Persistent Problems, Emerging Opportunities:

The 2019 State Share Report

Executive Summary

For each of the past seven years, ANCOR has compiled data from members from across the country about their priorities, struggles and concerns to help inform ANCOR's policy agenda. In April 2019, ANCOR queried its Board of Representatives and State Association Executives Forum for information related to intellectual and developmental disabilities (I/DD) services, including budget changes, regulatory and oversight activity, system changes and new initiatives. We received 36 completed surveys from 33 states and the District of Columbia, generating a vast array of data illustrating common trends—as well as some anomalies—throughout the country.

Generally, we found that there were some increases in HCBS Waiver program funding, with 13 respondents identifying an increase of three percent or more and 22 states reporting increases of less than three percent but more than one percent. Of the states that reported an increase or a likely increase (some state budgets had not been finalized at the time of the survey), most said that the funds were designated for Direct Support Professional (DSP) wage enhancements and/or in keeping with minimum wage increases. Similarly, twelve states reported increases in funding for waiver "slots." The area with the fewest states seeing a funding increase was capital expenses; only one state reported a modest gain in this area.

Other notable findings include significant activity around agency closures, minimum wage legislation and rate setting initiatives. However, regulatory, oversight and litigation activities held consistent without any trending increases. The majority of systems-change initiatives appear to focus on 1115 Waiver applications and Supported Decision Making. Relative to Electronic Visit Verification rollout, the majority of respondents reported that their states are opting to offer multiple EVV vendors from which providers can choose. The second-most common EVV model reported was the use of a single, customized system being adopted statewide. Members also reported that cost, training and privacy issues are of the greatest concern to them.

When asked about the top three priorities for members in their respective states, respondents indicated that the DSP workforce is number one, closely followed by the need for increased funding. The need to address Home- and Community-Based Services (HCBS) rate methodology was ranked a distant third. Respondents were also asked what they are most excited about, and top responses included (1) Connecting Quality and Outcomes to Payment, (2) Evolutions in Person-Centered Thinking and (3) Telehealth Opportunities.

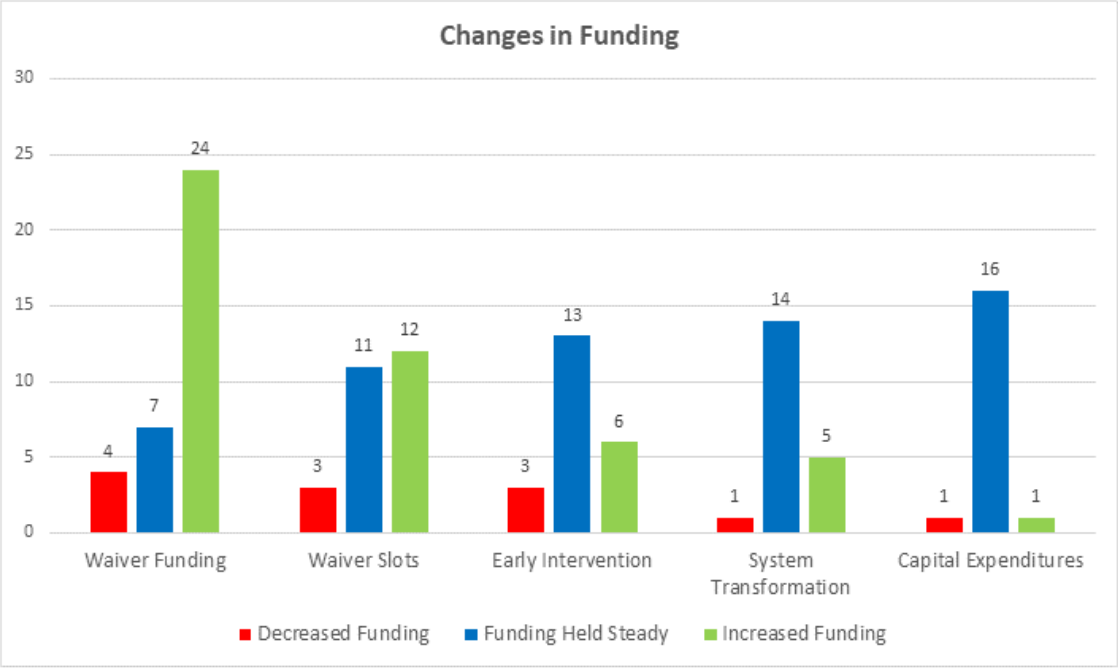
Finally, the State Share survey revealed that providers and associations are increasingly turning to coalition building, marketing and public relations campaigns, and independent rate studies as key strategies to help stabilize funding and revenues.

Funding and Appropriations

Funding appropriations is an ever-shifting landscape that is closely monitored by providers and advocates alike. Small reductions can have devastating impacts on services, as organizations have been living on very tight budgets for a number of years. This is compounded by the fact that states reporting an increase in funding generally saw that funding dedicated to DSP wages.

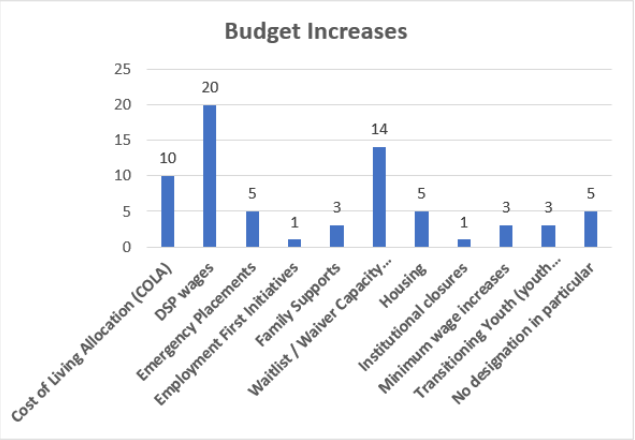
Although increased funds are critical to inching DSP wages toward living wage levels, wage increases have recently been appropriated simply to keep pace with rising minimum wage requirements—these increases aren't necessarily heralding a living wage for the profession. Most providers and associations recount that in years past, agencies were paying DSP significantly higher wages than the minimum. However, a decade or more of stagnant or declining funding has resulted in stalled wage growth in an environment of mandated minimum wage increases. Additionally, when investments are made in DSP wages, it generally does not include middle- or upper-management salaries, thereby creating wage compression between these positions and a disincentive for staff to assume greater responsibility or advance in the company.

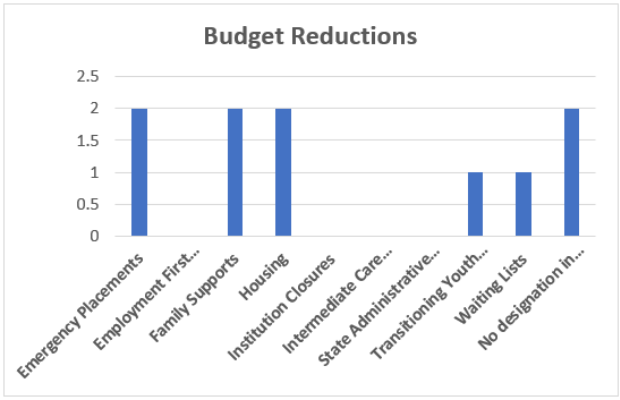
This year's State Share survey revealed that many states are appropriating some additional funding for Waiver services; only four states reported a reduction in this category.



Of the four states reporting a reduction in Waiver services funding, Louisiana and Alaska reported reductions of five percent or more. Oregon reported a three-percent reduction, while the District of Columbia reported a two-percent reduction from current fiscal year funding. Conversely, there are seven states reporting an anticipated increase of greater than five percent: Alabama, Missouri, North Carolina, Ohio, South Dakota, Tennessee and Virginia. The states reporting an increase in Waiver capacity or "slots" include Colorado, DC, Florida, Indiana, Missouri, North Carolina, New Jersey, Ohio, Oklahoma, Tennessee, Virginia and Washington. The five states allocating funding for system transformation include Alabama, DC, Illinois, North Carolina and Washington. The only state allocating additional funds for capital needs is Washington.

Other anecdotal budgetary information provided included enhanced funding for a general rate increase to HCBS programs in Kansas, Autism services in Illinois and Michigan, early intervention in Ohio, a four-percent undesignated increase in Oklahoma, and an increase for supported living services in Colorado. Also mentioned was increases to SLA, Respite, Personal Care, and some modest increases to vocational services and transportation.



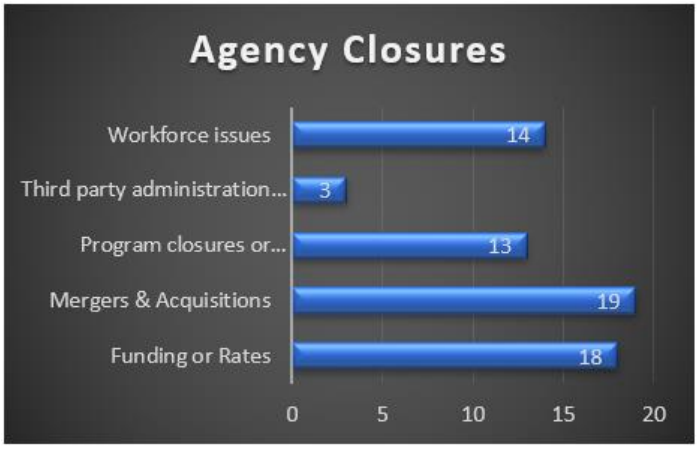


A couple of curious reductions include a cut to Social Security in New York and deep cuts to "adult foster care" in Massachusetts (with the added requirement that these providers must be accredited by the end of 2019). Finally, a bill in Arkansas called for a nine-percent funding increase to help providers meet the state's mandated minimum wage. The bill died in the legislature, resulting in an Executive Order requiring a Rate Review.

At the time of the survey, several states had not completed the appropriations process. In some cases, respondents had a reasonable expectation about how the appropriations process would play out; only one state was yet unable to project their state's outcome.

Attrition

The survey asked state association executives and members of the Board of Representatives about the occurrence of agency closures, mergers and acquisitions, or program contraction. Of the 36 respondents, the majority reported activity in agency attrition; 19 attributed attrition to mergers and acquisitions, while 18 attributed attrition to closures due to insufficient funding and/or rates. In addition, 14 respondents reported that agencies were closing or scaling back operations due to workforce issues.

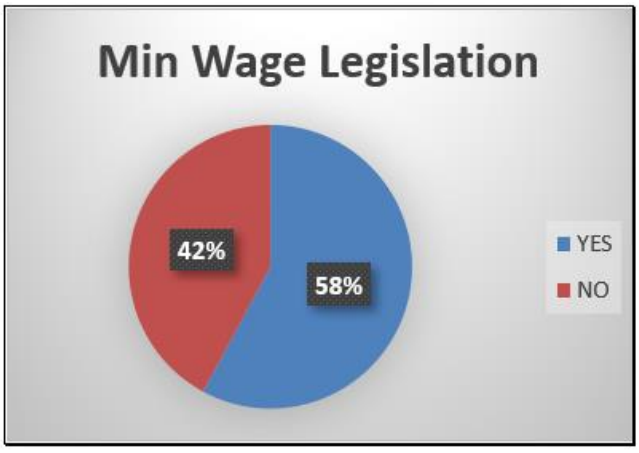


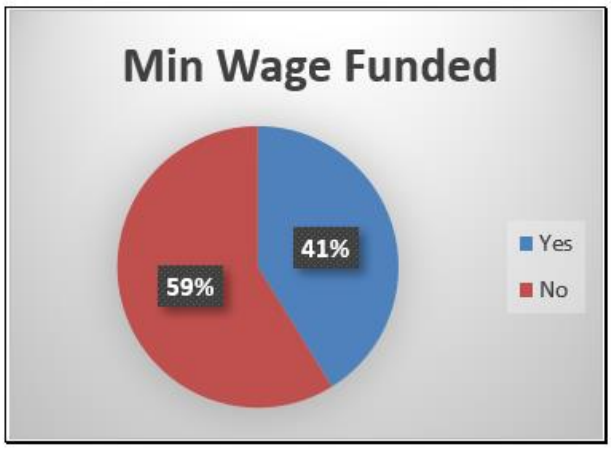
California reported approximately 38 closures from 2017-2018. In DC, there have been three organizations merged with larger ones and two acquisitions. Since 2008, Florida has lost 30% of its Medicaid providers, and Kansas is facing crumbling service capacity. Recently, Johnson County—the most populous county in Kansas—reported losing 22% of day service capacity, 26% of residential service capacity and 24% of case management service capacity within the past five years. Many states report overall system contraction.

Minimum Wage

Minimum wage issues continue to be a significant hurdle for providers. In this survey, 22 respondents reported that their legislature considered minimum wage increases or continued implementation of existing wage increase plans. Of those responding, most reported a multi-year phase-in plan generally increasing about $1 per year until the target is hit (which is generally, but not exclusively, set at $15 per hour). Detail provided by the respondents illustrated an *average* minimum wage target of $13 per hour.

- **Arizona** voters passed an increase from the current level of $8.25 to $11 by January 2021.
- **California**'s minimum wage is $12 per hour and will increase $1 each January until reaching $15. However, 30+ local ordinances have established a minimum wage higher than the state mandate, primarily in and around the Bay Area, Los Angeles and San Diego.
- **Colorado** passed a four-year minimum wage initiative in 2016 to bring the wage to $12 by 2020. This year the state passed a bill to allow local governments to set their own minimums starting in 2021.
- A proposal in **Washington, DC,** would link funding for DSP wages to the minimum wage and create a tiered system (e.g., DSP1, DSP2) to increase wages. Hearings on this initiative begin in June 2019.
- **Illinois** will have a $15 minimum wage by 2025, with a shorter timeframe for Cook County & Chicago.
- **Massachusetts** has a voter-approved wage increase plan to bring the minimum wage to $15 by 2022.
- **Maryland**'s minimum wage will increase to $15 by 2025 for employers with 15 or more employees and by 2026 for those with fewer than 15 employees.
- In 2018, **Missouri** passed a bill to increase the minimum wage to $12 by 2023.
- **New Jersey**'s minimum wage is set to rise to $15 by 2024. The state has formed a coalition to advocate for funding increases to keep DSP wages no lower than 125% of the state's minimum wage. In the first two years, New Jersey successfully advocated for $20 million in additional funding for wages; this year, advocates are requesting $54 million.
- In **New York City**, small employers will see their minimum wage increase to $15 this year (large employers were required to reach the $15 threshold last year). Minimum wages elsewhere in the state are lower than in New York City, but have also increased.
- **Ohio**'s minimum wage increases are tied to the Consumer Price Index and currently stand at $8.15.
- **Oregon**'s minimum wage is set to increase to $12.50 on July 1, 2019.
- **Rhode Island**'s minimum wage is increasing to $10.50 in January 2020.
- **Washington**'s minimum wage is increasing to $13.50 in 2020; Seattle's minimum is currently $16.

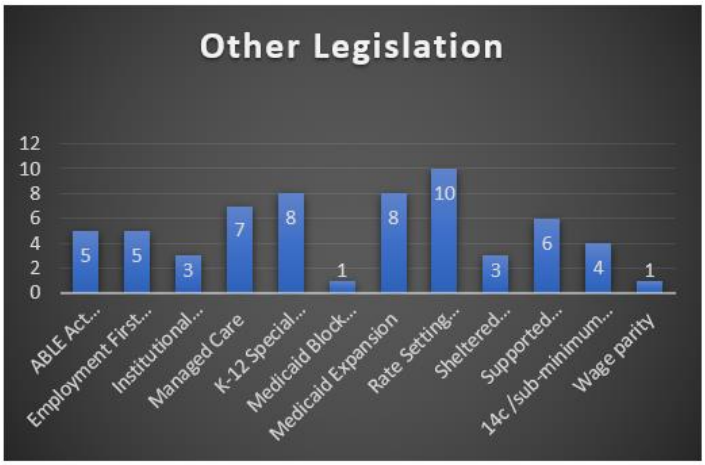




Seven respondents reported increased appropriations due to minimum wage increases, including DC, Florida, Illinois, Maryland, Michigan, New York and Ohio.

Legislation

When asked about legislative initiatives beyond budget and wages, respondents reported a fair amount of activity around rate setting initiatives, special education and Medicaid expansion. Only one state reported legislation related to block grants or per-capita caps.



Other legislative activity of note was identified in Colorado, where the state is mandating a permanent wage pass-through for home care rates, thereby creating a mechanism by which the public can obtain home care workers' personal information. Illinois is mandating sex education for adults with I/DD, as is the expansion of assistive technology and value-based payments in behavioral health. Maine is restructuring crisis services—the composition and policy of a state mortality review committee—and strengthening the authority of the Maine Developmental Services Oversight and Advisory Board. New Jersey is requiring heightened state oversight, including two unannounced visits to all residential and day program sites and an additional visit to require injuries to be reported to the state as unintended incidents. New York has introduced legislation to increase the allowable amounts in ABLE accounts. Ohio is increasing the franchise fee for Intermediate Care Facilities (ICFs). Texas is considering guardianship and criminal justice issues, and Virginia is pursuing more robust reference checks for potential staff.

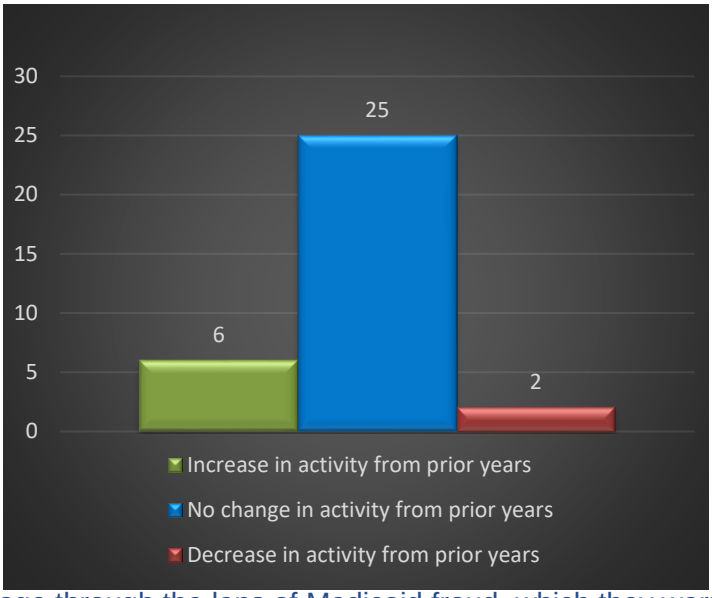
Compliance and Oversight

In general, states did not report a rising trend in compliance and/or oversight activity. Fifteen of thirty-six respondents said their states are experiencing an increase in audits with some tied to an increase in unannounced visits as mentioned in the preceding section. Three states (Maine, New Jersey and Pennsylvania) attributed the increase in audits to quality assurance protections and abuse, neglect or mistreatment investigations, while three others (Massachusetts, North Carolina and South Dakota) attributed increased audit activity to program integrity. Also under consideration are agency processes around human resources and background checks in New Jersey and person-centered plans in New York.

Department of Justice

Several states report ongoing U.S. Department of Justice (DOJ) settlement agreements, including Georgia, North Carolina, Oregon, Rhode Island and Virginia. However, only one state identified a newer DOJ agreement involving individuals with I/DD living in nursing homes, while one other state reported that DOJ is completing an "administrative review" but does not have onsite staff at any facilities.

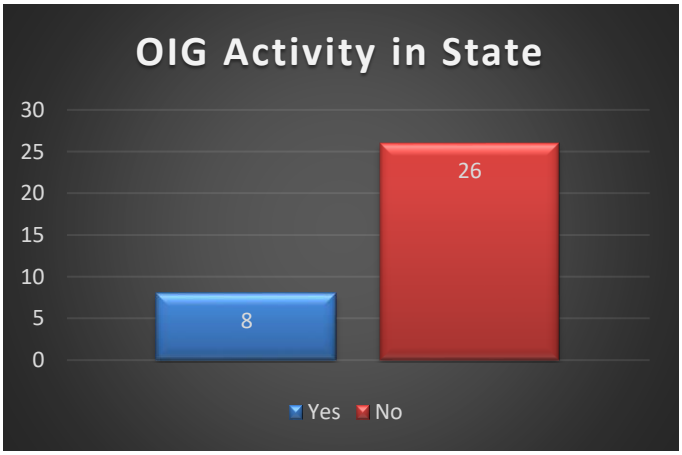
Attorney General / Medicaid Fraud



State reports suggest there is no upward trend in Attorney General or Medicaid Fraud Unit inquiries. Only six states identified increased activity in this area of oversight. Alabama reported that the Integrity Unit of Health Care Services instituted new regulations requiring self-audits and the stipulation that all HCBS services must be documented within 72 hours in order to be billed. In Massachusetts, MassHealth contracted with Optum to begin conducting program integrity audits of day habilitation programs. Six providers were surveyed and were assessed fees ranging from $11,000 to over $200,000 (before appeals). Maryland providers are concerned about efforts by the Medicaid Fraud Control Unit to view the DSP workforce shortage through the lens of Medicaid fraud, which they worry could result in staffing ratios being deemed fraudulent if they differ from those specified in individualized support plans. And in Ohio, the Attorney General's office is conducting look-back audits for Medicaid service providers.

Office of the Inspector General

In the wake of serious allegations, members of Congress have called for the Office of the Inspector General (OIG) reviews and heightened scrutiny of I/DD programs in several states. That said, only eight out of 33 states reported an increase in OIG presence in their state. These included Alaska, where OIG examined Critical Incident Reports. Resulting action called for more timely reports from providers but no further action.

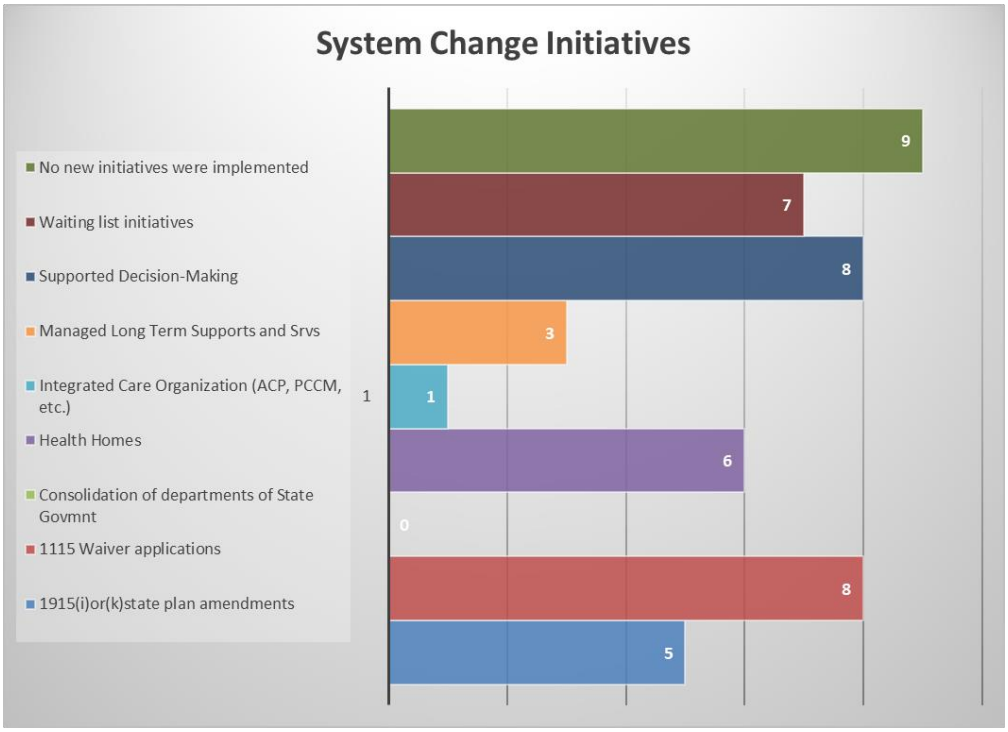


In Massachusetts, the Department of Developmental Disabilities Services (DDS) has implemented recommendations from a 2016 OIG report, along with several other quality improvement initiatives to continuously work to improve the DDS system to assure the health, safety and quality of life of all individuals served. In addition to adopting several strategies to refine and improve abuse and mistreatment processes, DDS also took steps to improve incident reporting systems.

Finally, Pennsylvania reported that a number of group homes are being reviewed for Medicaid fraud.

Litigation

The majority of respondents (19 out of 33 states) report little or no active litigation in their states from a field of three key issues. For those who did report litigative activity, two states identified suits related to waiting lists and sheltered workshop issues (two cases each) and one state identified a suit related to Medicaid rate cuts. Other interesting litigation activity includes prison overcrowding and mental health services, a class-action suit against the state and PASSEs on non-payment during the transition to the new provider-led model, a challenge by Disability Rights Florida to the adequacy of behavior services for individuals served via the iBudget Home and Community Based Services Waiver for individuals with intellectual disabilities, skilled nursing care in HCBS for medically fragile kids, a class-action lawsuit against the state's department of human services claiming it does not provide adequate resources to assist individuals in living more independent lives, and a suit filed by Disability Rights Ohio against Ohio's Department of Developmental Disabilities and Ohio County Boards of I/DD for funding not being used to transition individuals from institutions to community-based settings.



Systems Change Initiatives

Most states reported being in flux when it comes to systems change. Some reported moving from fee-for-service to value-based payment models or other alternative payment structures. One state (South Carolina) reported moving from bundled payment systems to fee-for-service systems. In every case, states appear to embrace the notion that "the grass is greener on the other side" to stem the swell of demand for Medicaid-funded programs. It is hard to determine whether this is due to the long-term impacts of the Great Recession or states simply not keeping investments in their safety nets on par with inflation. The result, however, is that 24 states report initiatives centered on systems change, including waiver changes, some form of Managed Care or Integrated Care, waiting list and health home initiatives.

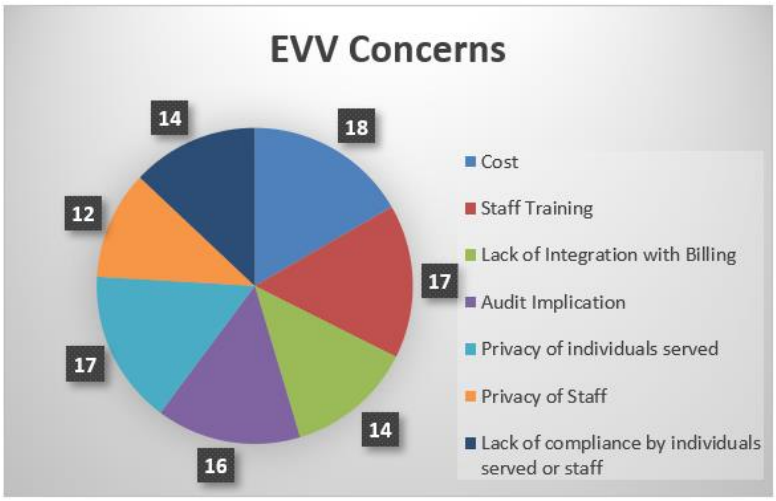
Some notable initiatives include:

- Alaska's 1115 waiver being implemented specific to behavioral health.
- California implementing a self-determination waiver.

- Florida pursuing a state plan amendment to increase the Medicaid financial eligibility from 300% to 550% of the federal poverty level for HCBS recipients who are employed and want to maintain their financial eligibility.
- Georgia's move to implement its 1115 Waiver to enable Sect. 1332 innovations waiver.
- Massachusetts continuing its program redesign yielding (1) five regional Accountable Care Organizations (ACOs) comprised of hospitals, outpatient services, etc.; (2) Managed Care Organizations that are care networks, such as insurance companies and Optum (the third-party administrator for long-term supports and services programs), and (3) ACOs contracting with Community Partners to provide community-level service.

State Support of HCBS Community Rule

Respondents were asked to identify what their states are doing to support the implementation of the HCBS Settings Rule. Responses were mixed but initiatives include California issuing $15 million in grants for three years for training on Person-Centered Planning, Maine creating a new position to oversee compliance with the state's transition plan, Ohio developing a unified service plan to be used across all I/DD service systems that is transforming Developmental Centers into Trauma Informed Care settings, and South Dakota introducing a new shared living services option along with new employment definitions and an expansion of the state's family support waiver.



Another shift in response to the HCBS Settings Rule revealed by the State Share survey is waiver alignment with necessary outcomes and the addition of new waiver services. With regard to waiver alignment, Arizona added a 1915i waiver and changed its Home and Community Based Waiver to a Community and Employment Support Waiver. Meanwhile, new waivers are being introduced in California (a Family Support Waiver and a Self-Determination waiver), the District of Columbia (a Family Support Waiver), Maine (expansion of in-home, family-centered SLA services and employment services) and Pennsylvania (a Community Participation Supports Waiver.

Electronic Visit Verification

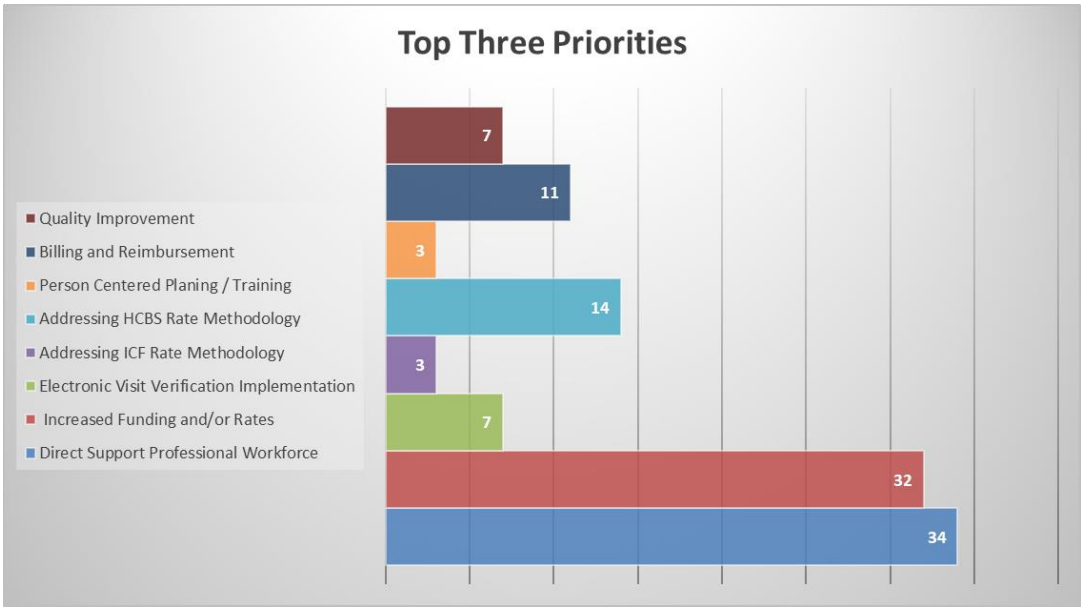
Among reform initiatives in the past decade, Electronic Visit Verification (EVV) is likely to have the among most significant impacts, perhaps second only to the HCBS Settings Rule. Providers routinely express concern about their state's level of preparedness for implementation, and their own.

Of great concern is the fiscal impact this initiative will have on organizations if implementation is not thoughtfully planned and tested.

When asked which model states are proposing, the majority of respondents indicated that their states are implementing a multiple vendor option, in which providers select from a state-approved list. When asked about their primary concerns regarding EVV implementation, respondents indicated that cost, training and privacy are the biggest concerns.

Priorities and Strategies

To round out our 2019 review of activity in I/DD services across the states, we asked members to comment on their top three priorities, as well as their strategies for achieving those priorities.



Clearly, the overarching concerns of respondents focus on DSP wages and funding for services; HCBS rate methodology was a distant third. Respondents reported many interesting strategies for achieving their priorities. For example:

- **Alaska** has secured legislative approval to allow providers to pay off student debt as a recruitment tool.
- **Colorado's** state association, Alliance Colorado, collected, analyzed and published a white paper on the state's workforce issues. After presenting the white paper to the Rate Review Task Force and various legislators, Alliance Colorado successfully championed a bill to implement a 6.5% rate increase for DSP wages.
- The **District of Columbia** formed a coalition to advance a bill to increase DSP wages to 125% of the District's Living Wage.
- **Kansas** is working on a new policy framework for legislators that would tie the need for capacity development to the elimination of waiting lists and develop quality outcomes for the community I/DD network.
- The **Maryland** Association for Community Services (MACS), Maryland's provider association, has engaged national rate-setting consultants to advise the association on the outcomes of the state's rate-setting process. MACS is also working with advocates to raise concerns regarding the implementation of major systems change efforts.

- **Missouri** commissioned an independent rate study focusing on the disparity between rates and the cost of services, and is implementing a professional marketing and messaging strategy process called Story Branding.
- **North Carolina** launched a statewide media campaign. Additionally, individual provider agencies are buying electronic health record software packages and connecting to a statewide network that will give providers greater care coordination capacity plus the ability to engage in two-way data reporting to benchmark quality and value in an evolving, value-based payment environment.

Most Exciting Initiatives

After being asked to consider what is happening in their states from budgetary, regulatory and innovation perspectives, respondents were asked what they're most excited about in the coming year. The responses point to quality, technology and person-centered planning. These responses affirm what we all know: providers strive to deliver the best services they can to the people they support, while provider associations strive to support their members through legislative, fiscal and regulatory advocacy.

In particular, respondents indicated excitement about supported decision-making (Alaska), investments in person-centered practices (Georgia and Rhode Island), the use of assistive technology for remote monitoring (Massachusetts), the inclusion of telehealth/telemedicine for underserved populations and for emergency department diversion (Illinois, Minnesota, New Jersey and North Carolina), and systems change related to alternative payment models (Kansas, Maine, North Carolina, Pennsylvania and Texas).

Conclusion

This year's State Share reflects some significant shifts toward new models of payment and service delivery, as well as a significant focus on person-centered practices, supported-decision making and greater inclusion of telehealth as a method of reaching underserved participants and saving money. While states continue to struggle with insufficient appropriations to meet the growing demand for community-based services, modest investments have brought DSP wages closer to states' rising minimums.

Nevertheless, of significant concern for most states is the reality that DSP wages are still not reflective of the importance of the work or the level of skill needed to successfully fulfill requirements of the job. Moreover, other job functions necessary in community-based organizations continue to be underfunded, and the exclusive focus on DSP wages is creating a compression between the entry-level workforce and frontline supervisors at middle-management levels.

Finally, and perhaps of gravest concern, is the indication that agency attrition is the bellwether of ongoing fiscal stagnation and the inability of organizations to sustain operations when there is little or no financial security in the sector. Without solutions to these ongoing and increasingly substantial problems, states will have little ground for scratching their heads when too few individuals with I/DD are being supported with the high-quality services providers are committed to delivering.