

Washington State Department of Social and Health Services

Transforming
Lives

Report to the Legislature

Medicaid Assisted Living Facility Rates Methodology
Workgroup Recommendations
Chapter 1, Laws of 2017,
SSB 5883, Section 206

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Executive Summary

The 2017 Legislature directed the Department of Social and Health Services (the Department) to facilitate a stakeholder work group review of the Medicaid payment methodology for contracted assisted living, adult residential care, and enhanced adult residential care. The initial methodology originates from the early to mid-2000s and for several reasons, a documented methodology to support assisted living Medicaid payments no longer exists (See *Background and Appendix B for details*).

In accordance with federal regulations, the Centers for Medicare and Medicaid Services (CMS) rely on states to help assure the sufficiency of rates and compliance with the Social Security Act 1902(1)(30)(A) – efficiency, economy, quality of care, and payments that are sufficient to enlist enough providers that Medicaid beneficiaries have access to services. Following CMS guidelines for ensuring rate sufficiency, the stakeholder work group:

- Reviewed changes in assisted living Medicaid client capacity;
- Established benchmarks for comparable services;
- Developed rate assumptions using available data; and
- Analyzed and incorporated feedback from stakeholder work group participants.

As required by Chapter 1, Laws of 2017, 3rd special session, (SSB 5883, Section 206), this report provides stakeholder recommendations to the Legislature to redesign the Medicaid assisted living payment methodology.

The work group recommendations fall into the following categories: system architecture; payment methodology for client services, operations, room and board; and timeline for implementation and rebasing. It is important to note that while the nursing facility Medicaid methodology has considerations for budgetary responsiveness built in, this proposed methodology does not. Budgetary actions would need to be either built in or addressed outside of the methodology components.

Final Recommendations

The work group recommends the 2018 Legislature provide the framework and rule-making authority in RCW 74.39A to establish a new Medicaid payment methodology for Assisted Living Medicaid rates. Beginning July 1, 2019, the Department would adopt the new data-driven payment methodology. An implementation schedule will be provided to the 2019 Legislature.

The work group recommends an updated rate methodology be implemented for multiple reasons, including the need for rates to reflect the contemporary cost of providing services and the desire to promote the least restrictive and most cost-efficient living options for clients. This work stands to impact the more than 6,000 Medicaid clients who live in assisted living facilities and the approximately 300 providers that serve them.

Recommendations for further review

Given the compressed timeline, the work group was not able to thoroughly address all areas of the payment system. The work group recommends additional research and discussion on two areas over the 2018 interim before the recommended implementation date of July 1, 2019:

- Review of the physical plant requirements by Medicaid contract type compared to Room and Board rates.
- Review of the various Medicaid contract types and the overlap between these for potential adjustments up or down from the base payment methodology.

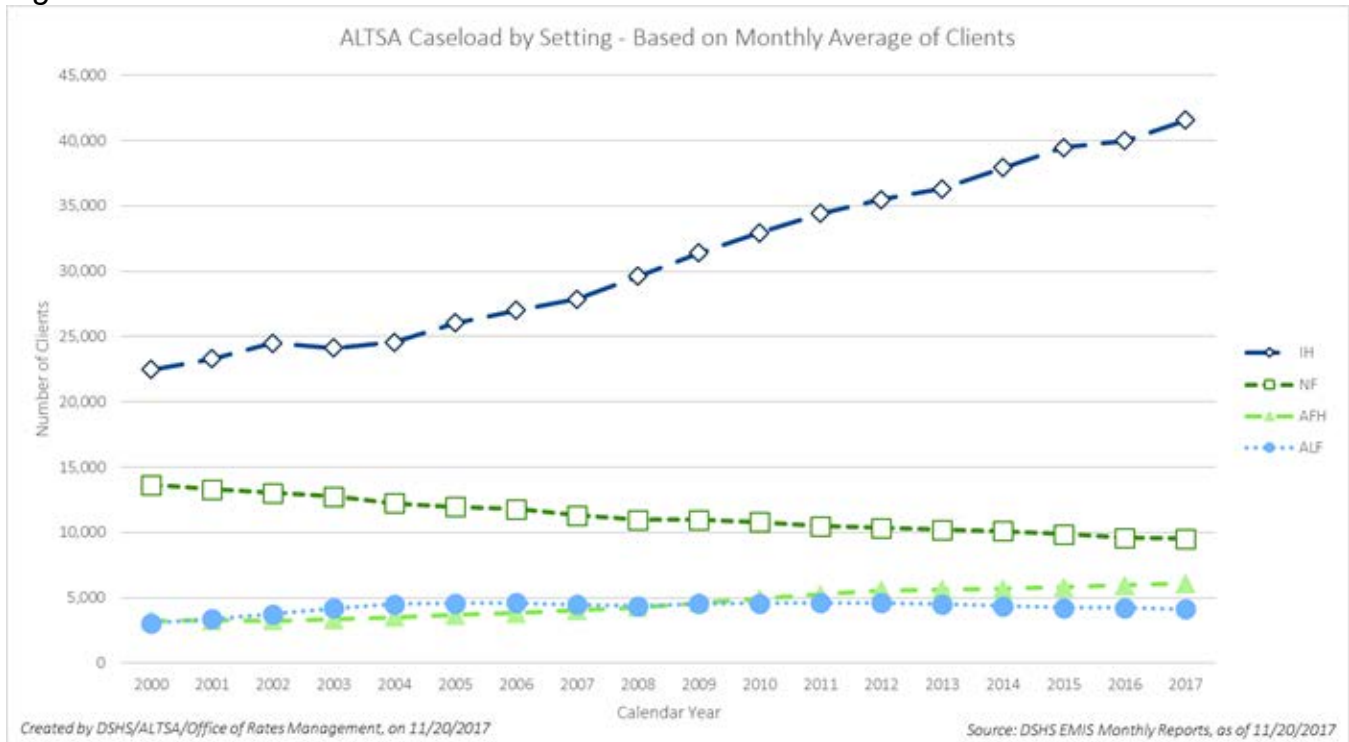
Overview

Assisted living facilities are an important piece of Washington's robust support network of community-based options for adults who are older and individuals with disabilities, offering assistance with: activities of daily living such as ambulation, medication administration, bathing, dressing and toileting; transportation and coordination for medical appointments; housekeeping laundry and dining services; daily activities; and trained staff available 24/7 to respond to any need or emergency. The average size for an assisted living facility in Washington is 60 beds. Depending on the contract type, the facility may also provide private, apartment-like settings and/or intermittent nursing. It is important to note that high Medicaid occupancy providers rely almost exclusively on Medicaid revenue to pay for their staff and operations. As of October 1, 2017 there are approximately 6,000 Medicaid authorized clients in licensed assisted living communities in Washington.

Assisted living facilities serving Medicaid clients may operate under any one or multiple of the separate available contracts which offer slightly different service options. (*See Appendix B*). Per the proviso, the work group discussed the contracts for adult residential care, enhanced adult residential care, and assisted living.

While Washington's Medicaid caseload continues to grow, especially for clients served in their own home, the number of clients served in assisted living facilities has declined, as have the number of assisted living facilities. (See Figure 1).

Figure 1



Background

In 2000, the Legislature established a task force to design an acuity-based payment system for home and community-based care. The goal was to keep lower acuity clients out of costly nursing homes and promote the least restrictive and the most cost-efficient options for higher acuity clients.

In 2001, the Department conducted a study to determine the average amount of staff time spent serving clients. Using this study, the Department designed an acuity-based assessment system with 12 Comprehensive Assessment Reporting and Evaluation (CARE) classifications for Medicaid residential services. The Department developed a corresponding payment methodology using time data to weight rates according to the estimated care needs. In 2003, the payment system began, however, funding limitations required initial rates to be collapsed: while there were 12 assessment classifications, there were only six levels of payment. (See *Appendix B*). Since then, assessment classifications and payment levels have been added, though there remain more assessment levels than payment levels.

When the Legislature expanded the CARE classifications from 12 to 17 levels with the goal of recognizing the higher cost of caring for clients with challenging behaviors, cognitive decline, and clinical complexity with higher reimbursement, the new system was partially funded. However, the recession in 2008 led to rate reductions in 2009 and 2013. Consequently, the Department discontinued the practice of updating the payment methodology with current data.

The result is that for nearly a decade, assisted living rates fell and remained below the 2007 funded level. A 2017 study conducted by Navigant Consulting, Inc., found the estimated Assisted Living rates for State Fiscal Year 2018 would be approximately 16 percent below the estimated weighted average cost of providing services.

The November 2016 Decision Package submitted by the Department, “Increase Client Access to Assisted Living Facilities”, stated “While the total number of private pay ALF beds increased 14 percent between Fiscal Years 2009 and 2016, the number contracted to serve Medicaid has declined by three percent. This endangers not only client choice in the range of available long-term care options, but also the ability to transition low-care people out of more expensive nursing facilities.”

Nursing facilities are the only entitlement in the Medicaid program. If there are not enough community alternatives, including assisted living facilities, clients will go to nursing homes. To effectively manage long-term care costs in the future, the state needs assisted living as a viable community option.

Work Group Process

The Department would like to thank all of the individuals who dedicated their time and commitment to the process of proposing modifications to the state’s assisted living payment methodology.

The Department conducted work group meetings over the summer and fall of 2017. The work group was open to anyone who wished to participate, while voting members were identified by the proviso.

LeadingAge Washington, Washington Health Care Association, the Long-Term Care Ombuds Program and the Department each had a voting member who would ultimately be responsible for voting on recommendations of the work group. A subgroup of technical experts was identified and asked to provide recommendations for consideration by the greater workgroup.

There were no limitations on who could attend workgroup meetings and providers representing assisted living communities participated. Additionally, representatives from the Department’s Aging and Long-Term Support Administration and the Developmental Disabilities Administration attended.

The recommendations in this report represent the consensus of the voting members.

Payment Methodology Recommendations

The work group found that much of the framework for the existing payment methodology was conceptually sound. The work group recommends re-establishing the fundamental architecture of the original payment methodology, updating it with current data and assigning variables based on today’s economic conditions.

For a summary of how these recommendations relate to the original 2001 payment methodology, please see Appendix A.

System Architecture

Throughout the work group session it was stressed that in order for an acuity-based system to be effective and incentivize changes in operational behavior, payment must clearly correspond with the client acuity and assessed care needs.

To do this, the work group recommends a system with three core components: Client Care, Operations, and Room and Board. In general, the work group recommends 17 distinct payment levels that correspond to the 17 CARE assessment levels. The 17 payment levels would be weighted according to the intensity of resources needed to promote the highest achievable level of client independence and functioning. An element of staff time will be assigned and used as the variable to weight each level of payment to the clients assessed acuity classification.

Further, the work group proposes that the client services component is adjusted for varying costs according to service areas, whereas the other components are fixed payments regardless of geographic location.

Additional payments or components may be added to the system to reward or incentivize certain operational behaviors. See “Recommendations for Future Consideration” for a discussion on a quality payment and several existing rate add-ons and payments. No additional components are recommended at this time.

Client Services Component

The Client Services component is calculated using hours from the 2001 time study and the Department’s corresponding model, wages from the Bureau of Labor Statistics (BLS), and payroll taxes and fringe benefits benchmarked from nursing facility cost reports. This is the only component adjusted for service areas and the service area designations are based on estimated wage costs.

Time in the Client Services Component

Using the data in the Department’s model, the work group agreed to the following groupings of time-study hours:

- “One-to-One” represents the original “face-to-face” time as it was captured in the original time study.
- “Client Care” represents any hours provided by Registered Nurses, Licensed Practical Nurses, and Certified Nurse Aides that is not part of One-to-One.
- “Support Services” represents any hours provided by non-nursing staff that is not part of One-to-One time. This includes hours provided by administration, activities workers, housekeeping, food services, and laundry.

The original 2001-2002 time study established twelve classifications and the hours for these are incorporated into the proposed methodology. The 2007 Legislature added an additional five classifications for a total of 17 classifications to better recognize the costs of individuals with more complex care needs. Hours for these additional classifications were assigned by the work group.

Data for some of the job classifications established in the Department's 2002-2003 model was scarce or not available. To obtain full set of wage data, the work group consolidated job classification from 18 to 15 along with the hours they were assigned. In some cases, job classifications were replaced with another that was similar with comparable wages and descriptions. Per the work group recommendation, the following occupational codes are assigned hours in the Department's model:

- Registered Nurses
- Licensed Practical Nurses
- Certified Nursing Assistants
- Social Workers
- Recreation Workers (Activities)
- Cooks
- Food Service Workers
- Food Preparation Workers
- Housekeeping Supervisor
- Housekeeping Workers
- Maintenance Supervisor
- Maintenance Workers
- Business and Financial Operations (Administrative)
- Receptionists
- Office Clerks (Secretary)

Blended Wage

The hours by job classifications were then used to calculate a blended wage that could be used to determine a client service component for each CARE classification. In order to calculate the rates for these hours, data from BLS was used to determine both the Washington state average and county-specific average hourly wage for the job categories listed above. The statewide average wages were blended using weighted proportions of the time required for each job category for an assisted living resident, producing a statewide blended wage that correlates with one hour of care for a hypothetical "average Washington assisted living resident." This statewide blended wage can be considered the statewide benchmark wage.

BLS calculates average wages for Metropolitan Statistical Areas (MSA) and non-Metropolitan Statistical Areas (NMSA), which were used to determine the wages for individual counties. MSA and NMSA wages were applied to any county that overlapped with the boundaries of the MSA or NMSA. For example, the data for the Bellingham MSA was applied to Whatcom County as a whole. A county wage index was created by calculating the average ratio between

the statewide average wages and county specific average wages. Multiplying the statewide benchmark by this county index created a blended wage for each county.

The work group recommends the initial system have three service area designations:

- Exceptionally High Labor Cost;
- High Labor Cost; and
- Standard Labor Cost.

To arrive at the service area designations, the blended county wages were arrayed from highest to lowest and broken into three categories: High Cost, which is counties at the 95th percentile or above (currently King and Snohomish counties); Medium-High Cost counties; and Standard Cost counties. The break between Medium-High and Standard Cost counties is at the median. Each of the two groups is then paid at the median of that group's wages. This produced three blended hourly wages with counties grouped by cost that would replace the current King/MSA/NMSA rate designations. Each of these blended wages were then multiplied by the hours in each CARE classification and index grouping to produce a table of client services component totals.

The work group recommends assigning staff time to each payment level using the residential care time study conducted in 2001 and the Department's corresponding estimate of the average staff hours per client by job position.

Because this component is directly related to wages, the group recommends that any job category below minimum wage be brought up to that standard as the higher minimum wages roll out. The BLS data used in this initial proposal is from 2016. State minimum wage increases to \$11.50 on January 1, 2018.

The work group recommends using the nursing facility cost report to establish the variables used to calculate payroll taxes and benefits.

Operations Component

The work group recommends the Operations component be a fixed payment for all recognized costs allowable under federal Medicaid rules for federal matching funds. These costs include supplies, staff education and training, licenses, and business and occupational taxes. The work group estimates that an appropriate benchmark to comparable nursing facility costs is 92% of the median or greater, however further work is required before a final recommendation can be made.

The work group used the following methods to estimate the minimum for this component, calculated as a percentage of the nursing facility median:

- Licensing costs are known because these fees are stated in proviso.
- Education and in-service training were compared to the amount funded by the Legislature in 2012 for the voter approved mandatory caregiver training.

- For all other cost centers, a comparative analysis was performed to AL median costs by reviewing data on western region assisted living from the 2016 State of Senior Housing report. In addition, a focus group of providers reviewed actual costs and provided feedback to the work group

Room and Board Component

The work group proposes to use a Room and Board component to recognize costs that do not qualify for federal matching funds under Medicaid rules. Non-Medicaid costs include the Medicaid client's share of raw food costs, and shelter costs including expenses related to the physical plant such as major building repairs, large equipment (e.g. commercial refrigerators, elevators, water heaters), property taxes, property and liability insurance, and debt services. These costs are typically paid by the client and are subject to Department and Health Care Authority rules regarding client participation.

Under current rules, compensation for Room and Board is the same for all residential providers regardless of contract requirements for each care setting. It is set in Washington Administrative Code by the Health Care Authority (HCA). The rate is calculated at the Supplemental Security Insurance benefit level less the personal care needs allowance. The 2017 rate is about \$672 per month, or \$22.10 per day, ^{A3} and is often paid in whole or in part with client resources. In looking at nursing facility costs for food, it was estimated that food costs are approximately \$6.70 per person per day. This is little more than \$200 per month, leaving around \$470 a month to cover shelter related costs.

Unlike other long-term care residential service settings, assisted living is defined in the building codes under institutional Group 1, Condition 2. This group also includes nursing facilities, psychiatric hospitals, detox facilities, and foster care facilities. As such, there are many physical plant requirements that are unique to assisted living facilities among the community options for care (*See Appendix C*). An assisted living facility with an Assisted Living contract is required to provide a private apartment with mandatory minimum square footage. Each apartment is required to have a private bathroom and a kitchenette. The building codes require central alarms, a centralized call system, sprinklers, a resident laundry facility, and more. Other provider types allow two individuals per room, have common bathrooms, and do not have most of the physical plant requirements that assisted living facilities do. These extra requirements require funds to implement and maintain. Therefore, given these complexities, the work group recommends reviewing the Room and Board component through future work group discussions.

Timeline for Implementation

It is recommended the Department adopt the new data-driven payment methodology beginning July 1, 2019.

The work group recommends the 2018 Legislature establish the framework for the proposed AL Medicaid payment methodology in RCW 74.39A.

*Proposed Assisted Living Facility Payment Methodology
DSHS Report, Page 10*

Rebase

The work group proposes that rates paid on July 1, 2019 be based on data from the 2016 calendar year, except for the time variable which would be based on the 2001 time study. It is recommended that the Medicaid rates (Client Services and Operations) be rebased in even numbered years. Beginning with rates paid on July 1, 2020, wages, benefits, payroll taxes, and operations costs would be rebased using 2018 calendar year data.

Recommendations for Future Consideration

Due to a compressed timeline, the work group was not able to thoroughly address all the areas of the payment system. Instead, work was prioritized toward reaching agreement on a solid framework and methodology for the core payment system. The stakeholders recommend the work group continue with the following efforts over the 2018 interim.

Review Contract Types for Potential Rate Adjustments

The work group briefly discussed contract differences between ARC, EARC, and AL. Some key differences were identified (*See Appendix C*). However, many assisted living facilities have multiple contracts for a single facility. In addition, contract requirements for the physical plant represent the major differences between facilities with ARC/EARC contracts and those with AL contracts. Before making any adjustments to ARC or EARC rates, the work group recommends reviewing the mechanisms of multiple and overlapping contract types and the physical plant requirements over the 2018 Interim.

Adjustments for Room and Board Rates

As part of its recommended payment methodology, the work group proposed the Room and Board component provide payment for non-Medicaid covered costs, but consensus is that adjustments should be made up or down to reflect varying physical plant requirements. For example contracts have varying minimum square footage requirements while others require private units with kitchenettes and private bathrooms. A significant difference between contracts is ARC and EARC contracts permit double occupancy while AL contracts do not. During the 2018 interim, the work group recommends physical plant requirements be reviewed by contract type and the Room and Board component be reviewed to see if adjustments can be made to reflect the differences. Possible areas of review would include client resources available by the population served in each care setting and an evaluation of any impacts to the State General-fund for lowering or raising the room and board standards according to each service setting's requirements.

Payment for High Medicaid Census

In all settings, Medicaid rates are lower than the private pay rates and facilities with a higher Medicaid census have less opportunity to recoup costs through other revenue sources. In order to address this, the work group discussed an additional payment for providers who care for a high percentage of Medicaid clients, also called a Medicaid Access component. The work group will continue working on this component with the goal of creating a financial incentive for facilities to admit more Medicaid clients. This would have the benefit of improving Medicaid client access to assisted living.

Quality Incentive Payment

The work group agreed to review and discuss the potential for a Quality Incentive Payment over the 2018 interim. More time is needed to determine what outcomes could be measured, what data is currently available, to what extent additional data might be captured, the methodology that would be used to tie payment to quality, and corresponding funding requirements.

Specialized Dementia Services and Enhanced Community Services Payments

Currently the Specialized Dementia Services Payment is a fixed amount for most of the CARE classifications. The work group recommends reviewing the impacts of this new methodology over the 2018 interim. Under the recommended methodology, the core rate system will be updated with current costs, leading base rates to exceed these specialized rates.

Enhanced Community Services are funded as rate add-ons for clients that might otherwise be in State psychiatric hospitals. The work group recommends reviewing this add-on over the 2018 interim to evaluate impacts of this add-on to the total rates paid once the recommended payment methodology is fully implemented.

Conclusion

The recommendations in this report represent months of dedicated work from a variety of interested parties. The work group is confident that these recommendations will create an assisted living Medicaid payment methodology that is sound, equitable, reasonable, and easily adaptable to ever changing conditions. An updated payment methodology will improve a client's ability to choose a setting that is reflective of their care needs and in their community.

With the work group's establishment of the core payment system, the work group looks forward to addressing the remaining items for consideration in 2018.

Appendix A

Summary Table: Work group Recommendations Compared to the Original Acuity-Based Payment Methodology

Comparison Item	Work group Recommendations	Original Acuity-Based Methodology
Number of payments	17 distinct payments that have a nexus with the 17 CARE assessment levels	6 payment levels. Very little nexus with the 12 CARE assessment levels
Hours	2001 Time Study with DSHS corresponding model. Minor updates: <ul style="list-style-type: none"> • Establish hours for five new classifications • Consolidate /update job classifications 	2001 Time Study
Wages	A blended wage developed using 15 Occupational Codes using publicly retrievable BLS wage data.	A blended wage developed using 18 Occupational Codes using BLS Wage Data
Payroll Taxes	SNF cost reports used to establish the benchmark	SNF cost reports used to establish the benchmark
Benefits	SNF cost reports used to establish the benchmark	SNF cost reports used to establish the benchmark
Operation Costs	SNF cost reports used to establish the benchmark- Only include costs that are allowable for federal matching funds	SNF cost reports used to establish the benchmark
Capital	Room and Board- <ul style="list-style-type: none"> • Set in WAC by HCA • Currently SSI less Personal Care Needs Allowance, but work group wants to look at other options • Paid for with client resources 	Fair Market Rental Value <ul style="list-style-type: none"> • Marshall Swift • Moveable Equipment costs from SNF Cost Reports • Paid for with Medicaid (including FFP) • Adjusted for minimum occupancy
Service area designations	<ul style="list-style-type: none"> • Service areas are set according to labor costs. • Use BLS wage data to set service areas • Adjustment only applies to wages • Operations and Room and Board flat rates 	<ul style="list-style-type: none"> • Service areas are set using MSA • Adjustments apply to wages, benefits, costs, fair market rental, payroll taxes, and benefits.

Appendix B

The Original Acuity-Based System and Payment Methodology (2001-Present)

Care Assessment

For all Medicaid clients in residential and in-home settings, the Department uses the CARE assessment to determine the needs of the client and place them into a general classification that roughly corresponds to the number of staff hours needed to care for the client. In 1998, the Legislature required the Department to review the appropriateness of incorporating client acuity as a determination for the level of Medicaid payment. To support this effort, the Washington State Residential Time Study (Time Study) was conducted in 2001 and 2002, and results were reported December 2002 (Semke). The report described data collection and how the use of one-to-one staff time with each client (a.k.a. face-to-face time) could be used to determine twelve acuity classifications or care levels. Based on the time study and the corresponding analysis, the CARE assessment tool was developed. Implementation began April 2003, and was rolled out statewide by March 2004. CARE assessments were completed on all residential and in-home Medicaid clients by March 2005.

Acuity-based Pricing Model

The acuity-based payment methodology would use the element of staff time to weight payments to corresponding CARE classifications. For this reason, the system needed to recognize the Medicaid share of all labor costs, regardless of whether staff had face-to-face time with a client or only provided ancillary services. However, the Time Study did not record any task-specific hours, and only one-to-one hours were dispersed into the twelve CARE classifications. The Department developed a corresponding model for Boarding Homes (Assisted Living) which further estimated and distributed staff hours that were not “clocked” to a specific resident or captured as one-to-one time in the Time Study. The Time Study hours were distributed in the model as follows:

- One-to-one hours from the Time Study were resident-specific and recorded by job title. These hours were distributed into acuity levels to correspond with the distribution used to design the twelve CARE classifications.
- For group activities, all the residents who participated were recorded along with staff job titles. Staff hours associated with group activities were spread among the residents who were identified as participants for each activity.
- For staff who provided support services, working hours were recorded by staff title but were not tied to specific residents. Staff hours for support services were assigned to individual residents using approximation.

In addition to assigning all staff hours to the twelve classifications, hours recorded by job title in the Time Study were collated in the model into eighteen job classifications. These job classifications were selected because they could be crosswalked to BLS occupational codes, thereby ensuring the same wage assumptions would be used for all providers in the payment model. Because job titles varied from facility to facility and hours were not recorded by task, “it is possible that some tasks that were timed might [have been] included in the category of an additional amenity.”

The Department conducted a stakeholder work group process to identify cost components and to choose proxies or benchmarks to establish a pricing model:

- Service hours by staff type were taken from the time study and the Department’s corresponding model;
- Wages were derived from the hourly wage rate by position in the labor market statistics data published by the Bureau of Labor and Statistics in 2002;
- Payroll taxes and fringe benefits were derived from the Washington State nursing facility Medicaid cost report for 1999 adjusted by a 2003 inflation rate;
- Operation costs were derived from the Washington State nursing facility Medicaid cost report for 1999 adjusted by a 2003 inflation rate. Costs included supplies, utilities, food, taxes, insurance, etc.; and
- Capital costs were determined using Marshall Swift Fair Rental Value adjusted for minimum occupancy.

All costs were adjusted by service area designation: King, Metropolitan Statistical Area, Non-Metropolitan Statistical Area.

Beginning April 2003, acuity-based payments were implemented.

Although clients were being assigned to twelve classifications using the new CARE assessment, the initial payment system only had six distinct payment rates. Rates were collapsed as follows:

Classifications with the Same Rate
Classifications 1 & 4
Classifications 2 & 7
Classifications 3, 8, & 11
Classifications 5 & 10
Classification 6
Classifications 9 & 12

Budget constraints also required that variables for all components in the initial model be based on the 25th percentile for all data sets. This included wages, payroll taxes, benefits, and operational costs.

2004 Review of Rate Adequacy and Validity of the CARE assessment

In December 2004, the Department provided a report to the Legislature on the validity of the new acuity-based system entitled, “CARE & Medicaid Payment System for License Boarding Homes, Chapter 231, Laws of 2003.” A test group of providers reported costs for the Department to review and compare to the rates. The report provided the following information:

- On a preliminary basis, the department found the CARE assessment was categorizing residents into meaningful care groups (page 3). The CARE assessment was still being rolled-out and all Medicaid clients had not yet been assessed using the CARE assessment tool (page 6).
- Rates being paid were generally lower than the rates produced by the new acuity-based payment model (page 28):

Comparison of the Modeled Rate and the Funded Rate (Statewide Weighted Average Rates)		
Contract Type	2003 Rate produced by the Model	Funded Rate Paid April 2003 to July 2004
ARC/EARC	\$71.95	\$52.36
AL	\$74.27	\$62.45
All providers	\$73.62	\$59.61

Table information from pages 20 and 22 of the report.

- “The rates currently paid by the department are based on the model rates, but reduced in operations and direct care because of budget limitations” (page 28)
- “Current rates do appear adequate from an access and quality perspective. However, with rising costs and model rates that indicate costs exceed rates, maintenance of these criteria may be short lived” (page 28).
- “The department’s Medicaid Rates (2003) capital rate component on average is significantly lower than capital costs incurred by the study Boarding Homes [Assisted Living]. Even raising the department’s capital rate to the Medicaid Rates (Model) benchmark would produce rates that are lower than costs incurred by the study Boarding Homes (Assisted Living). The Medicaid Rate (Model) capital rate determination may warrant further research” (page 29).

Appendix C

RCW and WAC Requirements by Medicaid Contract Type

RCW and/or WAC Contract Requirement	Medicaid Residential Care Contract Types				
	Licensed Assisted Living				License & Contract Adult Family Home (AFH)
	Contract Assisted Living (AL)	Contract Enhanced Adult Residential Center (EARC)	Contract Specialized Dementia (SDC)	Contract Adult Residential Center (ARC)	
Personal care	Yes	Yes	Yes	Yes	Yes
Intermittent Nursing (RN/LPN)	<ul style="list-style-type: none"> Medication administration Administration of health treatments Diabetic management Non-routine ostomy care Tube feeding Nurse delegation 	Same as AL	Same as AL	No	No
Medication Administration	Yes	Yes	Yes	No	With the use of nurse delegation.
Coordination of Healthcare	Yes	Yes	Yes	Yes	
Supervision	24/7	24/7	Awake 24/7	24/7	A provider or manager must reside at the home.
Activities	<ul style="list-style-type: none"> Facility Arrange Activities. Facilitated group activities 3 times per week. Furnish supplies and equipment. 	Same as AL	Make available on a daily basis	Same as AL	Ensure that residents are provided the opportunity for activities.
Food & Nutritional Services	<ul style="list-style-type: none"> Provide sufficient staff support for residents to consume meals. Menus approved by a dietician only for prescribed diets 3 meals a day & Nutritious snacks on a non-scheduled basis. Therapeutic meals when in the negotiated care agreement 	Yes- Same as AL	Same as AL	Same as AL	<ul style="list-style-type: none"> Serve 3 meals a day & have nutritious snacks available. Get input from residents on meal planning. Process any home-canned foods served in the home according to the latest guidelines of the county cooperative extension service.

RCW and/or WAC Contract Requirement	Medicaid Residential Care Contract Types				
	Licensed Assisted Living				License & Contract Adult Family Home (AFH)
	Contract Assisted Living (AL)	Contract Enhanced Adult Residential Center (EARC)	Contract Specialized Dementia (SDC)	Contract Adult Residential Center (ARC)	
					<ul style="list-style-type: none"> Ensure sufficient food is in supply, safe, sanitary, and uncontaminated.
Resident supplies for personal care	Yes, at no charge to the resident Includes: Toothbrush, shampoo, disposable razors, toilet paper, deodorant, and soap.	Same as AL	Same as AL	No	No
Laundry Services	<ul style="list-style-type: none"> Residents clothing Towels Bed Linens 	Same as AL	Same as AL	Same as AL	Provide as needed. Must launder sheets and pillowcases weekly.
Resident's Accommodations	<ul style="list-style-type: none"> Apartment unit with locking door. Includes mandatory closet and storage area 	<ul style="list-style-type: none"> Unit/Room Locking door at resident's choice Includes mandatory closet/ storage area 	<ul style="list-style-type: none"> Unit/Room Locking door at resident's choice Includes mandatory closet/ storage area 	Same as EARC	<ul style="list-style-type: none"> Bedroom in a residential home Resident may choose to have a lock on the door. Must have a closet, wardrobe, or armoire Must provide a 36" bed, pillow, mattress, and bedding.
Mandatory room/unit square footage per person	<ul style="list-style-type: none"> 220 sq. feet excluding bathroom 	<ul style="list-style-type: none"> Eighty or more square feet of useable floor space in a one-person sleeping room Seventy or more square feet of useable floor space per individual in a sleeping room 	Same as EARC	Same as EARC	<ul style="list-style-type: none"> 80 sq. feet for single occupancy 120 sq. feet for double occupancy

RCW and/or WAC Contract Requirement	Medicaid Residential Care Contract Types				
	Licensed Assisted Living				License & Contract Adult Family Home (AFH)
	Contract Assisted Living (AL)	Contract Enhanced Adult Residential Center (EARC)	Contract Specialized Dementia (SDC)	Contract Adult Residential Center (ARC)	
		occupied by two or more individuals <ul style="list-style-type: none"> • Must comply with Nursing Home building standards. 			
Occupancy	<ul style="list-style-type: none"> • Single occupancy unless married. 	Double occupancy permitted	Double occupancy permitted	Double occupancy permitted	Double occupancy permitted
Kitchen area	In private unit including: <ul style="list-style-type: none"> • Refrigerator; • Microwave, range, or cooktop; • Kitchen sink; • Storage space for utensils & supplies; and • A work counter surface. 	No	No	No	Common use access to the kitchen.
Bathroom	Private bathroom in unit with shower, toilet, and sink	Common use (some in room) Institutional minimum number per resident.	Same as EARC	Same as EARC	Common use shared by all residents
Laundry Facility for Resident Use	Washer, Dryer, & Utility Sink	Same as AL		Same as AL	
Common Space	<ul style="list-style-type: none"> • Day room with minimum 20 sq. ft. per resident (no less than one) • Group activity space. • Self-directed activity space. • Well maintained resident exterior grounds 	Same as AL	<ul style="list-style-type: none"> • Make multiple common areas available • One outdoor space enclosed by a wall or fence • Ensure that the outdoor area for residents: is accessible to residents without staff assistance; is surrounded by walls or fences at least seventy-two inches high; has areas protected from direct sunshine and rain throughout the day; has walking surfaces that are firm, stable, slip-resistant, and free from abrupt 	Same as AL	<ul style="list-style-type: none"> • Sufficient space for all residents at once in dining and living areas • Access to kitchen, dining & living area, & bathrooms

RCW and/or WAC Contract Requirement	Medicaid Residential Care Contract Types				
	Licensed Assisted Living				License & Contract Adult Family Home (AFH)
	Contract Assisted Living (AL)	Contract Enhanced Adult Residential Center (EARC)	Contract Specialized Dementia (SDC)	Contract Adult Residential Center (ARC)	
			changes and are suitable for individuals using wheelchairs and walkers; has suitable outdoor furniture; has plants that are not poisonous or toxic to humans, and has areas for appropriate outdoor activities of interest so residents, such as walking paths, raised garden or flower beds, bird feeders, etc.		
Other Space	<ul style="list-style-type: none"> On-site food service facilities Housekeeping supply area on each floor Clean Nurse station with medication storage, handwashing, and a place for nursing supplies Soiled nurse room for cleaning contaminants Separate area for laundry services (unless contracted offsite) Number of common area bathrooms based on the number of residents, staff, and visitors. 	Same as AL	Same as AL	Same as AL	No
Emergency Call System	In the following locations: <ul style="list-style-type: none"> Bathrooms Bedroom Living Room 	Corridor Call System	Corridor Call System	Corridor Call System	Not required, however, some may require a call bell or intercom system depending on the physical layout.
Safety	<ul style="list-style-type: none"> Automatic Sprinklers Fire Alarm connected to sprinklers Carbon Monoxide Alarm 	Same as AL	Same as AL	Same as AL	Smoke Detector

Appendix D

Definitions

CARE assessment: Comprehensive Assessment Reporting and Evaluation (CARE) is an assessment process used by DSHS Primary Case Managers and Case Aides to gather definitive information on a client's strengths and needs, which must be addressed in the individualized care plan. A computerized CARE assessment tool aides case managers in determining eligibility, generating and updating the individualized care plans, authorizing services, and tracking when assessments are needed.

Classification: The CARE assessment tool uses data input on cognitive performance, clinical complexity, mood/behavior symptoms, and Activities of Daily Living (ADL) to place clients into acuity groups or "classifications" that are used by DSHS to determine the amount and type of long-term care services a client can receive. The current CARE assessment has seventeen classification levels.

Components: Assisted Living (AL) payment rates are divided into subgroups referred to as components. Each component isolates calculations for variables that are similar in nature.

Core Components: Core components capture the fundamental costs associated with providing publicly-funded services to individuals eligible to receive them. The proposed Assisted Living Medicaid payment system has three core components.

Rebase: The process of updating or refreshing variables with data that captures more recent economic conditions.

Variables: Data is used to generate the mathematical calculations for each component. The results of these calculations are referred to as variables. Each component is a product (or quantity) of one or more variable/s. Because variables are based on data which changes overtime, variables must be updated or refreshed to be relevant to the most recent economic conditions.