

Some providers were asked to participate in more than one group depending on their size, services offered and the extent to which they support individuals with complex behavioral support needs.

We held a provider interview kick-off meeting in January 2023 to communicate the purpose of the interviews and review a supplemental Excel-based data request for all interviewees to complete. This data request collected information on 2022 wages and staffing and training needs, including staffing and training specific to individuals with complex behavioral support needs. Our analysis of this data helped inform the questions for the first round of provider interviews, which were held in April 2023.

The second round of interviews was held in September 2023, with the following two groups of providers:

- Providers reflect a mix of group homes, large supported living providers (60+ clients) and medium/small support living providers (less than 60 clients).
- Providers supporting individuals with complex behavioral support needs.

Some providers participated in both interviews depending on the extent to which they support individuals with complex behavioral support needs.

During these interviews, we obtained feedback on high level observations resulting from the rate study and draft recommendations. For all interviews, providers were given the opportunity to provide additional information or feedback after the interview.

State Association Interviews (January 2023)

We interviewed key staff from Washington's Community Residential Services Association and Community Protection Provider Association to obtain feedback on the following topics:

- Advocacy priorities.
- Notable challenges and successful strategies related to supporting and expanding the DSP workforce, including those specific to individuals with complex behavioral support needs or receiving services via the Community Protection Program.
- Supportive payment rate structure/strategies for building a DSP workforce.
- Payment approaches for individuals with complex behavioral needs.
- Alternative payment methods for community residential services that promote outcomes for value-based care.

Client Interviews (October 2022 to May 2023)

The University of Washington team conducted interviews with 25 individuals receiving Medicaid-funded community residential services. Information gathered during these interviews was intended to provide perspective on the quality, adequacy and appropriateness of community residential services received in Washington. These interviews were required by Milliman's contract with DSHS and conducted with DSHS' support.

Working with DSHS staff, the University of Washington team identified clients with behavioral support needs who typically require 24-hour support services. DSHS staff sent letters to these clients informing them of the study and the potential to be contacted by University of Washington. The University of Washington team drew two samples from the client list, ultimately identifying 316 clients maximizing variation across region, type of program and client demographic characteristics.

University of Washington recruiters contacted just over 300 clients via a combination of phone calls, emails and letters explaining the purpose of the study, offering to conduct interviews in-person or via the video conferencing platform Zoom. Clients were compensated with a $50 gift card at completion of the interview. Despite accommodations in place, recruiters encountered numerous barriers to participation when contacting clients, at times resulting in modified participation from clients due to limited communication capacities. Among the 25 clients interviewed, just over one-third (36%) were women; the majority (87%) were white, 4% were Black, 4% were Asian and the remaining 5% chose not to disclose their race. The majority (64%) were men. This distribution of gender, race and ethnicity among the clients interviewed is consistent with the population identified for interview purposes, with somewhat more men. The 25 interviews conducted, and subsequent findings, are not representative or generalizable of clients receiving Medicaid-funded community residential services in Washington; rather, the interviews provide 25 exploratory cases into how clients may understand their experiences within these services.

Appendix A provides a detailed report of the results of the interviews. We have also included key observations from the provider and state association interviews in the relevant sections of this report.

ANALYSIS OF PROVIDER COSTS AND STAFFING

We conducted an analysis of provider costs and related staffing using a wide range of data, as described in Exhibit 10 for primary data sources by key area of analysis. Appendix C provides additional details of the analyses.

EXHIBIT 10: SUMMARY OF DATA SOURCES USED IN ANALYSIS

DATA SOURCE	PROVIDER MEDICAID REVENUE AND EXPENSE ANALYSES	WAGE ANALYSES	STAFFING ANALYSES
Bureau of Labor Statistics wage data		2019-2022 National, Washington and Metropolitan Statistical Area	
Developmental Disabilities Administration Community Residential Provider Cost Reports	2019, 2021, 2022	2021	

DATA SOURCE	PROVIDER MEDICAID REVENUE AND EXPENSE ANALYSES	WAGE ANALYSES	STAFFING ANALYSES
Developmental Disabilities Administration Community Residential Staffing Survey data		2019 – 2022	2019, 2021, 2022
Washington and Seattle minimum wage amounts		2019 – 2022	

NATIONAL ENVIRONMENTAL SCAN

The development of the rate study included a national environmental scan to better understand other states' payment strategies and approaches, DSP workforce challenges and opportunities, alternative payment methods and overall trends across states.

Interviews with National Associations (Dec 2022 - Jan 2023)

We interviewed key staff from select national associations dedicated to supporting providers, DSPs and state leadership responsible for providing services to individuals with intellectual and developmental disabilities, specifically:

- American Network of Community Options and Resources.
- National Association of Direct Support Professionals.
- National Association of State Directors Developmental Disabilities Services.

Interview topics included innovation in payment rate model approaches, the evolution of current payment systems for community residential services, workforce challenges and related solutions, the use of enhanced payment rates for behavioral health needs and alternative payment models.

Other State Payment Methodologies

We reviewed payment approaches for community residential services for a targeted group of states: California, Colorado, Georgia, Minnesota and Oregon. The selection of these states reflected discussions with DSHS and was intended to observe a range of payment approaches and consider the perspective of neighboring states and states with similar geographic characteristics.

Review of Proposed Federal Access Rule

We reviewed the Centers for Medicare and Medicaid Services' notice of proposed rulemaking titled "Medicaid Program; Ensuring Access to Medicaid Services".[7] This proposed rule includes, among other provisions, new reporting requirements for home and community-based services and a requirement that direct care worker compensation represent at least 80% of the Medicaid payment for homemaker, home health aide and personal care services. The proposed rule also includes language indicated that the Centers for Medicare and Medicaid Services is considering applying a similar requirement to other home and community-based services.

[7] Centers for Medicare and Medicaid Services, "Medicaid Program; Ensuring Access to Medicaid Services", 88 Fed. Reg. 27960 (May 3, 2023) proposed rule. See https://www.govinfo.gov/content/pkg/FR-2023-05-03/pdf/2023-08959.pdf.

Limitations

The information contained in this report has been prepared for the Washington State Department of Social and Health Services for the legislatively-mandated Rate Study for Contracted Community Residential Services. This report may not be appropriate for other purposes. The terms of Milliman's contract 2234-42497 with DSHS apply to this report and its use.

To the extent that the information contained in this report is provided to third parties, the report should be distributed in its entirety.

The contents of this report are not intended to represent a legal or professional opinion or interpretation on any matters. Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for the Washington State Department of Social and Health Services by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has developed certain models to estimate the values included in this report. The intent of the models is to perform various analyses included in this report. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose.

In preparing this report, we relied on information provided by the Washington State Department of Social and Health Services and the U.S. Bureau of Labor Statistics. We accepted this information without audit, but reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate. This report also included collecting and reviewing feedback from a wide range of stakeholders, including providers, associations and individuals receiving services. The stakeholder feedback summarized in this report does not reflect the opinions of Milliman and is presented to provide additional context for this study.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The responsible actuary for this report, Mac Xu, is a member of the American Academy of Actuaries and meets the qualification standards for developing this report.

Appendix A: Client Interview Report

The University of Washington
Center for Technology and Disability

Washington State Department of Social and Health Services Development Disabilities Administration Client Interview Report

Oct. 25, 2023

Heather D. Evans, PhD
Ryan DeCarsky, Doctoral Student
Hannah Kaufman, MPH, PhD
Mark Harniss, PhD

This report was commissioned by the Washington State Department of Social and Health Services as part of a larger project. Milliman led a *Rate Study for Contracted Community Residential Services* and subcontracted with the University of Washington for the client interviews. Special thanks to Valerie Kindschy, Megan Kwak and Kenneth Callaghan at the Washington State Department of Social and Health Services for their assistance in recruiting Developmental Disability Administration clients for interviews.

Acknowledgements

We would like to thank all the clients and Washington state providers who helped facilitate this report. In addition, we would like to express our deep gratitude to the Director of the University of Washington Employment Program, Katherine Bournelis, MA, CRC, for facilitating the piloting of our interview protocol with community members with intellectual and developmental disabilities in the University of Washington Employment Program and to Lee Olsen for recruitment services. Partial support for this research in the form of computing and data analysis software came from the Center for Studies in Demography & Ecology at the University of Washington, supported by a Eunice Kennedy Shriver National Institute of Child Health and Human Development research infrastructure grant, P2C HD042828. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

Table of Contents

Executive Summary

The University of Washington conducted interviews with 25 individuals receiving Medicaid-funded community residential services as part of Washington state's legislatively-mandated *Rate Study for Contracted Community Residential Services*. Information gathered from these interviews was intended to provide perspectives on the client experience of community residential programing received across Washington state, providing insights to inform potential changes to the current payment rate methodology. Working with staff from the Washington State Department of Social and Health Services, the UW team identified clients with behavioral support needs who typically require 24-hour support services. DSHS staff sent letters to these clients informing them of the study and the potential to be contacted by UW. The UW team drew two samples from the client list (N=3,444), ultimately identifying a pool of 316 clients from which to sample, maximizing variation across region, type of program and client demographic characteristics. The 25 interviews conducted, and subsequent findings, are not generalizable to all clients receiving Medicaid-funded community residential services in Washington; rather, the interviews provide 25 exploratory cases into how clients understand their experiences within these services.

The client interviews conducted for this rate study provided insights into community integration and desirable staff qualities. Interactions with staff shape much of how each client experiences daily life. The relationship between Direct Support Professionals and the clients they work with is extremely intimate and at times can be complex to navigate for client and staff. Overall, interviews with clients revealed that positive staff interactions were largely characterized by clear communication, patience, shared understanding and care. In contrast, negative interactions were tied to clients feeling a lack of control over their daily activities or disrespect by staff. These findings are reflected in clients' clear message that honesty and trust are intertwined with the quantity and quality of communication staff engage in; that being ignored, dismissed or simply told what to do are experienced as disrespect; and those perceptions of safety, empowerment and feeling cared for are embedded in particularized treatment. These observations suggest that specialized expertise among direct support professional staff, whether acquired through training or experience, are a critical component to the quality of life for clients who receive Medicaid-funded residential services. The remainder of the section provides additional context for this observation.

Community Integration: Opportunities to Socialize with Others

Clients' descriptions of their daily activities provided a window into their opportunities to socialize with other clients in the program (e.g., organized crafting events or potluck socials), and people outside of the program (through activities such as bowling or visits to the local library). While most clients conveyed contentment with their opportunities to interact with community members, some clients indicated they would attend more events or spend more time in the community if they could. These clients reported two primary barriers to further community engagement: lack of transportation to events and not enough staff available to spend long amounts of time away from

the home for those with housemates. A small minority of clients also described reluctance to spend much time away from their home, preferring social interaction with online friends such as video gaming communities.

Many clients noted that they did not have enough money to go out to eat, shop or engage in costly activities as often as they might like. Clients with the experience of living in multiple towns or cities juxtaposed the availability of specific events or activities available to them in those places. More frequently, clients pointed to staff barriers to engaging in as many activities as they would like. These barriers include staff without the ability to drive (either because they do not drive or because there was not a vehicle available), staff who did not have the time to engage in one-on-one time with a client and staff who did not appear "interested" in activities preferred by the client. Conversely, a small number of clients relayed that they were not allowed enough privacy to engage in the activities they wanted, such as being allowed to go on dates by themselves. Notably, the interviews are absent any mentions of disability stigma or overt discrimination experiences as barriers to engagement in clients' local communities.

Desirable Staff Qualities: Be a Good Person

As part of the interview process, all clients were asked the hypothetical: if we were to hire another staff person to work with you, what qualities should we look for in that new staff person? Most clients' first response indicated demeanor was of utmost importance, with "kind", "nice" or "caring" listed as the most frequent descriptors. Several clients said that a good staff member should simply "be a good person." The next most frequent response focused on communication. Nearly all clients discussed the need for staff to be "a good listener", to talk with clients (e.g., asking questions, offering options, showing interest in clients' stories, not ignoring clients' attempts at conversation.) Several clients emphasized not only the quantity of communication with their staff but the quality, focusing on the need for honest, trustworthy staff that could be relied on as confidants who would not disclose their private affairs or spread gossip. Although only a few clients indicated a staff member should be able to drive, those who did list that quality emphasized its importance.

Many clients also indicated that staff should have a good sense of humor, enjoy joking around and ideally "be fun." These qualities were frequently juxtaposed with staff who "are stressed out". Anecdotes and examples of interactions show that clients are very aware of and sensitive to staff who are stressed and overburdened. Numerous clients described how high staff turnover, or instances when there weren't enough staff, creates a lot of stress and pressure for staff members, dulling their ability to engage with clients and forcing them to spend all their time doing administrative tasks. Several clients shared concerns that staff are not paid enough, not paid frequently enough (two clients mentioned that staff are only paid once per month) and expressed worry that the staff they liked working with the most might not be able to continue working with the client due to financial constraints.

Asking clients to describe desirable staff qualities prompted reflections on undesirable staff qualities, often shared through examples of prior negative interactions. Examples shared by

clients in the study are not an exhaustive list of experiences with direct support professionals; instead, the negative interactions with staff draw attention to behavior types that caused clients concern and may be areas for future consideration by stakeholders. Roughly one-third of clients shared examples of staff qualities that are not appreciated when providing support, such as behavior clients described as “bossy”, rude, or sarcastic. Many clients reinforced the importance and desire of communication by sharing concerns about staff who they felt consistently ignored clients or someone who repeatedly “doesn’t listen.” Despite many clients reporting contentment with their current staff, nearly all shared examples of staff they felt were unengaged and only present to assist with meals or medication. A repeated area of concern was that some staff members were “on their phone” all the time and unwilling or unable to engage in conversation with the client. When pressed, only a few clients felt able to distinguish between when staff were on their phone for work versus those engaged in personal affairs. A handful of clients also noted the need for staff to be what they perceive as “hardworking” and complained about staff members who did not complete chores in the home.

Best Staff: Helps Me Calm Down

As clients talked through their daily activities, provided examples of interactions with others and discussed their likes and dislikes, the importance of behavioral management techniques emerged in their stories. Among the interviews, only two clients explicitly discussed staff training in complex behavior management (both clients were working very intentionally on reducing the number of hours they are under supervision or working their way out of the program entirely). Among most clients’ stories, behavior management emerged as part of narratives of clients’ “favorite” staff members.

When prompted to explain why a client enjoyed spending time with a particular staff member or members, stories about being listened to and cared for were sprinkled with examples of behavioral support techniques being exercised. Many clients reported tendencies to feel anxious or become nervous. In multiple interviews, clients described their favorite staff as someone who “helps me calm down.” One client explained that they love window shopping and shared an instance when they started to feel really overwhelmed at a local mall and the staff member intervened. The client struggled to articulate how the staff member became aware of the client’s state, but when asked if the staff member ‘just knew’ that the client was anxious, the client nodded vigorously. At another point in the interview with client, when asked to describe the staff member they liked the most, they said: “She's special. She's smart. She's calm, she's collected. And she calms people down when they have anxiety.”

Other clients described staff intervening to deescalate situations when a client started to feel anxious or even angry when they became overwhelmed. One client explained that the arrival of a new housemate who frequently made loud vocalizations caused the client to become extremely irritated and annoyed at the newcomer. The client relayed that his favorite staff person talked to him, repeatedly coaching him on how to interact with the new housemate until the client felt calm enough to engage. The two clients eventually became friends. Another client described his

favorite staff person as someone with a “great sense of humor” who was also “very blunt.” The client stated that when starting to get angry, the staff member would say it was time to “calm down” and suggest the client take a little space. One client explained that a specific staff member can identify when the client is in a bad mood and will ask: “Do you want to talk? Let me know when you calm down. I can tell you're stressed out.”, and then gives the client the space needed to process. One client who shared stories of past abuse and often felt afraid of strangers, listed the reasons of a favorite staff member because he made the client feel protected, did recreational activities and remained calm.

Among client reports of staff members who worked with them to reduce anxiety, dampen feelings of anger, or help them feel safe, very few attributed these qualities explicitly to specialized staff training. Clients were more likely to describe these staff as “special” and described them as being able to recognize clients’ facial expressions, moods, or body language to know how to interact best with the client. However, stories of staff directing clients to take breaks, step away, take space, or providing coaching on ways to interact with others suggest specialized training, whether formal or informal. For many clients, it was clear that these supports enabled them to engage with housemates, friends, or members of the public more deeply. Not all clients were unaware of the importance of this role among staff. One client explained the reliance on staff interacting in this way, stating: “If I'm like not following my guidelines, tell me. Don't like just let it go like it's not happening. … Because if you don't -- if you don't tell me this, I can't work on it.”

Summary

Direct service professionals occupy an immensely important and intimate role in the lives of Developmental Disabilities Administration clients. Our interviews with clients revealed that clear communication, patience, shared understanding and care produce positive staff interactions. By contrast, negative interactions were tied to clients feeling a lack of control over their daily activities or disrespect by staff. These findings are reflected in clients’ clear message that honesty and trust are intertwined with both the quantity and quality of communication staff engage in and that being ignored, dismissed, or simply told what to do are experienced as disrespect. Clients’ stories also demonstrated that perceptions of safety, empowerment and feeling cared for are embedded in individualized treatment, crafted specifically for and in partnership with each client. Frequent changes in staff are particularly disruptive to establishing these dynamics, indicating a need to reduce high turnover among staff to create stable, consistent support for clients so that they can take full advantage of opportunities to integrate into their communities. These findings suggest that specialized expertise among direct support professional staff, whether acquired through training or experience, is a critical component to the quality of life for clients who receive Medicaid-funded residential services.

Report

Introduction

In 2022, the University of Washington's Center for Technology and Disability was contracted to conduct interviews with clients receiving Medicaid-funded residential services. Interactions with staff shape much of how each client experiences daily life. The relationship between direct support professionals and adult clients with intellectual and developmental disabilities in community residential services may be extremely intimate and at times can be complex to navigate for clients and staff. The client interviews conducted under Washington state's *Rate Study for Contracted Community Residential Services* aimed to capture clients' voices on their experience of community residential programing received across Washington state, providing insights to inform potential changes to the current payment rate methodology.

Medicaid-funded community residential programs are controlled at the state level, but operationally, the services are provided through contracted providers in local communities, meaning that even within a given state, the local providers of care may differ in policies and procedures (assuming overall state requirements are met). Each contracted provider is responsible for the hiring and training of DSPs who work with the clients. For Washington state's Medicaid-funded community residential services, DSPs must receive 75 hours of training when starting and then 12 hours annually. Client supports are determined using a Developmental Disabilities Administration assessment process that includes a Support Assessment, Service Level Assessment and Person-Centered Service Plan. The Person-Centered Service Plans describes the paid services the client is authorized to receive and includes informal (unpaid) supports and important goals to the client. While plans are routinely updated, Clients may have limitations in their ability to participate in service plan development and in some cases a legal representative may serve as a proxy. Due to the nature of this structure, interviews with clients offered a unique opportunity to gain insight into how clients perceive the way support is facilitated and how those supports affect day-to-day life.

Methods and Data

The University of Washington conducted interviews with 25 clients receiving Medicaid-funded residential services and support in Washington state. The study purpose, procedures and instruments were reviewed by the UW Institutional Review Board, was determined to pose minimal risk to participants and was thus found to be exempt from formal oversight.

Sampling and Recruitment

Working with Washington state Department of Social and Health Services staff, the UW team identified 3,444 clients receiving near or full 24-hour supervision. DSHS staff sent outreach letters to these clients informing them of the study and the potential to be contacted by UW. (See Attachment 1 for example letters sent to clients before and after study participation.) The UW team drew two samples from the client list, ultimately identifying 316 (or 9% of) clients and maximizing variation across region, type of program and client demographic characteristics. UW

recruiters contacted just over 300 clients via a combination of phone calls, emails and letters explaining the purpose of the study, offering to conduct interviews in-person or via the video conferencing platform Zoom; clients were offered a $50 gift card at completion of the interview. Despite accommodations in place, recruiters encountered numerous barriers to participation when contacting clients, at times resulting in modified participation due to limited communication capacity. (See Attachment 2 for a breakdown of specific recruitment barriers.) After attempting to reach roughly 9% of clients receiving the target support levels, 25 interviews with clients were completed. Twelve of the 25 interviews were conducted in-person; 13 were conducted over Zoom. Among clients interviewed, just over one-third (36%) are women and the majority (64%) are men. The majority (87%) are white, 4% are Black, 4% are Asian, 1% is Hispanic and the remaining 4% chose not to disclose their race. (See Table 1.)

Table 1. Comparison of Sample with Client Population Requiring 24-hour Support

	Client Population N=3,444	Interviews N=25
	%	%
Region		
1N	17.2	40.0
2N	12.6	8.0
3N	16.2	16.0
1S	8.5	8.0
2S	26.7	20.0
3S	18.7	8.0
Urban Designation		
KING	26.0	17.4
Metropolitan Statistical Area	67.0	78.3
Non-Metropolitan Statistical Area	7.0	4.3
Program Type		
Companion Home	2.0	0.0
Group Home	6.0	8.0
Supported Living	92.0	92
Level of Need		
Level 4	14.2	30.4
Level 5	75.1	43.5
Level 6	10.7	26.1

	Client Population N=3,444	Interviews N=25
*Behavior Support Needed		
No	36.8	28
Yes	63.2	72
+Multiple Behavior Supports Needed		
No	50.2	48
Yes	49.8	52
Sex		
Female	42.7	34.8
Male	57.3	65.2
Race and Ethnicity		
American Indian or Alaska Native	3.2	0
Asian	2.4	4
Black or African American	4.3	4
White	87.7	87
Hispanic	1.2	1
Client chooses not to report/unable to report	.6	4
Native Hawaiian/Other Pacific Islander	.7	0
Total Clients	100.0%	0.73%

Notes: Total Clients with a Need Level of 4, 5 or 6 = 3,444 or 82% of all clients (4,203). Support Level 4: Clients assessed to need this level receive supports in close proximity 24 hours per day. Support hours may be shared with neighboring households. Support Level 5: Clients assessed to need this level receive support 24 hours per day. Support Level 6: Clients to be supervised 24 hours per day.

* Behavior Support Needed is variable generated from the DSHS list of 17 possible behavior support needs; Client Behavior Support Needed identifies clients with a score of “2” for any of those 17 behavior supports.

+Multiple Behavior Supports Needed is a composite metric using the sum of scores across all 17 possible behavior support needs among clients who have at least one behavior support need that is scored at “2” to generate categories of clients who have multiple, behavior support needs.

Study Instruments

The UW team developed a plain language interview protocol asking clients to talk interviewers through a typical day, discuss the types of activities they engage in during the week and their interactions with DSPs and to describe what qualities were most desirable in a DSP. The initial set of interview questions were tested with the director of the UW Employment Program and two program participants with intellectual and developmental disabilities in one of the group’s weekly group meetings over Zoom. In the informal meeting, we were able to run through the questions from the interview guide and explore potential challenges and facilitators of successful virtual interviews. From the pilot interview we were able to incorporate techniques to clarify questions,

such as rephrasing and modeling, emphasizing waiting for responses and noting the importance of naming the person who is being asked a question when there are multiple people present in the room. (See Attachment 3 to view the finalized interview protocol used in this study.)

Analysis

In all but two cases, client interviews were recorded and transcribed; two clients preferred not to be recorded and instead asked that the interviewer take notes by hand. All personal identifying information was removed, and proper names were replaced with pseudonyms to protect clients' privacy. Deidentified transcripts were uploaded into the qualitative data analysis software "ATLAS.ti". Three members of the UW research team conducted a first round of closed coding of the transcripts, using the list of topics generated by the interview questions as topical themes. Closed codes were divided up among the team, with each coder responsible for a select set of codes to avoid inconsistency across coders. The coding team met three times during the first round of coding to further clarify definitional boundaries, examples and collectively determine how to code transcript segments that were difficult to categorize. Next, the team conducted open coding within and across closed code categories, unearthing additional themes that emerged from the data. Finally, codes were aggregated to create a system of 'parent' and 'child' codes representing larger themes. Each coder generated an analytic memo for parent codes and included all relevant text passages for group review and discussion to ensure consensus on analytic interpretation among the research team.

The 25 interviews conducted, and subsequent findings, are not generalizable to all clients receiving Medicaid-funded community residential services in Washington; rather, the interviews provide 25 exploratory cases into how clients understand their experiences within these services.

Findings

While there is extensive research into the utilization and effectiveness of community residential services in the United States, fewer studies seek to understand home and community-based services from the perspective of the clients enrolled. In our exploratory examination of adults with intellectual and developmental disabilities experiencing direct support services within community residential programing in Washington, we focused on the daily lives of clients. Our report identifies three primary findings relating to community involvement, staff qualities and staff interactions. In addition, we provide two secondary findings on home life and the COVID-19 pandemic.

A. Community Integration: Opportunities to Socialize with Others

Community residential services attempt to integrate clients with their community, and community integration efforts were a key focus of the client interviews. In our sample, we identified a combination of in-home and out-of-home activities shaping the lives of clients as well as provider or client-specific barriers to community integration efforts. In each interview, we asked clients to describe a current typical day or week as well as explain how the activities for the day or week were planned. The following review of integration efforts comes from 96 passages around activities done in the community, and 40 passages addressing barriers to activities experienced by clients.

Most clients discussed shopping as one of their main activities outside of their homes. Grocery shopping was the primary example used, but clients discussed shopping in a range of stores, especially when stores were near a client's home. Although some did shop alone (with staff nearby in the parking lot or another section of the store), due to the care level of our sample, almost all shopped directly with staff. One client enjoyed shopping in the store and getting food for the house. A few mentioned window shopping as an activity they enjoy. For some, the appeal of visiting stores is to see the people who work there. One client enjoyed going to the local grocery store and coffee shop to socialize with the friends made behind the counters.

Socializing with friends, family and staff is an important part of the time that clients spend outside their homes. One person talked about meeting up with friends to have barbecues, go to stores, or visit them at their homes. Some regularly visit with their families during the holidays or for weekends at their homes. When home on the weekends, one client engaged in a variety of activities in their community, including taking drama classes, going to dances, playing several sports and seeing their significant other.

Several clients talked about their jobs in the community. While a few lost their jobs during the pandemic, others continued to work or found other employment. One client previously worked with kids at church and hoped to start working there again soon after a break. Others worked at local stores or a nearby YMCA.

Being active by taking walks or playing sports was brought up by many clients. A few clients discussed their participation in Special Olympics activities, such as bowling, as a great way to make friends. Other examples of being active included playing pool, endurance sports, horseback riding, equine therapy and bike riding.

Many clients discussed taking walks in neighborhoods, shopping centers and scenic areas. They take walks as a form of exercise, to relax and to share time with friends, family and staff. Others explained that it was an important form of transportation and something that some valued being able to do independently. To get where they needed to go, clients explained that they walk, take buses and go in staff cars or company transportation.

Some clients discussed going for drives with staff and sometimes housemates or other clients living in different homes. One client likes to go for long drives on the weekends to break up the monotony. Two clients mentioned taking drives together to go to cemeteries nearby. While one was visiting a loved one, the other said that they liked riding in the car and enjoyed being outside in the cemetery. Clients also discussed a wide variety of activities they engaged with in the community. Some mentioned going to the library, school, zoo, holiday celebrations and to the movies. Others enjoyed going out to eat at restaurants or grabbing coffee from a nearby shop. A few clients talked about attending church on Sundays.

Overall clients' descriptions of their daily activities provided a window into their opportunities to socialize with other clients in the program (e.g., organized crafting events or potluck socials), and

people outside of the program (through activities such as bowling or visits to the local library.) Most clients conveyed contentment with their opportunities to interact with community members, although a portion of clients indicated they would attend more events or spend more time in the community if they could.

Barriers

When clients referred to a barrier to activities, it was most frequently one that had been put in place by a staff member, Developmental Disabilities Administration, or someone else in a position of authority. Some clients discussed having to have a staff member with them to leave the house or do certain activities inside the home. Several expressed frustrations that they could not do more things independently. A couple said that being required to have staff with them was a barrier to being able to do the activities that they enjoy. One individual, an avid bike rider, expressed frustration because policy requires staff to accompany the ride and many of the staff are not interested in doing so (and that they prefer to drive if they need to go somewhere).

Seven clients explicitly stated having control over what they do for the day, explaining to various degrees the way they work with staff to make their schedule for the week or each morning. In contrast, six clients shared barriers to deciding daily activities, including: issues with transportation availability or willingness of staff to transport them to desired locations, staff using two-choice systems allowing clients to only choose between predetermined activities and scheduling controlled by a guardian. In contrast, six other clients were frustrated with the complicated decision processes in place which they reported resulted in a decision being made for them, rather than by them. When asked why something they want to do may be denied, they explained it could be an issue with transportation, limited choices presented to them by staff and policies from providers or guardians the staff are compelled by. Our report does not include interviews with providers, staff or guardians about these restrictions or a review of the clients' support plans and as such these findings reflect how clients; experience these barriers, rather than address potential reasonings behind them. Example barriers described by clients include the following:

- One client would like to participate in more activities outside the home, but is frustrated by the process of having to check with multiple people to see if the van is available, and being told the activity is too far away.
- One client would like to go to a particular local store to do grocery shopping that is less expensive, but is taken to another store that is more expensive (per staff decision) which makes the client feel angry.
- Clients talked about landlord decisions, such as not being allowed to have a pet or a garden.

Clients discussed weather, money and other barriers to doing activities that they would like to join. Several people mentioned not wanting to go for walks or go shopping when the weather was too cold. A few discussed not having the money they needed to ride the bus, buy groceries, or get new video games. One client was taking classes to get a GED but was taking a break to get

a headset for transcription purposes. Another client expressed an interest in cooking more but has had some accidents in the past and is working with staff to learn to cook more independently.

While most clients conveyed contentment with their opportunities to interact with community members, a portion of clients indicated they would attend more events or spend more time in the community if they could. As shown above, the lack of transportation to events and not enough staff available among those with housemates to spend long amounts of time away from the home were common barriers. Conversely, a small number of clients relayed that they were not allowed enough privacy to engage in the activities they wanted, such as being allowed to go on dates by themselves. Notably, the interviews are absent any mentions of disability stigma or overt discrimination experiences as barriers to engagement in clients' local communities.

B. Desirable Staff Qualities: 'Be a Good Person'

As part of the interview process, all clients were asked the hypothetical: if we were to hire another staff person to work with you, what qualities should we look for in that new staff person? Most clients' first responses indicated demeanor was of utmost importance, with "kind", "nice" or "caring" listed as the most frequent descriptors. Several clients said that a good staff member should simply "be a good person." The next most frequent response focused on communication. Nearly all clients discussed the need for staff to be "a good listener", to talk with clients (e.g., asking questions, offering options, showing interest in clients' stories, not ignoring clients' attempts at conversation.) Several clients emphasized not only the quantity of communication with their staff but the quality, focusing on the need for honest, trustworthy staff that could be relied upon as confidants who would not disclose their private affairs or spread gossip. Although only a few clients indicated a staff member should be able to drive, those who did list that quality emphasized its importance.

Many clients also indicated that staff should have a good sense of humor, enjoy joking around and ideally "be fun." These qualities were frequently juxtaposed with staff who "are stressed out." Anecdotes and examples of interactions show that clients are very aware of and sensitive to staff who are stressed and overburdened. Numerous clients described how high staff turnover or instances when there weren't enough staff creates a lot of stress and pressure for DSPs, dulling their ability to engage with clients and forcing them to spend all their time doing administrative tasks. Several clients shared concerns that staff are not paid enough, not paid frequently enough (two clients mentioned that staff are only paid once per month) and expressed worry that the staff they liked working with the most might not be able to continue working with the client due to financial constraints.

Asking clients to describe desirable staff qualities prompted reflections on undesirable staff qualities, often shared through examples of prior negative interactions. Roughly one-third of clients pointed to staff qualities that are not appreciated, such as being "bossy", "rude", or "sarcastic." Many clients reinforced the importance of communication by giving examples of a having known a problematic staff person who consistently ignored clients or who "doesn't listen." Despite most clients reporting contentment with their current staff, nearly all were ready

to share examples of staff they felt were simply unengaged, and therefore viewed as merely present to assist with meals or medication. A repeated complaint was that some staff members were “on their phone” all the time and unwilling or unable to engage in conversation. When pressed, only a few clients felt able to distinguish between when staff were on their phone for work versus those engaged in personal affairs. A handful of clients also noted the need for staff to be “hardworking” and complained about staff members who did not complete chores in the home.

C. The Best Staff: ‘Helps Me Calm Down’

Interactions between staff and clients shape much of how the client experiences daily life. As an industry, direct support services face extremely high levels of worker turnover, resulting in many clients regularly receiving new DSP staff. As clients answered questions about activities, their home life and staff, they provided examples of interactions with others, discussing their likes and dislikes of the interactions. Across these stories, the importance of behavioral management techniques emerged. Among the interviews, only two clients explicitly discussed staff training in complex behavior management (both clients are working very intentionally on reducing the number of hours they are under supervision or working their way out of the program entirely). Among most clients’ stories, behavior management emerged as part of narratives of clients’ “favorite” staff members.

While all clients discussed interactions with staff, we noted 21 clients with stories of interactions outside routine activities. We found positive staff interactions were largely characterized by clear communication, patience, shared understanding and/or validation. Clients provided stories about being listened to and cared for and were sprinkled with examples of behavioral support techniques being exercised. Many clients reported tendencies to feel anxious or nervous. In multiple client interviews, participants described their favorite staff as someone who helped them regulate their moods and behaviors. As one client stated, one DSP is their favorite because “[she] helps me calm down.” When asked to provide an example, the client shared a story of feeling very anxious while shopping and the DSP recognized their distress and intervened. The client struggled to articulate how the staff became aware of their anxiety, but when asked if the staff member ‘just knew’ that the client was anxious, the client nodded vigorously. At another point in the interview with the same client, when asked to describe the staff member they liked the most, the client said: “She's special. She's smart. She's calm, she's collected. And she calms people down when they have anxiety.” Other clients echoed this type of approach, highlighting techniques of de-escalation when a client started to feel anxious or even angry when they became overwhelmed and staff quickly responded. One client explained that the arrival of a new housemate who frequently made loud vocalizations caused the client to get extremely irritated and annoyed at the newcomer. The client relayed that his favorite staff person talked to him, repeatedly coaching him on how to interact with the new housemate until the client felt calm enough to engage. The two clients eventually became friends.

Another client described his favorite staff person as someone with a “great sense of humor” who was also “very blunt.” The client stated that if getting angry the staff member would tell the client that it was time to “calm down” and suggest the client take a little space. One client explained that a specific staff member can identify when the client is in a bad mood and will ask: “Do you want to talk? Let me know when you calm down. I can tell you're stressed out.”, and then giving the client the space needed to process. One client, who shared stories of past abuse and often felt afraid of strangers, listed the reasons for a favorite staff member because he made the client feel protected, did recreational activities and remained calm. Among client reports of staff members who worked with them to reduce anxiety, dampen feelings of anger, or help them feel safe, very few attributed these qualities explicitly to specialized staff training. Clients were more likely to describe these staff as “special” and described them as being able to recognize clients’ facial expressions, moods, or body language to know how to interact best with the client. However, stories of staff directing clients to take breaks, step away, take space, or provide coaching on ways to interact with others suggest specialized training, whether formal or informal. For many clients, it was clear that these supports enabled them to engage with housemates, friends, or members of the public more deeply. Not all clients were unaware of the importance of staff training to engage with clients in this manner. One client explained the reliance on staff interacting in this way, stating: “If I'm like not following my guidelines, tell me. Don't like just let it go like it's not happening. … Because if you don't -- if you don't tell me this, I can't work on it.”

Overall, clients' view of interactions proved to be largely dependent on who is working a certain shift and what strategies the staff employed. For example, in one case, a client, who shared routine issues with some staff, described feeling “like a prisoner here. Like they [staff] don’t treat me right. I can’t be on the phone, I can't use the house phone”; however, the client also explained that another staff member can identify when the client is in a bad mood and prompts the client to step away and then giving the space needed to process. In most cases, clients identified one to two DSPs within their staff that offered consistent positive interactions; some articulate their relationships with these DSPs as friendships developed over time and through consistently positive experiences. One client who had a history of negative staff interactions, when discussing his relationship with the current lead staff said, “me and [DSP] are buddies” … and he “makes me feel like that I don't have to be ashamed of myself.”

In contrast, negative interactions reported by clients were tied to clients feeling a lack of control or respect by staff. One expressed routine issues with a staff member who refused to respect the clients' house rules around language use; while another told us that a staff member had overstepped by trying to control when the client would wake up and eat. Another common negative interaction reported was related to the client’s concern over the overuse of cellphones by staff resulting in an inability to listen or support the client when needed. One shared: “I get ignored a lot…When I go on walks, some of my caregivers, they like to be on their phones. And they like to -- when I'm talking about something, they like to, like, when I have to repeat it, it tells me they ignore me. Or when they go, like, "mm-hmm," like, that tells me they weren't exactly listening.”

D. Secondary Finding: Home Life

In supported living environments clients live in their own homes. Direct support professionals travel to or in some cases move into the home of the client, making the space a unique mix of a private home for the client and workplace for the DSP. As expected, the way that a space is understood actively shapes how people act within it. To explore these dynamics and better contextualize our primary findings, this section uses 76 passages around in-home activities and 32 passages on living situations to provide an overview of home life.

Due to the barriers to activities partially covered within the community integration section of this report, in-home activities become uniquely important for this population. While these are activities that do not normally get clients out among others or further integrate them into the community directly, they do serve an important role in maintaining quality of life by providing activities that are important to the person.

Many clients discussed using technology in the home, most often the importance of internet access to watch media or communicate with others. Clients shared enjoyment around watching online videos, shows or movies; in most cases, they reported watching media alone in their rooms if a television or tablet was accessible to them; if not, they would watch with staff and/or housemates in their home's common space. They also spent time playing video games, either alone or with people inside or outside the house. Several clients explained that playing video games was their main hobby and that they spent much of their time playing games. Video games can be played alone or used to interact with friends or members of online communities. A couple of clients highlighted the importance of video games for communicating with friends outside of the home, which was particularly important during the pandemic. Beyond video games, clients use technology to connect with people and activities outside of their home. One client said that they now use Zoom to talk with family, as well as take virtual fitness classes.

Creative expression and artistic engagement are important for many clients. Beyond listening to and making music, many draw, craft, write, read and garden. Many clients discussed their love of music, both listening to music and playing music. They talked about listening to the radio or putting on their own music to have alone time or share with others. Two clients described regularly writing cards and letters and sending them to friends and family. Another client was hoping to be able to have a garden in the coming year because the client loves to garden outdoors, but that would depend on whether the landlord would allow it. A few clients talked about playing with model cars.

Staff and clients prepare meals at home as part of daily life, sometimes together and sometimes separately. For clients interested in cooking, some prepare meals for themselves or receive assistance from staff. One client explained that they loved cooking and barbecuing and while they were able to do most of their cooking from recipes they knew or read, their staff was able to assist when needed. Another echoed that statement and said that the client's mom taught the client how to cook and clean and gave the client a big cookbook which enabled the client to know where to look and how to prepare food from it. Some clients mentioned learning to prepare food with staff

either through cooking lessons or by helping staff with preparing food and learning in the process. One explained that they were learning to prepare eggs in different ways with staff.

Several clients discussed exercise and rest in their daily lives at home. Walking in and around their homes was discussed by clients as a great way to get exercise, pass time and socialize with housemates and staff. One client walks up and down the hallways in the group home the client shares with ten housemates to exercise and pass time when they are bored. Another client enjoyed riding bikes near their home but had to stop because they had an accident. Sleeping and resting were mentioned by a few clients as ways that they spent some or much of their day.

Although socializing outside of home became greatly reduced during the pandemic, clients enjoyed opportunities to share with others in their homes. They described spending time with staff, friends and family in their homes or communicating with those outside the home via phone calls. One client discussed talking on the phone to friends and family as the way to spend much of the client's time. Another client was looking forward to having their parents come visit on Christmas morning and opening up presents with them. Beyond socializing with other people, pets can be a great way to share affection. One client explained spending most of their time with their dog at home.

Many clients described doing chores, often cleaning and doing laundry, as part of their daily or weekly activities. Some explained that they did chores because they enjoyed these activities, but others did them simply because they needed to be done. Clients said that they may do chores independently, have some help from staff, or assist staff depending on the task. One client spoke about how much joy the client got out of cleaning and "tuning up" the living spaces by moving furniture around with the assistance of staff members. The client has become more efficient with cleaning up after themself in the kitchen and enjoys being able to cook and clean up alone.

Privacy for clients was directly impacted by their support plan, the presence of housemates and the layout of their home. Our sample consisted of high care level individuals and those enrolled in community protection programming; as a result, almost all clients included in the study have DSPs with them or within the home 24/7. We asked clients about when and where they spend time alone, desire to be left alone, or desire not to be alone. Fourteen clients discussed having separate spaces within their home to be alone and gain privacy; in almost all cases, the space was the client's bedroom. Clients described the bedroom as a space to listen to music, watch television, or nap without staff around. In some cases, clients described the room as a place to specifically avoid being around staff and/or housemates. One client, who lives alone besides the on-shift DSP, lives in a small one-bedroom apartment and uses his room to gain privacy from staff when needed. When needing to be alone, the client stated: "I go into my room, I have a private room, of course, here. Yep, because I don't live with anybody. It's because I just want to be by myself." In one case, the layout of the apartment prevented any level of real privacy for the client because the one restroom in the apartment was attached to the client's bedroom, which meant the client was unable to lock the door or request the staff not enter the bedroom.

Fifteen clients discussed having housemates in the home, although only three discussed the presence of housemates as potentially negative. All housemates we encountered were clients under the same provider; we found that housemates are commonly facilitated by providers due to high rent costs that often are difficult for individual clients to afford or due to limited housing available. One client explained when discussing the acquiring of new housemates “It’s just, like, a lot of, like, -- and for me it's, like, I like my privacy. I like to be able to, you know, do my own things. And I just -- having different people come in every day is, like, it's not easy on me because I have mental health issues…I would prefer to live in my own place where I don't have housemates.” Other clients pointed to their own specific needs as reasons that housemates were not ideal, such as having different care needs or schedules. In a related interview, another client expressed being unable to afford housing without sharing rent costs and discussed the importance of finding the right housemate. In three other cases, the number of housemates, sharing of resources (staff, transportation) and constant change of housemates was described as difficult.

E. Secondary Finding: Navigating COVID-19

All clients were asked to speak about the COVID-19 pandemic. COVID-19 greatly affected community residential living and during the pandemic high infection rates, staffing issues and the inability to offer many services to clients created challenging dynamics for the field (17,18). The following review is based on 37 coded passages with any reference to COVID-19 by the client.

When discussing the personal impact of COVID-19, most clients interviewed focused on having to stay home and not being able to leave the house. In some cases, clients recalled the impacts of COVID-19, but did not recall much about the actual pandemic. Clients focused on how COVID related policies prevented them from doing many of the activities they previously enjoyed in the community, like going to work or shopping for groceries in the store. For about a year and a half during the pandemic, one client described only leaving his house for doctor’s appointments or other essential activities. Staff took over his shopping and other errands, so that the client was not exposed to the virus. While the client appreciated that staff took that on, the client was also concerned about their health. Often grocery shopping was described as a way that clients were able to get out of the house, practice independence and socialize outside the home. During the pandemic this changed to store pick up or deliveries. In essence, daily life shifted drastically and activities that once were routine became unobtainable. One client explained that they wanted to go places but had to stay inside and that made them angry. Another explained that the client was not able to go to the theme park they enjoyed, and they felt annoyed. Across all clients more time was spent watching TV, sleeping and talking with staff.

While some were able to continue to work or have limited activities outside their homes, others discussed the frustration of only being able to travel as far as their yard and not being able to see others in person. Social interactions outside the home were reduced or stopped altogether, like visiting friends, seeing romantic partners, or family. One client explained that despite the rules to physically distance, they continued to see their girlfriend by sneaking around against the rules.

Another described staff setting up a tent in the backyard to allow the client to provide physical distance from family but continue their visits. They could not hug, but they could celebrate the client's birthday together. Due to health concerns, some clients had to socially distance from staff in their own homes; in most cases staff continuously wore masks when on duty, which some clients noted was not a fun experience. At the height of the pandemic, due to the risk of infection, providers required mask wearing inside and outside the homes of clients. One support staff explained that the client they were working with loves big gatherings and socializing, but because the client did not want to wear a mask, they were unable to attend events. Another client described hating to have to wear masks everywhere. The client was also frustrated with having to test or quarantine each time a staff member or housemate tested positive. The client felt scared and anxious about the pandemic in the community and across the world. In fact, the client did their own research online to see and track rates across their county. During our interview period 2022-23, many clients explained that they still wear masks when someone comes to visit, but normally they do not wear them at home with staff. A few pointed to the vaccinations as a turning point, allowing for some to exit the home in certain circumstances and mask wearing requirements to loosen. After the height of the pandemic, clients described returning to previous routines, at least in part, focusing on the ability to have visitors in their homes again, reuniting with friends and family.

We asked clients if anything positive came out of the pandemic or if anything that changed during the pandemic should remain in place. One client explained that they did not mind the public health restrictions put in place because it meant that they were safe while others were falling ill or dying, and another said that they liked that people and businesses were more sanitary. Another client explained that provider approaches had changed explaining it became standard for houses under the provider to go on "quarantine because somebody is sick or something and that's no fun. And so you really can't go to the house. So that's one of the things that we still do nowadays and then you still have to wear masks too, like medical appointments and that's no fun. And so, I hope we stop doing that before this year is over." Several clients mentioned stimulus checks and that they were sad to have them end, some pointing to the financial instability facing them without the additional income.

Conclusion

Direct service professionals occupy an immensely important and intimate role in the lives of Developmental Disabilities Administration clients. Our interviews with clients revealed that clear communication, patience, shared understanding and care produce positive staff interactions. By contrast, negative interactions were tied to clients feeling a lack of control over their daily activities or disrespect by staff. These findings are reflected in clients' clear message that honesty and trust are intertwined with both the quantity and quality of communication staff engage in and that being ignored, dismissed, or simply told what to do are experienced as disrespect. Clients' stories also demonstrated that perceptions of safety, empowerment and feeling cared for are embedded in individualized treatment, crafted specifically for and in partnership with, each client. Frequent changes in staff are particularly disruptive to establishing these dynamics, indicating a need to

reduce high turnover among staff to create stable, consistent support for clients so that they can take full advantage of opportunities to integrate into their communities. These findings suggest that specialized expertise among direct support professional staff, whether acquired through training or experience, is a critical component to the quality of life for clients who receive Medicaid-funded residential services.

Limitations

The information contained in this report has been prepared for the Washington State Department of Social and Health Services for the legislatively-mandated Rate Study for Contracted Community Residential Services. The University of Washington performed this work under contract with Milliman. The terms of Milliman's contract 2234-42497 with DSHS apply to this report and its use.

The information contained in this report, including appendices, has been prepared for DSHS. To the extent that the information contained in this report is provided to third parties, the report should be distributed in its entirety.

The contents of this report are not intended to represent a legal or professional opinion or interpretation on any matters. Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for DSHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

In identifying clients for interview purposes, we relied on information provided by DSHS. We accepted this information without audit, but reviewed the information for general reasonableness. The resulting client interviews may have been different if this information was not accurate. The stakeholder feedback summarized in this report does not reflect the opinions of Milliman and is presented to provide additional context for this study.

Attachment 1: Client and Provider Letters

Sample Provider Letter

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Developmental Disabilities Administration

PO Box 45310, Olympia, WA 98504-5310 Date, 2023

Dear «ATTN»:

Dear Recipient Name:
The Washington DSHS Developmental Disabilities Administration is working with the University of Washington to interview a sample of clients who receive home and community-based services. These interviews will help us understand whether the services meet their needs and will help us to make improvements. At least one client in your care has been selected and you may be contacted by the University of Washington asking how to contact your client for an interview.

The names and emails of Individuals you may be contacted from UW include:

Ryan DeCarsky decarsky@uw.edu	Lee Olsen lmolsen@uw.edu
Heather Evans hdevans@uw.edu	Hannah Kaufman hkaufman@uw.edu

No client has to be interviewed; it is their choice whether to participate. If they agree to be interviewed, the University of Washington will set up a time to talk with the client. Clients may choose which questions they want to answer. They may also choose to have someone else present during the interview like an interpreter, a guardian, or a direct support professional. The interview will be audio recorded. Clients will receive a $50 gift card for their time at the end of the interview.

If your client would like to be interviewed, they do not have to wait to be contacted! They can contact Lee Olsen at UW directly to schedule by calling him at 206-543-6387 or by sending him an email at lmolsen@uw.edu .

If you have any questions or concerns, you can contact me directly at Developmental Disabilities Administration.

Valerie Kindschy

Unit Manager

Community Residential Services

Ph: 253-341-2044

Valerie.Kindschy@dshs.wa.gov

Sample Client Letter

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Developmental Disabilities Administration

PO Box 45310, Olympia, WA 98504-5310 Date, 2023

Dear «ATTN»:

Dear Recipient Name:
The Washington DSHS Developmental Disabilities Administration is working with the University of Washington to interview some clients who receive home and community-based services. These interviews will help us understand whether the services meet their needs and will help us to make improvements. **If you have any questions or concerns, you can contact me directly 253-341-2044.** Not everyone in Washington will be interviewed, but you have been selected and will be contacted by the University of Washington asking you to be part of an interview.

The names and emails of Individuals you may be contacted from UW include:

Ryan DeCarsky decarsky@uw.edu	Lee Olsen lmolsen@uw.edu
Heather Evans hdevans@uw.edu	Hannah Kaufman hkaufman@uw.edu

You do not have to say yes. The choice is up to you. If you agree to be interviewed, the University of Washington will set up a time to talk with you and ask you some questions about your life and the services you receive from Developmental Disabilities Administration. You may choose which questions you want to answer. You may also choose to have someone else with you during the interview like an interpreter, a guardian, or a direct support professional. You can choose which questions you want to answer. The interview will be recorded so UW staff can remember what you said. As a thank you for your time, UW will pay you $50 by check or gift card at the end of your interview.

If you would like to be interviewed, you don't have to wait to be contacted! You can also contact Lee Olsen at UW directly to schedule by calling him at:

Lee Olsen: 206-543-6387 or by sending him an email at lmolsen@uw.edu .

Valerie Kindschy

Unit Manager

Community Residential Services

Sample Participation Letter:

UW Medicine
DEPARTMENT OF
REHABILITATION MEDICINE

March 21, 2021

Name
Contact Information
Address

Dear Name of Person,

Thank you for letting us interview you about the home and community-based services you receive from the Washington Developmental Disabilities Administration. The information you provided was very useful!

As a small thank you, we are sending you $50 in the form of a U.S. Bank Visa card. This card can be used to purchase items at a store or online. It cannot be used at an ATM to receive cash. The card expires after 2 years, so please use it before then.

Once again, thank you for meeting with us and talking about your experiences.

Sincerely,

Mark Harniss

Mark Harniss
Associate Professor, Rehabilitation Medicine

Attachment 2: Recruitment Barrier Report

The UW recruitment team has attempted to contact 316 Developmental Disabilities Administration clients, many of which required engaging with at least one DSP (staff), case managers, service provider (supported living) managers, guardians, or family contacts in order to obtain current contact information for and/or to get direct access to Developmental Disabilities Administration clients. Despite DSHS mailing two letters, sent several months apart, and calling service provider managers overseeing clients in our sample, the recruitment process has been impeded by lack of awareness of the study and, in some cases, suspicions about being a scam. In addition, a number of clients (12) were identified as no longer receiving Developmental Disabilities Administration services in updated contact info lists provided by DSHS. Five of the clients interviewed were not included in the initial sample list: two clients reached out to recruiters after receiving a letter sent from DSHS; three clients were referred by other Developmental Disabilities Administration clients (their housemates) who had participated in an interview. Table A below shows the breakdown of documented impediments to conducting interviews.

Table A. Interviews & Recruitment Barriers

Recruitment Note	#
Client is nonverbal and unable to participate in interview	37
Client not interested; client interested by unable or unwilling to commit to scheduling interview (repeated attempts)	16
No answer; multiple voicemails not returned	140
Contact information wrong / unable to locate good contact info	55
Administrative block (includes repeated hang-ups by staff, no letter received / scam / suspicious (recruiter gave up after repeated attempts to verify study)	36
DSHS removed provider or client from list in subsequent updates	12
N/A (Client was contacted and interview scheduled)	20
Total Developmental Disabilities Administration Clients	316

Attachment 3: Interview Protocol

Client Interview Guide

Question = ask all clients

{Prompts} = ask under following circumstances: 1) participant gives short or relatively uninformative response, 2) participant seems to misunderstand question, 3) participant asks for examples or further explanation of question

[inserts} = use / mirror client language

Each interview will last 20-60 minutes. Given the size of the sample, these responses will not be used to generate statistical inference, but instead to gain substantive input from clients on direct support professional with whom they receive services. Interviews will be semi-structured, meaning that not all clients will be asked all the interview questions in the protocol. Instead, the interviewer will ask select questions and follow-up prompts based on the "flow" of the discussion with each client. Discussions will center on three main areas:

- Client satisfaction with services
- Client's sense of agency and autonomy in their daily lives
- Impact of the COVID-10 pandemic

CONSENT PROCESS

Component	**Script**
Introduction	Hi, are you [name]? Nice to meet you, my name is Ryan. I work at the University of Washington. How are you doing today?
Consent to participate	I'm here to ask you some questions about things you do during your day and services you receive that help you live in the community. Is that ok?
Process	{If yes}: Ok, great! So, I will just ask you a few questions. It should not take more than 1 hour. If you don't want to answer a question, you can just say "skip." And if you need to get up and move around while we talk or take a break, that is ok, too. Any questions? {If no}: That's okay. Would you like to talk to me during a different time or day? {If yes}: Reschedule. {If no}: Thanks for your time.

Component	Script
Consent to record	Great, so one last thing, I want to record our voices so I can remember what you tell me. Is that ok? {If others are present who will also participate, repeat process for each of them.} {If yes}: Ok, I am going to start recording. [Start recording]. I just want to double check, "Is it ok if I record us today?" {If yes} Great! Let's get started. {If no}: [Stop recording]. Did I misunderstand? Is it okay to record our voices so I can remember what you tell me?

INTERVIEW PROTOCOL

Question / Prompt
1. What did you do yesterday? Walk me through your day, starting with when you got up.
2. For any of these activities [repeat one or two activities just shared] – did anyone ask you if you wanted to do that? Did someone tell you that were going to [example activity]? Were you given several activities to choose from?
3. Do you remember what you did last weekend? What did you do on Saturday? * *If yesterday was Saturday, change to a weekday.
4. For any of these activities [repeat one or two activities just shared] – did anyone ask you if you wanted to do that? Did someone tell you that were going to [example activity]? Were you given several activities to choose from?
5. Do you ever change your mind about what you want to do during the day? {If yes}: Can you tell me about a time when you decided you didn't want to do one thing but wanted to do something else instead? How did that go? {If no}: Do you ever want to change what you are going to do? Can you think of a time when you would rather do something else? If that did happen. What would you do in that situation?
6. What parts of your day do you do alone? Are there any times of the day you want to be alone but aren't allowed to be? Are there any times of the day that you are alone, and you would prefer not to be?
7. Who are the main people who help you do things throughout the day?
8. In general, are you usually happy to see [name1]? Why is that? Are you usually happy to see [name2]? Why is that?
9. Are there times when you are not happy to see [name1]? Why is that?

Question / Prompt
Are there times when you are not happy to see [name2]? Why is that?
10. Do the helpers you have change a lot?
11. Do the helpers understand you when you tell them something you want?
12. What makes a good helper?
13. Do you think [name1] is a good helper most of the time? Can you give me an example of when [name1] is a good helper? Are there times when [name1] isn't a very good helper? Can you give me an example of when [name1] is not a very good helper?
14a. Do you think [name2] is a good helper most of the time? 14b.Can you give me an example of when [name2] is a good helper?
15a. Are there times when [name1] isn't a very good helper? 15b. Can you give me an example of when [name1] is not a very good helper?
16. A couple of years ago we all had to stay home all the time and couldn't go anywhere. People called it the COVID pandemic. Do you remember that time? {If no}: Okay, that's fine. [go to Q20] {If yes, continue to next question.]
17. Were you living here during the pandemic, when we all had to stay home all the time?
18. The COVID pandemic caused a lot of changes for all of us! How did the COVID pandemic change your life? What went away?
19. Were there any things that changed during the pandemic that you liked, or wish would keep going? {If yes}: What kinds of things?
20. Can you think of anything about the help you get that you want to talk about that we haven't talked about already?
21. Is there anything you wish you could change about living here?

Appendix B: Summary of Targeted State Research

The rate study included a review of other states' approaches to paying for community residential services. The states selected for analysis (California, Colorado, Georgia, Minnesota and Oregon) reflect discussions with DSHS regarding potential states for analysis, represent a range of payment approaches for community residential services, and include neighboring states and states with similar geographic characteristics. Four of the five states reviewed had tiered per diem payment structures for residential services, with Minnesota using a tailored interactive rate model for each service type. All of payment structures provided some type of rate variation by provider type and number of individuals served. Three of the five (California, Colorado and Minnesota) varied payment rates by geographic area. All of the states included some kind of specialized payments for behavioral health, with Georgia using a separately reimbursed behavior supports service (paid in 15-minute units). While none of the states currently use a quality incentive payment program, California is developing a program for implementation in 2025. The exhibit below provides additional detail by state.

EXHIBIT B-1: SUMMARY OF STATE APPROACHES FOR REFERENCE

STATE	OVERALL APPROACH	NUMBER OF RESIDENTIAL PAYMENT TIERS	BEHAVIORAL HEALTH SPECIALIZED PAYMENTS	PAYMENT RATES VARY BASED ON SIZE / TYPE OF RESIDENCE	PAYMENT RATE VARIES BASED ON GEOGRAPHY	RATE UPDATES	QUALITY INCENTIVE PROGRAMS OR DATA COLLECTION
Washington *(for reference)*	Tiered per diem rates	9	Not separately identified	Yes	Yes – Metropolitan Statistical Area and Non-Metropolitan Statistical Area and King County	Subject to legislative approvals	Submits National Core Indicator (NCI) data
California	Tiered per diem rates, with supported living paid on an hourly basis with rates varying by staffing (1:1, 1:2, 1:3) and region	6	Paid via specialized Adult Residential Facilities with customizable rate models	Yes	Yes – 21 regions	Subject to state budget process after 2025	Quality incentive program under development for implementation in 2025. Submits NCI data
Colorado	Tiered per diem rates	7	Reflected in the highest tiered rate level, and via specialized cost-based contracts	Yes	Yes – Denver County versus all other	Upon waiver renewals and as changes to minimum wages are effective	Submits NCI data
Georgia	Tiered per diem rates, with community living support services paid on a fifteen-minute basis with rates varying by	4	Behavior support services are independent of residential and community living supports and paid in 15-minute intervals.	Yes	No	Updated as needed	Submits NCI data

STATE	OVERALL APPROACH	NUMBER OF RESIDENTIAL PAYMENT TIERS	BEHAVIORAL HEALTH SPECIALIZED PAYMENTS	PAYMENT RATES VARY BASED ON SIZE / TYPE OF RESIDENCE	PAYMENT RATE VARIES BASED ON GEOGRAPHY	RATE UPDATES	QUALITY INCENTIVE PROGRAMS OR DATA COLLECTION
	staffing (1:1, 1:2, 1:3)						
Minnesota	Tailored interactive rate model frameworks by service (daily and hourly payment rates)	Not applicable	Rate model frameworks allow for tailoring specific to behavioral health needs	Yes	Yes – via a county-specific regional variance factor	Biannually for major rate buildup components, every six years for regional variance factor	Submits NCI data
Oregon	Tiered per diem rates for 24-hour residential services, with attendant care support paid hourly with rates varying for 1:1 versus 1:2 care	4	Not identified specifically, but an “Exceptional Approval” process is available for approving 2:1 hourly attendance and/or relief care	Yes	No	Updated as needed	Submits NCI data

Appendix C: Provider Financial Performance

This appendix provides additional detail regarding provider financial performance, as measured by provider revenue to expense ratio. We included COVID related expenses as providers indicated that the majority of the COVID funds were used to pay DSP wages and retention bonuses. Providers expect these expenses to continue in order to retain staff. In anticipation of the upcoming phase out of temporary COVID rate increases by July 1, 2024, we have also included analyses of what the provider financial performance would have been in 2021 and 2022 in the absence of this temporary COVID revenue. We have relied on 2019, 2021, and 2022 Developmental Disabilities Administration Residential Support Program Cost Report data for these calculations and did not include 2020 data due to the uniqueness of the experience in that year.

Transportation is separately funded outside the two major cost components (ISS and non-ISS). As such, we have excluded transportation revenue and expenses when calculating the ratio of total revenues to expenses (ISS and non-ISS combined) and the ratio of non-ISS revenues to expenses.

The remainder of this appendix provides summaries of various detailed provider financial performance analyses.

RATIO OF REVENUES TO EXPENSES – 2019 TO 2022

The following exhibit series summarizes provider financial performance in 2019, 2021 and 2022, both including and excluding COVID temporary revenue. These exhibits highlight the impact of the temporary COVID revenue, indicating that in the absence of this revenue, the overall ratio of provider revenue to expenses in 2022 would have been 90% as compared to 98.6%.

Exhibit C-1 below summarizes overall provider financial performance (with ISS and non-ISS components combined) in 2019, 2021 and 2022. This analysis includes temporary COVID revenue.

EXHIBIT C-1: PROVIDER COMBINED FINANCIAL PERFORMANCE WITH TEMPORARY COVID REVENUE (ACTUAL)

	CLIENT DAYS	ISS AND NON-ISS EXPENSES PER CLIENT DAY (EXCLUDING TRANSPORTATION)	ISS AND NON-ISS REVENUES PER CLIENT DAY (EXCLUDING TRANSPORTATION)	REVENUE AS % OF EXPENSES (EXCLUDING TRANSPORTATION)
2019	1,519,763	$361.61	$352.24	97.4%
2021	1,480,696	$475.13	$485.03	102.1%
2022	1,491,132	$552.49	$544.51	98.6%

Exhibit C-2 following summarizes overall provider financial performance (with ISS and non-ISS components combined) in the absence of temporary COVID revenue for 2019, 2021 and 2022. This analysis reflects the actual performance for 2019 and a hypothetical scenario for 2021 and 2022 that excludes the temporary COVID revenue.

EXHIBIT C-2: PROVIDER COMBINED FINANCIAL PERFORMANCE WITHOUT TEMPORARY COVID REVENUE (HYPOTHETICAL)

	CLIENT DAYS	ISS AND NON-ISS EXPENSES PER CLIENT DAY (EXCLUDING TRANSPORTATION)	ISS AND NON-ISS REVENUES PER CLIENT DAY (EXCLUDING TEMPORARY COVID REVENUE AND TRANSPORTATION)	REVENUE AS % OF EXPENSES (EXCLUDING TEMPORARY COVID REVENUE AND TRANSPORTATION)
2019	1,519,763	$361.61	$352.24	97.4%
2021	1,480,696	$475.13	$437.85	92.2%
2022	1,491,132	$552.49	$498.00	90.1%

Exhibits C-3 and C-4 provide a breakdown of financial performance excluding temporary COVID revenue for the ISS and non-ISS components, respectively. This analysis reflects the actual performance for ISS component and a hypothetical scenario for non-ISS component due to the exclusion of COVID revenue that providers reported as part of non-ISS revenue in the cost reports.

EXHIBIT C-3: PROVIDER FINANCIAL PERFORMANCE BY COMPONENT WITHOUT TEMPORARY COVID REVENUE – ISS

	CLIENT DAYS	ISS EXPENSES PER CLIENT DAY	ISS REVENUES PER CLIENT DAY (POST SETTLEMENT)	ISS REVENUE AS % OF EXPENSES
2019	1,519,763	$314.50	$308.38	98.1%
2021	1,480,696	$408.28	$387.54	94.9%
2022	1,491,132	$472.55	$443.34	93.8%

EXHIBIT C-4: PROVIDER FINANCIAL PERFORMANCE BY COMPONENT WITHOUT TEMPORARY COVID REVENUE – NON-ISS

	CLIENT DAYS	NON-ISS EXPENSES PER CLIENT DAY (EXCLUDING TRANSPORTATION)	NON-ISS REVENUES PER CLIENT DAY (EXCLUDING TEMPORARY COVID REVENUE AND TRANSPORTATION)	NON-ISS REVENUE AS % OF EXPENSES (EXCLUDING TEMPORARY COVID REVENUE AND TRANSPORTATION)
2019	1,519,763	$47.11	$43.86	93.1%
2021	1,480,696	$66.85	$50.31	75.3%
2022	1,491,132	$79.94	$54.66	68.4%

RATIO OF REVENUES TO EXPENSES – 2022 BY PROVIDER TYPE AND AREA, EXCLUDING TEMPORARY COVID REVENUE

Exhibit C-5 below summarizes providers' 2022 combined financial performance (ISS and non-ISS) by provider type and area in the absence of temporary COVID revenue. Exhibits C-6 and C-7 provide a similar analysis specific to the ISS and non-ISS components, respectively. These exhibits reflect a hypothetical scenario due to the exclusion of COVID revenue. The low non-ISS revenue to expense ratio as displayed for Non-Metropolitan Statistical Area in Exhibit C-7 is primarily due to one large provider with very high non-ISS cost reported in 2022.

EXHIBIT C-5: 2022 PROVIDER COMBINED FINANCIAL PERFORMANCE ANALYSIS

	PROVIDER COUNTS (BY 9 DIGIT ID)	CLIENT DAYS	ISS AND NON-ISS EXPENSES PER CLIENT DAY (EXCLUDING TRANSPORTATION)	ISS AND NON-ISS REVENUES PER CLIENT DAY (EXCLUDING TEMPORARY COVID RATE INCREASE AND TRANSPORTATION)	ISS REVENUE AS % OF EXPENSES (EXCLUDING TEMPORARY COVID RATE INCREASE AND TRANSPORTATION)
By Provider Type					
Supported Living Providers	117	1,281,979	$552.39	$497.33	90.0%
Group Home Providers	8	28,152	$490.02	$454.85	92.8%
Supportive Living and Group Home Providers	14	181,001	$562.96	$509.47	90.5%
By Area					
King County	34	377,245	$587.82	$539.98	91.9%
Non-Metropolitan Statistical Area	92	1,009,761	$546.75	$491.55	89.9%
Non-Metropolitan Statistical Area	13	104,126	$480.21	$408.49	85.1%
All Providers	**139**	**1,491,132**	**$552.49**	**$498.00**	**90.1%**

Exhibits C-6 and C-7 provide a breakdown of the 2022 revenue to expense ratios without temporary COVID revenue from Exhibits C-3 and C-4 by each component (ISS and non-ISS) and by provider type and area.

EXHIBIT C-6: 2022 PROVIDER FINANCIAL PERFORMANCE ANALYSIS WITHOUT TEMPORARY COVID REVENUE – ISS COMPONENT, WITH BREAKDOWN BY PROVIDER TYPE AND AREA

	PROVIDER COUNTS (BY 9 DIGIT ID)	CLIENT DAYS	ISS EXPENSES PER CLIENT DAY	ISS REVENUES PER CLIENT DAY (POST SETTLEMENT)	REVENUE AS % OF EXPENSES
By Provider Type					
Supported Living Providers	117	1,281,979	$472.48	$443.82	93.9%
Group Home Providers	8	28,152	$390.79	$386.61	98.9%
Supportive Living and Group Home Providers	14	181,001	$485.80	$448.82	92.4%
By Area					
King County	34	377,245	$510.99	$480.95	94.1%
Metropolitan Statistical Area	92	1,009,761	$468.03	$437.78	93.5%
Non-Metropolitan Statistical Area	13	104,126	$377.17	$361.10	95.7%
All Providers	**139**	**1,491,132**	**$472.55**	**$443.34**	**93.8%**

EXHIBIT C-7: 2022 PROVIDER FINANCIAL PERFORMANCE ANALYSIS WITHOUT TEMPORARY COVID REVENUE – NON-ISS COMPONENT, WITH BREAKDOWN BY PROVIDER TYPE AND AREA

	PROVIDER COUNTS (BY 9 DIGIT ID)	CLIENT DAYS	NON-ISS EXPENSES PER CLIENT DAY (EXCLUDING TRANSPORTATION)	NON-ISS REVENUES PER CLIENT DAY (EXCLUDING TEMPORARY COVID REVENUE AND TRANSPORTATION)	NON-ISS REVENUE AS % OF EXPENSES (EXCLUDING TEMPORARY COVID REVENUE AND TRANSPORTATION)
By Provider Type					
Supported Living Providers	117	1,281,979	$79.91	$53.51	67.0%
Group Home Providers	8	28,152	$99.23	$68.24	68.8%
Supportive Living and Group Home Providers	14	181,001	$77.16	$60.65	78.6%
By Area					
King County	34	377,245	$76.83	$59.04	76.8%
Metropolitan Statistical Area	92	1,009,761	$78.72	$53.77	68.3%

	PROVIDER COUNTS (BY 9 DIGIT ID)	CLIENT DAYS	NON-ISS EXPENSES PER CLIENT DAY (EXCLUDING TRANSPORTATION)	NON-ISS REVENUES PER CLIENT DAY (EXCLUDING TEMPORARY COVID REVENUE AND TRANSPORTATION)	NON-ISS REVENUE AS % OF EXPENSES (EXCLUDING TEMPORARY COVID REVENUE AND TRANSPORTATION)
Non-Metropolitan Statistical Area	13	104,126	$103.05	$47.39	46.0%
All Providers	**139**	**1,491,132**	**$79.94**	**$54.66**	**68.4%**

NON-ISS EXPENSE ANALYSIS

In addition to financial performance analysis, we also performed targeted non-ISS expense analyses using 2022 cost report data, specifically:

- Overall non-ISS expense percentage, measured as a percentage of total program expenses across all providers.
- Variation of non-ISS expense percentage by provider size, intended to evaluate the presence of economics of scale.
- Variation of non-ISS expense percentage by provider type, intended to examine any material non-ISS expense percentage difference between supported living providers and group home providers. We determined provider size at parent company level based on the first 7 digits of the 9-digit provider IDs.

Overall, we observe the following:

- Non-ISS expenses as a percentage of total program expenses was 14.5% in 2022.
- Variation in the non-ISS percentage across provider size indicates some level of economics of scale as the expense percentage decreases as provider size increase from micro size group to small size group and then to large size group. There is not, however, a straight linear relationship between provider size and non-ISS expense percentage in 2022 since the relationship reverses for medium size group and jumbo size group due to provider-specific variation in both the medium and jumbo size groups.

Exhibit C-8 following summarizes the overall non-ISS expense percentage and the variation of non-ISS expense percentage by provider size.

EXHIBIT C-8: NON-ISS EXPENSE PERCENTAGE BY PROVIDER SIZE, 2022

	PROVIDER COUNT (BY 7 DIGIT ID)	CLIENT DAYS	NON-ISS EXPENSES PER CLIENT DAY	TOTAL PROGRAM EXPENSES PER CLIENT DAY	NON-ISS EXPENSES PERCENTAGE
By Size					
Jumbo (100+ Clients)	7	475,294	$88.93	$623.44	14.3%
Large (60+ Clients)	15	384,357	$65.12	$546.55	11.9%
Medium (30+ Clients)	24	357,546	$89.33	$500.62	17.8%
Small (10+ Clients)	39	245,921	$70.96	$501.22	14.2%
Micro (<10 Clients)	19	28,014	$89.66	$542.43	16.5%
All Providers	**104**	**1,491,132**	**$79.94**	**$552.49**	**14.5%**

Exhibit C-9 below summarizes the variation of non-ISS expense percentage by provider type in 2022. Group home providers incurred materially higher non-ISS percentages in 2022 than supported living providers on average, which appears to align with the current non-ISS rate variations across the two types of services.

EXHIBIT C-9: NON-ISS COST PERCENTAGE BY PROVIDER TYPE, 2022

	PROVIDER COUNT (BY 9 DIGIT ID)	CLIENT DAYS	NON-ISS EXPENSES PER CLIENT DAY	TOTAL PROGRAM EXPENSES PER CLIENT DAY	NON-ISS EXPENSE PERCENTAGE
By Provider Type					
Supported Living Providers	117	1,281,979	$79.91	$552.39	14.5%
Group Home Providers	8	28,152	$99.23	$490.02	20.3%
Providers of Both SL and GH	14	181,001	$77.16	$562.96	13.7%
All Providers	**139**	**1,491,132**	**$79.94**	**$552.49**	**14.5%**

Appendix D: Instruction and Support Services Staff Wages and Staffing

Instruction and support services staff compensation is the largest cost component for community residential services. This appendix summarizes analyses of various aspects of ISS staff compensation, specifically:

- ISS staff hourly wages.
- Geographic wage variations.
- Wage trend analysis.
- Wage comparison to competing occupations.
- Employee related expenses.
- Turnover rate.
- Staffing.

Instruction and support service staff provide direct and indirect services related to providing the assessed level of support and instruction to clients.

Non-ISS staff support administrative, operating and other non-ISS functions.

DATA SOURCES USED IN ANALYSIS

We have primarily relied on 2019 – 2022 Developmental Disabilities Administration Community Residential Staffing Survey data for our analyses of ISS staff hourly wages and geographic wage variations, turnover rates and staffing. An analysis of average wages during the first six months and second six months of 2022 was possible as DSHS modified the cost report template for that year to collect data to assess the impact on wages of the July 1, 2022, ISS rate increase.

For the hourly wage, wage trend and competing occupations analyses, we also used Washington-specific minimum wage data and BLS average wage data. We used 2021 Developmental Disabilities Administration cost report data to perform the analysis of employee-related benefits as the detailed Schedule B and F 2022 data were not available at the time of this analysis.

Exhibit D.1 following provides a summary of the data sources used by type of analysis.

EXHIBIT D-1: SUMMARY OF DATA SOURCES USED FOR WAGE AND STAFFING ANALYSES

DATA SOURCE	ISS HOURLY WAGES	GEOGRAPHIC WAGE VARIATION	WAGE TREND	COMPETING OCCUPATIONS	TURN-OVER	STAFFING	EMPLOYEE RELATED BENEFITS
Developmental Disabilities Administration Community Residential Staffing Survey	2019-2022	July-December 2022	2019-2022	2022	2022	2019, 2022	
Developmental Disabilities Administration cost report data						2019, 2022	2021, Schedules B and F
Washington state minimum wage			2019-2022	2022			
Seattle minimum wage			2019-2022	2022			
BLS			2019-2022*	May 2022 - mean wages from competing occupations			

*Average wages from the Healthcare Support Occupations major occupational classification group (31-0000) for Residential Intellectual and Developmental Disability Facilities (North American Industry Classification System 623200). These data are only available at the national level.

AVERAGE HOURLY WAGE BY ISS STAFF TYPE

All ISS staff types for community residential services experienced notable increases in average hourly wages from 2019 to 2022 as illustrated in Exhibit D-2. Average hourly wages also increased notably within 2022, presumably as a result of the July 1, 2022, ISS rate increase.

EXHIBIT D-2: CALENDAR YEAR 2019 - 2022 AVERAGE HOURLY WAGE BY ISS STAFF TYPE

	ENTRY LEVEL (DSP)	1ST LINE SUPERVISORS	PROGRAM MANAGERS	SPECIALISTS	NURSES (RN, LPN)
2019	$14.38	$18.31	$22.82	$21.27	$31.48
2020	$15.38	$19.31	$23.72	$21.98	$32.23
2021	$16.73	$21.16	$26.73	$24.44	$32.38
2022 (Jan-Jun)	$17.89	$22.28	$28.55	$25.66	$33.96
2022 (Jul-Dec)	$20.12	$24.52	$30.94	$28.12	$36.11

Notes: The average hourly wage is equal to the average of the “Starting” (new hire wages) and “After Two Years” (wages for staffs with 2+ years of tenure) hourly wages as reported in the Developmental Disabilities Administration Community Residential Staffing Survey.

COMPARISON OF DSP WAGES TO COMPETING INDUSTRIES

DSPs are the primary staff position employed by providers to provide community residential services in Washington. As such, we have focused the wage comparison to similar occupations as DSPs to inform the competitiveness of current ISS staff wage levels. While there is no dedicated BLS occupational code available for DSPs, we considered “Home Health and Personal Care Aids” to be the most similar occupation to DSPs available in the BLS data. We identified competing occupations based on our experience working with other states and information gained from key informant interviews conducted for this rate study.

The average 2022 DSP wage ($20.12) from the Developmental Disabilities Administration Community Residential Staffing Survey was higher than BLS average wages for home health and personal care aides, and higher or similar to BLS average wages for competing industries in Washington, as illustrated in Exhibit D-3 below. The exhibit also includes the state minimum wage and Seattle minimum wage as additional comparison points. There were two Seattle minimum wages in 2022 and we used the higher wage for this analysis.

EXHIBIT D-3 AVERAGE HOURLY WAGE COMPARISON

Sources: Developmental Disabilities Administration Community Residential Staffing Survey, Washington-specific average BLS wages, Washington and Seattle minimum wages. For DSP average hourly wage is equal to the average of the “Starting” (new hire wages) and “After Two Years” (wages for staffs with 2+ years of tenure) hourly wages as reported in the Developmental Disabilities Administration Community Residential Staffing Survey.

WAGE VARIATION BY GEOGRAPHIC AREA

Average wages in 2022 were notably higher for King County but similar between Non-Metropolitan Statistical Area and Non-King Metropolitan Statistical Area when compared to the statewide level. Exhibit D-4 below provides a summary of the wage variation as measured by the geographical wage factors across the three mutually exclusive rating regions for the most prevalent ISS staff type (DSPs). We calculated regional wage factors by comparing the regional wage average available in the survey data to the statewide wage average.

EXHIBIT D-4: GEOGRAPHIC WAGE VARIATION ANALYSIS, 2022 JULY - DECEMBER

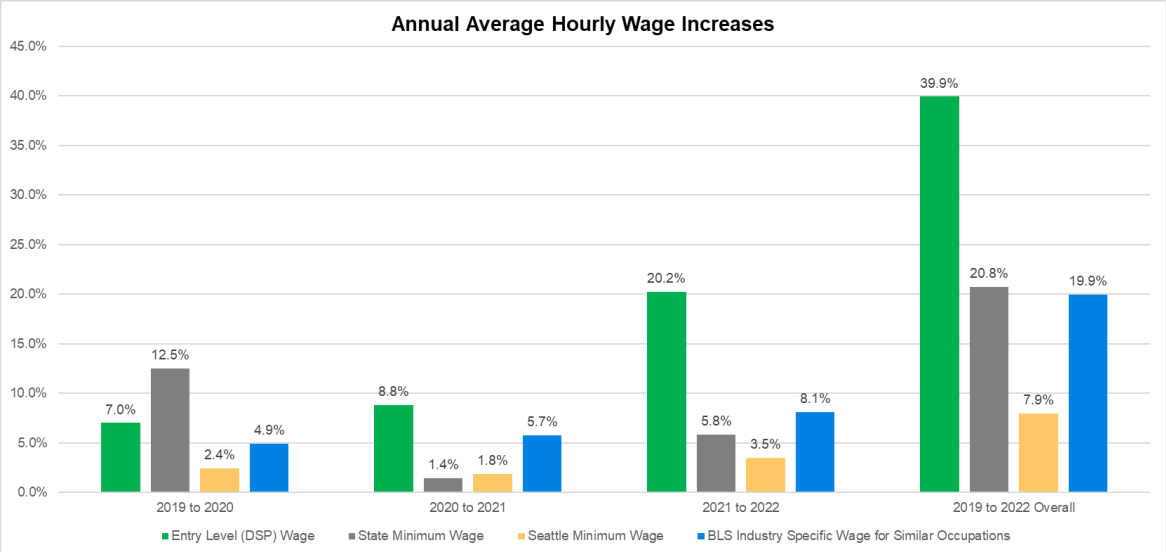
	DSP AVERAGE WAGE	GEOGRAPHICAL WAGE FACTORS
By Urban Designation		
King	$21.14	1.051
Metropolitan Statistical Area	19.79	0.984
Non-Metropolitan Statistical Area	19.61	0.975
Statewide Total	**$20.12**	**1.000**

Source: Developmental Disabilities Administration Community Residential Staffing Survey.

WAGE TREND ANALYSIS

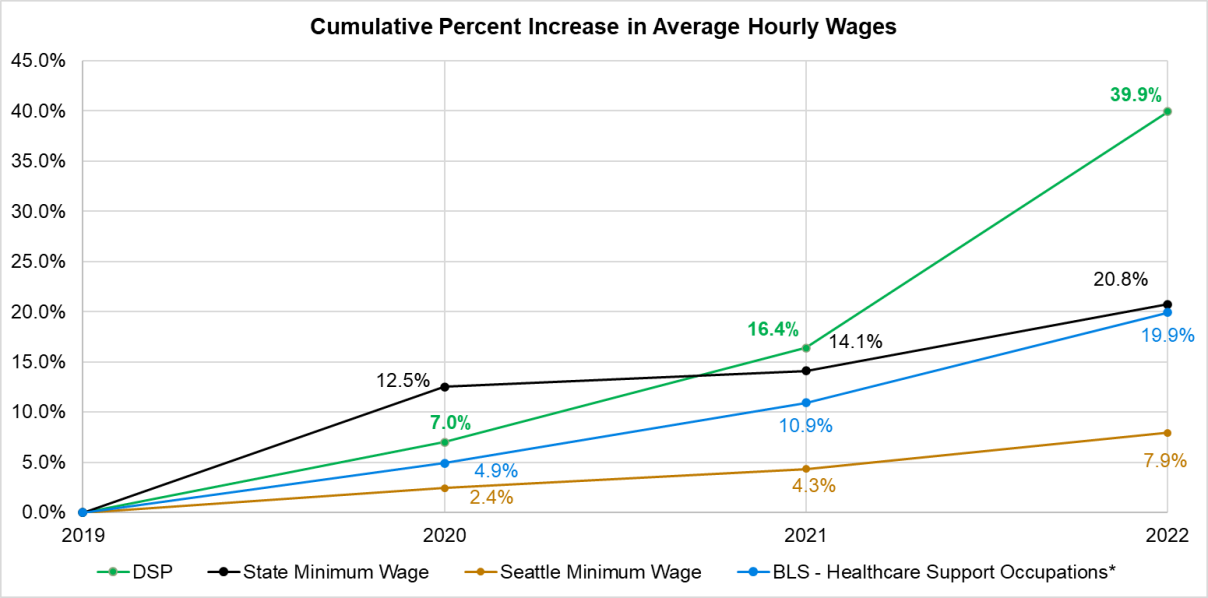
The annual and cumulative average DSP wage increases from 2019 to 2022 outpaced both Washington and Seattle minimum wages increases and national average wage increases for health care support occupations in residential facilities for people with intellectual and developmental disabilities. Exhibits D-5 and D-6 following provide additional detail.

EXHIBIT D-5: ANNUAL AVERAGE HOURLY WAGE INCREASES



Notes: The source for the average DSP wage was the Developmental Disabilities Administration Community Residential Staffing Survey. There are two Seattle minimum wages for each year and we used the higher wage from each year for this analysis. The source for the BLS industry specific wage for similar occupations was the Healthcare Support Occupations major occupational classification group (31-0000) for Residential Intellectual and Developmental Disability Facilities (North American Industry Classification System 623200); these data are only available at the national level.

EXHIBIT D-6: CUMULATIVE PERCENT INCREASE IN AVERAGE HOURLY WAGES, 2019-2022



Notes: The source for the average DSP wage was the Developmental Disabilities Administration Community Residential Staffing Survey. There are two Seattle minimum wages for each year and we used the higher wage from each year for this analysis. The source for the BLS industry specific wage for similar occupations was the Healthcare Support Occupations major occupational classification group (31-0000) for Residential Intellectual and Developmental Disability Facilities (North American Industry Classification System 623200); these data are only available at the national level.

EMPLOYEE RELATED EXPENSE ANALYSIS

Employee related expenses (ERE) generally include two major components:

- Tax/withholding component including various state and federal mandated payroll taxes.
- Benefit component reflecting the employer costs of benefits such as health insurance and retirement.

The median provider ERE as a percentage of total payments (net of overtime and other compensation) was 19.8% in 2021. Median provider tax and benefit portions of ERE for that same time period were 11.3% and 8.5% of total payments (net of overtime and other compensation), respectively. We excluded overtime pay and other compensation from total payments as employer sponsored benefits are generally not impacted by overtime pay and other compensation. Exhibit D-7 provides a summary of this analysis, which relies on Schedule B of the Developmental Disabilities Administration cost report data. Schedule B provides key payroll data for ISS staff that includes various wage components such as regular pay, overtime pay, paid time off, other compensation (primarily temporary COVID-19 bonus pay funded through the American Rescue Plan Act) and employee taxes and benefits.

EXHIBIT D-7: EMPLOYEE RELATED EXPENSE ANALYSIS, 2021

	MEDIAN
ERE % (Tax portion)	11.3%
ERE % (Benefit portion)	8.5%
ERE % (Total)	19.8%

Source: 2021 Developmental Disabilities Administration cost report data, Schedule B.

Approximately 86% of community residential service providers offered a health insurance benefit to their employees in 2021. For those providers offering a health insurance benefit, both the percentage of staff signing up for the employer sponsored health insurance (known as the participation or “take up” rate) and the monthly employer paid health insurance cost for each participant varied substantially at the provider level. In 2021, the median health insurance take up rate was 41%, and the average monthly health insurance cost paid by providers per participating employee was $455.92. Exhibit D-8 provides a summary of this analysis.

EXHIBIT D-8: HEALTH INSURANCE EXPENSE ANALYSIS, 2021

	MEDIAN
Staff Health Insurance Participation Rate	40.8%
Average Monthly Health Insurance Cost Paid by Providers per Participating Employee	$455.92

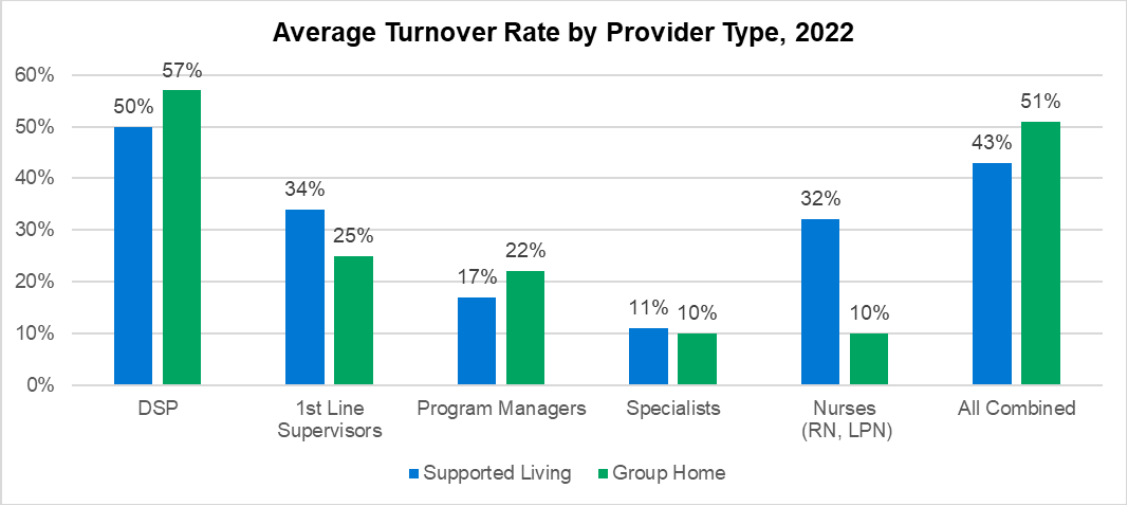
Source: 2021 Developmental Disabilities Administration cost report data, Schedule F.

ISS STAFF TURNOVER

Overall turnover rates for ISS staff were high despite the notable wage increases occurring within 2022. DSPs experienced the highest level of turnover compared to the other positions (50% for supported living), followed by 1st line supervisors (34% for supported living). The high DSP turnover rate likely reflects the high wage pressure on this staff type due to the inflation and the workforce shortage. While this dynamic is not unique to Washington state, the DSP turnover rate appears to be higher than the 33.3% national average for a comparable employee position listed in the 2021 National Core Indicator Intellectual and Developmental Disabilities Staff Stability Survey Report.[8] Exhibit D-9 provides a summary of turnover by provider type.

[8] Source: NASDDDS and HSRI. National Core Indicator Intellectual and Developmental Disabilities 2021: State of the Workforce Survey Report. Retrieved from: https://idd.nationalcoreindicators.org/wp-content/uploads/2023/02/2021StateoftheWorkforceReport_FINAL.pdf. Reflects reflecting 3,838 provider agencies from 29 states and including the District of Columbia.

EXHIBIT D-9: AVERAGE TURNOVER RATE BY PROVIDER TYPE, 2022



Source: 2022 Developmental Disabilities Administration Community Residential Staffing Survey

ESTIMATED ISS STAFFING PER CLIENT DAY

The overall estimated average number of ISS staff per client day increased slightly from 2.04 in 2019 to 2.17 in 2022 and is largely driven at the DSP staff level, as illustrated in Exhibit D-10. The overall estimated average number of ISS staff per client day is consistent with the most recent snapshot of client payment rate tier distribution, which shows the majority of individuals assigned to payment rate tiers 4 or 5. Thes tiers require approximately 2 shifts of ISS supports after adjustments for economics of scale gained from shared living arrangements for an average client day.

There were very few specialists identified in the Developmental Disabilities Administration Community Residential Staffing survey data, reflecting the staffing challenges and constraints that the providers currently face to provide behavioral supports to those clients with complex behavioral support needs.

The estimated average number of ISS staff per client day calculation includes the assumption that reported staff counts in the cost report data are equivalent to staff full time equivalent counts given the material amount of overtime worked (as informed by the cost report data). We estimated the average number of ISS staff per client day as the ratio of estimated paid staff days to paid client days (staff counts multiplied by 260 then divided by number of client day). We used the staff counts as summarized under “Total positions” in the Developmental Disabilities Administration Community Residential Staffing Survey data and the total client days as reported in the Developmental Disabilities Administration Residential Support Program Cost Report data.

EXHIBIT D-10: AVERAGE ISS STAFFING RATIOS, 2019 AND 2022

	DSP	1ST LINE SUPERVISORS	PROGRAM MANAGERS	SPECIALISTS	NURSES	ALL COMBINED
2019 Staff Per Client Day	1.74	0.16	0.08	0.05	0.01	2.04
2022 Staff Per Client Day	1.88	0.14	0.08	0.06	0.01	2.17

Source: Developmental Disabilities Administration Community Residential Staffing Survey and Developmental Disabilities Administration Residential Support Program Cost Report, 2019 and 2022

FEEDBACK FROM INTERVIEWS WITH NATIONAL AND STATE ASSOCIATIONS AND PROVIDERS

The following wage-related themes were raised during interviews with national and state associations and during provider group interviews:

- Expectations for DSPs are high as compared to other positions with similar wages levels. Interviewees expressed that DSPs face challenges related to the complexity of needs of the individuals they serve, the physicality of the role, intense hours and non-ISS responsibilities.
- Competing industries have lower entry requirements, e.g., less applicant screening and licensure requirements.
- Hiring staff to support individuals with high behavioral support needs is challenging and there is an overall need to provide a clear path to DSPs for advancement.

Washington providers and associations also provided the following feedback:

- Recent legislative increases helped providers “catch up” but competing industries continue to raise wages (and can pass the costs on to the consumer), while residential service providers are dependent on funding increases from the State Legislature.
- Current wages do not match the complexity of DSP responsibilities.
- Increases in wages do not keep pace with housing costs.
- Predictable increases in payment rates would support necessary wage increases.
- Health insurance benefit expenses have increased over tie.

Staff interviewed from Washington’s Community Protection Program Association indicated that Community Protection Program DSPs are not paid more than other caregivers and that tend to be more predominately male.

Appendix E: Fiscal Impact Analysis

This appendix provides a description of the high-level fiscal impact estimates associated with the following recommendations included in this rate study:

- **Update current tiered payment rates** to fully reflect increase in instruction and supportive services expenses and non-ISS expenses, specifically based on calendar year 2022 provider experience and anticipating the continuation of ISS staff compensation increases implemented by providers through temporary rate increases.
- Allow all providers the opportunity to access a set of **mutually exclusive add-on per diem payments** that reflect the range of approaches (and related costs) involved in supporting individuals with complex behavioral support needs.

Instruction and support services (ISS) expenses refer to expenses for direct and indirect services related to providing the assessed level of support and instruction to clients.

Non-ISS expenses are administrative, operating and other non-ISS costs (excluding transportation).

FISCAL IMPACT ESTIMATE FOR UPDATES TO CURRENT TIERED PAYMENT RATES

The estimated fiscal impact (including non-federal and federal share) of the recommendation to update rates as described above would be approximately $81 million (10.0% of total 2022 payments), based on calendar year 2022 utilization. The estimated fiscal impact would decrease to approximately $38 million (4.6% of total payments) if the portion of the rate updates intended to account for provider ISS expenses currently covered by temporary COVID revenue (for increases to compensation) are excluded. Legislative action would be required to implement any updates to payment rates.

The recommendation for updating current tiered payment rates does not include an estimate of cost increases beyond 2022 given the significant amount of uncertainties related to the current inflation environment, workforce shortage and the unwinding impact of public health emergency related to Medicaid financing. We recommend DSHS use a package of key community residential service program metrics to inform future funding decisions, as described in the recommendations section of this report.

The timing of the phase-out of the current temporary COVID revenue should be considered when evaluating timing for this recommendation, if adopted. Temporary COVID revenue is in the process of being phased out, with full phase-out occurring by July 1, 2024.

Exhibit E-1 on the following page provides a summary of the fiscal impact estimates, in total and by ISS component and non-ISS component. We did not vary the fiscal impact of removing temporary COVID revenues for the non-ISS component (Rows E and F) as a comparison of 2019 and 2022 cost report data for the related expense category (“Other Non-ISS Client Related Expenses”) shows a small aggregate change from 2019 to 2022 indicates an insignificant amount of COVID related non-ISS expense in 2022. Additionally, we do not expect a material change of COVID situation from 2022 to the near future so we concluded that it is not necessary to add additional scenarios for non-ISS cost increase related to COVID for the purpose of fiscal impact estimate.

EXHIBIT E-1: ANNUAL FISCAL IMPACT ESTIMATE OF RATE UPDATES TO COVER ISS AND NON-ISS COST AS REFLECTED IN 2022 COST REPORT

		ISS COMPONENT	NON-ISS COMPONENT	TOTAL
Client Days	A	1,491,132	1,491,132	1,491,132
Average payment rate per client day excluding temporary COVID revenue (CY 2022)	B	$443.34	$54.66	$498.00
Average cost per client day excluding ISS compensation increases funded by temporary COVID revenues (CY 2022)	C	$443.09	$79.94	$523.02
Average cost per client day including ISS compensation increases funded by temporary COVID revenues (CY 2022)	D	$472.55	$79.94	$552.49
Average payment rate increase necessary to cover expenses excluding ISS compensation increases funded by temporary COVID revenues	E=Max(C-B,0)	$0	$25.28	N/A
Average payment rate increase required to cover expenses including ISS compensation increases funded by temporary COVID revenues	F=Max(D-B,0)	$29.21	$25.28	N/A
Estimated fiscal impact excluding ISS compensation increases funded by temporary COVID revenues	G=A*E	$0	$37,696,157	$37,696,157
Estimated fiscal impact including ISS compensation increases funded by temporary COVID revenues	H=A*F	$43,555,841	$37,696,157	$81,251,998

Notes:
1. The average payment rate for ISS component reflects the adjusted reimbursement level post settlement.
2. The average payment rate for non-ISS component reflects the reimbursement level excluding temporary COVID revenue.
3. Estimate includes the assumption that there will be no material changes to the non-ISS cost absent temporary COVID revenue.
4. Calculation excludes transportation-related expenses and payments.

FISCAL IMPACT ESTIMATE FOR THE IMPLEMENTATION OF PER DIEM ADD-ON RATES FOR COMPLEX BEHAVIORAL SUPPORT NEEDS

The fiscal impact estimate for the per diem add-on rates for complex behavioral support needs is based on the three example add-on levels described in the report (Levels A, B and C) and includes two main steps.

Step 1: Estimate the per diem add-on rate for each of the three example levels.

We developed estimates of the three per diem add-on rates based on analyses of staffing and cost report data, discussion with DSHS program experts and feedback from the interviews with providers with experience providing complex behavioral supports. Exhibit E-2 at the end of this appendix provides a summary of the assumptions and calculations for each of the example levels described in the rate study. The lowest intensity per diem add-on (Level A) was $23.93 as compared to $183.88 for Level B and $384.07 for Level C.

Step 2: Estimate the total annual fiscal impact based using the estimated per diem add-on rates and assumed portions of total client days eligible for per diem add-on payments.

We first estimated the percentage of total clients or client days eligible for add-on rates based on a high-level analysis of 2022 member level assessment data provided by DSHS using the presence of behavioral score “2” for one or more of the six complex behavioral support indicators which include: emotional outburst, suicide attempt, sexual aggression, property destruction, self-injury and assaults or injuries to others. This analysis indicates that an estimated one third of clients have behavioral support needs. The actual distribution of eligible clients among the three levels is currently unknown, however, and will depend on the add-on eligibility criteria implemented.

As such, we created two distribution scenarios to illustrate the potential range of fiscal impact. The scenarios varied the proportion of applicable client days assumed by add-on level, specifically:

- Scenario 1 (low end) had a fiscal impact of $54 million and assumes that one third of total client days, or estimated half million client days, are eligible for add-on rates with a distribution that 60% of eligible client days would be assigned to Level A, 30% to Level B and 10% to Level C.
- Scenario 2 (high end) had a fiscal impact of $80 million and assumes that one third of total client days, or estimated half million client days, are eligible for add-on rates with a distribution that 40% of eligible client days would be assigned to Level A, 40% to Level B and 20% to Level C.

Exhibit E-3 at the end of this appendix provides additional detail regarding the calculation of the total annual fiscal impact.

EXHIBIT E-2: ESTIMATE OF RECOMMENDED ADD-ON RATES PER CLIENT DAY BY BEHAVIORAL SUPPORT ADD-ON LEVEL

		ADDITIONAL DSP TIME TO SUPPORT ENHANCED COORDINATION AND DOCUMENTATION	REDUCED GENERAL DSP TIME DUE TO USE OF "ENHANCED DSP" STAFF	"ENHANCED DSP" TIME FOR DIRECT CLIENT SUPPORT	BEHAVIORAL SUPPORT SPECIALIST TIME FOR OVERSIGHT, SUPERVISION, TRAINING AND COACHING	ALL ADDITIONAL STAFFING COMBINED
Hourly Wage	A	$21.76	$21.76	$26.76	$41.60	
Hourly wage adjustment for Employment Related Expenses	B	20%	20%	20%	20%	
Hourly wage adjustment for productivity (% of Paid Time working)	C	88%	88%	92%	92%	
Hourly wage with ERE and productivity adjustment	D=A*(1+B)/C	$29.52	$29.52	$34.79	$54.08	
Assumed additional # of working staff hours per client day (Level A)	E	0.40			0.16	0.56
Assumed additional # of working staff hours per client day (Level B)	F	0.60	(8.00)	8.00	1.80	2.40
Assumed additional # of working staff hours per client day (Level C)	G		(24.00)	24.00	3.73	3.73
Assumed non-ISS load	H	14.5%	14.5%	14.5%	14.5%	
Add-on rate per client day (Level A)	I=E*D/(1-H)	$13.81			$10.12	**$23.93**

		ADDITIONAL DSP TIME TO SUPPORT ENHANCED COORDINATION AND DOCUMENTATION	REDUCED GENERAL DSP TIME DUE TO USE OF "ENHANCED DSP" STAFF	"ENHANCED DSP" TIME FOR DIRECT CLIENT SUPPORT	BEHAVIORAL SUPPORT SPECIALIST TIME FOR OVERSIGHT, SUPERVISION, TRAINING AND COACHING	ALL ADDITIONAL STAFFING COMBINED
Add-on rate per client day (Level B)	J=F*D/(1-H)	$20.72	$(276.21)	$325.52	$113.85	**$183.88**
Add-on rate per client day (Level C)	K=G*D/(1-H)		$(828.64)	$976.57	$236.14	**$384.07**

Notes:

1. An "enhanced DSP" is defined as a behavioral technician or a DSP that completes a DSHS-approved credentialing program related to behavioral supports.
2. The hourly wage was informed by calendar year 2022 Developmental Disabilities Administration survey wage data (Jul-Dec 2022) and provider interview/feedback and trended to calendar year 2024 with a 4% annualized wage trend.
3. The employment related expense assumption was informed by calendar year 2021 cost report data.
4. The productivity adjustment reflects an assumption of 20 days of paid time off for all positions and an additional 80 hours of training for general DSPs providing PBSP and Functional Assessment supports.
5. It was assumed (informed by provider interviews and feedback) that Level A behavioral support expects the following additional staffing:
    a) An additional 0.4 hours of DSP time in an average client day to support PBSP development and Functional Assessment related activities
    b) An additional 0.16 hours of Behavioral Support Specialist time in an average client day to provide oversight regarding PBSP development and Functional Assessment related activities
6. It was assumed (informed by provider interviews and feedback) that Level B behavioral support expects the following additional staffing:
    a) An additional 0.6 hours of DSP time in an average client day to support PBSP development and Functional Assessment related activities
    b) An additional 1.8 hours of Behavioral Support Specialist time in an average client day to provide oversight, supervision, training and coaching regarding behavioral support needs
    c) A replacement of 8 hours of general DSP time with enhanced DSP time for direct client support in an average client day
7. It was assumed (informed by provider interviews and feedback) that Level B behavioral support expects the following additional staffing:
    a) An additional 3.73 hours of Behavioral Support Specialist time in an average client day to provide PBSP development and Functional Assessment related activities, supervision, training and coaching regarding behavioral support needs.
    b) A replacement of 24 hours of general DSP time with enhanced DSP time for direct client support in an average client day.

EXHIBIT E-3: ANNUAL FISCAL IMPACT ESTIMATE OF IMPLEMENTING RECOMMENDED ADD-ON RATES

	DISTRIBUTION OF ADD-ON LEVELS	ASSUMED CLIENT DAYS ELIGIBLE FOR ADD-ON RATES	IMPLIED CLIENT COUNTS ELIGIBLE FOR ADD-ON RATES	ADD-ON RATE PER CLIENT DAY	ESTIMATED FISCAL IMPACT
Scenario 1 (Low)	**A**	**B=All Levels Combined * A**	**C=B/365**	**D**	**E=B*D**
Level A	60%	300,000	822	23.93	$7,179,276
Level B	30%	150,000	411	183.88	$27,581,770
Level C	10%	50,000	137	384.07	$19,203,411
All Levels Combined		**500,000**	**1,370**		**$53,964,458**
Scenario 2 (High)	**A**	**B=All Levels Combined * A**	**C=B/365**	**D**	**E=B*D**
Level A	40%	200,000	548	23.93	$4,786,184
Level B	40%	200,000	548	183.88	$36,775,694
Level C	20%	100,000	274	384.07	$38,406,821
All Levels Combined		**500,000**	**1,370**		**$79,968,700**

Notes: It was assumed that one third of total existing clients, or an estimated 0.5 million out of a total 1.5 million client days in 2022, would need complex behavioral supports and be eligible for add-on rates.

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