DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS FOR MEDICARE & MEDICAID SERVICES
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State Demonstrations Group

June 4, 2025

Charissa Fotinos, MD
Medicaid Director
Washington Health Care Authority
626 8th Avenue
P.O. Box 45502
Olympia, WA 98504-5050

Dear Dr. Fotinos:

The Centers for Medicare & Medicaid Services (CMS) completed its review of Washington's Final Report for the section 1115 demonstration entitled, "Washington COVID-19 Public Health Emergency (PHE)" (Project No: 11-W-00345/0). This report covers the demonstration period from March 2020 through July 2023. CMS determined that the Final Report, submitted on May 19, 2025 is in alignment with the CMS-approved Evaluation Design, and therefore, approves the state's Final Report.

The approved Final Report may now be posted to the state's Medicaid website. CMS will also post the Final Report on Medicaid.gov.

We sincerely appreciate the state's commitment to evaluating the COVID-19 PHE demonstration under these extraordinary circumstances. We look forward to our continued partnership on Washington's other section 1115 demonstrations. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S
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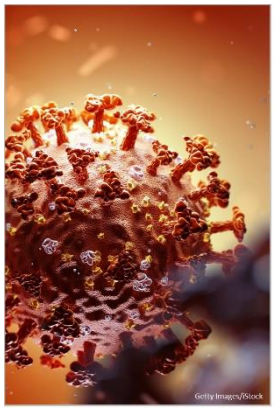
Date: 2025.06.04 04:20:15 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Edwin Walaszek, State Monitoring Lead, CMS Medicaid and CHIP Operations Group



Evaluation of Washington's COVID-19 Public Health Emergency Demonstration

The Impact of Waiver Authority on Stabilizing the Long-Term Support Services System during COVID-19

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Per the Centers for Medicare and Medicaid Services Special Terms and Conditions for the Washington COVID-19 Public Health Emergency 1115 Demonstration Authority (11-W-00345/0). In collaboration with the Department of Social and Health Services Aging and Long Term Supports Administration.

THE FIRST confirmed case of the coronavirus disease 2019 (COVID-19) in the United States occurred in Washington State on January 20, 2020. A public health emergency (PHE) was declared for the entire country on January 31, 2020, and not long after, Washington State was the first state in the nation to identify an outbreak of COVID-19 within a nursing facility that rapidly spread to other facilities. To help combat the rapid spread of COVID-19 in nursing facilities and to help stabilize the long-term services and supports (LTSS) systems more broadly, Washington State applied for a COVID-19 Disaster 1115 waiver and received approval on April 21, 2020.

The 1115 waiver focused on three main objectives: 1) Ensuring LTSS eligibility determinations were not being delayed for clients discharging from acute care, 2) Ensuring Medicaid clients were receiving the LTSS services they needed in a timely manner, and 3) stabilizing the LTSS provider system.

This evaluation is a required component of the COVID-19 Disaster 1115 waiver and examines if the state's strategies to mitigate the impact of the PHE on LTSS provider capacity and client access to services were successful.

Key Findings

1. **After an initial decline in service utilization, the use of LTSS services remained consistent with pre-COVID-19 trends.** This suggests that the strategies employed under the waiver were successful at stabilizing the Washington State LTSS systems throughout the COVID-19 PHE.
2. **Post-pandemic LTSS caseload growth recovery has been stronger in urban regions than in rural regions.** This reflects Age Wave demographic challenges that have particularly impacted the ability of rural regions to increase provider capacity to meet the need for Medicaid LTSS services.
3. **Expenditure trends show the impact of pandemic-era enhancements and provider rate increases** designed to stabilize provider capacity in the context of the challenges presented by the pandemic, including the impact of relatively high inflation.
4. **The ability to expedite financial eligibility based on self-attestation, along with presumptive disability determinations were effective in ensuring rapid access to LTSS services.** Testing this process during the COVID-19 PHE provided additional data to support implementation of presumptive eligibility in Washington State.

Background

On January 20, 2020, the first confirmed case of the coronavirus disease 2019 (COVID-19) in the United States was in discovered in a man living in Snohomish County in Washington State. On February 29, 2020, the Center for Disease Control and Prevention (CDC) and Washington Department of Public Health made the first announcement of a death from COVID-19 in the United States. The same day, Governor Jay Inslee declared a state of emergency in response to new cases of COVID-19. Several measures were implemented to prevent and control the spread of COVID-19 such as vaccinations; closing schools, businesses, and restaurants; a stay-at-home order; social distancing; and a mask mandate. Under the Governor's Stay Home, Stay Healthy order issued in March 2020, Washingtonians were asked to stay home and sequester themselves, limit contact with non-family members, switch to telework where feasible, and only leave their home for essential tasks such as grocery shopping and medical appointments.

The COVID-19 pandemic in Washington State has had disproportionate impact on people of color and other historically marginalized communities. A report conducted by the Washington State Department of Health found disparities between people of color and white people in the areas of confirmed or probable case, hospitalization, and death rates. Native Hawaiian and Pacific Islander (NHPI) and American Indian or Alaska Native (AI/AN), Black, and Hispanic or Latino populations had significantly higher COVID-19 age-adjusted rates and deaths compared Asian, White, and multiracial populations. Hospitalizations are the highest among NHPI population, being approximately five times higher than white populations. The rate was approximately two times higher than White populations among Hispanic or Latino, Black, and AI/AN populations (Washington State Department of Health, 2023). A study in King County also found that communities with a low socioeconomic status and existing health disparities faced high rates of COVID-19 and are least equipped to combat its health and financial consequences (Ingram et al., 2022).

Impact of the COVID-19 PHE on Washington's Long-Term Services and Supports System

The COVID-19 pandemic has profoundly altered the environment for delivering Medicaid-funded LTSS services, by pushing this system that was operating at a deficit prior to the pandemic well past its capacity to provide care. LTSS services include personal care, residential care, and institutional care for persons with physical, cognitive, developmental, or intellectual disabilities. These services encompass a broad range of paid medical and personal care services that assist with instrumental activities of daily living such as eating, bathing, housekeeping, and managing medication(s). These services may be needed for several weeks, months, or years.

The enormous number of COVID-19 cases requiring hospitalization and long-term care as well as the associated death toll created significant strain on hospitals and the systems delivering LTSS services. Near the beginning of the pandemic, within the span of a few days after the outbreak and spread of COVID-19 among nursing facilities, the existing LTSS system saw dramatic changes as providers closed their doors, clients refused to allow their care providers to enter their home, and home care aides were afraid to go to work and provide personal care services in their client's homes. Severe impacts on nursing facilities' ability to provide care cycled additional burden back to acute care hospitals who were already struggling to keep beds available for the influx of patients coming through their doors. There were limited options for the discharge of patients who needed longer-term but less-intensive care. A similar story unfolded with an outbreak of COVID-19 at the largest state psychiatric hospital; there was increased demand on the LTSS system to decrease the patient count at the hospitals. The community, including the Washington State Hospital Association, looked to the state for ways to transition patients rapidly out of acute care settings to make way for new patients entering the hospitals. The strategies used by the state to help alleviate this problem are described in the "COVID-19 Disaster 1115 Waiver" section.

Though the COVID-19 PHE has been officially ended, the numbers of COVID-19 cases, deaths and resources needed for patient care highlight the severity of the impact the PHE had on these systems. According to Washington State Department of Health data as of September 2023, there have been 1.98 million confirmed cases of COVID-19 in Washington. Additionally, around 88,000 people in the state have been hospitalized and around 16,000 deaths have occurred due to COVID-19 with nursing facilities bearing the brunt of the mortalities. The number of beds in use by COVID-19 patients was at its highest in January and February 2022, with an average 7-day count of 2191 beds in use making up 27 percent of hospital capacity (Respiratory Illness Dashboard, 2024).

The pandemic also highlighted ongoing challenges for LTSS delivery systems. According to the Kaiser Family Foundation, every one in five COVID-19 deaths has occurred in a long-term care facility such as nursing homes and assisted living facilities (Chidambaram & Burns, 2022). During the pandemic, the LTSS workforce decreased through 2021 and into the beginning of 2022. Between February 2020 and June 2022, the number of workers dropped by 14% in nursing care facilities and by 9% in community elder care facilities. In July 2022, home care agencies reported challenges in staffing and recruiting new staff and one in four certified nursing facilities reported a shortage of nurses and aides.

COVID-19 Disaster 1115 Waiver

Washington's LTSS system relies on a combination of 1915(c) and 1915(k) federal authorities that provide the state flexibilities in design of Medicaid programs including administration of LTSS services Section 1915(c) of the Social Security Act refers to the Medicaid Home-and Community-Based Services (HCBS) waiver program. Through this program, states can waive certain Medicaid program requirements to provide care and targeted services to people who need LTSS services (e.g., people with disabilities and chronic conditions) who might not otherwise be eligible under Medicaid (Centers for Medicare and Medicaid Services, 2023). Section 1915(k) of the Social Security Act refers to the Community First Choice option. Community First Choice allows states to provide home and community-based attendant services and supports to eligible Medicaid enrollees (Centers for Medicare and Medicaid Services, n.d.).

Responding to the COVID-19 crisis required the state to deliver services differently. Although the state already had eight approved federal waivers and had received other COVID-19 PHE-related waivers and amendments (Appendix K and 1135 waiver) earlier in 2020, these did not enable flexibilities needed for most of Washington's personal care services that are provided under 1915(k) Community First Choice. The Centers for Medicare and Medicaid Services provided this flexibility, and on April 21, 2020, with immense gratitude and relief, Washington became the first state in the nation to be approved for a COVID-19 Disaster 1115 waiver. This disaster waiver, the Washington COVID-19 Public Health Emergency (PHE) Demonstration (11-W-00345/0), referred to as "the 1115 waiver" or "the waiver" for the remainder of this report, was effective from March 1, 2020, through July 10, 2023 (60 days after the end of the PHE).

The 1115 waiver assisted Washington in promoting the objectives of the Medicaid statute and was expected to help the state furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19. Washington had the following main objectives under this 1115 waiver:

1. **Ensuring that eligibility determinations for clients discharging from acute care and state psychiatric hospitals were not delayed by lengthy disability determinations.** Acute care hospitals struggled with patients who faced barriers to discharge, but no longer met medical necessity criteria for an acute care setting. When a hospital patient has a functional impairment and needs personal care assistance with their daily living activities, they are referred to the Department of Social and Health Services (DSHS) for an eligibility assessment for LTSS services. The COVID-19 PHE intensified the critical need to discharge these patients expeditiously to ensure

hospital network adequacy for treatment of COVID-19 patients, and those in need of emergency and intensive care services during the ongoing outbreak. This goal targeted hospital patients who were discharging to Home and Community Services (HCS) who required a disability determination. Washington used the authority under the 1115 waiver to accept self-attestation for income and resources and in making disability determinations for these Medicaid applicants.

2. **Ensuring that Medicaid clients had continuity of care and did not go without needed LTSS services.** As a result of Governor Inslee's Stay Home, Stay Healthy order[1], many LTSS clients could no longer leave their homes to mail documents, staff could not complete in-person assessments except in emergency situations, and it was difficult to connect with many clients who did not have access to the internet or have enough cell phone minutes to complete the full assessment over the phone. Clients were also being moved rapidly from acute care hospitals to nursing facilities, and then into residential settings or returning home, making it extremely difficult to keep a plan of care up to date. The state asked for expenditure authority to authorize (1) services when the plan of care could not be updated in a timely manner during the pandemic and (2) services when a functional re-assessment could not be completed within a year because of the pandemic. The state was granted the flexibility to temporarily reduce or delay functional assessments to determine level of care and Person-Centered Care Plans for beneficiaries needing LTSS services.
3. **Ensuring the viability of Washington's LTSS providers.** Providers are the backbone of the LTSS service delivery system, and it was critical for the state to help ensure providers would be able to continue delivering services throughout the pandemic and its aftermath. Providers experienced a significant increase in costs with the implementation of infection control procedures and the need for personal protective equipment for staff and clients, while at the same time experiencing a rapid decrease in clients due to COVID-19. The state used a two-pronged approach to direct funding to LTSS providers received by Washington under the CARES Act and Families First Coronavirus Response Act by increasing provider rates and authorizing retainer payments.

1115 Wavier-based Strategies for Supporting Washington's LTSS System

Home-and Community-Based Services (HCBS) Rates

Washington State used the additional flexibility under the 1115 waiver to provide higher rates for HCBS providers to maintain capacity. To that end, the state identified key provider types at greatest risk of being adversely affected by the pandemic, to the extent that these providers would be unable to continue providing essential services. The state provided higher rates to preserve the network of these key providers and ensure essential services remained available through the pandemic and after.

Retainer Payments

Retainer payments are temporary payments intended to preserve the financial viability of providers during disruptions in care (Medicaid and CHIP Payment and Access Commission, 2021). These payments are not tied to specific services used by Medicaid enrollees, unlike most types of Medicaid payments. Many states used retainer payments authorities as a source of relief for HCBS providers experiencing decreased service utilization, temporary practice closures, or other circumstances that limited their ability to provide covered services to Medicaid beneficiaries. Washington State used the additional flexibility under the 1115 waiver to provide retainer payments to certain habilitation and personal care providers to maintain capacity. To that end, the state identified providers at greatest risk of insolvency due to forced closure or loss of clientele directly due to the pandemic. The state provided retainer payments to these key provider types to overcome the challenges of clients being absent for a long period of time and the corresponding financial impact this would have on the

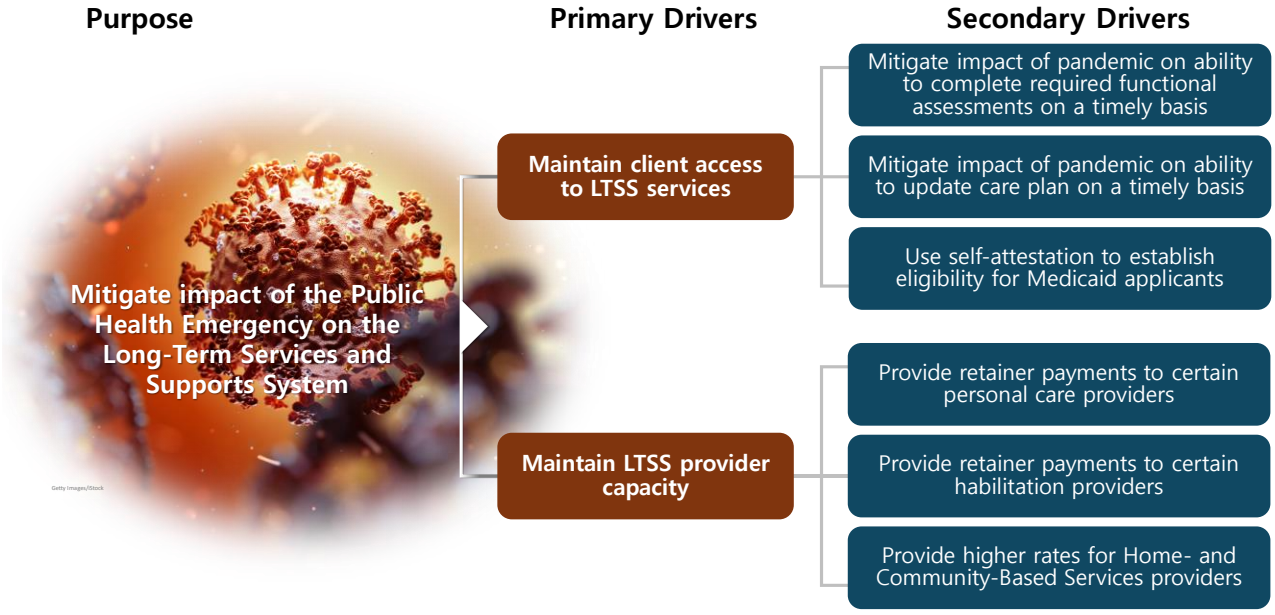
[1] https://governor.wa.gov/news/2020/inslee-announces-stay-home-stay-healthy-order#:~:text=This%20proclamation%20will%3A,all%20businesses%20except%20essential%20businesses.

provider's viability. This was particularly important for congregate and residential settings; the state was concerned that if these providers closed due to prolonged client absences related to COVID-19, there would be significant delays in discharging individuals who were admitted to acute care or psychiatric hospitals.

Study Design

This analysis examines if the state's strategies to mitigate the impact of the PHE on LTSS provider capacity and client access to services were successful. Specifically, we will examine LTSS caseload trends and expenditures pre- and post-PHE across a range of LTSS services, including services for persons with physical, cognitive, developmental, or intellectual disabilities (as described in the Methodology section). The Driver Diagram below illustrates the logic linking the authorities pursued under the 1115 waiver (Secondary Drivers) with the waiver goals of maintaining beneficiary access to LTSS services and LTSS provider capacity (Primary Drivers). While we will not attempt to formally evaluate the direct impact of specific, individual authorities pursued to mitigate the impact of the PHE, we will provide an assessment of the relationship between the authorities used under the 1115 waiver and the overall impact achieved in stabilizing LTSS provider networks and caseloads.

FIGURE 1.
Driver Diagram



LTSS Service Utilization Data

Data from the state's Caseload Forecast Council[2] (CFC) were used to examine trends in service utilization and expenditures from January 2018 to July 2023, a few months after the end of the PHE. The CFC is the state's official body for determining caseload forecasts for state budget purposes. CFC forecasts are updated three times per year on a February, June, and November cadence. Data for this analysis reflects historical actual caseload data for affected LTSS programs and services from the November 2023 CFC forecast. Service utilization trends were calculated for nursing home, community residential (includes adult family homes, assisted living centers, and adult residential care), and in-home personal care services (include agency providers, individual providers, and PACE recipients). In addition, separate trends were calculated for DSHS ALTSA and DSHS DDA programs.

[2] For more information, see https://cfc.wa.gov/.

LTSS Expenditures Data

The state maintains a comparable "per-cap" forecast process providing per-served-client, per-month expenditure data for the caseloads forecasted by the CFC. "Actuals" from the per-cap forecast process were combined with caseload "actuals" to provide monthly LTSS expenditure trend data, for the service categories previously identified.

We emphasize that expenditure metrics will focus on ALTSA and DDA LTSS services (including 1115 waiver-related expenditures), and will not include medical, mental health, or substance use disorder treatment services provided through the Washington State Health Care Authority. There are two main reasons for this approach. First, the goals of the waiver focused on stabilizing LTSS delivery systems. Second, most of the waiver population is dually eligible for Medicare, and the majority of non-LTSS health care costs for the demonstration population are Medicare-paid.

Based on these considerations, we are focusing expenditure measures on LTSS services. We calculated an overall LTSS expenditure and per-cap expenditure trend, an ALTSA-specific LTSS expenditure and per-cap expenditure trend, and a DDA-specific LTSS expenditure and per-cap expenditure trend.

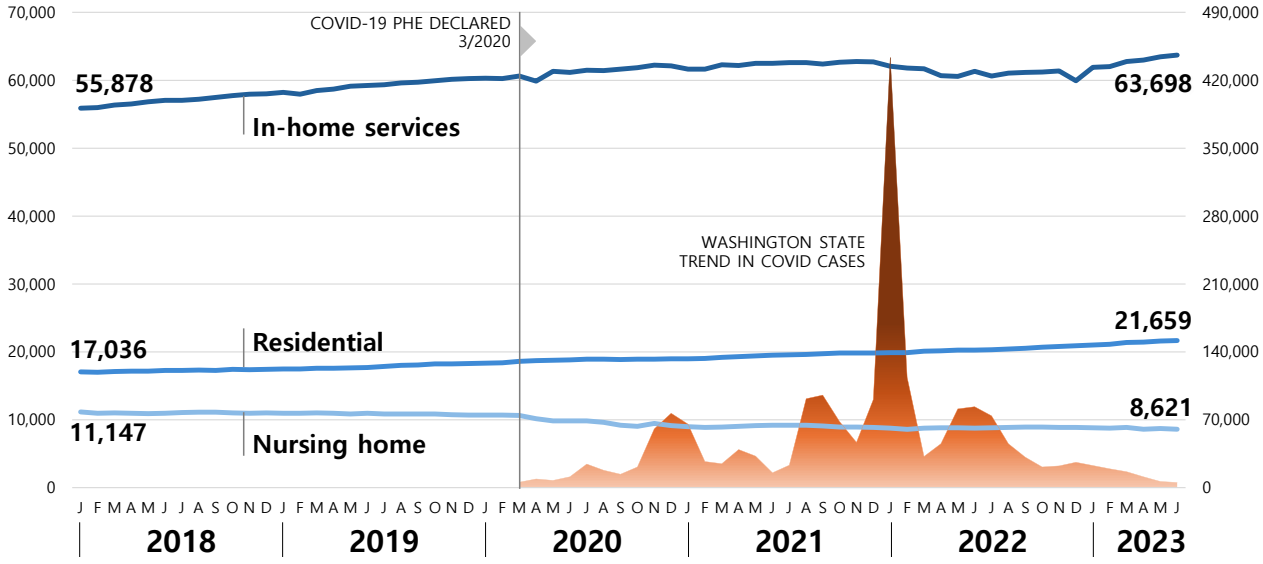
Findings

Overall, we found that, after an initial decline in service utilization, the use of LTSS services across ALTSA and DDA remained consistent with pre-COVID-19 trends (see Appendix Table A for monthly client counts). This suggests that the strategies employed under the waiver were successful at stabilizing the Washington State LTSS systems throughout the COVID-19 PHE.

Statewide LTSS Service Utilization Trends. Figure 2 (below) illustrates the combined ALTSA and DDA monthly counts of service utilization by modality (in-home services, residential services, and nursing homes) overlayed with Washington State COVID-19 cases. Prior to the COVID-19 PHE, the utilization trend of in-home services was steadily increasing. In the months following the declaration of the PHE, there was a temporary decrease in the use of in-home services. Utilization of in-home services returned to pre-PHE trends until the large increase in COVID-19 cases that occurred in late 2021/early 2022. This resulted in a sustained decrease in in-home service utilization until January 2023 when utilization returned to pre-PHE trends.

FIGURE 2.

LTSS Service Utilization Trends (January 2018 – July 2023)



The use of residential services was less impacted by the COVID-19 PHE. Continuing the pre-PHE trend, there was a steady increase in the use of residential services. More recent months show a slightly accelerating trend, which may be in part due to continued emphasis on increasing use of residential care settings for persons with significant behavioral health needs. As shown in Figure 2, prior to the PHE, nursing home utilization was slowly declining, reflecting the ongoing efforts of the State to increase use of home- and community-based care settings. However, the COVID-19 pandemic appears to have accelerated this trend, particularly in the first year of the PHE.

ALTSA LTSS Service Utilization Trends. Figure 3 shows monthly counts of ALTSA-based LTSS service utilization by modality. These trends are consistent with the overall statewide trends.

FIGURE 3.
ALTSA Service Utilization (January 2018 – July 2023)

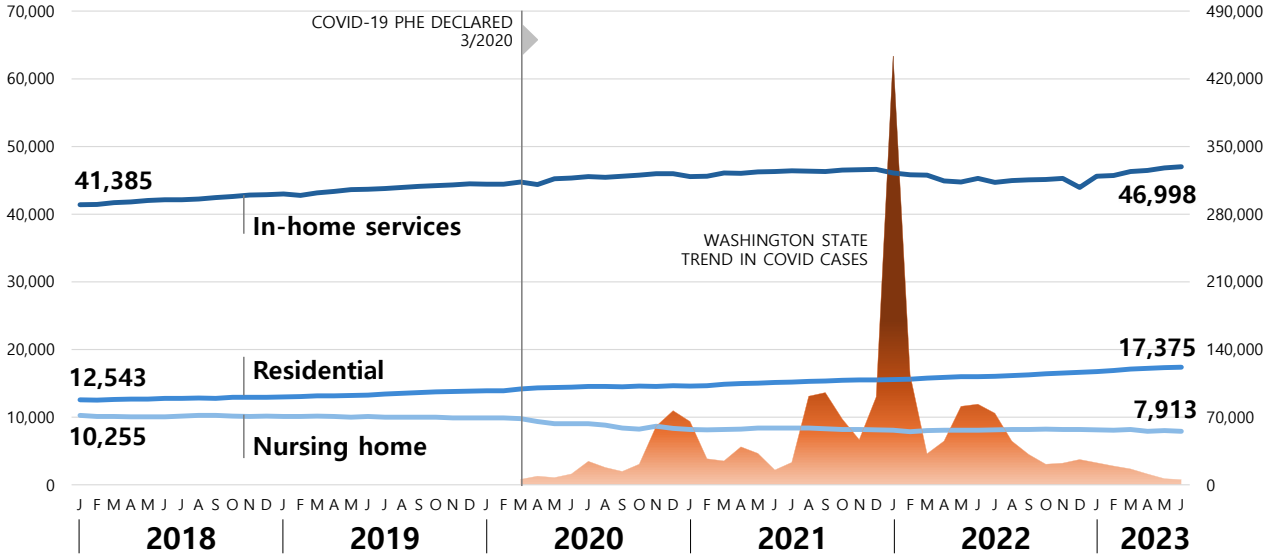
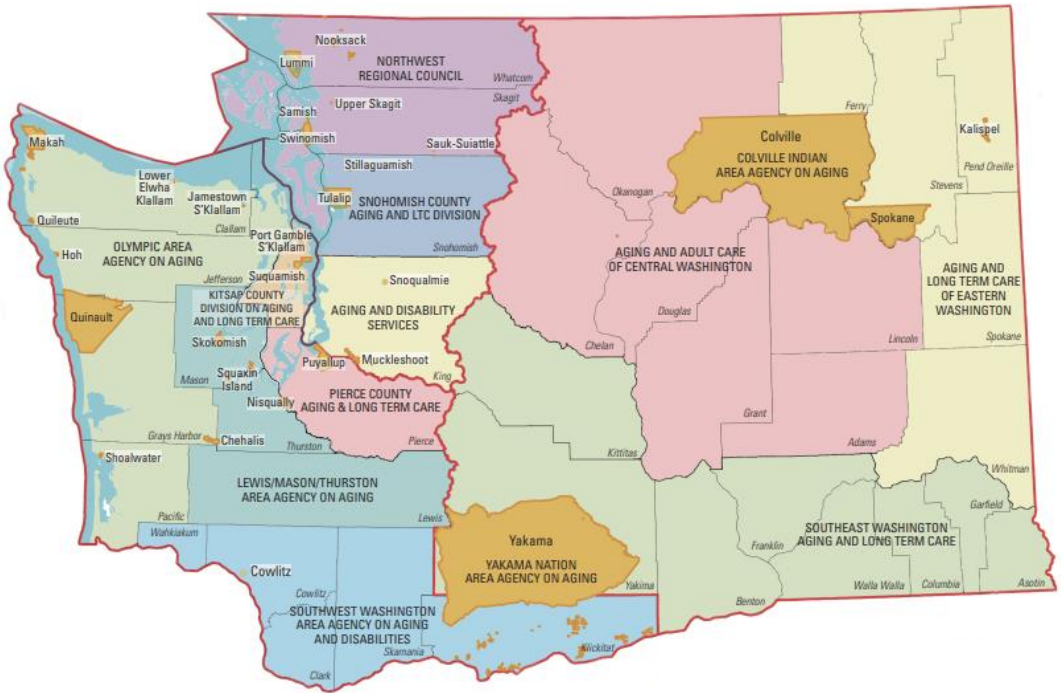


FIGURE 4.
Federally Recognized Washington State Tribes and Area Agencies on Aging



SOURCE: Washington State Department of Social and Health Services, Aging and Long Term Supports Administration, November 2019

Figures 5 and 6 highlight the geographic variation in overall ALTSA LTSS service use by region. Regions are defined by Area Agency on Aging service areas. All LTSS service modalities are combined in Figures 4 and 5 to preserve the confidentiality of clients in regions where there is a small population of eligible beneficiaries and/or low utilization of some services. In addition, due to differences in population sizes, utilization in the King County ALTSA Disability and Aging Services region is shown in a separate figure (Figure 5). The remaining ten regions and two tribal regions in the state are shown in Figure 5. Consistent with statewide trends, utilization of ALTSA LTSS services in the King County region decreased at the start of the PHE but returned to pre-COVID utilization trends by the end of the PHE.

FIGURE 5.

King County ALTSA Disability and Aging Services Utilization

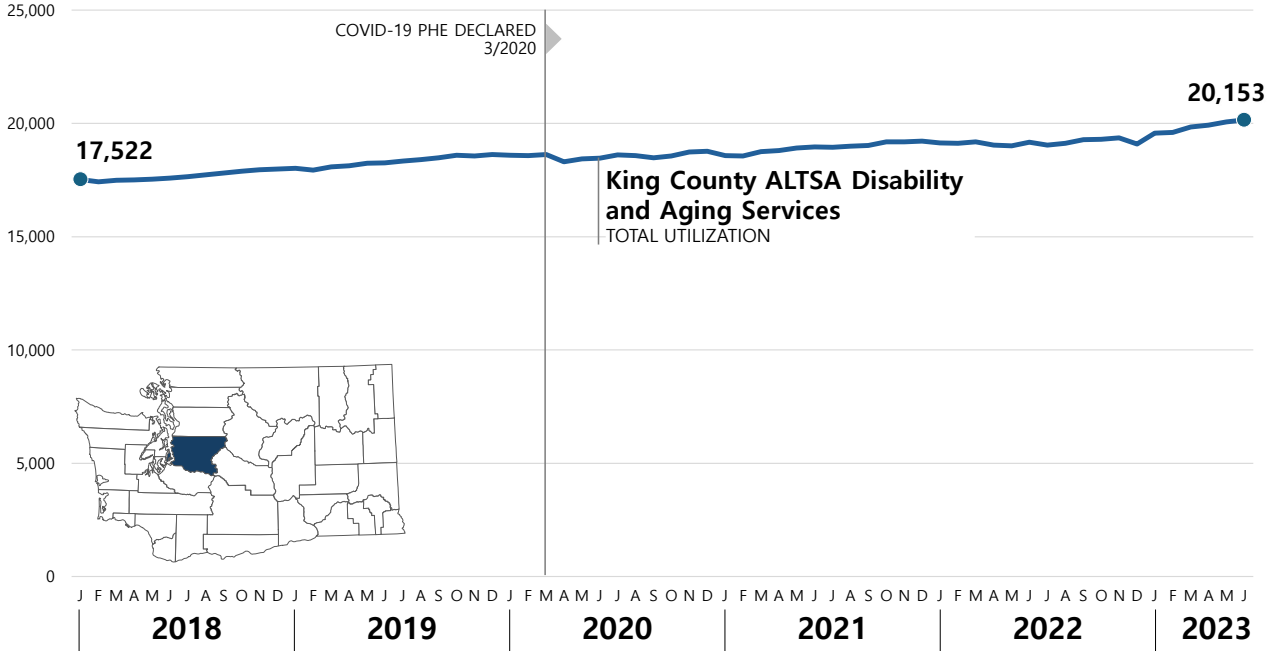
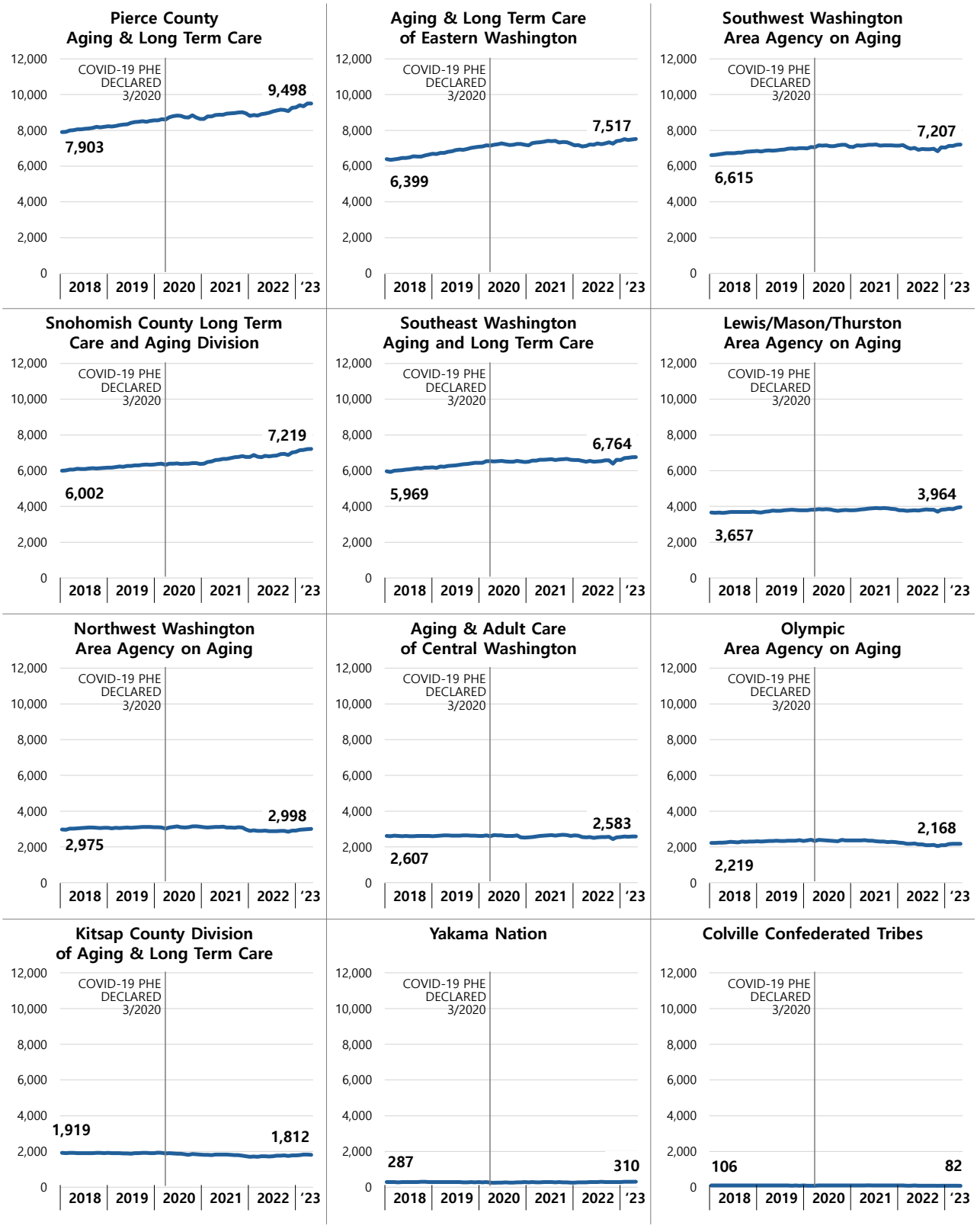


Figure 6 (next page) shows the ALTSA service utilization trends for the remaining regions. Seven regions had trends that were consistent with statewide trends – an initial decrease at the start of the PHE with an overall increase in LTSS service use by the end of the PHE. The magnitude of the increase in service utilization is likely tied to the overall size of the population in the region. The service utilization trend in two regions, Lewis/Mason/Thurston Area Agency on Aging and Northwest Washington Area Agency on Aging, was flat (minimal change from the pre-COVID time period through the end of the PHE). Three regions had a slight downward trend in the LTSS utilization. In addition, the two tribal-based regions also saw little change or a slight decrease in LTSS service utilization.

It is important to note that the seven regions that had flat or decreasing trends are rural regions. The ratio of working age persons to persons 85 and above (who have a much larger propensity to need LTSS) varies greatly among urban, suburban, and rural regions. While all regions will be impacted by the Age Wave (the rapid growth in the population of elders) over the next 20 years, the timing and magnitude of the impact will differ across urban, suburban, and rural areas. Rural regions are already experiencing the reduced ratio of "prime age" workforce to elder populations that the urban regions won't experience until approximately 2040. Those demographic challenges have particularly impacted the ability of rural regions to increase provider capacity to meet the need for Medicaid LTSS services.

FIGURE 6.

ALTSA LTSS Service Utilization by Region

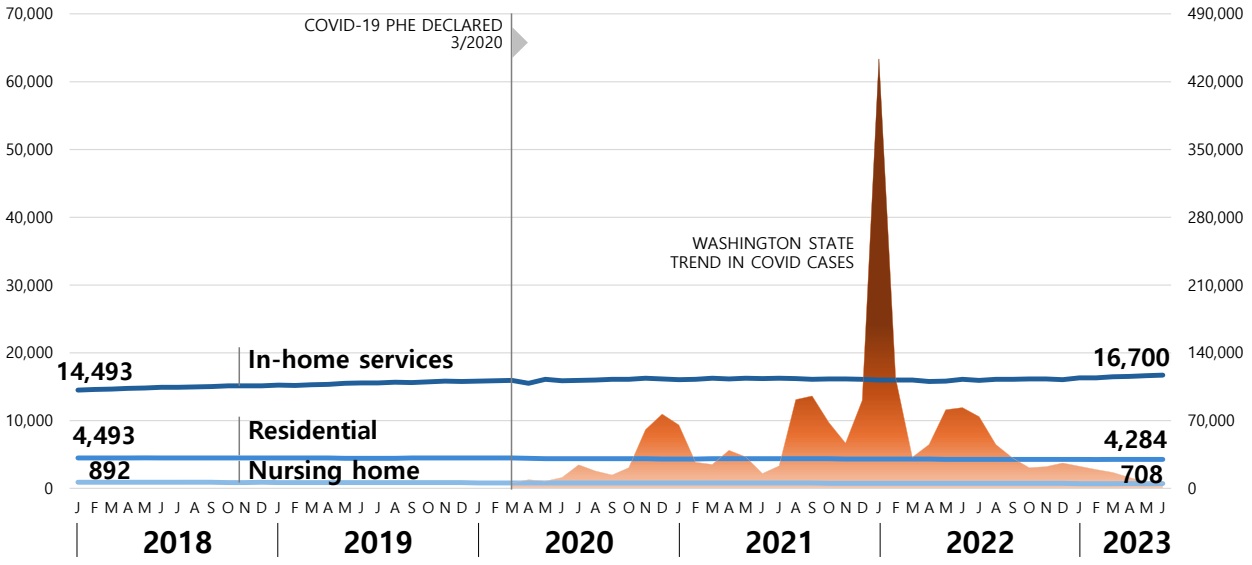


Additional ALTSA LTSS service utilization trends by client demographics are available in the Appendix. Appendix A contains monthly ALTSA client counts by modality and gender. Appendix B contains monthly ALTSA client counts by modality and age. Appendix C-E contains monthly ALTSA client counts by modality and race/ethnicity.

DDA LTSS Service Utilization. Figure 7 illustrates the trends in DDA LTSS service utilization by modality. Prior to the COVID-19 PHE, the utilization of in-home services was increasing slightly. Similar to ALTSA LTSS trends, in the months following the PHE declaration, there was a slight decrease in the use of in-home services, followed by a return to pre-PHE trends in late 2020.

In contrast to ALTSA, DDA residential and nursing home service utilization remained relatively stable throughout the PHE. The slower long-term growth rate in use of DDA LTSS services, relative to ALTSA LTSS services, in part reflects underlying differences in demographic growth of the populations served by the two programs. That is, the Age Wave is increasing the proportion of the population aged 75 and above, which has greater impact on the need for ALTSA LTSS services, relative to DDA LTSS services. This is in part due to the relatively low life expectancy among persons with intellectual and developmental disabilities.

FIGURE 7.
DDA Service Utilization (January 2018 – July 2023)



Total and Per Cap Expenditures. Figure 8 shows the total and per cap expenditures for ALTSA LTSS services from January 2018 to July 2023. Expenditure trends show the impact of pandemic-era enhancements and provider rate increases designed to stabilize provider capacity in the context of the challenges presented by the pandemic, including the impact of relatively high inflation in the pandemic period. Most direct care workers in Washington State are unionized and LTSS payment rates are determined in part through collective bargaining processes. The minimum wage in Washington State is indexed to inflation, and Washington currently has the highest statewide minimum wage of any state in the country.

FIGURE 8.

ALTSA Total and Per Cap Expenditures

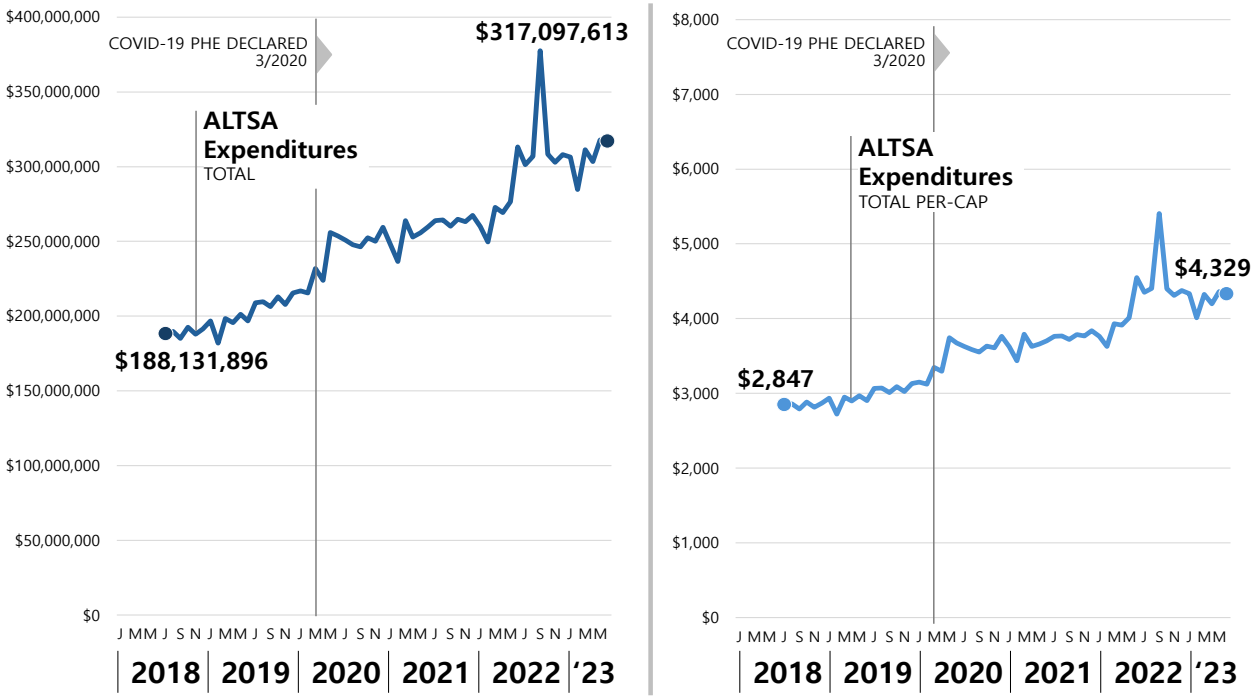
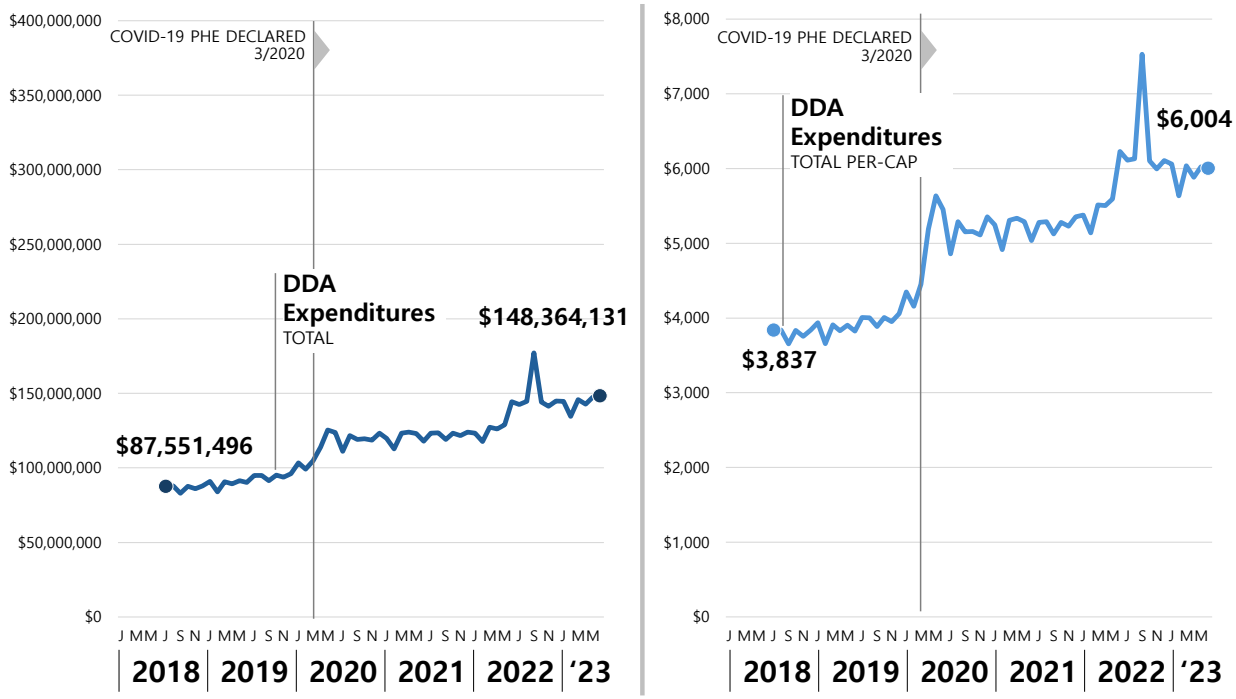


Figure 9 shows the total and per-cap expenditures for DDA LTSS services from January 2018 to July 2023.

FIGURE 9.

DDA Total and Per-Cap Expenditures



Policy Implications

The importance of LTSS during the pandemic cannot be overstated – with hospitals at capacity the LTSS system became a primary means for patients to leave the hospitals. In addition, with many patients being unwilling to discharge into nursing homes, in-home and residential services became the option of choice, and WA saw a significantly lower rate of death in these settings. This was a similar experience with our state psychiatric hospitals where Washington experienced frequent surges of clients needing to leave the hospital to provide capacity for an increasing number of individuals with intense behaviors and mental health related needs.

The authority to use self-attestation methodologies for both income and resources, along with self-attested disability status was a critical tool used by the state to address constant pressure to move clients rapidly out of acute care settings and local and state psychiatric hospitals. Using these streamlined eligibility processes also provided a testing ground for conversations with CMS that led to the approval and creation of a new presumptive eligibility model for LTSS clients in July 2023 under the Medicaid Transformation Project 1115 waiver.

While increased rates did help ensure Washington maintained a viable provider network, retainer payments had limited impact due to the short duration of the benefit and inability to provide multiple retainer payment periods. Although CMS subsequently approved a second 30-day retainer payment option, the strict requirements related to staffing levels meant there was limited uptake from providers.

Finally, the effects on staffing levels at ALTSA were catastrophic due to the imposition of a vaccine mandate on all state employees. This caused many staff to leave state employment and find work in other areas or out of state. The flexibility provided under the COVID-19 disaster 1115 waiver to temporarily reduce or delay functional assessments when the plan of care could not be updated in a timely manner during the pandemic, and to extend services when a functional re-assessment could not be completed within a year because of the pandemic was not only incredibly impactful to our beneficiaries, but also enabled the smaller workforce to manage workload and focus efforts on other COVID-19 related efforts.

APPENDIX TABLE A.

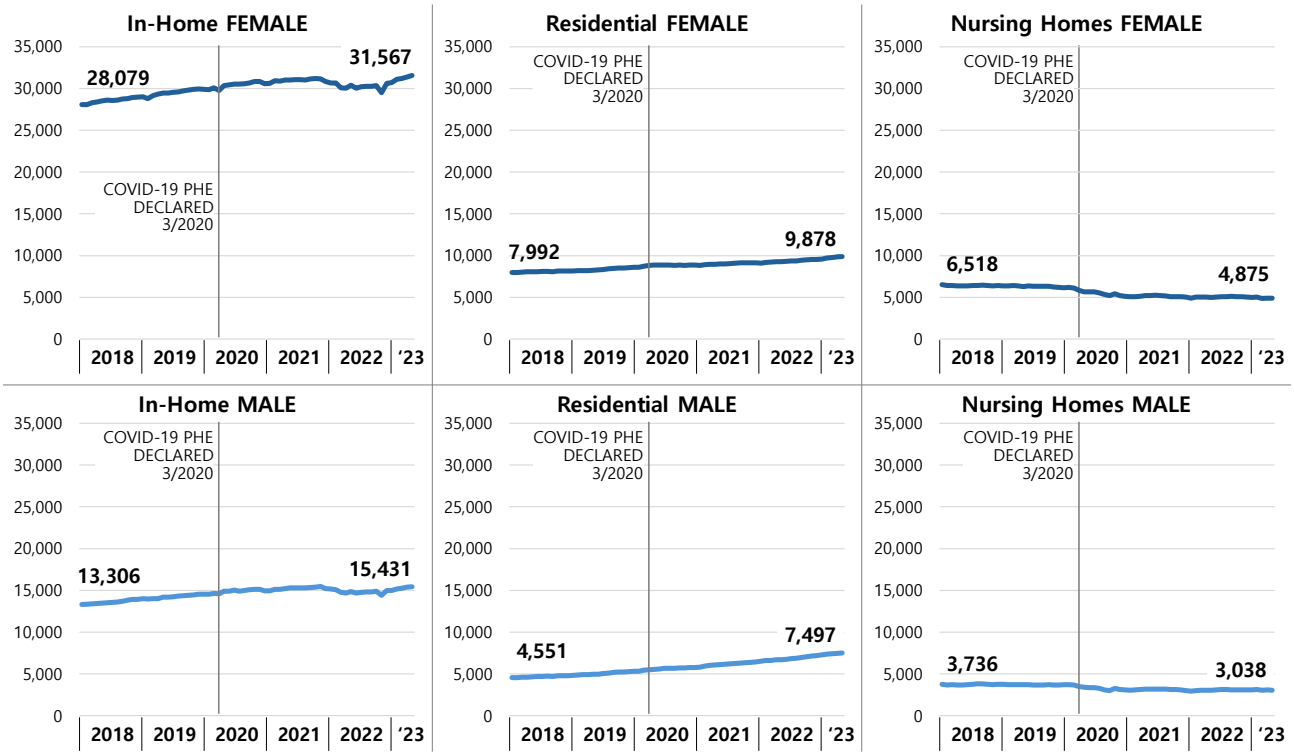
Monthly Service Counts by Modality January 2018 – June 2023

Month	ALTSA In-Home	ALTSA Residential	ALTSA Nursing Home	ALTSA Total	DDA Personal Care	DDA Residential	DDA Nursing Home	DDA Total
2018-01	41,385	12,543	10,255	**64,183**	14,493	4,493	892	**19,878**
2018-02	41,399	12,510	10,070	**63,979**	14,586	4,479	886	**19,951**
2018-03	41,714	12,634	10,110	**64,458**	14,644	4,478	893	**20,015**
2018-04	41,793	12,658	10,052	**64,503**	14,721	4,483	894	**20,098**
2018-05	42,034	12,683	10,029	**64,746**	14,787	4,495	890	**20,172**
2018-06	42,117	12,748	10,044	**64,909**	14,915	4,491	894	**20,300**
2018-07	42,109	12,765	10,153	**65,027**	14,921	4,482	896	**20,299**
2018-08	42,244	12,827	10,234	**65,305**	14,950	4,488	901	**20,339**
2018-09	42,462	12,784	10,243	**65,489**	14,998	4,485	889	**20,372**
2018-10	42,621	12,912	10,150	**65,683**	15,096	4,485	869	**20,450**
2018-11	42,819	12,908	10,089	**65,816**	15,144	4,478	864	**20,486**
2018-12	42,894	12,949	10,145	**65,988**	15,126	4,465	874	**20,465**
2019-01	42,998	12,987	10,113	**66,098**	15,220	4,470	860	**20,550**
2019-02	42,756	13,036	10,082	**65,874**	15,193	4,462	868	**20,523**
2019-03	43,159	13,121	10,135	**66,415**	15,301	4,463	870	**20,634**
2019-04	43,345	13,118	10,072	**66,535**	15,350	4,465	871	**20,686**
2019-05	43,634	13,187	9,993	**66,814**	15,506	4,445	864	**20,815**
2019-06	43,662	13,255	10,072	**66,989**	15,551	4,441	868	**20,860**
2019-07	43,782	13,407	10,002	**67,191**	15,573	4,448	865	**20,886**
2019-08	43,939	13,536	9,985	**67,460**	15,640	4,455	862	**20,957**
2019-09	44,104	13,627	9,973	**67,704**	15,602	4,459	847	**20,908**
2019-10	44,231	13,734	10,008	**67,973**	15,685	4,467	844	**20,996**
2019-11	44,335	13,763	9,908	**68,006**	15,807	4,470	824	**21,101**
2019-12	44,473	13,814	9,883	**68,170**	15,768	4,467	825	**21,060**
2020-01	44,444	13,865	9,864	**68,173**	15,843	4,463	815	**21,121**
2020-02	44,415	13,899	9,889	**68,203**	15,851	4,457	820	**21,128**
2020-03	44,715	14,158	9,795	**68,668**	15,907	4,459	811	**21,177**
2020-04	44,357	14,299	9,340	**67,996**	15,514	4,422	801	**20,737**
2020-05	45,245	14,381	9,040	**68,666**	16,071	4,400	802	**21,273**
2020-06	45,333	14,434	9,013	**68,780**	15,845	4,399	806	**21,050**
2020-07	45,537	14,528	9,000	**69,065**	15,942	4,390	810	**21,142**
2020-08	45,454	14,511	8,798	**68,763**	15,980	4,390	805	**21,175**

Month	ALTSA In-Home	ALTSA Residential	ALTSA Nursing Home	ALTSA Total	DDA Personal Care	DDA Residential	DDA Nursing Home	DDA Total
2020-09	45,577	14,480	8,384	**68,441**	16,058	4,371	796	**21,225**
2020-10	45,731	14,564	8,216	**68,511**	16,096	4,366	791	**21,253**
2020-11	45,984	14,559	8,674	**69,217**	16,223	4,361	785	**21,369**
2020-12	45,984	14,633	8,344	**68,961**	16,152	4,343	783	**21,278**
2021-01	45,564	14,612	8,194	**68,370**	16,049	4,346	782	**21,177**
2021-02	45,578	14,660	8,092	**68,330**	16,067	4,338	781	**21,186**
2021-03	46,055	14,857	8,153	**69,065**	16,239	4,352	784	**21,375**
2021-04	46,002	14,948	8,243	**69,193**	16,145	4,364	786	**21,295**
2021-05	46,232	15,038	8,377	**69,647**	16,240	4,370	780	**21,390**
2021-06	46,313	15,123	8,387	**69,823**	16,184	4,378	783	**21,345**
2021-07	46,387	15,162	8,383	**69,932**	16,227	4,370	780	**21,377**
2021-08	46,360	15,255	8,407	**70,022**	16,216	4,371	777	**21,364**
2021-09	46,316	15,359	8,302	**69,977**	16,086	4,363	768	**21,217**
2021-10	46,520	15,453	8,175	**70,148**	16,149	4,355	751	**21,255**
2021-11	46,579	15,473	8,175	**70,227**	16,152	4,345	749	**21,246**
2021-12	46,621	15,497	8,133	**70,251**	16,104	4,328	744	**21,176**
2022-01	46,083	15,570	8,043	**69,696**	15,997	4,309	740	**21,046**
2022-02	45,822	15,587	7,845	**69,254**	15,982	4,297	737	**21,016**
2022-03	45,739	15,775	8,023	**69,537**	15,951	4,304	734	**20,989**
2022-04	44,890	15,849	8,078	**68,817**	15,766	4,298	730	**20,794**
2022-05	44,731	15,950	8,081	**68,762**	15,816	4,282	725	**20,823**
2022-06	45,263	15,977	8,039	**69,279**	16,062	4,278	725	**21,065**
2022-07	44,708	16,043	8,100	**68,851**	15,901	4,274	725	**20,900**
2022-08	44,973	16,141	8,166	**69,280**	16,069	4,286	723	**21,078**
2022-09	45,036	16,227	8,190	**69,453**	16,102	4,280	721	**21,103**
2022-10	45,099	16,392	8,198	**69,689**	16,118	4,274	718	**21,110**
2022-11	45,249	16,505	8,162	**69,916**	16,112	4,282	715	**21,109**
2022-12	43,920	16,644	8,150	**68,714**	16,024	4,270	718	**21,012**
2023-01	45,597	16,736	8,114	**70,447**	16,309	4,254	709	**21,272**
2023-02	45,681	16,872	8,045	**70,598**	16,313	4,253	711	**21,277**
2023-03	46,298	17,090	8,145	**71,533**	16,452	4,261	712	**21,425**
2023-04	46,426	17,182	7,899	**71,507**	16,527	4,254	708	**21,489**
2023-05	46,799	17,308	7,990	**72,097**	16,633	4,257	713	**21,603**
2023-06	46,998	17,375	7,913	**72,286**	16,700	4,284	708	**21,692**

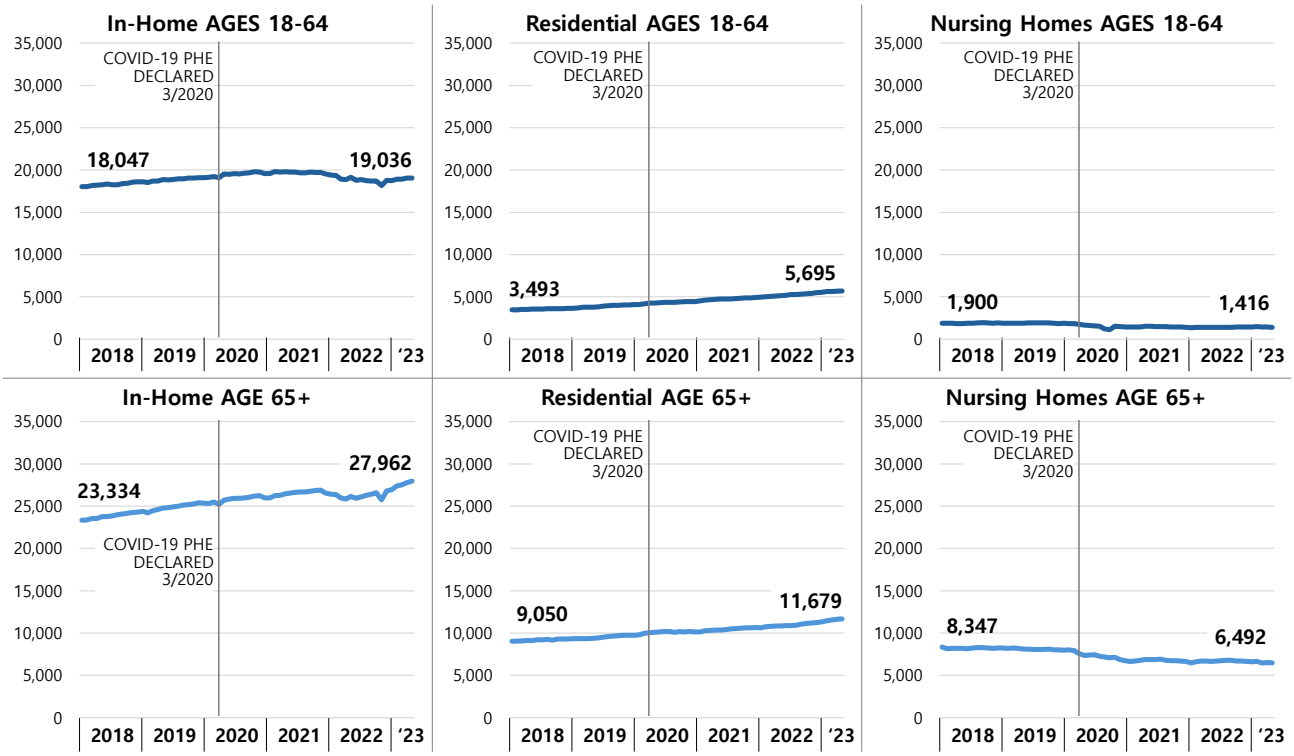
APPENDIX FIGURE A.

ALTSA Monthly Clients by Modality and Gender



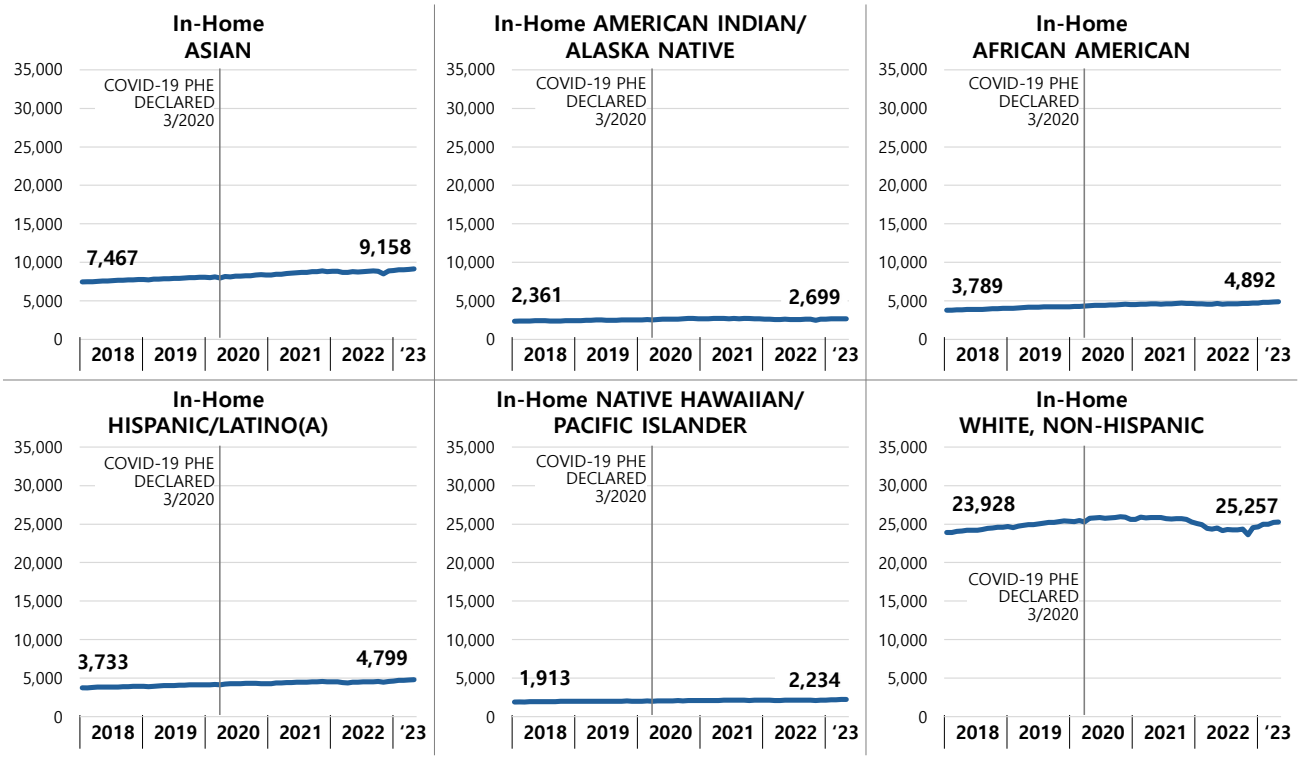
APPENDIX FIGURE B.

ALTSA Monthly Clients by Modality and Age



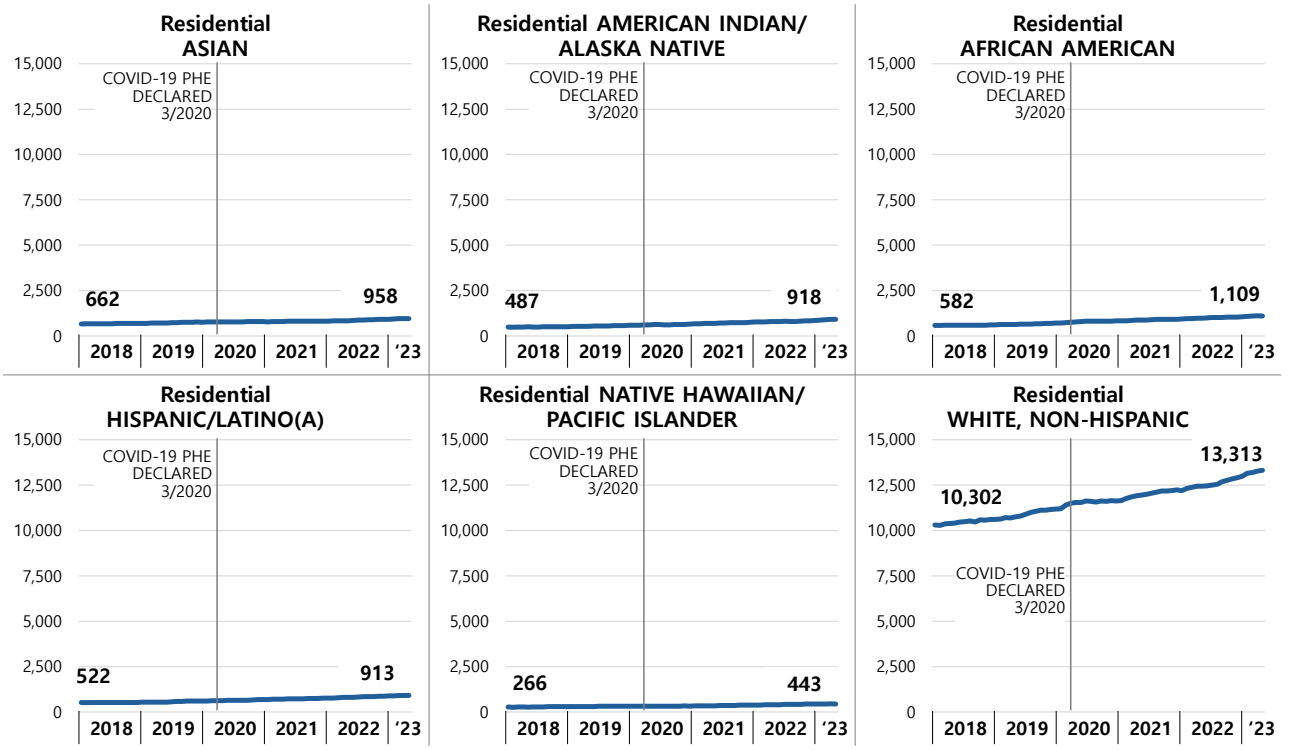
APPENDIX FIGURE C.

ALTSA Monthly In-Home Clients by Race/Ethnicity



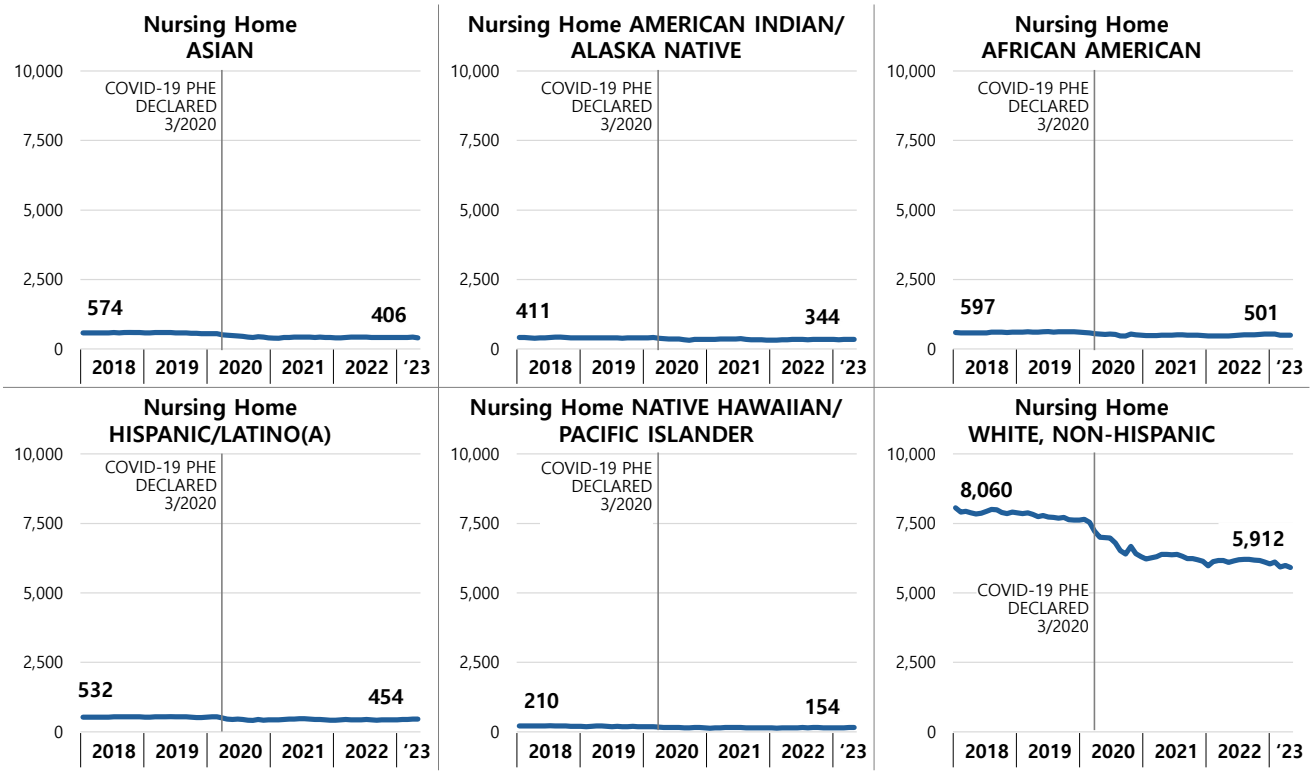
APPENDIX FIGURE D.

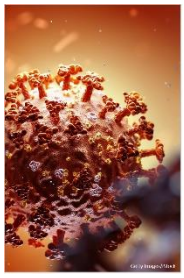
ALTSA Monthly Residential Clients by Race/Ethnicity



APPENDIX FIGURE E.

ALTSA Monthly Nursing Home Clients by Race/Ethnicity





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