IN THE MATTER OF THE ARBITRATION BETWEEN

Adult Family Home Council

&

State of Washington

PERC Case No. 135714-I-22

Appearances

For the Council:	Edward E. Younglove III Younglove & Coker, P.L.L.C.
For the State:	Margaret C. McLean Office of the Attorney General
	Kate S. Worthington Office of the Attorney General

CBA
2023 - 2025

Issues
Article 7 - Payments
Article 8 - Training and Healthcare

Hearing
August 29 - 31, 2022

Decision
State's BDR @ 95%

Date
September 23, 2022

PROCEEDING

This proceeding is an interest arbitration between the Adult Family Home Council and the Governor and State of Washington (collectively "the parties"). This proceeding functions as an extension or continuation of the parties' negotiations for the 2023 – 2025 collective bargaining agreement. This interest arbitration is not final-offer, issue-by-issue or final-offer package but conventional interest arbitration where the Arbitrator may accept a proposal as presented or direct a variation of it as warranted by law and the record.

The Arbitrator's issuance of an award concludes the parties' negotiations; an award represents a resolution of the issues in a manner that reflects the parties' intended voluntary agreement but for their negotiation impasse. In doing so, the Arbitrator recognizes that interest arbitration is legislative by design and purpose and subject to statutory criteria for determining contract rights to include in the collective bargaining agreement ("CBA"). The party proposing to include different or a new first-time right in the CBA accepts the responsibility to demonstrate the need for its proposal.

On August 29, 30 and 31, 2022, a telepresence hearing convened wherein each party was afforded an opportunity to present evidence, examine and cross-examine witnesses, and articulate its position with argument. The record closed on August 31, 2022, with the parties' summations.

The parties' stipulated to admission of all exhibits into evidence. In the record are twenty-five (25) joint exhibits, fifty-one (51) Council exhibits, twenty-seven (27) State exhibits and four (4) State rebuttal exhibits. Transcribed witness testimony is in a certified transcript.

Called by the State to testify were Robyn Williams, Senior Budget Advisor to the Governor, Office of Financial Management ("OFM"); Bea Rector, Assistant Secretary, Aging and Long-Term Care Support Administration ("ALTSA"); Deborah Roberts, Assistant Secretary, Developmental Disabilities Administration ("DDA"); Eric Mandt, Assistant Director, Management Services Division, ALTSA; Rachelle Ames, Manager, CARE Management Unit, ALTSA; Peter Graham, Chief, Office of Rates Management, ALTSA; Alec Graham, Chief, Home and Community Programs Division, ALTSA; Saif Hakim, Chief, Residential Employment Services Division, DDA; Kelly Hampton, Manager, State Plan Residential Unit, DDA; and Brenda Moen, Labor Negotiator, Human Resources-Labor Relations and Compensation Policy Section, OFM.

Called by the Adult Family Home Council ("AFHC") to testify were John Ficker, Executive Director, AFHC; Carma Matti-Jackson, Chief Executive Officer, C. Matti Consulting; Anne Kibicho, Adult Family Home ("AFH") licensed operator; Nyater "Martha" Kok, AFH licensed operator; and Madonna Maxaner, AFH licensed operator.

BACKGROUND

RCW 41.56.029(1) states that "[s]olely for the purposes of collective bargaining and as expressly limited in subsections (2) and (3) of this section, the governor is the public employer of adult family home providers who, solely for the purposes of collective bargaining, are public employees."

Within that legal framework, there is a collective bargaining agreement ("Agreement" - "CBA") by and between the Adult Family Home Council ("AFHC" - "Council") and the Governor and State of Washington ("State") effective July 1, 2021 through June 30, 2023. The Agreement covers a state-wide bargaining unit comprised of approximately 3,800 adult family home providers accepting Medicaid payment in the State's long-term care programs.

Bargaining unit adult family homes ("AFHs") provide long-term care with an approximated 17,000 health-care workers serving and supporting an estimated 19,000 AFH residents. Long-term care programs are under the purview of the Department of Social and Health Services ("DSHS") and administered by the DSHS' Aging and Long-Term Support Administration and Developmental Disabilities Administration. AFHs depend on these administrations for licensing, oversight, client assessment, client referrals and Medicaid payment.

Negotiations for the 2023 - 2025 CBA are deadlocked over certain issues that are scripted by RCW 41.56.029(2)(c): (i) economic compensation such as manner and rate of subsidy and reimbursement including tiered reimbursement; (ii) health and welfare benefits; (iii) professional development and training; (iv) labor-management committees; (v) grievance procedures; and (vi) other economics matters.

On August 17, 2022, the Washington Public Employment Relations Commission ("PERC") certified issues for interest arbitration. Six days later (August 23) the State filed an unfair labor practice ("ULP") charging the Council's proposal for Article 7.17 - Federal Holidays is a non-mandatory subject of bargaining.

On August 26 and 30, 2022, the PERC amended its issues certification and suspended the following articles from this interest arbitration pending disposition of the ULP: Article 7.5 - Private Duty Nursing Services, Article 7.12 - Medical Escort Fee and Article 7.17 - Federal Holidays. [Jt. Exhs. 5-9; State Reb. Exh. 4]

CERTIFIED ISSUES

Certified issues for interest arbitration are:

State Issues

Article 7 - Payment

7.1: Base Daily Rates (§§ A, B)
7.2: Expanded Community Service Daily Rate (§§ A, B, D)
7.3: Specialized Behavior Support Add-On Rate (§§ B, C)
7.4: HIV/AIDS House Rates (Excluding PACE Organizations) (§§ B, C)
7.6: Respite Services (Excluding PACE Organizations) (§§ B, C)
7.7: Community Integration Payment (§ (A))
7.11: DDA Meaningful Day and HCS Meaningful Day Activities Add-On Rate (§§ B.1, C.1)

Article 8 - Training and Healthcare

8.2: Adult Family Home Mandatory Training (§§ A, B, C)

AFHC Issues

Article 7 - Payment

7.1: Base Daily Rates (§§ A, B)
7.2: Expanded Community Service Daily Rate (§§ B, C, E)
7.3: Specialized Behavior Support Add-On Rate (§§ B, C, D, F)
7.4: HIV/AIDS House Rates (Excluding PACE Organizations) (§§ B, C)
7.6: Respite Services (Excluding PACE Organizations) (§§ B, C)
7.7: Community Integration Payment (§ (A))
7.9: Bed Hold Rates
7.11: DDA Meaningful Day and HCS Meaningful Day Activities Add-On Rate (§§ B.1, C.1)
7.13: Two Person Assist
7.14: Behavior Add-On
7.15: Capital Add-On
7.16: Hourly One-on-One Support
7.18: ProviderOne Payment System

Article 8 - Training and Healthcare

8.2: Adult Family Home Mandatory Training (§§ A, B, C)
8.3: Health Care

CRITERIA

The certified issues are assessed based on criteria in RCW 41.56.465 and 41.56.029:

(1) constitutional and statutory authority of the employer;
(2) parties' stipulations;
(3) cost of living measured by the average consumer prices for goods and services;
(4) changes in any of the circumstances in (1), (2) or (3) during the pendency of the proceedings;
wages, hours and working conditions - - comparability, bargaining history, prevailing practices, policies (equity and fairness) and demonstrated need to name some;
(6) State's financial ability to pay for the compensation and benefit provisions in the CBA.

RCW 41.56.029 designates the legislature as the final authority on funding a collective bargaining agreement, that is, assessing the financial feasibility to fund this CBA in relation to all collective bargaining agreements negotiated by the State. In other words, the legislature is the penultimate decider.

Each party addressed criteria relevant to each issue. No criterion is designated as dispositive of an issue than another criterion. The cumulative effect of the criteria relevant to each issue are assessed and considered.

LONG-TERM CARE - AFH

[Jt. Exh. 24]
[AFHC Exhs. 2-8]
[State Exhs. 2-9, 14-17, 19-21, 26]

The DSHS provides long-term care services and support for the Medicaid eligible population through its Aging and Long-Term Care Support Administration and Developmental Disabilities Administration. DSHS' continuum of long-term care services and support allows eligible recipients to choose a community or institutional setting. Regardless of choice, the DSHS' long-term care services and support promote living with dignity and independence within the scope of the resident's maximal health.

State funding for long-term care is accompanied with Medicaid funds where the amount provided depends on the legal authority - - "1915c" waivers or State Plan Community First Choice ("1915k"). Medicaid law, requirements and boundaries are substantial and prevalent in long-term care. For example, Medicaid requires the State to avoid duplicating services and to maintain cost neutrality. That is, the average cost for a service provided by a community-setting AFH cannot exceed the cost of that service in an institutional setting. AFH providers receiving Medicaid payment are reimbursed at rates consistent with efficiency, economy and quality of care and sufficient to attract providers into the business. Medicaid does not reimburse for room and board. Notwithstanding these legal and operational boundaries, independent organizations evaluating the State's programs consistently rank them at number one or number two in relation to six (6) states.

An AFH is an option for long-term care when the provider accepts Medicaid payment. This "home-like" environment is situated in a community neighborhood or rural setting. An AFH is staffed by a person or persons providing personal care, special care and room and board for two (2) to eight (8) unrelated residents. On average an AFH serves six (6) residents with a staff of five (5); there is no requirement to report occupancy rates or operating expenses.

A provider may be an individual, partnership, corporation, association or limited liability company licensed by the State to operate an AFH. Providers qualify as woman-owned and minority-owned businesses. A provider is not required to live on-site or offer awake night staff, one-on-one supervision for a resident or staff with a registered nurse although a nurse delegation may be available. Physical, speech or occupational therapy are not available.

The decision to accept Medicaid resides solely with the provider; an AFH may be occupied with Medicaid and private payers and it may focus on a segment of the long-term care population such as an age demographic or those with mental illness. The number of licensed AFH operators with licensed beds has increased annually since FY 2016. As of July 1, 2022, there were 3,876 licensed AFH facilities offering 21,859 licensed beds of which approximately 9,000 beds were occupied by Medicaid residents.

Across the long-term care spectrum the demand for services consistently points upward necessitating a supply of qualified workers. Recruiting and retaining a workforce to meet demand is omni-present in this regulated industry that requires a minimum of seventy-five (75) hours training to certify for the entry-level health-care assistant position plus twelve (12) hours annually of continuing education. Entry-level positions comprise the AFHs' workforce; providers incur constant turnover. Time dedicated to training and its expense influence recruitment and retention.

These workforce issues - - staffing and development - - are concerns for a provider where growth for long-term care is three percent (3%) to five percent (5%) annually but growth for long-term care services provided by an AFH is higher as its residents, in relation to others in community settings, are more dependent, that is, they require more direct personal care. Contributing to this growth rate is the 85 and older demographic projected to increase by triple digits yearly into 2025. The correlation between this demographic and its need for long-term services and support with daily life activities - - dressing, bathing, meals, laundry, housekeeping, medications, appointments - - is statistically significant.

Persons enters long-term care by initiating contact with the DSHS' administrations or by referral. They must be financially eligible for Medicaid and functionally eligible as determined by the CARE - - comprehensive assessment and reporting evaluation. This assessment places a person in one (1) of seventeen (17) classifications. Within each classification there are five (5) groups (A, B, C, D, E) and levels thereunder (low, medium, high). In short, Group A low in each classification represents the least dependent with minimum personal care needs (lowest "acuity" group) whereas Group E high in each classification is the highest "acuity" group and most dependent with maximum personal care needs. An estimated twenty-five percent (25%) of AFH residents are in the acuity classification Group E. They are immobile and bedridden; this is a higher percentage compared to residents in other home-care settings such as assisted living centers.

Based on the person's acuity classification a plan of care is developed to itemize the amount, duration and scope of services required to meet that person's needs. The acuity classification along with the AFH's geographic location(:service area") determine the all-inclusive base daily rate ("BDR") that the State will pay the provider. In addition to the BDR a provider may receive additional funds through a specialty contract at an hourly or daily rate. For example, a resident with severe or persistent mental illness and significant behaviors requiring an increase in personal care time may warrant the specialty contract Specialized Behavior Support. Another source for funds is Exception to Rule ("ETR"). Regardless of payment, only the provider decides whether to accept the eligible person and, in doing so, commit the resources to deliver the amount, duration and scope of services in the plan of care. The State is not authorized to assign or place a person in an AFH. This is part of the DSHS' transformation of lives based on personal choice.

REVENUE AND BUDGET

[Jt. Exh. 10 - State Exh. 13 - AFHC Exh. 50]

In June 2020 the forecast for General Fund revenues decreased by approximately $9 billion for the 2021 - 2023 biennia. The decrease was attributable to COVID-19 and the economic costs to address the pandemic. Public employees received no pay raises and some pay reductions occurred in the form of furloughs.

A year later - - June 2021 - - the General Fund revenue forecast improved to pre-pandemic levels although risks persist with COVID-19 measures, higher inflation and collectively bargained pay increases. The improving General Fund forecast continued and, as of June 2022, the 2021 - 2023 biennium revenue projection was $1.5 billion higher than the forecast and the revenue increase for the 2023 - 2025 biennium is forecast at $632 million.

Notwithstanding revenue increases realized and projected, concerns continue posed by higher inflation contributing to increasing cost-of-living expenses, on-going COVID-19 measures as well as global issues which could weaken domestic economy growth and decrease the State's exports to international markets. Approximately half of General Fund revenue is obtained from retail sales tax and use tax; monetary policy to deal with inflation may affect revenues. Aside from sales tax as a revenue source for the General Fund, approximately seventy percent (70%) of the budget is protected by law. Medicaid is one of the protected spending categories. Caseload forecasts for ALTSA and DDA increase annually dating from FY 2018 (84,324) and projected to FY 2025 (101,234). Medicaid recipients contribute to rising caseload numbers.

Amidst the numbers and forecast, the 2023 - 2025 budget faces the cessation of Federal funds for COVID relief, employment challenges posed by the "great resignation" and return to work, collective bargaining demands and continuing efforts to address homelessness, housing, behavioral health, health care and opioid crises to name a few.

NEGOTIATIONS - PRIORITIES

For the 2023 - 2025 bargaining cycle, the State identified four (4) priorities. One priority is to invest in the BDR's labor component (wages and benefits) in recognition of AFH providers' struggles during the pandemic delivering direct care services while coping with a workforce shortage posed by the "great resignation" and minimal pay for home-care workers. In support of this priority the State describes its proposal as an "unprecedented" twenty percent (20%) increase in the BDR's labor component which elevates that component to 90% funding. The State's goal in this cycle of negotiations is to direct the maximum revenue available into the BDR's labor component.

Another priority for the State was to invest in workforce development, recognizing the difficulty AFH providers encounter to attract staff and retain them. The State proposes to increase its contribution to the AFHC Foundation which provides the training to develop and retain the workforce as well as enabling health-care assistants to advance to certified nurse assistant or progress to licensed provider status should they choose to do so.

Priority three emphasizes support for mental health in recognition of the Governor's initiative to decrease the number of beds in institutions and transition those residents into the community with assistance through Specialized Behavior Support ("SBS"). These transitioning clients have severe and persistent mental illness; the SBS will provide continuing assistance with daily life activities such as reminders to take medication and follow-up with medical professionals.

Priority four is to enhance residents experience by improving their quality of life with the Community Integration Program ("CIP") and Meaningful Day ("MD") where activities focus on the residents' interests and activities thereby ensuring that quality time is dedicated to them.

The Council's priorities align with the State's priorities. For example, the Council agrees with the priority to increase funds dedicated to the BDR's labor component and proposes a sixty-three percent (63%) increase over the current level to attain full funding as well as proposing a health care benefit.

The Council agrees with the priority to invest in workforce development. It proposes that the State increase its contribution to the AFHC Foundation that provides training and career development through a network of contractors to ensure supply meets demand. With an increase in wages and a trained workforce, attracting and retaining workers will be enhanced.

Also agreeable to by the Council is the priority to enhance the client experience. This will occur with a better trained and skilled workforce delivering quality-care services in support to the resident's participation and activities in CIP and MD.

ARTICLE 7 - PAYMENT

PROPOSALS - POSITIONS

[Jt. Exhs. 6, 7]
[State Exhs. 11-27]
[AFHC Exhs. 9, 17, 20-39, 45-49]

Considering Article 7 in its entirety for the 2023 - 2025 biennium, there is a 63% differential between the parties' proposals which, in dollar terms, equates to $791,042,053. A breakdown of the difference follows:

- The Council proposes an 83% increase ($1,041,382,548) over current funding in the 2021 - 2023 CBA; its proposal elevates the total cost for Article 7 to $2,303,306,674.

- The State proposes a 20% increase ($250,340,495) over current funding in the 2021 - 2023 CBA; its proposal elevates the total cost for Article 7 to $1,512,264,621.

- The difference in the parties' proposals for the total cost of Article 7 is 63% or $791,042,053.

The State maintains it does not have the ability to pay the AFHC's 83% proposed increase for Article 7 whereas the Council maintains that healthy revenues and economic recovery from the pandemic confirm an ability to pay. The AFHC describes its proposal as competitive pay and benefits for AFH staff whereas the State's proposal is below minimum wage and exacerbates staffing issues.

When considering the Council's proposal and the criterion ability to pay, the State notes that it is burdened by Medicaid regulations such as cost neutrality whereas the Council is not encumbered by such constraints when seeking additional funds.

The disputed sections within Article 7 are addressed in seriatim. A party's proposal for a section is described with a synopsis of argument supporting its proposal. Relevant criteria are considered.

1. Article 7.1 - Base Daily Rates ("BDR")

a. BDR - Proposals and Positions

Under the 2021- 2023 CBA, the estimated total cost for Article 7 is $1,261,924,126 of which $1,034,037,444 is attributed to Article 7.1 - Base Daily Rates. Given the dollars directed to and consumed by the BDR, it is the featured and dominant section in Article 7.

For the imminent 2023 - 2025 CBA and, particularly Article 7.1 - BDR, the Council proposals a 63% increase which represents a dollar value estimated at $649,202,302 over the current funding level whereas the State proposes a 20% increase, equivalent to $211,971,529, over the current funding level. The cost difference between the parties' proposals for the BDR is $437,230,773.

The BDR is the collectively bargained, all-inclusive Medicaid reimbursement rate for AFH providers and, according to the Council, comprised of three (3) determinants: Direct Care and Services ("DCS"), Room and Board, and Operations and Administration. Comparing the determinants by dollars and cents, DCS dominants. It is determined by an hourly labor rate multiplied by the daily hours of care for each acuity classification. The parties agree that "daily hours of care" is based on the DSHS' time study and includes personal care plus other time incurred providing services.

The AFHC states that the hourly labor rate in the 2021 - 2023 CBA is derived from 2018 data for wage and benefit rates and not tied prevailing wage rates. According to the State the BDR is based on an assumption of hours and wages not a specific wage or hourly rate; the AFHC and State agree on that assumption.

The. parties' focus in this cycle of negotiations has been the BDR's labor (wages and benefits) component; it constitutes about 73% to 75% of the overall BDR payment assuming full funding. This percentage is based on the model from prior bargaining cycles and continuing into current negotiations. In this regard, in 2016 the parties agreed to a model that focused on funding wages instead of add-ons. This simplified model was easier to understand for providers and legislators. In 2018 the parties agreed to a funding model which continued with the time study but added other factors to consider when determining the BDR.

The BDR's labor component never has been fully funded. For the 2017 - 2019 CBA the parties agreed to fund labor at 73% with increases over succeeding bargaining cycles to attain full funding. During negotiations for the 2019 - 2021 CBA the parties agreed to fund labor at 73% and at 75% for the 2021 - 2023 CBA. Federal relief during COVID increased funding with a Memorandum of Understanding adding monies to the BDR. COVID-relief rate enhancements ranged from thirteen (13) to seventeen (17) dollars an hour to pay for labor and personal protective equipment among other items.

The model for these negotiations aligns AFH payment rates to 1 of the 17 acuity classifications. The BDR varies depending on the client's classification and, under the State's proposal, service area. A resident may move up or down in a classification depending on needs and support. This would affect the BDR paid to the provider.

The State's proposal funds labor at 90% and it applies an hourly wage rate for the service area designated as "high cost" counties (Snohomish, Pierce and King) that is higher than the hourly labor rate it proposes for the "standard cost" service area (remaining 36 counties). The high cost and standard cost designation is based on cost-of-living data maintained by the U.S. Bureau of Labor Statistics ("BLS").

Under the State's proposal the benchmark hourly rates are:

Service Area	Year 1: 2023 - 2024	Year 2: 2024 - 2025
Standard Cost	$14.20	$14.50
High Cost	$16.48	$16.80

According to the State, its proposal adds an "unprecedented" $211,971,529 to the BDR which is more funding than the prior four (4) years combined. No other group represented by a bargaining agent received a comparable increase from the State.

Whether the State's offer is "unprecedented" or not the AFHC points out that the State's benchmark rates are below minimum wage. In 2022 the minimum wage is $14.49 in an environment where the Consumer Price Index ("CPI") increased 9.1% in July 2022. In 2023 the minimum wage will be $15.81 and onward to $18.82 in 2025. The State's below-minimum-wage proposal falls further behind as years progress. Entry-level workers at Amazon earn a higher labor rate than AFH workers.

Notwithstanding benchmark rates and minimum wage, the State notes there are increasing numbers of licensed AFHs and current owners are adding homes. This ensures an ample number of beds available for Medicaid payers. This confirms that the BDR is sufficient to attract persons interested in long-term care as a licensed AFH operator. Providers operate with economies of scale and, those with multiple homes, can switch staff between homes as needed. In other words, there are sufficient numbers of AFH providers and beds available for Medicaid clients under the current and proposed BDR. Based on a weighted average, the BDR has maintained pace with inflation during the past two (2) years. Comparison to Amazon and other businesses where a wage rate exceeding the minimum wage is available with no training is not comparable because the State is not competing with Amazon. Rather, the State is administering a complex regulated public benefits program funded by taxpayers.

The State recognizes concerns about recruiting and retaining staff and its effect on quality of care; its proposals for other sections in Article 7 address workforce development through training, recruitment and retention.

The AFHC's proposal is full funding for labor applied state-wide, that is, no service area distinctions. The AFHC's expert witness observed that all Medicaid systems are chronically underfunded. Examples: AFH providers underfunded at 73% and assisted living centers underfunded at 63%. Recognizing prevailing wage rates corrects underfunding and enhances recruitment and retention of staff. The parties recognize these are minimal wage positions where the staff delivers quality care for the State's low-income and vulnerable long-term Medicaid populations.

The Council's proposal uses benchmarks based on prevailing wage rates for in-home health care workers, specifically, Individual Providers ("IPs") whereas the State's proposal uses wage-and-benefit benchmarks below minimum wage. According to the Council, the State's proposal fails to recognize that increases in minimum wage rates drive upward the wages for personal care aides.

When compared to other home health care providers, AFHC notes that long-term care assistants rank at or near the bottom for hourly rates. The State's consultant - - Navigent Consulting - - informed the State that AFHs entry-level positions are sensitive to minimum wage impacts and that implicates a providers ability to recruit and retain staff.

State-wide there are 63,000 personal care aides and 50,400 (87%) are in long-term care. There are 40,700 IPs in long-term care; sixty-five percent (65%) of them are represented by Local 775 - SEIU. AFH providers compete for caregivers from the same labor pool as in-home personal care IPs. AFH caregivers and IPs have equivalent training and certifications, skill sets and hours of experience. IPs hourly rates and benefits in their CBA remain in effect even though they are no longer represented by Local 775 but are part of the Consumer Directed Employer home-care network.

The benchmark wage rates in the AFHC's proposal are a calculated average of the prevailing wages for IPs in their 2022 - 2023 Tentative Agreement. For June 2023 the IP benchmark wage rate is $19.16. The historic growth rate factor of 5.03% is added to the benchmark. The Council's proposed hourly wage rate in Year 1 is $20.12 and in Year 2 is $21.13. Based on the 2020 Washington Skilled Nursing Facility Cost Report, taxes and benefits are calculated at 23.05%. Thus, the Council's proposal for the BDR's hourly wage rate is:

	Year 1	Year 2
Benchmark Wages	$20.12	$21.13
Benefits at 23.05%	4.64	4.87
Hourly Labor Rates	$24.76	$26.00

The Council states that applying its proposal state-wide simplifies the BDR calculation and assists providers in bordering counties to be consistent and competitive in the wages they offer. The hourly labor rates in AFHC' s proposal apply state-wide because the hourly labor costs state-wide for home-care workers are similar and IPs receive the same hourly rate wherever they work in the state.

Full funding the BDR's labor component enhances recruitment and retention because wages for home-care assistants will trend toward the labor rate occupied by IPs. This ensures that those entering the workforce will seek work in long-term care at a time when the demand for personal care services is growing annually. This is significant because the universe of available workers (ages 19-25) entering the workforce in coming years is smaller than the growing age demographic (75 and over) needing long-term care. This represents a short supply for a long demand.

In the State's view, IPs are not comparable to AFH providers. For example, an IP is paid an hourly wage rate for each hour worked for a client whereas AFH providers receive the all-inclusive BDR which is comprised of more than an hourly rate. An IP works in the home of the client whereas AFH staff care for multiple residents with different needs. The structure of an AFH offers economies of scale because there is no one-to-one worker to client ratio which is the IP structure. An IP is not comparable because a provider operates an independent business with discretion to determine the resources, including staffing, to meet residents' needs.

The revenue forecast has improved and exceeded pre-pandemic levels the Council posits whereas the State is cautious about revenues and risks. There are many priorities competing for the forecasted $632 million on 2023 - 2025. Should revenues dip, the Council states the legislature can implement appropriate measures which could include defunding the CBA.

b. BDR - Criteria and Conclusions

The parties recognize that AFH staff are compensated with low, minimal wage rates and they agree that AFH providers are beset with staff turnover which hinders recruitment, retention and workforce development. They agree, as a bargaining priority in this cycle of negotiations, to increase the BDR's labor component to a maximum level within available revenue.

These mutual interests are acknowledged but unresolved as the parties diverge on the amount of monies represented by a percentage of funding dedicated to the BDR's labor component - - the State's 90% ($211,971,529) versus the Council's 100% ($649,202,302). In dollars, the parties' proposals differ by $437,230,733.

The State has the ability to pay its proposal to fund BDR's labor component at 90%. This self-evident conclusion is drawn from a bargaining perspective and practice that the State would not propose funding labor at 90% ($211,971,529) were those dollars beyond its ability to pay. The State observes that under the current BDR labor component and continuing with its proposal there has been and will be sufficient numbers of AFH providers offering a sufficient number of beds for Medicaid payers seeking the AFH option. The supply side of the equation (licensed providers, available beds, eligible residents) is not stagnating or decreasing.

Despite concerns about workforce recruitment, retention and development, an AFH provider testified to operating multiple AFHs and another AFH provider testified that she was in the process of adding another AFH. The operational model attracts those seeking to own an independent business in a growth industry. The Arbitrator finds this distinguishes AFH providers from IPs but does not extinguish their comparability given that IPs and AFH caregivers perform the same tasks with the same training. Turnover within those positions exists; this is a common operational issue. Internal comparability is a strong norm in interest arbitration and the comparability of AFH caregivers and IPs is recognized.

The State maintains that its proposal for 90% funding is based on factors in the model which have been used in successive bargaining cycles and agreed-upon by the parties. That is, the BDR is calculated on data and benchmarks assessing and estimating AFH costs for salaries, wages, payroll taxes, fringe benefits, capital expenses and a weighted average CPI. In addition to maintaining the model, the State's focus on dedicating maximum funding to the BDR and not diverting funds to add-on rates and specialty contracts simplifies the funding model for current and potential operators. Simplicity in description of the BDR model contributes to maintaining the integrity of the acuity classification system.

Although the State's proposal reflects the demonstrated need to fund BDR's labor with maximum available revenues to increase caregivers wages and benefits, AFH staff remain near or at the bottom of wage rates when compared to other caregivers in different community-settings as well as those with private providers and institutions. The State's proposal does not elevate them to the well-known, identifiable standard of minimum wage. The State's proposal is an hourly labor rate that, in 2023, will fall below the minimum wage and fall further behind in succeeding years as the minimum wage trends towards $20 hourly.

The State accurately notes that the BDR is more than an hourly labor rate but the hourly labor rate is a benchmark recognized by those contemplating long-care as an entry-level position or a career field. Hourly labor rate is not an incidental consideration for the AFH workforce. The State recognizes this issue. In 2021 the Home and Community Programs Division Director stated that "[w]ages and benefits absolutely need to change . . . [a]nd . . . this is a workforce that's largely women, largely people of color, a very high proportion of immigrant workers . . . facing centuries of undervaluing what is termed domestic work, which really is not domestic work." Minimal wages, in relation to the minimum wage, impedes hiring and retaining a workforce.

The Council's proposal for Article 7.1 - - full funding - - is based on revenue forecasts. As of June 2021 revenues returned to pre-pandemic levels and, as of February 2022, the 2021 - 2023 biennium forecast was exceeded by $1.5 billion and the forecast for the 2023 - 2025 biennium has increased by $632 million. Amidst this healthy economic outlook the legislature reduced the State's revenue through tax deductions. As the Council observed but for those tax deductions the $1.5 billion and $632 million would be higher. The percentage or dollar value of those funds available and considered by the Council to show ability to pay is not well-defined. On a straightforward, aggregate basis the $2.132 billion ($1.5 billion plus $632 million) covers the Council's proposal for the BDR's labor ($649,202,302), thus, the State has the ability to pay. On a nuanced pragmatic level, when revenues swell beyond forecasts, competition stiffens and demands heighten for the available revenues in this post-pandemic environment. Notions of equity and fairness among competitors for finite resources are in play.

Ability to pay is considered in the context of the legislature considering to fund the Council's proposal for the 2023 - 2025 CBA at the same time it considers all CBAs negotiated by the State. This is the financial feasibility criterion which could be interpreted as the economic wherewithal to pay. In that context full-funding labor is problematic under the Council's proposal valued at $649,202,302. To reach full funding with that dollar value requires the State to add $437,230,723. The $473,230,723 constitutes approximately seventy percent (70%) of the forecasted $632 million increase in the 2023 - 2025 biennium. Competitors at the funding moat seek their fair share of those forecast revenues or other available revenues. Seventy percent is disproportionate for AFHC when the competitors present themselves as underfunded, e.g., assisted living centers underfunded at sixty-three percent (63%). When assessed in that context the AFHC's proposal is not financially feasible.

The Council finds support for ability to pay its proposal based on sales tax revenues, the dominant revenue source, continuing to increase. This is problematic because the Council views these increasing revenues as supportive of ability to pay but presents inflation as contributing to the 9.1% CPI consuming workers earnings. Should the forecasts dip and revenues stagnant or decline, the Council states the legislature can defund the CBA. This position by the AFHC is not persuasive.

The Arbitrator finds there is an ability to pay the State's proposal and the Council's proposal is not financially feasible. There is another consideration presenting another way to maximize the funding and achieve as many goals as possible within the criteria framework. The Arbitrator finds that the societal stereotype framing this work as menial domestic chores presents an impediment to wage and benefit increases. The work is devalued and underfunded because it is performed by women, minorities and immigrants. Devaluing the work and the workforce appear in the form of turnover and less than minimum wages. Based on the Navigent report a DSHS initiative is to establish wage requirements that set base pay between $15.40 and $17.90 per hour. The State's proposal is slightly short of those wage marks.

A step forward toward achieving those rates in a collective bargaining context is funding the State's proposal at ninety-five percent (95%) which is an additional $10,598,576 (the difference between 211,971,529 and 95% of that amount). This is an incremental amount in relation to the $632 million forecast, is within the State's ability to pay and financially feasible for the legislature.

This incremental increase supports the mutual goal to reach full funding for the BDR labor component over successive bargaining cycles. It supports and advances the parties' bargaining priorities to fund at the maximum available revenues. It aligns with the parties' view that these minimal and low paying AFH positions, dominated by women, minorities and immigrants, warrant recognition by valuing their work for the Medicaid population. This is not menial domestic work but personal care services delivered for increasing numbers of infirm and frail residents often without other options or family available. This incremental increase deflects the erosive effect on wages posed by the inflationary costs represented by the CPI. It is a nod toward the IP hourly rates and a step towards maintaining a steady supply of qualified workers in the AFHs. Workforce retention minimizes turnover and enhances quality of care. The debilitating stereotype devaluing this work and the workers can be deflected in Article 7.1 - BDR.

In **conclusion** the State's proposal is accepted with the incremental change to fund Article 7.1 at 95%. In reaching this conclusion the Arbitrator considered the relevant criteria and the record comprised of exhibits and testimony. Specifically, ability to pay, cost-of-living, other factors traditionally and normally considered included bargaining history, bargaining priorities, realized and forecasted revenues, comparability and demonstrated need. Finally the Arbitrator considered the financial feasibility of the proposals noting the legislature has the final say-so.

2. <u>Article 7.2 - Expanded Community Service Daily Rate</u>

The Expanded Community Service ("ECS") daily rate is for individuals with significant behavioral or mental health challenges and a history of failed placements. Individuals on an ECS may have psychiatric challenges and - or substance abuse issues which renders them difficult to place in the long-term care system.

In the 2021 - 2023 CBA, an AFH provider received the ECS daily rate *or* the resident's BDR *whichever is higher*.

For the 2023 - 2025 CBA the State's proposal deletes the proviso *whichever is higher* and, instead, offers a set sum of a $56.00 daily rate add-on to the BDR. In other words, the AFH provider receives the resident's BDR plus $56.00 daily.

The Council's proposal retains the proviso *whichever is* greater between the BDR and ECS flat rate. In Year 1 of the 2023 - 2025 CBA the Council proposes an ECS daily rate at $221.91 and in Year 2 an ECS daily rate at $232.39. This flat rate is not tied to the resident's classification.

There were competing statements from each party as to providers supporting either the State's proposal or the Council's proposal. These statements present a stalemate. The State's proposal to change the status quo model for payment falls short on demonstrated need. The Council's proposal is adopted.

3. Article 7.3 - Specialized Behavioral Support Add-On Rate

Specialized Behavior Support ("SBS") developed with the inception of the State's mental-health initiative to transition individuals out of the State's institutions such as Western State Hospital. These individuals receive the same 24/7 services as an ECS resident plus, through SBS, one-on-one supervision for six (6) to eight (8) hours daily. The SBS is added on to the BDR. The current SBS add-on rate is $153.00.

The State proposes an SBS add-on rate of $165.00 for each year of the 2-year CBA whereas the AFHC seeks $205.46 in Year 1 and $215.41 in Year 2.

Additional wording proposed by the AFHC:

> When an AFH requests placement for an SBS resident beyond a contracted limit and it is denied, the State will provide the AFH with a written response as to the concerns. An AFH can appeal this decision to the HCS director and the ALTSA Assistant Secretary.

The State maintains it offers an explanation and this appeal process poses scheduling problems for calendar time is limited for these officials. The Council has not demonstrated a need for this proposal.

The State's proposal is accepted as the daily rate is reasonable and there is no demonstrated need for the Council's appeal process.

4. Article 7.4 - HIV/AIDS House Rates

There are two AFHs for HIV/AIDS residents -- one in Tacoma and the other in Bellingham. Residents tend to be younger than the typical AFH resident, homeless and part of the criminal justice system. In the current CBA the parties agreed that a provider for HIV/AIDS care receives a specialized daily rate *or* the BDR *whichever is greater.* In the 2021 - 2023 CBA the specialized daily rate is $101.31.

In Year 1 the State's self-described "modest" proposal is $140.71 and in Year 2 is $143.96; the Council proposes $151.13 in Year 1 and $158.15 in Year 2.

Two modest proposals. The Council's proposal is adopted.

5. Article 7.6 - Respite Services (Excluding PACE Organizations)

Respite services are short-term support services offered by an AFH. Services are available for persons with developmental disabilities and living with their parents or family where the parent or family is the long-term care provider. When these caregivers seek relief with a vacation or weekend getaway from their constant care duties, a provider may live in their home and provide care during their absence or they may elect out-of-home respite care and take the family member to the provider's setting.

The State proposes an hourly rate at $19.16 for up to 9 hours in a 24-hour period in Year 1 and $19.56 in Year 2. When respite care is 9 hours or longer, the caregiver receives a maximum of $172.44 in Year 1 and $176.04 in Year 2. When the client's acuity classification BDR exceeds $172.44 the provider will receive up to 11 hours which is equivalent to $210.76 in Year 1 and in Year 2 receives $215.16 when the client's BDR exceeds $176.04.

The Council proposes an hourly rate at $24.76 for up to 9 hours in Year 1 and $26.00 in Year 2. For 9 hours or more the Council proposes a maximum of $222.83 in Year 1 and $234.03 in Year 2. When the client's acuity classification BDR exceeds $222.83 in Year 1 the care provider will receive $272.35 for up to 11 hours and, if the acuity classification BDR exceeds $243.03 in Year 2, the caregiver receives $286.04.

The State acknowledges it offers a modest increase (8%) to the hourly reimbursement rate whereas the Union offers a significant increase in that rate. The State's goal in this cycle of negotiations is to provide the maximum revenue available for the BDR. Since respite services are not used often by individuals and families, the State's offer is modest rather than the steep increase by the AFHC. Families do not access AFH as a preferred provider for respite services. Plus, AFH providers seek to maintain maximum bed capacity and tend not to have a bed available for a short-term resident with a 3-day or week-long respite. Use of AFH as a respite provider has decreased over the years as the State has developed other respite options.

The State's proposal is adopted for the reasons it advanced.

6. Article 7.7 - Community Integration Program

In 2016 Medicaid instituted a requirement that home-based settings must ensure a resident with access to the community. That is, residents in an AFH should have opportunities to partake in community events and use community resources. Examples are attending church, playing bingo or visiting a neighborhood park. The provider supports the resident by providing access to the activity in the community. Forty percent of AFH residents participate in the Community Integration Program ("CIP").

When this requirement surfaced in 2016 the parties agreed to fund an AFH provider for a total of 4 hours monthly per resident to support a resident's access to the community, e.g., make arrangements with the resident's family to transport the resident to church. They agree that 4 hours is insufficient and delete it; the difference in proposals is the daily reimbursement rate.

For the CIP daily rate the State proposes to add $3.15 to the BDR in Year 1 and $3.86 to the BDR in Year 2 whereas the AFHC proposes $4.05 in Year 1 and $5.10 in Year 2. The Council also proposes that "Community Integration payments will be visible in the ProviderOne Payment System." The Council states that providers are unaware whether they receive CIP payment since it is not itemized within or under the BDR.

CIP is a significant and salutary event in a resident's life as shown by the high participation rate. The Council's proposal for daily rate is adopted; its proposal to change ProviderOne payment system to identify the CIP payment in the BDR is not adopted. The payment system is owned the Health Care Authority and it is operated by a third-part contractor. This payment issue is not under the direction or bailiwick of DSHS.

The Council's proposal for Year 1 and Year 2 is adopted; its ProviderOne provision is not adopted.

7. Article 7.9 - Bed Hold Rates

This is payment for holding the resident's bed when that resident is placed in a medical institution but intends to return to the AFH.

The current Article 7.9 - Bed Hold Rates mirrors the rates in the WAC 388.105. That is, a provider receives 70% of the BDR during days 1 through 7 of the resident's absence and $15.00 daily for days 8 - 20. The State proposes to maintain the status quo. According to the State, increasing the rates is an incentive for a resident to remain in the medical institution.

The Council proposes that an AFH provider holding a bed for a resident receive 70% of the resident's BDR for days 1 through 20 and 50% of the BDR for days 21 through 30. AFHC's proposal is based on data from the Centers for Medicare and Medicaid Services which shows that a resident's stay in the hospital plus rehabilitation is 20 days or longer. A provider cannot retain staff at $15 a day for days 8 through 20. The resident stays in the hospital for a sufficient number of days for Medicaid to pay.

The State's position is adopted; the status quo is maintained. The Council's proposal is based on data for Medicare clients, not Medicaid clients.

8. Article 7.11 - DDA Meaningful Day and HCS Meaningful Day Activities Add On Rate

Approximately 3,000 residents of the AFH population participate in Meaningful Day ("MD"); providers develop a plan of activities and how to access the activities which occur inside the AFH or outside of it. The MD has contributed to significant improvement in the number of DDA clients supported in an AFH. The provider can support the client to access an activity or the provider can work with the community to access the activity, e.g., church member pick up resident and transport to church. MD is engaging the resident and planning what is meaningful for that individual to have a full day. Negative and challenging behaviors for residents in MD tend to moderate with activities participation.

The current rate is $30.00 a day per client. The State proposes $35 daily per client. AFHC's proposal is $40 daily per client. According to the State, the AFHC proposal diverts money for a segment of the population away money that could be added to the BDR which benefits a larger segment of the populace.

Two modest proposals for a program with significant salutary effects on the populations served. The Council's proposal is accepted.

New Sections Proposed by AFHC

Article 7.13: Two-Person Assist
Article 7.14: Behavioral Add-On

Article 7.15: Capital Add-On
Article 7.16: Hourly One-on-One Support
Article 7.18: ProviderOne Payment System

New sections in Article 7 are proposed by the Council and opposed by the State. There are no State proposals. The Council's proposals and associated costs are:

• Two Person Assist:	$134,530,931
• Behavioral Add-On:	$ 92,586,386
• Capital Add-On:	$ 40,317,678
• Hourly One-on-One Support:	$ 19,808,580
• ProviderOne Payment System:	$ 7,100,497
TOTAL	$274,546,052

According to the AFHC, sections 7.13, 7.14 and 7.16 are necessary due to the overuse and misuse of the Exception to Rule ("ETR") contract. Data show that in 2014, $6 million or 4% of specialty contract authorizations were tied to an ETR; now it is at 11% which does not include an estimated 450 ETRs through managed care organizations. Rates paid under an ETR are not collectively bargained but the result of discussions between a case manager and provider.

An ETR is authorized by the State when the resident's situation differs from the majority in his or her acuity classification but the situation does not necessitate placing the resident in another classification. An ETR affects costs and staffing for a provider. Examples listed in the State's Long-Term Care Manual where recurring use of an ETR are sanctioned are two-person assist, awake night staff and one-on-one supervision.

The State points to RCW 388.440.0001 where funds for an ETR reflect the unique status of the client's personal care needs relative to other clients in the class group. An ETR is not for additional personal care service; it is for personal care needs over and above others similarly situated in the class group. The State maintains that the Council's ETR concerns have been addressed and resolved in a Memorandum of Understanding Exception to Rule dated August 22, 2022. [State Reb. Exh. 2]

9. Article 7.13 - Two Person Assist

The Council proposes to add this section as a new term and condition in the CBA; the State opposes it.

For the 2023 - 2025 CBA the Council proposes an add-on rate to the BDR when a resident's care plan requires a 2-person assist. The Council states there is an area on the CARE assessment report that is marked to confirm the resident's plan of care includes 2-person assist. When the confirming mark is present, the Council's proposal will automatically provide an add-on rate to the BDR to pay for the expense of a second staff person for 2-person assist. Examples are bariatric residents, operation of a Hoyer lift, assisting a stroke victim to stand or pivot.

According to the State, the Council's proposal for a 2-person assist add-on is outside of the acuity classification system. Medicaid considers 2-person assist as considered and covered in the plan of care. The AFHC proposal diminishes the integrity of the system used to determine service level

and benefits and it undermines the State's authority to determine the amount, duration and scope of Medicaid services. The class system is based on the relative resource needs for each client. Separating 2-person assist and considering it as an add-on when it is already considered in the plan of care and factored into the BDR is duplicating service.

The State does not dictate or require a staffing level in an AFH; those decisions reside with the provider. Should an AFH have 2 residents needing 2-person assist at all times, then the AFH determines whether to have separate workers assigned for each of those residents. When a resident's level of care exceeds the class group and the AFH provider seeks additional staff to meet that need, then the State would consider an ETR which is based on client's exceptional care need without regard to whether provider believes more staff is needed.

Based on the State's position, the Council's proposal is not accepted and will be withdrawn.

10. <u>Article 7.14 - Behavioral Add-On</u>

The Council proposes to add this section as a new term and condition in the CBA; the State opposes it.

According to the Council, a resident in acuity classification Groups C, D and E have mood or behavior issues. A resident may have assaultive behavior in the group but another client in that group may not. The provider receives the same BDR for each client but one requires additional time compared to the other. For example, the resident may be combative and depressed in the morning and will not dress. Dedicating more time to this client throughout the day may ameliorate his behavior and result in cooperation where he agrees to dress in the afternoon. His mood and behavior impact personal care.

For the 2023 - 2025 CBA, the Council proposes a resident-specific behavior add-on rate to the BDR when additional staff is required for the safety of residents and the caregivers when a resident in acuity classifications C, D or E with care-plan behaviors listed in WAC 388-106-0100. Staff-time outside of or beyond the time already considered in the BDR includes additional support for resistance to bathing and hygiene activities, additional care coordination for medical and counseling, higher frequency of appointments, higher frequency of requests for emergency room visits or first responders, a higher need for monitors for smokers, extra supervision to ensure medications are adhered to, and higher levels of coordination with social workers.

In Year 1 the add-on hourly rate for residents in classifications C, D, or E that meet behavior criteria in WAC 388-106-0100 ranges from $16.49 (C Low) to $27.51 (E High) and in Year 2 the range is $17.24 (C Low) to $28.82 (E High).

The State opposes this proposal on the basis that the care plan considered the resident-specific behaviors and that time is factored into and compensated in the BDR. This represents duplication of services, that is, the AFHC proposal seeks more money for the same service and time already assessed and compensated in the BDR.

The Arbitrator finds there is a matter of risk placed on the State with this proposal should a program audit by Medicaid or other appropriate auditor view Article 7.14 as duplication of services. The AFHC's purpose to obtain more compensable time for resident-specific behavior may be addressed in an ETR.

Given that finding the Arbitrator concludes the AFH's proposal will not be accepted and shall be withdrawn.

11. Article 7.15 - Capital Add-On

The Council proposes to add this section as a new term and condition in the CBA; the State opposes it.

For the 2023 - 2025 CBA the Council proposes a capital add-on rate for AFHs with Medicaid occupancy at 60% or more. For qualifying facilities the add-on rate will be $7.94 added to the BDR in Year 1 and $8.31 added to the BDR in Year 2.

To determine Medicaid occupancy percentage the State will use the last six months' Medicaid resident days from the preceding calendar year divided by the product of all its licensed AFH beds, without regard to use, times the calendar days for the 6-month period. Medicaid resident days include those clients enrolled in a Medicaid managed long-term care program. The Medicaid occupancy percentage established on the first day of the fiscal year (July 1) determines whether the AFH qualifies for capital add-on.

Capital add-on started as an incentive program for assisted living centers to enlarge facilities and accept more Medicaid residents. The Council proposes to apply this program for assisted living centers to AFHs.

There is no demonstrated need for this proposal at this time given the increasing number of AFHs. The Council's proposal is not accepted; it will withdraw its proposal.

12. Article 7.16 - Hourly One-on-One Support

The Council proposes to add this section as a new term and condition in the CBA; the State opposes it.

For the 2023 - 2025 CBA the Council proposes an hourly add-on when the care plan requires one-on-one support. In Year 1 the rate is $24.76 per hour for documented one-on-one support required by the care plan and, when the support requires a behavioral specialist, the rate is $25.68 per hour. In Year 2 the rates are $26.00 and $26.93 with a behavioral specialist.

An ETR is commonly used on top of the ECS or SBS when the client has significant behavioral challenges.

This proposal presents the same concerns, according to the State, as Article 7.13 - Two Person Assist and Article 7.14 - Behavioral Add-On. On that basis the Arbitrator will not accept the Council's proposal; it will be withdrawn.

13. Article 7.18 - ProviderOne Payment System

The Council proposes to add this section as a new term and condition in the CBA; the State opposes it.

For the 2023 - 2025 CBA the Council proposes to compensate an AFH with an additional $6.19 for each resident per pay period for the purposes of recording and submitting into the ProviderOne payment system. In Year 2 the rate is $6.50 for each resident each pay period.

ProviderOne allows payment to be billed on Tuesday and paid the following Friday. The Council proposes that "[i]f due to holidays or scheduled maintenance this needs to be changed, ProviderOne will issue notice to AFHC and all bargaining unit members at least 6 weeks in advance of the change."

Also proposed by the AFHC is that "[a]ll components of the payment outlined in the CBA including ETRs will be visible within the authorization and payment screens for AFH providers billing in ProviderOne system."

The Council states that since its inception in 2015, this payment system has not been changed. It was designed as a medical payment system and is now applied to social services. A provider is unaware of overpayments, missed payments or underpayments. Some providers hire third-party vendors to handle the billing. There many on-going discussions between the DSHS and system-owner Health Care Authority ("HCA") - - the State's Medicaid authority - - where providers' problems using this payment system could be presented to HCA.

The State notes this system is required for providers to submit Medicaid billing. The BDR contains an operations and administration component to cover billing. Some providers use third-party vendors for Medicaid billing. Also, the Council's proposal requires changes to the software billing program. The system is owned by the HCA and it is operated by a contractor. They - - vendor and HCA - - are parties to the system for Medicaid billing. Also training is available through the AFHC Foundation and its network of trainers for providers to enhance their proficiency using ProviderOne.

There was discussion by the Council that those submitting payment should be compensated at their hourly rate for billing time in 15-minute increments which is the provision in the Local 775 - SEIU agreement. The State highlighted some concerns related to the Fair Labor Standards Act ("FLSA") that applies to IPs and applying the FLSA to AFH providers in their capacity as independent business operators was problematic.

Based on the State's position, the Arbitrator will not accept the Council's proposals.

ARTICLE 8 - TRAINING AND HEALTHCARE

PROPOSALS AND POSITIONS

[Jt. Exhs. 8, 9]
[AFHC Exhs. 40-42]

1. Article 8.2 - Adult Family Home Mandatory Training

To qualify as a provider, WAC 388-112A requires certain training. Article 8.2 - Adult Family Home Mandatory Training addresses payment to cover time spent in training and the costs for core basic, continuing education and other required training.

The 2021 - 2023 CBA adds $1.28 per client per day to the BDR. The State proposes to maintain its contribution level into the 2023 - 2025 CBA whereas the Council proposes that the State's contribution increase by $1.49 per client per day in Year 1 and, in Year 2, increase by $1.52 per client per day.

As for the AFHC Training Network, the State proposes that all classifications receive an additional seventy-five cent (.75) contribution per client per bed day in Year 1 and, in Year 2, it add $1.00 per bed per client whereas the Council proposes all classifications have $2.75 contributed per client per bed day.

The Council notes that to qualify for an entry-level position in an AFH the worker must have completed at least seventy-five (75) hours of mandatory training as a home-care assistant and to maintain the position must complete twelve (12) hours annually in continuing education. At this time some AFH providers pay for the continuing education or allow staff to complete continuing education during work hours. Although the Council's proposal does not require the provider to use these funds for training, the provider has an obligation to ensure that staff is trained. The Council's proposal addresses training for providers and staff. Training is foundational to resolving recruitment and retention issues besetting the AFH business. The Council seeks comparability to the IPs where they are paid for their time in training and tuition. According to the Council, is estimates that a properly funded network can train up to 3,000 annually.

According to the State, a component of the BDR encompasses training or education. The State notes it already has contributed approximately $40 million but the results have not corresponded to the investment. That is, numbers completing the training and qualifying for AFH work have been disappointing. The State's proposal is $3,259,642 which elevates total funding to $43,239,350 whereas the Council's proposal represents a 498% increase in funds or $17,986.940.

On-balance the State's proposal is accepted as, at this time, it provides sufficient funds to move forward in training and developing the workforce.

The State's proposal is accepted.

2. Article 8.3 - Health Care

In the 2021 - 2023 CBA the State adds $3.35 per client per day to the BDR for health care coverage costs for AFH owners.

The State's proposal maintains the status quo whereas the Council's proposal is for the State to add $4.93 per client per day to the BDR in Year 1 and, in Year 2, add $5.05 per client, per day to the BDR.

Wording in Article 8.3 specifically identifies "adult family home owners" as the recipients of this health care and not, as the Council seeks, owners to include staff. The Council's expansive reading of Article 8.3 is not consistent with the specific term owner in the article.

The Council's proposal is not accepted.

The **Award** that follows captures the findings, criteria and conclusions on the certified issues.

Award

1. Article 7.1 - Base Daily Rates
   The State's proposal is adopted as modified to fund the BDR labor component at 95%.

2. Article 7.2 - Expanded Community Service Daily Rate
   The AFHC's proposal is adopted.

3. Article 7.3 - Specialized Behavioral Support Add-On Rate
   The State's proposal is adopted.

4. Article 7.4 - HIV/AIDS House Rates (Excluding PACE Organizations)
   The AFHC's proposal is adopted.

5. Article 7.6 - Respite Services (Excluding PACE Organizations)
   The State's proposal is adopted.

6. Article 7.7 - Community Integration Program
   The AFHC's proposal is adopted for daily rate; the AFHC will withdraw its provision addressing ProviderOne Payment System.

7. Article 7.9 - Bed Hold Rates
   The State's proposal to maintain status quo is adopted.

8. Article 7.11 - DDA Meaningful Day and HCS Meaningful Day Activities Add-On Rate
   The AFHC's proposal is adopted.

9. Article 7.13 - Two Person Assist
   The AFHC's proposal is not adopted and will be withdrawn.

10. Article 7.14 - Behavioral Add-On
    The AFHC's proposal is not adopted and will be withdrawn.

11. Article 7.15 - Capital Add-On
    The AFHC's proposal is not adopted and will be withdrawn.

12. Article 7.16 - One-on-One Support
    The AFHC's proposal is not adopted and will be withdrawn.

13. Article 7.18 - ProviderOne Payment System
    The AFHC's proposal is not adopted and will be withdrawn.

14. Article 8.2 - Adult Family Home Mandatory Training
The State's proposal is adopted.

15. Article 8.3 - Health Care
The AFHC's proposal is not adopted; it will be withdrawn.

Patrick Halter /s/
Patrick Halter
Arbitrator

Signed on this 23rd day
of September 2022